SUBJECT: Creating procedures for in-hospital do-not-resuscitate orders

COMMITTEE: State Affairs — committee substitute recommended

VOTE: 9 ayes — Cook, Geren, Guillen, K. King, Kuempel, Meyer, Oliveira, Paddie, E. Rodriguez

0 nays

4 absent — Giddings, Craddick, Farrar, Smithee

SENATE VOTE: On final passage, July 25 — 21-10 (Garcia, Hinojosa, Menéndez, Miles, Rodríguez, Uresti, Watson, West, Whitmire, Zaffirini)

WITNESSES: No public hearing

DIGEST: CSSB 11 would establish a definition for "DNR order," specify when a do-not-resuscitate (DNR) order could be considered valid, add notification requirements related to DNR orders, provide a procedure for revoking a DNR order, specify when a physician or other entity would not be criminally or civilly liable, and create a criminal offense.

CSSB 11 would define the term "DNR order" to mean an order instructing a health care professional not to attempt cardiopulmonary resuscitation (CPR) on a patient whose circulatory or respiratory function ceased. The bill would apply to DNR orders that were issued in a health care facility or hospital, not to an out-of-hospital DNR order as defined by Health and Safety Code, sec. 166.081.

Under the bill, a DNR order would take effect at the time the order was issued, provided it was placed in the patient’s medical record as soon as practicable.

**Types, notice of DNR orders.** A patient's DNR order would be valid if it was issued by a patient's attending physician, was dated, and complied with:

- a competent patient's written directions;
- a competent patient's oral directions delivered to or observed by two competent adult witnesses, at least one of whom was not the attending physician or certain other employees of the facility;
- the directions in a properly executed advance directive;
- the directions of a patient's legal guardian or agent with medical power of attorney; or
- a treatment decision that followed the procedure under state law for when a person has not executed or issued a directive and is incompetent or incapable of communication.

If a DNR order of this type conflicted with a treatment decision or valid advance directive, the one made later in time would control.

A DNR order also would be considered valid if it was not contrary to the directions of a patient who was competent when conveying them and if, according to the reasonable judgment of the attending physician, the order was medically appropriate and the patient's death was imminent. This type of valid DNR order could be revoked at any time by the patient's attending physician.

Before a DNR order of this type was placed in a patient's medical record, a patient would have to be informed of the order's issuance or, if the patient was incompetent, the physician or other person acting on behalf of a health care facility or hospital would have to make a diligent effort to contact and inform the patient's known agent under a medical power of attorney or legal guardian. If the patient did not have an agent or guardian, the patient's spouse, adult children, or parents, in that order, would have to be notified.

The physician, physician assistant, or nurse who provided direct care to a patient would have to disclose such a DNR order to the patient's known agent under a medical power of attorney or legal guardian if that individual arrived at the health care facility or hospital. If the patient did not have a known agent or legal guardian, the DNR order would have to

be disclosed to the patient's spouse, adult children, or parents, in that order, if one of those individuals arrived. Notice would not need to be given to additional people beyond the first person notified. Failure to give such notice would not affect the DNR order's validity.

If a person made a good faith effort to disclose the DNR order and recorded that effort in the patient's medical record, that person would not be civilly or criminally liable or subject to disciplinary licensure action.

Upon a patient's admission, CSSB 11 would require the facility or hospital to provide to the patient or an authorized agent notice of the facility's or hospital's policies on the rights of the patient and the agent authorized to make treatment decisions on the patient's behalf.

**Revocation of DNR orders.** CSSB 11 would provide a procedure for revoking a DNR order. A physician providing direct care to a patient with an issued DNR order would be required to revoke the order if the patient or, as applicable, the patient's agent under a medical power of attorney or the patient's legal guardian:

- effectively revoked an advance directive for which a DNR order was issued in accordance with the bill; or
- expressed to any person providing direct care to the patient a revocation of consent to or intent to revoke a DNR order.

A person providing direct care to a patient under a physician's supervision would have to notify the physician of the request to revoke a DNR order.

Except as otherwise provided by the bill, CSSB 11 would exempt from civil or criminal liability a person who failed to act on a revocation unless the person had actual knowledge of it.

**Failure to execute DNR order.** CSSB 11 would require an attending physician, health care facility, or hospital that did not wish to execute or comply with a DNR order or the patient's instructions regarding CPR to inform the patient, the patient's legal guardian, or certain others of the

benefits and burdens of CPR. If the patient or person acting on the patient's behalf remained in disagreement with the physician, facility, or hospital, the bill would require that a reasonable effort be made to transfer the patient to another physician, facility, or hospital willing to execute or comply with a DNR order or the patient's instructions regarding CPR.

