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PERSPECTIVES

A Catholic Perspective on COVID-19

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It took nearly two thousand years for society to recognize the Hippocratic insistence that "the doctor knows best"[1] was an inadequate approach to medical decisionmaking. Today, patient-centered medicine has come to understand that the individual patient has a significant role in the decisionmaking process.[2]

In the situation of a pandemic, it is also important to realize that a patient or proxy's wish for a specific treatment is not the sole operative ethical value. "Patient autonomy," the prevailing standard in Western bioethics, focuses on the interests of an individual patient. It might have to yield in times of a pandemic to a different allocation process, one that looks not exclusively at the interests of a particular patient but at the interests of the whole population. Such a shift may prove uncomfortable, but in a crisis situation, it might be imperative.

During the current crisis, physicians in the Lombardy region of Italy were overwhelmed with the need for scarce intensive care unit (ICU) beds and ventilators.[3] A decision was made to use age as the determinant for who would be allotted an ICU bed or ventilator. Once the health authorities recognized that age alone was not determinative of vulnerability, age was no longer used as the standard. Comorbidities and medical status were added to the calculation for eligibility.[4] Outrage at the use of age as the standard led to the involvement of the public in determining who would be left behind.

Even during a crisis, allocation decisions must be made. During the recent "force majeure" situation of the post-Hurricane Katrina flooding of New Orleans that quickly engulfed that city's largest hospital, the New Orleans District Attorney proposed prosecuting the doctors and nurses at Memorial Medical Center.[5] They were accused of administering large doses of morphine to gravely ill ICU patients who had been abandoned by the state during the flooding.[6] A grand jury declined to indict. The District Attorney who sought the charges was defeated in the next election. The public understood that even in a crisis situation, as long as there was no gross negligence, difficult decisions must and will be made.

There are, however, limits on how worst-case allocation choices are made. This is seen in an 18th century English case entitled *R v. Dudley and Stephens*, in which a yacht was shipwrecked in a storm.[7] Although the crew succeeded in launching a lifeboat prior to the boat sinking, the crew soon realized that the lifeboat lacked adequate supplies of food and water. The crew's captain (Tom Dudley) and a member of the crew (Edwin Stephens) proposed killing a 17-year-old cabin boy for food. Following the crews' rescue and return to England, Dudley and Stephens were tried in a British court on a charge of murder. What upset the court was not the reverting to cannibalism for survival, but targeting the vulnerable youth for death. Dudley and Stephens were found guilty. Necessity alone was not an adequate defense against the charge. In its opinion, the English High Court noted that if a member of the crew in the lifeboat had volunteered to be the victim or if the crew had drawn lots to determine who would be sacrificed, there would have been no controversy.[8]

Insight into how end-of-life decisions ought to be made is found in the nearly two-thousand-year-old tradition of Catholic moral analysis of the issue.[9] The most recent statement on the topic is found in the Vatican's 1980 *Declaration on Euthanasia.*[10] That document notes that progress in "medicine sometimes give rise to moral problems."

Those problems are addressed in Section IV of the *Declaration* entitled, "Due Proportion in the Use of Remedies." It begins with the observation, "It is very important to protect, at the moment of death, both the dignity of the human person and the Christian concept of life, against a technological attitude that

threatens to become an abuse." Here the document is referring to the relatively new notion that the physician has a duty to do everything possible to extend life.[11] Such a position maintains "there is a technological fix to every medical problem." That proposition translates into the belief that if only physicians worked hard enough, not only could disease be conquered, but also death itself could be overcome. Such an attitude led to what one distinguished American observer of health care, Daniel Callahan, described as "the illusion that death is an option."[12]

Richard A. McCormick addressed the issue in a 1974 essay in *JAMA*.[13] Although his article was published in a leading medical journal, it was more a theological analysis on the meaning and purpose of creation than a medically focused assessment of the case on which he commented. "We are," he stated, "created not merely for physical existence, but for a higher goal, eternal union with God."[14] For McCormick, physical life is "a relative good." The duty to preserve it is thus "a limited one." The limits are defined by the *means* required to sustain life.

In support of his analysis, McCormick cited Pius XII's 1957 address to an International Congress of Anesthesiologists.[15] In that talk, Pius XII noted that "We are normally obligated to use only ordinary means to preserve life. A stricter obligation," the Pope observed, "would be too burdensome for most men."[16] From this McCormick concluded, "It is neither inhuman nor un-Christian to say that there comes a point where an individual's condition itself represents the negation of anything truly human."[17] When that point is reached, McCormick rhetorically asks, "Is not the best treatment, no treatment?"[18] His response was affirmative.

That judgment is readily accepted for a 93-year-old demented patient who is suffering from metastatic cancer and multisystem organ failure. It is not so readily supported for the newborn infant dying of coronavirus disease (COVID-19). From a theological perspective, McCormick noted, "There is no significant difference due to age."[19] The life of each individual, regardless of the time spent on earth, has achieved its maximum potential.

McCormick concluded his *JAMA* article with the reminder that 'allowing to die' is not the same as "euthanasia." Nor, he emphasized, "Does it imply that there is such a thing as 'a life not worth living'." Every human being—regardless of age or condition—is of incalculable value. The issue, he wrote, is not whether this or that individual has value. In his words, "Of course he has, or rather, *is* a value." The point for McCormick was whether this individual has any potential for maintaining physical survival—other than by the use of aggressive medical measures.

