DOUBLE EFFECT IN THE *CRIMINAL CODE 1899* (QLD): A CRITICAL APPRAISAL

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I INTRODUCTION

In Queensland, the *Criminal Code 1899* (Qld) has been recently amended to excuse 'a person' from criminal responsibility if, as a result of providing palliative care to a terminally ill patient, he or she should incidentally hasten a patient's death.[1] The amending legislation has been described as 'a statutory enactment of the "double effect" principle for palliative care'.[2] This paper considers the doctrine of double effect afresh, in the light of concerns that the legislation may have legalised euthanasia through the back door. Those concerned that euthanasia is effectively sanctioned by the doctrine of double effect deny that a meaningful distinction can be drawn between pain relief administered in the knowledge that the relief will accelerate the patient's death, and mercy killing. They insist that, in palliative care, no less than in euthanasia, if death is *known* to be a consequence of the treatment, and the treatment is proceeded with in that knowledge, the death of the patient must be intended. If that is so, palliative care administered with knowledge of the consequences must be seen to be a species of euthanasia. This concern is, I argue, inadequately dealt with in the second reading speech to the Bill, the Explanatory Notes, and in some of the secondary literature, and requires a response. My argument will be that a clear and coherent distinction can indeed be drawn between instances of palliative care where death is known to be a certain consequence of the treatment, and mercy killing or euthanasia, and that, consequently, concerns that euthanasia is effectively permitted by the legislation are precipitate.[3]

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1 *Criminal Code 1899* (Qld) s 282A.

2 See the Long Title to *Criminal Code (Palliative Care) Amendment Act 2003* (Qld).

3 It is not my intention to discuss here the interesting issue of whether euthanasia should be legalised. Although this issue is important, it is beyond the scope of the present paper. My concern here is merely to defend the distinction between palliative care as defined by s 282A of the *Criminal Code 1899* (Qld) and euthanasia.

II THE DOCTRINE OF DOUBLE EFFECT AT COMMON LAW

Under the doctrine of double effect, a recognised, though, as we shall see, somewhat controversial principle of applied ethics, an action that has a bad effect is defensible providing it complies with the following four requirements:

1. the action itself must be good or indifferent
2. the good effect, not the bad effect, must be the one sincerely intended by the agent
3. the good effect must not be produced by means of the bad effect; and
4. there must be a proportionate reason for permitting the foreseen bad effect to occur.[4]

Thus, in the context of palliative care, an action that has both a good effect (relieving pain) and a bad effect (causing or hastening death) is permissible if it is not wrong in itself, if the bad effect is not directly intended (that is, deliberately aimed at), and the good effect is not produced by means of the bad effect. It should be stressed that requirements 2 and 3 are treated as separate requirements.[5] The doctrine recognises but forbids the possibility that a good effect could be sincerely intended, yet produced by means of the bad effect.

Conditions 2 and 3 have received the most attention from critics and supporters of the doctrine. Central to the doctrine of double effect is the distinction, drawn by condition 2, between intended consequences, on the one hand, and unintended, but foreseen, consequences, on the other. An agent is permitted, under the doctrine, to perform an act which he or she can foresee will have an unwanted consequence, provided that the consequence is not itself directly intended, but is merely a secondary consequence of the act. In such a case, the secondary consequence, though *foreseen* by the agent (that is, even though the agent is fully aware that the consequence will ensue) is held not to be *intended* by the agent when performing the act. Thus, in the context of palliative care, a doctor who foresees that, as a consequence of administering further pain relief to a patient, the patient's death may be hastened, is nevertheless permitted to administer that treatment, if his or her intention is merely to alleviate the patient's pain, rather than bring about the patient's death. If the patient dies as a consequence of the treatment, the doctor is said not to intend that death – even though he or she knows that the patient's death may be hastened – because the patient's accelerated death is merely a (foreseen) secondary consequence of his or her act of relieving the patient's pain.

The doctrine was first explicitly stated as a common law doctrine applicable to medical contexts[6] in *R v Adams* by Lord Devlin:

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4 A D Lieberson, *Treatment of Pain and Suffering in the Terminally Ill*, appendix to Queensland, *The Care of Terminally-Ill Patients Bill 2002 (Qld): Clarifying the Right of Medical Practitioners to Administer Treatment*, Research Brief 29 (2002).

