ADVANCE DIRECTIVES IN TEXAS: ADVANCE DIRECTIVES ACT OF 1999

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Growth in the number of people living to very old age and progress in health care technology are creating important new challenges for our society. Among them is modern medicine's ability to extend some people's lives beyond the point where they are capable of making decisions or expressing their needs and desires, resulting in the very complex problem of knowing when to allow a person to die. In part, advance directives were created to solve this problem. Texas has been busy developing changes to existing state laws in an effort to create more "user-friendly" directives. This paper explores the history of advance directives, and discusses the details and nuances of the Texas Advance Directives Act of 1999.

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CHAPTER 1

INTRODUCTION

Advances in medical technology have afforded men and women the opportunity to extend their lives through improved treatment for what once were terminal illnesses. With these advances has come a very complex problem of knowing when to allow a person to die. In part, advance directives were created to solve this problem. Although many beneficial outcomes have resulted due to advance directives, they have also created challenges in medical decision-making and treatment. Texas has been busy developing changes to existing state laws in an effort to create more user-friendly advance directives. By exploring the history of advance directives, looking at present developments in Texas state law, and discussing the details and nuances of the new law governing advance directives in Texas, we will have a better understanding of the complex nature of this problem.

Growth in the number of people living to very old age and progress in health care technology continue to create important new challenges for our society. Among them is modern medical care's ability to extend some peoples' lives beyond the point where they are capable of deciding or expressing their needs and desires. Older Americans are especially prone to serious illness and incapacity, often decreasing their ability to make and communicate choices about their health care.

The American Association of Retired Persons (1992) notes that state legislative bodies, along with the courts, medical professionals, and advocates for the elderly and disabled, have devised mechanisms for Americans to express their wishes and make choices in advance about future health care needs. Among these advance directives are so-called Living Wills and Durable Powers of Attorney for Health Care. In Texas, these document names have recently been changed to Directive to Physicians and Family or Surrogates and Medical Power of Attorney. Although these are not the only possible ways to make wishes known, their widespread availability and use make them a subject of great interest to those who work with the aged and terminally ill.

In order to make a decision, a person must be able to communicate and understand available treatments. Equally important, people need to understand what will happen if they choose one option over another. If the person is not capable of making a choice or communicating that preference, then the decision will be made by someone else.

Advance communication is a reliable way of making sure that individuals' preferences and values are considered. AARP (1992) states that family members, caregivers, judges, and legal representatives are the ones who, traditionally, are called upon to make health care decisions for incapacitated adults. If there has been no prior communication with the patient, these decision-makers will find it difficult to know what choices the patient would make under a given set of circumstances. Worse, they may disagree among themselves as to what the patient would prefer. In many cases, when the decision-makers disagree among themselves, a court ruling is the result. In order to

understand the historical implications of this type of situation, we will review both the Karen Ann Quinlan and Nancy Beth Cruzan cases, which established important legal precedents.

The cases of Karen Ann Quinlan and Nancy Beth Cruzan serve as examples of some of the questions we face. Beltran (1994) states, "these two women represent hundreds of litigations and literally thousands of patients for whom treatment/nontreatment decisions are made each year" (p. 3).

CHAPTER 2

HISTORY AND BACKGROUND OF ADVANCE DIRECTIVES

Karen Ann Quinlan

In April 1975, 21-year-old Karen Ann Quinlan returned home from a party and went to bed not feeling well. During the night she lapsed into a coma-like state and never awoke. During the next few months, Karen lost 60 pounds and slowly curled into a fetal position. A ventilator assisted her breathing, and an intravenous tube supplied her food. Her prognosis was grim: her chance of regaining consciousness was small; and, if she did, she would be severely disabled mentally and physically. The ventilator seemed to prolong her inevitable death and kept her in a vegetative state.

Karen's parents requested that the hospital wean her from the ventilator, but the hospital refused the family's request. Hospital officials were concerned that removing the ventilator might be seen as immoral and illegal. After the hospital denied their request, the Quinlans took the case to a lower New Jersey court, which upheld the hospital's interpretation that prolonging her life was in the best interest of all concerned (Ruling in the Matter of Karen Quinlan, an alleged incompetent, November 10, 1975). On March 31, 1976, almost a year after her accident, the New Jersey Supreme Court overruled the lower court and decided in favor of the Quinlan family (Ruling in the Matter of Karen Quinlan, an alleged incompetent, March 31, 1976). The New Jersey Supreme Court based

its decision on the "Right to Privacy." The court said that the hospital had gone too far and had invaded the privacy of Karen, or her parents as the guardians and surrogates. Equally important, the court stated that persons who carry out familial instructions are legally immune from criminal prosecution (Ruling in the Matter of Karen Quinlan, an alleged incompetent, March 31, 1976). The court ruled that a person's right to privacy did include the right to terminate treatment. It also ruled that a state's interest in protecting life diminishes as a person's right to privacy increases with the invasiveness of medical interventions.

