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Objectives

- Define “Advance Directive”;
- Provide examples of Advance Directives;
- Identify who can serve as a witness to an Advance Directive;
- Identify signature requirements for an Advance Directive; and
- Identify licensing requirements regarding Advance Directives.
DISCLAIMER

The purpose of this presentation is not to offer legal advice, but to walk you through statutory and regulatory requirements for Home and Community Support Services Agencies regarding Advance Directives. Consult your attorney if you have specific questions regarding your legal obligations and risks.

What are Advance Directives?

“Advance directives are legal documents that allow you to convey your decisions about end-of-life care ahead of time. They provide a way for you to communicate your wishes to family, friends and health care professionals, and to avoid confusion later on.”

See, https://hhs.texas.gov/laws-regulations/forms/advance-directives
The Center for Medicare and Medicaid Services (“CMS”) State Operations manual, Appendix M – Guidance to Surveyors: Hospice (“SOM”), indicates in its Interpretive Guidelines that Advanced Directives generally are:

“...refer to written statements or instructions, completed in advance of a serious illness, about how an individual wants medical decisions made.”

Available at: https://www.cms.gov/Medicare/Provider-Enrollment-and-Certification/GuidanceforLawsAndRegulations/Hospice

Texas requirements for Advanced Directives are detailed in the Advance Directives Act (“ADA”), previously the “Natural Death Act”, available at:

https://statutes.capitol.texas.gov/Docs/HS/htm/HS.166.htm#166.032
The ADA defines Advance Directives as:

1. a written instruction made by a competent adult; a nonwritten instruction by a competent qualified patient who is an adult; or a written instruction executed on behalf of a patient younger than 18 years of age; to administer, withhold, or withdraw life-sustaining treatment in the event of a terminal or irreversible condition;

2. an out-of-hospital DNR order, as that term is defined by Section 166.081; or

3. a medical power of attorney.

The ADA allows affirmative acts to permit the natural process of dying under strict regulatory guidelines. It does not condone, authorize, or approve mercy killing or permit an affirmative or deliberate act or omission to otherwise end life.
A competent adult is:

An adult who possesses the ability, based on reasonable medical judgment, to understand and appreciate the nature and consequences of a treatment decision, including the significant benefits and harms of and reasonable alternatives to a proposed treatment decision.

An adult competent qualified patient is:

1. a competent adult patient;

2. with a terminal or irreversible condition that has been diagnosed and certified in writing by the attending physician.
To administer, withhold or withdraw life sustaining treatment means to:

Administer, withhold, or withdraw treatment that, based on reasonable medical judgment, sustains the life of a patient and without which the patient will die. The term includes: Life-sustaining medications and artificial life support, such as mechanical breathing machines, kidney dialysis treatment, and artificially administered nutrition and hydration.

Life sustaining treatment does not include:

1. the administration of pain management medication;

2. the performance of a medical procedure considered to be necessary to provide comfort care;

3. or any other medical care provided to alleviate a patient's pain.
"Irreversible condition" means:

a condition, injury, or illness:

• 1. that may be treated but is never cured or eliminated;

• 2. that leaves a person unable to care for or make decisions for the person's own self; and

• 3. that, without life-sustaining treatment provided in accordance with the prevailing standard of medical care, is fatal.

"Terminal condition" means:

an incurable condition caused by injury, disease, or illness that according to reasonable medical judgment will produce death within six months, even with available life-sustaining treatment provided in accordance with the prevailing standard of medical care.
A patient who has been admitted to a program under which the person receives hospice services provided by a home and community support services agency licensed in Texas is presumed to have a terminal condition for purposes of the ADA.

"Out-of-hospital DNR order" is:

a. a “legally binding out-of-hospital do-not-resuscitate order, in the form specified by department rule under Section 166.083, prepared and signed by the attending physician of a person, that documents the instructions of a person or the person's legally authorized representative and directs health care professionals acting in an out-of-hospital setting not to initiate or continue the following life-sustaining treatment:
"Out-of-hospital DNR order" definition - continued

(i) cardiopulmonary resuscitation;
(ii) advanced airway management;
(iii) artificial ventilation;
(iv) defibrillation;
(v) transcutaneous cardiac pacing; and
(vi) other life-sustaining treatment specified by department rule under Section 166.101(a); and

b. does not include authorization to withhold medical interventions or therapies considered necessary to provide comfort care or to alleviate pain or to provide water or nutrition.

See: https://statutes.capitol.texas.gov/Docs/HS/htm/HS.166.htm#166.088
"Medical power of attorney" means:

a document delegating to an agent authority to make health care decisions executed or issued under Subchapter D of the ADA.

26 Tex. Admin. Code §558.283

Mirrors the ADA requirements in section 166.004.

This rule regarding minimum licensing standards for all home and community support services agencies indicates that:

“(a) An agency must maintain a written policy regarding implementation of advance directives. The policy must comply with the Advance Directives Act, Texas Health and Safety Code Chapter 166. The policy must include a clear and precise statement of any procedure the agency is unwilling or unable to provide or withhold in accordance with an advance directive.”
26 Tex. Admin. Code §558.283 - continued

(b) The agency must provide written notice to a client of the written policy required by subsection (a) of this section. The notice must be provided at the earlier of:

(1) the time the client is admitted to receive services from the agency; or
(2) the time the agency begins providing care to the client.

26 Tex. Admin. Code §558.283 - continued

“(c) If, at the time notice must be provided under subsection (b) of this section, the client is incompetent or otherwise incapacitated and unable to receive the notice, the agency must provide the required written notice, in the following order of preference, to:

(1) the client's legal guardian;
(2) a person responsible for the health care decisions of the client;
(3) the client's spouse;
(4) the client's adult child;
(5) the client's parent; or
(6) the person admitting the client.”
“(d) If subsection (c) of this section applies, except as provided by subsection (e) of this section, if an agency is unable, after a diligent search, to locate an individual listed by subsection (c) of this section, the agency is not required to provide the notice.”

“(e) If a client who was incompetent or otherwise incapacitated and unable to receive the notice required by this section, at the time notice was to be provided under subsection (b) of this section, later becomes able to receive the notice, the agency must provide the written notice at the time the client becomes able to receive the notice.”
26 Tex. Admin. Code §558.283 - continued

“(f) DADS assesses an administrative penalty of $500 without an opportunity to correct against an agency that violates this section.”

