

Providing Health Care to Patients against Their Will

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Abstract. Obtaining a patient's informed consent to treatment is an ethical, legal, and professional requirement based on the defense of human dignity. In some cases, however, a government may mandate treatment for patients without their consent if their failure to obtain treatment could endanger the common good. Such a need may arise, for example, in public emergencies, with cases of tuberculosis, and with patients who have mental health issues. May a Catholic health care professional or institution ethically provide treatment to patients who resist or refuse it? The author replies with a qualified yes. Legally mandated treatment may be given without a patient's consent so long as the treatment is necessary to protect the lives of others, it is limited strictly to what is necessary to protect others, and the principle of subsidiarity applies. *National Catholic Bioethics Quarterly* 13.3 (Autumn 2013): 483–498.

At the heart of Catholic health care ministry is the “commitment to promote and defend human dignity.”¹ This commitment to human dignity includes a commitment to respect for the legitimate autonomy of patients and the right of each patient to make decisions regarding his or her own health care.² Because of these commitments, Catholic health care providers and institutions must usually obtain the “free

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¹ US Conference of Catholic Bishops (USCCB), *Ethical and Religious Directives for Catholic Health Care Services*, 5th ed. (Washington, DC: USCCB, 2009), 10.

² Pontifical Council for Health Care Workers, *Charter for Health Care Workers* (Boston: Pauline Books and Media, 1995), n. 72. This section of the Charter cites addresses by Pope Pius XII and Pope John Paul II, as well as *Some Ethical Questions Relating to the Gravely Ill and the Dying* by the Pontifical Council “Cor Unum” (1981).

and informed consent” of the patient before providing any health care services.³ An exception exists for emergency situations in which the patient’s consent cannot be obtained, but whenever the patient is able to make a free and informed decision, that decision should be followed by the Catholic health care provider unless doing so would violate a moral principle.⁴

In some cases, however, governments authorize individuals to be treated when the individual objects to receiving treatment. In the United States, examples of compelled or mandatory treatment include cases of tuberculosis and mental health problems as well as mandatory vaccinations.⁵ Many states also have statutory provisions for compelled treatment for substance use disorders (drug and alcohol addiction).⁶ The threat of a terrorist attack with biological weapons could lead to other possibilities: specifically, mandatory treatment or vaccination before the lifting of quarantines could be vital to limiting the effects of such an attack.⁷ In all these instances, a patient may actively refuse the medical treatment that the law requires him to receive. The health care provider who is asked to provide the treatment is thus faced with a dilemma: the patient actively declines to give the consent ordinarily required before receiving medical care, yet the government insists that the care be given. May a Catholic health care professional or institution ethically provide treatment to a patient who is resisting or refusing the treatment? The answer is a qualified yes.

In this paper I argue that a Catholic health care professional or institution may treat an individual against the individual’s will if authorized to do so by a just law. For example, a legitimate authority, including a legitimately constituted government, may give consent for treatment for an individual who is not competent, based on the duty to care for the person. A legitimate authority with a responsibility to protect the common good may make medical care compulsory even for a competent person, if failure to obtain the treatment would result in a grave danger to the common good. In either situation, a Catholic health care professional or institution may carry out medical treatment over the objection of the patient.

Background

Classical, Byzantine, and medieval sources refer to the expectation that those who provide medical care will obtain the consent of the patient, at least before surgical

³ USCCB, *Ethical and Religious Directives*, n. 26.

⁴ *Ibid.*, nn. 26, 28.

⁵ Lawrence Gostin et al., *Law, Science, and Medicine*, 3rd ed. (New York City: Foundation Press, 2005), 544–545, 557. *City of New York v. Antoinette R.*, 630 N.Y.S.2d 1008 (Sup. Ct. Queens Cty. 1995) authorized detention in hospital of a patient with tuberculosis.

⁶ For example, Minnesota state law authorizes courts to compel participation in chemical dependency treatment. Minnesota Commitment and Treatment Act, Minn. Stat. § 253B (2006).

⁷ John Grabenstein, “Ethical Issues in Defending against Bioterrorism,” in *Walk as Children of Light: The Challenge of Cooperation in a Pluralistic Society*, eds. Edward Furton and Louise Mitchell (Boston: National Catholic Bioethics Center, 2003), 116.

interventions.⁸ In *The Laws*, Plato describes how in caring for a slave, a physician might simply order the treatment he believes will be effective, but when dealing with a freeman, the physician must persuade the patient to accept his treatment.⁹ Later, in the Byzantine Empire, it seems to have been the custom that a patient about to undergo surgery would hand the cutting instrument to the surgeon as a way of indicating consent.¹⁰

In modern times, obtaining the free and informed consent of the patient before providing health care is required by law, by professional codes of ethics, and by magisterial teaching on health care ethics. All these sources assume that a health care professional will obtain the informed consent of the patient except when the patient is not able to provide it because of incapacity.

