

EXHIBIT 1
DATE 2/4/05
HB 526

IF PATIENTS CAN CHOOSE TO DIE SHOULDN'T THEY ALSO BE ABLE TO CHOOSE TO LIVE?

Unfortunately, many doctors and hospital ethics committees are now arguing they should have a veto over a patient's request to be allowed to live if the doctor, in disagreement with the patient or the patient's family, thinks the patient's "quality of life" is so poor her or his life is not worth living. They consider "medically inappropriate" not just treatment that will *not* save a patient's life, but also treatment that *would* save life if the life's quality is deemed poor.

M California hospitals are implementing procedures for the involuntary denial of life-saving medical treatment, announced in a Fall 2000 medical journal article:

In its Fall 2000 issue, the *Cambridge Quarterly of Healthcare Ethics* published a study of the "futile care" policies at 26 California hospitals.

Fourteen of the hospitals specifically defined clinical conditions that did not warrant providing life support. **Most of them would deny treatment to patients with severe, irreversible dementia. This would presumably include people with Alzheimer's disease.**

All but two of them specifically defined circumstances in which treatments should be considered nonobligatory even if requested by a patient or patient representative. Only one stated that "physicians should act to support the patient's life," without any further qualification.

Of the hospitals who declared

sometreatments nonobligatory, 22 of them made it clear that the criteria for judging whether to provide the treatment hinged on patient awareness and potential to appreciate its benefit. Whether or not the treatment would preserve the patient's life, and whether the patient or family wanted to pursue that goal were not deemed decisive factors.

In cases in which all efforts to resolve disputes fail, 9 of the hospitals give the physician the final authority.

The authors of the study note that, "Physicians should not expect the courts to give them prior permission to forgo futile treatment..." but suggested that they, "refuse to provide nonbeneficial treatment and then defend their decisions as consistent with professional standards."¹

The California hospitals are not alone. Medical journals are full of articles advocating involuntary denial of life-saving medical treatment:

M Murphy and Finucane openly advocate policies that would involuntarily deny life-saving medical treatment to control costs, initially to those with a low probability of survival. "Explicit limits will mean that a small number of 65-year-olds with pancreatic cancer or 19-year-olds with severe head trauma will die months or weeks earlier than they would have with CPR." They see this as only the beginning, however: "A second reason that new DNR policies will help control costs is that they may influence practitioners' practices in other areas of medicine. ... The cost-conscious physician of the 21st century must be comfortable in limiting other therapies and diagnostic tests that rarely lead to desirable outcomes."²

M In 1999 *Critical Care Medicine* published a study on ethics consultations in situations where physicians intended to write DNAR (Do Not Attempt Resuscitation) orders against the wishes of the patients or families. Of the 31 patients the physicians deemed futile, 8 survived to discharge. The authors noted,

"Indeed, the fact that...26% survived suggests that considerable prognostic uncertainty may exist in cases that involve unilateral DNAR orders."³

M One study, based on physician interviews, found that "Most often when futility arguments were invoked, they were used to support evaluative judgments based on quality of life considerations, only rarely to designate treatments that were medically inefficacious. Indeed, throughout the transcripts, physicians sought to frame value judgments as medical decisions. All but one physician seemed unaware of the double meaning they ascribed to the word."⁴

M A nursing home study in the March 1991 *New England Journal of Medicine* found that 25% of the time advance directives were not followed by the nursing home and medical staff. *In 18% of the cases the patients were denied treatment they had requested, compared to only 7% of cases in which treatment they had rejected was provided.*⁵

How Would a Law Against Involuntary Euthanasia Work?

The proposed law simply says this: ~~if denial of treatment against the will of a patient or the patient's surrogate would cause the patient's death, the provider must allow the patient to be transferred to a provider willing to preserve the patient's life. The unwilling doctor or hospital would merely have to provide treatment to preserve the status quo--the patient's life--until the transfer is completed.~~

Should Patients "Practice Medicine?" How Can You Force a Doctor to Give Treatment He or She Thinks Is Medically Inappropriate?

~~The proper role of a physician includes diagnosis, making judgments about the probable~~

~~effect of providing alternative medical treatments, and administering medical treatment; it does not include judging that a life that can be preserved is not worth preserving, overriding the opinion of the person whose life it is.~~

It is appropriate for a physician or other health care provider to refuse *physiologically futile* treatment – treatment that, in reasonable medical judgment, will neither prevent the death nor ameliorate or preserve the health of the patient. What is objectionable is for a health care provider to refuse treatment that *would* prevent death on the grounds that the patient's life would not be worth living – despite the contrary opinion of the patient or the patient's surrogate.