26 Tex. Admin. Code §558.301 – Client Records

Indicates in pertinent part: (a) In accordance with accepted principles of practice, an agency must establish and maintain a client record system to ensure that the care and services provided to each client are completely and accurately documented, readily accessible and systematically organized to facilitate the compilation and retrieval of information.

... (9) Each client record must include the following elements as applicable to the scope of services provided by the agency:

... (O) acknowledgement of receipt of the notice of advance directives;

Failure to comply is a Severity Level A violation ($100 to $250 per violation)
26 Tex. Admin. Code §558.880

This rule applies to the provision of hospice care to a Resident of a Skilled Nursing Facility, Nursing Facility, or Intermediate Care Facility for Individuals with an Intellectual Disability or Related Condition.

Subsection d regarding coordination of services indicates that, In addition to the requirements in §558.288 of this chapter (relating to Coordination of Services) and §558.823 of this subchapter (relating to Coordination of Services by the Hospice), a hospice must:

(3) provide the SNF, NF, or ICF/IID with:

... 

(B) the hospice election form and any advance directives specific to the client.

Failure to comply with this requirement is a Severity Level B violation with a penalty between $500 and $1000 per violation.
Medicare Conditions of Participation

“CMS develops Conditions of Participation (CoPs) and Conditions for Coverage (CfCs) that health care organizations must meet in order to begin and continue participating in the Medicare and Medicaid programs. These health and safety standards are the foundation for improving quality and protecting the health and safety of beneficiaries. CMS also ensures that the standards of accrediting organizations recognized by CMS (through a process called "deeming") meet or exceed the Medicare standards set forth in the CoPs / CfCs.”

https://www.cms.gov/Regulations-and-Guidance/Legislation/CFCsAndCoPs

42 CFR 489.102 regarding Standards and Certification

Subsection a requires hospitals, critical access hospitals, skilled nursing facilities, nursing facilities, home health agencies, providers of home health care (and for Medicaid purposes, providers of personal care services), hospices, and religious nonmedical health care institutions to maintain written policies and procedures concerning advance directives with respect to all adult individuals receiving medical care, or patient care in the case of a patient in a religious nonmedical health care institution, by or through the provider and are required to:
42 CFR 489.102(a) - continued

“(1) Provide written information to such individuals concerning:

(i) An individual's rights under State law (whether statutory or recognized by the courts of the State) to make decisions concerning such medical care, including the right to accept or refuse medical or surgical treatment and the right to formulate, at the individual's option, advance directives. Providers are permitted to contract with other entities to furnish this information but are still legally responsible for ensuring that the requirements of this section are met. Providers are to update and disseminate amended information as soon as possible, but no later than 90 days from the effective date of the changes to State law; and

(ii) The written policies of the provider or organization respecting the implementation of such rights, including a clear and precise statement of limitation if the provider cannot implement an advance directive on the basis of conscience. At a minimum, a provider's statement of limitation should:

(A) Clarify any differences between institution-wide conscience objections and those that may be raised by individual physicians;

(B) Identify the state legal authority permitting such objection, and

(C) Describe the range of medical conditions or procedures affected by the conscience objection.
42 CFR 489.102(a) - continued

(2) Document in a prominent part of the individual’s current medical record, or patient care record in the case of an individual in a religious nonmedical health care institution, whether or not the individual has executed an advance directive;

(3) Not condition the provision of care or otherwise discriminate against an individual based on whether or not the individual has executed an advance directive;

(4) Ensure compliance with requirements of State law (whether statutory or recognized by the courts of the State) regarding advance directives. The provider must inform individuals that complaints concerning the advance directive requirements may be filed with the State survey and certification agency;

42 CFR 489.102(a) - continued

(5) Provide for education of staff concerning its policies and procedures on advance directives, and

(6) Provide for community education regarding issues concerning advance directives that may include material required in paragraph (a)(1) of this section, either directly or in concert with other providers and organizations. Separate community education materials may be developed and used, at the discretion of providers. The same written materials do not have to be provided in all settings, but the material should define what constitutes an advance directive, emphasizing that an advance directive is designed to enhance an incapacitated individual’s control over medical treatment, and describe applicable State law concerning advance directives. A provider must be able to document its community education efforts.
42 CFR 489.102(b)(3)

(i) In the case of a home health agency, in advance of the individual coming under the care of the agency. The HHA may furnish advance directives information to a patient at the time of the first home visit, as long as the information is furnished before care is provided.

(ii) In the case of personal care services, in advance of the individual coming under the care of the personal care services provider. The personal care provider may furnish advance directives information to a patient at the time of the first home visit, as long as the information is furnished before care is provided.

42 CFR 489.102(b)(4)

In the case of a hospice program, the information required under subsection a must be provided to the client, at the time of initial receipt of hospice care by the individual from the program.
42 CFR 489.102(c)

Home Health and Hospice agencies:

1. Are not required to provide care that conflicts with an advance directive; and

2. Are not required to implement an advance directive if, as a matter of conscience, it cannot implement an advance directive and State law allows the hospice to conscientiously object.

If an adult individual is incapacitated at the time of admission or at the start of care and is unable to receive information (due to the incapacitating conditions or a mental disorder) or articulate whether or not he or she has executed an advance directive, then the hospice may give advance directive information to the individual's family or surrogate in the same manner that it issues other materials about policies and procedures to the family of the incapacitated individual or to a surrogate or other concerned persons in accordance with State law. The hospice is not relieved of its obligation to provide this information to the individual once he or she is no longer incapacitated or unable to receive such information.

CoPs for Medicare Certified Home Health Agencies

G574 - 42 C.F.R. §484.60(a)(2)(xv) – The individualized plan of care must include, among others, information related to any advanced directives.
L503 – §418.52(a)(2) - The hospice must comply with the requirements of subpart I of part 489 of this chapter regarding advance directives. The hospice must inform and distribute written information to the patient concerning its policies on advance directives, including a description of applicable State law.


A clinical record containing past and current findings is maintained for each hospice patient. The clinical record must contain correct clinical information that is available to the patient's attending physician and hospice staff. The clinical record may be maintained electronically.

(a) Standard: Content. Each patient's record must include the following:

... 
(6) Any advance directives as described in § 418.52(a)(2).
L781 – 42 CFR §418.112(e)(3)

Requires hospice agencies to provide the SNF/NF or ICF/IID with the following information:

...  

(ii) Hospice election form and any advance directives specific to each patient...

