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WITHHOLDING AND WITHDRAWING LIFE-SAVING TREATMENT: ORDINARY/EXTRAORDINARY MEANS, AUTONOMY & FUTILITY[***]

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Introduction

The issue of the limits of medical interventions has intensified with technology and science constantly pushing the boundaries of the delivery of medical care in general and the preservation and prolongation of life in particular. The application of breakthroughs in medical science and technology in health care often generates new moral issues and turbulent experiences for families and health care providers especially in situations where patients are left in less than ideal quality of life states. There can be a genuine conflict on the part of the physicians as to whether to withhold or withdraw medical interventions. For patients it can be difficult to decide whether to accept certain treatments especially if such decisions may lead to the conclusion of their lives. All the decisions may spark strong reactions from those who are centrally involved in providing care and medical treatments as well as for family members. Ethically speaking, it is generally accepted that there are limits to using medical interventions. The question, however, is by what principles[1] are these limits to be set.

In ethical discussions about withholding and withdrawing life-saving treatments, three main principles can be identified: 1) the principle of ordinary and extraordinary means, 2) the principle of respect for patient autonomy and 3) the principle of futility. These principles can be employed to provide normative direction on where the obligation might lie when deciding to use or forego treatment, especially in the context of emerging new technologies, medical science and biological knowledge. However, each principle sets forth different obligations. For example, with the principle of ordinary and extraordinary means there is an obligation to use treatments that are deemed to be "ordinary", whereas there is a moral option to use treatments that are deemed to be "extraordinary". With the principle of respect for patient autonomy, there is the obligation to uphold the patient's right to self-determination and the patient's right to refuse treatments, even if they are "ordinary". Finally, with the principle of futility there is an obligation not to offer treatments that are deemed to be ineffective regardless of whether they are "ordinary" or "extraordinary" or whether a competent and informed

[1] For the purpose of this paper, we accept that a principle can be understood to be "[…] a fundamental standard of conduct from which many other moral standards and judgments draw support for their defense and standing" (Beauchamp, 2003, p. 17).

patient autonomously demands it. Hence conflicts can arise, and the question of which principle should take precedence becomes pressing.

This paper firstly examines the specific aspects of these three principles. Secondly, it outlines the possible conflicts emerging from the interface between the principles. Thirdly, after outlining well-established approaches to deciding between ethical principles, Veatch's mixed strategy of balancing and lexical ordering is applied to the principles of ordinary and extraordinary means, respect for patient autonomy and futility. Although finding a resolution between conflicting principles is never easy, the position of this paper is that this mixed strategy of balancing and lexical ranking provides a useful approach to navigate and advance discussions regarding the ethical obligations regarding withholding and withdrawing life-saving treatments.

The Principle of Ordinary and Extraordinary Means

The principle of ordinary and extraordinary means has greatly influenced the Catholic theological tradition in terms of how it reflects on the issue of preserving and prolonging life and is well established (Panicola, 2001, p. 16; Bedford, 2011, p. 107). The principle has provided normative direction about obligations regarding withholding and withdrawing treatments for a quincentenary (Clark, 2006, p. 43; also see Zientek, 2006, p. 67). The prime function of the principle is to enable people to discern when it is morally obligatory to start or to continue a medical treatment and when it is morally justifiable to refuse or discontinue a treatment even if this would lead to death.[2] The principle of ordinary and extraordinary means has also influenced how health care practitioners *do* ethics in end of life situations and has been be used by judges in court rulings (Buchanan, 1978, p. 387; Lynn

[2] The location of the historical genesis of this principle lies mainly with 16th Century Catholic theologians, Francisco De Vitoria (1486–1546), Domingo Soto (1494–1560), Domingo Bañez (1528–1604) and Juan Cardinal De Lugo (1583–1660), whose contributions helped to shape our present-day understanding (Clark, 2006, pp. 50–51). These moral theologians from the School of Salamanca are generally accredited with originally using the terms 'ordinary' and 'extraordinary' in discussions on the preserving life (Calipari, 2004, p. 391). Bañez, in particular, coined the terminology of ordinary and extraordinary means (Gillon, 1986a, p. 259).

and Childress, 1983, p. 19). It is recognized that the principle is employed in non-religious discussions and policies as well (Kelly, Magill and Have, 2013, p. 126). The principle of ordinary and extraordinary means primarily aims to guide patients on the moral obligation to undergo treatments. At the same time, it is a principle that is also there to guide physicians and other health care professionals on their obligation to provide treatments (see Cronin, 1989, p. 127).

There has been an impressive amount of scholarship on the principle of ordinary and extraordinary means (e.g. Cronin, 1989, pp. 1–145; Kelly, 1950, pp. 203–220; Kelly, 1951, pp. 550–556; Kelly, 1958; McCartney, 1980, pp. 215–224; Sullivan, 2007, pp. 386–397; Wildes, 1996, pp. 500–512). At the heart of the principle is the idea that if the potential burdens of a proposed treatment were disproportionate in terms of the overall possible benefits to the patient, it could be deemed extraordinary as a means. In that case there would be no moral obligation to start the treatment, although the patient would still be ethically allowed to undergo it. On the other hand, if the expected burdens – that would be brought about by a programme of treatment – were proportionate in terms of the anticipated benefits to the patient, then that treatment would be deemed to be ordinary as a means. Hence there would be an ethical obligation to engage with it.

