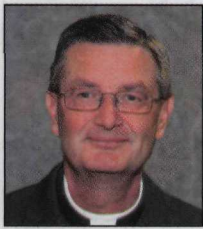


The Ethics of the Ordinary



BY FR. RUSSELL
SMITH, STD

Fr. Smith is senior director, ethics, Catholic Health Association, St. Louis, Mo.

The recent “Responses” of the Congregation for the Doctrine of the Faith (CDF) have raised the same concerns throughout health care that the 2004 allocution of Pope John Paul II did. Both the “Responses” and allocution are concerned with the relatively rare situation involving the use of feeding tubes for patients in a persistent vegetative state (PVS). Although this is certainly an important issue, I propose that it is the ordinary, day-to-day ethical decisions that challenge most families. And it is in these more ordinary times that we are gifted with opportunities to do the most good.

In response to the CDF’s “Responses,” CHA has summarized the teaching this way:

The CDF document makes two important points. First, the provision of artificially administered nutrition and hydration to patients in a PVS is morally obligatory except when they cannot be assimilated by the patient’s body (and, hence, don’t achieve their purpose) or cause significant discomfort. Second, artificially administered nutrition and hydration cannot be discontinued for a patient in a persistent vegetative state even when physicians have determined with reasonable certainty that the patient will never recover consciousness. This is due to the fact that the person in a PVS retains his or her fundamental human dignity and, therefore, must be provided ordinary and proportionate care which includes nutrition and hydration.

It has been widely noted in these pages and elsewhere that Pope John Paul’s allocution and the CDF “Responses” clearly teach that caregivers may never directly shorten a patient’s life by removing the feeding tube. In articulating the doctrine in this way, the allocution and “Responses” focus upon the intention of the agent and the action by which the agent’s intention is affected. This approach clearly arises from a suspicion (or project) of euthanasia.

The pope and the CDF are neither denying nor repeating past answers to past questions. Rather, they are at this time “closing a loop” in the more general doctrine of appropriate care of the sick. The atmosphere of euthanasia needs to be addressed at this time because of such initiatives, especially in Europe and elsewhere. The definition of euthanasia is by now well-rehearsed. It is “an act or an omission, which of itself or by intention, brings about death so that suffering may be eliminated.” Therefore, the focus of the doctrine regarding euthanasia is squarely on the *intention* and the *object* of the moral act. It deals with clearly *inappropriate* care of patients.

The “loop” that is closed completes the doctrine of appropriate care of patients articulated by Pope Pius XII in his allocution regarding the distinction between ordinary and extraordinary means. This is an entirely different environment and scenario. Here, ordinary means are distinguished from extraordinary means by an evaluation of “*circumstances* of persons, places, times and culture,” as opposed to a purely clinical assessment of an intervention’s characteristics of being scientifically established, statistically successful and readily available. Except in *extraordinary circumstances*, most people, especially at the end of life, would prefer to be treated only by *ordinary* means.

The two allocutions come from two vastly different challenges in health care, but both stem from a fundamental conviction about the sanctity of human life. That is not to say that the most recent allocution of Pope John Paul and the “Responses” of the CDF clear up all the questions they raised. Quite the contrary. But one thing is crystal clear: It is now the official teaching of the church that, all things being equal, the feeding tube is a morally *ordinary* means for patients in PVS. That said, several points must be made. First, this *doctrine* prescinds entirely from *any* consideration of the patient’s overall condition. Co-morbidities are not a part of the teaching, though they most certainly are part of the

patient's condition. This condition, the overall status of the patient, forms the constellation of *circumstances* about which, and on the basis of which, treatment decisions must be made. The doctrine of the church is not making a medical decision, but a moral distinction.

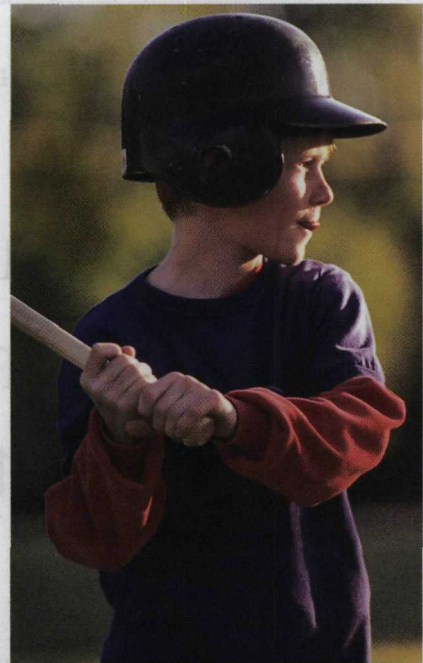
Second, church documents must be read "strictly," that is, as applying precisely to the question they are answering. In this case, the questions are about patients in PVS, *and only patients in PVS*. Already, other voices are being raised that say this doctrine applies across the board of diseases. This is not the intent, nor the express desire, of the pope or the CDF. These voices may say, in scholastic terms, that this may be proposed as a "safe" opinion as described in the *New Catholic Encyclopedia* ("a truth unanimously held by all schools of theologians, which is derived from revealed truth, but by more than one step of reasoning"). However, it has not been taught authoritatively, and is far from the opinion of the vast majority of theologians.

The more recent allocation and the "Responses" will surely continue to roil in the delivery of health care, especially for level-four trauma centers and long-term care. This will probably have at least two results. First, a re-evaluation of the criteria for the determination of personal demise. Total brain criteria (Harvard) as determinative will be challenged by criteria based on higher brain destruction (Vanderbilt criteria). Second, better management of coma, as the pathway to PVS. As "code blue" numbers have dramatically decreased because of the number of "flags" that indicate a patient's condition is worsening, as opposed to letting them "crash," so studies on coma now allow

clinicians to better understand, evaluate and base decisions on a large body of patient outcomes.

Perhaps a real-life example will illustrate the challenge that many families face. In 2006, a 16-year-old male suffered a recurrence of leukemia. Wishing to avoid another round of difficult chemotherapy, he and his parents sought alternative treatment out of state. The local family and children's services agency took the family to court in Norfolk, Va., which remanded him to a hospital for the mandatory, involuntary therapy. The case went to the commonwealth's Supreme Court, which allowed the family to follow its wishes. It is the specter of mandatory involuntary, often over-the-top treatment many wish to avoid. It should also ultimately limit medically inappropriate treatment that must be checked.

Regardless, an enormously disproportionate amount of resources are spent on a tiny fraction of the patient population, much of it as unwanted as it is inappropriate. Fifty percent of the average American's total health care dollar is spent in the last six months of life. We need an "ethics of the ordinary" to overcome all the forces that drag us along the path of the "technological imperative," fueled by fascination with machinery, clinical culture that sees death as the enemy, the financial benefits of expensive treatment and fear of litigation. We have to ask ourselves, apart from surgery and severe injury, why is anyone dying in intensive care? By applying "ethics of the ordinary," we more reflexively comply with most patients' wishes on the one hand, and end the denial manifested in morally certain inappropriate treatment. ■



Nobody dreams of having multiple sclerosis

Some dreams are universal: hitting a ball over the Green Monster; winning the World Series with a grand slam in the bottom of the ninth inning. Finding out that you have MS is not one of them.

Multiple sclerosis is a devastating disease of the central nervous system where the body's immune system attacks the insulation surrounding the nerves. It strikes adults in the prime of life — and changes lives forever.

This is why the National MS Society funds more research and provides more services for people with multiple sclerosis than any other organization in the world. But we can't do it alone.

To help make the dream of ending MS come true, call 1-800-FIGHT MS or visit us online at nationalmssociety.org.

