

# *When Medical Treatment Is No Longer in Order*

## *Toward a New Interpretation of the Ordinary-Extraordinary Distinction*

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One of the most prevalent and most complex problems in modern medical ethics is that of futile end-of-life medical care. After half a century of remarkable improvements in life-sustaining technologies, we have unexpectedly found ourselves questioning the benefits of these same technologies. It has become painfully evident that these technologies are a mixed blessing. Even worse, we do not know when their benefit turns into harm.

American bioethics—and increasingly European bioethics—have responded to this problem by evading it. Rather than addressing the question *what* is beneficial and *why*, it has focused on the issue of *decision-making authority* and, hence, *decision-making responsibility*. How could this have happened? In much abbreviated form, the steps leading up to this outcome are as follows.<sup>1</sup>

Physicians are excellent at what they do: extending patients' lives. In the course of the twentieth century, physicians have mastered the necessary science and technology and have become extremely adroit at applying them. Unfortunately, it has also become clear that physicians have a tendency to apply these technologies for the presumed benefit of patients without asking the patients themselves whether they

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<sup>1</sup> For a more elaborate discussion and critique of this line of argumentation, the reader is referred to my *In the Face of Suffering: The Philosophical-Anthropological Foundations of Clinical Ethics* (Omaha, NE: Creighton University Press, 1998).

want to have their lives extended. In medicine, the late twentieth century has been as much an age of paternalism toward patients as have ages past.

The answer to that problem seems quite simple at first: involve patients in the treatment planning. Unfortunately, life in our pluralistic and postmodern world is not that simple. For involving patients in the treatment planning assumes that physicians and patients speak the same language, can understand one another, can have a sensible discussion, and can reach agreement on the treatment plan. But this, as it has been eloquently argued by many contemporary bioethicists, is no longer possible. The age of modernity is over. All hope to ever again reach societal agreement on what counts as a good life seems to have vanished. In fact, it has even become doubtful that such agreement can be reached in local communities, whether they be culturally or religiously defined. Neighbors have become moral strangers. Likewise, physicians and their patients have become moral strangers to one another. Constructive debates among physicians and patients about such morally loaded issues as a “beneficial treatment plan” or “forgoing futile care” are therefore unlikely to end in consensus. They might end in a negotiated settlement, but not in mutual understanding and true consensus.<sup>2</sup>

Granted, few people truly believe the situation is as grim as the foregoing analysis suggests. Most patients continue to trust their physicians, and most physicians continue to talk about their patients, whom they presume to know well and for whom they genuinely care. But if pressured, if asked how much moral agreement really exists between them and their patients, they immediately revert back to the politically correct answer: As a physician, I do not want to impose my personal moral views on my patients—I want *them* to decide what treatments they want and do not want to undergo. There seems no third alternative possible; either the physician imposes her moral views onto the patient, or she abstains altogether from making morally laden choices, leaving such decision making up to the patient instead.

As I have argued elsewhere,<sup>3</sup> I do not think this analysis of our predicament at the dawn of the twenty-first century is philosophically convincing. I maintain that the modern tendency to leave all morally laden decisions up to the patients themselves, while politically correct, amounts to patient abandonment. The more difficult question is whether a convincing alternative can be formulated. Is it possible to formulate a discourse once again that can be understood by both physician and patient? Or, at any rate, is it possible to formulate a discourse that can accommodate both the subjective concerns of the individual patient and the objective maxims of medical science?

### **The Power to Consent versus Best-Interest Judgments**

Before we address this issue, it should be emphasized that the question at hand is not one of decision-making power. The question is not who in the end decides whether a ventilator or feeding tube will be removed. It has been well established by

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<sup>2</sup> H. T. Engelhardt, *The Foundations of Bioethics*, 2nd ed. (Oxford, UK: Oxford University Press, 1996); and R. M. Veatch, “Abandoning Informed Consent,” *Hastings Center Report* 25.2 (March 1, 1995): 5–12.

<sup>3</sup> J. V. M. Welie, *In the Face of Suffering*.

now that this final decision-making power lies with the patient. Whereas the physician determines the range of medically feasible interventions, it is up to the patient to consent to any particular one of them. For it is the patient who will be undergoing those interventions; it is the patient's life that is at stake, her bodily integrity that is invaded, her well-being and privacy that are manipulated. A competent patient can refuse any medical intervention. The patient does not have to provide good reasons for her refusal; in fact, the patient does not have to give any reasons.

But that does not mean that the patient's refusal is always reasonable, let alone morally justifiable. A decision made by the patient is not necessarily in the patient's own best interests. All of us, patients included, make many decisions in the course of our lives against the advice of wise friends or experienced experts, even against our own better judgment—decisions that we later regret. Contrary to what Socrates once argued, knowing what is the good is not a sufficient condition for acting accordingly. The patient is thus faced with two decisions: (1) What medical interventions are in my best interests? and (2) Shall I consent to those interventions?

If a patient has been found incompetent, and a proxy decision maker must decide on behalf of the patient, that proxy faces the same two questions: (1) What medical interventions are in the patient's best interests? and (2) Would the patient have consented to those interventions, such that I can consent on the patient's behalf? It is debatable whether a proxy can consent on behalf of a patient to medical interventions that the proxy knows are *not* in the patient's best interests, but to which the proxy knows the patient would have consented had the patient been competent.<sup>4</sup> Maybe human beings can sacrifice only themselves (e.g., to undergo a nontherapeutic experiment). If so, a proxy may not sacrifice the patient on the patient's behalf. There is no question, however, that patients and proxies alike must address the first question: What *is* in the patient's best medical interests? And it is with this question that we are concerned here.

It is often argued that proxies should not engage in judgments about what is in the best interests of patients because those judgments are too generic and cannot be tailored adequately to each unique patient. I do not see why that is so, unless, of course, one accepts the "moral strangers hypothesis" (i.e., that it is impossible for one individual to discern what is for the good of another individual). But that hypothesis has far-reaching ramifications. For example, it would entail a denial of the art of medicine. One would have to deny that physicians can determine what will benefit individual patients; one would have to assume that clinicians can only provide patients with a smorgasbord of options, explain the statistical likelihood that each of these options will have certain effects and certain side-effects, and let the patients choose from the menu.

Another staggering ramification of the moral strangers hypothesis is that proxies could not decide on behalf of patients who have never before been competent. Parents would not be able to determine the best interests of their own children. Such

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<sup>4</sup> J. V. M. Welie, "Living Wills and Substituted Judgments: A Critical Analysis." *Medicine, Health Care and Philosophy*, 4.2 (January 2001): 169–183.

counter-intuitive conclusions lead to very twisted and paradoxical verdicts, as when the Massachusetts Supreme Court in its 1977 decision in the matter of Joseph Saikewicz, and again in its 1992 decision about Jane Doe,<sup>5</sup> insisted that a substituted judgment be reached about a patient who had never before been competent, while at the same time admitting that such a judgment would be a legal fiction.

