

ORDINARY AND EXTRAORDINARY MEANS AND THE QUALITY OF LIFE

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CATHOLIC MORALISTS today appear hesitant to speak about “quality of life.” A number of Catholic hierarchs and theologians tend to avoid that expression because of public-policy debates surrounding abortion and physician-assisted suicide. In fact the term has been deployed by many hostile to traditional Christianity’s views on these moral issues. While it is understandable that in today’s political and cultural climate, particularly in the U.S., one might wish to avoid the term, it is important that Roman Catholic bioethicists and moral theologians recognize that quality-of-life judgments have played a central role in the traditional distinction between ordinary and extraordinary means. If we fail to understand the importance of quality-of-life judgments, we run the risk of misunderstanding that distinction and the important moral commitments it implies—all in the interests of winning a political battle.

I contend that the distinction between ordinary and extraordinary means cannot be understood without quality-of-life judgments. In assessing the benefits and burdens of treatments, the distinction between ordinary and extraordinary means turns on an assessment of medical treatment relative to the patient. The judgment whether or not to pursue a particular treatment is based in part on a judgment about how a treatment will affect the quality of life for a patient, one’s family, and others. Failure to appreciate this underlying framework of the distinction is a failure to understand traditional moral teaching. Such failure is partly due to an oversimplification of language found, for example, in the pro-life agenda and partly due to a modern secular view of medicine. To make my argument I will first review the history of the distinction between extraordinary and ordinary means, then analyze important elements in the distinction, and finally review several current applications of the distinction that have been made by certain sectors of the Roman Catholic episcopacy, with special attention to moral issues related to feeding and hydrating a certain type of patient.

HISTORY OF THE DISTINCTION

Since the 16th century Roman Catholics have reflected on the extent of one’s obligation to preserve life.¹ These reflections were partly in-

¹ My research on the history of this distinction grows out of a study regarding the use

fluenced by developments in medicine during the Renaissance. This was the age in which A. Vesalius published his *De humani corporis fabrica* (1542), from which the study of anatomy as we know it emerged, Harvey (1578–1657) advanced his theory of circulation, and Thomas Sydenham (1624–1689) published *Observationes medicae* (1676), a systematic description of diseases that brought to medicine Bacon's discipline of scientific observation. Against this backdrop of advances in medicine such as the development of surgery, moralists from Francisco de Vitoria (1486–1546) to Juan Cardinal de Lugo, S.J. (1583–1660) explored the positive obligation of Christians to preserve life. Unlike the "perfect" obligation not to take innocent human life intentionally, the "positive" obligation was often ambiguous and open ended. While it was clear that a Christian was not obligated to do everything to preserve life, it was unclear to what extent one was obligated to preserve life. Decisions about pursuing life-prolonging treatments were set within certain boundaries. On the one hand, one could not intentionally take innocent human life, including one's own; but, on the other hand, one need not maintain life at all costs. To do everything to maintain life at all costs could be nothing short of idolatry as Pius XII stated in 1958; it is to put human life before all else including God. Most medical decisions, however, fall somewhere in between these boundaries. Reflections on these decisions were articulated in the language of ordinary and extraordinary means.

In his doctoral dissertation first published in 1958 that examined the obligation to conserve human life, Daniel A. Cronin, now Archbishop of Hartford, repeated the conviction that the human person lacks perfect dominion over his or her own life. Since life is a gift from God, each person has only an imperfect dominion over it.² Dominion over one's own life differs from the dominion human beings have over the rest of the creation. Juan de Lugo, who played an important role in developing the distinction between ordinary and extraordinary means argued that there is a fundamental difference between the dominion men and women possess over things and the dominion over their own life.

Now we prove that man is not the master of his life this way: although man can receive dominion over things which are extrinsic to himself or which are distinct from him, he cannot, however, receive dominion over himself, because from the very concept and definition, it is clear that a master is something relative, for example, a father or a teacher; and just as no one can be father or teacher of himself, so neither can he be master of himself, for to be master

of intensive-care medical resources; see my essay, "Conserving Life and Conserving Means: Lead Us Not into Temptation," in *Critical Choices and Critical Care: Catholic Perspectives on Allocating Resources in Intensive Care Medicine*, ed. Kevin W. Wildes, S.J. (Dordrecht: Kluwer Academic, 1995) 105–18.