Kelly and Cronin's well-established definitions of ordinary and extraordinary means are standard reference points in discussions about this principle. Kelly explains ordinary means to be "[…] all medicines, treatments, and operations, which offer a reasonable hope of benefit for the patient and which can be obtained and used without excessive expense, pain, or other inconvenience", and extraordinary means refer to "[…] all medicines, treatments, and operations, which cannot be obtained or used without excessive expense, pain, or other inconvenience, or which, if used, would not offer a reasonable hope of benefit" (Kelly, 1958, p. 129). According to Cronin (1989), ordinary means are those […] "commonly used in given circumstances, which this individual in his present physical, psychological, and economic condition can reasonably employ with definite hope of proportionate benefit" (p. 143). Furthermore, extraordinary are "[…] those means not commonly used in given circumstances, or those means in common use which this individual in his present physical, psychological, and economic condition cannot reasonably employ, or, if he can, will not give him definite hope of proportionate benefit" (Cronin, 1989, p. 143).

The Catholic Church's Congregation for the Doctrine of the Faith's *Declaration on Euthanasia*, within the context of extraordinary means, instructs that a rejection of treatment "[…] should be considered as an acceptance of the human condition, or a wish to avoid the application of a medical procedure disproportionate to the results that can be expected, or a desire not to impose excessive expense on the family or the community" (SCDF, 1980, sec. IV). In the encyclical *Evangelium Vitae*, Pope John Paul II (1995) explains that treatments that are considered to be "aggressive" are "[…] 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" (sec. 65). In the United States, the *Ethical and Religious Directives for Catholic Health Care Services* maintains that everyone has a moral obligation to employ means that are ordinary for the preservation of their health, once there is a reasonable hope of benefit that is not overly risky or burdensome or expensive for themselves, their family or their community (USCCB, 2009, sec. 32).

The principle of ordinary and extraordinary means is theologically inspired. It assumes that life is a divine and sacred gift and that persons have a moral obligation to look after it and to uphold it as best as they can (Bedford, 2011, p. 107; Sullivan, 2007, p. 387). The person is therefore obliged to take care of his or her life and not to deliberately end it. The taking of innocent human life is not considered to be morally licit (see Biggar, 2004, p. 18; Fischer, 2012, p. 5). For this reason, there is a moral obligation to use ordinary means of life-saving treatments in the Catholic tradition.

Once it is established that the means of treatment is deemed to be ordinary, then there is *no* moral option *but* to use it. Rejecting an ordinary means of treatment would in effect mean foregoing the obligation to take care of life. Should this rejection of ordinary means lead to death, this would be tantamount to deliberately ending life, which is ethically unacceptable in the context of the Catholic theological view. However, the obligation to preserve life is not absolute (Calipari, 2004, p. 394). The person is obliged to use means of preserving his or her life that are morally possible or physically possible (Sullivan, 2007, p. 387). The justification of being excused from the moral duty to preserve life lies in the person's lack of ability to fulfil this duty because of a physical or moral reason (e.g. because of a situation of fear or other hardship) (Sullivan, 2007, p. 387). When the person refuses

a treatment that is not beneficial, he or she is not rejecting the gift of life, they are rejecting the treatment (Meilaender, 2005, p. 69; also see Ashley, O'Rourke, 2002, p. 189).

At the bedrock of this principle lies the distinction in moral theology between positive and negative obligations. While there is a negative obligation not to intentional end innocent human life, there is a positive obligation to look after life. A negative obligation is always binding in every situation, whereas a positive obligation may always be binding but it may not be fulfillable in every situation (see Bretzke, 2013, p. 114). Sullivan (2007, p. 387) explains it in this way: that there is a general unremitting obligation to preserve life, yet the person may be discharged from this obligation in specific situations. In sum, there is no moral obligation to use extraordinary means (albeit the person can still choose it), whereas there is a moral obligation to use ordinary means.

The Principle of Respect for Patient Autonomy

Respect for patient autonomy is a key moral principle in bioethics and medical ethics (see Chandler, 2011, p. 905; Gillion, 1986b, p. 48; Stammers, 2015, p. 155; Brody, 1985, p. 380; Molyneux, 2009, p. 245). The word "autonomy" comes from the Greek *autos* and *nomos*, which, when combined, can be translated as "self-rule" (May, 1994, p. 139; Quante, 2011, p. 597; Beauchamp, Childress, 2013, p. 101; Pellegrino, 1990, p. 362). As put by Schwartz (1999), "autonomy is the authority to make decisions in accord with one's own values, unrestrained by the values of others who do not suffer the consequences of the decision" (pp. 518–519). An autonomous act is one that is carried out with intention and understanding and is free from unduly influences that have a dominant hold over the person (Beauchamp, Childress, 2013, p. 104; also see Dooley, McCarthy, 2005, p. 3). A person can be said to be autonomous in terms of 1) deciding to carry out (or not) an act, 2) being able to decide what they want to think about, 3) being able to decide what actions to take regarding moral concerns and being able to decide on what moral beliefs to hold (Downie, Telfer, 1971, pp. 293–295).

The principle of autonomy, in essence, means that the patient's right to self-determination should be respected (Brody, 1985, p. 380). The principle of autonomy enables the person to set forth their independence as a moral

agent (Callahan, 1984, p. 40). The principle places a normative limitation on medicine (Fagan, 2004, p. 16; Nessa, Malterud, 1998, p. 397). According to Beauchamp and Childress (2013), "to respect autonomous agents is to acknowledge their right to hold views, to make choices, and to take actions based on their values and beliefs" (p. 106). As an ethical principle, autonomy can be viewed from two perspectives of obligation – as a positive and as a negative (Beauchamp, Childress, 2013, p. 107). As a positive, the principle obliges health care practitioners to cultivate the making of autonomous decisions by patients, whereas as a negative the principle demands that the person's actions are not to be subjected to unduly external controls from other people (Beauchamp, Childress, 2013, p. 107).

