Patient agency, autonomy and consent. Catholic perspectives

Agenciamiento del paciente, autonomía y consentimiento. Perspectivas católicas

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Abstract

This paper seeks to review the current state of the art in Catholic thinking about respect for patient agency, autonomy, and consent. No attempt, however, is made to reach a definitive review. Indeed, we will find that the widespread support of these concepts within Catholic bioethics notwithstanding, important dissensus persists about specific aspects. First, the article provides a summary description of some important differences between the prevailing understanding of patient autonomy in secular bioethics and in Catholic bioethics. In the former, respect for patient autonomy is often understood as respecting the patient's subjective needs and wishes even when or maybe precisely because they fall outside of the realm of understanding of the healthcare professional. In the latter, this respect is grounded in the dignity of the individual patient, which encompasses the patient's subjective wishes and

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needs but which is essentially an objective and hence intersubjectively accessible concept. To further explicate how patient agency can be respected within such an objective frame of reference, the paper discusses different types of patient agency within the therapeutic relationship. For health care to be clinically optimal and ethically sound –as the ethical principles of beneficence and non-maleficence demand– the patient needs to be actively engaged in 1) the assessment and diagnosis, 2) treatment planning, and 3) the actual therapy. In addition –as the ethical principle of respect for patient autonomy demands– the healthcare provider must 4) protect patient confidentiality, 5) provide patients with adequate information, and 6) obtain the patient's consent for any intervention. The article then reviews different types of consent. In a final section, the question will be reviewed whether it is ever morally permissible for healthcare providers to force treatments on to patients whose refusal of such treatments is judged to be immoral.

Key words: agency, autonomy, consent, dignity.

Introduction

From a historical perspective, discussions about respect for patient[1] autonomy and consent arose first in reference to persons becoming research subjects in biomedical experiments. Notable examples include the medical experiments performed in Germany during World War II and the Tuskegee Study in the United States which lasted from 1932 to 1972, and ultimately led to the famous *Belmont Report* in which the bioethical principle of respect for patient autonomy was explicated authoritatively for the first time (National Commission for the Protection of Human Subjects of Biomedical and Behavioral Research 1979).

Biomedical research involving individuals with limited decision-making capacity remains a widely acknowledged ethical conundrum. It is, however, also an area in which, for that very reason, a lot of ethical policy development has taken place under the auspi-

ces of global organizations such as the World Medical Association (WMA) and the Council for International Organizations of Medical Sciences (CIOMS). While by no means perfect, the rights of vulnerable research subjects are protected quite robustly, particularly when compared to patients with similar decision-making limitations who are undergoing healthcare interventions This review focuses on the context of health care, that is, on interventions that are intended to restore, improve or at least sustain the health status of those undergoing these interventions. In contrast, the primary goal of biomedical research is to gain new knowledge that will hopefully benefit future patients.[2]

Two of the bioethicists involved in drafting the aforementioned *Belmont Report* from 1979 later that year published the first edition of their textbook *Principles of Biomedical Ethics,* now in its 8th edition (2019). In it, Childress and Beauchamp developed what became known as «principlism». This theory of ethics –or more precisely, this method of ethical analysis– is structured around a set of four principles proposed by Beauchamp and Childress: Respect for patient autonomy, beneficence, non-maleficence, and (distributive) justice. The second and third of these principles have historical roots that can be traced back as far as the Hippocratic Oath; the first and fourth are more recent.

The idea that health care providers must respect patient autonomy is frequently interpreted as a counterbalance against a long tradition of medical paternalism, that is, physicians making all health care-related decisions for their patients without involving the patients in the decision-making process (soft paternalism) or even against patients' explicit wishes (hard paternalism). This paternalism once was thought to be ethically justified when and because it was for the good of the patient and/or protected the patient against harm or, in modern jargon, when and because it fulfilled the principles of beneficence and non-maleficence. Thus a very unfortunate, and in fact incorrect, dichotomy arose: The principles of beneficence and nonmaleficence came to be equated with

unilateral judgements by healthcare providers about what is for the good of the patient from the perspective of biomedical science, whereas consideration of the needs and wishes of the unique individual receiving treatment was considered a matter of respect for patient autonomy.

In its most extreme version, as advocated by other leaders of American bioethics such as Veatch and Engelhardt, this meant that healthcare professionals should abstain from making judgments about the unique interests of an individual patient, because they are unable to do so. Only the individual patient him or herself can know what is truly in his or her own interests. Hence it is the right, but also the responsibility, of individual patients to make any and all decisions regarding their own interests, or so adherents of this understanding of the relationship between healthcare provider and patient have argued (30).

As O'Rourke & Boyle summarize well in the fourth edition of their *Medical Ethics. Sources of Catholic Teachings*, in this secular system of bioethics, «the subjective desire of the patient becomes the gold standard for determining the moral norm of health care» (15, p. 16). They go on to contrast this secular perspective with a Catholic understanding of autonomy and the role of informed consent: «In the Catholic theory of bioethics, informed consent is required as a means of recognizing the dignity of the patients, which enables them or their proxies to make free decisions in accord with the moral law. Thus, the moral norm in Catholic ethics is basically objective, even though the subjective desires of the patient are often significant» (15, p. 16).

In order to better understand this essential difference between the secular understanding of patient agency and autonomy represented most poignantly by Engelhardt and Veatch, and a Catholic approach, it will be helpful to briefly review the relationship between a healthcare provider and a patient, and the various decision-making phases within a typical encounter between care provider and patient.

1. The therapeutic relationship and the clinical encounter

The relationship between a healthcare provider and a patient has been the topic of many analyses and a variety of models have been proposed to describe the specific nature of that relationship. It is a complex relationship, which is understood differently depending on the context. For example, many codes of civil law will define the relationship in contractual terms, whereby the healthcare provider and the patient agree to exchange specified treatments for specified payments. This exchange is similar to other commercial exchanges. Then again, most such codes of law also acknowledge that health care is unlike other commodities that can be traded on the free market, and patients are unlike assertive consumers free to purchase or forgo services offered. Hence the relationship is also qualified as a fiduciary relationship by those same civil codes.

To further complicate matters, the expertise offered by the healthcare provider is generic only. By definition, biomedical science applies to groups of patients who share some characteristic. Where individual patients are concerned, scientific findings are only probably true. Science cannot access the unique characteristics, needs and goals of individual patients. Traditionally, medicine has been called a science *and* an art. How the artistic aspect of the therapeutic relationship is to be realized is far less clear than the scientific aspect. At a minimum, however, it requires the healthcare provider and the patient to meet as persons in an ongoing dialogue. In the words of the *New Charter for Health Care Workers*, published by the Pontifical Council for Pastoral Assistance to Health Care Workers: «The relationship between the healthcare worker and the patient is a human relationship of dialogue, and not a subject-object relation» (20, p. 71).