² Daniel A. Cronin, "Moral Law in Regard to the Ordinary and Extraordinary Means of Conserving Life," in *Conserving Human Life*, ed. Russell E. Smith (Braintree, Mass.: Pope John Center, 1989) 1–145, at 10.

always denotes superiority with regard to the one over whom he is the master. Hence, God Himself cannot be master of Himself, even though He possesses Himself most perfectly. Therefore man cannot be master of himself, however, he can be master of his operations, and therefore, he can sell himself and thus, improperly speaking, we might say he gives mastery of himself to another but, he really does not give over mastery of himself basically or radically, but only mastery over certain of his operations, . . . therefore a man can dispose only of his own operations of which he is master, not of himself, (or to say the same thing) not of his own life over which he is not master, nor can he be.³

What emerged in Roman Catholic traditional teaching was an understanding of human life in which there is considerable, though limited, freedom given to human beings. One such limitation is that we do not possess total disposition over our own life. We are obliged to conserve human life. This obligation forbids any person to take his or her own life.⁴ The more difficult dimension of the obligation, however, is to determine the positive duty one has to conserve life. What is the nature and extent of one's duty to conserve life? This question has particular importance in health care in determining the extent to which a person must seek treatment for disease or illness. In articulating one's obligation to seek treatment, traditional teaching sets out a distinction framed in terms of an understanding of one's earthly life and ultimate end. Life is understood as a gift in relationship to personal salvation and eternal happiness. So traditional teaching has argued for an obligation to conserve life that is balanced by other obligations and by the view that love of God orders all obligations.

THE ELEMENTS OF THE DISTINCTION

Traditional teaching has commonly distinguished between the affirmative and negative precepts of the natural law.⁵ Negative precepts were said to be always binding since they forbid what is intrinsically evil and not even death itself would make it licit to perform evil. Such precepts bind *semper* and *pro semper*. Affirmative precepts bind always, *semper*, but not *pro semper*, in that one is not bound, always and everywhere, under every circumstance, to do something positively good. An affirmative precept and its correlative duty need not be carried out in the face of physical or moral impossibilities.⁶ When an individual is unable to make use of the means of conserving his or her life, such a situation presents a physical impossibility. Nonetheless, a person may be able physically to utilize means for preserving life but still be incapable of using the available means because of fear, danger,

³ Juan de Lugo, S.J., *Disputationum de iustitia et iure* 10, section 1, no. 9; cited in Cronin 10.

⁴ Thomas Aquinas, *Summa theologiae* 2-2, q. 64, a. 5.

⁵ Hieronymus Noldin and Albert Schmitt, *Summa theologiae moralis* 1 (Ratisbonne: Feliciani Rauch, 1940) 179, n. 177; cited in Cronin 30.

⁶ See Gerard Kelly, *Medico-Moral Problems* (St. Louis: Catholic Hospital Association, 1958) 8-9.

or inconvenience. Such conditions create a moral impossibility that establishes a sufficient condition to consider these means as *extraordinary* and hence not obligatory. Means that do not create moral or physical impossibilities are called *ordinary*.⁷ The distinction between the two is not exact and is misnamed, since it focuses not on the means of treatment or care but on the effect of the treatment or care on the life of a patient, a family, and others. Traditional teaching elaborates certain elements central to the description for distinguishing between ordinary and extraordinary means.

Before setting out these elements, it is important to point out two threads that run through the different elements in the description. First, in each element of the distinction, there is the question of a norm for the element. Discussion in traditional teaching often explored the question whether or not there is an absolute or relative standard for each element, such as expense. In general, writers opted for the relative standard in discussing each element. Cronin notes that "it is difficult to establish an absolute norm when determining the required hope of success and benefit in any procedure designed to conserve life. In point of fact, it is difficult to apply an absolute norm to any of the elements of ordinary means."⁸

A second point of methodology concerns the importance of prudent judgment. Although prudence in contemporary philosophy has come to mean the notion of rational self-interest, within Roman Catholic traditional teaching it was understood as a cardinal virtue that judges not only according to rational self-interest but according to the promptings of the Holy Spirit. In traditional teaching one will not be able to legislate what should be done. Choices will have to be left to individual conscience.

Extraordinary Means

Extraordinary means are those that would constitute a moral impossibility for human beings in general (absolute norm) or for a particular person (relative norm). Cronin observes that theologians have used a variety of phrases to describe such impossibilities. Following his lead, one can gather these elements together into five general headings.

