BILL ANALYSIS

C.S.H.B. 3162
By: Klick
Public Health
Committee Report (Substituted)

BACKGROUND AND PURPOSE

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, to address this issue to balance the rights and needs of patients and their families with the best medical judgment of physicians. C.S.H.B. 3162 is the result of hundreds of hours of negotiations between stakeholders representing medical professionals, medical facilities, and patient advocate groups. C.S.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.

CRIMINAL JUSTICE IMPACT

It is the committee's opinion that this bill does not expressly create a criminal offense, increase the punishment for an existing criminal offense or category of offenses, or change the eligibility of a person for community supervision, parole, or mandatory supervision.

RULEMAKING AUTHORITY

It is the committee's opinion that rulemaking authority is expressly granted to the executive commissioner of the Health and Human Services Commission in SECTION 6 of this bill.

ANALYSIS

C.S.H.B. 3162 amends the Health and Safety Code to revise provisions of the Advance Directives Act relating to procedures with respect to directives to physicians, reporting requirements, and do-not-resuscitate orders and provisions of the Consent to Medical Treatment Act.

Advance Directives Act

Procedures Regarding Directives to Physicians

C.S.H.B. 3162 limits the applicability of provisions prescribing procedures for use when 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, which involve review of the refusal by an ethics or medical committee, to only those situations in which the refusal relates to health care and treatment for a patient who is determined to be incompetent or otherwise mentally or physically incapable of communication. The bill specifies that the prohibition against the physician being a member of the ethics or medical committee reviewing the refusal applies during the review period.

C.S.H.B. 3162 requires an ethics or medical committee reviewing a physician's refusal to honor an advance directive of or health care or treatment decision made by or on behalf of an applicable patient to consider the patient's well-being in conducting the review but prohibits the committee from making any judgment on the patient's quality of life. 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, the bill requires the committee to consider whether provision of the life-sustaining treatment meets any of the following criteria:

- will prolong the natural process of dying or hasten the patient's death;
- will result in substantial, irremediable, and objectively measurable physical pain that is not outweighed by the benefit of providing the treatment;
- 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;
- is consistent with the prevailing standard of care; or
- is contrary to the patient's clearly documented desires.

The bill establishes that the committee's consideration of those factors is not a judgment on the patient's quality of life for purposes of the prohibition against the committee making such a judgment.

C.S.H.B. 3162 revises provisions regarding the notice provided to the person responsible for a patient's health care decisions with respect to the process following an attending physician's refusal to honor an advance directive of or health care or treatment decision made by or on behalf of the patient in the following manner:

- replaces an authorization 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 given a written description of the ethics or medical committee review process and any other applicable policies and procedures adopted by a health care facility regarding the process with a requirement that the person responsible for the patient's health care decisions be informed in writing of such information;
- additionally requires the person to be informed in writing of the following:
    - certain rights to which the person is entitled with respect to the process;
    - the date, time, and location of the meeting;
    - 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;
    - the factors the committee is required to consider in determining whether the requested life-sustaining treatment is medically inappropriate; and
    - the decision of the committee related to patient disability as provided by the bill;
- extends the duration of notice that must be provided to the person of the committee's review process and the facility's policies and procedures, a copy of the appropriate statement explaining a patient's right to transfer, and a copy of the registry list of health care providers and referral groups volunteering to assist with transfers from not less than 48 hours before the meeting is called to discuss the patient's directive to not less than seven calendar days before the a meeting is called and specifies that a mutual agreement providing otherwise must be a written mutual agreement;
- applies that seven calendar day notice requirement and written mutual agreement requirement to the provision of all such additional information prescribed by the bill of which the person must be informed; and

- updates the specified statutory language for statements explaining a patient's right to transfer that are provided for cases in which the attending physician refuses to honor or comply with an advance directive or health care or treatment decision requesting the provision of, or the withholding or withdrawal of, life-sustaining treatment to reflect the bill's provisions.