The legal requirement for the patient's informed consent is based on international human rights law, common law, and statutes.¹¹ In addition, the US Supreme Court has held that a person's right to accept or refuse medical treatment is a liberty interest protected under the Fourteenth Amendment to the Constitution.¹²

International law related to informed consent deals largely with consent in the context of medical research and experimentation. During World War II, Nazi officials authorized large-scale medical experimentation on prisoners of war and civilian internees without the consent of the research subjects.¹³ During the Nuremberg Trials, several physicians were charged with war crimes in connection with the experiments. The tribunal's decision in the physicians' trial listed ten requirements for medical experimentation to be legal and ethical.¹⁴ These principles became known as the Nuremberg Code.¹⁵ The first principle of the Nuremberg Code is that "the voluntary consent of the human subject is absolutely essential," and the subject of an experiment must be advised of the "nature, duration, and purpose of the experiment" as well as the "inconveniences and hazards reasonably to be

⁸ P. Dalla-Vorgia et al., "Is Consent in Medicine a Concept Only of Modern Times?" *Journal of Medical Ethics* 27.1 (February 2001): 59–61.

⁹ Plato, *The Laws*, trans. Thomas Pangle (Chicago: University of Chicago Press, 1988), bk. 4, 720b–e.

¹⁰ Dalla-Vorgia et al., "Is Consent in Medicine a Concept Only of Modern Times?" 60.

¹¹ Common law refers to a body of legal principles gradually developed in English and American courts. The primary source for common law is "case law," decisions from other courts that have precedential value, but the major scholarly compilations of the principles are also considered persuasive authority. In common law jurisdictions, contract, property, and tort (civil liability) cases are decided under common law principles unless a statutory provision applies.

¹² *Cruzan v. Director, Missouri Department of Health*, 497 U.S. 261 (1990).

¹³ *The Medical Case*, vols. 1 and 2 of *Trials of War Criminals before the Nuernberg Military Tribunals under Control Council Law No. 10* (Washington, DC: US Government Printing Office, 1949).

¹⁴ *Ibid.*, vol. 2, 181–182.

¹⁵ Gostin et al., *Law, Science, and Medicine*, 882–885.

expected.”¹⁶ The Nuremberg Code thus provided a requirement in international law for free and informed consent from any subject of medical experimentation. This requirement has also been codified in the United Nations International Covenant on Civil and Political Rights, which provides that “no one shall be subjected without his free consent to medical or scientific experimentation.”¹⁷

The common law requirement for informed consent is derived from two separate tort law doctrines. First, the common law torts of assault and battery provide legal remedies for any harmful or offensive touching.¹⁸ Lack of consent “is inherent in the very idea of those invasions of interests of personality which, at common law, were the subject of an action of trespass for battery, assault, or false imprisonment.”¹⁹ Provision of medical care without consent falls within this doctrine: “A surgeon who performs an operation without his patient’s consent commits an assault, for which he is liable in damages.”²⁰ The second applicable common law doctrine is the negligence or malpractice standard, which holds the health care professional liable for any harm caused by failure to provide the patient the level of information that a reasonable professional would have provided.²¹ Together, these common law rules require the health care professional to obtain informed consent prior to providing treatment. Consent must be obtained, or the health care professional is committing assault or battery; and the consent must be *informed* consent, or the health care professional is being negligent. The common law requirement of informed consent is also reiterated in federal and state statutes²² and, as noted, is constitutionally protected under the due process clause of the Fourteenth Amendment.

Professional codes of ethics also require health care professionals to obtain the free and informed consent of patients. For physicians, the American Medical Association code states that “patients may accept or refuse any recommended medical treatment.”²³ Likewise, the American Nurses Association code indicates that nurses must respect the right of patients to “accept, refuse, or terminate treatment” on the

¹⁶ *United States v. Karl Brandt*, in *Medical Case*, vol. 2, 181, 182, quoted in Gostin et al., *Law, Science, and Medicine*, 882.

¹⁷ UN General Assembly, resolution 2200A (XXI), International Covenant on Civil and Political Rights, (Dec. 16, 1966), art. 7, <http://www.ohchr.org/en/professionalinterest/pages/ccpr.aspx>.

¹⁸ American Law Institute, *Restatement of the Law Second, Torts* (Philadelphia: American Law Institute, 1965), secs. 13 and 18. In common law, a tort is a civil wrong, an act that has injured another and for which the common law provides a remedy.

¹⁹ *Ibid.*, sec. 13, comment d.

²⁰ *Schloendorff v. Society of New York Hospital*, 105 N.E. 92 (N.Y. 1914).

²¹ Dan Dobbs and Paul Hayden, *Torts and Compensation: Personal Accountability and Social Responsibility for Injury*, 4th ed. (Saint Paul, MN: West Group, 2001), 361–362.