In its 2017 *Consensus Statement*, the International Association of Catholic Bioethics (IACB) further elaborates that «patients and their

healthcare providers each have specific roles, and both strive, through dialogue, to discern which healthcare assessments and interventions are medically appropriate and acceptable. Input from patients and their family caregivers aids healthcare professionals' diagnoses and recommended interventions. Ethical deliberation involves the patient and family's discerning among proposed options, with a view to identifying preferred interventions based on their values and goals of care» (28, p. 322-323).

Generally, this dialogue will proceed through three phases: a) assessment and diagnosis, b) treatment planning, and c) actual therapy. These are often understood as medical phases and the domain of the healthcare professional. In fact, each requires patient engagement if the ethical principles of beneficence and non-maleficence are to be fulfilled.

a) Patient participation in the assessment and diagnosis

In the first phase of the therapeutic relationship, the healthcare provider seeks to ascertain the needs and interests of the individual patient who approaches the healthcare provider for assistance. Evidently, this first phase cannot be performed solely by the patient him or herself. That is why he or she seeks the help of a healthcare professional. However, usually the healthcare providers cannot make that assessment on their own either; they need to involve the patient. Typically, the patient can and must participate with his or her healthcare provider in this first phase by (a) describing the problem, symptoms or any other concerns. The patient will next be asked (b) to share information about his or her medical history. At times this may require the patient (c) to divulge private, sensitive or even painful information. Finally, (d) the patient will have to cooperate in various diagnostic exams, whether simply looking to the left and the right, making a urine sample available or undergoing a neuropsychological assessment spread over multiple sessions.

b) Patient participation in treatment planning

The assessment and diagnosis phase will generally be followed by an attempt to prevent, cure, or at least relieve the patient's needs, symptoms and concerns. As has been underscored by virtually every bioethicist of the past half-a-century, including leading Catholic bioethicists such as Sporken (26), Grisez (7), and Sgreccia (25), this cannot happen effectively unless the healthcare provider knows what outcomes the patient is seeking. Thus (e) the patient must be invited to explain what the (s)he expects or hopes can be achieved through medical treatment.[3]

Sometimes healthcare providers simply presume to already know what the patient wants. Presumably, a patient who comes to the physician with a urinary tract infection or to the dentist with a toothache wants the pain to go away. It is risky, however, to make such presumptions. For different patients may prefer different outcomes, particularly when their conditions are complex or chronic and there is no easy intervention to quickly cure the patient. Furthermore, the medical intervention might itself have undesirable consequences, ranging from discomfort to high cost, and from necessitating lifestyle limitations to putting the patient's life at risk. For some patients, particular religious or cultural beliefs might play roles that are irrelevant to other patients. There may also be truly unique interests and preferences at stake. Lest the therapeutic relationship slips back into a paternalistic relationship, balancing all of these side effects and weighing the statistical odds of their occurrence will generally require (f) a detailed conversation with the patient who is, after all, the one to undergo most or all of these effects. In the words of Sgreccia: «The patient's involvement in managing his own illness and the personalization (where possible) of treatment plans and health care protocols are... all objectives that should be pursued according to an ethics that looks to the dignity of the person, promotes the humanization of medicine, and

strives to replace the paternalistic model with the model of beneficence based on trust» (25, p. 227).

c) Patient participation in the actual therapy

In almost all health care interventions, (g) the patient's active participation is required in order to maximize the success of the treatment. This is particularly true for life-style changes or exercise regimens, but also for scheduled medication intake or post-operative self-care. If patients decide not to, or because of other reasons are unable to, comply with a prescribed treatment, its effectiveness can decrease significantly, and the patient may be worse off than without treatment. Even if the patient decides to comply, the intervention's ultimate success can only be determined by (h) learning from the patient to what extent the patient's complaints have been truly heard, needs met, and concerns relieved.

Clearly, then, the dialogue between healthcare providers and their patients needs to continue over time. As the IACB *Consensus Statement* from 2015 emphasizes: «Health care providers, in planning care with their patients, should always evaluate the goals, benefits, risks and burdens of various interventions to meet those goals. They should also *continue to* assess, together with their patients, the actual outcomes of initiated interventions and be ready to discontinue those that have failed to deliver the hoped-for benefits or have become disproportionately burdensome for particular patients» (27, p. 13; emphasis mine).

We can thus discern at least eight different ways spread over three phases in which patients' active engagement in their own health care is necessary to achieve a truly beneficial outcome (Table 1). To put it in principlist terms: Fulfillment of the principles of beneficence and non-maleficence necessitates active engagement by the patient.

Parallel to these three phases in the process of achieving beneficent care, healthcare professionals must also respect the principle

Table 1

Ethical principle	Component	Specific patient engagement
Beneficence and non-maleficence	I. Assessment & diagnosis	(a) Describe problem, symptoms, needs, etcetera. (b) Provide info on medical history. (c) Divulge private information. (d) Engage in diagnostic exams.
	II. Treatment planning	(e) Explain expectations/hopes. (f) Evaluate means, side-effects, stats, etcetera.
	III. Actual therapy	(g) Comply with treatments. (h) Assess success of treatments.
Ethical principle	**Component**	**HC Professional Engagement**
Respect for the patient autonomy	(A) Confidentiality	(a) Safeguard individual patients' privacy. (b) Warrant patients' trust in general.
	(B) Information	(c) Inform to enable active patient engagement. (d) Inform out of respect for human dignity.
	(C) Consent	e) Ascertain (non)consent before starting intervention. (f) Ascertain (non)consent to its continuation.

Source: Own elaboration.

Table 1 summarizes the manifold ways in which a patient's active engagement is necessary to fulfil the principles of beneficence and non-maleficence as well as the principle of respect for autonomy. The table is flawed, however, in suggesting that the first eight engagement are then followed by six more, when the latter six are concurrent with the first eight.

A more correct image would be that of a road along which patient and health care provider are jointly travelling. Now, the first three components (I, II, & III) are analogous to mileage markers on the side of the road. And the last three (A, B & C) are the white lines marking the lanes within which travel is safe and secure.

of patient's autonomy. Here too at least three overlapping but different components can be distinguished.

(i) Patient confidentiality and privacy protection
As already mentioned, a patient must often reveal sensitive and otherwise private information in order to enable an accurate assessment and beneficial treatment plan. Patients will only do so, and continue to do so, if they can trust that, a) the health care professional will maintain confidentiality. More generally, patients will only trust health care providers if, b) all of them respect and safeguard the privacy of patients.

