Texas Natural Death Act: *Directive to Physicians*

Texas Medical Association

PHYSICIANS CARING FOR TEXANS

Guidelines and Directives

The Texas Legislature has enacted the Natural Death Act[1] which authorizes use of written directives in accordance with the guidelines set out below. The U.S. Congress has enacted the Patient Self Determination Act[2] which provides that information concerning written directives be provided to all adults at the time of admission as a hospital in-patient, at the time of admission as a skilled nursing facility resident, in advance of coming under the care of a home health agency, or at the time of initial receipt of hospice care.

Printed and distributed courtesy of the **Texas Medical Association Board of Councilors** 401 West 15th Street, Austin, Texas 78701-1680 512/370-1341.

12/93

Guidelines for Signers

General Information

If you are at least 18 years old, of sound mind, and acting on your own free will in the presence of two qualified witnesses, you may sign a DIRECTIVE TO PHYSICIANS (DIRECTIVE) concerning your own care. The DIRECTIVE allows you to instruct your physician not to use artificial methods to extend the natural process of dying. Before signing the DIRECTIVE, you may ask advice from anyone you wish, including your attorney.

If you sign the DIRECTIVE, talk it over with your physician and ask that it be made part of your medical record. If you have signed a written DIRECTIVE of which your doctor is unaware, and if you become physically or mentally unable to inform your doctor of its existence, another person may do so.

Witnesses

The DIRECTIVE must be WITNESSED by two adults who (1) are not related to you by blood or marriage, (2) are not mentioned in your will, and (3) would have no claim on your estate.

The DIRECTIVE may NOT BE WITNESSED by your physician or by anyone working for your physician. If you are in a health care facility at the time you sign the DIRECTIVE, none of its patients may be a witness, and none of its employees may be a witness if they are involved in providing direct patient care to you, or are directly involved in the financial affairs of the health care facility. You do not have to have your signature or your witnesses' signatures notarized before the DIRECTIVE is a legal document.

Effect of Directive

The DIRECTIVE does not become effective - meaning that no life-sustaining treatment can be withdrawn - until such time as you become a "qualified patient." You become a qualified patient only when you have been diagnosed and certified in writing to have a terminal condition by two physicians, one of whom is your attending physician, who have both personally examined you.

No one may force you to sign the DIRECTIVE. No one may deny you insurance or health care services because you have chosen not to sign it. If you do sign the DIRECTIVE, it will not affect your insurance or any other rights you may have to accept or reject medical treatment.

Your physician will be guided by the DIRECTIVE only (1) if he/she is satisfied that the DIRECTIVE is valid, and (2) if he/she and another doctor have certified your condition as terminal.

If your attending physician chooses not to follow the DIRECTIVE, he/she must make a reasonable effort to transfer responsibility for your care to another physician.

You are permitted to designate another person to make treatment decisions for you if you become comatose, lack the ability to understand the nature and consequences of a treatment decision or are otherwise mentally or physically incapable of communication. Doing so does not convert this document into a Durable Power of Attorney for Health Care, however.

You do not have to designate another person to make treatment decisions in order for the DIRECTIVE to be a legal document.

[1]Texas Health & Safety Code Ann., §672.001 (Vernon 1993).

[2]42 USC §1395cc(a)(1).

Revocation

The DIRECTIVE is valid until it is revoked. You may revoke the DIRECTIVE at any time, even in the final stages of a terminal illness. If you revoke the DIRECTIVE, be sure your physician is told of your decision. If you change your mind after executing a DIRECTIVE, your expressed desire to receive life-sustaining treatment will at all times supersede the effect of a DIRECTIVE.

Minors

If a qualified patient is under 18 years of age, any of the following persons may execute a DIRECTIVE on behalf of the patient: (1) the patient's spouse, if he/she is an adult; (2) the patient's parents; or (3) the patient's legal guardian. However, the desires of a competent qualified patient who is under 18 years of age shall always supersede a DIRECTIVE executed on his/her behalf. A form which may be executed on behalf of a minor is provided on the back of the form for adult patients.

