

**ORDINARY AND EXTRAORDINARY MEANS OF THE PRESERVATION OF
LIFE: THE TEACHING OF MORAL TRADITION¹**

Paulina Taboada, MD, PhD

**Adjunct Professor
Director of the Center for Bioethics
Pontifical Catholic University of Chile**

Email: ptaboada@med.puc.cl

Address: **Centro de Bioética
Facultad de Medicina
Pontificia Universidad Católica de Chile
Casilla 193, Correo 22
Santiago - Chile**

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SUMMARY

This work undertakes two fundamental aspects:

1. The historical development and the essential content of the traditional distinction between the 'ordinary' and 'extraordinary' means of the conservation of life.
2. Some inadequate forms of interpretation and application of the traditional teaching in the field of contemporary medical ethics.

The formal origin of the traditional distinction between 'ordinary' and 'extraordinary' means of preserving life can be found in the great commentators of Saint Thomas Aquinas of the XVI Century. The advances of medicine during the Renaissance obliged the moralist of the time to approach the question of the moral limits of preserving health and life. Thus the traditional teaching arose which affirmed the existence of a 'positive' moral duty of preserving health and life by way of using medical treatments that offer a reasonable hope for beneficial results (*spes salutis*) and that does not involve a physical or moral impossibility for the individual (*quaedam impossibilitas*). Both conditions must be met simultaneously for the means of the preservation of life to be considered 'ordinary' and, therefore, morally obligatory. When at least one of these conditions is not fulfilled, the treatment is considered 'extraordinary' and its use is morally elective for the individual (relative norm).

The actual use of this teaching has been confirmed by the Magisterium of the Church during the 20th century, before the complex ethical dilemmas that contemporary medical practices have presented. The magisterial documents stress the importance of understanding and applying this classical doctrine in light of the unconditional respect that is due to all human life – from conception to natural death – by reason of its ontological dignity (given as much by its origin as by its destiny). This anthropological concept offers the hermeneutical key for an adequate application of the traditional teaching to particular cases. Outside of this context, it is easy for the content of the traditional teaching to be interpreted and applied in an inadequate way, as demonstrated by a brief analysis of four forms of interpreting this doctrine in the field of contemporary medical ethics.

I. INTRODUCTION^{2,3}

The moral tradition of the Catholic Church has made a significant contribution to respond to the question of the limits of the duty of preserving health and life by proposing the distinction between means which are ‘ordinary’ and ‘extraordinary’. The organizers of this Congress have asked me to offer a brief review of this traditional teaching. In order to accomplish this review, a doctor with philosophical formation – like myself– cannot fail to ask himself about the way in which this doctrine is presented, in light of the bioethical literature and the medical practice of today. A quick search of the principal medical databases (e.g. PubMed, MeSH, etc.) allows one to find close to a hundred references.⁴ It could seem that the classic distinction between ‘ordinary’ and ‘extraordinary’ means had been incorporated into the language of contemporary medical ethics.⁵ Nevertheless, the literature shows evidence of certain ambiguities and inconsistencies in the interpretation and application of the traditional teaching, which goes to show that its content is not always adequately understood.

Therefore, in what follows I will refer fundamentally to two aspects:

1. The historical development and the essential content of the classic distinction between ‘ordinary’ and ‘extraordinary’ means of preserving life.

² I am sincerely grateful to the President and the Board of Directors of the Pontifical Academy for Life for the invitation to participate in this International Congress, dedicated to analyzing the scientific and ethical aspects related to the care for the dying. This opportunity to put my academic work at the service of the Church and the Gospel of Life constitutes for me reason for great joy, for which I am profoundly grateful.

³ I am grateful for the valuable contributions and commentaries received from Alfonso GÓMEZ-LOBO, Alejandro SERANI and William F. SULLIVAN during the elaboration of this text.

⁴ It is fitting to note here that a centenary of references is not much, if it is compared with the thousands of references that should be obtained when key words such as ‘utility/futility’, ‘do not resuscitate order’, ‘vital testament’, etc. are consulted.

⁵ Cf. Editorial, *Ordinary and extraordinary means*. J Med Eth, 1981, 7 (2): 55-56.

2. Some forms of inadequate interpretations and applications of this teaching in the field of medical ethics today.

II. HISTORICAL DEVELOPMENT AND ESSENTIAL CONTENT OF THE TRADITIONAL DISTINCTION BETWEEN ‘ORDINARY’ AND ‘EXTRAORDINARY’ MEANS.

A historical and systematic review of the traditional distinction between ‘ordinary’ and ‘extraordinary’ means does not need to depart *de novo* today. Fortunately, we counted on excellent contributions of authors like Mons. Daniel Cronin⁶ (Archbishop of Hartford, USA), North American Jesuit priests Gerard Kelly⁷ and Kevin Wildes⁸ and - more recently - Mons. Maurizio Calipari⁹. With the contributions of these authors and others as the fundamental basis, I will briefly summarize the historical development and the essential content of this traditional teaching.¹⁰

2. 1. Historical and systematic analysis of the traditional teaching.

⁶ Cf. CRONIN D., *Conserving human life*, in SMITH R. (Ed.), *Conserving human life*, Massachusetts: Pope John XXIII Medical-Moral Research and Educational Center, 1989: 1 - 145.

⁷ Cf. KELLY G., *The Duty to Preserve Life*. Theological Studies 1951, 12: 550 - 556.

⁸ Cf. WILDES K., *Conserving Life and Conserving Means: Lead us not into Temptation*. In: *Philosophy and Medicine* 51, Dordrecht: Kluwer Academic Publishers, 1995. Also cf. : WILDES K., *Ordinary and extraordinary means and the quality of life*. Theological Studies 1996, 57 (3): 500 – 512.

⁹ Cf. CALIPARI M., *Curarse y hacerse curar. Entre el abandono del paciente y el encarnizamiento terapéutico*. Buenos Aires: Educa, 2007. Also cf. : CALIPARI M., *The principle of proportionality in therapy: foundations and applications criteria*. NeuroRehabilitation 2004, 19 (4): 391 – 7.

¹⁰ The content of this section is fundamentally based on the contributions of CALIPARI, 2004, 2007, CRONIN, 1989 y WILDES, 1995, 1996, as well as in the articles of McCARTNEY J.J., *The Development of the Doctrine of Ordinary and Extraordinary Means of Preserving Life in Catholic Moral Theology Before the Karen Quinlan Case*. Linacre Quarterly 1980 Aug, 47 (3): 215 – 24 y MEILAENDER G., *Questio Disputata. Ordinary an Extraordinary Treatments: When does quality count?* Theological Studies 1997, 58 (3): 527 – 31.

The existence of a ‘positive’ moral duty of caring for health and life – one’s own and another’s – has been recognized since the origins of Christianity. Already in the writings of Saint Basil (329 – 379) we find paragraphs destined to praise the art of medicine as a divine gift that permits us to heal the sick.¹¹ Nevertheless, having medicine in mind, Saint Basil condemned “whatever requires an undue amount of thought or trouble or involves a large expenditure of effort and causes our whole life to revolve, as it were, around the concern for the flesh.”¹² This quote invites a theological reflection of the limits of the moral duty to preserve (physical) life, a reflection that the moralists of the 16th Century would carry out, developing the traditional distinctions between ‘ordinary’ and ‘extraordinary’ means.

2.1.1. Discourse on suicide and the distinction between ‘positive’ and ‘negative’ precepts.

For the development of this teaching, the moralists of the tradition were fundamentally based on the previously expounded concepts of Saint Thomas Aquinas (1225 – 1274) in his analysis of suicide and mutilation (questions 64 and 65 of the *Secundae Secundae*).¹³ The analysis of the Angelic Doctor demonstrates that not only a moral ‘negative’ obligation to not deprive oneself voluntarily of one’s own life (through suicide) exists, but there also exists a ‘positive’ obligation to use the necessary means to preserve

¹¹ “Each of the arts is God’s gift to us, remedying the deficiencies of nature...the medical art was given to us to relieve the sick, in some degree at least.” Cf. ST. BASIL: *The long rules* (Transl. Sister Monica Wagner). Washington D.C: Catholic University of America Press, 1962: 330-31. Citado en: ENGELHARDT T. & SMITH A., *End-of-life: the traditional Christian view*. The Lancet 2005, 366: 1047.

¹² Proper translation of the citation in English: “whatever requires an undue amount of thought or trouble or involves a large expenditure of effort and causes our whole life to revolve, as it were, around the solicitude for the flesh.” Cf. ST. BASIL, *The long rules* (Transl. Sister Monica Wagner). Washington D.C: Catholic University of America Press, 1962: 330-31. Citado en: ENGELHARDT T. & SMITH A., *End-of-life: the traditional Christian view*, The Lancet 2005, 366: 1047.

¹³ Cf. SANTO TOMÁS DE AQUINO, *Summa Theologiae*, II - II, q. 64, a. 5; q. 65, a. 1.