In spite of the popularity of postmodernism, even among such esteemed bodies as the Massachusetts Supreme Court, I prefer to cling to the ways of modernity and insist that it is possible to reach an ethical determination of an individual patient's moral good.<sup>6</sup> Surely, that determination is much easier when a patient is competent and can participate in the process. Although patients can be mistaken about their own best interests, they are generally the best judges of those interests. They are certainly the best source of information regarding this question. For it is the subject of the individual patient that needs to be brought to light and inserted into the objective discourse of medical science and technology. But best-interest judgments (such as the ordinary-extraordinary distinction) are not necessarily judgments *by* the patient. They are judgments *about* and *with* the patient.<sup>7</sup>

Such a subjective-objective discourse is not needed just with regard to end-of-life care. Medicine and health care overall are in dire need of it. But the need is certainly greatest and most urgent in the area of end-of-life medical care. I therefore propose to examine some of the vocabulary that has been employed in the debate about limits for life-extending medical interventions.

### A Review of Terms

One of the earliest terms coined for this very purpose can be found in the Hippocratic corpus. In the text "On the Art," the physician is explicitly told not to try to heal a patient who is overmastered by his disease.<sup>8</sup> However, it is all but clear whether this exhortation was motivated by a concern about the patient or rather about the physician himself. It may well be that the author of "On the Art" (probably not Hippocrates himself) wanted to make sure that these itinerant physicians of old would not ruin their good names by fighting lost battles. Dead patients make bad advertising. Whatever the correct interpretation, the term *overmastered* connotes the

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<sup>5</sup> *Superintendent of Belchertown State School v. Saikewicz*, 373 Mass. 728, 370 N.E. 2d 417 (1977); *In re: Guardianship of Jane Doe*, 411 Mass. 512, 583 N.E. 2d 1263 (1992).

<sup>6</sup> See also D. C. Blake, "Reconsidering the Distinction of Ordinary and Extraordinary Treatment: Should We Go 'Back to the Future'?" *HEC (Healthcare Ethics Committee) Forum*, 8.6 (December 1996): 355–371.

<sup>7</sup> This is contrary to what Reich and Ost have argued, which was: "Because of the prudential nature of the judgment, it is presumed that the *patient* normally judges what is extraordinary and nonobligatory" (W. T. Reich, D. E. Ost, "Infants: Ethical Perspectives on the Care of Infants," in *Encyclopedia of Bioethics*, ed. W. T. Reich [New York: Macmillan, 1978], 727; italics in the original).

<sup>8</sup> Hippocrates, "On the Art," in *Hippocrates*, vol. 2, trans. and ed. W. H. S. Jones (Cambridge, MA: Harvard University Press, 1943), 193.

complete absence of choice. The only one in power is the disease. There is absolutely nothing the physician can still do that might be of any benefit.

The modern term *futility* is interpreted by some in the same absolute sense. A medical intervention is futile if (and only if) it is physiologically impossible to attain a desired goal via that intervention. For example, it is futile to treat a chronic infection with an antibiotic to which the bacterium has already been proved resistant.

Others, however, have proposed a much broader interpretation of futility. After all, when interpreted very narrowly as physiological impossibility, the term *futility* loses much of its normative relevance. Whether a particular intervention is physiologically impossible is a scientific question. Once proved impossible, there is no moral quandary left. Granted, it is not always fully clear whether a particular intervention is really physiologically impossible. But then the moral question has turned into one of odds; it has become a quantitative rather than a qualitative quandary.<sup>9</sup>

Those favoring a broader interpretation of futility generally advocate a merger between the objective, physiological connotation of the term and a more subjective reference to the interests of the individual patient. They propose to use the term *futility* as a synonym for the German term “sinnlos” or the Dutch term “zinloos.” These terms literally translate into the English term *meaningless*. But, phenomenologists excluded, the term *meaningless* has simply no meaning to most bioethicists, clinicians, and health lawyers.<sup>10</sup> Unfortunately, the term *futile* does not seem to fare much better in that regard.

A second limitation of the term *futile* is that there is no evident opposite. Not only is *futile* (Latin for “flowing away”) etymologically unrelated to *utile* (Latin for “useful”), but the latter term simply plays no role in medical discourse except in the new discipline of utility assessment. Although it yields extremely valuable information for the issue at hand, the assessment and measurement of utilities is a purely quantitative and, hence, objective endeavor. An individual patient can be figured into the calculation of utilities only as an instance within multiple overlapping patient populations, never as a true subject. And yet it is clear that the moral quandaries at the end of life are invoked by the apparent incompatibility between such objective medical discourse and the subjective voice of the patient.

So far, we have looked only at the earliest term (*overmastered*) and the most recent one (*futile*). A cursory review of the literature reveals a host of other terms (Table 1, next page). Unfortunately, most are also seriously flawed. Terms such as

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<sup>9</sup> An example is the definition provided by Schneiderman et al. when they propose to call a treatment “futile” if it has not worked in the last one hundred cases (L. J. Schneiderman, N. S. Jecker, and A. R. Jonsen, “Medical Futility: Its Meaning and Ethical Implications,” *Annals of Internal Medicine* 112.12 [December 1990], 949–954).

<sup>10</sup> Unfortunately, the Dutch term “zinloos” seems to have lost its phenomenological richness for many Dutch commentators, too, as is evidenced by the introduction of the term “medisch zinloos” as the supposedly more objective variant of the term “zinloos.” See, for example, F. C. L. M. Jacobs, “Medisch Zinloos Handelen en Zinloos Medisch Handelen,” *Medisch Contact* 45.17 (April 27, 1990), 541–543.

<b>The patient is</b> managing	vs.	overmastered by his/her disease
<b>Medicine is</b> powerful	vs.	powerless
<b>Specific medical interventions are</b>		
standard normal basic routine customary	vs.	heroic overzealous complex advanced experimental
usual	vs.	unusual
simple	vs.	complex
minimal	vs.	maximal
(con)natural	vs.	artificial
appropriate	vs.	inappropriate
reasonable	vs.	unreasonable
proportionate	vs.	disproportionate
ordinary	vs.	extraordinary
utile	vs.	futile

FIGURE 1. Terms used in the literature to distinguish between medical treatments to be employed or forgone.

