FADE TO BLACK: TEXAS'S DO-NOT-RESUSCITATE LAW

Comment

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I. CODE BLUE

"At its core, end-of-life care is one of the most difficult topics in medicine, particularly when circumstances push a doctor and the patient, or the patient's family, to an emotional and philosophical standoff."[1] In 1999, the Texas Legislature enacted the Advance Directives Act (ADA) in an attempt to address end-of-life treatment standards.[2] An advance directive is "an instruction made . . . to administer, withhold, or withdraw life-sustaining treatment in the event of a terminal or irreversible condition."[3] Advance directives include do-not-resuscitate (DNR) orders, containing instructions for resuscitative treatment in emergency situations and durable powers of

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1. Joey Berlin, *Difficult Situations*, TEX. MED. ASS'N (Dec. 2017), https://www.texmed.org/difficultsituations/.

2. *Id.*

3. TEX. HEALTH & SAFETY CODE ANN. § 166.031(1).

attorney for health care, which give a patient's agent the power to make health care decisions for him.[4]

More specifically, a DNR order is "an order instructing a health care professional not to attempt cardiopulmonary resuscitation on a patient whose circulatory or respiratory function ceases."[5] DNR orders give patients the opportunity to express their personal values by allowing them to decide how they want to be treated in end-of-life scenarios.[6] The discussion of DNR orders and whether a patient should receive cardiopulmonary resuscitation (CPR) in an emergency situation typically occurs near the end of life when patients are suffering from an illness with little to no hope of improvement.[7] This discussion is critical because although television depicts resuscitated patients as recovering quickly, CPR is not so clean and gentle.[8] Rather, there is a stigma associated with CPR because of its aggressive nature; it can lead to broken ribs, punctured lungs, and the chances of its success are low.[9] The issue for patients and their families becomes whether it is worth it to put themselves or their loved ones through that traumatic process.[10]

The 1999 ADA laid out procedures and protocols for issuing DNR orders, but it only explicitly regulated *out-of-hospital* DNR orders, leaving *in-hospital* DNR orders unregulated.[11] Independent of the ADA, hospitals employed their own practices requiring physicians to consult with patients and their families before issuing DNR orders.[12] Nevertheless, the law essentially made it legal for physicians to forcibly place "secret" DNR orders in patients' medical records without giving notice to or over the objections

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4. *See Advance Directives: Definitions*, PATIENTS RTS. COUNCIL, http://www.patientsrightscouncil.org/site/advance-directives-definitions/ (last visited Mar. 1, 2020).

5. HEALTH & SAFETY § 166.201.

6. *See* Karen Telschow Johnson, *The Time Is Now for the Five Wishes Document in Texas*, 10 EST. PLAN. & COMMUNITY PROP. L.J. 101, 111 (2017); *Do-Not-Resuscitate Order*, MEDLINEPLUS (Feb. 18, 2018), https://medlineplus.gov/ency/patientinstructions/000473.htm.

7. *See Do-Not-Resuscitate Order*, *supra* note 6.

8. *See* Angela Morrow, *When Is a "Do Not Resuscitate" Order the Right Choice?*, VERYWELL HEALTH (Nov. 10, 2019), https://www.verywellhealth.com/hands-off-do-not-resuscitate-1132382. CPR requires health care professionals to compress a patient's chest deep and hard to pump blood out of the heart. *Id.* In turn, CPR can have profound and long-lasting effects on patients, which is why the decision to administer CPR should be made by patients and their families. *See id.*

9. *Id.*; Jeffrey P. Burns et al., *Do-Not-Resuscitate Order After 25 Years*, 31 CRITICAL CARE MED. 1543, 1546 (2003).

10. *See* Morrow, *supra* note 8.

11. *See* TEX. HEALTH & SAFETY CODE ANN. § 166.002; *Your Pocket Guide to Texas' New DNR Law*, TEX. MED. ASS'N (Apr. 19, 2018), https://www.texmed.org/TexasMedicineDetail.aspx?id=46955. An *out-of-hospital* DNR order contains a patient's instructions not to be resuscitated in an out-of-hospital setting. HEALTH & SAFETY § 166.081. An *in-hospital* DNR order contains similar instructions when a patient is being treated in a hospital. *Id.* §§ 166.201–.202.

12. *See* Chris Vogel, *Doctors vs. Parents: Who Decides Right to Life?*, HOUS. PRESS (Apr. 30, 2008, 4:00 AM), https://www.houstonpress.com/news/doctors-vs-parents-who-decides-right-to-life-6573899 (statement of Dr. Robert Fine of Baylor Healthcare Systems in Dallas).

of those patients or their families.[13] As a result, Texas patients and their families have allegedly fallen prey to physicians' abuse of this law.[14]

Historically, health care professionals' motivation behind issuing secret DNR orders was that although CPR was effective at its inception, it created new problems, such as prolonging patient suffering.[15] In turn, when hospital staff believed CPR would not benefit patients, it was common for staff and physicians to secretly issue orders not to resuscitate patients without documenting them.[16] Individuals also contend that physicians used secret DNR orders as a tool—motivated by questionable quality of life determinations—disproportionately impacting older patients and patients with serious illnesses.[17] Still to many individuals, it is not clear why physicians would choose to engage in such a risky, unethical practice because they understandably want to avoid liability and act according to their own ethics and those widely held within the medical profession.[18]

Prior to Senator Charles Perry's effort in 2017, legislators have unsuccessfully attempted to amend the ADA.[19] Senator Perry, with encouragement from patient advocates, sought to change Texas's DNR law and solve the secret DNR order problem by writing Senate Bill 11 (the Bill).[20] Despite its minor shortcomings, the Bill rightfully puts the power of making life and death decisions back in the hands of patients and their families by extending the 1999 ADA to apply to DNR orders issued in health care facilities and hospitals.[21] The Bill became effective in April 2018, marking a significant change to the ADA.[22]

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13. *See* S.J. of Tex., 85th Leg., 1st C.S. 193 (2017) (statement of Sen. Charles Perry); Robert Painter, *Texas Allows Doctors to Sign Unauthorized Do Not Resuscitate (DNR) Orders Without Telling You*, PAINTER LAW FIRM (Apr. 11, 2017), http://www.painterfirm.com/a/219/Texas-allows-doctors-to-sign-unauthorized-do-not-resuscitate-DNR-orders-without-telling-you#tab-1; Joshua Newman, *SB 11: How the Do Not Resuscitate Law Changed in Texas*, TEX. HOME SCH. COALITION ASS'N, https://www.thsc.org/sb-11-do-not-resuscitate-law/ (last visited Mar. 1, 2020).

14. *See* Newman, *supra* note 13.

15. *See* Burns et al., *supra* note 9, at 1543.

16. *See id.*

17. *See Texas Legislature Reaffirms Patient's Rights with Passage of DNR Law*, PRO-LIFE HEALTHCARE ALL. (Aug. 17, 2017) (on file with author).

18. *See, e.g.*, Telephone Interview with Michael Economidis, Assoc. Gen. Counsel, Univ. Med. Ctr. Health Sys. (Sept. 10, 2018) (pointing out that the lack of a motivation for issuing secret DNR orders weakens the argument that physicians issue them very frequently).

19. *See* S.J. of Tex., 85th Leg., 1st C.S. 207 (2017) (statement of Sen. Charles Perry on S.B. 303); Painter, *supra* note 13.

20. *See* TEX. HEALTH & SAFETY CODE ANN. §§ 166.201–.209; Andy Duehren & Shannon Najmabadi, *Senate Gives Early OK to Bill Regulating Do-Not-Resuscitate Orders*, TEX. TRIB. (July 26, 2017), https://www.texastribune.org/2017/07/25/senate-gives-early-ok-bill-regulating-do-not-resuscitate-orders/.

21. *See* HEALTH & SAFETY § 166.202; S.J. of Tex., 85th Leg., 1st C.S. 190 (2017) (statement of Sen. Charles Perry); Duehren & Najmabadi, *supra* note 20.

22. *See* HEALTH & SAFETY §§ 166.201–.209; *Your Pocket Guide to Texas' New DNR Law*, *supra* note 11.

This Comment discusses the legal implications of the Bill and what it means for physicians practicing in and patients treated in hospitals.[23] Part II explains the constitutional groundwork for patient autonomy (the main idea behind the Bill) and cases involving secret DNR orders from various states.[24] It also describes the regulations that existed for out-of-hospital DNR orders before the Bill's enactment and gives an in-depth look at what the Bill requires for in-hospital DNR orders to be valid.[25] Part III analyzes the two major schools of thought on the Bill and compares and contrasts the Bill to other state laws.[26] Part IV discusses the issue of medical futility, a concept that relates to DNR orders, and evaluates how the Bill contributes to the medical futility discussion.[27] Part V contains recommendations for how physicians should act in light of the Bill's enactment and what changes could be made to the Bill to enable it to better promote patient autonomy.[28] Finally, Part VI concludes by reiterating the importance of patients or their agents—as opposed to physicians—serving the roles of lead decision makers in end-of-life situations.[29]

II. BEGIN CHEST COMPRESSIONS

Patient autonomy, the primary motivation behind the Bill, originated from this country's jurisprudence in the nineteenth century.[30] It is frequently discussed and litigated in connection with the secret DNR order problem, not only in Texas, but also in many other states.[31] This Section lays out this case law, explains the 1999 ADA, and describes how the Bill changed the ADA in response to case law.[32]

A. The Origins of Patient Autonomy

Any discussion of DNR orders must begin with tracking the origins of patient autonomy: the touchstone of a patient's right to create an advance directive.[33] Over 120 years ago, the U.S. Supreme Court acknowledged that

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23. *See infra* Part IV (exploring patient and physician autonomy).