5 The requirements are often run together. For instance, Peter Wellington MP, in the Second Reading Speech, glosses the doctrine as follows: 'an action that has both a good effect and a bad effect is permissible if it is not wrong in itself, and if the bad effect is not directly intended', Queensland, *Parliamentary Debates*, Legislative Assembly, 12 March 2003, 494 (Peter Wellington) ('*Hansard*').

6 The doctrine has also been accepted as law in the United States: *Vacco v Quill* 117 S Ct 2258 (1997); and Canada: *Rodriguez v British Columbia (Attorney General)* [1993] 3 SCR 519 (Sopinka J).

> If the first purpose of medicine, the restoration of health, can no longer be achieved, there is still much for a doctor to do, and he is entitled to do all that is proper and necessary to relieve pain and suffering, even if the measures he took *might* incidentally shorten life.[7]

The position at common law is therefore that, provided the intention is to alleviate pain, the doctor will not be deemed to have caused the death of the patient, and will therefore not be guilty of either murder or manslaughter, if he or she incidentally hastens the death of the patient.[8]

III THE DOCTRINE OF DOUBLE EFFECT IN QUEENSLAND

Prior to the amendment to the *Criminal Code 1899* (Qld), the legal position in Queensland was unclear. Section 296 of the Code provided that a person who does any act or makes any omission which hastens the death of another person who, at the time, is labouring under a disorder or disease arising from another cause, is deemed to have killed that person. Since this could be construed as inconsistent with (and therefore as overriding) the common law doctrine of double effect, it was technically possible that a doctor could be incriminated, even though the purpose of the treatment was only to alleviate the patient's pain, not to kill the patient. Although no person was ever prosecuted in Queensland, and s 296 was generally not considered to override double effect, this situation called for clarification. The amendment purports to provide the required clarification. Section 282A of the *Criminal Code* now provides as follows:

> (1) A person is not criminally responsible for providing palliative care to another person if –
> (a) the person provides the palliative care in good faith and with reasonable care and skill; and
> (b) the provision of the palliative care is reasonable, having regard to the other person's state at the time and all the circumstances of the case; and
> (c) the person is a doctor or, if the person is not a doctor, the palliative care is ordered by a doctor who confirms the order in writing.
> (2) Subsection (1) applies even if an incidental effect of providing the palliative care is to hasten the other person's death.
> (3) However, nothing in this section authorises, justifies or excuses –
> (a) an act done or omission made with intent to kill another person; or
> (b) aiding another person to kill himself or herself.

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7 *R v Bodkin-Adams* [1956] Crim LR (UK) 365, 375 (Devlin J). I have italicised 'might' because this subjunctive is, as we shall see, ultimately crucial, yet often overlooked. Thus Devlin J's statement is sometimes misquoted, with 'might' omitted, as follows : 'a doctor can do all that is proper and necessary to relieve pain and suffering, even if the measures he takes incidentally shorten life'. See Queensland, *Parliamentary Debates*, Legislative Assembly, 19 June 2002, 1874 (Peter Wellington).

8 It is noteworthy, however, that some specialists believe that good palliative care should *never* result in the patient's hastened death. See M Ashby, 'Of Life and Death: The Canadian and Australian Senates on Palliative Care and Euthanasia' (1997) 5 *Journal of Law and Medicine* 40, 45; D Mendelson, 'Quill, Glucksberg and Palliative Care: Does Alleviation of Pain Necessarily Hasten Death' (1997) 5 *Journal of Law and Medicine* 110; E G Brownstein, 'Pain Relief and Causation of Death in the Context of Palliative Care' (2001) 8 *Journal of Law and Medicine* 433. See also the comments of Bonny Barry in Queensland, *Parliamentary Debates*, Legislative Assembly, 2 April 2002, 1181.

(4) To remove any doubt, it is declared that the provision of palliative care is reasonable only if it is reasonable in the context of good medical practice.

(5) In this section

'**good medical practice**' means good medical practice for the medical profession in Australia having regard to –

(a) the recognised medical standards, practices and procedures of the medical profession in Australia; and

(b) the recognised ethical standards of the medical profession in Australia.

'**palliative care**' means care, whether by doing an act or making an omission, directed at maintaining or improving the comfort of a person who is, or would otherwise be, subject to pain and suffering.

