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Intended goals and appropriate treatment: an alternative to the ordinary/extraordinary distinction

Christopher Meyers *Department of Philosophy, University of Tennessee, Knoxville*

Author's abstract

This article argues that the ordinary/extraordinary distinction has little or no moral value when preservation of life is not given a near absolute status. What is appealed to instead is a determination of both medical and moral duties, upon which appropriate treatment decisions should be based. Included is a partial delineation of those duties.

During a recent practicum* rotation with a medicine team in a major metropolitan hospital I had the opportunity to witness and analyse the decision-making processes of the residents and staff. Of particular interest to me was their reaction to extremely sick, elderly patients. While there frequently was an overtly expressed attitude that many of these patients would be 'better off dead', the team none the less felt a stated moral obligation to proceed with a wide range of treatments, from the insertion of Dobbhoff feeding tubes to intubation on a ventilator.

In nearly all of these cases there was, at the least an implicit appeal to the concept of ordinary care; ie the team felt they had a moral obligation to perform any treatments that could be classified as 'ordinary'. This appeal, and the conceptual confusion that often accompanied it, led to a medical ethics lecture/presentation in which the philosophers suggested that the ordinary/extraordinary distinction, when used as a *moral* distinction, is neither valid nor useful. The following paper, and the suggested alternative to the distinction, evolved from that presentation and the informal discussions that surrounded it.

An understanding of the ordinary/extraordinary distinction requires a quick look at its historical roots. As medical technology advanced in the middle part of this century Roman Catholic theologians found themselves facing a conflict between their long-held views on the sanctity of life and the enormous costs (physical, spiritual, economic, etc) sometimes associated with an adherence to those views. They had to ask themselves whether life was so sacred as to justify the use of any means whatsoever in its preservation. The Church's response was the now famous Papal pronouncement in 1957 in which Pius XII declared that 'Normally one is held to use only ordinary means . . . that is to say, means that do not involve any grave burden for oneself or others' (1). Defining what would represent a 'grave burden' has occupied the time and attention of many a philosopher/ethicist. Such is not, however, my purpose in this paper. Instead, it is my claim that the ordinary/extraordinary distinction is only of moral import if one adheres to a sanctity of life position; a position I, without argument, will reject (2). That is, if the value is not assigned to the preservation of life, but instead is assigned to the goods that life acts as a means to (for example interrelational ability, self-awareness, moral existence, etc), then the need for the moral 'excuse' the concept of extraordinary care provides will disappear.

The predominant concern with the use of the distinction has been to provide a justification for overriding what was perceived as a near absolute obligation – to preserve life. If that obligation does not exist, or if it at least does not exist with the stringency traditionally assigned to it, then the concern becomes identifying what obligations do exist with respect to an individual patient and basing determinations of appropriate care on those obligations. Hence, an alternative to the ordinary/extraordinary distinction emerges: determinations of appropriate treatment result from specifying what obligations (medical, moral, and legal) exist in an individual case and deciding which forms of treatment best satisfy those obligations (3). With this perspective, the concern is not what will justify our *not doing* X to preserve life; but, rather, what do we have an obligation to *do* in a particular case.

Before turning to what those obligations are there is another, more practically oriented reason for discarding the distinction. The prevailing attitude of physicians (4) with respect to the distinction is that it refers to *usual/unusual* treatment. That is, it is most often viewed as a distinction between what is

*A practicum is a period of time in which philosophers, theologians and other non-doctors studying medical ethics are integrated into clinical practice–Ed.

Key words

Ordinary/extraordinary distinction; usual/unusual distinction; sanctity of life; duties of health-care practitioners.

commonly practised in a medical community and what is seen as being unusual care in that community. Hence, when a decision was made whether to insert a gastrostomy tube in a post-stroke, severely demented 79-year-old woman, the primary concern was whether that would be considered 'standard' care at the other institutions in the area. While this is a legitimate concern for the physician attempting to avoid litigation, the fact that it would or would not be standard care elsewhere does not provide a *moral* justification (5). As Carson Strong puts it: 'The idea that whatever is customary is *always* ethically indicated is simply mistaken' (6).