²² For example, Minnesota Statute 144.292, subdivision 5 (2012) requires health care professionals to provide “all information necessary for the patient’s informed consent.” Likewise, the *Code of Federal Regulations* requires most federally funded research to obtain informed consent from participants. 45 C.F.R. §46.116 (2011).

²³ American Medical Association, *Code of Medical Ethics*, opinion 10.01 (June 1992), n. 2.

basis of the patient's "right of self-determination."²⁴ The ANA code does concede that "there are situations in which the right to individual self-determination may be outweighed or limited by the rights, health and welfare of others, particularly in relation to public health considerations." It holds that this limiting should be rare, however, a "serious deviation" from the norm "justified only when there is no less restrictive means available to preserve the rights of others and the demands of justice."²⁵

In addition to the legal standards and the applicable professional codes of ethics, magisterial teaching on health care also articulates a requirement for informed consent. The *Charter for Health Care Workers*, prepared by the Pontifical Council for Health Care Workers, states, "To intervene medically, the health care worker should have the express or tacit consent of the patient,"²⁶ and quotes Pope Pius XII's statement that the health care provider can act only if the patient authorizes him to do so.²⁷ In addition, 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" so that his decision can be made with "full awareness and freedom."²⁸ With competent patients, this consent should be "clear and explicit."²⁹

In the United States, Catholic health care institutions must adhere to the *Ethical and Religious Directives for Catholic Health Care Services*. Directive 26 provides that "the free and informed consent of the person or the person's surrogate is required for medical treatments and procedures, except in an emergency situation when consent cannot be obtained and there is no indication that the patient would refuse consent to the treatment."³⁰ To ensure that consent is free and informed, the patient must be provided "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."³¹

The health care provider is ethically obligated to obtain informed consent before providing care. As we have seen, however, there are several circumstances in which governments might compel individuals to receive treatment. This apparent conflict is not as intractable as it may first appear; examination of the principles underlying the requirement for informed consent will show that in most of situations where

²⁴ American Nurses Association, *Code of Ethics for Nurses with Interpretive Statements* (Silver Spring, MD: ANA, 2001), 1.4.

²⁵ *Ibid.*

²⁶ Pontifical Council for Health Care Workers, *Charter*, n. 72.

²⁷ *Ibid.*, quoting Pius XII: "[The doctor] can take action only if the patient explicitly or implicitly, directly or indirectly, gives him permission." "The Prolongation of Life," Address to an International Congress of Anesthesiologists (November 24, 1957), reprinted in *National Catholic Bioethics Quarterly* 9.2 (Summer 2009): 331.

²⁸ Pontifical Council for Health Care Workers, *Charter*, n. 72.

²⁹ *Ibid.*, n. 73.

³⁰ USCCB, *Ethical and Religious Directives*, n. 26.

³¹ *Ibid.*, n. 27.

treatment might be compelled, the Catholic health care professional or institution is justified in carrying out the treatment without obtaining consent.

Informed Consent: Based in Human Dignity

According to the ANA *Code of Ethics*, “Self-determination, also known as autonomy, is the philosophical basis for informed consent in health care.”³² Respect for the patient’s autonomy is rooted in recognition of the patient’s human dignity, and nurses should provide health care “with compassion and respect for the inherent dignity, worth, and uniqueness of every individual.”³³

Human dignity is a complex concept. William E. May argues that there are three types of dignity which belong to human beings: inherent dignity based on our being made in the image of God, dignity we achieve by making moral choices, and the dignity we receive by becoming children of God.³⁴

The first type of dignity belongs inherently to all “living members of the human species” simply by our being made in the image of God.³⁵ The *Catechism of the Catholic Church* indicates that the “fundamental reason” for human dignity is that every human person is “called to share, by knowledge and love, in God’s own life,” and the basis of human dignity is “being [made] in the image of God” (nn. 356, 357). This type of dignity is “intrinsic, natural, inalienable”: every person has it and cannot lose it.³⁶ The *Compendium of the Social Doctrine of the Church* maintains that “the roots of human rights are to be found” in a dignity that is “inherent in human life and equal in every person” and “present in all human beings, without exception of time, place, or subject.”³⁷ These rights include recognition of a sphere of human freedom in which each person can make their own decisions, a realm of “rightful autonomy” in which “man himself has been entrusted to his own care and responsibility.”³⁸ The human person includes the human body, so being responsible for one’s own being necessarily includes responsibility for one’s health. To be responsible for his own body, each individual must be able to make decisions regarding his health care. Respect for the inherent dignity of the human person requires that his decisions be “according to a knowing and free choice that is personally motivated and prompted from within, not under blind internal impulse nor by mere external

³² ANA, *Code of Ethics for Nurses with Interpretive Statements*, 1.4.

³³ *Ibid.* provision 1.

³⁴ William E. May, *Catholic Bioethics and the Gift of Life*, 2nd ed. (Huntington, IN: Our Sunday Visitor, 2008), 54–55.