*standard, normal, routine, advanced, and experimental* all refer to the practice of medicine as viewed by physicians only. A treatment is deemed routine or advanced, not because a particular patient deems it routine or advanced, but because a physician, the local medical community, or the medical profession at large labels it such. The term *basic* can be interpreted in more than one sense. When a physician deems an intervention basic, she is most likely thinking in medical-practical terms only, of something that is easy to do, is often done, has a predictable outcome, and has no risky side effects. For example, because of extensive brain damage (cortical death), a patient in a persistent vegetative state suffers from multiple medical problems and requires very complicated multidisciplinary care,

including (but certainly not limited to) artificial nutrition. But many family members may nevertheless consider artificial nutrition of such a patient basic. Conversely, a cardiac monitor, urethral catheter, and wrist restraints may not be deemed at all basic by the family, let alone the patient himself, but may be deemed very basic by the attending physician.

To add to the confusion, the term *basic* has become a staple in discussions on distributive justice in health care and allocation of resources. For example, one could argue that citizens are not entitled to all available dental treatments, but they are entitled to basic oral health care. Judging by his choice of words, Pope John Paul II appeared to be making a similar claim in 2004 when he stated that “the sick person in a vegetative state ... still has the right to basic health care.”<sup>11</sup> But the context makes clear that he was not discussing the allocation of medical resources, but rather the difference between care and treatment. Hence, the term *basic* cannot function as a facilitator of joint discourse. The same is true of the term *heroic*. Heroic for whom? For the patient who has to undergo it? For the physician who has to beat the odds?

All these terms pose the same problem as does the term *futile*: there is no evident antonym. Without an antonym, one cannot adequately describe and discuss both sides of the equation. For example, when a patient states that he does not wish to undergo

<sup>11</sup> John Paul II, “On Life-Sustaining Treatments and the Vegetative State: Scientific Advances and Ethical Dilemmas” (March 20, 2004), *National Catholic Bioethics Quarterly* 4.2 (Summer 2004), 368.

“heroic care,” surely the doctor should not limit herself to cowardly care. Likewise, the opposite of *advanced care* cannot be *outdated care*, and the opposite of *normal care* cannot be *abnormal care*. The term *unusual treatment* is equally troublesome. Even though the term *minimal treatment* does intuitively make sense,<sup>12</sup> the issue at hand is not simply one of extremes (with only minimal treatment being obligatory and only maximal treatment being optional). Another term, *natural*—and likewise the term *(con)natural*, which suggests a human intervention that supports the natural—assumes that nature is not only a biological but also an ethical concept. So-called natural law theories of ethics hinge on this assumption. But as the ongoing debate about artificial nutrition makes clear, many who underscore the “naturalness” of nutrition nevertheless deny the moral relevance of the adjective *artificial*, at least in this instance.

This leaves us with four sets of terms: *appropriate* vs. *inappropriate*, *reasonable* vs. *unreasonable*, *proportionate* vs. *disproportionate*, and *ordinary* vs. *extraordinary*. An obvious advantage of these terms is that they are nicely paired.

The pair *appropriate-inappropriate* is certainly to the point, for our very search for pertinent terms has been motivated by the conviction that certain medical interventions are no longer appropriate for the dying patient. But calling a particular medical intervention inappropriate is begging the question. The term *appropriate* is a normative label, to be applied once it has been determined whether a particular treatment ought to be forgone. The term does not give any indication as to *why* a particular intervention should be forgone. One can envision a physician explaining to family members that tube-feeding is inappropriate for the patient because tube-feeding in this case is “x.” But it is this “x” label that we are after.

The *reasonable-unreasonable* distinction entails the same problem. Once we have determined that an intervention is indeed unreasonable, that there are really no valid reasons to proceed with the proposed intervention, it is also clear that we ought not to proceed with it. But it is those reasons we are trying to clarify. We lack a suitable discourse to address the reasonableness of continuing or forgoing certain medical interventions toward the end of life.

The terms *proportionate* and *disproportionate* have much more explanatory force, because they have both normative and descriptive significance. By calling an action proportionate, we express a sense of balance. As Aristotle has already pointed out, the moral good is usually a matter of balance, of a golden mean. Virtue is located between two vices. Thus, by labeling a proposed intervention “proportionate,” we imply that the intervention is morally justifiable. Conversely, the label “disproportionate” entails the suggestion that an intervention ought not to be made. But unlike the term *inappropriate*, the term *disproportionate* also entails a suggestion as to *why* it should not happen, what it is that makes the intervention immoral. Apparently, the medical intervention under consideration is off-balance. A balance between what? A balance between what medicine necessarily strives to do (i.e., benefit the patient) and what it tries not to do (i.e., harm the patient). In short, a treatment is disproportionate when the expected harms outweigh the expected benefits.

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<sup>12</sup> John Paul II, “On Life-Sustaining Treatments,” 369.

Indeed, medicine is always a matter of balancing benefits against harms. There are very few beneficial medical interventions that do not also have harmful side-effects. Fortunately, modern medicine has tremendously advanced in the past century, and the arsenal of proportionate treatments has greatly increased. However, by their very nature, human beings are mortal; death will eventually overtake each of us, and there is nothing medicine can do about that. Hence, the balancing act will be an everlasting challenge for medicine.

Of all the terms discussed so far, the *proportionate-disproportionate* pair seems to best reflect clinical reality and have the greatest explanatory force. This pair of terms is therefore preferred by many over the other pairs, including *ordinary-extraordinary*. This last pair was originally coined and developed by Catholic moral theologians as early as the sixteenth century and was underwritten by Pope Pius XII in his 1957 address to the International Congress of Anesthesiologists.<sup>13</sup> But in the authoritative *Declaration on Euthanasia* by the Congregation for the Doctrine of the Faith from 1980, it is at least suggested that the *proportionate-disproportionate* pair may be superior to the *ordinary-extraordinary* pair:

In the past, moralists replied that one is never obliged to use “extraordinary” means. This reply, which as a principle still holds good, is perhaps less clear today, by reason of the imprecision of the term and the rapid progress made in the treatment of sickness. Thus some people prefer to speak of “proportionate” and “disproportionate” means.<sup>14</sup>

Unfortunately, one quandary remains, a quandary faced by all ethical theories that equate the morally proper course of action with the course in which the benefits outweigh the harms: What counts as a benefit, what as harm? And how can the various benefits and harms be standardized so that they can be entered into the final calculus? It is very difficult (if at all possible) to compare and weigh against one another such diverse benefits as life years gained versus lesser degrees of nausea, or reduction in pain against lucid communication with family and friends. More importantly, how is the empirical fact of a 5 percent chance of a successful resuscitation to be weighed against the probable moral benefit of healed family relations?

In all areas of medicine, these questions surface. But it is at the end of life that the usual answers no longer hold true. A commonly accepted goal such as the extension of life is no longer an evident benefit. Hence, cardiac monitoring and resuscitation, mechanical ventilation, intravenous feeding, and the other modern technologies commonly used in emergency rooms and intensive care units with obvious success, suddenly become of dubious benefit when life’s end nears.

