Interim Report
to the 86th Texas Legislature

House Committee on State Affairs

November 2018

HOUSE COMMITTEE ON STATE AFFAIRS
TEXAS HOUSE OF REPRESENTATIVES
INTERIM REPORT 2018

A REPORT TO THE
HOUSE OF REPRESENTATIVES
86TH TEXAS LEGISLATURE

BYRON COOK
CHAIRMAN

TONI BARCELLONA
CHIEF COMMITTEE CLERK

ALICIA SEAGRAVES
ASSISTANT COMMITTEE CLERK

Committee On
State Affairs

November 26, 2018

Byron Cook
Chairman

P.O. Box 2910
Austin, Texas 78768-2910

The Honorable Joe Straus
Speaker, Texas House of Representatives
Members of the Texas House of Representatives
Texas State Capitol, Rm. 2W.13
Austin, Texas 78701

Dear Mr. Speaker and Fellow Members:

The Committee on State Affairs of the Eighty-fifth Legislature hereby submits its interim report including recommendations for consideration by the Eighty-sixth Legislature.

Respectfully submitted,

Byron Cook, Chairman

Helen Giddings, Vice-Chair

Tom Craddick

Jessica Farrar

Charlie Geren

Ryan Guillen

Ken King

John Kuempel

Morgan Meyer

René Oliveira

Chris Paddie

Eddie Rodriguez

John Smithee

Helen Giddings
Vice-Chair

Members: Tom Craddick, Jessica Farrar, Charlie Geren, Ryan Guillen, Ken King, John Kuempel, Morgan Meyer, René Oliveira, Chris Paddie, Eddie Rodriguez and John Smithee

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STATE AFFAIRS

Under House Rule 3, Section 35, the House Committee on State Affairs shall have 13 members, with jurisdiction over all matters pertaining to:

1) questions and matters of state policy;
2) the administration of state government;
3) the organization, operation, powers, regulation, and management of state departments, agencies, and institutions;
4) the operation and regulation of public lands and state buildings;
5) the duties and conduct of officers and employees of the state government;
6) the operation of state government and its agencies and departments; all of above except where jurisdiction is specifically granted to some other standing committee;
7) access of the state agencies to scientific and technological information;
8) the regulation and deregulation of electric utilities and the electric industry;
9) the regulation and deregulation of telecommunications utilities and the telecommunications industry;
10) electric utility regulation as it relates to energy production and consumption;
11) pipelines, pipeline companies, and all others operating as common carriers in the state;
12) the regulation and deregulation of other industries jurisdiction of which is not specifically assigned to another committee under these rules; and
13) the following organizations and state agencies: the Council of State Governments, the National Conference of State Legislatures, the Office of the Governor, the Texas Facilities Commission, the Department of Information Resources, the Inaugural Endowment Fund Committee, the Sunset Advisory Commission, the Public Utility Commission of Texas, and the Office of Public Utility Counsel.[1]

On October 23, 2017, Texas House Speaker Joe Straus released interim charges listing specific topics for committees to study prior to the start of the 86th Legislative Session.[2]

An interim hearing was held on September 6, 2018, during which four witnesses provided testimony on the implementation of Senate Bill 11 85(1)-2017.

The hearing can be viewed at the following link:
http://tlchouse.granicus.com/MediaPlayer.php?view_id=40&clip_id=15477

Having completed its study on the interim charge assigned by Speaker Straus, the Committee has adopted the following report.

INTERIM CHARGE

Charge: Monitor the agencies and programs under the Committee's jurisdiction and oversee the implementation of relevant legislation passed by the 85th Legislature.

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MONITORING AGENCIES AND LEGISLATIVE IMPLEMENTATION

Interim Charge: Monitor the agencies and programs under the Committee's jurisdiction and oversee the implementation of relevant legislation passed by the 85th Legislature.

Public Hearing

The House Committee on State Affairs ("the Committee") held a public hearing on September 6, 2018 at 9:30 a.m. in Austin, Texas in the Capitol, room E2.014, to address the above interim charge regarding the implementation of Senate Bill (SB)11 85(1)-2017. The Committee heard testimony from invited witnesses from the Texas Health and Human Services Commission (HHSC) and resource witnesses representing medical professionals. The following individuals testified:

Witnesses are listed in alphabetical order

- Kristi Jordan, *Director of Health Care Quality, Regulatory Services Division, Health and Human Services Commission*
- Cesar Lopez, *Associate General Counsel, Texas Hospital Association*
- Arlo Weltge, M.D., *Texas Medical Association*
- Cecile Young, *Acting Executive Commissioner, Health and Human Services Commission*

Introduction

Issues surrounding end-of-life care, including do-not-resuscitate (DNR) orders, have been before the Committee for several legislative sessions. After years of hard work and intense negotiations, the Committee passed an "agreed-to" bill during the 2017 first-called special session that increased requirements for DNR orders. Attached is the bill signed by stakeholders who expressed their agreement with the legislation through support or neutrality (Exhibit A).

The bill, SB 11, amended the Health and Safety Code to set out the circumstances under which a DNR order issued for a patient in a health care facility or hospital is valid. This legislation strengthened patient protections and closed a loophole in state law that allowed doctors to place DNR orders on patients without their consent.

SB 11 passed the House on second reading with a voice vote, garnered 122 ayes on third and final passage, and became effective on April 1, 2018. The purpose of this report is to document for future legislatures the unconventional method by which HHSC chose to adopt the rule for SB 11.

Background

Rule Adoption Process

SB 11 directed the executive commissioner of HHSC to adopt a rule for implementing the bill as soon as practicable after the April 1, 2018 effective date.[3] A rule was proposed and published in

the April 20, 2018 issue of the *Texas Register*, which initiated a mandatory 30-day public comment period before the rule could be finalized. Public comments reflected strongly divergent opinions – some interested parties believed the proposed rule went too far, while others thought it did not go far enough.

After the public comment period ended, medical professionals and other groups that participated in the negotiations for the law sought answers as to the rulemaking direction the agency would take, but received no response and subsequently reached out to the Committee for assistance.

The Committee contacted HHSC to find out the status of the rule and the agency's timeline for finalization, inquiring if it was the agency's intent to re-write a new proposed rule for another round of public comments, or if the agency intended to finalize a new rule using the first set of public comments.

The Committee found the agency to be unresponsive to its inquiries, thus the Committee and some stakeholders became concerned if the agency was following the legislative intent of the "agreed-to" bill in the rulemaking process – or, if they were attempting to write a rule that went outside the bounds of the law. Such an act would dramatically compromise lawmakers' efforts by circumventing the legislative process and would set a dangerous precedent.

The Hearing

The aforementioned concerns resulted in the chair calling for a public hearing on September 6, 2018.

During the hearing, the chair presented two letters that were entered into the official public comment record by the agency (Exhibits B and C). The first letter was signed by a number of lawmakers, and the second was from an interest group. These letters presented serious trepidations for the Committee, which are outlined below:

1) None of the House joint sponsors, including the first joint sponsor and chair of the Committee, is signed on to the letter from other lawmakers, which immediately raised red flags. Most importantly, the chair stated at the hearing that he never even knew anything about this letter until the Committee began to look into the rulemaking status.

2) All but the last provision of the lawmaker letter is almost identical to the stakeholder's public comment letter (Exhibit C) that egregiously seeks to go outside the bounds of the law with provisions that this stakeholder unsuccessfully attempted to write into the bill.

After discovering these facts and recognizing the weight the agency was affording the lawmaker letter, these two letters became the focal point of the hearing. In the hearing, the vice-chair recounted a conversation with a lawmaker who signed the letter because she thought she was supporting the law and its provisions, only to discover later that was disappointingly not the case. The Committee learned that other signatories on the lawmaker letter also thought the same; therefore the chair asked the acting executive commissioner what remedy was available to those legislators who misunderstood what they had signed and desired to have their names removed from the letter. Although all state agencies receive ongoing input from legislators, it was unfortunately impossible to correct the official record because the rule had been adopted.

