

The Debate Over the Fate of the Texas “Futile-Care” Law: It Is Time for Compromise

By Cynthia S. Marietta, J.D., L.L.M. Candidate

The controversial debate over reform of the Texas “futile-care” law pits right-to-life advocates against medical professionals. With the fate of the current law now pending in the Legislature, it is time to pursue compromise and to embrace an “open communication” approach for handling emotionally-charged end-of-life decisions.

I. What is the Texas “futile care” law?

The Texas “futile-care” law,¹ which was originally enacted in 1999, is contained within the Texas Advance Directives Act (“TADA”).² According to this law, a physician may refuse to honor a patient’s advance directive or decision to continue life-sustaining treatment if the physician believes the continued treatment would be medically hopeless or futile.³ The physician’s decision to refuse treatment is subject to review by the hospital’s ethics committee, and if the committee agrees with the physician and determines the case is futile, the patient’s family or surrogate decision-maker has ten days to make arrangements to transfer the patient to a facility willing to continue the treatment.⁴ While the hospital must provide life-sustaining treatment pending transfer arrangements, the hospital has no obligation to continue the treatment after ten days.⁵ The patient’s family or surrogate may seek court intervention to extend the ten-day period, but before a court can grant such an extension, it must find by a preponderance of the evidence there is a reasonable expectation that the family or surrogate will find a physician or facility that will honor the patient’s directive if the time extension is granted.⁶

Nationwide, “futile-care” statutes vary from state to state. Texas is but one of two states with a specific timetable for terminating a patient’s life-sustaining treatment if a successful transfer has not been arranged.⁷ According to the National Right to Life Committee, ten states have laws requiring life-sustaining treatment pending transfer, but there are no time constraints imposed on arranging the transfer.⁸ Forty-one states and two territories have either questionable laws regarding the continuation of life-sustaining treatment pending transfer, or have no effective

¹ TEX. HEALTH & SAFETY CODE, § 166.046 (Vernon Supp. 2006).

² TEX. HEALTH & SAFETY CODE, Chapter 166; Todd Ackerman, *Bills Would Force Care of End-Stage Patients*, HOUSTON CHRONICLE, Feb. 14, 2007, at 1, available at <http://www.chron.com/disp/story.mpl/metropolitan/4555047.html>.

³ TEX. HEALTH & SAFETY CODE § 166.046(a); see generally Steve Jacob, *At the End of the Medical Road*, STAR TELEGRAM, Apr. 8, 2007 at 1-2, available at <http://www.star-telegram.com/242/story/61115.html>.

⁴ *Id.* at § 166.046(a), (d) and (e).

⁵ *Id.* at 166.046(e).

⁶ TEX. HEALTH & SAFETY CODE § 166.046(g).

⁷ ROBERT POWELL CENTER FOR MEDICAL ETHICS OF THE NATIONAL RIGHT TO LIFE COMMITTEE, *Will Your Advance Directive Be Followed?*, 9-10 (2005), available at <http://www.nrlc.org/enthanasia/willtolive/statestatutereport.pdf>; Virginia allows 14 days to arrange a transfer while life-preserving measures are provided. *Id.* at 10.

⁸ *Id.* at 10.

protection of a patient's advance directive to continue life-sustaining treatment if the patient's physician is unwilling to continue treatment.⁹

II. What is the controversial debate?

In the wake of the nationally publicized Terry Schindler-Schiavo case,¹⁰ much emphasis has been placed on the urgent need for individuals to execute advance directives.¹¹ Advance directives are legal documents that allow a person to specify whether and under what circumstances he or she wants life-sustaining medical treatment, food or fluids when he or she is no longer able to make such health care decisions.¹² An advance directive gives an individual the choice to decide in advance whether he or she wants to pursue a fighting chance to live regardless of the financial cost or potential suffering, or die without medical intervention.¹³