C.S.H.B. 3162 entitles the person responsible for a patient's health care decisions to the following with respect to the process for review of an attending physician's refusal to honor an advance directive of or health care or treatment decision made by or on behalf of the patient:

- to participate in the meeting as scheduled by the committee, in addition to attending the meeting as is provided in current law;
- to 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;
- subject to the authority of a health care facility to adopt and implement a policy for such meetings as provided by the bill, to 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;
- subject to the authority of a health care facility to adopt and implement a policy for such meetings as provided by the bill, to have an opportunity during the open portion of the meeting to either directly or through another individual attending the meeting:
    - explain the justification for the health care or treatment request made by or on behalf of the patient;
    - respond to information relating to the patient that is submitted or presented during the open portion of the meeting; and
    - state any of the person's concerns regarding compliance with provisions relating to the review process and with the bill's patient disability provisions, 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; and
- to receive a written notice of the following:
    - with respect to the explanation of the decision reached during the review process, notice of which is already required by current law, an accompanying explanation, if applicable, of the committee's reasoning for affirming that requested life-sustaining treatment is medically inappropriate, which also must be included in the patient's medical record;
    - 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;
    - the committee's compliance with the bill's provisions relating to the factors to be considered by the committee, including the restriction on consideration of patient disability; and
    - the health care facilities contacted before the meeting as part of required efforts to transfer a patient to a physician who is willing to comply with the directive and, if provided, the reason for denial for each listed facility that denied the transfer request.

The bill entitles the person to receive electronic access to the portion of the patient's medical record related to the treatment received by the patient in the facility and to all of the patient's reasonably available diagnostic results and reports related to that medical record as an alternative to receiving a copy of those records, results, and reports. The bill changes the medical records that the person is entitled to receive, whether with a copy or electronic access, from the records related to the treatment the patient received in the facility for the lesser of the period of the patient's current admission to the facility or the preceding 30 calendar days to the records related to the treatment the patient received in the facility for the period of the patient's current admission to the facility.

C.S.H.B. 3162 authorizes a health care facility to adopt and implement a written policy for committee meetings that is reasonable and necessary to do the following:

- 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
- 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.

The bill requires the person responsible for a patient's health care decisions to be informed in writing of such a policy subject to the same deadline applicable to other information that must be provided to the person before the meeting.

C.S.H.B. 3162 prohibits attendance at or participation in the executive session of the ethics or medical committee by the physicians or health care professionals providing health care and treatment to the patient, the person responsible for the patient's health care decisions, or any of the other persons authorized to accompany that person at a committee meeting. The bill requires a health care facility or person responsible for the patient's health care decisions, if they intend to have legal counsel attend the meeting, to make a good faith effort to provide written notice of that intention not less than 48 hours before the meeting begins.

C.S.H.B. 3162 removes language that conditions the requirement for a patient's attending physician to make a reasonable effort to transfer the patient to a physician who is willing to comply with the directive on a disagreement existing between the attending physician, the patient, or the person responsible for the individual's health care decisions regarding a decision reached during the review process. The bill instead requires the attending physician to make such an effort after the person responsible for the patient's health care decisions is provided with the requisite written notice regarding the meeting to discuss the patient's directive.

C.S.H.B. 3162 requires the personnel of the health care facility assisting with the patient's transfer efforts, 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 is performed on the patient. The bill establishes that the term "medical procedure" includes only a tracheostomy procedure or a percutaneous endoscopic gastrostomy for purposes of this requirement and other provisions of the bill that reference that term.