To respect the autonomy of the patient indicates that if a competent and well-informed person has decided to carry out a particular act of their own volition, this should not be impeded even if it an alternative action would be more beneficial for them (Baines, 2008, p. 141). However, a common restriction that is placed on autonomy is the harm that is caused to the autonomy of another person (see Agich, 1990, p. 12; Beauchamp, 2003, p. 25; Baines, 2008, p. 141; Gillon, 1986b, p. 48; Komrad, 1983, p. 38; Pellegrino, 1990, p. 364) or if it impinges on the rights of another person (Coy, 1989, p. 827). In addition, it is pointed out that there is a distinction between respecting the moral agency of the person that is articulated in an autonomous decision and agreeing with the decision taken (Brody, 1985, pp. 380–381). In other words, we can respect a person as an autonomous moral agent without necessarily agreeing with their decisions.

From the perspective of autonomy, persons are entitled to rule or govern themselves and to refuse or give permission for a proposed medical treatment through informed consent (Newham, Hawley, 2007, p. 79). The principle of respect for patient autonomy is the bedrock on which the requirement to attain informed consent is founded (Escalante, Martin, Elting, Rubenstein, 1997, p. 275). The ascent of respect for patient autonomy and informed consent in modern health care started in clinical research after World War II with the Nuremberg Code in 1947. This document was developed in the course of the Nuremberg Trials against the backdrop of the horrific Nazi experiments performed in the concentration camps during the war. The development of a focus on autonomy together with process of attaining informed consent in medical *research* did not occur in isolation. Quite the contrary. It increasingly influenced moral thinking about the provision of medical *treatment* as well,

thereby replacing a strong tradition of paternalism that had persisted since the time of Hippocrates. For example, in the Oviedo Convention (1997), the first and only legally binding international instrument focused on human rights and biomedicine, it is clearly stated that – as a general rule – consent that is voluntarily granted and informed is a necessary requirement for any medical intervention (article 5). Similarly, UNESCO's *Universal Declaration on Bioethics and Human Rights* (2005) states that autonomy is to be respected (article 5) and that "[…] preventive, diagnostic and therapeutic medical intervention is only to be carried out with the prior, free and informed consent of the person concerned, based on adequate information" (article 6). According to these documents then informed consent is a necessary condition for any ethical medical intervention on an autonomous patient. Whether the patient has considered whether the proposed intervention is in line with any other criteria is not important. It is up to the patient to weigh the expected benefits and harms and determine whether the overall balance is *acceptable* or not. The principle of patient autonomy and these norms around informed consent in medical interventions have now been incorporated in many national legal frameworks (see Greaney, O'Mathúna, 2017, p. 83).

The Principle of Futility

Of the three principles used to decide on withholding and withdrawing treatment, futility is probably one of the oldest. The idea of futility is anticipated in the works of Hippocrates (Schneiderman, 2011, p. 124; Halliday, 1997, p. 148; Jecker, 1995, p. 288; Kasman, 2004, p. 1053; Truog, Brett, Frader, 1992, p. 1560). Although futility has had an integral relationship to medicine for a very long time, the advent of the modern concept took place in the latter part of the 1980s (Aghabarary, Nayeri, 2016, pp. 3–4; Brown, 2014, p. 39; Gómez, Meana, 2017, p. 261; Heft, Siegler, Lantos, 2000, p. 293; Schneiderman, 2011, p. 124). As a concept, futility developed as a rejoinder to the advancement of patient autonomy (Aghabarary, Nayeri, 2016, p. 4; Fontugne, 2014, p. 533; Smith II, 1995, pp. 20–21). It is one thing for an autonomous patient to have a right to refuse treatment but it is quite another to demand treatment, especially if the treating physicians consider such treatment to be ineffective (see Fontugne, 2014, p. 533; Moratti, 2009, p. 369). Just as a patient could claim a right to refuse a treatment using the

principle of respect for patient autonomy, so too could a physician claim a right to refuse or withdraw a treatment using the concept of futility (see Fontugne, 2014, p. 533; Heft, Siegler, Lantos, 2000, p. 293). Any patient demands to be treated could thus be limited by the medical judgment of the treating physician if the treatment was indeed considered to be futile. Just as the principle of autonomy has been articulated and enforced in policies in health care settings and court rulings, so too has the concept of futility (Bernat, 2005, p. 199; Gampel, 2006, p. 92; Jecker, Schneiderman, 1993, p. 156; Bailey, 2003, p. 77; Truog, Brett, Frader, 1992, p. 1560).

The principle of futility is explained by Bernat (2005) as "[…] a physician's prognostic pronouncement that as a consequence of irretrievable illness or injury, further therapy will not improve the patient's condition and, therefore, should not be attempted" (p. 198). The principle of futility "[…] refers to a medical determination that a therapy is worthless to the patient and, therefore, ought not to be prescribed" (Post, 1995, p. 23). According to Schneiderman (2011), futility is "[…] the unacceptable likelihood of achieving an effect that the *patient* has the capacity to appreciate as a *benefit*" (p. 125). A great deal has been written about futility. Aghabarary and Nayeri (2016) provide a comprehensive outline of various definitions and examples of futility from the literature (pp. 4–6). From this, it is clear that there is no universally agreed upon definition of the concept of futility.

The principle of futility does not only attempt to put a limit on an unfettered view of the autonomy of the patient, from the perspective of the physician and the treating team; it also attempts to guarantee certain quality standards for professional medical treatments. If a physician, in his or her professional judgment, considers the treatment to be futile, then he or she is not morally obliged to offer it, even if the autonomous patient demands it (see Gillion, 1997, p. 339; Bailey, 2004, p. 80; Bernat, 2005, p. 198). In addition, however, they should not offer futile treatment (Kelly, Magill, Have, 2013, p. 223; see Bernat, 2005, p. 199). The principle of futility can arguably be best regarded as a principle of professional ethics that bans dubious treatments.[3] Not only does it protect patients, it also demarcates an area of professional

[3] There is a debate about whether futility is purely a medical decision. Kelly, Magill and Have (2013), for example, make the point that: "once a treatment has been categorized as medically futile, physicians must withhold it or withdraw it, regardless of the wishes of the patient or surrogate. This is a medical decision, not an ethical one, and depends on the proper application of medical expertise" (p. 222).

autonomy of medical experts whereby they cannot be forced by anyone to apply treatments that are hard to distinguish from charlatan interventions and/or torture. The principle of futility therefore protects the professional autonomy of the treating physician.