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<sup>13</sup> M. Panicola, “Catholic Teaching on Prolonging Life: Setting the Record Straight,” *Hastings Center Report* 31.6 (2001), 14–25; Pius XII, “The Prolongation of Life: Allocation to the International Congress of Anesthesiologists” (November 24, 1957), *The Pope Speaks* 4 (1958), 393–397.

<sup>14</sup> Congregation for the Doctrine of the Faith, *Declaration on Euthanasia* (May 5, 1980), in *Vatican Council II: More Post-Conciliar Documents*, ed. A. Flannery (Northport, NY: Costello Publishing Co., 1982), 515.



Many such changes in viewpoint occur toward the end of life. For example, during most of one's life, a state of unconsciousness is commonly preferred to one of pain. In fact, anesthesiologists intentionally induce unconsciousness to combat the pain of a major surgery. But unconsciousness is no longer an evident benefit at the end of life, even when weighed against the experience of pain. In fact, many dying patients try to tolerate some degree of pain, so that they are sufficiently lucid to communicate with loved ones. Another example concerns the locus of medical care. In virtually every instance of serious illness, patients in the developed world are taken from their homes and moved to the monitored and controlled environment of modern hospitals, thereby isolating them from such infectious sources as family and friends. But that very routine is no longer desired by the terminally ill patient.

In short, the question remains why medical interventions that are proportionate for some patients are not for others. More precisely, why do medical interventions that are proportionate for a particular patient during most of her life become disproportionate toward the end of her life? What determines whether a particular medical intervention for a particular patient in a particular situation is proportionate or disproportionate?

### **Common Misinterpretations of the Ordinary-Extraordinary Distinction**

This brings us back to the final pair of terms: *ordinary* vs. *extraordinary*. I will argue that this pair can yield an answer to the question of why a particular treatment should or should not be forgone. Granted, the answer is neither final nor complete. However, the foregoing analysis of alternative terms suggests that any answer, even a partial or tentative answer, would be a step forward.<sup>15</sup> Before elaborating on my

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<sup>15</sup> Interestingly, E. J. Emanuel rejects the ordinary-extraordinary distinction for the very reason that I advocate it—namely, that this distinction implies both a judgment about *what* should be forgone and *why* it should be forgone. Emanuel concludes that the distinction is “parasitic on other more fundamental ethical judgments which are neither articulated nor justified” (E. J. Emanuel, *The Ends of Human Life: Medical Ethics in a Liberal Polity* [Cambridge, MA: Harvard University Press, 1991], 61). To the extent that these judgments cannot be articulated or justified, the distinction evidently would be liable to criticism. It would be unfair, however, to label reliance on background moral theories as “parasitic.” Any ethical concept necessarily presumes an ethical background theory, lest it becomes meaningless. As Aristotle had already pointed out, there is a circular element in any ethical analysis. Emanuel's criticism, hence, does not really pertain to the ordinary-extraordinary distinction, but to the underlying ethical theory.

Indeed, Emanuel charges that the distinction assumes that it is possible to make judgments about a patient's best medical interests. Yet, “according to liberal political philosophy there is no single human good true for all people; pluralism implies differing views of what is ultimately worthy and valuable” (62). This statement reveals that Emanuel agrees with other libertarian bioethicists that patients and their care providers are moral strangers. As pointed out before, advocates of the ordinary-extraordinary distinction (I included) typically do not underwrite this “moral strangers” hypothesis, and therefore reject the liberal theory of ethics erected upon it.

interpretation of these terms (which will turn out to be somewhat unorthodox indeed), let us review why this pair of terms is commonly rejected. Four different objections are examined.

*The Terms Are Imprecise*

We have already seen that the authors of the *Declaration on Euthanasia* hesitantly conceded that the distinction between *ordinary* and *extraordinary* "is perhaps less clear today." This, the authors speculate, is due on the one hand to "the imprecision" of the terms and on the other to "the rapid progress made in the treatment of sickness."<sup>16</sup>

Vagueness of the terms has been held out by many as an argument to reject the *ordinary-extraordinary* distinction.<sup>17</sup> The President's Commission had a point when it wrote that the present multiplicity of interpretations does not foster the "clarity and understanding" that is urgently needed to develop policies and laws in this area.<sup>18</sup> However, my analysis here has shown that the alternative terms, including the *proportionate-disproportionate* distinction favored by the commission, are certainly not clear either, and may be even less clear than the *ordinary-extraordinary* distinction.<sup>19</sup>

As we will see shortly, the terms *ordinary* and *extraordinary* are frequently misinterpreted. Moreover, the interpretation that I will advance moves beyond the original interpretation. But misinterpretation is not a very sound reason to dismiss a

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<sup>16</sup> Congregation for the Doctrine of the Faith, *Declaration on Euthanasia*, in Flannery, 515.

<sup>17</sup> See, for example, P. Ramsey, *Ethics at the Edge of Life* (New Haven, CT: Yale University Press, 1978), 153; President's Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research, *Deciding to Forego Life-Sustaining Treatment: A Report on the Ethical, Medical, and Legal Issues in Treatment Decisions* (Washington, DC: Government Printing Office, 1983), 88–89; and R. Gillon, "Ordinary and Extraordinary Means," *British Medical Journal* 292.6515 (January 25, 1986): 259. Gillon deems the nomenclature misleading, but does not reject the philosophy underlying the distinction.

<sup>18</sup> President's Commission, *Deciding to Forego Life-Sustaining Treatment*, 89.

<sup>19</sup> One wonders why the ordinary-extraordinary distinction continues to be used in the face of its rejection by so many authoritative authors. Consider the following paradoxical example: Joanne Lynn is among those who reject the term, as she makes clear in a co-authored contribution to a book on artificial nutrition and hydration (J. Lynn and J. F. Childress, "Must Patients Always Be Given Food and Water," in *By No Extraordinary Means: The Choice to Forgo Life-Sustaining Food and Water*, ed. J. Lynn [Bloomington, IN: Indiana University Press, 1986]: 47–60, esp. 54). Her co-author, James Childress, rejects the distinction again in a later chapter, as does Dan Brock, the third of the four contributors who analyze it (J. F. Childress, "When Is It Morally Justifiable to Discontinue Medical Nutrition and Hydration?" 67–83; esp. 69; and D. W. Brock, "Forgoing Life-Sustaining Food and Water: Is It Killing?" 117–134, esp. 130). The only exception is the Catholic moral theologian E. J. Bayer, in his chapter "Perspectives from Catholic Theology" (89). And yet Lynn, who is also the editor of the book, titled it *By No Extraordinary Means*.

term, particularly when the misinterpretation is itself highly problematic. For example, it is a highly troubling fact that many clinicians misinterpret *ordinary* as “simple” or “routine” and, more seriously, think that the technical simplicity or routine quality of a particular intervention *justifies* their doing it. No intervention should ever be done to a patient just because it is simple or routinely done. Rather than discarding the *ordinary-extraordinary* distinction as a potentially confusing set of terms, we should forcefully rebuke any clinician who thinks simplicity or routine justifies medical treatment.