³⁵ *Ibid.*, 54.

³⁶ May, *Catholic Bioethics and the Gift of Life*, 54.

³⁷ Pontifical Council for Justice and Peace, *Compendium of the Social Doctrine of the Church* (2004), n. 153. This section cites addresses by John Paul II, the encyclical letter *Pacem in terris* by Pope John XXIII, and the pastoral constitution *Gaudium et spes* (December 7, 1965) from the Second Vatican Council.

³⁸ John Paul II, *Veritatis splendor* (August 6, 1993), nn. 38–40. See also Vatican Council II, *Gaudium et spes*, n. 17.

pressure.”³⁹ The requirements of free and informed consent to health care can be extracted, then, from the inherent dignity of the human person. Each person, being made in the image of God, has an intrinsic responsibility for his own person. To carry out this responsibility, each person has a right to make free and informed decisions regarding his own person. In the context of health care, this alone would require the informed consent of patients before providing care.

May describes the second type of human dignity as the dignity persons are called to give themselves by “freely choosing to shape [their] choices and actions in accord with the truth.”⁴⁰ All persons are called to this dignity by being made in the image of God, but must then achieve it by pursuing good.⁴¹ The Second Vatican Council states that a person “achieves such dignity when, emancipating himself from all captivity to passion, he pursues his goal in a spontaneous choice of what is good.”⁴² To allow humanity to achieve this type of dignity, “God has willed that man remain ‘under the control of his own decisions,’ so that he can seek his Creator spontaneously.”⁴³ God desires people to seek him of their own free will, and “only in freedom can man direct himself toward goodness.”⁴⁴ Because we are designed to freely seek the good, humanity “rightly appreciates freedom.”⁴⁵ Human freedom is absolutely necessary to this type of dignity, as it can only be achieved through free choices. Therefore, the “economic, social, juridic, political, and cultural order” should set the general conditions for the “proper exercise of personal freedom.”⁴⁶ This includes the health care system: health care professions and institutions should be structured to provide for patients’ proper exercise of freedom. Failing to obtain the free consent of patients would deny them an opportunity to achieve this type of dignity and would be unjust.

The final type of human dignity is the dignity granted by receiving the “gift of divine life” through regeneration.⁴⁷ Recipients of this gift become “‘children of God,’ brothers and sisters of Jesus.”⁴⁸ Scripture informs us that Jesus considers our treatment of his brothers and sisters, specifically including the sick, as our treatment of him (Matt. 25:31–46).⁴⁹ Therefore, every patient should be treated as Christ himself. Approaching the patient with this level of respect makes obtaining consent a minimum requirement.

³⁹ Vatican Council II, *Gaudium et spes*, n. 17.

⁴⁰ May, *Catholic Bioethics and the Gift of Life*, 55.

⁴¹ *Ibid.*

⁴² Vatican Council II, *Gaudium et spes*, n. 17.

⁴³ *Ibid.*, quoting Sir. 15:14.

⁴⁴ *Ibid.*

⁴⁵ *Compendium*, n. 135.

⁴⁶ *Ibid.*, n. 137.

⁴⁷ May, *Catholic Bioethics and the Gift of Life*, 55.

⁴⁸ *Ibid.*

⁴⁹ Pontifical Council for Health Care Workers, *Charter*, n. 4.

In summary, each type of human dignity independently supports the requirement of obtaining consent from patients before providing health care. Inherent human dignity based on our having been made in the image of God requires recognition of each person's responsibility for his own person, including the care of his own health. Achieving the dignity that comes from acting in accordance with the truth requires recognition of a sphere of human freedom in which individuals can freely choose to pursue the good, and this sphere of freedom includes the freedom to make one's own health care decisions. The gift by which we share in the life of Christ leads to the call to treat each patient as Christ, which includes respecting the decisions of patients regarding their care.

Exceptions to Informed Consent Requirements

Because the need for informed consent is based on human dignity, providing care without obtaining consent risks violating human dignity. However, providing care without the prior consent of the patient is clearly allowed in two types of situations. First, both Church teaching and American law recognize a principle of implied or presumed consent when a patient is not capable of giving consent. Second, both Church and secular standards for informed consent permit parents to give consent for health care for their children, even children who have never been able to express their own wishes. These exceptions allow for health care decisions to be made in situations where they otherwise could not be made. By understanding the philosophical basis for these exceptions, it is possible to extrapolate other situations in which it is morally permissible to provide health care without obtaining informed consent.

Presumed Consent in Emergency Situations

In American law, a health care provider may provide emergency care to a patient who is not capable of giving consent. The health care provider faced with an unconscious patient, for example, is permitted to presume that the patient would consent to life-saving treatment. This principle was developed in common law⁵⁰ and is also codified in various statutes and regulations. For example, the *US Code of Federal Regulations* permits an institutional review board to authorize an experiment on human subjects without their consent if the subjects' condition is life-threatening, there is no satisfactory or proven treatment, the experimental treatment is believed to be of "direct benefit to the subjects," and it is not feasible to obtain informed consent."⁵¹ These legal provisions allow health care to be provided to individuals who are not in a position to make their own decision.

