

The Texas Advance Directives Act: A Threat to Catholic Identity?

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Introduction

Medical “futility” cases have generated controversy among medical professionals, bioethicists, legal professionals and the public for decades due to widespread disagreement about the point at which a medical intervention is no longer considered beneficial to a critically ill patient. To date, no uniform method has been established to resolve these cases. This has prompted the enactment of laws including the Texas Advance Directives Act of 1999 (TADA). The TADA establishes a process for discerning the appropriateness of a physician’s request to withhold life-sustaining treatment (LST), despite the patient’s pre-existing advanced directive. This process includes a consultation between the patient’s family and an ethical/medical review committee to analyze the patient’s medical record and determine whether the LST in question is medically inappropriate. If the treatment is deemed inappropriate, the physician is afforded legal safe-harbor to unilaterally withhold LST after a minimum ten-day waiting period, despite the family’s

objection, unless another facility is willing to accept the transfer of the patient.

This legal protection granted to physicians requesting to unilaterally withhold LST despite a family’s objection raises the question whether such a law poses a threat to the identity of Catholic hospitals. Most immediately, it raises concerns with regard to observance of the *Ethical and Religious Directives for Catholic Health Care Services* (ERDs). Applicable directives include Directive 57 since a physician can decide to withhold treatment from a patient if it is deemed medically inappropriate, Directive 58 because it allows physicians to withhold artificial nutrition and hydration, and Directive 60 which prohibits euthanasia. Moreover, even if the TADA does not threaten Catholic identity with regard to these directives, it raises concerns whether it threatens a Catholic institution’s commitment to provide high quality end-of-life care to suffering and vulnerable patients and families. To address these concerns it is necessary to review data collected from health care institutions that have made use of the process. An analysis of recent review studies lends insight into the effects of the TADA on cases of medically inappropriate treatments, and will help evaluate the potential impact of these laws on Catholic hospitals.

Does the TADA Violate the ERDs?

Contentious medical “futility” cases including that of Emilio Lee Gonzales, a 16-month-old pediatric patient suffering from a fatal neurological condition known as Leigh’s disease, have raised questions regarding the law’s compliance with the church’s moral tradition, articulated in part by the ERDs, in the context of end-of-life decision making.¹ The tradition teaches that individuals have a duty to preserve their life, but not by any means necessary. In 1957, Pope Pius XII attempted to clarify that individuals have an obligation to preserve their life by ordinary means, “that is to say, means that do not involve a grave burden for oneself or another.”² This obligation does not extend to the use of extraordinary or disproportionate means. Directive 57 represents this teaching of Pius XII, stating:

A person may forgo extraordinary or disproportionate means of preserving life. Disproportionate means are those that in the patient’s judgment do not offer a reasonable hope of benefit or entail an excessive burden, or impose excessive expense on the family or the community.³

Given the significance that Directive 57 places on the patient’s ability to determine whether a treatment is ordinary or extraordinary, it may appear that the TADA violates this directive because it allows physicians to withhold LST from a patient based on an external extraordinary means judgment.

However, this argument is flawed as it misinterprets the directive. Directive 57 morally justifies a patient’s decision to refuse a given treatment based on the principle that they themselves have judged the benefits associated with the treatment to be insufficient or the burdens to be excessive. A true violation of Directive 57 would occur if a physician imposed a treatment on a patient, who has judged it extraordinary, because the physician has deemed it ordinary. As mentioned, Directive 57 morally justifies a patient’s ability to refuse a treatment in instances in which it provides insufficient benefit or excessive burdens or harm. Therefore, in its application, this directive assumes that a treatment is offered to the patient. It does not authorize a patient to request a treatment, either ordinary or extraordinary.

