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Oregon State Senate

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Chair Patterson and Members of the Committee,

Thank you again for taking time to hear SB 567. Since I introduced the bill to your committee last week, I noted some testimony in the record that raised some questions and concerns about the measure. I wanted to try to provide a direct response to those statements and questions for the record.

Ultimately, the Special Session committee declined to adopt the provision on discrimination and no additional work between stakeholders has taken place during the interim.

It is true that this language was not adopted during the special session. The discussion at that time was in the context of the Crisis Care Guidelines. Subsequently, the Oregon Health Authority revoked the crisis care guidelines on the basis they were discriminatory. They also issued new guidance clearly using the language included in SB 567. "Decisions by covered entities about treatment should be based on an individualized assessment of the patient based on the best available objective medical evidence." https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/le2288R.pdf

As this was adopted and the crisis care guidelines issue became moot, there was no need for a workgroup to reform them in large part because OHA committed to put such a committee together. The language in SB 567 is consistent with federal law. It imposes no new requirements no health care providers. It simply makes it more clear to patients what their rights are and creates clear statutory guidance that federal law must be followed when making any decisions related to allocation of resources in times of scarcity.

SB 567 amends ORS 659A.855, which is a statute that primarily applies to state government and prohibits unlawful employment practices. Adding new provisions governing the practice of medicine and administration of health care is inconsistent with the other provisions and causes confusion.

This section of Oregon statute addresses disability discrimination in a variety of settings, including all places of public accommodation. Health are facilities are places of public accommodation. BOLI currently enforces these laws in a variety of settings, not just in employment settings.

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The Oregon Health Authority's own documentation also points to BOLI as an enforcement agency. Please see the 2020 *"Non-Discrimination in Medical Treatment for COVID-19"* which is found here: https://sharedsystems.dhsoha.state.or.us/DHSForms/Served/le2288R.pdf

There is more information about BOLI's responsibilities here: https://www.oregon.gov/boli/civil-rights/Pages/your-rights-to-public-places.aspx#:~:text=In%20Oregon%2C%20this%20includes%20%E2%80%9Cpublic,%2C%20lodging%2C%20amusements%20or%20otherwise.

The bill appears to create a legal cause of action for providing or withholding health care in violation of the new law as well as impose oversight by a state agency with authority wholly unrelated to health care.

SB 567 restates the rights of individuals who are members of protected class to be free of discrimination in the provision of health care. This is not a new law. It is a restatement of federal laws. Those whose rights have been violated are entitled to seek remedy. As stated above, BOLI currently has jurisdiction to enforce civil rights protections in **all** places of public accommodation. Hospitals and other medical facilities are places of public accommodation.

A breach of the new statutory provision would be enforced by the Bureau of Labor and Industries or a private cause of action under ORS 659A.885, which allows for compensatory damages, punitive damages, and attorney fees. If the intent is to correct discriminatory conduct in a health care facility or by a provider, it would seem alternate approaches such as raising a complaint with a relevant and appropriate state licensing agency rather than forcing a patient to bring a lawsuit or file a complaint with an employment oversight agency would be a more effective corrective action approach.

Nothing in SB 567 would force anyone to file a lawsuit. However, it clarifies their right to seek remedy if they believe they have been denied health care on the basis of their membership in a protected class. This does not preclude an individual from filing a complaint with a licensing agency. That said, a complaint to a licensing agency may change practice prospectively, but it would do nothing to provide remedy to the person harmed by the discriminatory act.

OHA already indicates that health settings are places of public accommodation and that those believing they have experienced discrimination can pursue claims through BOLI.

SB 567 creates two new standards that are drafted so broadly and vaguely that almost any type of treatment or medical decision about a patient could be called into question and result in litigation.

The only decisions this bill addresses are decisions to deny care to an individual who would benefit from a treatment ***on the basis of their membership in a protected class.***

The first standard under paragraph (6)(a)(A), would make it unlawful to deny medical treatment that is likely to benefit a patient based upon an individualized assessment. While this should be based upon objective medical evidence, it is not clear who ultimately decides, and the provision invites unwarranted lawsuits as well as unnecessary health care services provided solely to avoid a lawsuit.

This language is consistent with language published by the Oregon Health Authority and by the United States Office of Health and Human Services. The bill simply states that decisions about which care is offered or provided to a patient **cannot be based on the patient's membership in a protected class**. It continues to be the patient who consents to or refuses to consent to a procedure.

A cause for action would only arise when a patient would benefit from a desired treatment(a test, a ventilator, a surgery) that would normally be provided to other people **but is denied on the basis of their membership in a protected class.** The construction of the statute is important here. Failure to provide a treatment, service or supply based on objective medical evidence is not what is contemplated here. **Rather, the bill clearly states that the cause of action arises when the denial of a beneficial treatment is "based on the patient's race, color, national origin, sex, sexual orientation, gender identity, age or disability."**

A provider must work with a patient, a patient's family and others who are so authorized to decide what medical treatment is likely to benefit a patient and there often will be disagreement as to that benefit.

