2005 Habtegiris case

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Tirhas Habtegiris Case: Media Statement

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News media coverage has misstated the facts and drawn incorrect conclusions regarding the case of Tirhas Habtegiris, a former patient at Baylor Regional Medical Center at Plano. We have no negative feelings toward those family members of Ms. Habtegiris who called on the media and made statements critical of our actions. We know that her family did not agree with the treatment team and ethics committee about the most appropriate way to face her terrible suffering from terminal cancer. We, too, are saddened by the death of one so young. We understand that Ms. Habtegiris's family was in a stage of acute grief when they spoke with members of the press and we also know that grief may alter one's perception of reality. Perhaps members of the press were not aware of how grief may affect the very words a person may use and the grieving party may not have heard accurately their own words or those of others. These are but some of the reasons for us to set the record straight.

News media statements that Ms. Habtegiris "was removed from her ventilator last month because she couldn't pay her medical bills," that "she was fully conscious and responsive," and that she "suffocated" for "16 minutes" are false, as are other allegations that have now become part of the public record.

This statement and the links herein are intended to set the record straight that physicians at Baylor, supported by state law and an ethics committee provided compassionate care to Ms. Habtegiris until her final breath and that they ultimately withdrew treatment because it was the only humane, ethical option. It was the unwavering intent of all of the health care providers at Baylor Regional Medical Center at Plano to provide compassionate care to Ms. Habtegiris at all times, allowing her to pass away without pain and with peace and dignity.

Until now, Baylor was unable to provide detailed information about this case because of legal constraints on the release of medical information under HIPPA and state law. We have now been released from those constraints by court order, and we believe the following information from the medical record must be disclosed to respond adequately to questions about the case and to correct the incorrect, misleading and inflammatory statements in the public record.

We regret that we have been forced into this situation. Baylor respects, and is committed to protecting patient privacy. Consequently, although we have been legally released from these privacy restrictions, we are withholding certain personal information out of respect for the privacy of Ms. Habtegiris and her grieving relatives. And we again extend our most sincere condolences to Ms. Habtegiris's family.

Case Details
In the case of Tirhas Habtegiris, treating physicians at Baylor Regional Medical Center at Plano concluded after several weeks of intensive care that due to her severe terminal illness – incurable, widely spread metastatic angiosarcoma from her abdomen to her lungs – the only compassionate course of action was to not prolong suffering and to allow her to die as peacefully and gently as possible. The decision that Ms. Habtegiris's condition was incurable was also shared by physicians at a non-Baylor hospital where her family sought treatment prior to bringing her to Baylor Plano. A detailed case history is available on Ms. Habtegiris's condition.

Weeks were spent helping Ms. Habtegiris' family understand this unfortunate reality. Social, legal and other assistance was offered to the family to help in their decision-making process regarding her continued care and with their comfort level in accepting her terminal condition.

Ethics Committee Supports Baylor
Tirhas Habtegiris's treating physicians also sought review of their conclusion regarding her condition and what they felt was the most medically appropriate and humane course of action for her. They consulted a multidisciplinary ethics committee – a standard step in many end-of-life cases – comprised of Baylor colleagues. The ethics committee's work was further reviewed by the Director of the Office of Clinical Ethics for Baylor Health Care System, a nationally recognized expert in clinical ethics and end-of-life care. The ethics committee supported the treating physicians' decision that they should withdraw life-sustaining treatment despite the objection of Ms. Habtegiris's family. The ethics committee and the treating physicians were following a process clearly delineated by Texas law.

Same Care for All
Baylor hospitals provide millions of dollars of unfunded medical care, including critical care in the ICU, when the treatment is beneficial rather than harmful to the patient. In this case, treatment was harmful and only prolonged the dying process caused by the untreatable terminal illness from which Ms. Habtegiris suffered. Physicians would have pursued the same course of action in a fully insured patient because they believe it is fundamentally unethical to provide non-beneficial and/or harmful treatment to patients, especially when death is inevitable from a terminal illness. This is true even if the family is demanding that such treatment be provided.

From the point of view of the health care professionals involved, a decision to allow death to come naturally was based upon a

compassionate approach to Ms. Habtegiris's terminal clinical condition, suffering, and inevitable death.