Others may also argue that under the provisions of Directives 56 and 57, physicians have an obligation to honor a patient’s request for treatments, especially those that the patient considers ordinary.⁴ However, neither directive speaks to the physician’s duty to offer a treatment. Since the Catholic tradition supports the physician’s ability to conscientiously object in certain circumstances, the tradition does generally recognize that the duty to offer treatment is not absolute.⁵ Yet, under the TADA the physician’s ability to refuse is clearly limited. Recent studies in *Critical Care Medicine* and the *Journal of Perinatology* report that the

review committee disagreed with the physician in 30 percent and one-third of cases, respectively.⁶ In the case that the committee disagrees with the physician's judgment, the law specifies that the physician must continue to provide treatment. Therefore, the comprehensive review process can be understood, in part, as a means of determining the duty of the physician to provide LST or, rather, the threshold at which a physician can legitimately refuse. In essence, this law enables physicians to practice conscientiously in cases in which treatment is medically inappropriate and even harmful. Therefore, it seems the TADA does not violate Directive 57 because the directive speaks only to the patient's ability to refuse treatment, not request it. Thus, the TADA allows physicians the limited ability to refuse to provide treatment, not because they can judge means to be extraordinary, but because they have, in principle, a limited duty to offer or provide treatments to patients.

While Directive 57 does not speak to the physician's duty to provide treatment, the same cannot be said for Directive 58.⁷ Though there has been considerable debate over the proper interpretation of the language used in the directive, it seems that, at a minimum, Directive 58 establishes that medically assisted nutrition and hydration (MANH) need not be provided in all circumstances.⁸ This is especially true when it is objectively discernible that nutrition and hydration are not achieving their

physiologic ends (e.g. when they are not being assimilated) or when the artificial means (e.g. surgery, tube, maintenance) used to administer the nutrition and hydration have become harmful to the patient.

Given the controversy concerning the provision of MANH in Catholic health care, its status under the TADA is a particularly sensitive issue.⁹ Some critics may hold that this law enables institutions to withhold MANH from a patient even if it is the only LST being provided.¹⁰ This would entail: (1) the physician judging the treatment to be medically inappropriate; (2) the committee agreeing with the physician's judgment; (3) no other medical institution is willing to accept transfer; and (4) the family hasn't filed or received a court-ordered injunction. Further, actual practices involved with implementing the TADA guard against this scenario. The patients in cases that appeal to the TADA process are typically admitted in the intensive care unit of the hospital, have multiple co-morbidities, and are considered to be imminently dying.¹¹ In one pediatrics study, all but one patient was ventilator dependent, all had do not resuscitate orders, were receiving MANH and suffered from a range of devastating conditions.¹² Interestingly, the one patient who was not ventilator dependent but received MANH, a patient who suffered from severe hypoxic ischemic encephalopathy, aspiration pneumonia, and seizure disorder, was transferred to another facility on day eight of ten for a

tracheotomy and was discharged home.¹³ However, given the uniformly severe condition of the patients reported in these studies, in addition to the multiple decision points within the process, data suggest that the process is not invoked or carried to conclusion in order to simply remove MANH.

Rather, it seems physicians are willing to provide MANH to patients even if the purpose for doing so is primarily for the benefit of the family. For instance, one study notes that, “Although nutrition and hydration are not obligatory when death is imminent, they may be made available in amounts carefully adapted to the patient’s hemodynamic and respiratory status to avoid potentially distressing respiratory or gastrointestinal symptoms. Many families find the continued provision of discrete amounts of nutrition comforting.”¹⁴

At first glance, the use of the term obligatory may rouse the attention of moral theologians, especially in light of the “in principle...obligation” language of Directive 58. However, as the researchers explain, the concern regarding the provision of MANH in these circumstances is the harm that it causes patients, which is a consideration that the directive explains is significant. However, the concern for gauging the appropriateness of the use of MANH in these cases highlights the need for at least some members of the review committees to possess adequate expertise in applying the ERDs to these difficult situations.¹⁵