C.S.H.B. 3162 requires the attending physician or another physician responsible for the care of a patient for whom life-sustaining treatment is requested through the patient's advance directive or through the person responsible for the patient's health care decisions, if the attending physician has decided and the committee has affirmed that the life-sustaining treatment is medically inappropriate, to perform on the patient each medical procedure that satisfies each of the following conditions:

- in the attending physician's professional medical judgment, the medical procedure is reasonable and necessary to help effect the patient's transfer to another physician, an alternative care setting of the facility, or another facility that will comply with the directive;
- an authorized representative for another health care facility with the ability to comply with the patient's advance directive or a health care or treatment decision made by or on behalf of the patient has expressed to the facility personnel overseeing the transfer efforts 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;
- in the medical judgment of the physician who would perform the medical procedure, performing the medical procedure is within the prevailing standard of medical care and not medically contraindicated or medically inappropriate under the circumstances;

- 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;
- 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;
- 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
- the person responsible for the patient's health care decisions provides consent on behalf of the patient for the medical procedure.

C.S.H.B. 3162 extends the date after which the attending physician, any other physician responsible for the care of a patient, and the health care facility are not obligated to provide life-sustaining treatment from the 10th day after both the written decision of the committee and the patient's medical record are provided to the patient or the person responsible for the health care decisions of the patient unless ordered to do so by a court to the 25th calendar day after a start notice is provided to the person responsible for the patient's health care decisions or a medical procedure for which a delay notice was provided is performed, whichever occurs first, unless ordered to extend the period by a court. The bill defines the following terms:

- "delay notice" means a written notice that, unless a court grants an extension, the first day of the 25-day period after which life-sustaining treatment may be withheld or withdrawn will be delayed until the calendar day after a medical procedure is performed unless, before the medical procedure is performed, the person receives written notice of an earlier first day because one or more conditions for the medical procedure are no longer satisfied; and
- "start notice" means a written notice that, unless a court grants an extension, the 25-day period after which life-sustaining treatment may be withheld or withdrawn will begin on the first calendar day after the date the notice is provided.

The bill specifies that any substantial irremediable physical pain resulting from the provision of artificially administered nutrition and hydration must be objectively measurable in order to constitute an exception to the requirement to provide that nutrition and hydration to the patient following the 25-day period. The bill prohibits the 25-day period, after it begins, from being suspended or stopped for any reason, but the bill establishes that this prohibition does not limit or affect a court's ability to order an extension of the period. The bill clarifies that the requirement for a physician or other physician responsible for the patient's care to perform the applicable medical procedure under certain conditions does not require a medical procedure to be performed after the expiration of the 25-day period.

C.S.H.B. 3162 entitles the person responsible for the patient's health care decisions, if the attending physician has decided and the committee affirmed that the requested life-sustaining treatment is medically inappropriate, to receive the following:

- a delay notice if, at the time the written decision of the committee is provided, a medical procedure satisfies all of the conditions for performing the procedure or satisfies all of the conditions except with respect to facility resources and with respect to the person responsible for the patient's health care decisions providing consent, but the person 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;
- a start notice if, at the time the written decision of the committee is provided, no medical procedure satisfies all of the conditions for performing the procedure or satisfies all of the conditions except with respect to facility resources and with respect to the person responsible for the patient's health care decisions providing consent, but the person 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
- a start notice accompanied by a statement that one or more of the conditions for performing the applicable procedure are no longer satisfied if, after a delay notice is

provided in accordance with the bill 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.

C.S.H.B. 3162 establishes 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 tracheostomy or a percutaneous endoscopic gastrostomy medical procedure performed in accordance with the bill's provisions. The bill establishes that such a physician or professional is not subject to criminal liability for participating in the medical procedure unless:

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

The bill establishes 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 in accordance with the bill's provisions unless the physician or health care professional in participating in the medical procedure acted with a specific malicious intent to harm the patient.

C.S.H.B. 3162 prohibits the ethics or medical committee from considering a patient's disability, defined by reference to the federal Americans with Disabilities Act of 1990, that existed before the patient's current admission unless the disability is relevant in determining whether the medical or surgical intervention is medically appropriate.