In the hearing the chair questioned the agency's sudden adoption of the rule just days before the hearing, especially after delaying action for a number of months. He inquired as to why the agency did not wait until the Committee's public hearing had occurred before they adopted the final rule. In other words, why would HHSC not consider input from the House Committee on State Affairs of value? Moreover, he questioned the rationale for not issuing a second rule for another 30-day public comment period, noting it was regrettable that did not happen on a matter that deals with life and death. The chair also asked why the agency did not wait until the newly-appointed executive commissioner took office on October 19, 2018 to adopt the rule.[4]

Representative Kuempel expressed the frustration that many lawmakers have had with HHSC over the years, citing numerous issues in the past with emergency leave and contracting. He concluded, "This certainly doesn't help the legislature's confidence of what we do and what we have done with the actions you all [the agency] have taken. So at least you can go back and make sure the organization knows we're still watching."

Conclusion

The fact that the agency gave heavy consideration to a highly problematic letter that sought to go beyond the bounds of the law when crafting the final rule is a substantially negative precedent that should concern every Texan and all legislators.

Recommendations

While the final rule did not include matters outside the legislative scope of SB 11, according to medical professionals the rule does have problems that can create uncertainty for practitioners. As a result, a majority of the stakeholders involved with the negotiations for the law met to discuss these matters after the hearing. Attached is their joint letter outlining their apprehensions and proposed recommendations (Exhibit D).

Through the passage of SB 11 lawmakers worked to gain clarity for those who are facing devastating decisions in emotional circumstances. However because of the agency's actions, the final rule does not fully adhere to the language or legislative intent of SB 11. The rule's problems will likely need to be addressed in the future, and it is the intent of this report to provide the facts to successive legislators who may be facing this issue again.

HHSC should amend the rule to remove regulations regarding medical staff bylaws that relate to DNR orders.

The agency should include clarifying language to 25 Texas Administrative Code §§133.41(f)(6)(G) and 133.41(k)(3)(G) to ensure that only one notice is required, and that providing one notice satisfies the other, in accordance with legislative intent.

HHSC should incorporate language from SB 11 to 25 Texas Administrative Code §§133.41(f)(6)(G) and 133.41(k)(3)(G) to ensure the rules accurately and completely state the requirements of Section 166.206(a), Health and Safety Code.

EXHIBIT A

By: C. Perry S.B. No. 11

Substitute the following for S.B. No. 11:

By: G. Bonnen C.S.S.B. No. 11

A BILL TO BE ENTITLED

AN ACT

relating to general procedures and requirements for certain do-not-resuscitate orders; creating a criminal offense.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF TEXAS:

SECTION 1. Chapter 166, Health and Safety Code, is amended by adding Subchapter E to read as follows:

SUBCHAPTER E. HEALTH CARE FACILITY DO-NOT-RESUSCITATE ORDERS

Sec. 166.201. DEFINITION. In this subchapter, "DNR order" means an order instructing a health care professional not to attempt cardiopulmonary resuscitation on a patient whose circulatory or respiratory function ceases.

Sec. 166.202. APPLICABILITY OF SUBCHAPTER. (a) This subchapter applies to a DNR order issued in a health care facility or hospital.

(b) This subchapter does not apply to an out-of-hospital DNR order as defined by Section 166.081.

Sec. 166.203. GENERAL PROCEDURES AND REQUIREMENTS FOR DO-NOT-RESUSCITATE ORDERS. (a) A DNR order issued for a patient is valid only if the patient's attending physician issues the order, the order is dated, and the order:

(1) is issued in compliance with:

(A) the written and dated directions of a patient who was competent at the time the patient wrote the directions;

(B) the oral directions of a competent patient

delivered to or observed by two competent adult witnesses, at least one of whom must be a person not listed under Section 166.003(2)(E) or (F);

(C) the directions in an advance directive enforceable under Section 166.005 or executed in accordance with Section 166.032, 166.034, or 166.035;

(D) the directions of a patient's legal guardian or agent under a medical power of attorney acting in accordance with Subchapter D; or

(E) a treatment decision made in accordance with Section 166.039; or

(2) is not contrary to the directions of a patient who was competent at the time the patient conveyed the directions and, in the reasonable medical judgment of the patient's attending physician:

(A) the patient's death is imminent, regardless of the provision of cardiopulmonary resuscitation; and

(B) the DNR order is medically appropriate.

(b) The DNR order takes effect at the time the order is issued, provided the order is placed in the patient's medical record as soon as practicable.

(c) Before placing in a patient's medical record a DNR order issued under Subsection (a)(2), the physician, physician assistant, nurse, or other person acting on behalf of a health care facility or hospital shall:

(1) inform the patient of the order's issuance; or

(2) if the patient is incompetent, make a reasonably

diligent effort to contact or cause to be contacted and inform of the order's issuance:

(A) the patient's known agent under a medical power of attorney or legal guardian; or

(B) for a patient who does not have a known agent under a medical power of attorney or legal guardian, a person described by Section 166.039(b)(1), (2), or (3).

(d) To the extent a DNR order described by Subsection (a)(1) conflicts with a treatment decision or advance directive validly executed or issued under this chapter, the treatment decision made in compliance with this subchapter, advance directive validly executed or issued as described by this subchapter, or DNR order dated and validly executed or issued in compliance with this subchapter later in time controls.

Sec. 166.204. NOTICE REQUIREMENTS FOR DO-NOT-RESUSCITATE ORDERS. (a) If an individual arrives at a health care facility or hospital that is treating a patient for whom a DNR order is issued under Section 166.203(a)(2) and the individual notifies a physician, physician assistant, or nurse providing direct care to the patient of the individual's arrival, the physician, physician assistant, or nurse who has actual knowledge of the order shall disclose the order to the individual, provided the individual is:

(1) the patient's known agent under a medical power of attorney or legal guardian; or

(2) for a patient who does not have a known agent under a medical power of attorney or legal guardian, a person described by Section 166.039(b)(1), (2), or (3).

(b) Failure to comply with Subsection (a) does not affect the validity of a DNR order issued under this subchapter.

(c) Any person, including a health care facility or hospital, who makes a good faith effort to comply with Subsection (a) of this section or Section 166.203(c) and contemporaneously records the person's effort to comply with Subsection (a) of this section or Section 166.203(c) in the patient's medical record is not civilly or criminally liable or subject to disciplinary action from the appropriate licensing authority for any act or omission related to providing notice under Subsection (a) of this section or Section 166.203(c).

(d) A physician, physician assistant, or nurse may satisfy the notice requirement under Subsection (a) by notifying the patient's known agent under a medical power of attorney or legal guardian or, for a patient who does not have a known agent or guardian, one person in accordance with the priority established under Section 166.039(b). The physician, physician assistant, or nurse is not required to notify additional persons beyond the first person notified.

(e) On admission to a health care facility or hospital, the facility or hospital shall provide to the patient or person authorized to make treatment decisions on behalf of the patient notice of the policies of the facility or hospital regarding the rights of the patient and person authorized to make treatment decisions on behalf of the patient under this subchapter.

Sec. 166.205. REVOCATION OF DO-NOT-RESUSCITATE ORDER; LIMITATION OF LIABILITY. (a) A physician providing direct care to

a patient for whom a DNR order is issued shall revoke the patient's DNR order if the patient or, as applicable, the patient's agent under a medical power of attorney or the patient's legal guardian if the patient is incompetent:

(1) effectively revokes an advance directive, in accordance with Section 166.042, for which a DNR order is issued under Section 166.203(a); or

(2) expresses to any person providing direct care to the patient a revocation of consent to or intent to revoke a DNR order issued under Section 166.203(a).

(b) A person providing direct care to a patient under the supervision of a physician shall notify the physician of the request to revoke a DNR order under Subsection (a).

(c) A patient's attending physician may at any time revoke a DNR order issued under Section 166.203(a)(2).

(d) Except as otherwise provided by this subchapter, a person is not civilly or criminally liable for failure to act on a revocation described by or made under this section unless the person has actual knowledge of the revocation.