These advance directives can take many names and forms, besides those identified by the ADA. At the end of the day, compliance with legal requirements is what makes the document, not the name.
According to the Hospice SOM’s Interpretative Guidelines:

“The two most common forms of advance directives are a living will and a durable medical power of attorney for health care. It is the patient’s right to formulate an advance directive should he/she wish to do so. The patient’s admission to hospice should not be affected by his/her desire not to formulate an advance directive or by the contents of an advance directive. There may be State specific requirements for advance directives that must be followed.”

Texas Health and Human Services - Advance Directives

Texas Health and Human Services identifies the following Advance Directives and provides information and forms for providers and customers:

1. Declaration of Mental Health Treatment;
2. Directive to Physicians and Family or Surrogates;
3. Medical Power of Attorney; and
PLEASE REMEMBER

A Statutory Durable Power of Attorney is used to designate someone to make decisions regarding one’s property to someone else, not to make medical decisions.

Enforceability of Foreign Advance Directive

An advance directive or similar document validly executed in another state or jurisdiction shall be given the same effect as a one executed under Texas law, as long as the administration, withholding, or withdrawal of health care is not otherwise prohibited by the laws of Texas.

If there is conflict between 2 or more directives, the latest one executed will control.

Sec. 166.005
Insurance Policy and Premiums

You cannot restrict, inhibit, or impair in any manner the sale, procurement, or issuance of a life insurance policy to a person; or (2) modify the terms of an existing life insurance policy of a person, just because such person has executed or issued an advance directive.

Sec. 166.006(1)

Insurance Policy and Premiums - continued

Electing to have life-sustaining treatment withheld or withdrawn does not legally impair or invalidate that person's life insurance policy and may not be a factor for the purpose of determining, under the life insurance policy, whether benefits are payable or the cause of death, nor can be considered in any way in establishing insurance premiums.
Insurance Policy and Premiums - continued

“A physician, health facility, health care provider, insurer, or health care service plan may not require a person to execute or issue an advance directive as a condition for obtaining insurance for health care services or receiving health care services.”

Sec. 166.007

Who can be a Witness to an Advance Directive?

Whenever the ADA requires an advance directive or the issuance of a nonwritten advance directive to be witnessed:

(1) each witness must be a competent adult; and
(2) at least one of the witnesses must be a person who is not:

(A) a person designated by the declarant to make a health care or treatment decision;
(B) a person related to the declarant by blood or marriage;
(C) a person entitled to any part of the declarant's estate after the declarant's death under a will or codicil executed by the declarant or by operation of law;
(D) the attending physician;
(E) an employee of the attending physician;
Who can be a Witness to an Advance Directive? - continued

(F) an employee of a health care facility in which the declarant is a patient if the employee is providing direct patient care to the declarant or is an officer, director, partner, or business office employee of the health care facility or of any parent organization of the health care facility; or

(G) a person who, at the time the written advance directive is executed or, if the directive is a nonwritten directive issued under the ADA, at the time the nonwritten directive is issued, has a claim against any part of the declarant's estate after the declarant's death.

Signature Requirements

For an advance directive in which a signature by a declarant, witness, or notary public is required or used, the declarant, witness, or notary public may sign the directive or a written revocation of the directive using:

(1) a digital signature that:
   (A) uses an algorithm approved by the department;
   (B) is unique to the person using it;
   (C) is capable of verification;
   (D) is under the sole control of the person using it;
   (E) is linked to data in a manner that invalidates the digital signature if the data is changed;
   (F) persists with the document and not by association in separate files; and
   (G) is bound to a digital certificate; or
Signature Requirements - continued

(2) an electronic signature that:

(A) is capable of verification;
(B) is under the sole control of the person using it;
(C) is linked to data in a manner that invalidates the electronic signature if the data is changed; and
(D) persists with the document and not by association in separate files.

Signature Requirements - continued

In approving an algorithm for purposes of Subsection (a)(1)(A), the department may consider an algorithm approved by the National Institute of Standards and Technology.
"Digital signature" means an electronic identifier intended by the person using it to have the same force and effect as the use of a manual signature.

"Electronic signature" means a facsimile, scan, uploaded image, computer-generated image, or other electronic representation of a manual signature that is intended by the person using it to have the same force and effect of law as a manual signature.

You can find details about the digital signature algorithm approved by the National Institute of Standards and Technology (“NIST”) by using the following link:

Signature Requirements - continued

The NIST’s definition of digital signature can be found by following this link:


“As an electronic analogue of a written signature, a digital signature provides assurance that:

1. the claimed signatory signed the information, and
2. the information was not modified after signature generation.”

Follow the same link for information approved digital signature algorithms and signature standards:

“DSA, RSA, and ECDSA. All three are used to generate and verify digital signatures, in conjunction with an approved hash function specified in FIPS 180-4, Secure Hash Standard or FIPS 202, SHA-3 Standard: Permutation-Based Hash and Extendable-Output Functions.”

Requirements for Different Types of Advance Directives in the ADA
Written Directive by Competent Adult

a. competent adult may execute a written directive at any time.

b. The declarant must sign the directive in the presence of two qualified witnesses, one of which must meet the requirements of Section 166.003(2), discussed above.

c. The witnesses must sign the directive.

d. The declarant, in lieu of signing in the presence of witnesses, may sign the directive and have the signature acknowledged before a notary public.

e. A declarant may include in a directive directions other than those suggested under the ADA Section 166.033. Suggested form and language available.

Written Directive by Competent Adult - Continued

f. A declarant may designate in a directive a person to make a health care or treatment decision for the declarant in the event the declarant becomes incompetent or otherwise mentally or physically incapable of communication.

g. A declarant shall notify the attending physician of the existence of a written directive.

h. If the declarant is incompetent or otherwise mentally or physically incapable of communication, another person may notify the attending physician of the existence of the written directive.

i. The attending physician shall make the directive a part of the declarant's medical record.

The directive will be valid until revoked.
Nonwritten Directive

A competent qualified patient who is an adult may issue a directive by a nonwritten means of communication.

It must be issued in the presence of the attending physician and two witnesses who qualify under Section 166.003, at least one of whom must be a witness who qualifies under Section 166.003(2).

The physician shall make the fact of the existence of the directive and the identity of the witnesses a part of the declarant's medical record.