(ii) Provision of adequate information to the patient
Secondly, health care providers must provide adequate information to patients; c) they need to do so to move the diagnostic process forward or to motivate compliance with a prescribed treatment, but not only for such instrumental reasons; d) patients must be informed by healthcare professionals because it is *their* health, *their* body, *their* mind, *their* life that is affected. Even if their condition is beyond medical relief and hence no decisions about treatment have to be reached, they need to be informed about that fact. Information is not merely a means towards some other end, be it a more precise diagnosis, greater compliance, or a more rational decision. Informing patient is an important part of respecting their dignity.

For sure, providing patients with correct, adequate and helpful information is itself a complex and challenging process for both healthcare providers and patients. Indeed, it is a never ending, fluid process. However, the very dignity of those served by healthcare providers requires that they not be kept in the dark or, worse, lied to. Patients may themselves elect not to be informed, but except in very rare situations, that choice cannot be made for them.

(iii) Patient consent
Thirdly, patients must always (e) be afforded an opportunity to freely and explicitly consent to, or refuse, healthcare interventions

offered to them. Consent may not simply be presumed, in any event not if the patient is competent to make healthcare decisions, as the Pontifical Council for Pastoral Assistance to Health Care Workers admonished in 1995.[4] The competent patient's choice –whether to consent or refuse proposed treatments– must be respected. In the words of Sporken, «An ethically responsible attitude requires that one unconditionally takes seriously the other, that –moved by the need of the other– one is willing to consider the other's authentic interests as norm of the care» (26, p. 100).

It is clear that, if the proposed medical interventions are very burdensome or dangerous, a patient's consent is needed to initiate them. Even for treatments that are evidently beneficial, however, the patient's consent must be obtained: «The professional may not perform any examination or apply any treatment without the explicit or implicit authorization of the patient» (22, p. 298-299).[5]

The obligation on the part of the healthcare professional to obtain consent not only pertains to new interventions proposed, but f) also to interventions already started. The mere fact that they have been started does not justify coercing the patient into continuing them (more on this below). Sometimes patients can terminate treatment on their own accord. Sometimes a sudden end to treatment can be dangerous or burdensome and the health care provider must try to facilitate the safe discontinuation of the now non-consented-to treatment. Sometimes patients are physically unable to terminate the treatment themselves (as in the mechanical ventilation of a quadriplegic patient) in which case the health care provider must undo the intervention. Regardless of the degree of help needed to get a particular treatment discontinued, healthcare providers must respect the refusal of further treatment by the patient. The patient can grant the healthcare provider the right to start treatment by consenting, but by the same token, the patient can also rescind that right again by withdrawing his/her consent.

Indeed, almost 70 years ago Pope Pius XII already acknowledged that a healthcare provider, merely by being an expert who can

and wants to benefit the patient, does not thereby obtain the right to impose medical interventions onto another human being: «First of all, one must suppose that the doctor, as a private person, cannot take any measure or try an intervention without the consent of the patient. The doctor has only that power over the patient which the latter gives him, be it explicitly, or implicitly and tacitly. The patient, for his part, cannot confer rights which he does not possess. The decisive point, in this problem, is the moral legitimacy of the right which the patient has at his own disposal. This is where is marked out the moral frontier for the doctor who acts with the consent of the patient... [T]he doctor... disposes of rights and those rights alone, which are granted by the patient» (16, p. 200).[6] In 1980 and 1982, that view was confirmed by pope John Paul II,[7] and again by the Pontifical Council for Pastoral Assistance to Health Care Workers in 1995.[8] In other words, without consent, the healthcare professional is not authorized to initiate treatment. The consent gives the health care provider a right he or she did not have before, that is, to move from benevolence (wanting the good of the patient) to beneficence (doing the good of the patient). «Without this authorization, the health care worker is arrogating an arbitrary power to himself» (20, p. 96).

Today, the words of Pius XII will strike few readers as radical. As late as 1976, however, writing in the prestigious *Journal of the American Medical Association*, Dr. Eugene Laforet still insisted that «[i]nformed consent is a legalistic fiction that destroys good patient care and paralyzes the conscientious physician. It hedges the experimental situation with barriers that cannot be surmounted. It is not applicable, even by definition, to a large segment of the involved population. The term has no place in the lexicon of medicine» (10, p. 1584-5). Of note: Dr. Laforet not only was Chief of Thoracic Surgery at Newton-Wellesley Hospital in Boston, but also served as professor of medical ethics at Boston College (a pre-eminent Jesuit university in the US) and as editor of *Linacre Quarterly* (a leading Catholic journal of medical ethics).

Unquestionably, within a Catholic frame of reference, healthcare providers have a moral obligation to offer help to others in need of their expertise. That duty, however, does not entail the right to force their beneficent actions onto patients. The Pontifical Council Cor Unum expressed this forcefully in its 1981 report: «The patient cannot be the object of decisions which he will not make, or, if he is not able to do so, which he could not approve. The 'person', principally responsible for his own life, should be the center of any assisting intervention: others are there to help him, not to replace him» (18, p. 1137, n. 2.1.2). Except in rare exceptions, such force will be a violation of persons' fundamental human dignity.

This is a crucially important insight. As we already saw in the introductory section of this paper, respect of a patient's autonomy is not merely a matter of respecting the patient's freedom. From a Catholic perspective, it is that too, because nobody can assume another person's calling to be a good steward of his or her life. First and foremost, however, «the principle of informed consent is grounded on the dignity and inviolability of the human person» (Griese 1987, p. 154).

Two final comments need to be made about patient consent. Firstly, it is important to emphasize that the patient's right to consent to treatments proposed does not equate a right to demand treatments. As the word «consent» (Lat: *con-* = *with*) itself underscores, the patient's right is limited to agreeing with or refusing an intervention proposed by the health care provider. As explained above, the health care professional may only propose interventions that are beneficent, and the health care provider will generally only be able to craft a beneficent treatment plan in close dialogue with the patient. A patient's needs may be unique and the health care providers must consider those needs lest the proposed intervention ends up harming the patient. On this understanding of consent, therefore, a patient cannot walk into a medical office and demand a particular intervention.

Secondly, it is important to emphasize that genuine respect of a patient's choice is not simply a matter of giving the patient the opportunity to say «yes» or «no» to a proposed intervention. The patient must be enabled by the health care provider to make a decision that, as much as possible, reflects the patient's freedom and authentic wishes. This is why the gold standard for consent is *informed* consent, and it is up to the health care provider to provide the patient with the necessary information to reach such an informed consent. The 6th edition of the *Ethical and Religious Directives for Catholic Health Care Services* (ERDs), issued by the United States Conference of Catholic Bishops (USCCB), insists that «that the person or the person's surrogate receive all reasonable information about the essential nature of the proposed treatment, and its benefits; its risks, side-effects, consequences, and cost; and any reasonable and morally legitimate alternatives, including no treatment at all» (29, p. 27).

