BILL ANALYSIS

Senate Research Center

H.B. 3162
By: Klick et al. (Springer)
Health & Human Services
5/13/2023
Engrossed

AUTHOR'S / SPONSOR'S STATEMENT OF INTENT

The Texas Advance Directives Act was written in 1999. Virtually all of the stakeholders involved with end-of-life decisions have expressed their frustration and disagreement with the current law. Legislation has been filed since the 80th Legislature, Regular Session, 2007, to address this issue to balance the rights and needs of patients and their families with the best medical judgment of physicians. H.B. 3162 is the result of hundreds of hours of negotiations between stakeholders representing medical professionals, medical facilities, and patient advocate groups.

H.B. 3162 seeks to address the shortcomings of existing law and improve protections for patients, medical professionals, and medical facilities. This legislation requires physicians to perform certain procedures to facilitate a patient's transfer to another physician or health care facility, sets out requirements for ethics or medical committees that review a physician's refusal to honor an advance directive or health care or treatment decision, extends the duration of notice provided to a patient's medical decision-makers of such a meeting, extends the period during which all avenues of transfer may be explored if the committee decides to override and withdraw life-sustaining treatment, prohibits disabilities from being considered by the ethics or medical committee, creates a reporting mechanism at the Health and Human Services Commission for data collection, prohibits a patient's wishes regarding do-not-resuscitate (DNR) orders from being overridden by other medical decision-makers, and removes a duplicative notice requirement for medical decision-makers of DNR orders.

H.B. 3162 amends current law relating to advance directives, do-not-resuscitate orders, and health care treatment decisions made by or on behalf of certain patients, including a review of directives and decisions.

RULEMAKING AUTHORITY

Rulemaking authority is expressly granted to the executive commissioner of the Health and Human Services Commission in SECTION 6 (Section 166.054, Health and Safety Code) of this bill.

SECTION BY SECTION ANALYSIS

SECTION 1. Amends Subchapter B, Chapter 166, Health and Safety Code, by adding Section 166.0445, as follows:

> Sec. 166.0445. LIMITATION ON LIABILITY FOR PERFORMING CERTAIN MEDICAL PROCEDURES. (a) Provides that a physician or a health care professional acting under the direction of a physician is not subject to civil liability for participating in a medical procedure performed under Section 166.046(d-2).
>
> (b) Provides that a physician or a health care professional acting under the direction of a physician is not subject to criminal liability for participating in a medical procedure performed under Section 166.046(d-2) unless:
>
> (1) the physician or health care professional in participating in the medical procedure acted with a specific malicious intent to cause the death

of the patient and that conduct significantly hastened the patient's death; and

(2) the hastening of the patient's death is not attributable to the risks associated with the medical procedure.

(c) Provides that a physician or a health care professional acting under the direction of a physician has not engaged in unprofessional conduct by participating in a medical procedure performed under Section 166.046(d-2) unless the physician or health care professional in participating in the medical procedure acted with a specific malicious intent to harm the patient.

SECTION 2. Amends the heading to Section 166.046, Health and Safety Code, as follows:

Sec. 166.046. PROCEDURE IF NOT EFFECTUATING DIRECTIVE OR TREATMENT DECISION FOR CERTAIN PATIENTS.

SECTION 3. Amends Section 166.046, Health and Safety Code, by amending Subsections (a), (b), (c), (d), (e), and (g) and adding Subsections (a-1), (a-2), (b-1), (b-2), (b-3), (d-1), (d-2), (d-3), and (i), as follows:

(a) Provides that this section applies only to health care and treatment for a patient who is determined to be incompetent or is otherwise mentally or physically incapable of communication.

(a-1) Provides that if an attending physician refuses to honor an advance directive of or health care or treatment decision made by or on behalf of a patient to whom this section applies, the physician's refusal is required to be reviewed by an ethics or medical committee. Prohibits the attending physician from being a member of that committee during the review. Deletes existing text providing that if an attending physician refuses to honor a patient's advance directive or a health care or treatment decision made by or on behalf of a patient, the physician's refusal is required to be reviewed by an ethics or medical committee.