Some individuals fear that the TADA will legally protect physicians in cases of passive euthanasia, even though the law forbids it.¹⁶ Euthanasia, an act or omission intended to alleviate a patient’s suffering through death, is always forbidden in Catholic hospitals under Directive 60.¹⁷ Nonetheless, there is a significant moral difference between removal of inappropriate and harmful medical treatments and euthanasia. First, there exists a difference of intention. One seeks to relieve suffering through the discontinuation of inappropriate and harmful treatment and the other seeks to relieve suffering through death. Second, there is a difference in causation. One allows the progression of the underlying terminal condition and the other hastens death of the patient through a given act or omission. As previously mentioned, under the TADA, case review studies have demonstrated that physicians use the TADA process in cases in which the LST appears to be both inappropriate and causing harm to patients that are imminently dying. Therefore, in these cases, removal of LST can rightly be understood as allowing the underlying terminal condition to run its course and not as an act of euthanasia by omission. Furthermore, this withholding of treatments is not done in order to relieve the patient’s suffering by causing their death but rather to relieve the patient of the suffering the LST is causing while foreseeing that the underlying condition will bring about their death. Moreover, physicians are only allowed to withhold LST which, “does not include the

administration of pain management medication or the performance of a medical procedure considered to be necessary to provide comfort care.”¹⁸

Hence the law protects against concerns that “if the patient in question cannot find alternative care, then all treatment is denied and the patient dies a tragic and painful death.”¹⁹ Hence, the TADA protects against such misgivings and explicitly specifies that unilaterally withholding LST does not apply to pain or comfort measures.

In summation, the TADA does not seem to represent a threat to the identity of a Catholic health care institution seeking to adhere faithfully to the ERDs. Specifically, it does not threaten to violate Directives 57, 58 or 60. Since the TADA does not represent a violation against Directive 57 and case review studies indicate that actual practices guard against violations of Directives 58 and 60, one must question whether the TADA negatively affects the identity of a Catholic hospital as an health care institution committed to providing compassionate, high quality end-of-life care.

How Does the TADA Influence the Provision of High Quality Medical Care?

Although I have specifically addressed Catholic objections to the law, there are also general concerns applicable to all health care institutions, secular and religious.²⁰ One of the law’s most vocal critics, Robert Truog, a physician who

practices in Boston, argues against the TADA because of “the possibility that the law is being used as a way to bypass the hard work of engaging families in the difficult conversations often necessary to reach agreement in the face of conflict.”²¹ Catholic health care ethicists, Ron Hamel and Michael Panicola, have reported a similar caution of so-called “futility” policies because of the danger that physicians will view recourse to the “futility” policy as the predominant method for handling difficult cases instead of attempting to increase the quality of communication between families and staff.²² Drs. Hamel and Panicola fear the law negatively influences physician and patient-family communication, and, in cases of conflict, enables the physician to merely approach the review committee instead of meaningfully engaging with the family. Hence, they propose improving communication practices in order to proactively avoid conflict cases instead of defensively creating “futility” policies and laws. In contrast, Truog supports developing a robust internal hospital “futility” policy such as the model he developed at the Children’s Hospital Boston.

Truog is therefore wary of the statistics reported by Robert Fine, MD and lawyer Thomas Mayo of Dallas, who state that in the Baylor University Medical Center, during the two years after the enactment of the TADA, explicit futility consults increased 67 percent while general consults increased 39 percent.²³ Truog’s concern stems from the propensity of the

committee to agree with the physician, which another study indicates happens in 70 percent of cases.²⁴ He claims the committee concurrence rate is “essentially the inverse of our experience with a hospital policy” and so raises questions of committee bias in favor of physicians.²⁵ Truog views these statistics as confirmation of his suspicions that physicians are neglecting communication with the family and instead using the review committee to resolve conflict. Though Truog is skeptical of the rise in ethics consultation, Fine, one of the law’s most ardent supporters, views it positively. Fine argues in support of the law because it gives physicians something that Truog’s proposal does not: legal support.²⁶ Fine further claims, “before that [full dispute resolution] process happens, the very presence of the law encourages conversation between surrogates and health-care professionals, with referral to ethics committees as needed.”²⁷ Thus, according to Fine, the rise in ethics consultations actually indicates an increased propensity for physicians to discuss end-of-life concerns with families and other professionals.²⁸

