Texas Hospital Association

TexasMedical Association

Texas Catholic Conference of Bishops
THE PUBLIC POLICY VOICE OF THE CHURCH

Texans for Life Committee

TEXAS Alliance for Life
Changing Hearts, Saving Lives Since 1988

CTD Coalition of Texans with Disabilities

Catholic Health Association of Texas

Texas Patient Advocates Oppose SB 2089 and SB 2129

*Urge lawmakers to **VOTE NO** on both bills*

To ensure the highest quality of care for patients and to respect patient autonomy at the end of life, Texas patient advocates oppose proposed changes to the highly negotiated and unanimously agreed upon Texas Advance Directives Act, in statute since 1999.

Proposed changes would force physicians and nurses to perform painful medical interventions indefinitely on terminally ill patients.

A coalition of organizations, represented by the Catholic Health Association of Texas, the Coalition of Texans with Disabilities, Texas Alliance for Life, the Texas Catholic Conference of Bishops, the Texas Hospital Association, Texans for Life Committee and the Texas Medical Association, are united in **opposition to Senate Bill 2089**, by Sen. Bryan Hughes (R-Mineloa), and **Senate Bill 2129,** by Sen. Brandon Creighton (R-Conroe), related to advance directives and medical treatment decisions.

This coalition supported TADA when it was enacted in 1999 and still generally support its structure now. Both chambers of the Texas Legislature passed the bill unanimously, and it was signed into law by then-Governor George W. Bush (R). It should not be amended absent the support of the community of physicians, nurses, clinical ethicists, hospitals, nursing homes and hospices that provide patient care near the end of life. Neither SB 2089 nor SB 2129 were developed or supported by our organizations before being set for a public hearing.

SB 2089 would amend the TADA to require a hospital—even after its committee of medical ethicists and physicians, under the dispute resolution process, determines further treatment would harm the patient—to continue providing medical interventions until the patient is transferred to another facility that is willing to provide medical interventions.

In doing so, SB 2089:

- **Would prolong and increase suffering for families and loved ones without medical benefit.**
- **Would mandate the provision of potentially unethical, medically inappropriate procedures, outside the standard of care services.** A physician should not be required to misuse medical technology to prolong imminent and certain death. A physician should not be required to use his or her skills and technologies if not in the best interest of the patient or if medically inappropriate.

- **Would subvert the dispute resolution process of the TADA.** The TADA recognizes that disagreements can arise between health care providers and families in the setting of making health care decisions for patients with terminal illness. The stress and grief are very real factors. Families sometimes may request either the premature termination of treatment or may request interventions that promote suffering without medical benefit and prolong dying. Rather than giving either the physician or the family unilateral decision-making power, TADA provides a mechanism to resolve any dispute. This ethical mechanism has safeguard provisions for families and surrogates who request indefinite life support for their terminally or irreversibly ill loved ones. The indefinite provision of such interventions at the insistence of a surrogate creates an ethically untenable default position.
- **Could negatively impact acceptance of transferred critically ill patients.** Physicians at tertiary care centers may be reluctant to accept critically ill patients from smaller hospitals if doing so commits the physician and facility to open-ended and indefinite interventions irrespective of the physician's reasonable medical judgment that the interventions are harmful to the patient and are medically inappropriate.

SB 2129 would amend the TADA to define reasonable medical judgement and make the statute's dispute resolution process more prescriptive and limit providers' ability to honor patient wishes.

In doing so, SB 2129 would:

- **Create confusion and potential liability.** There are many terms and standards in this bill that are not adequately defined or are based on subjective standards. There are also standards that require more certainty about end-of-life situations than medicine will ever be able to provide. Any legislation should be clear and precise to avoid inconsistent interpretation and to ensure physicians have clear guidance on how to implement the changes.
- **Allow non-physicians to determine reasonableness of medical judgment.** The bill requires an ethics or medical committee to make determinations relating to reasonable medical judgment, which the bill defines as including what a reasonable and prudent physician would do. Non-physicians cannot be arbiters of what is "reasonable medical judgment," or what a reasonable physician would do in certain circumstances. Medical judgment should be the purview of physicians.
- **Create opportunity for rules to impose unnecessary limitations on a physician's reasonable efforts to transfer.** The Texas Health and Human Services Commission's rules adopted under this bill that would describe what a "reasonable effort" requires would impose unnecessary limitations on a physician's effort to transfer a patient. What is reasonable will depend on a patient's individual and specific circumstances, and any rules that seek to describe those circumstances will be inadequate and limited because they cannot capture the unlimited circumstances that may arise, thus limiting flexibility for determining what is reasonable.
- **Require continued treatment despite a determination that treatment is futile.** In this bill, a determination that treatment is futile is not enough—it must meet other subjective standards that may, in some situations, mean that physicians would legally be required to continue futile treatment. The bill does not define "futile." Bioethicists cannot agree on a standard definition for this term, which is why the TADA does not use it. Using this term likely means decisions would be made based on subjective standards. This is a violation of a physician's medical ethics.