(a-2) Provides that an ethics or medical committee that reviews a physician's refusal to honor an advance directive or health care or treatment decision under Subsection (a-1) is required to consider the patient's well-being in conducting the review but is prohibited from making any judgment on the patient's quality of life. Provides that a decision by the committee based on any of the considerations described by Subdivisions (1) through (5), for purposes of the section, is not a judgment on the patient's quality of life. Requires the committee, if the review requires the committee to determine whether life-sustaining treatment requested in the patient's advance directive or by the person responsible for the patient's health care decisions is medically inappropriate, to consider whether provision of the life-sustaining treatment:

(1) will prolong the natural process of dying or hasten the patient's death;

(2) will result in substantial, irremediable, and objectively measurable physical pain that is not outweighed by the benefit of providing the treatment;

(3) is medically contraindicated such that the provision of the treatment seriously exacerbates life-threatening medical problems not outweighed by the benefit of providing the treatment;

(4) is consistent with the prevailing standard of care; or

(5) is contrary to the patient's clearly documented desires.

(b) Provides that the person responsible for the patient's health care decisions:

(1) is required to be informed in writing not less than seven calendar days before the meeting called to discuss the patient's directive, unless the period is waived by written mutual agreement, of:

(A) the ethics or medical committee review process and any other related policies and procedures adopted by the health care facility, including any policy described by Subsection (b-1);

(B) the rights described in Subdivisions (3)(A)-(D);

(C) the date, time, and location of the meeting;

(D) the work contact information of the facility's personnel who, in the event of a disagreement, will be responsible for overseeing the reasonable effort to transfer the patient to another physician or facility willing to comply with the directive;

(E) the factors the committee is required to consider under Subsection (a-2); and

(F) the language in Section 166.0465;

(2) at the time of being informed under Subdivision (1), is required to be provided:

(A)-(B) makes no changes to these paragraphs; and

(3) is entitled to:

(A) attend and participate in the meeting as scheduled by the committee;

(B) receive during the meeting a written statement of the first name, first initial of the last name, and title of each committee member who will participate in the meeting;

(C) subject to Subsection (b-1):

(i) be accompanied at the meeting by the patient's spouse, parents, adult children, and not more than four additional individuals, including legal counsel, a physician, a health care professional, or a patient advocate, selected by the person responsible for the patient's health care decisions; and

(ii) have an opportunity during the open portion of the meeting to either directly or through another individual attending the meeting:

(a) explain the justification for the health care or treatment request made by or on behalf of the patient;

(b) respond to information relating to the patient that is submitted or presented during the open portion of the meeting; and

(c) state any concerns of the person responsible for the patient's health care decisions regarding compliance with this section or Section 166.0465, including stating an opinion that one or more of the patient's disabilities are not relevant to the committee's determination of whether the medical or surgical intervention is medically appropriate;

(D) receive a written notice, rather than explanation, of:

(i) the decision reached during the review process accompanied by an explanation of the decision, including, if applicable, the committee's reasoning for affirming that requested life-sustaining treatment is medically inappropriate;

(ii) the patient's major medical conditions as identified by the committee, including any disability of the patient considered by the committee in reaching the decision, except the notice is not required to specify whether any medical condition qualifies as a disability;

(iii) a statement that the committee has complied with Subsection (a-2) and Section 166.0465; and

(iv) the health care facilities contacted before the meeting as part of the transfer efforts under Subsection (d) and, for each listed facility that denied the request to transfer the patient and provided a reason for the denial, the provided reason;

(E) receive a copy of or electronic access to the portion of the patient's medical record related to the treatment received by the patient in the facility for the period of the patient's current admission to the facility; and

(F) receive a copy of or electronic access to all of the patient's reasonably available diagnostic results and reports related to the medical record provided under Paragraph (E), rather than Paragraph (C).