Conflicts between Principles

Following on from the above accounts of the three principles that can be used in deciding to withhold or withdraw life-saving treatments, it is clear that each principle sets forth different obligations for patients and physicians. Each of the three principles can therefore pose challenges to the other two. For instance, if a patient autonomously wants to reject, start, stop or continue a treatment, should it matter whether it is deemed to be ordinary or extraordinary? If the treating physician deems a treatment to be futile, should it matter whether the treatment is deemed to be ordinary or whether the patient autonomously wants to start or continue it? It is clear that it would be naive to think that clashes between these three principles can always be avoided.

There are various situations in which the application of the principles can lead to conflict. First, conflicts can arise from different interpretations of one and the same principle. When assessing the impact of a programme of chemotherapy to treat a type of cancer, for example, a patient may consider it to be an extraordinary means of treatment for him or her. However, the treating physician (and others such as family members) may consider it to be an ordinary means of treatment. This does not imply that the patient's autonomy is to be simply curtailed. Even as far back as Pope Pius XII's explanation of the principle of ordinary means in 1957 to anaesthetists, it is recognised that "the doctor, in fact, has no separate or independent right where the patient is concerned. In general, he can take action only if the patient explicitly or implicitly, directly or indirectly, gives him permission" (cited in O'Rourke, Boyle, 1999, p. 280). Nonetheless, there is a problem for a physician if he or she believes that there is a moral obligation to provide a treatment and not to do so would lead to the patient's death. It may be slightly easier if it is the other way around: If the patient considered a programme of chemotherapy to be an ordinary means of treatment but the treating physician considered it to be an extraordinary means of treatment,

then the patient's decision could be seen to be heroic as they can still morally choose what others consider to be an extraordinary means of treatment.

Second, conflicts can occur from clashes between different principles. For example, there are potentially fundamental points of difference between the principle of autonomy and the principle of ordinary and extraordinary means. If the patient is autonomous – unless otherwise proven – it is up to him/her to give voluntary informed consent about authorising a programme of treatment. Therefore, if a competent patient has an autonomous right to refuse a treatment, should it matter whether the patient has weighed the prospective benefits and harms of a particular treatment in accordance with the principle of ordinary and extraordinary means? It would be up to the patient to decide whether the treatment at hand is acceptable based on the available relevant information. So the patient may still autonomously reject what is deemed to be ordinary despite the moral obligation to use it that is inherent to this principle. Once the patient understands the risks involved in not accepting the treatment and freely chooses to refuse it, there is no moral issue with this, from the perspective of autonomy at least. The patient's right to refuse treatment that is based on the principle of respect for patient autonomy does not mean the right to refuse only extraordinary means of treatment.

Likewise, with the principles of ordinary/extraordinary means and futility, it is not unlikely that the scenario could emerge in which a physician may have to struggle between deeming a treatment to be either extraordinary or futile. Brown (2014) makes the point that when a treatment is deemed to be "futile", it has no benefit to it, whereas if the treatment is deemed to be "extraordinary", this suggests that there might still be an element of benefit to it (p. 41). In this sense, it can be said that futility goes beyond deeming a treatment to be extraordinary (Brown, 2014, p. 41). If a treatment is deemed to be futile, then what should be done when the treatment is seen as ordinary by the patient? A treatment of chemotherapy that is assessed to be futile from a medical viewpoint could still be seen as ordinary from the perspective of the patient. The patient may believe that they have a moral obligation to use this treatment whereas for the physician he or she may be obliged not to offer it, according to his or her professional ethics. By offering a futile treatment, s/he would be allowing the patient to fulfil what they deem to be a moral obligation (or a moral choice) but, at the same time, they would be breaking a professional ethic requirement not to offer a treatment that is

not medically indicated as it is not effective therapeutically and therefore not (or no longer) appropriate.

What we are witnessing then are two reverse developments. On the part of patients, the assessments about acceptability of medical treatments have become more individualized with the ascent of the principle of autonomy. They have become less exclusively focused on the principle of ordinary and extraordinary means. On the other hand, medical assessments about acceptability of medical treatments have become less individual and more based on empirical research and discussions of effectiveness and futility of particular interventions in professional medical organizations.

Approaches to Dealing with Conflicts between Principles

If and when conflicts occur, it is important to discuss the differences and have an exchange of viewpoints and modes of reasoning between patients and physicians. Therefore an approach to adjudicating between these three principles if and when they conflict with each other would be pivotal. In this section, we outline three well-established approaches to dealing with conflicts between ethical principles. For the purpose of this examination, none of the three principles are rejected but are part of the ethical deliberation.

Hierarchical or Lexical Ranking of Principles

One approach is to have a hierarchical/lexical ranking of principles (see Paulo, 2016, p. 156; Childress, 2007, p. 28). With a hierarchical ranking, ethical principles are ordered in a kind of lexical ranking of a), b), c), etc. To take one example, Beauchamp and Childress' (2013) four principles of bioethics – beneficence, non-maleficence, autonomy and justice – could be ranked as follows a) autonomy, b) non-maleficence, c) beneficence and d) justice. In other words, the principle of autonomy would always come first, whereas considerations of non-maleficence would come second and so on in situations of conflict between principles. It would seem that some kind of rigid hierarchical ordering would provide an ideal solution to dealing with conflicts between principles as we would simply claim which principle takes priority. In the context of withholding or withdrawing treatments, the principle of respect for patient autonomy could be ranked first above the

other principles of ordinary/extraordinary means and futility. Nowadays, court rulings generally side with the principle of autonomy when adjudicating refusals of treatment decisions (Kelly, Magill, Have, 2013, pp. 141–142; also see Schneiderman, Jecker, Jonsen, 1990, p. 949).