Presumed consent is also permitted by directive 26 of the *Ethical and Religious Directives*, which requires "free and informed consent . . . except in an emergency situation when consent cannot be obtained and there is no indication that the patient would refuse consent to the treatment."⁵² The *Charter for Health Care Workers* also

⁵⁰ See *Canterbury v. Spence*, 464 F.2d 772 (D.C. Cir. 1972).

⁵¹ "Exception from Informed Consent Requirements for Emergency Research," 21 C.F.R. §50.24 (2011).

⁵² USCCB, *Ethical and Religious Directives*, n. 26.

addresses this issue at n. 73, stating that “consent cannot be presumed” if the patient is “in a condition to know and will,” but it can be presumed when the patient is not in condition to understand or decide. In fact, the Charter states that “in extreme situations,” the health care provider “must presume the consent to therapeutic interventions, which from his knowledge and in conscience he thinks should be made,” implying a duty to provide life-saving care even when consent cannot be obtained. The Charter then makes a distinction between patients faced with a temporary loss of their ability to know and will, and patients who seem to have a permanent loss of those capabilities. In the case of patients with a temporary incapacity, the health care provider may “act in virtue of *the principle of therapeutic trust*, that is, the original confidence with which the patient entrusted himself” to the provider (original emphasis). On the other hand, if the loss of capacity to consent is permanent, the provider may “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” (original emphasis). These principles provide two independent bases for providing care without obtaining consent.

The principle of therapeutic trust is articulated as stemming from the individual’s entrustment of himself to the health care provider, phrasing that the Charter uses in earlier sections. The Charter discusses the necessity of a “dialogic” relationship between the provider and the patient (n. 72), an “interpersonal relationship of a special kind” in which the patient “entrusts himself to the ‘conscience’ of another who can help him in his need and who comes to his assistance to care for him and cure him” (n. 2).⁵³ The principle of therapeutic trust, then, is based on a pre-existing relationship between the health care provider and the patient. Because the patient has entrusted himself to the health care provider, the health care provider has a responsibility to act for the good of the patient. The good of the patient includes his human dignity, and as a result, his responsibility for his own person, as described above. Therefore, the Charter notes, in order to serve the good of the patient, the health care provider will treat a patient as “a responsible person, who should be called upon to share in the improvement of his health and in becoming cured” and who “should be given the opportunity of personally choosing” (n. 72). When this cannot be achieved, the health care provider must still act for the good of the person to the best of his ability. The unconscious patient cannot be asked to personally choose or to help in the improvement of his own health, so the health care provider is not able to help him achieve the goods of responsibility, freedom, and autonomy.

However, the Charter acknowledges that life itself is a good of the person (n. 1), and so the health care provider can and should act to preserve life. Therefore, the health care provider should, in many situations, provide life-saving treatment to a patient even in the absence of consent from the patient or the patient’s representative. If the patient has previously provided instructions indicating that they do not desire a particular intervention or if the patient’s representative refuses the intervention,

⁵³ See also USCCB, *Ethical and Religious Directives*, part 3, intro.

the health care provider may legitimately omit extraordinary measures.⁵⁴ When no instructions exist and no representative is available, the health care provider may carry out the interventions “which from his knowledge and in conscience he thinks should be made” (n. 73). The principle of therapeutic trust requires the health care provider to use his best judgment, morally and professionally, on how to act in the best interests of the patient when the patient lacks the ability to act or decide.

The principle of responsibility for health care, unlike the principle of therapeutic trust, is not based on any prior relationship between the provider and the patient. Instead, the Charter states that, when a health care professional is faced with a patient with “a permanent loss of knowing and willing,” the principle “obliges the health care worker to assume responsibility for the patient’s health” (n. 73). In short, when faced with a patient who is not expected to ever be able to make decisions, the health care provider has three possible substitutes for the patient’s own consent. First, if the person has previously had the capacity to make informed decisions, the person may have appointed a representative to act on his or her behalf; if so, the representative’s decisions should be respected.⁵⁵ Second, if no representative has been appointed, the health care provider should consult with the patient’s family.⁵⁶ Third, if the patient’s family is not available and the patient requires immediate care, the principle of responsibility for health care allows the health care provider to provide care on their own initiative.

The Charter describes health care as a “*vocation*,” a “divine mission,” and a “transcendent call” to serve “life in its totality,” requiring “complete commitment” (n. 3). The calling to serve life with complete commitment means that even when the patient has not specifically entrusted himself to the health care provider, the health care provider has a responsibility to act for the good of that person. As with the principle of therapeutic trust, this responsibility to act for the good of the person is normally carried out only with the consent and cooperation of the patient, because the good of the patient includes the patient’s own responsibility and freedom. When the patient is unable to exercise his freedom, the health care provider acts to preserve the good he can, carrying out his own calling to serve life. Therefore, in providing emergency care even without consent, the health care provider does not violate the human dignity of the patient. Instead, human dignity is respected by the efforts to preserve the life to which that dignity belongs.

