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In Defense of the “Ordinary”/ “Extraordinary” Distinction

Richard O’Neil

The author, an assistant professor of philosophy at Emory and Henry College, Emory, Virginia, explains that his paper “defends the traditional doctrine against a recent proposal by Robert M. Veatch in his popular Death, Dying, and the Biological Revolution.”

Discussions and policy statements on the ethics of the cessation of life-prolonging medical care often refer to the distinction between “ordinary” and “extraordinary” treatment. Briefly, the idea is that while it is never justified to cease ordinary measures, the use of extraordinary means is morally optional. Unfortunately, “ordinary” and “extraordinary” are vague and potentially misleading, and many believe we ought to speak instead simply of morally required and expendable means, or their equivalents. In addition to this terminological change, Robert M. Veatch proposes a substantive shift from the traditional doctrine in his recent book, *Death, Dying, and the Biological Revolution*.¹ He suggests that we adopt the “language of reasonableness” and “patient’s perspective,” and from those perspectives ask “What treatments is it reasonable to refuse?”

I believe Veatch’s proposal is defective. It arises from a failure to keep distinct two questions: 1) What are the obligations of doctors and patients regarding the use of life-prolonging treatment?; 2) When does a patient have a right to refuse treatment? The language of reasonableness is proper in answering the first but not the second question. The converse is true of the patient’s perspective. Veatch attempts to answer both questions from a combination of the two perspectives. The result is a proposal which requires the physician to ignore the burdens a patient’s treatment may have on others and restricts the patient’s right to refuse treatment. Furthermore, there is an interpretation of the traditional doctrine which permits the appropriate use of the two perspectives. This paper therefore defends the traditional view against Veatch’s alternative.

Pope Pius XII’s 1957 address to a group of anesthesiologists expresses the traditional doctrine.² It asserts, first of all, the general right and duty of all persons, and physicians in particular, to preserve life and health. One has this duty “toward himself, toward God, toward the human community, and in most cases toward certain determined persons.” One’s duty, however, is limited. “But normally one is held to use only ordinary means, according to circumstances of persons, places, times, and culture, that is to say, means that do not involve any grave burden for oneself or another.” Doctor and patient

each have the general right to use extraordinary means, but normally neither is obligated to do so. For example, an anesthesiologist has the right to use a respirator in completely hopeless cases, but "he is not bound to do so."

We may interpret the Pope's remarks here in terms of the language of reasonableness. The physician and patient are required to use treatment only when it is reasonable to do so. A respirator may be reasonable for a polio victim but unreasonable for an irreversibly comatose person. The reasonableness of a treatment may be determined by reference to the standard, frequently used in the law, of the "reasonable man." A measure is reasonable if it is acceptable to the reasonable person. The reasonable person, according to the traditional view, would find a treatment unacceptable if it is either not useful in treating a patient's condition or creates significant burdens for the patient or others.

In contrast, what is required of doctors and patients according to Veatch's proposal is "what the patients would find reasonable (in cases where they are competent) and what the reasonable man would find reasonable (when the patient is not competent)." Though the language of reasonableness is used here, the emphasis is on the patient's perspective. For competent patients can have or refuse any treatment so long as they can offer "reasons valid to themselves." And in the case of incompetent patients, objections to treatment are to be considered only if they are patient-centered, i.e., based on burdens it will cause the patient. Consequently, a physician has an obligation to provide treatment for a competent patient whenever he requests it and for an incompetent patient whenever a reasonable person would consider it in the best interests of the patient.

Is this what we want to say? Are there not cases in which the burdens *for others* are so severe as to require the physician not to treat? Consider a patient who requests treatment which in the doctor's judgment will produce no benefit and which will place the patient's family in debt for years. Or a patient who demands the only space in the intensive care unit when there are other patients more likely to benefit from it. In Veatch's view the doctor is obligated to accede to these requests. But this seems wrong, and it is because we believe the legitimate interests of others are relevant to determining a physician's obligations. The patient-centered perspective, by excluding the interests of others (except to the extent that they are among the patient's concerns), fails in this regard.

