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by

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One of the most persuasive arguments for assisted suicide and euthanasia is made from the perspective of mercy. Brock has argued that it should be the evaluation of this motive, not the structure of the act, that determines the ethical appropriateness of assisted suicide.[1] Duntley argues that in a covenantal physician/patient relationship, assisted suicide can be an experience of mercy and grace.[2] Two recently published articles likewise appeal to mercy. Quill *et al* describe both euthanasia and assisted suicide as humane,[3] while Brody describes both euthanasia and assisted suicide as an extraordinary act of compassion.[4]

As compelling as the argument from motive is, and even opponents agree that it is the most compelling,[5] one must ask if it is sufficient. Is it sufficient that human acts in general, and medical acts in this situation, be motivated by mercy? I suggest that the answer is no. I take this position for three reasons, which I will develop briefly here. First, the ethical tradition that calls for mercy has never suggested that it is, by itself, sufficient to judge the appropriateness of human acts. Second, the criteria for determining those situations in which assisting in another's suicide or engaging in an act of euthanasia is said to be merciful is impossible to define with precision. Third, only by examining one's intention can a judgement be made about the appropriateness of what may appear to be a merciful act in a hopeless situation.

The Place of Motive in Ethics

The foundation for acting out of mercy can be traced back through Joseph Fletcher[6] to the Augustinian maxim: "Love, and do what you will." In its original form, the maxim is not rendered *Ama, et quod vis fac;* "Love with desire or empathy, and do what you will." Rather, Augustine wrote *Dilige, et quod vis fac;*[7] "Love *carefully,* and do what you will." By choosing the Latin *diligere,* Augustine taught that one must love carefully and reasonably. Fletcher grounds his situation ethics in the notion that one should love with calculation. It is not

sufficient to love with desire or empathy. One must love with reason and care.

This qualification is important. Acting with mercy is not always easy, and can become more difficult in different situations. Fatigue is just one impediment to certainty in acting according to motives. Desperation and fear are others. To judge euthanasia and assisted suicide on the basis of mercy presumes that human motives can be pure and objective. That is, it presumes that we can be free from the undue influence of fatigue and fear, which can color our judgements, when it may be fatigue and fear, not objective facts, that cause us to judge a situation to be hopeless. It also presumes that we can sort through the many contradictory emotions, such as love and anger, loss and relief, that are part of grief. Human experience witnesses to the fact that human motives are rarely, if ever, pure and objective. For that reason, the ethical tradition to which we subscribe, even the situation ethics description of that tradition, has insisted on tempering motives. We are to act not only out of mercy, but with mercy that is reasonable and careful.

Hopelessness As a Reason for Mercy

It is not uncommon in the literature to refer to some persons as being hopelessly ill.[8,9,10] Writers who hold that mercy is a sufficient basis upon which to justify assisted suicide and euthanasia often appeal to this hopelessness as a justification.[3,4,11,12] If it is hopelessness that justifies these extraordinary acts of mercy, certain questions must be addressed: Does hopelessness constitute a medical reality, like futility, or is it a state of mind? Does the term denote an objective reality, or is it a subjective perception?

Let us suppose for a moment that hopelessness is an objective reality. By what criteria is it to be judged as existing? Studies suggest that clinical assessments in estimating prognosis[13] and diagnosis[14] are limited. Are we to assume that the ability to estimate hope, which is often rooted in these judgements, is any less limited? It has also been shown that physicians have a tendency to remember the unusual and bizarre case. This memory predisposes healthcare workers to make decisions on the basis of those few cases, which may not reflect the physicians' overall experience.[15] It is legitimate to question the extent to which the memory of a particularly heart wrenching case will predispose healthcare workers to judge similar cases as hopeless.

Schneiderman *et al.* reject this idea of hopeless as an objective reality.[16] In contrasting it from what they define as the objective notion of futility, they describe hopelessness as a subjective attitude. If they are correct, it would mean that hopelessness is more difficult to determine than futility. That this is somewhat troublesome can be seen in the fact that the notion of futility is itself nearly impossible to define. The bioethical literature speaks, for example, of "virtual,"[10] "quantitative and qualitative,"[13] and "physiologic"[17] futility. Are we to speak also of virtual, quantitative, qualitative and physiologic hopelessness? Cases of euthanasia, which could conceivably find their way to court, would probably show as wide a range of rulings on hopelessness as are presently found on futility.[18] It is difficult to see how assisted suicide and euthanasia can be a careful and reasoned expression of mercy when the criteria used to determine the

hopelessness of the case which allows for such extraordinary acts of mercy are so difficult to determine.