The legislation goes beyond double effect to the extent that it would not necessarily be fatal to the prosecution's case that it could not prove, beyond reasonable doubt, that the intention of the doctor was not to alleviate pain. Under the legislation, the prosecution could succeed in negativing a defence to murder or manslaughter if it could show that the care was not reasonable,[9] that is, in accordance with what is accepted as good medical practice in Australia,[10] or if the care was provided by someone other than a doctor without the written authority of a doctor.[11] These additional requirements were provided to ensure that the statutory defence cannot be abused, either by a pro-euthanasia doctor, or by a doctor with more sinister intentions.[12] As the Explanatory Note to the Bill makes clear:

> Section 282A(3) provides that nothing in section 282A authorises, justifies or excuses an act done or omission made with intent to kill another person or aiding another to kill himself or herself. Section 282A does not, and cannot, provide any justification for euthanasia or suicide.[13]

This point was repeatedly stressed during the parliamentary debates following the second reading speech. The point is made emphatically by the Hon Dr Dean Wells:

> Let me make it very clear that palliative care is not mercy killing. Whatever we think about euthanasia, that debate has no bearing on the issue of palliative care. The Bill leaves untouched the principle that the intentional taking of a human life is a crime.[14]

Nevertheless, the doctrine of double effect is at the heart of the legislation, and, owing to a perceived problem with the doctrine, it is possible to argue that euthanasia is not entirely ruled out by the legislation, in spite of an express parliamentary intent to prevent euthanasia from being legalised by the doctrine. Indeed, it is precisely the issue

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9 Section 282A(1)(b).

10 Section 282A(5)(a),(b).

11 Section 282A(1)(c). For a comprehensive discussion of all the legal implications of s 282A for medical and non-medical practitioners, see B White and L Willmott, 'The Edge of Palliative Care: Certainty, But at What Price?' (2004) *Flinders Journal of Law Reform* (forthcoming).

12 For example, a Harold Shipman. See the concerns raised on this, with reference to Shipman, in *Hansard*, above n 8, 1182 (Rosa Lee Tong). With regard to the concerns about euthanasia, the legislation makes it explicit that it does not authorise or excuse either an act done or omission made with intent to kill (s 282A(3)(a)) or aiding another person to kill themselves (s 282A(3)(b)).

13 Explanatory Notes, Criminal Code (Palliative Care) Amendment Bill 2003 (Qld).

14 *Hansard*, above n 8, 1183.

of whether the doctrine double effect itself effectively sanctions the intentional taking of a human life which threatens the principle, expressed here by Wells, that the intentional taking of a human life is a crime. It is to this problem that we now turn.

IV PROBLEMS WITH THE DOCTRINE OF DOUBLE EFFECT: INTENDED AND FORESEEN CONSEQUENCES

The main difficulty that has been raised by critics of the doctrine concerns the distinction between an intended consequence and a foreseen consequence. Roger Hunt, for example, asks:

> Can a hastened death be truly described as 'unintended' or 'incidental' if clinical reasoning makes it foreseen, it is discussed with the patient and carers, agreed to, and then deliberately proceeded with?[15]

If this distinction cannot be validly maintained, then concerns about the extent to which the doctrine may remain a cloak for euthanasia would prove well founded – for in both euthanasia and palliative care administered in the knowledge that the patient's death will be accelerated, the doctor will have intended the death of the patient, and so intended to kill the patient, not merely to alleviate the patient's pain.

This criticism is not answered by the explicit provisions in the legislation stating that nothing in the legislation shall be construed as authorising or excusing acts or omissions made with intent to kill or aiding another person to kill themselves,[16] because the point of the criticism is that the circumstances in which the doctrine could be interpreted to apply may themselves constitute instances of euthanasia, yet such circumstances could be the very ones in which the legislature intended to protect a practitioner from prosecution. If a valid distinction cannot be drawn, the legislation is itself threatened with the incoherence that would infect the ethical doctrine of double effect it enshrines.

