Essay

Justice and health care: When “ordinary”[†] is extraordinary

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In some Asian countries, the poor are often denied access to health care. In the Philippines, we have thousands of Catholic doctors, Catholic nurses, even Catholic administrators, but not a Catholic, understood as “universal,” healthcare system available to all. This is a scandal and places heavy emotional and financial burdens on many families who need to pay the healthcare costs of sick loved ones. The Church teaches the principles of ordinary and extraordinary care, with only the former being morally obligatory. Extraordinary care, that involving excessive burden or cost may be foregone. Many families and healthcare professionals are uncertain about these principles and their application in practice. It would be helpful to more widely disseminate the Catholic Church teaching regarding ordinary and extraordinary care, especially in poor countries, to also avoid unnecessary or futile treatments, especially in critical or end-of-life situations.

Lay Summary: *The poor have limited access to health care in many countries. Even one episode of sickness often places the patient and their family under considerable financial strain. Many times they simply cannot afford even basic treatments. This is a scandal and an injustice which is the concern of us all. The Church teaches that when a treatment becomes very expensive it may be considered “extraordinary care” and not morally obligatory. It would be helpful to more widely disseminate this Catholic Church teaching, helping families to avoid unnecessary treatments especially in critical or end-of-life situations.*

Keywords: Health care, Injustice, Poor, Scandal, Ordinary and extraordinary care

INTRODUCTION

In many Asian countries world class medical facilities exist, yet the poor are often denied access to them. In the Philippines, the *Catechism for Filipino Catholics* describes the situation well: “a society where the

majority of the population do not enjoy even adequate elementary health care” (*Catechism for Filipino Catholics* 1997, n. 1039). Yet this health care is a universal right. If we understand “Catholic” as meaning “universal” and “all-embracing,” the Philippines cannot be said to have a “Catholic” healthcare system despite having tens of thousands of Catholic doctors, Catholic nurses, even Catholic administrators, as health care is not universally available here and the poor are largely

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excluded. This is an injustice and a scandal as the Second Vatican Council reminded us (Vatican Council II 1965, n. 88).¹

THE CALL OF THE CHURCH

Ecclesia in Asia notes that “the Church in Asia is committed to becoming still more involved in the care of the sick, since this is a vital part of her mission of offering the saving grace of Christ to the whole person” (John Paul II 1999, n. 36). Many religious men and women, such as the Camillians, dedicate themselves to the care of the sick, but an overall mobilization of the laity is needed.² Pope Francis also expressed a concern for the quality of medical care available to the poor and stressed the importance of access to health care: “It is vital that government leaders and financial leaders take heed and broaden their horizons, working to ensure that all citizens have dignified work, education and health-care” (Francis 2013, n. 205).

INEQUITY IN HEALTHCARE ACCESS

Many state-of-the-art hospitals in Manila offer the latest in world class health care but due to the high cost not all can afford them. In their comprehensive report, titled “The Philippines Health System Review,” the Asia Pacific Observatory on Health Systems and Policies confirmed that there exist “considerable inequities in healthcare access and outcomes between socio-economic groups” with a major driver of inequity being “the high cost of accessing and using health care” (APOHSP 2011, xvii). Most Filipinos support the care of their loved ones out of their own pocket. While acknowledging some progress in health reforms, the Observatory concludes that “for many Filipinos, health services have remained less than adequate”

(APOHSP 2011, 122) and “reforms in all areas of the Philippine health system are required in order for the country to attain universal health care” (APOHSP 2011, 123).