1. An impossibility factor (*quaedam impossibilitas*) exists in cases where it is impossible either to obtain the means or to use them even if attainable. Gerard Kelly expressed this as follows: "[I]n concrete cases it is not always easy to determine when a given procedure is an *extraordinary* means. It is not computed according to a mathematical formula, but according to the reasonable judgments of prudent and

⁷ Benedikt H. Merkelbach, *Summa theologia moralis ad mentem D. Thomae* 1 (Paris: Desclée de Brouwer, 1935) no. 222.

⁸ Cronin 90.

conscientious men."⁹ The essential element of an extraordinary means is that it presents a moral impossibility.

2. Roman Catholic moralists have also relied on the notion that an effort might be too difficult (*summus labor* and *nimis dura*) in order to allow for a means that would require excessive effort. A favorite example of excessive effort used in traditional teaching has been the requirement of a long journey in order to live in a more healthful land. Following this line of thought, Zalba argued that one is not bound to submit to a very dangerous operation or to a burdensome convalescence.¹⁰

3. The question of pain (*quidam cruciatus, ingens dolor*) also comes into play when deciding whether or not a means is extraordinary. A common traditional example is amputation. The distinction originated at a time when surgery was practiced without anesthesia. While advances in medicine now allow us to control and alleviate pain to a large extent, considerable pain and discomfort are involved in many procedures. One can think for example of pain and discomfort experienced by cancer patients in chemotherapy.

4. Moralists have always taken into account the element of expense (*sumptus extraordinarius, media pretiosa, media exquisita*). Expense can constitute an excessive hardship which in turn can make the means extraordinary. When moralists have spoken of cost, they have done so in terms of the expression *secundum proportionem status*. The norm of excessive expense is relative to one's economic status and also varies from country to country.¹¹ Medical expense, it was argued, needs to be judged in light of a person's financial position. This element poses an important point of reflection for contemporary Roman Catholic thought on health care. Traditional moral theology recognized different stations and economic inequalities as part of the human condition. Thus, what could be considered extraordinary for one person may be ordinary for another. However, much of contemporary discussion, both secular and religious, has focused on equality of treatment in health care, a fact which Roman Catholic social teaching must also take into account.

5. Traditional moralists recognized the role that emotions of fear and repugnance (*vehemens horror*) could play. When fear is present, even when judged to be irrational and unwarranted, it can make a means extraordinary. Distaste for a particular treatment such as being treated by a physician of the opposite sex or repugnance for amputation could render a means extraordinary. Not only means could cause repugnance but one's subsequent state after treatment. Cronin, in writing about amputation, observed that

⁹ Kelly 135.

¹⁰ Eduardo Regatillo and Marcellino Zalba, *Theologiae moralis summa* 2 (Madrid: Biblioteca de Autores Cristianos, 1952) 269.

¹¹ Cronin 108.

moralists cite an amputation as an example of an extraordinary means, due to the grave danger and intense pain involved. Science has improved the technique in operations and thus the amputation is no longer as dangerous as it was. Anesthesia has removed the pain. Yet repugnance to living with a mutilated body could just as readily constitute a grave inconvenience. This point should be remembered when determining such a procedure as ordinary and extraordinary for a particular individual.¹²

Cronin cited the Ballerini-Palmieri edition of Gury's moral theology which raises the question whether the use of anesthesia would render surgery "ordinary." He thinks it is an open question whether living with a mutilated body is just as much an excuse as pain associated with surgery. Such concerns are not simply about the means or the quality of life during treatment, but also about the quality of life after treatment. This category of *vehemens horror* is one that has been overlooked in some of the bishops' statements on feeding and hydrating patients who are in a persistently vegetative state.

In each of these five elements the reaction of the patient (e.g. fear) is what makes a means extraordinary. It is not anything extraordinary in the nature of the treatment itself, but in the patient's reaction to the treatment, the burden the treatment imposes on him or on others.

Ordinary Means

Ordinary means of conserving one's life are distinguished from ordinary medical procedures, in that what may be an ordinary (common) medical procedure may nonetheless be extraordinary to a patient. In understanding what constitutes an ordinary means of conserving one's life, traditional teaching outlined five elements.