Furthermore, it is peculiar that Truog would consider a rise in ethics consultations as cause for concern or that it indicates a decline in effective communication between the medical team and the family, even if there is a tendency for the review committee to agree with the referring physician’s decision. Effective communication in difficult conversations regarding challenging treatment decisions

is the ethics consultation service’s *raison d’être*. Referring to the very study that concerned Truog, Fine emphasizes that “basic clinical ethics consultation alone, without entering the formal dispute resolution process...brought closure to 98 percent of cases in which an ethics consultation was requested, including 86 percent of explicit futility cases.”²⁹ Moreover, one recent study indicates that ethics consultations lead to a reduction in hospital days, days spent in the ICU and days on a ventilator for patients who received a consultation but did not survive to discharge, and that, “more than 80 percent of both health care providers and patients/surrogates agreed or strongly agreed that ethics consultations were helpful in addressing treatment conflicts.”³⁰ Thus, it seems that an increase in ethics consultations improves communication and that these efforts are successful at producing better outcomes. These data are encouraging since ineffective communication both among medical staff and between medical staff and families are two of the leading causes for initiating medically inappropriate treatment.³¹

Despite this positive development, Truog remains concerned that the increasing number of ethical consultations changes the dynamics of the communication between family and physician. Effectively, he holds that although there is an increase in consultations, it does not follow that the communication is improved. However, the number of cases examined under the TADA process, as evidenced in

several studies, is miniscule compared to the amount of ethical consultations for cases of inappropriate medical treatments.³² This indicates that most cases of futility conflict are resolved through other means.³³ Furthermore, Fine and Mayo report the greatest impact of the law is its influence on communication between staff and family, explaining, “We believe that the greatest significance of the law is how it changes the nature of conversations between providers and patients’ families about futile-treatment situations by providing conceptual and temporal boundaries.”³⁴ Other studies make similar claims that communication between staff and families benefited because of the process, claiming, “We conclude that the MARC [Medical Appropriateness Review Committee] promoted communication and provided additional protections to patients, families, physicians, and staff.”³⁵ Truog’s main concern, that the quality of care and communication with the family is being diminished, does not seem to find support. Quite the opposite, experience reveals that the process—or simply its mere presence—actually increases and improves communication between all parties.

As outlined in the TADA, the process introduces certain boundaries, which as Fine reports, has led to this improvement in communication. As Fine mentions, the boundaries that the process establishes are important for both families and physicians. He explains:

“It clearly places limits on families and surrogates who request therapies that the profession considers futile. At the same time, it forces the profession to think carefully about the concept, for if another physician and facility are willing to provide the “futile” treatment, then the law does not allow withdrawal of that treatment on grounds of futility. The law also provides temporal boundaries (12 days) for resolving disagreements over futile treatments.”³⁶

Given this temporal boundary, most families do not insist on further treatment.³⁷ He explains:

“We have had many conversations with families who have said in essence, “If you are asking us to agree with the recommendation to remove life support from our loved one, we cannot. However, we do not wish to fight the recommendation in court, and the law says it is OK to stop life support, then that is what should happen.”³⁸

Fine notes that the conceptual and temporal limitations of the process actually provide relief to families, and the time needed to achieve family agreement after ethics intervention changed from “days to weeks,” before the TADA, to “hours to days” after the TADA.³⁹ Similarly, the authors of another study described how the process provided significant benefits for the family, noting that the family felt relieved that all options had been exhausted and the burden of the