M The American Medical Association's Council on Ethical and Judicial Affairs has warned that assessments of futility based on "quality of life" judgments threaten patient autonomy:

This approach to defining futility replaces a medical assessment (ie, whether a reasonable potential exists for restoring cardiopulmonary function to the patient) with a nonmedical value judgment that is made by the treating physician (ie, whether 1 day, 1 week, or 1 month of survival by the patient -- perhaps in a severely debilitated state -- is of value to him or her). This interpretation of futility is inconsistent with the principle of patient autonomy, which requires that patients be permitted to choose from among available treatment alternatives that are appropriate for their condition, particularly when such choices are likely to be influenced by personal values and priorities.

... Examples of some benefits that have been described as appropriate indications for CPR [cardio-pulmonary resuscitation] are a "meaningful existence" after resuscitation or an acceptable quality of life for the patient. These determinations, which attempt to define the types of treatment and the qualities of existence that constitute a benefit for the patient, undermine patient autonomy because they are based on the value judgments of someone other than the patient.

These judgments of futility are appropriate only if the patient is the one to determine what is or is not of benefit, in keeping with his or her personal values and priorities.⁶

REMEMBER . . .

**PATIENT AUTONOMY INCLUDES THE
RIGHT TO CHOOSE LIFE !**

Endnotes

REMEMBER . . .
PATIENT AUTONOMY INCLUDES THE
RIGHT TO CHOOSE LIFE !

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1. Lawrence Schneiderman and Alexander Morgan Capron. "How Can Futility Policies Contribute to Establishing Standards of Practice?" *Cambridge Quarterly of Healthcare Ethics* Vol. 9 (Fall 2000): pp. 524-531.
 2. Donald J. Murphy, M.D. & Thomas E. Finucane, M.D., "New Do-Not-Resuscitate Policies: A First Step in Cost Control," *Archives of Internal Medicine* vol. 153 (July 26, 1993): pp. 1641, 1644, 1647.
 3. David Casarett and Mark Siegler. "Unilateral Do-Not-Attempt-Resuscitation Orders and Ethics Consultation: A Case Series," *Critical Care Medicine* vol. 27, no. 6: pp. 1116-1120.
 4. Mildred Z. Solomon, "How Physicians Talk about Futility: Making Words Mean Too Many Things," *The Journal of Law, Medicine & Ethics* vol. 21, no. 2 (Summer 1993): pp. 231, 232-33.
 5. Marion Danis, M.D., et al., "A Prospective Study of Advance Directives For Life-Sustaining Care," *New England Journal of Medicine*, vol. 324 (March 28, 1991): p. 882.
 6. American Medical Association Council on Ethical and Judicial Affairs. "Guidelines for the Appropriate Use of Do-Not-Resuscitate Orders," *Journal of the American Medical Association* vol. 265, no. 14 (April 10, 1991): pp. 1868, 1870.

ANNOTATION OF MONTANA BILL CONCERNING INVOLUNTARY DENIAL OF LIFESAVING MEDICAL TREATMENT

Section 1 of the draft bill adds a new definition to Mont. Code Ann. §50-9-102 in the “Rights of the Terminally Ill Act”, for the term, later to be used in the substantive amendment of §50-9-203, “Direction to provide treatment, nutrition, or hydration”.

The objective is to cover all the possible cases in which a valid directive to provide treatment might be given:

Competent person : “by an individual currently able to make decisions regarding administration of medical procedures or interventions”

The underlying Montana law does not include any definitions of, or references to, competent or incompetent individuals, those with or without capacity, or other clear shorthand phrase. §§50-9-105(1)(b) and 50-9-106(1)(a) refer to an individual determined to “no longer be able to make decisions regarding administration of life-sustaining treatment”. 50-9-102 (9) defines “life-sustaining treatment” to mean “any medical procedure or intervention that, when administered to a qualified patient, serves only to prolong the dying process.” It is important to protect the right of competent people to choose life-saving treatment regardless of whether they are “qualified”, i.e. terminally ill, “patients” and regardless of whether someone might judge the treatment as “serv[ing] only to prolong the dying process.” Therefore, drawing on the rest of the definition of “life-sustaining treatment”, competent persons are covered by the phrase “able to make decisions regarding administration of medical procedures or interventions.”

Advance directive : “by an individual’s declaration”. It is important to include protection for instances in which a person no longer competent has, while competent, executed an advance directive such as the Montana Will to Live directing that he or she be provided life-saving treatment, nutrition or hydration. The legal term used in Montana for such advance directives is “declaration”.