Karen Quinlan's ordeal was far from over. Respectful of the hospital's position, the family had Karen transferred to a facility that supported their wishes and helped wean her from the ventilator. As Beltran (1994) notes, "Ironically, Karen Ann continued to breathe independently" (p. 5). Her family would allow her to die if she could not breathe on her own, but they were determined to care for her in her ongoing condition.

One important fact is that Karen was receiving artificial nutrition and hydration. The family was reluctant to press the case in order to have these artificial treatments removed (Beltran, 1994). The family continued to care for Karen, and 10 years after the initial incident she died.

Nancy Beth Cruzan

Equally important is the case of Nancy Cruzan. In January 1983, 25-year-old Nancy Cruzan suffered extensive brain damage as the result of an automobile accident. Finding her unconscious, the paramedics took her to the hospital, where three weeks later

she advanced to a persistent vegetative state. She could breathe without a respirator, but she was placed on tube feeding.

Four years later, when it was not probable that she would regain consciousness, her parents asked to have the tube feeding stopped. The hospital employees refused to honor their request without court approval. The Cruzans petitioned a Missouri trial court to discontinue artificial feeding. Missouri probate Judge Charles Teel granted an order to remove the feeding tube, but Missouri's attorney general appealed the decision to the state supreme court. The higher court reversed Teel's ruling and determined that there needed to be "clear and convincing evidence" that an incompetent patient, such as Nancy Cruzan, would have chosen to terminate treatment (Cruzan v. Harmon, 1988). In other words, there needed to be proof of Nancy's prior desires in order to override the state of Missouri's interest in preserving life.

This case was then appealed to the United States Supreme Court. In a 5-4 decision, issued on June 25, 1990, the Supreme Court affirmed the "principle that a competent person has a constitutionally protected liberty interest in refusing unwanted medical treatment" (Cruzan v. Director, 1991). However, the majority opinion determined that the United States Constitution does not forbid states from requiring "clear and convincing evidence" of an incompetent patient's prior wishes regarding the withdrawal of life-sustaining treatment. The court further determined that evidence submitted to Judge Teel could be deemed insufficient to fulfill the State of Missouri's requirement for being "clear and convincing" (Cruzan v. Director, 1991).

Thus, the U. S. Supreme Court upheld the Missouri Supreme Court's decision to refuse the Cruzan family's request, based on the premise that there was insufficient evidence of Nancy's prior wishes. However, Beltran (1994) states, "the Cruzans provided further evidence of Nancy's prior values and wishes to Judge Teel, who deemed the evidence 'clear and convincing' and granted the Cruzans' renewed petition. Missouri's attorney general did not challenge this second decision by Judge Teel and the feeding tube was withdrawn. On December 26, 1990, almost seven years after her car accident, Nancy died" (p. 8).

Impact of Quinlan and Cruzan

These two cases were extremely important because they set precedents. Kane (1993) states, "The U.S. Supreme Court ruling in the Cruzan case addresses the process whereby we guarantee, enforce, and protect our right to self-determination regarding medical treatment" (p. 70). Thus, the court reaffirmed the right of individuals to make their own health care decisions. Equally important, the court reaffirmed the right of individuals to make a written statement in advance, before they may no longer have decision-making capacity, to communicate their wishes for treatment. Furthermore, the court said that the states will have the ability to require patients to provide "clear and convincing evidence" of their values concerning medical treatment.

Fifteen years elapsed between the time of Karen Ann Quinlan's tragic mishap in 1975, the car accident that permanently disabled Nancy Cruzan in 1983, and the court's 1990 decision in the Cruzan case. According to Beltran (1994), during that time, a

societal consensus evolved concerning the right of a patient or a patient's family to refuse or to stop life-sustaining medical treatment. On December 1, 1991, this consensus became the law of the land. Called the Patient Self-Determination Act, this federal legislation requires health care providers to inform all patients in writing of their right to refuse unwanted medical treatment and their right to formulate a document called an advance directive (Patient Self-Determination Act, 1990).

