

# Difficult choices

TMA seeks balanced end-of-life debate

BY AMY LYNN SORREL

When Bellaire emergency physician Arlo F. Weltge, MD, received a chronically and terminally ill patient in the emergency department, he knew he had to make some quick and complex decisions. The man had terminal cancer and end-stage HIV-AIDS and, because he was nearing cardiopulmonary arrest, could not express his care wishes. Nor had he signed an advance directive.

After calling EMS to take the patient to the hospital, his caregiver told Dr. Weltge her partner did not want aggressive cardiopulmonary resuscitation (CPR) or to end up on a ventilator in his final days; nor did she want that for him.

Dr. Weltge had no record of the patient's wishes, no verification of a formal relationship with the caregiver, and no time. "I needed to make a decision now, and it was clear to me where this situation was headed," said Dr. Weltge, a consultant to the Texas Medical Association's Council on Legislation and a member of TMA's end-of-life workgroup.

The lack of signed documentation, for example, would have made it difficult to take the matter to a hospital ethics committee. So after discussing the situation with the caregiver and verifying the patient's terminal condition in the medical record, it was up to Dr. Weltge to honor the patient's wishes and record the treatment plan. He did so in the form of a do-not-



Emergency physician Arlo F. Weltge, MD, can testify that end-of-life decisions are among the most difficult decisions doctors have to make in balancing their medical and ethical duties with patients' wishes.

resuscitate (DNR) order.

"On the one hand it was very appropriate for me to give the patient some comfort care, like fluids and treatment of his infection. But I also had the tough job of saying, 'If his heart stops, I don't think we need to inflict further pain by breaking his ribs, pushing on his chest, or placing a plastic tube in his throat,'" he said.

At the same time, Dr. Weltge recognized that his decision in the emergency room would have "downstream effects."

The DNR order meant that instead of putting the patient in an intensive care unit, where his partner could not be with him, Dr. Weltge could transfer him to intermediate level care where he could receive palliative treatment with her there. Dr. Weltge also discussed the situation with the physicians who would care for him, and they agreed with the decision.

Different circumstances bring different levels of complexity to end-of-life care decisions, but one thing stays the same, Dr. Weltge says. "As physicians, our job is to act in the best interest of the patient, but with the ethical responsibility of not doing any intentional harm."

That responsibility does not end just because a patient is nearing his or her final days. "We need a law that is nuanced enough to recognize that there are very different contexts in which these decisions are made," he said.

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As end-of-life issues heat up once again in Capitol debates, protecting physicians' ability to carry out that duty under the 1999 Texas Advance Directives Act (TADA) is a key feature of legislation TMA developed in collaboration with the Texas Hospital Association (THA), the Texas Catholic Conference, the Texas Alliance for Life, and other faith-based groups.

At the same time, the groups are pushing for reforms they believe will improve transparency and communication for all parties affected by these decisions.

Sen. Robert Deuell, MD (R-Greenville), was to file the bill in January.

## Finding balance

TADA allows patients to issue an out-of-hospital DNR or advance directive for physicians and family members on administering or withholding life-sustain-

ing treatment if they are in a terminal or irreversible condition and cannot make their wishes known.

TADA and TMA policy encourage patients to express those wishes in advance.

If that does not happen, however, or if a family member or surrogate disagrees with a physician or hospital recommendation to discontinue what the health professionals believe to be medically unnecessary or unethical treatment in a patient's final days, the dispute goes to a hospital ethics panel. If the panel determines that limiting treatment is in the patient's best interest, and the surrogate still disagrees, he or she has 10 days to find another facility to care for the patient, during which time the patient still would receive life-sustaining treatment.

But this year's legislative session likely will see a resurgence of efforts to pass “treat until transfer” bills. They would require physicians and hospitals to continue treating terminal patients as long as the family wishes — or until they can find a facility that will — despite medical advice to the contrary.

