Ordinary, Extraordinary, and Artificial Means of Care

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In order to understand the distinction between ordinary and extraordinary means, let us consider two cases:

Case #1

A sixty-four-year-old woman, Emma, was diagnosed with non-Hodgkins lymphoma six months previously. After receiving chemotherapy and radiation treatments, the lymphoma returned, this time with metastases to the brain and liver. Emma is disoriented and delirious at times. Then she develops bacterial pneumonia. She decides that she wants to forgo the antibiotic treatment normally given for her type of pneumonia. She wants to go home to die without receiving further treatment. Two days later, Emma slips into a coma and dies peacefully, surrounded by her family and friends.

Case #2

A forty-year-old man, Joseph, is admitted to the emergency room and is diagnosed with bacterial pneumonia. Joseph is otherwise healthy, but he has been depressed since the death of his wife six months previously. The attending physician informs Joseph of his condition and tells him that antibiotics should have him feeling better in ten days. Much to the doctor's amazement, Joseph refuses the treatment. He wants to go home to die and to be with his wife.

Legally, of course, both Emma and Joseph have the right to refuse treatment. Doctors may try to persuade one or the other to take the antibiotics, as this is a medically "ordinary" means of treating bacterial pneumonia. Legally, however, they cannot be impelled to take them. But whether or not Emma and Joseph may refuse such treatment raises a number of ethical questions that go to the heart of determining what constitutes ordinary and extraordinary means of treatment. It is with this distinction that this article is concerned.

Another, and not unrelated, issue that needs to be addressed is the use and misuse of the term "artificial." This word has often been used, rightly or wrongly, in discussions concerning ventilation, nutrition, and hydration: the latter two recently and most dramatically seen in the case of Terri Schiavo. While I will not treat her case fully, as that would require an entire article of its own, I will refer to it by way of example. Before dealing with these matters, let us return to Emma and Joseph.

Discussion

Emma, who is in the end stages of non-Hodgkins lymphoma may, ethically speaking, accept or refuse to be treated for her bacterial pneumonia with antibiotics. The benefit of accepting such treatment would be the prolongation of her life. She may opt for this for several reasons: she may want to finish unfinished business with family, relatives, and friends; she may want to prepare herself spiritually if she feels that this has not been adequately done; she may fear death or hope for a miracle; or she may simply have a tenacious will to live. All of these are valid reasons for accepting treatment in spite of the fact that she is clearly and imminently dying of cancer. In these instances and perhaps others, the giving of antibiotics would be a medically "ordinary" means of treatment. The burden of accepting the antibiotic treatment is that, while she may be cured of the pneumonia, she will also face greater debilitation, additional suffering, etc. Even with the burden that faces her, it is for her to decide. But what if Emma were to decide to refuse treatment? What if she had already taken care of business, had prepared spiritually, had come to terms with the fact that she was dying or, after months of suffering, no longer held out hope for a last-minute miracle cure? She may, ethically speaking, refuse treatment. In these circumstances, and perhaps others, the giving of antibiotics would be an "extraordinary" treatment.

After examining Joseph's situation, I will return to the nettlesome question of how the same treatment (antibiotics), an "ordinary" treatment by medical standards, may be, from an ethical point of view, either "ordinary" or "extraordinary."

Like Emma, Joseph, too, has bacterial pneumonia. Unlike her, he is, except for the pneumonia, physically healthy. While he is depressed because of the recent death of his wife, he is not actively dying of some kind of biological pathology. Giving Joseph antibiotics is "ordinary" medical care for someone, like him, who has bacterial pneumonia. His acceptance of them would be the proper course of action for someone in his situation, as they would restore him to his former physically healthy self. But to refuse treatment, as Joseph has done, is a form of suicide. While it is quite understandable, given the death of his wife and his subsequent depression, that he would wish to die in order to end his emotional and psychological suffering and to be reunited to his wife, his refusal would, ethically speaking, be a form of suicide. Unlike Emma's case, there are not, in Joseph's case, extraordinary means being used. Giving him antibiotics is "ordinary" medical care and "ordinary" care morally understood. In addition to the antibiotics, what Joseph needs are time, professional psychiatric care, and maybe even treatment with antidepressants, at least temporarily.