CHAPTER 3

FEDERAL AND STATE STATUTES GOVERNING ADVANCE DIRECTIVES

The Patient Self-Determination Act

The Patient Self-Determination Act of 1990 modifies the federal law known as the Social Security Act, particularly the parts related to the Medicare and Medicaid program. The Patient Self-Determination Act requires any health care organization that is a Medicare provider--acute hospital, skilled nursing facility, home health agency, hospice program, or prepaid health organization--to ensure patients' rights to participate in and direct the health care decisions affecting them. The American Association of Retired Persons (1992) states, "virtually every doctor, HMO and the like in the United States receives reimbursement from Medicare, which is why this program was chosen as the vehicle by which to inform patients of their (p. 1). The Patient Self-Determination Act requires Medicare providers to do the following:

1. Maintain written policies and procedures which ensure that written information is provided to patients regarding the following:
    a. Their rights as recognized by the courts of the state where they are being treated to make decisions regarding medical care, including the right to accept or to refuse medical or surgical treatment and the right to formulate advance directives;

b. Provider's maintenance of written policy and procedure that ensures respect for the patient's right to accept or to refuse medical treatment;

2. Document in each patient's medical record whether the individual has written an advance directive;

3. Refrain from determining levels of care or otherwise discriminating against an individual based on whether he or she has written an advance directive;

4. Ensure compliance with state law respecting advance directives;

5. Provide staff members and the community with education on issues concerning advance directives.

The Patient Self-Determination Act of 1990 also states that patients are to be told of their rights under this law by almost any health care organization: acute hospitals must inform patients at the time of their inpatient admission, skilled nursing facilities must inform patients at the time of their admission as residents, home health agencies must inform patients when they are taken under the care of the agency, hospice programs must inform patients at the time they initially receive hospice care, and prepaid health organizations must inform patients at the time of their enrollment.

Beltran (1994) states that the intention and the spirit of the Patient Self-Determination Act of 1990 is to move the physician/patient relationship in the direction of a shared partnership. He feels that this partnership can be accomplished by encouraging communication between physician and patients and by encouraging patients to document their values concerning life-sustaining medical treatment. It is important to realize that

decisions regarding medical treatments, particularly the decision to refuse or withdraw life-sustaining support, require a strong joining between health care professionals and decision-makers. Many states now have legislation that gives patients more control over end-of-life decisions.

Texas Laws, Rules, and Regulations

Texas has enacted several laws that address concerns of physicians, terminally ill patients and their families, and concerned citizens. One of the earliest laws was the Texas Natural Death Act, which was enacted in 1977 to authorize physicians to carry out advance directives. Another important law enacted in 1989 was the Durable Power of Attorney for Health Care. This law allowed one adult to delegate to another the power to make health care decisions if the person delegating is unable to do so. One of the most recent laws, enacted in 1995, created the Out-of-Hospital-Do-Not-Resuscitate Order. This law protects a person who has completed an such an order from being resuscitated by emergency medical services personnel.

All three advance directive provisions were located in different parts of the Texas legal code, allowing room for inconsistent interpretation and application. Therefore, in 1999, the Texas legislature took action to combine all the different provisions into one act, called the Advance Directives Act.

Texas Advance Directives Act

Effective September 1, 1999, Senate Bill 1260 consolidated three previously separate acts, found in two different legal codes, into the Advance Directives Act

(Texas Hospital Association,1999). The following are highlights of changes in the law resulting from the enactment. Although I will focus on the new Advance Directives Act, it is important to note the locations of the former acts. Directives executed prior to the Advance Directives Act effective date of September 1, 1999, remain valid and are governed by the law in effect on the date the directive was issued (Texas Hospital Association, 1999).

The Natural Death Act (Chapter 672, Health and Safety Code), the Durable Power of Attorney for Health Care Act (Chapter 135, Civil Practices and Remedies Code), and the Out-of-Hospital-Do-Not-Resuscitate Act (Chapter 674, Health and Safety Code) are consolidated into a single new Advance Directives Act (Chapter 166, Health and Safety Code). Although changes have been incorporated, each former act is now a subchapter of Chapter 166, making these laws more readily available and usable by laypersons and professionals. The former Natural Death Act is now known as Subchapter B of the Advance Directives Act, and the former Durable Power of Attorney for Health Care is now known as Subchapter D and the document as the Medical Power of Attorney. The Out-of-Hospital-Do-Not-Resuscitate Act is now categorized as Subchapter C, and the name of the document has not changed.

One inconsistency in the three former acts was the definitions and terms they used. The new act has not only introduced some new definitions, but made the fundamental terms in the old acts consistent. Some of the key definitions are as follows.

1. Advance directive means (1) a Directive to Physicians and Family or Surrogates, either written or nonwritten; (2) an Out-of-Hospital- Do-Not-Resuscitate Order; and (3) a Medical Power of Attorney (Advance Directives Act of 1999, chap. 166.002(1)).

2. Health care or treatment decision means consent, refusal to consent, or withdrawal of consent to health care, treatment, service, or a procedure to maintain, diagnose, or treat an individual's physical or mental condition (Advance Directives Act of 1999, chap. 166.002(7)).