Directive on behalf of a minor

A directive for a qualified patient who is under 18 years of age may be executed by:

(1) the patient's spouse, if the spouse is an adult;
(2) the patient's parents; or
(3) the patient's legal guardian.
Except as previously specified regarding absence of witnesses, the written directive will be effective regardless of whether it was notarized.

Healthcare providers cannot require patients to use a specific form.

Patient can change his or her mind

The patient’s desire, even a minor patient, supersedes the directive.

Directives can be revoked or reexecuted.
Incompetence or Incapacity after Execution of Written Directive

When an adult qualified patient has executed or issued a directive and is incompetent or otherwise mentally or physically incapable of communication.

a. If the adult qualified patient has designated a person to make a treatment decision, the attending physician and the designated person may make a treatment decision in accordance with the declarant's directions.

b. If the adult qualified patient has not designated a person to make a treatment decision, the attending physician shall comply with the directive unless the physician believes that the directive does not reflect the patient's present desire.

Incompetence or Incapacity of Patient without a Written Directive

If an adult qualified patient has not executed or issued a directive and is incompetent or otherwise mentally or physically incapable of communication:

a. the attending physician and the patient's legal guardian or an agent under a medical power of attorney may make a treatment decision that may include a decision to withhold or withdraw life-sustaining treatment from the patient.
Incompetence or Incapacity of Patient without a Written Directive - continued

b. If the patient does not have a legal guardian or an agent under a medical power of attorney, the attending physician and one person, if available, from one of the following categories, in the following priority, may make a treatment decision that may include a decision to withhold or withdraw life-sustaining treatment:

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.

This decision must be documented in the patient’s medical record and signed by the attending physician.

c. Under (a) or (b) above, decision must be based on knowledge of what the patient would desire, if known.

d. If the patient does not have a legal guardian and a person listed in Subsection (b) is not available, a treatment decision made under Subsection (b) must be concurred in by another physician who is not involved in the treatment of the patient or who is a representative of an ethics or medical committee of the health care facility in which the person is a patient.

e. Failure to execute directive not controlling regarding patient’s desire. The fact that an adult qualified patient has not executed or issued a directive does not create a presumption that the patient does not want a treatment decision to be made to withhold or withdraw life-sustaining treatment.
Incompetence or Incapacity of Patient without a Written Directive - continued

g. A person listed in Subsection (b) who wishes to challenge a treatment decision must apply for temporary guardianship under Chapter 1251, of the Texas Estates Code. The court may waive applicable fees in that proceeding.

Pre-requisite for Complying with Directive

An attending physician who has been notified of the existence of a directive shall provide for the declarant's certification as a qualified patient on diagnosis of a terminal or irreversible condition.

Before withholding or withdrawing life-sustaining treatment from a qualified patient, the attending physician must determine that the steps proposed to be taken are in accord with the ADA and the patient's existing desires.
Revocation of Directive

A declarant may revoke a directive at any time without regard to the declarant's mental state or competency.

Who can revoke a directive?

A directive may be revoked by:

(1) the declarant or someone in the declarant's presence and at the declarant's direction canceling, defacing, obliterating, burning, tearing, or otherwise destroying the directive;
(2) the declarant signing and dating a written revocation that expresses the declarant's intent to revoke the directive; or
(3) the declarant orally stating the declarant's intent to revoke the directive.
Effectiveness of Revocation

A written revocation takes effect only when the declarant or a person acting on behalf of the declarant notifies the attending physician of its existence or mails the revocation to the attending physician.

The attending physician or the physician's designee shall record in the patient's medical record the time and date when the physician received notice of the written revocation and shall enter the word "VOID" on each page of the copy of the directive in the patient's medical record.

Oral revocation of Directive

An oral revocation takes effect only when the declarant or a person acting on behalf of the declarant notifies the attending physician of the revocation.

The attending physician or the physician's designee shall record in the patient's medical record the time, date, and place of the revocation, and, if different, the time, date, and place that the physician received notice of the revocation. The attending physician or the physician's designees shall also enter the word "VOID" on each page of the copy of the directive in the patient's medical record.
Failure to Act on Revocation

Except as otherwise indicated in the ADA, a person is not civilly or criminally liable for failure to act on a revocation unless the person has actual knowledge of the revocation.

Limits on Liability for Following Written Directives

A physician, or a health professional acting under the direction of a physician, who causes or participates in withholding or withdrawing life-sustaining treatment from a qualified patient is not civilly or criminally liable or guilty of unprofessional conduct as a result of that action unless the physician or health professional fails to exercise reasonable care when applying the patient's advance directive.

Life-sustaining treatment cannot be withheld or withdrawn from a pregnant patient.
Limits on Liability for Health Care Facilities

Healthcare facilities are also protected from civil liability for following directives unless it fails to exercise reasonable care when applying them.

Following directives does not mean you are aiding someone to commit suicide.
Liability for Not Following Directives

a. Provider not civilly or criminally liable if no knowledge of existence of directive.

b. A physician, or a health professional acting under the direction of a physician, is subject to review and disciplinary action by the appropriate licensing board for failing to effectuate a qualified patient's directive in violation of the ADA or other Texas laws.

c. A physician, health professional acting under the direction of a physician, or health care facility is not civilly or criminally liable or subject to review or disciplinary action by the person's appropriate licensing board if the person has complied with the procedures established in the ADA for refusals to comply with a directive or treatment decision.

Refusal to Follow Directive

If an attending physician refuses to follow a directive or treatment decision and does not wish to follow the procedure established for refusal sunder the ADA, life-sustaining treatment shall be provided to the patient, but only until a reasonable opportunity has been afforded for the transfer of the patient to another physician or health care facility willing to comply with the directive or treatment decision.
Procedure to Follow for Refusal – not applicable to all

Procedure to follow when refusing to follow directives under the ADA cannot be construed to impose an obligation on a facility or a home and community support services agency licensed or similar organization that is beyond the scope of the services or resources of the facility or agency. Furthermore, the required procedure does not apply to hospice services provided by a home and community support services agency licensed under Chapter 142.

Clarification on Required Procedure

The ADA provides a procedure for providers refusing to effectuate a directive or treatment decision.

Although this procedure would usually not apply to you, understanding it may assist you in determining how to approach this type of situation with your clients. It boils down to “due process”.

For a full description of the process follow this link:

https://statutes.capitol.texas.gov/Docs/HS/htm/HS.166.htm#166.046
Do not mess with the Directive!!!

A person who intentionally conceals, cancels, defaces, obliterates, or damages another person's directive without that person's consent, commits a Class A misdemeanor (could carry imprisonment of up to one year in a county jail).

