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ANALYSIS of Texas Senate Bill 303 Substitute 83R25498 JSC-D:

I. HOW THE SB303 SUBSTITUTE DANGEROUSLY WORSENS CURRENT LAW

A. Reduction in Effective Access to Independent Advocates

The current Texas Advance Directives Law enables health care providers to force patients to die against their will, when they, their family members, or other surrogates want life-saving medical treatment. In practice, however, there is one provision of that law that has enabled many effectively to fight for their lives, often successfully. That is the requirement in Tex. Health & Safety Code § 166.046 (b)(3)(B) (2012) that before an ethics committee hearing they must be given a copy of a registry list of independent patient advocates who can assist them.

That list includes attorneys and advocacy groups, such as Texas Right to Life, who have been able in many cases to assist patients and their surrogates to obtain extensions of time in order realistically to be able to achieve transfer to a provider willing to respect the wish for life-sustaining care, and in some cases even to forestall or partially or completely reverse decisions to deny treatment. www.dshs.state.tx.us/thcic/Registry.shtm

Section 8 of the S.B. 303 substitute would insert a facility-chosen so-called "patient liasion" who supposedly is "to assist the patient or surrogate throughout the process" and an "advisory ethics consultation" by a sub-group of the facility committee that is to meet "with the patient or surrogate" *before* the formal facility committee review and *consequently before the patient or surrogate must be provided with the list of external referral groups that can provide patient advocacy.* This is a veiled attempt to reduce the prospect of involvement of non-facility-affiliated advocates who could counsel and effectively assist the patient or surrogate.

In the typical situation in which a patient in a hospital or other health care facility is about to be denied life-sustaining treatment sought by the patient or surrogate, the patient or surrogate is at a tremendous disadvantage. Surrounded by white-coated "experts" exerting every possible means of pressure to accept the treatment denial, and normally without knowledge of or access to alternative sources of medical or legal opinion, the patient or surrogate must have extraordinary internal resources and tenacity to continue to fight for life. The interposition of a so-called "advisory ethics consultation" by "one or more representatives of the ethics or medical committee" is likely to be as intimidating and challenging as the "official" committee review, and it is easy to conceive that the committee members participating may well convince the patient or surrogate that they are highly unlikely to prevail in the formal committee review if they persist in resisting treatment denial – causing many to accede to the "inevitable" *before being notified of the availability of external advocates with access to other medical experts and experience in successfully fighting treatment denial or accomplishing transfer to a willing provider.*

Moreover, the SB 303 substitute inserts a curious phrase into the provision governing the registry: that the list must be "in compliance with the laws prohibiting barratry." Under Texas Tex. Penal Code § 38.12 (2012):

> A person commits . . . [the] offense [of barratry] if the person:
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> (1) is an attorney, chiropractor, physician, surgeon, or private investigator licensed to practice in this state or any person licensed, certified, or registered by a health care regulatory agency of this state; and
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> (2) with the intent to obtain professional employment for the person or for another, provides or knowingly permits to be provided to an individual who has not sought the person's employment, legal representation, advice, or care a written communication or a solicitation, including a solicitation in person or by telephone, that:
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> (A). . . relates to an accident or disaster involving the person to whom the communication or solicitation is provided or a relative of that person and that was provided before the 31st day after the date on which the accident or disaster occurred . . . .

The purpose of the barratry law is to restrict "ambulance chasers" who contact recent victims of accidents to urge them to hire attorneys, and health care practitioners who might serve as expert witnesses, in lawsuits against those who allegedly caused the accident. At present, if the barratry statute were to be misused in an attempt to intimidate attorneys and health care practitioners who, by listing themselves on the registry, make known their availability to assist patients and surrogates threatened with involuntary denial of lifesaving treatment, the fact that the registry is specifically provided in statute would likely be enough to block such an attempt.

However, by inserting the inappropriate reference to the barratry statute, this protection would be stripped away. Indeed, its citation in that context might well lead the department charged with maintaining the registry[1] to exclude from it the very health care practitioners, facilities, and attorneys the registry now so helpfully makes known to threatened patients and their surrogates–since their listing might be deemed a "solicitation" which, in cases in which the patient's treatment is threatened to be denied within 31 days of an "accident or disaster" that caused the condition for which treatment is needed.

It is noteworthy that not only the registry list of external advocates, but also information about the right to seek second opinions and the statutory statement describing the patient's and surrogate's rights, such as the right to a copy of the patient's medical record, need only be provided before the formal hearing, *not before the pseudo-hearing* "advisory ethics consultation." If adopted, this cleverly disguised set of provisions is in practice likely dramatically to reduce the number of cases in which efforts involuntarily to deny life-saving treatment are successfully overcome. **Indeed, these provisions in practice probably constitute the greatest and gravest threats incorporated in the S.B. 303 Substitute.**

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[1] The SB 303 substitute transfers responsibility for the registry from the Texas Health Care Information Council to the Department of Health .

B. Involuntary Denial of Resuscitation Against the Wishes of Patients

Instead of treating cardiopulmonary resuscitation (CPR) like any other life-sustaining treatment (which must be provided, if directed by the patient or surrogate, at least through an ethics or medical committee proceeding and for a stated time thereafter while transfer is sought), the SB303 substitute allows the health care facility to impose a do-not-attempt-resuscitation order (DNAR) against the wishes of the patient or surrogate, to take effect immediately.

Moreover, the patient or surrogate may not appeal the DNAR to the facility ethics or medical committee if "based on reasonable medical judgment, death is imminent and resuscitation would be medically ineffective." [SB303 Substitute 83R25498 JSCD p. 5, ll. 4-5: §166.012(g)].[2] While on its face this language may appear reasonable, neither "imminent" nor "medically ineffective" is defined.

