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CAUSE NO. 2015-69681

EVELYN KELLY, INDIVIDUALLY AND ON BEHALF OF THE ESTATE OF DAVID CHRISTOPHER DUNN,	§	IN THE DISTRICT COURT OF
	§	
PLAINTIFF.	§	
	§	
v.	§	HARRIS COUNTY, TEXAS
	§	
THE METHODIST HOSPITAL,	§	
	§	
DEFENDANT.	§	189TH JUDICIAL DISTRICT

BRIEF OF *AMICI CURIAE*
TEXAS ALLIANCE FOR LIFE, TEXAS CATHOLIC CONFERENCE OF BISHOPS, TEXAS BAPTIST CHRISTIAN LIFE COMMISSION, TEXANS FOR LIFE COALITION, COALITION OF TEXANS WITH DISABILITIES, TEXAS ALLIANCE FOR PATIENT ACCESS, TEXAS MEDICAL ASSOCIATION, TEXAS OSTEOPATHIC MEDICAL ASSOCIATION, TEXAS HOSPITAL ASSOCIATION, AND LEADINGAGE TEXAS

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INTEREST OF *AMICI CURIAE*

The amici are dedicated to a diverse set of goals, including preserving the integrity of the medical profession, ensuring high-quality medical care, promoting medical liability reform, protecting life, assuring dignity at the end of life, and protecting Texans with disabilities. All agree that the Texas Advance Directives Act, TEX. HEALTH & SAFETY CODE ch. 166, helps achieve these essential objectives. The amici believe the statute easily overcomes Plaintiff's constitutional challenge.

Texas Alliance for Life (TAL). TAL opposes "the advocacy and practice of abortion (except to preserve the mother's life), infanticide, euthanasia, and all forms of assisted suicide." https://www.texasallianceforlife.org/about-us/ (last visited June 23, 2017). In 1999, TAL, together with Texas Right to Life, helped negotiate §166.046 and urged its enactment. Texas Right to Life (which represents the Plaintiff here) now actively challenges the statute it also helped enact. This discordance is difficult to understand. Since 1999, TAL has supported various bills to increase patient protections in the Texas Advance Directives Act. However, TAL has been and continues to be unwavering in its support for §166.046 because it strikes a just and appropriate balance between the rights of patients to autonomy regarding decisions involving life-sustaining procedures and the conscience rights of health care providers to not have to provide medically and ethically inappropriate and harmful interventions to dying patients.

Texas Catholic Conference of Bishops (TCCB). TCCB has sought reforms in advance directives to highlight—as a matter of policy—the dignity inherent in a natural death. https://txcatholic.org/medical-advance-directives/ (last visited June 23, 2017). "Human intervention that would deliberately cause, hasten, or ***unnecessarily prolong*** the patient's death violates the dignity of the human person." *Id.* (emphasis added). "Reform efforts should prioritize the patient, while also recognizing the emotional and ethical concerns of families, health care

providers, and communities that want to provide the most compassionate care possible." *Id.* TCCB strongly supports §166.046 as indispensable for ensuring dignity at end of life.

Texas Baptist Christian Life Commission (CLC). The CLC is the ethics and public policy ministry of the Baptist General Convention of Texas (Texas Baptists), which includes 5,400 churches. The CLC does not speak for Texas Baptists, but it addresses policy issues that are of concern to Texas Baptists from a biblical perspective. Texas Baptists affirm the value of human life from conception to natural death and affirm the importance of honoring the rights of conscience of all Americans. While recognizing the inherent difficulties of these decisions for families, medical professionals, and patients, §166.046 strikes the appropriate balance between patients and medical professionals' rights of conscience. CLC supports §166.046 because it respects the inherent dignity of those created in the image of God, in death, in medical decisions, and in the provision of treatment.

Texans for Life Coalition (TLC). TLC has been educating and advocating for the sanctity of human life since 1974. After previously opposing the Texas Advance Directives Act, TLC changed its position after witnessing the Act's benefits. TLC now recognizes that, while imperfect, the Act provides a reasonable process for resolving differences between medical practitioners and patient surrogates regarding end-of-life treatment. Furthermore, TLC does not believe that patients have a *constitutional* right to medical care.

Coalition of Texans with Disabilities (CTD). Founded in 1978, CTD is a statewide, cross-disability non-profit organization. CTD has been involved in end-of-life policy discussions for several Texas legislative sessions. People with disabilities express considerable respect and appreciation for their health care providers, often crediting them with their lives. Yet, people with disabilities often report experiences where their lives are devalued, throughout society and

sometimes in health care situations. CTD staff has been told many times by the disability community that it wants to be sure its wishes are heard and respected in end-of-life decisions. CTD believes the Texas Advance Directives Act has advanced the rights of people with disabilities at this sensitive time.

The Texas Alliance for Patient Access (TAPA). TAPA is a statewide coalition of over 250 doctors, hospitals, clinics, nursing homes, and physician liability insurers. http://www.tapa.info/about-us.html (last visited June 23, 2017). TAPA promotes health care liability reform to help ensure that Texans receive high-quality, affordable medical care. TAPA supports §166.046 because it (1) preserves a doctor's existing right to refuse to provide medical intervention that violates his or her ethics or conscience, and (2) provides immunity from liability if doctors and hospitals adhere to predetermined procedures before declining to provide such intervention. Section 166.046's immunity protects doctors and nurses from exposing themselves to malpractice suits when adhering to professional and personal ethics.

TAPA is paying all fees associated with preparing this brief.

The Texas Hospital Association (THA). THA, a non-profit trade association, represents 459 Texas hospitals. THA advocates for legislative, regulatory, and judicial means to obtain accessible, cost-effective, high-quality health care. THA supports §166.046, which provides a safe harbor for physicians and hospitals that refuse to provide medically unnecessary interventions.