3. Irreversible condition means a condition, injury or illness (A) that may be treated but is never cured or eliminated; (B) that leaves a person unable to care for or make decisions for the person's own self; and (c) that, without life-sustaining treatment provided in accordance with the prevailing standard of medical care, is fatal (Advance Directives Act of 1999, chap. 166.002(9)).

4. Life sustaining treatment means treatment that, based on reasonable medical judgement, sustains the life of a patient and without which the patient will die. The term includes both life-sustaining medications and artificial life support, such as mechanical breathing machines, kidney dialysis treatment, and artificial nutrition and hydration. The term does not include the administration of pain management medication or the performance of a medical procedure considered to be necessary to provide comfort care, or any other medical care provided to alleviate a patient's pain (Advance Directives Act of 1999, chap. 166.002(10)).

5. 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. A patient who has been admitted to a program under which the person receives hospice services provided by a home and community support services agency licensed under Chapter 142 is presumed to have a terminal condition for purposes of this chapter (Advance Directives Act of 1999, chap. 166.002(13)).

One important point is that, although the Advance Directives Act went into effect on September 1, 1999, changes in the civil and criminal liability and disciplinary standards applicable under Directives to Physicians and Family or Surrogates and Out-of-Hospital-Do-Not-Resuscitate Orders apply only to conduct that occurred on or after January 1, 2000. For the first time, the act adds enforcement authority to advance directives by adding a new provision stipulating that a physician, health facility, health care professional, or entity who has knowledge of a qualified patient's directive and fails to execute it is subject to review and disciplinary action by the appropriate licensing board. Moreover, the act repealed a provision granting absolute immunity from civil or criminal liability to a physician or health professional who failed to effectuate a known directive. The act reads,

> A physician or a health professional acting under the direction of a physician, is subject to review and disciplinary action by the appropriate licensing board for failing to effectuate a qualified patient's directive in violation of this subchapter or

other laws of this state. This subsection does not limit remedies available under other laws of this state.(Advance Directives Act of 1999, chap. 166.045 (b))

and

A health care professional or health care facility or entity is subject to review and disciplinary action by the appropriate licensing board for failing to effectuate an Out-of-Hospital-Do-Not-Resuscitate order. This subsection does not limit remedies available under other laws of this state. (Advance Directives Act of 1999, chap. 166.095 (b))

Another obstacle in the former Out-of-Hospital-Do-Not-Resuscitate Act (Chapter 674, Health and Safety Code) was the provision that the Texas Department of Health was the sole source of Out-of-Hospital-Do-Not-Resuscitate Orders. The Advance Directives Act eliminates the regulatory requirement that the Texas Department of Health be the sole source of an Out-of-Hospital-Do-Not-Resuscitate Order form, by permitting the copying and use of the official Texas Department of Health approved form. The act states, "A photocopy or other complete facsimile of the original written out-of-hospital DNR order executed under this subchapter may be used for any purpose for which the original written order may be used under this subchapter" (Advance Directives Act of 1999, chap. 166.083 (d)).

The act retains the current good faith standard of liability applicable to health care professionals or health care facilities withholding or withdrawing life sustaining procedures under an Out-of-Hospital-Do-Not-Resuscitate Order, in order to provide additional legal

protection to such professionals and facilities acting in emergency circumstances. It also retains the current good faith standard of liability applicable to agents acting under the Medical Power of Attorney.

The witness qualifications and requirements for all three types of documents--the Directive to Physicians and Family or Surrogates, the Out-of-Hospital-Do-Not-Resuscitate Order, and the Medical Power of Attorney--are made consistent. For each type of document, two witnesses are required, each of whom must be a competent adult, but only one of whom must satisfy the other statutory qualifications of witnesses, which remain unchanged from the former law. These changes are intended to significantly expand the pool of available witnesses and make execution of these documents easier for health care providers and patients and their families.

> WITNESSES. In any circumstance in which this chapter requires the execution of an advance directive or the issuance of a nonwritten advance directive to be witnessed:
>
> (1) each witness must be a competent adult; and
>
> (2) at least one of the witnesses must be a person who is not:
>
> (A) a person designated by the declarant to make a treatment decision;
>
> (B) a person related to the declarant by blood or marriage;

(C) a person entitled to any part of the declarant's estate after the declarant's death under a will or codicil executed by the declarant or by operation of law;

(D) the attending physician;

(E) an employee of the attending physician;

(F) an employee of a health care facility in which the declarant is a patient if the employee is providing direct patient care to the declarant or is an officer, director, partner, or business office employee of the health care facility or of any parent organization of the health care facility; or

(G) a person who, at the time the written advance directive is executed or, if the directive is a nonwritten directive issued under this chapter, at the time the nonwritten directives issued, has a claim against any part of the declarant's estate after the declarant's death.