“Futile-care” laws effectively disregard a patient's directive or family member's decision, and instead, place control of end-of-life matters in the hands of physicians and hospital ethics committees.¹⁴ Most hospitals have their own “futility” policies that give deference to the hospital ethics committee on such decisions regarding the quality of a patient's life and the efficacy of treatment.¹⁵

The Texas “futile-care” law has increasingly come under fire by right to life, patient advocate, and disability rights groups, including Texas Right to Life, over the concern that physicians and hospitals routinely trump the wishes of patients and families.¹⁶ Critics of the law claim that physicians and hospitals are making value judgments about whether the quality of life for some terminally-ill patients is too poor to continue treatment.¹⁷ These critics condemn the notion that a health care provider or ethics committee could know better than the patient himself about the value of quality of life.¹⁸ The critics believe that, when it comes to a decision of whether a life is worth living, the decision should be one for the patient or family to make, and not the doctor.¹⁹

The proponents of the law, on the other hand, contend that hospital representatives and physicians try to act in the best interests of the patient, who may be in pain while being kept alive

⁹ *Id.* at 7-9.

¹⁰ *See Schiavo ex rel. Schindler v. Schiavo ex rel. Schiavo*, 403 F.3d 1289 (11th Cir. 2005); *see also Schiavo ex rel. Schindler v. Schiavo ex rel. Schiavo*, 403 F.3d 1223 (11th Cir. 2005), *stay denied*, 125 S.Ct. 1692 (2005).

¹¹ ROBERT POWELL CENTER FOR MEDICAL ETHICS OF THE NATIONAL RIGHT TO LIFE COMMITTEE, *supra* note 7, at 1, 11; Jacob, *supra* note 3, at 1-2.

¹² *See generally* TEX. HEALTH & SAFETY CODE Chapter 166; ROBERT POWELL CENTER FOR MEDICAL ETHICS OF THE NATIONAL RIGHT TO LIFE COMMITTEE, *supra* note 7, at 1.

¹³ Jacob, *supra* note 3, at 3.

¹⁴ Kelley Shannon, *Critics Oppose Stop-Treatment Law*, ASSOCIATED PRESS, Dec. 2, 2006, at 1, *available at* <http://www.ilusacom/news/futile-law.html>.

¹⁵ *Id.* at 1.

¹⁶ *Id.* at 2; *see also* Mary Ann Roser, *Debate Heats Up on “Medical Futility” Law at House Hearing; Opponents Seek End to 10-Day Deadline to Move Patients Out*, AUSTIN AMERICAN-STATESMAN, Aug. 10, 2006, at 2, *available at* <http://www.cotued.org/press-room.html>.

¹⁷ Mary Alice Robbins, *Proposed Bill Give Families Final Say on Life-Sustaining Treatment for Patients*, TEXAS LAWYER, Mar. 2, 2007, at 1, *available at* <http://www.law.com/jsp/tx/pubarticlefriendlytx.jsp?id=1172829796788>.

¹⁸ Shannon, *supra* note 14, at 1.

¹⁹ Ackerman, *supra* note 2, at 1 (noting remarks by State Rep. Bryan Hughes, R-Mineola).

and while family members and surrogates feud over letting their loved one go.²⁰ It is inhumane to prolong a dying process that causes pain to a patient, and physicians believe they should not be forced to provide treatment that violates their ethics.²¹ Arguably, some end-of-life treatments can cause patients to suffer. For instance, in the case of a young woman who developed metastatic cancer that had filled her lungs, the woman's family insisted that treatment should continue. The hospital placed the woman on a high-pressure ventilator that forced air into her lungs causing so much pain that she had to be sedated with morphine and other narcotics.²² It is tough for physicians and nurses to watch their patients suffer horribly, and yet so unnecessarily.²³ When patients reach the point when their treating physicians determine that continuing life-sustaining treatment is inappropriate, the patients are typically suffering from multiple organ failure, which usually prompts physicians to request an ethics committee review.²⁴

