SUBJECT: Amending provisions related to life-sustaining care and DNR orders

COMMITTEE: Public Health — committee substitute recommended

VOTE: 8 ayes — Klick, Campos, Jetton, J. Jones, V. Jones, Oliverson, Price, Smith

0 nays

3 absent — Collier, A. Johnson, Tinderholt

WITNESSES: For — Kyleen Wright, Texans for Life Committee; Jack Frazee, Texas Nurses Association; John Seago, Ashley Solano, Miranda Willborg, Texas Right to Life; Jennifer Allmon, The Texas Catholic Conference of Bishops (*Registered, but did not testify*: Dennis Borel, Coalition of Texans with Disabilities; Ashley Morgan, Texas Alliance for Patient Access; Fred Shannon, Texas Medical Liability Trust; Caroline Welton, Texas Public Policy Foundation; Samantha Farnsworth, Rebecca Parma, Texas Right to Life)

Against — None

On — Tommie Farrell, Hendrick Health System, Texas Hospital Association; Hannah Mehta, Protect TX Fragile Kids; Terri Carriker, PTFK; Joe Pojman Ph.D., Texas Alliance for Life; Cesar Lopez, Texas Hospital Association; Mark Casanova, Texas Medical Association, Baylor Scott & White Health Care System; Patrick Roughneen (*Registered, but did not testify*: Dr. Tim Stevenson, Department of State Health Services; Calvin Green, Kristi Jordan, Health and Human Services Commission; Rebecca Galinsky, Protect TX Fragile Kids; Linda Litzinger, Texas Parent to Parent; Maxcine Tomlinson, Tx New Mexico Hospice Organization)

BACKGROUND: Health and Safety Code sec. 166.046 requires an ethics or medical committee review for an attending physician who refuses to honor a patient's advance directive or a health care or treatment decision made by or on behalf of a patient and specifies procedures for attempting to

transfer the patient to another facility.

Some have suggested that current law does not sufficiently protect patients, medical professionals, and medical facilities regarding life-sustaining care and do-not-resuscitate (DNR) orders for certain patients.

DIGEST:

CSHB 3162 would revise provisions related to life-sustaining treatment and DNR orders for patients who were incompetent or otherwise mentally or physically incapable of communication.

Reviews of life-sustaining treatment. The bill would specify that Health and Safety Code sec. 166.046 applied only to a patient who was determined to be incompetent or was otherwise mentally or physically incapable of communication. Under this section, a health care facility's ethics or medical committee that reviewed a physician's refusal to honor an advance directive or health care or treatment decision would have to consider the patient's well-being but could not make any judgement on the patient's quality of life.

If the review required the committee to determine whether life-sustaining treatment requested in the patient's advance directive or by the person responsible for the patient's health care decision was medically inappropriate, the committee would be required to consider whether the provision of life-sustaining treatment would:

- prolong the natural process of dying or hasten the patient's death;
- result in substantial, irremediable, and objectively measurable physical pain not outweighed by the treatment's benefit;
- be medically contraindicated such that the provision of the treatment seriously exacerbated life-threatening medical problems not outweighed by the treatment's benefit;
- be consistent with the prevailing standard of care; or
- be contrary to the patient's clearly documented desires.

The committee could not consider a patient's disability that existed before the patient's current admission unless the disability was relevant in

determining whether the medical or surgical intervention was medically appropriate.

The bill would extend the requirement for a 48 hour advance notice of an ethics or medical committee review meeting to seven calendar days and require that the notice be provided in writing. The notice would be required to provide certain information specified in the bill, including the committee's decision related to the patient's disability. The bill also would specify that a person responsible for the patient would be entitled to receive a written notice of the decision reached during the review process accompanied by the committee's reasoning for affirming that life-sustaining treatment was medically inappropriate, along with other relevant information.

A health care facility could adopt and implement a written policy for ethics or medical committee review meetings reasonable and necessary to facilitate information sharing and discussion of the patient's medical status and treatment requirements and preserve the effectiveness of the meeting.

If the health care facility or person responsible for the patient intended to have legal counsel attend the ethics or medical committee meeting, the facility or person would be required to make a good faith effort to provide written notice of that intention at least 48 hours before the meeting began.

Transfer requests. The bill would remove a provision stipulating that a relevant party had to disagree with the decision reached during the review process for a physician to be required to make a reasonable effort to transfer the patient to another physician willing to comply with the directive.

If another health care facility denied the patient's transfer request, the personnel of the facility assisting with the patient's transfer would be required to make a good faith effort to inquire whether the facility that denied the request would be more likely to approve the transfer request if a medical procedure was performed on the patient. "Medical procedure"

would include only a tracheostomy or a percutaneous endoscopic gastrostomy.