decision to remove LST from their loved one had been eased.⁴⁰

Still, some family members may question the physician's dismal prognosis and feel these boundaries indicate a physician is prematurely "giving up." However, physicians' projections of imminent patient demise seem to be accurate in cases in which the review committee is in agreement with the physician, and has been reflected in two recent studies. In one study, 29 percent of patients died prior to the end of the ten-day waiting period, even though they continued to receive LST.⁴¹ In another study, two of six patients died before the waiting period ended.⁴² However, even given their general accuracy in predicting the ineffectiveness of a treatment or the imminence of the patient's demise, research indicates that surrogates often doubt the physician's prognosis.⁴³ A review of these cases indicates that mere judgments about the ineffectiveness of treatments or the imminence of the patient's demise were not the sole reason physicians initially invoked the process. One study noted, "in each of the six cases reviewed here, the MARC process demonstrated concern by caregivers both for futility of treatment and that the continuation of treatment would be inhumane, two of the criteria under CATA [the Child Abuse and Treatment Act of 1984]."⁴⁴ Reports such as these indicate that physicians do not invoke the process based solely on belief in the accuracy of prognosis but rather approach this process due to ethical concerns regarding the best interests of the patient.

Still, others concerned with the law's influence on the quality of end-of-life care might argue that the TADA allows physicians and institutions to abandon or "dump" vulnerable patients. However, the law requires the institution to assist the family in exhaustively exploring an appropriate transfer for the patient during the mandated ten-day waiting period. The decision to discontinue LST in patients for whom an appropriate transfer is not achieved therefore extends beyond the institution. Medically inappropriate treatment is "community-based...in that if another institution is willing to provide a disputed treatment that the first institution believes is medically inappropriate or futile, the disputed treatment may not be stopped."⁴⁵ This means that LST can be removed only when no other physician or institution would be willing to provide it. Transfer, nevertheless, is a real possibility. According to one such study, transfer outcomes were almost equal to the number of outcomes in which LST was withdrawn after the designated waiting period.⁴⁶ Moreover, transfer can be considered a good outcome as "the transfer process can actually result in an amicable solution between the family and the caregivers."⁴⁷ Finally, the authors of another study noted how all parties involved with the decision, especially the family, felt relief because, through their thorough examination of all the options, they have done everything within their respective power to properly care for their loved one.⁴⁸

Conclusion

In conclusion, it seems that, with certain qualifications, Catholic hospitals should support laws that use the TADA as a model because, in the rare case that the process is actually implemented, it allows physicians to practice according to professional conscience and seeks the good of the patient by preventing the harmful prolongation of the dying process while avoiding euthanasia. Furthermore, evidence from those who have reviewed experiences of cases that invoked the process indicates that, in general, the law tends to improve the quality of the end-of-life care in the most difficult circumstances because it increases communication between staff and families. Specifically, it often provides relief to families struggling with the weight of the decision to remove LST from their loved one.

The general concern regarding the law's compatibility with the ERDs highlights another important point: the TADA establishes minimums. Catholic hospitals can make internal policies regarding the implementation of the TADA that go beyond the minimums that the law establishes. For instance, a hospital might adopt a policy extending the waiting period or requiring a second opinion before the physician can submit the case to the review committee. Additionally, it could even revise the policy for the implementation of the TADA process to specify that it cannot be applied to a case in which the patient is merely receiving

MANH. In fact, the law encourages developing just such a policy.⁴⁹ While other means of resolving conflicts over medically inappropriate treatment are highly successful, used comparatively often, and should be explored before turning to legal means for resolution, laws like the TADA are, and should be, a last option that is nonetheless worthy of qualified support by Catholic hospitals.

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NOTES

¹ Elizabeth Cohen, "Fight over Baby's Life Support Divides Ethicists," http://articles.cnn.com/2007-04-25/health/baby.emilio_1_ventilator-life-support-medical-experts?_s=PM:HEALTH.

² Pope Pius XII, "The Prolongation of Life: Address to and International Congress of Anesthesiologists," in *Catholic Health Care Ethics: A Manual for Practitioners*, ed. Edward James Furton, Peter J. Cataldo, and Albert S. Moraczewski (Philadelphia, PA: National Catholic Bioethics Center, 1957), 300.

³ United States Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services*, 5th Edition, (Washington, D.C.2009), n.57.

