The Patient and Family Treatment Choice Rights Act . . . Problem Solved?

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During its 80th Legislative Session, the Texas Legislature will once again tackle the issue of medical futility in defining the roles and responsibilities of physicians and hospitals in the context of end-of-life decision-making. In doing so, it will consider bills comprising the Patient and Family Treatment Choice Rights Act of 2007 (hereinafter 2007 Act). If the 2007 Act is passed, it will have a major impact on the Texas Advance Directives Act of 1999 (hereinafter the 1999 Act). Unfortunately, neither the 1999 Act nor the 2007 Act offer viable solutions to complex problems, involving professional ethics and patient autonomy.

It has been almost a decade since the Texas Legislature enacted the 1999 Act, also known as the “Texas Futile Care Law.” In part, the 1999 Act requires physicians who refuse to follow a patient’s advance directive or treatment decision concerning life-sustaining treatment to continue to provide such treatment pending review by an ethics or medical committee. If the ethics committee agrees that life-sustaining treatment is improper, then the patient will continue to receive life-sustaining treatment until the patient is transferred to either “another physician, an alternative care setting within [the same] facility, or another facility.” However, if a patient’s transfer has not taken place within ten days following the patient’s receipt of the ethics committee’s written decision, the physician and the hospital are no longer required to administer life-sustaining treatment.

In stark contrast, the bill containing the 2007 Act proposes that most of same procedures be followed as described in the 1999 Act, except that the patient must be provided life-sustaining treatment until a transfer can be accomplished. In other words, treatment must be provided without regard to any time limitation. The 2007 Act’s requirement to

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3 See Not Dead Yet: The Resistance, The Disability Advocates: Texas Futile Care Law Should Be Euthanized, available at http://www.notdeadyet.org/docs/TXfutilecarelawPR0506.html (last viewed Apr. 11, 2007) “The publicity surrounding the struggle to save the life of Andrea Clark - sentenced to die under Texas’ ‘Futile Care’ Statute - has brought attention once again to little-known hospital policies regarding so-called ‘futility.’” Id.

4 TEX. HEALTH & SAFETY CODE ANN. § 166.046(a) (2006).


6 TEX. HEALTH & SAFETY CODE ANN. § 166.046(e) (2006).


8 See id.
treat until the patient can be successfully transferred clearly accomplishes its stated purpose, which is “to protect the right of patients and their families to decide whether and under what circumstances to choose or reject life-sustaining treatment.”

Although the 1999 Act provides the patient and her family ten days to find a facility willing to provide life-sustaining treatment, it ignores the reality that there may never be a facility willing to do so. Among four cases receiving media attention where medical providers invoked the law, one Medicare patient in a persistent vegetative state was successfully transferred to a nursing home in San Antonio, Texas. However, for Sun Hudson, a Medicaid patient, and Tirhas Habtegiris, an uninsured patient, obtaining transfers before their respective hospitals disconnected their ventilator support proved to be impossible. These failures were not for lack of trying. For example, the hospital where Sun Hudson was a patient contacted forty other medical facilities, and all refused to accept him as a patient. For another Medicaid patient, Emilio Gonzales, transfer has also not occurred, although he is still receiving life-sustaining treatment under a court injunction. As of April 8, 2007, Seton Hospital had contacted thirty hospitals, all of which declined to accept Emilio as a patient. Though hospitals deny that a patient’s ability to pay for long-term treatment is a factor in their decision to end treatment, it certainly does play a role in medical facility’s decision to accept a patient for long-term or indefinite treatment.