### *The Terms Are Outdated with Regard to Modern Medicine*

The second reason given by the Congregation for the Doctrine of the Faith for hesitating to use the terms *ordinary* and *extraordinary* concerns the advancement of medicine. The contemporary bioethicist Devettere appears to reject the *ordinary-extraordinary* distinction on similar grounds when he contends that “there is no way to provide a satisfactory definition of extraordinary treatment in modern medicine,” and that the term might even be invoked to circumvent the need for sound moral deliberation and reasoning.<sup>20</sup> It is certainly true that many interventions that were extraordinary fifty years ago have become ordinary. We have learned how to significantly reduce the harmful side-effects of radiation and chemotherapy, and the risks of infection and shock that were so prevalent at the dawn of modern surgery. We have moved from using iron lungs, which virtually imprisoned patients, to portable ventilators. But the balancing act remains; the same interventions and technologies, though highly improved, may still be extraordinary for certain patients in certain situations. Medicine’s rapid progress has not made the terms themselves any less precise. The same considerations factor into the calculus that leads to a judgment of ordinariness or extraordinariness. The only difference is that the calculus itself has become much more complicated.

### *Ordinariness Is Confused with Accepted Routine*

I suspect that the hesitance of the Congregation to insist on the *ordinary-extraordinary* vocabulary—which “as a principle still holds good,” according to the Congregation<sup>21</sup>—is motivated foremost by the very prevalent misinterpretation of the *ordinary-extraordinary* distinction which occurs within the medical field. Many clinicians interpret *ordinariness* to refer to medical commonness or currency of use. An intervention is thought to be ordinary if it is frequently used, or is part of a generally accepted routine in a particular hospital or the medical profession at large.<sup>22</sup>

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<sup>20</sup> R. J. Devettere, *Practical Decision Making in Health Care Ethics: Cases and Concepts*, 2nd ed. (Washington, DC: Georgetown University Press, 2000), 71.

<sup>21</sup> Congregation for the Doctrine of the Faith, *Declaration on Euthanasia*, in Flannery, 515.

<sup>22</sup> For advocates of this interpretation, see the sources cited in the report *Deciding to Forego Life-Sustaining Treatment* by the President’s Commission for the Study of Ethical Problems in Medicine and Biomedical Research, where the report discusses the ordinary-extraordinary distinction. It should be noted that the Commission itself does not think that these characteristics of a medical intervention are morally significant. President’s Commission, *Deciding to Forego Life-Sustaining Treatment*, 83–88.

But as Bole has noted, this distinction was never meant to “depend upon a contrast between the *usual*, *customary*, or *standard* medical practice, and the contrary.” Nor does it imply that “expensive, low-yield procedures which are well established” are required, whereas “inexpensive, high-yield care which is novel, and so not customary” is optional only.<sup>23</sup> Or, in the words of the Catholic moral theologian William May:

The terms “ordinary” and “extraordinary” are to be taken in their moral sense, which need not coincide with their meaning in a *technological* sense. A procedure that may be ordinary in the medically technological sense (e.g., intravenous feeding, a heart pacemaker, etc.), because it is commonly followed and readily available, may be extraordinary in the moral sense.<sup>24</sup>

Even though intravenous feeding is commonly, successfully, and justifiably used for some patients, the same technique may nevertheless be extraordinary in a moral sense, because it “might constitute a senseless and brutal prolongation of the dying process and hence be directed against the integrity and dignity of a 95-year-old person in a coma, suffering from bone cancer, renal failure, and pneumonia.”<sup>25</sup>

#### *The Terms Are Relative*

What determines whether an intervention is ordinary or extraordinary, if the technical aspects of an intervention do not? The *Declaration on Euthanasia*, for all its clarity in other regards, does not give a very clear answer:

In any case, 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.<sup>26</sup>

This statement could easily be misread as a defense of situation ethics. Indeed, if the distinction hinges fully on the circumstances, “a procedure may be called extraordinary if there is *any* overwhelming reason why it ought not to be undertaken.”<sup>27</sup> If this interpretation were indeed true, the *ordinary-extraordinary* distinction at best would seem to be synonymous with the *required-allowable* distinction, so that it loses all clarificatory power. At worst, the *ordinary-extraordinary* distinction would be an invitation to moral relativism.

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<sup>23</sup> T. J. Bole, “The Ordinary-Extraordinary Distinction Reconsidered: A Moral Context for the Proper Calculus of Benefits and Burden.” *HEC (Healthcare Ethics Committee) Forum* 2.4 (December 1990): 219–232, esp. 222.

<sup>24</sup> William E. May, *Human Existence, Medicine and Ethics* (Chicago, IL: Franciscan Herald Press, 1977), 146–147.

<sup>25</sup> *Ibid.*, 147.

<sup>26</sup> Congregation for the Doctrine of the Faith, *Declaration on Euthanasia*, in Flannery, 515.

<sup>27</sup> Sissela Bok, “Death and Dying: Euthanasia and Sustaining Life: Part II,” in Reich, *Encyclopedia of Bioethics* (New York: MacMillan, 1978), 271.

As May has granted, “the terms have great relativity, not because of any moral relativism, but because they are *relative to the condition of the patient*, to the morally significant reality-making and truth-making factors that give them their moral meaning.”<sup>28</sup> As will be explained at greater length in a subsequent section, this is not an explanation favoring subjective relativism or postmodern pluralism. Rather, it is an exhortation to have serious regard and respect for the unique aspects of each individual patient’s life. But before we further discuss this interpretation, we should first examine the original interpretation of the *ordinary-extraordinary* distinction.

### **The Original Interpretation of the Ordinary-Extraordinary Distinction**

It is a commonly accepted maxim that human beings are not morally obligated to be extraordinarily courageous, extraordinarily altruistic, or extraordinarily gracious. While it is certainly laudable to assume duties that are out of the ordinary, human beings are not obligated to fulfill such supererogatory charges. We honor the soldier who jumps on the grenade to save his platoon. But we do not reprove the soldier who leaps away from the grenade to save his own life. We praise the dentist who unselfishly treats every poor and desperate patient who knocks on her door, irrespective of personal losses. But we do not expect all dentists to do the same. Likewise, we admire the patient who bears the burdens of dying with courage, faith, and an unwavering spirit. But it is all too human to shun pain, fear, and suffering. Hence, terminally ill patients are not obligated to accept non-palliative life-sustaining treatments that are beyond the ordinary.