Reporting Requirements

C.S.H.B. 3162 requires a health care facility, not later than the 180th day after the date written notice is provided of an upcoming meeting to discuss the directive of a patient whose attending physician refuses to honor the directive or health care or treatment decision, to prepare and submit to the Health and Human Services Commission (HHSC) a report that contains the following information:

- the number of days that elapsed from the patient's admission to the facility to the date notice was provided;
- whether the ethics or medical committee met to review the case and, if the committee did meet, the number of days that elapsed from the date notice was provided to the date the meeting was held;
- whether the patient was transferred to a physician within the same facility who was willing to comply with the directive or decision, transferred to a different health care facility, or discharged to a private residence or other setting that is not a health care facility;
- whether the patient died while receiving life-sustaining treatment at the facility;
- whether life-sustaining treatment was withheld or withdrawn from the patient at the facility after expiration of the applicable required period for providing such treatment and the disposition of the patient after the withholding or withdrawal of life-sustaining treatment at the facility, as selected from categories specified by the bill;
- the age group of the patient, as selected from the categories specified by the bill;
- the health insurance coverage status of the patient as selected from the categories specified by the bill;
- the patient's sex and race;
- whether the facility is notified of 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

- whether the facility is notified of 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.

The bill requires HHSC to ensure information provided in each report submitted by a health care facility is kept confidential and not disclosed in any manner, except as provided by the bill. The bill requires HHSC, not later than April 1 of each year, to prepare and publish on its website a report that contains the following information:

- aggregate information compiled from the reports from health care facilities submitted to HHSC during the preceding year based on specified types of information provided in those reports; and
- if the total number of reports submitted by health care facilities to HHSC for the preceding year is 10 or more, aggregate information compiled from those reports on the total number of patients categorized by sex, race, age group, insurance coverage status, and, if applicable, disposition after life-sustaining treatment is withheld or withdrawn.

The bill authorizes HHSC, if it receives fewer than 10 reports for inclusion in the annual report, to include in the next annul report 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 and requires HHSC to include in the next annual report a statement that identifies each year during which an underlying report was submitted.

C.S.H.B. 3162 prohibits HHSC's annual report from including any information that could be used alone or in combination with other reasonably available information to identify any individual, entity, or facility. The bill establishes the following provisions regarding information collected or submitted to HHSC as required under the bill's provisions:

- the information 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;
- the information may not be 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
- the information is not public information or subject to disclosure under state public information law, except as permitted for legislative purposes.

C.S.H.B. 3162 requires the executive commissioner of HHSC to adopt rules to establish a standard form for the bill's reporting requirements and to protect and aggregate any information HHSC receives under the bill's reporting requirements.

Do-Not-Resuscitate Orders

C.S.H.B. 3162 revises general procedures and requirements for do-not-resuscitate (DNR) orders in the following manner:

- changes the physician authorized to issue an order in compliance with any of the following directions from the patient's attending physician to a physician providing direct care to the patient:
    - the written and dated directions of a patient who was competent at the time the patient wrote the directions;
    - the oral directions of a competent patient delivered to or observed by two competent witnesses;
    - the directions in a qualifying advance directive;
    - the directions of a patient's legal guardian or agent under a medical power of attorney; or
    - a treatment decision made in accordance with the procedure when a person has not executed or issued a directive and is incompetent or incapable of communication;

- includes certain out-of-hospital orders among the qualifying advance directives;
- includes as a valid order issued by a physician providing direct care one that is issued in compliance with the directions of a patient's proxy as designated and authorized by a directive executed to make a treatment decision for the patient if the patient becomes incompetent or otherwise mentally or physically incapable of communication;
- specifies that, for purposes of the authority of an attending physician to issue an order for a patient whose death is imminent regardless of the provision of cardiopulmonary resuscitation, an imminent patient death is one that is within minutes or hours;
- considers as valid an order issued by the attending physician of a patient who is incompetent or otherwise mentally or physically incapable of communication and in compliance with a decision that is agreed on by the attending physician and the person responsible for the patient's health care decisions and is 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;
- authorizes an order to be issued and entered into a format acceptable under the policies of the applicable health care facility or hospital; and
- clarifies the process for providing notice of an order's issuance.