The hierarchal ranking of the principles of ordinary/extraordinary means, respect for patient autonomy and futility is, however, problematic. It appears to go against common sense morality which indicates that in different situations different principles should apply and dominate. For example, autonomy may trump the principle of ordinary/extraordinary means when an informed and competent patient refuses treatment. However, futility trumps the principles of ordinary/extraordinary means and autonomy when there is an evidence-based medical verdict of futility. So although having a hierarchy or ranking of principles seems theoretically attractive, in practice it would not work.

Balancing of Prima Facie Principles

Paulo (2016) observes that hierarchical ranking cannot be applied to the four principles of bioethics (i.e. beneficence, non-maleficence, autonomy and justice) as they are *prima facie* (p. 156; also see Beauchamp, Childress 2013, pp. 17–24). Another approach to dealing with conflict between principles would be balancing. Balancing of principles is understood as "[…] a process of adjudicating conflicts among principles in the context of a particular case" (Beever, Brightman, 2016, p. 282). In this context, the technical term *prima facie* is used to contend that a principle has an obligatory force unless it clashes with some other one (Gillon, 1994, p. 184). W. D. Ross introduces the term *prima facie* when outlining the scenario between keeping a promise to meet a friend and preventing some harm from occurring.[4] If I should do the latter at the expense of upholding a promise it is "[…] because I think it is the duty which is in the circumstances more of a duty" (Ross, 2002, p. 18). Keeping a promise would have been an actual duty in another set of circumstances. As Atwell explains (1978), "[…] to say that there is a prima facie duty to do act-token X is to say that there is an actual duty to do X provided there is no overriding prima facie duty to do X" (pp. 241–242).

[4] W.D. Ross' thesis regarding *prima facie* duties has distinguished him in the history of moral philosophy (Atwell, 1978, p. 240).

A *prima facie* duty is a conditional duty (Ross, 2002, p. 19), compared to a duty which is actual or absolute (Ross, 2002, p. 28). Ross (2002) makes the point that when we break a promise to fulfil the duty to prevent a harm, we continue to observe that keeping a promise is a *prima facie* duty and we will experience a certain level of regret about this (p. 28). With their four principles of bioethics, Beauchamp and Childress (2013) accept the Rossian difference that is made between obligations that are *prima facie* and actual (p. 15). They present beneficence, non-maleficence, autonomy and justice as *prima facie* principles that need to be balanced when they conflict (pp. 17–24; also see Dawson, Garrard, 2006, pp. 200–201; Gillon, 1994, p. 184).

A distinction is made between intuitive and deliberative balancing (Demarco, Ford, 2006, p. 491). The former refers to a balancing of principles without providing justified reasons for it, whereas the latter refers to a balancing of principles with justified reasons given (Demarco and Ford, 2006, p. 491). For Ross (2002), judgements about which *prima facie* duty is an actual duty "[…] are not logical conclusions from self-evident premises […] judgement as to rightness of a particular act is just like the judgment as to the beauty of a particular natural object or work of art" (p. 31). Discernment of an actual duty rests on intuition (also see Thiroux, 2004, p. 65; Lillie, 1966, p. 129; Gibson, 2014, p. 84). For some, this presents a problem with attempting to decide how to balance between *prima facie* principles as that it depends too much on intuition (see Beauchamp, Childress, 2013, p. 22; Childress, 2007, p. 29; Heinrichs, 2010, p. 74; Veatch, 2012, p. 168). Veatch (1995) is critical of a solely balancing approach to dealing with conflicts between ethical principles stating that "[…] a balancing theory is nothing more than an elaborate rationale for letting preconceived prejudices rise to the surface" (p. 209).[5] In addition, Veatch (2012) makes the point that a solely balancing approach would have to admit of the possibility that in some situations some principles may have more moral weight than others which could lead to moral conclusions that go against the moral beliefs that are important to us (p. 168). He gives the example of slavery. We may hold the moral belief that slavery is wrong because it goes against the principle of respect for the autonomy of the person. However, it is not inconceivable

[5] Against such objections, Beauchamp and Childress (2013) put forward six conditions as a way of providing a rational justification for taking one principle in favour of another (pp. 22–23).

that when autonomy is weighed against beneficence, it could be argued that in some situations more good may be maximised by allowing slavery and therefore it could be deemed to be acceptable (Veatch, 2012, p. 168).

Mixed Strategy of Balancing and Lexical Ranking

Veatch (1995) offers a "mixed strategy" of balancing and lexical ranking[6] of principles (p. 119). With this approach, Veatch (1995) classifies principles into two categories: consequence-maximizing and non-consequentialist (p. 200). The aforementioned bioethical principles of beneficence and nonmaleficence fall into the category of consequence-maximizing, as they are concerned with the maximization of good and minimisation of what is harmful. The principles of autonomy and justice fall into the category of non-consequentialist as they are not concerned with maximization of good and minimisation of what is harmful (Veatch, 1995, p. 200).

The mixed strategy of balancing and lexical ranking is as follows (Veatch, 1995, pp. 211–213): In the first instance, we should balance the principles which are consequence-maximizing. After that, the principles that are non-consequentialist should also be balanced. Then, the accumulated outcome of the non-consequentialist should be lexically ranked above the consequence-maximizing principles. The non-consequentialist principles take a ranking of priority above the consequence-maximizing principles. The consequence-maximizing principles are obligations that are deemed imperfect, whereas non-consequentialist principles are obligations that are deemed perfect. Should a conflict emerge between perfect obligations in a non-consequentialist set of principles, they need to be balanced.