⁴ Directive 56 discusses "ordinary means". It reads, "A person has a moral obligation to use ordinary or proportionate means of preserving his or her life. Proportionate means are those that in the judgment of the patient offer a reasonable hope of benefit and do not entail an excessive burden or impose excessive expense on the family or the community." Ibid., n.56.

⁵ See, Daniel P. Sulmasy, "What Is Conscience and Why Is Respect for It So Important?," *Theoretical Medicine & Bioethics* 29, no. 3 (2008).

⁶ Martin L. Smith et al., "Texas Hospitals' Experience with the Texas Advance Directives Act," *Critical Care Medicine*. 35, no. 5 (2007): 1274. E. B. Eason et al., "Withdrawal of Life Sustaining Treatment in Children in the First Year of Life," *Journal of Perinatology* 28, no. 9 (2008): 643.

⁷ Directive 58 reads, "In principle, there is an obligation to provide patients with food and water, including medically assisted nutrition and hydration for those who cannot take food orally. This obligation extends to patients in chronic and presumably irreversible conditions (e.g., the "persistent vegetative state") who can reasonably be expected to live indefinitely if given such care. Medically assisted nutrition and hydration become morally optional when they cannot reasonably be expected to prolong life or when they would be "excessively burdensome for the patient or [would] cause significant physical discomfort, for example resulting from complications in the use of the means employed." United States Conference of Catholic Bishops, "ERDs," n..58.

⁸ See, Christopher O. Tollefsen, *Artificial Nutrition and Hydration the New Catholic Debate* (Dordrecht: Springer, 2008).

⁹ See, David M. Zientek, "The Impact of Roman Catholic Moral Theology on End-of-Life Care under the Texas Advance Directives Act," *Christian Bioethics* 12, no. 1 (2006).

¹⁰ For instance, it could be the case that a review committee agrees with a physician's judgment that the provision of MANH to an otherwise stable, i.e. not considered to be imminently dying, patient in a persistent vegetative state (PVS) to be medically inappropriate. It could further be the case that no other health care institution is willing to accept patient transfer and that, after the waiting period has expired, the MANH is withheld from the patient. This would seem to touch on the same question (question #2) that the American bishops posed to the Congregation for the Doctrine of the

Faith in the 2007 statement, "Responses to Certain Questions of the United State Conference of Catholic Bishops Concerning Artificial Nutrition and Hydration" See, Congregation for the Doctrine of the Faith, "Responses to Certain Questions of the United State Conference of Catholic Bishops Concerning Artificial Nutrition and Hydration," *The National Catholic Bioethics Quarterly* 8, no. 1 (2007): n.2.

¹¹ R. Okhuysen-Cawley, M. L. McPherson, and L. S. Jefferson, "Institutional Policies on Determination of Medically Inappropriate Interventions: Use in Five Pediatric Patients," *Pediatric Critical Care Medicine* 8, no. 3 (2007): 227-8.

¹² Eason et al., "Withdrawal," 643.

¹³ *Ibid.*, 643.

¹⁴ Okhuysen-Cawley, McPherson, and Jefferson, "Institutional Policies," 227.

¹⁵ This hypothetical scenario raises another interesting question: would a Catholic hospital be morally obliged to accept the transfer of such a patient if the physician and review committee at his current hospital agree that the treatment is medically inappropriate? According to Directive 58, it would seem the answer would be a qualified yes, since other considerations of the concrete circumstances would have to be taken into account. Nonetheless, if this is true then it would seem to be a check against other hospitals removing MANH from un-consenting PVS patients.

¹⁶ *Texas Advance Directive Act*, (1999), 166.050.

¹⁷ Directive 60 reads, "Euthanasia is an action or omission that of itself or by intention causes death in order to alleviate suffering. Catholic health care institutions may never condone or participate in euthanasia or assisted suicide in any way. Dying patients who request euthanasia should receive loving care, psychological and spiritual support, and appropriate remedies for pain and other symptoms so that they can live with dignity until the time of natural death." United States Conference of Catholic Bishops, *Ethical and Religious Directives for Catholic Health Care Services* n.60.