C.S.H.B. 3162 requires a physician, physician assistant, or nurse providing direct care to a patient who was incompetent at the time notice of the issuance of a DNR order would have been provided to the patient, but who is later determined to have become competent by the physician providing direct care based on the physician's reasonable medical judgment, to disclose the order to the patient, provided that the physician, physician assistant, or nurse has actual knowledge of the order and that a physician providing direct care to the patient has determined that the patient has become competent. The bill establishes 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 of a DNR order if the person makes a good faith determination that the circumstances that would require the person to perform an act under the applicable notice requirements are not met.

C.S.H.B. 3162, with respect to the revocation of a DNR order, replaces the requirement that a physician providing direct care revoke the patient's order if the patient, the patient's agent under a medical power of attorney, or the patient's legal guardian if the patient is incompetent, as applicable, effectively revokes an advance directive for which an order is issued or expresses to any person providing direct care a revocation of consent to or intent to revoke an order with a requirement that the physician revoke the patient's order if any of the following circumstances apply:

- an advance directive that serves as the basis of the order is properly revoked in accordance with the Advance Directives Act;
- the patient expresses to any person providing direct care a revocation of consent to or intent to revoke an order; or
- the order was issued in compliance with the directions of a patient's legal guardian, agent under a medical power of attorney, or proxy or in compliance with a treatment decision in accordance with the procedure when a person has not executed or issued a directive and is incompetent or incapable of communication, 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 order.

The bill requires a person providing direct care under the supervision of a physician to a patient for whom a DNR order is issued to notify the physician of a revocation of an advance directive for the patient. The bill includes the following among the circumstances under which a patient's attending physician may revoke a DNR order:

- the order was issued in compliance with written or oral directions of a patient who was competent at the time of issuance or the directions in a qualifying advance directive, provided that the order is for a patient who is incompetent or otherwise mentally or physically incapable of communication and the decision to revoke the order is agreed on

by the attending physician and the person responsible for the patient's health care decisions and 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;

- the order was based on a treatment decision that was made in accordance with the procedure when a person has not executed or issued a directive and is incompetent or incapable of communication and was concurred in by another physician due to the lack of availability of a legal guardian or another authorized person; and
- the order was issued for a patient who is incompetent or otherwise mentally or physically incapable of communication and in compliance with a decision agreed on by the attending physician and the person responsible for the patient's health care decisions and 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.

The bill requires an attending physician who issues a DNR order on the basis that it is medically appropriate and that the patient's death is imminent regardless of the provision of cardiopulmonary resuscitation to revoke the order if, in the attending physician's reasonable medical judgment, the condition of the patient's death being imminent is no longer satisfied.

C.S.H.B. 3162 exempts a physician, physician assistant, nurse, or other person from the application of the Class A misdemeanor offense for a person who intentionally conceals, cancels, effectuates, or falsifies another person's DNR order or conceals or withholds personal knowledge of another person's revocation of a DNR order in violation of applicable law if the person's 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. With respect to that criminal offense, the bill specifies that a person committing the offense must have the specific intent to violate provisions relating to health care facility DNR orders. The bill's changes relating to the offense apply only to conduct that occurs on or after the bill's effective date.

Applicability

C.S.H.B. 3162 establishes that its provisions amending the Advance Directives Act apply only to a review, consultation, disagreement, or other action relating to a health care or treatment decision made on or after the bill's effective date.