The Place of Intention in Ethics

For mercy to be careful and reasoned, it must be more than an empathetic response to a desperate situation. The only way to be certain that mercy is careful and reasoned is to examine human intentions. One's intention, as distinct from one's motive or rational for acting, is the judgement made about one's ultimate *goal,* and the *means* used to achieve that goal. Intention does not depend on motives or subjective attitudes. It speaks of the decision or judgement an individual has made about means and ends.

As humans, we cannot always control or be free of the undue influence of our emotions. There will always be times when we will not feel merciful, yet know we must act on another's behalf. There will be times when the apparent hopelessness of a situation will move us profoundly to want to act even when we know that, in this particular case, it is more prudent to do nothing. Human emotions, out of which motives often emerge, can be deceptive. This is illustrated clearly in the anguish of physicians trying to act ethically in difficult sutiations.[19] What we can control is the judgement of how to respond to these situations. Whether or not we are motivated by mercy, whether or not we perceive a situation as hopeless, we can make a judgement about the correct action to take by examining goals and the means to achieve them. We will know we are being merciful in a careful and reasoned way when we form an intention that seeks to protect and promote a human good as its end and in the means.

Our society holds that life is a good. When that good is threatened by some pathology or trauma, medicine seeks to protect and promote it through prophylactic, diagnostic, therapeutic, prosthetic and palliative interventions. Medicine intends the good of life as a goal, and uses means to attain that goal which protect and promote that good.

This may sound to some like vitalism. It is not, and it is wrong to suggest that the ethical tradition holds that the mere preservation of physical existence is necessary for promoting life as a good. Whereas the good of life is to be protected and promoted, it need not always be realized. There is no reason why life-sustaining medical interventions cannot be foregone for a patient for whom they are of no benefit, as there is no obligation to realize the good of life at all costs. The realization of any good needs to be balanced against the burdens endured to ensure that realization. When the burdens are disproportionate, or there is no benefit to be gained, medical interventions are foregone, even when death will result. This is referred to ethically as "allowing to die." The judgement is made that, while life is a good, some medical interventions are no longer of value to that life.

Although promoting and protecting a good does not mean that it must always be realized, it does mean that the good should not be directly attacked. That is, we ought not intend to destroy a good, either as a goal or as means to a goal. Life is a good to be promoted and protected, even if not always realized. We should not

intend to attack that good, either as an end in itself or as a means to an end. To intend to end another's life, euthanasia, because his or her situation is hopeless may be motivated by mercy, but it is not careful or reasoned. To intend to cooperate in another's attempt to end that other's own life, assisted suicide, as a way of relieving pain and suffering may also be motivated by mercy. Like euthanasia, it is not careful or reasoned. Mercy is not careful or reasonable when it attacks a good as a means or as an end.

Whatever our motives, we can be sure that we are acting in a careful and reasoned way when we intend to promote and protect the good of life, or when we make a judgement that the burdens of continuing to realize that good are disproportionate to the benefits. Whatever our motives, we can be sure that we are not acting in a careful and reasoned way when we attack the good of life.

Conclusion

Quill *et al.* begin their article by describing several moving "predicaments [that] do not fall into simple diagnostic categories."[3] They then outline a carefully reasoned procedure for a merciful response. Yet, the question is not whether the procedure to be followed for euthanasia or assisted suicide is carefully reasoned, but whether euthanasia or assisted suicide are careful and reasoned.

Simple mercy cannot, it seems to me, navigate society and medicine through the criteria needed to define what is and is not hopeless, what constitutes sufficient hopelessness, and who ought to receive assistance in suicide or euthanasia. We deceive ourselves if we think it can. Terminal illness and desperate situations require a careful and reasoned reflection on how to protect and promote the good of human life. If, as a society and a medical profession, we hold that life is a human good, then we ought always to intend to promote and protect that good, even in the face of medical failure.[4] We need not always realize that good, and often we ought to stop trying to do so long before some of these desperate situations arise.[20] But, we ought never intend to attack that good. However sincere our motives, they are not sufficient. We need always to intend good, both as our goal and our means to achieve that goal, if we are to be truly merciful.

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