TEXAS NURSES ASSOCIATION

END OF LIFE

2018-2019 Policy Positions

BACKGROUND

Two cases set precedent for end-of-life decisions: Karen Ann Quinlan and Nancy Beth Cruzan. These cases involved patients who no longer had capacity to make health care decisions. Family and health care providers disagreed on management in the face of terminal or irreversible condition and the cases were settled in court.

In the case of Quinlan, her parents requested the hospital wean her from the ventilator, but the hospital refused.[1] The lower New Jersey court ruled in favor of the hospital. The New Jersey Supreme Court ruled in favor of the parents, basing their decision on the "Right to Privacy." This 1976 ruling determined a person's right to privacy did include the right to terminate treatment. The court also ruled a state's interest in protecting life diminishes as a person's right to privacy increases with the invasiveness of medical interventions.

In 1988, Nancy Beth Cruzan's family petitioned Missouri court to discontinue artificial nutrition and hydration.[2] Missouri probate judge Charles Teel, granted an order. Missouri's attorney general appealed to the state Supreme Court.[3] The higher court reversed Teel's ruling and determined there needed to be "clear and convincing evidence" that an incompetent patient (such as Cruzan) would have chosen to terminate treatment. This case was appealed to the United States Supreme Court affirmed the principle that a competent person has a constitutionally protected liberty in refusing unwanted medical treatment.

The case of Quinlan and Cruzan brought awareness to the issues surrounding end-of-life decisions, particularly for patients who can no longer communicate their wishes. Social consensus evolved concerning the right of a patient or a patient's family to refuse or to stop life-sustaining medical treatment, giving rise to the Federal Patient Self Determination Act of 1990, which gave consumers of health care the right to stipulate how they would like to

[1] In re Quinlan, 70 N.J. 10, 355 A.2d 647 (NJ 1976)
[2] Cruzan by Cruzan v. Harmon, 760 SW 2d 408 (MO 1988)
[3] Cruzan by Cruzan v. Director, Missouri Department of Health, 497 U.S. 261 (1990)

be treated. Wishes could be conveyed by Advance Directive or by appointing someone as a health care agent (Medical Power of Attorney). This was one of the first steps in creating a shared partnership between provider and consumer.

During this time, several laws were enacted in Texas. One of the earliest laws was the Texas Natural Death Act, enacted in 1977 to authorize physicians to carry out advance directives. Another important law enacted in 1989 was the Durable Power of Attorney for Health Care. This law allows patients to delegate the power to make health care decisions to another person if the patient is incapable of making such a decision. One of the most recent laws, enacted in 1995, created the Out-of-Hospital-Do-Not-Resuscitate Order, allowing patients to complete an order to prevent being resuscitated by emergency medical services personnel. These three provisions were located in different parts of the Texas legal code, which allowed for inconsistent interpretation and application. In 1999, the Texas Legislature combined the different provisions into one act, called the Advance Directives Act.

Advanced directives are crucial in communicating preferences for care in advanced, serious, or life-threating situations. A landmark study with several nurse authors, SUPPORT was a controlled trial to improve care for seriously ill hospitalized patients.[4] The objective was to improve end-of-life decision making and reduce the frequency of a mechanically supported, painful, and prolonged process of dying. This was a two-year prospective observational study with 43-1 patients followed by a two-year controlled clinical trial with 4,804 patients and their physicians randomized by specialty group to intervention group or control group. It involved five teaching hospitals in the United States. Results from the study revealed only 47% of physicians knew their patient's preference to avoid CPR, 46% of do-not-resuscitate (DNR) orders were written within two days of death; 38% of patients who died spent at least 10 days in an ICU; and for 50% of conscious patients who died in the hospital, family members reported moderate to severe pain at least 50% of the time.

Palliative care was only recognized as a distinct medical subspecialty in the 2000s. Ideally, palliative care would begin at or near the beginning of a terminal or life limiting diagnosis. At the time of diagnosis, palliative care plays a small part in the care of the patient; however, as the disease progresses and the patient's physical and cognitive function declines, palliative care becomes more important than curative or restorative care. Unfortunately, palliative services are consulted near the end of the disease, causing confusion between palliative and hospice care.