(physical) life. This idea will give origin to the theological reflection on the ‘positive’ duties related to the care and preservation of health and life (one’s own and another’s). Following Saint Thomas, the tradition has made the distinction between the ‘affirmative’ precepts (*bonum est faciendum*) and the ‘negative’ precepts (*malum vitandi*) of the natural law, proposing that the ‘negative’ prescriptions are always obligatory in every circumstance (*semper et pro semper*), while the ‘affirmative’ precepts always obligate, but not in every circumstance (*semper sed non pro semper*). The reason is that the affirmative precepts (*bonum est faciendum*) impel us to do everything that is possible in a determined situation, but this could be limited by proportionately grave causes that, therefore, justify it. On the contrary, the ‘negative’ precepts (*malum vitandi*) do not admit limits to their fulfillment. The prohibition against doing a moral evil is always valid and obligatory in every circumstance, being that nothing could excuse us from the obligation to abstain from committing a moral evil.¹⁴ This basic distinction between negative and affirmative precepts also applies to the good of human life and the moral duty to preserve it.¹⁵

2.1.2. *Medical advances of the Renaissance and the development of the traditional teaching.*

The formal application of these concepts to the question about the limits of the moral obligation to preserve health and life by means of the use of medical therapies began to materialize from the recent systematic approach of the 16th century, thanks to the work of

¹⁴ Cf. JUAN PABLO II, *Veritatis Splendor*, Ciudad del Vaticano, 1993, n. 52. Also, cf. CONCILIO ECUMÉNICO VATICANO II, *Constitución pastoral Gaudium et Spes (sobre la Iglesia en el mundo actual)*, n. 10; SAGRADA CONGREGACIÓN PARA LA DOCTRINA DE LA FE, *Declaración Persona Humana (concerning certain questions about sexual ethics)*, 4: AAS 68 (1976): 80.

¹⁵ CALIPARI, *Curarse y...* p. 159.

some famous commentators of Saint Thomas Aquinas, such as Francisco de Vitoria, Domingo de Soto and Cardinal Juan de Lugo, to name just a few.

The medical advances of the Renaissance required the moralists of the time to directly approach the question of the causes that could exempt a Christian from the moral duty of preserving health and life by means of recourse to the new therapies that medicine was beginning to offer. One may recall that it was precisely in the 16th century that Vesalio (1514 – 1564) published his book *De humani corporis fabrica* (1542), which originated the study of anatomy as we understand it today; Harvey (1578 – 1657) made the discoveries that led him to propose the theory of the circulation of blood; and Sydenham (1624 – 1689) published his book *Observationes medicae* (1676), with a systematic description of diseases, in that way, introducing the method of scientific observation to clinical practice.

These discoveries made the development of new treatments possible, as – for example – surgical amputation. Confronted with the medical advances of the Renaissance, moralists were faced with the necessity of exploring the limits of the moral obligation to preserve health and life through the use of these new techniques. Thus, among the concrete problems that presented themselves there was, for example, the doubt as to the moral duty of subjecting oneself to a surgical amputation in an age when asepsis and the anesthetic technique were not known.

Among the commentators of Saint Thomas who approached the ‘new’ moral problems, Francisco de Vitoria (1483 – 1546) stands out and his writings set the basis for the development of the traditional teaching that distinguishes between ‘ordinary’ and ‘extraordinary’ means. In his famous *Relectiones Theologiae*, Vitoria treats some moral

problems linked to the preservation of life through the ingestion of food. In agreement with Aquinas, his arguments favoring the existence of a moral obligation to receive nourishment is based on the natural inclination of self-preservation, in the love of oneself and the evil of suicide.¹⁶ In a famous passage, Vitoria affirms:

“that if a sick person is able to take nourishment with the hope of life, he has the obligation to take it, just as he must be given it if he is not able to do so himself. [...] if the decline of the spirit is so great and the alteration of appetite is much, so much so that the infirm is able to take nourishment only with great trouble and almost a certain torment, than it can be considered an impossibility and one is excused from sin, at least mortal sin, especially when there is little or no hope for life.”¹⁷

Therefore, in spite of affirming that a moral duty of self-preservation through the taking of nourishment exists, Vitoria holds that an infirm person could be excused from mortal sin if he is experiencing a moral impossibility in fulfilling that duty, especially if his hope for life is little or none. In agreement with the mentality of that time, Vitoria centers his fundamental analysis on the moral obligation of the infirm person. This focus is

¹⁶ Arguing about the moral evil of suicide, the Angelic Doctor fundamentally proposed three reasons (Cf. SAINT THOMAS AQUINAS: *Summa Theologiae*, II- II, q. 64, a. 5):

- The first refers to a violation of the natural law, according to which all men love themselves and tends towards self-preservation, resisting all that could destroy him.
- The second is founded in the fact that each individual is part of a social whole. Committing suicide would be committing a wrong against the human community to which he belongs, being a privation of one of its members.
- The third reason is based on the radical relevance of all human life to God, the Creator, who he has loved and maintained in existence. Therefore, to deny oneself of life itself would be a wrong against God, assuming to himself the right to judge the value of existence itself without having jurisdiction over it, being that the judgment over life and death is God's alone.

¹⁷ Cf. VITORIA F., *Relecciones Teológicas* (trans. from Latin by Jaime Torrubiano), Argentina: Ed. January, 1946. *Relecciones de la Templanza*, p. 448.

Cf. Citation in Latin:

*"Ad argumentum in contrarium [...] secundo dico quod si aegrotus potest sumere cibum vel alimentum cum aliqua spe vitae, tenetur sumere cibum, sicut teneretur dare aegrotanti. Tertio dico, quod si animi deiectione tanta est et appetitivae virtutis tanta consternatio, ut non nisi per summum laborem et quasi cruciatum quendam aegrotus possit sumere cibum, iam reputatur quaedam impossibilitas et ideo excusatur, saltem a mortali; maxime ubi est exigua spes vitae aut nulla". Cf. VITORIA F. *Relecciones Theologicae*, Lugduni, 1587, *Relectio de Temperantia* n. 1, cited in: CALIPARI, *Curarse y...* p. 96.*

characteristic of the moralists of the Renaissance, who were interested in identifying those elements that could excuse a person of mortal sin in the case that one did not draw upon the use of the ‘new’ means of preserving life that medicine put at their disposal. From this perspective, centered on the duties of the infirm, Vitoria contrasts the moral obligation of nourishing oneself with the obligation of using medical treatment and he concludes that:

“...Medicine and nourishment are not the same. Nourishment is part of the ordered means for animal and natural life, but not medicine, and man does not have the obligation to make use of all the possible means of preserving life, but only the means ordered towards life.

Second, it is one thing to die of the lack of nourishment, that which is ascribed to man [...] but it is another thing to die under the power of an illness that has invaded the body naturally. In that way, to not eat would be to kill oneself; but to not take medicine is to not impede the death that is already approaching [...] one thing is to not prolong life, but it is another thing altogether to cut one’s life short. The second is always illicit, but not the first.

Thirdly, that if someone was to have the moral certitude that through medicine their health would recover and without it they would die, it does not seem that they can be excused from mortal sin.”¹⁸

The analogy of the moral duty to nourish oneself – introduced by Vitoria in *Relectio de Temperancia* – leads him to propose that the justification of the obligation to use medical treatments is founded on the ‘moral certainty’ of its eventual benefits, understood as the possibility of recovering health and of preventing an inevitable death. On the other hand, in *Relectio de Homicidio*, Vitoria holds that even in those cases in which recourse to medicine could serve to prolong life for a short while, a person could be exempt from the

¹⁸ Cf. VITORIA F. *Relecciones Teológicas... Relecciones de la Templanza*, p. 449.

Cf. Citation in Latin:

"...aliud est non protelare vitam, aliud est abrumpere: nam ad primum non semper tenetur homo et satis est quod det operam per quam homo regulariter potest vivere; nec puto, si aeger non posset habere pharmacum nisi daret totam substantiam suam, quod teneretur facere". Ibid. n. 12 - "...non tenetur quis uti medicinis ad prolongandam vitam, etiam ubi esset probabile periculum mortis, puta quotannis sumere pharmacum ad vitandas febres, vel aliquid huiusmodi". Cf. VITORIA F. *Relecciones Theol... Relectio de Temperantia* n. 9, cited in: CALIPARI, *Curarse y...* p. 96.

moral duty to use it if the conditions exist that cause a ‘moral impossibility’ such as – for example – excessive expense:

“[...] In the case that has been presented, I believe that the person is not obligated to give all his patrimony to preserve life [...]. The result is that, if one becomes so sick as to have no hope for life, admitting that a certain valuable medication might procure hours or even days of life, he would not be obligated to buy it, but it would be sufficient to utilize the common remedies.”¹⁹

2.1.3. Nature of the ‘ordinary’ means.

In this way, in the writings of Francisco de Vitoria we find the explicit recognition of the requisites that the tradition has recognized as the foundation of the moral obligatory nature of ‘ordinary’ means of preserving life:

1. the hope of a reasonable benefit (understood as recuperation of health or the prevention of an avoidable death). The moralists of the tradition usually designate this requisite with the Latin expression, *spes salutis*, which in contemporary medical literature could respond to – the much debated – criteria of ‘benefit’ or the scientific-technical ‘usefulness’ of the measure;²⁰ and

¹⁹ Cf. VITORIA F. *Relecciones Teológicas... Relección del Homicidio*, p. 487.

