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Paul A. Byrne

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Health Care Decisions

by

Paul A. Byrne, M.D.

The author is President of the Catholic Medical Association. With permission, some of this article has been excerpted from the booklet Life, Life Support and Death, *published by American Life League, Inc., Stafford, VA.*

The media and the press have brought to our attention the recent appeal to the Supreme Court regarding "physician assisted suicide". We have heard and read that there is no difference between a doctor giving medication to "help" a patient to die and the doctor giving medication for pain to a dying patient. Much of the confusion would be clarified if "physician assisted suicide" would more correctly be called "physician imposed death". Further, it behooves all of us to learn how to make difficult medical decisions for ourselves and how a conscientious, caring, non-killing physician helps us make these decisions.

When a patient has a disease process for which the doctor does not have a treatment that will cure, or when your relative develops complications after routine surgery that result in unconsciousness and a ventilator is required to support breathing, decisions have to be made by the doctor, the patient, and the relatives. In modern times emphasis is on the patient making decisions for himself or herself. This is called the ethical principle of autonomy. Seldom is a decision made without following the advice of a physician. After all, shouldn't one follow the advice of the physician?

The condition of the patient can be so serious that the relatives might be told that the patient is likely to die, and if the

patient should continue to live, full recovery will not occur. "Modern technology is keeping your relative alive," they are told. Sometimes this is interpreted as if "keeping alive" can be done indefinitely, "denying" natural death and "assaulting dignity."

It is said that new technologies have resulted in ethical dilemmas that did not exist in the past. However, the moral questions are no different. One question is, may a physician impose death on the patient? The answer must be no! Another question can be, may the physician deliberately cause harm to the patient? The answer again must be no! The physician must first do no harm. There are distinctions between imposing death (killing) and "allowing to die".

The Patient's Self Determination Act (PSDA), a federal law effective December 1, 1991, requires that all hospitals and nursing homes inform "...all adult individuals receiving medical care..." of their right to execute an advance directive for purposes of making decisions about medical care. An advance directive can be a so-called living will, or it can be a Durable Power of Attorney for Health Care (DPAHC). Often a patient is encouraged to sign a living will that is made available immediately to the patient in the admitting area of the hospital or nursing home. The PSDA law does not call for such encouragement. The legal requirement is only that patients are informed of the opportunity to execute such documents.

When a living will is signed to be carried out sometime later, there can be only speculation and supposition about future conditions and decisions regarding particular treatments. Every physician, and for that matter everyone, knows that it is impossible to predict the future with certainty regarding possible health conditions. Likewise, the state of medical knowledge and practice cannot be known. Consider the advances of the past ten years, and then try to predict the advances for the next ten years. It should be obvious therefore, that a typical living will violates the principle of using current information to make current decisions.

Another kind of advance directive is known as a Durable Power of Attorney for Health Care (DPAHC). With this type of document a person designates someone to speak for him or her when unable to speak for himself/herself. This designated person must be a proxy, that is, someone who will make decisions as close as

possible to what the patient himself would direct if able, and those decisions cannot violate basic ethical principles. In order for this to occur, the decision-making process must be known.

Basic principles include, first, "Thou shalt not kill." One must not commit suicide and one must not impose death on another. This principle has been and should still be a tenet that must not be violated by those entrusted with decision making about delivery of health care.

Secondly, even if one were to obtain every bit of medical treatment and care possible, no one will live forever on earth. The question then becomes, what is the obligation for the patient to obtain medical care?

An ethical construct that has been in existence for more than four hundred years is known as the Principle of Ordinary/Extraordinary Means. Decisions to use or not to use a particular medical treatment, medication, procedure or operation should be considered according to this principle. "Ordinary" and "extraordinary" means represent ethical constructs enabling an understanding of such decisions by the *individual patient.*

As a general principle, a person has an obligation to try to live the entire life span given by God. Therefore he/she must not kill him/herself by intentional act or omission. When it comes to specific decisions regarding medical treatment, this obligation requires the patient to use all "ordinary means" to preserve his/her life.

"Ordinary means" include any treatment, medication, procedure and operation which offer a reasonable hope of benefit without requiring heroic virtue, that is, virtue above and beyond the ordinary. For example, an effective treatment which does not cause pain, expense or other burden that is grave or too excessive for the patient himself/herself to bear is ordinary means.

On the other hand, life on earth for everyone will end, even when everything possible to be done is done. Thus, while the responsibility to avoid deliberately causing one's own death is absolute, the responsibility to preserve and prolong life is not. Because the constitution of the person, the ability of the person and the burdens of medical treatment differ from person to person, the obligation to obtain medical treatment varies, and there is no general

obligation to obtain every treatment all the time. The burden of medical treatment could be extremely great, that is, beyond what would be expected of human beings in general, or even for this particular human being under certain circumstances. Therefore, some treatments, medications, procedures and operations are optional, and these have been classified by ethicists as "extraordinary means."