10 See Maureen Kwiecinski, To Be or Not to Be: Should Doctors Decide? Ethical and Legal Aspects of Medical Futility Policies, 7 MARQ. ELDER’S ADVISOR 313, 352 (2006). “Finally, the ability to transfer the patient to another setting is also an ineffective protective mechanism. Transferring a seriously ill patient who is dependent on expensive technology is inevitably complicated by economics. A potential receiving institution may decline to accept a patient, not because of a determination that the treatment the patient seeks is inappropriate, but because the treatment in question is costly.” Id. See also Mary Alice Robbins, Proposed Bills Give Families Final Say on Life-Sustaining Treatment for Patients, TEX. LAWYER, Mar. 2, 2007, available at http://www.law.com/jsp/tx/PubArticleTX.jsp?id=1172829796788 (last viewed Apr. 11, 2007). “[R]ight-to-life groups decided to seek legislation based on the treat-to-transfer concept.” Id. “[T]hat means physicians must provide life-sustaining treatment in accordance with the wishes of the patient’s family until the family can transfer the patient—an action that . . . may never occur.” Id.
11 Kwiecinski, supra note 10, at 355 n.5; see also http://www.answers.com/topic/spiro-nikolouzos. “On March 21, 2005 Spiro Nikolouzos was removed to Avalon Place Nursing Home in San Antonio, Texas.” Id. Avalon Place had rejected his application nine days earlier.” Id.
15 Mary Ann Roser, Time Running Out for Baby on Life Support, AUSTIN AMERICAN-STATESMAN, Apr. 8, 2007, available at http://www.statesman.com/search/content/news/stories/local/04/08/08emilio.html (last viewed Apr. 11, 2007). “Children’s Hospital has contacted 30 hospitals on behalf of Emilio, including ones that specialize in treating patients like him, said Michael Regier, general counsel for the Seton Family of Hospitals, which operates Children’s.” Id.
16 Robbins, supra note 10. “Dr. Robert Fine, director of the Office of Clinical Ethics for the Baylor Health Care System and a member of the Advance Directives Act Coalition, says the treat-to-transfer concept
In essence, the 2007 Act solves this dilemma. After all, its purpose is to provide patients and family members a choice in deciding whether to accept or reject life-sustaining treatment.\textsuperscript{17} One could argue that a confronting a deadline to obtain a transfer that, in reality, may never happen is akin to having no choice at all, and that physicians should not be making quality of life decision based on their personal sense of ethics.\textsuperscript{18}

However, supporters of the 1999 Act argue that if life-sustaining treatment is indefinitely rendered, then the patient is at risk for extreme suffering.\textsuperscript{19} And requiring physicians to breach their own ethical standards in providing care is arguably untenable.

From the time of Hippocrates, the principles of beneficence and nonmaleficence were key principles directing the doctor-patient relationship.\textsuperscript{20} Under the principle of beneficence, the physician must take action that benefits the patient or “preserve the patient’s life.”\textsuperscript{21} Under the principle of nonmaleficence, the physician has a duty not to harm the patient.\textsuperscript{22} In accordance with these principles, the physician’s primary goal should be to ease the patient’s suffering “when life can no longer be preserved.”\textsuperscript{23}

Beginning in the previous century, the principle of autonomy joined beneficence and nonmaleficience in guiding the practice of medicine.\textsuperscript{24} Autonomy forms the basis for the doctrine of informed consent and the right to die movement and “it includes the right to be a fully informed participant in every aspect of the medical decision-making process, as well as the right to refuse medically prescribed life-saving treatment.”\textsuperscript{25} Hence, it is well-established that under the doctrine of informed consent, a competent patient does have the limited right to refuse life-sustaining treatment, following the balancing of liberty interests against state interests.\textsuperscript{26} It has not been established, however, that an individual has a right to demand a particular treatment or that a physician is under a duty to administer medically futile treatment.\textsuperscript{27}


\textsuperscript{17} \textit{See H.R. 1094, 2007 Leg., 80\textsuperscript{th} Reg. Sess. (Tex. 2007).}

\textsuperscript{18} Robbins, \textit{supra} note 10. “Burke J. Balch, an attorney who serves as director of the Robert Powell Center for Medical Ethics of the National Right to Life Committee, says doctors and hospitals are making decisions that the quality of life for some terminally ill patients is too poor to continue treatments.” \textit{Id.}

Jerry Ward, an attorney, stated that “[s]he doesn’t think people should die because of a hospital’s view on ethics, . . . I don’t think the doctor’s ethics should trump the family’s wishes.” \textit{Id.}

\textsuperscript{19} \textit{See Robbins, supra} note 10.


\textsuperscript{21} \textit{Id.}

\textsuperscript{22} \textit{Id.}

\textsuperscript{23} \textit{Id.}

\textsuperscript{24} \textit{Id.} at 30.