Sec. 166.206. PROCEDURE FOR FAILURE TO EXECUTE DO-NOT-RESUSCITATE ORDER OR PATIENT INSTRUCTIONS. (a) If an attending physician, health care facility, or hospital does not wish to execute or comply with a DNR order or the patient's instructions concerning the provision of cardiopulmonary resuscitation, the physician, facility, or hospital shall inform the patient, the legal guardian or qualified relatives of the patient, or the agent of the patient under a medical power of

attorney of the benefits and burdens of cardiopulmonary resuscitation.

(b) If, after receiving notice under Subsection (a), the patient or another person authorized to act on behalf of the patient and the attending physician, health care facility, or hospital remain in disagreement, the physician, facility, or hospital shall make a reasonable effort to transfer the patient to another physician, facility, or hospital willing to execute or comply with a DNR order or the patient's instructions concerning the provision of cardiopulmonary resuscitation.

(c) The procedures required by this section may not be construed to control or supersede Section 166.203(a).

Sec. 166.207. LIMITATION ON LIABILITY FOR ISSUING DNR ORDER OR WITHHOLDING CARDIOPULMONARY RESUSCITATION. A physician, health care professional, health care facility, hospital, or entity that in good faith issues a DNR order under this subchapter or that, in accordance with this subchapter, causes cardiopulmonary resuscitation to be withheld or withdrawn from a patient in accordance with a DNR order issued under this subchapter is not civilly or criminally liable or subject to review or disciplinary action by the appropriate licensing authority for that action.

Sec. 166.208. LIMITATION ON LIABILITY FOR FAILURE TO EFFECTUATE DNR ORDER. A physician, health care professional, health care facility, hospital, or entity that has no actual knowledge of a DNR order is not civilly or criminally liable or subject to review or disciplinary action by the appropriate licensing authority for failing to act in accordance with the

The undersigned have agreed to, through support or neutrality, this legislation. The author will not accept amendments and any amendment could jeopardize the passage of the bill.

order.

Sec. 166.209. ENFORCEMENT. (a) A physician, physician assistant, nurse, or other person commits an offense if the person intentionally conceals, cancels, effectuates, or falsifies another person's DNR order or if the person intentionally conceals or withholds personal knowledge of another person's revocation of a DNR order in violation of this subchapter. An offense under this subsection is a Class A misdemeanor. This subsection does not preclude prosecution for any other applicable offense.

(b) A physician, health care professional, health care facility, hospital, or entity is subject to review and disciplinary action by the appropriate licensing authority for intentionally:

(1) failing to effectuate a DNR order in violation of this subchapter; or

(2) issuing a DNR order in violation of this subchapter.

SECTION 2. The executive commissioner of the Health and Human Services Commission shall adopt rules necessary to implement Subchapter E, Chapter 166, Health and Safety Code, as added by this Act, as soon as practicable after the effective date of this Act.

SECTION 3. Subchapter E, Chapter 166, Health and Safety Code, as added by this Act, applies only to a do-not-resuscitate order issued on or after the effective date of this Act.

SECTION 4. This Act takes effect April 1, 2018.

Texas Catholic Conference of Bishops

Coalition of Texans w/ Disabilities

Texas Medical Association

Texas Alliance for Life

TEXANS FOR LIFE COALITION

EXHIBIT B

Commissioner Charles Smith
Texas Health and Human Services Commission
4900 N. Lamar Blvd.
Austin, TX 78751

May 18, 2018

Dear Commissioner Smith,

As the Author, Sponsor, and members in support of Senate Bill 11 85(1), we write to publicly comment on the proposed rules regarding Do-Not-Resuscitate orders that were published in the *Texas Register* on April 20, 2018.

We believe that the passage of Senate Bill 11 was a significant victory to strengthen the rights of patients in Texas. We worked tirelessly to ensure that, in the vast majority of cases, applicable DNR orders comply with either: 1) the written instructions of the patient; 2) oral directions of the patient with two qualified witnesses; 3) a legally valid advance directive; 4) directions of a patient's Medical Power of Attorney or legal surrogate, as directed by §166.203(a)(1), Health and Safety Code. Upon reviewing, we believe the rules proposed by the Health and Human Service Commission to implement S.B. 11 may be further improved to accomplish the purpose of the legislation.

The proposed rules simply require hospitals to develop their own internal policies about how to execute, revoke, and settle disputes regarding DNR orders. Rather than deferring to the judgement of hospitals in the drafting of relevant DNR policies, HHSC should write rules outlining the specific requirements of Senate Bill 11 to ensure that DNR policies carried out in Texas hospitals are fully consistent with the patient-centric law.

Changes in the proposed rules, include:

- The addition of several new definitions to the rules *(§133.2);*
- The stipulation that a physician enter a DNR order in the patient's medical file or revoke the order as soon as practicable (§133.41(j)(5));
- The requirement that nursing plans for patients include whether a physician has authorized a DNR order and ensure the patient or surrogate is informed about the order (§133.41(o)(2)(E)); and,
- Clarification of the notice provisions applicable to in-hospital DNR orders (§133.41(j)(5)(G).

To accomplish these clarifications, we make the following recommendations:

1. **Instead of simply requiring facilities to create their own DNR policies, include the specific requirements of Senate Bill 11.**

While the changes listed above are improvements on the silence of the previous rules, these changes are marginal apart from the two most consequential sections (proposed rules, §133.41(k)(3)(G) and §133.41(f)(6)(G)). However, as currently drafted, these two sections are vague, nonspecific, open-ended and do not fully capture the requirements of Senate Bill 11. These two sections should be replaced with rules requiring the governing body of healthcare facilities and their medical staff to adopt policies and bylaws compliant with the specific requirements of Senate Bill 11.

Currently, §133.41(f)(6)(G) of the proposed rules state:

> *"(G) the governing body shall adopt, implement, and enforce policies and procedures regarding DNR orders issued in the facility, the rights of the patient and person authorized to make treatment decisions regarding the patient's DNR status, and actions the physician and facility must take when the physician or facility and the patient are in disagreement about the execution of, or compliance with, a DNR order."*

This language, and similar language in proposed §133.41(k)(3)(G), may inadvertently imply that facilities are legally allowed to determine what constitutes a valid DNR order, what rights patients and their surrogates have, and what procedure the facility would like to follow when disagreements arise concerning a DNR order. The proposed rules should address how Senate Bill 11 outlines exactly when DNR orders are valid (compliant with the patient or surrogate's written or oral instructions in most cases), what rights patients have (not to be subjected to forced or secret DNR orders), and how disputes over a DNR order should be handled (the physician communicates the benefits and burdens of CPR and an effort to transfer the patient to another physician or facility willing to comply with the patient's decision).

2. **Clarify DNR orders are only valid if compliant with a patient or surrogate's decision, in most cases.**

Section 166.203(a)(1) of Senate Bill 11 stipulates that a DNR order, in most cases, is only valid if compliant with the written or oral instructions of the patient or patient's surrogate. Proposed rule §133.41(k)(3)(G) reads, in part,

> "...procedures to ensure that the physician establishing a DNR order informs the patient of the order's issuance and documents the notification in the patient's medical record."

This may also imply that a DNR order may originate with the physician outside of the knowledge or decision of the patient or applicable surrogate. In Senate Bill 11, Section 166.203(a) lists the limited circumstances under which a DNR order being issued by a

physician is valid. The Legislature stipulated that a DNR order may only be valid without patient or surrogate authorization in rare circumstances when the patient has not objected to a DNR order, when the patient's death is imminent, and when the DNR order is medically appropriate. The current proposed rules do not clarify the typical requirements of patient or surrogate involvement and the limited exception.

3. **Include clarifying definitions for consequential terms.**

The proposed rules do not define some of the most critical terms that could greatly undermine the intent of Senate Bill 11. The proposed rules should define consequential terms that are used in Senate Bill 11 and will be used in hospitals' policies, including, but not limited to: "as soon as practicable," "attending physician," "competent," "direct care," "imminent death," "incompetent," "medical appropriateness," "promptly notify," "reasonable effort to transfer," and "reasonable medical judgment."