TNA POSITION

TNA supports the recommendations presented by American Nurses Association in the 2017 Call for Action: Nurses Lead and Transform Palliative Care, developed in partnership with organizational affiliate Hospice and Palliative Nurses Association, which addressed education, practice, administration, research, and policy. TNA supports the end-of-life related position statements that help to make up the ANA statement of Ethics and Human Rights and the ANA Code of Ethics for Nurses.

[4] Connors, A. F., et al. (1995). *JAMA 274(20)*,1591-1598. Retrieved from https://jamanetwork.com/journals/jama/article-abstract/400879.

TNA supports the original 1990 Patient Self-Determination Act, including education regarding an individual's rights under state law to make health care decisions and the right to refuse treatment. Toward this end, we support health care provider education, initiatives that encourage the public to complete advance directives and appointing a medical power of attorney consistent with Texas law.

TNA supports medical powers of attorneys as useful tools for advance care planning but does not support the issuance of more than one primary medical power of attorney. Having multiple primary medical powers of attorney causes confusion for patients, families, and health care staff.

TNA supports efforts to avoid unnecessary patient suffering from non-beneficial, unnecessary, or unwanted treatments.

TNA supports person-centered care that includes Goals of Care conversations and education that is sensitive to cultural and spiritual values, and emotional and biophysical needs. Discussions should encourage engagement of the patient and family as partners in advance care planning. Such conversations should be honest, compassionate, and factual. TNA supports establishment of training, resources, and tools in multiple languages and made available across the state.

TNA supports the direct involvement of key stakeholders in the development of any end-of-life related legislation, especially nursing.

TNA supports education for health profession students, clinicians, and the general public to increase awareness of the meaning and purpose of palliative supportive care and hospice care. The goals would be more appropriate use of resources, and more timely referrals.

TNA supports team-based solutions and strategies that fully engage RNs, APRNs and other professionals in the guidance of patient and family decision making and advance care planning.[5]

TNA supports targeted research and the development of useful data that can be provided to legislators, health care administrators and clinical specialists to better formulate solutions.

TNA opposes any effort to expect or coerce a nurse to participate in or be present for euthanasia, assisted suicide, or medical aid in dying.

LEGISLATIVE HISTORY

SB 11 (2017 1ST C.S. — PASSED)

Established requirements for in-hospital DNR orders. They must be issued by the attending physician and directed by a competent patient or their guardian. Also provides procedures for executing DNR orders.

[5] Hebert, K., Moore, H., Rooney, J. (2011). The Nurse Advocate in End-of-Life Care. *The Oschner Journal* 11(4): 325–329. Retrieved from https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3241064/.

HB 995 (2017 — PASSED)

Provided that an agent's authority under medical power of attorney is revoked if the marriage to the principal is dissolved, annulled, or declared void. Modified the medical power-of-attorney form to explain the legal significance of the document.

HB 439 (2017 — LEFT PENDING IN COMMITTEE)

Would have repealed laws that invalidate DNR orders when the patient is known to be pregnant.

HB 919 (2017 — PASSED)

As filed, would have allowed APRNs and PAs to sign death certificates and out-of-hospital DNR orders. The version of the bill passed only allowed APRNs to sign death certificates.

HB 2949 (2015 — REFERRED TO COMMITTEE)

Would have required facilities to file an application for appointment of temporary guardianship if no legal guardian or relative is available. Would have also applied out-of-hospital DNR orders laws to in-hospital DNRs.

AMERICAN NURSES ASSOCIATION RESOURCES

Call for Action: Nurses Lead and Transform Palliative Care

Nurses' Roles and Responsibilities in Providing Care and Support at the End of Life

Nursing Care and Do Not Resuscitate (DNR) and Allow Natural Death (AND) Decisions

Nutrition and Hydration at the End of Life