It is unfortunate and misleading, in some ways, that Tirhas Habtegiris's death at such a young age from terminal cancer has been pulled into the controversial public debate over end-of-life and health coverage issues. As mentioned by several of the reporters who have made incorrect statements regarding this case, there is a health insurance problem in the U.S. and in Texas in particular, where one in four people lacks either public or private insurance.

However, Tirhas Habtegiris's death was not due to any financial reason.

Baylor response
Because cases like Ms. Habtegiris's can be complex and charged with emotion, Baylor offers herein a full, detailed response to the questions and inaccurate statements about her case that have found their way into the public domain.

To help educate the public and members of the media on the issue of ethics and end-of-life care, Baylor also offers supporting resources.

Finally, to assist journalists and policy makers in understanding end-of-life issues, Baylor offers a special Webinar on The Ethics of End-of-Life Care.

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Tirhas Habtegiris Case: Medical History

Due to the highly damaging nature of media reports on this case and Baylor's inability to set the record straight in any other way, we believe the following information from the medical record must be disclosed in order to respond to the serious misrepresentations in the public domain and questions raised by the Texas Advance Directives Coalition, other health care providers, the media and other interested parties who have contacted us. Our goal is to correct the incorrect, misleading and inflammatory statements in the public record.

Until now, Baylor was unable to provide this information because of legal constraints on the release of medical information under HIPPA and state law. We have now been released from those constraints by court order. Baylor is committed to protecting and respecting patient privacy; therefore, despite the current situation, we are withholding certain personal information out of respect for Ms. Habtegiris and her grieving family.

Tirhas Habtegiris: medical condition, treatment, and death (synopsis)
Ms. Habtegiris, a 26-year-old Eritrean immigrant and resident of Dallas County, was diagnosed with incurable, widely metastatic angiosarcoma from her abdomen to her lungs in August 2005 at a non-Baylor hospital in Plano, Texas. Following this diagnosis, she was treated with radiation and chemotherapy at a Dallas hospital affiliated with the local medical school. Unfortunately, the cancer did not respond to treatment and she did not do well. She was evaluated by specialists in end-of-life care at that hospital and eventually discharged to home on November 7, 2005 with palliative medications designed to treat symptoms such as pain and shortness of breath and an appointment for outpatient follow-up in the hospital's palliative care clinic.

Eight days later, on November 15, 2005, having developed increasing pain and shortness of breath, an ambulance was called to her home. She was in obvious distress. Ambulance records indicate she was placed on supplemental oxygen and the paramedics made plans to take her to the closest hospital (where in fact she had first been diagnosed with terminal cancer). Ambulance records indicate that either she or her family asked that she instead be taken not to that nearby hospital, and not to the medical school-affiliated hospital where she had recently been treated, but to a new hospital, actually further away from her home. That new hospital was Baylor Regional Medical Center at Plano. She arrived at the Emergency Department at Baylor with severe pain (8 out of 10 on a standard pain scale where 10 is the maximum) and respiratory distress. She was, in essence, actively dying. She was rapidly evaluated and found to have multiple bilateral lung masses, significant pleural effusions (fluid between the lung and the chest wall), and a 61 pound weight loss by her history, all compatible with the history she reported of cancer. She was treated with non-invasive ventilator support, oxygen, morphine, and IV antibiotics for possible infection. Shortly after admission to the hospital, however, her respiratory rate rose to over 50 breaths a minute and it was apparent that her death was imminent. She was intubated and placed on mechanical ventilation to save her life. Before becoming unresponsive and requiring intubation, she designated in writing two cousins as decision-makers for her if she was unable to make her wishes known.

On November 16, the internist and critical care specialist taking care of her arranged for an oncology consultation. The oncologist noted that her cancer was very aggressive, had been treated, and had not responded. It was noted that she suffered from a terminal illness, that there was no other effective treatment, and that palliative/hospice care was again recommended. Both internal medicine and critical care specialists agreed.

