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Editorial

Ordinary and extraordinary means

In this issue we publish several articles which in some degree consider the concepts of ordinary means and extraordinary means in relation to medical treatment. At first sight this might seem inappropriate in a non-theological journal. However not only is the distinction employed by Roman Catholics, in the context especially of patients in intensive care (following a Papal statement in 1957 on this matter), but it has also gradually come to be used in medical ethics more generally both by non-Catholics and by those of no religion. The concepts thus require analysis from a secular as well as a theological standpoint, and the debate between Ms Kuhse and Father Hughes, the review by Professor Downie and the article by Dr Strong provide such analysis.

Suffice it to note here that thoughtful proponents of the use of the distinction between ordinary and extraordinary means agree with opponents that the moral assessment of any individual's case must properly come *before* it is decided whether any particular treatment is to be classfied as ordinary or extraordinary; moreover not only the 'means' (*ie* the proposed means of treatment) but also the patient's particular circumstances and the anticipated harms and benefits to him in those circumstances of those means of treatment must be assessed before the means can be classified as being either ordinary or extraordinary. Thus there is no question of observing whether some proposed means of treatment X is, as a matter of non-evaluative fact, ordinary or extraordinary and then using this observation or 'fact' to decide whether or not patient Y in circumstances Z should be treated with X; rather it is a matter of first deciding whether or not it would be *right* to treat patient Y in context Z with treatment X and then, depending on that decision, classifying X as ordinary or extraordinary means of treatment.

Non-Catholics are often – perhaps always – surprised at this revelation when first they meet it, supposing reasonably enough that 'ordinary' means 'usual, commonplace, not exceptional' (to quote the Oxford English Dictionary) and conversely that 'extraordinary' means 'unusual, uncommon, exceptional.' However, although these concepts may obliquely enter the analysis of specific cases it is clear that, as Strong explicitly states, the conflation of 'ordinary' with 'customary' and of 'extraordinary' with 'unusual' must be rejected; he indeed goes further and suggests that for the purpose of medical ethics 'perhaps we would avoid confusion if we used the terms "ethically indicated," and "ethically non-indicated" in place of the terms "ordinary" and "extraordinary".' Of course once we accept such an understanding of the distinction it remains open to ask what are the criteria upon which it should be made – what are the substantive moral principles upon which we can decide whether treatment X is or is not 'ethically indicated' (*ie* indicated by some process of ethical analysis) for patient Y in circumstances Z.

Roman Catholic authorities have proposed excessive expense, excessive pain, excessive difficulty or other inconvenience, and no reasonable or 'proportionate' hope of benefit as criteria for deciding that a treatment is 'extraordinary' in the context of a particular patient in particular circumstances. This approach is reflected by the Church of England. Thus the moral theologian Professor G R Dunstan in an article on this subject in the *Dictionary of Medical Ethics* suggests that the distinction has different connotations for moralists and for doctors but is used by both with the same intention, notably 'to insist that it is the patient's ultimate interest which should determine the treatment he receives, that interest being seen in relation to his unique being and his unique human and social environment.' Dunstan states that ordinary (and hence morally obligatory) procedures are for the moralist those which, when relativised to a particular patient in a particular context offer the patient 'a reasonable hope of benefit, without excessive expense, pain or other serious inconvenience.' Similarly in medical usage 'ordinary' would indicate 'what is normal, established, well-tried; of known effectiveness, within the resources and skills available; of calculable and acceptable risk; of generally low mortality; involving pain, disturbance, inconvenience, all within predictable limits of acceptability and control; and all proportionate to an expected and lasting benefit to the patient.'

Conversely 'extraordinary' (and hence morally optional) means are for the moralist those means which, when relativised to a particular patient in a particular context, do not satisfy the criteria for being 'ordinary' and which would impose on the patient 'undue suffering or expense, or, it may be,

an undue distortion of his personality or a barrier in his relationships with his kin, a lessening of his human capacity, and all without a reasonable hope of benefit.' In the medical connotation extraordinary procedures would be those which in relation to a particular patient in a particular context would fail to meet the criteria for being ordinary – they would include for instance 'investigatory and experimental procedures of uncertain efficacy, or even carrying a high mortality rate; those involving a heavy disproportion between the pain, mutilation, disfigurement or psychological disruption of the patient and any immediate or long-term benefit reasonably predictable; or of disproportionate cost.'

There can be few people involved in making medical-ethical decisions, whether in practice or merely in theory, who would disagree with the general principles of assessment proposed in either the Roman Catholic or Church of England positions as outlined above. Both, however, knowingly leave many important moral questions unanswered. What is to count as 'excessive' expense, pain, difficulty or other inconvenience; what is a 'reasonable' or 'proportionate' hope of benefit; what indeed is to count as a 'benefit'; and who should decide these weighty matters? No attempt is made to answer such questions here. Rather, the crucial point for health workers not versed in Christian theology to appreciate is that an appeal to the ordinary/extraordinary means distinction can not help them to answer these questions, for the distinction itself can only be made *after* the questions have been answered.

The distinction between ordinary means and extraordinary means has a dangerously deceptive appearance of simplicity. It appears to be a distinction made by assessing means of treatment, whereas in fact, as Dunstan puts it 'the criteria for decision relate primarily to the patient not to the remedy.' It appears to be a distinction made by determining whether particular means of treatment are usual or unusual, and again this is not the case. It appears to give a single *criterion* for making a moral decision whereas in fact it is only a label for a decision making process which uses a cluster of different moral criteria: above all it appears to be a distinction based upon a simple, uncontroversial, morally non-evaluative assessment, whereas in fact it is based upon complex potentially controversial and essentially moral assessments.

Those who are motivated by their religious orientations to use the distinction between ordinary and extraordinary means in the context of medical ethics may be expected to be aware of all this; those who are not so motivated need to appreciate these complexities before using the distinction at all. However all health workers will risk less confusion, if not for themselves then at least for their patients and for their patients' relatives, if they specify the moral criteria which they believe should be used when deciding whether or not to undertake particular treatments for particular patients in particular circumstances. Specifying the criteria, which may well relate to the risks, costs, pain, likelihood of success, anticipated results and side effects, both physical and psychological of a proposed treatment, will not only reduce confusion but will also provide an opportunity for discussion of the complex issues, both among staff involved and also with patients and/or their relatives. Moreover once the actual criteria of decision are specified the misleading labels 'ordinary means' and 'extraordinary means' become superfluous and may be safely allowed to 'drop out of the picture' by those who have no special reason to retain them.