A Guardian’s Consent to Treatment for Minors

In the United States, the legal criteria for determining whether a minor has capacity to consent to medical treatment differ significantly from state to state. However, there is broad agreement that there is an age or level of maturity below which a child lacks the ability to understand the risks and benefits of proposed medical treatment. Patients who are unable to understand a decision that needs to be made are unable to give legally effective consent, and the law then expects the child’s parent or other legal guardian to make the decision on the child’s behalf.

⁵⁴ USCCB, *Ethical and Religious Directives*, nn. 24–25, 28, 32–33.

⁵⁵ *Ibid.*, nn. 25–26.

⁵⁶ *Ibid.*

The Charter's requirements for informed consent illustrate why a young child is unable to provide the type of consent that is required. The Charter states that decisions regarding a proposed treatment should be made with "full awareness and freedom" by a patient who is "given a precise idea of his illness and the therapeutic possibilities, with the risks, the problems, and the consequences that they entail" (n. 72). If the child lacks the ability to understand his illness, the proposed treatment, and the possible risks of the proposed treatment, he cannot make a decision with full awareness.

The *Ethical and Religious Directives* imply that the child's parents may give consent on the child's behalf. For example, they require obtaining at least the consent of the mother for procedures for prenatal diagnosis⁵⁷ and for experimental treatment on an unborn child.⁵⁸ The provisions regarding informed consent also reference the possibility that a surrogate, or proxy, will give consent on behalf of the patient.⁵⁹ A young child cannot designate a surrogate to act on his behalf, but the child's parents or guardians, by virtue of their responsibility to care for the child, may make decisions on behalf of the child.⁶⁰

The ability to make health care decisions on behalf of another is sometimes referred to as proxy consent. May points out that this term is reasonable when someone is appointed as the patient's representative to make decisions based on what they know of the patient's values and preferences. However, when parents are required to make health care decisions on behalf of an infant, who has "never expressed personal preferences," they are not truly giving consent on behalf of the infant, but are instead "exercising their own proper moral responsibility."⁶¹ That is, they are not exercising the infant's responsibility for his own health on the infant's behalf, because the infant has never been able to assume that responsibility. Instead, the parents are exercising their own responsibility for the infant's health, which they hold by virtue of their responsibility to provide for the "physical and spiritual needs" of their children.⁶² Consequently, May argues, a parent is giving "personal consent" as the "one morally responsible for the care" of the child.⁶³ May argues that when the "health or life of a fellow human person for whom we have responsibility (as parents do for their children) is in danger," and means are available to address the danger, "we are morally obligated to authorize use of those means."⁶⁴ This principle can then be extended beyond the parent-child relationship. While the relationship of a parent to an infant is a common and natural example of a relationship in which one has responsibility for the health or life of another, another legitimate authority may have the same responsibility.

⁵⁷ USCCB, *Ethical and Religious Directives*, n. 50.

⁵⁸ *Ibid.*, n. 51.

⁵⁹ *Ibid.*, nn. 26–28, 31.

⁶⁰ May, *Catholic Bioethics and the Gift of Life*, 220–221.

⁶¹ *Ibid.*

⁶² *Catechism*, nn. 2222, 2228.

⁶³ May, *Catholic Bioethics and the Gift of Life*, 221.

⁶⁴ *Ibid.*, 220–221.

Compelled Treatment

Individuals Not Competent to Consent

A legitimate government may compel treatment of an individual who is not competent, on the basis of the duty to care for the person. An individual who does not have current use of his power of knowing and willing cannot exercise his own responsibility for his health. If he has designated a representative, the representative may make decisions on his behalf; by appointing a representative, he has pre-emptively exercised his responsibility and freedom, and this should generally be respected. If the individual is of an age or maturity where another person has responsibility for caring for him, that guardian, usually a parent, may make decisions on his behalf by virtue of the parent's responsibility for his well-being. If the individual has committed himself to the care of a health care provider before becoming unable to make his own decisions, then by the principle of therapeutic trust, the provider is obligated to use his best judgment to act in the patient's best interests.

In some cases, none of these well-defined principles will apply. An abandoned infant, whose parents cannot be found and who has not yet been committed to anyone's care, may need medical attention. A mentally ill person found on the street may clearly need treatment but lack the capacity to seek it. An ambulance crew arriving on the scene, or the staff of the emergency department to which the person is transported, may presume his consent to life-saving care, basing the presumption on the principle of responsibility for health care, but vital follow-up care will be difficult to provide without anyone to make decisions on how it can be pursued.