In the medical and bioethical literature, articles frequently refer to treatment as futile or medically ineffective if, with it, the patient is not expected to survive beyond six months or a year. While a lay person might assume that "imminent" means that even with CPR the patient will only survive for minutes to hours, a health care practitioner could, with scholarly support, interpret it to mean that with CPR the patient might survive six months to a year.

By exempting any claim by a physician or facility that a patient's death is "imminent" and resuscitation would be "medically ineffective," all checks and balances on abuse of the exception are removed. Indeed, the SB303 substitute provides:

> (h) This section does not create a cause of action or liability against a physician, health professional acting under the direction of a physician, or health care facility.
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> (i) A physician, health professional acting under the direction of a physician, or health care facility is not civilly or criminally liable or subject to review or disciplinary action by the appropriate licensing authority if the actor has complied with the procedures under this section . . . .
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> SB303 Substitute 83R25498 JSCD p. 5, ll. 8-15: §166.012(h)&(i)

Thus, the patient and surrogate are effectively prevented from challenging the assertion that the patient's death is "imminent," or that resuscitation would be "medically ineffective," either before or after the patient's death without CPR.

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[2] When the physician does not make this claim, the patient or surrogate may appeal to the ethics or medical committee. However, the SB303 substitute makes clear that the committee may enforce a DNAR even against the wishes of a competent patient who is terminally ill. SB303 Substitute 83R25498 JSCD p. 14, l. 25, to p. 15, l. 1: Section 166.046(a-3).

II. APPARENT IMPROVEMENTS IN THE SB303 SUBSTITUTE ARE IN FACT EVISCERATED BY LOOPHOLES

A. The Standards the SB303 Substitute Adds for Involuntary Denial of Treatment Are Broad Enough to Allow The Same Denials As Under the Current Standardless Law

What the S.B. 303 Substitute appears to give with one hand, it takes away with the other. Section 8 presents itself as putting limits on the otherwise unbounded discretion of facility committees to decide that life-sustaining treatment should be denied against the will of the patient or surrogate. However, it specifically authorizes such denial whenever provision of treatment needed to preserve the patient's life, in the view of the ethics or medical committee, would "seriously exacerbate other major medical problems" or "result in severe irremediable . . . discomfort not outweighed by the benefit of the treatment." [SB303 Substitute 83R25498 JSCD p. 14, ll. 5-9, 18-22: Section 166.046(a-1)(2)&(3), (a-2)(2)&(3)]

A judgment whether one's life is worth living with "major medical problems" or while experiencing "severe discomfort" is a very subjective one. A gangrenous leg may well require amputation in order to prevent death, which certainly could be characterized as seriously exacerbating a major medical problem. However, there are thousands of wounded warriors and others who find their lives quite worth living although they use a prosthetic leg. They might well disagree with another's view that "the benefit of the treatment" does not outweigh the loss of the leg. Many people with a disability – what the bill terms "an irreversible nonterminal condition" – that requires the 24-hour use of a respirator, such as the portable ones attached to a wheelchair, may well periodically experience "irremediable severe discomfort" associated with its use – yet consider their lives well worth living. [3]

The fundamental point is that the judgment whether "other major medical problems" or "severe discomfort" outweigh the value and dignity of preserving a person's life is a value judgment, not a medical judgment. While appearing to put constraints on the grounds under which a hospital committee may override the choice of a patient or the patient's surrogate for life, the bill in fact contains loopholes so broad as to authorize virtually any realistically conceivable denial. It operates not as a shield for patients but as a sword for medical imperialists who want to impose their own "quality of life" views on their patients – views that impose involuntary death.

In practice, therefore, medical and ethics committees will be quite as free as they were before passage of the bill to use their own subjective value judgments to condemn patients to death against their will.

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[3] The SB303 Substitute says the ethics or medical committee "should" make its judgment about whether life-sustaining treatment "is medically appropriate for an individual without regard to the individual's PERMANENT physical or mental disability .. . ." [SB303 Substitute 83R25498 JSCD p. 15, ll. 9-12: Section 166.046(A-5) (emphasis added).] Evidently, a "temporary" disability is quite permitted as a basis to rule against someone's life. The term "permanent" is not defined; it could be interpreted as applying only to congenital disabilites. Hence, for example, Alzheimer's disease, which typically develops only late in life could be considered a temporary disability and thus might well suffice to deny life-sustaining treatment.

B. The Apparent Requirement for Continuing Artificially Administered Food and Fluids Is in Fact Non-existent

Much of the argument that SB303 is an improvement on the existing law is based on the frequently repeated claim that it ensures that even after the days during which life-sustaining treatment must be provided while efforts are undertaken to achieve transfer, artificially administered food and fluids must still be given.

On the contrary, that requirement does not apply *in any of the exact same conditions under which the facility committee is authorized to rule against the provision of life-sustaining treatment, including food and fluids*, including if its provision would "seriously exacerbate other major medical problems" or "result in severe irremediable . . . discomfort not outweighed by the benefit of the treatment.") [SB303 Substitute 83R25498 JSCD p. 14, ll. 5-9, 18-22: Section 166.046] In other words, if the facility committee decided to deny artificially administered food and fluids during its formal review under the loophole-ridden standards the bill would enact, then *by that very fact* the same food and fluids need *not* be provided after the period during which *all* life-sustaining treatment must still be given. The apparent exception for food and fluids thereafter is literally meaningless.

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