Cf. Citation in Latin:

“Unde in casu posito credo quod non tenetur dare totum patrimonium pro vita servanda [...]. Ex quo etiam infertur quod cum aliquis sine spe vitae aegrotat, dato quod aliquo pharmaco pretioso posset producere vitam aliquot horas, aut etiam dies, non tenetur illud emere, sed satis erit uti remediis communibus”. Cf. VITORIA, *Relecciones Theol... Relectio de Homicidio*, n. 35, in: CALIPARI, *Curarse y...* p. 97.

²⁰ To enter into the debate about the concepts of medical ‘utility’/‘futility’ would move surpass the limits of this work. Some references, however, could be mentioned here. Cf. SCHNEIDERMAN L., *Commentary: Bringing Clarity to the Futility Debate: Are the Cases Wrong?* Cambridge Quarterly of Healthcare Ethics. 1998; 7: 269-278; SCHNEIDERMAN L., JECKER N., JONSEN A., *Medical Futility: Its Meaning and Ethical Implications*. Ann Intern Med. 1990; 112: 949-954; SCHNEIDERMAN L., FABER-LANGENDOEN K., JECKER N., *Beyond Futility to an Ethical Care*. Am J Med. 1994; 96: 110-114; SCHNEIDERMAN L., JECKER N. et al., *Medical Futility: Response to Critiques*. Ann Intern Med. 1996; 125: 669-674; CHRISTENSEN K., *Applying the Concept of Futility at the Bedside*. Cambridge Quarterly of Healthcare Ethics. 1992; 1: 239-248.

2. the absence of a physical or moral impossibility in its utilization on the part of the individual (designated by the Latin expression *quaedam impossibilitas*).²¹

Tradition holds that both conditions must be met simultaneously for a means to be defined as ‘ordinary’ and – therefore – morally obligatory.²² Thus, among the expressions that the moralists of the tradition utilized to describe the nature of ‘ordinary means’ are:²³

- “the hope of beneficial results” (*spes salutis*);
- “common means” (*media communia*);
- “in accordance with the proportion of one’s state in life” (*secundum proportionem status*);
- “easy means” (*media facilia*); and
- “means that are not difficult to obtain or use” (*media non difficilia*)

It is notable that, to describe the ‘ordinary’ means, in the classical texts ‘negative’ formulations are frequently used, in the sense of defining as ordinary means those whose use does *not* have the typical characteristics of the extraordinary means.²⁴ Given that – as we will see further on – the principal elements that connotate the ‘extraordinary’ character of a means of preserving life refer to different difficulties that are linked to their use, a recourse that the moralists of the tradition utilize to describe the ‘ordinary’ character of a means of preserving life was precisely the negation of grave difficulties (physical or moral).

²¹ Cf. CRONIN, *Conserving...*, p. 102.

²² Cf. WILDES, *Ordinary and...*, p. 506.

²³ Cf. CRONIN, *Conserving...*, pp. 84 - 98. Cf. also CALIPARI, *Curarse y...* pp. 151 – 158.

²⁴ Cf. CALIPARI, *Curarse y...* pp. 156 – 157.

2.1.4. Nature of the ‘extraordinary means’ and causes of moral impossibility..

Developing this idea, the moralists of the Renaissance²⁵ put forth important efforts to identify the diverse causes of physical and moral impossibility that a person could experience in the utilization of means to preserve life. Thus, for example, analyzing the problem of moral obligation of subjecting oneself to surgical amputation (in the pre-anesthesia era), Domingo de Soto (1494 - 1570) concludes that the superiors of a religious order could not obligate their subordinates – interfering under the vow of obedience – to resort to interventions that would cause an enormous pain (*ingens dolor*), so no one would be obligated to suffer such torments (*cruciatu*) to preserve one’s life.²⁶

In this way, the identification of the diverse causes of physical or moral impossibility that a person could experience in utilizing the ‘new’ medical treatments of the Renaissance served so that the commentators of St. Thomas would develop and necessitate progressively what is contained in the teaching of moral tradition regarding the limits of moral duty to preserve life through the distinction within ‘ordinary’ and ‘extraordinary’ measures.

Among the possible causes of the physical impossibility, we can mention that the measurement is simply not available or that it cannot be utilized; that the physical conditions of the infirm are incompatible with its use; etc.²⁷ Among the expressions that

²⁵ I refer, for example, to Domingo de Soto, Luis de Molina, Domingo Bañez, Francisco Suárez, Juan de Lugo, etc.

²⁶ Cf. SOTO |D., *Theologia Moralis, Tractatus de Justitia et Jure*, Lib. V, q. 2, art. 1 - "... .praelatus vero cogere posset subditum propter singularem oboedientiam illi promissam, ut medicamina admittat quae commode recipere potest. At vero quod ingentissimum dolorem in amputatione membri aut corporis incisione ferat, profecto nemo cogi potest: quia nemo tenetur tanto cruciatu vitam servare. Neque ille censendus est sui homicida. Imo vera est illa Romani vox dum crus illi aperietur: Non est tanto dolore digna salus." In: CALIPARI, *Curarse y...* p. 97.

²⁷ Cf. CALIPARI, *Curarse y...* p. 160.

the moralists of the tradition utilized to designate the causes of the moral impossibility stand out:²⁸

- “Ultimate effort” (*summus labor*) and “extremely difficult means” (*media nimia dura*);
- “Certain torment” (*quidam cruciatus*) y “enormous pain” (*ingens dolor*);
- “Extraordinary cost” (*sumptus extraordinarius*), “valuable means” (*media pretiosa*) y “exquisite means” (*media exquisita*);
- “Severe horror” (*vehemens horror*).

It is like this that the traditional teaching originated that holds that a means of preserving life that involves at least one of the four elements of ‘moral impossibility’ for the individual or that is not capable of offering a hope of beneficial results, should be considered ‘extraordinary’ and – therefore - morally non-obligatory (facultative). On the contrary, those means which are capable of offering the hope of beneficial results (*spes salutis*) and that do not impose excessive burden on the patient (*summus labor*), should be considered ‘ordinary’ and – as a consequence – morally obligatory.

As an anecdotal fact, I just mentioned that it was Domingo Bañez (1528 – 1604) who - in 1595 – introduced the terms ‘ordinary’ and ‘extraordinary’ in the debate over the moral obligatory nature of the means of preserving life.²⁹ Therefore, it was just at the end of the

²⁸ Cf. CRONIN, *Conserving...*, pp. 98 - 112. Also cf. CALIPARI, *Curarse y...* pp. 158 - 166

²⁹ McCARTNEY J.J., *The Development of the Doctrine of Ordinary and Extraordinary Means of Preserving Life in Catholic Moral Theology Before the Karen Quinlan Case*. *Linacre Quarterly* 1980 Aug, 47 (3): 216.

16th Century when the moralists began to articulate their teachings through the expressions ‘ordinary means’ and ‘extraordinary means’.³⁰

2.1.5. Absolute norm vs. relative norm.

From what has been said so far it is clear that, in accordance with the teachings of tradition, the distinction between ‘ordinary’ and ‘extraordinary’ does not refer primarily to the type of means in general, but more so to the moral character that the utilization of the means has for the person in particular. It has to do with the distinction focused on the person of the infirm and his moral obligation to care for his health and life.³¹ Therefore, the elements that should be taken into consideration to determine the grade of moral obligation of a determined means of preserving life, more than describing the technical aspects of the means in question, tend to characterize the particular situation for how it affects the infirm.

It makes sense to ask, then, if to define the ‘extraordinary’ (i.e. non-obligatory) character of a means of preservation of life it would be enough in a concrete case to identify some element that causes a physical or moral impossibility for a person in particular (relative

³⁰ Bañez made the distinction that, although it is reasonable to affirm that every person is obligated to use the necessary means to preserve life itself, no one would be obligated to employ ‘extraordinary’ means, but only those means which are common to everyone, such as giving nourishment, being clothed and using ordinary medicines. On the contrary, those means which cause unbearable pain, place an excessive burden, or cause an ‘extraordinary’ and disproportionate cost for the conditions of the life of the infirm (*sumptus extraordinarius*) could not be morally binding for that person. Cf. JANINI J., *La operación quirúrgica, remedio ordinario*. Revista Española de Teología 1958; 18: 331 – 348.