Corruption as one causative factor

In his visit to the Philippines, Pope Francis made reference to “a society burdened by poverty and corruption” and invited the crowds to “reject every form of corruption which diverts resources from the poor” (Francis 2015). Corruption robs the world’s developing countries of more than a trillion dollars every year. If invested in health, this amount could prevent 3.6 million deaths (ONE 2014, 1).³ Omar Azfar and Tugrul Gurgur report that in the Philippines

corruption lowers the immunization rate of children, delays the vaccination of newborns, prevents the treatment of patients, discourages the use of public health clinics, reduces satisfaction of households with public health services, and increases waiting time of patients at health clinics. (Azfar and Gurgur 2008, 197)

How many deaths might be prevented in the Philippines if embezzled money had instead been invested in creating a universally accessible healthcare system?⁴ It means people like Juan (name changed to protect anonymity) are denied the possibility of reasonable health care. Juan is a 24-year-old man who works with poultry. He presented to the emergency room with fever and strong headaches. He was diagnosed with cerebral cryptococcal infection. The medicine prescribed, a powerful anti-fungal, costs \$100 per day. How long can he afford that treatment with a salary of \$7 per day?

Exorbitant cost of medicines

Drug prices in the Philippines are recognized to be among the highest in Asia. Dr. Dennis B. Batangan reports that “pharmaceuticals are expensive in the Philippines in comparison to prices in neighboring countries such as Thailand, Malaysia and Indonesia” (Batangan et al. 2006, 7). Less than 30 percent of the population has access to essential medicines. In a telling article Annie Ruth Sabangan reports that

Sixteen of the top 20 drug companies in the Philippines are multinational firms with combined sales of P58.23 billion in 2007, nearly eight times more than the Philippines’ P7.39 billion GDP in 2008 ... Their sales represent about 82% of the total volume sales of foreign pharmaceutical firms in the country. (Sabangan 2009)

Pharmaceutical sales are big business, and to be convinced of this one need only walk the corridors of any large hospital here to purvey the incessant hordes of drug reps plying their wares. Doctors should thus strive to maintain a good ethical code of conduct lest the lure of perks from the pharmaceutical industry unduly influence their prescribing habits.

WHEN ORDINARY BECOMES EXTRAORDINARY

A bout of prolonged sickness, an accident, or an end-of-life situation can tip patients and their families into financial despair. For a poor family a relatively straightforward treatment such as a blood transfusion may simply be beyond their budget. In a developed context, it would be generally inconceivable to consider a blood transfusion as “extraordinary” treatment from a financial point of view. However in the Philippines when patients need a

transfusion, they have to pay from \$10 up to \$225 per unit of blood depending on the type of hospital they are staying in (charity or private). This can be exorbitantly expensive in a country where the minimum daily wage is \$10. What is ordinary care in developed countries often becomes extraordinary in the developing world.

What to do when a loved one is critically ill

When loved ones reach the end of their earthly life, it can be a psychologically and emotionally draining experience for them and for their family. Sometimes the family can feel caught in a quandary—the desire for their loved ones to live on and survive but also the desire that they do not suffer too much unnecessarily. In the Filipino setting, the final sickness of a loved one not only places heavy affective burdens on the family but also financial ones. Obviously loving concern should be shown by trying to ensure good treatment of sick loved ones, but there may be some situations where it can be very hard for the family or even impossible to provide the necessary care. They may want to continue care, but simply run out of money. And even with sufficient funds, situations arrive when nothing more should be done, only to accept that the time has come for the suffering of the patient to come to its natural end.

Avoid euthanasia

Believing that God is the giver of life, we have no right to take it away prematurely. Euthanasia needs to be avoided. It is defined in the Church’s *Declaration on Euthanasia* as “an action or an omission which of itself or by intention causes

death, in order that all suffering may in this way be eliminated” (*Sacred Congregation for the Doctrine of the Faith* 1980, part II). The *Catechism of the Catholic Church* states,

direct euthanasia consists in putting an end to the lives of handicapped, sick, or dying persons. Thus an act or omission which, of itself or by intention, causes death in order to eliminate suffering constitutes a murder gravely contrary to the dignity of the human person and the respect due to the living God, his Creator. The error of judgment into which one can fall in good faith does not change the nature of this murderous act, which must always be forbidden and excluded. (*Catechism* 1997, n. 2277)

Euthanasia can thus be performed by *act* or *omission*. An “act” could include giving a lethal injection to a patient, and an “omission” would involve failing to provide life-saving medical care with the intention and result of causing the patient’s death.