Earlier Treatments

How, then, are we to understand the terms "ordinary" and "extraordinary," and that the same medical treatment may be, in some instances, ordinary and, in others, extraordinary? In one of the earliest articles on the subject, Gerald Kelley, S.J., defines ordinary means as "all medicines, treatments, and operations, which offer a reasonable hope of benefit and which can be obtained and used without excessive expense, pain, or other inconveniences." He defines extraordinary means as "all medicines, treatments, and operations, which cannot be obtained or used without excessive expense, pain, or other inconveniences, or which, if used, would not offer a reasonable hope of benefit."[1] Reasonable hope, expense, pain, or other inconveniences are, for Kelley, the operative words in distinguishing between what constitutes ordinary from extraordinary means.

The distinction can also be found in Pope Pius XII's allocution to doctors and students of anesthesiology at the Gregor Mendel Institute. Before responding to three specific questions presented to him, Pius sets out some general principles of medical ethics that pertain to the subject of this article. He writes:

> Natural reason and Christian morality say that man (and whoever is charged with caring for his fellow human beings) has the right and the duty to take necessary care to preserve his life and health in the case of a serious illness. This duty, that he has toward himself, toward God, toward the human community, and most often toward certain specific persons, flows from a well-ordered charity, from submission to the Creator, from social justice and even from justice strictly speaking, as well as from respect for his family. But this duty does not usually oblige except in the use of ordinary means (according to the circumstances of person, place, epochs or culture), that is, means that are not burdensome either for oneself or for another. A stricter duty would be too heavy for most men, and would make the achievement of more important superior goods too heavy to bear. Life, health, all temporal activity are, in effect, subordinate to spiritual goals. In other respects, it is not forbidden to do more than what is absolutely necessary to preserve life and health as long as it does not interfere with more serious duties.[2]

Like Kelley, Pius speaks about the "duty" one has to preserve one's life, making more explicit, however, the bases for this duty: charity, submission to God, social justice, simple justice, and respect for family. Interestingly, to Kelley's operative words (reasonable hope, expense, pain, or other inconveniences), Pius also adds, but without further comment, the circumstances of person, place, epochs, or culture.

One can already see in Kelley and Pius not only the distinction between ordinary and extraordinary care, but also the circumstances in which the *same* treatments, for a variety of reasons, may be deemed to be ordinary or extraordinary.

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[1] Gerald Kelley, S.J., "The Duty to Preserve Life," *Theological Studies* (1951): 550–556.

[2] Pius XII, "Address on 'Reanimation'" (November 24, 1957), *Acta Apostolicae Sedis* 49 (1957): 1027–1033 (my English translation, from the French in *Acta Apostolicae Sedis*).

These reasons may obtain to the patients themselves (e.g., reasonable hope or pain), to other considerations (e.g., expense and other inconveniences), or to even broader and less-defined areas (e.g., circumstances of place, epochs, or culture).

More recently, the U. S. Conference of Catholic Bishops has provided additional information for our understanding of ordinary and extraordinary means of care. In the fourth edition of its *Ethical and Religious Directives for Catholic Health Care Services,* published on June 15, 2001, the bishops provide the following directives:

> A person has a moral obligation to use ordinary or proportionate means of preserving his or her life. Proportionate means are those that in the judgment of the patient offer a reasonable hope of benefit and do not entail an excessive burden or impose excessive expense on the family or the community.[3]
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> A person may forgo extraordinary or disproportionate means of preserving life. Disproportionate means are those that in the patient's judgment do not offer a reasonable hope of benefit or entail an excessive burden, or impose excessive expense on the family or the community.[4]

Several interesting points stand out in these two directives. Whether a means is deemed to be ordinary or extraordinary is not reached on the basis of the medical treatment as such. Rather, it is the *judgment of the patient* that pertains in deciding what is, for him or her, ordinary or extraordinary care. The patient's judgment is not made in isolation, however. After consulting with doctors, maybe even family members, etc., the patient may judge that a given treatment is either ordinary or extraordinary.[5] This judgment may be based on whether there is or is not a reasonable hope of benefit; whether the treatment does or does not entail an excessive burden; or whether it does or does not impose excessive expense on the family or the community. Whatever the patient's judgment is, it is ultimately his or hers to make.

