Even after allowing for inflation, the figures show that there has been a threefold rise in spending per head over the past 20 years.

In truth it seems that the main beneficiaries of the gold in this era have been the providers of care. Estimates in the late 1970s suggested that 18% of health care spending was taken up by doctors' salaries, which in 1981 averaged \$93 000,¹⁸ with top salaries in the \$300 000 range, and that doctors controlled or influenced most of the rest of the spending. Life may not have been a bed of roses, and many doctors are quick to point to the problems of practising under the constant and expensive threat of malpractice suits, but there is no denying that the profession as a whole has done very nicely.

Before moving on to look at how HMOs have contributed to the change in the status quo it is important to appreciate how the traditional fee for service system evolved and flourished until the early 1980s, and this will be discussed in the second article in this series. This is not to imply that it is not still the major way in which health care in America is delivered, for it is, but doctors working in this sector are beginning to practise in less expansive styles for they are aware that "the fee for service system will not survive unless it can match the cost effectiveness of HMOs and well organised private clinics (such as Mayo, Ochsner, Lahey, and Cleveland)."¹⁹

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Philosophical Medical Ethics

Ordinary and extraordinary means

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In the last two articles I pursued the theme of killing versus letting die, and particularly the "Clough doctrine": thou shalt not kill; but needs't not strive officiously to keep alive. I argued that no consistent moral difference could be found between acts and omissions to support the Clough doctrine but that something similar could be supported as a rule of thumb by accepting that intentionally bringing about the death of one's patients (whether by action or omission) is, at least generally speaking, wrong (I argued against the absolutist claim that it is without exception wrong). On the other hand, knowingly risking death or other harm in the pursuit of the patient's good may often be justified, provided the importance of the good and its probability of being attained are sufficiently great to outweigh that risk of death or other harm. This position corresponds, at least roughly, with the fourth clause of the Roman Catholic doctrine of double effect.

In this article I wish to pursue the same theme, and especially the question of striving to keep alive, via another Roman Catholic doctrine, that of ordinary and extraordinary means. Unravelling and stripped of its misleading name, this doctrine offers patients and doctors, regardless of their religious orientation, a reasonable and straightforward basis for assessing how much to strive to keep alive. To this critical non-Catholic the doctrine seems remarkably similar to the fourth clause of the doctrine of double effect, which again seemed uncontroversial in requiring sufficient or proportionately grave reason when the pursuit of good means risking or inflicting harm. Thus the doctrine of ordinary and extraordinary means

states, in essence, that the good of saving life is morally obligatory only if its pursuit is not excessively burdensome or disproportionate in relation to the expected benefits.

The distinction between ordinary and extraordinary means seems to have been introduced in Roman Catholic theology in the sixteenth century by the Spanish theologian Dominic Banez, who said that while it was reasonable to require people to conserve their lives by ordinary means such as ordinary nourishment, clothing, and medicine, even at the cost of ordinary pain or suffering, people were not morally required to inflict on themselves extraordinary pain or anguish or undertakings that were disproportionate to their state in life.¹ The doctrine was applied by Pope Pius XII in 1957 to an anaesthetist's questions about when to use and stop using mechanical respirators in the case of deeply unconscious patients, who, if not already dead, would be likely to die soon after disconnection from mechanical ventilation.^{2,3} According to the Pope, people had "the right and the duty in case of serious illness to take the necessary treatment for the preservation of life and health." "Normally," however, "one is held to use only ordinary means—according to circumstances of persons, places, times, and cultures—that is to say means that do not involve any grave burden for oneself or another. A more strict obligation would be too burdensome for most men and would render the attainment of the higher more important good too difficult. Life, health, all temporal activities are in fact subordinated to spiritual ends."

Doctors can act only with patient's permission

In relation to the doctor's obligations the Pope reminded his audience of anaesthetists that "the rights and duties of the doctor are correlative to those of the patient. The doctor in fact has no separate or independent right where the patient is concerned. In general he

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can take action only if the patient explicitly or implicitly, directly or indirectly gives him permission." So far as the techniques of resuscitation in such circumstances are concerned patients and doctors are morally permitted to use them, but since they "go beyond the ordinary means to which one is bound, it cannot be held that there is an obligation to use them, nor consequently that one is bound to give the doctor permission to use them." Families too must base their decisions in such matters on the "presumed will of the unconscious patient if he is of age and 'sui juris.' Where the proper and independent duty of the family is concerned they are usually bound only to the use of ordinary means. Consequently if it appears that the attempt at resuscitation constitutes in reality such a burden for the family that one cannot in all conscience impose it upon them, they can lawfully insist that the doctor should discontinue these attempts and the doctor can lawfully comply."³ (The Pope went on to state that such compliance was not euthanasia in the sense of intentionally bringing about a patient's death, for it was never more than an indirect cause of the cessation of life, and he justified this assertion by appealing to the principle of double effect and the distinction between causation—namely, of the ensuing death—for which a person is morally responsible—"voluntarium in causa"—and that for which he is not responsible.) The contents of this papal allocution have been widely accepted within the Roman Catholic faith and were reaffirmed in the 1980 Declaration on Euthanasia of the Sacred Congregation for the Doctrine of the Faith.⁴