On November 17 and 18, the patient continued to decline. The nurses noted that she required increasing doses of medications to treat her pain and other suffering. The combination of these medications, her underlying terminal illness, and mechanical ventilation made it impossible to effectively communicate with her, even with non-verbal techniques. Her doctors recommended the placement of a tube in her chest for the purpose of draining the pleural fluid. It was their hope that this would allow a partially collapsed lung to re-expand and at least improve her condition for a short while. Because she was unable to communicate as noted above, one of the cousins she had appointed as her decision-maker consented to this procedure. The tube was inserted and a large amount of bloody fluid was withdrawn. Unfortunately, the fluid rapidly re-accumulated due to the untreatable cancer in her chest. All three specialists explained to the family that the doctors at the prior hospital were correct - the patient was terminally ill and there was no effective therapy available that could even slow down the cancer, let alone cure it. They explained that further life-sustaining treatment was prolonging her dying and increasing her suffering without benefit of possible cure, and they too recommended palliative/hospice treatment, including removal of the mechanical ventilator while maintaining aggressive comfort measures. Intolerable suffering

During the time from November 19 to 21, a different oncologist saw the patient and agreed with the first oncologist (as well as those at the prior hospital where she was treated) that removal of the ventilator with palliative or hospice care was the most appropriate treatment. The two cousins, whom the patient had designated to make decisions for her if she was unable, indicated they could not make such a life and death decision and expressed a desire to await the arrival of other family, including at least one family member coming from Germany. Nurses continued to note clinical signs of suffering and continued to adjust narcotics and sedative drugs appropriately. Periodically throughout the hospitalization, the nurses and physicians would attempt to decrease the medications being used to treat the patient's severe pain and distress in hopes they might communicate directly with her. Not surprisingly in a patient such as this, each time they tried to do this, the patient's grimacing, flailing, and intolerance of the ventilator increased to such a degree that the pain and sedative medications again had to

be increased. On November 21, social work records indicate that the patient would qualify for Medicaid coverage for her hospital stay. Medicaid is a joint federal - state program offering health care coverage to certain persons.

On November 22, now seven days into the patient's hospitalization on a breathing machine in the ICU without any signs of improvement, other family members finally arrived, including two persons who introduced themselves as brothers of the patient. A multidisciplinary group of health care professionals including physicians, a nurse, a social worker and a chaplain met with the family and attempted to help them understand the patient's imminently terminal incurable illness, the fact that treatment was prolonging the process of dying, the fact that the treatment was increasing the patient's suffering, and the recommendation of all caring for her that it was time to remove artificial life support and provide "comfort treatment only." The family was unable to accept this recommendation for a variety of reasons. It became increasingly apparent that there were irreconcilable differences of opinion between the medical professionals and the family as to the most appropriate treatment for this dying patient. On this day the social work progress notes reflect that the Texas Advance Directives Act dispute resolution process was explained to the family. This would be explained many more times before finally being invoked.

On November 23 a 90-minute meeting among the family, a nurse and physician from the ethics committee, physicians from internal medicine, critical care medicine, and oncology and representatives from pastoral care and social work occurred. The family continued to insist that no treatment could ever be stopped, at which time the Texas Advance Directives Act dispute resolution process was explained again. Nursing noted that even after this meeting many questions from the cousin and brother were answered. The family had expressed a desire to bring the patient's mother from Eritrea and the social worker noted her previous and ongoing efforts to assist in bringing the patient's mother to America such as writing letters and calling the relevant U.S. Embassies. Baylor offered to pay for the services of an immigration attorney to assist the family.

From November 24 to 27, the patient continued her inexorable decline from terminal cancer as she did throughout her 27-day hospitalization. Doctors again noted that they discussed the Texas law in regards to family - physician disputes over medically appropriate treatment at the end of life.
On November 28, now 13 days into the patient's mechanical ventilation in the ICU, the nurses again noted, as they often did throughout the hospital stay, the ongoing discomfort of the patient and the need to further adjust her symptom medications. The family reaffirmed to the social worker that they would never be able to decide to remove life support. The social worker gave the family the written 48-hour notice of a more formal review process with the hospital ethics committee as required by the Texas Advance Directives Act when physicians wish to stop treatment on a terminally ill patient and the family disagrees. The family was also given a written statement explaining the process that is followed under the Act when such a disagreement arises, as well as a list from the Texas Health Care Information Council of possible alternative providers, all as required by the Act.