Deletes existing text providing that the patient or the person responsible for the health care decisions of the individual who has made the decision regarding the directive or treatment decision may be given a written description of the ethics or medical committee review process and any other policies and procedures related to this section adopted by the health care facility. Deletes existing text requiring that the patient or the person responsible for the health care decisions of the individual who has made the decision regarding the directive or treatment decision be informed of the committee review process not less than 48 hours before the meeting called to discuss the patient's directive, unless the time period is waived by mutual agreement.

(b-1) Authorizes a health care facility to adopt and implement a written policy for meetings held under this section that is reasonable and necessary to:

(1) facilitate information sharing and discussion of the patient's medical status and treatment requirements, including provisions related to attendance, confidentiality, and timing regarding any agenda item; and

(2) preserve the effectiveness of the meeting, including provisions disclosing that the meeting is not a legal proceeding and the committee will enter into an executive session for deliberations.

(b-2) Prohibits the following individuals from attending or participating in the executive session of an ethics or medical committee under this section, notwithstanding Subsection (b)(3):

(1) the physicians or health care professionals providing health care and treatment to the patient; or

(2) the person responsible for the patient's health care decisions or any person attending the meeting under Subsection (b)(3)(C)(i).

(b-3) Requires the facility or person, as applicable, if the health care facility or person responsible for the patient's health care decisions intends to have legal counsel attend the meeting of the ethics or medical committee, to make a good faith effort to provide written notice of that intention not less than 48 hours before the meeting begins.

(c) Requires that the written notice required by Subsection (b)(3)(D)(i) be included in the patient's medical record. Makes conforming changes.

(d) Requires the patient's attending physician, after written notice is provided under Subsection (b)(1), to make a reasonable effort to transfer the patient to a physician who is willing to comply with the directive. Requires the health care facility's personnel to assist the physician in arranging the patient's transfer to:

(1)-(3) makes no changes to these subdivisions.

Deletes existing text providing that if the attending physician, the patient, or the person responsible for the health care decisions of the individual does not agree with the decision reached during the review process under Subsection (b), the physician is required to make a reasonable effort to transfer the patient to a physician who is willing to comply with the directive. Deletes existing text providing that if the patient is a patient in a health care facility, the facility's personnel is required to assist the physician in arranging the patient's transfer to another location.

(d-1) Requires the personnel of the health care facility assisting with the patient's transfer efforts under Subsection (d), if another health care facility denies the patient's transfer request, to make a good faith effort to inquire whether the facility that denied the patient's transfer request would be more likely to approve the transfer request if a medical procedure, as that term is defined in this section, is performed on the patient.

(d-2) Provides that if the patient's advance directive or the person responsible for the patient's health care decisions is requesting life-sustaining treatment that the attending physician has decided and the ethics or medical committee has affirmed is medically inappropriate:

(1) the attending physician or another physician responsible for the care of the patient is required to perform on the patient each medical procedure that satisfies all of the following conditions:

(A) in the attending physician's judgment, the medical procedure is reasonable and necessary to help effect the patient's transfer under Subsection (d);

(B) an authorized representative for another health care facility with the ability to comply with the patient's advance directive or the health care or treatment decision made by or on behalf of the patient has expressed to the personnel described by Subsection (b)(1)(D) or the attending physician that the facility is more likely to accept the patient's transfer to the other facility if the medical procedure is performed on the patient;

(C) in the medical judgment of the physician who would perform the medical procedure, performing the medical procedure is:

(i) within the prevailing standard of medical care; and

(ii) not medically contraindicated or medically inappropriate under the circumstances;

(D) in the medical judgment of the physician who would perform the medical procedure, the physician has the training and experience to perform the medical procedure;

(E) the physician who would perform the medical procedure has medical privileges at the facility where the patient is receiving care authorizing the physician to perform the medical procedure at the facility;

(F) the facility where the patient is receiving care has determined the facility has the resources for the performance of the medical procedure at the facility; and

(G) the person responsible for the patient's health care decisions provides consent on behalf of the patient for the medical procedure; and

(2) the person responsible for the patient's health care decisions is entitled to receive:

