ADVANCE DIRECTIVE LEGISLATION INTRODUCED IN THE TEXAS LEGISLATURE

As many of you may know, Advance Directive legislation has been a hot and often controversial topic in many legislative sessions since 1995. More bills have been filed on this topic during this legislative session than ever before.

During the interim the Texas Catholic Conference, the Texas Hospital Association, the Texas Medical Association, the Catholic Health Association of Texas, the Christian Life Commission and the Texas Alliance for Life worked to craft legislation addressing nutrition and hydration as ordinary care for patients and the treatment of individuals with life-threatening but not terminal conditions. These are issues they felt that were not adequately addressed in current statute. This work resulted in the filing of SB 303 by Senator Bob Deuell and HB 1444 by Rep. Susan King in the House. This legislation improves communication, provides transparency to families and surrogates protects physicians and hospitals from having to provide morally unethical treatment and helps to avoid the continuing threats of frivolous lawsuits.

- Improving notification and appeal processes for families or surrogates when a Do-Not-Resuscitate Order is used;
- Ensuring artificially administered nutrition and hydration cannot be withheld or withdrawn from a patient, unless continuing to provide that treatment would harm the patient;
- Ensuring the process is applied only to patients for whom life-sustaining treatment would be medically inappropriate and ineffective, and are difficult for the patient to endure;
- Respecting the conscience of physicians and other health care providers so the law does not require them to provide unethical treatment;
- Extending the notification time to a family or surrogate from 48 hours to seven days in advance of an ethics committee meeting;
- Extending the time to find an alternative willing provider from 10 to 14 days;
- Providing the family or surrogate with a patient liaison to help guide them through the process;
- Providing the family or surrogate with a free copy of the patient’s medical record;
- Inviting the family or surrogate to attend the ethics committee meeting at which future care for their loved one will be discussed; and
- Creating reporting requirements for hospitals or hospital systems that have one or more ethics committee meeting on the 166.046 process annually.

Even though this bill does not directly address hospice, the Texas & New Mexico Hospice Organization endorses the legislation as it is good public policy.

Unfortunately, not all of the bills introduced are as positive in nature.

**HH 1455** by Representative Stephanie Click of Fort Worth (who is a nurse) introduces a bill relating to in-hospital and out-of-hospital do-not-resuscitate orders and advance directives; providing a criminal penalty

- Defines reasonable medical judgment and in-hospital DNR order
· Adds "fluids or nutrition" to the definition of out-of-hospital DNR orders and defines when they are appropriate

· Establishes a form and procedures for in-hospital DNR orders

· Allows another person, not the declarant, to revoke an out-of-hospital or in-hospital DNR at any time

· Requires the DNR revocation be placed in the EMR of the patient

· Stipulates that an in-house DNR is only revoked when the patient or guardian communicates the intent to a health care professional at the hospital

· Requires that order be removed from the person’s physical and EMR

· If a health care professional fails to comply an injunction to enforce revocation is allowed

· Creates a Class A misdemeanor offense for knowingly executing an out-of-hospital or in-hospital DNR not in compliance with the Chapter

**HB 1464 by Rep. Bryan Hughes (R-Mineola), relating to advance directives or health care or treatment decisions made by or on behalf of patients**

· Requires treatment until transfer

· Excludes the directive to provide artificial nutrition and hydration from review by ethics committee

· Deletes language not obligating physicians/facilities from providing life sustaining treatment after the 10th day after written decision from ethics committee is delivered

· Requires DSHS, not THCIC, to maintain list of willing providers

· Deletes language allowing life-sustaining treatment to be withdrawn after 10 days if a transfer facility is not found

· Repeals Health and Safety Code Sections 166.046 (f) and (g) language which addresses life sustaining treatment not being entered into the medical record as medically necessary until a certain period of time as well as language addressing the courts ability to extend the time frame of life sustaining treatment if reasonably certain a transferring facility may be found

**HB 1539 by Rep. Charles Perry (R-Lubbock) relating to certain advance directives and health care and treatment decisions.**

· Restricts a physician from refusing to honor a patient’s advance directive and many not consider life-sustaining treatment to be inappropriate based on age and disability

· If it is determined a physician refused to honor an advance directive for a reason prohibited (age and disability) the ethics commission may not approve the withdrawal of care
SB 675 by Senator Kelly Hancock (R-North Richland Hills) related to certain advance directives and health care treatment decision