(Advance Directives Act of 1999, chap. 166.003)

Certain general provisions, such as the enforceability of documents executed in other jurisdictions, the effect of such documents on insurance policies and premiums, and the resolution of conflicts between the documents, are applied uniformly to all three documents. This is another example of the legislature's intent to make these laws easier to understand, use, and administer.

ENFORCEABILITY OF ADVANCE DIRECTIVES EXECUTED IN ANOTHER JURISDICTION. An advance directive or similar instrument validly executed in another state or jurisdiction shall be given the same effect as an advance directive validly executed under the law of this state. This section does not authorize the administration, withholding, or withdrawal of health care otherwise prohibited by the laws of this state. (Advance Directives Act of 1999, chap. 166.005)

EFFECT OF ADVANCE DIRECTIVE ON INSURANCE POLICY AND PREMIUMS. (a) The fact that a person has executed or issued an advance directive does not:

(1) restrict, inhibit, or impair in any manner the sale, procurement, or issuance of a life insurance policy to that person; or

(2) modify the terms of an existing insurance policy.

(b) Notwithstanding the terms of any life insurance policy, the fact that life-sustaining treatment is withheld or withdrawn from an insured qualified patient under this chapter does not legally impair or invalidate that person's life insurance policy and may not be a factor for the purpose of determining, under the life insurance policy, whether benefits are payable or the cause of the death.

(c) The fact that a person has executed or issued or failed to execute or issue an advance directive may not be considered in any way in establishing insurance premiums. (Advance Directives Act of 1999, chap. 166.006)

EXECUTION OF ADVANCE DIRECTIVE MAY NOT BE REQUIRED. A physician, health facility, health care provider, insurer, or health care service plan may not require a person to execute or issue an advance directive as a condition for obtaining insurance for health care services or receiving health care services. (Advance Directives Act of 1999, chap. 166.007)

CONFLICT BETWEEN ADVANCE DIRECTIVES. To the extent that a treatment decision or an advance directive validly executed or issued under this chapter conflicts with another treatment decision or an advance directive executed or issued under this chapter, the treatment decision made or instrument executed later in time controls. (Advance Directives Act of 1999, chap. 166.008)

A new provision required hospitals, nursing and certain other facilities, and home and community support services agencies to adopt and maintain written policies regarding their implementation of advance directives, including clear and precise statements regarding any procedure that they are unwilling or unable to perform or withhold, and to provide patients or their families or agents with written notice of those policies upon admission to the facility or upon the initiation of the provision of care. A facility that fails to comply with this requirement is subject to an administrative penalty by the appropriate regulatory agency of the state (Advance Directives Act of 1999, chap. 166.004).

A new provision prohibits a physician, health care facility or provider, insurer, or health care services plan from requiring a person to execute or issue an advance directive

as a condition for obtaining insurance or plan coverage or receiving health care services (Advance Directives Act of 1999, chap. 166.007).

A new provision clarifies the effect of a directive which, instead of requesting the withholding or withdrawal of life-sustaining treatment, affirmatively requests its provision by health care professionals, by stating that such a directive does not require the provision of treatment to the requesting patient that cannot be provided without denying the same treatment to another patient. For example, the mere existence of such a directive for Patient A does not give him or her any kind of legal preference over Patient B, who has executed no directive, in an organ transplant situation where only one organ is available (Advance Directives Act of 1999, chap. 166.009).

The new act permits a competent adult to execute any of the three documents, including an Out-of-Hospital-Do-Not-Resuscitate Order, at any time, even prior to a diagnosis of terminal illness. Previously, the Out-of-Hospital-Do-Not-Resuscitate Order could be executed or issued only by a competent adult who had been diagnosed as having a terminal condition (Advance Directives Act of 1999, chap. 166.082).

The new act permits a Directive to Physicians and Family or Surrogates to become effective upon the certification, by only one physician, rather than two physicians, that the patient has a terminal or irreversible condition. The previous requirement that two physicians certify the patient as having a terminal condition was changed to make such documents more usable for patients in settings where multiple physicians are not readily available, such as nursing facilities and hospices. The form states,

> If, in the judgment of my physician, I am suffering with a terminal condition from which I am expected to die within six months, even with available life-sustaining treatment provided in accordance with prevailing standards of medical care: I request . . . . (Advance Directives Act of 1999, chap. 166.033 - Form)

The use of a nonwritten Directive to Physicians and Family or Out-of-Hospital-Do-Not-Resuscitate Order is simplified by permitting the notation of the existence of such a directive, and the names of the witnesses to it, to be entered in the patient's medical record, instead of requiring the witnesses to sign the entry in the medical record itself. Unlike the other two forms of advance directives, a Medical Power of Attorney may actually be signed by another person, and there is no requirement in the act that the document must be entered in the patient's medical record.