24. *See infra* Part II (discussing secret DNR orders).

25. *See infra* Part II.C (elaborating on Texas's solution to secret DNR orders).

26. *See infra* Part III (analyzing various state laws).

27. *See infra* Part IV (explaining that the Bill is implicated in the medical futility discussion as it limits physicians' ability to issue secret DNR orders).

28. *See infra* Part V (arguing that the Bill does not expose physicians to increased liability).

29. *See infra* Part VI (focusing on the Bill's purpose to address its shortcomings).

30. *See* Union Pac. Ry. Co. v. Botsford, 141 U.S. 250, 251 (1891).

31. *See, e.g.*, Bryan v. Rectors and Visitors of Univ. of Va., 95 F.3d 349 (4th Cir. 1996); *Hearings on Tex. S.B. 11 Before the Senate Comm. on Health & Human Servs.*, 85th Leg., Spec. Sess. (Tex. 2017) (statements by Carol Williams, David Covey, Rebecca Parma, and Katherine Procter in support of Senate Bill 11, relating personal and anecdotal experiences with secret DNR orders); Vogel, *supra* note 12.

32. *See infra* Parts II.A–D (discussing relevant case law that has shaped the Bill).

33. *See Botsford*, 141 U.S. at 250.

"[n]o right is held more sacred, or is more carefully guarded, by the common law, than the right of every individual to the possession and control of his own person, free from all restraint or interference of others."[34] In turn, "[e]very human being of adult years and sound mind has a right to determine what shall be done with his own body."[35]

In 1973, the Supreme Court established that the constitutional right to privacy reinforces the foundation of patient autonomy by guaranteeing that certain zones of privacy exist under the Constitution.[36] The Court recognized that the specific guarantees found in the Bill of Rights have penumbras that give substance to those guarantees.[37] These penumbras create the constitutionally protected zones of privacy, which protect the right of an individual to make some of "the most intimate and personal choices a person may make in a lifetime, choices central to personal dignity and autonomy, . . . [and] to the liberty protected by the Fourteenth Amendment."[38]

In 1990, with respect to medical law, the Court weighed in on whether a patient has a constitutionally protected right to refuse medical treatment.[39] The Court held that a patient generally does have such a right.[40] Seven years later, in a case regarding physician-assisted suicide, the Court reiterated that an individual's decision on how and when he or she should die is the type of decision that is constitutionally protected.[41] Life and death decisions are directly related to "the right to define one's own concept of existence, of meaning, of the universe, and of the mystery of human life."[42] Nevertheless, the Court did not advance a sweeping conclusion that protects *all* personal and intimate decisions.[43] Finally, in *In re Quinlan*, a well-known case from New Jersey, the New Jersey Supreme Court relied on the connection between the right to privacy and patients' autonomy in medical decision-making when

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34. *Id.* at 251.

35. Schloendorff v. Soc'y of N.Y. Hosp., 105 N.E. 92, 93 (N.Y. 1914).

36. Roe v. Wade, 410 U.S. 113, 152 (1973).

37. Griswold v. Connecticut, 381 U.S. 479, 484 (1965).

38. Planned Parenthood of Se. Cal. v. Casey, 505 U.S. 833, 851 (1992); *see Griswold*, 381 U.S. at 484 (stating that protected personal choices include those relating to procreation, child rearing, and contraception).

39. *See* Cruzan v. Mo. Dep't of Health, 497 U.S. 261, 269 (1990).

40. *See id.* at 269–70. Nevertheless, on the facts of the case, the Court held that there was insufficient evidence of the patient's wishes before she fell into a vegetative state to require the hospital to stop her medical treatment. *Id.* at 285. Although the Court's treatment of patient autonomy was a victory on a macro level, in this particular case, the patient and her family were unsuccessful. *Id.* at 286.

41. *See* Washington v. Glucksberg, 521 U.S. 702, 726 (1997) (quoting Compassion in Dying v. Washington, 79 F.3d 790, 813–14 (9th Cir. 1996), *rev'd*, 521 U.S. 702, 726 (1997)).

42. *Casey*, 505 U.S. at 851.

43. *See Glucksberg*, 521 U.S. at 727. For example, the Court did not hold that an individual's autonomy includes the right to physician-assisted suicide, but it does include the right to independently make personal decisions for oneself. *Id.* Similar to *Cruzan*, this case marked a step toward bolstering the idea of patient autonomy, although in the area of physician-assisted suicide, it was not as successful. *See id*; *see also* Megan S. Wright, *End of Life and Autonomy: The Case for Relational Nudges in End-of-Life Decision-Making Law and Policy*, 77 MD. L. REV. 1062, 1080–81 (2018) (discussing the different points of view on physician-assisted suicide and patient autonomy).

it upheld a patient's right to choose to forgo life-sustaining medical treatment.[44] The court further emphasized the individualistic nature of the "right of choice" by stating that any consideration of individuals' interests other than the patient's interest should be limited.[45]

B. Code Status: Do Not Resuscitate

Texas's perspective on patient autonomy is reflected by the requirements and contents of the ADA.[46] The ADA allows physicians to issue DNR orders in two instances.[47] An out-of-hospital DNR order is a legally binding directive containing a patient's instructions to health care professionals not to resuscitate in out-of-hospital settings, such as "in-patient hospice facilities, private homes, . . . and vehicles during transport."[48] Similarly, in-hospital DNR orders provide instructions for health care professionals "in a health care facility or hospital."[49]

The ADA imposes several requirements for issuing valid DNR orders in out-of-hospital settings.[50] A competent individual can execute a written DNR order; the individual must sign the order in front of two witnesses, and the witnesses along with the attending physician must also sign the order.[51] If an individual is incompetent but had a previously issued directive, a physician can rely on that directive to issue an out-of-hospital DNR order.[52] A written DNR order must meet certain requirements and it should meet others, including the following: (1) it must be a distinct, single-page document; (2) its title should identify it as a DNR order; (3) it must name the patient; (4) it should contain a statement that the physician is the attending physician and that other health care professionals should not initiate life-sustaining treatment; and (5) it must contain the names and signatures of the witnesses and attending physician.[53] A competent individual may also execute an out-of-hospital DNR order orally.[54] With respect to liability, the ADA shields physicians from liability if they withhold treatment in good

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44. *See In re* Quinlan, 355 A.2d 647, 663–64 (N.J. 1976); James H. Beauchamp, *What if Karen Quinlan Had Lived in Oklahoma: A Guide to the Issuance of No Cardiac Resuscitation Order ('No Code' Order)*, 50 OKLA. B.J. 661, 664 (1979).

45. *Quinlan*, 355 A.2d at 664; Wright, *supra* note 43, at 1069.

46. *See* House Research Org., Bill Analysis, Tex. S.B. 11, 85th Leg., 1st C.S. (2017).

47. *See* TEX. HEALTH & SAFETY CODE ANN. § 166.002.

48. *Id.* § 166.081.

49. *Id.* § 166.202.

50. *See id.* § 166.082.

51. *Id.*

52. *See id.*

53. *See id.* § 166.083.

54. *Id.* § 166.084. Oral DNR orders must be issued in front of an attending physician and two witnesses. *Id.* The attending physician and witnesses must sign the order executed pursuant to a patient's oral request for the order. *Id.*

faith or if the physician has no actual knowledge of a DNR order in place and resuscitates that patient with the belief that there is no active DNR order.[55]

In Texas, the case law on secret DNR orders is thin; however, there are many instances of individuals sharing their personal experiences.[56] In 2015, the court of appeals in Dallas decided a case in which a physician issued a DNR order at the patient's request, and the patient's family sued when the patient was not resuscitated.[57] The issue in the case was not the secretive nature of the DNR order, but whether the hospital should have allowed the patient to consent to a DNR order based on the patient's competence.[58] Although the court quickly remanded the case for procedural reasons, it showed a Texas court grappling with the standard of care applied to hospitals and physicians with respect to the validity of DNR orders.[59] The court stated that a fair summary of the standard of care reflects that hospitals and their staff must ensure that all DNR order documents are valid.[60]

Again, in 2015, a case developed between the mother of a man named Chris Dunn and the Houston Methodist Hospital after Chris died during a conflict about whether to continue his treatment because of his terminal condition.[61] The hospital sought to end Chris's life-sustaining treatment, but his mother disagreed with that decision.[62] Chris's mother criticized the ADA for allowing physicians to have absolute authority over administering life-sustaining treatment, even if a surrogate already made a medical decision or a patient had expressed contrary wishes.[63] Unfortunately, the court sided with the hospital based on the judge's belief that if the ADA did not provide enough protection for patients, the legislature—and not the judiciary—should be the entity to remedy that.[64]

The case of fourteen-year-old Sabrina Martin vividly illustrates the harsh reality of secret DNR orders.[65] Sabrina was admitted to Children's Memorial Hermann Hospital after she developed a brain abscess.[66] After her condition deteriorated to the point where she was dying, her parents stated that the hospital staff issued two DNR orders against their wishes, and the hospital staff began "doing everything they could to try to end Sabrina's

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55. *See id.* §§ 166.094–.095.