³¹ CALIPARI recalls this idea in the following way:

“What distinguishes the thought of tradition on the topic in study is the great attention that these authors have showed about the human person. It is exactly the person, in effect, with his resultant peculiar and inalienable dignity of having being created “ in the image and likeness of God” and whose destination is fulfilled in plenitude in the eternal life, that is to say in the full and definitive communion with the Holy Trinity, who is firmly at the center of any moral reasoning; it constitutes the real "norm", the measurement of the beginning and of the ethical proposed analyses, whose only end is to guide the decisions and the actions of singular individuals, in a field as delicate as that of the conservation of the life, towards the achievement of the authentic and integral good of the person in need of care. ” Cf. CALIPARI, *Curarse y...* p. 166-167.

norm) or if it would have to refer, more so, to those circumstances that cause an impossibility for all human beings in general (absolute norm). In accordance with the tradition, it would be enough to adopt the 'relative norm' at the hour of defining the 'ordinary' and 'extraordinary' means of preserving life. However, it is necessary to make some clarifications. In a case where a physical impossibility exists it is not difficult to conclude that the person can be excused from the duty to preserve life, in accordance with the classic aphorism 'no one is obligated to the impossible' (*nemo ad impossibilia tenetur*).³² However, when it concerns a moral impossibility one should take into account the distinction between negative and affirmative precepts. Given that the first is always obligatory and in every circumstance (*semper et pro semper*), it would not fit to justify an action that directly violates a negative precept, not even by offering as proof a supposed moral impossibility to be able to do it in another way. But when we refer to the positive duties related to the care and preservation of life, the existence of a moral impossibility could exempt its fulfillment.³³ It is, therefore, in the area of the positive duties pertaining to the preservation of life where it would be sufficient with adopting the 'relative norm' to define the 'ordinary' character (i.e. morally obligatory) or 'extraordinary' (non-obligatory) character of a means.³⁴ That is to say, what is 'ordinary' or 'extraordinary' for one patient in a determined clinical condition, could not be so for another patient in a similar situation, including for the same patient in other circumstances.³⁵

³² Cf. CALIPARI, *Curarse y...* p. 160.

³³ *Ibid.* p. 161

³⁴ Cf. CRONIN, *Conserving...*, pp. 91 – 92; KELLY, *The duty...* p. 214; CALIPARI, *Curarse y...* pp. 166 – 168.

³⁵ Cf. CALIPARI, *Curarse y...* pp. 166 – 168.

2.1.6. Theological Foundation of the traditional teaching.

Another question that we should analyze in relation to the content of the traditional teaching refers to its foundation. Following Saint Thomas, the moralists of the tradition understood the moral duty of preserving life in the context of the virtue of justice and, in particular, of commutative justice.³⁶ As a matter of fact, Aquinas approached the theme of suicide in his treatment of the virtue of justice.³⁷ It should not surprise us – therefore – that in analyzing the foundations of the moral duty to preserve life, Cardinal Juan de Lugo, S.J. (1583 – 1660) emphasizes the radical difference that exists between the dominion that man has over things and the dominion he has over his own life. Thus, while a person can insist that things belong to him, it would not be correct to insist that his life belongs to him in an equal way. Given that life is a gift, the person does not have perfect dominion over it, but is more its administrator.³⁸

The (physical) life is recognized by the moralists of the tradition as a fundamental and primary good of the person, but not as an absolute good, therefore only the eternal beatitude can be considered an absolute good.³⁹ The classic teaching that distinguishes between ‘ordinary’ and ‘extraordinary’ means affirms that the positive duty to preserve and advance this primary good (the physical life) admits some circumstantial limits (such as all the positive moral prescriptions). However, given the importance of the value that is in play – the life of a person – it requests that every reasonable effort be made to

³⁶ Cf. CALIPARI, *The principle...* p. 393.

³⁷ Cf. SANTO TOMÁS DE AQUINO: *Summa Theologiae*, II- II, c. 64, a.5. As we have previously recalled in the argument over the moral evil of suicide, the Angelic doctor fundamentally proposed three reasons. The third argument is based on the radical pertence of all human life to God, the Creator, which he has love and maintained in existence. Thus, to deny oneself of one’s life would be to commit a wrong against God, man giving himself the right to judge the value of one’s existence, without having ‘jurisdiction’ over it, because the judge over life and death belongs to God alone.

³⁸ Cf. JOHN PAUL II: *Evangelium Vitae*, Vatican City, 1995, n. 34.

³⁹ Cf. CALIPARI, *Curarse y...* p. 167; also cf. CALIPARI, *The principle...* p. 393.

⁴⁰ Cf. CALIPARI, *Curarse y...* p. 167

safeguard it. Therefore, only proportionately grave causes could exempt one from the positive duties related to the preservation of life.

Health, in so far as the positive quality of the physical life, also merits being conserved and guarded. “There thus subsists the duty to cure oneself and to be cured.”⁴⁰ The traditional distinction between ‘ordinary’ and ‘extraordinary’ means offers the criteria to establish the limits of this positive moral obligation, affirming that it is morally obligatory to use ‘ordinary’ treatments and that the use of ‘extraordinary’ treatments is morally facultative. Nevertheless, an adequate understanding and application of the traditional teaching to particular cases is supported in the premise that every human life merits an unconditional respect – from conception to natural death – by reason of its ontological dignity. At the margin of this anthropological conception it is easy for the content of this traditional teaching to be interpreted and applied in an inadequate form, as it occurs with some frequency nowadays.

2. 2. Incorporation of the traditional teaching in the documents of the Magisterium.

The traditional teaching, proposed by the moralists of the 16th century, was transmitted during approximately five centuries without great variations. Its actual validity has been officially recognized by the Catholic Church, that in the 20th century has incorporated this doctrine into some magisterial documents. Given that the pronouncements of the Magisterium have been analyzed in depth by Professor John Haas (in this volume), I will limit myself to offer here a brief enumeration of some of these documents, with the proposition of emphasizing the confirmation that the Church has given to the traditional teaching in the context of the advances in contemporary medicine, advances which

⁴⁰ Cf. CALIPARI, *Curarse y...* p. 167

undoubtedly present ‘new’ and complex challenges to the question about the limits of the moral duty to preserve life.

- It is well known that – in the year 1957 – Pope Pius XII applied the classic distinction between ‘ordinary’ and ‘extraordinary’ means in his speech to a group of anesthesiologists, who he advised on the moral obligation of the use of the (then) ‘new’ techniques of cardiopulmonary resuscitation.⁴¹
- In the year 1981, the Sacred Congregation for the Doctrine of the Faith promulgated the Declaration *Iura et Bona* (on Eutanasia).⁴² In the fifth part of this document it refers to the distinction between ‘ordinary’ and ‘extraordinary’ means in the context of the decisions of limiting therapeutic efforts at the end of life, proposing – for the first time in a magisterial document – the alternative use of the terms ‘proportionate’ and ‘disproportionate’ therapies (principle of therapeutic proportionality).⁴³ It affirms that “it is licit to be satisfied with the normal means that medicine can offer”⁴⁴ and that “before the imminence of an inevitable death [...] it is licit in conscience the decision to renounce some treatments that would solely procure a precarious and painful prolongation of existence.”⁴⁵ It also emphasizes the duty to not interrupt the “normal duties to the infirm in similar cases.”⁴⁶

⁴¹ Cf. PIO XII, *Answers to some relevant questions on resuscitation* AAS 49, November 24, 1957.

⁴² Cf. SACRED CONGREGATION FOR THE DOCTRINE OF THE FAITH: *Declaración Iura et Bona (Sobre la Eutanasia)*, Vatican City, May 5, 1980.

⁴³ The origin of this new terminology is ascribed to the thought of some authors that are proposed. . However, the document does not make reference to their names. Cf. CALIPARI, *Curarse y ...* p. 117 + 144.

⁴⁴ Cf. SACRED CONGREGATION FOR THE DOCTRINE OF THE FAITH: *Iura et Bona*, n. 28

⁴⁵ *Ibid.*

⁴⁶ *Ibid.*

- A little later, in the same year 1981, the Pontifical Council *Cor Unum* promulgates a document on “Ethical questions relative to the gravely ill and the dying”.⁴⁷ In this document – known for its French name *Dans le Cadre* – the distinction between ‘ordinary’ and ‘extraordinary’ means is also utilized and it specifies that to search for the global efficacy of a means of preserving life it should be taken into account as many quantitative elements as qualitative. It insists on the moral obligation of utilizing the so-called ‘minimal’ care, defined as those means that in normal conditions are destined to maintain the life of a person (as, for example, nourishment).⁴⁸
- In 1995, the Pontifical Council for the Pastoral Assistance of Health Care Workers, publishes the Charter for Health Care Workers,⁴⁹ in which is proposed – among other things – that the distinction between ‘ordinary’ and ‘extraordinary’ means (or ‘proportionate’ and ‘disproportionate’ means) does not only apply to decisions at the end of life, but also in whichever situation during the length of a person’s life in which the question of the moral obligation of utilizing a medical therapy is contemplated.⁵⁰
- The same year 1995, His Holiness Pope John Paul II publishes the encyclical *Evangelium Vitae*, which is without a doubt the most important magisterial document that confirms the traditional teaching. This encyclical distinguishes the fundamental difference that exists between euthanasia (“Euthanasia's terms of

⁴⁷ Cf. PONTIFICIO CONSEJO *COR UNUM* : *Dans le Cadre*, Ciudad del Vaticano, 27 Junio 1981.