On November 30, the family met with the ethics committee for the final formal review of the case. The ethics committee ultimately decided to support the recommendation of the treating physicians to remove life-sustaining treatment and focus on comfort care only. The social worker noted that she had spoken with US officials in Washington, DC and had attempted to contact the U.S. Embassy in the patient's home country. The social worker also started contacting multiple health care facilities to determine if a different facility and medical staff would be willing to continue mechanical ventilation for this terminally ill patient.

On December 1, the family was given the written report of the ethics committee, affirming the treatment decisions of the primary team that further life-sustaining treatment was medically inappropriate and would be withdrawn on the eleventh day (December 12) unless an alternative willing provider was found or the family obtained a court order delaying such removal.

From December 1 to 5, the social worker's and physician's notes reflect further search for an alternative willing provider - that is, another facility and medical staff willing to provide the life sustaining treatment that the Baylor medical staff as well as the first treating hospital's medical staff felt was no longer medically appropriate.

On December 6, the social worker's progress notes again report that the family could not accept the discontinuation of life support. The family asked about a lung transplant and were provided with an explanation why that was not a medically viable option. On this date, the social worker also noted that the family had decided against trying to bring the patient's mother to America for their own reasons and they declined further assistance from Baylor.

Physician progress notes from December 7 and 8 reflect further meetings with the family, attempting to help them understand the patient's condition, including plans to remove the mechanical ventilator and allow her to die naturally on December 12. Meanwhile, the patient demonstrated increasing distress on the ventilator and the morphine and sedative drugs were increased once again to address the patient's obvious pain and suffering.

From December 9 to 11, the critical care specialist noted that physicians at the original treating hospital again refused to accept the patient back, noting that they had no other effective treatment to offer. Ultimately, twelve different health care facilities refused to accept the patient in transfer. The nurses continued to maintain the patient's comfort. 12 + tried +lf

Finally, on December 12, now the eleventh day after delivery of the formal written notice of the ethics committee's decision to support the recommendations of the treatment team, the critical care specialist tried one last time at the request of the family to allow the patient to awaken enough to communicate. She again demonstrated signs of severe distress. Sedation was again increased with two different medications to maintain the patient's comfort. Family, nurses, a physician, and a chaplain were in attendance and the social worker was directly outside the room with additional family, attempting to comfort them, when the patient was finally extubated and allowed to breathe naturally without further mechanical assistance. According to the physician and nurses, the patient died peacefully and rapidly. Her

respirations stopped within seconds. The chaplain and social worker continued to console the grieving family.

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Tirhas Habtegiris Case: Medical Definitions

Angiosarcoma: Angiosarcomas are uncommon malignant cancers characterized by rapidly growing malignant cells derived from blood vessels. Because they are derived from blood vessels, they may start in any part of the body and rapidly spread (metastasize) throughout the body. Angiosarcomas are very aggressive cancers, respond poorly to treatment, and have a very high death rate.

Chest tube: A tube placed through the chest wall and into the space between the chest wall and the lung. Chest tubes are placed to drain pleural fluids out of the chest cavity.

Ethics committee: All Baylor Health Care System facilities have an ethics committee or have access to an ethics committee. The Committee on Institutional Ethics at Baylor Dallas is one of the oldest clinical ethics committees in the country, dating back to 1976. In 1984-85 it was reorganized into its present multidisciplinary form with physicians, nurses, chaplains, social workers, dieticians, administrators, health law attorneys, community representatives and others. The ethics committee has three major areas of responsibility:

1. Ethics education of both staff and community. This is accomplished through lectures, videos, and written materials.
2. Ethics policy development and maintenance. The committee is responsible for a diverse group of policies dealing with issues ranging from those at the beginning of life, to informed consent, to pain management/palliative care, and end of life issues such as withholding and withdrawing life-sustaining treatments.
3. Clinical ethics consultation. Members of the committee work in teams to provide ethical guidance to those who ask. Under Texas law, ethics committees may be asked to review disputes between physicians and families over end-of-life decisions for terminally or irreversibly ill patients. Ethics consultation is available on an open access basis and is free of charge.

Hospice care: Care rendered either on an inpatient basis or in the home setting for a terminally ill patient. Often referred to as "palliative" or "supportive" care, hospice care focuses on patients for whom cure is no longer possible and emphasizes the management of pain and other symptoms, as well as emotional support for the patient and family.

Life sustaining treatment: Any treatment that sustains the life of a patient and without which the patient will die.

