In the
Court of Appeals
Second Appellate District of Texas
at Fort Worth

No. 02-20-00002-CV

T.L., A MINOR, AND MOTHER, T.L., ON HER BEHALF, Appellants

V.

COOK CHILDREN'S MEDICAL CENTER, Appellee

On Appeal from the 48th District Court
Tarrant County, Texas
Trial Court No. 048-112330-19

Before Gabriel, Birdwell, and Wallach, JJ.
Opinion by Justice Birdwell
Dissenting Opinion by Justice Gabriel

OPINION

I. Introduction

In 1975, the State Bar of Texas and the Baylor Law Review published a series of articles addressing the advisability of enacting legislation that would permit physicians to engage in "passive euthanasia"[1] to assist terminally ill patients to their medically inevitable deaths.[2] One of the articles, authored by an accomplished Austin pediatrician, significantly informed the reasoning of the Supreme Court of New Jersey in the seminal decision *In re Quinlan*, wherein that court recognized for the first time in this country a terminally ill patient's constitutional liberty interest to voluntarily, through a surrogate decision maker, refuse life-sustaining treatment. 355 A.2d 647, 662–64, 668–69 (N.J. 1976) (quoting Karen Teel, M.D., *The Physician's Dilemma: A Doctor's View: What the Law Should Be*, 27 Baylor L. Rev. 6, 8–9 (Winter 1975)). After *Quinlan*, the advisability and acceptability of such voluntary passive euthanasia were "proposed, debated, and

[1]"Passive euthanasia is characteristically defined as the act of withholding or withdrawing life-sustaining treatment in order to allow the death of an individual." Lori D. Pritchard Clark, *RX: Dosage of Legislative Reform to Accommodate Legalized Physician-Assisted Suicide*, 23 Cap. Univ. L. Rev. 689, 692 (1994). "A noteworthy distinction drawn between active and passive euthanasia turns on whether the patient's death is the direct result of human intervention (active euthanasia), or the result of natural causes permitted to run their course (passive euthanasia)." *Id.* This distinction is crucial "because some find it acceptable to withhold life-sustaining treatment and allow a patient to die, but unacceptable to take active measures to kill a patient." Michael Weiss, *Illinois Death With Dignity Act: A Case for Legislating Physician Assisted Suicide and Active Euthanasia*, 23 Annals Health L. Advanced Directive 13, 16 (Spring 2014).

[2]Ed W. Schmidt, M.D. & Lloyd Lochridge, *Statement of the Issue*, 27 Baylor L. Rev. 1, 1–2 (Winter 1975).

[ultimately] accepted in American law[] and medical ethics"[3] with an important exception being passive euthanasia of infants with disabilities. Edward R. Grant & Cathleen A. Cleaver, *A Line Less Reasonable: Cruzan and the Looming Debate Over Active Euthanasia*, 2 Md. J. Contemp. Legal Issues 99, 100–01 & n.5, 222–23 & nn.547–56 (Summer 1991). Fast-forward over four decades from *Quinlan*, and this court confronts, as a question of first impression, the issue of whether the committee review process outlined in Section 166.046 of the Texas Advanced Directives Act (TADA), *see* Tex. Health & Safety Code Ann. §§ 166.001–.209, when invoked by the attending physician for a terminally ill infant, provides sufficient procedural due process to authorize involuntary passive euthanasia—allowing the physician to unilaterally withdraw life-sustaining treatment from the ailing child over her mother's objection—and thereby to

[3]The same year as *Quinlan*, California enacted the first advance directive—living will—statute; since then, all states have enacted some form of advance-directive legislation. *See* Elizabeth Villarreal, *Pregnancy & Living Wills: A Behavioral Economic Analysis*, 128 Yale L. J. F. 1052, 1056–57 (2019); Hannah Tuschman, *Birth Directives: A Model to Address Forced and Coerced Cesareans*, 69 Case W. Res. L. Rev. 497, 501–03 (Winter 2018).

cause her natural death.[4] We hold that, as applied in this instance, Mother pleaded—and introduced evidence supporting a viable claim—that the Section 166.046

[4]In only one other instance has this court had the opportunity to address the discontinuation of life-sustaining treatment pursuant to Section 166.046. In *In re Cook Children's Medical Center*, we denied mandamus relief requested by the hospital when a district court temporarily enjoined the hospital from discontinuing life-sustaining treatment for a minor patient over parental objection. No. 02-18-00326-CV, 2018 WL 5095176, at *1 (Tex. App.—Fort Worth Oct. 19, 2018, orig. proceeding) (per curiam) (mem. op.). Because we denied mandamus relief without explaining the reason for our denial, the decision is without precedential authority. *See* Tex. R. App. P. 52.8(d) ("When denying relief, the court may hand down an opinion but is not required to do so."); *In re Schneider*, 134 S.W.3d 866, 870–71 & n.4 (Tex. App.—Houston [14th Dist.] 2004, orig. proceeding) (Frost, J., concurring) (citing opinions from other jurisdictions that hold decisions issued without an opinion have no precedential value as to legal issues raised therein).

There appear to have been only two other cases involving the application of the committee review process to a minor patient; neither addressed the merits of a constitutional challenge. In *Hudson v. Texas Children's Hospital*, the First Court of Appeals in Houston reversed the trial court's denial of temporary injunctive relief sought by the mother of a newborn infant suffering from thanatophoric dysplasia—an inevitably fatal genetic disease requiring mechanical ventilation—on the grounds of recusal error. 177 S.W.3d 232, 233–38 (Tex. App.—Houston [1st Dist.] 2005, no pet.). The mother did not challenge the constitutionality of the committee review process but sought additional time to find another physician or facility to continue life-sustaining treatment for her son. *See id.* at 233–34. On remand, the trial court again denied injunctive relief, holding that "there was no reasonable expectation that another health care provider would agree to continue treatment if time were further extended." *See* Amir Halevy, M.D. & Amy L. McGuire, *The History, Successes and Controversies of the Texas "Futility" Policy*, 43 Hous. Law. 38, 40 (May/June 2006). The infant died the following day when the hospital removed him from life support. *Id.*

In *Gonzales v. Seton Family of Hospitals*, Travis County Probate Court No. 1 entered an order temporarily restraining Children's Hospital of Austin from discontinuing life-sustaining treatment for a sixteen-month-old infant suffering from Leigh's disease, a uniformly fatal progressive neurological illness that eventually destroys all brain function, and setting a hearing to consider whether to grant a temporary injunction to the child's mother, who challenged the constitutionality of the committee review

committee review process did not provide her sufficient procedural due process, such that she was entitled to temporary injunctive relief.

Specifically, appellants here—T.L., the infant patient, and her mother, T.L., on her behalf (individually, T.L. and Mother)—appeal from the denial of a temporary injunction sought to enjoin, under 42 U.S.C.A. § 1983, the unilateral discontinuation of the ailing child's ongoing course of life-sustaining treatment at Appellee Cook Children's Medical Center (CCMC). CCMC had affirmed this treatment decision of T.L.'s attending physician after he had invoked the committee review process set forth in Section 166.046, a key component of the TADA. In so doing, CCMC had authorized the attending physician to discontinue T.L.'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.

Because Section 166.046 delegates through this process two traditional and exclusive public functions—(1) the sovereign authority of the state, under the doctrine of *parens patriae*, to supervene the fundamental right of a parent to make a medical treatment decision for her child and (2) the sovereign authority of the state, under its

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process. Thaddeus Mason Pope, *Involuntary Passive Euthanasia in U.S. Courts: Reassessing the Judicial Treatment of Medical Futility Cases*, 9 Marquette Elder's Advisor 229, 233–35 (2008) (citing filings in No. 86,427 (filed Mar. 20, 2007)); *Austin Toddler at Center of Texas Legal Fight Dies*, Weatherford Democrat, May 22, 2007, https://www.weatherforddemocrat.com/news/local_news/austin-toddler-at-center-of-texas-legal-fight-dies/article_797d47d0-badb-5c3c-9cd5-210133b94783.html (last visited July 21, 2020). The child died before the court could conduct the hearing. *Austin Toddler at Center of Texas Legal Fight Dies*, *supra*.

police power, to regulate what is and is not a lawful means or process of dying—the decision rendered thereby constitutes "state action" within the meaning of the Fourteenth Amendment of the United States Constitution and 42 U.S.C.A. § 1983. As a state actor, then, CCMC had to comply with the procedural and substantive dictates of due process before affirming and thereby effectuating such a treatment decision. Because Mother (1) pleaded—and showed a probable right to recover under a viable cause of action—that the committee review process set forth in Section 166.046 and followed by CCMC fails to comply with the dictates of procedural due process, at least as applied in these circumstances, and (2) established that the failure to maintain the status quo ante would result in immediate irreparable harm, the trial court erred by denying Mother temporary injunctive relief, and we reverse the trial court's order denying it.

II. The Section 166.046 Procedure

Because it is undisputed that Section 166.046's committee review process applies to this dispute and is integral to understanding the factual background of the case, we preface our discussion of the facts with a summary of the process.