Consent to Medical Treatment Act

C.S.H.B. 3162 revises the procedure for obtaining consent for medical treatment through an adult surrogate of 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, who is comatose, incapacitated, or otherwise mentally or physically incapable of communication in the following manner:

- additionally conditions the use of a surrogate on the individual not having a legal guardian or an agent under a medical power of attorney who is reasonably available after a reasonably diligent inquiry;
- specifies that the availability of a potential surrogate must be based on the surrogate's reasonable availability;
- with respect to who may serve as an adult surrogate:
    - replaces an adult child of the patient who has the waiver and consent of all other qualified adult children of the patient to act as the sole decision-maker and a majority of the patient's reasonably available adult children with the patient's adult children; and
    - removes the individual clearly identified to act for the patient by the patient before the patient became incapacitated and removes a member of the clergy; and

- establishes that, if the patient does not have a legal guardian, an agent under a medical power of attorney, or a person to serve as a surrogate who is reasonably available after a reasonably diligent inquiry, another physician who is not involved in the medical treatment of the patient may concur with the treatment, but treatment concurred with as such must be based on knowledge of what the patient would desire, if known.

EFFECTIVE DATE

September 1, 2023.

COMPARISON OF INTRODUCED AND SUBSTITUTE

While C.S.H.B. 3162 may differ from the introduced in minor or nonsubstantive ways, the following summarizes the substantial differences between the introduced and committee substitute versions of the bill.

Both the introduced and the substitute provide for a limitation of liability for a physician or health care professional participating in a tracheostomy or a percutaneous endoscopic gastrostomy medical procedure performed in accordance with the bill's provisions unless the physician or health care professional acted with a specific intent to cause the death of the patient, that conduct hastened the patient's death, and the hastening of death is not attributable to the procedure's risks. However, the substitute specifies that such a physician or professional must have acted with a specific malicious intent and that conduct significantly hastened the patient's death, whereas the introduced did not.

The introduced established that a physician or a health care professional acting under the direction of a physician has not engaged in unprofessional conduct by conducting an applicable medical procedure unless the physician or health care professional fails to exercise reasonable medical judgment in doing so and established the standard of care for that exception. The substitute establishes instead that a physician or health care professional acting under the direction of a physician has not engaged in unprofessional conduct by participating in an applicable medical procedure unless the physician or health care professional acted with a specific malicious intent to harm the patient.

Both the introduced and the substitute limit the applicability of provisions prescribing procedures for use when 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 to only those situations in which the refusal relates to health care and treatment for a patient who is determined to be incompetent or otherwise mentally or physically incapable of communication. However, the introduced additionally specified that the patient who is the subject of that refusal be a qualified patient, whereas the substitute does not.

The substitute clarifies the period during which a physician is prohibited from being a member of an ethics or medical committee that reviews the physician's refusal to honor a patient's advance directive or a health care or treatment made by or on behalf of a patient, whereas the introduced did not include this change.

The substitute revises the provision of the introduced listing the factors that a review committee is required to consider in its decision for life-sustaining treatment of an applicable patient by omitting the requirement to consider whether provision of the treatment, without regard to any judgment on the patient's quality of life, will be medically ineffective at improving the patient's current condition or reducing the patient's current medical support level. The substitute instead includes a provision not in the introduced prohibiting the committee from making any judgment on the patient's quality of life and specifying that consideration of the factors specified by the bill is not considered a judgment on the patient's quality of life. The substitute makes certain other changes to the listed factors, including by adding a specification not in the introduced that

the criteria regarding physical pain be objectively measurable with respect to the provision of life-sustaining treatment. The substitute makes a similar change with respect to artificially administered nutrition and hydration.

With respect to the notice sent to the person responsible for the patient's health care decisions before the committee meeting to discuss the patient's directive, the introduced and substitute differ as follows:

- while both versions require the notice to include the work contact information of facility personnel who will be responsible for overseeing transfer efforts, the substitute omits the requirement from the introduced for the notice to also include the name and title of such personnel; and
- the substitute includes a requirement absent from the introduced for the notice to include the decision of the committee related to patient disability.

The substitute replaces a provision from the introduced entitling the person responsible for the patient's health care decisions to receive before or during the committee meeting a written statement of the full name and title of each committee member who will participate in the meeting with a provision that entitles such a person to receive during the meeting only 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.