"Circumstances of persons, places, times, and cultures"

What becomes immediately clear from these various complex accounts is that the doctrine of ordinary and extraordinary means is not simply a matter of looking at some proposed treatment, asking whether it is ordinary or extraordinary in the usual dictionary sense of the terms—that is, common or uncommon, usual or unusual, mundane or exceptional—and then concluding that if the treatment is ordinary it is morally obligatory, if extraordinary it is morally optional. There is no question, therefore, of looking for some morally neutral description of the proposed treatment (Is it common rather than uncommon, simple rather than complicated, non-technological rather than technological, and so on?) and deriving from that a moral conclusion. As usual, one cannot derive an "ought" from an "is" (a morally neutral is, that is). Instead, as these accounts and various contemporary accounts emphasise,⁶⁻¹⁰ the proposed treatment has to be assessed on the basis of what would be excessively or disproportionately burdensome in the context of the particular patient in his particular circumstances—as Pope Pius XII put it, in the context of "circumstances of persons, places, times, and cultures—that is to say means that do not entail any grave burden for oneself or another." Only after the assessment of whether the burden of treatment would be too great for, or disproportionate to, the likely benefit in the particular circumstances can the treatment be labelled ordinary if it is morally obligatory or extraordinary if it is morally optional. (Furthermore, even if it is morally optional there remains a decision to be made by the patient or his proxies whether to carry it out.)

Burdensomeness of treatment

Of course, the criteria for assessing whether a proposed treatment is disproportionately burdensome are not precise, especially as laid down in the papal statement, which requires that the proposed life preserving treatments, in the "circumstances of persons, places, times, and cultures . . . do not involve any great burden for oneself or another." One American authority on Roman Catholic medical ethics has interpreted this to mean that extraordinary means are those that cannot be obtained or used without excessive expense, pain, or other inconvenience or that do not offer a reasonable hope of success.¹¹ The Sacred Congregation's Declaration on Euthanasia says that in assessing burdensomeness the type of treatment, its risk and cost, and the difficulties of using it should be compared with the

result to be expected, "taking into account the state of the sick person and his or her physical and moral resources." Patients may justifiably reject "a technique which is already in use but which carries a risk or is burdensome" and such rejection should be considered not as the equivalent of suicide but as an acceptance of the human condition, a wish to avoid the application of a medical procedure disproportionate to the expected results, or a desire not to impose excessive expense on the family or community.⁴

Burdens on others may be relevant

Understood thus the doctrine would surely be uncontroversial to most practising doctors, regardless of their religious faith or lack of it. Part of its uncontroversialness, however, lies precisely in its vagueness. What is meant by "disproportionately" or "excessively" burdensome? Whose opinion is to count when there is disagreement? Are some means always proportionate and thus morally obligatory or ordinary? In particular, is feeding always morally obligatory? When does the distinction apply? This is not the place to go into the considerable debate within the Roman Catholic church over these issues: suffice it to note that there seems to be general agreement that the patient's interests and perception of those interests are the primary moral consideration but that he and his proxies are morally permitted, perhaps even morally obliged, to take account not only of the burdens a proposed treatment would place on himself but also of the burdens it would impose on others.

There seems to be disagreement, however, about whether certain treatments are always morally obligatory, and especially so when the treatment is simply nourishment. Yet if the principle is accepted that the moral assessment must always be made in relation to the particular circumstances of a particular patient then it should always be possible in principle for a given means of treatment not to be morally obligatory, however common its use. This principle is widely accepted by Roman Catholic commentators in relation to such simple and widely available treatments as antibiotics (which may, it is widely agreed, be properly withheld from, for example, people who are already dying or who will soon die—the "old man's friend" approach¹²). Yet the logic of the underlying position seems to be too much for some commentators to stomach when it comes to the possibility of considering feeding as extraordinary or morally optional in particular cases. Thus Father John Mahoney SJ seems to reject the possibility that nourishment may be properly discontinued in any circumstances. Arguing that if ordinary feeding is impossible or extremely uncomfortable it may be discontinued "and attention switched to other possible means of nourishment," he goes on: "But nourishment itself, it appears, cannot be classed as medical 'treatment' to be assumed or discontinued, if only because to deprive a person of nourishment is more of the nature of undermining his resources and actively contributing to his death than of simply permitting his illness to take its course."¹³

May nutrition be withheld?

This view is widespread but not universal within the Roman Catholic church. Thus Father John Parris SJ, writing in collaboration with a professor of paediatrics and criticising the then proposed American "Baby Doe" regulations requiring that nutrition and fluids be provided to every infant no matter how incurably and severely defective or diseased, argued that there are certain limited circumstances "in which nourishment and fluids may be entirely futile treatment."¹⁴ Anencephaly and severe brain damage were offered as examples of such futility. Total necrotising enterocolitis was also offered as an example in which intravenous feeding would be inappropriate, despite the likely considerable prolongation of such an infant's life. The reasoning here, it seems clear from the context, is that because the infant would be committed to intravenous feeding for the rest of its life (at least until such time as bowel transplants became a clinical reality) such a treatment would be excessively burdensome.