The competing core values — the physician's ethical concerns and the family's intent to honor what they believe to be the patient's desires — may pit physicians and family members against one another in the most vulnerable of circumstances. When an ethics committee deems that continued treatment is futile, yet the family members want to continue treatment, arguably the balance of bargaining power tips in favor of the physicians and hospitals, leaving the family without recourse if they cannot find a transfer facility willing to honor the patient's directive.²⁵ There is no formal process for appeal of the merits of the ethics committee's decision available for the family.²⁶ The family is left with the option of having ten days to either prepare for withdrawal of life support or make arrangements for a transfer..²⁷

The hot question is whether ten days is sufficient, or whether any certain number of days would be sufficient, for family members to arrange for a transfer.²⁸ This question has arisen in several recent highly publicized cases in Texas in which family members have pleaded for more time to make transfer arrangements, and in at least two cases, sought court intervention.²⁹ Critics of the current "futile-care" law say the ten-day window is not enough time, and while proponents acknowledge the time period may not be sufficient, the parties have failed to reach a compromise or consensus on a sufficient time frame.³⁰

²⁰ Roser, *supra* note 16, at 2.

²¹ Ackerman, *supra* note 2, at 1.

²² *Id.* at 3.

²³ *Id.* at 3.

²⁴ *Id.* at 3 (noting remarks by Elizabeth Sjoberg, Associate General Counsel of the Texas Hospital Association).

²⁵ Roser, *supra* note 16, at 2; *see also* Todd Ackerman, *Move to Chicago Will Keep Patient on Life Support: St. Luke's Won't Pull Plug After Reaching Deal Amid Controversy Over Futile-Care Law*, HOUSTON CHRONICLE, Apr. 28, 2006, (noting remarks by Dr. William Winslade), *available at* <http://www.utmb.edu/imb/announcements.asp?id=125>.

²⁶ *Id.* at 166.046 (e).

²⁷ *See generally*, TEX. HEALTH & SAFETY CODE § 166.046.

²⁸ Roser, *supra* note 16, at 2.

²⁹ Ackerman, *supra* note 25, at 2; *see* Nikolouzos v. St. Luke's Episcopal Hosp., 162 S.W.3d 678 (Tex.App.—Houston [14th Dist.] 2005, no pet. h.); *see also* Wanda Hudson v. Texas Children's Hosp., No. 352,526 (Probate Court No. 4, Harris County, Texas, March 14, 2005).

³⁰ Robbins, *supra* note 17, at 2-3.

The ten-day timetable has been the subject of much discussion about the reform of the “futile-care” law.³¹ Legislators from the 2005 session charged the Texas Advance Directives Act Coalition (“Coalition”) with the task of studying this issue and determining whether the ten-day period is sufficient.³² The Coalition, an ad hoc group, is composed of two dozen diverse stakeholder groups including physician and hospital organizations, disability rights advocates, and national right-to-life advocates.³³ This Coalition was responsible for drafting the 1999 “futile-care” law legislation after intense negotiations and has been working for the past several months to reach an agreement on submitting a proposed bill to the current Legislature that would reform the “futile-care” law.³⁴ A handful of legislators had released statements saying they hoped to have the Coalition’s recommendations before proceeding on the issue.³⁵ The Coalition has been unable to reach a consensus on how much time to expand the ten-day time period.³⁶

III. Pending legislation may determine the fate of the current “futile-care” law.

In February 2007, the right-to-life advocacy groups diverted from the Coalition and pressed for legislation amending the current law to require a hospital to treat a terminally-ill patient indefinitely until the patient can be transferred to another accepting facility.³⁷ Two identical pending bills,³⁸ authored by legislators aligned with Texas Right to Life, basically “gut” the current futile-care” law, which during the past seven years has allowed doctors to withhold treatment they believe is unethical.³⁹ These two bills, filed by State Representative Bryan Hughes, R-Mineola (HB 1094), and State Senator, Robert Deuell, R-Greenville (SB 439), are based on the “treat-to-transfer” concept, meaning a hospital must provide life-sustaining treatment in accordance with the wishes of the patient’s family until the family can make successful arrangements to transfer the patient.⁴⁰ Opponents of the pending bills say the “treat-to-transfer” concept really means open-ended treatment for terminally-ill patients because such patients require multiple high technology treatments in intensive care units, and not many facilities are willing to take on those types of patients.⁴¹

In March 2007, State Representative Dianne Delisi, R-Temple, filed the Coalition backed bill (HB 3474), which appears to contain some seeds of compromise, extending the ten-day transfer period to eleven business days.⁴² All three pending bills are still “in committee.”⁴³ A public

³¹ Ackerman, *supra* note 2, at 1.