1. A means of conserving life must offer some hope of benefit (*spes salutis*) if it is to be ordinary and considered obligatory. This hope of benefit must be more than simply the hope of postponing the inevitable. De Lugo gives an example of a man condemned to death by fire.¹³ In the case, he supposes that while surrounded by flames the man notices that he has sufficient water to extinguish some of the fire but not all of it. He then asks whether the man is obliged to use the water and he answers "no." Even though the means is common and it would offer some benefit (prolonged life), it is considered of no value since it only postpones the inevitable. The derived benefit must be worthwhile in both quality and duration.

2. An element frequently mentioned is that ordinary means must be "common" (*media communia*). In the language of contemporary medicine, "common" means would be part of the normal standard of care. This quality would exclude as morally obligatory both experimental means or means that are otherwise outside of normal care. However, it

¹² Ibid. 111.

¹³ De Lugo, *De iustitia et iure* 10, section 1; cited in Cronin 85.

is important to note that simply because a means is common, understood as part of standard care, does not mean that one is morally obligated to use such a means. The use of a means needs to be viewed in light of the patient's general condition, desires, and hope of health. That a means is part of standard care is a necessary condition, but not a sufficient one, to make it morally obligatory or "ordinary."¹⁴

3. A person's social position or particular status (*secundum proportionem status*) is a relevant factor in deciding whether or not a means is common. This also includes evaluation of a treatment's cost. De Lugo discusses this element helpfully with the case of a novice in religious life who is suffering from ill health. The novice may be told that the best treatment for his illness is to return to the world in order to have the food and surroundings needed for recovery. De Lugo argues that the obligation to conserve one's life does not require the novice to return to the world, and that he would satisfy his obligation by using means which others in religious life commonly use.¹⁵

4. According to Cronin, traditional teaching has also raised another element, this time asking whether the means are not difficult (*media non difficilia*).¹⁶ The notion of difficulty is general and not specific; it can involve elements of pain, cost, danger to life, fear, etc. In making a judgment about the difficulty of a treatment, traditional moral teaching tried to balance the serious demand of the natural law to conserve one's life with the proportionate difficulty of fulfilling the law. This criterion was also captured by the expression *media facilia*, which implied that a treatment should be convenient and reasonable to employ.

These concerns are expressed by the distinction used in modern Roman Catholic documents such as the *Declaration on Euthanasia*, which speaks of one's "duty to care for his or her own life or to seek such care from others."¹⁷ Yet that document states the limits on this obligation. One is not obliged to seek experimental treatment and can "make do with the normal means that medicine can offer."¹⁸ It also speaks of situations "when inevitable death is imminent in spite of the means used," in which "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."¹⁹ One needs to judge the means used by "studying the type of treatment to be used, its degree of complexity or risk, its cost and the possibilities of using it, and comparing these elements with the result that can be expected, taking into account the state of the sick person and his or her physical and moral

¹⁴ Cronin 93.

¹⁵ De Lugo, *De iustitia et iure* 10, section 1, n. 36; cited in Cronin 93.

¹⁶ Cronin 96.

¹⁷ Congregation for the Doctrine of the Faith, *Declaration on Euthanasia* (May 5, 1980) part 4, cited in *Conserving Human Life* 278-85, at 283-84.

¹⁸ *Ibid.*

¹⁹ *Ibid.*

resources."²⁰ Finally, the Congregation for the Doctrine of the Faith reflects traditional teaching when it writes: "Life is a gift of God, and on the other hand death is unavoidable; it is necessary, therefore, that we, without in any way hastening the hour of death, should be able to accept it with full responsibility and dignity."²¹

More recent literature has shifted away from the distinction between ordinary and extraordinary means to speak rather of medical treatments that are proportionate or disproportionate. This is a helpful shift since, in an environment of rapidly developing technology, medical interventions that are common and part of standard care (i.e. ordinary in the practice of medicine) can be extraordinary and nonobligatory from the viewpoint of morality. The language of "the proportionate" and "the disproportionate" focuses on the relationship of the treatment to the patient's condition. The use of a technological intervention can be disproportionate or burdensome, given an individual patient's hope of recovery or benefit.