The TADA defines "[l]ife-sustaining treatment" as

> treatment that, based on reasonable medical judgment, sustains the life of a patient and without which the patient will die. The term includes both life-sustaining medications and artificial life support, such as mechanical breathing machines, kidney dialysis treatment, and artificially administered nutrition and hydration. The term does not include the administration of pain management medication or the performance of a medical procedure

> considered to be necessary to provide comfort care, or any other medical care provided to alleviate a patient's pain.

Tex. Health & Safety Code Ann. § 166.002(10). Section 166.046 of the TADA provides a set of procedures by which an attending physician[5] may obtain immunity 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[6] or against the wishes of the person responsible for the patient's health care

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[5]An "[a]ttending physician" is "a physician selected by or assigned to a patient who has primary responsibility for a patient's treatment and care." *Id.* § 166.002(3).

[6]The TADA defines a "[t]erminal condition" as "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." *Id.* § 166.002(13). It defines an "[i]rreversible condition" as

> a condition, injury, or illness: (A) that may be treated but is never cured or eliminated; (B) that leaves a person unable to care for or make decisions for the person's own self; and (C) that, without life-sustaining treatment provided in accordance with the prevailing standard of medical care, is fatal.

Id. § 166.002(9). A "patient with a terminal or irreversible condition that has been diagnosed and certified in writing by the attending physician" is referred to as a "[q]ualified patient." *Id.* § 166.031(2).

Although a terminal condition and an irreversible condition are distinct conditions subject to the provisions of the TADA, we will refer to patients suffering from either condition as "terminally ill" because both definitions anticipate such patients will die upon the withdrawal of life-sustaining treatment.

decisions. *Id.* §§ 166.045(d)–.046.[7]

The centerpiece of those procedures is a review of the attending physician's decision by a health care facility's ethics or medical committee[8] in a meeting that the patient or patient's representative is entitled to attend upon notice given no less than forty-eight hours beforehand:

> (a) If an attending physician refuses to honor a patient's advance directive or a health care or treatment decision made by or on behalf of a patient, the physician's refusal shall be reviewed by an ethics or medical committee. The attending physician may not be a member of that

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[7]"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 outlined in Section 166.046." *Id.* § 166.045(d).

[8]An "[e]thics or medical committee" is "a committee established under Sections 161.031–166.033" of the Texas Health & Safety Code. *Id.* § 166.002(6). Section 161.031 broadly defines a "medical committee" to include "any committee, including a joint committee" of certain types of health care facilities, including hospitals, either tasked with conducting a specific investigation on an ad hoc basis or established under state or federal law or under the bylaws or rules of the institution, often with the purpose of improving the provision of health care through medical peer review. *Id.* §§ 161.031–.0315(a). *See generally In re Mem'l Hermann Hosp. Sys.*, 464 S.W.3d 686, 716 (Tex. 2015) (orig. proceeding) (discussing the statutory functions and confidentiality of medical committees). "The records and proceedings of a medical committee are confidential and are not subject to court subpoena." Tex. Health & Safety Code Ann. § 161.032(a). A medical-committee member

> is not liable for damages to a person for an action taken or a recommendation made within the scope of the functions of the committee if the committee member acts without malice and in the reasonable belief that the action or recommendation is warranted by the facts known to the committee member.

Id. § 161.033 (granting qualified immunity to committee members).

committee. The patient shall be given life-sustaining treatment during the review.

(b) The patient or the person responsible for the health care decisions of the individual who has made the decision regarding the directive or treatment decision:

(1) may be given a written description of the ethics or medical committee review process and any other policies and procedures related to this section adopted by the health care facility;

(2) shall be informed of the committee review process not less than 48 hours before the meeting called to discuss the patient's directive, unless the time period is waived by mutual agreement;

(3) at the time of being so informed, shall be provided:

(A) a copy of the appropriate statement set forth in Section 166.052 [explaining state law, the patient's rights, and the resources available to the patient when the attending physician refuses to honor the patient's decision to continue or discontinue life-sustaining treatment]; and

(B) a copy of the registry list of health care providers and referral groups that have volunteered their readiness to consider accepting transfer or to assist in locating a provider willing to accept transfer that is posted on the website maintained by the department under Section 166.053; and

(4) is entitled to:

(A) attend the meeting;

(B) receive a written explanation of the decision reached during the review process;

(C) receive a copy of the portion of the patient's medical record related to the treatment received by the patient in the facility for the lesser of:

> (i) the period of the patient's current admission to the facility; or
>
> (ii) the preceding 30 calendar days; and
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> (D) receive a copy of all of the patient's reasonably available diagnostic results and reports related to the medical record provided under Paragraph (C).

Id. § 166.046(a)–(b).

If, after following the prescribed procedures, the committee "affirm[s]" the attending physician's decision to discontinue "medically inappropriate" life-sustaining treatment, "[t]he attending physician, any other physician responsible for the care of the patient, and the health care facility are not obligated to provide life-sustaining treatment after the 10th day after both the written decision and the patient's medical record" are provided to the patient. *Id.* § 166.046(e). A physician may not, however, withhold or withdraw "pain management medication, medical procedures necessary to provide comfort, or any other health care provided to alleviate a patient's pain" unless such care would be "medically contraindicated" or "contrary to the patient's or surrogate's clearly documented desire not to receive artificially administered nutrition or hydration." *Id.* The physician must also make a reasonable effort to transfer the patient to another physician who is willing to comply with the treatment decision refused by the attending physician, whether within "an alternative care setting" of the health care facility itself or another facility. *Id.* § 166.046(d). The ten-day time period for effectuating the attending physician's refusal may be extended by a district or county

court only upon a finding, "by a preponderance of the evidence, that there is a reasonable expectation that a physician or health care facility that will honor the patient's directive will be found if the time extension is granted." *Id.* § 166.046(g). Section 166.046 does not otherwise authorize judicial review of either the attending physician's refusal or the written decision of the committee affirming it. *See id.*

We now turn to the specific facts of this case, in which the Section 166.046 procedure was invoked and followed.

III. Medical History and Procedural Background

In February 2019, T.L. was born with serious, life-threatening medical complications. Mother was twenty weeks pregnant when doctors told her that T.L. suffered from a severe form of Ebstein's anomaly, a congenital defect in which the right atrium of the heart is enlarged and misshapen. At birth, T.L.'s heart filled ninety percent of her chest cavity, compared with forty to fifty percent for a normal newborn. T.L.'s doctors also diagnosed her with pulmonary atresia: a condition in which the pulmonary valve that is responsible for blood flow from the heart into the lungs for oxygenation is not fully formed. Complicating matters further, T.L. was born severely premature at thirty-two weeks' gestation, with lungs insufficiently developed to adequately exchange oxygen and carbon dioxide into and out of her already-compromised cardiovascular system, and her massive heart compressed her lungs down and to the sides of her chest cavity. During pregnancy, T.L. had received oxygen from Mother, but at birth, the defects in T.L.'s cardiopulmonary system left her ability to oxygenate her own blood

seriously impaired. As a result, CCMC admitted her to its Cardiac Intensive Care Unit ("CICU") on the day she was born, and she remains there to this day.

To describe the care provided to T.L. by CCMC's physicians, nurses, and staff as anything less than heroic would be a disservice to their labors. Shortly after T.L.'s birth, her doctors performed open-heart surgery to reconstruct and reduce the size of her right atrium, to limit the blood flow into her right ventricle, and to revise her pulmonary valve to improve blood flow into her lungs. To further assist with pulmonary circulation, the surgery included the placement of a shunt routing additional blood to the lungs. And to maintain adequate cardiopulmonary function during this and additional surgeries, T.L. was temporarily placed on a heart–lung bypass.

Postoperatively, T.L. was placed on a ventilator for a time, and periodically thereafter. Unfortunately, the pressure of the ventilation over time damaged her still-developing lungs, scarring the tissue and leaving her with a chronic lung disease resembling emphysema. T.L.'s chronic oxygen insufficiency also caused another problem: overdevelopment of the vascular muscles in her lungs. When she became agitated or irritated, the muscles in her pulmonary blood vessels would clamp down, causing the blood pressure in her lungs to soar and her oxygen levels to plummet. These "crash" or "dying" events put her life in immediate jeopardy.

To relieve these pulmonary hypertension crises, the CICU nursing staff would turn off the ventilator and begin to manually pump air into her lungs using a bag, while doctors administered sedatives, nitric oxide, and paralytic medications to relax the

muscles. Because any number of things—from necessary medical and nursing care to simply changing her diaper or repositioning her to prevent bed sores—could bring on a crisis, the CICU staff scheduled as much of her care as possible during a minimal time frame to avoid triggering multiple events. T.L. might have had no crashes in a day, or she might have had as many as three, and she required round-the-clock monitoring and care.

