TEXAS MEDICAL ASSOCIATION

Physicians Caring for Texans

House Human Services
Testimony on House Bill 2050 by Rep. Chris Paddie
March 19, 2019

Chairman Frank, members of the committee, I am Dr. Michael Krol. I am a geriatrician practicing in central Texas and a member of the Texas Medical Association. On behalf of TMA and our nearly 53,000 members, I am here to testify in opposition to House Bill 2050.

We share the author's intent to reduce the burden and misuse of antipsychotic medications among residents in our long-term care facilities. These patients' cases frequently are complicated, involving both physical and mental concerns. As physicians, we desire to have strong communication with our patients, or if they are without capacity, the loved ones responsible for their decisions.

Physicians seek consent from the outset to provide care and treatment. In practice, nursing facility patients receive informed consent documents upon admission, and may or may not consent to the administration of a psychoactive drug, including neuroleptics and antipsychotics. HB 2050 may have the unintended consequence of changing written forms for consent to *all* psychoactive drugs to forms for consent to just antipsychotics and neuroleptics. Further, verbal de-escalation techniques, not reactionary administration of antipsychotic drugs, are the norm in these settings to calm a patient down.

This type of consent needs a qualified review process to ensure it will heed and not interfere with proper informed consent and clinical care. HB 2050's requirements are not tailored to achieve balance of proper informed consent and avoiding barriers to timely care. Informed consent is supposed to provide a patient or his or her authorized representative with appropriate information so the person can make a well-informed decision regarding treatment. A layperson's decision is less likely to be influenced by information on dosage, the administration schedule, method of delivery, and expected duration of administration, which is what HB 2050 would require. Current informed consent requirements are better tailored to inform decisionmaking based on (1) the specific condition to be treated, (2) the beneficial effects, (3) probable clinical side effects and risks, and (4) the proposed course of the medication.

Further, many of the resident-patients who receive antipsychotic and neuroleptic drug prescriptions do not have an "administration schedule" or anticipated "duration of administration." In many instances, these prescriptions are necessary to be available based on a situational occurrence **instead of a daily administration**. The anticipated duration may be unknown or indefinite.

The Texas Legislature created the Texas Medical Disclosure Panel (TMDP) under the Texas Department of State Health Services to thoroughly examine needed areas of consent and determine what risks and hazards related to medical care physicians and health care providers must disclose their patients or authorized representative for consent. TMDP is also tasked with

establishing the general form and substance of such disclosure. TMDP informed consent forms are based on qualified physician review, are clinically and legally thorough, and provide uniformity. If the current informed consent requirements need to be reviewed and revised, TMDP is the qualified entity to entrust with that process.

HB 2050 does not provide physicians with the rebuttable presumption that informed consent is valid. A form approved under HB 2050 does not satisfy the rebuttable presumption that appropriate informed consent was given to a resident-patient. If physicians or their delegates use a TMDP form, which has undergone clinical review, they benefit from the legal presumption that the informed consent provided is valid.

HB 2050 creates an unnecessary administrative burden. HB 2050's informed consent requirement for antipsychotic and neuroleptic drugs creates an unnecessary administrative burden on physicians and their delegates. Some of the required information, such as the nature of the medication, potential consequences of the medication, and right of refusal, is duplicative of current law. Also, HB 2050 would allow facilities to create a second form for these two categories of drugs, which would be just yet another form physicians would have to maintain.

HB 2050 may threaten patient-resident safety as well as that of physicians and facility personnel or visitors. The language of proposed subsection (i) of HB 2050 appears to mandate that the facility inform the patient-resident or the patient's authorized representative about the facility's informed consent policies and procedures ***each time*** before administration of an antipsychotic or neuroleptic. This would create a huge safety risk for patients and for the physicians and health care providers. This level of complicated care requires significant continuity.

Many times, a patient in this situation is not in "imminent" risk of "probable death or substantial bodily harm," nor is the patient an "imminent physical or emotional" danger to another resident, which is the qualification for the exception to administer a psychoactive drug. However, the patient is nearly always decompensating and behaving in way to cause self-harm or pose a risk to another patient. In these instances, it is not realistic to engage the patient or the patient's representative in a conversation about the facility's informed consent policies and procedures. Restricting a physician's ability to intervene is dangerous to the patient exhibiting self-harm or aggressive behaviors to others that do not necessarily rise to the high standard of "probable death or substantial bodily harm."

For example, a patient engaging in aggressive self-harm by trying to pull out a feeding tube or otherwise hurting himself or herself may not rise to the level of "imminent" but requires intervention. The physician already has obtained informed consent on the front end from the patient or the patient's authorized representative to provide appropriate medical treatment. It would be completely unworkable to require the facility to tell the patient or authorized representative at such a moment that it has policies and procedures regarding informed consent. Many times, relatives and contacts for these patients are disengaged and unavailable. Valuable time can be lost attempting to contact an authorized representative, leaving patients, physicians, and health care providers at risk. Failure to act expediently and appropriately from a medical standpoint is far riskier than administering an antipsychotic or neuroleptic medication.

Conclusion. To be clear, TMA supports obtaining prior *written* informed consent from a long-term care facility resident before administering psychoactive drugs in nonemergencies. Indeed, TMA has worked with the state to help address issues involving inappropriate use of

antipsychotic medications with these types of patients. Thanks to those efforts, Texas has reduced inappropriate use of antipsychotic medications in individuals in nursing facilities.

However, informed consent requirements for medications must be developed within the right parameters to ensure appropriate review and application. Physician input is essential on the risks and hazards related to psychoactive drugs, including antipsychotics and neuroleptics, and necessary to ensure a thorough, qualified review. This is why, ultimately, TMDP should be tasked with reviewing the risks associated with psychoactive drugs, and TMDP should determine what information patients need to know to make well-informed decisions about treatment.

Chairman Frank and members, I thank you for the opportunity to testify today, and I appreciate your willingness to consider our recommendations.