

Ordinary Duties, Extraordinary Means

David S. Oderberg

Within morality, there are things a person must do but also many things that it would be beyond a person's moral obligation to do. There are heroic acts, acts that we call "above and beyond the call of duty," acts that are admirable but not strictly required. To take a simple example, if a person can pull a drowning child from a shallow pond with little difficulty, he is bound to do so; but no one is obliged to risk his life by diving into raging surf (unless the person is a lifesaver and it is his job), however much we would admire his heroism if he did so.

This distinction applies across the board, as much in medical ethics as in everyday life. No one is obliged to do what it is beyond his mental or physical powers to do. In general, grave hardship and oppressive burdens can tax a person's capacities, and morality must draw a line between what can and cannot legitimately be expected. On the other hand, doctors have a special expertise that requires them to do things that are not usually expected of a layman. Just as policemen and firefighters, by the very nature of their job, are expected to take risks that others are not, so doctors are expected, by the very nature of their profession, to go to great lengths to save and preserve life.

But how far must they go? They cannot simply ignore the desires of their patients and of the families and loved ones closely concerned, but nor should they bow to every whim and wish. Deciding how a doctor should act in a given situation is often a delicate and subtle task, which decision moralists have the primary responsibility of guiding: moralists, that is, who are not caught up in the death culture that now sadly pervades so much of the medical profession. It is for that profession to listen to and heed the considered opinions of the moral experts who care about life and are trained to balance the competing considerations that must be weighed in difficult cases.

The general ethical principle that must be recognized is that man is morally obliged to adopt all *ordinary* means of preserving health and life. At its most general, ordinary means are those that do not entail grave hardships. If the means do involve grave hardship, they are to be classed as *extraordinary* and hence usually not obligatory. There are exceptions. A person whose continued existence is vital for the common good is obliged to submit to more than ordinary attempts to keep him alive: for instance, a gravely ill

David S. Oderberg is Professor of Philosophy at the University of Reading, England.

president or military leader should submit to extraordinary treatment, especially at a time of national crisis. Also, if a person is not spiritually prepared for death, he should submit to extraordinary means to keep him alive until he can be so prepared.

In general, however, submitting to extraordinary means is not obligatory for a patient, hence it is not the duty of a doctor to employ them. We can define ordinary means as including not only food, drink, shelter and rest, but also all treatments and medicines that offer a reasonable hope of benefit for the patient and can be obtained and used without excessive pain, suffering or other inconvenience, including expense, on the part of the patient, his family and loved ones, and the doctors concerned. Means that are not ordinary are extraordinary. Ordinary means are absolutely binding—they must be used, and the failure to supply them is gross negligence. If the failure leads to death, it is morally equivalent to euthanasia.

Food, drink, shelter and rest are ordinary means since there is nothing in the doctor's duty *as a doctor* that makes them special: *any* person is obliged to render another food, drink, shelter and rest if they need it and no hardship is involved in supplying it. But medical expertise brings in other types of assistance that, given the doctor's special knowledge and abilities, are for him, in his situation, what providing food, drink, shelter and rest are for everyone else—a normal duty within the capacity of most people to perform most of the time. The mere fact that the treatment is *artificial* rather than *natural* makes no difference in itself—why should it? Every pill, every injection, every operation is artificial treatment, but many such treatments are ordinary means within the capacity of both patient to undergo and doctor to supply without excessive hardship. There is nothing magical about being artificial that makes a treatment extraordinary. Nor is there anything special about its being expensive, or intricate, or unusual: “extraordinary” in the medico-ethical sense does *not* mean “novel,” “strange” or “atypical.”

Nevertheless, in the circumstances of the case, and according to the definition I gave above, a treatment, whether artificial or not, may be considered extraordinary. Consider artificial feeding. In most cases, such feeding is quite ordinary: the means are ready to hand, easily employed under normal hospital conditions, with no notable inconvenience to patient, doctor, nurses or others involved. Usually it is a *temporary* measure to help the patient get through a difficult period. Sometimes, though, the patient may be terminally ill, or require permanent artificial feeding. Consider the first case. Suppose Fred, a cancer patient, is in unbearable and unrelievable pain, and is being fed artificially. His agony will last a few weeks, but if his artificial feeding is stopped he will die in a few days. Suppose also that he is not

capable of making his own considered request one way or the other. May the physician remove the artificial feeding *in order to shorten the time of Fred's suffering*? Yes, if that were his intention, because the feeding itself conveys no long-term benefit, but does maintain the patient's agony. The patient's suffering in such a case can reasonably be seen as outweighing the loss of a few weeks' life, assuming the patient to be spiritually prepared for death. If he cannot express a wish, his family are permitted to presume that he does not want the feeding to continue (absent other evidence).

On the other hand, whilst this judgment is available in *principle*, in *practice* a doctor should be very reluctant indeed to remove the feeding: (1) there would be, especially in the current climate, a grave risk of scandal—the family and others might well think Fred had been deliberately killed; (2) a doctor who did not understand the subtle moral distinctions in play would be at risk of carrying his behaviour over into cases he regarded as “useless,” as involving lives “not worth living” and so on; (3) the presumption that Fred wants the feeding removed may well be rash—where there is life there is hope, and few people who are ill do not think they just might get better again. Therefore, given the present climate of moral opinion, I would not in general regard the removal of Fred's artificial feeding as permissible.