Health care agent : “by an individual designated to act for a declarant”. When an advance directive names someone to make health care decisions if the person who executes the advance directive is unable to do so, that person’s decision for treatment should be protected. The term “individual designated to act for a declarant” comes from §50-9-103(4), which also establishes that the term includes a person designated by judicial appointment to do so, as well as an “attorney-in-fact” named by a power of attorney.

Surrogate : “by an individual authorized to consent or withhold consent under 50-9-106(2)”. This covers cases in which a now incompetent individual has left no advance directive, so that under Montana law decisions are made by a prioritized list of individuals, beginning with family members.

Section 2 of the bill is the key substantive protection. A new subsection 2 for §50-9-203 states:

(2) In the case of a direction to provide treatment, nutrition, or hydration to an individual, any health care provider who has responsibility for the treatment and care of the individual must provide the directed treatment, nutrition, or hydration so long as its denial would in reasonable medical judgment be likely to result in the death of the individual, the health care provider is physically and legally able to provide it, and its provision would not require denial of the same treatment, nutrition, or hydration to another patient. A health care provider who objects to providing it may instead transfer the individual to a health care provider willing to honor the direction, but must continue to provide it until the transfer is effectuated.

“so long as its denial would in reasonable medical judgment be likely to result in the death of the individual”

This phrase makes clear that the bill requires ONLY treatment whose denial “IN REASONABLE MEDICAL JUDGMENT” would be likely to result in the death of the patient. Treatment that would be physiologically futile, such as laetrile, or providing CPR when doctors judge it would not be likely to save the patient’s life, is not required. While the decision *whether* to save the patient’s life, a value judgment, should be left to the patient or those speaking on the patient’s behalf, the judgment whether the patient’s life *can* be saved, and the best medical *means* to save it, are technical medical judgments that this amendment leaves to the physician. This amendment does NOT interfere with the practice of medicine by allowing the substitution of lay views for the MEDICAL judgment of the doctor.

“so long as ... the health care provider is physically and legally able to provide it”

This phrase ensures:

- 1) that health care providers are not required to provide treatment, even pending transfer, outside their legal scope of practice, and
- 2) that doctors are not required to provide treatment they are physically unable to provide (for example, treatment unavailable in the facility where the patient is located—although, if the treatment could physically be provided by transferring the patient to another facility, e.g. from a nursing home to a hospital, that would be required).

“so long as ... its provision would not require denial of the same treatment, nutrition, or hydration to another individual.”

This phrase ensures that the requirement to provide treatment does not apply when more patients need it than can be provided it, as is frequently the case with organ transplants. If there are 500 people whose lives could be saved by a kidney transplant, but only 100 kidneys available for transplant, this language means the amendment would give no individual patient a legal claim to a transplant. Similarly, if there were a major disaster that swamped a hospital emergency room, such as a chain automobile collision that resulted in 10 people needing respirators when there were only 3 available, this language would protect health care providers from any legal liability for engaging in triage, necessarily denying respirators to 7 people who could benefit from them. “A health care provider who objects to providing it may instead transfer the individual to a health

care provider willing to honor the direction, but must continue to provide it until the transfer is effectuated.”

This crucial sentence mandates treatment pending transfer. The opportunity for someone on a respirator to be transferred would be fairly meaningless if the health care provider could disconnect the respirator while looking for another provider willing to accept transfer or while transporting the patient. The patient in all likelihood would not survive to be transferred. Note that if for any reason a transfer is not in fact arranged, the requirement to treat remains in full force.

New subsections 3 and 4 facilitate the chance for patients to find health care providers with compatible values who may accept transfer. It is extremely difficult for most lay people, knowing little or nothing about the network of doctors and hospitals, or their views on a patient’s right to life, to know how to go about looking for a place to transfer. Setting up a registry, with a requirement that a printout of the website including it be given to the patient or surrogate, should help facilitate transfers.

Section 3 provides a critically important conforming amendment. Without the proposed amendment, section 2 could be rendered meaningless by §50-9-204(2), which essentially allows any health care provider to excuse a violation of the act by claiming the violation “is in accord with reasonable medical standards.” Since many bioethicists, physicians, and medical groups have taken the position that it is appropriate for health care providers to deny life-saving medical treatment, food, and fluids against the will of a patient or the patient’s surrogate if they consider the patient’s quality of life too poor, this would create a giant loophole. The proposed amendment ensures that the subsection cannot be invoked to authorize violation of section 2.