³² *Id.* at 1.

³³ Joint Interim Report to the 80th Legislature, Senate Committee on Health and Human Services and Senate Committee on State Affairs, December 2006; Robbins, *supra* note 19, at 1; Jacob, *supra* note 3, at 1.

³⁴ See Robbins, *supra* note 17, at 1.

³⁵ Roser, *supra* note 16, at 2.

³⁶ Ackerman, *supra* note 2, at 2; see also, Jacob, *supra* note 3, at 2.

³⁷ Ackerman, *supra* note 2, at 1.

³⁸ Tex. HB 1094, 80th Leg., R.S. (2007), filed on February 5, 2007, is co-authored by nearly one-half of House members. Tex. SB 439, 80th Leg., R.S. (2007), filed February 5, 2007, is co-authored by nearly one-third of Senate members; see also Jacob, *supra* note 3, at 2.

³⁹ Ackerman, *supra* note 2, at 1.

⁴⁰ Robbins, *supra* note 17, at 2.

⁴¹ *Id.* at 2.

⁴² Tex. HB 3474, 80th Leg., R.S. (2007), filed on March 9, 2007; Texas Legislation Online, available at <http://www.capitol.state.tx.us>; see Jacob, *supra* note 3, at 3.

hearing on SB 439 was held on April 12, 2007, during which thirty-one witnesses testified in favor of SB 439, and seven witnesses testified in opposition to the bill.⁴⁴

IV. It is time for compromise and to embrace a “front-end” open communication approach for handling end-of-life decisions.

It is time for compromise. The Coalition fears the “futile-care” law will be overhauled by lawmakers and reduced to a “treat to transfer” concept unless legislators, the medical community, and the right-to-life organizations can reach some kind of compromise.⁴⁵ Two pivotal matters need resolve: (1) an expansion of the ten-day transfer period; and (2) the opportunity for more effective communication between health care providers and patients’ families at the front-end of the decision-making process and before the time period for transfer is invoked.⁴⁶

A. The ten-day period should be expanded.

Parties on both sides of the fence recognize the existing ten-day time frame may be insufficient to allow an adequate opportunity to locate an accepting transfer facility.⁴⁷ Put in perspective, the ten-day window is less than the permissible fifteen-day period in which a hospital must comply with a patient’s request for medical records.⁴⁸

It stands to reason that some time limitation should be placed on the time window for transfer; otherwise, a family would have no incentive to pursue diligent efforts to make transfer arrangements if the law provides for indefinite, open-ended treatment. While not a perfect solution, fifteen business days may prove to be a more reasonable time frame for arranging a transfer. If, during this time frame, the family is unable to find a willing transfer facility, this may allow the family the opportunity to realistically rethink their original decision and reconsider whether continued treatment would be in the best interest of the patient. Moreover, the family may be less apt to seek court intervention knowing it would be difficult to prove that there is a reasonable expectation they could locate a willing facility if the extension was granted.

B. Family members should be provided the opportunity for ongoing, effective communication and mediation to facilitate resolution.

⁴³ Texas Legislation Online Process for a Bill, available at <http://www.capitol.state.tx.us>; Committees are created in the rules of procedure of the respective House and Senate chambers to consider introduced bills and to advise on their disposition. *Id.* Committee action is the first crucial step in the process by which a bill becomes law. *Id.*

⁴⁴ Texas Legislation Online, *supra* note 43, at Committee Minutes. A committee substitute for SB 439 was adopted without objection during the hearing.