The introduced entitled a person responsible for the patient's health decisions to be accompanied at the meeting by up to 10 individuals selected by the patient or surrogate, including legal counsel, physicians, health care professionals, or patient advocates, whereas the substitute instead entitles such a person to 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.

Both the introduced and substitute entitle a person responsible for the patient's health care decisions to have an opportunity during the meeting to explain the justification for the health care or treatment request made by or on behalf of the patient, respond to information relating to the patient that is submitted or presented, and state any concerns of the person responsible for the patient's health care decisions regarding compliance with applicable law. However, the substitute specifies that such an opportunity is to be provided only during the open portion of the meeting, whereas the introduced did not include such a specification. The substitute includes a provision absent from the introduced that specifies that the stated concerns may include 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.

The substitute includes a provision absent from the introduced entitling the person responsible for the patient's heath care decisions to a written notice of the patient's major medical conditions as identified by the committee, including any disability of the patient considered by the committee in reaching its decision, except the notice is not required to specify whether any medical condition qualifies as a disability.

The substitute gives the person responsible for the patient's health care decisions the option to access the patient's applicable medical records electronically as an alternative to receiving a copy and removes the 30-day limitation on the records the person may receive or have access to with respect to treatment received in the applicable facility, whereas the introduced did not.

Whereas the introduced specified that the policy that a health care facility may adopt and implement for committee meetings is an attendance and confidentiality policy, the substitute does not. The substitute does, however, specify that the policy includes provisions related to attendance, confidentiality, and timing regarding any agenda item. The substitute includes, with respect to the policy's use to preserve the effectiveness of the meeting, provisions disclosing that

the meeting is not a legal proceeding and the committee will enter into an executive session for deliberations, whereas the introduced did not.

Whereas the introduced prohibited the physicians or health care professionals providing health care and treatment to an applicable patient, the patient or the person responsible for that patient's health care decisions, or certain persons authorized to attend the meeting from participating in the deliberations of an ethics or medical committee, the substitute instead prohibits such persons from attending or participating in the executive session of the committee.

The substitute includes a provision absent from the introduced requiring a health care facility or person responsible for the patient's health care decisions, if they intend to have legal counsel attend the meeting, to make a good faith effort to provide written notice of that intention not less than 48 hours before the meeting begins.

The substitute includes a provision that was not in the introduced requiring the personnel of the health care facility assisting with the patient's transfer efforts to make a good faith effort to inquire whether a health care facility that denies the patient's transfer request would be more likely to approve the request if an applicable medical procedure is performed on the patient.

Whereas the introduced set the date after which life-sustaining treatment may be withheld or withdrawn from an applicable patient as the 21st business day after both the written decision of the committee and the patient's medical record are provided to the person responsible for the patient's health care decisions, the substitute sets that deadline as the 25th calendar day after a start notice is provided to that person or a medical procedure for which a delay notice was provided is performed, whichever occurs first.

The substitute includes provisions not included in the introduced that do the following:

- define "delay notice" and "start notice" for the bill's purposes;
- specify the circumstances under which the person responsible for the patient's heath care decisions is entitled to a start notice or a delay notice;
- establish that the bill does not require a medical procedure to be performed on the patient after the expiration of the 25-day period;
- prohibit the 25-day period from being suspended or stopped once it begins; and
- establish that the prohibition does not limit or affect a court's ability to order an extension.

Both the substitute and the introduced restrict the committee's consideration of a patient's disability that existed before the patient's current admission. While the introduced allowed for such consideration if the disability is relevant in determining whether life-sustaining treatment is medically appropriate, the substitute allows for such consideration if the disability is relevant in determining whether the medical or surgical intervention is medically appropriate.

The substitute includes provisions not included in the introduced specifying that the forms pertaining to cases in which the attending physician refuses to honor or comply with an advance directive or health care or treatment decision requesting the provision, withholding, or withdrawal of life-sustaining treatment apply only to life-sustaining treatment for a patient who is determined to be incompetent or is otherwise mentally or physically incapable of communication.