Identical to HB 1539

HB 1889 by Rep. Stephanie Klick (R-Ft. Worth), relating to withdrawal of certain life-sustaining treatment

- Requires a written, signed statement on a form prescribed by the Department to be completed to withdraw artificial nutrition and hydration
- Requires a signed receipt that the form has been completed and submitted
- Requires the form to be placed in a separate conspicuous and colored section at or near the top of a patient’s chart
- Restricts an ethics or medical committee from finding the provision of artificial nutrition or hydration inappropriate if form hasn’t been executed
- Inserts statement in the actual advance directive form language that nutrition and hydration may only be withdrawn based on signed receipt of the prescribed form.

BILL ANALYSES:

   a. What is the basic idea?
      i. The Hughes bill represents “treat to transfer” – no matter what the treating physicians and medical/ethics committee determine in a 166.046 dispute resolution process, treatment must be maintained indefinitely until transfer or death.
   b. Analysis
      i. This bill guts the entire dispute resolution process by removing the need for the surrogate to participate because he or she knows treatment cannot be stopped. IN essence, **it empowers surrogates to demand and receive any medical intervention he or she wishes.** Physicians will have no reason to ask for a 166.046 process as that process cannot change the outcome. This was introduced in the last session and was defeated in committee.
   c. What is the net effect of this amendment if passed?
      i. This bill takes us back to pre-1999 times. Terminally and or irreversibly ill patients will be subjected to increased suffering. Nurses and physicians will experience increased frequency and duration of moral distress with increased risk of burnout. Costs will increase.

   TX & NM Hospice Organization opposes this bill as written.

   a. What is the basic idea?
      i. The Perry and Hancock bills prohibit the withdrawal of treatment from a terminally ill patient if that withdrawal is based upon the idea that the terminally ill patient’s life is of “lesser value” than a non-terminal, non-elderly
or non-disabled person or that length of life of the patients is valued more by the surrogate than the risk of disability of the patient.

b. Analysis:
   i. The sponsors seem to believe that doctors seek to withdraw medically inappropriate interventions because a patient is elderly or disabled. This demonstrates that opponents of the Texas Advance Directive Act (TADA), almost all of whom are non-physicians, don't understand medical science or medical ethics.
   ii. Physicians seek to stop medically inappropriate interventions because such interventions violate good clinical medical science and medical ethics. This has nothing to do with devaluing the life of the terminal, elderly or disabled.
   iii. It is precisely because physicians value the lives of the most vulnerable among us (the terminal, the elderly, the disabled), that they do not wish to see those patients subjected to further suffering caused by medical interventions demanded by surrogates (who often have both conscious and unconscious motives) for their requests to maintain medically inappropriate interventions.
   iv. What is the net effect of this amendment if passed?
   v. This bill has potential to interfere in medical decision making not only in a 166.046 process, by allowing an outside party to claim that the reason a physician seeks to stop medically inappropriate treatment is because the physician devalues the elderly, disabled, or terminal. Could this become a cause of action in a lawsuit? I fear so.
   vi. By creating confusion and the potential for investigation of physician motivation for limiting medically inappropriate interventions, patient suffering, professional moral distress, and costs will increase.
   vii. It might create a cause of action if a transplant review committee refuses to approve an organ transplant for a patient.

**TX & NM Hospice Organization opposes this bill as written.**

   a. What is the basic idea?
      i. The King bill is the house companion to Deuell’s Senate Bill 303 which is the Texas Medical Assoc. (TMA)/Texas Hospital Assoc. (THA) supported legislation. It is meant to offer a counter to the other bills rather than only defending the status quo. The Texas Catholic Bishops and Senator Deuell want these changes including:
         1. Extending the notice period in 166.046 to 7 days and the search for alternative willing provider to 14 days.
         2. Creating a state reporting mechanism.
   b. Analysis:
      i. It has some problematic and difficult to understand language related to resuscitation status that could even be interpreted as allowing doctors not to inform patients or surrogates in certain circumstances of resuscitation status (a major violation of health care policy across most health care systems).
      ii. The time extensions to 7 days and 14 days are patient centered provisions and are a political necessity.
      iii. **This bill should be greatly improved if the if Texas Right to Life (TRL) and other advocacy groups are removed from the legislation. The current law requires that surrogates be given**
contact information for TRL and others who oppose the law as part of the “notice” process under 166.046.