The Texas Medical Association (TMA) and Texas Osteopathic Medical Association (TOMA). TMA and TOMA are private, voluntary, non-profit associations. Founded in 1853, TMA is the nation's largest state medical society, representing over 50,000 Texas physicians and residents. https://www.texmed.org/Template.aspx?id=5 (last visited June 23, 2017). Founded in

1900, TOMA represents more than 5,000 licensed osteopathic physicians. Both organizations consider §166.046 vital to the ethical practice of medicine and the provision of high quality-care.

LeadingAge Texas (LAT). LAT provides leadership, advocacy, and education for Texas faith-based and not-for-profit retirement housing and nursing home communities. https://www.leadingagetexas.org/. The organization works extensively with the Texas Legislature on an array of issues affecting the elderly, including hospice and end-of-life matters.

SUMMARY OF THE ARGUMENT

End-of-life decisions are wrenching for patients, their families, and treating physicians. Interventions that prolong life may also prolong—or even intensify—suffering. Circumstances arise in which a family member wants to keep such procedures going after a doctor, compelled by her ethical obligation to do no harm, concludes that further intervention would only extend or enhance suffering. As even *conversations* about the end of life are difficult to begin, these conflicts between medical ethics and patient wishes have historically been intractable.

The Texas Advance Directives Act provides a resolution. When a life-sustaining intervention conflicts with medical ethics, the physician can initiate §166.046's procedure, allowing an ethics committee to review the patient's case and evaluate the appropriateness of further intervention. When this procedure is followed, the physician is not subject to liability. But the patient's wishes are respected too—the physician and hospital must work with the patient or his family to find a facility that will accommodate the patient's or his family's wishes if they are contrary to the committee's determination.

Section 166.046 exists to spur doctors and patients to have the difficult, but critical, dialogue that end-of-life care requires. Life-sustaining intervention has rarely been withdrawn under the Act. Much more often, the family and hospital come to an agreement, or the patient's disease runs its natural course. This is what happened in this very case: David Christopher Dunn died of natural causes while the §166.046 procedure was underway.

Plaintiff claims that §166.046 unconstitutionally deprives patients of life and the right to make independent medical decisions. As demonstrated below, however, the legislation offends no constitutional provision and, importantly, implements public policy that the Legislature enacted after years of compromise and debate. Challenges to that policy belong in the Capitol, not this Court.

Plaintiff's due-process claim fails for two reasons. First, the Due Process Clause is properly invoked only where a constitutionally protected interest is at stake. Here, none is. Nothing in the Constitution compels physicians to provide any particular course of treatment when it violates their own beliefs. Neither does §166.046 deprive any patient of life. As the Supreme Court of the United States has acknowledged, when life-sustaining interventions are discontinued, death is caused by the underlying disease—not the withdrawal of treatment. Because there is no constitutional right to a particular form of medical treatment—including life-sustaining intervention—its withdrawal cannot violate the Constitution.

Second, because the Constitution protects an individual from a *governmental* deprivation, a plaintiff cannot prevail on a due process claim without first showing state action. But medical treatment decisions are quintessentially private. Section 166.046 has not altered that reality. It does not require a physician to take any action. Rather, it provides immunity if a physician voluntarily complies. The private employment of a state-sanctioned remedy is not state action. In fact, both the Supreme Court and the Fifth Circuit have held that a legislative grant of immunity is not state action.

Section 166.046 is constitutional—an enactment designed to resolve otherwise-intractable end-of-life disputes. In almost every case—including this one—it does so *without* violating patient wishes. If reform is necessary, it should take place in a legislative venue.

STATUTORY BACKGROUND

The Legislature enacted the Texas Advance Directives Act, TEX. HEALTH & SAFETY CODE ch. 166, order to "set[] forth uniform provisions governing the execution of an advance directive" regarding health care. Senate Research Ctr., Bill Analysis, Tex. S.B. 1260, 76th Leg., R.S. (1999). The Act was the culmination of a six-year joint effort between a diverse array of stakeholders, including Texas and National Right to Life, the Texas Conference of Catholic Health Care Facilities, the Texas Medical Association, the Texas Hospital Association, and the Texas and New Mexico Hospice Organization. *See* Hearing on H.B. 3527, Comm. on Pub. Health, 76th Leg., R.S. (Apr. 29, 1999) (statement of Greg Hooser, Texas and New Mexico Hospice Organization); *see also id.* ("[W]e like it and the whole coalition seems to be in agreement with this. . . . [W]e are really united behind this language.") (statement of Joseph A. Kral, IV, Legislative Director, Texas Right to Life).[1] The bill passed the Senate unanimously and passed the House on a voice vote. Act of May 11, 1999, 76th Leg., R.S., ch. 450, §3.05, 1999 Tex. Gen. Laws 2835, 2865.

Among the Act's reforms was to provide immunity to hospitals and health-care providers that reasonably comply with patients' advance directives. TEX. HEALTH & SAFETY CODE §166.044. It also acknowledged the potential for conflicts between patients' wishes and physicians' ethical duties. It thus provided a procedure by which a physician or hospital that wished not to comply with a patient's wishes—including by withholding or withdrawing life-sustaining intervention—could act without risking malpractice liability. *Id.* §166.046. This is known as TADA's "medical futility" provision.

[1] No one registered as opposed to the bill. *See* Hearing on H.B. 3527, Comm. on Pub. Health, 76th Leg., R.S. (Apr. 29, 1999) (statement of Greg Hooser, Texas and New Mexico Hospice Organization) ("Mr. Hildebrand, no sir, there is no opposition."); *see also id.* (witness list).

I. **Medical futility laws are necessary to maintain the integrity of the medical profession.**

Although TADA does not define "medical futility," the term necessarily incorporates a complex array of medical and ethical judgments. Instead of substituting its judgment for physicians', the Legislature adopted "a process-based approach" similar to one recommended years earlier by the American Medical Association Council on Ethical and Judicial Affairs. Robert L. Fine, M.D., *Medical futility and the Texas Advance Directives Act of 1999*, 13 B.U.M.C. PROCEEDINGS 144, 145 (2000).[2] The AMA's approach had little practical effect because even when a physician concluded additional medical intervention was futile, the specter of potential malpractice liability kept the physician from contravening patient wishes. *Id*. The Texas statute solved that problem by providing a safe harbor procedure which, if followed, conferred immunity. *Id*. at 146.