The decision of whether to accept or decline a medical treatment remains the decision of the individual. The reason this language is important is to avoid inappropriate decisions made by medical professional regarding the perceived value or quality of life of the individual. Only the individual, and those they trust, can decide whether prolonging life or accepting a treatment is worthwhile as it relates to quality of life. Individuals and their family members know the individual's baseline, skills, desires and hopes. Testimony in these hearings regarding Sarah McSweeney and the Benco client in Corvallis starkly demonstrates the risks of a medical provider substituting their judgement regarding quality of life for the wishes of the patient.

Treatment decisions are medical decisions for which a patient may give or decline consent. Many treatments give a patient or a family member hope, but due to a patient's medical condition ultimately may be of limited benefit. These are difficult medical decisions providers face every day.

Again, ultimately, these are decisions for the patient to make. If it is a treatment would benefit the individual, it is up to the patient to decide whether to receive or decline the treatment based on their own values. Their ability to make that decision should not be influenced in any way by their membership in a protected class. This statement, in and of itself, makes clear the importance of SB 567. The decision about whether to accept or decline a treatment belongs ONLY to the patient and their authorized representatives.

The decision of whether to act on hope is not a decision that belongs to a provider. It belongs to the patient.

SB 567 would allow family or others to make a claim of unlawful practice when they disagree with a determination that a treatment is unlikely to benefit a patient or force provision of the treatment through threat of lawsuit.

This would only be the case if the determination was based on the individual's membership in a protected class. For instance, denying a person with Down Syndrome a kidney transplant on the basis of their IQ and independence or denial of a desired course of chemotherapy to a person on the basis of their age or significant other underlying condition or disability.

Lawsuits also could arise when a treatment is likely to benefit a patient, but the patient expressed a clear desire to forgo the treatment.

Nothing in this legislation undermines the right of the individual patient to consent to or refuse treatment. There is no restriction placed on the decision making authority of the patient or that patient's chosen health care representative.

If adopted as law, health care providers would be required to provide all medical resources to any patient of any age or medical condition regardless of the efficacy or appropriateness of the treatment.

No. The only treatments required to be offered are those that, based on objective medical evidence and an individualized assessment, would likely benefit the patient AND that the patient desire to receive.

Would a frail elderly patient whose family members desire a knee replacement be required to have a knee replacement?

No patient would ever be required to consent to treatment under this law. However, a frail elderly patient who ***wanted*** a knee replacement could not be denied the ability to pursue one on the basis of her age or disability.

Would a provider for a pediatric patient under age 16 or adult patient under age 65 who are not yet eligible for COVID vaccines under federal and state age category limitations be required to be provided the vaccine?

No. Nothing in this bill requires something be offered to a member of a protected class that would not be offered to individuals not in the protected class. COVID vaccines are not denied to children on the basis of their age, but instead because they vaccines have not been developed and tested for that age group. Adult patients under 65 are not categorically denied vaccine on the basis of age. They may be eligible because of other factors not related to a protected class--- their occupation, their living situation, their medical need.

Would the husband of a spouse with severe dementia be able to demand that all available treatments be provided regardless of their efficacy?

That depends. If the spouse was the wife's authorized health care representative, he would have the ability to request all treatments necessary to meet his wife's wishes and values. For instance, if she had an advanced directive that stated that she wanted all interventions, including a ventilator or dialysis or artificial nutrition, she should receive those things according to her directive. The point of that health care directive is to ensure a health care provider's beliefs are not substituted for the patient's values. She should not be denied on the basis of her age or her dementia diagnosis. If she did not have a health care directive but had named him as her personal health care representative, he would still have the authority to make those decisions and it would be inappropriate for care to be withheld on the basis of her age or her dementia diagnosis.

All that said, the wife had a health care directive stating she did NOT want these interventions, those are the wishes that should be respected. Nothing in SB 567 changes the current rights of Oregonians related to self determination of end of life care. In fact, it is intended to strengthen it. It is not just a right to deny care, it is the right to choose to continue receiving care regardless of others' assessment of the patient's quality of life.

What about a patient with a POLST limiting end of life treatment; must all medical resources nonetheless be provided?

No. This bill changes nothing about the POLST. That is a medical order and is a decision made by the patient or their authorized representative.

Would a patient desiring a specific brand name prescription drug have the right to be provided that drug even though a lower cost, generic drug or alternate therapy would be considered more appropriate?

Not unless the denial of the brand name prescription was made on the basis of the individual's membership in a protected class. If the generic is routinely prescribed there is no reason why a person in a protected class would be treated differently.

As written, however, SB 567 would fundamentally change the practice of medicine and health care protocols, substantially increase of the cost of the health, and lead to unnecessary and costly lawsuits.

This should not be the case. SB 567 simply states that beneficial care cannot be denied on the basis of a patient's membership in a protect class, which is a violation of federal law. This bill is very limited, consistent with language used by state and federal agencies, and only precludes denial of care based on protected class. To the extent that this changes cost because care is available to people who were otherwise denied on the basis of their disability, age, race or other protected class that would be an intended consequence of the bill. Despite best intentions, discrimination and denial of care is real. It has been documented in this past year. This bill seeks to clarify and clearly state that cannot happen in Oregon, and that there is a path to remedy for those who do believe they have experienced such discrimination.

Thank you for your attention to these issues. I strongly urge your support of SB 567 as introduced.

Sara

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