Ordinary and Extraordinary Treatment - Hydration and Nutrition

Although this is not an easy question to answer, one ought to break the question down by attempting to establish correct definitions and then consider the correct application of the definitions to the ethical issue involved. It is important to add at this juncture that the right to life should be considered as a fundamental right but not an absolute right although one may say that it is quasi-absolute.

One must start by defining which treatment is ordinary and which is extraordinary (proportional and disproportional are alternative terms). Doctors mistakenly tend to use the terms as referring to 'standard' or 'non-standard' forms of treatment. However ethicists claim that these words mean differently. 'Ordinary' is often used to describe those means of prolonging life which are available, offer a reasonable hope of benefit and do not cause unbearable pain and suffering. In contrast, the term 'extraordinary' is used to describe those means or measures which are not usually available, do not offer a reasonable hope of benefit and cause unbearable pain and suffering[1].

A treatment which is standard for a certain class of patient may be more likely to be morally 'ordinary' than a treatment which is non-standard. However this analogy may not always hold true. There may be reasons why the standard treatment is not morally required in the case of an individual patient[2]. There is no obligation for a patient to take extraordinary or disproportionate measures to promote life and health if these measures will involve excessive burdens. One might think of the pain or discomfort, which can accompany some medical treatments or of the financial cost of the treatments to the patient, family, hospital or health service in general[3].

A treatment or life-sustaining measure can be extraordinary because it is too painful, frightening, hazardous or disruptive for the patient, or it is financially too burdensome for the patient, family, hospital or health service which must also consider other patients who would benefit more from the same resource allocation[4].

A treatment can be extraordinary because it is simply futile. Those who are dying of one illness have no obligation to accept treatment for a second life-threatening one, which is at a less advanced stage. Often however, a treatment will be extraordinary not because that treatment is in any way futile, but because its burdens will be disproportionate

[1] 'Ordinary' and extraordinary means of prolonging life', The Linacre Centre for Healthcare Ethics, extract from *Life and Death in Healthcare Ethics*, Routledge, 2000.
http://www.lifeissues.net/writers/mis/mis_01prolonginglife.html [07.01.2010]
[2] *Ibidem.*
[3] *Ibidem.*
[4] *Ibidem.*

to the benefits it will bring. Borderline cases may be resolved by seeking the evaluative help of the competent patient[5].

Another view is that ordinary means of preserving life consists of the medical treatment that offers a reasonable hope of *benefit* for the patient or that can be obtained or used without excessive pain, burden, or expense. Extraordinary treatment is the medical treatment that cannot be used or obtained without excessive expense, pain or other burden or that does not offer a reasonable hope of *benefit*[6].

Two important considerations are the *effectiveness* and *benefit* of the proposed treatment. An effective treatment is that which demonstrably alters the natural history of an illness or alleviates an important symptom. A beneficial treatment is that which brings some good to the patient, not only medical benefit but also in terms of quality of life. Treatment may be effective but not beneficial by simply prolonging the life of a patient while at other times it might be both effective *and* beneficial. The key word here is benefit to the patient![7]

One should respect the desire and freedom of the patient not to have one's life prolonged unnecessarily by extraordinary means, that is in cases where artificial means for the prolongation of life could or should be stopped especially when there is no hope whatsoever that health can be regained. One should maintain a sharp distinction between cases where there is a real chance of serving human life as opposed to other cases where medical treatment would simply be a means to interfere with death or to artificially sustain the process of death[8].

"But one is normally held to use only ordinary means – according to circumstances of persons, places, times and culture – that is to say, means that is to say means that do not involve any grave burden for oneself or another. A more strict obligation would be too burdensome for most men and would render the attainment of the higher, more important good too difficult. Life, death, all temporal activities are in fact subordinated to spiritual ends. On the other hand, one is not forbidden to take more than strictly necessary steps to preserve life and health as long as one does not fail in some more serious duty"[9].

Taken in this sense, extraordinary treatment approaches the shortening of agony or even of a fatal disease through planned withdrawal or omission of life prolonging treatment. The intention is not to prolong suffering which is considered opposed to the idea of

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[5] *Ibidem.*
[6] Agius, E., 'Problems in Applied Ethics', from Friggieri, J., (Ed.), *Philosophical Studies*, University of Malta, 1994, pg. 26.
[7] *Ibidem.*
[8] Häring, B., *Medical Ethics*, St. Pauls, UK, 1991, pg. 132.
[9] Pius XII, *A.A.S.*, 49 (1957), 1031-1032.

dying in dignity and peace. Considerations of bare utility are not to be allowed to enter the picture[10].

In its declaration on euthanasia the Congregation for Catholic Faith states that "it is also permissible to make do with the normal means that medicine can offer. Therefore one cannot impose on anyone the obligation to have recourse to a technique which is already in use but which carries a risk or is burdensome. Such a refusal is not the equivalent of suicide; on the contrary, it should be considered as an acceptance of the human condition, or a wish to avoid the application of a medical procedure disproportionate to the results that can be expected, or a desire not to impose excessive expense on the family or community. When inevitable death is imminent in spite of the means used, it is permitted in conscience to take the decision to refuse forms of treatment that would only secure a precarious and burdensome prolongation of life, so long as the normal care due to the sick person in similar cases is not interrupted. In such circumstances the doctor has no reason to reproach himself with failing to help the person in danger"[11].

The next part of this treatise is more difficult to establish. This pertains to the question of whether artificial hydration and nutrition itself constitutes ordinary or extraordinary treatment therefore allowing one to withdraw it if it is considered to be extraordinary. Many scholars have said that it is legitimate to withdraw intravenous feeding in particular circumstances, on the assumption that it was not a case of ordinary means[12]. There are different views as to whether such treatment is ordinary and extraordinary with some scholars agreeing and others disagreeing.