The *Declaration* is a summary of teaching dating from the 4th century writing of St. Basil the Great. Basil, after noting that the art of medicine was a divine gift that permits us to heal the sick, nevertheless condemned "Whatever causes our whole life to revolve, as it were, around the solicitude of the flesh."[20]

That quotation, which invites reflection on the limits of the moral duty to preserve physical life, became in the 13th century the basis of Aquinas's reflections on suicide and mutilation.[21] It was also the foundation for the reflection of the 16th century moral theologians on the obligation to preserve health and life by means of the scientific advances of the Renaissance. Among the questions raised was the moral duty of an individual to undergo surgery without the availability of asepsis and anesthesia.

Such well-known 16th century commentators the Dominicans theologians Francisco de Vitoria, Domingo de Soto, and Domingo Banez developed the doctrine on the use of "ordinary and extraordinary" measures to preserve health and prolong life. For moralists of that time "ordinary" and "extraordinary" referred not to technique or hardware, but to moral obligation. Failure to adhere to one's moral duties was considered sinful behavior. The practical issue was "what excused" an individual from the duty to utilize an intervention that was available and might restore health or prolong life, but at the cost of great personal suffering?

Throughout the centuries clear limits were established on what one is obliged to undergo to preserve life. The most famous formula for that limitation was proposed in 1595 by Domingo Banez, the distinction between "extraordinary" and "ordinary" means, by which was meant measures proportionate to the individual's subjective assessment of his or her medical condition. Thus, if something were very costly, extremely painful, or excessively burdensome—or if it did not offer substantial benefit of recovery —there was no moral obligation to use it. That standard applied even to life-saving measures.

That doctrine has continued to prevail. The clearest formulation of that teaching is found in the *Relecciones Theologiae* by Francisco de Vitoria.[22] In a commentary on the obligation to use food to preserve life, de Vitoria was asked, "Would a sick person who does not eat because of some disgust for food be guilty of a sin equivalent to suicide?" His reply was negative.

de Vitoria provides a simple example of the type of 'delicate treatment' that would be beyond what one is obligated to use to preserve life: chickens and partridges. Even if prescribed by the doctor, de Vitoria held, these special foods need not be chosen over eggs and other common items. This was true, he observed, even when the individual knew for certain that he could live another 20 years by eating such special foods.

That de Vitoria's views were neither unique nor subsequently abandoned by the Catholic moralists is seen in an essay published by Gerald Kelly in 1950 in *Theological Studies.*[23] Kelly was concerned with the question of whether there is a moral obligation to continue medical interventions for an irreversibly comatose patient. After a thorough survey of the prior teachings on the topic, Kelly found that the authors hold that "No remedy is obligatory unless it offers a reasonable hope of checking or curing a medical condition."[24] From this, he concluded that no one is under a moral obligation to use any means if it does not offer a reasonable hope of success in overcoming the person's medical condition.

When asked specifically whether oxygen or intravenous feeding must be used to extend the life of a patient in an irreversible coma, Kelly responded:

> I see no reason why even the most delicate professional standard should call for their use. In fact, it seems to me that, apart from very special circumstances, the artificial means not only need not, but should not be used, once the coma is reasonably diagnosed as terminal [irreversible]. Their use creates expense and nervous strain without conferring any real benefit.

How then did the idea that some medical measures, for example, artificial nutrition and hydration, must always be provided to a patient, gain currency?[25]

Perhaps it rose from the hesitancy expressed by Gerald Kelly to advise physicians that it is morally permissible to discontinue intravenous feeding lest such action be misinterpreted as a form of euthanasia.

That reluctance was intensified in Charles McFadden's widely circulated 1949 textbook on *Medical Ethics.*[26] McFadden held that while the long-term use of artificial feeding could constitute a grave and non-obligatory burden as a practical matter once a medical intervention had been instituted, he would never propose its removal. The dangers he feared were those of scandal by those unaware of the tradition, guilt on the part of the family, or misuse by insensitive or unscrupulous physicians.

Opposition to the applications of the traditional doctrine to medical practice soon led to the notion that what was theoretically correct was not only rash; it was wrong. From there it was an easy step to the position that it was wrong because it violated fundamental principles such as "One must always use 'ordinary' means to preserve life."

Until such emotionally charged cases as those of *Karen Ann Quinlan*,[27] *Terri Schiavo*,[28] or *Charlie Gard*[29] became headlines throughout the world, there was little ambiguity or hesitancy about ending medical measures to prolong life. For example, in his frequently anthologized 1976 discourse to the Massachusetts Medical Society, the distinguished surgeon, Dr. J. Englebert Dunphy, admonished his fellow physicians, "There is no need to prolong a useless and tragic life [of a patient racked with cancer] by force feeding or giving antibiotic.[30] In his sharply stated summary, Dunphy wrote that dragging out of the dying process for a few more agonizing days or weeks, "is the science without the humanity of medicine."[31]

The subordination of physiological concerns to the patient's spiritual needs is the bedrock teaching of Catholic theology on the meaning of life and death—neither of which in the Catholic framework is to be made absolute.

It is this understanding—and not a misplaced debate on the need to ration scarce medical resources in a crisis situation or the potential efficacy of an unproven experimental therapy—that should guide our judgments on the difficult medical decision cast up by the COVID-19 pandemic. To do otherwise—to

count mere biological existence as a patient benefit—is to let slip one's grasp on these matters at the heart of our moral tradition.

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