2. Different forms of consent

We have seen that consent is a necessary condition for treatment. Without consent, treatment cannot be commenced or continued. Explicit informed consent is the gold standard. Since it is not always possible to obtain explicit informed consent, however, other forms of consent can be used in such circumstances. Examples include:

- *Implied* consent (when consent for a particular component of an encompassing treatment can be logically deduced from the patient's explicit consent for that more encompassing treatment).
- *Advance* consent (given by the patient in advance of becoming incapable of making decisions, for example in a living will).
- *Substitute* or *surrogate* consent (when a third person is authorized to «speak on behalf of» [Lat: *sub-rogare*] a now-incapable patient); also called consent by proxy;

- *Parental* consent (when the patient is a minor).
- *Presumed* consent (when, in a true emergency, the patient's or surrogate's explicit consent cannot be obtained nor any other form of consent as listed above is available, and the health care providers presume the patient would have consented had he or she been competent to do so).

The aforementioned types of consent each pose their own ethical challenges. Not surprisingly, authors writing in the Catholic tradition also hold diverging opinions about their validity and what may or may not be done if, in a particular situation, a patient is found to be incapable of making explicit informed decisions.

a) Implied consent

Of all the types of consent listed above, only two can be said to approximate the gold standard of explicit and informed consent by the patient him or herself: Implied consent and advance consent. For only these two consents are issued by the patient him or herself.

The *New Charter for Health Care Workers* explains: «The health care worker can intervene if he has previously obtained the patient's consent, implicitly (when the medical acts are routine and involve no particular risks) or explicitly (in documentable form when the treatments involve risks)» (20, p. 96). As the term indicates, «implied consent» can only be invoked if a patient's previous explicit consent to a treatment also implies consent for a minor intervention that is a component of the treatment already consented to or a subsequent intervention that is logically related to the consented-to treatment.

What is implied and what is not is not always clear. It is not quite a matter of the intervention being routine and free of particular risks, however, as the *New Charter* suggest. Rather, there (i) must be a logical connection between the intervention to which the patient

has already consented explicitly. Consider the patient with ovarian cancer. Explicit consent to undergo surgical removal of her cancerous ovaries includes consent for blood tests, cauterization of cut vessels, and post-operative sutures. It does not imply consent to remove her uterus. Among other factors that may necessitate a separate explicit consent for an intervention are the following: (ii) The intervention is performed by a different healthcare provider who hence needs to be authorized by the patient separately. For example, consent for anesthesia generally is not deemed implied in the surgical consent because an anesthesiologist, rather than the surgeon, is responsible for performing the anesthesia; (iii) There are different ways of performing the intervention, each with its own benefits and harmful side-effects, each of which hence needs to be discussed separately such that the patient can make an informed choice among them; (iv) The intervention raises specific moral concerns that may be evaluated differently by different groups of patients. An example is an emergency blood transfusion during surgery: Since Jehovah's witnesses evaluate a blood transfusion very differently than do Catholics, an explicit consent for transfusion is necessary.

b) Advance consent (consent by living will)

The second type of consent approximating an explicit patient consent is what is called here an «advance consent.» It is a consent to treatment, or refusal thereof, given by the patient *in advance of* becoming incapable of making healthcare decisions. When this is done in writing, it is called commonly called a living will.[9] Unlike implied consent, however, advance consent has been criticized by many Catholic scholars as a morally problematic or even unacceptable form of consent.

Advance consent is generally justified by arguing that individual autonomy is not merely a matter of a person's freedom to make choices in the here and now. Rather, it is the freedom to shape

one's life into the future. Consent for oncological breast surgery is not merely required because removal of the tumor will involve an invasion of the woman's body; rather, it is the particular way that the woman's life will unfold following the surgery –a way that will be different if a different therapy is selected or no therapy at all– that renders it so important to respect the woman's autonomy by obtaining her consent. Unfortunately, many of us will, at some time in our life, become unable autonomously to shape our lives. To prepare for that eventuality, a person can, in advance of becoming unable to make healthcare decisions, write down his or her decisions regarding consent or refusal of future care.

Ideally, such an advance consent is an informed advance consent, that is, the patient has been informed about his or her diagnosis, prognosis and treatment options before writing down his or her decisions. Too often, however, these decisions are written down without such detailed information, without the patient having first-hand experience of the predicted life-limiting conditions or years before knowing how life will unfold (31).

To insist that such advance consent is equivalent to an explicit informed consent is to misunderstand the main objective of patient consent, that is, to enable patients to shape and keep reshaping their lives. Such insistence risks holding the patient hostage to decisions made while still capable of making informed decisions, instead of assisting the patient to keep reshaping his or her own life in spite of such decision-making incapability.

Many authors in contemporary bioethics, specifically in secular bioethics, nevertheless insist that a living will trumps any decisions expressed by the now-incompetent patient. They argue that the state of being fully able to exercise one's autonomy is morally superior to the state of being only partially able to exert one's autonomy or to being completely unable to act autonomously due to decision-making limitations. Hence, they often insist that a living will, written while the person was still competent, not only is an important and significant guide when making healthcare decisions

for a patient who is incapable of independent decision making, but should be the final word. In other words, they appear to insist that one ought to respect not the person as he or she exists in the here and now, but rather as he or she existed in the past.

This approach is fundamentally at odds with a Christian anthropology in which the journey of life continues from conception to death, with each leg in that journey being important and significant in its own right. Within the Catholic tradition, living wills and other expressions by patients of their wishes and their permissions to undergo certain treatments (or not) are to be taken very seriously. Even the most informed, explicit, and detailed living will, however, is rarely a sufficient guide for healthcare practitioners in deciding about health care for patients who presently are incapable of independent decision making, precisely because such documents are always historic, yet life's journey goes on.

The degree to which a living will is binding on healthcare professionals may depend on what that document is intended to do. As mentioned before, a living will in which a person demands treatments does not bind the healthcare provider. One of the reasons why some Catholic commentators reject the validity of living wills is exactly the fear that patients will demand certain interventions in these documents that are at odds with Catholic moral doctrine (e.g., euthanasia) and healthcare providers are then legally obligated to abide by those living wills. This fear, however, reflects an incorrect understanding of the nature of living wills (although it cannot be denied that some legislatures unfortunately reinforce this incorrect understanding).