(A) a delay notice:

(i) if, at the time the written decision is provided as required by Subsection (b)(3)(D)(i), a medical procedure satisfies all of the conditions described by Subdivision (1); or

(ii) if:

(a) at the time the written decision is provided as required by Subsection (b)(3)(D)(i), a medical procedure satisfies all of the conditions described by Subdivision (1) except Subdivision (1)(G); and

(b) the person responsible for the patient's health care decisions provides to the attending physician or another physician or health care professional providing direct care to the patient consent on behalf of the patient for the medical procedure within 24 hours of the request for consent;

(B) a start notice:

(i) if, at the time the written decision is provided as required by Subsection (b)(3)(D)(i), no medical procedure satisfies all of the conditions described by Subdivisions (1)(A) through (F); or

(ii) if:

(a) at the time the written decision is provided as required by Subsection (b)(3)(D)(i), a medical procedure satisfies all of the conditions described by Subdivision (1) except Subdivision (1)(G); and

(b) the person responsible for the patient's health care decisions does not provide to the attending physician or another physician or health care professional providing direct care to the patient consent on behalf of the patient for the medical procedure within 24 hours of the request for consent; and

(C) a start notice accompanied by a statement that one or more of the conditions described by Subdivisions (1)(A) through (G) are no longer satisfied if, after a delay notice is provided in accordance with Subdivision (2)(A) and before the medical procedure on which the delay notice is

based is performed on the patient, one or more of those conditions are no longer satisfied.

(d-3) Provides that after the 25-day period described by Subsection (e) begins, the period is prohibited from being suspended or stopped for any reason. Provides that this subsection does not limit or affect a court's ability to order an extension of the period in accordance with Subsection (g). Provides that Subsection (d-2) does not require a medical procedure to be performed on the patient after the expiration of the 25-day period.

(e) Requires the patient, if the patient's advance directive or the person responsible for the patient's health care decisions is requesting life-sustaining treatment that the attending physician has decided and the ethics or medical committee has affirmed is medically inappropriate treatment, to be given available life-sustaining treatment pending transfer under Subsection (d). Provides that this subsection does not authorize withholding or withdrawing pain management medication, medical interventions necessary to provide comfort, or any other health care provided to alleviate a patient's pain. Provides that the patient is responsible for any costs incurred in transferring the patient to another health care facility. Provides that the attending physician, any other physician responsible for the care of the patient, and the health care facility are not obligated to provide life-sustaining treatment after the 25th calendar day after a start notice is provided in accordance with Subsection (d-2)(2)(B) or (C) to the person responsible for the patient's health care decisions or a medical procedure for which a delay notice was provided in accordance with Subsection (d-2)(2)(A) is performed, whichever occurs first, unless ordered to extend the 25-day period under Subsection (g), except that artificially administered nutrition and hydration must be provided unless, based on reasonable medical judgment, providing artificially administered nutrition and hydration would:

(1)-(2) makes no changes to these subdivisions;

(3) result in substantial, irremediable, and objectively measurable physical pain not outweighed by the benefit of providing the treatment;

(4)-(5) makes no changes to these subdivisions;

Deletes existing text providing that if the patient or the person responsible for the health care decisions of the patient is requesting life-sustaining treatment that the attending physician has decided and the ethics or medical committee has affirmed is medically inappropriate treatment, the patient is required to be given available life-sustaining treatment pending transfer under Subsection (d). Deletes existing text providing that this subsection does not authorize withholding or withdrawing pain management medication, medical procedures necessary to provide comfort, or any other health care provided to alleviate a patient's pain. Deletes existing text providing that the attending physician, any other physician responsible for the care of the patient, and the health care facility are not obligated to provide life-sustaining treatment after the 10th day after both the written decision and the patient's medical record required under Subsection (b) are provided to the patient or the person responsible for the health care decisions of the patient unless ordered to do so under Subsection (g), except that artificially administered nutrition and hydration is required to be provided unless, based on reasonable medical judgment, providing artificially administered nutrition and hydration would be medically contraindicated such that the provision of the treatment seriously exacerbates life-threatening medical problems not outweighed by the benefit of the provision of the treatment.

