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Also in this issue: "A Catholic Perspective on End-of-Life Care," by Joseph Meaney

Compromised Patients and the Culture-of-Death Mentality in Health care

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In November of 2020, *Clinics in Dermatology* published a study that investigated the influence of do-not-resuscitate (DNR) status on the mortality of hospital inpatients who died of COVID-19. The study included 1,270 patients admitted to two New Jersey hospitals from March 15, 2020, to May 15, 2020, who had, or developed, COVID-19. Of these 1,270 COVID-19 positive patients, 640 patients died and 630 survived. Of the 640 patients who died, 570 (89.1 percent) had a DNR order at the time of admission, and 70 patients (10.9 percent) did not. Any patients who received a DNR order after admission were excluded from the study, and the deceased patients in the study all had COVID-19 listed as the cause of death (thus eliminating any other cause of death in this sample). Other variables such as age, sex, reason for admission, COVID-19 symptoms at time of admission, and comorbidities were considered to further specify the patient sample studied. With careful analysis and accounting for variables, the researchers concluded, "The risk of death from COVID-19 was significantly influenced by the patients' DNR status."[1]

The study notes that patients with DNR orders on admission were quite ill to begin with and had significant risk factors for death, such as multiple comorbidities. In a discussion of the various factors contributing to poorer outcomes, the study's authors make an important observation:

> Notably, a DNR order has been documented to negatively impact the implementation of other treatment modalities (i.e., "failure to rescue phenomenon"), which could explain the increased mortality of these patients …
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> DNR status may be requested by patients and/or their families to avoid prolonged life support, including application of a respirator, at the end of life when there is little or no expectation that these measures would be beneficial. Treatment for severe COVID-19 may require such measures as well, but usually for only a much shorter interval, days or weeks, and usually with the expectation of recovery. Patients with severe COVID-19 whose physicians feel that they need such measures short-term to treat the disease may be discouraged from offering them if the patient has a DNR order. This may unnecessarily negatively impact patient care and increase mortality in COVID-19 patients.[2]

The study's authors conclude, "In this cohort of patients with COVID-19, a DNR order was found to be a significant predictor of mortality, a finding that persisted after adjustment for other important clinical factors."[3]

One could also reasonably conclude that patients who had a pre-existing DNR may have done so out of fear of "over-treatment" that could prove excessively burdensome or disproportionate relative to their irreversible medical conditions. Since this study was conducted in the early months of the COVID-19 pandemic, patients with pre-existing DNR orders had no opportunity to consider the options of what might happen if they contracted the virus, since it was simply an unknown possibility at the time.

While the use of DNR orders generally is a different discussion beyond the scope of this article,[4] the aforementioned study of mortality rates of COVID-19 patients with DNR orders, raises related questions about how a culture-of-death mentality in healthcare may affect other kinds of vulnerable patients, such as the disabled or chronically ill, who may be treated less than optimally if their lives and personhood are not viewed to be as valuable as that of a healthier person.

The Case of Michael Hickson

In a case that gained national attention, Michael Hickson was refused treatment for COVID-19 at a Texas hospital in June 2020. Several years earlier Michael, a 46-year-old married father of five, experienced a brain injury after a cardiac arrest, leaving him a quadrapalegic. Despite his cognitive disability he could still do math calculations and answer questions. When Michael became sick with COVID-19, the hospital withheld his tube-supplied food and water and refused to treat him, despite the objections of his wife. The medical team and a court-appointed guardian decided Michael would not be treated for COVID-19, because he did not have a sufficient "quality of life".

Michael's wife, Melissa, recorded a conversation she had with Michael's doctor, the transcript of which has been widely circulated. The doctor's words were chilling and devoid of human compassion. Despite his wife's protests, guardianship was given to the state and Michael was sent to hospice with comfort care, deprived of nutrition and hydration, and died six days later.[5] These actions stand in stark contrast to St. John Paul II's description of authentic compassion: "True compassion leads to sharing another's pain; it does not kill the person whose suffering we cannot bear."[6]

Fighting for Appropriate Care

Another (non-COVID) case provides an additional example.[7] N., a fully functioning, self-sufficient middle-aged male with previously well-managed diabetes, suddenly began to suffer complications after receiving insufficient care for what should have been an