This does not mean, ethically speaking, that one can make just any kind of judgment. An important corrective is found in directive 59:

> The free and informed judgment made by a competent adult patient concerning the use or withdrawal of life-sustaining procedures should always be respected and normally complied with, unless it is contrary to Catholic moral teaching.[6]

For example, in our second case study, Joseph, albeit a competent adult, made a judgment to forgo "ordinary" care for the treatment of bacterial pneumonia. In his

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[3] United States Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services,* 4th ed. (Washington, DC: United States Conference of Catholic Bishops, 2001), n. 56. Here, the bishops refer the reader to the Congregation for the Doctrine of the Faith's *Declaration on Euthanasia* (May 5, 1980), part IV.

[4] Ibid., n. 57.

[5] See Benedict Ashley and Kevin O'Rourke, *Health Care Ethics: A Theological Analysis*, 4th ed. (Washington, DC: Georgetown University Press, 1997), 428.

[6] United States Conference of Catholic Bishops, *Ethical and Religious Directives*, n. 59. See also Congregation for the Doctrine of the Faith, *Declaration on Euthanasia*, Part II.

case, this is a decision with which one should not comply, ethically speaking, as it was a form of suicide, even though, legally speaking, the doctor would have to comply. Emma's case is quite different. She, too, is a competent adult, and has decided to forgo life-sustaining means, namely, the taking of antibiotics to cure her bacterial pneumonia. In her judgment, such means would merely prolong her dying from non-Hodgkins lymphoma. This is not suicide. It is simply the recognition that her death is imminent and that prolonging it would only add to her suffering.

A second point of note is the *Directives'* use of the terms "proportionate" and "disproportionate" as synonyms for "ordinary" and "extraordinary." Some ethicists, like Richard McCormick,[7] Stuart Showalter, and Brian Andrew,[8] use the terms "proportionate" and "disproportionate." A difficulty with these terms, according to Benedict Ashley and Kevin O'Rourke, is the possibility of confusing their use with the proportionalist methodology used by these ethicists.[9] In light of Ashley and O'Rourke's concerns, which are mine as well, it would be better, perhaps, to use the language of the *Declaration on Euthanasia,* which distinguishes between the proportion of risk to benefit.[10] The advantage of using the *Declaration*'s distinction is that it avoids confusion regarding what is meant by "ordinary" and "extraordinary." The *Declaration* also states that,

> it will be possible to make a correct judgment as to the means by studying the type of treatment to be used, its degree of complexity or risk, its cost and the possibilities of using it, and comparing these elements with the result that can be expected, taking into account the state of the sick person and his or her physical and moral resources.[11]

This statement captures well not only the complex dynamics at play in a given situation, but also the possibility of arriving, with some moral certainty, at a possible resolution.

Incompetent Patients

Thus far we have dealt with competent adults. But what about cases in which the person has never been competent (e.g., infants, children, and the severely mentally handicapped), or was once competent but is no longer (e.g., those who have suffered a stroke and can no longer express themselves clearly, those in a coma of varying degrees of profundity, those with Alzheimer's disease as well as those in a persistent vegetative state)? What we have said above obtains in these situations as

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[7] See Richard McCormick, *Health and Medicine in the Catholic Tradition: Tradition in Transition* (New York: Crossroad Publishing Company, 1984), 140.

[8] See J. Stuart Showalter and Brian L. Andrew, *To Treat or Not to Treat: A Working Document for Making Critical Life Decisions* (St. Louis, MO: Catholic Health Care Association of the United States, 1984).

[9] See Ashley and O'Rourke, 420–421.

[10] See Congregation for the Doctrine of the Faith, *Declaration on Euthanasia*, Part IV; Ashley and O'Rourke, 421.

[11] Congregation for the Doctrine of the Faith, *Declaration on Euthanasia*, Part IV.

well, with the exception that a surrogate or proxy must make the judgment for the patient. If the person had been competent but is no longer, the surrogate makes a "substitution judgment." This is a judgment that can be phrased as "what the person would want if he or she were able to use his or her own judgment." Ideally, the surrogate's judgment would be that of the now-incompetent person—thus the need to discuss one's wishes with one's health care proxy. If the person has never been competent and has, therefore, never expressed his or her wishes, the proxy then uses the "best interest standard." This standard involves choosing a course of action that is for the patient's overall good, based on what the average, reasonable person would want.