> The physician shall make the fact of the existence of the directive a part of the declarant's medical record, and the names of the witnesses shall be entered in the medical record. (Advance Directives Act of 1999, chap. 166.034 (c) and chap. 166.084 (c))

A new provision prohibits any physician, health care facility, or health care professional from requiring that a Directive to Physician and Family or Surrogates be notarized or that the patient use a particular form of the directive provided by the physician, facility, or health care professional (Advance Directives Act of 1999, chap. 166.036).

Several important changes are made in the former Directive to Physicians which are intended to make the new Directive to Physicians and Family or Surrogates more user-friendly to patients and health professionals alike, including the following.

1. Key definitions and explanations of terms used in the document are provided, including artificial nutrition and hydration, irreversible condition, terminal condition, and life-sustaining treatment (Advance Directives Act of 1999, chap. 166.033 - Form);
2. Clarifying language expressly provides that the patient's Directive becomes effective only when the patient, at some time in the future, becomes unable to make medical decisions about himself or herself because of illness or injury and the patient's physician (note that only one physician is required) determines that the patient is suffering from either a terminal condition or an irreversible condition (Advance Directives Act of 1999, chap. 166.033-Form);
3. An opportunity is provided in the body of the document for the person who has not executed a Medical Power of Attorney to designate a surrogate to make treatment decisions with the patient's physician under the directive which are compatible with the patient's personal values (Advance Directives Act of 1999, chap. 166.033 - Form);
4. An opportunity is provided in the body of the document for the person to indicate additional treatment requests for specific circumstances, such as artificial nutrition

and fluids and intravenous antibiotics (Advance Directives Act of 1999, chap. 166.033 - Form);

5. For the first time, the person executing the directive may, under either class of condition (terminal or irreversible) express his or her treatment wishes by selecting one of two options concerning treatment: request the discontinuation or withholding of all treatments except those needed to keep the patient comfortable, or request that he or she be kept alive in the condition using available life-sustaining treatment–in effect, this new election option permits a person for the first time in the recommended statutory form to state affirmatively that he or she wishes to receive all of the life-sustaining treatment available under the prevailing standard of medical care (Advance Directives Act of 1999, chap. 166.033 - Form);

6. An exception to the patient's treatment election under both terminal condition and irreversible condition provides that, if the patient elects hospice care, the conflicting selection that the patient request that he or she be kept alive using available life-sustaining treatment does not apply and the patient agree that only those treatments needed to keep him or her comfortable would be provided (Advance Directives Act of 1999, chap. 166.033 - Form);

7. For the first time, a distinction is made in the directive between patients suffering from a terminal condition (one that, according to reasonable medical judgment, will result in death within six months even with available life-sustaining treatment provided in accordance with the prevailing standard of medical care) and an

irreversible condition (a treatable condition for which there is no cure that leaves a person unable to care for or make decisions for himself or herself but with which the patient can be kept alive for prolonged periods by means of life-sustaining treatment) (Advance Directives Act of 1999, chap. 166.033 - Form); and

8. A new preamble to the document explains in simple language the purpose of the document and encourages discussion of its provisions between the patient, the patient's family, and health care providers.

In circumstances in which a patient who has not executed a directive becomes unable to communicate, the act permits the attending physician and either the patient's legal guardian or an agent acting under a Medical Power of Attorney to make treatment decisions on behalf of the patient, including a decision to withhold or withdraw treatment. Previously, only the attending physician and the patient's legal guardian could make such decisions (Advance Directives Act of 1999, chap. 166.039 (a)).

In circumstances in which a patient who has not executed a directive becomes unable to communicate and does not have either a legal guardian or an agent under a Medical Power of Attorney, the act permits the attending physician and one relative, instead of two relatives from a prioritized list, to make treatment decisions on the patient's behalf, provided such decisions are documented in the patient's medical record and signed by the attending physician. The prioritized list of relatives has been changed to delete the requirement that a majority of the patient's reasonably available adult children are required,

now permitting merely the reasonably available adult children to serve as surrogate decision-makers.