While the introduced required the Department of State Health Services to receive reports from health care facilities regarding ethics or medical committee processes and prepare and publish on its website an annual report with certain compiled information from those reports, the substitute requires HHSC to receive, prepare, and submit such reports. Both the introduced and substitute require applicable health care facilities to submit, for the purposes of a report, information regarding whether life-sustaining treatment was withheld or withdrawn from patients at the facility after the expiration of the required time period. However, the substitute

additionally requires the facilities to report the disposition of the patient after the withholding or withdrawal of life-sustaining treatment at the facility, as selected from the categories specified by the substitute, whereas the introduced did not. Furthermore, the substitute requires an applicable facility to report to HHSC the following information that was not required in the introduced:

- whether the facility is notified of 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 committee in connection with the patient's stay at the facility; and
- whether the facility is notified of 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.

Accordingly, the substitute also includes a requirement absent from the introduced for HHSC to include in the annual report prepared and published on the HHSC website the total number of cases for which the facility is notified of such public disclosures.

The substitute includes a provision absent from the introduced requiring HHSC to include in its annual report, if the total number of reports submitted to HHSC for the preceding year is 10 or more, certain information about the disposition of patients for whom life-sustaining treatment was withheld or withdrawn.

Both the introduced and substitute exempt the information collected or submitted under the bill's reporting requirement provisions from disclosure under state public information law. However, the substitute provides an exception to that exemption for the use of such information for legislative purposes, whereas the introduced did not.

The substitute omits a provision included in the introduced that limited the applicability of provisions relating to health care facility DNR orders to a DNR order issued for a patient admitted to a health care facility or hospital, rather than issued in a heath care facility as provided by current law.

The substitute includes provisions absent from the introduced that include among the DNR orders considered valid an order that is issued by a patient's attending physician for a patient who is incompetent or otherwise mentally or physically incapable of communication and in compliance with a decision agreed on by the attending physician and the person responsible for the patient's health care decisions and 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.

The substitute clarifies that that an imminent patient death for purposes of a DNR order issued by an attending physician is one that is within minutes or hours, whereas the introduced did not.

The substitute omits a provision included in the introduced requiring a physician, a physician assistant, a nurse, or another person acting on behalf of a health care facility or hospital, if a patient's attending physician issues an applicable DNR order, to provide notice of the order to the appropriate persons.

The substitute includes provisions that were not in the introduced that do the following with respect to DNR notice requirements:

- require a physician, physician assistant, or nurse providing direct care to a patient who was incompetent at the time notice of the issuance of a DNR order would have been provided to the patient, but who is later determined to have become competent by a physician providing direct care to the patient, to disclose the order to the patient, provided that the physician, physician assistant, or nurse has actual knowledge of the

order and that a physician providing direct care to the patient has determined that the patient has become competent; and

- establish 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 of a DNR order if the person makes a good faith determination that the circumstances that would require the person to perform an act under the applicable notice requirements are not met.

The substitute includes provisions absent from the introduced including among the circumstances under which a patient's attending physician may revoke a DNR order:

- the order was issued in compliance with written or oral directions of a patient who was competent at the time of issuance or the directions in a qualifying advance directive, provided that the order is for a patient who is incompetent or otherwise mentally or physically incapable of communication and the decision to revoke the order is agreed on by the attending physician and the person responsible for the patient's health care decisions and 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;
- the order was issued based on a treatment decision that was made in accordance with the procedure when a person has not executed or issued a directive and is incompetent or incapable of communication and was concurred in by another physician due to the lack of availability of a legal guardian or another authorized person; and
- the order was issued for a patient who is incompetent or otherwise mentally or physically incapable of communication and in compliance with a decision agreed on by the attending physician and the person responsible for the patient's health care decisions and 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.

The substitute includes a provision that was not in the introduced requiring a patient's attending physician to revoke an applicable order issued for a patient if, in the attending physician's reasonable medical judgment, the condition relating to the patient's death being imminent is no longer satisfied.