A *An Ambiguity in the Doctrine of Double Effect*

Before attempting a response to this criticism, it should be noted that there is an ambiguity in the doctrine of double effect, at least as used in the context of palliative care, and this ambiguity is reproduced in the Queensland legislation. The ambiguity has a direct bearing on the problem. It is sometimes said that treatment is allowed 'even when it is foreseen that the harm *will* eventuate', or 'in *full knowledge* that the action *will* also bring about bad effects'.[17] But it is also said that treatment is allowed where 'it is *possible* that it will shorten the patient's life by some hours, days, or weeks',[18] or where 'it *may* also have the ancillary effect of hastening death'.[19] Is palliative care permitted where the death of the patient is foreseen as a *certain* consequence, or is it

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15 R Hunt, 'Intention, The Law, and Clinical Decision-Making in Terminal Care' (2001) 175(10) *Medical Journal of Australia* 516.

16 *Criminal Code 1899* (Qld) s 282A(3).

17 Emphasis added. See D Solomon, *The Encyclopaedia of Ethics*, cited by Wayne Jarred in Queensland, *The Care of Terminally-Ill Patients Bill 2002 (Qld): Clarifying the Right of Medical Practitioners to Administer Treatment*, Research Brief 29 (2002) 5, 26.

18 Emphasis added. See *Hansard*, above n 7, 1874 (Peter Wellington).

19 *Hansard*, above n 8, 1178 (Kerry Shine).

permitted only where death is foreseen as a *possible* (or probable, but uncertain) consequence?

The Vatican's *Declaration on Euthanasia*, in which the Catholic Church formalised its position with respect to euthanasia and palliative care respectively, fails to clarify matters. It states that 'death is in no way intended or sought, even if the *risk* of it is *reasonably* taken',[20] which implies that death should not be known to be a *certain* outcome – if it were, death would not be a risk which could be *reasonably* weighed against the consequences of refraining from administering the relief, but an absolute certainty. The difference between whether relief can be administered if death is a *certain* consequence, or whether it can be administered if death is merely a *possible* consequence, or a risk, is crucial. Certainly, if the legislature intended that treatment could only be given in circumstances where the doctor merely foresees that the patient's death *may* be hastened, but is uncertain as to the extent of that possibility, the criticism raised by Hunt would have no bite. For in such a circumstance, the risk of death can be meaningfully weighed against the consequences of refraining from administering the relevant pain relief at all. Thus, provided that risk is uncertain, it is clearly meaningful to describe the death of the patient as 'incidental' or 'unintended'.[21]

Nevertheless, in spite of these ambiguities, the classical formulation of the doctrine of double effect is meant to deal with cases where the bad effect is certain to eventuate. The most famous example to which the doctrine of double effect is said to apply is a case of abortion. A pregnant woman who has a life-threatening cancerous uterus can have her pregnancy terminated in order to save her, even though the result of removing the cancerous uterus is the *certain* death of the foetus, because the latter is merely a secondary, unwanted consequence of the removal of the uterus.[22]

How is this ambiguity between the two formulations of the doctrine to be explained? In my view, it is the perceived unpalatability of the stronger version of the doctrine that might be responsible for the glide between speaking of knowing that the patient *will* die, and knowing that the patient *may* die. Indeed, even those who recognise the stronger version of the doctrine are prone to wavering between the two different versions of it. Thus Jonathan Glover, having recognised that the doctrine purports to deal with events which are 'foreseen as *inevitable* consequences' of an act, also speaks of 'the *virtual* inevitability of the deaths' under the doctrine.[23] Of course, a death that is merely

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20 Emphasis added. See Sacred Congregation for the Doctrine of the Faith, *Declaration on Euthanasia*, Vatican City, 1980.

21 It is, perhaps, for this reason that Dr David Van Gend wanted the words 'may possibly' inserted into s 282A(2) of the Act, so that it would refer to care which '*may possibly* have the unintentional effect of' rather than care which '*has* the unintentional effect of'. See *Hansard*, above n 8, 1180 (Lawrence Springborg). The second reading speech does not indicate why the recommendation of Dr David Van Gend was considered unnecessary. It may have been unnecessary because double effect permitted palliative care even if it is certain that death *will* eventuate. Alternatively, it may have been considered unnecessary to make it explicit that a doctor is protected from prosecution only in cases where he or she administers the treatment while anticipating that death *might* occur as an unwanted consequence.

22 See the articles by Solomon and Lieberson appended to Wayne Jarred, Jarred, above n 17. See also J Glover, *Causing Death and Saving Lives* (Penguin, 1977) 86-91; P Singer, *Practical Ethics* (Cambridge University Press, 2nd ed, 1993) 209-10; and H Kuhse, *The Sanctity-of-Life Doctrine in Medicine: A Critique* (Oxford University Press, 1987) 83-165.