"There are those who believe that respect for human life demands that we continue feeding seriously ill people, even artificially, and that includes people in irreversible comas, because feeding and hydration are part of the minimum care that compassion demands. On the other hand, there are theologians and philosophers who maintain that recourse to artificial nutrition and hydration does not involve the same moral obligation as the natural process of ingesting solids and liquids. This is a medical technique more akin to treatment than to everyday care"[13]. One must mention for example, the case of *Tony Bland* a person in PVS (persistent vegetative state, where only the

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[10] Häring, B., *Medical Ethics*, op.cit., pg. 137. See also Thielicke, H., 'Ethische Fragen der modernen Medizin', in *Archive für klinische Chirurgie*, 321 (1968), 13, with regards to intention. " Of course it does make a great difference whether I accept an evil or a questionable result as a by-product of my therapeutic intention or seek it directly as a good in itself".

[11] *Declaration on Euthanasia*, 30. From Elizari Basterra, F.J., *Bioethics*, St. Pauls, UK, 1994, pg. 190.

[12] Kelly, G., *Medico-Moral Problems*, Catholic Hospitals Association, St. Louis, 1958, 130; McFadden, J.C., *Medical Ethics*, F.A. Davis, Philadelphia, 1957, 246-247; Healy, G., *Medical Ethics*, Loyola, Chicago, 1956,80.

[13] From Elizari Basterra, F.J., *Bioethics*, St. Pauls, UK, 1994, pg. 191 quoting Durand, G., and Saint-Arnaud, J.

brain stem remains functioning whereas all higher brain functions have ceased) for five years since the Hillsborough football disaster of 1989. Although there was a difference of opinion medically, the High Court eventually ruled that feeding should be seen as medical treatment rather than elementary care and that its withdrawal was lawful in this case.

Two main issues need to be considered for finding a solution to the permissibility of this dilemma. The *first* constitutes the notion of the dying patient. What is a dying patient? Two criteria can guide us to this answer. Is a return to normal life relatively possible? And will the patient be ultimately independent from the technology? Add to this the question whether there a reasonable hope of benefit. The answer to these questions will determine whether one can consider such treatment as optional or appropriate.

The *second* dilemma pertains to the nature of artificial hydration/nutrition as whether being a medical procedure or simply proportionate care for basic human needs. Many medical ethicists say that these procedures fall under the heading of a medical procedure, as they require skilled medical interventions. In that case they should be handled ethically like other normal medical procedures.

If the patient is viewed as non-dying, then hydration/nutrition should be seen a constituting ordinary care therefore the omission of hydration/nutrition would be considered inappropriate. If on the other hand the patient is dying and if artificial hydration/nutrition is considered as a medical procedure, then its withdrawal is considered as a procedure done in order to let nature take its course[14]. "When artificial feeding is futile and useless, it can be considered as extraordinary and consequently morally justifiable to be withheld or withdrawn. There is no moral obligation to use extraordinary means of treatment; our obligations extend only to the provision of ordinary means"[15].

Although we need to have a presumption in favour of providing nutrition and hydration to all patients[16], we need to be concerned with the individual characteristics of patients and their circumstances, as this is the whole key to the issue. Clinical studies have shown that although ANH may benefit terminally ill patients, if carried out in inappropriate circumstances, it may actually also cause suffering and also itself be the cause for shortening life. This is because of certain problems. First, the insertion of a gastrostomy tube (PEG) has been

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[14] Agius, E., 'Problems in Applied Ethics', op.cit., pg. 29.
[15] *Ibidem*.
[16] U.S.Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, 4th ed. (Washington, D.C.: USCCB, 2001). "There should be presumption in favour of providing nutrition and hydration to all patients, including patients who require medically assisted nutrition and hydration, as long as this is of sufficient benefit to outweigh the burdens involved to the patients".

associated with an indirect and direct increase in aspiration pneumonia and death. Secondly, there is no evidence to hold that in terminal patients, the use of a PEG tube increases the nutritional status or the prevention of pressure sores of the patient. Some studies have linked the use of PEG tubes to a higher level of development of sores. Thirdly, there is strong evidence to suggest that the use of PEG and NG (naso-gastric) tubes, not only does not decrease the occurrence of infections in terminal patients but they actually increase them. Fourthly, since emaciated patients have slower functional improvements, nutritional intervention at the end of life may not make much of a difference and is in fact ineffective for the frailest patients. Lastly, evidence suggests that tube feeding does not prolong the lives of most terminal patients, with some studies in fact showing a decrease in the length of survival for tube-fed patients.

Some studies show that end-stage patients do not seem to experience feelings of hunger or thirst and in those that do, relief can be achieved better by oral means. Other studies show that tube-fed patients in terminal stages of life, may have to make use of the amino-acids from their muscles to supplement nutrition leading to quicker emaciation and death, while voluntary fasting leads to the production of ketones from fat breakdown and these may be used as an energy source. Hydration and nutrition might also feed a tumour, making it grow faster and escalate pain and suffering, while oral food and water is enough to relieve discomfort. It is obvious therefore that the clinical reality is that ANH may cause more physical harm than good for many patients in the terminal stages and without careful consideration of the clinical facts of individual cases, we may do more harm to patients than help them if we feed and hydrate them artificially[17].

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[17] Sanders, A., 'The Clinical Reality of Artificial Nutrition and Hydration for Patients at the End of Life', from *The National Catholic Bioethics Quarterly*, Vol. 9, Num. 2, Summer 2009, Philadelphia .