If the patient's advance directive or the person responsible for the patient's health care decisions was requesting life-sustaining treatment that the attending physician had decided and the ethics or medical committee had affirmed was medically inappropriate, the attending physician or another physician responsible for the patient's care would be required to perform each medical procedure on the patient that:

- would make another facility more likely to accept the patient's transfer;
- would be medically appropriate and within the prevailing standard of care; and
- the person responsible for the patient's health care decisions had provided consent for.

Life-sustaining care. CSHB 3162 would extend the requirement for providing life-sustaining care from 10 days to 25 calendar days after a start notice was provided to the person responsible for the patient's care or after a medical procedure for which a delay notice was provided was performed, unless a court ordered an extension of the 25-day period.

The person responsible for the patient's care would be entitled to receive either a delay notice or a start notice, as applicable. Under the bill, "Delay notice" would be defined as a written notice that the first day of the 25-day period would be delayed until the calendar day after a medical procedure was performed, except under certain conditions. "Start notice" would mean a written notice that the 25-day period would begin on the first calendar day after the notice was provided.

Limiting liability. A physician or health care professional acting under the direction of a physician would not be subject to civil liability for participating in a medical procedure performed under the bill's provisions. Such a physician or health care professional also would not be subject to criminal liability for participating in such a medical procedure unless:

- the physician or health care professional acted with a specific malicious intent to cause the death of the patient, and the conduct significantly hastened the patient's death; and
- the hastening of the patient's death was not attributable to the risks associated with the medical procedure.

A physician or health care professional acting under the direction of a physician would not have engaged in unprofessional conduct by participating in such a medical procedure unless they acted with a specific malicious intent to harm the patient.

Reporting requirements. Within 180 days after the person responsible for the patient's care received written notice of a meeting called to discuss the patient's advance directive, a health care facility would be required to submit a report to the Health and Human Services Commission (HHSC) that contained certain information related to ethics or medical committee reviews and the patient's treatment and outcomes.

HHSC would be required to ensure that this information was kept confidential. By April 1 of each year, the bill would require that HHSC publish a report on its website that contained certain aggregate information compiled from prior year facility reports. The bill would specify procedures for reporting aggregated demographic and disposition information. The report could not include any information that could be used alone or in combination with other reasonably available information to identify any individual, entity, or facility.

Information collected under these provisions would not be admissible in a civil or court proceeding in which a physician, health care professional acting under the direction of a physician, or health care facility was a defendant. The information could not be used in relation to any disciplinary action by a licensing or regulatory agency with oversight of certain health care workers or a health care facility and would not be public information.

DNR orders. The bill would remove a requirement that a patient's attending physician issue a DNR order for the order to be valid. Instead, a physician providing direct care to the patient or the patient's attending physician could issue a DNR order under certain conditions. A patient's attending physician could issue a DNR order for a patient who was incompetent or otherwise mentally or physically incapable of communication if the order was in compliance with a decision agreed upon by the attending physician and the person responsible for the patient's health care decisions. In order for such a DNR to be considered valid, another physician who was not involved in the direct treatment of the patient or who was a representative of an ethics or medical committee of the facility where the person was a patient also would have to concur.

If a patient was incompetent at the time that notice of the DNR order would have been provided to the patient and if a physician providing direct care to the patient later determined that the patient had become competent, a physician, physician assistant, or nurse providing direct care to the patient would be required to disclose the DNR order to the patient, provided that the physician, physician assistant, or nurse had actual knowledge of the order and that a physician had determined that the patient had become competent.

A person would not be civilly or criminally liable or subject to disciplinary action for any act or omission related to providing notice if the person made a good faith determination that the circumstances that would require a person to provide notice were not met.

A physician providing direct care to a patient would be required to revoke the patient's DNR order if the patient was incompetent or otherwise mentally or physically unable to communicate, and the person responsible for the patient's health expressed a revocation of consent to or intent to revoke the DNR order. An attending physician could revoke DNR orders for patients who were incompetent or otherwise mentally or physically incapable of communication under certain conditions. An attending physician would have to revoke a DNR for certain patients whose death was no longer imminent. The physician also would be required to revoke

a DNR order if an advance directive was properly revoked.

Certain enforcement provisions would not apply to a person whose act or omission was based on a reasonable belief that the act or omission was in compliance with the wishes of the patient or the person responsible for the patient's health care decisions.

The bill would revise the list of people who could consent to medical treatment on behalf of an adult patient of a home and community support services agency or in certain facilities who was mentally or physically incapable of communication to include those who did not have a legal guardian or an agent under a medical power of attorney. If the patient did not have a legal guardian, an agent under a medical power of attorney, or another person allowed to consent to medical treatment, another physician who was not involved in the patient's medical treatment could concur with the treatment.

The bill would take effect September 1, 2023, and would apply only to actions occurring on or after the effective date.

NOTES:

According to the Legislative Budget Board, CSHB 3162 would have a negative impact of about $2.8 million on general revenue related funds for fiscal 2024-25.