Patient's Obligations

The patient-centered perspective also yields counter-intuitive judgments concerning the patient's obligations. On Veatch's view competent patients are only morally required to use those measures they themselves find reasonable. That is, they not only have the right to

refuse any treatment to which they object, but it is never wrong for them to do so. This conflicts with our belief that it is sometimes wrong to refuse treatment even when one believes the treatment would be personally burdensome. We may want to grant the Christian Scientist the right to refuse a blood transfusion, but this does not entail that the refusal is the morally right decision. By insisting that it is wrong for a patient to decline ordinary or reasonable measures, the traditional doctrine supports our belief that the subjective decisions of patients do not possess the power to make treatments right or wrong.

What does the traditional view say concerning the patient's right to refuse treatment? According to the Pope, "The doctor, in fact has no separate and independent right where the patient is concerned. In general he can take action only if the patient explicitly or implicitly, directly or indirectly, gives him permission." The patient has a general obligation to himself and others to receive ordinary treatment, i.e., it would be wrong for him to refuse it. But the doctor has no right to impose *any* treatment, ordinary or extraordinary, against the patient's wishes. In other words, the patient has no obligation *to the physician*. If, therefore, the patient wishes to violate his duty to preserve his life and health by refusing treatment, the doctor must let him. Thus the traditional doctrine takes a completely patient-centered view of the right to refuse treatment.

For Veatch, on the other hand, it is not sufficient, apparently, that a competent patient expresses a desire not to be treated. Reasons must also be offered, though only "reasons valid to themselves." This is obviously an attempt to join together the requirements of reasonableness and patient-centeredness. But the notion of a "reason valid to oneself" is either redundant or nonsensical. What could possibly count as a reason seriously offered by a patient which was *not* valid to himself? Moreover, why should we require that reasons be given at all? It should be sufficient that a competent patient state his sincere desire not to be treated. Respect for a person's autonomy demands that we respect his wishes not to be treated whatever the grounds for the refusal.

The overemphasis on reasonableness also appears in Veatch's discussion of refusals for incompetent patients. For them, he adopts the "reasonable man" standard. In acting as agents for those incapable of making their own decisions we are to ask whether the reasonable person would consider refusal of treatment acceptable.

Unfortunately, this approach is not as patient-centered as it appears. For what the reasonable person would find acceptable may differ from what the incompetent patient would choose if he were able. That is, it is one thing to act as a patient's agent and decide for him what is in his best interests. It is quite another to adopt the patient's perspective, based on what one knows of his past expressed wishes and interests, and choose that course which one believes would

be the patient's choice. The former, "reasonable man," standard is appropriate in determining the reasonableness of a treatment. The latter, "surrogate agent," standard is proper if one is concerned to protect the incompetent patient's right of refusal.

Implications of Standards

The reasonable man and surrogate agent standards have different implications for the choice of a patient's agent. On the surrogate agent model the presumption is that decisions concerning cessation of treatment should be made by an incompetent's family. The family is most likely to be familiar with his past expressed wishes and interests. They are to judge as the patient would judge. This is the Pope's view. "The rights and duties of the family depend upon the presumed will of the unconscious patient."

The reasonable man standard does not create the same presumption. For the patient's family may not be the best judge of what the reasonable person would decide is in the patient's best interests. In fact, a case could be made that the best judge is the physician, though this clearly is not Veatch's intention. The physician, after all, is most aware of the medical facts, the chances of recovery, and how similar cases have been decided.

Which model, reasonable man or surrogate agent, should be adopted for the incompetent patient? Well, if a thoroughly patient-centered approach is correct for the competent patient, I see no reason that it should not be correct for the incompetent patient. Incompetent persons have the same rights to autonomy as competent persons. The only difference is that incompetents must exercise their autonomy by proxy. Since the surrogate agent standard is more patient-centered than the reasonable man standard, it is the proper approach. And it, we have seen, is the standard endorsed by the traditional view.

I have not argued that the terms "ordinary" and "extraordinary" are the most appropriate to use in distinguishing life-prolonging measures which one has an obligation to use from those which are optional. Perhaps it would be better to adopt the language of required and expendable means. However, one should be careful that in exchanging terminology the substantive doctrine associated with the original language is not abandoned for a less adequate replacement. If my reasoning is correct, Robert Veatch's proposal is no improvement on the traditional doctrine and, in fact, represents a step backward.

REFERENCES

1. Veatch, Robert M., *Death, Dying, and the Biological Revolution* (New Haven, Conn.: Yale University Press, 1976), pp. 110-114.
2. Pius XII, Pope, "The Prolongation of Life," *The Pope Speaks* Vol. 4 (1958), pp. 395-97.