In summary, I have shown in this section that in order for a treatment to be obligatory there must be some hope of health. This is a necessary condition for a treatment to be considered ordinary, but it alone is not a sufficient condition. Absence of hope of health, however, is a sufficient condition for withholding or withdrawing a treatment. In assessing the benefit or burden ratio one assesses what the treatment does for the patient and others. A hope of benefit is a necessary, though not sufficient, condition for treatment. If a treatment is either physically or morally burdensome for the patient or others, a sufficient condition exists to withhold or withdraw the treatment. The assessment of the burdensome nature of a treatment is a quality-of-life judgment. Is the treatment itself a burden to the patient, or does the treatment leave the patient in a condition that the patient finds repugnant? Since there is no absolute standard by which to make these judgments, they will be relative to the patient's perception of his or her own life.

MORAL ISSUES IN FEEDING AND HYDRATING PATIENTS

In recent years, advances in life-sustaining medical technology have led various groupings of bishops to revisit the distinction between ordinary and extraordinary means and apply it to contemporary medical-moral questions. They have been concerned particularly about artificial feeding and hydration of patients who are in a persistently vegetative state.²² Several excellent statements by groups of bishops in

²⁰ Ibid.

²¹ Ibid.

²² Persistent vegetative state (PVS) is a state of permanent unconsciousness with loss of all cerebral cortical functions that leads to complete unawareness of self or of one's environment, although there is a persistence of sleep-wake cycles; see Executive Board, American Academy of Neurology, "Position Statement on the Management and Care of the Persistent Vegetative State Patient," *Neurology* 39 (1989) 125-26.

various states have preserved the core of the traditional teaching and applied it to contemporary issues.²³ In some instances, however, bishops' statements have failed to preserve distinctions as formulated in traditional teaching. My comments here are restricted to that second group.

Given the troubling issues the bishops are addressing, it is not difficult to understand their desire to find answers to guide the faithful. In the face of the common practice of abortion and the increased practice of assisted suicide, bishops have been concerned with protecting human life. In their efforts to do so they have sought to address broad public audiences. To be understood by those wide audiences their discourse has been simplified to the extent that it risks misstating traditional teaching. Their statements also reflect a tendency to use a modern secularized view of medicine and medical technology. These factors have led them to objectivize the benefits of interventions such as nutrition and hydration.

Furthermore, the expression "quality of life" has been used by the proponents of practices such as abortion, assisted suicide, and euthanasia; indeed "quality of life" has become a rallying slogan for those who favor such practices. There is an understandable tendency in some of these episcopal statements to avoid any public formulation that might suggest endorsement of that kind of quality-of-life ethic. In the public context, these bishops tend to speak in language that portrays life as an absolute good and to eschew language about the quality of life. Such statements sometimes convey the impression that the distinction between ordinary and extraordinary means can be worked out in fairly objective terms (e.g. benefits of treatment, the proximity of a patient to death). In fact the language of benefit vs. burden ratio or proportionate vs. disproportionate treatment lends itself to images of a mathematical measurement. But this does not retain all the nuances of traditional teaching. While there are objective elements, such as whether or not a treatment is available or will be physiologically useful, the history of the distinction between ordinary and extraordinary means makes it clear that its deployment turns on the prudent judgment of the patient with the help of family and physician. The patient is the one who weighs risks, burdens, and benefits in light of a treatment's probable impact. The distinction depends upon the patient's quality-of-life judgments.

The Pennsylvania bishops' statement on nutrition and hydration illustrates the tendency both to objectify the judgment about ordinary and extraordinary means and to misrepresent traditional teaching. For example, the bishops write that "the patient in the persistent vegetative state is not imminently terminal (provided that there is no

²³ The Texas Bishops, "On Withdrawing Artificial Nutrition and Hydration," *Origins* 20 (June 7, 1990) 53-55; Oregon and Washington Bishops, "Living and Dying Well," *Origins* 21 (November 7, 1991) 345-52.

other pathology present). The feeding—regardless of whether it be considered as treatment or as care—is serving a life-sustaining purpose. Therefore, it remains an ordinary means of sustaining life and should be continued.²⁴ The bishops of the Maryland Catholic Conference also wrote that “[a] medical treatment should not be deemed useless, however, because it fails to achieve some goal beyond what should be expected.” For them, medically assisted feeding and hydration is useful as long as the patient is capable of absorbing the nutrients delivered by the treatment.²⁵

These kinds of statements reflect an erosion of the distinction between ordinary and extraordinary means. There are a number of ways in which the traditional teaching is being lost. First, it should be noted that the distinction between ordinary and extraordinary means traditionally has not been limited only to those patients who were considered to be terminal.²⁶ In creating such a restriction the bishops are being quite innovative in their interpretation of the distinction. Pope John Paul II seems to limit the distinction’s application to those who are close to death; in *Evangelium vitae* he distinguishes euthanasia from withdrawing aggressive treatment and, in so doing, appears to limit the distinction between ordinary and extraordinary means to situations “when death is clearly imminent and inevitable.”²⁷ The distinction, however, has not traditionally been tied to closeness of death, but to a judgment about the treatment’s benefits and burdens.