Terri Schiavo's case raises issues that are pertinent to our discussion. Many people believed that, had Terri made it unequivocally known that she did not want to be kept alive by means of hydration and nutrition, then her wishes should have been respected. Her husband stated that her wish was not to be kept alive artificially, and that he was merely respecting her wishes. Her family, however, believed that Terri had not made such a wish known, and that she would have wanted to live no matter what. Hydration and nutrition should, therefore, have been continued. For many people, then, the ethical dilemma turned not so much on the use of hydration and nutrition as such, but on what, if any, decision Terri Schiavo had made prior to entering into a persistent vegetative state (PVS).

This is one way of looking at this case. But it stops short of addressing the more important question: is hydration and nutrition ordinary care for someone in a PVS or is it not? A pastoral letter published by the Texas Catholic Bishops claimed that such treatment is burdensome and, therefore, not obligatory. [12] The Bishops of Pennsylvania reached the opposite conclusion, stating that nutrition and hydration are generally obligatory.[13] The U.S. Bishops' Committee for Pro-Life Activities reached a similar conclusion,[14] although they acknowledged that "legitimate Catholic moral debate continues" (710). Ashley and O'Rourke, stressing the Committee for Pro-Life Activities letter which says that legitimate Catholic moral debate continues, and interpreting the statement in the *Declaration on Euthanasia*, Part IV, that "one cannot impose on anyone the obligation to have recourse to a technique which is already in use but which carries a risk or is burdensome," opt for the moral legitimacy of withdrawing nutrition and hydration.[15] William May disagrees with their position, arguing that life is an intrinsic good and that withdrawing nutrition and hydration from PVS patients would be illicit, as they are not suffering from a fatal

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[12] Texas Catholic Bishops and Texas Conference of Catholic Health Facilities, "On Withholding Artificial Nutrition and Hydration" (May 7, 1990), *Origins* 20.4 (June 7, 1990): 53–55.

[13] Bishops of Pennsylvania, "Nutrition and Hydration: Moral Considerations" (December 12, 1991), *Origins* 21.34 (January 30, 1992): 542–553.

[14] U. S. Bishops' Committee for Pro-Life Activities, "Nutrition and Hydration: Moral and Pastoral Reflections" (April 2, 1992), *Origins* 21.44 (April 9, 1992): 705–712.

[15] See Ashley and O'Rourke, 427.

pathology.[16] More recently, Pope John Paul II in his March 20, 2004, "Address to the Participants in the International Congress on 'Life-Sustaining Treatments and the Vegetative State: Scientific Advances and Ethical Dilemmas,'" stated that hydration and nutrition were *minimal care* that could not be interrupted or stopped in PVS patients.[17] So as things stand now, and until such time that a clear and definitive teaching is issued on the matter, whatever might or might not have been Terri Schiavo's request, the judgment withholding nutrition and hydration was morally impermissible.

The Term "Artificial"

The final issue to be dealt with is that of the use and misuse of the term "artificial." One hears such statements as "I don't want to be kept alive artificially," "I understand that we are not obliged to use artificial means," and "Being kept alive artificially is not in keeping with the dignity of the person." Statements such as these betray a serious misunderstanding of what artificial means are, to what if any extent they are obligatory, and the putative dehumanizing effect of their use.

Etymologically, "artificial" comes from the Latin words *ars* and *facere* and means literally "to make art" or, by extension, "that which is made by humans and not by nature." "Artificial" applies, therefore, to the entire gamut of medicines, treatments, and operations used in the practice of the healing arts. Something as "ordinary" as antibiotics is no less artificial than the more "extraordinary" ventilator or gastrointestinal tube. Whatever the sophistication of the medicines, treatments, and operations used, whether "ordinary" or "extraordinary," their purpose is to aid where nature is deficient. Antibiotics help the body to heal from bacterial infections. Ventilators assist those who are unable to breathe on their own. Gastrointestinal tubes replace normal feeding for those who cannot obtain nourishment otherwise. Normally, their use is relatively short-term and they are used until such time that the person can naturally reassume those functions on his or her own. In these instances, artificial means are considered to be ordinary means of care. And most of us, at one time or another, will have recourse to them. But they may become, even quickly, extraordinary means of care.

