Senate Bill 11 (2017): Do-Not-Resuscitate Orders
Sen. Charles Perry (R-Lubbock) & House Sponsor Greg Bonnen, MD (R-Friendswood)

Senate Bill 11, passed by the 85th Texas Legislature in its First Called Session, provides a framework that regulates in-facility do-not-resuscitate (DNR) orders. Prior to the enactment of this bill, only out-of-hospital DNR (“OOH DNR”) orders were explicitly regulated, so the bill marks a significant change. Assisting patients in making end-of-life decisions can be difficult as it involves a sensitive and highly personal subject matter. This document summarizes the new requirements relating to in-facility DNR orders based on S.B. 11; however, the touchstone for legal compliance is the language of the law itself. It may be difficult to contemplate every possible situation where an in-facility DNR order may be appropriate, so there may be outstanding questions. If there are questions about complying with the requirements of S.B. 11, one should review the law and consult with a private attorney and/or consult hospital or health care facility policy and legal counsel.

What is a “DNR order” under the bill?

The bill defines a “DNR order” as an “order instructing a health care professional not to attempt cardiopulmonary resuscitation on a patient whose circulatory or respiratory function ceases.”

Notably, this bill’s regulations apply only to “cardiopulmonary resuscitation,” which is a more narrow scope than that of an out-of-hospital DNR order (an OOH DNR order applies to life-sustaining treatment), but this term is still broader than just chest compressions. Texas law defines “cardiopulmonary resuscitation” as “any medical intervention used to restore circulatory or respiratory function that has ceased.”

It is also important to note that this bill applies to a “DNR order” issued only in a hospital or health care facility, and does not affect an OOH-DNR order as the term is defined in state law. (In this document, “DNR” or “DNR order” refers to that which is defined and regulated in S.B. 11, and does not include an OOH-DNR order).

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What makes a DNR order “valid”? 

A physician may enter an order to not attempt CPR on a patient whose circulatory or respiratory function ceases, but unless it complies with the requirements of S.B. 11, the order would not be valid and the physician may thus be subject to civil, criminal and administrative liability. The bill establishes that in order to be valid, the DNR order must be dated, issued by the patient’s attending physician, and be in compliance with one of the following:

1. **Written and dated directions of a patient who was competent at the time the patient wrote the directions**
2. **Oral directions of a competent patient**, if the directions are delivered to or observed by two competent adult witnesses, at least one of whom is not:
   - an employee of the attending physician or
   - an employee of the facility who is
     - providing direct patient care to the patient or
     - an officer, director, partner, or business office employee of the facility or any parent organization of the facility
3. **An advance directive that was validly executed in another state**
4. **A properly executed written directive**, meaning it is witnessed by qualified witnesses or notary public
5. **A nonwritten directive of a competent patient**, who has a terminal or irreversible condition diagnosed and certified in writing by the attending physician, witnessed by the attending physician and two other qualifying witnesses (one of whom must not have certain relations to the patient according to state law)
   - NOTE: there are subtle differences between this option and option no. 2 above. The requirements under this option are slightly more stringent, requiring more witnesses with less flexibility, and specifying that the patient be certified as having a terminal or irreversible condition. On the other hand, this option allows for types of nonwritten communication other than oral communication.
6. **A directive issued on behalf of a person younger than 18 years of age**, by the patient’s adult spouse, parents, or legal guardian
7. **The directions of the patient’s legal guardian or agent under a medical power of attorney**
8. **A mutual decision** agreed upon by the patient’s attending physician and:
   - the patient’s legal guardian or agent under medical power of attorney
   - if no guardian or agent, the patient’s (listed in priority):
     - spouse
     - reasonably available adult children
     - parents
     - nearest living relative
   - if no guardian, agent, or other relative, another physician who is:
- not involved in treating the patient, or
- a representative of the facility’s ethics or medical committee

9. A physician’s reasonable medical judgment, if the patient has not conveyed directions against a DNR order at a time when the patient was competent, and if the physician’s judgment is that:
   - the patient’s death is imminent (though the bill does not specify a time frame for what is meant by “imminent”) regardless of the provision of CPR; AND
   - the DNR is medically appropriate

A valid DNR order takes effect at the time of issuance as long as it placed in the patient’s medical records as soon as practicable. When placing the order in the patient’s medical records, though, a physician should keep in mind that: (i) certain notice requirements (discussed next) apply to DNR orders issued under certain circumstances (i.e., option 9 described above) and (ii) some of these notice requirements must be satisfied before placing the order in the medical record.

The bill leaves open the question of whether failure to provide the required notice before placing the order in the medical records could invalidate the DNR order itself. Ensuring compliance with the notice requirement before the DNR order is placed in the medical records is thus of significant importance.

Is a physician required to provide notice of a DNR order?

If an attending physician issues a DNR order under option 9 above (i.e., on the basis that the DNR order is not contrary to the directions of a patient who was competent at the time the patient conveyed the directions and, in the physician’s reasonable medical judgment; (i) the DNR order is medically appropriate and (ii) the patient’s death is imminent, regardless of the provision of CPR), two distinct notices may be required. Both notices apply after the decision to issue the DNR order has been made, but one notice is conditional upon the occurrence of a trigger.