Doctors believe that being forced to provide medically futile treatment threatens the proper and ethical practice of medicine. "It is inhumane to prolong a dying process that causes pain to a patient, and physicians believe they should not be forced to provide treatment that violates their ethics." CYNTHIA S. MARIETTA, THE DEBATE OVER THE FATE OF THE TEXAS "FUTILE CARE" LAW: IT IS TIME FOR COMPROMISE 3 (April 2007).[3]

So while patients' and families' wishes are entitled to substantial deference, they do not negate medical judgment or conscience. Doctors must consider whether a given treatment will help or harm the patient. Testifying against an amendment to TADA, one physician gave the example of a terminal cancer patient whose family wished to continue an intervention that required high-pressure intubation to force oxygen into the patient's lungs. *See* Hearing on C.S.S.B. 439

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[2] https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1312296/pdf/bumc0013-0144.pdf (last visited June 23, 2017).

[3] https://www.law.uh.edu/healthlaw/perspectives/2007/(CM)TXFutileCare.pdf (last visited June 23, 2017).

before the Senate Comm. on Health & Human Servs., 80th Leg., R.S. (April 12, 2007) (statement of Dr. Bob Fine, Texas Medical Association & Baylor Healthcare System). This intubation caused her lungs to rupture, inflicting severe pain. *See id.* Her pain, in turn, required substantial pain medication and paralytics. *See id.* Against her physicians' contrary medical advice, the patient's family persisted in keeping her on this painful course of intervention—and even tried to have her taken off the paralytics and painkillers. *See id.* It was TADA's dispute-resolution process that finally allowed the patient to pass peacefully, in a single minute, after enduring 20 days of agony. *See id.*

But it is not only extreme cases that present these dilemmas. As Dr. Ray Callas testified, even routine treatments like CPR can cause much more pain than benefit:

> Effectiveness: Whether CPR is likely to be effective depends on medical conditions and circumstances subject to medical decisionmaking. The physician must consider the patient's age, the circumstances in which the patient's cardiac arrest occurred, and the patient's other medical conditions. Some injuries or illnesses are simply not survivable. However, even in the best of circumstances, CPR is effective in only about 12 percent of cases when performed outside the hospital and in less than 25 percent of the time in a hospital setting.
>
> Possible Harm: Even when the medical circumstances are optimal and the results are good, CPR can cause pain, damage, and distress to patients. For example, chest compressions commonly result in broken ribs, and repeated attempts can cause those broken rib fragments to puncture lungs and damage other body tissues. These problems can become particularly acute when patients are elderly and frail. When there is no ultimate benefit to a patient, CPR can turn a tragic death into prolonged suffering or even torture.

Hearing on H.B. 2063 before the House Comm. on State Affairs, 85th Leg., R.S. (April 5, 2017) (statement of Dr. Ray Callas).[4] Dr. Callas concluded:

[4] https://www.texmed.org/Template.aspx?id=44569 (last visited June 23, 2017)

> When patients are dying due to the terminal stages of disease or the expected effects of advanced age, sometimes the best possible medical care is to take measures to relieve suffering but allow a natural death.

Id.

Dr. Ann Miller, a pediatric chaplain, made a similar point to the Legislature:

> In a hospital, you see we frequently must ask patients for permission to hurt them, to give them medicine, our children, that make them sick, to, it makes their hair fall out, burns their skin or makes huge bruises, treatment that is painful, frightening, embarrassing and undignified. . . . What makes the pain and indignity acceptable is our noble purpose. We have medical evidence that the benefits to the patient's health have a good chance of far outweighing the risk and the pain that we're going to inflict, and this noble purpose of affecting a patient's health is the only way we can justify our actions to patients and families, and the only way we can look ourselves in the mirror.

Hearing on C.S.S.B. 439 before the Senate Comm. on Health & Human Servs., 80th Leg., R.S. (April 12, 2007) (statement of Dr. Ann Miller, Director of Pastoral Care, Cook Children's Medical Center). But where the treatment brings only pain, and no benefit, Dr. Miller explained that for many doctors, prolonging life cannot be squared with their ethical duties: "[F]orcing physicians to continue to do painful treatments without a medical goal is something that shouldn't happen." *Id.*

The pressure to provide medically futile procedures takes a toll on medical personnel. A study of critical care nurses in Australia concluded that "moral issues faced by nurses in medically futile situations may be distressing enough to result in them leaving intensive care practice, or leaving nursing altogether." Melodie Heland, *Fruitful or futile: intensive care nurses' experiences and perceptions of medical futility*, AUSTRALIAN CRITICAL CARE 25, 27, Feb. 2006.

II. Texas's statutory medical-futility procedure only rarely causes a patient's wish for further intervention to be disregarded.

Texas is one of the few states in which medical-futility laws have been effective at fostering compromise and relieving suffering—most likely because of TADA's safe-harbor provision. But Texas doctors and hospitals rarely arrive at discontinuing life-sustaining intervention under the

Act. After surveying 409 Texas hospitals on their experience with the medical futility procedure between 1999 and 2004, one survey found:

> Most cases were resolved before the end of the mandated 10-day waiting period because patients died, patients or representatives agreed to forgo the treatment in question, or patients were transferred. Discontinuation of life-sustaining treatment against patient or patient representative wishes occurred in only a small number of cases.

M.L. Smith, et al., *Texas hospitals' experience with the Texas Advance Directives Act*, 35 CRIT CARE MED. 1271 (2007).[5]

This trend has continued in recent years. A Texas Hospital Association survey of 202 hospitals revealed that between 2007 and 2011 ***no*** patient was deprived of life-sustaining intervention against the patient's or family's wishes. In that time, almost four million patients were admitted to the responding hospitals. Section 166.046 was invoked just 30 times. In several of those cases, the patient was transferred. In others, the process caused the physician or the family to reassess their position. Much of the time, the patient passes naturally while the process is in motion.