Mechanical ventilation: Mechanical ventilators are machines that breathe for a patient by forcing oxygen-enriched air, sometimes under pressure, into a patient's lungs. They are used in a variety of circumstances ranging from general anesthesia, other temporary impairments of breathing, and cases of otherwise fatal illness. A patient must be "intubated" in order to be maintained on a mechanical ventilator. This means that a tube is placed through either the nose or mouth and into the trachea (windpipe), and thus the patient is unable to talk, even if awake. “Extubation” means to remove this "breathing tube." Although mechanical ventilators can support ineffective breathing in many cases, the ventilator does not cure the underlying disease (for example, cancer). Mechanical ventilators are often associated with significant suffering and patients are given pain medications and sedatives to treat this suffering. Patients are sedated for their comfort when a mechanical ventilator is withdrawn with the intent of allowing the terminally ill patient a natural death.

Metastatic cancer: A cancer that has spread from its primary site of origin to other sites in the body.

Oncologist: A physician who specializes in the treatment of cancer.

Pain scale: Pain is a first person, subjective experience. A patient's pain is what they say it is. In the case of chronic pain, patients may appear withdrawn and apathetic and to the untrained eye, will not appear to be in distress. Patients are asked to grade their pain on a scale of 0 to 10, where 0 is no pain at all and 10 is the worst ever or the worst imaginable to the patient. Patient-reported pain scores of 7 to 10 are indicative of severe pain and will typically require higher dosages of narcotics.

Palliative care: Palliative care is multidisciplinary care that aims to relieve suffering and improve quality of life for patients (and their families) with advanced life-limiting illness. This suffering is not only physical but also may be psychological, spiritual, or social.

Pleural effusions: A pleural effusion is fluid trapped between the lung and the chest wall. This fluid can impair the lungs from expanding and filling with air. Thus, physicians will often attempt to remove this fluid in an effort to improve lung function.

Sedation: There are variable degrees of sedation, ranging from the lightest sleep (from which the patient is easily aroused) all the way to a drug-induced coma. Patients are sedated for a variety of reasons ranging from their own comfort to making mechanical ventilation or other treatments more effective for the patient.

Terminal Illness: Definitions of terminal illness or terminal condition vary. Texas law provides the following statutory definition - "Terminal condition means an incurable condition caused by injury, disease or illness that according to reasonable medical judgment, will produce death within six months, even with available life-sustaining treatment provided in accordance with the prevailing standard of medical care."

Texas Advance Directives Coalition: The Texas Advance Directives Coalition is a stakeholders group that works to develop consensus legislation on advance directives and other issues related to end-of-life care in Texas. The Coalition is comprised of diverse groups representing a wide range of viewpoints on the ethically sensitive issues related to medical treatment near the end of life. Current members include representatives from many Texas hospitals and health care systems, National and Texas Right to Life groups, nursing homes, hospices, the Texas State Bar Association, the TMA, TNA, THA, AARP, disability rights groups, and many others. The group does not reach consensus on all issues, but when consensus is reached, the group then recommends to the legislature and the governor specific legislative proposals related to treatment near the end of life. Citizens of Texas can be proud that through this consensus building process, prior Texas legislation was revised and the Texas Advance Directives Act was adopted in 1999. Although member organizations have historically supported the coalition's consensus bills, there is nothing that prevents any of those organizations from advocating for other measures or choosing to leave the Coalition process entirely.

Tirhas Habtegiris Case: Incorrect Statements

In recent weeks, many incorrect and sometimes inflammatory statements have been made through a variety of news outlets regarding the withdrawal of life-sustaining treatment from Tirhas Habtegiris, a terminally ill cancer patient treated at Baylor Regional Medical Center at Plano.

Among the inaccurate and inflammatory statements published or broadcast are the following:

- From Janet St. James, news reporter, on WFAA-TV Ch. 8:
  The [Habtegiris] family "was stunned to get this hand-delivered notice invoking a complicated and rarely used Texas law." The family says "Tirhas still responded and was conscious." "Her family feels caught in America's health crisis."
- From Steven Landsburg, University of Rochester economist, in an online article on Slate:
  The patient "was removed from her ventilator last month because she couldn't pay her medical bills."
- From Robert Frank, Cornell University economist and sometime columnist for The New York Times, in an opinion editorial in The Times:
  Ms. Habtegiris "had little money and no health insurance. . . Unlike the comatose Terri Schiavo, Ms. Habtegiris was fully conscious and responsive when she was disconnected, according to her brother. She wanted to continue breathing. Her brother and several other family members have described the agonizing spectacle of her death by suffocation over the next 16 minutes."