4. **Clarify that Disagreements over DNR orders are not subject to Section 166.046, Health and Safety Code.**

Currently proposed rule §133.41(f)(6)(G), states that the governing bodies of health facilities shall adopt policies and procedures for the

> *"actions the physician and facility must take when the physician or facility and the patient are in disagreement about the execution of, or compliance with, a DNR order..."*

After much deliberation and input from stakeholders, the Legislature included Section 166.206 in Senate Bill 11 to address potential disagreements over a DNR order that may arise between patients or surrogates and medical professionals. Since decisions surrounding DNR orders are so fundamental to the patients' and surrogates' autonomy and right to life, the only resolution process the Legislature thought appropriate was for medical professionals to explain the burdens and benefits of CPR if the disagreement continues, and for the medical professional or facility to make a reasonable effort to transfer the patient to a physician or facility willing to comply with the patient's decision on the DNR order. In cases where the disagreement is not immediately or easily resolved, the Legislature included the clarification in Section 166.206(c) that

> *"The procedures required by this section [informing patient of burdens and benefits and reasonable effort to transfer] may not be construed to control or supersede Section 166.203(a)." – Health & Safety Code.*

Even when there is disagreement, no DNR order is valid if not compliant with the patient or surrogate's written or oral instructions as outlined in Section 166.203(a). This should be reflected in the rules.

The Legislature also intentionally ensured that disputes over affected DNR orders are not subject to the 10-day hospital committee review in Section 166.046, Texas Health and Safety Code. Accordingly, the proposed rules should ensure that disputes between physicians, hospitals, and patients under S.B. 11 are not resolved by a hospital committee using the process in Section 166.046. Allowing medical professionals or healthcare facilities override or disregard a patient's or surrogate's written or oral request or revocation of a DNR order by an internal review process would contradict the legislative intent of Senate Bill 11.

5. **Clarify the satisfaction of Notice provisions contained in the bill.**

The bill contains two notice provisions—one notice to be given before the DNR is put in the record (§166.203(c), Health & Safety Code) and the other after the DNR order has been issued and a certain person related to the patient arrives at the hospital (§166.204, Health & Safety Code). The first notice must be provided, if the patient is incompetent, to a "*known agent under a medical power of attorney or legal guardian.*" §166.203(c)(A). The rules should clarify that this applies for both a known agent and a known legal guardian. The statutory language does not make it clear that the "known" applies to both the agent and the guardian.

Second, the provision does not indicate who must know of the agent or guardian. As the attending physician is issuing the DNR, it would make sense that it should be the physician's knowledge. Alternatively, it could be the knowledge of any person obligated to provide the notice (physician, physician assistant, nurse, or other person acting on behalf of a health care facility or hospital). The rule should simply clarify who is responsible for this action.

Furthermore, the rules should clarify that providing one required notice satisfies the requirement to provide the other. A person could arrive at a hospital after the facility has already provided notice over the phone. In that case, the facility should not have to worry about an ongoing obligation to provide notice to additional individuals who may show up after they have already actually successfully given notice.

We appreciate the work of the Health & Human Services Commission to implement and enforce Senate Bill 11, and we look forward to seeing the improved and updated version of the proposed rules.

Thank you,

Sen. Charles Perry

Rep. Greg Bonnen

Additional Support:

Sen. Paul Bettencourt

Sen. Brian Birdwell

Sen. Konni Burton

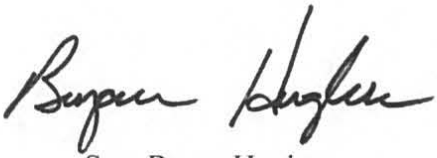
Sen. Donna Campbell

Sen. Brandon Creighton

Sen. Bob Hall

Sen. Kelly Hancock

Sen. Don Huffines



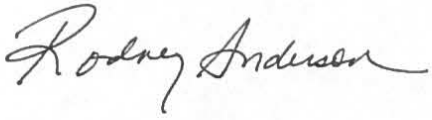
Sen. Bryan Hughes

Sen. Lois Kolkhorst

Sen. Larry Taylor

Sen. Robert Nichols

Rep. Doc Anderson



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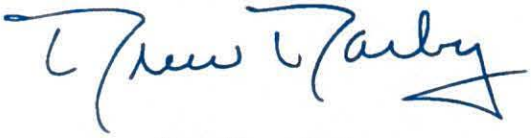

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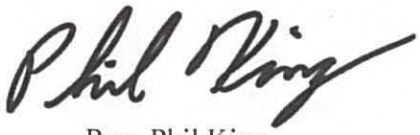

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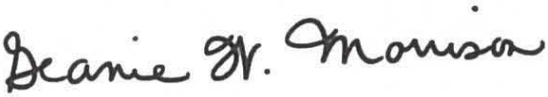
Rep. Rick Miller

Rep. Will Metcalf



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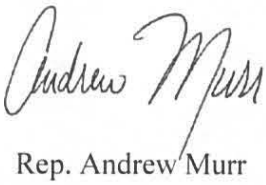
Rep. Jim Murphy



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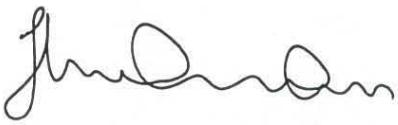
Rep. Poncho Nevárez



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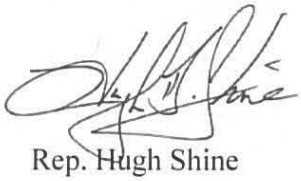

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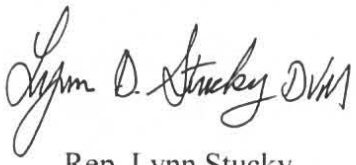

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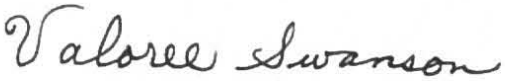

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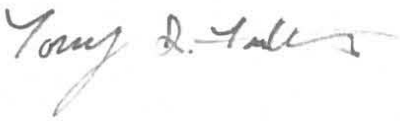
Rep. Shawn Thierry



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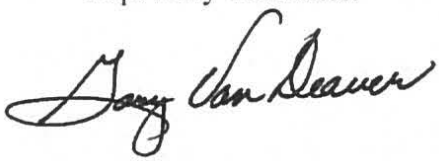
Rep. Ed Thompson



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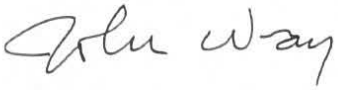
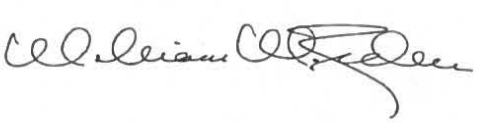
Rep. James White



Rep. John Wray



Rep. Bill Zedler

Rep. John Zerwas

EXHIBIT C

713.782.LIFE 9800 Centre Parkway, Suite 200, Houston, TX 77036 TexasRightToLife.com

Dear Commissioner Charles Smith,

The following are comments from Texas Right to Life on the proposed rules to implement and enforce Senate Bill 11 (First Called Special Session of the 85th Texas Legislature), which were published in the *Texas Register* on April 20, 2018.

Texas Right to Life was a key stakeholder and supported the legislation because of the core purpose of the legislation that, in the vast majority of cases, Do-Not-Resuscitate orders comply with: 1) the written instructions of the patient; 2) oral directions of the patient with two qualified witnesses; 3) a legally valid advance directive; 4) directions of a patient's Medical Power of Attorney or legal surrogate (See Section 166.203(a)(1), Health and Safety Code).

Texas Right to Life is gravely concerned that the rules proposed by the Health and Human Services Commission to implement and enforce SB 11 are contradictory to the legislative intent and will not accomplish the obvious goal of the legislation. We are convinced that the proposed rules will have a detrimental effect on vulnerable Texas patients unless the proposed rules are rewritten.

The proposed rules simply require hospitals to develop their own internal policies about how to execute, revoke, and settle disputes regarding DNR orders. Rather than deferring to the judgement of hospitals, HHSC should write explicit rules outlining the specific requirements of SB 11 to ensure that DNR policies carried out in Texas hospitals are fully consistent with the patient-centric law.