More specifically, extraordinary means for extending life may overtax a patient’s so-called moral resources. Consequently, the patient may lack the necessary will power to fulfill the kinds of obligations at the end of life that are more important than extending life itself. In theological language, these are the spiritual goods—saying goodbye to family members and close friends, settling old quarrels, making peace with oneself, getting ready to meet God.

The question next arises how to determine whether a particular act is ordinary (and hence obligatory for every human being) or extraordinary (and thus not obligatory, but still permissible). Traditionally, a distinction was made between a relative and an absolute norm. Some acts are ordinary for some people but would entail an extraordinary burden on others because of the latter’s circumstances. Rescuing a child about to drown in a swimming pool would be an ordinary duty for most adults but an extraordinary duty for anyone unable to swim. There are other acts which would be extraordinary for all people.<sup>29</sup> Jumping on a grenade to save others would certainly fall into the latter category.

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<sup>28</sup> May, *Human Existence*, 147.

<sup>29</sup> With this interpretation of the distinction between relative and absolute categories of ordinary and extraordinary duties, I digress from what seems to have been the more prevalent interpretation of the distinction. In a bioethics textbook from 1956 by the Catholic theologian E. F. Healy, we find the following example: “For determining what would be

As the example of the soldier jumping on the grenade shows, nobody is morally obligated to exhibit extraordinary courage. The same is true for extraordinary medical treatment. Nobody is morally obligated to undergo it. Conversely, "there is nothing that forbids our using extraordinary measures to conserve or to regain our health."<sup>30</sup> But this characteristic of the *ordinary-extraordinary* distinction also evokes a paradox.

As we have seen, the argument that justifies forgoing certain extraordinary life-extending medical interventions runs as follows: If life-extending measures are applied, it may become impossible for the patient to attain more important spiritual ends. Extending life is subordinate to such higher ends. Obviously, if the higher ends can be attained along with the extension of life, the latter may not be forgone. Hence, a moral dilemma arises only when the extension of life is so burdensome that it endangers the fulfillment of the higher ends. But if life-extending measures are extraordinary because their application is so burdensome as to endanger the attainment of higher ends, surely it would be immoral for the patient to opt to undergo those life-extending measures anyway. In that scenario, undergoing extraordinary treatments would entail moral hazards.<sup>31</sup>

This paradox is revealed more clearly by the alternative terms. The moment a treatment is deemed disproportionate because the harms outweigh the benefits, there is at least a *prima facie* prohibition against its use, for the physician's primary rule is not to harm, *primum non nocere*. The same can be said about unreasonable, inap-

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considered extraordinary in the matter of expense, we may view the case according to either the *relative* or the *absolute* norm. If, for example, a man were very poor and the medical care prescribed to save his life were to cost a sum which to the average man would not be prohibitive but to him would prove a very grave burden, he would not be obligated to go to the expense of obtaining this medical care....The absolute norm, on the other hand, establishes a maximum amount beyond which no one need go in spending money to care for his health. This norm is based on that which *people in general* would find very costly. ... Let us suppose that an individual whose health requires costly treatments is exceedingly wealthy. He could, without being caused any inconvenience by the expense, pay for such medical care. Despite his financial status, treatment costing \$2000 or more would be considered extraordinary means of preserving his life." (E. F. Healy, *Medical Ethics* [Chicago, IL: Loyola University Press, 1956], 68) Now it is true that *people in general* find an expense of \$2,000 prohibitive for extending one's life for an extra year or so—or let's make that \$200,000 for contemporary Americans. But that is only because most Americans accidentally do not have that much money and would only be able to get it if they sold everything they owned, which would risk their children's financial future as well. On the other hand, the fact that most people do not feel they have to jump on a grenade does not depend on any such accidental circumstances. Here we are dealing with a truly absolute limit to what can be expected of a human being.

<sup>30</sup> Healy, *Medical Ethics*, 61. See also J. Torchia, "Artificial Hydration and Nutrition for the PVS Patient: Ordinary Care or Extraordinary Intervention?" *National Catholic Bioethics Quarterly* 3.4 (Winter 2003): 719–730.

<sup>31</sup> See also T. J. Bole, "Intensive Care Units (ICUs) and Ordinary Means: Turning Virtue into Vice" *Linacre Quarterly* 57.1 (February 1990): 68–77.

propriate, and overzealous care. It would be very awkward for a physician to admit that artificial ventilation is unreasonable, inappropriate, even overzealous, and at the same time continue it. Thus, the traditional interpretation of extraordinary medical treatment as supererogatory is paradoxical.

### **Toward a New Interpretation of Ordinarity**

In more recent documents, including those from Catholic moral authorities, we find indications that extraordinary treatments may indeed pose moral hazards. Certain medical interventions which are typically classified as extraordinary can be harmful to patients, and should hence be forgone. The *Catechism* talks about over-zealous attempts on the part of physicians to extend patients' lives.<sup>32</sup> John Paul II in *Evangelium vitae* argued that medical procedures are extraordinary when they "no longer correspond to the real situation of the patient."<sup>33</sup> It is clear that his statement is not a plea for subscribing to situation ethics. The key term in his statement is not *situation* but the qualifier *real*.

William May writes that if we invoke the terms *ordinary* and *extraordinary*, we should examine "the morally significant reality-making and truth-making factors that give them their moral meaning." He notes: "Among the factors that are reality-making in determining the condition of the patient are his freedom to die the death he is in fact dying and the fact that he has already begun the process of dying."<sup>34</sup> This language reflects a personalist ethics in which certain medical interventions are characterized as extraordinary when and because they no longer foster, but rather frustrate, the self-realization of the individual. It is evidently very difficult to spell out what this self-realization is, and to do so in a discourse that bridges the subjective and the objective. But I submit that there is a certain *order* involved in this self-realization. A medical intervention is extraordinary if it is no longer *in order* for this particular patient.<sup>35</sup>

But what kind of order? Most assuredly, the order that is violated by certain so-called extraordinary medical interventions defies a narrow biomedical interpretation. While life, health, and physical ability certainly factor into this order, the order of a patient's life contains much more richness than just these aspects.

Furthermore, the order of life is not a mere rational order (in the sense of formal logic). While there is reason to the way most people order their lives, those lives cannot be reduced to formal logic. We make many decisions and choices that defy such logic, yet these decisions and choices do make sense because they appear

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<sup>32</sup> *Catechism of the Catholic Church* (New York: Doubleday, 1994), n. 2278.

<sup>33</sup> John Paul II, *The Gospel of Life: Evangelium Vitae* (Washington, DC: United States Catholic Conference, 1995), n. 65.

<sup>34</sup> May, *Human Existence*, 147.