Guidelines for Physicians

Introduction

This DIRECTIVE has no operative effect until two physicians diagnose and certify in writing that the patient has a "terminal condition" and that death is imminent whether or not "life-sustaining procedures" are utilized or will result within a relatively short time without application of such procedures. This fact must be noted in the patient's medical record. "Life-sustaining procedures" include mechanical or other "artificial means" which would sustain, restore or supplant vital functions of the patient but would only postpone the moment of death. These do not include medications or procedures deemed necessary to provide comfort or care or alleviate pain.

A "terminal condition" means an incurable or irreversible condition caused by injury, disease, or illness, which, without the use of life-sustaining procedures, would, within reasonable medical judgment, produce death, and where the use of life-sustaining procedures serves only to postpone the moment of the patient's death.

Under the Act a "qualified patient" is a person diagnosed and certified in writing to be afflicted with a terminal condition by two physicians, one of whom shall be the attending physician, who have personally examined the patient.

Carrying out a Directive

Upon receipt of a DIRECTIVE from a patient (qualified or unqualified) the attending physician must determine that the DIRECTIVE meets legal requirements before withdrawing or withholding any life sustaining treatment. The following steps are suggested:

1. Is the DIRECTIVE properly witnessed? (See WITNESSES above.)
2. Is the DIRECTIVE part of the patient's medical record? (Federal law requires all Medicare certified facilities to document whether a patient has executed a directive or written advance directive. Thus, a person signing a DIRECTIVE should present the document to his/her physician so that it can be made part of his/her current medical records.)
3. Is the patient a "qualified patient" ? (See definition of "qualified patient" above)
4. Is the treatment to be withheld or withdrawn truly a "life-sustaining treatment"? The Texas Attorney General rendered the opinion[3] that artificial or tube feeding may constitute a "life-sustaining procedure" under the Natural Death Act. In each individual case physicians must determine whether it serves to artificially prolong the moment of death, and this depends upon the expertise of physicians according to accepted medical standards. In any case, care should be taken that the patient's wishes be followed.
5. Has the patient designated another person to make treatment decisions for them?
6. Is the patient pregnant? (The DIRECTIVE is invalid and has no effect if the patient is pregnant at the time it is to be carried out).
7. Has the DIRECTIVE been revoked? (Should you receive such revocation from or on behalf of a patient who has previously signed a DIRECTIVE, enter that information promptly and prominently in the patient's current medical record).
8. Does the DIRECTIVE still reflect the patient's wishes?

Liability Questions

The law provides that a physician who carries out the DIRECTIVE is protected from civil and criminal liability, unless he/she acts negligently. However, if you do not choose to carry out the DIRECTIVE of a qualified patient, for whatever reason, you must make a reasonable effort to transfer the patient to another physician. No physician, health care facility, or other health care professional will be civilly or criminally liable for failure to carry out a DIRECTIVE if the person involved had no knowledge of the DIRECTIVE.

[3] Attorney General Opinion No. JM-837 (1987).

Directive to Physicians
For Persons 18 Years of Age and Over

DIRECTIVE made this _____ day _____ month, year).

I _____, being of sound mind, willfully, and voluntarily make **known** my desire that my life shall not be artificially prolonged under the circumstances set forth below, and do hereby declare:

1. If at any time I should have an incurable or irreversible condition caused by injury, disease, or illness certified to be a terminal condition by two physicians, and if the application of life-sustaining procedures would serve only to artificially prolong the moment of my death and where my attending physician determines that my death is imminent or will result within a relatively short time without application of life-sustaining procedures, I direct that such procedures be withheld or withdrawn, and that I be permitted to die naturally.
2. In the absence of my ability to give directions regarding the use of such life-sustaining procedures, it is my intention that this DIRECTIVE shall be honored by my family and physicians as the final expression of my legal right to refuse medical or surgical treatment and accept the consequences from such refusal.
3. If I have been diagnosed as pregnant and that diagnosis is known to my physician, this DIRECTIVE shall have no force or effect during the course of my pregnancy.
4. This DIRECTIVE shall be in effect until it is revoked.
5. I understand the full import of this DIRECTIVE and I am emotionally and mentally competent to make this DIRECTIVE.
6. I understand that I may revoke this DIRECTIVE at any time.
7. I understand that Texas law allows me to designate another person to make a treatment decision for me if I should become comatose, incompetent, or otherwise mentally or physically incapable of communication. I hereby designate

   _____, who resides at _____
   (print or type name)

   to make such a treatment decision for me if I should become incapable of communicating with my physician. If the person I have named above is unable to act on my behalf, I authorize the following person to do so:

   Name _____

   Address _____

   I have discussed my wishes with these persons and trust their judgment.