We recommend the following changes:

1. **Instead of simply requiring facilities to create their own DNR policies, include the specific requirements of Senate Bill 11.** As currently drafted, the two most consequential sections (§133.41(k)(3)(G) and §133.41(f)(6)(G)) are vague, nonspecific, open-ended, and do not reflect the straightforward requirements of Senate Bill 11. These two sections represent the greatest threats to the rights of vulnerable Texas patients in the proposed rules and need to be replaced with rules requiring the governing body of healthcare facilities and their medical staff to adopt policies and bylaws compliant with the specific key requirements of Senate Bill 11.

   Currently, proposed rule §133.41(f)(6)(G) states *"(G) the governing body shall adopt, implement, and enforce policies and procedures regarding DNR orders issued in the facility, the rights of the patient and person authorized to make treatment decisions regarding the patient's DNR status, and actions the physician and facility must take when the physician or facility and the patient are in disagreement about the execution of, or compliance with, a DNR order."* This language (and language in proposed §133.41(k)(3)(G)) implies that facilities are legally allowed to determine what constitutes a valid DNR order, what rights patients and their surrogates have, and what procedure the facility would like to follow when disagreements arise concerning a DNR order.

The proposed rules ignore that Senate Bill 11 outlines exactly when DNR orders are valid (compliant with the patient or surrogate's written or oral instructions in most cases), what rights patients have (not to be subjected to forced or secret DNR orders), and how disputes over a DNR order should be handled (the physician communicates the benefits and burdens of cardiopulmonary resuscitation (CPR), and if the dispute remains, an effort is made to transfer the patient to another physician or facility willing to comply with the patient's decision).

2. **Clarify DNR orders are only valid if compliant with a patient or surrogate's decision, in most cases.** Currently, proposed rules §133.41(k)(3)(G) wrongly implies that physicians must merely "inform" patients or surrogates of a DNR order; however, Section 166.203(a)(1) of SB 11 stipulates a DNR order, in most cases, is only valid if compliant with the written or oral instructions of the patient or patient's surrogate. Part of §133.41(k)(3)(G) reads, *"...procedures to ensure that the physician establishing a DNR order informs the patient of the order's issuance and documents the notification in the patient's medical record."* This wrongly implies that a DNR order may originate with the physician outside of the knowledge or decision making of the patient. In SB 11, Section 166.203(a) lists the limited circumstances under which a DNR order being issued by a physician are valid. The Texas Legislature stipulated that a DNR order may only be valid without patient or surrogate authorization in the rare circumstances when the patient has not objected to a DNR order, when the patient's death is imminent regardless of the provision of cardiopulmonary resuscitation, and the DNR order is medically appropriate. The current proposed rules do not clarify the typical requirements of patient or surrogate involvement and the limited exception.

3. **Include more definitions for consequential, yet currently vague, terms.** The proposed rules do not define some of the most critical terms that could drastically undermine the intent of SB 11. The proposed rules should define consequential terms that are used in SB 11 and will be used in hospitals' policies, including but not limited to: "as soon as practicable," "attending physician," "competent," "direct care," "imminent death," "incompetent," "medical appropriateness," "notify," "reasonable effort to transfer," and "reasonable medical judgment."

4. **Clarify that disagreements over DNR orders are not subject to Section 166.046, Health and Safety Code.** Currently, proposed rule §133.41(f)(6)(G) states that the governing bodies of health facilities shall adopt policies and procedures for the "*actions the physician and facility must take when the physician or facility and the patient are in disagreement about the execution of, or compliance with, a DNR order*" After much deliberation and input from stakeholders, the Texas Legislature included Section 166.206 in SB 11 to address potential disagreements over a DNR order that may arise between patients or surrogates and medical professionals. Because decisions surrounding DNR orders are so fundamental to the autonomy and right to life of the patient, the only resolution process the Legislature thought appropriate was for the

procedures required by this section [informing the patient of the burdens and benefits of CPR and making a reasonable effort to transfer the patient] may not be construed to control or supersede Section 166.203(a)." Even when there is disagreement, no DNR orders are valid if not compliant with the patient or surrogate's written or oral instructions as outlined in Section 166.203(a).

The Legislature intentionally ensured that disputes over DNR orders are not subject to the unprecedented, unethical, and unconstitutional 10-day hospital committee law in Section 166.046, Texas Health and Safety Code. Accordingly, the proposed rules should ensure that disputes over DNR orders between physicians, hospitals, and patients are not resolved by a hospital committee using the legal process in Section 166.046. Allowing medical professionals or healthcare facilities to override or disregard a patient or surrogate's written or oral request or revocation of a DNR order by an internal review process would contradict the legislative intent of SB 11.

To adequately and effectively implement these changes to the proposed rules, attached is a list of amendments to the proposed rules including the exact wording that Texas Right to Life recommends the Health and Human Services Commission use when rewriting the rules concerning DNR orders.

Texas Right to Life appreciates the work of the Health and Human Services Commission to implement and enforce SB 11. Please feel free to contact Texas Right to Life for any further explanation or suggested rule language.

We look forward to seeing the improved and updated version of the proposed rules.

Please see attachment.

Thank you,

John Seago
Legislative Director
Texas Right to Life
936-672-0233
JSeago@TexasRightToLife.com

Specific Recommended Amendments from Texas Right to Life

Texas Right to Life recommends the Health and Human Services Commission adopt the following amendments to the proposed rules intended to implement and enforce Senate Bill 11 (First Called Special Session of the 85th Texas Legislature), which were published in the *Texas Register* on April 20, 2018:

1. **Amend §133.2 by adding the following definitions, and renumbering the subsections in the rule accordingly:**

    a. "As soon as practicable," means no later than one hour and immediately after the attending physicians' emergency duties and responsibilities.

    b. "Attending physician," means a physician selected by or assigned to a patient who has primary responsibility for a patient's treatment and care. [This is the definition according to Section 166.002, Texas Health and Safety Code]

    c. "Competent," means possessing the ability, based on reasonable medical judgment, to understand and appreciate the nature and consequences of a treatment decision, including the significant benefits and harms of and reasonable alternatives to a proposed treatment decision. [This is the definition according to Section 166.002, Texas Health and Safety Code]

    d. "Providing direct care to the patient" means having some immediate medical responsibility for the care, health, or well-being of the patient.

    e. "Imminent death," means, based on reasonable medical judgment, death is expected within twenty-four hours even if cardiopulmonary resuscitation is provided.

    f. "Incompetent," means lacking the ability, based on reasonable medical judgment, to understand and appreciate the nature and consequences of a treatment decision, including the significant benefits and harms of and reasonable alternatives to a proposed treatment decision. [This is the definition according to Section 166.002, Texas Health and Safety Code]

    g. "Medically appropriate" means, based on reasonable medical judgment, the treatment or treatment decision would achieve the specific benefit intended by that treatment or treatment decision and would not hasten the death of the patient.

    h. "Reasonable effort to transfer," means that the attending physician or the facility assign an appropriate employee of the facility to actively search and attempt, in good faith, to facilitate a transfer of the patient to an appropriate physician or facility for at least but not limited to twenty-one days.

    i. "Reasonable medical judgment," means a medical judgment that would be made by a reasonably prudent physician, knowledgeable about the case and the treatment possibilities with respect to the medical conditions involved. [This is the definition according to Section 285.202, Texas Health and Safety Code]

2. **Amend §133.41(f)(6)(G) to read:** "(G) the governing body shall adopt, implement, and enforce policies and procedures regarding DNR orders issued in the facility, the rights of the patient and person authorized to make treatment decisions regarding the patient's DNR status. The policies and procedures shall:"

3. **Amend §133.41(f)(6)(G) by adding the following subsections to outline the requirements of SB 11 that should be adopted into the governing body's policies and procedures, to read:**

"(i) Clarify that, except in circumstances described by §133.41(f)(6)(G)(ii), a DNR order issued for a patient is valid only if the patient's attending physician issues the order, the order is dated, and the order is issued in compliance with:

(I) the written and dated directions of a patient who was competent at the time the patient wrote the directions;

(II) the oral directions of a competent patient delivered to or observed by two competent adult witnesses, at least one of whom must be a person not listed under Health and Safety Code, §166.003(2)(E) or (F);

(III) the directions in an advance directive enforceable under Health and Safety Code, §166.005 or executed in accordance with Health and Safety Code, §166.032, 166.034, or 166.035;

(IV) the directions of a patient's legal guardian or agent under a medical power of attorney, a treatment decision made in accordance with Health and Safety Code, §166.039;

(ii) Clarify that, a DNR order not in accordance with §133.41(f)(6)(G)(i) is valid only if the patient's attending physician issues the order, the order is dated, and:

(I) is not contrary to the directions of a patient who was competent at the time the patient conveyed the directions;

(II) in the reasonable medical judgment of the patient's attending physician, the patient's death is imminent, regardless of the provision of cardiopulmonary resuscitation; and

(III) in the reasonable medical judgement of the patient's attending physician, the DNR order is medically appropriate.