(g) Requires that at the request of the person responsible for the patient's health care decisions, the appropriate district or county court extend the 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. Deletes existing text requiring that at the request of the patient or the person responsible for the health care decisions of

the patient, the appropriate district or county court 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.

(i) Defines "delay notice," "medical procedure," and "start notice."

SECTION 4. Amends Subchapter B, Chapter 166, Health and Safety Code, by adding Section 166.0465, as follows:

Sec. 166.0465. ETHICS OR MEDICAL COMMITTEE DECISION RELATED TO PATIENT DISABILITY. (a) Defines "disability."

(b) Prohibits the ethics or medical committee, during the review process under Section 166.046(b), from considering a patient's disability that existed before the patient's current admission unless the disability is relevant in determining whether the medical or surgical intervention is medically appropriate.

SECTION 5. Amends Sections 166.052(a) and (b), Health and Safety Code, as follows:

(a) Requires that the statement required by Section 166.046(b)(2)(A), rather than Section 166.046(b)(3)(A), in cases in which the attending physician refuses to honor an advance directive or health care or treatment decision requesting the provision of life-sustaining treatment for a patient who is determined to be incompetent or is otherwise mentally or physically incapable of communication, be in substantially a certain form. Sets forth the language required to be included in the form.

(b) Requires that the statement required by Section 166.046(b)(2)(A), rather than Section 166.046(b)(3)(A), in cases in which the attending physician refuses to comply with an advance directive or a health care or treatment decision requesting the withholding or withdrawal of life-sustaining treatment for a patient who is determined to be incompetent or is otherwise mentally or physically incapable of communication, be in substantially a certain form. Sets forth the language required to be included in the form.

SECTION 6. Amends Subchapter B, Chapter 166, Health and Safety Code, by adding Section 166.054, as follows:

Sec. 166.054. REPORTING REQUIREMENTS REGARDING ETHICS OR MEDICAL COMMITTEE PROCESSES. (a) Requires a health care facility, not later than the 180th day after the date written notice is provided under Section 166.046(b)(1), to prepare and submit to the Health and Human Services Commission (HHSC) a report that contains the following information:

(1) the number of days that elapsed from the patient's admission to the facility to the date notice was provided under Section 166.046(b)(1);

(2) whether the ethics or medical committee met to review the case under Section 166.046 and, if the committee did meet, the number of days that elapsed from the date notice was provided under Section 166.046(b)(1) to the date the meeting was held;

(3) whether the patient was:

(A) transferred to a physician within the same facility who was willing to comply with the patient's advance directive or a health care or treatment decision made by or on behalf of the patient;

(B) transferred to a different health care facility; or

(C) discharged from the facility to a private residence or other setting that is not a health care facility;

(4) whether the patient died while receiving life-sustaining treatment at the facility;

(5) whether life-sustaining treatment was withheld or withdrawn from the patient at the facility after expiration of the time period described by Section 166.046(e) and, if so, the disposition of the patient after the withholding or withdrawal of life-sustaining treatment at the facility, as selected from the following categories:

(A) the patient died at the facility;

(B) the patient is currently a patient at the facility;

(C) the patient was transferred to a different health care facility; or

(D) the patient was discharged from the facility to a private residence or other setting that is not a health care facility;

(6) the age group of the patient selected from the following categories:

(A) 17 years of age or younger;

(B) 18 years of age or older and younger than 66 years of age; or

(C) 66 years of age or older;

(7) the health insurance coverage status of the patient selected from the following categories:

(A) private health insurance coverage;

(B) public health plan coverage; or

(C) uninsured;

(8) the patient's sex;

(9) the patient's race;

(10) whether the facility was notified of and able to reasonably verify any public disclosure of the contact information for the facility's personnel, physicians or health care professionals who provide care at the facility, or members of the ethics or medical committee in connection with the patient's stay at the facility; and

(11) whether the facility was notified of and able to reasonably verify any public disclosure by facility personnel of the contact information for the patient's immediate family members or the person responsible for the patient's health care decisions in connection with the patient's stay at the facility.

