Texas Hospital Association
1108 Lavaca Street, Suite 700
Austin, Texas 78701
512/465-1000
www.tha.org

December 2, 2019

via electronic submission to:
pamela.adams@hhsc.state.tx.us

Pamela Adams, Manager
Facility Licensing Group
Texas Health and Human Services Commission

Re: Proposed Amendments to Anesthesia Informed Consent Rules and Form (25 Tex. Admin. Code §601.9)

Dear Ms. Adams:

On behalf of its more than 465 hospital and hospital system members, the Texas Hospital Association appreciates the opportunity to provide comments on the proposed changes to the Disclosure and Consent – Anesthesia and Perioperative Pain Management (Analgesia) form (Figure 6.01(9), referenced in 25 Tex. Admin. Code §601.9 as published in the November 1, 2019 *Texas Register*. THA urges the Texas Medical Disclosure Panel to reconsider the proposed changes and leave the form unchanged (except as noted below) in light of the disruption of current processes the changes will likely cause as well as the potential unintended consequences resulting from the changes.

The current form contains the following language in the first paragraph after the opening paragraph:

> I voluntarily request that anesthesia and/or perioperative pain management care (analgesia) as indicated below be administered to me (the patient). I understand it will be administered by an anesthesia provider and/or the operating practitioner, and such other health care providers as necessary. Perioperative means the period shortly before, during and shortly after the procedure.

The form relates to the administration of anesthesia/analgesia. The current form accurately conveys that anesthesia and/or perioperative pain management care (analgesia) will be administered by an anesthesia provider and/or the operating practitioner, and such other health care providers as necessary, covering all scenarios related to the administration of anesthesia/analgesia. It correctly takes into account that the person responsible for obtaining the informed consent of the patient, that is, the person actually administering the anesthesia, might be a physician or a nurse anesthetist acting under the delegation and supervision of a physician. The revised form changes the above-quote paragraph to read as follows:

> I voluntarily request that anesthesia and/or perioperative pain management care (analgesia) as indicated below be administered to me (the patient). I understand it will be delegated/supervised and/or personally performed by Dr. _____ and/or physician associates and such other health care providers as necessary. Perioperative means the period shortly before, during and shortly after the procedure.

The revised language requires the name of a physician to be inserted into the consent form. In many hospitals whose anesthesia service is covered by a group practice, the particular anesthesia professional who will be involved in a case is not known ahead of time, thereby making it impossible to identify on the consent form who will be administering anesthesia or who is the supervisor of the non-physician anesthetist who will be involved in the actual case. This practice is common in many facilities and is an appropriate and accepted practice in the healthcare industry. The inclusion of a specific provider's name, even with a qualifier of "and/or physician associates," could lead patients and/or their surrogate decision-maker to believe only the provider listed would be involved in the patient's care. This may cause unnecessary confusion or concern in cases involving another provider. Further, the inclusion of a specific provider name may lead to patient care delays when care must be delayed to ensure the provider's name is accurate on the consent form. The revised form simply does not accurately reflect the common anesthesia workflow in a busy facility.

Further, the revised form contemplates that a physician who has only delegated the act of administering anesthesia/analgesia for the particular procedure in question might be the name written into the form. A delegating physician is only delegating the ordering of drugs and devices to a nurse anesthetist. The delivery of anesthesia from the point of the delegation of the ordering of drugs and devices going forward is the responsibility of the nurse anesthetist. Adding the name of the delegating physician to the anesthesia consent implies some involvement in the administration of anesthesia/analgesia beyond delegation, which is simply inaccurate. Again, the responsibility for obtaining informed consent falls on the practitioner performing the procedure. Adding the name of the delegating physician does nothing to enhance the informed consent process and may be perceived by the delegating physician as increasing their liability exposure for acts they are not directly involved in, and they may choose to mitigate this perceived exposure to liability by simply refusing to serve as a delegating physician. If that happens, access to surgical and obstetric care in the state of Texas, particularly in rural and underserved areas, will be severely curtailed.

The rationale offered for the change is to "ensur[e] the physician delegating/supervising or performing the anesthetic will be privileged with the rebuttable presumption intended." This appears to be a reference to the legal presumption described in Texas Civil Practice and Remedies Code §74.106. While we do not comment here on the legal soundness of the rationale, which ultimately will be a matter of interpretation for the courts, the change nonetheless seems to be an unnecessary foray into the well-known and long-standing division between physicians and nurse anesthetists. Furthermore, the change may actually increase liability exposure for a physician who is not named in the form but who is ultimately involved in administering anesthesia or delegating the administration of anesthesia under industry-wide workflow processes.

The Panel's current form reflects the reality of facility-based anesthesia practice. The proposed revisions do not enhance the informed consent process, will have a deleterious and disruptive effect on hospitals, anesthesia providers, and patients, and will likely decrease access to care in many vulnerable areas of the state.

Again, the Texas Hospital Association appreciates the opportunity to provide this information to the Panel. Please feel free to contact me by telephone at 512/465-1577 or email at swohleb@tha.org with any questions.

Sincerely,

Stephen G. Wohleb
Senior Vice President and General Counsel
Texas Hospital Association