56. *See, e.g.*, *Hearings on Tex. S.B. 11 Before the Senate Comm. on Health & Human Servs.*, 85th Leg., Spec. Sess. (Tex. 2017) (statements by Carol Williams, David Covey, Rebecca Parma, and Katherine Procter in support of Senate Bill 11, relating personal and anecdotal experiences with secret DNR orders).

57. Tex. Health Harris Methodist Hosp. Fort Worth v. Frausto, No. 05-14-00895-CV, 2015 WL 1941515, at *1 (Tex. App.—Dallas Apr. 30, 2015, pet. denied).

58. *See id.*

59. *See id.* at *3, *5–6.

60. *Id.* at *3, *5.

61. *See* Berlin, *supra* note 1.

62. *Id.*

63. *Id.*

64. *See id.*

65. Vogel, *supra* note 12.

66. *Id.*

life."[67] Sabrina was eventually transferred to a different hospital that saved her life.[68] However, Sabrina's family sued Memorial Hermann for improperly treating Sabrina as a way to hide evidence of the staff's malpractice.[69] Elizabeth Graham, the Director of Texas Right to Life, argued that hospitals routinely engage in this "disturbing" practice.[70] Yet, Dr. Robert Fine of Baylor Healthcare Systems stated that DNR orders "are almost always done in collaboration and with consent of the patient's family."[71]

Prior to enacting the Bill, the Senate Committee on Health and Human Services listened to testimony of Texas citizens who had personal experiences with secret DNR orders.[72] Carol Williams described how her husband passed away after a hospital placed an unauthorized DNR order in his medical records, contrary to his existing advance directive.[73] Because of the invalid DNR order, nurses refused to resuscitate him even though Williams repeated to them that any order in place was revoked.[74] She alleged that it was not until she threatened to take legal action against the hospital and its staff that the nurses began to help.[75] David Covey, the grandson of a woman who died after hospital staff failed to administer CPR, stated that the hospital where his grandmother was treated placed a DNR order on her records without her family's consent.[76] Rebecca Parma, an author for Texas Right to Life, testified on behalf of Layne, a baby who had a DNR order attached to his crib by hospital staff without his mother's consent while he was in the neonatal intensive care unit.[77] Finally, Katherine Procter testified on behalf of Grayson, a child who had a DNR order placed on him by the hospital staff that was treating him.[78] His mother maintains that she had no knowledge of the order, although the hospital insists that she signed it.[79]

Similarly, in *Bryan v. Rectors and Visitors of University of Virginia*, the family of a patient sued a hospital, alleging that it issued a DNR order against

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67. *Id.* Sabrina experienced extreme nausea and pain because of the pressure caused by the swelling of her brain. *Id.*

68. *Id.*

69. *Id.*

70. *Id.* Texas Right to Life is the largest and oldest pro-life organization in Texas that advocates for the rights of the unborn, disabled, sick, and elderly based on its belief that every human being is vested with an immeasurable and inalienable dignity. *Who We Are*, TEX. RIGHT TO LIFE, https://www.texas righttolife.com/who-we-are/ (last visited Mar. 10, 2020).

71. Vogel, *supra* note 12.

72. *See Hearings on Tex. S.B. 11 Before the Senate Comm. on Health & Human Servs.*, 85th Leg., Spec. Sess. (Tex. 2017) (statements by Carol Williams, David Covey, Rebecca Parma, and Katherine Procter in support of Senate Bill 11, relating personal and anecdotal experiences with secret DNR orders).

73. *Id.*

74. *Id.*

75. *Id.*

76. *Id.*

77. *Id.*

78. *Id.*

79. *Id.*

the family's wishes and caused the patient to die.[80] For reasons unrelated to the validity of the DNR order, the court ruled in favor of the hospital.[81] In 2016, a Connecticut court decided a case in which a patient's surviving family members sued a hospital for the patient's death, alleging that the hospital breached its duty of care when it entered a DNR order against the family's wishes.[82] Because of issues related to the plaintiff's pleadings, the hospital also prevailed in this case.[83] In the United Kingdom, the parents of Charlie Gard faced a similar issue when physicians caring for him applied for a court order to override the family's wishes to continue his treatment.[84] Surprisingly, the court upheld the override of Charlie's parents' wishes, and perhaps unsurprisingly, this decision troubled many across the world.[85]

C. Texas's Solution to Secret DNR Orders

Before the Bill, the legislature had attempted to address the secret DNR order problem.[86] One potential law helped patients relocate to different hospitals when they disagreed with their physicians about administering resuscitative treatment.[87] In practice, however, it seemed like the law would do nothing to give ultimate decision-making power to patients and would leave that power to the hospital staff.[88] For example, within the administrative panels and hearings that would take place to resolve such disagreements, the patient's family would essentially have had no input in the discussions.[89]

The Bill is the attempt that succeeded, and it became effective in April 2018, imposing several requirements that physicians must satisfy for an in-hospital DNR order to be valid.[90] Senator Perry intended the Bill to provide "adequate direction for the execution of a DNR order within a health care facility or hospital."[91] He believed that additional direction was needed because "[d]octors [could] (and have) unilaterally written DNR orders for patients without discussion, let alone consent, from either the patient or surrogate decision-maker."[92] As a way to protect patients' rights, the Bill

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80. Bryan v. Rectors and Visitors of Univ. of Va., 95 F.3d 349, 350 (4th Cir. 1996).
81. *Id.* at 353.
82. *See* Marsala v. Yale-New Haven Hosp. Inc., 142 A.3d 316, 323, 332 (Conn. App. Ct. 2016).
83. *Id.* at 456.
84. Rosalyn Broad, Gard v. United Kingdom*: Does the State Know Best?*, 26 TUL. J. INT'L & COMP. L. 405, 405 (2018).
85. *See id.* at 413–14.
86. *See* S.J. of Tex., 85th Leg., 1st C.S. 207 (2017).
87. *Id.*
88. *See id.*
89. *See id.*
90. TEX. HEALTH & SAFETY CODE ANN. §§ 166.201–.209; *Your Pocket Guide to Texas' New DNR Law*, *supra* note 11.
91. Senate Comm. on Health & Human Servs., Bill Analysis, Tex. S.B. 11, 85th Leg., 1st C.S. (2017).
92. *Id.*

provides a good—but imperfect—solution to this problem by codifying a process through which valid DNR orders may be issued.[93]

On second reading before the Senate Committee on Health and Human Services, Senator Perry answered questions posed by other senators regarding how various medical scenarios would play out under the Bill.[94] Perry emphasized the Bill's notice requirements as a means of ensuring that physicians are openly discussing DNR orders with their patients before DNR orders are issued.[95] In response to concerns about patient privacy, he clarified that these important notice requirements must be satisfied only if a patient does not already have an advance directive in place *and* is incompetent; they need not be satisfied if a patient is competent and requests a DNR order.[96]

Several aspects of the Bill are worth explaining. In an in-hospital setting, there are two ways for a physician to issue a valid DNR order.[97] First, the order must be issued by the patient's attending physician, it must be dated, and it must comply with multiple other requirements.[98] Specifically, the order must be issued according to (1) the written directions of a competent patient, (2) the oral directions of a competent patient in the presence of two witnesses, (3) the directions in another advance directive, (4) "the directions of a patient's legal guardian or agent," or (5) another treatment decision.[99]

In the alternative, an order may be issued if it is consistent with a competent patient's directions and with "the reasonable medical judgment of the patient's attending physician."[100] This second avenue also requires that the death of the patient be imminent and the order be medically appropriate.[101] Before an order may be placed in a patient's medical records, the physician, nurse, or individual acting on behalf of the facility must inform the patient that the order has been issued.[102] If the patient is incompetent, the physician or individual acting on behalf of the facility must make a reasonably diligent effort to inform either the patient's agent under a medical power of attorney or the patient's legal guardian.[103] In effect, this portion of the Bill is redundant, although more protective, because it requires a second level of consent.[104] The physician would have obtained the patient's consent when she first discussed issuing a DNR order, and she must also obtain

93. *See* S.J. of Tex., 85th Leg., 1st C.S. 196–97 (2017).
94. *Id.*
95. *See id.*
96. *Id.* at 196.
97. TEX. HEALTH & SAFETY CODE ANN. § 166.203.
98. *Id.*
99. *Id.*
100. *Id.*
101. *Id.*
102. *Id.*
103. *Id.*
104. *See* Telephone Interview with Michael Economidis, *supra* note 18.

consent when she informs the patient that she is putting the order in the patient's medical records.[105]