End-of-life discussions also took a turn in 2011 with legislation that sought to severely restrict and possibly criminalize physicians' ability to execute DNR orders. The bills never made it out of committee, due in part to TMA efforts.

The measures emerged largely out of concerns that TADA lacks sufficient safeguards for a patient's right to have a say in end-of-life decisions and that the law should be reformed.

Rep. Bryan Hughes (R-Mineola), who carried the “treat until transfer” bills over the past three sessions, said he will “be involved” in filing similar legislation this session.

He said some families have had “very difficult experiences” because of the current law. “This is a vexing matter, difficult for the patients, medical providers, and families involved. There is a general consensus that the current law needs to be amended. The degree and nature of the amendments is where we need to continue to have a robust debate.”

Another reform advocate, Elizabeth Graham, director of the antiabortion group Texas Right to Life, agrees that judgments over a patient's care and treatment are appropriate in any medical setting.

“But judgments about a patient's quality of life rest with the family. They are the ones who should have the autonomy to say, ‘I do want to continue treatment. I do understand my limitations. However that's my decision,’” she said.

Ms. Graham added that the 10-day transfer window in the current statute often is not enough time for families to find an alternative care setting.

Physicians already can opt out of providing care they find unethical, she says. But she called the decision-making process one-sided, saying patients don't get the same choice to continue life-sustaining care.

Beaumont anesthesiologist Gerald Ray Callas, MD, says collaboration is the standard of care. The physician, as the professional in the relationship, brings a legitimate voice in recognizing whether certain treatments help or harm a dying patient's condition.

“But these issues are not always black and white,” he said.

A patient may have an advance directive to withhold care, for example. But Dr. Callas explains to patients that once in the operating room, his job is to do everything to improve a patient's quality of life.



Sen. Robert Deuell,  
MD



Gerald Ray Callas,  
MD

In the recovery room, however, there are tough choices about what's right for the patient, while respecting end-of-life wishes. "If I can't get you off a ventilator, do I just shut it off right away because of a DNR order, or do I give it a little bit of time?"

There are gray areas, "and dictating the practice of medicine is not in anyone's best interest," said Dr. Callas, also a member of TMA's Council on Legislation and end-of-life workgroup.

The joint bill aims to preserve the ethics hearing process and other TADA provisions that physicians and hospitals say generally work as intended.

However, recognizing the often emotional and complicated nature of the medical and ethical decision-making process, they want to ensure that best practices are the standard of care across the board, while balancing the rights of all parties involved.

"TMA is aligned with other faith-based groups to do everything we can to respect the conscience of physicians and other health care providers so that the law does not require unethical treatment. We also want patients in this trying and difficult time to know we are acting in their best interest," Dr. Callas said.

### Improving communication

When it comes to withdrawing care, a key compromise in the TMA-backed legislation allows families 14 days instead of 10 to find an alternative treating facility and extends the time in which hospitals must notify patient families or surrogates before an ethics panel hearing from 48 hours to seven days.

The bill also clarifies that physicians and hospitals cannot withhold certain comfort care, such as artificially administered hydration and nutrition, from a terminal patient unless continuing such treatment would further harm his or her condition.

To assist families during the decision-making and ethics hearing processes, hospitals would have to give them a free copy of the patient's record, invite them to attend the meeting, and provide a liaison to guide them throughout the proceedings.

## TMA guidance on DNRs

**The Board of Councilors** adopted new ethics policy to help guide physicians in executing do-not-resuscitate orders (DNRs). Among other tenets, it says:

