

**Testimony of Wesley J. Smith, JD, Before the Texas Senate Health and Human Services Committee in Opposition to S.B. 303**

**March 19, 2013**

Good afternoon. My name is Wesley J. Smith. I am a lawyer, author, and consumer advocate. I am a senior fellow at the Discovery Institute's Center on Human Exceptionalism, and a consultant for both the Patients Rights Council and Center for Bioethics and Culture.

For the last twenty years I have been deeply engaged internationally in public policy debates about the most important bioethical issues facing our nation and global community. These include researching and writing about the ongoing erosion of Hippocratic medical values in bioethics involving areas such as assisted suicide, end of life medical treatment, and other areas of concern. I am the author or coauthor of 12 books, including *Forced Exit: Euthanasia, Assisted Suicide, and the New Duty to Die*, which was first published in 1997 and now in its third edition. I also wrote *Culture of Death: The Assault on Medical Ethics in America*. *Culture of Death* was named "Best Health Book of the Year" at the 2001 Independent Publishers Book Awards. Both books deal substantially with the issues involving end of life care. I have also written extensively in the professional and popular media about matters involving bioethics, human exceptionalism, and the intrinsic equality of all human life. My biography is attached to my testimony.

My work in the fields about which I advocate is entirely secular, which I believe is appropriate to the creation of public policy in a nation governed by the rule of law.

I appear today to urge this committee to reject SB 303. It is my understanding that the primary purposes of the bill are to improve Texas's (terrible, from my

perspective) medical futility bill and fix into Texas statutory law, the standards for applying Do Not Resuscitate orders. The bill fails in its former purpose and makes things even worse with regard to the latter.

#### UNILATERAL OR “FORCED” DNR ORDERS SHOULD NOT BE ALLOWED

There is much about which to be concerned in S.B. 303. Foremost in my mind is the prospect of doctors placing DNR orders on a patient’s chart unilaterally, which once done, places onerous burdens on patients, family members, or surrogates to have the order removed if that is not the desired course. Moreover, doctors would appear to be able to issue DNR orders on a patient’s chart—which would mean no medical action would be taken to resuscitate in the event of cardiac arrest—*without notice or permission—even if the patient is competent!* From the text of S.B. 303:

#### Sec.A166.012. STATEMENT RELATING TO DO-NOT-RESUSCITATE ORDERS.

- (c) Before placing a do-not-resuscitate (DNR) order in a patient’s medical record, the physician or the facility’s personnel shall *make a reasonably diligent effort to contact or cause to be contacted the surrogate.* The facility shall establish a policy regarding the notification required under this section. The policy may authorize the notification to be given verbally by a physician or facility personnel. (d) *The DNR order takes effect at the time it is written in the patient’s chart* or otherwise placed in the patient’s medical record. (e) *If the patient or surrogate disagrees* with the DNR order being placed in or removed from the medical record, the patient or surrogate *may request a second opinion at the patient’s or surrogate’s expense.*

Please notice that the bill does not require the doctor to discuss the DNR with the patient before it is placed on the chart. Nor, beyond seeking to “contact” a surrogate, is

there any requirement about what should happen once the contact has been made. Does the doctor have to ask permission? It would seem not. Does the doctor have to explain his or her reasons for placing the DNR on the chart? It would seem not. Indeed, the bill *doesn't even specify that the patient or surrogate has to be told the DNR has been imposed!* Indeed, the bill merely states that facilities are to “establish a policy regarding the notification required” when, in fact, *the bill itself is silent about such a requirement.*

And what happens if the patient, family, or surrogate learns about the DNR and disagrees with the decision? The onus is wholly on the objecting party, who is allowed to obtain a second opinion at their own expense.

That is the reverse of a proper and equitable approach: If a doctor wishes to impose an unwanted DNR on a chart, the doctor should have the burden of demonstrating why it is necessary to go against the wishes of patient, family, or surrogate.

Senators, many of the people who will fall afoul of this provision if it is enacted into law will be poor or uninsured. They may not have the money to pay for a second opinion. They may not speak English. They may not understand medical nomenclature. And what if the second opinion physician concludes that the DNR was misapplied? That doesn't settle the matter! The family then has to convene a bioethics committee meeting to present their “case” for the DNR to be removed. And during the entire time it would take to:

- ◆ Retain another doctor;
- ◆ Have the patient's files transferred for review;
- ◆ Arrange for the second doctor, who is presumably busy with existing patients, examine the patient;

- ◆ Ask for a bioethics committee hearing; and,
- ◆ Convene the hearing,

the DNR will remain on the chart, and the patient will be denied resuscitation in the event of a cardiac or respiratory arrest.

And please consider what this will mean to the people—your constituents—who will have to work within the law and whatever procedures the hospitals may establish. These will be people in crisis: A loved one is lying in a hospital bed away from home—seriously, perhaps deathly, ill. We have all experienced the stressful and emotionally draining experience of having a loved one’s life hanging in the balance. Adding such an additional and onerous burden upon people who are in such demanding, perhaps even, traumatic circumstances—to, in essence, *require them to fight for their loved one’s life against their own doctor*—is simply beyond the pale.

More than that, it is the antithesis of social justice. Many simply will not be able to do it. Maneuvering through the medical system is a daunting task for anyone, particularly those untrained in the field. Asking people who may not have the education, life skills, or ability to carry the burden of removing an unwanted order is unfair and unwise. It will breed distrust in the medical system and lead many to conclude—whether rightly or wrongly—that in a time of health care cost cutting, their loved one was crassly deemed too expensive to save.