In contrast, a living will, in which a patient requests certain treatments, is more complicated. Such requests can be understood in two ways. Firstly, they provide an indication of the patient's needs, wishes and values, all of which are crucially important to craft a beneficial treatment plan particularly when the patient is no longer capable of explaining his or her needs, values, and wishes. As we have seen, however, needs, wishes and values can shift

throughout a patient's lifetime. They do not suddenly become fixed when and because the patient has lost decision-making capacity.[10]

Secondly, the patient's requests for a treatment can be understood to signal consent. One would now reason that the patient, had he or she been capable to consent, would have consented to the treatment if proposed by the healthcare provider, thereby authorizing the healthcare provider to commence the intervention.

This is a reasonable conclusion, provided there are no acts undertaken by the patient that contradict that conclusion. Consider the patient who had expressed a wish for artificial feeding in her living will. Now, in the grip of dementia, she no longer can change that authorization. She is now confounded by and scared of the tube going into her abdomen and keeps pulling it out. Her sense of alienation and fear, clearly not predicted when she wrote her living will, should raise doubts about the overall benefit of artificial nutrition. If we add that to the statistical reality that artificial nutrition is not likely to extend the life of patients with advanced dementia, the question arises whether continued artificial nutrition is even beneficial and hence should be proposed by the physician. Even if, for the sake of argument, however, we assume that artificial nutrition is medically indicated in this particular case, the question remains whether the surgeon is authorized by the patient's living will to keep reinserting the feeding tube. One has to doubt that the original informed consent by the patient to undergo artificial nutrition can truly be characterized as an *informed* consent. Even if the patient was informed about the possibility that, as a result of the progressing dementia, she might become fearful of the feeding tube in her abdomen and try pulling it out, being told about that theoretical scenario is very different from actually experiencing a feeding tube as some kind of alien invasion.

The question whether a living will retains its power to authorize healthcare providers when the patient's illness progresses, personality changes occur, and needs and wishes change, is frequently dis-

cussed by Catholic bioethicists, but as of yet, this complex ethical quandary has not been resolved. What is clear, however, is that this problem surfaces regardless of whether the patient consents to treatments in his or her living will (as in our scenario above) or refuses them. Yet, some Catholic scholars appear to reject the validity of living wills only when the patient uses them to refuse treatments, specifically life-saving treatments. This selective rejection is illogical. Readers are reminded that consent is a necessary condition to start or continue any treatment. Hence, if the living will in which a patient refuses treatment X is deemed invalid, the net result is the same as if the living will would have been accepted: The health care team does not have consent to treat and hence may not commence or continue treatment X. Even if X is an emergency treatment, it probably may not be commenced because, as we will see shortly, the ERDs insist that such emergency treatment may only be started on the basis of a presumed consent if there is no indication that the patient, had he or she been competent, would have refused consent to the treatment. A refusal of treatment X in a living will, even if the living will is not considered binding, still qualifies as such an *indication* that the patient would have refused X had he or she been competent rather than consented to X.

c) Consent by surrogate or proxy

Because of the ethical challenges involved with living wills, many Catholic commentators prefer consent by surrogate or proxy. Surrogates may derive their authority from a declaration issued by the patient his or herself (which, using American jargon, means the surrogate then holds the «power of attorney for health care»). They may derive their authority from the court, when a judge appoints them to that role. In case of minor patients, no such judicial verdict is necessary since state law typically assigns parents that right to make decision on behalf of immature children. In some

states, the law makes similar assignments for adult patients who are incompetent.

In addition to the question *who* shall speak on behalf of the patient, there is the question *how* the surrogate shall reach a decision. This is complex ethical question, about which several lengthy treatises have already been written, including by Catholic ethicists, e.g., Mazur (11).[11] Even a summary of these analyses would exceed the scope of this review article. Suffice it to point out that typically two modes of decision making are distinguished: «Decisions by the designated surrogate should be (1) faithful to... the person's intentions and values or (2) if the person's intentions are unknown, to the person's best interests» (29, p. 25). The first is commonly called a «substitute judgment» because the surrogate steps in the shoes of the now incompetent patient and tries to determine what the patient would have decided had he or she been competent. The quotation from the USCCB makes clear that the second mode of decision-making shall only be employed by surrogates if they cannot make the first type because they lack the necessary information about the patient to reconstruct what the patient would have consented to or refused had the patient been competent.

Note that the same ethical problems that surfaced in reference to living wills surface in reference to substituted judgments. In order for a surrogate to reconstruct what the patient would have decided had the patient been competent, the surrogate must rely on expressions of will voiced by the patient *before* slipping into incompetence. These are, by definition, past expressions, voiced when the patient had not yet been robbed of his or her decision-making capacity by the progressing illness or unexpected trauma. Unlike the patient who wrote a living will and is now no longer competent to update that will, the surrogate is still competent and could attempt such an update. When doing so, however, the surrogate must rely on sources of information *other* than the patient's own past expressions of will. The question remains whether surrogates

can actually do this without their judgment turning into a best interest judgment (31).

Readers are reminded once more that a patient who is incompetent to consent to a proposed treatment plan, such that a surrogate or proxy will have to authorize the healthcare provider to initiate or continue the treatment, is not necessarily incapable of participating in the development of the treatment plan itself.[12]

c) Presumed consent

Presumed consent tends to be the fallback when no other form of consent can be secured. It is tempting to invoke it because it enables health care professionals to provide the treatment that they themselves deem beneficial and are eager to provide. As the Pontifical Council (19; 2017) has pointed out, presumed consent should not be invoked lightly.[13] The risk of undue paternalism remains significant. Hence, the USCCB insist in the aforementioned ERDs that consent may only be presumed if at least four conditions are met: (1) there must be a medical emergency; (2) the patient is not competent to consent him or herself; (3) there is no surrogate who can consent on behalf of the patient, and, crucially, (4) there is no indication that the patient, had (s)he been competent, would have refused consent to the treatment (29; p. 26).[14]

Cardio-pulmonary resuscitation (CPR) is a good example to illustrate when consent may be presumed, and when it should not. If a patient collapses at work due to a cardiopulmonary arrest and is rushed unconsciously to the emergency room in an ambulance, the ambulance team may invoke presumed consent and initiate CPR. The situation changes fundamentally, however, if an elderly patient with a history of cardiac incidents is admitted to the hospital because of persistent shortness of breath. Suppose this patient suffers cardiac arrest on the fourth day of his or her hospitalization. Many hospital policies do not require explicit patient consent but allow the initiation of CPR on the basis of a presumed consent.