(b) Requires HHSC to ensure information provided in each report submitted by a health care facility under Subsection (a) is kept confidential and not disclosed in any manner, except as provided by this section.

(c) Requires HHSC, not later than April 1 of each year, to prepare and publish on HHSC's Internet website a report that contains:

(1) aggregate information compiled from the reports submitted to HHSC under Subsection (a) during the preceding year on:

(A) the total number of written notices provided under Section 166.046(b)(1);

(B) the average number of days described by Subsection (a)(1);

(C) the total number of meetings held by ethics or medical committees to review cases under Section 166.046;

(D) the average number of days described by Subsection (a)(2);

(E) the total number of patients described by Subsections (a)(3)(A), (B), and (C);

(F) the total number of patients described by Subsection (a)(4);

(G) the total number of patients for whom life-sustaining treatment was withheld or withdrawn after expiration of the time period described by Section 166.046(e);

(H) the total number of cases for which the facility was notified of and able to reasonably verify the public disclosure of the contact information for the facility's personnel, physicians or health care professionals who provide care at the facility, or members of the ethics or medical committee in connection with the patient's stay at the facility; and

(I) the total number of cases for which the facility was notified of and able to reasonably verify the public disclosure by facility personnel of contact information for the patient's immediate family members or person responsible for the patient's health care decisions in connection with the patient's stay at the facility; and

(2) if the total number of reports submitted under Subsection (a) for the preceding year is 10 or more, aggregate information compiled from those reports on the total number of patients categorized by:

(A) sex;

(B) race;

(C) age group, based on the categories described by Subsection (a)(6);

(D) health insurance coverage status, based on the categories described by Subsection (a)(7); and

(E) for patients for whom life-sustaining treatment was withheld or withdrawn at the facility after expiration of the period described by Section 166.046(e), the total number of patients described by each of the following:

(i) Subsection (a)(5)(A);

(ii) Subsection (a)(5)(B);

(iii) Subsection (a)(5)(C); and

(iv) Subsection (a)(5)(D).

(d) Requires HHSC, if HHSC receives fewer than 10 reports under Subsection (a) for inclusion in an annual report required under Subsection (c), to include in the next annual report prepared after HHSC receives 10 or more reports the aggregate information for all years for which the information was not included in a preceding annual report. Requires HHSC to include in the next annual report a statement that identifies each year during which an underlying report was submitted to HHSC under Subsection (a).

(e) Prohibits the annual report required by Subsection (c) or (d) from including any information that could be used alone or in combination with other reasonably available information to identify any individual, entity, or facility.

(f) Requires the executive commissioner of HHSC to adopt rules to:

(1) establish a standard form for the reporting requirements of this section; and

(2) protect and aggregate any information HHSC receives under this section.

(g) Provides that information collected as required by this section or submitted to HHSC under this section:

(1) is not admissible in a civil or criminal proceeding in which a physician, health care professional acting under the direction of a physician, or health care facility is a defendant;

(2) is prohibited from being used in relation to any disciplinary action by a licensing or regulatory agency with oversight over a physician, health care professional acting under the direction of a physician, or health care facility; and

(3) is not public information or subject to disclosure under Chapter 552 (Public Information), Government Code, except as permitted by Section 552.008 (Information for Legislative Purposes), Government Code.