(iii) Require that before placing a DNR order outlined in §133.41(f)(6)(G)(ii) in a patient's medical record, the physician, physician assistant, nurse, or other person acting on behalf of a health care facility or hospital shall notify the patient of the order's issuance, or, if the patient is incompetent, make a reasonably diligent effort to contact or cause to be contacted and notify the patient's known agent under a medical power of attorney or legal guardian, or, for a patient who does not have a known agent under a medical power of attorney or legal guardian, a person described by Health and Safety Code, §166.039(b)(1), (2), or (3), in that order, and this effort to contact and notify must be recorded in the patient's medical record;

(iv) Clarify that a treatment decision or DNR order validly executed or issued later in time controls;

(v) Clarify that, when a DNR order is issued for a patient by the patient's attending physician according to §133.41(f)(6)(G)(ii) and an individual arrives at the patient's health care facility or hospital, the individual notifies a physician, physician assistant, or nurse providing direct care to the patient of the individual's arrival, and the individual is the patient's known agent under a medical power of attorney or legal guardian or a person described by Health and Safety Code, §166.039(b)(1), (2), or (3), the physician, physician assistant, or nurse who has actual knowledge of the DNR order must disclose the order to the individual, regardless of the patient's competency status;

(vi) Clarify that the notification under §133.41(f)(6)(G)(iii) and §133.41(f)(6)(G)(v) are not mutually exclusive and one notification does not replace the requirements of the other;

(vii) Require a physician providing direct care to a patient for whom a DNR order is issued shall revoke the patient's DNR order if the patient or, as applicable, the patient's agent under a medical power of attorney or the patient's legal guardian if the patient is incompetent, effectively revokes an advance directive or expresses to any person providing direct care to the patient a revocation of consent to or intent to revoke a DNR order, and the person providing direct care to a patient under the supervision of a physician shall notify the physician of the request to revoke a DNR order;

(viii) Require a notice of the policies and procedures outlined in §133.41(f)(6)(G) must be provided to a patient or person authorized to make treatment decisions on behalf of the patient upon admission to a health care facility or hospital.

(ix) Clarify a patient's attending physician may at any time revoke a DNR order issued under §133.41(f)(6)(G)(ii).

4. **Add a new subsection to §133.41(f)(6) to outline exactly what SB 11 requires when a disagreement arises between a physician and patient or the patient's agent regarding a DNR order:** (H) the governing body shall adopt, implement, and enforce policies and procedures regarding actions the physician and facility must take when the physician or facility and the patient or another person authorized to act on behalf of the patient, are in disagreement about the execution of, or compliance with, a DNR order. The policies and procedures shall:

(i) Require the physician or facility to inform the patient, the legal guardian or qualified relatives of the patient, or the agent of the patient under a medical power of attorney, of the benefits and burdens of cardiopulmonary resuscitation, including the fact that one objective benefit of cardiopulmonary resuscitation is the potential of extending the patient's life;

(ii) Clarify that if after receiving the information under §133.41(f)(6)(H)(i), the patient or another person authorized to act on behalf of the patient and the attending physician or facility remain in disagreement, the physician or facility must make a reasonable effort to transfer the patient to another physician or facility willing to execute or comply with a DNR order or the patient's instructions concerning the provision of cardiopulmonary resuscitation;

(iii) Clarify that "reasonable effort to transfer the patient" includes but is not limited to assisting the patient or another person authorized to act on behalf of the patient in communicating with another physician or facility, and securing a transfer for the patient to another physician or facility willing to execute or comply with the patient's instructions; and

(iv) Prohibit Texas Health and Safety Code, §144.046, from being used in situations of disagreement regarding a DNR order that may arise between the physician or facility and the patient or another person authorized to act on behalf of the patient; and

(v) Clarify that while the hospital's ethics committee may assist in mediating disagreements between the physician or facility and the patient or another person authorized to act on behalf of the patient, no physician of facility may authorize a DNR order in violation of the will of the patient as required in §133.41(f)(6)(G)(i) even after a committee at the hospital meets about the disagreement.

5. **Amend §133.41(j)(5) as proposed by adding,** "If a physician receives notification from a person providing direct care to the patient under the supervision of the physician that the patient or another person authorized to act on behalf of the patient, effectively revokes or expresses a revocation of consent to or intent to revoke a DNR order, that revocation shall be entered into the patient medical record as soon as practicable. A DNR order or the revocation of the order takes effect immediately."

6. **Amend §133.41(j)(8) by adding the following subsection.** "(D) This subsection does not apply to verbal orders relating to DNR orders, including the revocation of DNR orders, which take effect immediately." Subsection §133.41(j)(8) refers to all verbal orders, which may include verbal requests for a DNR order or the request to revoke a DNR order. However, this is contrary to the provisions of Senate Bill 11 and other proposed rules.

7. **Strike the following from §133.41(k)(3)(G) as proposed:** ~~The procedures shall include the actions the physician and facility must take when the physician or facility and the patient are in disagreement about the execution of, or compliance with, a DNR order.~~

8. **Amend §133.41(k)(3)(G) as proposed by replacing the word "informs" with the word "notifies" the two times the term appears in the section.**

9. **Amend §133.41(k)(3)(G) by adding the following sentence and subsections to the end of the proposed language to outline the exact requirements of SB 11, to read,** "The procedures regarding DNR orders shall:

   (i) Clarify that, except in circumstances described by §133.41(k)(3)(G)(ii), a DNR order issued for a patient is valid only if the patient's attending physician issues the order, the order is dated, and the order is issued in compliance with:

      (I) the written and dated directions of a patient who was competent at the time the patient wrote the directions;

      (II) the oral directions of a competent patient delivered to or observed by two competent adult witnesses, at least one of whom must be a person not listed under Health and Safety Code, §166.003(2)(E) or (F);

      (III) the directions in an advance directive enforceable under Health and Safety Code, §166.005 or executed in accordance with Health and Safety Code, §166.032, 166.034, or 166.035;

      (IV) the directions of a patient's legal guardian or agent under a medical power of attorney, a treatment decision made in accordance with Health and Safety Code, §166.039;

   (ii) Clarify that, a DNR order not in accordance with §133.41(k)(3)(G)(i), is valid only if the patient's attending physician issues the order, the order is dated, and:

      (I) is not contrary to the directions of a patient who was competent at the time the patient conveyed the directions;

      (II) in the reasonable medical judgment of the patient's attending physician, the patient's death is imminent, regardless of the provision of cardiopulmonary resuscitation; and

      (III) in the reasonable medical judgement of the patient's attending physician, the DNR order is medically appropriate

   (iii) Require that before placing a DNR order outlined in §133.41(k)(3)(G)(ii) in a patient's medical record, the physician, physician assistant, nurse, or other person acting on behalf of a health care facility or hospital shall notify the patient of the order's issuance, or, if the

patient is incompetent, make a reasonably diligent effort to contact or cause to be contacted and notify the patient's known agent under a medical power of attorney or legal guardian, or, for a patient who does not have a known agent under a medical power of attorney or legal guardian, a person described by Health and Safety Code, §166.039(b)(1), (2), or (3), in that order, and this effort to contact and notify must be recorded in the patient's medical record;