If a DNR order is issued under the latter circumstance and an individual arrives at the treating facility and notifies a physician or staff member providing direct care to the patient that he has arrived, the physician or staff member must disclose the order to him.[106] To trigger this notice requirement, the individual must be "the patient's known agent under a medical power of attorney or legal guardian."[107] Alternatively, notice may be given to the patient's spouse, reasonably available adult child, or parent.[108] The Bill sets out the order of priority for how these individuals should be notified.[109] The physician or staff does not have to notify additional individuals beyond the first individual notified.[110]

The Bill regulates revocation of DNR orders by requiring a physician who is providing direct care to a patient revoke an order if it is revoked by a competent patient, an incompetent "patient's agent under a medical power of attorney," or a patient's legal guardian.[111] The Bill does not allow a surrogate decision maker—including a patient's spouse, reasonably available adult child, or parent—to revoke a DNR order, although those individuals may consent to an order.[112] The reason for limiting who may revoke a DNR order stems from the legitimate concern that surrogate decision makers will override a now-incompetent patient who previously expressed that she did not want to be resuscitated in an emergency situation.[113] This restriction is evidence of the author's intent to bolster patient autonomy in the Bill, although in this instance it is not protecting patients from their physicians but from their own family members.[114] Although the focus of the Bill is to protect patients from their physicians, this additional level of protection is another way in which the legislature has taken great strides toward keeping patients in control of their own bodies.[115]

The concept of medical futility comes into play in the next portion of the ADA because it sets out a procedure for how to proceed when a patient (or his family) and a physician do not agree on the treatment plan.[116] The

105. *See id.*
106. HEALTH & SAFETY § 166.204.
107. *Id.*
108. *Id.* §§ 166.204, .039.
109. Senate Comm. on Health & Human Servs., Bill Analysis, Tex. S.B. 11, 85th Leg., 1st C.S. (2017).
110. *See* HEALTH & SAFETY § 166.204.
111. *Id.* § 166.205.
112. *See* Telephone Interview with Michael Economidis, *supra* note 18.
113. *See id.*
114. Senate Comm. on Health & Human Servs., Bill Analysis, Tex. S.B. 11, 85th Leg., 1st C.S., 1 (2017).
115. *See id.*
116. *See* Maureen Kwiecinski, *To Be or Not To Be, Should Doctors Decide? Ethical and Legal Aspects of Medical Futility Policies*, 7 MARQ. ELDER'S ADVISOR 313, 314–15 (2006).

ADA provides that if a physician does not want to comply with a DNR order, she must explain the benefits and burdens of CPR to the patient.[117] If the patient and his physician continue to disagree, the physician must make reasonable efforts to transfer him to a physician or hospital who is willing to comply with the order.[118]

Finally, the Bill's portion on enforcement limits physicians' liability in certain circumstances.[119] As long as a physician is acting in good faith when issuing a DNR order, or withholding CPR in accordance with an order, she will not be civilly or criminally liable.[120] In addition, if a physician does not have actual knowledge of a DNR order and fails to act in accordance with it, she will not be civilly or criminally liable.[121] However, if a physician intentionally conceals or falsifies a DNR order or she conceals the revocation of a DNR order, she will be subject to prosecution.[122]

Consistent with the Bill's goal of reinforcing patient autonomy, the Bill's intricacies place extensive limits on when a physician can unilaterally issue a DNR order.[123] It is only when a patient does not already have an advance directive in place, the hospital cannot find any surrogates to consult, and two physicians decide together that a DNR order should be issued because the patient's death is imminent (regardless of whether CPR is administered) that a physician can issue a DNR order without the patient's consent.[124] Even so, the fact that two physicians must make the decision to issue an order means that no physician can actually act alone.[125]

D. Schools of Thought

The legislature's enactment of the Bill created a divide between patients and their advocates, and physicians and their representatives.[126] Patients and their advocates praised Senator Perry and the Bill for reviving their efforts to reinforce patients' rights.[127] Believing that "Texas is home to some of the most dangerous anti-patient bioethics laws in the country," these individuals

117. TEX. HEALTH & SAFETY CODE ANN. § 166.206.
118. *Id.*
119. *Id.* §§ 166.207–.208.
120. *Id.* § 166.207.
121. *Id.* § 166.208.
122. *Id.* § 166.209.
123. *See* S.J. of Tex., 85th Leg., 1st C.S., 203 (2017).
124. *Id.*
125. *Id.* Although this is a circumstance in which a DNR order may be issued without a patient's consent, it is very rare. *See* Telephone Interview with Arturo Martinez, Internal Med. Specialist, Doctors Hosp. at Renaissance (Sept. 16, 2018).
126. *See* S.J. of Tex., 85th Leg., 1st C.S. (2017).
127. *See Texas Legislature Reaffirms Patient's Rights with Passage of DNR Law*, *supra* note 17; Newman, *supra* note 13 (noting that the Bill will give proper respect to patients' rights in DNRs).

fought in favor of the Bill and the idea that life and death medical decisions should be left in patients' hands.[128]

In contrast, groups opposed to the Bill contend that physicians are not systematically issuing secret DNR orders as its supporters suggest.[129] Individuals in the medical field have even expressed that they have not had any personal experience with secret DNR orders.[130] In addition, opponents believe, and Texas Senator Kirk Watson acknowledged, that the complex requirements that must be satisfied for a DNR order to be valid leads to concern among physicians who believe it will be difficult to determine when a DNR order is valid and can legally be acted upon.[131] The reasons why opponents' arguments are not well-founded will be explained in the next Part.[132] Nevertheless, both sides' interests are not mutually exclusive, and although the Bill may be viewed as imperfect or unnecessary, the purpose behind the Bill is good.[133]

III. CLEAR!

The supporters and opponents of the Bill come from various walks of life and have different motivations underlying their perspectives.[134] This Section will lay out the motivations and nuances of both sides' arguments while also noting that both are flawed.[135] Next, this Section will compare and contrast the Bill with other states' laws to understand how consistent it is with other laws already in place.[136]

A. What Side Are You On?

Given its unique character, many individuals and groups have expressed strong opinions in favor of and in opposition to the Bill.[137] However, although there are differences of opinion regarding the Bill, both sides' interests are far from irreconcilable.[138] As stated earlier, supporters of the Bill include patients, their families, and groups who advocate on behalf of those

128. *Texas Legislature Reaffirms Patient's Rights with Passage of DNR Law*, *supra* note 17.

129. *See* Courtenay R. Bruce et al., *Legislating How Critical Care Physicians Discuss and Implement Do-Not-Resuscitate Orders*, 44 J. CRITICAL CARE 459, 459 (2018).

130. *See, e.g.*, Telephone Interview with Michael Economidis, *supra* note 18 (claiming that he has not had any experience with secret DNR orders); Telephone Interview with Arturo Martinez, *supra* note 125 (same).

131. S.J. of Tex., 85th Leg., 1st C.S., 193 (2017); Bruce et al., *supra* note 129, at 459.

132. *See infra* Part IV (exploring the opponents' arguments).

133. *See* Telephone Interview with Michael Economidis, *supra* note 18.

134. *See* S.J. of Tex., 85th Leg., 1st C.S. (2017).

135. *See infra* Part III.A (evaluating arguments of the Bill's proponents and opponents).

136. *See infra* Parts III.B.1–4 (reviewing other state's laws for comparison).

137. *See* S.J. of Tex., 85th Leg., 1st C.S. (2017).

138. *See* Telephone Interview with Michael Economidis, *supra* note 18.

individuals.[139] These individuals rightfully believe that the Bill, although in need of some changes, represents a major victory for patients and their families because it reestablishes their constitutionally protected right to execute and revoke DNR orders.[140] Texas Home School Coalition stated that the Bill sends a strong message to health care professionals that parents, not physicians or hospitals, should have the final say on making decisions for their children.[141] Jeremy Newman, the Director of Public Policy for the Texas Home School Association, testified before the Texas Senate on behalf of the group stating that a fundamental aspect of parental rights is the ability to protect the rights of one's child, and that their ability is usurped when physicians issue secret DNR orders.[142] Those views are consistent with patient autonomy—the well-established notion that patients have the constitutional right to control the course of their own medical treatment.[143]

In addition, supporters appreciate the complex nature of the Bill and the various requirements physicians must satisfy for a DNR order to be valid because it forces physicians to be transparent throughout the process and prioritizes patient involvement.[144] The need to hold physicians accountable by imposing these requirements is clear according to John Seago, a representative of Texas Right to Life.[145] Seago testified that physicians in hospitals and their attorneys believed they could do whatever the physicians wanted because the existing DNR laws did not apply to them.[146]

On the other hand, the group opposed to the Bill is mostly comprised of hospital associations, physicians, and those who represent hospitals and physicians.[147] They have pointed out several shortcomings of the Bill, the first of which is that the supposed need for the Bill misrepresents what actually occurs in hospitals.[148] From their perspective, because only about 6% of all physicians and about 20% of all pulmonary critical care physicians

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139. *See, e.g.*, S.J. of Tex., 85th Leg., 1st C.S., at 192, 195 (2017) (referring to pro-life groups including Texas Alliance for Life and Texas Right to Life as supporters of the Bill, as well as Texas citizens who have personal experience with secret DNR orders).