In an attempt to improve T.L.'s cardiopulmonary condition sufficiently to enable her discharge from the hospital, doctors performed multiple major heart surgeries over several months: the original surgery to reduce the size of her right atrium and place the shunt designed to improve blood flow between the heart and lungs, another to revise the shunt, and additional exploratory and other surgical procedures. According to the attending physician, one of six physicians on T.L.'s CICU team, the surgeries created "windows" of seeming improvement, only to see each improvement meet with "steps backward."

The gravest setback occurred on July 9, 2019. T.L. suffered another severe pulmonary hypertension crisis. This time, however, none of the usual treatments for relaxing her pulmonary vessels worked. The team intubated her, anesthetized her, and administered sedatives, paralytics, and nitric oxide—all to no avail. After a quick consult, her doctors performed emergency surgery to put T.L. on a form of heart–lung bypass called extracorporeal membrane oxygenation (ECMO) while they addressed the

pulmonary hypertension crisis. Eventually, they were able to relax her lungs sufficiently to remove her from ECMO and return her to ventilation.

Unfortunately, while T.L. had often been able to breathe without a ventilator before her crash in July 2019, enabling her to interact with Mother and her family before that event, thereafter she required mechanical ventilation continuously. To minimize the risk of triggering additional hypertensive crises due to the discomfort of the ventilator, the CICU physicians kept T.L. deeply sedated and administered pain medication intravenously. All told, by the time of the temporary injunction hearing, T.L. had ventilation and nasogastric tubes and two IVs for purposes of oxygenation, medication, hydration, and nutrition.

Following the July 2019 crash, T.L.'s attending physician began to view her situation as "hopeless." In consultation with the other CICU physicians and T.L.'s cardiothoracic surgeons, the attending physician concluded that there were no further surgical options available, no likelihood of eventual improvement, and no hope for her continued survival without repeated emergent interventions to address her recurring pulmonary hypertension crises. In light of T.L.'s irremediable cardiopulmonary complications and the consensus medical judgment that she was "suffering," the CICU team viewed the continuation of life-sustaining treatment as "cruel" and "unnatural" and considered its discontinuation to be in her best interest.

Over the course of the next couple of months, the attending and other CICU physicians began to "escalat[e]" their conversations with Mother, urging her to

discontinue life-sustaining treatment and to let T.L. die naturally. The CICU nursing staff also had "multiple conversations"—"days, weeks of . . . conversations"—with Mother, with some members eventually opting to take shifts that would not involve caring for T.L. to avoid the emotional distress of watching her suffer.

Mother resisted the doctors' and staff's entreaties, even to the point of avoiding contact with the physicians when possible, due to her firm belief, informed by her religious faith, that there was some solution that the doctors were just not seeing. She did not agree that T.L. was suffering in the manner represented by the CICU staff or that she was without hope of recovery. All the while, and despite the deep sedation and pain medication, T.L. continued to experience pulmonary hypertension events.

In apparent response to conversations with physicians and CCMC staff, in late September or early October 2019, Mother reached out to Boston Children's Hospital and Texas Children's Hospital in Houston to see if either would accept a transfer of T.L. from CCMC. CCMC coordinated with both institutions, sharing heart ultrasounds, echocardiograms, cardiac catheterization data, progress notes, operative summaries, and laboratory data, as requested. T.L's CICU physicians also made themselves available for telephone consultations with the physicians at those institutions responsible for evaluating T.L.'s condition for transfer. In both instances, the physicians contemplating transfer agreed that there were no further surgical interventions available to relieve T.L.'s suffering and informed CCMC that their institutions would not accept her for

transfer. The doctor from Boston Children's contacted Mother directly to explain her institution's decision.[9]

Having reached an intractable impasse with Mother, and reluctant to continue providing life-sustaining care without any reasonable hope of improving T.L.'s condition, on or about September 27, 2019, T.L.'s attending physician invoked the statutory procedure for discontinuing her life-sustaining treatment under Section 166.046 of the TADA by contacting the chair of CCMC's ethics committee and requesting a consultation to that end.

After first meeting with the attending physician to confirm his request for consultation and the basis thereof, the committee chair asked another member of the committee to meet with Mother to explain the committee review process and to confirm that there had not been any miscommunication between Mother and the attending physician concerning T.L.'s condition and prognosis. The conversation did not include any discussion of the possibility of withdrawing life-sustaining treatment from T.L.

[9]After these two institutions declined to accept T.L. for transfer, there appears to have been one other transfer inquiry made during this time frame. The attending physician recalled specifically suggesting Children's Medical Center of Dallas to Mother, only to have her decline the inquiry thinking it unlikely to result in a transfer given the results from Boston and Houston. Nevertheless, the record reflects that on or about October 28, 2019, Children's Medical declined transfer for much the same reasons as had Boston Children's and Texas Children's.

After this one-on-one meeting, the committee chair personally communicated with Mother about T.L.'s medical circumstances, the challenges she faced, and how CCMC could help fulfill Mother's hopes for T.L. None of these communications included any discussion of the withdrawal of treatment recommended by the attending physician. As the next step in the committee review process, the chair asked Mother to meet with a three-member subcommittee. To accommodate Mother's schedule, the chair scheduled the meeting on October 22, 2019, but in the end, Mother was unable to attend.

On Friday, October 25, 2019, the committee chair notified Mother, in the following letter, that the full committee would hold a meeting at noon on Wednesday, October 30, 2019, to consider whether continuing to provide life-sustaining treatment to T.L. was medically inappropriate and not in her best interest:

> I am writing you to ask that you attend a meeting with members of Cook Children's ethics committee regarding [T.L.]'s future medical care, and to explain why an ethics committee review has been requested. This meeting is part of a formal review process available under a state law called the Texas Advance Directives Act. That law allows a physician to request a formal review by the hospital's ethics committee when the physician feels that continuing to honor a family's request to provide life-sustaining treatment to a patient with a terminal or irreversible condition is medically inappropriate. As you know, [T.L.] is gravely ill, and in the professional opinion of the physicians caring for her, escalating care and continuing to provide life-sustaining treatment is medically futile and not in [T.L.]'s best interest.
>
> Enclosed is a copy of a notice we are required by law to provide you, and which includes a detailed explanation of the review process and your rights related to that process. Also enclosed is a list maintained by the Texas Department of State Health Services that identifies health care

> providers and referral groups that have volunteered their readiness to consider accepting transfer or to assist in locating a provider willing to accept transfer. **The meeting is scheduled for Wednesday, October 30, 2019, at 12:00 p.m., and will be held in Room 1163 of the Medical Center's South Tower.**
>
> It is very important that you attend the meeting next Wednesday so that the ethics committee can hear from you directly before making a determination regarding the appropriateness of continuing to sustain [T.L.]'s life through artificial means. The chaplain will meet you in [T.L.]'s room at 11:30 a.m., and will escort you to the meeting. You are welcome to invite any involved family members to support you at the meeting. In the meantime, please do not hesitate to call me with any questions you might have.

In addition to sending the written notice, the chair spoke personally with Mother to explain what could be expected procedurally at the meeting.

On October 30, 2019, CCMC's ethics committee held the meeting as planned. Of the committee's twenty-five members, twenty-two—nineteen of whom were CCMC employees—attended the meeting. Members of the committee included physicians and other health care providers with no involvement in T.L.'s care, as well as nonmedical members including the committee chair and a parent of a former CCMC patient. Mother attended with her parents.

During the two-hour meeting, the committee heard from the attending physician on behalf of himself and other physician members of the CICU team who were providing care to T.L. The attending physician recounted T.L.'s medical history and the team's consensus view of her prognosis. The committee also heard from Mother and

her father, both of whom urged the committee to continue life-sustaining treatment for T.L.

After excusing the attending physician, Mother, and her parents, the committee went into closed session to deliberate the case. After thirty to forty-five minutes of deliberations, the committee reached a unanimous decision affirming the attending physician's recommendation that life-sustaining treatment should be discontinued for T.L. Having excused Mother and her parents, the committee did not return to an open meeting to announce its decision. Neither did the committee formally transcribe either the presentations or its deliberations.[10]

Late in the evening on the day following the meeting—Thursday, October 31, 2019—the committee chair provided the statutorily required written notice of the committee's decision by having the nurse supervisor deliver the following letter to Mother informing her that life-sustaining treatment would be guaranteed for only ten days, through Sunday, November 10, 2019, and could be discontinued thereafter:

> I am writing to notify you of the recommendation of Cook Children's ethics committee relating to the continuation of life-sustaining treatment for your daughter, [T.L.]. After receiving the required notice from Cook Children's on October 25, 2019, you, along with your mother and father, participated in the October 30th meeting of the ethics committee. [T.L.]'s attending physician . . . was also in attendance.
>
> As previously discussed, [T.L.] has been diagnosed with severe congenital heart disease, lung disease, and pulmonary hypertension. [T.L.]'s attending physicians have determined her condition is irreversible,

[10]The chair testified that the committee secretary took notes of the meeting but that she had not reviewed those notes.

meaning it may be treated but will never be cured or eliminated, and, without life-sustaining treatment provided in accordance with the prevailing standard of medical care, her condition is fatal.[11] [T.L.]'s physicians feel that she is suffering. [The attending physician] provided an overview of [her] medical history and current condition to the committee, and explained that all of her physicians (including her pulmonologist, the cardiac surgeons, cardiac intensivists, and cardiologists) agree that continuing to provide life-sustaining treatment to [T.L.] is futile. The committee members also heard you express your sincere belief that [she] is not suffering, and that her condition will improve.