\textsuperscript{25} \textit{Id.; see also George P. Smith, Utility and the Principle of Medical Futility: Safeguarding Autonomy and the Prohibition against Cruel and Unusual Punishment, 12 J. CONTEMP. HEALTH L. & POL’Y 1, 21 (1995).}

\textsuperscript{26} \textit{See Cruzan v. Dir. Mo. Dept. of Health, 497 U.S. 261, 277-79 (1990).}

\textsuperscript{27} \textit{See Smith, supra} note 25, at 1. “When medical treatment is deemed to be “futile,” it frees the physician from the moral, medical, and legal duty to provide such treatment.” \textit{Id.} “[T]he patient has a right to refuse
There are many arguments in support of a physician’s right to withdraw treatment. One argument is that the principles of beneficence, nonmaleficence and justice validate the unilateral withdrawal of medically futile treatment because rendering such treatment could subject the patient to other risks. Some assert that “administering futile treatment, in fact, undermines patient autonomy . . . [by] ‘implying a real choice when none exists’ . . . distort[ing] the patient’s perspective and depriv[ing] him of the opportunity to make informed decisions.” It has also been argued that the provision of futile treatment undermines the physician’s professional integrity and the medical profession at large.

Unfortunately, there is no uniform definition of futility. The American Medical Association’s Council on Ethical and Judicial Affairs recognized that all health care facilities should have a medical futility policy but later realized “that futility is ‘inherently a value-laden determination;’ therefore, ‘[a] fully objective and concrete definition of futility is unattainable.’” Advocates of the concept of futility believe that it is sufficient that “[physicians know [futility] when they see it,” but this can be challenging for society to accept and the uncertainty arguably grants health professionals too much freedom. Thus, the 1999 Act establishes procedural safeguards, in part, protecting a physician’s refusal to provide treatment based upon a concept for which there is no consensus in the medical community. To complicate matters, an ethics committee, likely comprised of the treating physician’s colleagues, is charged with the responsibility of reviewing the physician’s refusal.

Although many agree that it is nearly impossible to define medical futility, it is important that non-procedural guidelines for determining futility are proposed that are free of

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28 Kwiecinski, supra note 10, at 314; Smith, supra note 25, at 22-23.
29 See Smith, supra note 25, at 22-23 (quoting Stuart J. Youngner, Futility in Context, 264 JAMA 1295, 1295 (1990)).
30 Arthur L. Caplan, Editorial, Odds and Ends: Trust and the Debate over Medical Futility, 125 ANN. INTERNAL MED. 688 (Oct. 15, 1996) available at http://aaa.annals.org/cgi/content/full/125/8/688. See also Amir Halevy, The History, Successes and Controversies of the Texas “Futility” Policy, 43 HOUS. LAW. 38, 39 (May/June 2006) (stating that “[p]rofessional integrity serves as a counter balance to respect for patient autonomy and should ground a prohibition on patients and families forcing these same health care professionals to provide treatments they judge as inappropriate”); Kwiecinski, supra, at 337.
31 See Smith, supra note 25, at 2 (stating that “[m]uch disagreement exists as to the definition of futile treatment and who decides whether a given treatment is futile.”); see also Kwiecinski, supra note 10, at 324 (stating that “[d]espite decades of widespread discussion and numerous attempts to identify the circumstances in which a medical intervention can be described as ‘futile,’ commentators have been unable to agree on a practical, objective definition.”); Caplan, supra note 34 (“[A]nalysis of the concept [of futility] has failed to produce a consensus about how [futility] should be defined or used.”).
32 Kwiecinski, supra note 10, at 325.
33 Kwiecinski, supra note 10, at 349-50.
34 See Smith, supra note 25, at 2.
35 TEX. HEALTH & SAFETY CODE ANN. § 166.046(a) (2006).
subjective quality of life decisions and bedside rationing. It is also important that either mediation or the involvement of an impartial body be mandated in order to even the playing field for the patient or the patient’s family.

All in all, physicians are in the best position to determine medical outcomes. More often than not, physicians and family members are ultimately able to reach agreements regarding life-sustaining treatment. However, in the rare instances that patients and physicians disagree, neither the 1999 Act nor the 2007 Act offer any palatable solutions.

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36 See Smith, supra note 25, at 13-16. See Kwecinski, supra note 10, at 335-36. “Even if a substantial reduction in costs could be realized, and ‘savings’ achieved from the withdrawal of treatment from an individual patient is not necessarily channeled to other supposedly more worthwhile patients.” Kwecinski, supra note 10, at 335-36.
38 See Smith, supra note 25, at 36.
39 Leigh Hopper, No Easy Calls When Baby Is Terminally Ill, HOUS. CHRON., Feb. 9, 2005; see Kwecinski, supra note 10, at 353.