140. *See Texas Legislature Reaffirms Patient's Rights with Passage of DNR Law*, *supra* note 17.

141. Newman, *supra* note 13.

142. *Hearings on Tex. S.B. 11 Before the Senate Comm. on Health & Human Servs.*, 85th Leg., Spec. Sess. (Tex. 2017) (statement by Jeremy Newman on behalf of the Texas Home School Coalition in support of Senate Bill 11).

143. *See* Jon D. Feldhammer, *Medical Torture: End of Life Decision-Making in the United Kingdom and United States*, 14 CARDOZO J. INT'L & COMP. L. 511, 522 (2006).

144. *Hearings on Tex. S.B. 11 Before the Senate Comm. on Health & Human Servs.*, 85th Leg., Spec. Sess. (Tex. 2017) (statement by Jennifer Allmon on behalf of the Texas Catholic Conference of Bishops in support of Senate Bill 11).

145. *Id.*

146. *Id.* (stating that placing a secret DNR order on a patient is adverse to the pro-life ethic that emphasizes abiding by patients' wishes).

147. *See, e.g.*, S.J. of Tex., 85th Leg., 1st C.S., at 192, 195 (2017) (noting Sen. Perry's list with the Catholic Hospital Association and Texas Medical Association as critics of the Bill, in addition to the Texas Hospital Association and its representatives).

148. Bruce et al., *supra* note 129, at 459.

report unilaterally issuing DNR orders, there is no secret DNR order problem.[149] Even conceding the fact that physicians may issue DNR orders unilaterally, opponents argue that the frequency with which physicians do so is unclear.[150] Considering that uncertainty in combination with the fact that physicians have no apparent motivation for issuing secret DNR orders, opponents argue that the intent behind the Bill is questionable.[151] The critical drawback of this argument is that it denigrates the rights of the patients who comprise those percentages by sending the erroneous message that their rights are not important until their cumulative numbers reach an arbitrary minimum threshold, an idea in direct contravention to *individuals'* constitutional rights to control their own bodies.[152] Whether physicians unilaterally issue DNR orders frequently or just occasionally, the intent behind the Bill remains valid if even a single patient's right to make his or her own life and death decisions is protected.[153]

Second, opponents criticize the Bill for legislating in an area that medical professionals regard as outside the scope of lawmakers' expertise.[154] They argue that it disturbs the balance between reinforcing patient autonomy and respecting medical judgment and integrity.[155] For example, when a physician believes, in his medical and professional judgment, that a patient should not be resuscitated because of her condition, the Bill makes it very difficult for a physician to issue a DNR order if the patient's family wants her to be resuscitated at all costs.[156] However, this argument has less to do with unjustifiably limiting physicians' actions than it does with limiting the extent to which family problems affect medical decisions.[157] In other words, the issue is not that the Bill itself prevents physicians from exercising their medical judgment, but that patients' family members may have their own reasons, apart from the best interest of the patient, for wanting a patient to be resuscitated.[158]

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149. *Id.*

150. *Id.*

151. *See* Telephone Interview with Michael Economidis, *supra* note 18 (explaining physicians' concerns with doing the right thing when treating their patients and how they would not want to place their professional careers in jeopardy by issuing secret DNR orders). In contrast to what opponents argue, there is a likely motivation for engaging in this risky practice. *See* Vogel, *supra* note 12. For example, if a physician erroneously treats a patient and makes his condition worse, then it may be in the physician's interest to withdraw life-sustaining treatment and allow the patient to die. *Id.* If the patient dies, then the physician will likely be liable for less damages than if the patient had lived, because damages for a living patient would include payment for the increased medical care caused by the physician's mistake. *Id.*

152. *See* Union Pac. Ry. Co. v. Botsford, 141 U.S. 250, 251 (1891).

153. *See* Feldhammer, *supra* note 143, at 522.

154. Bruce et al., *supra* note 129, at 459–60.

155. *Id.* at 460.

156. *Hearings on Tex. S.B. 11 Before the Senate Comm. on Health & Human Servs.*, 85th Leg., Spec. Sess. (Tex. 2017) (statement by Dr. Robert Fine on behalf of Baylor Scott and White Health and the Texas Hospital Association in opposition to Senate Bill 11).

157. *See* Telephone Interview with Michael Economidis, *supra* note 18.

158. *See* Telephone Interview with Arturo Martinez, *supra* note 125.

Finally, opponents argue that the requirements imposed by the Bill will make it more difficult for physicians to know when a DNR order is valid.[159] In turn, physicians will try to avoid liability by resuscitating more patients than usual.[160] Although this is a way for physicians to avoid the difficulties of complying with the Bill, it results in circumstances in which patients' wishes are not respected (the exact motivation behind the Bill) when they actually do not want to be resuscitated.[161] Again, this fear is not well-founded and apparently has not materialized because physicians have not suddenly become more cautious when issuing DNR orders.[162]

In general, both the supporters and opponents of the Bill make valid arguments, but neither of their perspectives fully and accurately depict the state of the law before or after the Bill was passed.[163] The Bill's supporters do not acknowledge the negative impact the overbreadth of the Bill may have on medical practice in hospitals; however, the Bill's opponents are overstating the extent to which the Bill will interfere with how physicians practice in hospitals.[164] Nevertheless, the supporters have the stronger argument because although the Bill may create more hoops for physicians to jump through, procedures for issuing DNR orders have not become markedly different since the Bill was enacted.[165] Before the Bill, it was common practice for physicians to talk with patients about DNR orders, put the order in if the patient requested it, and then sign the order.[166] After the Bill, the same procedure is followed with little to no additional confusion.[167]

Further, although individuals in the medical field may not see the need for such an extensive process for a DNR order to be valid, there is no doubt that those same individuals believe the purpose behind the Bill is good, and patients should always actively participate in making their own life and death

159. *See Hearings on Tex. S.B. 11 Before the Senate Comm. on Health & Human Servs.*, 85th Leg., Spec. Sess. (Tex. 2017) (statement by Missy Atwood on behalf of Texas Hospital Association in opposition to Senate Bill 11).

160. *Compare id.* (statement by Missy Atwood on behalf of Texas Hospital Association in opposition to Senate Bill 11), *with* Telephone Interview with Michael Economidis, *supra* note 18 (stating that the concern that more patients will be resuscitated is valid, but as long as physicians act professionally, they likely will not have to worry about liability).

161. *See Hearings on Tex. S.B. 11 Before the Senate Comm. on Health & Human Servs.*, 85th Leg., Spec. Sess. (Tex. 2017) (statement by Missy Atwood on behalf of Texas Hospital Association in opposition to Senate Bill 11).

162. *See* Telephone Interview with Arturo Martinez, *supra* note 125 (explaining that he has not experienced any significant changes in how he issues DNR orders since the Bill was passed).

163. *See* Telephone Interview with Michael Economidis, *supra* note 18; Bruce et al., *supra* note 129, at 459.

164. *See* Telephone Interview with Michael Economidis, *supra* note 18; Bruce et al., *supra* note 129, at 459.

165. *See* Telephone Interview with Arturo Martinez, *supra* note 125 (explaining that he has not experienced any significant changes in how he issues DNR orders since the Bill was passed).

166. *See id.*

167. *See id.*

decisions.[168] No physician wakes up and goes to work thinking they want to do something wrong; physicians go to work with the intent to act in the best interest of their patients with their patients' consent.[169] In this sense, it is difficult to see how a law simply codifying this practice is a bad thing.[170]

B. Other State's Approaches

With respect to state legislatures' regulation of in-hospital DNR orders across the country, Texas's approach in adding to the ADA was an unprecedented step in the right direction.[171] Only about nine states have passed laws similar to the Bill that specifically require patients' consent for DNR orders to be valid.[172] Among this small group, an even smaller portion of those states have laws that are as complex as the Bill.[173] Even if some laws require that physicians obtain patients' consent before issuing DNR orders, those requirements are not as strict as the Bill when it comes to the exact procedure physicians must follow when issuing DNR orders.[174] This becomes particularly evident when comparing and contrasting the Bill to laws in other states.[175]

1. New York

New York's DNR law is most similar to Texas's Bill because of New York's comparable history with secret DNR orders.[176] At the La Guardia community hospital, the staff developed a policy of issuing DNR orders to patients without their consent and without recording the orders in patients' medical records.[177] This was known as the Purple Dot Affair because nurses placed dot-sized, purple decals in patients' records to signify that DNR orders

168. *See Hearings on Tex. S.B. 11 Before the Senate Comm. on Health & Human Servs.*, 85th Leg., Spec. Sess. (Tex. 2017) (statement by Dr. Robert Fine on behalf of Baylor Scott and White Health and the Texas Hospital Association in opposition to Senate Bill 11, explaining that all DNR orders should be issued with the consent of the patient and not in secret); Telephone Interview with Michael Economidis, *supra* note 18 (stating that the enactment of the Bill was not a bad thing, but perhaps a bit unnecessary); Telephone Interview with Arturo Martinez, *supra* note 125 (explaining how it is regular practice for him to include patients in decisions regarding their medical treatment).