¹⁸ *Tada*, 166.002.(10).

¹⁹ Joseph Graham, "President Bush and Texas Law,"

http://www.texasrighttolife.com/lifeIssues_euthanasia_bush.php.

²⁰ One that is particularly concerning for Catholic health care institutions maintains that the law disproportionately affects poor and minority patients. For instance, all 11 patients in both studies by Okuysen-Cawley et al. and Eason et al. were non-white; all patients in the former study were reported to be on Medicaid. Okhuysen-Cawley, McPherson, and Jefferson, "Institutional Policies."; Eason et al., "Withdrawal." Truog cites statistics from S. E. Shannon that 14 (61%) of the first 23 cases reviewed by a group of institutions under the TADA the patients were African-American. R. D. Truog and C. Mitchell, "Futility-From Hospital Policies to State Laws," *American Journal of Bioethics* 6, no. 5 (2006): 20. Citing, S. E. Shannon, "Medical Futility and Professional Integrity, Religious Tolerance, and Social Justice," *ASBH Exchange* Spring(2006): 5,10. While research indicates some truth, several factors might contribute to this state of affairs. One possible reason, for which there is empirical data, is that distrust of the medical profession is higher among minority groups such as African-Americans than it is among non-minorities. See, Thomas A. LaVeist, Kim J. Nickerson, and Janice V. Bowie, "Attitudes About Racism, Medical Mistrust, and Satisfaction with Care Among African-American and White Cardiac Patients," *Medical Care Research and Review* 57, no. 4 suppl (2000).

²¹ Truog and Mitchell, "Futility-From Hospital Policies to State Laws," 20.

²² See, Ron Hamel and Micheal Panicola, "Are Futility Policies the Answer? Caregivers Must Improve Communication with Patients and Their Families," *Health Progress (Saint Louis, Mo.)* 84, no. 4 (2003).

²³ Robert Fine and Thomas Mayo, "Resolution of Futility by Due Process: Early Experience with the Texas Advance Directives Act," *Annals of Internal Medicine* 138, no. 9 (2003): 745.

²⁴ Smith et al., "Texas Hospitals," 1274.

²⁵ Truog and Mitchell, "Futility-From Hospital Policies to State Laws," 20.

²⁶ One of the main reasons that the TADA was developed was the fact that no matter how robust a given institution's futility policy was for a physician to withdraw treatment, physicians felt

legally vulnerable. See, Elizabeth Heitman and Virginia Gremillion, "Ethics Committees under Texas Law: Effects of the Texas Advance Directives Act," *HEC Forum* 13, no. 1 (2001): 90. Fine explains the significance of legal support for physicians, stating, "Immunity from civil or criminal prosecution for decisions to withhold or withdraw medical interventions from a terminally ill patient over the objection of a surrogate is critical in the view of most if not all practicing physicians." Robert L. Fine, "Point: The Texas Advance Directives Act Effectively and Ethically Resolves Disputes About Medical Futility," *Chest* 136, no. 4 (2009): 965.

²⁷ Fine, "Point," 965.

²⁸ While all hospitals are dedicated to providing compassionate high-quality care to patients and their families, Catholic health care organizations are also committed to treating their employees with the utmost respect and dignity. Research consistently indicates that the provision of treatments that the staff, particularly nurses, perceive as overly aggressive is the most commonly cited source of moral distress. See, P. S. Pendry, "Moral Distress: Recognizing It to Retain Nurses," *Nursing Economics* 25, no. 4 (2007); L. S. Meltzer and L. M. Huckabay, "Critical Care Nurses' Perceptions of Futile Care and Its Effect on Burnout," *American Journal of Critical Care* 13, no. 3 (2004). Understanding this, the Catholic hospital has an obligation to address the moral distress of staff members, not only out of a business concern – moral distress is a leading cause of nursing burnout– but also from a moral obligation that is grounded in the very identity of the Catholic institution. See, K. M. Gutierrez, "Critical Care Nurses' Perceptions of and Responses to Moral Distress," *Dimensions of Critical Care Nursing* 24, no. 5 (2005).