> PROCEDURE WHEN PERSON HAS NOT EXECUTED OR ISSUED A DIRECTIVE AND IS INCOMPETENT OR INCAPABLE OF COMMUNICATION. (a) If an adult qualified patient has not executed or issued a directive and is incompetent or otherwise mentally or physically incapable of communication, the attending physician and the patient's legal guardian or an agent under a Medical Power of Attorney may make a treatment decision that may include a decision to withhold or withdraw life-sustaining treatment from the patient.
>
> (b) If the patient does not have a legal guardian or an agent under a Medical Power of Attorney, the attending physician and one person, if available, from one of the following categories, in the following priority, may make a treatment decision that may include a decision to withhold or withdraw life-sustaining treatment.
>
> (1) the patient's spouse;
>
> (2) the patient's reasonably available adult children;
>
> (3) the patient's parents; or
>
> (4) the patient's nearest living relative. (Advance Directives Act of 1999, chap. 166.039 (a) and (b))

In circumstances in which a patient who has not executed a directive becomes unable to communicate and does not have either a legal guardian, an agent under a Medical Power of Attorney, or an available relative to make a health care decision, the act permits a treatment decision, including a decision to withhold or withdraw life-sustaining treatment, to be made by the patient's attending physician, so long as the treatment decision is concurred with by either another physician not involved in the patient's treatment or an ethics committee of the facility. Previously, the treatment decision had only to be witnessed by another physician (Advance Directives Act of 1999, chap. 166.039 (b)).

In circumstances in which a patient who has not executed a directive becomes unable to communicate and a treatment decision, including a decision to withhold or withdraw life-sustaining treatment, has been made for him or her by the attending physician and either the patient's legal guardian, agent acting under a Medical Power of Attorney, relative, or concurring physician or ethics committee, the act expressly provides that a relative of the patient within the priority list wishing to challenge the decision may apply for a temporary guardianship of the patient under Section 875 of the Probate Code (Advance Directives Act of 1999, chap. 166.039 (b)).

If an attending physician refuses to comply with a patient's directive or treatment decision, the act expressly requires the physician to continue to provide life-sustaining treatment until a reasonable opportunity has been afforded for the transfer of the patient to another physician or health care facility willing to comply with the directive or decision,

and the physician is not immune from civil or criminal liability unless he or she follows a new special procedure governing such circumstances (Advance Directives Act of 1999, chap. 166.045 (c)).

The Act provides a new procedure for the resolution of conflicts arising from an attending physician's refusal to honor a patient's advance directive or a treatment decision (whether to withhold/withdraw or to provide life-sustaining treatment), such as a determination that further treatments is futile. The procedure provides a review of the physician's decision by an ethics or medical committee, with notice and explanation to the patient or the patient's surrogate decision-maker. During the decision process, the act imposes a duty to continue to provide life-sustaining treatment and, if the decision to withhold or withdraw treatment is upheld by the committee, for a period of 10 days thereafter, while efforts are made to transfer the patient. The committee's decision is subject to a limited appeal to the district or county court for an extension of the time for transfer. If the procedure is followed, the physician, health care professional, or facility is immune from civil or criminal liability and disciplinary action by the appropriate licensing authority (Advance Directives Act of 1999, chap. 166.046 and 166.045 (d)).

> PROCEDURE IF NOT EFFECTUATING A DIRECTIVE. (a) If the attending physician refuses to honor a patient's advance directive or a treatment decision under Section 166.039, the physician refusal shall be reviewed by an ethics or medical committee. The attending physician may not be a member of that

committee. The patient shall be given life-sustaining treatment during the review. (Advance Directives Act of 1999, chap. 166.046)

If the attending physician and the patient or the patient's surrogate disagree with the decision of the review process, life-sustaining treatment shall be continued for a period of 10 days while efforts are made to transfer the patient to another physician or health care facility willing to comply with the patient's directive or treatment decision. After the 10th day, the physician and facility may withhold or withdraw life-sustaining treatment (Advance Directives Act of 1999, chap. 166.046).

> At the request of the patient or the person responsible for the health care decisions of the patient, the appropriate district or county court shall extend the time period provided under Subsection (e) only if the court finds, by a preponderance of the evidence, that there is a reasonable expectation that a physician or health care facility that will honor the patient's directive will be found if the time extension is granted. (Advance Directives Act of 1999, chap. 166.046 (g))

An additional provision clarifies that the duty to continue to provide life-sustaining treatment does not impose an obligation on a facility or a home and community support services agency beyond the scope of services or resources of that facility or agency and that the duty imposed does not apply to hospice services provided by a licensed home and community support services agency (Advance Directives Act of 1999, chap. 166.046 (h)).

The act provides that the legal standard to which physicians, health facilities, or health professionals are held in the withholding or the withdrawing of life-sustaining

procedures under a Directive to Physicians and Family or Surrogates and Medical Power of Attorney is the standard of reasonable care, and it specifies that the standard is that degree of care that others of ordinary prudence and skill would have exercised under the same or similar circumstances in the same or similar community (Advance Directives Act of 1999, chap. 166.044 and 166.160).