c. What is the net effect of this amendment if passed?
i. Notice of a 166.046 process must now be 7 days. Many ethics committee members believe this will lead to earlier and more frequent 166.046 processes because physicians will be less likely to give counseling and mediation time to work, given the overall increase time allowed to resolve the dispute once the 16.046 process is initiated. However, this change is a political necessity.

ii. The extension to 14 days from 10 days to find an alternative willing provider will not likely change the number of alternative providers found, as most are found in days when one is found at all. It will increase the time frame the patient is subjected to medically inappropriate treatment. Nurse and physician moral distress will increase.

iii. Costs will increase.

iv. If passed as written, it appears to allow some DNR orders to be written without informing the surrogate.

TX & NM Hospice Organization supports this bill.


a. What is the basic idea?

i. The bill will restrict unilateral In-Hospital DNR orders to circumstances where “death is imminent within minutes to hours even if CPR is provided.”

ii. It establishes more forms and procedures for hospital DNR orders.

iii. It allows a surrogate to overrule an incompetent patient who when competent requested DNR status.

b. Analysis:

i. This again reflects a fundamental misunderstanding of clinical medical science and medical ethics. Physicians can know on an empiric basis that CPR, in reasonable medical judgment, won't work to promote survival to discharge in certain circumstances, but physicians can't know the timing of death within “minutes to hours” in most cases.

ii. This allows non-physicians to tell a physician how to practice medicine and specifically forces physicians and nurses to perform a harmful intervention on a patient merely because a surrogate says to do so. In essence, the surrogate is empowered to practice medicine.

iii. This may lead to more last minute DNR orders as demonstrated in the following telephone call from a nurse to a physician: “Dr. Jones, the Stage IV Pancreatic Cancer patient in bed 3 has a pulse of 30, a blood pressure of 60 and appears imminent. Can I have a DNR order so we can spare this poor person a traumatic death?” At that point at least some doctors will be brave enough to unilaterally issue a DNR order, but others will find it easier to just have the patient coded when the cardiac arrest occurs. I've in fact seen times when patients such as this undergo multiple CPR attempts over hours to days prior to death. It is very brutal and very sad.

c. What is the net effect of this amendment if passed?

i. Many more known futile CPR attempts will be made.

ii. The patient suffers physically.

iii. The code team suffers emotionally and spiritually.

iv. The doctor who refused the last minute "death is imminent in minutes to hours" DNR order may feel guilty (moral distress) or may go back to sleep or
on about his or her day feeling secure that he or she can’t be accused of violating state law.

v. Costs prior to death will increase.

**TX & NM Hospice Organization opposes this bill as written.**

5. HB 1889 (<http://www.capitol.state.tx.us/BillLookup/Text.aspx?LegSess=83R&Bill=HB1889>)
   a. What’s the basic idea
      i. Further regulations and limitations on withdrawal of ANH, most importantly preventing withdrawal of ANH unless a specific form is completed by the patient or surrogate in all circumstances, no exceptions!
   b. Analysis:
      i. Lots of paperwork involved including requirements for a signed statement on a state approved form from patient or surrogate directing a withdrawal or withholding of ANH and additional signatures on a receipt of the signed statement.
      ii. Requires the form to be placed in a separate conspicuous and colored section at or near the top of a patient’s chart.
      iii. Restricts an ethics or medical committee from finding the provision of artificial nutrition or hydration inappropriate if the state required form hasn’t been executed.
   c. What is the net effect of this amendment if passed?
      i. Most importantly, this law would overrule a patient’s living will directing the withholding or withdrawal of Artificial Nutrition & Hydration (ANH). If the patient or surrogate hasn’t completed the state required paperwork, ANH can’t be stopped. There appear to be no exceptions.
      ii. More non-beneficial ANH, more patients harmed and caused to suffer because of non-beneficial ANH. A patient being drowned in fluids or aspirating enteral alimentation cannot have those fluids or enteral alimentation stopped unless certain state legal forms are completed. It will be easier for the physician to just maintain the harmful ANH than to stop it. The patient dies either way, but dies more peacefully if stopped and dies with greater suffering if maintained.
      iii. More paperwork at a time when we are moving to electronic medical records. Most major health care systems don’t have paper charts any longer.

**TX & NM Hospice Organization opposes this bill as written.**