Strong goes on to argue, however, that 'the latter terms [ie ordinary/extraordinary] are so firmly entrenched in medical discourse that it is doubtful that we shall abandon them in favor of the more precise alternative' (6). While Strong's concern is a legitimate one, I feel it is that very entrenchment that suggests appealing to an alternative. For it is not just that the terms are a standard part of medical vocabulary; it is that they are so misunderstood that creates the problem. Rather than attempting to re-define the terms for the physicians, we would do well to concede their legitimate legal and medical use and then deny a legitimate moral use, offering an alternative in the process.

Since, on my alternative model, we are not looking for justifications for not treating, but instead, are looking for what *positive* duties exist, it becomes crucial to ascertain the extent of those duties. In other words, and what follows will be a greatly oversimplified account, we need to determine the proper role of the physician, at least insofar as his or her *direct* duties towards patients are concerned.

The first and most obvious is the duty to provide competent medical care. This is clearly the underlying focus of Paul Ramsey's argument for a 'medical indications' policy. The physician's first goal is to give, to the best of his or her ability, an accurate diagnosis, coupled with a determination of what medical procedures will be effective in improving the health of the patient. The two examples Ramsey provides help illustrate the crucial need for competent knowledge (7). He suggests there are two groups of spina bifida babies for whom current medical treatments would not be efficacious. The first group are those babies who the physician feels reasonably certain will die, regardless of treatment. 'None of these babies should be operated on because to do so would have no bearing at all on whether it lived or died' (8). The second group includes those babies for whom, while death is not imminent, current treatment methods will provide no benefit. 'If the operation were performed it is likely that healing would not occur, that there would be wound breakdown, and that infection could be far worse than if no operation were done at all. In these cases the baby would be given simply dressing' (9).

In both of these cases the medical indication for non-treatment is a crucial consideration. However, by reducing the total decision to this element Ramsey has oversimplified the role of the physician to that of a mere technician. An appropriate treatment plan in either of the cited cases would need to appeal to other physician duties.

While it is not applicable in those cases, another obvious duty is to consider the patient's wishes. Ramsey goes to great lengths, in his response to Robert Veatch, to argue that the right to refuse treatment (and hence the corresponding duty to respect that refusal) is merely 'relative'. A patient's 'freedom and dignity do not encompass the right to do wrong, a right to assault the value of his own life with or without medical assistance' (10). While I agree that Veatch's position denies room for physician conscience, Ramsey's goes too far the other way. Individuals *do* have the right to 'assault the value of their own lives', so long as in the process they do not cause excessive harm to others. However, individuals do *not* have the right to demand that another (ie a physician) carries out that 'assault'. A physician may, in many circumstances, refuse further association with a patient with whom he or she has a moral conflict. However, any appropriate treatment plan must consider, and most often respect, the competent patient's wishes, regardless of whether they are consistent with medical indications.

A third duty is to attempt to improve the quality of the patient's life. Included in this is the obligation to 'do no harm,' so long as it is understood that it oftentimes may be necessary to incur some harm (most frequently, causing pain) so as to bring about a higher good of improving the quality of life. While I do not have the space either to list or analyse those elements that lead to such an improvement, it is important to note that prolongation of life is not necessarily included. It is easy to imagine conditions (for example, prolonged intractable pain, near total loss of dignity, etc) wherein continued existence represents a harm. Hence, as I noted at the outset, the physician only has a duty to preserve life if it can serve as a means to a higher good.

A fourth duty is to consider the family's wishes, and to a lesser degree, to attempt to understand and work with the social interaction of that family, at least insofar as that interaction pertains to the effective treatment of the primary patient. While I recognise that the majority of physicians reject the family-practice model of the family as a whole being the patient, few would deny that family interaction is frequently a critical element of patient care. The most obvious examples are like the previously cited cases provided by Ramsey (2). His focus in the discussion of the cases is on the patient's potential quality of life and, in fact, he does not even consider the impact of the child on its family's life, nor does he discuss the parents' rights to be involved in the decision-making process. Both exclusions represent a gross oversimplification of the wide range of important family oriented elements involved in such a decision.