The tragedy of this young patient's death from incurable cancer was only compounded by the above writers and reporters when they inaccurately stated the facts about the humane, ethical medical care that was provided by the doctors, nurses and other health care professionals who devoted themselves to her unfortunate situation.

These statements have resulted in members of the public contacting Baylor directly with disparaging comments about a hospital and staff that did all in their power - and within the law - to give medically appropriate, humane care to a suffering, terminally ill and dying patient. A detailed summary of the medical record of Tirhas Habtegiris' condition, medical treatment and death support every step that Baylor and the treating physicians took in this unfortunate case.

This record shows that:

- The workings of the Texas Advance Directives Act were fully explained to the family in person and in writing. The family knew the hand-delivered notice was coming; therefore, while the letter did not deliver the news that they wanted, it is highly unlikely that the family would have had occasion to be "stunned," as reported.
- Ms. Habtegiris' hospital bill was covered by Medicaid; thus, she was not uninsured, as reported. Regardless, whether or not she was insured was irrelevant. The treatment decisions by physicians and the ethics committee and the subsequent outcome would have been the same.
- Yes, there certainly is a health insurance problem in the U.S. and in Texas in particular, where one in four people lacks either public or private insurance. However, Ms. Habtegiris's death was not due to any financial reason.
- Ms. Habtegiris was not conscious for the majority of her 27 day hospitalization and was not conscious at the time of her death. She died almost immediately upon the removal of artificial life support.

Finally, the incorrect statements in the media have led to questions about this case at a recent meeting of the Texas Advance Directives Coalition, the advisory group that developed the Texas Advance Directives Act (Chapter 166 of the Texas Health and Safety Code). The Texas Advance Directives Act was unanimously adopted by the Texas Legislature and signed into law by the governor. As a first- of-its-kind law in the country, the coalition that developed the law has re-examined and modified it since it was adopted. This year, members of the Texas Legislature have asked the coalition to provide further advice on aspects of this unique law related to end-of-life treatment, and in particular, to comment on issues directly related to this case and similar cases elsewhere in Texas.

Incorrect and misleading statements in broadcast, print and online media stories greatly complicate the work of the Advance Directives Coalition and the Texas Legislature as they work to provide Texans with the best possible legal framework for facing the sometimes tragic choices that patients, families, and health care providers are confronted with at the end of life. For a detailed response to the incorrect and inflammatory media statements noted above, please see Baylor Response.

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Tirhas Habtegiris Case: Baylor Response

Below are some of the incorrect statements made about the Tirhas Habtegiris case, followed by Baylor's responses, which are based on facts from the medical record as summarized in the online report, Tirhas Habtegiris: medical condition, treatment and death:

1. It has been stated that Tirhas Habtegiris was fully conscious and responsive and that life-sustaining treatment was withdrawn over her objection. It has been further stated that after treatment was withdrawn she "suffocated" and did not die for 16 minutes.
   - A. Ms. Habtegiris was not conscious at the time of her death and was not consistently conscious after the first few hours in the hospital. The medical record reflects that she was given morphine for severe pain shortly after arriving in the Emergency Department, and she was further sedated when she required mechanical ventilation shortly after admission to the hospital. From that point forward, she was never again able to speak because of the tube in her windpipe (trachea), and she was never able to meaningfully communicate by other means because she required ongoing narcotics for pain and sedatives for anxiety and agitation. Every time the doctors or nurses tried reducing the doses of pain medicine and sedatives so they might meaningfully communicate with her, the patient showed evidence of such severe distress that clinical staff had no choice but to restore full sedation. This is not an uncommon problem in terminally ill patients on life support in the Intensive Care Unit.
   - B. Baylor medical and nursing staff consider pain and symptom management one of their most important duties as explained in our Personal Choices and Patients Rights brochure, which is given to all patients and families upon admission to Baylor. At the time treatment was withdrawn, Ms. Habtegiris was already sedated for her comfort as noted above. Her grieving family no doubt did not want to see her removed from the mechanical ventilator and perhaps this caused them to perceive that their loved one was suffering when she was not. However, both medical professionals and the hospital chaplain (who tried to help the family cope with their grief) noted that Ms. Habtegiris died peacefully. The statement that she "suffocated" for 16 minutes is false.