The committee discussed the information that was presented and reviewed the benefits versus the burdens of continued treatment. After weighing all of the information presented, the committee concluded that the goal of restoring [T.L.]'s health is unattainable, that no other medical benefits can be accomplished by continuing treatment that artificially sustains her life, and that it is in [T.L.]'s best interest to allow her to die naturally. As a result, you have been informed that the committee concurs with the physicians' opinion that further treatment would be inappropriate, should not be continued, and that [T.L.] should be allowed to die naturally. Despite this, it is my understanding that you do not agree with this decision and desire further treatment to be given to your daughter. We will continue to provide life-sustaining treatment to [T.L.] for up to ten (10) days from the date you receive this letter, pending transfer to another facility. As you know, we have already made several unsuccessful attempts to locate a facility willing to accept [T.L.] as a patient. We will continue to make reasonable efforts to find a facility that is acceptable to you that is willing to accept [T.L.] as a patient and comply with your treatment directives. Please note that under state law, Cook Children's is not obligated to provide life-sustaining treatment after the tenth day following your receipt of this letter. However, we will continue

[11]As noted above, *see* note 6 *supra*, at 7, this finding of an irreversible condition without reference to a concurrent terminal condition meant that withdrawing life-sustaining treatment from T.L. would result in her immediate natural death, while maintaining such treatment would keep her alive at least for the following six months. The attending physician subsequently testified at the temporary injunction hearing that T.L.'s condition was such that she would likely not survive another six months even if she continued to receive life-sustaining treatment. Because Mother complains of the trial court's refusal to enjoin the *immediate* withdrawal of life-sustaining treatment, this discrepancy is immaterial for purposes of our review.

> to provide artificial nutrition and hydration for as long as is medically appropriate.
>
> Along with this letter, and as you requested, you are receiving paper copies of [T.L.]'s medical records for the last thirty (30) days, including all diagnostic reports. I understand that you also recently requested an abstract of [T.L.]'s records for the entire admission, and that those records were provided to you on CD earlier this week.
>
> We appreciate the difficulty of making decisions concerning the withdrawal of artificial life support. If you have any questions or if I can be of any further assistance, please do not hesitate to contact me.

The timing of the delivery of the letter left Mother with six business days in which to obtain a transfer, if possible, although the CICU team was available throughout the two intervening weekends to facilitate a transfer if one became available.

At some point, Mother gave CCMC a long list of other hospitals to contact concerning a possible transfer.[12] The CICU team began to contact these hospitals during the ten-day window. Although a few hospitals considered accepting T.L. for transfer—with some even requesting additional testing, which CCMC provided—none agreed to accept T.L. as a patient.[13] The attending physician spoke with many of the

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[12]Mother testified that she gave one list to CCMC before she received notice of the ten-day time frame; then she added another list after she received the committee's written decision. A summary of conversations between Mother, the CICU team, and other facilities concerning possible transfer indicates that Mother verbally asked CICU staff to seek a transfer to certain specific hospitals on Friday, November 1; provided a written list of potential hospitals the following day; and verbally confirmed that she had already provided another list to one of the attending physicians without saying when she had done so.

[13]During the eventual temporary injunction hearing, Mother presented evidence that some hospitals were equivocal and potentially still considering the case. This

providers considering transfer; he objectively recounted T.L.'s medical history and then-current status but left the providers to conduct their own evaluation of her prognosis. Based upon these conversations, however, the attending physician believed a transfer was unlikely.

On the last day of the ten-day period, Mother filed this suit under 42 U.S.C.A. § 1983 and Texas's Uniform Declaratory Judgments Act, (1) alleging that CCMC's decision to discontinue life-sustaining treatment interfered with her civil right as a parent to make treatment decisions for her minor child and violated T.L.'s civil right to life and did so without providing Mother or T.L. sufficient procedural-due-process protection; (2) seeking a declaration that Section 166.046 is constitutionally infirm under both the United States and Texas Constitutions due to a lack of substantive and procedural due process; and (3) requesting a temporary restraining order, followed by temporary and permanent injunctive relief, enjoining CCMC from discontinuing life-sustaining treatment for T.L. Mother took no issue with the care provided by CCMC and the CICU staff; indeed, she praised the hospital for its months-long effort to help T.L.

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testimony came chiefly from two witnesses from Protect TX Fragile Kids—a private organization dedicated to helping medically fragile children—who began assisting Mother in obtaining a transfer hospital. The witnesses were motivated to help Mother because of experiences with their own children, who had prevailed over medical adversity and long odds.

Rather, Mother solely complained that Section 166.046 effectively empowered private health care providers such as CCMC to deprive their patients of fundamental rights—life itself and the right to determine the course of medical care—without due process of law. Before such a great deprivation, she said, due process requires that she and T.L. be provided certain procedural guarantees, such as adequate notice (more than forty-eight hours) and a meaningful opportunity to participate in a hearing before a neutral arbiter (not to merely attend a meeting of a medical review committee made up largely of CCMC's employees) utilizing ascertainable standards for determining whether the continuation of life-sustaining treatment is "medically inappropriate" (rather than the personal judgments of the attending physician or committee members), with more than a mere ten days to seek a transfer.[14]

On November 10, 2019, the trial court issued a temporary restraining order until a full hearing could be held on Mother's request for a temporary injunction, which the parties agreed to extend due to procedural delays. In the interim, Mother continued to seek another hospital to accept the transfer of T.L., with the CICU team assisting as requested. Several amici curiae, including the Attorney General for the State of Texas, filed briefs with the trial court.

[14]Mother also argued that the same provision violated substantive due process, though her reasoning in support of this argument was much the same as the reasoning she offered concerning procedural due process.

At the hearing, multiple witnesses—including Mother, the attending physician, the committee chair, and a nurse on the CICU team—testified to the factual circumstances recounted herein. The committee chair elaborated on the committee review process and the procedures employed, explained that attending physicians invoked the process "[m]aybe once a year," and denied that the process was merely a "rubber stamp" for the physicians who treated pediatric patients at CCMC. According to the chair, Mother did not have legal counsel or, necessarily, the right to legal counsel before the committee, and Mother was not guaranteed the opportunity to present any medical opinion contrary to that of the attending physician or the CICU team. The chair agreed that the committee was the hospital's "decision-making body,"[15] though the committee followed no particular evidentiary standards in making its decision; instead, the committee simply "consider[ed]" what the attending physician and family had to say and made its decision.

After the trial court considered (1) the evidence presented, including expert medical testimony concerning T.L's condition, treatment options, and prognosis and an extensive summary of CCMC's efforts to find another hospital for her transfer;

[15]To the same end, at the time of the hearing, the hospital had an internal policy concerning the committee, which variously described the committee's function as "Conflict Resolution Ethics Case Review" and "Case Review – To provide support and advice to those responsible for treatment decisions." Under the heading of case review, the policy recited the majority of Section 166.046's text as the procedure that should govern any committee meeting, and the policy stated that in this setting, "the Ethics Committee acts as a 'decision-making' body under the provisions of the Texas Advance Directives Act."

(2) the thorough briefing of the parties, the Attorney General (on behalf of amicus curiae the State of Texas),[16] and various other amici urging both the constitutionality[17]

[16]In considering the constitutionality of a statute, the state judiciary may "be guided by reasoned interpretations of a statute by officials of the state executive branch, particularly the attorney general." *See In re Smith*, 333 S.W.3d 582, 588 (Tex. 2011) (citing *Koy v. Schneider*, 221 S.W. 880, 885–86 (Tex. 1920)). The opinion of the Attorney General is not binding but is often persuasive—whether presented as a formal administrative opinion or as argument in briefing when the Attorney General is a party or is acting as amicus curiae. *Id. Compare City of Dallas v. Abbott*, 304 S.W.3d 380, 383–84 (Tex. 2010) (in interpreting Public Information Act, citing and relying on two formal administrative opinions in agreeing with part of briefing argument of Attorney General when he was a party), *with Holmes v. Morales*, 924 S.W.2d 920, 923–25 (Tex. 1996) (interpreting Open Records Act and rejecting both formal administrative opinions and briefing argument of Attorney General when he was a party), *and City of Aransas Pass v. Keeling*, 247 S.W. 818, 819–21 (Tex. 1923) (rejecting Attorney General's briefing argument as a party that challenged statute was unconstitutional).

For this reason, both the Texas Constitution and the Texas Government Code prohibit a court from rendering a judgment holding a statute unconstitutional until the Attorney General has been given notice of the challenge and has had a reasonable opportunity to inform the court of the State's position on the matter. Tex. Const. art. V, § 32; Tex. Gov't Code Ann. § 402.010. Whether the Attorney General formally states such a position, the interpreting court has an independent duty to determine the constitutional validity of the challenged statute. *See* Tex. Gov't Code Ann. § 402.010(b)–(c); *Jones v. Williams*, 45 S.W.2d 130, 131 (Tex. 1931).