⁴⁸ *Ibid*, n. 2.4.

⁴⁹ PONTIFICIO CONSEJO PARA LA PASTORAL DE LOS AGENTES DE LA SALUD: Carta a los Agentes de la Salud. Ciudad del Vaticano, 1995., n. 64 – 65.

⁵⁰ Cf. CALIPARI, *The principle...* p. 395.

reference, therefore, are to be found in the intention of the will and in the methods used⁵¹) and the rejection of the so called ‘aggressive medical treatment’ (that is to say, the recourse to “medical procedures which no longer correspond to the real situation of the patient, either because they are by now disproportionate to any expected results or because they impose an excessive burden on the patient and his family”⁵²). The conclusion is that “to forego extraordinary or disproportionate means is not the equivalent of suicide or euthanasia; it rather expresses acceptance of the human condition in the face of death.”⁵³

- Another document – undoubtedly very important – is the Catechism of the Catholic Church, which confirms this doctrine by affirming that “it makes sense to evaluate if the therapeutic means that are available are objectively proportionate with respect to the perspective improvement”.⁵⁴

III. INADEQUATE INTERPRETATIONS AND APPLICATIONS OF THE TRADITIONAL TEACHING IN CONTEMPORARY MEDICAL ETHICS.

If it seems that the distinction between ‘ordinary’ and ‘extraordinary’ means of preserving life has been incorporated into the language of contemporary medical ethics⁵⁵ and it is mentioned with some frequency in biomedical literature as a criteria capable of orienting decisions to limit therapeutic efforts, an updated review shows that this distinction is not always understood and applied adequately. In what follows I will briefly

⁵¹ JUAN PABLO II: *Evangelium Vitae*, Ciudad del Vaticano, 1995, n. 65.

⁵² *Ibid.*

⁵³ *Ibid.*

⁵⁴ JUAN PABLO II: *Catecismo de la Iglesia Católica*. Asociación de Editores del Catecismo, Madrid, 1992, n. 2278.

⁵⁵ Cf. *Editorial. Ordinary and extraordinary means*. *J Med Eth*, 1981, 7 (2) : 55-56.

summarize some of the forms in which – in my opinion – the content of the traditional teaching is being inadequately interpreted and applied today, seeking to give evidence of the reasons that lie behind these ambiguities.

3. 1. Inadequate interpretation of the significance of the terms ‘ordinary’ and ‘extraordinary’.

As the British moral theologian Dunstan⁵⁶ affirms, in an article published in the Dictionary of Medical Ethics, the significance of the terms ‘ordinary’ and ‘extraordinary’ means has a different connotation for doctors and moralists. Among health professionals it is frequent that the expression ‘ordinary means’ is equated with the idea of ‘common’, ‘habitual’, or ‘non-exceptional’ therapies, while the term ‘extraordinary means’ refers to those therapies that are ‘uncommon’, ‘non-habitual’, ‘exceptional’ or that ‘that are still found in an experimental stage’. As a matter of fact, this is the interpretation of the terms that, for example, the American Medical Association (AMA)⁵⁷ and the President’s Commission for the Study of Ethical Problems and Behavioral Research of USA propose.⁵⁸ It is not surprising, therefore, that the prevalent attitude among doctors is to interpret the distinction between ordinary/extraordinary as the difference between usual/unusual, equating the ‘ordinary’ measures with the so called ‘standard therapies’ according to pathology.⁵⁹

⁵⁶ Cf. DUNSTAN, GR. Citado en: *Editorial*, J Med Eth, 1981, 7: 55.

⁵⁷ Cf. AMERICAN MEDICAL ASSOCIATION. *Principles of Medical Ethics*. Chicago, Illinois: AMA, 1981. For a critical analysis of the interpretation of the AMA cf.: FISCHER S.A., *Correspondence: "Ordinary" and "extraordinary" vary with the case*. Hastings Center Report, 1983; 13 (5): 43 - 4.

⁵⁸ Cf. *The President’s Commission for the Study of Ethical Problems in Medicine and Biomedical and Behavioral Research: Deciding to forgo life-sustaining treatment*. Washington, D.C.: U.S. Government Printing Office, 1983.

⁵⁹ Cf. MEYERS C., *Intended goals and appropriate treatment: an alternative to the ordinary/extraordinary distinction*. J Med Eth, 1984, 10 (3): 128 – 130.

Although this interpretation has some relation with the distinction between ‘ordinary’ and ‘extraordinary’ proposed by the moralists of the tradition, it seems evident that the simple reference to the ‘usual’, or to that which is considered ‘standard therapy’ for a determined clinical condition, would not be enough to determine if that therapy is or is not morally obligatory for a particular patient. Thus, for example, the anti-retroviral therapy is actually the standard therapy for the treatment of the HIV infection. Just the same, it could happen that a particular patient could be physically or morally helpless to be able to undergo legitimate therapy (as it has in fact occurred in the hospital).⁶⁰ In these circumstances, the utilization of that therapy would not be morally required for that particular patient, though its use is what is habitually done in those cases. Thus, despite being the standard therapy, it would be treated as an ‘extraordinary’ measure for that particular patient (relative norm).

Therefore, to equate the ordinary/extraordinary distinction with the duplicate usual/unusual supposes to incur a logical error, as some contemporary authors have shown.⁶¹ In fact, it would not be correct to infer a moral obligation based off the mere statistical frequency that an act occurs. To derive an ‘ordinary’ (morally obligatory) or ‘extraordinary’ character (facultative) of a therapy exclusively from the frequency of its

⁶⁰ The case corresponds to a real clinical situation that occurred in the Clinical Hospital of our University and that motivated a consultation of the Ethical Committee. Cf. Taboada P., *Principles of Bioethics in Palliative Care*. En: Bruera E., Higginson I., Ripamonti C., von Gurten C., *Textbook of Palliative Medicine*. London: Hodder Arnold, 2006: 85-91; Taboada P., *Ethical Issues in Palliative Care*. En: Bruera E., De Lima L., Wenk R., Farr W., *Palliative Care in the Developing World. Principles and Practice*. Houston: IAHP Press, 2004: 39 – 51; Taboada P., *Principios éticos en Medicina Paliativa*. En: Bruera E., De Lima L. (Eds.), *Cuidados Paliativos: Guías para el Manejo Clínico* (2nd. Ed) Washington D.C.: IAHP/OPS: 2004: 9-14; Taboada P., *El derecho a morir con dignidad*. Acta Bioethica. 2000; VI (1): 91 – 101.

⁶¹ Cf. BEAUCHAMP T., CHILDRESS J., *Principles of Biomedical Ethics*. (Fifth Edition). Oxford: Oxford University Press, 2001: 200 -201; MEYERS C., *Intended goals...* p. 128, PERRY C., *Ordinary, extraordinary and neutral medical treatment*. Theor Med 1983, 4 (11): 43 – 56; BOLE T., *The ordinary-extraordinary distinction reconsidered: a moral context for the proper calculus of benefits and burdens*. HEC Forum. 1990; 2 (4): 219 – 232;

utilization in the clinic would be to incur in a ‘statistical’ version the naturalistic fallacy: to identify the ethic with the statistic.⁶²

We remember that the moralists of the tradition introduced the terms ‘ordinary’ and ‘extraordinary’ to refer to the moral character (obligatory vs. facultative) that the use of means of preserving life would have for the individual patient. In other words, gathering the significance of their Latin roots (*ordo-ordinis*), the expressions ‘ordinary’ and ‘extraordinary’ denote the moral ‘order’ or ‘disorder’ that the utilization of a medical therapy involves in the life of the individual patient.⁶³ This moral ‘order’ or ‘disorder’ refers to the place where it concedes to the moral obligation to ‘cure oneself and to be cured’⁶⁴ in the wider context of the other moral obligations and of the particular circumstances in the life of a person, taking into account an adequate axiological scale. This moral connotation of the terms ‘ordinary’ and ‘extraordinary’ does not necessarily coincide with the idea of that which is habitually done or which occurs occasionally from a medical perspective, as I have previously attempted to demonstrate.

3. 2. Interpretation of the ordinary/extraordinary distinction centered on the means.

Another inadequate interpretation of the distinction between ‘ordinary’ and ‘extraordinary’ means – closely linked to the matter of the previous point and also

⁶² Cf. MOORE G.E., *Principia Ethica*. New York, Cambridge University Press, 1959: 39 - 40.