⁴⁵ Emily Ramshaw, *Bills Challenge Care Limits for Terminal Patients*, DALLAS MORNING NEWS, Feb. 15, 2007, at 2 (noting remarks by Greg Hooser, Chairman of the Coalition), available at <http://www.dallasnews.com/sharedcontent/dws/dn/latestnews/stories/02157dntexendoflife.html>.

⁴⁶ See Shannon, *supra* note 14, at 3 (noting remarks made by Dinah Welsh, a lobbyist for the Texas Hospital Association).

⁴⁷ Robbins, *supra* note 17, at 3.

⁴⁸ TEX. HEALTH & SAFETY CODE § 241.154(a) (Vernon 2001).

It is hard to imagine a more difficult and stressful situation than when one is faced with making a heart-wrenching decision to withdraw life-sustaining treatment from a loved one.⁴⁹ A first instinct may be to take action to sustain life and hope for a miracle.⁵⁰ Family members may feel that any agreement to withdraw life-sustaining treatment would be akin to imposing a death sentence on a loved one.⁵¹ While family members may have known for some time that ultimately they would be faced with this decision, it is not a decision one is usually willing to embrace. The stress in this situation is compounded by time constraints placed on the decision-making process and the overwhelming, helpless feelings that family members may experience when they believe health care providers are not listening, or at least, do not understand the emotional, physical, moral, and spiritual impact of these end-of-life decisions.

Effective communication is a key component for breaking barriers of misunderstanding. While the current law requires some communication between the physician and family, it does not provide a forum to facilitate ongoing and effective communication. The primary purpose of ongoing communication is to educate the family in a non-coercive way about the medical issues and the futility of continued treatment, and while at the same time, allow the family to enlighten and share with the health care providers their point of view on the emotional, spiritual, and medical concerns.

Under the current law, the hospital must provide the family with 48 hours notice of the scheduled committee meeting to discuss the patient's directive, and the family is invited to attend.⁵² The committee provides the family with a written explanation of the committee's decision reached during the process.⁵³ If the committee decides to end treatment, the hospital does its best to help a patient's family timely find a transfer facility.⁵⁴

Neither the current law not the pending bills provide a forum to encourage ongoing effective communication between the health care providers and family or a process for mediation, all of which is crucial to facilitate resolution.

1. Ongoing, effective communication is crucial.

None of the JCAHO standards specify a protocol for hospital ethics committees to follow when dealing with end-of-life matters and other emotionally-charged decisions.⁵⁵ These protocols are left up to the individual hospital to devise. The following proposals would enhance effective communication on the "front end" of the end-of-life decision process and facilitate resolution:

- a. *The hospital should provide at least five-days notice of the ethics committee meeting.*

⁴⁹ Jacob, *supra* note 3, at 3.

⁵⁰ *Id.* at 3.

⁵¹ *Id.* at 3.

⁵² TEX. HEALTH & SAFETY CODE § 166.046(a), (b).

⁵³ TEX. HEALTH & SAFETY CODE § 166.046(b).

⁵⁴ Ramshaw, *supra* note 45, at 2 (noting remarks by Dr. Robert Fine).

⁵⁵ *See generally* 2005 Comprehensive Accreditation Manual for Hospitals: The Official Handbook "Ethics, Rights, and Responsibilities," (2005).

Five-days advance notice is not only reasonable, but may serve a practical purpose. At least one study indicates that 90% of surrogate decision makers, who initially disagreed with the physician, changed their minds within five days.⁵⁶

- b. *The members of the ethics committee should be hand selected for each case and should include at least one impartial third party consultant.*

In the few days prior to the committee meeting, the hospital should take care in selecting the most appropriate members to sit on the ethics committee for each particular case. This should include at least one, if not more, outside impartial third-party consultants. It should also include members of the medical staff with expertise in the medical condition at issue. An outside, impartial third party consultant should be a medical expert, who would be prepared to address the medical issues and provide an educational forum for the family on these issues. An ethics consultant may be helpful, as well, and one who would be prepared to address the ethical considerations of continuing and discontinuing treatment. The primary purpose for including impartial third party consultants would be to convey a sense of objectiveness and impartiality to the process and lend credibility to the medical expert's opinions.