I believe the above provide abundant reasons reject S.B. 303. But adding insult to injury, the “reasonably diligent effort to contact” requirement *only applies to patients who are not expected to die within weeks or days*. If the patient is expected to die imminently, or if resuscitation is deemed “medically ineffective,” the minimal

obligation *to even attempt notification* and the right to a self-paid second opinion *does not exist*:

(f) Subsection (c) [the notification section quoted above] *does not apply to a DNR order* placed in the medical record of a patient:(1) whose death, based on reasonable medical judgment, is imminent despite attempted resuscitation; (2) for whom, based on reasonable medical judgment, *resuscitation would be medically ineffective* and there is insufficient time to contact the surrogate;...

Subsection (e) [right to obtain second opinion] does not apply to a DNR order placed in the medical record of a patient with respect to whom, based on reasonable medical judgment, death is expected in days to weeks and resuscitation would be medically ineffective.

What does “medically ineffective” mean? The term isn’t defined. Moreover, it couldn’t be the same as “imminent despite attempted resuscitation,” or that language would have been repeated. Given the justifications for futile care arguments, this could reflect a *judgment based on “quality of life”* rather than the resuscitation being physiologically useless. At the very least, the language—which again, involves life and death—is imprecise and confusing.

Doctors who impose DNRs on charts without permission would be accorded extraordinary legal protection for their mistakes or unilateral inactions:

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...*

So, even if the physicians are negligent in placing the DNR on the chart, so long as they follow the procedure, they are home free? This would mean that there would be *no checks and balances in an issue of life and death!* More ironically, a doctor who did not place a DNR on the chart could face greater legal scrutiny for that decision in the event of a later dispute than if he did issue the order.

There is a fundamental principle at stake in the DNR section of S.B. 303. Such decisions *should not be doctor's to make unilaterally* based the doctor's own medical opinion or value judgment. It's a simple matter of checks and balances. If a doctor believes resuscitation would violate ethics or be harmful to the patient, the hospital should have the burden of proof and expense of obtaining court permission. And certainly, the patient or surrogate should always be consulted first, or a guardian named to represent the patient if none can be found.

### **The Problem of Imprecise Language in S.B. 303**

Section 166.046, which would set forth the procedure if a physician disagrees with a decision for treatment is rife with vague and imprecise language to the detriment of the patients and families who would be impacted, often adversely, by the provisions of the bill.

The term "terminal illness: is not defined: Section 7, a-1 states:

#### **If the patient has been diagnosed with a terminal condition...**

What is a terminal condition under the bill? Does it mean a month to live based on reasonable medical certainty? Six months? Does the diagnosis include a terminal

expectation even if treatment is provided, or does it refer to a condition likely to cause death only if untreated? After all, diabetes is a terminal illness without the administration of insulin. AIDS is a terminal illness, but patients can live for years with proper treatment.

The bill then states:

**...the ethics or medical committee shall determine if, based on reasonable medical judgment, the treatment would:**

- 1) hasten the patient's death;**
- 2) seriously exacerbate other major medical problems;**
- 3) result in irremediable physical pain or discomfort not outweighed by the benefit of the treatment; or**
- 4) be medically ineffective in prolonging the patient's life.**

The language used to describe these four criteria are vague and imprecise. For example, what is a "major medical problem?" And as discussed above, medically ineffective is not defined.

But the most egregious problem is with criterion 3: Whether an intervention's "pain or discomfort" is or is not "outweighed by the benefit of the treatment" is entirely a *subjective matter of values and personal preferences*, not a matter for medical diagnosis or determination. That being so, which party's values or moral views should prevail? The patient's/family's/surrogate's or the bioethics committee members' who are strangers to the patient? Would any of you want a stranger to make this intimate decision on your behalf, to be imposed even if you, your spouse, child, or designated surrogate disagreed? I can't imagine so.

The same problem exists with regards to the language of section a-2, but the implications may be worse than regarding patients with terminal illness. The clause begins:

### **If the patient has been diagnosed with an irreversible nonterminal condition...**

The problems of the four criteria are similar or identical as set forth above in the discussion of patients with terminal illnesses, so I won't belabor the points again. But let's be very clear about what we are talking about here: The "irreversible nonterminal condition" will often be a serious disability, such as paralysis caused by spinal cord injury, a neuromuscular disease, or debilitation—with the prospect that bioethics committees and doctors would be placed in a position to refuse *wanted* treatment because the committee members or doctor, perhaps subliminally, don't believe that *the life of the seriously disabled patient is worth living*. To put it another way, it could be all too tempting (and human) for the decision makers to think, "If I were like that, I wouldn't want to live," and *project their fears and their desires onto the patient* who does not share the opinion. The potential for invidious discrimination against people with serious disabilities in the medical context seems so obvious, that it does not require further discussion.

### **Conclusion**

S.B. 303 is fatally flawed. It undermines patient autonomy and the right of informed consent and refusal. It permits DNR orders to be placed on patient's charts without consent—perhaps even without notice. It imposes such onerous burdens on dissenting patients, families, and surrogates that many will fall into impotent despair. It is imprecise in its language and overbearing in its effect. Perhaps worst of all, this proposal has been made at a time when many people worry that those expensive to care are

coming to be seen as burdens on society, and thus, expendable and discardable. If this bill becomes law, it can only further erode the trust people have in the medical system generally, and their hospitals and doctors more specifically.

Thank you for allowing me to share my views. I would be happy to answer any questions you might have.