Moore describes naturalists fallacy in the following way:

“I shall deal with theories which owe their prevalence to the supposition that good can be defined by reference to a *natural object* [...] and I give it but one name, the naturalistic fallacy.[...] This method consists in substituting for ‘good’ some one property of a natural object or of a collection of natural objects; and in thus replacing Ethics by some one of the natural sciences. “

⁶³ Cf. McCARTNEY J.J., *The Development of the Doctrine of Ordinary and Extraordinary Means of Preserving Life in Catholic Moral Theology Before the Karen Quinlan Case*. *Linacre Quarterly* 1980 Aug, 47 (3): 215 – 24; WILDES K., *Conserving Life and Conserving Means: Lead us not into Temptation*. In: *Philosophy and Medicine* 51, Dordrecht: Kluwer Academic Publishers, 1995; WILDES K., *Ordinary and extraordinary means and the quality of life*. *Theological Studies* 1996, 57 (3): 500 – 512.

⁶⁴ Cf. CALIPARI, *Curarse y...* p. 41 – 45.

prevalent in the medical area – consists in centering the distinction on the ‘means’ and not on the person that utilizes those means. We intend, thus, to make a list of those medical interventions that should always be done to be considered ‘ordinary’, setting off this list with the enumeration of those interventions that fall in the area of the facultative, to be considered ‘extraordinary’.⁶⁵ Those therapies of ‘common’ use in medicine are numbered in the supposed list of ‘ordinary’ medical interventions for being relatively simple, such as – for example – antibiotics, steroids, blood transfusions, etc.⁶⁶ On the contrary, included in the enumeration of the list of ‘extraordinary’ therapies are those interventions that are only exceptionally utilized, since they are highly complex or they are still in an experimental stage, as for example, extracorporeal circulation with a hyperbaric camera, regenerative therapy with stem cells extracted for the umbilical chord, certain forms of genetic therapy, etc.

This way of understanding the distinction between ‘ordinary’ and ‘extraordinary’, centered more on the ‘means’ than on the moral duty of the person that utilizes those means, may lead one to fall into the similar error of the previous point.⁶⁷

If it is in fact true that those medical interventions which are relatively simple to implement are more likely to fall into the area of what is morally obligatory for a patient, it would not be correct to identify the simple with the ethically binding.⁶⁸ It could happen that a simple intervention, which is in itself effective, would not be morally required for a patient in a particular situation. That could be, for example, the case of a patient with an

⁶⁵ Cf. *Editorial. Ordinary and extraordinary means*. J Med Eth, 1981, 7 (2) : 55-56; PERRY C., *Ordinary, extraordinary...*p. 43 – 56; Meyers, *Intended goals...*p. 128-129; O’NEIL R., *In defense of the “Ordinary”/“Extraordinary” Distinction*. Linacre Quarterly, 1978; 45 (1) 37 – 40;

⁶⁶ Cf. PERRY C., *Ordinary, extraordinary...*p. 43 – 56.

⁶⁷ Cf. PERRY C., *Ordinary, extraordinary...*p. 43 – 56;

⁶⁸ Cf. BEAUCHAMP T., CHILDRESS J., *Principles of ...* pp. 200 -201.

elevated level of potassium in the blood (hyperkalemia) secondary to a renal insufficiency caused by the tumoral infiltration of his ureters. Although, from the medical point of view, simple and effective means for reducing potassium in blood exist, to resort to these measures could be morally facultative for this particular patient, who is the carrier of cancer in the terminal stage, which implies that the cause of his hyperkalemia cannot be corrected.⁶⁹

On the other hand, to hold that the inherent values of the classification (that is to say, the morally obligatory character of ‘ordinary’ means and the facultative character of ‘extraordinary’ means) are principally related to the medical procedures in so far as this would suppose to accept that its moral character could be determined independently of the particular circumstances in which a therapy is going to be used, which does not seem reasonable.⁷⁰

Therefore, to identify the ethically obligatory therapies (‘ordinary’ means) with a list of simple or commonly used medical interventions (and vice-versa) seems inadequate. In fact, the texts of the moralists never intend to offer an exhaustive and complete list of ‘ordinary’ and ‘extraordinary’ means. The references to concrete situations that appear in their writings merely have the function of giving example that seeks to show that the moral quality of ‘ordinary’ and ‘extraordinary’ cannot be evaluated in abstract, but it

⁶⁹ The description of the case corresponds to a real situation that recently occurred in the Clinical Hospital of our University, which motivated a consultation of the Ethical Committee. Cf. TABOADA P., *Principles of Bioethics in Palliative Care*. In: BRUERA E., HIGGINSON I., RIPAMONTI C., VON GURTEN C., *Textbook of Palliative Medicine*. London: Hodder Arnold, 2006: 85-91; TABOADA P., *Ethical Issues in Palliative Care*. In: BRUERA E., DE LIMA L., WENK R., FARR W., *Palliative Care in the Developing World. Principles and Practice*. Houston: IAHP Press, 2004: 39 – 51; TABOADA P., *Principios éticos en Medicina Paliativa*. In: BRUERA E., DE LIMA L. (Eds.), *Cuidados Paliativos: Guías para el Manejo Clínico* (2nd. Ed) Washington D.C.: IAHP/OPS: 2004: 9-14; TABOADA P., *El derecho a morir con dignidad*. Acta Bioethica. 2000; VI (1): 91 – 101.

⁷⁰ Cf. PERRY C., *Ordinary, extraordinary...*p. 44 – 45; RACHELS J., *More impertinent distinction*, en: MAPPS T.A., ZEMBATY J.S. (eds.), *Biomedical Ethics*, New York: McGraw Hill 1981: 335 359.

must be judged here and now (*hic et nunc*), according to the specific circumstances of each patient.⁷¹

3. 3. Confusion between ‘therapeutic proportionality’ and ‘proportionalism’.

A group of outstanding moral theologians of the 20th century⁷² has proposed a way of ethical reasoning that is known as ‘the theory of proportionality’. Ethical proportionalism – a variation of consequentialism – sustains that the moral goodness or evil of an action exclusively derives from the proportion of good or bad consequences from which they continue or can continue, including in this balance some pre-moral or non-moral goods.⁷³ In the context of concrete situations in which good and bad coexist, which creates an ethical dilemma of difficult resolution, these authors propose that the moral judgment centers on the recognized proportion between good or bad effects, in view of the ‘greater good’ or the ‘lesser evil’, that are effectively possible in a determined situation.⁷⁴

Basing their thought on this current ethic, some contemporary bioethicists – such as Paul Schotsmans⁷⁵ and Ludger Honnefelder⁷⁶ – criticize the classic distinction between

⁷¹ Cf. CALIPARI, *The principle...* p. 393:

“Contrary to what is affirmed in some quarters, a careful reading of the texts of these moralists shows that they were careful not to attempt to draw up exhaustive and definitive lists of ordinary and extraordinary therapeutic means (possible references to specific medical actions present in their tracts, in fact, have a purely example-giving function), and they well brought out how the ‘ordinary’ or ‘extraordinary’ character of a therapeutic action was an ethical *quality* that can and must be fully assessed not in the abstract but in the concrete circumstances of clinical use, *hic et nunc*, and for a specific patient. All this clearly bears witness to the centrality that the classic moralists gave to the person as such in the way in which they argued and justified their ethical conclusions.”

⁷² I refer here, concretely, to authors such as Janssens, Knauer, Fuchs, Schüller, Van de Poel, Van der Marck and McCormick

⁷³ Cf. JUAN PABLO II: *Veritatis Splendor*, Ciudad del Vaticano, 1993, n. 74 - 79.

⁷⁴ Cf. JUAN PABLO II: *Veritatis Splendor*, n. 75.

⁷⁵ Cf. SCHOTSMANS P., *Equal Care as the Best Care: A Personalist Approach*. En: ENGELHARDT H.T., CHERRY M. (Eds.), *Allocating Scarce Medical Resources: Roman Catholic Perspectives*, Washington, D.C., Georgetown University Press, 2002: 125 – 139.

‘ordinary’ and ‘extraordinary’ means, because they believe that these concepts solely operate in the context of the ethical model called ‘act deontology’⁷⁷, for which they do not agree. For Schotsmans, for example, the principal insufficiency of the classic model is rooted in what is ‘static’ and – therefore – incapable of dynamically integrating in its analysis the changing perspectives that characterize the evolution of contemporary medicine.⁷⁸ To overcome this supposed insufficiency of the traditional model, Schotsmans proposes to adopt a proportionalist theory⁷⁹ that – according to this author – more than a ‘system’ or ‘methodology’ of analysis, it would consist in a way of seeing human acts in terms of the relation between the ends and the good.⁸⁰ The morality of an

⁷⁶ Cf. HONNEFELDER L., *Quality of Life and Human Dignity: Meaning and Limits of Prolongation of Life*. En: ENGELHARDT H.T., CHERRY M. (Eds.), *Allocating Scarce Medical Resources: Roman Catholic Perspectives*, Washington, D.C., Georgetown University Press, 2002: 140 – 153.

⁷⁷ The classic theory of the moral action is designated with this name, according to which the source of the morality are given by the object, the end and the circumstances of the human act. This classic theory holds that the first moral qualification of an act is given by its moral object or ‘species’, from which the existence of actions that are always and in every circumstance a moral evil (*intrinsece malum*) are deduced. Cf. SANTO TOMÁS DE AQUINO, *Summa Theologiae*, I-II, q. 6 – 21.