A person who, with the intent to cause life-sustaining treatment to be withheld or withdrawn from another person contrary to the other person's desires, falsifies or forges a directive or intentionally conceals or withholds personal knowledge of a revocation and thereby directly causes life-sustaining treatment to be withheld or withdrawn from the other person with the result that the other person's death is hastened is subject to prosecution for criminal homicide.

Out of Hospital DNR Order

1. A competent person may at any time execute a written out-of-hospital DNR order directing health care professionals acting in an out-of-hospital setting to withhold cardiopulmonary resuscitation and certain other life-sustaining treatment designated by department rule.

2. The declarant must sign the out-of-hospital DNR order in the presence of two witnesses, at least one of whom must be a witness who qualifies under Section 166.003(2).

3. The witnesses must sign the order.
Out of Hospital DNR Order - continued

4. The attending physician of the declarant must sign the order and shall make the fact of the existence of the order and the reasons for execution of the order a part of the declarant's medical record.

5. The declarant, in lieu of signing in the presence of witnesses, may sign the out-of-hospital DNR order and have the signature acknowledged before a notary public.

6. An out-of-hospital DNR order is effective on its execution.

Incompetence or Incapacity after Execution of out-of-hospital DNR

A physician, if the person is incompetent but previously executed or issued a directive to physicians, may rely on the directive as the person's instructions to issue an out-of-hospital DNR order and shall place a copy of the directive in the person's medical record.

The physician shall sign the order in lieu of the person signing under Subsection (b) and may use a digital or electronic signature.
If Proxy had been previously designated

If the person is incompetent but previously executed or issued a directive to physicians designating a proxy, the proxy may make any decisions required of the designating person as to an out-of-hospital DNR order and shall sign the order in lieu of the person signing the directive.

IF Agent had been designated through MPA

If the person is now incompetent but previously executed or issued a medical power of attorney designating an agent, the agent may make any decisions required of the designating person as to an out-of-hospital DNR order and shall sign the order in lieu of the person signing the directive.
Minimum requirements for the out-of-hospital DNR

The standard form of an out-of-hospital DNR order specified by department rule must, at a minimum, contain the following:

1. a distinctive single-page format that readily identifies the document as an out-of-hospital DNR order;
2. a title that readily identifies the document as an out-of-hospital DNR order;
3. the printed or typed name of the person;

Minimum requirements for the out-of-hospital DNR - continued

4. a statement that the physician signing the document is the attending physician of the person and that the physician is directing health care professionals acting in out-of-hospital settings, including a hospital emergency department, not to initiate or continue certain life-sustaining treatment on behalf of the person, and a listing of those procedures not to be initiated or continued;

5. a statement that the person understands that the person may revoke the out-of-hospital DNR order at any time by destroying the order and removing the DNR identification device, if any, or by communicating to health care professionals at the scene the person's desire to revoke the out-of-hospital DNR order;
Minimum requirements for the out-of-hospital DNR - continued

6. places for the printed names and signatures of the witnesses or the notary public's acknowledgment and for the printed name and signature of the attending physician of the person and the medical license number of the attending physician;

Minimum requirements for the out-of-hospital DNR - continued

7. a separate section for execution of the document by the legal guardian of the person, the person's proxy, an agent of the person having a medical power of attorney, or the attending physician attesting to the issuance of an out-of-hospital DNR order by nonwritten means of communication or acting in accordance with a previously executed or previously issued directive to physicians under Section 166.082(c) that includes the following:

a. a statement that the legal guardian, the proxy, the agent, the person by nonwritten means of communication, or the physician directs that each listed life-sustaining treatment should not be initiated or continued on behalf of the person; and

b. places for the printed names and signatures of the witnesses and, as applicable, the legal guardian, proxy, agent, or physician;
Minimum requirements for the out-of-hospital DNR - continued

8. a separate section for execution of the document by at least one qualified relative of the person when the person does not have a legal guardian, proxy, or agent having a medical power of attorney and is incompetent or otherwise mentally or physically incapable of communication, including:

a. a statement that the relative of the person is qualified to make a treatment decision to withhold cardiopulmonary resuscitation and certain other designated life-sustaining treatment and, based on the known desires of the person or a determination of the best interest of the person, directs that each listed life-sustaining treatment should not be initiated or continued in behalf of the person; and

b. places for the printed names and signatures of the witnesses and qualified relative of the person;

9. a place for entry of the date of execution of the document;

10. a statement that the document is in effect on the date of its execution and remains in effect until the death of the person or until the document is revoked;

11. a statement that the document must accompany the person during transport;

12. a statement regarding the proper disposition of the document or copies of the document, as the executive commissioner determines appropriate; and

13. a statement at the bottom of the document, with places for the signature of each person executing the document, that the document has been properly completed.
Original not Necessary

A photocopy or other complete facsimile of the original written out-of-hospital DNR order executed may be used for any purpose for which the original written order may be used.

Out-of-hospital DNR order by nonwritten communication

a. A declarant must issue the nonwritten out-of-hospital DNR order in the presence of the attending physician and two qualified witnesses, at least one of whom must be a witness who qualifies under Section 166.003(2).

b. The attending physician and witnesses shall sign the out-of-hospital DNR order in the place of the document provided by Section 166.083(b)(7) and the attending physician shall sign the document in the place required by Section 166.083(b)(13).
Out-of-hospital DNR order by nonwritten communication - continued

c. The physician shall make the fact of the existence of the out-of-hospital DNR order a part of the declarant's medical record and the names of the witnesses shall be entered in the medical record.

d. An out-of-hospital DNR order issued in the manner provided by the ADA is valid and shall be honored by responding health care professionals as if executed in written form.

Out-of-hospital DNR order on behalf of a Minor

If a minor has been diagnosed by a physician as suffering from a terminal or irreversible condition, the Out-of-hospital DNR order on behalf of the minor can be executed by:

1. the minor's parents;
2. the minor's legal guardian; or
3. the minor's managing conservator.
Desire v. Order

The desire of a competent person, including a competent minor, supersedes the effect of an out-of-hospital DNR order executed or issued by or on behalf of the person when the desire is communicated to responding health care professionals as required under the ADA.