Less obvious, but equally important examples are

those in which the entire family's life-style will be altered so as to accommodate the ill patient; for example dietary changes (hypertensives, diabetics), reductions in activity (cardiac patients), adherence to strict medication schedules, etc. While I do not feel the family's responses to these problems should necessarily be respected as ultimately authoritative, the physician does have an obligation to take them into consideration when determining appropriate treatment.

A fifth duty is to consider what cost will be incurred in society (including for example the psychological/emotional costs to the health care team) as a result of a given treatment. What is the economic source of the treatment? How will the treatment, or lack thereof, affect the morale (and hence other patient care) of the team? How, in extreme cases, will treatment, or lack thereof, affect public perception of the institution? Though these considerations should and do carry less weight in the decision-making process, determinations of appropriate treatment should include them.

A sixth and final duty is to avoid litigation. The impact of a lengthy and costly court trial on other patient care and on overall medical costs, combined with possible financial or criminal retribution for the physician, make this last duty of utmost concern. While it can be forcibly argued that this consideration should be ultimately authoritative when those harms represent a significant threat, it must also be recognised that physicians will, not infrequently, find their medical and moral obligations in conflict with their legal obligations. In such situations the physician will be faced with a difficult decision as to which option represents the greatest harm.

One might object that the task I have presented to the physician is too overwhelming. If he or she must consider in each case what took me several pages to spell out, he or she will never assign *any* treatment, appropriate or not. My response is that in many cases all these duties are already taken into consideration, if only on a non-reflective level. Further, the extent to which each duty must be considered will vary from case to case. When determining appropriate treatment for a sprained ankle, the duties need only be given a cursory examination. Whereas, in the case briefly described on page 129, where the treatment represents a substantial alteration of the patient and family's future existence, the listed duties must be given serious and careful attention. This does represent a considerably more difficult task than the relatively easy appeal to what is customary/non-customary treatment. But, since the intended goal of the ordinary/extraordinary distinction was to ensure *ethically* (as well as medically) appropriate treatment, the more difficult task simply cannot be avoided.

References and notes

(1) Pope Pius XII. *Acta apostolicae sedis* 1957; 49: 1031–1032.

(2) Any number of sources for such an argument are available. A few of the better ones include: the debate between Kuhse H and Hughes G. *Journal of medical ethics* 1981; 2: 74–82; McCormick R A. To save or let die: the dilemma of modern medicine. *Journal of the American Medical Association* 1974; 2: 172–176; Ramsey P. 'Euthanasia' and dying well enough. In: Ramsey P. *Ethics at the edges of life*. New Haven: Yale University Press, 1978: 145–188; and Kohl M. Voluntary beneficent euthanasia. In: Kohl M, ed. *Beneficent euthanasia*. Buffalo: Prometheus Books, 1975: 130–141.

(3) This proposed alternative is a combination of two previously argued positions. See Strong C. Can fluids and electrolytes be 'extra-ordinary' treatment. *Journal of medical ethics* 1981; 2: 83–85, especially his concept of 'ethically indicated' treatment. See also, Ramsey P. reference (2): 154ff, especially his concept of 'medically indicated' treatment.

(4) While this attitude is prevalent, in my experience, among nearly all the members of the health-care team, the focus of my paper will be limited to the physician, though most of my argument holds for the other members as well. The exception lies in the delineation of duties section, though here too there is much overlap.

(5) It can, rightfully, be argued that since the physician has a moral obligation to avoid litigation, and since malpractice rulings often rest on the customary/non-customary distinction, such a consideration takes on moral import. However, if my rejection of the ordinary/extraordinary distinction is valid from an ethical perspective, it also is from a legal perspective. That is, the law should appeal to something like my alternative in determining physician negligence. In the meantime, unfortunately, the physician does need to address the distinction in order to avoid litigation.

(6) See reference (3): Strong C: 84.

(7) See reference (2): Ramsey P: 182–183.

(8) See reference (2): Ramsey P: 182.

(9) See reference (2): Ramsey P: 183.

(10) See reference (2): Ramsey P: 158.