SECTION 7. Amends Sections 166.203(a), (b), and (c), Health and Safety Code, as follows:

(a) Provides that a DNR order issued for a patient is valid only if the order is dated and:

(1) is issued by a physician providing direct care to the patient in compliance with:

(A)-(B) makes no changes to these paragraphs;

(C) the directions in an advance directive enforceable under Section 166.005 or executed in accordance with certain sections, including Section 166.082, 166.084, or 166.085;

(D) the directions of a patient's:

(i)-(ii) creates these subparagraphs from existing text; or

(iii) proxy as designated and authorized by a directive executed in accordance with Subchapter B (Directive to Physician) to make a treatment decision for the patient if the patient becomes

incompetent or otherwise mentally or physically incapable of communication; or

(E) makes a nonsubstantive change to this paragraph;

(2) is issued by the patient's attending physician and:

(A) makes a nonsubstantive change to this paragraph; and

(B) in the reasonable medical judgment of the patient's attending physician:

(i) the patient's death is imminent, within minutes to hours, regardless of the provision of cardiopulmonary resuscitation; and

(ii) creates this subparagraph from existing text; or

(3) is issued by the patient's attending physician:

(A) for a patient who is incompetent or otherwise mentally or physically incapable of communication; and

(B) in compliance with a decision:

(i) agreed on by the attending physician and the person responsible for the patient's health care decisions; and

(ii) concurred in by another physician who is not involved in the direct treatment of the patient or who is a representative of an ethics or medical committee of the health care facility in which the person is a patient.

Deletes existing text providing that a DNR order issued for a patient is valid only if the patient's attending physician issues the order. Makes nonsubstantive changes.

(b) Provides that 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 and is authorized to be issued and entered in a format acceptable under the policies of the health care facility or hospital.

(c) Requires a physician, physician assistant, nurse, or other person acting on behalf of a health care facility or hospital, unless notice is provided in accordance with Section 166.204(a), before placing in a patient's medical record a DNR order issued under Subsection (a)(2), to take certain actions. Makes nonsubstantive changes.

SECTION 8. Amends Section 166.204, Health and Safety Code, by amending Subsections (a), (b), and (c) and adding Subsection (a-1), as follows:

(a) Requires the physician, physician assistant, or nurse who has actual knowledge of the order, 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, unless notice has been provided in accordance with Section 166.203(c), to disclose the order to the individual, provided the individual is:

(1)-(2) makes no changes to these subdivisions.

(a-1) Requires a physician, physician assistant, or nurse providing direct care to the patient, for a patient who was incompetent at the time notice otherwise would have been provided to the patient under Section 166.203(c)(1) and if a physician providing direct

care to the patient later determines that, based on the physician's reasonable medical judgment, the patient has become competent, to disclose the order to the patient, provided that the physician, physician assistant, or nurse has actual knowledge:

(1) of the order; and

(2) that a physician providing direct care to the patient has determined that the patient has become competent.

(b) Provides that failure to comply with Subsection (a) or (a-1) or Section 166.203(c) does not affect the validity of a DNR order issued under Subchapter E (Health Care Facility Do-Not-Resuscitate Orders).

(c) Provides that any person, including a health care facility or hospital, 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) or (a-1) of this section or Section 166.203(c) if the person:

(1) makes a good faith effort to comply with Subsection (a) or (a-1) or Section 166.203(c) and contemporaneously records in the patient's medical record the person's effort to comply with those provisions; or

(2) makes a good faith determination that the circumstances that would require the person to perform an act under Subsection (a) or (a-1) or Section 166.203(c) are not met.

Makes nonsubstantive changes.

SECTION 9. Amends Section 166.205, Health and Safety Code, by amending Subsections (a), (b), and (c) and adding Subsection (c-1), as follows:

(a) Requires a physician providing direct care to a patient for whom a DNR order is issued to revoke the patient's DNR order if:

(1) an advance directive that serves as the basis of the DNR order is properly revoked in accordance with Chapter 166 (Advance Directives);

(2) the patient 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); or

(3) the DNR order was issued under Section 166.203(a)(1)(D) or (E) or Section 166.203(a)(3), and the person responsible for the patient's health care decisions expresses to any person providing direct care to the patient a revocation of consent to or intent to revoke the DNR order.

Deletes existing text requiring a physician providing direct care to a patient for whom a DNR order is issued to 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, in accordance with Section 166.042 (Revocation of Directive), for which a DNR order is issued under Section 166.203(a).