Incompetence or Incapacity of Adult after execution of DNR

When a person 18 years of age or older has executed or issued an out-of-hospital DNR order and subsequently becomes incompetent or otherwise mentally or physically incapable of communication;

a. If the adult person has designated a person to make a treatment decision, the attending physician and the designated person shall comply with the out-of-hospital DNR order.

b. If the adult person has not designated a person to make a treatment decision, the attending physician shall comply with the out-of-hospital DNR order unless the physician believes that the order does not reflect the person's present desire.
Incompetence or Incapacity of person without DNR

What happens when there is no DNR and the patient is incompetent or incapable of communication?

a. The attending physician and the person's legal guardian, proxy, or agent having a medical power of attorney may execute an out-of-hospital DNR order on behalf of the person.

b. If the person does not have a legal guardian, proxy, or agent under a medical power of attorney, the attending physician and at least one qualified relative, may execute an out-of-hospital DNR order.

Under (a) and (b), a decision to execute an out-of-hospital DNR order must be based on knowledge of what the person would desire, if known.

Incompetence or Incapacity of person without DNR - continued

c. An out-of-hospital DNR order executed under (b) must be made in the presence of at least two witnesses, at least one of whom must be a witness who qualifies under Section 166.003(2).

d. The fact that an adult person has not executed or issued an out-of-hospital DNR order does not create a presumption that the person does not want a treatment decision made to withhold cardiopulmonary resuscitation and certain other designated life-sustaining treatment designated by department rule.

e. If there is not a qualified relative available to act for the person under (b), an out-of-hospital DNR order must be concurred in by another physician who is not involved in the treatment of the patient or who is a representative of the ethics or medical committee of the health care facility in which the person is a patient.
Compliance with DNR Order

a. When responding to a call for assistance, health care professionals shall honor an out-of-hospital DNR order in accordance with the statewide out-of-hospital DNR protocol and, where applicable, locally adopted out-of-hospital DNR protocols not in conflict with the statewide protocol if:

1. the responding health care professionals discover an executed or issued out-of-hospital DNR order form on their arrival at the scene; and
2. the responding health care professionals comply with the ADA.

Compliance with DNR Order - continued

b. If the person is wearing a DNR identification device, the responding health care professionals must honor the DNR identification device as if a valid out-of-hospital DNR order form executed or issued by the person were found in the possession of the person.

c. The responding health care professionals must establish the identity of the person as the person who executed or issued the out-of-hospital DNR order or for whom the out-of-hospital DNR order was executed or issued.
Compliance with DNR Order - continued

d. The responding health care professionals must determine that the out-of-hospital DNR order form appears to be valid in that it includes:

1. written responses in the places designated on the form for the names, signatures, and other information required of persons executing or issuing, or witnessing or acknowledging as applicable, the execution or issuance of, the order;
2. a date in the place designated on the form for the date the order was executed or issued; and
3. the signature or digital or electronic signature of the declarant or persons executing or issuing the order and the attending physician in the appropriate places designated on the form for indicating that the order form has been properly completed.

Compliance with DNR Order - continued

e. If the responding health care professionals at the scene determines the previous conditions do not apply, the out-of-hospital DNR order may not be honored and life-sustaining procedures otherwise required by law or local emergency medical services protocols shall be initiated or continued.

f. Health care professionals acting in out-of-hospital settings are not required to accept or interpret an out-of-hospital DNR order that does not meet the requirements of this subchapter.
Compliance with DNR Order - continued

g. The out-of-hospital DNR order form or a copy of the form, when available, must accompany the person during transport.

h. A record shall be made and maintained of the circumstances of each emergency medical services response in which an out-of-hospital DNR order or DNR identification device is encountered, in accordance with the statewide out-of-hospital DNR protocol and any applicable local out-of-hospital DNR protocol not in conflict with the statewide protocol.

Compliance with DNR Order - continued

i. An out-of-hospital DNR order executed or issued and documented or evidenced in the manner prescribed by the ADA is valid and shall be honored by responding health care professionals unless the person or persons found at the scene:

1. identify themselves as the declarant or as the attending physician, legal guardian, qualified relative, or agent of the person having a medical power of attorney who executed or issued the out-of-hospital DNR order on behalf of the person; and

2. request that cardiopulmonary resuscitation or certain other life-sustaining treatment designated by department rule be initiated or continued.
Health Care Facilities’ Compliance

If the policies of a health care facility preclude compliance with the out-of-hospital DNR order of a person or an out-of-hospital DNR order issued by an attending physician on behalf of a person who is admitted to or a resident of the facility, or:

if the facility is unwilling to accept DNR identification devices as evidence of the existence of an out-of-hospital DNR order:

that facility shall take all reasonable steps to notify the person or, if the person is incompetent, the person's guardian or the person or persons having authority to make health care treatment decisions on behalf of the person, of the facility's policy and shall take all reasonable steps to effect the transfer of the person to the person's home or to a facility where the provisions of the ADA can be carried out.

DNR Identification Device

A person who has a valid out-of-hospital DNR order may wear a DNR identification device around the neck or on the wrist.

The presence of a DNR identification device on the body of a person is conclusive evidence that the person has executed or issued a valid out-of-hospital DNR order or has a valid out-of-hospital DNR order executed or issued on the person's behalf.
Revocation of Out-of-Hospital DNR

A DNR can be revoked without regard to the declarant's mental state or competency or reexecuted, even after the declarant has been diagnosed as having a terminal or irreversible condition.

Who may Revoke the DNR

A DNR order may be revoked by:

1. the declarant or someone in the declarant's presence and at the declarant's direction destroying the order form and removing the DNR identification device, if any;

2. a person who identifies himself or herself as the legal guardian, as a qualified relative, or as the agent of the declarant having a medical power of attorney who executed the out-of-hospital DNR order or another person in the person's presence and at the person's direction destroying the order form and removing the DNR identification device, if any;
Who may Revoke the DNR - continued

3. the declarant communicating the declarant's intent to revoke the order; or

4. a person who identifies himself or herself as the legal guardian, a qualified relative, or the agent of the declarant having a medical power of attorney who executed the out-of-hospital DNR order orally stating the person's intent to revoke the order.

Effectiveness of oral revocation?

Oral revocation takes effect only when the declarant or a person who identifies himself or herself as the legal guardian, a qualified relative, or the agent of the declarant having a medical power of attorney who executed the out-of-hospital DNR order communicates the intent to revoke the order to the responding health care professionals or the attending physician at the scene.
Documenting revocation of DNR

The responding health care professionals shall record the time, date, and place of the revocation.