1. The first notice: before the DNR order is placed in a patient’s medical record, the physician or a physician assistant, nurse, or another person acting on behalf of a health care facility or hospital shall inform the patient of the order’s issuance, or if the patient is incompetent, make a reasonably diligent effort to contact the patient’s legal guardian or agent under a medical power of attorney, or if no guardian or agent is known, the patient’s spouse, adult children, or parents. For liability protection purposes, record of the notice or notice effort should be placed in the patient’s medical record.

2. The second notice: if an individual arrives at the patient’s hospital/health care facility and notifies a physician, physician assistant, or nurse providing direct care to the patient that the individual has arrived and if the individual is the patient’s known agent under a medical power of attorney or known legal guardian, or (if the patient
has no known agent or guardian) the patient’s spouse, adult child, or parents, the applicable physician, physician assistant or nurse is required to disclose the DNR order to the arriving individual and, for liability protection purposes, should record the notice in the patient’s medical records. If one person has already received this notice, it is not required that additional persons receive the same notice.

The bill does not clarify how these two notice requirements work together. In some cases, it may be that notice to one individual may satisfy both requirements. On the other hand, there may be other circumstances in which physicians must provide two distinct notices. Because of the lack of clarity surrounding the notice provisions, being aware of the requirements and making a good faith effort to comply and recording that effort is crucial. The bill provides that a person who makes a good faith effort to comply with the notice requirements and contemporaneously records those efforts is afforded protection from civil liability and criminal, as well as from disciplinary action from the person’s licensing authority (i.e., the Texas Medical Board).

**Can a DNR order be overridden?**

The short answer is yes. S.B. 11 requires a physician providing direct care to a patient for whom a DNR order is issued to revoke a DNR order for a patient if the patient or, as applicable and if the patient is not competent, the patient’s agent under a medical power of attorney or the patient’s legal guardian, either:

1. effectively revokes the advance directive, in accordance with Texas Health and Safety Code Section 166.042, on which the DNR order was based (i.e., by destroying or defacing the directive, by signing and dating a written revocation, or by orally stating an intent to revoke the directive); or
2. expresses to anyone providing direct care to the patient a revocation of consent to the DNR order or an intent to revoke a DNR order.

This is also consistent with the general “last-in-time” principle stated in the bill. The bill states that if a DNR order conflicts with a treatment decision made in compliance with the laws related to DNR orders or another advance directive, that decision or directive, if made later in time, would control. On the other hand, if a valid DNR order is issued later in time and conflicts with a previous treatment decision or advance directive, the DNR order would control.

Additionally, the bill states that an attending physician may at any time revoke a DNR order if the DNR order was issued on the basis set forth in option 9, above (i.e., on the basis that the DNR order is not contrary to the directions of a patient who was competent at the time the patient conveyed the directions and, in the attending physician’s reasonable medical judgment, (i) the DNR order is medically appropriate and (ii) the patient’s death is imminent, regardless of the provision of CPR).
What happens if an attending physician does not wish to execute or comply with a DNR order or the patient’s instructions concerning the provision of CPR?

Whenever an attending physician does not wish to execute or comply with a DNR order or a patient’s instructions concerning the provision of CPR, the physician is required 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 performing CPR on the patient.

If the attending physician and the patient or other person authorized to make decisions on behalf of the patient are still in disagreement after the physician has explained the benefits and burdens of performing CPR on the patient, the physician or facility must make a reasonable effort to transfer the patient to another physician or facility that is willing to execute or comply with the DNR order or the patient’s instructions concerning the provision of CPR.

Taking the aforementioned steps does not permit the physician to issue a DNR order that would otherwise be invalid. When there is still disagreement about a course of treatment for a patient after a reasonable but unsuccessful effort to transfer the patient, it is important that a physician consult with a private attorney and/or consult hospital or health care facility policy and legal counsel to determine how to proceed.

Is there any liability protection for a physician who issues or executes a DNR order?

The bill does provide limited liability protection (and protection from disciplinary review and action) for physicians and other health care professionals who act in good faith to issue a DNR order under the subchapter or who, in accordance with the subchapter, cause CPR to be withheld or withdrawn from a patient in accordance with a DNR order. Similarly, the bill provides that physicians and other health care professionals are not liable or subject to disciplinary action if they fail to act in accordance with a DNR order of which they have no actual knowledge.

Are there any additional legal risks associated with DNR orders?

The bill added a criminal Class A misdemeanor offense that applies when a physician or other person intentionally conceals, cancels, effectuates, or falsifies another person’s DNR order or if the person intentionally conceals or withholds personal knowledge of another person’s revocation of a DNR order in violation of the law.

Additionally, a physician or other health care professional is also subject to review and disciplinary action by the Texas Medical Board or other appropriate licensing board if the person intentionally fails to effectuate a DNR order in violation of the law, or intentionally issues a DNR order in violation of the law.
These two enforcement provisions are drafted very broadly and it thus may be difficult to properly and adequately assess associated legal risks. Thus, it is recommended that physicians consult with private counsel and/or consult hospital/health care facility policies and legal counsel in order to understand where individual physicians may face the greatest legal risks.

What is the effective date of S.B. 11 and will any rules be promulgated regarding DNR orders?

S.B. 11 takes effect April 1, 2018. The law specifies that the new subchapter, which regulates in-facility DNR orders, applies only to a DNR order issued on or after the effective date of the law.

The executive commissioner of the Health and Human Services Commission is required to adopt rules necessary to implement the new law as soon as practicable after the effective date of the law.

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