(NOTE: This clause is optional. You do not have to designate another person to make treatment decisions.)

Signed _____

City, County and State of Residence _____

Two witnesses must sign the DIRECTIVE in the spaces provided below.

I am not related to the declarant by blood or marriage. I would not be entitled to any portion of the declarant's estate on the declarant's death. I am not the attending physician of the declarant or an employee of the attending physician. I am not a patient in the health care facility in which the declarant is a patient. I have no claim against any portion of the estate of the declarant on the declarant's death. Furthermore, if I am an employee of a health facility in which the declarant is a patient, I am not involved in providing direct patient care to the declarant nor am I directly involved in the financial affairs of the health facility.

Witness _____

Witness _____

TEXAS LAW DOES NOT REQUIRE THIS DIRECTIVE TO BE NOTARIZED.

Directive to Physicians

For Persons Under 18 Years of Age

DIRECTIVE made this _____ day _____ (month, year).

On behalf of _____, a qualified patient under the Texas Natural

Death Act who is under 18 years of age, I/we _____, being of sound mind, willfully and voluntarily make known my/our desire that his/her life not be artificially prolonged under the circumstances set forth below, and do hereby declare:

1. If at any time the patient whose name appears above has an incurable or irreversible condition caused by injury, disease, or illness certified to be a terminal condition by two physicians, and if the application of life-sustaining procedures would serve only to artificially prolong the moment of his/her death and if his/her attending physician determines that his/her death is imminent or will result within a relatively short time without application of life-sustaining procedures, I/we direct that such procedures be withheld or withdrawn, and that he/she be permitted to die naturally.

2. On behalf of the said patient, it is my/our intention that this DIRECTIVE shall be honored by his/her physicians as the final expression of my/our legal right to refuse medical or surgical treatment on behalf of the said patient and to accept the consequences from such refusal.

3. If she has been diagnosed as pregnant and that diagnosis is known to her physician, this DIRECTIVE shall have no force or effect during the course of her pregnancy.

4. This DIRECTIVE shall be in effect until it is revoked. I/we understand that my/our authority to execute this DIRECTIVE on behalf of the above-named patient expires on his/her 18th birthday.

5. I/we understand the full import of this DIRECTIVE and I/we am/are emotionally and mentally competent to make this DIRECTIVE.

6. I/we understand that the desire of the above-named patient, if mentally competent, to receive life-sustaining treatment shall at all times supersede the effect of this DIRECTIVE.

Signed _____

City, County, and State of Residence _____

Indicate relationship to patient _____ Adult Spouse _____ Parents _____ Legal Guardian

Two witnesses must sign the DIRECTIVE in the spaces provided below.

I am not related to the declarant by blood or marriage. I would not be entitled to any portion of the declarant's estate on the declarant's death. I am not the attending physician of the declarant or an employee of the attending physician. I am not a patient in the health care facility in which the declarant is a patient. I have no claim against any portion of the estate of the declarant on the declarant's death. Furthermore, if I am an employee of a health facility in which the declarant is a patient, I am not involved in providing direct patient care to the declarant nor am I directly involved in the financial affairs of the health facility.

Witness _____

Witness _____

TEXAS LAW DOES NOT REQUIRE THIS DIRECTIVE TO BE NOTARIZED.

Figure: 25 TAC §157.25 (h)(2)

STOP DO NOT RESUSCITATE

TEXAS DEPARTMENT OF STATE HEALTH SERVICES
STANDARD OUT-OF-HOSPITAL DO-NOT-RESUSCITATE ORDER

This document becomes effective immediately on the date of execution. It remains in effect until the patient is pronounced dead by authorized medical or legal authority or the document is revoked. Comfort measures will be given as needed.

All persons who sign the form must sign again under number 3.

1. _____ **Date of Birth:** _____ **Male/Female** (Circle One)

Patient's full legal name — printed or typed

2. COMPLETE ONE OF THE FOUR BOXES: **A, B, C,** or **D.** If using Box **A, B,** or **C,** Witnesses and Physician's Statement must be completed.