- When a patient suffers cardiac or respiratory arrest, attempt to resuscitate the patient, except when cardiopulmonary resuscitation (CPR) is not in accord with the patient's expressed desires or is clinically inappropriate.
- Encourage all patients to express in advance their preferences regarding the extent of treatment after cardiopulmonary arrest, especially patients at substantial risk of such an event. During discussions regarding patients' preferences, physicians should include a description of the procedures encompassed by CPR. Document patients' preferences as early as possible and revisit and revise them as appropriate.
- Honor advance directives stating patients' refusals of CPR whether patients are in or out of the hospital. When patients refuse CPR, physicians should not permit their personal value judgments to obstruct implementation of the refusals.
- If a patient lacks the ability to make or cannot communicate a decision regarding CPR, a surrogate decision maker may make a decision based upon the previously expressed preferences of the patient. If such preferences are unknown, make decisions in accordance with the patient's best interests. If no surrogate decision maker is available, an attending physician contemplating a "Do Not Resuscitate" order (DNR) should consult another physician or a hospital ethics committee, if either is available.
- If a patient (either directly or through an advance directive) or the patient's surrogate requests resuscitation that the physician determines would not be medically effective, the physician should seek to resolve the conflict through a fair decision-making process, when time permits.
- The attending physician should enter DNR orders, as well as the basis for their implementation, in the medical record.
- DNR orders and a patient's advance refusal of CPR preclude only resuscitative efforts after cardiopulmonary arrest and should not influence other medically appropriate interventions, such as pharmacologic circulatory support and antibiotics, unless they also are specifically refused.

# “We want to do everything we can to maintain patients’ rights at the end of life and to maintain the patient-physician relationship.”

The bill also creates similar notification and appeals processes for executing DNR orders when a patient’s death is not imminent and there is no clear directive as to his or her end-of-life wishes, and patients’ families would have access to an ethics committee hearing if they disagreed.

But Dr. Weltge was careful to note that unlike decisions over withdrawing futile care, which typically occur in longer term care, those involving DNRs can mean deciding whether to order additional aggressive interventions, often in an acute setting and without the luxury of time.

“We do think pieces of the law are working and being used appropriately. But there are some tweaks that could help make the process a little more transparent and give people more time” to cope, said Denise Rose, senior director of government relations for THA.

A 2012 THA survey of 200 hospitals revealed that 46 percent began implementing many processes included in the health care groups’ proposed reforms after Senator Deuell introduced similar legislation in 2007. That measure, Senate Bill 439, came in response to interim negotiations after Representative Hughes amended a broad Medicaid bill with a “treat until transfer” provision.

Senator Deuell’s legislative director, Scot Kibbe, says the goal of these reforms is to get everyone to the table.

“This is about getting a better process in place and having more safeguards so everybody is able to make informed decisions. At the same time, we have to address the fact that there are situations where treatment to transfer is just not viable,” he said.

The issue has been difficult for the legislature in the past “and one in which every side needs to have its views respected,” Mr. Kibbe added. “We are hoping this time that happens.”

The THA survey also reported that the dispute resolution process is rarely used.

In 2012, the process was initiated 21 times, and in 18 of those instances a resolution was reached, either because the physicians or surrogates involved changed their minds, the patient was successfully transferred during the 10-day window, or the patient died while continuing to receive treatment during that timeframe. Hospitals did not report the outcomes in the remaining three cases.

“We don’t think [such disputes] are happening often, but if this [legislation] is something we can do to alleviate fears or concerns without infringing on the

practice of medicine, then we should try to move forward,” Ms. Rose said.

Physicians recognize that end-of-life decisions often bring confusion.

Dr. Callas hopes the legislation will provide a framework to establish balanced and compassionate end-of-life care discussions. Without that, “the only way these decisions get made is by litigating them,” which also can be emotionally devastating for everyone involved.

“We want to do everything we can to maintain patients’ rights at the end of life and to maintain the patient-physician relationship,” he said.

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## Specialists outline 2013 legislative priorities

**Improving Medicare** and Medicaid payments, boosting the physician workforce through increased graduate medical education (GME) funding, and stopping scope-of-practice expansions by nonphysicians were among the top legislative priorities that medical specialty society representatives set at the Texas Medical Association’s 2012 Advocacy Retreat in December.

Physicians also heard from leaders of several state agencies about their goals and challenges during the 83rd Texas Legislature.