"Extraordinary means" (or disproportionate means, as preferred by some in modern times) include any treatment, medication, procedure and operation that would be gravely burdensome for the patient to bear or otherwise would require heroic virtue. Strong language - *gravely* burdensome - is used to express this situation; others use excessively burdensome or excessively difficult. Also, *heroic* virtue is used. The use of strong language is used not trying to be scrupulous and not trying to cause others to be so. However, it must be made clear that the burden must be extremely great or the virtue required must be beyond ordinary virtue, before the means can be classified as extraordinary. In other words, the means must involve an excessive hardship – tremendous effort, suffering, cost (unreasonable expense) – more than moderately difficult to obtain or to use. Personal fear, horror or repugnance on the *patient's* part about a particular means could cause it to be considered extraordinary.

Generally speaking, the patient is not obligated to use extraordinary means; he or she may decide to do so. Such a course could constitute an act of heroic virtue. Examples might include a treatment that requires travel to a distant location in a very weakened condition. Similarly, some varieties of chemotherapy could cause overwhelming malaise and fatigue so that the treatment, from the patient's perspective, would be far worse than the disease. Note, however, that medical progress may render today's extraordinary means tomorrow's ordinary means. For example, renal dialysis, a method of cleaning the patient's blood of nitrogenous waste products and other toxins, was unknown 30 years ago. Today it is available in virtually all urban areas.

In the ethical construct of ordinary versus extraordinary means, extraordinary means are limited to treatments, medications, procedures and operations that *may* or *may not* be employed by a

patient himself/herself to preserve his or her own life. It should not be implied by an extraordinary means that such means *must not* be used. A decision not to use an extraordinary means does not foreclose other treatments, and certainly all ordinary treatments because of a diagnosis of an irremediable illness cannot be construed as acceptable behavior within the ethical construct of ordinary/extraordinary means. More-over, extraordinary means cannot be withheld or withdrawn in order to kill the patient or to advance other immoral ends. A physician may not encourage a patient to violate his or her moral obligations, help him or her to do so, or refuse a patient's request for treatment that is obligatory. The physician and the hospital are obliged to try to provide an extraordinary means of treatment when the patient wishes it.

Although generally optional, extraordinary means would become obligatory if the patient is not reconciled with God or if the lives of others depend on the life of the patient. Alternatively, the patient may not choose to use an extraordinary means if it would cause him or her to fail in some more serious duty.

In sum, not to commit suicide is always required and expected. One should live a virtuous life in all ways including taking care of one's own health. To obtain ordinary means of medical treatment and to take good care of one's health is virtuous. If the medical means are gravely burdensome or if they otherwise would require heroic virtue, the means are optional. There is no requirement to obtain such means; in other words, one is dispensed from an obligation to obtain them.

When the patient is unable to speak for himself/herself, the decision regarding treatment becomes more complicated. As a general rule in such a case, the physician must find out any wishes the patient had expressed previously. Then, the physician must obtain consent from a proxy. The instruction to the physician should be as close as possible to that which the patient himself/herself, if able, would give. Almost always the patient has a close family tie with a spouse, a parent or a child. As a result of these bonds, when the patient is unable to communicate for himself/herself, the physician has an obligation to communicate with the family. Pertinent information from relatives and close friends is extremely helpful at these times. Communication with loved ones offers the

best chance for personalized care for the patient unable to speak for himself/herself.

Decisions regarding health care must be *current* decisions based on *current* information. While one may have thoughts about how one would make a decision under a given set of circumstances, the decision *actually* must be made using current facts, including applicable treatments, medications, procedures and operations, all of which are constantly being updated. The necessity to use current information should be sufficient, in itself, to invalidate so-called living wills. While a "durable power of attorney for health care" meets this requirement of access to current data, one must make certain that the philosophy of the durable power of attorney and the decision-making by the proxy designated under the durable power of attorney are consistent with these principles. When the decision must be made and what the patient would want isn't known, one may have to make a judgment based on the patient's "best interest", always keeping foremost that human life is sacred and that life and the life span on earth are gifts from God, a span that must be determined only by God Himself.

When the patient is unable to communicate and it has been made known that the patient still has the obligations to others that an extraordinary means of treatment could help the patient to meet, the physician should gently encourage its use. There is a similar obligation when the patient is unable to communicate and it has been made known that the patient's spiritual needs have not been met. In this circumstance the family and/or proxy should be involved with the hospital staff to provide for the patient's spiritual well-being.

In modern times bioethicists provide "help" for patients, physicians and others involved in the delivery of health care. It would seem that the ethical principles could and should be learned by physicians, if they don't already know them. The language of the bioethicists is not always understood by patients or physicians and decisions often are not easy for anyone involved in the decision-making process.

Everyone involved in health care, including the patient, should be learning how to make a medical treatment decision. It is a responsibility that everyone has when making decisions for their own health care. If we choose not to learn these things for ourselves as a

patient or as a physician, it behooves us to be careful who we follow. Just because something is legal does not necessarily mean that it is good for us or that it is moral. Imposed death will never be good for the patient or the physician.