Although this mixed strategy is not without its critics (see Mallia, 2013, pp. 19–20; Heinrichs, 2010, p. 75), our position is that it can still provide a useful approach for advancing discussion about conflicts between the principles of ordinary/extraordinary means, respect for patient autonomy

[6] This lexical ranking is inspired by the work of Rawls (Veatch, 1995, p. 210; Paulo, 2016, p. 164). It is termed "lexical" because it is comparable to the type of grouping as found in a lexicon (Veatch, 1995, p. 210). As Veatch (2012) puts it "[…] one principle before any of the next just as in a dictionary all words starting with *a* come before any words starting with *b*" (p. 168). As will be shown, the non-consequentialist principles are ranked above the consequence-maximizing principles (Veatch, 1995, p. 210).

and futility in the context of the ethical obligations regarding withholding and withdrawing treatments.

Application of the Mixed Strategy to the Three Principles

To apply and adapt Veatch's mixed strategy of balancing and lexical ranking to the three principles, we need to first categorise the principles into consequence-maximizing and non-consequentialist.

The principle of ordinary and extraordinary means could be interpreted as both consequence-maximizing and non-consequentialist. Firstly, the principle of ordinary and extraordinary means could be interpreted as consequence-maximizing.[7] The principle could be seen to be *consequence-focused* as it is concerned with the possible beneficial effect that a treatment could have for a particular patient, i.e. whether a treatment could have a positive impact proportionately to the present condition of the patient. Cronin (1989), referring to the 16th Century School of Salamanca original thinkers on this issue, makes the point that the means offered need to provide "[…] some *hope of beneficial result*" (p. 85). The Catholic Church's *Declaration on Euthanasia* contends that decisions about ordinary and extraordinary means would need to consider the proposed treatment, any complications, financial implications and measure such aspects with the anticipated outcomes (see SCDF 1980 sec. IV). The principle can be understood to be implicitly *maximising* as well. Referring back to Kelly's (1958) definition of ordinary means, implicit in the principle is that if there is a choice between two treatments, the patient would go for the one that offers the most in terms of a reasonable hope of benefit, one with the least impact in terms of financial cost or pain, for example. According to Clark (2006), the principle has hinged "[…] on the prudential judgment of the patient or surrogate on whether the means used offered a proportionate hope of benefit without imposing excessive burdens to the overall quality of the patient's life" (p. 44). In terms of weighing benefits and harms proportionate to the

[7] This would be an understanding of consequence-maximising not in the strict sense of consequentialism. In line with traditional Catholic theological ethics, examining consequences would be part of the triple-font theory of act, intention and circumstances: "The circumstances, including the consequences, are secondary elements of a moral act" (Catechism of the Catholic Church, 2003, sec. 1754).

state of the patient, the patient would most likely go for the treatment that is most beneficial or least harmful or burdensome. It would seem that the principle would direct the patient to choose the treatment that, in terms of its effects, is more aligned to what is "ordinary" than what is "extraordinary". Therefore, the principle could be interpreted as consequence-maximizing.

Secondly, the principle of ordinary and extraordinary can also be interpreted as non-consequentialist. The theological foundation of this principle – which leads to the negative obligation not to intentionally end innocent human life and to the positive obligation to preserve life as best as we can in terms of our physical and moral resources – makes it non-consequentialist as it can be seen to be a ban on patients refusing treatments that are deemed to be ordinary.

The principle of respect for patient autonomy is non-consequentialist as it is not concerned with the maximisation of a good but upholding the self-determination and self-rule of the patient. Autonomy protects and enables the patient to be an independent moral agent (see Callahan, 1984, p. 40, 41). What is at stake here is not the maximisation of their benefit but upholding their agency to set forth their wishes and to live according to their own values even if their choices would not bring complete overall benefit to them (see Baines, 2008, p. 141).

The principle of futility could also be interpreted as both consequence-maximizing and non-consequentialist. Firstly, the principle of futility could be seen to be *consequence-focused* as it is concerned with the possible effect a treatment would have on a particular patient, i.e. whether it would effective or futile. Following Kasman (2004), a treatment is futile when it does not perform a profitable function to achieve a specific outcome for the patient concerned (p. 1053). At the same time, the principle of futility can be understood to be implicitly *maximising*: If there is a choice between two treatments – all things being equal – the physician would most likely go for the most effective or the least futile treatment. Futility, has been regarded as having a quantitative and qualitative dimension (Schneiderman, Jecker, Jonsen, 1990, p. 951). Quantitative futility pertains to the empirical probability that a proposed treatment will have little or no effect of attaining its preferred outcome. This is normally articulated in terms of the statistical success and non-success rates. Qualitative futility is focused on the benefit or value of providing a treatment to the patient even if it could successfully attain some outcome. This is can be articulated in terms of whether it has

value for the patient's quality of life (Gampel, 2006, pp. 94–95; Kasman, 2004, p. 1054; Miles, 1992, p. 311; Shelton, 1998, p. 385; Schneiderman, 2011, pp. 124–126; Schneiderman, Jecker, Jonsen, 1990, pp. 951–953).[8] Whether it be from a quantitative or a qualitative perspective, the physician would – *ceteris paribus* – go for the treatment that would produce the greatest benefits (or the least futile). Futility has also been understood as a medium through which to employ the principle of doing what is in the patient's best interest (Bailey, 2003, pp. 77–78). Therefore, the principle of futility could be interpreted as consequence-maximizing.