Discontinuing burdensome or futile treatment

In most cases in the Philippines, the problem will not be a desire to commit euthanasia. Rather, problems come in knowing when “enough is enough”, or when to say “no” to further unnecessary treatment. We would not want our loved ones to undergo unnecessary or futile (“useless”) treatments and to make them suffer a treatment that would not be helpful. The *Catechism of the Catholic Church* has some very helpful advice: “Discontinuing medical procedures that are burdensome, dangerous, extraordinary, or disproportionate to the expected outcome can be legitimate; it is the refusal of ‘over-zealous’ treatment. Here one does not will to cause death; one’s inability to impede it is merely accepted” (*Catechism* 1997, n. 2278).

Discontinuing the treatment such as turning off a ventilator when it has become excessively burdensome is *not* euthanasia. It is rather the acceptance that medically nothing more can be done. There is no desire to kill the patient, rather there is an acceptance of our human, medical, and even financial limits in front of sickness and death.

Family tensions

At times, the final sickness of a loved one can cause various family tensions to surface. A real-life scenario (based on a similar case) illustrates this: a grandmother, 85 years old, with heart failure and respiratory failure, has a family who loves her very much and wants to do everything possible to “save” her. One daughter, who has lived with her and cared for her for many years, peacefully accepts that the end is near. But a son who has spent years away in the US wants his mother to live so that he can spend time with her. In these situations, there can be conflicting views in the family. Dialogue is important to clarify the position of each one. It is important to be aware that sometimes the sick one becomes like a pawn in a game of chess, and often unreconciled family issues can arise in these stressful and tense moments.

Let the patient decide!

The desire and request of the patient should be taken into consideration—the patient is the first one to decide the steps of their treatment. The *Catechism* teaches that decisions “should be made by the patient if he is competent and able or, if not, by those legally titled to act for the patient, whose reasonable will and legitimate interests must always be respected” (*Catechism*

1997, n. 2278). We should take care to avoid deciding everything for the patient. Family members sometimes make the excuse that their loved one could not bear to hear the news especially if negative, but perhaps the one who cannot bear it is them and they are just projecting their fears. It is a grave injustice when all the family and friends know, even the neighbors, but often the patient is left in the dark.

What care would be necessary?

A caring doctor can give very helpful advice about the treatment required. At times the family may feel pressure to do everything possible to keep their loved ones alive but our heart needs to be guided also by our head. It helps to try to be objective in these situations, not to be taken solely by sad or heavy feelings. A family may feel guilty when nothing more can be done and inadvertently put their sick loved one through further unnecessary suffering which will not help the patient. The patient, doctor, and family may all decide beforehand not to undertake resuscitation, deeming it over-aggressive or futile, in line with Church teaching. The family should avoid the temptation to subsequently change that decision in moments of medical crisis except for valid, serious, and medically justifiable reasons, not merely misplaced emotional ones. Overly aggressive and futile treatment should never be employed just to try to meet unrealistic demands.

“ORDINARY MEANS” ARE OBLIGATORY

One very helpful principle here from Catholic healthcare ethics is the principle of ordinary means. Stated by Gerard Kelly, the principle of ordinary means reads, “Ordinary means are all medicines,

treatments and operations which offer a reasonable hope of benefit and which can be obtained and used without excessive expense, pain or other inconvenience” (Kelly 1951, 551). Ordinary means are morally obligatory. So if the treatment does not offer reasonable hope, is excessively expensive, or is inconvenient, then it would be classified as an extraordinary intervention and would only be optional and not be morally obligatory—a conclusion which can give peace of mind to the family who may be facing a dilemma as to what is the correct course of action to take.

What if no funds are available?