²⁹ Fine, "Point," 964.

³⁰ Lawrence Schneiderman, "Effect of Ethics Consultations in the Intensive Care Unit," *Critical Care Medicine* 34, no. 11 (2006): S362.

³¹ Robert Sibbald, James Downar, and Laura Hawryluck, "Perceptions of "Futile Care Among Caregivers in Intensive Care Units," *CMAJ Canadian Medical Association Journal* 177, no. 10 (2007). This study indicated that families or surrogates not understanding the nature of the

patient's condition or the treatment involved was the primary reason for their requests for treatment the medical staff judged to be inappropriate.

³² For instance, Fine recounts that, "In a report by multiple ethics committees to the Texas legislature in 2005, of 2,922 ethics consults, including an estimated 974 futility consults, only 65 10-day letters were issued. Of those 65 cases, 11 patients were transferred within 10 days, 22 patients died during the 10-day period, 27 patients had the disputed treatment withdrawn, and 5 patients had treatment extended and/or were transferred later." Fine, "Point," 967.

³³ One such alternative might be effective palliative care initiatives. According to one recent study, palliative care initiatives are highly effective at reducing conflict cases as one study suggests that integrating a palliative care team into the ICU, "may be associated with improved quality of life, higher rates of formalization of advance directives and utilization of hospices, as well as lower use of certain non-beneficial life-prolonging treatments for critically ill patients who are at the end of life." S. O'Mahony et al., "Preliminary Report of the Integration of a Palliative Care Team into an Intensive Care Unit," *Palliative Medicine* 24, no. 2 (2010).

³⁴ Fine and Mayo, "Resolution," 746.

³⁵ Eason et al., "Withdrawal," 641.

³⁶ Fine and Mayo, "Resolution," 746.

³⁷ Smith et al. report that hospitals reported 71 outcomes – out of a possible 265 – of the family agreeing to discontinue treatment before the end of the ten-day period. Smith et al., "Texas Hospitals," 1274.

³⁸ He explains, "Most families, when confronted by an ethics report that does not support their view and a failed search for an alternative willing provider, do not wish to draw out the process for the full time allotted under the law." Fine and Mayo, "Resolution," 745.

³⁹ Ibid.

⁴⁰ Okhuysen-Cawley, McPherson, and Jefferson, "Institutional Policies," 228-9.

⁴¹ Smith et al., "Texas Hospitals," 1274.

⁴² Fine and Mayo, "Resolution," 745.

⁴³ For example, Zier et al. found that 64% of surrogates expressed doubts about the accuracy of a

physician's futility predictions, 32% elected to continue life support when the physicians' survival estimate was less than one percent, and 18% chose to continue when the physician estimated the patient had no chance of survival. See, Lucas S. Zier et al., "Surrogate Decision Makers' Responses to Physicians' Predictions of Medical Futility," *Chest* 136, no. 1 (2009): 110.

⁴⁴ Eason et al., "Withdrawal," 644.

⁴⁵ R. L. Fine et al., "Medical Futility in the Neonatal Intensive Care Unit: Hope for a Resolution," *Pediatrics* 116, no. 5 (2005): 1222.

⁴⁶ Of 265 reported outcomes for cases in which the review committee concurred with the physician, patient transfer (30) was the outcome almost exactly as much as was the withdrawal of LST after the ten-day period (33). Smith et al., "Texas Hospitals," 1274.

⁴⁷ Eason et al., "Withdrawal," 643.

⁴⁸ Okhuysen-Cawley, McPherson, and Jefferson, "Institutional Policies," 230.

⁴⁹ Section 166.004 states, "A health care provider shall maintain written policies regarding the implementation of advance directives. The policies must include a clear and precise statement of any procedure the health care provider is unwilling or unable to provide or withhold in accordance with an advance directive." *TADA*, 166.004.

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