Case #3

Elizabeth is eighty-four years old and is brought to the emergency room suffering from respiratory failure. Her grandson, Michael, is with her. The doctors inform Michael that without a ventilator, his grandmother will die soon. Michael asks the doctors if they know the cause of the respiratory failure. They do not. So Michael makes the decision to have his grandmother placed on a ventilator until a diagnosis can be made. This is done, and Elizabeth's pallor and unresponsiveness quickly disappear.

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[16] William E. May, "Tube Feeding and the 'Vegetative State,'" *Ethics and Medics* 23.12 (December 1998): 1–2.

[17] For the full text of the Pope's address, see *National Catholic Bioethics Quarterly* 4.3 (Autumn 2004): 573–576. For commentary and discussion on the address, see articles by D. O'Brien, J. P. Slosar, A. Tersigni, P. Cataldo, and G. Kopaczynski in the same issue.

In this instance, the use of a ventilator, while artificial, is ordinary care. It allows Elizabeth to breathe and to live until a diagnosis can be made. Although unable to speak, Elizabeth makes known to Michael that she does not want the ventilator. But he reassures her that it will only be for a short time. The following day, a now fully alert Elizabeth makes it clear that she cannot bear the thought of being on a ventilator. Michael asks the doctor if there is any chance that she will be able to come off of it soon. The doctor reviews her charts and tells Michael that, given the condition of her lungs, she will probably need to remain on it for the rest of her life and will have to go to a nursing home. What will happen, Michael asks the doctor, if his grandmother is taken off the ventilator? The doctor tells him that her various systems will begin to fail and that she will die.

Armed with this information, Michael gently informs his grandmother of the doctor's prognosis. She understands the consequences of being taken off the ventilator and insists that it be done. She has made the judgment that it is her time and that she does not want to live the rest of her life dependent on a machine to breathe for her. Nor does she want to lose her independence by being placed in a nursing home. Clearly, the ventilator has quickly become a psychological and physical burden for Elizabeth. She simply cannot endure having it. The ventilator is, therefore, removed and, just as the doctor had said, Elizabeth's systems begin to shut down. She makes it clear to the doctors that she wants a "do not resuscitate" order in place and that nothing but regular nursing care should be afforded her. Michael, now her durable power of attorney for health care, makes sure that his grandmother's wishes are respected. Elizabeth dies peacefully four days later, having been strengthened by the sacraments of the Church. What had, the evening before, been a medically ordinary means of care has now become ethically extraordinary and no longer obligatory. Elizabeth's decision to have the ventilator removed is morally licit, not because it is artificial, but because it is, for her, excessively burdensome, and offers no hope of recovery.

The reaction against the use of the term "artificial" when describing means, and the unreflective response not to employ artificial means arises, I suspect, from the fear of lifelong dependence on techniques that limit one physically, increase one's dependency, and forestall dying. There are those who, in spite of physical limitation and dependency, want to be kept alive at all costs. But many people do not want this for themselves. Whatever judgment is ultimately reached in these kinds of situations, care must be taken to ensure that the person's wishes be respected (if he or she is able to articulate those wishes and, if not, by having recourse to the person's durable power of attorney for health care) so long as those wishes do not violate the moral order. What obtains when judging between ordinary and extraordinary care obtains as well when it comes to the use of artificial means.

Regardless of the level of one's education, much confusion reigns when talking or thinking about ordinary, extraordinary, and artificial care. It can be hoped that articles such as this will lessen the confusion and give others more confidence when it comes to deciding treatment for oneself or for one's loved ones. This is not the end of the story. Other issues need to be discussed more fully, but they, unfortunately, fall outside of the purview of this article. For example, further exploration needs to be undertaken regarding issues raised by Pius XII about the roles culture and epochs play in deciding what constitutes ordinary and extraordinary care. And, finally, in our own epoch, when health-care costs are rising at a rate greater than that of inflation, what role do finances play in decision making, not only for individual families but for a society?