Experience shows that §166.046 is rarely invoked. And when it is, its principal impact is not halting medical intervention. Rather, the procedure's mere existence fosters informal resolution among patients, families, and doctors.

[5] https://www.ncbi.nlm.nih.gov/pubmed/17414082 (last visited June 23, 2017).

ARGUMENT

I. Section 166.046 gives medical professionals a safe harbor, but it does not mandate a specific course of action.

Physicians have long been free to choose who they will treat and what treatments they will provide. "The physician-patient relationship is 'wholly voluntary.'" *Gross v. Burt*, 149 S.W.3d 213, 224 (Tex. App.—Fort Worth 2004, pet. denied) (quoting *Fought v. Solce*, 821 S.W.2d 218, 220 (Tex. App.—Houston [1st Dist.] 1991, writ denied)). Even once a physician-patient relationship has begun, either party may terminate it at will. AM. MED. ASS'N COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, CODE OF MED. ETHICS §1.1.5 (2016).

While a physician cannot countermand a patient's wish, she can *abstain* from providing a particular treatment when her medical judgment, her conscience, or her ethics, demands it. The Code of Medical Ethics protects physicians' right "to act (*or refrain from acting*) in accordance with the dictates of conscience in their professional practice," allowing them "considerable latitude to practice in accord with well-considered, deeply held beliefs." *Id.* §1.1.7 (emphasis added). The key limitation is that the physician has an ethical duty not to terminate the relationship without "[n]otify[ing] the patient (or authorized decision maker) long enough in advance to permit the patient to secure another physician." *Id.* §1.1.5. The physician must also "[f]acilitate transfer of care when appropriate." *Id.*; *accord King v. Fisher*, 918 S.W.2d 108, 112 (Tex. App.—Fort Worth 1996, writ denied) (describing elements of a common law abandonment claim); *see also Tate v. D.C.F. Facility*, Civil Action No. A407CV162-MPM-JAD, 2009 WL 483116, at *1 (N.D. Miss. Jan. 23, 2009) ("Doctors and hospitals of course have the right to refuse treatment . . . .").

The Legislature passed the Texas Advance Directives Act, TEX. HEALTH & SAFETY CODE §§166.001–.166, to create a legal framework governing how physicians should handle and comply with advance directives, out-of-hospital do-not-resuscitate orders, and medical powers-of-attorney

in the context of life-sustaining intervention. *See* TADA §§166.002(1), (10) (defining "advance directive" and "life-sustaining treatment").

But TADA operates within the historical framework governing physician-patient relationships. The Legislature preserved patients' and doctors' rights to make decisions about care. TADA disclaims any intent to "impair or supersede any legal right or responsibility a person may have to effect the withholding or withdrawal of life-sustaining treatment in a lawful manner." *Id.* §166.051. The Act requires a physician or health-care facility that "is unwilling to honor a patient's advance directive or a treatment decision to provide life-sustaining treatment" to nevertheless provide that treatment, but "only until a reasonable opportunity has been afforded for transfer of the patient to another physician or heath care facility." *Id.* This is wholly consistent with physicians' ethical rights and duties.

Generally, TADA requires a physician to follow an advance directive or treatment decision made by or on behalf of a patient. However, it acknowledges that a patient's wishes may conflict with a physician's conscience or understanding of medical necessity. It thus provides a procedure by which physicians can seek to harmonize their ethical duties with patients' wishes. *Id.* §166.046. This is the procedure that is the subject of Plaintiff's constitutional challenge, but it applies regardless of whether the doctor wishes to *withhold* or *provide* life-sustaining intervention over the patient's wishes. *Id.*; *id.* §166.052. The procedure calls for a medical review committee to consider the case while a decision is made, with the patient's directive honored in the interim. *Id.* §166.046(a).

The §166.046 procedure gives the patient or his representative a right to notice of and to attend the committee's meeting, but it leaves the decision regarding whether to disregard the advance directive to the committee. *Id.* §166.046(b). If the committee makes the difficult decision

to countermand the patient's or family's wish, the physician or hospital must "make a reasonable effort to transfer the patient to a physician who is willing to comply with the directive." *Id.* §166.046(d). And if the committee's decision is to withdraw life-sustaining intervention, the hospital must continue the intervention for at least 10 days while efforts are made to transfer the patient. *Id.* §166.046(e).

TADA generally provides physicians who withdraw life-sustaining intervention in accordance with its provisions immunity from civil and criminal liability, as well as professional discipline, "unless the physician or health care facility fails to exercise reasonable care when applying the patient's advanced directive." *Id.* §§166.044(a), (c). Section 166.046 goes further, providing an absolute safe-harbor to physicians who comply with it when abstaining from compliance with a patient's wishes. *Id.* §166.045(d).

But §166.046 does not create a *mandatory* procedure, even for physicians wishing to abstain:

> If an attending physician refuses to comply with a directive or treatment decision *and does not wish to follow the procedure established under Section 166.046*, 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.

Id. §166.045(c) (emphasis added). A physician who elects not to comply with the §166.046 procedure will lose the benefit of the safe-harbor provision. But he would still have the benefit of TADA's immunity to the extent that he withdrew life-sustaining intervention without "fail[ing] to exercise reasonable care when applying the patient's advance directive." *Id.* §166.044(a).

II. Section 166.046 is constitutional.

A. Plaintiff's arguments are based on a misconception about §166.046.

Plaintiff argues that §166.046 "violated David Christopher Dunn's [substantive and procedural] due process rights under the Texas Constitution and the U.S. Constitution," and she seeks a declaration to this effect. Plaintiff's First Am. Pet. ¶3. She complains that §166.046 "allows doctors and hospitals the absolute authority and unfettered discretion to terminate life-sustaining treatment of any patient," regardless of the patient's or his decision-maker's wishes. *Id.* ¶4.

Plaintiff's arguments are predicated upon a misconception about §166.046. The core of her arguments is that by "delegati[ng] decision-making authority to hospital systems in Texas, the state has authorized the deprivation of life to Texas patients." MSJ at 2. This argument relies on an understanding that §166.046 granted physicians "statutory authority" to withdraw life-sustaining intervention. *Id.* at 8.