What about permanent feeding? The question, again, is whether permanent feeding involves excessive pain, suffering or other inconvenience, including expense, on the part of the patient, his family and loved ones, and the doctor concerned. The usual answer must be that permanent feeding is *not* extraordinary. It usually does *not* cause any suffering, let alone unbearable pain, it is not a major inconvenience either for the patient, family or health care system, and is not in itself a great expense, certainly no more expensive than many of the one-off, costly procedures that are now a routine part of medicine. In each case, however, we must look at the specific circumstances of the patient. Is the patient in a permanent coma, or a persistent non-responsive state, or conscious and responsive but permanently immobile?

In the latter case, as long as the feeding did not cause long-term insupportable pain, how could it be considered anything but ordinary, humane treatment? If we say this about that case, why should a patient in a non-responsive state be treated any differently? Such a person is profoundly incapacitated and dependent, to be sure, but what is the criterion for making a moral distinction, short of making a perverse judgment about which lives are “worth living”? When it comes to permanent coma, on the other hand, intuitions among moralists of good will do differ. Some have held (including Catholic medical ethicists in the 1950s) that a patient in a permanent coma

has no prospect of recovery, and so continuing with artificial feeding does nothing but prolong the distress of the family and divert medical resources that could be more usefully employed.

Karen Ann Quinlan, who had been in a drug- and alcohol-induced coma, died in 1985, nine years after the court allowed her to be taken off a respirator at the wish of her family. Normally, artificial respiration is in the same category as feeding, being the provision of basic assistance with essential biological functioning. Terri Schiavo, on the other hand, requires tube feeding but is quite clearly, as the videos of her demonstrate, conscious and responsive, if profoundly disabled. The cases are factually poles apart—but does that mean there must be a moral difference? Some moralists who have no time for the death culture interpret in a rather broad sense the proposition that to be ordinary, a treatment has to have a reasonable prospect of benefiting the patient: Terri Schiavo is clearly someone who, if her life were maintained by artificial feeding, could well benefit from therapy and be enabled to live a relatively pain-free, comfortable existence; whereas someone like Karen Ann Quinlan had no such hope.

Although I can understand the distinction, it is not clear to me that it licenses the placing of a permanently comatose patient into a different category, ethically, from one who is conscious. Recall that ordinary treatment is treatment that offers a reasonable chance of benefiting the patient. To exclude feeding a permanently comatose person—to say that there is something “extraordinary” about it—on the ground that, although being kept alive by feeding, the patient was still not capable of benefiting from *any additional treatment or therapy*, seems to me to twist the natural meaning of what constitutes ordinary treatment. Assuming they are capable of keeping down food and digesting it, feeding benefits people, whatever state they are in—it does exactly what it is supposed to do. The fact that a permanently comatose patient cannot, if she continues to live, benefit from some *other* therapy that being kept alive by feeding makes possible does not mean that *feeding* does not confer the benefit it is supposed to.

So it is not clear, to me at least, that the “reasonable chance of benefit” criterion applies to feeding any more than to any other treatment or procedure that *in and of itself* has a good chance of benefiting the patient. Contrast this with the case of a patient who is in such a chronic state that he continually vomits up any food administered, is persistently ill from feeding, cannot digest the food, perhaps has severe allergic reactions to the food, and so on—in *that* sort of case feeding might well be extraordinary by virtue of its futility, its discomfort for the patient and its burdensomeness on hospital staff. (Needless to say, such a case would be quite rare.)

It is clear that Terri Schiavo is conscious, can benefit from therapy, and is likely, whatever the results of any therapy, to live (if she is fed) a relatively comfortable existence (in the videos she looks physically to be quite robust). Feeding her is without doubt an ordinary and hence morally binding procedure. What about the distress of family and loved ones? It is indeed relevant, but must always be reasonable. In the Schiavo case, it seems the only “distressed” person is the husband who wants her out of the way; the rest of her family is loving and dedicated to helping her. In general, distress merely because someone is profoundly disabled is not reasonable, at least not reasonable in the sense of constituting a burden that could legitimate withdrawing treatment that was otherwise easy to administer. Comatose patients, however, are slightly different, and I can see why moralists of good will have allowed the withdrawal of feeding in cases where there is palpable distress to the family. A comatose patient *looks* dead and, as far as therapy or family interaction is concerned, might as well *be* dead. If the comatose person has already (while conscious) been spiritually prepared for death, if the family are genuinely seriously distressed by the plight of their loved one, and perhaps if hospital resources are being diverted from more pressing cases where lives can be saved and substantial benefits conferred, then, at least in principle, it might be arguable that feeding may be withdrawn, so long as there is *no intention to kill*.