As health care here is not free, many families find that the final sickness of a loved one puts them under tremendous financial burdens especially if the illness is prolonged or complicated. A family should do all they reasonably can to care for their loved one, but there may come a moment when the treatment proposed, such as a ventilator, is simply too costly, or if the treatment is prolonged, such as dialysis, funds run out. They may even decide to remove their sick loved one from the hospital and to spend their remaining time together at home. The Church clearly teaches that all things practically possible should be done, such as basic care of the person and providing appropriate nutrition and hydration. However, there will be times when the family simply cannot afford further care and it would be considered as extraordinary treatment. Extraordinary means of preserving life are those treatments, medicines, and operations which are gravely burdensome to the patient, and 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 to the patient. Extraordinary treatments such as excessively

expensive treatments or operations way beyond the reasonable effort or budget of the family are optional and not morally obligatory. The Catholic Medical Association (United States), in their guidelines note that

While people *may* use extraordinary means, they are not morally obligated to do so since earthy life for humans is not an absolute good and because, at some point, medical interventions are no longer effective and/or because the costs and burdens of medical interventions are out of proportion to the good of earthy life that they are intended to serve. (Catholic Medical Association 2007, 2A)

This frees the family from feeling over-guilty when situations come when they run out of funds. And even if funds are available, not everything that is technically or medically possible would necessarily be ethical. Sometimes we just need to accept the will of God.

ORDINARY OR EXTRAORDINARY?

How can we know when a treatment is ordinary (thus morally obligatory) or extraordinary (only optional)? The Church gives us helpful advice: “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 resources” (Sacred Congregation for the Doctrine of the Faith 1980, part IV).⁵

In determining whether a treatment is ordinary or extraordinary one should not merely consider the degree of technology involved. It would be erroneous to state that “the treatment is ordinary, but the family could not afford it.” If the family cannot afford it, then the treatment is not ordinary but extraordinary. Ordinary (or

extraordinary) is not simply a technical explanation of the complexity of a treatment, but rather a description of the overall set of circumstances including the treatment proposed, the burden imposed, the degree of success, pain incurred, as well as the financial situation of the patient and family. For patient A, kidney dialysis can be “extraordinary” because it is not available in his geographical location and to receive it three times per week would result in an insurmountable travel burden. For patient B, the same dialysis may be available locally but be “extraordinary” because the cost may be beyond the available resources of the family. For patient C, dialysis may be accessible and affordable, but having a minimal chance of success it can be deemed “extraordinary.” In some ways a dynamic and real-time analysis of the patient and his or her medical situation needs to be performed. On day one of a sickness, a family could have funds to pay for a ventilator (so it could be “ordinary”); but on day 10 their funds may be exhausted and thus the same treatment (a ventilator) can become extraordinary. Or a patient receiving chemotherapy may tolerate the first round of drugs and expect a reasonable chance of success. But if the cancer proves resistant, further rounds of chemotherapy, which are much less likely to cure and more likely to become increasingly burdensome for the patient, would be “extraordinary” and thus not obligatory. Further examples could be given but the point has been made – the situation of a sick person needs to be continually re-assessed, and what is judged “ordinary” treatment may later become “extraordinary.”

Hospital bias may exist

It may be that, in healthcare systems that are subsidized by the state, pressure may be put on families to coerce or “encourage” them not to pursue certain treatment

options. Stopping such treatments could thus save the state large sums of money. In other countries, such as the Philippines, where adequate, state-funded coverage is lacking, patients and families have to pay for the medical services. Here the opposite scenario may be encountered—the hospital or attending doctors may over-encourage a patient or family to pursue a treatment option that is not so viable. This is a very sorry state of affairs especially in a Catholic country like the Philippines where the hospital and attending physicians may be motivated by financial gain rather than merely patient welfare.

Can treatment plans be specified in advance?

Various options exist for trying to decide in advance what treatment courses to take or avoid. Examples include so-called living wills, advanced directives, power of attorney, and POLST (physician orders for life-sustaining treatment). One challenge is it is difficult to foresee all the possible future health scenarios. Perhaps this can be illustrated through a humorous example recounted by a professor of bioethics at the Regina Apostolorum University in Rome to show that what we specify regarding future medical interventions may be subject to misinterpretation. A man is taking sips of his beer every few seconds and playing with his iPad and iPod. He turned on the TV, and there was a program on euthanasia. On screen a man was hooked up to a life support machine and receiving fluids through a drip. He called his wife and said “Darling, if you ever see me dependent on liquids and relying on technology just shoot me!” This could be understood to be an instruction for the here and now as indeed this man was dependent on his beer (liquids) and his iPod and iPad (technology).