The act retains the current good faith standard of liability applicable to health care professionals or health care facilities withholding or withdrawing life sustaining procedures under an Out-of-Hospital-Do-Not-Resuscitate Order, in order to provide additional legal protection to such professionals and facilities acting in emergency circumstances. It also retains the current good faith standard of liability applicable to agents acting under the Medical Power of Attorney (Advance Directives Act of 1999, chap. 166.094 and 166.160).

CHAPTER 4

SUMMARY

All the changes that resulted from the Advance Directives Act of 1999 were well thought out and a result of much deliberation and compromise. Ultimately, I think the law addresses many issues and concerns that will truly help people in Texas to have better health care outcomes.

From my perspective, one of the many positive changes that occurred was the change from two witnesses to one. Many problems arose out of the two witness requirement, due, I believe, largely to the fact that in many settings the person creating an advance directive was a patient in a health care facility such as a hospital, nursing home, home health or hospice. To my knowledge, none of these organizations had people sitting around waiting to witness these documents. Therefore, the staff of the organizations had a difficult time tracking down two people that met the very specific requirements and qualifications of a witness. Usually the volunteer was another family member, a visitor, or possibly a volunteer of the organization who stood in as a witness. Although it can still be difficult, it is much easier to find one person to witness the document. In addition, the qualifications for a witness have changed, and staff of the health care organization can serve as witnesses. Therefore, I feel this is an excellent change for all parties involved.

Another important change due to the Advance Directives Act that I feel will lead to increased use of the Out-of-Hospital-Do-Not-Resuscitate Order, is that a person no longer needs to have a terminal diagnosis of six months or less in order to complete such an order. It has been my observation that, not only does the attending physician of the patient have a difficult time coming to the conclusion and awareness that his or her patient might die, but it is extremely difficult for a physician to determine whether a person will live less than six months and give up on aggressive treatment for the patient. An interesting conclusion from the Study to Understand Prognosis for Outcomes and Risks of Treatment (SUPPORT) was that, although 79% of the patients in Phase I had a DNR when they died in the hospital, 46 of the orders were written within two days of death (Moskowitz & Nelson, 1995). Our medical professionals are trained to save lives, not let their patients die. In addition, the patient and family rarely want to face the reality of a "six months or less" diagnosis. For these reasons, many Out-of-Hospital-Do-Not-Resuscitate Orders were never completed, or not completed until very close to the end of the person's life when the person might not be capable of adequately expressing his/her wishes. The change to not requiring a "six months or less" prognosis is a benefit that should help with some of these challenges. It is my desire that this change will allow the physician and the patient to truly discuss and explore what the person will want later, when he or she may not be capable of communicating wishes. After all, this is the entire rationale for advance directives. People make their decisions and give direction to the

individuals who will be providing care and services prior to the occurrence, or, in other words, in advance.

Many times in the past people who had properly completed advance directives did not have those directives honored at the end of their lives. Currently, half of the deaths in America occur in a hospital (Moskowitz & Nelson 1995). SUPPORT was started in 1989. It enlisted more that 9,000 patients suffering from life-threatening illnesses in five teaching hospitals throughout the United States. One of the investigator's major findings was a significant lack of understanding of patients' wishes. Moskowitz and Nelson (1995) report, "Thirty-one percent of Phase I patients expressed a preference not to be resuscitated, but slightly fewer than half of their physicians accurately understood this preference." (p. S4). I think this not only is disturbing, but also shows how the changes in the Advance Directives Act of 1999 can make a difference. Physicians or other health care providers who fail to honor an advance directive, that they know exists, are subject to disciplinary review by their professional licensing body. However, the law does provide a review process of the matter. In my opinion, this is an attempt to get physicians and health care providers to not only understand what their patients' preferences are but, more importantly, to carry out their desires.

Many people die in nursing homes, hospices, or hospitals each year. To maintain as much dignity and control as possible at the end of their lives, many patients are choosing to outline exactly what steps they want taken and not taken, if and when they should become incapacitated or diagnosed with a terminal or irreversible condition.

Through advance directives, individuals can express their treatment preferences before they actually need such care, ensuring that their wishes will be carried out and that their families and others will not be faced with making these difficult decisions.

Therefore, an advance directive is the way by which patients can communicate their treatment wishes. It ensures that a person's right to refuse or accept medical treatment is respected. It can help physicians better understand their patients' values and can help patients clarify those values. It can encourage the shared trust and respect necessary for health care professionals and patients to make health care decisions.

My wish is that all people will take the time to thoroughly contemplate, discuss, and come to an agreement concerning their health care wishes with their families and physicians, and at the very least complete a Directive to Physicians and Family or Surrogates and a Medical Power of Attorney. Lastly, I pray that their wishes are respected and followed.

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