2. It has been suggested or implied that continuing life-sustaining treatment would have benefited Tirhas Habtegiris.
   - A. Although the mechanical ventilator was definitely delaying a natural death from incurable cancer, it was neither curing nor benefiting Ms. Habtegiris, who had reached the point of constant pain and suffering. Ms. Habtegiris had already been diagnosed and treated unsuccessfully for metastatic angiosarcoma prior to arriving at Baylor. Prior to arriving at Baylor, Ms. Habtegiris and her family had been informed there was no other effective treatment except palliative care for her progressive symptoms. Her terminal condition was reconfirmed by multiple members of the Baylor medical staff. Most tellingly, the medical professionals who first treated her for her cancer and who knew her condition well refused to accept her return to their hospital because, as they said, they had no further treatment to offer. Eleven other facilities made the same decision.
   - B. It was medically inappropriate, on scientific grounds alone, for Baylor to go along with the family's request to maintain the ventilator indefinitely for Ms. Habtegiris (whose lungs filled each day with more and more cancer), to provide CPR at the moment of death, or to provide a lung transplant. More importantly, it is outside the ethical standard of care of both physicians and nurses to keep a suffering patient alive merely because of others' belief that it is never appropriate to stop any medical treatment. Twelve other facilities also refused to provide the medically inappropriate treatment that Ms. Habtegiris's family was requesting, including the hospital where she had previously been treated and where the staff knew her condition best. This demonstrates that the doctors at Baylor were not alone in their medical judgments. Dating to the time of Hippocrates, physicians have acknowledged that when cure and relief of suffering are no longer possible, the only appropriate course of action is to allow natural death.

3. IIt has been suggested that the hospital withdrew life-sustaining treatment on Tirhas Habtegiris for economic reasons.
   - A. The hospital did not stop treatment because of economic considerations. The doctors and nurses at bedside as well as the ethics committee that reviewed the case did not engage in cost-benefit analysis, but rather an analysis of the benefit and burden to Ms. Habtegiris of further life-sustaining treatment. The use of such benefit-burden analysis from the patient's perspective is a well-established framework within the discipline of clinical ethics for facing the tragic choices and choosing the "least terrible" alternatives that we are confronted with in some end-of-life decisions.
   - B. The medical record reflects that the hospital never raised payment issues with the family. As is routine for all patients without private insurance who might qualify for public assistance, the family was given contact information to apply for Medicaid. The medical record clearly reflects Medicaid would pay for the patient's hospital care. However, even if Medicaid did not step in or if the patient had a private insurance plan, the decisions of the medical staff and ethics committee would have been the same. Baylor provides millions of dollars of charitable treatment and care for indigent patients every year. Sometimes, when it can improve a patient's condition or their perceived comfort, Baylor spends sums significantly higher than that spent on Ms. Habtegiris. The same course of action followed in this case has in the past been followed with privately insured patients because we believe it is fundamentally unethical to provide non-beneficial treatment or treatment that is disproportionately burdensome to a terminally ill patient.

4. It has been suggested by some, in an online publication, that treatment was withdrawn from Tirhas Habtegiris because she was from an ethnic minority group and was an immigrant.
   - A. Baylor's professional staff is ethnically, culturally and religiously diverse. We are proud of our cultural awareness and sensitivity. Many members of our staff are immigrants themselves. When dealing with patients and families from diverse cultures, conflicts may arise. Unlike most cases involving cultural conflict, in this case we were not able to counsel family through the differences of opinion due to their need for significant time and how that conflicted with our responsibility to Ms. Habtegiris.