⁷⁸ Cf. SCHOTMANN, *Equal Care...*p. 134:

“Traditionally, moral theology applied in this context the concepts of ‘ordinary’ and ‘extraordinary’ means. ... This distinction may be adequate for static and poor medical environments, but it is no longer apt to cope with the rapid evolutions of medical technology at the moment. From a more methodological point of view, we may say that these concepts functioned indeed very well in the context of the ethical model of so-called act deontology, but they lack sufficient dynamic integration of new evolutions and changing perspectives.”

⁷⁹ Cf. SCHOTMANN, *Equal Care...*p. 134:

“All this makes clear that speaking in terms of ‘proportionate and disproportionate’ is preferable. The general dissatisfaction with the concepts of ‘ordinary’ and ‘extraordinary means’ (e.g. in situations in which good and evil coexist) led many eminent moral theologians, including Janssens, Knauer, Fuchs, Schüller, Van de Poel, Van der Marck and McCormick, to explore a way of reasoning that is known as the ‘theory of proportionality’.”

⁸⁰ Cf. SCHOTMANN, *Equal Care...*p. 134:

“as noted by Selling, ‘proportionality’ is neither a ‘system’ nor a ‘determinative methodology’, but is only a way of “looking at things proportionally” (Selling 1986). According to Janssens (1980-81), proportionality is a question of relation between end and good. There must not be any intrinsic contradiction between the basic or ontic good that we want to preserve and the means we use for that end. As Knauer says, this postulate of noncontradiction between the means and the end is a central norm for determining the proportionate reason of any human act (Knauer 1965).”

Las citas incluidas en el texto de Schotsmans se refieren específicamente a los siguientes textos: SELLING J., *The development of proportionalist thinking*. *Chicago Studies* 1986, 25: 167 – 175; JANSSENS L., *Artificial insemination: Ethical considerations*. *Louvain Studies* 1980-1, 8: 3 – 29; KNAUER P., *La détermination du bien et du mal moral par le principe du double effet*. *Nouvelle Revue Théologique* 1965, 87 : 356 – 376.

act should be evaluated by a differentiated mode: on the one hand, it would be necessary to consider its moral 'goodness', that would be fundamentally based on the intention of the subject (in as much as it refers to moral goods, such as benevolence, justice, etc.); on the other hand, it would be necessary to establish its 'integrity', which would result from the proportion of the foreseeable effects and consequences of the action.⁸¹

From the perspective, to speak of 'ordinary' and 'extraordinary' means would end up being ineffective and so it would be preferable to utilize the terms 'proportionate' and 'disproportionate means'.⁸² To justify the proportionality of a therapy, the good of health – and in extreme circumstances, including the good of life itself – it should be balanced against other active values in an 'actual system of values' (for example, containment of costs, equity, solidarity, justice, etc.).⁸³ Therefore, the determination of what constitutes a 'proportionate' treatment (the 'best' care or 'adequate treatment') for a patient would be the result of a dialogue between health professionals, the patient and the insurance companies. In that way, the moral character of the therapeutic action ('proportionate' vs. 'disproportionate') would be founded on the balance of its results, the ethically correct course being that which would produce the greater good or the 'lesser evil' possible of attaining in the given situation.⁸⁴ If the intention of the subject is directed toward the good (charity, justice, etc.), that action would be morally good (independent of the proper

⁸¹ *Ibid.*

⁸² Cf. SCHOTMANN, *Equal Care...* p. 136:

"All this makes clear that speaking in terms of 'proportionate and disproportionate means' is preferable."

⁸³ Cf. SCHOTMANN, *Equal Care...* p. 136:

"we understand by 'best' of care the appropriate care for every unique patient. This implies that the medical profession in dialogue with the representatives of patients (e.g., mutual insurance funds) must define adequate health care... the value of 'health must be balanced against other values incumbent value systems."

⁸⁴ Cf. SCHOTMANN, *Equal Care...*, HONNEFELDER, *Quality of Life...*

object of the act or the moral ‘species’). In this way, the proportionalist balance includes the possibility that some non-moral responsibilities associated with the therapies or with the particular circumstances of the patient could overcome the value of the life itself and justify acts which – of themselves – could end the life of the patient.

In actuality, this type of ‘proportionalist’ interpretation of the distinction between ‘ordinary’ and ‘extraordinary’ means is very wide-spread among moralists. It is probable that its diffusion is seen as having been facilitated by the replacement of the terms ‘ordinary’ and ‘extraordinary’ means for ‘proportional’ and ‘disproportional’ therapies in the last decades. On the other hand, there is no doubt that – as John Paul II indicates in *Veritatis Splendor* – the consequentialist and proportionalist ethical theories “can gain a certain persuasive force from their affinity to the scientific mentality, which is rightly concerned with ordering technical and economic activities on the basis of a calculation of resources and profits, procedures and their effects.”⁸⁵ Though, - continues the quotation of John Paul II - “such theories, however, are not faithful to the Church's teaching, when they believe they can justify as morally good deliberate choices of kinds of behavior contrary to the commandments of the divine and natural law.”⁸⁶

In this way, when it is proposed in the traditional teaching and in the most recent ecclesial documents of the Magisterium to apply the ‘principle of therapeutic proportionality’ to the decisions to limit the therapeutic efforts,⁸⁷ the ‘proportionality’ is

⁸⁵ Cf. JUAN PABLO II: *Veritatis Splendor*, Ciudad del Vaticano, 1993, n. 76.

⁸⁶ *Ibid.*

⁸⁷ Cf. SAGRADA CONGREGACIÓN PARA LA DOCTRINA DE LA FE: Declaración *Iura et Bona*, 5 Mayo 1980, n. 27; PONTIFICIO CONSEJO PARA LA PASTORAL DE LOS AGENTES DE LA SALUD: Carta a los Agentes de la Salud. Ciudad del Vaticano, 1995, n. 64; PONTIFICIO CONSEJO *COR UNUM* : *Dans le Cadre*, Ciudad del Vaticano, 27 Junio 1981, n. 2-4; 7.2; 7.3.

conceived from a mode that is organically integrated with the concepts of classic morals.⁸⁸ As Sulmasy affirms, an adequate interpretation and application of therapeutic proportionality demands that both the benefits and the responsibilities associated with a treatment be evaluated as a whole and weighed against the practical reasonableness of implementing the said therapy, with the understanding that the existence of a moral duty to preserve health and (physical) life is accepted.⁸⁹ In other words, to justify the ‘proportionality’ (a moral obligation) of a therapy, it does not seem adequate to place a set of moral and pre-moral values before the good of health and life— as proportionalism proposes – but, rather, it should be established whether elements that constitute a ‘proportionally grave’ inconvenience (a ‘moral impossibility’) exist or not so that a person can comply with the ‘positive’ duty of preserving his health and his life, assuming that life itself is an ‘indispensable’ good. From this perspective, based on the premise that (physical) life is a primary and fundamental good over which we do not have perfect dominion, the conclusion is that the value can never be placed before a set of non-moral goods, however adverse the circumstances are. According to the negative precept, the moral duty to not commit an act that could directly violate the life and health of a human person is always and in every circumstance obligatory (*semper et pro semper*). This duty includes the obligation to maintain a certain level of minimal care or medical treatments (understood in a wide sense) that are directly related with the preservation of the

⁸⁸ TABOADA P., *What is Appropriate Intensive Care? A Roman Catholic Perspective*. En: Engelhardt H.T., Cherry M. (Eds.), *Allocating Scarce Medical Resources: Roman Catholic Perspectives*, Washington, D.C.: Georgetown University Press, USA, 2002: 53 – 73.

⁸⁹ Cf. SULMASY D., *Double-Effect Reasoning and Care at the End of Life: Some Clarifications and Distinctions*. En: MONSOUR H.D., SULLIVAN W.F., HENG J. (Eds.), *Dignity in Illness, Disability, and Dying*. Toronto: International Association of Catholic Bioethicists, 2007: 49 – 109.

(physical) life⁹⁰ and that – in principle – could never be considered ‘disproportionate’ or ‘extraordinary’. In other words, these measures will always be ‘ordinary’, for it would never be licit to omit them if the life and the ontological dignity of all human persons wants to be respected.⁹¹

3. 4. Interpretation centered on the ‘quality of life’.