In fact, TADA purported to "delegate" no such authority. It explicitly *did not* alter "*any* legal right or responsibility a person may have to effect the withholding or withdrawal of life-sustaining treatment in a lawful manner." TADA §166.051 (emphasis added). It did not grant physicians any new powers, and did not even require them to follow any procedure. It created a safe harbor for—that is, granted immunity to—physicians who withhold or withdraw life-sustaining intervention in a specific manner.

B. Section 166.046 is consistent with due-process guarantees.

To establish a constitutional violation, a party must prove state action. But §166.046 does not even impose a duty on—let alone control the actions of—private actors. Thus even if Plaintiff could show a constitutionally protected interest at stake in this case—and she cannot—her claim would founder on the state action prong.

The traditional procedural due-process inquiry has two parts: (1) whether the plaintiff had a protected liberty or property interest; and (2) what process is due. *Logan v. Zimmerman Brush Co.*, 455 U.S. 422, 428 (1982); *Univ. of Tex. Med. School at Hous. v. Than*, 901 S.W.2d 926, 929 (Tex. 1995).[6] The substantive due-process inquiry looks at whether the state has arbitrarily deprived the plaintiff of a constitutionally protected interest. *Patel v. Tex. Dep't of Licensing & Regulation*, 469 S.W.3d 69, 86–87 (Tex. 2015); *Simi Inv. Co. v. Harris Cty., Tex.*, 236 F.3d 240, 249 (5th Cir. 2000).

But because neither the Texas nor U.S. Constitution protects against purely private harms, Plaintiff must also demonstrate that the deprivation occurred due to state action. *Shelley v. Kraemer*, 334 U.S. 1, 13 (1948) (holding that the Constitution "erects no shield against merely private conduct, however discriminatory or wrongful"); *Republican Party of Tex. v. Dietz*, 940 S.W.2d 86, 90–91 (Tex. 1997) (applying same doctrine to the Texas Constitution).

Plaintiff can show neither a constitutionally protected interest nor state action. Accordingly, her constitutional claims fail.

1. Plaintiff fails to identify a protected interest.

To state a due-process claim, a plaintiff must identify an interest the constitution protects. Plaintiff identifies two purported interests: life, and the right to make individual medical decisions. In fact, neither of those interests are implicated here.[7]

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[6] The federal Due Process Clause, U.S. CONST. amend. XIV, §1, and Texas's Due Course of Law Clause, TEX. CONST. art. I, §19, are functionally similar, and the Texas Supreme Court routinely relies on federal precedent in interpreting the state clause. *Univ. of Tex. Med. School at Hous. v. Than*, 901 S.W.2d 926, 929 (Tex. 1995). This is especially true of "state action issues," with respect to which the Court has explained that "[f]ederal court decisions provide a wealth of guidance." *Republican Party of Tex. v. Dietz*, 940 S.W.2d 86, 91 (Tex. 1997).

[7] For the purposes of this section, it is assumed that physicians are state actors. Of course, reality is to the contrary. *See infra* § II.B.2.

Plaintiff argues that TADA "authorize[s] the deprivation of life to Texas patients" and "delegat[es]" to physicians "the right to make life-related medical decisions," in contravention of the constitutional requirement "that the State not allow anyone 'but the patient' to make decisions regarding the cessation of life-sustaining treatment." MSJ at 2, 7. Plaintiff's arguments are premised on their mistaken understanding of TADA, and they imply that a patient has a *constitutional right* to receive treatment from a physician that the physician does not wish to give.

The constitution "generally confer[s] no affirmative right to governmental aid, even where such aid may be necessary to secure life, liberty, or property interests of which the government itself may not deprive the individual." *DeShaney v. Winnebago Cty. Dep't of Soc. Servs.*, 489 U.S. 189, 196 (1989). Only those whom the state has deprived of their freedom—prisoners and the involuntarily committed, for example—have a constitutional right to be protected by the state. *Id.* at 198–99 (citing *Youngberry v. Romeo*, 457 U.S. 307, 314–15 (1982) (involuntary commitment); *Estelle v. Gamble*, 429 U.S. 97, 103–04 (1976) (prisoners)). Otherwise, the state has no obligation to affirmatively provide services to protect a person's constitutionally protected interests.

Plaintiff has not confronted these fundamental precepts. Take, for example, her claim that TADA deprives patients of "life." In fact, it is the patient's illness that causes death; it is merely forestalled by life-sustaining intervention. *Vacco v. Quill*, 521 U.S. 793, 801 (1997) ("[W]hen a patient refuses life-sustaining medical treatment, he dies from an underlying fatal disease or pathology . . . ."). In *DeShaney*'s language, the life-sustaining treatment is "aid" that "secure[s]" the patient's life. 489 U.S. at 196. But patients have no constitutional right to this aid. *Id.* A physician is not *constitutionally obligated* to provide *any* treatment, including life-sustaining treatment.

A contrary holding would have severe consequences. Any illness or medical condition, if the responsibility of state actors, may cause constitutional injuries. If Plaintiff were right that the Constitution requires doctors to undertake treatment that *prevents or forestalls* illness, then patients would have a constitutional right to have *any and all* ailments treated. Yet the United States Supreme Court has expressly rejected this position. *Id.* at 198–99; *accord Abigail Alliance for Better Access to Developmental Drugs v. von Eschenbach*, 495 F.3d 695, 710 n.18 (D.C. Cir. 2007) (en banc) ("No circuit court has acceded to an affirmative access [to medical care] claim.");[8] *Johnson v. Thompson*, 971 F.2d 1487, 1495–96 (10th Cir. 1992) (rejecting argument that right to life includes right to receive medical care). Indeed, even in the unique prison context, courts have roundly rejected the notion that a patient has a right to receive "any particular type of treatment." *Long v. Nix*, 86 F.3d 761, 765 (8th Cir. 1996); *accord Jenkins v. Colo. Mental Health Inst. at Pueblo*, 215 F.3d 1337, at *1–2 (10th Cir. 2000) (unpublished).