169. *See* Telephone Interview with Arturo Martinez, *supra* note 125.

170. *See* Telephone Interview with Michael Economidis, *supra* note 18; Telephone Interview with Arturo Martinez, *supra* note 125.

171. *See* Bruce et al., *supra* note 129, at 459.

172. *Id.*

173. *Id.*

174. *See id.*

175. *See id.*

176. *See* Stuart J. Younger, *Do-Not-Resuscitate Orders: No Longer Secret, but Still a Problem*, 17 HASTINGS CTR. REP. 24, 25 (1987).

177. *Id.*

had been placed on the patients' records but would discard the decal after the patients died from lack of resuscitation to hide the evidence.[178]

In response, the New York Legislature passed a groundbreaking and ambitious law regulating DNR orders in 1987.[179] The law's purpose was similar to the Bill's purpose: The New York Legislature wanted to emphasize the importance of patient consent to DNR orders by codifying a formal procedure for issuing valid DNR orders.[180] In practice, the New York law is similar to the Bill in that both greatly restrict the circumstances in which physicians can unilaterally issue DNR orders.[181] A physician in New York can unilaterally issue a DNR order only when a patient has not expressed his wishes regarding CPR, there is no surrogate decisionmaker who can make decisions for the patient, and the patient is terminally ill or permanently unconscious.[182]

A key difference between the two laws—a difference that makes the New York law more appealing—is that New York's law imposes a presumption in favor of resuscitation unless a physician has obtained consent to issue a DNR order.[183] In contrast, the Texas ADA—at least in the out-of-hospital context—specifically states that the fact that a patient does not already have an advance directive in place does not create a presumption that the patient wants to be resuscitated.[184] In general, it is better practice to err on the side of resuscitation because of the obviously permanent nature of death.[185] This is especially true when it is presumably possible to make a clear determination of whether a patient wants to be resuscitated.[186]

Another important difference between the two laws is that New York's law allows a physician to enter a DNR order for a patient over the objection of his agent if CPR would be futile and a second physician agrees with that determination.[187] In Texas, a physician can issue a DNR order after getting a second opinion from another physician but only in rare cases when a patient is incompetent and no family members or agents can be found.[188] This distinction makes New York's law less appealing than the Bill because it

178. *Id.*; *see generally* Burns et al., *supra* note 9 (noting that some institutions would write cryptic initials in patients' medical records while others would simply issue verbal DNR orders to hospital staff, which would be passed from shift-to-shift).

179. *See* Edward F. McArdle, *New York's Do-Not-Resuscitate Law: Groundbreaking Protection of Patient Autonomy or a Physician's Right to Make Medical Futility Determinations?*, 6 DEPAUL J. HEALTH CARE L. 55, 55 (2002).

180. *Id.* at 58 n.5 (citing N.Y. PUB. HEALTH LAW, art. 29-B, §§ 2960–2979 (McKinney, Westlaw through 2019 Legis. Sess.)).

181. *See id.* at 64.

182. *See* PUB. HEALTH LAW § 2966; McArdle, *supra* note 179, at 64.

183. PUB. HEALTH LAW § 2962.

184. TEX. HEALTH & SAFETY CODE ANN. § 166.088.

185. *See Texas Legislature Reaffirms Patient's Rights with Passage of DNR Law*, *supra* note 17.

186. *See id.*

187. McArdle, *supra* note 179, at 74.

188. S.J of Tex., 85th Leg. 1st C.S., at 202–03 (2017).

allows physicians to override the wishes of a patient's family member or agent who is presumably acting in accordance with the patient's wishes.[189] However, the New York law is more appealing because physicians' consideration of futility ensures that the best interest of the patient is given priority over what may be a family member's guilt or selfishness.[190] Again, the New York law provides a greater benefit to patients because under the Bill, gaps remain that allow family members to interject their own interests when the main purpose behind the Bill is to prioritize and strengthen patients' interests.[191]

2. Nevada

Nevada's law only allows physicians to issue DNR orders to patients who are in terminal condition.[192] Further, the Nevada law requires that, before a DNR order may be issued, patients must have agreed to the order while they were capable of giving informed consent.[193] Although critics of the Bill argue that it unjustifiably limits physicians' medical judgment, it is not as limiting as Nevada's DNR law.[194] In Texas, a competent patient may request a DNR order even if the patient is not in terminal condition.[195] Consistent with the Texas Legislature's emphasis on patient autonomy, the Bill is better suited to achieving that end than the Nevada law.[196] When a patient is not in terminal condition but does not want to be resuscitated in an emergency situation, the patient has the option to request a DNR order, an option that does not exist under the Nevada law.[197]

The Bill also does not impose an explicit requirement that an incompetent patient has to have given informed consent for a DNR order while they were still competent.[198] However, the Bill does state that a DNR order cannot be issued if it would be contrary to instructions given by the patient when they were capable of giving such instructions and certain other conditions are met.[199] In this way, the Texas and Nevada laws are similar enough in that both prevent a healthcare provider from issuing a DNR order

189. *See* McArdle, *supra* note 179, at 74.

190. *Id.* at 65.

191. *See* S. Comm. on Health & Human Servs., Bill Analysis, Tex. S.B. 11, 85th Leg., 1st C.S. (2017).

192. NEV. REV. STAT. ANN. § 450B.510 (West, Westlaw through 2019 Legis. Sess.).

193. *Id.*

194. *See Hearings on Tex. S.B. 11 Before the Senate Comm. on Health & Human Servs.*, 85th Leg., Spec. Sess. (Tex. 2017) (statement by Dr. Robert Fine on behalf of Baylor Scott and White Health and the Texas Hospital Association in opposition to Senate Bill 11).

195. TEX. HEALTH & SAFETY CODE ANN. § 166.203.

196. *Compare* NEV. REV. STAT. § 450B.510 (stating the process a patient must consent to for a DNR), *with* HEALTH & SAFETY § 166.203 (explaining how a patient can consent to a DNR).

197. TEX. HEALTH & SAFETY CODE ANN. § 166.203.

198. *Id.*

199. *Id.*

against a patient's wishes.[200] In general, the Nevada law is more limited in scope because it restricts the number of patients for which DNR orders may be issued.[201] But the Bill is still unique and provides extra protection against unilateral DNR orders because the procedure it prescribes is more extensive and complex.[202]

3. West Virginia, New Jersey, and Wisconsin

One of the main and most important features of the Bill is the notice requirement triggered when a DNR order is issued for an incompetent patient who does not already have an advance directive in place.[203] This feature clearly sets the Bill apart from several other state laws that do not require a similar type of notice to be given.[204] For example, none of the DNR laws in West Virginia, New Jersey, or Wisconsin require that hospital staff notify anyone after a DNR order has been issued for an incompetent patient who does not already have an advance directive in place.[205] Not only does the Bill require that such notice be given, but the notice-requirement provision is one of the lengthiest portions of the Bill (apart from the provision that lays out the procedure for issuing a DNR order).[206] In turn, the Bill's unprecedented notice requirement ensures that a physician cannot issue a secret DNR order.[207] This notice requirement forces physicians to be transparent about their actions in these rare cases, and it decreases the likelihood that physicians would even try to issue secret DNR orders because of the increased chances of getting caught.[208] Even if a physician were to try to issue a secret DNR order, the fact that someone has to be notified about the order increases the chances that someone will find out about the order and have an opportunity to revoke it.[209]

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200. HEALTH & SAFETY § 166.203; NEV. REV. STAT. § 450B.510.

201. *Compare* NEV. REV. STAT. § 450B.470 (determining who qualifies as a "qualified patient" for a DNR), *with* HEALTH & SAFETY § 166.203 (explaining how a patient can consent to a DNR).

202. HEALTH & SAFETY § 166.203.

203. *Id.* § 166.204.

204. *See, e.g.*, N.J. STAT. ANN. § 26:2H-56 (West, Westlaw through 2019 Legis. Sess.); W. VA. CODE ANN. § 16-30C-6 (West, Westlaw through 2019 2d Extraordinary Sess.); WIS. STAT. ANN. § 154.19 (West, Westlaw through 2019 Legis. Sess.).

205. N.J. STAT. § 26:2H-56; W. VA. CODE § 16-30C-6; WIS. STAT. § 154.19.

206. HEALTH & SAFETY § 166.204.

207. *See* Bruce et al., *supra* note 129.