23 Emphasis added. See Glover, above n 22, 88.

virtually inevitable, is not a death that is inevitable, and so, strictly speaking, cannot be qualified as certain, but merely as *possible* (however probable it might be).

For the remainder of the paper, it will be prudent to assume that the legislature does intend the stronger, and familiar, reading of the doctrine whereby it is permissible for a doctor to administer pain relief even in situations where he or she is aware that the patient's death *will* be hastened by the treatment. If a response can be given to the criticism raised by Hunt, even on the stronger reading of the doctrine, then whether or not the weaker or stronger of the two readings of the doctrine was intended by the legislation will become merely an academic, rather than a live moral and legal, issue.

B *Drawing the Distinction Between Intended and Foreseen Consequences*

What, then, would be the situation if the legislature does indeed intend that a doctor can administer the treatment even if he or she foresees that death *will* be hastened? *Prima facie*, it might seem that Hunt's criticism is cogent. In such a case, to the extent that a doctor *knows* that death will be the consequence of administering the treatment, but goes ahead and administers that treatment in that knowledge, it would seem difficult to describe the death as an unintended or incidental consequence.

Peter Wellington MP, the member for Nicklin, anticipates a version of the objection expressed by Hunt when delivering the Bill's second reading speech, but his response to it does not go far enough:

> the idea that a distinction can be drawn between the intention of relieving pain and the intention of causing death has been criticised; but, of course, it can be drawn. Doctors…know perfectly well what their intention is each time they administer the drugs.[24]

There are, of course, instances in which the distinction between intending to relieve pain and intending to cause death is clear. This is most obvious in a case where there is no possibility that the dosage a doctor needs to administer to relieve pain will bring about the patient's death, because the required dosage is too small to have that effect. Clearly in such a case, a doctor who administers only that small dose, and not a dose high enough to kill a patient, will intend merely to alleviate the patient's pain, not cause their death. Equally, if, in such a case, a doctor administers a higher dose, knowing that this will kill the patient, and that it is more than necessary to relieve the pain, the doctor will have intended to cause death, and not merely to relieve pain. Such examples are, however, beside the point. The real issue, as we have seen, is whether a doctor can meaningfully have an intention *merely* to alleviate pain, when that doctor is in the invidious position of knowing that nothing less than the dosage to be administered will suffice to relieve the pain, and yet also knows that, as a consequence of administering that dosage, the patient's death will be hastened. Simply insisting that the distinction can of course be drawn conflates the very clearest of cases with the hard cases, and therefore begs the question.

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24 *Hansard* above n 7, 1876.

The inadequacy of Wellington's response, as it stands, can be brought out as follows: in both the case of a doctor administering a sufficiently high dosage to bring pain relief in a context where the doctor *knows* that death will be hastened (palliative care), and the case of a doctor killing a patient in order to alleviate the patient's pain and suffering (a mercy killing), the intention or object of administering the drug is *to relieve pain/suffering*. What is it, therefore, that is *added* by the situation in which the doctor is performing a mercy killing, which is absent in situations of palliative care where death is known to be the consequence of administering the treatment? The answer can only be that in the former case there is also an intention to kill the patient,[25] whereas in the latter case there is not. Thus the question becomes: why is it that, in permissible palliative care on the stronger reading of it, a death foreseen as certain to be hastened by the treatment is nevertheless not an intentional killing of the patient?

Two features should be noted concerning permissible palliative care (where a hastened death is known to be a consequence of the treatment) which distinguish it from mercy killing. First, mercy killing can be achieved by drugs which have no other relevant property than that of causing death. For instance, carbon monoxide gas has no independent property of relieving pain when used as a means of mercy killing. It can only be used to terminate the patient's life. It is significant that, by contrast with carbon monoxide, morphine, used in the provision of palliative care, has the property of relieving pain independently of its capacity, in increased doses, to hasten death. Since its primary function is to relieve pain, it makes sense to say that, provided it is administered in good faith, the intention of administering morphine is to alleviate pain, even though it may have the unwanted consequence of hastening the patient's death. By contrast, in the case where carbon monoxide is administered to a patient, it cannot be said that the death of the patient is unwanted, since, owing to its properties, it can be used for no other purpose than that of terminating the patient's life.