So do many statutory laws, and the same view is expressed in many bioethical publications. However, in this scenario the four conditions listed above are not all met. First, there is no real emergency. The patient was known to be at increased risk of a cardiopulmonary arrest, and there clearly had been time to discuss with the patient the option of CPR. Secondly, this patient is competent to provide an explicit informed consent. Thirdly, if the patient is not competent after all (for example, due to dementia), there is ample time to identify a surrogate. Most importantly, there are important reasons to presume that the patient, had he been informed and then asked to consent, would *not* have consented. For the success rate of in-hospital CPR is dismally low, and the intervention is frequently refused by patients (and by the vast majority of healthcare providers when they themselves have become patients). Hence, the common policy of presuming consent for in-hospital CPR of admitted patients also violates the fourth condition listed in the ERDs.[15]

3. Is forcing treatment onto a patient ever justified?

We have seen that Catholic moral teaching endorses the importance of patient agency and hence, the need to respect the autonomy of the patient and to obtain the patient's consent for a medical intervention. That does not mean the reason for endorsing patient agency and consent is exactly the same reason as advanced by secular bioethics. We have seen that autonomy is to be respected, not because a human being's dignity is a function of his or her free self-determination. Rather, for Christians, that dignity is grounded in each human person being created by God and in God's image, and in being called specifically by God to lead a life back to God. However, this calling is unique and must be freely accepted and then freely fulfilled by that person. One person cannot fulfill that

responsibility for another person. I can try to help others make sound decisions, but not make the decisions for them, not even when they are about to make unwise decisions, lest I risk violating their freedom and ultimately their dignity.

Practically, this means that medical interventions cannot be forced onto patients, not even treatments that are objectively beneficent.[16] Earlier, we saw that a number of Catholic authorities (8, 9, 16, 17, 19, 20) affirmed that obtaining the consent of a patient who is capable of making decisions is a necessary requirement for medical treatment. Without such consent, the treatment may not be imposed onto the patient.

Other Catholic authorities, however, appear to disagree. For example, the USCCB instructs all American health care facilities that «the free and informed health care decision of the person... is to be followed *so long as it does not contradict Catholic principles*» (29, p. 24, emphasis added-JW). This seems to suggest that if a patient refuses treatment, it may be forced onto the patient when the refusal contradicts moral principles advanced in the Catholic tradition, e.g., when the patient refuses an ordinary medical intervention.[17] Similar views are expressed by other authors writing from a specifically Catholic perspective. For example, Brugger insists that a doctor «has a duty to refuse to carry out a patient's intention to die through an order to remove or withdraw life support» (3, p. 167). Commenting on a specific type of advance care planning document known as the Physician Orders for Life-Sustaining Treatment (POLST), Brugger and colleagues complain that «the POLST model and POLST forms make no distinction between ordinary and extraordinary means. This sets up an obvious conflict between the moral obligation of Catholic institutions not to honour, in the words of ERD (29, no. 24), 'an advance directive that is contrary to Catholic teaching' and the legal liberties of patients in those institutions to write such a directive» (4, p. 113).[18] This line of reasoning logically leads to the conclusion that Catholic health care

professionals may or actually must force ordinary life-sustaining treatments onto a patient, once incompetent, even if the latter has refused those treatments in a living will.

Still others appear to seek a middle ground. For example, Sgreccia (25) has argued that «[i]n the case of an unimpaired, adult patient who refuses medical treatments, the physician cannot consent to... interruption of efficacious and proportionate treatments... because he cannot act against life and good of the patient. However, the physician can request a consultation and attempt to make the patient aware of both his duty to seek and accept appropriate care and the consequences of refusal. If the patient persists, the physician cannot force him but must request to be released from his own responsibilities...»[19]

Judging by the examples given, most authors favoring forced treatment of decisionally-capable patients allow this only when an ordinary treatment has already been initiated and the patient now wants it to be withdrawn. When a decisionally-capable patient refuses a *new* treatment proposed by a healthcare provider, it may not be forced onto the patient, even if that refusal is immoral (for example because the treatment refused is «ordinary»). Hence, we can conclude that the difference in opinion between the authorities cited in the second paragraph of this section who never allow forced medical treatment and those who are inclined to accept force in some circumstances reflects divergence in their understanding of what, morally, withdrawing treatment entails.

There is consensus between both groups that initiating a new medical treatment involves a fundamental change in the natural course of events for which the individual who initiates the treatment can be held morally responsible. To act responsibly, the new treatment must, as we have seen, benefit the patient while keeping harmful side effects to a minimum. It must also be consented to by the patient. If either of these two necessary conditions is not met, treatment may not be initiated. The natural course of events must be allowed to unfold.

The authors approving limited coercion appear to hold that once treatment has been started, that treatment becomes part of the natural course of events. The physician who had to justify initiating the treatment no longer has to justify its continuation in reference to both the aforementioned necessary conditions. Instead, the state of being hooked-up to some medical machinery is considered a natural state of being for the patient; it is the interruption of that natural state that occurs when the machinery is withdrawn that now must be justified.

This view is actually quite widespread among healthcare professionals, including non-Catholic providers. The ability of modern life-sustaining medical technologies to sustain themselves almost forever, certainly without the assistance of the attending physicians, generates a feeling or wish among physicians not to be held responsible any longer for the continuation of the technologies. As a result, discontinuing the technology becomes the morally challenging decision. Many legal authorities likewise hold that withdrawal of a life-sustaining treatment is a new act, a new intervention in the natural course of events, that must be justified, and if the withdrawal cannot be justified, the treatment must continue by default.

We cannot here attempt to resolve this fundamental ontological and ethical disagreement about the role of medical technology –see (19) for a review of ongoing debates within Catholic bioethics–. Nor can we here discuss whether withdrawing a life-sustaining medical treatment that is now refused by a decisionally-incapable patient is indeed morally more precarious than never initiating the same treatment in the first place when it is refused by a capable patient –see (33) for a more in-depth analysis–. Suffice it to say that the tendency to blur the boundaries between natural state of being human and a technological state of being is most precarious. Not surprisingly then, the same authors who are willing to blur that boundary when patients refuse an ordinary life-sustaining treatment in a living will are far less willing to blur that boundary

when a competent patient insists on artificial reproduction or human enhancement. The moral risk of respecting a patient's non-consent to treatment expressed in an admittedly flawed living will may be far smaller than the moral risk we incur by blurring the boundary between nature and technology.

Conclusion

In this review paper, we have argued that the development of a treatment plan that truly benefits the unique patient, while at the same time preventing harm to that individual –as required by the bioethical principles of beneficence and non-maleficence– necessitates the active engagement of the patient. If a patient lacks such agency, this will seriously complicate the development of such a treatment plan. The bioethical principle of respect for patient autonomy furthermore underscores the importance of sustaining and supporting patient agency. This is because even an objectively beneficent treatment may not be forced onto a patient. Such force undermines the freedom, personal responsibility, and ultimately the intrinsic dignity of the individual involved.