[17]These amici included the Texas Alliance for Life, Texas Catholic Conference of Bishops, Texans for Life Coalition, Coalition of Texans with Disabilities, Texas Alliance for Patient Access, Texas Hospital Association, Texas Medical Association, Texas Osteopathic Medical Association, LeadingAge Texas, and Tarrant County Medical Society.

and unconstitutionality[18] of Section 166.046;[19] and (3) the argument of counsel, including counsel from the Office of the Attorney General urging the constitutional infirmity of Section 166.046, the trial court denied Mother's request for a temporary injunction. Mother appeals from this ruling. Although Mother raises three issues, only her third is dispositive: that the trial court erred by denying the temporary injunction because she had shown the "necessary elements" entitling her to that relief on her Section 1983 claim.

IV. Standard of Review and Law Applicable to Temporary Injunctions

A temporary injunction is an extraordinary remedy that does not issue as a matter of right. *Butnaru v. Ford Motor Co.*, 84 S.W.3d 198, 204 (Tex. 2002) (op. on reh'g). Its purpose is to preserve the status quo of the litigation's subject matter until a trial on the merits. *Clint ISD v. Marquez*, 487 S.W.3d 538, 555 (Tex. 2016). The status quo is "the last, actual, peaceable, non-contested status which preceded the pending controversy." *In re Newton*, 146 S.W.3d 648, 651 (Tex. 2004) (orig. proceeding).

[18]These amici included the Texas Home School Coalition and four individuals who recounted their own adverse experiences with hospitals that were able to override a family member's desire to continue receiving life-sustaining treatment by invoking Section 166.046.

[19]Each of the amici in the trial court are similarly amici in this court with the exception of the Governor of the State of Texas, who joined the Attorney General herein on behalf of amicus curiae the State of Texas, and the four individuals referenced in note 18 above.

We review a trial court's decision to deny a temporary injunction for an abuse of discretion. *Butnaru*, 84 S.W.3d at 204; *Schmitz v. Denton Cty. Cowboy Church*, 550 S.W.3d 342, 363 (Tex. App.—Fort Worth 2018, pet. denied) (mem. op. on reh'g). A trial court abuses its discretion if it rules in an arbitrary manner or without reference to guiding rules and principles. *Butnaru*, 84 S.W.3d at 211. Although a trial court does not abuse its discretion by basing its temporary injunction ruling on conflicting evidence or when some evidence of substantive and probative character exists to support its decision, a trial court does abuse its discretion by misapplying the law to established facts. *Henry F. Coffeen III Mgmt., Inc. v. Musgrave*, No. 02-16-00070-CV, 2016 WL 6277375, at *2 (Tex. App.—Fort Worth Oct. 27, 2016, no pet.) (mem. op.); *Tom James of Dallas, Inc. v. Cobb*, 109 S.W.3d 877, 883 (Tex. App.—Dallas 2003, no pet.). We review de novo any question-of-law rulings necessary to resolve whether a temporary injunction should issue. *Tom James*, 109 S.W.3d at 883; *see also, e.g.*, *Oil Field Haulers Ass'n v. R.R. Comm'n*, 381 S.W.2d 183, 192–95, 197 (Tex. 1964); *Camp v. Shannon*, 348 S.W.2d 517, 519–20 (Tex. 1961); *Sw. Greyhound Lines, Inc. v. R.R. Comm'n*, 99 S.W.2d 263, 266–68 (Tex. 1936).

To obtain a temporary injunction, an applicant must plead and prove (1) a cause of action against the defendant; (2) a probable right to the relief sought; and (3) a probable, imminent, and irreparable injury in the interim. *Butnaru*, 84 S.W.3d at 204. The applicant bears the burden of production to offer some evidence on each of these elements, *see In re Tex. Nat. Res. Conservation Comm'n*, 85 S.W.3d 201, 204 (Tex. 2002) (orig. proceeding), but she is not required to establish that she will ultimately prevail at

trial on the merits, only that she is entitled to preservation of the status quo until then. *Walling v. Metcalfe*, 863 S.W.2d 56, 58 (Tex. 1993); *Brooks v. Expo Chem. Co.*, 576 S.W.2d 369, 370 (Tex. 1979); *Millwrights Local Union No. 2484 v. Rust Eng'g Co.*, 433 S.W.2d 683, 686 (Tex. 1968). Therefore, we do not consider the ultimate merits of the underlying case and "will not assume that the evidence taken at a preliminary hearing will be the same as the evidence developed at a full trial on the merits." *Davis v. Huey*, 571 S.W.2d 859, 862 (Tex. 1978); *Burgess v. Denton Cty.*, 359 S.W.3d 351, 359 n.35 (Tex. App.—Fort Worth 2012, no pet.).

A probable right of recovery is shown by alleging a cause of action and presenting evidence tending to sustain it. *Frequent Flyer Depot, Inc. v. Am. Airlines, Inc.*, 281 S.W.3d 215, 220 (Tex. App.—Fort Worth 2009, pet. denied). To prove probable injury, an applicant must show that she has no adequate remedy at law. *Savering v. City of Mansfield*, 505 S.W.3d 33, 49 (Tex. App.—Fort Worth 2016, pet. denied) (op. on reh'g). An injury is irreparable if damages would not adequately compensate the injured party or if they cannot be measured by any certain pecuniary standard. *Butnaru*, 84 S.W.3d at 204; *Frequent Flyer Depot*, 281 S.W.3d at 220; *cf. Guajardo v. Neece*, 758 S.W.2d 696, 698 (Tex. App.—Fort Worth 1988, no writ) (noting that to obtain a temporary injunction to enforce a real property restrictive covenant, an application "need only prove an *intent* to do an act that would breach the covenant" (emphasis added)).

The allegations in this case focus on the constitutionality of the TADA. We must, however, remember that the principle of judicial restraint requires us to avoid deciding

constitutional questions when a case can be decided on nonconstitutional grounds. As the Supreme Court of Texas noted in *VanDevender v. Woods*,

> [j]udicial restraint cautions that when a case may be decided on a non-constitutional ground, we should rest our decision on that ground and not wade into ancillary constitutional questions. In such cases, "the cardinal principle of judicial restraint—if it is not necessary to decide more, it is necessary not to decide more—counsels us to go no further."

222 S.W.3d 430, 432–33 (Tex. 2007) (footnotes omitted). This principle applies to appeals involving temporary injunctions. Courts should not decide constitutional issues in such cases unless it is necessary to do so. *Henson v. Denison*, 546 S.W.2d 898, 900 (Tex. App.—Fort Worth 1977, no writ); *Sobel v. City of Lacy Lakeview*, 465 S.W.2d 794, 795 (Tex. App.—Waco 1971, no writ); *see also Shoppers Fair of N. Hous., Inc. v. City of Houston*, 406 S.W.2d 86, 88–89 (Tex. App.—Eastland 1966, writ ref'd n. r. e.); *State v. Markle*, 363 S.W.2d 332, 336 (Tex. App.—Houston 1962, orig. proceeding); *City of Houston v. Adams*, 326 S.W.2d 627, 630 (Tex. App—Houston 1959, writ ref'd n.r.e.). In affirming the granting of a temporary injunction, the court stated in *Texas State Board of Pharmacy v. Walgreen Texas Co.*,

> In the hearing on the temporary injunction it was not necessary for appellees to establish that they would finally prevail in their contention that the statutes were unconstitutional. From the pleadings and the evidence the trial court was convinced that appellees' constitutional contentions were bona fide and that irreparable harm would ensue to appellees in the event appellants were not enjoined.

520 S.W.2d 845, 848 (Tex. App.—Austin 1975, writ ref'd n. r. e.) (citing *Tex. Foundries v. Int'l Moulders & Foundry Workers' Union*, 248 S.W.2d 460 (Tex. 1952)); *see also Markle*,

363 S.W.2d at 336. Thus, if the allegations of wrongful conduct—e.g., deprivation of constitutional rights—assert a viable right to relief, the evidence introduced supports such a right, and there is evidence to establish an imminent and irreparable harm if the injunction is not granted, the party seeking temporary injunctive relief has established a right to such relief. *Ebony Lake Healthcare Ctr. v. Tex. Dep't of Human Servs.*, 62 S.W.3d 867, 871, 874 (Tex. App.—Austin 2001, no pet.).

If the trial court does not make findings of fact and conclusions of law in support of its temporary injunction ruling, we must uphold the trial court's order on any legal theory supported by the record. *Davis*, 571 S.W.2d at 862; *Mabrey v. SandStream, Inc.*, 124 S.W.3d 302, 309 (Tex. App.—Fort Worth 2003, no pet.).