A. **Patient's Statement:** I, the undersigned, am an adult capable of making an informed decision regarding the withholding or withdrawing of CPR, including the treatments listed below, and I direct that none of the following resuscitation measures be initiated or continued: **Cardiopulmonary Resuscitation (CPR), Transcutaneous Cardiac Pacing, Defibrillation, Advanced Airway Management, Artificial Ventilation.**

Signature _____ Date _____ Printed or Typed Name _____

B. **Only use this box if the order is being completed by a person acting on behalf of an adult patient who is incompetent or otherwise unable to make his or her wishes known.**

I am the patient's: ☐ legal guardian; ☐ agent under Medical Power of Attorney; ☐ or Qualified Relative (see back); **AND:**

☐ I attest to issuance of an Out-of-Hospital DNR by the patient by nonwritten means of communication; **OR**
☐ I am acting under the guidance of a prior Directive to Physicians; **OR**
☐ I am acting upon the known values and desires of the patient; **OR**
☐ I am acting in the patient's best interest based upon the guidance given by the patient's physician.

I direct that none of the following resuscitation measures be initiated or continued on behalf of the patient: Cardiopulmonary Resuscitation (CPR), Transcutaneous Cardiac Pacing, Defibrillation, Advanced Airway Management, Artificial Ventilation.

Signature _____ Date _____ Printed or Typed Name _____

C. **Only use this box if the order is being completed by a person acting on behalf of a minor patient who has been diagnosed with a terminal or irreversible condition.**

I am the minor patient's: ☐ Parent; ☐ legal guardian; or ☐ managing conservator.

I direct that none of the following resuscitation measures be initiated or continued on behalf of the patient: Cardiopulmonary Resuscitation (CPR), Transcutaneous Cardiac Pacing, Defibrillation, Advanced Airway Management, Artificial Ventilation.

Signature _____ Date _____ Printed or Typed Name _____

WITNESSES: (see qualifications on reverse) We have witnessed all of the above signatures.

Witness 1 Signature _____ Date _____ Witness Printed or Typed Name _____

Witness 2 Signature _____ Date _____ Witness Printed or Typed Name _____

PHYSICIAN'S STATEMENT: I, the undersigned, am the attending physician of the patient named above. I have noted the existence of this order in the patient's medical records, and I direct out-of-hospital health care professionals to comply with this order as presented.

Date _____ Physician's signature _____ Printed name _____ License number _____

D. **Only use this box if the order is being completed by two physicians acting on behalf of an adult who is incompetent or otherwise unable to make his or her wishes known, and who is without a legal guardian, agent, or qualified relative.**

☐ I attest to issuance of an Out-of Hospital DNR by the patient by nonwritten communication; **OR:**
☐ The patient's specific wishes are unknown, but resuscitation measures are, in reasonable medical judgement, considered ineffective in these circumstances or are otherwise not in the best interest of the patient.

I direct that none of the following resuscitation measures be initiated or continued on behalf of the patient: Cardiopulmonary Resuscitation (CPR), Transcutaneous Cardiac Pacing, Defibrillation, Advanced Airway Management, Artificial Ventilation.

Signature _____ Treating Physician Date _____ Printed or Typed Name _____

Signature Second Physician who is not involved in treating the patient _____ Date _____ Printed or Typed Name _____

3. **ALL PERSONS WHO SIGNED MUST SIGN HERE (Pursuant to H&SC 166.083(b)(13). This document has been properly completed.**

Signature of Patient, Agent or Relative (A, B, or C) _____ Signature of Second Physician (D) _____ Signature of Attending Physician _____

Signature of Witness _____ Signature of Witness _____ Date _____

SHOULD TRANSPORT OCCUR, THIS DOCUMENT OR A COPY MUST ACCOMPANY THE PATIENT.

Figure: 25 TAC §157.25 (h)(2)

OUT-OF-HOSPITAL DNR INSTRUCTIONS

PURPOSE:
This form was designed to comply with the requirements as set forth in Chapter 166 of the Health and Safety Code (H&SC) relating to the issuance of Out-of-Hospital Do-Not-Resuscitate (DNR) orders for the purpose of instructing Emergency Medical Personnel and other health care professionals to forgo resuscitation attempts and to permit the patient to have a natural death with peace and dignity. This order does NOT affect the provision of other emergency care including comfort care.