The same analysis dooms Plaintiff's stated interest in the individual right to make medical decisions. That right is not diminished by TADA. Rather, TADA protects individuals' right to make their own medical decisions, confirming the longstanding rule that before terminating a patient-physician relationship, the physician must give the patient reasonable notice so that he can find someone who will comply with his wishes. But under *DeShaney*, an individual's right to make a decision does not compel a physician to implement it against the physician's own will. The patient's right is to make his choice, but this right does not overpower the physician's conscience. *See Harris v. McRae*, 448 U.S. 297, 318 (1980) ("Whether freedom of choice that is

[8] In *Abigail Alliance*, the *en banc* D.C. Circuit held that the Due Process Clause does not give terminally ill patients a right of access to potentially life-saving experimental drugs that have not been approved by the FDA. *Abigail Alliance for Better Access to Developmental Drugs v. von Eschenbach*, 495 F.3d 695, 711 (D.C. Cir. 2007) (en banc).

constitutionally protected warrants federal subsidization is a question for Congress to answer, not a matter of constitutional entitlement.”).[9]

Plaintiff’s claims of constitutional injury are predicated on the notion that a patient has a constitutional right not only to receive medical care, but to receive medical care of a specific type. But there is no constitutional right to medical care, let alone specific types of care, even if the care would save a person’s life.

Because physicians have no constitutional obligation to provide treatment they wish not to provide, Plaintiff’s claims cannot succeed.

2. A private physician’s treatment decision does not constitute state action.

Proof of a constitutional claim requires state action. Where, as here, the person effecting the alleged deprivation is a private party, the Supreme Court has nevertheless found state action in only a few unique circumstances:

- The *public function test* asks “whether the private entity performs a function which is ‘exclusively reserved to the State.’” *Cornish v. Corr. Servs. Corp.*, 402 F.3d 545, 549 (5th Cir. 2005) (quoting *Flagg Bros., Inc. v. Brooks*, 436 U.S. 149, 158 (1978).

- The *state compulsion test* attributes a private actor’s conduct to the state when the state “exerts coercive power over the private entity or provides significant encouragement.” *Id.* at 549–50 (citing *Adickes v. S.H. Kress & Co.*, 398 U.S. 144, 170–71 (1970).

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[9] *Harris* illustrates the danger in Plaintiff’s conception of constitutional rights. If a constitutional life interest conferred an affirmative right to medical care, so would the constitutional abortion right confer an affirmative right to have the state provide abortions. Yet *Harris* rejected precisely such an argument, explaining:

> It cannot be that because the government may not prohibit the use of contraceptives or prevent parents from sending their child to a private school, government, therefore, has an affirmative constitutional obligation to ensure that all persons have the financial resources to obtain contraceptives or send their children to private schools.

Harris v. McRae, 448 U.S. 297, 318 (1980) (citations omitted).

- And the *nexus test* asks if "the State has inserted 'itself into a position of interdependence with the private actor, such that it was a joint participant in the enterprise.'" *Id.* at 550 (quoting *Jackson v. Metro. Edison Co.*, 419 U.S. 345, 357–58 (1974)) (brackets omitted).

The Supreme Court has not resolved "[w]hether these different tests are actually different in operation or simply different ways of characterizing the necessarily fact-bound inquiry that confronts the Court in" state-action cases. *Lugar v. Edmondson Oil Co.*, 457 U.S. 922, 939 (1982).

Construed generously, Plaintiff's motion for summary judgment relies on the public-function and state-compulsion tests. MSJ at 8 ("[T]he hospital exercised statutory authority evocative of a government function . . . ."); *id.* at 9 ("[A] private hospital, when taking action under the statute, is performing a State function."). Plaintiff does not appear to argue that the State and defendants are joint actors.[10]

a. Section 166.046 does not satisfy the state-compulsion test.

Supreme Court precedent firmly refutes any notion that a hospital or physician invoking §166.046's safe harbor is a state actor. In the first place, §166.046 provides a discretionary, not mandatory, procedure; it requires no action from any private actor. The Supreme Court has repeatedly held that "[a]ction taken by private entities with *mere approval or acquiescence* of the State is not state action." *Am. Mfrs. Mut. Ins. Co. v. Sullivan*, 526 U.S. 40, 52 (1999) (emphasis added); *accord Blum v. Yaretsky*, 457 U.S. 991, 1004–05 (1982); *Flagg Bros.*, 436 U.S. at 154–65; *Jackson*, 419 U.S. at 357.

Indeed, the "[p]rivate use of state-sanctioned private remedies or procedures does not rise to the level of state action." *Tulsa Prof'l Collection Servs., Inc. v. Pope*, 485 U.S. 478, 485–86 (1988); *accord Flagg Bros.*, 436 U.S. at 161–62. A physician or hospital making use of §166.046

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[10] Nor could she. Nothing in Plaintiff's pleadings or motion for summary judgment suggests that the State is involved in the §166.046 procedure, beyond having created it.

is doing no more than using a state-provided remedy; the physician or hospital does not receive the type of "overt, significant assistance of state officials" that creates state action. *Pope*, 485 U.S. at 485–86; *cf. id.* at 487 (finding state action in private use of probate procedure, where probate judge was "intimately involved" in the procedure's operation); *Lugar*, 457 U.S. at 941 (holding that private use of prejudgment-attachment procedure constituted state action, where acts by sheriff and court clerk showed "joint participation with state officials in the seizure of the disputed property").