Secondly, the principle of futility can also be interpreted as non-consequentialist for the following reason. Supposing a patient has a viral infection and demands antibiotics as a treatment. The physician knows that antibiotics do not work against viral infections: it would be a futile medical intervention. The professional ban on offering futile treatments holds up even if the overall consequences of proving antibiotics would be better than refusing to do so, e.g. prescribing the antibiotics might benefit the patient psychologically in the sense that he or she may feel that they are "being treated". The principle of futility would still hold that futile treatments should not be offered from a professional point of view. Once a treatment is deemed to be futile, there is a duty not to offer it as a rule of professional ethics.

By using the division between consequence-maximizing and non-consequentialist, it can be claimed that there are in fact five principles: a) the principle of ordinary and extraordinary means as *consequence-maximizing*; b) the principle of ordinary and extraordinary means as *non-consequentialist*; c) the principle of autonomy as *non-consequentialist*; d) the principle of futility as *consequence-maximizing* and e) the principle of futility as *non-consequentialist*.

Following Veatch's (1995) mixed strategy the following would then need to be done (pp. 211–213): From the perspective of the patient, there is one consequence-maximizing principle, i.e. the principle of ordinary and extraordinary means as *consequence-maximizing*. Secondly, there are two non-consequentialist principles: the principle of ordinary and extraordinary

[8] Quantitative futility is generally acknowledged to be incipiently found in the work of Hippocrates, whereas qualitative futility is generally acknowledged to be incipiently found in the work of Plato (Schneiderman, 2011, p. 124; Schneiderman, Jecker, Jonsen, 1990, p. 951).

means as *non-consequentialist* and the principle of autonomy as *non-consequentialist*. Both principles would need to be balanced. Thirdly, the principles that are non-consequentialist would need to be ranked above the consequence-maximizing. The principle of ordinary and extraordinary means as *non-consequentialist* and the principle of respect for patient autonomy as *non-consequentialist* would therefore be ranked above the principle of ordinary and extraordinary means as *consequence-maximizing*. Both the principle of ordinary and extraordinary means as *non-consequentialist* and the principle of respect for patient autonomy as *non-consequentialist* can be deemed to be perfect obligations, which are co-equal. Should the two principles come into conflict with one another, they would need to be balanced. Though principles that are consequence-maximizing can never trump non-consequentialist principles on their own, Veatch (1995) contends that consequence-maximizing principles could be used as a "tie breaker" for a deadlock between two perfect duties arising from non-consequentialist principles (p. 213; Veatch, 2012, p. 170). As put by Paulo (2016), "A non-consequentialist can […] never be overridden by a consequentialist principle alone; but the latter can serve as an intensifier to a non-consequentialist principle so that their combined force overrides the principle" (p. 164).

From the perspective of the physician, there are two consequence-maximizing principles, i.e. the principle of ordinary and extraordinary means as *consequence-maximizing* and the principle of futility as *consequence-maximizing*. Both need to be balanced. There are also three non-consequentialist principles, i.e. principle of ordinary and extraordinary means as *non-consequentialist*, principle of respect for patient autonomy as *non-consequentialist* and the principle of futility as *non-consequentialist*. The three principles would need to be balanced as well. The principle of ordinary and extraordinary means as *non-consequentialist*, the principle of respect for patient autonomy as *non-consequentialist* and the principle of futility as *non-consequentialist* would be ranked above the principle of ordinary and extraordinary means as *consequence-maximizing* and the principle of futility as *consequence-maximizing*. The three principles of ordinary and extraordinary means as *non-consequentialist*, respect for patient autonomy *as non-consequentialist* and futility as *non-consequentialist* can be deemed to be perfect obligations. Should the three principles come into conflict with one another, they would need to be balanced.

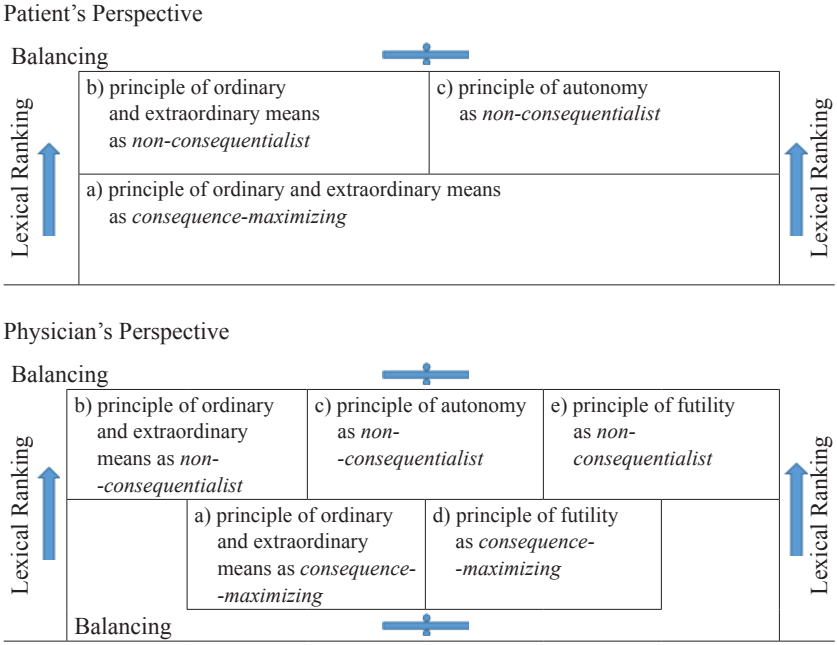

Figure 1. Patient's and physician's perspectives

Source: author's elaboration.