Translating this anecdote into a real life medical scenario of a chronic debilitating illness, I may state today that I do not wish to be put on a ventilator, but what if, after writing and signing such a statement, the next day I fall and sustain a head injury that requires a ventilator for 1 or 2 days until my brain swelling subsides? It is different to be on a ventilator for 2 days or 2 months. In view of this, of the available options, POLST has been heavily criticized by recognized Catholic experts and is not recommended by this author (Brugger et al. 2013).

ACCEPTING GOD’S WILL

When the family is desperate, they can even search for alternative cures and ignore the advice of the doctors. In Tobit 2:10 we hear the complaint “I went to see some doctors for a cure, but the more they anointed my eyes with various ointments, the worse I became.” And in Luke’s gospel we are told of “a woman afflicted with hemorrhages for twelve years, who had spent her whole livelihood on doctors and was unable to be cured by anyone” (Lk 8:43). It is also true that we should “Hold the physician in honor, for he is essential to you, and God it was who established his profession. From God the doctor has his wisdom ... He who is a sinner toward his Maker will be defiant toward the doctor” (Sir 38:15). Sometimes in desperation a family may be willing to try anything, but care should be taken as sometimes sadness or fear of impending death of a loved one can impede good judgment. Instead of seeking a weird and wonderful cure there are times when one has to accept that the time has come for our loved one to depart from this earthly life.

Even if we pray for a miracle God does most of his good work through everyday ways. The real miracle will not be that we

do not die, but rather that he gives us the gift of eternal life. We hope to be with our loved ones forever, but not in this life. This is the promise of our Lord and the hope of our faith. “He will wipe every tear from their eyes, and there shall be no more death or mourning, wailing or pain, for the old order has passed away” (Rev 21:4).

May we place all our trust and hope in our Lord, the giver of Life, who announces, “I am the Resurrection and the Life; whoever believes in me, even if he dies, will live” (John 11:25). Jesus, our Good Doctor, pray for us!

CONCLUSION

All Catholics should be concerned about universal health care for all. As William May reminded us,

we the people have a strict obligation in justice to see to it that the health care needs of the poor in our society are met. In addition, since we are obligated to honor the universal common good, we need to think of the health care needs of the millions of poor throughout the world. Although we are not obligated to do the impossible, and although we simply cannot do everything, we must seek to do something to bring to people in other societies a decent minimum in health care. (May 1989)

A simple step could be to remind doctors who may be working far from their native lands not only to enjoy the perks and salary of their new homeland but also to consider the medical ill fortune of many compatriots back home. I call on all Filipino doctors, especially the many working in the United States, in some of the world’s most advanced hospitals and institutions, to please resist the temptations of careerism and materialism and instead to spare a thought, a prayer, and perhaps even a

dollar for millions of their brothers and sisters who lack access to even basic health care. The call of Christ, “I was sick and you healed me” (Matt 25:36), can remind them of the duty of their mission—not only to become materially well off, but to be rich in mercy and compassion.

NOTES

- 1 “Do not let men, then, be scandalized because some countries with a majority of citizens who are counted as Christians have an abundance of wealth, whereas others are deprived of the necessities of life and are tormented with hunger, disease, and every kind of misery” (*Vatican Council II 1965*, n. 88).
- 2 In Asia, the lay have been referred to as the “sleeping giant” (*Cervellera 2010*).
- 3 “ONE estimates that as many as 3.6 million deaths could be prevented each year in the world’s developing countries if action is taken to end the secrecy that allows corruption and criminality to thrive and the recovered revenues were invested in health system” (*ONE 2014*).
- 4 For more information on how corruption affects delivery of healthcare services see *Vian (2008)*. Also *Olarte and Chua (2005)*.
- 5 These norms are repeated in *USCCB (2009)*, dirs. 56 and 57.

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