**Liability, offense.** The bill would specify that a physician, health care professional, health care facility, hospital, or entity acting in good faith would not be civilly or criminally liable or subject to review or disciplinary action by a licensing agency for issuing a DNR order or causing CPR to be withheld or withdrawn from a patient in accordance with a DNR order. A physician, health care professional, health care facility, hospital, or entity that had no actual knowledge of a DNR order also would not be civilly or criminally liable or subject to review or disciplinary action for failing to act in accordance with the order.

The bill would create a class A misdemeanor offense (up to one year in jail and/or a maximum fine of $4,000) for a physician or other person who intentionally concealed, canceled, effectuated, or falsified another person's DNR order or who intentionally concealed or withheld personal knowledge of another person's revocation of a DNR order.

A physician, health care professional, health care facility, hospital, or entity would be subject to review and disciplinary action by the appropriate licensing authority for intentionally failing to effectuate a DNR order or issuing a DNR order in violation of the bill.

**Rules and effective date.** The executive commissioner of the Health and Human Services Commission would be required to adopt rules necessary to implement the bill's provisions as soon as practicable after the effective date.

The bill would take effect April 1, 2018, and would apply only to a DNR order issued on or after that date.

SUPPORTERS

CSSB 11 would give patients more input into the process of issuing a do-

SAY:

not-resuscitate (DNR) order and would help ensure that a patient's family or authorized representative received appropriate notification of the existence of a DNR order. Existing law does not provide adequate direction for the execution of a DNR order within a health care facility or hospital and could allow an order to be issued against a patient's will, possibly resulting in his or her death. CSSB 11 would help ensure that a patient's wishes were followed in these facilities and that patients received resuscitation if they desired it. The bill also would implement one of the governor's priorities for the special legislative session.

The bill represents a compromise that would balance patient protections with other stakeholder concerns. It would provide civil, criminal, and licensure liability protections for a person, including a health care facility or hospital, who acted in good faith. The bill makes it clear that a failure to disclose a DNR order would not affect the order's validity. The patient protections in the bill that prevent a physician from issuing a DNR order without patient input also would help prevent a physician or other medical professional from making a value judgment about a patient's life.

CSSB 11 would provide important clarifications in statute regarding in-hospital DNR orders. It would specify that a physician could issue a DNR order for a patient if the patient's death was imminent and the order was medically appropriate and not contrary to the patient's wishes. This provision would allow physicians to make necessary spur-of-the-moment decisions while still following the patient's wishes.

The bill would protect patients who issued oral DNR orders by requiring that at least one of the two witnesses not be an employee of the attending physician or of the patient's health care facility. This requirement would help ensure that the order accurately reflected the patient's wishes, rather than the wishes of the health care facility.

The bill would apply existing law regarding decision-making surrogates to in-hospital DNR orders and, as in existing law, only would allow a family member to be involved in a patient's care if the patient was incapacitated and did not have a legal guardian or an agent under a medical power of

attorney.

OPPONENTS SAY:

CSSB 11 could have unintended consequences and interfere in the ability of patients and physicians to make appropriate decisions regarding end-of-life care. Physicians sometimes need to make serious decisions on the spur of the moment, and the bill could make it more difficult for physicians to make ethically and medically appropriate decisions in the patient's best interest. Ambiguity in the bill language, such as a lack of certain definitions, also could increase liability issues for physicians.

The bill also could make it difficult for patients to issue an oral DNR order by requiring a patient to have two witnesses, at least one of whom could not be the patient's physician or employed by the health care facility. Patients could have trouble meeting these requirements.

CSSB 11 also could allow for the invasion of a patient's privacy by requiring certain relatives to be notified of the patient's DNR order. While some patients may want their families involved in their end-of-life care, others may not. The bill should make it easier for patients to prohibit certain individuals from being involved in their care, especially if those individuals could have the power to change a DNR order if the patient became incapacitated.

NOTES:

CSSB 11 differs from the Senate-passed bill by revising the definition of a DNR order, adding certain notice requirements, specifying that the most recent valid DNR order or directive would control, adding provisions related to liability, specifying that a physician or facility could transfer a patient in the case of a disagreement, adding a provision related to the procedure for revoking a DNR order, and establishing a criminal penalty.

A companion bill, HB 12 by G. Bonnen, was left pending following a formal meeting of the House Committee on State Affairs on August 3.