In practice, however, given the current death-oriented climate, I find it hard to see how a routine practice of withdrawing feeding from permanently comatose patients would not cause scandal, especially when supported by pro-life people who might be thought (falsely) to be licensing a kind of “pro-life euthanasia.” Moreover—and perhaps more importantly—even a cursory examination of the facts about recovery from coma (patients have made a full recovery *years* after the coma began) shows that the diagnosis of permanent coma is often tentative and unreliable, and the principle “where there’s life there’s hope” must be given its due weight. If this is the situation with coma, how much more is it the case with diagnosis of the so-called “persistent vegetative state,” where it is established by empirical research that there is a significant amount of misdiagnosis (43% in one study)? This hardly gives one confidence; added to the ignorance clinicians have of just what is going on inside the head of a person who is not able physically to respond to stimuli, we must conclude that it would be a rash doctor who judged the prospects for such a patient to be certainly dim, especially given the therapies that exist and are constantly being improved. Nevertheless, the best judgment in a particular case might be that certain therapies were not likely

to benefit the patient, and if so there would be no obligation to use them.

Apart from the distress at seeing a loved one in a comatose or other disabling condition requiring constant care, perhaps the two factors that make many people of good will worry about how doctors are to decide upon such cases are the thought of it happening to them and the prospect of great expense with no end in sight. I have already said that distress—*reasonable and properly motivated* distress—is one factor to take into account in deciding whether treatment is extraordinary. Expense—both to family and to the medical system—is another. For one thing, a person does not have to subject himself or his dependants to grave hardship in order to fulfil the duty of preserving life. A family might collectively decide to take on the financial hardship of keeping a loved one on life support (let us suppose the expense is great), even if it involved impoverishing the entire family. But to say that it was obligatory would be too strong, and it would be wrong of a person to impose such an obligation (say, in an advance directive) on his family.

As to the worry that a person might find himself comatose and on life support, and his thinking, “If it were me I’d want them to pull the plug,” we do need to respect that concern. No one *wants* ever to be in that situation, and no one wants to subject their family to such a state of affairs. There is nothing whatsoever wrong—and perhaps it should be encouraged—for people to frame advance directives for what should happen to them were they to end up in such an extreme situation and could not communicate their desires at the time. Without such a directive, the family is generally entitled to assume that the person *would* want everything to be done to keep them alive short of treatment that was immensely painful, distressing, impoverishing or futile. A casual remark made by someone in response to a television show or a newspaper report (“If that ever happened to me, I hope you’d pull the plug”) does *not* constitute evidence of a settled intention; and it is well known that people’s desire for survival can radically change when they finally do face a life-or-death situation. An advance directive could certainly aid decision-making, but would also be superseded should the patient be able to communicate his current state of mind.

No advance directive, however, may contradict morality. A person cannot require extraordinary treatment as an obligation, though he may ask doctors to do as much as they can, even if it involves highly experimental therapies. An advance directive cannot prevent a doctor from concluding, on the best evidence available, that a patient is incurable, and so from ceasing to try to administer a cure. (He should, of course, continue trying to find a remedy for the disease itself, if that is his business.) Further, as long as there is even

a slight hope of curing a patient, a doctor should seek to use every promising remedy at his command, subject to the patient's being free to refuse extraordinary treatment.

A decision about the maintenance of life (note: we are not talking at all about the deliberate *ending* of life, which is murder) must ultimately be made in the best interests of the patient and in accordance with his reasonable wishes, express or implied. Ordinary treatment is a duty: food, drink, nursing care, pain relief. The use of artificial methods of maintaining life are not extraordinary *merely* because they are artificial. In the abstract, there is in general no obligation to use any procedure or administer any treatment that does not hold out real hope of some benefit to the patient. In general, food, drink and life support *do* benefit the patient. Nevertheless, in particular cases they may involve genuine hardship, whether for the patient (to be considered first), the family (to be considered next) and the hospital (to be considered third). If so, then like any other assistance that is extraordinary, they may be withdrawn so long as there is no intention to kill or to shorten life.

Nevertheless, in today's climate of death, where euthanasia is rife throughout the world, where mass murderers masquerading as nurses are regularly arrested and paraded before the media, where shortage of resources is used as an excuse for any sort of medical neglect, where care homes are sometimes no more than cemetery holding bays, and where people increasingly do not want to take responsibility for those under their charge, thinking it is for the "system" to do what it must do, it would be a rash medical ethicist who laid down a blanket permission for doctors to withdraw life-sustaining treatment even where the burden was heavy and the distress difficult to bear. Any decision to withdraw treatment in an individual case must be influenced only by the right sorts of consideration. It must involve lengthy reflection and lengthy consultation with the people directly concerned (including spiritual advisers) and no one else *apart* from (a) experts who can supply objective medical information and (b) experts and advisers who are ethically trained in the right sort of morality and have nothing whatsoever to do with the serial-killer ethic that characterizes much of contemporary bioethics. If there is even the slightest suspicion that the motives of those involved are anything other than pure, withdrawal of treatment cannot be allowed. If there is the slightest risk of scandal, again it cannot be allowed. The position of doctors is now more imperilled than ever—they need as much guidance as they can get.