Second, it is meaningful to intend to relieve pain rather than cause the death of the patient in situations where pain relief *precedes* death. This temporal lag between pain relief and death is of the utmost importance. If a doctor administered a high dosage of morphine, knowing that the high dosage would kill the patient instantaneously, then, in *that* case, there would indeed be no distinction between intending to alleviate the patient's pain, and intending to kill the patient – the independent property of relieving pain in this case would be redundant. The crucial distinguishing factor is therefore that there is a period of relief prior to the patient's death. To express the point differently, a

[25] The reason why, in mercy killing, there is, in addition to the intention to relieve pain, also an intention to kill the patient, is that death is the *means* by which the intention to alleviate pain is achieved: the intention to alleviate the pain can only be carried out by killing the patient and so the practitioner must intend the patient's death in order to realise the former intention. For this reason, mercy killing could not be permitted under double effect. It should also be noted here that *intention* is not to be confused with *desire*: *R v Moloney* (1985) 1 AC 905. I may *intend* to go to London on business, but not actually like London, and have no desire to go there – I simply have to go because of my job, and when I chose to go, I intend to go regarless of the fact that I have no desire to go. The confusion arises because, ordinarily, if we do not intend to do something, we do not *desire* to do it either, but the converse does not hold – we often intend to do things we don't desire to do, as the example just given shows. When we speak, in the medical context, of a death as *unintended*, the death is also, in these contexts, not *desired*. In both palliative care and euthanasia, no one *desires* the death of the patient – if there was a way to relieve the pain without bringing about or hastening the patient's death a doctor acting in good faith would do so. In the case of palliative care, however, unlike in the case of euthanasia, the death is, I argue, *unintended* as well as undesired, but in euthanasia, it is nevertheless intended, even though it is undesired.

temporal lag between pain relief, on the one hand, and death, on the other, prevents death from being the *means* by which pain relief is brought about in the case of palliative care. If, by contrast, death is known to be an instantaneous consequence, and the doctor nevertheless administers the relief in that knowledge, it is difficult to see how death could not in that case be anything other than the means by which pain relief is achieved, and, again, there would be no meaningful distinction between intending to relieve the pain and intending to kill the patient.

It should also be noted that that there is a tendency, by those who are suspicious of the distinction between consequences intended and consequences foreseen, to conflate two separate issues: 1) whether the distinction is *applicable* to a given fact scenario; and 2) whether the distinction itself is a *valid* distinction. Thus Helga Kuhse claims that the principle of double effect's 'central distinction – that between intention and foresight…is problematic'.[26] Her argument is that '[w]hilst it is, in many cases, intuitively obvious when an agent can be said to have intended a bad effect, there are other cases where it is not'.[27] Nevertheless, from the fact that there are complex cases where the distinction may indeed be *difficult to apply*, it does not, of course, follow that the distinction *itself* is problematic. If it has a clear application in other cases, as Kuhse here concedes, then it is obviously a meaningful, and hence useful, distinction, and the issue is simply whether the case at hand – here palliative care – is one in which the distinction has a clear application. In short, borderline cases are just that: borderline cases. They have no implications for the applicability of the distinction in clear cut cases. Indeed, recognition of a case as precisely a *borderline* case presupposes the clarity of the distinction in clear cut cases.[28] The central issue, for the purposes of the Queensland legislation, is therefore whether the case of permissible palliative care constitutes a scenario where the distinction between the intended and merely foreseen applies. We have seen above that, in fact, the distinction genuinely applies to the case of palliative care by reason both of the temporal lag between pain relief and death, and of the pain relieving properties of the drugs used to administer pain relief, which properties are independent of the drugs' capacity to hasten a patient's death if used in excessively large doses.[29]

C *Distinguishing Between Unintended and Incidental Consequences*

Hunt and like minded critics might alter their position by conceding that a hastened death can be described as an *unintended* consequence, while nevertheless insisting that it cannot be described as an *incidental* one.[30] Yet s 282A(2) provides that the defence to

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26 Kuhse, above n 22, 83-165, 93.

27 Ibid.

28 If it didn't, how could the concept of a borderline case even get a grip? The point derives from L Wittgenstein, *Philosophical Investigations* (Blackwell, 1953).