In the absence of overt assistance from or coercion by the State, even compliance with a *mandatory* procedure does not implicate state action. Consider *Blum v. Yaretsky*, in which "a class of Medicaid patients challeng[ed] decisions by the nursing homes in which they reside to discharge or transfer [them] without notice or an opportunity for a hearing." 457 U.S. at 993. Federal law *required* nursing homes to establish utilization review committees to "periodically assess[] whether each patient is receiving the appropriate level of care, and thus whether the patient's continued stay in the facility is justified." *Id.* at 994–95. The *Blum* plaintiffs were found by their respective URCs to not require a higher level of care, and were therefore transferred to other institutions in accordance with the statutory procedure. *Id.* at 995. Yet the Supreme Court held that there was no state action: the nursing homes, not the state, initiated the reviews and judged the patients' need for care on their own terms, not terms set by the state. The nursing homes' decisions "ultimately turn[ed] on medical judgments made by private parties according to professional standards that are not established by the State." *Id.* at 1008; *see also id.* at 1010 ("[The] regulations themselves do not dictate the decision to discharge or transfer in a particular case.").

Similarly, the decision to abstain from following a patient's wishes—and thus whether to initiate the §166.046 procedure—originates with the physician, who acts according to his own

conscience, expertise, and ethics. *Cf. id.* at 1009 (noting that nursing homes' transfer decisions were based on judgments that "the care [the patients] are receiving is medically inappropriate"). As in *Blum*, the State does not determine when or for what reasons a physician may invoke the §166.046 procedure. Moreover, unlike in *Blum*, use of §166.046 is permissive, even for physicians wishing to abstain. This case thus fits easily within *Blum*'s no-state-action holding.[11]

Another consideration cutting strongly against state action is that §166.046 does no more than immunize a physician who employs it. A similar issue arose in *Flagg Brothers*, in which the plaintiff sued to stop a warehouse from selling, pursuant to a warehouseman's lien, goods she had abandoned at the warehouse. *See* 436 U.S. at 153–54. State law provided the warehouse a procedure for making the sale and absolved it from liability if it complied. *See id.* at 151 n.1. The Court rejected the argument that the statute, or the state's decision to deny relief, constituted state action:

> If the mere denial of judicial relief is considered sufficient encouragement to make the State responsible for those private acts, all private deprivations of property would be converted into public acts whenever the State, for whatever reason, denies relief sought by the putative property owner.

Id. at 165. Likewise, the Legislature's decision to provide safe harbor for a physician's acts does not convert those acts into public acts.

The Fifth Circuit has applied these principles in even more analogous circumstances. In *Goss v. Memorial Hospital System*, 789 F.2d 353, 356 (5th Cir. 1986), the court considered a

[11] Even a private hospital's involvement in an involuntary commitment, pursuant to state law, is not state action. *See, e.g.*, *Estades-Negroni v. CPC Hosp. San Juan Capestrano*, 412 F.3d 1, 5–6 (1st Cir. 2005) (holding that the "scheme does not compel or encourage involuntary commitment," but "merely provides a mechanism through which private parties can, in their discretion, pursue such commitment"); *Bass v. Parkwood Hosp.*, 180 F.3d 234, 242 (5th Cir. 1999); *S.P. v. City of Takoma Park, Md.*, 134 F.3d 260, 269 (4th Cir. 1998); *Harvey v. Harvey*, 949 F.2d 1127, 1130–31 (11th Cir. 1992); *see also Loce v. Time Warner Entm't Advance/Newhouse P'ship*, 191 F.3d 256, 266–67 (2d Cir. 1999) (holding that Time Warner's congressionally authorized, but non-mandatory, indecency policy was not state action).

provision of the Texas Medical Practice Act that immunized hospitals' medical peer review committees from civil liability for reporting physician incompetency to the Board of Medical Examiners.[12] The plaintiff argued "that this immunity granted appellees by the State of Texas provided such encouragement to appellees that the peer review committee acted as an investigatory arm of the state." *Id.* Relying on *Flagg Brothers*, the Fifth Circuit rejected this argument, writing that the conferral of immunity "did not make the action of appellees state action." *Id.*

Similarly, in *White v. Scrivner Corp.*, 594 F.2d 140, 141 (5th Cir. 1979), the Fifth Circuit considered whether a grocery store security guard's detention of a shoplifter constituted state action. The plaintiff relied on a Louisiana statute "insulating merchants from liability for detention of persons reasonably believed to be shoplifters." *Id.* at 143. The court held that *Flagg Brothers* "require[d] rejection of this argument." *Id.* Noting that the statute allowed, but did "not compel merchants to detain shoplifters," the court held that the immunity statute could not constitute state action. *Id.*

Because §166.046 is a permissive statute, initiated at a physician's sole option, and because it does no more than withhold a cause of action, there is no coercion or participation rising to the level of state action.

b. Section 166.046 does not satisfy the public-function test.

The Supreme Court holds that state action exists when a private entity performs a function that is "traditionally the *exclusive* prerogative of the State." *Jackson*, 419 U.S. at 353. These are powers "traditionally associated with sovereignty." *Id.* The public-function test is "exceedingly difficult to satisfy." MARTIN A. SCHWARTZ, SECTION 1983 LITIG. CLAIMS & DEFENSES §5.14[A]. The Court has "rejected reliance upon the doctrine in cases involving":

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[12] An amended version of this statute is codified at TEX. OCC. CODE §160.010.

> coordination of amateur sports, the operation of a shopping mall, the furnishing of essential utility services, a warehouseman's enforcement of a statutory lien, the education of maladjusted children, the provision of nursing home care, and the administration of workers' compensation benefits.

Id. (footnotes omitted).

Plaintiff argues that "section 166.046 gives hospitals the power to decide a patient is no longer worthy of life-sustaining treatment," which is "a State function" because "the ability to take action which will result in death is not available to the public." MSJ at 9; *see also id.* at 11 (arguing that this power is "normally only held in the hands of State officials such as police officers and executioners who can take a person's life against that person's wishes with immunity").

There are any number of problems with Plaintiff's arguments, first among which is her misunderstanding of §166.046. The statute does not give doctors or hospitals the power to take life; it acknowledges their right not to provide treatment inconsistent with their own conscience. In this respect, Plaintiff's premise is deeply flawed.

Second, even accepting Plaintiff's characterization, she still could not show a public function. It is true that in one exceptionally narrow circumstance—legally sanctioned executions—the state has an affirmative power to take life. But the power ends there; it has not "traditionally" or "exclusively" extended into the field of medicine. On the contrary, centuries of common law, and the state and federal constitutions, *bar* the State from taking the lives of private citizens. Thus Plaintiff cannot cite, for example, a case in which a prison hospital has been held to have the power to deny a patient needed care.