<sup>35</sup> It should be noted that the etymological significance of the term "ordinary" disappears in certain foreign language translations. For example, the usual Dutch translation of "ordinary" as "gewoon" has no connection whatsoever with the term "order." Conversely, the Dutch word "ordinair" (a more literal translation of "ordinary") connotes vulgarity.

to be very much in keeping with the individual order for each one of us. More importantly, this order probably cannot be determined a priori. It is an experiential order. When we see an instance of extraordinary treatment, we recognize it as such. But it is very difficult, if at all possible, to spell out in advance what is or will be extraordinary for any given patient. Still, it may be possible to uncover the general nature of the order of people's lives, with which certain medical inventions are consistent and others are at odds.

If this order is neither biological nor rational, what is its nature? Many contemporary bioethicists propose to consider the patient's life as a text, to be written and read, to be interpreted and retold. Narrative ethicists, hermeneuticists, and deconstructivists all rely on the literary order that is thought to be present in a text and, analogously, in a patient's life. Presumably, the patient's story—or, more radically, the story which is the patient—not only reveals the meaningful aspects of the case, but is normative as well. It reveals what is in order for this patient and, hence, ought to happen; and what medical interventions ought to be forgone because they are at odds with the patient's story. Consider the following sketch of an imaginary patient at the end of life:

Ms. K has lived a long life. Life has not been happy all the way through; it has had its ups and downs, its bright and its melancholic moments. But it is a life that is coming to an end. With modern medical help, we manage to motivate her life to regain power again. We hope to extend the ongoing movement within her life a bit longer. Maybe a new, although minor, theme within this life will develop. This extension of her life is appreciated by all concerned: patient, family, and care providers. However, they have some impatience; there is a sense of dragging things out, of postponing a closure that really ought to come. Life itself seems to be calling for this closure, a closure that may be sad and silent, like a setting sun on a hazy autumn day, or loud and shocking like a resonant implosion. Either way, this closure ought to come. But it does not seem to be happening. Medicine seems to be extending a theme, a movement that has already been developed in full.

This case description is very sketchy. To many contemporary narrative bioethicists, it will not suffice. It violates the tenet of having a sound, thick case description to analyze, because it does not do justice to the textual and contextual richness of the story. But is a text a proper analogy to human life? Is it the only proper analogy? Is it the best analogy when end-of-life decisions must be made? In the final section of this article, I examine one more analogy for the order of human life, that is, music.

### **The Musical Order of Human Life**

Dufrenne explicitly draws an analogy between human existence/being (i.e., Heidegger's *Dasein*) and musical being. At the heart of this analogy lies the idea of time or temporality.

The human self implies both temporality and spaciality, and the *Da* ("there") of *Dasein* ("being-there," "existence") has a meaning which is both temporal and spatial ... Time is seen as a relationship of the self with itself ... The self is what endures and what remains the same in becoming other ... [As opposed to clock time], the time proper to the living being expresses the interiority of



life and what Kant calls its internal finality. We shall see how the aesthetic object also involves such internal finality.<sup>36</sup>

Like music, life develops in time. While that seems to be true of a text as well, the text is not temporal in at least one crucial regard: one can stop reading a text and later resume reading it again without there necessarily being a breach. The same is true for writing a text. One can even rewrite what was written and certainly read a preceding sentence again. But none of this is possible in music. Music develops in a linear way; if the music stops (which is not the same as silence), it disappears. It is necessarily one-directional. And so is human life. No experience can be relived; no act can be undone or even redone. Life cannot be interrupted or resumed. It is a continuous one-way journey.

More importantly, there is a logic to music that is very different from the logic within a text. The logic in music arises only as the music unfolds. "A note must always be conceived in relation to other notes."<sup>37</sup> This logic is not moved forward by the past as a text is, but is rather pulled forward by the future. When we listen to music, we always already hear what has not yet come into being, and when we hear what had yet to be, it confirms what was. Again, this is very different from the logic of a text, but actually seems very much like of the logic inherent in life. Our future actions are not meaningful if, and because, they follow logically from past decisions; rather, the past acquires its meaning in view of, and because of, our future actions. There is, in other words, a certain order to music (as well as to human life) that is not composed of an a priori logic, but rather is composed of an experiential logic.

This quality of music makes it difficult to characterize its logic. Indeed, Dufrenne warns us that music "lacks the internal logic of a rational construction, and it is difficult to distinguish the necessary elements from the contingent ones or, better, the natural ones from the artificial ones."<sup>38</sup> Here, the word *natural* is not (or not foremost) a matter of acoustical physics, but of aesthetic perception. Dufrenne distinguishes three aspects of this aesthetic perception: harmony, rhythm, and melody.

Harmony grants music its objectiveness. "Harmony makes sound into a graspable reality—as opposed to noise which startles us initially but fails to hold our

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<sup>36</sup> M. Dufrenne, *The Phenomenology of Aesthetic Experience* (Evanston, IL: Northwestern University Press, 1973), 242–243. This quote comes from Dufrenne's introduction to the chapters on the "Musical Work." There is, of course, the risk of circularity in my quoting Dufrenne. An analogy has argumentative power if something unknown is compared to something known. Dufrenne assumes that we know human existence (drawing on twentieth century existentialist philosophy) and then uses this knowledge to explain the unknown, that is, the musical piece. I, on the other hand, want to use what we know about music to clarify unknown aspects of human existence. If I do so by simply reversing Dufrenne's analogy, I invoke a circle. However, my point in drawing from Dufrenne is not to prove that music is indeed a proper analogy to human existence. Rather, if we accept Dufrenne's analyses as convincing, his drawing an analogy between human existence and music is at least suggestive of a comparable structure that can be known.

<sup>37</sup> Ibid., 255.

<sup>38</sup> Ibid., 252.

attention.”<sup>39</sup> Because of harmony, an identifiable, unified object arises in the ongoing flow of sound. “To harmonize ... is to construct a chord.”<sup>40</sup> Still, this object is never static. “Whether the chord expresses stability, as a major chord does, or whether it conveys an uncertain transitory effect, as does a seventh chord, its role is always defined in terms of possible movement.”<sup>41</sup> Likewise, in the course of human life, harmonies arise. Some of these traits, patterns, and styles are lasting; others are transient. But they are never fixed, permanent, cast in stone, or even in text. They always remain open to the future, directed toward the possible.

As music unfolds into the future, it does so rhythmically; this is the second aspect of musical order.

The self-movement of the work is ... genuinely part of its being, and this movement is manifested in its rhythm ... The rhythm of the musical object ... is its very being. This rhythm expresses its own duration by measuring, not the time which contains the object, but the time which it *is*, the initial becoming which constitutes it.<sup>42</sup>

While the tempo of a certain piece of music is seldom fixed to an exact number of beats per second, the performer is not fully free to choose the tempo. The music itself calls for a certain tempo. Consider the opening bars of Beethoven’s Fifth Symphony. If these chords are played too slowly, the gripping effect disappears; but if they are played too fast, they lose their gravity.