Individuals in mental health crises frequently pose this dilemma. The health care provider clearly may provide care to save the person's life and ensure his basic safety. To address the underlying problem, however, much more invasive, long-term care may be required. Providing mind-altering drugs or similar interventions without the consent of the patient risks violation of human dignity; they touch on deep aspects of the human person. However, the patient may be unable to understand the nature of his illness and may have no capability to weigh the risks and benefits of a proposed treatment. The patient is thus unable to exercise his responsibility for his own person. A patient in this position may not have appointed any representative, and with an adult, it may not be clear that any family member has the responsibility to make decisions for him. In addition, the patient's inability to recognize the nature of his illness may be so severe as to cause him to actively refuse care. Finally, the person's mental capacity may vary from day to day, or may be difficult to evaluate, causing a legitimate question of fact as to whether he does or does not have capacity to understand and decide.

In these circumstances, a legitimate government may make health care decisions for someone who is, or is likely to be, unable to exercise responsibility for his own person. This is an extension of May's explanation of the authority of parents to make health care decisions for their children. Parents may make health care decisions for their children on the basis of their moral responsibility to care for them. This authority is inherently limited by its purpose; the parents may consent to care

for their child only insofar as the decision is made in the best interests of the child. In doubtful cases, the parents' assessment of the best interests of the child should be given deference, precisely because the parents hold that responsibility for the child.

A lawfully constituted government also has responsibility (of a different kind) for those under its authority, because the state has a responsibility for the common good.⁶⁵ This responsibility for the common good includes a responsibility to "make accessible to each what is needed to lead a truly human life: food, clothing, health ... and so on."⁶⁶

Governments should not normally exercise this responsibility by directly telling individuals to receive specific treatments, because respect for the rights of individuals is a requirement of legitimate authority.⁶⁷ Those rights include an individual's responsibility for his own person and the corresponding right to make decisions regarding his own health care. Even when the individual is unable to make free and informed decisions regarding his own health, government should defer to the patient's representative or, in the case of children, to the parents, in accordance with the principle of subsidiarity. Subsidiarity requires higher authorities to refrain from making decisions that would supplant the role of lower authorities.⁶⁸ However, when an individual is unable to exercise his own responsibility, and when no lower authority has responsibility for the individual, the state may assume responsibility for the individual and may consent to health care on his behalf.

In deciding to consent to health care on behalf of incompetent patients who have no one else to assume responsibility, the state must act with respect for the patient and his rights. The state must also act to promote the common good. Therefore, these actions must be authorized by a legitimately enacted law. This law should contain safeguards to ensure that the capacity of the patient is being properly evaluated, the dignity of the patient is always respected, and treatment decisions are based on the best interests of the patient. In addition, the public servants who carry out these laws must act for the good of the patient, viewing their exercise of authority as a service to those involved.⁶⁹ When these conditions are met, a court or a government agency may legitimately assume responsibility for health care for an individual, and may then consent to treatment for the individual.

Even if the individual objects to the treatment at the time, if there is moral certainty that he lacks the capacity to understand his condition and treatment options, a Catholic health care provider or institution may provide the care that has been ordered by the governmental authority. For example, just as a nurse may provide an immunization to a child who objects to it, if the parent asks for it on the basis of the best interests of the child, so may the nurse administer psychiatric drugs to an incompetent patient who objects to it if a court orders the medication on the basis of

⁶⁵ *Catechism*, nn. 1898, 1903, 1927.

⁶⁶ *Ibid.*, n. 1908.

⁶⁷ *Ibid.*, n. 2237; see also *Compendium*, nn. 388, 389, 394.

⁶⁸ *Compendium*, nn. 186–188, 419.

⁶⁹ *Catechism*, n. 2235.

the best interests of the patient. If the patient is unable to exercise his own responsibility for his health, and if the intervention is truly carried out for his best interests, no violation of human dignity has occurred. Indeed, exercising proper authority to intervene for the good of the person is an act of love and justice which, when necessary, may be the only way to respect the dignity of the person.

Individuals Competent to Consent

Governments have an obligation to protect the common good, and in cases of grave danger, may make medical care compulsory even over the objections of competent patients.