Indeed, Plaintiff explicitly argues that the State *lacks* the power she nevertheless calls a public function. *See* MSJ at 7 (arguing that "the Constitution requires that the State not allow anyone 'but the patient' to make decisions regarding the cessation of life-sustaining treatment" (quoting *Cruzan ex rel. Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261, 286 (1990)). There

is an obvious illogic in holding that a power the Constitution *denies* the State is nevertheless "traditionally the exclusive prerogative" *of the State*. No court has ever embraced such a conclusion.

Section 166.046 concerns a quintessentially *private* function: medical decision-making. *See Blum*, 457 U.S. at 1011 ("We are also unable to conclude that nursing homes perform a function that has been traditionally the exclusive prerogative of the State." (quotations omitted)). Even when overlaid with state regulations,[13] a hospital's decisions are its own. *See id.* 1011–12 (holding that even if the state were obligated to provide nursing home services, "it would not follow that decisions made in the day-to-day administration of a nursing home are the kind of decisions traditionally and exclusively made by the sovereign").

Decisions about when to enter into and leave doctor-patient relationships are governed by the desires of the doctor and patient. A doctor's decision to terminate that relationship is left to his medical judgment and conscience, provided that he conforms to a non-statutory code of medical ethics. These private, personal decisions are not—and never have been—regarded as public functions.

c. Plaintiff's cases are inapposite.

Rather than confront these cases, Plaintiff relies on a variety of public-function cases arising under entirely different factual scenarios. *See Brentwood Academy v. Tenn. Secondary Sch. Athletic Ass'n*, 531 U.S. 288, 295–96 (2001) (highlighting the fact-bound nature of the state-action

[13] Plaintiffs emphasize the fact that hospitals are "heavily regulated." MSJ at 9. But even "[i]n cases involving extensive state regulation of private activity," the Supreme Court has "consistently held that '[t]he mere fact that a business is subject to state regulation does not by itself convert its action into that of the State." *Am. Mfrs. Mut. Ins. Co. v. Sullivan*, 526 U.S. 40, 52 (1999) (quoting *Jackson v. Metro. Edison Co.*, 419 U.S. 345, 350 (1974)) (alteration in original).

inquiry). Not one comes close to suggesting that decisions about the provision or non-provision of medical care in a private setting is an exclusive public function.

Plaintiff's most similar case is *Belbachir v. McHenry County*, 726 F.3d 975, 978 (7th Cir. 2013), which held that a private medical-services company employed to treat inmates at a county jail was a state actor when it provided that care. But *Belbachir* did not hold that the provision of medical care was a public function. Rather, the key to its holding was that the care was provided *in a jail, to incarcerated persons*. *Id.* This is consistent with longstanding Supreme Court precedent holding that when a physician "is authorized and obliged to treat prison inmates," she does so "clothed with the authority of state law." *West v. Atkins*, 487 U.S. 42, 55 (1988) (quotations omitted). The public-function requirement is satisfied in this context by the fact of incarceration:

> Under state law, the only medical care West could receive for his injury was that provided by the State. If Doctor Atkins misused his power by demonstrating deliberate indifference to West's serious medical needs, the resultant deprivation was caused, in the sense relevant for the state-action inquiry, by the State's exercise of its right to punish West by incarceration and to deny him a venue independent of the of the State to obtain needed medical care.

Id. But where the patient has access to an independent venue, decisions about medical care are not attributable to the state.

The remainder of Plaintiff's cases have no resemblance to the facts of this case:

- *Marsh v. Alabama*, 326 U.S. 501, 508–09 (1946), which long predates *Jackson*'s exclusivity test, concerned a company-run town in which the company exercised the gamut of traditional municipal powers. The Court held that the town's streets were therefore public fora. *Id.* at 509.

- *Watchtower Bible & Tract Society of New York, Inc. v. Sagardia de Jesus*, 634 F.3d 3 (1st Cir. 2011), is to similar effect. It holds that privately controlled *public* streets are public fora. *Id.* at 10. Likewise, *Lee v. Katz*, 276 F.3d 550, 555–56 (9th Cir. 2002), found state action when a private actor regulated speech in a public forum.

- *Smith v. Allwright*, 321 U.S. 649, 664 (1944), one of the *White Primary Cases*,[14] concerned the Texas Democratic Party's exclusion of African-Americans from its primary elections. The Court concluded that the holding of primaries, which often control the outcome of the general election, constitutes state action. *Id. Duke v. Massey*, 87 F.3d 1226 (11th Cir. 1996), and *Duke v. Smith*, 13 F.3d 388 (11th Cir. 1994), which Plaintiff also cites, are merely applications of the *White Primary Cases*.

- *Romanski v. Detroit Entertainment, LLC*, 428 F.3d 629, 637 (6th Cir. 2005), held that private security guards "endowed by law with plenary police powers such that they are *de facto* police officers" were state actors. But the court held that a more limited conferral of power would not constitute state action. *Id.*; *see also White*, 594 F.2d at 143.

Because neither logic nor precedent supports a finding of state action in this case, Plaintiff's constitutional claims are without merit.

CONCLUSION AND PRAYER

For physicians, patients, and families, no aspect of health care is more fraught than end-of-life decision-making. In many instances, physicians face a difficult choice between their desire to carry out their patients' wishes and their ethical duty, as medical professionals, not to increase or prolong their patients' suffering. TADA's §166.046 provides an important tool for balancing these competing concerns.

Plaintiff's constitutional challenge misapprehends both the statute and its purpose. As a consequence, Plaintiff has failed to demonstrate two fundamental prerequisites to a successful due process claim: a constitutionally protected interest and state action.

Amici request that this Court deny Plaintiff's motion for summary judgment.

[14] *See also Dietz*, 940 S.W.2d at 91–92 (discussing the *White Primary Cases*).

Respectfully submitted,

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