The attending physician or the physician's designee shall record in the person's medical record the time, date, and place of the revocation and, if different, the time, date, and place that the physician received notice of the revocation. The attending physician or the physician's designee shall also enter the word "VOID" on each page of the copy of the order in the person's medical record.

No knowledge of Revocation; No liability

Unless specifically indicated in the ADA, a person is not civilly or criminally liable for failure to act on a revocation made unless the person has actual knowledge of the revocation.
Limits on Liability for Following DNR

A health care professional or health care facility or entity that in good faith causes or participates in withholding cardiopulmonary resuscitation or certain other life-sustaining treatment from a person in accordance with the ADA is not civilly or criminally liable, guilty of unprofessional conduct, or in violation of any other licensing or regulatory laws or rules of this state and is not subject to any disciplinary action or sanction by any licensing or regulatory agency of this state as a result of that action.

Limits on Liability for not Following DNR

A health care professional or health care facility or entity are not civilly or criminally liable for failing to act in accordance with a DNR, unless they had actual knowledge of the existence of the order.

If the health care professional or health care facility or entity knows of the existence of the DNR and fails to follow it, it is subject to review and disciplinary action by the appropriate licensing board.
Physician’s refusal to honor DNR

If an attending physician refuses to execute or comply with an out-of-hospital DNR order:

a. the physician shall inform the person, the legal guardian or qualified relatives of the person, or the agent of the person having a medical power of attorney; and

b. if the person or another authorized to act on behalf of the person so directs, shall make a reasonable effort to transfer the person to another physician who is willing to execute or comply with an out-of-hospital DNR order.

Protecting DNRs

A person who intentionally conceals, cancels, defaces, obliterates, or damages another person's out-of-hospital DNR order or DNR Device without that person's consent, or the consent of an authorized person, commits a Class A misdemeanor (could carry imprisonment of up to one year in a county jail).

A person who, with the intent to cause cardiopulmonary resuscitation or certain other life-sustaining treatment to be withheld or withdrawn from another person contrary to the other person's desires, falsifies or forges an out-of-hospital DNR or intentionally conceals or withholds personal knowledge of a revocation and thereby directly causes cardiopulmonary resuscitation or certain other life-sustaining treatment to be withheld or withdrawn from the other person with the result that the other person's death is hastened is subject to prosecution for criminal homicide.
If pregnant?

Cardiopulmonary resuscitation or certain other life-sustaining treatment cannot be withheld from a pregnant person.

Medical Power of Attorney

A person qualified under the ADA to serve as agent of another (the principal), may make any health care decision on the principal's behalf that the principal could make if the principal were competent, if the principal's attending physician certifies in writing and files the certification in the principal's medical record that, based on the attending physician's reasonable medical judgment, the principal is incompetent.
Objections by Principal

Treatment may not be given to or withheld from the principal if the principal objects, regardless of whether, at the time of the objection:

(1) a medical power of attorney is in effect; or
(2) the principal is competent.

Physician’s duty to Inform

The principal's attending physician shall make reasonable efforts to inform the principal of any proposed treatment or of any proposal to withdraw or withhold treatment before implementing an agent's advance directive.
Decisions by Agents

After consultation with the attending physician and other health care providers, the agent shall make a health care decision:

1. according to the agent's knowledge of the principal's wishes, including the principal's religious and moral beliefs; or
2. if the agent does not know the principal's wishes, according to the agent's assessment of the principal's best interests.

Agent’s consent irrelevant

An agent may not consent to:

(1) voluntary inpatient mental health services;
(2) convulsive treatment;
(3) psychosurgery;
(4) abortion; or
(5) neglect of the principal through the omission of care primarily intended to provide for the comfort of the principal.
Effectiveness of Medical Power of Attorney

The power of attorney is effective indefinitely on execution and delivery of the document to the agent, unless it is revoked as provided by this subchapter or the principal becomes competent.

If it includes an expiration date and on that date the principal is incompetent, the power of attorney continues to be effective until the principal becomes competent unless it is revoked as provided by in the ADA.

Who cannot serve as agent?

The following may not exercise the authority of an agent while the person serves as:

1. the principal's health care provider;
2. an employee of the principal's health care provider unless the person is a relative of the principal;
3. the principal's residential care provider; or
4. an employee of the principal's residential care provider unless the person is a relative of the principal.
MPA - Execution and Signature

The medical power of attorney must be signed by the principal in the presence of two witnesses, at least one of whom must be a witness who qualifies under Section 166.003(2). The witnesses must sign the document.

The principal, in lieu of signing in the presence of the witnesses, may sign the medical power of attorney and have the signature acknowledged before a notary public.

If the principal is physically unable to sign, another person may sign the medical power of attorney with the principal's name in the principal's presence and at the principal's express direction. The person may use a digital or electronic signature.

Revocation of MPA

A medical power of attorney is revoked by:

1. oral or written notification at any time by the principal to the agent or a licensed or certified health or residential care provider or by any other act evidencing a specific intent to revoke the power, without regard to whether the principal is competent or the principal's mental state; or

2. execution by the principal of a subsequent medical power of attorney.
Spouse as Agent – revocation of MPA

An agent's authority under a medical power of attorney is revoked if the agent's marriage to the principal is dissolved, annulled, or declared void unless the medical power of attorney provides otherwise.

Duty to Document Revocation

A principal's licensed or certified health or residential care provider who is informed of or provided with a revocation of a medical power of attorney shall immediately record the revocation in the principal's medical record and give notice of the revocation to the agent and any known health and residential care providers currently responsible for the principal's care.
Court may Revoke MPA

On motion filed in connection with a petition for the appointment of a guardian, or by petition of a guarding, the probate court can determine whether to revoke a medical power of attorney.

Agent’s Right to Information

An agent may, for the purpose of making a health care decision:

1. request, review, and receive any information, oral or written, regarding the principal's physical or mental health, including medical and hospital records;
2. execute a release or other document required to obtain the information; and
3. consent to the disclosure of the information.
Obligation to follow Agent’s directives

A principal's health or residential care provider and an employee of the provider who knows of the existence of the principal's medical power of attorney shall follow a directive of the principal's agent to the extent it is consistent with the desires of the principal, this subchapter, and the medical power of attorney.

The attending physician does not have a duty to verify that the agent's directive is consistent with the principal's wishes or religious or moral beliefs.