“The bottom line is, we need more doctors,” said Troy T. Feisinger, MD, a Sugar Land family physician and president of the Texas Academy of Family Physicians.

Other top legislative issues included reversing the state budget cuts to payments for care of dually eligible Medicare and Medicaid patients; preserving physicians’ rights to own specialty hospitals and to participate in coordinated care models such as accountable care organizations; protecting Texas’ strong medical liability reform laws; and administrative simplification.

From implementing electronic medical records, to meeting state and federal

audit criteria, to following health plan regulations for recouping payments, “it is seemingly impossible for Texas practices to comply” with the ever-increasing red tape and to manage the costs associated with it, said Texas Medical Group Management Association President Pam Potter.

She added that new antifraud rules promulgated by the Texas Health and Human Services Commission are unclear on what constitutes intentional versus unintentional mistakes, “making for a very scary proposition for physician practices.”

As for GME funding, Beaumont orthopedist David D. Teuscher, MD, a member of the Texas Higher Education Coordinating Board (THECB), reassured physicians that “help is on the way.”

He said restoring GME funding is “a top priority” for the board, which is asking lawmakers for a \$10 million increase in funding for the Family Practice Residency Program and another \$4.7 million for the Physician Education Loan Repayment Program, among other restorations to major cuts made last session.

David W. Gardner, THECB deputy commissioner for academic planning and policy, also told physicians that the board will continue to advocate for a 1:1 ratio of GME residency training slots to medical graduates, and it has requested \$11.5 million for that purpose.

“We have made clear to [lawmakers] that this is the board’s minimum recommendation,” he said.

Ensuring health plans maintain adequate networks and protecting physicians’ right to bill for out-of-network services they provide were key goals for a host of medical specialty societies, including those of anesthesiologists, emergency physicians, pathologists, and radiologists.

Dallas pathologist A. Joe Saad, MD, said he was “alarmed” by Texas Department of Insurance (TDI) Commissioner Eleanor Kitzman’s decision to rescind previously adopted rules that required insurers to maintain adequate physician and hospital networks and to disclose to patients their out-of-network obligations. TMA strongly supported those rules.

Austin gastroenterologist Bruce A.

Levy, MD, who has participated in TDI workgroups over the years, said a committee of payers, providers, consumers, and former TDI leaders “did reach a consensus” on the original regulations after 18 months of discussions, despite the newly appointed commissioner’s statement to the contrary. Undoing these negotiations could “chill the desire” of stakeholders to put in the same hard work in the future, he added.

Ms. Kitzman said the department decided to redraft the rules because it “needed additional guidance from the legislature” to address “inconsistencies” in various state laws governing exclusive provider networks.

She said some provisions in the earlier rules created “an unlevel playing field between various entities,” but the recent version “comes as close to holding a patient harmless as possible” when health plans do not have a complete network. “That’s my goal.”

TMA opposed the latest draft of the new regulations.

The Division of Workers’ Compensation, meanwhile, has undergone so many reforms over the years, “it’s time to take a breath and see if they are working,” Commissioner Ron Bordelon said.

The division continues to move forward this year with one of those reforms, a closed drug formulary, which the legislature continues to look at as a cost-saver and a way to reduce prescription drug overuse and abuse (see “Closed Formulary, Part Two,” pages 41–43).

“It doesn’t look like it’s going to be a bad budget year for small state agencies,” Texas Medical Board (TMB) Executive Director Mary Robinson said.

However, less than half of the revenue TMB brings in from things like physician licensing fees stays within the agency. With record numbers of physician license applicants coming in and limited staff and resources, the medical board is considering asking the legislature to allow the agency to fund itself independently from the state budgeting process.

The move could result in higher licensing fees. ■

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Texas Medical Board Executive Director Mari Robinson, left, spoke during the TMA 2012 Advocacy Retreat about the challenges facing state agencies during the 83rd Texas legislative session that will impact physicians.