In order for treatment to be initiated, the patient must consent. This consent authorizes the health care professional to commence the proposed intervention. Hence, in the absence of a patient's consent to treatment, in principle such treatment may not be commenced, and if a patient withdraws his/her consent, the treatment must be stopped.

The patient may be making a moral error in not consenting to the start or continuation of a particular medical intervention (for example, because it concerns an ordinary treatment needed to sustain his/her life).[20] In such instances, health care providers may and should make an extra effort to understand, inform, and even counsel the patient. But the health care provider may not paternalisti-

cally override the patient's wishes and commence or continue treatment of the patient anyway.

The gold standard for a patient's consent is explicit informed consent. It is the responsibility of the health care team to provide the patient with sufficient information to reach an authentic decision. Other forms of patient consent may be invoked to commence or continue treatment if explicit informed consent cannot be obtained, notably when the patient is not capable to consent explicitly. Examples include consent given by the patient him/herself in advance of becoming incapable to consent; parental consent for minors; or consent by a surrogate, that is, a person who is authorized to make (non)consent decisions on behalf of the patient. Each of these alternate forms of consent falls short of the gold standard, though in different ways. Health care teams hence have to proceed with great caution when invoking these alternate forms of consent. However, the most precarious of these alternate forms of consent is presumed consent. Hence, consent may only be presumed in genuine emergencies when the patient is unable to consent him/self and no more reliable form of consent can be obtained.

Finally it is important to underscore that even if a patient is deemed incompetent to autonomously consent to proposed interventions, the patient's active engagement in his/her own health care must be secured and encouraged to the greatest extent possible. For as was said at the outset of this Conclusion, the development of a treatment plan that truly benefits the unique patient, while at the same time preventing harm to that individual, necessitates the active engagement of the patient. Moreover, a patient may lose his legal competence to consent, but that loss does not entail a loss of dignity; we owe such patients assistance to maximize their capacity to freely shape their own lives and we must, as much as possible, respect their decisions to that effect.

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Bibliographic notes

[1] When in this paper the word «patient» is used, this is not to suggest that the individuals concerned are mere patients, that is, human beings whose personhood is adequately and comprehensively captured by this label. Nor does it signal that the individuals concerned are passive subjects undergoing health care. Concerns about such limited interpretations of the word «patient» motivate many authors to instead use the word «client». That term, however, likewise has connotations that are potentially troublesome, as if health care is a commodity similar to other marketable goods that are bought by free and assertive customers. Still others insist on replacing the word «patient» with «persons with condition X». However, even this phrase –in addition to being more cumbersome– is open to diverse interpretations, including the idea that illness, trauma or disability are external to the person, like clothing or a hairstyle, which the person «has» but can also freely take off or exchange, and which hence have no impact on the very being of that person. None of these restrictive interpretations is correct. Regardless of the particular word employed in this paper, readers should be mindful of their own potential biases and not interpret terms such as «patient» in a manner that undermines recognition of, and respect for, the intrinsic dignity of human beings. Similarly, when the adjectives «incapable», «incapacitated», and «incompetent» are used, these qualifiers refer only to one aspect of a person's existence, that is, his or her inability to make free and reasonable decisions about his or her own health care. Such inability is a limitation that renders individuals vulnerable; it does not in any way reduce their personhood or intrinsic dignity.

[2] In so-called «therapeutic research» projects, medical interventions seek to both generate new knowledge and benefit the patient undergoing the intervention. However, that dual goal does not change the fact that these goals are themselves very different, and the ethical concerns involved diverge as well.

[3] According to Sporken, «The fundamental norm of all health care is determined by patient in his totality or by the authentic interests of the patient... In general it is true that the patient is the person best able to determine what is in his interests» (26, p. 71).
Grisez says, «[T]he duty to obtain the informed consent of competent patients is grounded in the facts that only they can mediate among their own interests, integrate medical treatment with other aspects of their lives, limit it in accord with their other responsibilities, and effectively carry out their own part in it» (7, p. 220).
Sgreccia says, «It is clear... that the concept of the patient's good must also include the patient's perception of the good, that is, the patient's idea of his own good… When the patient is capable of expressing it, no one better than he can determine what his best interest is...» (25, p. 228).
[4] Pontifical Council (19): «P. 73. With regard to presumed consent, a distinction must be made between the patient who is in a condition to know and will and one who is not. In the former, consent cannot be presumed: it must be clear and explicit».
[5] The manner in which consent is expressed explicitly may differ. While normally, that consent must be expressed verbally, a patient's gesture may sometimes suffice. For example, the patient's act of freely walking into the orthopedic surgery clinic logically can be interpreted to constitute the patient consent to being questioned about his medical needs by the surgeon and undergoing a basic physical examination. The act of walking into the clinic, however, does not constitute consent to hip replacement surgery. An affirmative nod to the question whether the patient agrees to a simple $150 X-ray of his knee may suffice to take the X-ray; but that same nod may not suffice if the question concerns a $3,500 PET scan.
[6] Pope Pius XII made this claim while discussing the «moral justification of *new* processes, *new* experiments, and methods of research» (1952, p. 196; emphasis added - JW). However, the logic of the argumentation developed by the Pope appears to apply as well to established treatments. Indeed, in 1957, Pius XII reiterated this view, this time in reference to unconscious patients on life-support: «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 can take action only if the patient explicitly or implicitly, directly or indirectly, gives him permission» (Question 1).
[7] John Paul II (1980): «Indeed, the physician has vis-à-vis the patient only that power and those rights that the patient himself awards him (I*l medico, infatti, ha sul paziente solo quel potere e quei diritti, che il paziente stesso gli conferisce*» (p. 5). (Note: Comment made in the context of a discussion of medical experiments).
John Paul II (1982): «Indeed, the patient… is not an anonymous individual onto which one can apply the fruits of your knowledge, but a responsible person, who must be called upon to share in the improvement of his health and in becoming cured. He should be given the opportunity of personally choosing, and not be made to submit to the decisions and choices of others» (p. 4).

[8] Pontifical Council (1995): «To intervene medically, the health care worker should have the express or tacit consent of the patient. In fact, he 'does not have a separate and independent right in relation to the patient. In general, he can act only if the patient explicitly or implicitly (directly or indirectly) authorizes him'. Without such authorization he gives himself an arbitrary power. Besides the medical relationship there is a human one: dialogic, non-objective. The patient 'is not an anonymous individual' on whom medical expertise is practiced, but 'a responsible person, who should be called upon to share in the improvement of his health and in becoming cured. He should be given the opportunity of personally choosing, and not be made to submit to the decisions and choices of others'. So that the choice may be made with full awareness and freedom, the patient should be given a precise idea of his illness and the therapeutic possibilities, with the risks, the problems and the consequences that they entail. This means that the patient should be asked for an informed consent» (p. 72).