From the perspective of the physician, considering that futility is a principle of professional ethics, it would seem that his or her perfect obligation not to supply futile treatments could be balanced against the principle of ordinary and extraordinary means as *non-consequentialist* and respect for patient autonomy as *non-consequentialist*. What we see nowadays is that the principle of futility as *non-consequentialist* does usually act as a kind of threshold principle for the others. If the treating physician declares a treatment to be futile, it would be unprofessional to offer it to the patient. So as a matter of fact, there is no treatment being offered to and to be ethically assessed by the patient. Hence the principle of futility as *non-consequentialist* tends to trump the two other non-consequentialist principles from the viewpoint of the physician. Interestingly, in the tradition of ordinary and extraordinary means there appears to be the recognition that if the physician deems a treatment to be futile, then it would be morally impossible

for him or her to provide it (see Cronin, 1989, p. 128). In addition, if there is no treatment offered, then there is no possibility of a patient autonomously accepting or rejecting it. The patient's right to self-determination does not come into question because the physician cannot offer something that is ineffective.

If the treating physician does not declare the proposed treatment to be futile, then the principle of ordinary and extraordinary means as *non-consequentialist* and the principle of respect for patient autonomy as *non-consequentialist* would need to be balanced. In cases where the principle of respect for patient autonomy as *non-consequentialist* conflicts with the principle of ordinary and extraordinary means as *non-consequentialist*, e.g. when an informed and competent patient refuses an ordinary treatment, the first usually trumps the latter. Many countries have legislative frameworks at play stipulating informed consent as a necessary requirement to start medical treatments. In sum, once the principle of futility is not invoked to refuse offering a treatment, then the balance between the principle of ordinary and extraordinary means as *non-consequentialist* and respect for patient autonomy as *non-consequentialist* should be made by the patient. On the other hand, if an autonomous patient were to demand an extraordinary treatment, the physician would only be required to offer the treatment, if it were not futile. Thus autonomous patients generally have stronger entitlements to refuse treatments than to demand them.

What is fundamental to autonomy is that it "[…] holds that actions or rules tend to be right insofar as they respect the autonomous decisions of others" (Veatch, 1995, p. 202). Yet, the problem with the principle of autonomy is that it does not provide any normative guidance on how to ethically assess whether to withdraw or withhold treatment. There is no inherent moral obligation or normative direction built into autonomy for decisions regarding withholding and withdrawing treatments. As pointed out by Ten Have (2016), one of the issues about a solely autonomy-based approach is that, "as long as decisions are freely made by autonomous individuals, the substance of their decisions cannot be morally assessed" (p. 39). However, an autonomous person could choose to use elements of the principle of ordinary and extraordinary means to give him or her moral guidance on withholding and withdrawing treatment such as whether there is a reasonable hope of proportionate benefit and whether the treatment is overly burdensome. This principle does appear helpful to autonomy.

It must be remembered that Veatch's mixed approach of balancing and lexical ranking is situated in the context of a contractual model of the physician-patient partnership (Veatch, 1972; Mallia, 2013, p. 18). This contractual model should not be viewed from a purely legalistic perspective but rather should be more aligned to the religious symbolism of covenant of partnership (Veatch, 1972, p. 7). As Veatch (1972) maintains, "with the contractual relationship there is a sharing in which the physician recognizes that the patient must maintain freedom of control over his own life and destiny when significant choices are to be made" (p. 7). In addition, this contract should not be made, or should be concluded, if the physician cannot follow it from a moral perspective (Veatch, 1972, p. 7). Therefore, this will demand transparency about the "moral premises" grounding the medical deliberations, prior to and during them (Veatch, 1972, p. 7). Where possible, knowing something of what ethical principles are important for the patient and the physician in decisions about withholding or withdrawing treatment may provide a transparent moral premise from which to navigate should conflicts arise.

Conclusion

Given the developments in medical practice due to the advances in new technologies and biosciences, the three principles – ordinary and extraordinary means/autonomy/futility – that can be used to decide on withholding and withdrawing life-saving treatments will remain a point of debate for some time in ethical and medical discussions. The emergence of each principle is historically conditioned, and their theoretical underpinnings are distinct with possibly diverging moral conclusions when applied to clinical situations. Having a framework to decide between principles should they conflict is pivotal. Although finding a resolution between conflicting principles is never easy, the position of this paper is that the mixed strategy of balancing and lexical ranking provides a useful framework to navigate and advance discussions regarding the ethical obligations regarding withholding and withdrawing life-saving treatments.

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ZAWIESZENIE I ZAPRZESTANIE LECZENIA RATUJĄCEGO ŻYCIE. ZWYKŁE I NADZWYCZAJNE ŚRODKI, AUTONOMIA I BEZSKUTECZNOŚĆ

Streszczenie

W artykule zarysowano trzy zasady określające refleksję etyczną nad zaniechaniem i zaprzestaniem stosowania środków medycznych podtrzymujących życie: 1) zasadę zwyczajnych i nadzwyczajnych środków medycznych, 2) zasadę poszanowania autonomii pacjenta i 3) zasadę daremności. Gdy należy podjąć decyzję o stosowaniu albo zaniechaniu/zaprzestaniu stosowania środków medycznych, zasady te zapewniają perspektywę normatywną, służącą stwierdzeniu, jakie postępowanie jest obowiązkowe. Każda z zasad ustanawia jednak inny obowiązek, co prowadzi do konfliktu, i naglącym czyni pytanie, której z nich należy przyznać pierwszeństwo. Po naszkicowaniu powszechnie uznanych sposobów rozsądzania konfliktu zasad etycznych, zastosowano do zasad zwyczajnych i nadzwyczajnych środków medycznych, poszanowania autonomii pacjenta i daremności zaproponowaną przez Veatcha mieszaną strategię równoważenia i porządkowania leksykalnego. Przedstawiono opinię, że aczkolwiek rozwiązanie konfliktu zasad nigdy nie jest łatwe, to jednak przyjęcie mieszanej strategii równoważenia i porządkowania leksykalnego pozwala posunąć naprzód dyskusję nad obowiązkami etycznymi odnoszącymi się do zaniechania i zaprzestania stosowania środków medycznych podtrzymujących życie.