APPLICABILITY:
This form applies to all health care professionals operating in any out-of-hospital setting to include hospital outpatient or emergency departments and physician's offices.

IMPLEMENTATION:
A competent adult may execute or issue an Out-of-Hospital DNR Order. The patient's attending physician will document the existence of the directive in the patient's permanent medical record.

If an adult patient is capable of providing informed consent for the order, he/she will sign and date the out-of-hospital DNR order on the front of this sheet in Box A. In the event that an adult patient is unable to provide informed consent, his/her Legal Guardian, agent under Medical Power of Attorney, or Qualified Relative may execute the order by signing and dating the form in Box B. If an adult patient is unable to provide informed consent and none of the persons listed in Box B are available, the treating physician may execute the order using Box D with the consent of a second physician who is not treating the patient and/or is a member of the health care facility ethics committee or other medical committee.

The following persons may execute an out-of-hospital DNR order on behalf of a minor: the minor's parents, the minor's legal guardian or the minor's managing conservator. A person executing a DNR order on behalf of a minor may execute the order by signing and dating the form in Box C. **An out-of-hospital DNR order may not be executed unless the minor has been diagnosed by a physician as suffering from a terminal or irreversible condition.**

The form must be signed and dated by two witnesses except when executed by two physicians only (Box D).

The original standard Texas Out-of-Hospital DNR form must be completed and properly executed. Duplicates may be made by the patient, health care provider organization or attending physician as necessary. **Copies of this completed document may be used for any purpose that the original may be used and shall be honored by responding health care professionals.**

The presence of a Texas DNR identification device on a person is sufficient evidence that the individual has a valid Out-of-Hospital DNR Order. Therefore, either the original standard form, a copy of the completed standard form, or the device is sufficient evidence of the existence of the order.

For information on ordering identification devices or additional forms, contact the Texas Department of State Health Services at (512) 834-6700.

REVOCATION:
The Out-of-Hospital Do-Not-Resuscitate Order may be revoked at ANY time by the patient **OR** the patient's Legal Guardian/Agent/Managing Conservator/Qualified Relative, Parent (if a minor), or physician who executed the order. The revocation may involve the communication of wishes to responding health care professionals, destruction of the form, or removal of all or any Do-Not-Resuscitate identification devices the patient may possess.

AUTOMATIC REVOCATION: This Out-of-Hospital DNR order is automatically revoked if the patient is known to be pregnant or in the case of unnatural or suspicious circumstances.

DEFINITIONS:
Attending Physician: The physician who is selected by or assigned to a patient who has primary responsibility for a person's treatment and care and is licensed by the Texas State Board of Medical Examiners or who is properly credentialed and holds a commission in the uniformed services of the United States and who is serving on active duty in this state. **(H&SC 166.002 (3) & (12))**

Qualified Relatives: Those persons authorized to execute or issue an out-of-hospital DNR order on behalf of a person who is comatose, incompetent, or otherwise mentally or physically incapable of communication under Section 166.088 H&SC Section 166.088 refers to 166.039; "One person, if available, from one of the following categories, in the following priority...: (1) The patient's spouse; (2) the patient's reasonably available adult children; (3) the patient's parents; or (4) the patient's nearest living relative."

Health Care Professional: Means physicians, nurses, physician assistants and emergency medical services personnel, and, unless the context requires otherwise, includes hospital emergency department personnel. (H&SC 166.081 (5))

Witnesses: Two competent adult witnesses must sign the form acknowledging the signature of the patient or the person(s) acting on the patient's behalf (except when signed by two physicians in Section C). Witness One must meet the qualifications listed below. Witness Two may be any competent adult. Witness One (the "qualified" witness) may not be: (1) person designated to make a treatment decision for the patient; (2) related to the patient by blood or marriage; (3) entitled to any part of the estate; (4) be a person who has a claim against the estate of the patient; (5) the attending physician or an employee of the attending physician; (6) an employee of a health care facility in which the patient is being cared for, if he or she is involved in providing direct patient care to the patient; or (7) an officer, director, partner, or business office employee of a health care facility in which the patient is being cared for or any parent organization of the health care facility.

Please report any problems with this form to the Texas Department of State Health Services at (512) 834-6700.

Revised July 19, 2005
Texas Department of State Health Services