208. HEALTH & SAFETY § 166.203.

209. *Id.*

4. Michigan

Michigan may be following in Texas's footsteps because of its similar history with secret DNR orders.[210] House Bill 5071 and Senate Bill 597 were proposed to require physicians and hospitals to notify family members that they are going to the courts to take control of a patient's medical treatment.[211] The laws were not only written to address secret DNR orders but also secret court proceedings instituted to establish guardianship over patients.[212] Both pieces of legislation were referred to the state's committees, but have not been enacted.[213] If these laws are enacted, then they may be even more far-reaching than the Bill because of their regulation of out-of-hospital proceedings, apart from the procedure actually used in hospitals to issue DNR orders.[214] Because it is not clear whether secret court proceedings are also a problem in Texas, the current scope of the Bill seems more appropriate.[215]

IV. LIVE AND LET DIE: PATIENT AUTONOMY V. PHYSICIAN AUTONOMY

In the midst of the legislature's enactment of the Bill, medical futility is a concept that has consistently been discussed.[216] It factors into the precarious balance between patient autonomy and physician autonomy that arguably has been tilted in favor of patient autonomy because of the Bill.[217] Medical futility refers to circumstances when physicians may withhold care—irrespective of a patient's directive—when care would have no beneficial effect and would actually harm the patient.[218] The connection between medical futility and patient autonomy is particularly evident given that "[a] declaration of medical futility is useful when there is a disagreement between the patient and the health care providers because it allows the health care providers to unilaterally stop treatment."[219] With respect to DNR orders, medical futility frequently arises in physician-refusal cases when physicians want to place a DNR order on a patient because resuscitative treatment would

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210. *See Doctors and Hospitals Are Placing Secret DNR Orders in Patients' Files*, LIFENEWS (Nov. 16, 2017, 6:46 PM), https://www.lifenews.com/2017/11/16/doctors-and-hospitals-are-placing-secret-dnr-orders-in-patients-files/.

211. *See id.*

212. *See id.*

213. H.B. 5076, 99th Leg., R.S. (Mich. 2017); S.B. 0597, 99th Leg. R.S. (Mich. 2017).

214. *See Doctors and Hospitals Are Placing Secret DNR Orders in Patients' Files*, *supra* note 210.

215. *See* Vogel, *supra* note 12.

216. *See, e.g.*, Feldhammer, *supra* note 143.

217. *See Texas Legislature Reaffirms Patient's Rights with Passage of DNR Law*, *supra* note 17; Feldhammer, *supra* note 143.

218. *See* Feldhammer, *supra* note 143, at 518–19 (citing United States v. Rutherford, 442 U.S. 544, 555 (1979)) (explaining that to have a "beneficial effect," a treatment should fulfill a health care provider's claims that the treatment will promote continued life, improved health conditions, or less pain).

219. *Id.* at 520.

not be beneficial, but the patient's family wants the physician to resuscitate at all costs.[220]

The Bill is implicated in the discussion of medical futility because its purpose is to strictly limit physicians' ability to issue secret DNR orders, a practice that is most prevalent when patients and physicians disagree about whether resuscitative treatment should be administered.[221] This poses a problem because although patients do have a constitutional right to make their own life and death decisions, physicians also have the right to decide, based on their own ethical and professional judgment, what treatments they are comfortable administering.[222] Again, this is because physicians do not necessarily enjoy the aggressive and the harmful nature of resuscitative treatment.[223] Although patient autonomy is a major motivation behind the Bill, the Bill's supporters should also take note of the need to maintain the ethical integrity of the medical profession.[224] The Hippocratic Oath commits all physicians to "do no harm."[225] But what if not issuing a DNR order because a patient's family refuses to consent means that a physician will in fact cause harm to the patient if he is forced to resuscitate the patient?[226]

As explained earlier, the ADA lays out the procedure physicians must follow when there is a disagreement between a patient and his physician over administering resuscitative treatment.[227] The physician should make reasonable efforts to transfer the patient to be treated by another physician or hospital.[228] However, another physician or hospital will not always be willing to accept that patient.[229] The reality is that generally, when a physician

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220. *Id.* at 521.

221. *See* S. Comm. on Health & Human Servs., Bill Analysis, Tex. S.B. 11, 85th Leg., 1st C.S. 1 (2017).

222. *See* Washington v. Glucksberg, 521 U.S. 702, 726 (1997); Feldhammer, *supra* note 143, at 522, 525.

223. *See* Morrow, *supra* note 8; *Code Status, Resuscitation, DNR…What Does It All Mean?*, COVENANT HEALTHCARE, https://www.covenanthealthcare.com/Uploads/Public/Documents/Workfiles/Pastoral%20Care/Advanced_Care_Planning/What_is_Code_Status.pdf (last visited Mar. 10, 2020) (stating that although sometimes helpful, resuscitative treatments may only unnecessarily prolong dying, which is reflected by the fact that less than 25% of in-hospital resuscitative efforts are successful).

224. *See* Feldhammer, *supra* note 143, at 525.

225. *Greek Medicine*, NAT'L LIBR. OF MED., https://www.nlm.nih.gov/hmd/greek/greek_oath.html (last visited Mar. 10, 2020).

226. *See Hearings on Tex. S.B. 11 Before the Senate Comm. on Health & Human Servs.*, 85th Leg., Spec. Sess. (Tex. 2017) (statement by Dr. Arlo Weltge testifying on Senate Bill 11 as a practicing physician and representing the members of the Texas Medical Association to argue that forcing physicians to provide resuscitative treatment when it is medically futile compromises physicians' ethical and medical obligations to their patients); *e.g.*, Alexander v. Scripps Mem'l Hosp. La Jolla, 232 Cal. Rptr. 3d 733, 757–58 (Ct. App. 2018) (explaining how the treating physicians argued that they did not want to continue treating the patient because doing so would not have been beneficial and would have caused the patient to suffer); Marsala v. Yale-New Haven Hosp. Inc., 142 A.3d 316, 322–23 (Conn. App. Ct. 2016) (recognizing that physicians should consider the wishes of the patient, but they should do so with an eye toward providing the best medical judgment).

227. TEX. HEALTH & SAFETY CODE ANN. § 166.206.

228. *Id.*

229. *See* Feldhammer, *supra* note 143, at 527.

believes that further treatment of a patient would be medically futile, no one will accept that patient.[230] In turn, although it may seem like the ADA provides a way out for physicians when their treatment plan is at odds with that of the patient, there is a serious issue with the practical reality of that way out.[231]

This criticism is further supported by the fact that in many cases when physicians believe a patient's case is medically futile and the family refuses to consent to a DNR order, it is because no family member wants to be responsible for "killing" the patient.[232] In turn, preventing a physician from entering a DNR order is forcing that physician to ignore what the patient actually wants and cater to what the patient's family prefers.[233] Restricting physicians' abilities to act in these circumstances does nothing to protect patient autonomy but only allows family members to act selfishly and ignore the interests of the patient.[234]

On the other hand, the Bill provides more protection for disabled patients who disproportionately have had secret DNR orders placed on them because treatment would be "medically futile."[235] Dennis Borel, on behalf of the Coalition of Texans with Disabilities, expressed his support for the Bill because it bolsters disabled patients' rights, which he believes physicians value less than the rights of other patients.[236] Logically, patients with more severe illnesses are more likely to have DNR orders in place because their likelihood of survival is less promising than that of a less severely ill patient.[237] However, the practice of issuing DNR orders becomes questionable when it is used to prevent the resuscitation of patients with disabilities that do not directly or significantly affect their chances of survival at all.[238] For example, in 2011, a DNR order was placed on a patient with Down's syndrome, and the hospital listed the patient's disability as one of the reasons for issuing the order.[239] The hospital did not consult the patient's

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230. *See id.*

231. *See id.*

232. *See id.* at 529.

233. *See* Telephone Interview with Arturo Martinez, *supra* note 125 (explaining how it is very common for family members to want to continue to resuscitate patients, not because that is what the patient would want, but because the family member feels guilty for having a problematic relationship with the patient).

234. *See id.*

235. *See* Burns et al., *supra* note 9, at 1545 (stating that the rate at which physicians issue DNR orders directly correlates with the severity of a patient's illness).

236. *See Hearings on Tex. S.B. 11 Before the Senate Comm. on Health & Human Servs.*, 85th Leg., Spec. Sess. (Tex. 2017) (statement by Dennis Borel on behalf of the Coalition of Texans with Disabilities in support of Senate Bill 11).

237. *See* Burns et al., *supra* note 9, at 1546.

238. *See* Damien Gayle, *Hospital Says Sorry for Do Not Resuscitate Order on Man with Down's Syndrome*, GUARDIAN (Dec. 8, 2015, 6:14 AM), https://www.theguardian.com/society/2015/dec/08/hospital-says-sorry-for-do-not-resuscitate-order-on-man-with-downs-syndrome.

239. *Id.*

family prior to issuing the order.[240] The order stated that his family had been unavailable for consultation even though they visited the hospital daily.[241] Based on this example, the new limits placed on physicians' ability to issue DNR orders are more well-founded than not because they restrict physicians' actions when they are not reasonably connected to legitimate medical judgment.[242]

V. SHE HAS A PULSE: RESUSCITATING SENATE BILL 11

Based on the positive and negative aspects of the Bill as expressed by its supporters and opponents, and although it clearly reflects great strides toward protecting patient autonomy, it is still new and in need of refining and definitive interpretation.[243] One of the main, recurring concerns expressed by the Bill's opponents is that it will expose physicians to increased liability because the complex nature of the Bill makes it easier for a physician to violate the ADA.[244] In addition, they do not believe that the Bill's good faith defense will adequately protect physicians because of the lack of clarity in the Bill's requirements.[245]

Although it is still unclear how courts will interpret the Bill, it is unlikely that physicians' fears will materialize.[246] Nevertheless, because the Bill has not been litigated, physicians' fears are understandable to the extent that the practical application of the Bill is very uncertain.[247] In response to this criticism, physicians concerned about their potential liability should not necessarily practice defensive medicine, but they should ensure that they act thoroughly and precisely in regards to a patient's treatment.[248] In general, as long as physicians document their thought processes when they make

240. *Id.*

241. *Id.*

242. *See supra* Part IV (exploring the limitations on physicians' ability to issue DNRs).