To bestow a superior value to the ‘quality of life’⁹² as the criteria that would permit the distinguishing of the morally obligatory therapies from those that are not, is another very wide-spread form of interpreting the distinction between ‘ordinary’ and ‘extraordinary’ measures nowadays.⁹³ Beauchamp and Childress, for example, suggest that it would be better to replace the distinction between ‘ordinary’ and ‘extraordinary’ treatments with the distinction between ‘morally obligatory’ and ‘optional’ treatments, in accordance with a balance between the benefits and the responsibilities of the patient in which the

⁹⁰ I refer here to measures such as hygien, hydration, nutrition, etc. Cf. HEANEY S., “*You Can’t be any poorer than dead*”: *Difficulties in Recognizing Artificial Nutrition and Hydrations as Medical Treatments*. *Linacre Quarterly*, May 1994: 77 – 87; ASHBY M., STOFFELL B., *Artificial hydration and alimentation at the end of life: a reply to Craig*. *J Med Ethics*. 1995; 21 (3): 135-40. DUNLOP R.J., ELLERSHAW J.E., BAINES M.J., SYKES N., SAUNDERS C.M., *On withholding nutrition and hydration in the terminally ill: has palliative medicine gone too far?*

⁹¹ This idea has been emphasized in numerous recent magisterial documents: Cf. SAGRADA CONGREGACIÓN PARA LA DOCTRINA DE LA FE: Declaración *Iura et Bona*, 5 Mayo 1980, n. 28; PONTIFICIO CONSEJO PARA LA PASTORAL DE LOS AGENTES DE LA SALUD: Carta a los Agentes de la Salud. Ciudad del Vaticano, 1995, n. 120; JUAN PABLO II: Discurso a los participantes en el Congreso Internacional ‘Life-sustaining Treatments and Vegetative State: Scientific Advances and Ethical Dilemmas.’ 20 de Marzo 2004, Ciudad del Vaticano (online: www.vatican.va); SAGRADA CONGREGACIÓN PARA LA DOCTRINA DE LA FE, *Respuestas a algunas preguntas de la conferencia episcopal estadounidense sobre la alimentación e hidratación artificiales*. Roma, 1 de agosto de 2007.

⁹² A critical analysis of the concept of quality of life and of its role in the decisions of limiting therapies far exceeds the limits of this work.

⁹³ Cf. BEAUCHAMP T., CHILDRESS J., *Principles of Biomedical Ethics*. (Fifth Edition). Oxford: Oxford University Press, 2001; BOLE T., *Intensive Care Units (ICUs), and the ordinary means: turning virtue into vice*. *Linacre Quarterly*. 1990; 51 (1): 68 – 77; BOLE T., *The ordinary-extraordinary distinction reconsidered: a moral context for the proper calculus of benefits and burdens*. *HEC Forum*. 1990; 2 (4): 219 – 232; WILDES K., *Ordinary and extraordinary means and the quality of life*. *Theological Studies* 1996, 57 (3): 500 – 512.

quality of life plays a central role.⁹⁴ For these authors, the principle criterion that allows the determination of whether a treatment is morally obligatory or ‘excessive’ is the consideration of the probability and magnitude of its benefits, weighed against the probable burdens. In this way, the conditions that could justify violating the *prima facie* obligation that we have to treat, would be the ‘futility’ of the treatment or that for which the burdens exceed the benefits.

In accordance with this perspective, the distinction between ‘obligatory’ and ‘optional’ treatments admits that conditions can exist in which the value of actual living could not be adequately counterbalanced by those goods – such as happiness and pleasure – that in reality make life worth living. Therefore, the principle of non-maleficence does not imply the obligation of maintaining the biological life, or the duty of initiating or continuing treatments in the condition of pain, suffering and discomfort for the patient. In this way, when the ‘quality of life’ is very bad, it could be considered that the treatment is imposing more burdens than benefits on the patient. In other words, life would not have an intrinsic value, if it were not by virtue of the goods that it permits us to experience and, especially, the happiness and pleasure that can be experienced. On this point, the argument agrees with the utilitarian position.

As a matter of fact, the utilitarian criteria of maximizing happiness for the majority of persons has found wide acceptance today, especially among Anglo-Saxon moralists and bioethicists. In the debate over the limits of the obligation to preserve life, the utilitarian argument has been manifested in the form of a strong rejection of the idea that a moral

⁹⁴ Cf. BEAUCHAMP T., CHILDRESS J., *Principles of ...* p. 202: “We conclude that the distinction between ordinary and extraordinary treatments is morally irrelevant and should be replaced by the distinction between optional and obligatory treatment, as determined by the balance of benefits and burdens to the patient.” ... *Ibid*, p. 215: “Our arguments thus far give considerable weight to quality-of-life judgments in determining whether treatments are optional or obligatory.”

obligation to maintain hydration and nutrition in severely demented patients or patients in a persistent vegetative state exists.⁹⁵

It becomes evident that this interpretation of the distinction between ‘ordinary’ and ‘extraordinary’ means contains profound deviations from the traditional teaching. Among the most important deviations, they draft a proposition of maximizing certain non-moral goods and the idea that life would only have value if it is a source of pleasure. The great acceptance that the ‘quality of life’ has encountered in contemporary biomedical literature as the predominant criteria in the decisions about limiting therapeutic efforts gives evidence that our societies are losing the sense of the value of human life and the significance of being a part of the human community.⁹⁶

IV. FINAL REFLECTIONS

Recapitulating, we can say that the formal origin of the traditional moral teaching that distinguishes between ‘ordinary’ and ‘extraordinary’ means of preserving life is found in

⁹⁵ CLARK P., *Tube feedings and persistent vegetative state patients: ordinary or extraordinary means?* Christ Bioeth. 2006; 12 (1): 43 - 64. CRAIG G., *On withholding nutrition and hydration in the terminally ill: has palliative medicine gone too far?* J Med Eth, 1994, 20: 139-143; CRAIG G., *On withholding artificial hydrating and nutrition from terminally ill sedated patients. The debate continues.* J Med Eth, 1996; 22: 147-153; DUNLOP R.J., ELLERSHAW J.E., BAINES M.J., SYKES N., SAUNDERS C.M., *On withholding nutrition and hydration in the terminally ill: has palliative medicine gone too far? A Reply.* J Med Eth 1995; 21: 141-143; GUEVIN B., *Ordinary, extraordinary, and artificial means of care.* Natl Cathol Bioeth Q. 2005 Autumn; 5 (3): 471-9; HEANEY S., *“You Can’t be any poorer than dead”:* *Difficulties in Recognizing Artificial Nutrition and Hydrations as Medical Treatments.* Linacre Quarterly, May 1994: 77 – 87; HICKEY J.V., FISCHER S.A., RACHELS J., *“Ordinary” and “extraordinary” vary with the case.* Hastings Cent Rep. 1983; 13 (5):43 – 4; SHANNON T., *Nutrition and hydration: an analysis of the recent papal statement in the light of the Roman Catholic bioethical tradition.* Christ Bioeth. 2006 Apr; 12 (1): 29 – 41; TORCHIA J., *Artificial hydration and nutrition for the PVS patient: ordinary care or extraordinary intervention?* Natl Cathol Bioeth Q. 2003 Winter; 3 (4): 719 – 30; WILKES E., *On withholding nutrition and hydration in the terminally ill: has palliative medicine gone too far? A commentary.* J Med Eth, 1994; 20: 144-145.

⁹⁶ Cf. MARKWELL H., *End-of-life: A Catholic View.* The Lancet. 2005, 366: 1132 – 35; BLAKE D.C., *Reconsidering the distinction of ordinary and extraordinary treatment: should we go “back to the future”?* HEC Forum 1996; 8 (6): 355 – 71.

the great commentators of Saint Thomas Aquinas of the 16th century. The advances of medicine during the Renaissance obligated the moralists of the time to directly approach the question of the limits of the moral duty to preserve health and life. In that way, the traditional teaching emerged that affirmed the existence of a ‘positive’ moral duty to preserve health and life through the utilization of available medical therapies when they offer a reasonable hope for beneficial results (*spes salutis*) and when their utilization does not cause a physical or moral impossibility for the individual patient (*quaedam impossibilitas*).⁹⁷ Both conditions must be simultaneously fulfilled for a means of preserving life to be considered ‘ordinary’ and, therefore, morally obligatory. When at least one of these conditions is not met, the therapy is considered ‘extraordinary’ and its use becomes morally facultative for the individual (relative norm). However, the tradition also affirms that the utilization of an ‘extraordinary’ means could be morally required *per accidens* in particular circumstance, such as – for example – when its use represents the only way a patient has to be able to comply with other superior duties, “such as those of mercy, charity and justice (to God, society and family, etc.).”⁹⁸ The actual validity of the traditional teaching has been confirmed by the Magisterium of the Church during the 20th century, in the context of the complex moral dilemmas presented by the practice of contemporary medicine. The magisterial documents emphasize the importance of understanding and applying this doctrine in light of the unconditional respect that all human life merits – from conception to natural death – by reason of its ontological dignity (given as much by its origin as by its destiny). This anthropological conception offers the hermeneutical key for an adequate prudential

⁹⁷ Cf. MEILAENDER, 1997, p. 527; KELLY, 1951, p. 550.

⁹⁸ Cf. CALIPARI, *Curarse y...* p. 167.

application of the traditional teaching to particular cases. Outside of this context, it is easy for the content of this traditional teaching to be interpreted and applied in an inadequate way, of which the brief analysis that we have made of some of the forms of interpretation of this doctrine in the area of contemporary medical ethics has given evidence.