29 Aside from palliative care, there are many other instances where a consequence foreseen as certain is nevertheless not intended. For instance, when a police officer breaks bad news to a person concerning the loss of a loved one, he or she foresees that the person will be upset, but the police officer does not *intend* to upset that person. Or when a doctor administers chemotherapy, he or she foresees that the patient will certainly suffer from side effects of the treatment, but the doctor does not intend to inflict those side-effects on them.

30 It should be stressed that Hunt himself does not, of course, alter his position. As I argue below when discussing the views of Peter Singer, Hunt, in my view, conflates an unintended consequence with an incidental one. Here, however, I am trying to anticipate what would follow from a

palliative care 'applies even if an *incidental* effect of providing the palliative care is to hasten the other person's death' (emphasis added). This reply should be conceded. If indeed the legislature intended that a doctor who foresaw death as a certain consequence of the treatment could nevertheless permissibly administer the pain relief, the use of the term 'incidental' in the legislation is certainly unfortunate.[31] It is arguably nonsensical to describe a foreseen death as an 'incidental' consequence of the treatment when it is foreseen as a certain consequence of it. However, to rule out euthanasia, it is not necessary that the death be merely *incidental*; it is only necessary that it be *unintended*. Thus the concession to Hunt is not fatal to the rationale behind the legislation.[32]

One might deny there is a distinction between an unintended and an incidental consequence in this context, and insist that the two terms are synonymous. But whilst the two terms *can* be, and are sometimes, used synonymously, it does not follow that they have the same meaning in all contexts. In the case of palliative care, unlike in the case of mercy killing, it is, as we have seen, meaningful to say that the practitioner does not intend the patient's death because death is not the *means* by which pain relief is achieved. Nevertheless, it would surely be too weak to say that the patient's death is merely an *incidental* consequence of my intended action, viz, relieving the patient's pain. The *gravity* of the foreseen consequence, together with the fact that it is foreseen, renders the word 'incidental' an inappropriate term, because 'incidental' implies that the consequence would be merely a chance or contingent occurrence, something over which I have no control whatsoever. A distinction between unintended and incidental consequences can therefore cogently be drawn.

D *The Source of Dissatisfaction with the Intention/Foresight Distinction*

This failure to distinguish between describing a consequence as *incidental*, and describing it as *unintended*, is a significant source of the dissatisfaction with the intention/foresight distinction. It is the fact that we *hold people responsible* for some foreseen consequences that leads some ethicists to the conclusion that it is nonsensical to describe those consequences as *unintended*. Consider, for instance, the following criticism of the doctrine of double effect by Peter Singer:

> [T]he distinction between directly intended effect and side effect is a contrived one. We cannot *avoid responsibility* simply by directing our intention to one effect rather than another. If we see both effects, *we must take responsibility* for the foreseen effects of what we do.[33]

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concession that a foreseen consequence is *not* an intended one, but where the critic who makes this concession nevertheless insists that a foreseen consequence cannot be described as incidental.

31 The use of this term might therefore be cited as evidence that only the weaker interpretation of what is permitted is intended by the legislation, viz, that a doctor can administer the relief if he or she merely foresees that death *may* be hastened, rather than foreseeing that death *will* be hastened. Against this, however, must be counted the equally clear intention of the legislature to enshrine the full doctrine of double effect – which does, as I have shown above, excuse acts done even in the knowledge that death *will* result. It should be noted here that the term 'incidental' in s 282A(2) echoes Devlin J in *R v Bodkin-Adams* [1956] Crim LR 365 (UK).

32 In my view, it is the tendency to confuse the question of whether a consequence is *intended* with whether it is *incidental* that is primarily responsible for the concerns that euthanasia is permitted by double effect. Once this confusion is exposed, the concerns are shown to be unfounded.