243. *See supra* Part III.A (evaluating the strengths and weaknesses of the Bill).

244. *See Hearings on Tex. S.B. 11 Before the Senate Comm. on Health & Human Servs.*, 85th Leg., Spec. Sess. (Tex. 2017) (statement by Missy Atwood on behalf of Texas Hospital Association in opposition to Senate Bill 11). In other words, because of the complex nature of the Bill, physicians will more easily fail to comply with the requirements. *Id.* If, more often than not, physicians incorrectly comply with the Bill's requirements, then the complexity of the Bill will cause physicians to be liable for violations of the Bill more frequently than before. *Id.*

245. *Id.*

246. *See* Telephone Interview with Arturo Martinez, *supra* note 125 (explaining that he has not experienced any significant changes in how he issues DNR orders since the Bill was passed).

247. *See Hearings on Tex. S.B. 11 Before the Senate Comm. on Health & Human Servs.*, 85th Leg., Spec. Sess. (Tex. 2017) (statement by Missy Atwood on behalf of the Texas Hospital Association in opposition to Senate Bill 11).

248. *See* M. Sonal Sekhar & N Vyas, *Defensive Medicine: A Bane to Healthcare*, 3 ANNALS OF MED. & HEALTH SCI. RES. 295 (2013), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3728884/. Practicing defensive medicine means that a physician is going beyond what is required by normal medical practice in order to protect herself from malpractice litigation. *See id.* Defensive medicine is criticized because it increases healthcare costs and encourages physicians to perform unnecessary treatments on their patients. *See id.*

decisions and communicate with their patients, they should not have to worry about being sued.[249] So far, the Bill has not scared physicians into taking extra protective measures in DNR situations because more often than not, the courts will stand behind physicians acting in the best interest of their patients.[250] In other words, if physicians act professionally, then they will be fine.[251]

Granted, this recommendation, that physicians simply continue to act professionally, seems to direct physicians to "sit and wait."[252] Opponents of the Bill would argue that physicians cannot just wait to see how courts will interpret the Bill, and in the meantime, hope that they are acting in a way that future courts will approve.[253] The risk of liability is far too great for some physicians, and patients will pay the high price of death if physicians do not have better instructions on what the legislature wants them to do.[254] Still, based on Senator Perry's expressed intent behind the Bill, it is unlikely that a reasonably prudent, well-intentioned physician was on his mind when he sought to cure the secret DNR order problem.[255] Conceding that there is a great deal of uncertainty surrounding the Bill, it does not make sense for physicians to fear increased liability because of it.[256]

Additionally, the legislature should broaden the Bill to allow others apart from the attending physician, such as a physician who is not a patient's primary physician, to issue DNR orders.[257] The Bill requires that a patient's attending physician be the individual who issues a DNR order, and the ADA defines "attending physician" as the physician who has "primary responsibility for a patient's treatment and care."[258] According to one physician, this part of the Bill is what has caused the most change in how he issues DNR orders.[259] He explained how now, he has to actually be at the hospital to sign every DNR order, whereas before, certain other individuals could fill that role.[260] Although it makes sense that the physician with primary

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249. *See* Telephone Interview with Arturo Martinez, *supra* note 125 (explaining how he writes his notes as if a lawyer would be reading them).

250. *E.g.*, Marsala v. Yale-New Haven Hosp., 142 A.3d 316, 328 (Conn. App. Ct. 2016) (recognizing that courts respect physicians' medical judgment); *see* Telephone Interview with Arturo Martinez, *supra* note 125.

251. *See* Telephone Interview with Michael Economidis, *supra* note 18.

252. *See supra* notes 246–49 and accompanying text (explaining how physicians can avoid liability).

253. *See Hearings on Tex. S.B. 11 Before the Senate Comm. on Health & Human Servs.*, 85th Leg., Spec. Sess. (Tex. 2017) (statement by Missy Atwood on behalf of Texas Hospital Association in opposition to Senate Bill 11).

254. *See supra* notes 247–48 and accompanying text (noting that the unknown application of the Bill had led physicians to practice defensive medicine).

255. *See* S. Comm. on Health & Human Servs., Bill Analysis, Tex. S.B. 11, 85th Leg., 1st C.S. 1 (2017).

256. *See supra* notes 119–21 and accompanying text (noting how physicians can avoid liability).

257. *See supra* notes 123–25 and accompanying text (noting how DNR orders currently function).

258. TEX. HEALTH & SAFETY CODE ANN. §§ 166.002(3), .203.

259. Telephone Interview with Arturo Martinez, *supra* note 125.

260. *Id.*

responsibility for a patient should be the one to issue a DNR order for their patient, when it comes to convenience and efficiency, it would be easier for a patient to obtain a DNR order if this requirement was not in place.[261]

Consistent with the intent behind the Bill, allowing other physicians to issue DNR orders allows a patient to obtain an order when they want it without having to wait until her attending physician is present at the hospital.[262] Even if more individuals have the authority to issue DNR orders, there may be times when one of those individuals is either not at the hospital or is unavailable, so the patient will still have to wait to obtain a DNR order.[263] Nevertheless, broadening the Bill to allow more individuals to issue DNR orders would provide more flexibility for patients (a feature promoting patient autonomy) because they would be better able to make requests for DNR orders on their own time, as opposed to just when their attending physician is available.[264]

Finally, the legislature should amend the Bill to eliminate the redundancy caused because of the two levels of consent that are required before a physician can issue a valid DNR order.[265] This dual-consent requirement is not necessarily a bad thing because it ensures that the patient or their family is fully aware that a DNR order is being issued.[266] However, just like the previous recommendation, this recommendation is based on matters of efficiency and convenience.[267] The dual-consent requirement unnecessarily increases the burden on physicians when they issue DNR orders.[268] The burden is not wholly unreasonable, but it is still a requirement that does not need to be in place.[269]

It would be better practice to only require physicians to obtain consent from patients or their families during their initial discussion about issuing a DNR order but not right before the order is going to be executed.[270] To relieve fears about this change, physicians could be required to thoroughly document their discussions with patients to create a record showing that the patient or

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261. *See id.*

262. *See id.*

263. *See id.*

264. *See id.* The fact that discussions on DNR orders arise in emergency and end-of-life situations provides support for the argument that patients should not have to wait for their attending physician to arrive at the hospital to be able to obtain a DNR order. *See* Johnson, *supra* note 6; *Do-Not-Resuscitate Order*, *supra* note 6.

265. *See* TEX. HEALTH & SAFETY CODE ANN. § 166.203. As mentioned earlier, a physician first has to get consent from a patient or his family to issue a DNR order, and then the physician has to get consent from the patient or family again when she is actually going to issue the DNR order. *Id.*; *see* Telephone Interview with Michael Economidis, *supra* note 18.

266. *See supra* notes 104–05 and accompanying text (noting how dual consent can protect patients).

267. *See supra* note 261 and accompanying text (noting how removing the dual-consent requirement could improve efficiency).

268. *See* Telephone Interview with Michael Economidis, *supra* note 18.

269. *See id.*

270. *See id.*

their family did consent to the order.[271] With this requirement, there remains the risk that physicians may fabricate notes to make it seem like they discussed an order with a patient when they actually did not.[272] However, the fact that physicians know of the risks and consequences of being sued makes it unlikely that they would do that.[273] Again, the dual-consent requirement is not necessarily bad law but requiring only one level of consent would streamline the DNR process, which would facilitate patients' ability to obtain DNR orders when they want them and physicians' ability to meet those requests quickly.[274]

VI. VISITING HOURS ARE OVER

The enactment of Senate Bill 11 marked a major success for patients and patient advocates.[275] It made clear that patients are in control of their medical treatment and that when and how they choose to live or die is a decision only they (or their chosen agents or guardians) can make.[276] Nevertheless, the Bill has its shortcomings that must be redressed to allow it to properly achieve what its author and supporters believe it should achieve—protection of patients from predatory medical practices.[277] With the changes recommended above, the Bill will not only protect patients but also put physicians at ease by ensuring that the legislature is not overburdening their already complicated jobs.

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271. *See* Telephone Interview with Arturo Martinez, *supra* note 125 (explaining how he writes his notes as if a lawyer would be reading them).

272. *See id.*

273. *See id.*

274. *See supra* note 261 and accompanying text (noting how removing the dual-consent requirement can improve efficiency).

275. *See supra* note 144 and accompanying text (noting why proponents of the Bill support it).

276. *See supra* note 144 and accompanying text (exploring how patients will benefit from the Bill).

277. *See supra* note 248 and accompanying text (determining that physicians practicing defensive medicine are focusing on protecting themselves from malpractice liability).