V. Elements of a Section 1983 Cause of Action

To state a claim under Section 1983, a plaintiff must (1) allege a violation of a right secured by the Constitution or laws of the United States and (2) demonstrate that the alleged deprivation was committed by a person acting under color of state law. *Davis v. Barnett*, No. 2-09-207-CV, 2010 WL 3075670, at *3 (Tex. App.—Fort Worth Aug. 5, 2010, no pet.) (mem. op.). Mother alleges a constitutionally protected right on behalf of T.L.—the right to life—that the state may not deprive her of without due process. *See Tennessee v. Garner*, 471 U.S. 1, 9, 105 S. Ct. 1694, 1700 (1985) ("[The] fundamental interest in [one's] own life need not be elaborated upon."). Mother also alleges her own constitutionally protected right of which the state may not deprive her without due process—the parental right to make decisions concerning the care, custody, and control

of her child. *See Troxel v. Granville*, 530 U.S. 57, 65, 120 S. Ct. 2054, 2060 (2000) (describing this right as "perhaps the oldest of the fundamental liberty interests"). For purposes of the second element of her claim, the alleged deprivation of those rights by a person acting under color of state law, Mother contends that despite the attending physician's being a private physician and CCMC's being a private health care entity, the threatened discontinuation of life-sustaining treatment pursuant to Section 166.046 is fairly attributable to the State of Texas and therefore constitutes "state action" that is actionable under Section 1983.

CCMC responds that Mother cannot plead a viable civil rights cause of action because it is a private entity affirming the treatment decision of private physicians and, therefore, cannot be a state actor as a matter of law. Denying the delegation of state authority to private actors through the Legislature's enactment of Section 166.046, CCMC argues that the statutory framework created thereby merely codifies the common law contractual rights of attending physicians to withdraw from a physician–patient relationship when a dispute concerning treatment arises. CCMC further asserts that the rights of conscience of all health care providers to withdraw from providing treatment they deem futile and injurious to the patient justifies this framework and that the TADA's provision of a "safe harbor" of statutory immunity from civil liability and criminal prosecution does nothing more than protect this valuable private right without implicating state action. Because our discussion of the state-action element provides a useful background and framework for our discussion of whether Mother sufficiently

alleged a violation of a constitutional right, we examine the state-action question first in determining whether Mother pleaded a viable cause of action and showed a probable right to recover.

VI. Section 166.046's Delegation of Sovereign Authority to Discontinue Life-sustaining Treatment for T.L. Over Mother's Objection Makes CCMC a State Actor

A. A private individual or entity is subject to Section 1983 liability when the alleged civil rights violation arises from "state action" in the form of a sovereign delegation of a traditionally and exclusively public function

The Fourteenth Amendment to the United States Constitution prohibits the State of Texas from "depriv[ing] any person of life[or] liberty . . . without due process of law." U.S. Const. amend. XIV, § 1. Due process includes both a procedural component and a substantive component, "guarantees more than fair process," and "provides heightened protection against government interference with certain fundamental rights and liberty interests." *Washington v. Glucksberg*, 521 U.S. 702, 719–20, 117 S. Ct. 2258, 2267 (1997); *In re N.G.*, 577 S.W.3d 230, 235 (Tex. 2019); *Doe v. Univ. of N. Tex. Health Sci. Ctr.*, No. 02-19-00321-CV, 2020 WL 1646750, at *4 n.2 (Tex. App.—Fort Worth Apr. 2, 2020, pet. filed) (mem. op.) ("In essence, substantive due process deals with whether the government may make a decision limiting a person's rights while procedural due process deals with the protections that must be afforded when the government goes about making that decision."). Because the Fourteenth Amendment is directed to the states, only conduct that can be characterized fairly as

"state action" will violate it. *Lugar v. Edmondson Oil Co.*, 457 U.S. 922, 924, 102 S. Ct. 2744, 2747 (1982). Thus, the ultimate question to be answered in determining whether a person has acted under color of state law for Section 1983 purposes is the same as the ultimate question of whether state action has occurred in cases arising under the Fourteenth Amendment: Is the alleged infringement of civil rights "fairly attributable to the [s]tate?" *Id.* at 926–37, 102 S. Ct. at 2748–53. In other words, when considering whether the procedural and substantive components of Fourteenth Amendment due process apply to the conduct made the basis of a Section 1983 claim, conduct that meets the state-action requirement of the Fourteenth Amendment also constitutes action under color of state law under Section 1983. *West v. Atkins*, 487 U.S. 42, 48, 108 S. Ct. 2250, 2254–55 (1988).

Consistent with the text and structure of the Fourteenth Amendment, the state-action doctrine distinguishes the government from individuals and private entities. *Manhattan Cmty. Access Corp. v. Halleck*, 139 S. Ct. 1921, 1928 (2019); *Brentwood Acad. v. Tenn. Secondary Sch. Athletic Ass'n*, 531 U.S. 288, 295–96, 121 S. Ct. 924, 930–31 (2001). "By enforcing that constitutional boundary between the governmental and the private, the state-action doctrine protects a robust sphere of individual liberty." *Halleck*, 139 S. Ct. at 1928.

Under this doctrine, a private entity may nevertheless qualify as a "state actor" in a few limited circumstances, including (1) when the private entity performs a function "traditionally exclusively reserved to the State," *see, e.g.*, *Jackson v. Metro. Edison Co.*, 419

U.S. 345, 352–54, 95 S. Ct. 449, 454–55 (1974); (2) when the government compels the private entity to take a particular action, *see, e.g.*, *Blum v. Yaretsky*, 457 U.S. 991, 1004–05, 102 S. Ct. 2777, 2785–86 (1982); or (3) when the government acts jointly with the private entity, *see, e.g.*, *Lugar*, 457 U.S. at 941–42, 102 S. Ct. at 2755–56.

Under the public-function test for state action, "[i]t is not enough that the federal, state, or local government exercised the function in the past, or still does." *Halleck*, 139 S. Ct. at 1928. Nor is it enough that the function serves the public good or the public interest in some way. *Id.* at 1928–29. Instead, to qualify as a traditional, exclusive public function within the meaning of the state-action doctrine, "the government must have traditionally *and* exclusively performed the function." *Id.* at 1929.

By way of example, those functions held to be traditionally and exclusively public include running elections and operating a company town. *See Terry v. Adams*, 345 U.S. 461, 468–70, 73 S. Ct. 809, 813–14 (1953) (elections); *Marsh v. Alabama*, 326 U.S. 501, 505–09, 66 S. Ct. 276, 278–80 (1946) (company town); *Smith v. Allwright*, 321 U.S. 649, 662–66, 64 S. Ct. 757, 764–66 (1944) (elections); *Nixon v. Condon*, 286 U.S. 73, 84–89, 52 S. Ct. 484, 485–87 (1932) (elections).

By comparison, a variety of functions have been held not to fall into the public-function category, including operating public-access channels on a cable system, running sports associations and leagues, administering insurance payments, operating nursing homes, providing special education, representing indigent criminal defendants, resolving private disputes, and supplying electricity. *See Halleck*, 139 S. Ct. at 1929–30

(public-access channels); *Am. Mfrs. Mut. Ins. v. Sullivan*, 526 U.S. 40, 55–57, 119 S. Ct. 977, 987–89 (1999) (insurance payments); *Nat'l Collegiate Athletic Ass'n v. Tarkanian*, 488 U.S. 179, 197 n.18, 109 S. Ct. 454, 465 n.18 (1988) (college sports); *San Francisco Arts & Athletics, Inc. v. U.S. Olympic Comm.*, 483 U.S. 522, 544–45, 107 S. Ct. 2971, 2985–86 (1987) (amateur sports); *Rendell-Baker v. Kohn*, 457 U.S. 830, 842, 102 S. Ct. 2764, 2772 (1982) (special education); *Polk Cty. v. Dodson*, 454 U.S. 312, 318–19, 102 S. Ct. 445, 449–50 (1981) (public defender); *Flagg Bros., Inc. v. Brooks*, 436 U.S. 149, 157–63, 98 S. Ct. 1729, 1734–37 (1978) (private dispute resolution); *Jackson*, 419 U.S. at 352–54, 95 S. Ct. at 454–55 (electric service).

B. Most medical treatment decisions made by private health care providers are not traditionally or exclusively public functions

More specific to the circumstances of this case, most authorities hold that treatment decisions made by private health care providers do not fall within the public-function exception, even if the provider is subject to considerable state regulation in providing such care. For example, in *Blum v. Yaretsky*, the United States Supreme Court held that unilateral decisions made by private physicians and nursing home administrators to involuntarily discharge or to transfer Medicaid patients to lower levels of care were not state action. 457 U.S. at 1004–12, 102 S. Ct. at 2785–90. This was so even though federal regulations required the establishment of and imposed guidelines for a utilization review committee of physicians "whose functions include[d] periodically assessing whether each patient [was] receiving the appropriate level of care,

and thus whether the patient's continued stay in the facility [was] justified." *Id.* at 994–95, 102 S. Ct. at 2781. Nor did the fact that the state regulated the nursing homes and adjusted the payment of benefits in response to the discharge and transfer decisions make those decisions state action. *Id.* at 1007–12, 102 S. Ct. at 2787–90. "Those decisions ultimately turn[ed] on medical judgments made by private parties according to professional standards that [were] not established by the State." *Id.* at 1008, 102 S. Ct. at 2788. Accordingly, they were neither traditionally nor exclusively public functions. *Id.* at 1011–12, 102 S. Ct. at 2789–90; *see also Gray v. Woodville Health Care Ctr.*, 225 S.W.3d 613, 615–16 (Tex. App.—El Paso 2006, pet. denied) (holding no state action by private physician and private nursing home in decision to return elderly Parkinson's patient to nursing home for hospice care).