Second, in writing about a treatment and the preservation of life in isolation from a person’s life, these particular bishops give the impression of having an incomplete model of medicine. One reason for the success of modern medicine has been increased specialization and attendant technology. Such advances present a difficulty, however, in that often no one is looking after the whole patient. A wide range of literature in bioethics, the philosophy of medicine, and medical sociology has addressed the complaints of patients and the concerns of physicians about the failure to treat the whole patient.²⁸ The approach of modern, scientific medicine has tended to follow a Cartesian model of the human being and to treat the pathological body (*res extensa*) as a broken machine separate from the person (*res cogitans*). This mechanistic view of medicine and of the patient has increased with medical

²⁴ Pennsylvania Bishops, “Nutrition and Hydration: Moral Considerations,” *Origins* 21 (January 30, 1992) 541–53, at 548.

²⁵ Maryland Catholic Conference, *Pastoral Letter on the Care of the Sick and Dying*, October 14, 1993 (Annapolis: Maryland Catholic Conference, 1993) 4.

²⁶ For an excellent history of the distinction, especially as applied to feeding and hydration, see John J. Paris, S.J., “The Catholic Tradition on the Use of Nutrition and Fluids,” in *Birth, Suffering, and Death*, ed. Kevin W. Wildes et al. (Dordrecht: Kluwer Academic, 1992) 189–208.

²⁷ John Paul II, *Evangelium vitae* (March 25, 1995), *Origins* 24 (April 6, 1995) 687–727, at 712.

²⁸ See Eric Cassell, *The Nature of Suffering and the Goals of Medicine* (New York: Oxford University, 1991).

specialization and subspecialization. These bishops reflect this tendency by looking at medical interventions in isolation from the whole patient. In trying to objectivize the benefits of medically assisted feeding and hydration they neglect the subjective element for determining ordinary care. The benefits of a treatment can only be determined within the context of a patient's life. Those episcopal statements appear to assess the objective physiological benefits of nutrition and hydration at the risk of neglecting the context of the whole patient.

Third, assessing benefit in health care necessitates an important subjective component. What counts as benefit for one person may not hold for another. Cancer patients with similar pathologies and prognoses make different choices about proposed therapies because they view their benefits and burdens differently. What may seem to hold benefit at one point in a patient's life may not do so at another point. Discussion in bioethics and health policy has been ongoing over the past decade about "futile treatment".²⁹ Aside from what is physiological futility, the term "futile" is highly subjective; what may be futile for one patient or family may be good for others.

Benefit does not mean simply the prolongation of life. Cronin is helpful here. In his study of the distinction between ordinary and extraordinary means, Cronin explores the idea of a treatment offering a benefit. That a treatment must offer some hope of benefit accords with common sense; the real question is how much benefit and what type of benefit must be realized. The idea of benefit, as understood in traditional teaching, is not merely the conservation of life. According to de Lugo and others, the benefit must be worthwhile in quality and duration. A treatment that fails to meet such criteria would not be considered ordinary and obligatory.

Some statements that we have cited reduce the subjective element in the distinction by arguing that a treatment can be refused because it is burdensome but cannot be refused because the life effected will be burdensome. The 1992 statement of the U.S. Bishops' Pro-Life Committee states: "In keeping with our moral teaching against the intentional causing of death by omission, one should distinguish between a repugnance to a particular procedure and repugnance to life itself."³⁰ The problem, insofar as nutrition and hydration are concerned, is that one cannot draw a sharp distinction between life and the means used to sustain life. Artificial nutrition and hydration become part of a patient's life the way amputation does. Here traditional teaching about amputation is instructive. When introduced as a surgical procedure without anesthesia, it was argued that one could refuse amputation because the treatment represented a *vehemens horror*, meaning that

²⁹ See "Moral and Conceptual Disputes about When Treatments are Medically Futile," thematic issue of *Journal of Medicine and Philosophy* 20 (1995) 109-226.