(iv) Clarify that a treatment decision or DNR order validly executed or issued later in time controls;

(v) Clarify that when a DNR order is issued for a patient by the patient's attending physician according to §133.41(k)(3)(G)(ii) and an individual arrives at the patient's health care facility or hospital, the individual notifies a physician, physician assistant, or nurse providing direct care to the patient of the individual's arrival, and the individual is the patient's known agent under a medical power of attorney or legal guardian or a person described by Health and Safety Code, §166.039(b)(1), (2), or (3), the physician, physician assistant, or nurse who has actual knowledge of the DNR order must disclose the order to the individual, regardless of the patient's competency status;

(vi) Clarify that the notification under §133.41(k)(3)(G)(iii) and §133.41(k)(3)(G)(v) are not mutually exclusive and one notification does not replace the requirements of the other;

(vii) Require a physician providing direct care to a patient for whom a DNR order is issued shall revoke the patient's DNR order if the patient or, as applicable, the patient's agent under a medical power of attorney or the patient's legal guardian if the patient is incompetent, effectively revokes an advance directive or expresses to any person providing direct care to the patient a revocation of consent to or intent to revoke a DNR order, and the person providing direct care to a patient under the supervision of a physician shall notify the physician of the request to revoke a DNR order;

(viii) Require a notice of the policies and procedures outlined in §133.41(k)(3)(G) must be provided to a patient or person authorized to make treatment decisions on behalf of the patient upon admission to a health care facility or hospital.

(ix) Clarify a patient's attending physician may at any time revoke a DNR order issued under §133.41(k)(3)(G)(ii).

0. **Add a new subsection to §133.41(k)(3) to outline exactly what SB 11 requires when a disagreement arises between a physician and patient or the patient's agent regarding a DNR order:** (H) the medical staff shall adopt, implement, and enforce policies and procedures regarding actions the physician and facility must take when the physician or facility and the patient or another person authorized to act on behalf of the patient, are in disagreement about the execution of, or compliance with, a DNR order. The policies and procedures shall:

(i) Require the physician or facility to inform the patient, the legal guardian or qualified relatives of the patient, or the agent of the patient under a medical power of attorney, of the benefits and burdens of cardiopulmonary resuscitation, including the fact that one objective benefit of cardiopulmonary resuscitation is the potential of extending the patient's life;

(ii) Clarify that if after receiving the information under §133.41(k)(3)(H)(i), the patient or another person authorized to act on behalf of the patient and the attending physician or facility remain in disagreement, the physician or facility must make a reasonable effort to

transfer the patient to another physician or facility willing to execute or comply with a DNR order or the patient's instructions concerning the provision of cardiopulmonary resuscitation;

(iii) Clarify that "reasonable effort to transfer the patient" includes but is not limited to assisting the patient or another person authorized to act on behalf of the patient in communicating with another physician or facility, and securing a transfer for the patient to another physician or facility willing to execute or comply with the patient's instructions; and

(iv) Prohibit Texas Health and Safety Code, §144.046, from being used in situations of disagreement regarding a DNR order that may arise between the physician or facility and the patient or another person authorized to act on behalf of the patient; and

(v) Clarify that while the hospital's ethics committee may assist in mediating disagreements between the physician or facility and the patient or another person authorized to act on behalf of the patient, no physician of facility may authorize a DNR order in violation of the will of the patient as required in §133.41(k)(3)(G)(i) even after a committee at the hospital meets about the disagreement.

11. **Add the following to the end of §133.41(o)(2)(E) as currently proposed:** If nursing staff is providing direct care to a patient under the supervision of a physician, and the patient, or as applicable, the patient's agent under a medical power of attorney or the patient's legal guardian if the patient is incompetent, effectively revokes or expresses a revocation of consent to or intent to revoke a DNR order issued under Texas Administrative Code §133.41(f)(6)(G)(ii) or §133.41(k)(3)(G)(ii), the nursing staff shall promptly notify the physician of the request to revoke a DNR order and record the notification to the attending physician of the request for revocation in the patient's medical file as soon as practicable.

12. **Amend the proposed rules to add a section amending TAC Title 25, Part 1, Chapter 133, Subchapter C, Rule 133.42, by adding a new subsection to 133.42(a)(1)(C), to read,** "(iii) the right of the patient to request or revoke a DNR order or any other order or document instructing a health care professional not to attempt cardiopulmonary resuscitation on a patient whose circulatory or respiratory function ceases."

13. **Amend Rule 133.42(a)(1)(D), to read,** "(D) the right of the patient to the information necessary to enable him or her to make treatment decisions that reflect his or her wishes; a policy on informed decision making shall be adopted, implemented and enforced by the medical staff and governing body and shall be consistent with any legal requirements, including:

(i) the right of the patient to request or revoke a DNR order or any other order or document instructing a health care professional not to attempt cardiopulmonary resuscitation on a patient whose circulatory or respiratory function ceases;

(ii) the right to receive information about the benefits and burdens of cardiopulmonary resuscitation, including the fact that one objective benefit of cardiopulmonary resuscitation is the potential of extending the patient's life; and

(iii) the right to be transferred to another physician or facility in the case of a disagreement over life-sustaining treatment and procedures including cardiopulmonary resuscitation."

14. **Amend §133.42(a)(1)(F), to read,** "(F) the right of the patient or the patient's designated representative to participate in the consideration of ethical issues that arise in the care of the patient. The hospital shall have a mechanism for the consideration of ethical issues arising in the care of patients and to provide education to care givers and patients on ethical issues in health care~~;~~. During disagreements over DNR orders and the provision of cardiopulmonary resuscitation, the patient or another person authorized to act on behalf of the patient has the right to having their request for a DNR order or the request for the order to be revoked to be honored according to the policies and procedures described in §133.41(k)(3)(G) and §133.41(f)(6)(G) and have the right to the information and process outlined in Section 166.206, Texas Health and Safety Code."

EXHIBIT D

September 20, 2018

Mrs. Cecile Young
Acting Commissioner, Health and Human Services Commission
Mail Code 1065
PO Box 13247
Austin, TX 78711

Via email to SB11DNRrulecomments@hhsc.state.tx.us

Re: Comments on DNR Proposed Rules

Dear Commissioner:

The Texas Medical Association, Texas Catholic Conference of Bishops, Texas Alliance for Life, Coalition of Texans with Disabilities, and Texans for Life (representing the vast majority of stakeholders participating in discussions on Senate Bill 11, and referred to collectively herein as the "stakeholders") write regarding the Health and Human Services Commission's (HHSC's) final adopted rules published on Sept. 14 relating to the implementation of the recently enacted SB 11.

We thank the agency for the many improvements made from the initially proposed rules and the agency's effort to adhere to the language and intent of the bill, including the agency's refusal to make any changes regarding the process outlined in §166.046, Health and Safety Code. However, the rule changes do not go far enough to implement the bill properly in accordance with the legislative intent. While the rules are now final, our organizations still feel it is critically important to stress to HHSC the need to mitigate departures from the legislative intent and stakeholder agreements on the bill that are still present in the adopted version of the rules. Texas legislators would not have supported any legislation without these agreements. In light of this, the stakeholders petition HHSC to adopt rules to

address these issues.[1] To be specific, the final rules' provisions relating to medical staff bylaws, notice, and disagreements relating to cardiopulmonary resuscitation or a do-not-resuscitate (DNR) order all should be amended to reflect legislative intent more accurately.

1. HHSC's Rules Relating to Medical Staff Bylaws Are Duplicative and Superfluous

In the proposed version of the rules published in the April 20, 2018, edition of the *Texas Register*, HHSC proposed regulations for medical staff bylaws that differed from the proposed regulations for a hospital's governing body's policies and procedures relating to DNR orders. In the final rules, HHSC puts forward regulations for medical staff bylaws that almost identically mirror the regulations for governing body policies relating to DNR orders.

