1999

Texas' New Advance Directives Act

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BY TOM MAYO, JD

The Advance Directives Act, a new law that became effective Sept 1, developed from a failed attempt to reform the previous three laws that addressed end-of-life care.

Texas has recognized "living wills" (called "directives to physicians" in Texas) since 1977, the "durable power of attorney for health care" since 1989, and the "out-of-hospital do not resuscitate" order (DNR) since 1995. These advance directives address three distinct situations:

- The directive to physicians permits competent patients to express their nontreatment preferences in the event they are diagnosed with a terminal condition and are no longer competent to make or express their own decisions about life-sustaining treatments.
- The durable power of attorney for health care permits competent patients to designate a person who can make all medical decisions on their behalf (not only those that concern life-sustaining treatment) in the event they lose decision-making capacity (even if they do not have a terminal condition).
- The out-of-hospital DNR order allows a physician and a patient who has been diagnosed with a terminal condition to execute an order that would instruct emergency medical personnel and other healthcare professionals to withhold CPR in the event of cardiac or respiratory arrest.

When inconsistencies among the three laws began to creep in and, as we gained experience with the different directives, some of their flaws became increasingly apparent. In 1997 Gov George W. Bush vetoed a comprehensive reform of all three laws, then asked a committee to hammer out a law that would eliminate inconsistencies, enhance patient autonomy, and provide physicians with a more useful set of documents to guide decision making at the end of life. The result of this work was Senate Bill 1260—the "Advance Directives Act."

Among the improvements, for example, there is now one set of witnessing requirements for all three directives. Qualifications for witnesses have been streamlined and made applicable to only one of the two required witnesses; the second witness may be anyone selected by the person executing the directive. Other major changes effected by this law are described below.

Directives to physicians

- The diagnosis of "terminal condition" now may be made by only one physician, rather than two.
- The phrase "terminal condition" no longer includes "irreversible condition" and instead refers simply to an incurable condition that is expected to bring about the patient's death within six months, even with the provision of life-sustaining treatment. "Irreversible condition" is separately defined as a condition that is incurable, severely debilitating, and—without life-sustaining treatment—fatal. Either condition (plus incompetency), however, will still trigger the patient's directive.

The suggested form of the directive to physicians has been rewritten to make the document more user friendly and to emphasize the need for people to discuss their end-of-life preferences with family members and their physician. Two substantive changes are: (1) People may express their preferences separately for when they have a terminal condition and when they have an irreversible condition and (2) people may express their affirmative treatment preferences as well as their nontreatment preferences. For situations in which a physician cannot honor the preferences expressed in the directive to physicians, the physician and healthcare entity will need to follow certain procedures to secure immunity from civil or criminal liability. Because the directive may express affirmative treatment preferences, these procedures were written to encompass so-called "futility dilemmas," when the patient or surrogate decision maker requests treatment deemed by the physician to be of no benefit to the patient. The procedures include a mandatory ethics consultation, a reasonable attempt to transfer the patient to another provider, and the continuation of life-sustaining procedures for a minimum of 10 days after the ethics consultation and written notice to the patient's surrogate. Alternatively, life-sustaining treatment can be continued long

enough to afford a reasonable opportunity to transfer the patient. If the latter course is followed, the statute's immunities are not available, but the liability question appears to be limited to whether the patient was provided a reasonable opportunity to be transferred.

Durable power of attorney

This advance directive now is officially called a "medical power of attorney," which is how it has been more commonly known by physicians and patients. Under prior law, if the agent was the spouse of the patient, the directive automatically would be revoked upon the couple's divorce. Under the new law, the directive may provide that it is to remain in effect even if the principal and the agent become divorced. The "consult, treat, and transfer provisions" described above apply to medical powers of attorney, as well.

Out-of-Hospital DNR

A terminal diagnosis is no longer required to execute an out-of-hospital DNR order. The "out-of-hospital settings" in which the directive is effective now include hospital emergency departments. A copy of the directive, rather than only an original or identifying bracelet, will trigger the duty to withhold CPR. The new law eliminates the legal immunity provisions that applied when a responding healthcare professional knew of the existence of a valid out-of-hospital DNR order and failed to effectuate it.

Although advance directives executed before Sept 1 will continue to be valid, Texas physicians will be challenged to familiarize themselves with the many changes in the new law and to be prepared to counsel their patients about it. DMJ

Case Study

The principle of double effect

BY LLOYD W. KITCHENS, JR, MD
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A previously healthy 28-year-old postal worker and weekend rodeo cowboy presented with a 3-week history of nonproductive cough and left testicular mass. He had recently lost 10 pounds. He was moderately dyspneic on exertion. There was no history of hemoptysis, fever, testicular trauma, or undescended testis. Family history and the patient's medical history were unremarkable.

Examination showed a healthy appearing, intelligent, and cooperative man in no acute distress. There was no palpable lymphadenopathy, and examination of the heart, lungs, and abdomen was unrevealing. There was generalized firm, nontender enlargement of the left testis, without a discrete mass.

Studies included a chest X-ray revealing multiple bilateral round lesions measuring up to 3 cm in diameter, consistent with metastases. Alpha-fetoprotein, beta-HCG, and serum LDH were elevated.

A left inguinal orchiectomy was done , with pathologic findings of an embryonal cell carcinoma, with elements of choriocarcinoma.

Aggressive platinum-based chemotherapy was initiated, with a good response evidenced by disappearance of the pulmonary nodules and normalization of the alpha-fetoprotein and the beta-HCG. After four cycles of chemotherapy, treatment was stopped, and the patient was followed closely. His cough had subsided and he regained his weight, felt well, and returned to his activities, including weekend rodeo competition.

Six months after chemotherapy, he developed uncharacteristic weakness, gradual weight loss, malaise, nonproductive cough, and low back pain—the latter which he attributed to a rodeo injury. However, chest X-ray showed recurrent bilateral pulmonary nodules, and alpha-fetoprotein and beta-HCG again were elevated. Bone scan showed extensive increased uptake consistent with metastatic disease, particularly in the lumbar spine.

"Salvage" chemotherapy was initiated, but was fraught with severe toxicity, including nausea, vomiting, and severe suppression of white blood cells and platelets. The low back pain moderately decreased, yet remained severe enough to require palliative radiotherapy. The pulmonary lesions initially regressed by 50%, then began to enlarge again.

Despite the patient's stoic nature, his skeletal pain was such that fentanyl transcutaneous patches, high-dose sustained-release oxycodone, and prn "rescue" doses of oral morphine elixir were necessary. His analgesic program produced only modest pain relief and was complicated by severe constipation and intermittent confusion and disorientation. The pain was too diffuse for significant benefit from TENS units.

Communications with his physician were frank and straightforward. The patient understood that his life expectancy was quite limited and that his pain was likely to continue to be difficult to control. He was completely lucid despite the required large doses of opiates. Psychiatric evaluation