33 Emphasis added. Singer, above n 22, 210.

Here, Singer argues that the distinction between intention and foresight is contrived because we hold people responsible for certain foreseen consequences. But if this argument is to work as an attack on the intention/foresight distinction, Singer would be forced to assume that we *only* hold people responsible for consequences they have intended.[34] In fact, however, the point that we must take responsibility for the foreseen effects of what we do is logically independent of the intention/foresight distinction, and so Singer's point, contrary to what he believes, leaves that distinction intact. His point simply boils down to a claim that even if there are foreseen events we do not intend, we sometimes expect people nevertheless to take responsibility for actions which bring about those foreseen events. No supporter of the doctrine of double effect, however, would deny that. The point stressed by supporters of the doctrine is simply that foreseen events are not always intended. In short, Singer should really be attacking the view that a foreseen consequence can nevertheless be described as *incidental*, rather than the view that it can be described as *unintended*. However, since his criticism commits him to the view that to hold someone responsible for foreseen consequences just *is* to admit that those consequences are intended, it is easy to see how he might consider there to be an incoherence between, on the one hand, holding someone responsible for a foreseen consequence, while, on the other, refusing to count that foreseen consequence as an intended consequence. It is then an easy step to conclude that supporters of the doctrine of double effect have failed to come clean and admit that, effectively, they allow an exception to the principle that an intentional killing is always wrong.[35] Nevertheless, once it is seen that holding someone responsible for consequences is not tantamount to admitting that those consequences are intended, Singer would have to concede that the doctrine of double effect remains unaffected by the criticism he directed against it. The doctrine of double effect does not, as critics of the doctrine claim, effectively admit of an exception to the rule that an intentional killing is a crime. Rather, it admits of an exception to circumstances in which we are prepared to hold someone responsible for consequences of their actions which they foresee will occur. There is no more an inconsistency in allowing such an exception than there is in allowing that there are some circumstances in which a duty of care will not be owed in negligence.

E *Other Considerations Relevant to the Distinction Between Permissible Palliative Care which Results in the Patient's Death, and Mercy Killing*

It is important to note that the principled grounds by means of which the relevant palliative care can be distinguished from mercy killing are also supplemented by considerations of policy which would carry considerable weight with the legislature. Consider, for instance, the enormous difficulties which would be encountered in seeking to control situations where mercy killing is permitted, and the difficulties in deciding *when* it should be permitted – what degree of suffering should be made a precondition to permissible killing, over what period of time the patient must be committed to the

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34 I am sure, of course, that Singer would not believe that we only hold people responsible for intended consequences.

35 See Singer, above n 22, where he claims that consequentialism, that is, a value judgement as to the *quality* of certain kinds of life, and not a belief in the sanctity of life, enters into the judgments of those who nevertheless purport to adhere to the doctrine of double effect and the sanctity of human life.

desire for his or her life to be terminated (in case the patient's judgement is merely coloured by a period of intense suffering that might abate), etc.

Does this mean that the distinction is merely a mask for policy considerations? No. There remains, as we have seen, a distinction of principle between an intended consequence and a merely foreseen one. We have seen that, to the extent that Hunt, Singer, and others attack this distinction, their criticism of the doctrine is unsuccessful. However, once it is conceded that we nevertheless in some circumstances hold people *responsible* even for consequences that are unintended, we must at this point recognise that a space is opened for something like policy to work in maintaining a *legal* distinction between the two categories of case. It is not so much that policy considerations *support* the distinction between the cases. On the contrary, it is because the distinction is coherent that policy considerations can then enter into the arena to justify a *legal* distinction between palliative care and mercy killing. Thus, policy does not mask any 'reality' that the legislature has effectively allowed a circumstance in which one can intend the death of a patient, as Hunt and Singer might claim, but it *does* lie behind the distinction between *circumstances* in which we are prepared to hold people legally responsible for their actions. The important point to note is that, in the case of palliative care, the legislature has not, contrary to what is implied by criticism of double effect, refused to come clean and concede that it has allowed an exception to the principle that intentional killing is never permissible.

V CONCLUSION

In conclusion, the attack on the distinction between intended consequences and foreseen consequences, as a basis for undermining the rationale for the operation of the principle of double effect in the context of palliative care, is not successful. The distinction has a clear application to palliative care, primarily because, unlike in mercy killing, it is meaningful to describe the purpose of palliative care in terms which make no essential reference to the death of the patient. In the final analysis, the criticism of the distinction is based on one or both of two erroneous assumptions. First, the assumption that, if a consequence is *not* properly described as 'incidental', it must be 'intended'. Second, the assumption that, if a distinction is *difficult to apply* to *some* fact situations, the distinction itself must be invalid. Once these erroneous assumptions are exposed, concerns that double effect – and the Queensland legislation enshrining it in law – 'would score as some form of victory for pro-euthanasia groups'[36] prove to be without foundation.

[36] This concern was expressed by Dr David Van Gend, cited in *Hansard*, above n 8, 1180.