Widdershoven draws a comparison between human life and the recitation of a poem.<sup>43</sup> The timing has to be just right; without the proper tempo of recitation, the poem “won’t work,” it will not come alive.<sup>44</sup> So it can be argued that there is a proper tempo to human life; that is, there are proper tempi to life’s various movements. There is a cadence to life. Certain themes demand a slower, more reflective tempo to fully express their significance. Other themes require lighthearted swiftness. In each human life, there will be unexpected, surprising turns and modulations. At other times, familiarity and even repetition are becoming.

Also, each of these themes should have a fitting, that is, timely end. Much more so than a text, a musical composition that is unfinished or, even worse, discontinued mid-course leaves a very deep sense of dissatisfaction. Something is interrupted, which calls to be finished; the sudden silence is deafening. Again, an analogy presents itself: this sudden musical silence seems analogous to the premature death of an adult

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<sup>39</sup> Ibid., 255.

<sup>40</sup> Ibid., 254.

<sup>41</sup> Ibid.

<sup>42</sup> Ibid., 257, 261–262.

<sup>43</sup> G. Widdershoven, *Principe of Praktijk: Een Hermeneutische Visie op Gezondheid en Zorg* (Maastricht, the Netherlands: University of Maastricht, 1995), 31–32.

<sup>44</sup> Although poetry is generally considered to be literary rather than musical, the aspect to which Widdershoven refers (i.e., its recitation) is truly musical. It is this musical aspect that turns a poem into a hybrid form of art, merging the qualities of literature and music.

in mid-life or, worse, of a growing child. The deceased seems more present in his absence than he seemed to be prior to his suddenly passing away. Conversely, we have all become bored while listening to never-ending scores, when the composer apparently was unable to write the proper closure. He drags out the theme, adding bang after bang after bang, so that it becomes almost painful to listen to, or, for the musicians among us, embarrassing to play. Life, too, can be dragged out, so much so that no one (neither the patient herself, her family members, or her care providers) seems able to compose a fitting closure. The end only comes when the soloist finally runs out of air, when the last string snaps, or the drumhead tears.

The third defining aspect of the musical order is the melody. It is what “spontaneously appears in the work when we yield to it.” Dufrenne insists that the melody, though inseparable from harmony and rhythm, is of a different class altogether. Although each melody has distinct themes and motives, it defies the schemata that characterize harmony as well as rhythm. “Melody is the work itself *qua* duration.”<sup>45</sup> Likewise, we can come to fully appreciate the beauty of a human life only when we meet that person “in person.” In being with another human person, in investing oneself in another, even yielding to him or her, the other appears with a clarity and sonority, the force of which we become fully aware of only in the sudden silence of his or her absence.

### The Order of Life

In decades past, the *ordinary-extraordinary* distinction has lost much of its ethical significance. Confusion about the terms and interpretive differences have led to the demise of this once-eminent distinction in end-of-life medical decision making. Although not all of the criticism of the use of these terms is fair, some of it is certainly pertinent. Hence, there would be little sense in trying to revive the use of these terms if better ones had come available. Unfortunately, that has not happened. Many alternative terms have been proposed and tried, but most suffer from equally or even more serious ethical deficits. Hence, none of these alternatives has gained widespread acceptance.

In this article, I have proposed to revive the *ordinary-extraordinary* distinction. The interpretation that I have defended is rooted in its original interpretation, which focuses on the subjectivity of the individual patient. The ordinariness or extraordinariness of medical treatment cannot be determined generically, but should always be determined in reference to a particular patient. In what turns out to be much more than a play on words, the crucial question is whether a particular medical intervention is “in order” for the patient at hand.

Without any pretense of exhaustiveness, I have briefly discussed four intersecting axes, or orders. First, I discussed the biological order that is the foundation of medicine itself. All of a physician’s observations and ideas are ordered along this axis. Undeniably, it is a pertinent order, but the discussion must not be reduced to that single order.

The same is true for the second order mentioned, the rational order. Traditionally, it is the order of legal and economic reflection, as well as of the realms of

<sup>45</sup> Dufrenne, *The Phenomenology of Aesthetic Experience*, 265.

philosophy and ethics. This order is a valuable complement to the biological order. Informed consent, living wills, powers of attorney, and ethics committees notwithstanding, it has become painfully clear that even a bi-axial approach to end-of-life care decision making does not suffice.

In recent years, the answer to this problem has been sought in literary analogies. Reading the patient as a text has allowed for a much richer understanding of the order of a unique patient's life story. Thus a third, literary axis has emerged.

In this article, I have advocated a fourth, complementary decision-making axis. Rather than reading the patient, I propose that one listen to the life of the patient, so as to discover its musical order.

Interpreted in this way, the *ordinary-extraordinary* distinction actually has certain advantages over the alternative terms. First, it has prescriptive force. It follows logically that what is not "in order" for a patient ought not be forced onto the patient. Conversely, a patient is morally required—at least *prima facie*—to accept medical interventions that are in order for him or her. But the terms are also descriptively helpful. They refer to a certain way of being, an order that is internal to, even constitutive of, the life of the patient, the individual self, the unique person.

The second important advantage of the *ordinary-extraordinary* distinction is that the order to which it refers is both an objective order and a subjective order. The patient's order is objective because it is constituted by, and contingent on, the laws of nature (whether physical or aesthetic). But the patient is never a mere object. She is always also a subject, a self-constituting person, who escapes the fixed givenness of nature.

In the previous paragraph, the labels *objective* and *subjective* have been used to indicate ontological characteristics. But these labels can also have epistemological significance. Yet again, we find that the order to which the *ordinary-extraordinary* distinction refers is both an objective and a subjective order. From an epistemological perspective, the patient's order is objective, because it is accessible for replicable diagnostic and prognostic examinations by third persons. On the other hand, this order is never fully accessible to that scientific purview. This is because each individual person's particularity defies the generalities of the biomedical sciences. Interpersonal sympathy can partially bridge the gap, but there always remains a private nucleus that is known only to the person herself. In that sense, the order is always subjective as well.

Evidently, the *ordinary-extraordinary* distinction is much more complex and potentially confounding than the *proportionate-disproportionate* distinction and terms like *routine*, *heroic*, or even *futile*. But the *ordinary-extraordinary* distinction also has a richness that is promising. It allows for a meaningful dialogue among all involved: patients, physicians, family members, and nurses. I submit that the simplicity and clarity that many clinicians, patients, families, hospital administrators, and health lawyers strive for is an impossible ideal in the area of end-of-life care. Human mortality is a mystery. Any attempt to reduce that mystery to simple, clear, one-dimensional, and quantifiable terms is bound to be a flawed, even dangerous reduction.