³⁰ U.S. Bishops' Pro-Life Committee, "Nutrition and Hydration, Moral and Pastoral Reflections," *Origins* 21 (April 9, 1992) 705-12, at 708.

the treatment represented great fear and pain such that the treatment could be regarded as extraordinary.³¹ Furthermore, traditional teaching also took into account the repugnance to living with a mutilated body which could constitute a moral impossibility for a patient.

To summarize this section, I have noted that from the history of the distinction it has been clear that one of the necessary conditions for a treatment to be ordinary and hence obligatory is that it offer some hope of health. Some of the statements we have cited, in seeking to affirm life as a good, have argued that even the permanently vegetative state is beneficial in itself. This would make sense if one were foreclosing judgments about the quality of life. But this argument eliminates any subjective dimension in the distinction between ordinary and extraordinary means. One should be on guard not to accept a modern, secular view of medical technology and care of patients. The long Roman Catholic tradition of distinguishing between ordinary and extraordinary means is valuable. There are two conditions that are necessary for a treatment to be ordinary. A treatment is morally obligatory if and only if it offers a benefit and does not impose burden. Neither condition is sufficient by itself. There is an obligation only when both are met. Since there is no absolute standard for such judgments, they rely on the discernment of the patient.³² The decision to withdraw or withhold treatment is not a decision to end life, but a choice not to preserve it because the emotional, psychological, and spiritual cost of preservation is too high. This is a decision by a patient or a designated decision-maker about the quality of life. It is not made by some social standard, but by seeing the life and the treatment in the context of one's relationship to God.

CONCLUSION

The obligation to sustain one's life extends to using those means that do not cause an undue burden or moral impossibility and that offer some reasonable expectation of health. This obligation is rooted in a conviction that one's life is not one's own. The core of the distinction is not merely a question of determining the obligations one has towards preserving one's life. Rather, as de Lugo and Pius XII both noted, there is a spiritual insight that life is not the paramount value. De Lugo ruled out the necessity of an extraordinary means because the *bonum* of one's life is not so important as to demand conservation by any and

³¹ Cronin 110.

³² Many of those who argue for the preservation of life, without any account for the quality of life, assert that those who want to take stock of the quality of a patient's life are viewing life instrumentally and setting up a dualism between the person and the life. Such arguments make a crucial assumption that the dualism of life and person is necessarily ontological. However, it can be a simply categorical explanation; one can make a conceptual distinction without claiming it to be ontological; see Kevin W. Wildes, S.J., "Life as a Good and Our Obligations to Persistently Vegetative Patients," in *Birth, Suffering, and Death* 145-54.

all possible means: the *bonum* of one's life "is not of such great moment, however, that its conservation must be effected with extraordinary diligence: it is one thing not to neglect and rashly throw it away, to which a man is bound: it is another, however, to seek after it and retain it by exquisite means as it is escaping away from him, to which he is not bound."³³

Pope Pius XII, addressing an international congress of anesthesiologists in 1957, spoke of the good life as subordinated to "spiritual ends."³⁴ In the view of the traditional moral teaching, the conservation of life is an imperfect obligation that must be ordered in relationship to other obligations. If one gives improper weight to life, there is the risk of idolatry, inasmuch as preserving one's life is an imperfect obligation ordered to attaining a higher spiritual end.

In some contemporary discussions of bioethics within the Catholic Church there is real possibility that insight reflected in the distinction between ordinary and extraordinary means could be lost. Such a possibility is real because secular moralists do not appreciate the traditional teaching nor what led to its formulation. Another danger arises from moralists charged with the task of preserving the traditional teaching. Some charged with the task of helping the community preserve itself and its traditional doctrine are unwittingly undermining the distinction and the understanding behind it. A careful historical review of traditional teaching makes it clear that the distinction between ordinary and extraordinary means involves patient-centered judgments about the quality of life, which must take into account the usefulness of the treatment, one's understanding about death and dying, and the repugnance one may have toward one's life after subjection to a particular medical treatment.

³³ De Lugo, *De iustitia et iure* 10, section 1; cited in Cronin 53.

³⁴ Pope Pius XII, "The Prolongation of Life," in *Conserving Human Life* 312-18, at 315; also in *The Pope Speaks* 4 (1958) 396-98, at 397.