The promotion of the common good is a fundamental obligation of the state, and it legitimately exercises authority only by seeking the common good.⁷⁰ The Compendium defines the common good as the “sum total of social conditions which allow people, either as groups or as individuals, to reach their fulfillment more fully and more easily,” but it is more than the “simple sum of the particular goods” of each person.⁷¹ Rather, it is the “social and community dimension of the moral good.” The common good includes “essential services” including “basic health care.” The state is not exclusively responsible for the common good, but is responsible for “the coherency, unity, and organization” of society so “the common good may be attained with the contribution of every citizen.” A critical component of the state’s duty in setting the conditions for the attainment of the common good is the “reconciling of the particular goods of groups and those of individuals” in accordance with “the requirements of justice,” which is “one of the most delicate tasks of public authority.”⁷² This includes adjudicating between competing interests “in the name of the common good.”⁷³

In a large-scale epidemic, whether one that occurs naturally or results from the use of a biological weapon, the state “would confront multiple decisions putting individual liberties in potential conflict” with the best methods to contain the spread of a contagious disease.⁷⁴ These decisions would require making trade-offs between competing interests, and judgments regarding how best to attain the common good. In making these trade-offs, as in any exercise of authority, those in authority should strive to “give outward expression to a just hierarchy of values.”⁷⁵ In doing so, the state should place strong value on preserving life, as life is the condition for the exercise of other rights and the pursuit of other goods. To preserve life, the extent of the outbreak must be contained. For example, in the event of an act of bioterrorism with smallpox, limiting the number of casualties would require both “isolation of patients and quarantine of healthy people.”⁷⁶ Once a quarantine area is established,

⁷⁰ Ibid., nn. 1903, 1921.

⁷¹ *Compendium*, n. 164, quoting Vatican Council II, *Gaudium et spes*, n. 26.

⁷² Ibid., nn. 164, 166, 168, 169.

⁷³ *Catechism*, n. 1908.

⁷⁴ Grabenstein, “Ethical Issues in Defending against Bioterrorism,” 109–110.

⁷⁵ *Catechism*, n. 2236.

⁷⁶ Grabenstein, “Ethical Issues in Defending against Bioterrorism,” 115.

all individuals in the quarantine area might be compelled to receive appropriate vaccination. Most individuals would not object to such a requirement in a true emergency, but those who refused could legitimately be compelled to receive the treatment if their failure to do so posed an unacceptable risk to lives of others.

All individuals have an obligation to promote the common good; “no one is exempt from cooperating, according to each one’s possibilities, in attaining it and developing it.”⁷⁷ This includes a duty of each individual “to cooperate and refrain from actions that put neighbors at risk for contagious diseases.”⁷⁸ When failure to abide by this duty would pose an immediate risk to the lives of others, it is reasonable for the state to turn this moral duty into a legal duty. The state may then impose “appropriate consequences for those who choose to act irresponsibly.”⁷⁹ If no other measures are sufficient to address the risk to the lives of others, governments can and should compel an individual to receive medical treatment. This authority has been exercised to compel individuals with active tuberculosis to receive treatment; lawful authorities determined that individuals who were a risk to others because of their failure to comply with treatment could be compelled to receive treatment.⁸⁰ This decision was an ethically justifiable action to protect the lives of others, and similar action would likewise be justified following a bioterrorist attack with smallpox or any similarly contagious agent.

By this logic, the state’s authority to compel treatment would be limited by several other principles. First, the argument articulated here would only justify intervention to protect the lives of others. An individual who has capacity to consent retains responsibility for his own person, including his own health. While there may be situations that justify compelled treatment of a competent patient solely for the good of the patient himself, this would require reliance on different principles, not articulated here. The authority to compel treatment on the basis of the public good would only apply when the treatment is necessary to protect the lives of others.

Next, the state retains the requirement to respect the dignity and rights of the person, even when legitimately compelling the person to do something against his will. Therefore, to protect the patient’s rights, the intervention should be strictly limited to what is necessary to protect others. Finally, the principle of subsidiarity should apply, which means that any coercion should be applied by the lowest level of government that is able to address the threat.

If these conditions exist, a Catholic health care professional or institution may carry out compelled treatment over the objection of the patient. The *Ethical and Religious Directives* state, “Catholic health care ministry seeks to contribute to the common good.”⁸¹ When legitimate authority acts in pursuit of the common

⁷⁷ *Compendium*, n. 167.

⁷⁸ Grabenstein, “Ethical Issues in Defending against Bioterrorism,” 117.

⁷⁹ *Ibid.*

⁸⁰ *City of New York v. Antoinette R.*

⁸¹ USCCB, *Ethical and Religious Directives*, part 1, intro.

good, health care professionals may follow the orders for compelled treatment and participate in this contribution to the common good.

Self-Giving Love

All Christians are called to imitate Christ in his self-giving love.⁸² Health care providers have a specific vocation to do so as “a ministerial instrument of God’s outpouring love for the suffering person” and by acting as *ministers of life*.⁸³ This calling is normally carried out with and through the cooperation of the person in need, out of respect for their human dignity. In the circumstances described here, however, the health care provider may provide care even to patients who do not want it. A legitimate authority may order treatment of an incompetent person on the basis of the duty to care for the person, and may compel even a competent person to receive treatment if failure to obtain the treatment would endanger the lives of others. In these situations, the health care professional, by providing the care, carries out his duties as a minister of life, in service to the public good.

⁸² John Paul II, *Veritatis splendor*, nn. 17, 20.

⁸³ Pontifical Council for Health Care Workers, *Charter*, n. 4, original emphasis.