The stakeholders thus encourage HHSC to eliminate the regulations on medical staff bylaws. Perhaps most importantly, nowhere in SB 11 does the legislature direct HHSC to implement the law through regulation of medical staff bylaws. Now that the regulations of medical staff bylaws mirror the regulations for governing body policies on DNR orders, having two sets of requirements for the same subject matter is unnecessary and superfluous, and only presents opportunity for conflict and confusion.

HHSC accordingly should strike the regulations in the final rules regarding medical staff bylaws that relate to DNR orders.[2]

2. HHSC's Rules Need to Clarify the Legislatively Intended Requirement to Provide Only One Notice

The initially proposed rules diverged from the provisions of SB 11 in several ways with respect to the required notice in §§166.203(c) and 166.204, Health and Safety Code. These included requiring only the physician to provide the notice and requiring notice for all DNR orders issued in accordance with SB 11. While the final rules make incremental improvements by more closely following the statutory language, the rules still do not add requisite clarity; rather, the modified rules insert additional confusion.

The final rules require in §§133.41(f)(6)(G) and 133.41(k)(3)(G), Health and Safety Code, that governing body policies and medical staff bylaws include "notice and medical record requirements for DNR orders and revocations." The final rules also require a physician, physician assistant, nurse, or other person acting on behalf of the hospital to provide notice of a DNR order issued under §166.203(a)(2), Health and Safety Code, by restating the statutory requirement in §166.203(c) for notice or a reasonably diligent effort to contact certain individuals before a DNR order issued under §166.203(a)(2) is placed in the patient's medical record.

One significant problem with the final rules is that they fail to mention the notice provision in §166.204, Health and Safety Code, which requires notice to certain individuals after they arrive at the facility. By failing to even mention this notice provision, the rules leave unanswered the question of

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[1] See §2001.021, Texas Government Code, providing authority for interested persons to request the adoption of a rule. Though HHSC is required under this section to prescribe the form for a petition for rulemaking, the stakeholders are unaware of and were unable to find such a form.

[2] The remainder of the comments here will still recommend amendments to the regulations on medical staff bylaws, but this should be interpreted only as an alternative solution. The stakeholders' preferred amendment is to eliminate regulation of medical staff bylaws as it relates to DNR orders.

how the two statutory notice provisions work together, and further create confusion of how facilities are to treat the notice provision under §166.204.

Despite the two notice provisions, the legislature intended that the two processes would work together to require only one notice. This is evidenced by Senator Perry's explanation of the two processes to provide one notice when he described the House amendments on the Senate floor.[3] The final rules have not clarified this point; rather, by omitting the second process, the rules only add confusion.

The stakeholders thus urge HHSC to further clarify the requirements surrounding notice. Specifically, the final rules should completely state both notice processes, and clarify that **fulfilling one fulfills the other**. This could be done by stating, for example, that providing notice or making a reasonably diligent effort to provide notice to a known agent under a medical power of attorney or legal guardian or, if there is no known agent or guardian, then a person described by §166.039(b)(1), (2), or (3), will satisfy all legal obligations to provide notice relating to the DNR order, but if an earlier, reasonably diligent attempt to provide notice before the DNR was placed in the patient's medical record was unsuccessful and the patient's agent, guardian, or appropriate other relative later arrives at the facility, then notice requirements can be satisfied with the first notice provided in that circumstance. The stakeholders suggest the following language in §§133.41(f)(6)(G) and 133.41(k)(3)(G) to clarify these notice provisions in accordance with legislative intent:

> Before placing in a patient's medical record a DNR order issued under Section 166.203(a)(2), Health and Safety Code, a physician, physician assistant, nurse, or other person acting on behalf of a health care facility or hospital shall inform the patient of the order's issuance, or if the patient is incompetent, make a reasonably diligent effort to contact or cause to be contacted and inform of the order's issuance the patient's known agent under a medical power of attorney or legal guardian, or, for a patient who does not have a known agent under a medical power of attorney or legal guardian, a person described by Section 166.039(b)(1), (2), or (3).
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> If a physician, physician assistant, nurse, or other person acting on behalf of a health care facility or hospital provides notice of a DNR order issued under Section 166.203(a)(2), Health and Safety Code to any person other than the patient, all obligations relating to notice under Subchapter E, Chapter 166, Health and Safety Code, are satisfied. If a physician, physician assistant, nurse, or other person acting on behalf of a health care facility or hospital made a reasonably diligent but unsuccessful effort to provide notice, but the patient's known agent under a medical power of attorney or legal guardian or, for a patient who does not have a medical power of attorney or legal guardian, a person described by Health and Safety Code, §166.039(b)(1), (2), or (3), later arrives at the health care facility or hospital in the circumstances described in Section 166.204(a), Health and Safety Code, the physician, physician assistant, or nurse notified of that individual's arrival shall provide notice to that individual of the issuance of the DNR order, and all obligations relating to notice under Subchapter E, Chapter 166, Health and Safety Code, are satisfied. Any person who makes a good-faith effort to comply with the notice requirements of this subparagraph and contemporaneously records the person's efforts to comply is not subject to disciplinary action for any act or omission related to providing such notice.

3. HHSC Rules Must Address the Full Scope of Disagreements Regarding the Provision of

[3] Senator Perry suggested that the notice requirements of the bill were to "attempt to notify upon issuing, and if unreachable, attempt to notify upon arrival." See video of floor discussion for SB 11, 85th Legislature, First Called Session (August 15, 2017), available at: http://tlcsenate.granicus.com/MediaPlayer.php?view_id=42&clip_id=12939.

Cardiopulmonary Resuscitation

The final rules also made some modifications regarding SB 11's provision treating disagreements regarding a DNR order or the provision of cardiopulmonary resuscitation between an attending physician, health care facility, or hospital and the patient or authorized surrogate. However, the rule still fails to capture fully the legislature's intent and the clear statutory language provided in the bill.

The final rules in §§133.41(f)(6)(G) and 133.41(k)(3)(G) require medical staff bylaws and governing body policies to include actions physicians and hospitals must take when there is a disagreement about "the execution of, or compliance with, a DNR order." This captures only *some* of the possible scenarios regarding a patient's DNR status because it assumes that a DNR order *already exists*. In actuality, there may be disagreements between physicians, hospitals, and patients and their surrogates *before* a DNR order is even issued. This possibility is expressly accounted for in SB 11's language, when it considers disagreements concerning a "DNR order **or the patient's instructions concerning the provision of cardiopulmonary resuscitation**."[4]

The failure of the final rules to account for this scenario will almost assuredly cause confusion. For this reason, the stakeholders encourage HHSC to further amend the rules to be consistent with SB 11's dispute resolution process. This can be accomplished by amending the appropriate portions of both of §§133.41(f)(6)(G) and 133.41(k)(3)(G) to read as follows:

> … and actions the attending physician and hospital must take pursuant to Health and Safety Code §166.206 when the attending physician or hospital and the patient or person authorized to make treatment decisions regarding the patient's DNR status are in disagreement about the execution of, or compliance with, a DNR order or the patient's instructions concerning the provision of cardiopulmonary resuscitation. …

Conclusion

Because of the sensitive subject matter of SB 11 and these rules, ensuring the bill is properly implemented in accordance with legislative intent is of paramount importance. Should you have any questions, please contact the following individuals:

Sincerely,

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[4] §166.206(a), Health and Safety Code (emphasis added).

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ENDNOTES

[1] Texas House of Representatives, *Rules and Precedents of the Texas House,* 85th Legislature, Texas Legislative Council, January 2017.
[2] Office of the Texas Speaker of the House, "House Interim Charges Focus on Hurricane Harvey," October 23, 2017, https://house.texas.gov/news/press-releases/?id=6395.
[3] Chapter 11 (S.B.11), Acts of the 85th Legislature, 1st Called Session, 2017.
[4] Office of the Texas Governor, "Governor Abbott Names Dr. Courtney Phillips Executive Commissioner of Texas Health and Human Services Commission," August 23, 2018, https://gov.texas.gov/news/post/governor-abbott-names-dr.-courtney-phillips-executive-commissioner-of-texas-health-and-human-services-commission.