(b) Requires a person providing direct care to a patient under the supervision of a physician to notify the physician of the request to revoke a DNR order or of the revocation of an advance directive under Subsection (a).

(c) Authorizes a patient's attending physician to revoke at any time a DNR order issued under:

(1) Section 166.203(a)(1)(A), (B), or (C), provided that:

(A) the order is for a patient who is incompetent or otherwise mentally or physically incapable of communication; and

(B) the decision to revoke the order is:

(i) agreed on by the attending physician and the person responsible for the patient's health care decisions; and

(ii) concurred in by another physician who is not involved in the direct treatment of the patient or who is a representative of an ethics or medical committee of the health care facility in which the person is a patient;

(2) Section 166.203(a)(1)(E), provided that the order's issuance was based on a treatment decision made in accordance with Section 166.039(e);

(3) Section 166.203(a)(2); or

(4) Section 166.203(a)(3).

(c-1) Requires a patient's attending physician to revoke a DNR order issued for the patient under Section 166.203(a)(2) if, in the attending physician's reasonable medical judgment, the condition described by Section 166.203(a)(2)(B)(i) is no longer satisfied.

SECTION 10. Amends Sections 166.206(a) and (b), Health and Safety Code, as follows:

(a) Requires the physician, facility, or hospital, if a physician, health care facility, or hospital, rather than 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, 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.

(b) Makes a conforming change to this subsection.

SECTION 11. Amends Section 166.209, Health and Safety Code, as follows:

Sec. 166.209. ENFORCEMENT. (a) Provides that a physician, physician assistant, nurse, or other person, subject to Sections 166.205(d) (relating to providing that a person is not civilly or criminally liable for failure to act on a revocation unless the person has actual knowledge of the revocation), 166.207 (Limitation on Liability for Issuing DNR Order or Withholding Cardiopulmonary Resuscitation), and 166.208 (Limitation on Liability for Failure to Effectuate DNR Order) and Subsection (c), commits an offense if, with the specific intent to violate this subchapter, the person intentionally:

(1) conceals, cancels, effectuates, or falsifies another person's DNR order in violation of this subchapter; or

(2) creates this subdivision from existing text and makes a nonsubstantive change.

(a-1) Creates this subsection from existing text. Makes conforming changes.

(b) Provides that a physician, health care professional, health care facility, hospital, or entity, subject to Sections 166.205(d), 166.207, and 166.208, is subject to review and disciplinary action by the appropriate licensing authority for intentionally taking certain actions.

(c) Provides that Subsection (a) does not apply to a person whose act or omission was based on a reasonable belief that the act or omission was in compliance with the wishes of the patient or the person responsible for the patient's health care decisions.

SECTION 12. Amends Section 313.004, Health and Safety Code, by amending Subsections (a) and (c) and adding Subsection (a-1), as follows:

(a) Provides that if an adult patient of a home and community support services agency or in a hospital or nursing home, or an adult inmate of a county or municipal jail, is comatose, incapacitated, or otherwise mentally or physically incapable of communication and does not have a legal guardian or an agent under a medical power of attorney who is reasonably available after a reasonably diligent inquiry, an adult surrogate from a list of certain persons, in order of priority, who has decision-making capacity, is reasonably available after a reasonably diligent inquiry, and is willing to consent to medical treatment on behalf of the patient is authorized to consent to medical treatment on behalf of the patient.

(a-1) Authorizes another physician who is not involved in the medical treatment of the patient, if the patient does not have a legal guardian, an agent under a medical power of attorney, or a person listed in Subsection (a) who is reasonably available after a reasonably diligent inquiry, to concur with the treatment.

(c) Requires that any medical treatment consented to under Subsection (a) or concurred with under Subsection (a-1) be based on knowledge of what the patient would desire, if known.

SECTION 13. Makes application of Chapter 166, Health and Safety Code, as amended by this Act, prospective.

SECTION 14. Makes application of Section 166.209, Health and Safety Code, as amended by this Act, prospective.

SECTION 15. Effective date: September 1, 2023.