[9] The term «advance consent» is rarely used in the literature, although the term «advance directive» is. The latter term is imprecise and potentially confusing in at least two ways. First, in the North-American context, there are two types of advance directives. The first is the aforementioned living will. The second is a declaration in which the patient authorizes somebody else (a substitute decision maker or surrogate) to make consent decisions on his or her behalf once the patient is no longer competent to make such decisions him or herself (In the United States, this is formally called an assignment of the Power of Attorney for Health Care Decisions). While both of these documents are indeed written in advance of the patient becoming incompetent, only the first qualifies as the patient having given consent or refusing proper. The second declaration identifies the surrogate, but that person then still has to reach a consent decision on behalf of the patient. More problematic than the term «advance directive» comprising two very different documents is the word «directive», for it suggests that the patient can «direct» the healthcare provider to do something. Now the patient can indeed direct the healthcare provider to respect the decisions reached by the surrogate identified by the patient regarding offered options for treatment. The patient cannot, however, direct the healthcare provider to perform some medical intervention. As we have seen before, the patient can only consent to –or refuse– one or all interventions proposed by the healthcare professional. The patient cannot demand interventions from a healthcare provider, neither orally nor in a written living will.

[10] One of the key objectives of the 2019 IACB Colloquium was exactly to examine ways in which even patients whose formal decision making competence is insufficient to make autonomous decisions independently can nevertheless be enabled to participate in the decision making surrounding their own health care, by clarifying their current needs, values, and wishes.

[11] Mazur is primarily concerned with consent by proxies in the context of research on incompetent human subjects. However, much can be learned from this in-depth book-length treatise on the clinical care context as well.

[12] As mentioned, one of the principal purposes of the 2019 Colloquium was exactly to explore ways of enabling the patient to maximally participate, as needed with the assistance of others.

[13] Pontifical Council (1995): «With regard to presumed consent, a distinction must be made between the patient who is in a condition to know and will and one who is not. In the former, consent cannot be presumed: it must be clear and explicit. In the latter case, however, the health care worker can, and in extreme situations must, presume the consent to therapeutic interventions, which from his knowledge and in conscience he thinks should be made. If there is a temporary loss of knowing and willing, the health care worker can act in virtue of the principle of therapeutic trust, that is the original confidence with which the patient entrusted himself to the health care worker. Should there be a permanent loss of knowing and willing, the health care worker can act in virtue of the principle of responsibility for health care, which obliges the health care worker to assume responsibility for the patient's health» (19, p. 73).

Pontifical Council (2017). «Consent may be presumed in a case where the health care worker is called to intervene on a patient who is momentarily or permanently incapable of understanding and deciding, so as to save the patient from a situation of serious danger to his life or his health, with treatments appropriate to the risks and the urgency» (20, par 97).

[14] At times, the term «implied consent» is used when «presumed consent» is meant. Yet as the term indicates, *implied* consent can only be invoked if some previous patient consent to a treatment *implies* consent as well for a minor intervention that is a component of the treatment already consented to, or a subsequent intervention that is logically related to the consented-to treatment. Being brought unconsciously to an emergency room (ER) does not imply any choice on the part of the patient. Hence, the ER medical team cannot invoke implied consent to start treatment; it can only presume the patient would have consented to emergency treatments had the patient been conscious and competent to do so.

[15] The practice of in-hospital CPR is further complicated by the fact that many hospital policies, state laws, and bioethical publications alike insist that a decision *not* to resuscitate needs to be justified and then consented to by the patient, e.g., Moraczewski 2009 (12). But this approach is fundamentally at odds with everything we have discussed before. For it is medical interventions (whether antibiotics, surgery, or resuscitation) that must be justified and hence need consent, not forgoing an intervention. Therefore, it is the act of CPR that needs to be justified and consented to, not a DNR decision, according to Welie & ten have 2014 (33).

[16] In this subsection, we do not address the morality of forced medical interventions in the context of public health (e.g., fluoridation of drinking water or mandatory vaccinations) nor situations in which the actions of psychiatrically ill persons pose a serious risk to third persons.

[17] Neumann 2013 (14, pp. 325-316) likewise interprets this paragraph to amount to a justification of extra-legal, coerced medical treatment: «Because Catholic hospitals are protected by the conscience clauses that allow them to deviate from gene-

ral medical ethics, and because vulnerable patients and their families often do not know what their options are and look to attending doctors for direction, patients are effectively denied an established legal right that would, outside a Catholic institution, be recognized. In other words, patients in Catholic hospitals have fewer autonomy rights than those in non-Catholic hospitals».

[18] The same conclusion is reached by Gasbarre Black 2010 (5, p.2): «If a patient's POLST order permits the patient to refuse routine use of these procedures, ...the result could be that instead of benefiting from ordinary and proportionate treatment, the patient foregoes such treatment and thus hastens his or her own death. In such a case, a Catholic physician who signs a POLST order risks exposing the patient and himself to noncompliance with the ERDs, which state that «a person has a moral obligation to use ordinary or proportionate means of preserving his or her life».

[19] Unfortunately, Sgreccia's admonition is confounding for three reasons. Firstly, in this paragraph an odd reversal has taken place. Normally, it is the health care professional who proposes to undertake a medical intervention, and the patient consents to it (or does not consent). But in the paragraph above, the physician is the one doing the consenting. This is odd because there is nothing the patient proposes to undertake to which the physician must consent. Rather, the patient is withdrawing his or her previous consent to a medical intervention, and all that is asked of the physician is to cease the treatment previously commenced. Secondly, Sgreccia initially appears to justify forcing continued treatment onto the patient: The physician is not required to cease the treatment that is now refused by the patient. He then appears to rule out force, however, in the final sentence. Thirdly, Sgreccia insists that the physician must ask to be released from his or her own responsibilities towards the patient, i.e., stop caring of the patient. This suggests a physician may and in fact must refuse to provide further health care to a patient who is not being a good steward of the gift of life by refusing ordinary treatments. That is, the physician must abandon the patient in such circumstances, or so it could be concluded from this paragraph. Patient abandonment, however, is principally at odds with the Christian duty to care for a fellow human being in need, even a sinful person.

[20] The term «ordinary» is used here in the specific sense in which it functions in Catholic bioethics. See, for example, Welie 2015 (32, p. 18) for discussion of the ordinary-extraordinary distinction in this tradition.

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