Similarly, a majority of federal circuits hold that a private mental health care provider or entity is not a state actor when it involuntarily commits a mentally ill individual, even if the commitment is pursuant to state law and the individual is brought for treatment by officers of the state. For example, in *Spencer v. Lee*, the Seventh Circuit rejected the application of the public-function exception to a private physician and a private hospital because the involuntary commitment of the mentally ill is not traditionally or exclusively a function of the state. 864 F.2d 1376, 1379–82 (7th Cir. 1989). Citing Blackstone's Commentaries on the Laws of England and noting that the "notorious lunatic asylum" of London nicknamed "Bedlam" actually started as a private institution, the court observed that the history of such involuntary commitments

demonstrated they were not exclusively the prerogative of the state, but included private self-help. *Id.* at 1380–81 ("[I]t was representative of private medieval institutions to which the insane were committed to have their demons exorcised."). The court explained that as a matter of practicality, and oftentimes self-defense or self-help, private action in such matters was necessary: "If a person displays symptoms of acute and violent mental illness, his family or physician—[or] in an appropriate case a passerby or other stranger—may have to act immediately to restrain him from harming himself or others, and there may be no public institution at hand." *Id.* at 1381 ("When family members commit a person who has just tried to kill himself, they do not, by virtue of this action, become state actors subject to suit under [S]ection 1983.").

In *Bass v. Parkwood Hospital*, the Fifth Circuit adopted the reasoning of the Seventh Circuit regarding the inapplicability of the public-function exception, agreeing that the unilateral, involuntary commitment of a mentally ill individual by a private physician in a private hospital was not state action. 180 F.3d 234, 241–43 (5th Cir. 1999) (interpreting Mississippi law); *see also Lewis v. Law–Yone*, 813 F. Supp. 1247, 1253–57 (N.D. Tex. 1993) (mem. & order) (holding, under Texas law, that the voluntary commitment and retention of an individual for mental health treatment by a private physician and private hospital was not done under color of state law for purposes of supporting a federal civil rights action, in part upon the persuasive historical context of private involuntary mental illness commitments recounted by the Seventh Circuit to reject the application of the public-function exception).

Nevertheless, when the private treatment decision is one traditionally and exclusively within the sovereign prerogative of the state, the public-function exception applies. In *West v. Atkins*, the United States Supreme Court recognized that a private physician may be deemed a state actor when he provides medical care to prison inmates who are in the state's exclusive custody. 487 U.S. at 54–57, 108 S. Ct. at 2258–60. Although the Court did not invoke the public-function exception in so holding, its reasoning implied its application, i.e., because the state was traditionally and exclusively obligated to provide medical care to prison inmates in its custody, the care provided by a private physician contracted to provide such care was fairly attributable to the state. *See id.*, 108 S. Ct. at 2258–60. Moreover, in emphasizing the exclusive custodial nature of the treatment decision, the Court likened the care provided by the private physician to care provided by physicians employed directly by the state to treat incarcerated and involuntarily committed patients. *See id.*, 108 S. Ct. at 2258–60; *Estelle v. Gamble*, 429 U.S. 97, 103–04, 97 S. Ct. 285, 290–91 (1976) (holding that by reason of the state's deprivation of a prisoner's liberty to care for himself, the state assumes the duty to provide adequate medical care to those whom it incarcerates); *see also Youngberg v. Romeo*, 457 U.S. 307, 314–25, 102 S. Ct. 2452, 2457–63 (1982) (holding that the substantive component of Fourteenth Amendment due process requires the state to provide mental patients involuntarily committed to state institutions with such services as are necessary to ensure their reasonable safety from themselves and others). Summarizing these decisions, when the state deprives patients of their ability to care for themselves

medically through the exclusive custodial authority of the state, the provision of such care becomes a public function and the treatment decisions of the private physicians and entities providing such care constitutes state action.

By way of contrast, in *DeShaney v. Winnebago County Department of Social Services*, the Court held that county social services employees had no constitutional duty to protect a minor child from his abusive father—even after receiving reports of possible abuse, briefly transferring custody to a local hospital during treatment of suspicious injuries, and monitoring the child's well-being thereafter—because the tragic neurological injuries eventually inflicted by the father occurred while the child was in his custody, not the state's, and his abuse was therefore not fairly attributable to the state. 489 U.S. 189, 194–201, 109 S. Ct. 998, 1002–06 (1989).

Declining to extend the reasoning of *Estelle* and *Youngberg*, the *DeShaney* Court explained that

> these cases afford petitioners no help. Taken together, they stand only for the proposition that when the State takes a person into its custody and holds him there against his will, the Constitution imposes upon it a corresponding duty to assume some responsibility for his safety and general well-being. The rationale for this principle is simple enough: when the State by the affirmative exercise of its power so restrains an individual's liberty that it renders him unable to care for himself, and at the same time fails to provide for his basic human needs—e.g., food, clothing, shelter, medical care, and reasonable safety—it transgresses the substantive limits on state action set by the Eighth Amendment and the Due Process Clause. The affirmative duty to protect arises not from the State's knowledge of the individual's predicament or from its expressions of intent to help him, but from the limitation which it has imposed on his freedom to act on his own behalf. In the substantive due process analysis, it is the State's affirmative act of restraining the individual's freedom to

> act on his own behalf—through incarceration, institutionalization, or other similar restraint of personal liberty—which is the "deprivation of liberty" triggering the protections of the Due Process Clause, not its failure to act to protect his liberty interests against harms inflicted by other means.

Id. at 199–200, 109 S. Ct. at 1005–06 (citations and footnotes omitted).

The fact that the state had temporarily exercised sovereign authority over the child by obtaining a court order granting not just physical, but legal, custody of the child to the hospital for treatment purposes did not change the analysis because the hospital had discharged the child after treatment and the state had returned him to the legal custody of his father before the subject abuse occurred:

> The *Estelle–Youngberg* analysis simply has no applicability in the present case. Petitioners concede that the harms [the child] suffered occurred not while he was in the State's custody, but while he was in the custody of his natural father, who was in no sense a state actor. While the State may have been aware of the dangers that [the child] faced in the free world, it played no part in their creation, nor did it do anything to render him more vulnerable to them. That the State once took temporary custody of [the child] does not alter the analysis, for when it returned him to his father's custody, it placed him in no worse position than that in which he would have been had it not acted at all; the State does not become the permanent guarantor of an individual's safety by having once offered him shelter. Under these circumstances, the State had no constitutional duty to protect [the child].

Id. at 201, 109 S. Ct. at 1006 (footnote omitted).

Critically, by distinguishing *Estelle* and *Youngberg* due to the change in legal custody from the state back to the father, the Court implicitly recognized the exclusive authority of the state to admit the child to the hospital and consent to treatment while the child was in the state's legal custody. *See id.* Stated differently, the Court tacitly

acknowledged that treatment decisions for minor patients in the legal custody of the state mirror those made for patients who are in the legal custody of the state via incarceration or involuntary civil commitment. The test is whether the state is exclusively responsible for the medical well-being of the individual patient. If so, treatment decisions for that patient constitute state action.

Despite relating to medical treatment and decisions, none of these cases deals with a physician and hospital's joint decision to withdraw life-sustaining treatment against the wishes of a patient or patient's representative. Thus, we must look beyond this case law to inform our resolution of the question presented here: whether the decision to discontinue life-sustaining treatment for a minor patient such as T.L. is a traditionally and exclusively sovereign decision fairly attributable to the state.

C. Despite the fact that most medical decisions do not involve state action, only the sovereign authority of the state may override a parent's refusal to consent to recommended treatment for her child

Both traditionally and exclusively, a medical treatment decision made for a minor child, *contrary to the desires of the child's parents*, is the sovereign prerogative of the state as *parens patriae*. Stated differently, if a parent refuses to consent to medical treatment recommended for the welfare of a child, the state—and only the state—has the sovereign authority to override the parent's refusal and to consent to the recommended treatment on behalf of the minor patient. Ordinarily, an attending physician, being neither a natural parent nor *parens patriae*, cannot both recommend a course of treatment for a minor patient and then consent to the treatment so recommended on behalf of

his patient. Extraordinarily, emergent circumstances excuse a physician's administration of lifesaving treatment to a child in the absence of parental consent. But, uniquely, the committee review process established by Section 166.046 is the only means by which a physician may discontinue an ongoing course of life-sustaining treatment to hasten the natural death of a child over the objections of her parent. Absent *parens patriae* authority exclusively attributable to the state, such an action is without legal sanction and likely subject to criminal prosecution.