Obligation to follow Agent’s directives - continued

A principal's health or residential care provider who finds it impossible to follow a directive by the agent because of a conflict with this subchapter or the medical power of attorney shall inform the agent as soon as is reasonably possible.

The agent may select another attending physician. The procedures established in the ADA for providing, withholding, or withdrawing life-sustaining treatment apply.

The ADA, regarding medical powers of attorney, do not require a health or residential care provider who is not a physician to act in a manner contrary to a physician's order.
Prohibition against Discrimination

A health or residential care provider, health care service plan, insurer issuing disability insurance, self-insured employee benefit plan, or nonprofit hospital service plan may not:

1. charge a person a different rate solely because the person has executed a medical power of attorney;
2. require a person to execute a medical power of attorney before:
   a. admitting the person to a hospital, nursing home, or residential care home;
   b. insuring the person; or
   c. allowing the person to receive health or residential care; or
   d. refuse health or residential care to a person solely because the person has executed a medical power of attorney.

Limitation on Liability for following MPA directives

1. An agent is not subject to criminal or civil liability for a health care decision if the decision is made in good faith under the terms of the medical power of attorney and the provisions of the ADA.

2. An attending physician, health or residential care provider, or a person acting as an agent for or under the physician's or provider's control is not subject to criminal or civil liability and has not engaged in unprofessional conduct for an act or omission if the act or omission:
   a. is done in good faith under the terms of the medical power of attorney, the directives of the agent, and the provisions of the ADA; and
   b. does not constitute a failure to exercise reasonable care in the provision of health care services.
Limitation on Liability for following MPA directives - continued

3. An attending physician, health or residential care provider, or person acting as an agent for or under the physician's or provider's control has not engaged in unprofessional conduct for:

   a. failure to act as required by the directive of an agent or a medical power of attorney if the physician, provider, or person was not provided with a copy of the medical power of attorney or had no knowledge of a directive; or

   b. acting as required by an agent's directive if the medical power of attorney has expired or been revoked but the physician, provider, or person does not have knowledge of the expiration or revocation.

Facility DNRs

The ADA further provides for do-not-resuscitate orders issued in a health care facility or hospital. Follow this link for additional information:

https://statutes.capitol.texas.gov/Docs/HS/htm/HS.166.htm#166.201
Forms and Additional Information

Forms and information on advance directives, other than those suggested in the ADA, available at:

https://www.tha.org/AdvanceDirectives

and

https://hhs.texas.gov/laws-regulations/forms/advance-directives

Miller Ex Rel. Miller v. HCA, INC., 118 SW 3d 758 - Tex: Supreme Court 2003

The parents of a premature child filed suit because their premature infant, born alive but in distress at only twenty-three weeks of gestation, was provided resuscitative medical treatment by physicians at a hospital without parental consent.

The Court of Appeals had decided that neither claim could be maintained as a matter of law because parents have no right to refuse urgently-needed life-sustaining medical treatment for their child unless the child's condition is "certifiably terminal" under the Natural Death Act, and in this case it was indisputable that the new-born infant was not "certifiably terminal."
The Supreme Court had to decide whether the parents had a claim for battery or negligence. They agreed with the Appellate court but with a slightly different reasoning.

The Supreme Court found that there was no dispute in the evidence that the infant could not be fully evaluated for medical treatment until birth and therefore, decisions concerning treatment for would not be fully informed decisions until birth. The Court further found that the evidence established that once the infant was born, the physician attending the birth was faced with emergent circumstances, for example, the child might survive with treatment but would likely die if treatment was not provided before either parental consent or a court order overriding the withholding of such consent could be obtained.

Based on those circumstances, the Court held that an exception to the general rule imposing liability on a physician for treating a child without consent applied. That exception eliminated the plaintiffs’ claim for battery and negligence. The Court explained that the claim for negligence was premised, not on any physician's negligence in treating the infant but on the hospital's policies, or lack thereof, permitting a physician to treat their infant without parental consent. Thus, the claim for negligence would fail under the same reasoning.

Case available at:
https://scholar.google.com/scholar_case?case=9581557038083094318&q=%22advance+directives%22&hl=en&as_sd_t=4,44&as_ylo=2016
Case involved Section 166.046 of the ADA which provides procedures by which an attending physician may be immune from civil liability and criminal prosecution for a decision to unilaterally discontinue life-sustaining treatment against the wishes of a patient suffering from a terminal or irreversible condition or against the wishes of the person responsible for the patient's health care decisions.

The core of the process mandated by Section 166.046 of the ADA is a review of the attending physician's decision by a health care facility's ethics or medical committee in a meeting that the patient or patient's representative is entitled to attend upon notice given no less than forty-eight hours beforehand.

In this case, T.L., the infant patient, and her mother, T.L., on her behalf, appealed from the denial of a temporary injunction sought to enjoin, under 42 U.S.C.A. § 1983, the unilateral discontinuation of the child's ongoing course of life-sustaining treatment at Appellee Cook Children's Medical Center (CCMC).

CCMC had affirmed this treatment decision of the child's attending physician after he had invoked the committee review process set forth in Section 166.046.

CCMC had authorized the attending physician to discontinue the child's life-sustaining treatment and thereby cause her natural death if, at the end of ten days, no other physician or health care facility could be found to continue the treatment.

The Court thoroughly discussed Section 166.046 of the ADA and whether it implicated state action, the Supreme Court's decision in Miller Ex Rel. Miller v. HCA, INC., 118 SW 3d 758, as well as other applicable statutes.
TL v. COOK CHILDREN'S MEDICAL CENTER, Tex: Court of Appeals, 2nd Dist. 2020

The Court found the mother was not given sufficient procedural due process, did not receive reasonable notice or meaningful opportunity to be heard, and that Section 166.046 fails to articulate any objective evidentiary standard or burden of proof for the committee review process and eschews completely the statutory and constitutional "best interests" standard for terminally ill children. The Court further found that because the treatment decision to discontinue life-sustaining treatment over the wishes of the terminally ill patient invokes not just the state's regulatory authority over the private practice of medicine but also the state's traditional and exclusive police power to determine what is and what is not a lawful means or process of dying, Section 166.046 of the ADA implicates state action.

The Court found the mother had a probable right to relief on her Section 1983 claim and therefore, a right to a temporary injunction.

Case available at:
https://scholar.google.com/scholar_case?case=16491671425150367545&q=%22advance+directives%22&hl=en&as_sdt=4,44&as_ylo=2016

Questions?