- c. *The family should be afforded the opportunity to openly participate in the ethics committee meeting.*

Appropriate decision makers and family members should participate in the committee meeting. The committee format should include a question and answer session with the opportunity for family members to pose questions and obtain answers as a means to facilitate effective communication between the parties with an underlying educational purpose.

⁵⁶ See Thomas J. Prendergast, et al. A National Survey of End-of-Life Care for Critically Ill Patients, 158 AM. J. RESPIRATORY CARE MED. 1163 (1998)..

- d. *The family should be encouraged to invite spiritual advisors and religious counselors to the committee meeting, as necessary.*

More often than not, the family's or patient's decisions on preferences for end-of-life care are based on moral, spiritual and/or religious beliefs.⁵⁷ The presence of a familiar religious or spiritual advisor during the committee meeting may give the family comfort, solace, opportunity for prayer, and necessary guidance to reach a sense of reconciliation on end-of-life decisions.

- e. *Upon reaching a decision, the committee should provide the family with an oral and written explanation of the decision and should provide time for additional questions and answer, if requested.*

The committee's decision should be presented to the family in both oral and written form. The oral presentation of the decision should be conducted in such a manner and by appropriate committee members and in an appropriate, comfortable setting to convey a sense of empathy and understanding. The family should be given the opportunity to ask questions.

- f. *Ongoing open lines of communication should be encouraged and facilitated.*

The committee or designated representatives of the committee and the family may need to reconvene on one or more occasions to revisit the issues or to address new developments of the patient's status in the case, as needed. Open lines of communication between the parties will foster ongoing mutual education about the issues.

⁵⁷ National Cancer Institute, U.S. National Institutes of Health, *End of Life Decisions*, at 1, available at <http://www.cancer.gov/cancertopics/pdq/supportivecare/transitionalcare/HealthProfessional>; see also Center for Christian Bioethics at Loma Linda University, *Statements on Clinical Issues at the End of Life, Advanced Directives*, p. 3, available at <http://www.llu.edu/llu/bioethics/cmds.4.htm>

2. Mediation may facilitate resolution.

If a patient's family or surrogate decision makers are amenable to mediation, the facility should consider implementing this effective, impartial dispute resolution process at the "front-end" of the decision-making process after the ethics committee has rendered its opinion.⁵⁸ Mediation is a process in which a neutral third party, the mediator, assists disputing parties in reaching a mutually agreeable resolution.⁵⁹ Mediators aim to facilitate exchange of information, promote understanding among the parties, and encourage exploration of creative solutions.⁶⁰ A mediator invites the parties to engage in potentially creative and collaborative methods of problem solving without forcing a decision on either party.⁶¹ Many disputes arise because people do not understand or appreciate what the other has said or the perspective the other one holds.⁶² By shaping the exchange of information, mediators can help parties to understand each other better.⁶³

In summary, the fate of the Texas "futile-care" law rests in the hands of legislators and the Coalition, both of which should be willing to compromise on the ongoing debate concerning the time window for transfer and should embrace a "front-end" open communication approach for handling end-of-life decisions, with the primary focus on encouraging mutual education for both parties on the issues.

April 2007

⁵⁸ See Ackerman, *supra* note 25, at 2 (comments by Dr. William Winslade).

⁵⁹ MICHAEL L. MOFFITT AND ROBERT C. BORDONE, *THE HANDBOOK OF DISPUTE RESOLUTION*, p. 304 (1st ed. 2005); see also TEX. CIV. PRAC. & REM. CODE § 154.023.

⁶⁰ See *MOFFITT supra* note 59, at 304.

⁶¹ *Id.* at 304.

⁶² *Id.* at 304.

⁶³ *Id.* at 308.