5. It has been stated that Tirhas Habtegiris' family wanted to keep her on life support until her mother could reach the U.S. from Eritrea.
   - A. Baylor professionals actively helped the family by writing and calling the relevant government agencies. Baylor offered the services of an experienced immigration lawyer at no expense to the family to assist in facilitating the arrival of Ms. Habtegiris's mother to the U.S. Ultimately, the family informed the hospital six days before treatment was withdrawn that they were no longer interested in bringing Ms. Habtegiris's mother to the United States for their own reasons. would they have waited -?, 10 day trigger already pulled

6. There has been much confusion about, and misinterpretation of, the Texas law that allows for the withdrawal of life-sustaining treatment on terminally and irreversibly ill patients.
   - A. The Texas Advance Directives Act (Chapter 166 of the Texas Health and Safety Code) regulates decisions about end-of-life care in Texas. It was developed by a diverse coalition of groups concerned about the treatment and care of patients near the end of life and was approved by both the Texas Legislature and the governor. It sets out definitions of terminal and irreversible illness, provides for various advance directives and sets forth various procedural rules related to end-of-life decisions. It specifically provides a procedure for resolving disagreements about treatment decisions near the end of life.
   - B. Texas law recognizes that good families and good physicians may at times disagree about the best course of action for a terminally or irreversibly ill patient. In some circumstances, a family may demand that all life-sustaining treatment be stopped and the doctors disagree. In other circumstances, physicians may believe further life-sustaining treatment is medically inappropriate but the family disagrees. Texas law provides what has been referred to as an "extra-judicial due process mechanism" for resolving these disagreements, thus encouraging a process rather than a specific outcome in any particular case. When doctors and families are unable to resolve disagreements about the treatment of terminally ill patients through counseling and dialogue, the doctor may have his or her decision reviewed by an ethics committee. Families are notified of the process in writing and are invited to participate. Families may bring personal advisors and attorneys to this meeting if they so desire. The family is entitled to a written report from the committee. If the committee affirms the decision of the treating physician that further life-sustaining treatment is inappropriate, the family may request a search for an alternative health care provider that is able and willing to provide the disputed treatment. If such a provider is located, the patient is transferred. If no alternative provider is found within 10 days, treatments other than those necessary to maintain the patient's comfort may be withdrawn on the eleventh day, unless the family obtains a delay through court intervention by showing the court that there is a reasonable expectation that an alternative provider can be found if additional time is granted. In this case, the family did not pursue court intervention. As clearly reflected in the medical record shared herein, this careful, legally mandated process of family, physicians and the ethics committee working together to obtain the best resolution for Ms. Habtegiris was not rushed into and was faithfully followed.

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Webinar: The Ethics of End-of-Life Care

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Contact Information

Available for logged-in reporters only

Description

Dallas-based Baylor Health Care System, co-sponsored with the Cary M. Maguire Center for Ethics and Public Responsibility at Southern Methodist University, encourages journalists who want to learn more about medical ethics related to irreversible illness and medical futility to participate in our webinar on Thursday, Feb. 23.

Newswise — The ethical issues involved in end-of-life care are significant, intersecting with our personal morality and public policy-making as well. Dallas-based Baylor Health Care System, co-sponsored with the Cary M. Maguire Center for Ethics and Public Responsibility at Southern Methodist University, encourages journalists who want to learn more about medical ethics related to irreversible illness and medical futility to participate in our webinar on Thursday, Feb. 23 from 9:30 a.m. to 10 a.m. Central Standard Time, with additional time for questions.

Medical ethics experts will address some of the key end-of-life care issues facing individuals, families and society as a whole, as well as a Texas law, known as the Texas Advanced Directives Act of 1999, which is used to help resolve disputes over end-of-life care for terminally and irreversibly ill patients. In addition, the speakers will discuss recent cases, such as the Sun Hudson case in Houston, Texas, and the Tirhas Habtegiris case in Dallas, Texas, that have made the news.

To register please send an email message with the word "Webinar" in the subject line to Wendy Walker at wendyw@baylorhealth.edu. Include your name, your news outlet, city and state as well as your e-mail address and telephone number.

Speakers:

Robert L. Fine, MD, FACP
Director, Office of Clinical Ethics, Baylor Health Care System, Dallas
Chairperson, Institutional Ethics Committee, Baylor University Medical Center
Director of Palliative Care, Baylor University Medical Center

Thomas Wm. Mayo
Director, Cary M. Maguire Center for Ethics and Public Responsibility, Southern Methodist University
Associate Professor, Southern Methodist University/Dedman School of Law

See notes