The doctrine of ordinary and extraordinary means is misleadingly

named, and some Roman Catholics prefer to speak of "proportionate" and "disproportionate" means.⁴ When stripped of its misleading nomenclature, however, it provides reasonable non-absolutist guidance on how much doctors should strive to keep their patients alive. Essentially the answer is based on respect for the patient's own assessment of whether the struggle to stay alive would entail acceptable or excessive burdens, taking into account not just burdens on himself but those on his family and others. When such assessment is unavailable then his legitimate proxies should make the same assessment on his behalf. Such an approach is entirely consistent with a secular moral pluralist's assessment based on the principles of respect for autonomy, beneficence, non-maleficence, and justice. Nor does it seem to be radically different from the sorts of assessment of harm and benefit advocated by sophisticated utilitarians or from the assessments of harm and benefit that lead some clinicians to advocate allowing severely handicapped infants to die when their parents and doctors reasonably believe that treatment is futile or excessively burdensome,¹⁵ and even to advocate withholding of nutrition when its provision is reasonably believed to be either futile or excessively burdensome.^{16 17}

The final assessment

Of course, in particular cases there may be vigorous divergence of opinion about the final assessment. Roman Catholic opinion is, for example, widely, perhaps universally, opposed to the sort of letting die in which rejected infants with Down's syndrome are not fed and sedated and not given straightforward, life saving operations such as relief of duodenal atresia.^{6 7 10 14 18 19} My impression, however, is that when there is a difference between thoughtful Roman Catholic and thoughtful non-Catholic thinking in such cases it often results from different weightings of the harms and benefits concerned in specific cases rather than from fundamental disagreement about the appropriate moral approach to such decision making—an approach which it is widely agreed requires that medical attempts to preserve

people's lives should be regarded as an extremely important good, which it is morally important to pursue except when to do so is either futile or causes disproportionate harm.

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MEDICINE AND THE MEDIA

MEDICAL TREATMENT going wrong and the difficulties of getting compensation were the subject of the first of a series of live television shows that "aim to help viewers" (Central Television, 17 January). Roger Cook, well known for his investigative journalism, presented a 90 minute programme with patients, some already known to viewers, and a selected audience. The object was "to take on the medical profession" and find out whether patients got a fair deal.

Poignant stories of patients were told at length: a man with a brain tumour treated for depression for four years; a woman conscious during a caesarean operation; brain damaged babies; and others. Two doctors were accused of repeated mistakes; one, a junior hospital anaesthetist, was chased through the residents' quarters until—not surprisingly—he locked himself in his room to avoid an interview. The other, an obstetrician, was also harassed by Roger Cook and a close up of his Harley Street plate is unlikely to improve his practice. One would have liked to know more about the cases—to confirm that it was the doctor's mistake and not a natural event—but so often only half the story is shown in these programmes. We saw no patient who had received compensation through a quick out of court settlement.

Comments were provided by Arnold Simanowitz, the director of Action for the Victims of Medical Accidents, Jack Ashley MP, Anne Winyard, a plaintiff's solicitor, Jean Robinson, formerly of the Patients' Association and now on the General Medical Council, and Ivan Cox, a general practitioner. James Ackers, chairman of the West Midlands Regional Health Authority, represented doctors well and ably corrected mis-statements in the brief time that he was allowed.

Next, viewers were taken to New York and introduced to a neurosurgeon turned lawyer who is making his fortune by suing his

former colleagues. The evil effect of defensive medicine was described: professional judgments being influenced by legal and not clinical considerations, the ordering of unnecessary investigations, and more hazardous operations not being performed—obstetricians are even stopping delivering babies. (Get ready for a suit when your son does not get into Harvard—his brain must have been damaged at birth.) The battle for compensation may go on for years, the average award now being £90 000. An obstetrician said that he paid a fifth of his income for insurance: £36 000 a year is common, but many pay double. One insurance company secretly filmed a patient who claimed inability to walk properly or to lift anything, and he behaved normally—a useful disclosure of fraud. Defensive medicine is bad for both doctors and patients, and those shown in the studio preferred the British system despite its failings.

No fault compensation, as practised in New Zealand and Sweden, was discussed, and a fresh look was advocated—several studies have already assessed its advantages and disadvantages: "There is no perfect solution that can be operated immediately."

The medical defence bodies were criticised, and unfortunately no member of their secretariat was present; one had been invited but had to refuse. The conspiracy of silence came up, but Richard Cherry, an orthopaedic surgeon, interjected by saying that this was necessary only when a writ was received. He was correct.

But the law is very slow, and hospitals are often slow in producing reports or case notes. Audits and regular tests for doctors were mentioned. What should doctors themselves do? The message stated unanimously by patients and all the others was surprisingly simple: patients are more anxious to find out what has gone wrong than to make money.

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