1. The state as *parens patriae*

To understand the application of this authority to the present circumstances, we must provide some background of its scope. "'*Parens patriae*,' literally 'parent of the country,' refers traditionally to the role of the state as sovereign and guardian of persons under legal disability." *Alfred L. Snapp & Son, Inc. v. Puerto Rico ex rel. Barez*, 458 U.S. 592, 600 n.8, 102 S. Ct. 3260, 3265 n.8 (1982) (quoting Black's Law Dictionary 1003 (5th ed. 1979)). "Traditionally, the term was used to refer to the King's power as guardian of persons under legal disabilities to act for themselves." *Hawaii v. Standard Oil Co. of Cal.*, 405 U.S. 251, 257, 92 S. Ct. 885, 888 (1972). Under this sovereign authority, as to minors, "[t]he state thus act[s] upon the assumption that its parentage supersedes all authority conferred by birth on the natural parents, [and] takes upon itself the power and right to dispose of the custody of children as it shall judge best for their welfare." *In re Barry*, 42 F. 113, 118 (S.D.N.Y. 1844), *approved by and attached as appendix to Ex parte*

Burrus, 136 U.S. 586, 594–95 & n.1, 10 S. Ct. 850, 853 & n.1 (1890) (referring to *parens patriae* as a "common-law function" of the state).

As explained by the United States Supreme Court in *Schall v. Martin*, there are only two possible decision makers when contemplating the welfare of children, i.e., their natural parents and the state as *parens patriae*:

> Children, by definition, are not assumed to have the capacity to take care of themselves. They are assumed to be subject to the control of their parents, and if parental control falters, the State must play its part as *parens patriae*. In this respect, the [child]'s liberty interest may, in appropriate circumstances, be subordinated to the State's "*parens patriae* interest in preserving and promoting the welfare of the child."

467 U.S. 253, 265, 104 S. Ct. 2403, 2410 (1984) (citations omitted) (quoting *Santosky v. Kramer*, 455 U.S. 745, 766, 102 S. Ct. 1388, 1401 (1982)); *Ex parte McIntyre*, 558 S.W.3d 295, 300 n.3 (Tex. App.—Fort Worth 2018, pet. ref'd) (per curiam) (quoting *Schall*). And as observed by Justice Scalia in *Reno v. Flores*, "'[Children], unlike adults, are always in some form of custody' and where the custody of the parent or legal guardian fails, the government may (indeed, we have said *must*) either exercise custody itself or appoint someone else to do so." 507 U.S. 292, 302, 113 S. Ct. 1439, 1447 (1993) (citation omitted) (quoting *Schall*, 467 U.S. at 265, 104 S. Ct. at 2410).

Parens patriae, which originated in the since-amended constitutional grant of "original jurisdiction and general control"[20] over minors to district courts, has a long history in Texas jurisprudence:

[20] *See* Tex. Const. art. V, § 8 (amended 1973 and 1985).

> While a minor child is not "property" within the ordinary meaning of that term, nor is the right to [the child's] custody based upon any property right, [her] welfare has always been of such paramount importance, both to [the child] and society, as to require at the hands of some branch of government a supervisory control, and this control was anciently exercised by the courts of chancery in England, and under our system, as well as our Constitution, this power is exclusively vested in the district courts and the judges thereof, as is expressly provided in article 5, § 8 of our state Constitution.

Green v. Green, 146 S.W. 567, 569 (Tex. App.—Amarillo 1912, writ dism'd) (holding even absent statutory divorce or habeas jurisdiction, district court had inherent constitutional authority to act to guard the welfare of the subject children), *holding approved by Worden v. Worden*, 224 S.W.2d 187, 189 (Tex. 1949); *see Ex parte Bartee*, 174 S.W. 1051, 1054 (Tex. Crim. App. 1915) (observing that it is the "prerogative" of the state, "arising out of its power and duty, as *parens patriae*, to protect the interests of infants" (quoting *Lindsay v. Lindsay*, 100 N.E. 892, 894 (Ill. 1913))); *Ex parte Reeves*, 103 S.W. 478, 480 (Tex. 1907) (explaining that Article V, § 8 of the Texas Constitution of 1876 granted district courts "original jurisdiction and general control" over minors and that such jurisdiction under the common law included promoting "the highest welfare of the infant, where there is already a guardian, natural or legal, by controlling the person of the infant, and by removing [the infant] personally from the custody of its natural or legal guardian, even from the custody of [his] own parents" (quoting 3 Pomeroy's Equity § 1307 (3d ed.))); *Wright v. Wright*, 285 S.W. 909, 910 (Tex. App.—San Antonio 1926, no writ) ("The district court holds a constitutional supervisory control and supervision of all infants, and the court had the power and authority to issue orders

necessary and proper for the welfare of the infants."); *see also* Tex. Const. art. V, § 8 (amended 1973 and 1985); Tex. Const. of 1845, art. IV, § 15 (providing "the district courts shall have original . . . jurisdiction and . . . general control over . . . minors, under such regulations as may be prescribed by law").

2. *Parens patriae* overrides a parent's medical treatment decision only in limited circumstances

It is axiomatic that parents enjoy a fundamental right to the care, custody, and control of their children. *See Troxel*, 530 U.S. at 65–66, 120 S. Ct. at 2060 (recounting the constitutional history of parental rights generally); *Santosky*, 455 U.S. at 753, 102 S. Ct. at 1394–95 (discussing "[t]he fundamental liberty interest of natural parents in the care, custody, and management of their child"); *Quilloin v. Walcott*, 434 U.S. 246, 255, 98 S. Ct. 549, 554 (1978) ("We have recognized on numerous occasions that the relationship between parent and child is constitutionally protected."); *Prince v. Massachusetts*, 321 U.S. 158, 166, 64 S. Ct. 438, 442 (1944) ("It is cardinal with us that the custody, care and nurture of the child reside first in the parents, whose primary function and freedom include preparation for obligations the state can neither supply nor hinder."); *In re A.B.*, 437 S.W.3d 498, 502 (Tex. 2014) (quoting *Troxel*, stating that parents possess a fundamental right to make decisions concerning "the care, the custody, and control of their children"); *Holick v. Smith*, 685 S.W.2d 18, 20 (Tex. 1985) ("The natural right existing between parents and their children is of constitutional dimensions."); *Legate v. Legate*, 28 S.W. 281, 282 (Tex. 1894) ("The law recognizes the

parent as the natural guardian of, and entitled to the custody of, his minor child, so long as he discharges the obligation imposed upon him by social and civil law, of protecting and maintaining his offspring.").

This right includes the right of parents to give, withhold, and withdraw consent to medical treatment for their children. In *Parham v. J.R.*, the United States Supreme Court observed that parents have a natural right, coupled with a "'high duty' to recognize symptoms of illness and to seek and follow medical advice" on the child's behalf:

> Simply because the decision of a parent is not agreeable to a child or because it involves risks does not automatically transfer the power to make that decision from the parents to some agency or officer of the state. The same characterizations can be made for a tonsillectomy, appendectomy, or other medical procedure. Most children, even in adolescence, simply are not able to make sound judgments concerning many decisions, including their need for medical care or treatment. Parents can and must make those judgments. . . . The fact that a child may balk at hospitalization or complain about a parental refusal to provide cosmetic surgery does not diminish the parents' authority to decide what is best for the child.

442 U.S. 584, 602–04, 99 S. Ct. 2493, 2504–05 (1979). Indeed, because the interest of a minor patient in a treatment decision "is inextricably linked with the parents' interest in and obligation for the welfare and health of the child, the private interest at stake is a *combination* of the child's and parents' concerns." *Id.* at 600, 99 S. Ct. at 2503 (emphasis added).

In *Miller ex rel. Miller v. HCA, Inc.*, the Supreme Court of Texas reaffirmed the authority of parents to make medical treatment decisions for their children:

> The Texas Legislature has likewise recognized that parents are presumed to be appropriate decision-makers, giving parents the right to consent to their infant's medical care and surgical treatment. A logical corollary of that right, as the court of appeals here recognized, is that parents have the right not to consent to certain medical care for their infant, *i.e.*, parents have the right to refuse certain medical care.

118 S.W.3d 758, 766 (Tex. 2003) (citations omitted). Moreover, the court confirmed that the authority of the parents is subject only to the *parens patriae* authority of the state to "supervene" their refusal to consent to treatment recommended for the welfare of their child. *Id.* at 766–67 (quoting *Bowen v. Am. Hosp. Ass'n*, 476 U.S. 610, 627 n.13, 106 S. Ct. 2101, 2113 n.13 (1986)); *see Bowen*, 476 U.S. at 627, 106 S. Ct. at 2112–13 ("In broad outline, state law vests decisional responsibility in the parents [of disabled infants], in the first instance, subject to review in exceptional cases by the State acting as *parens patriae*.").

Confirming the necessity of obtaining a court order to supervene the decisional authority of parents, *Miller* cited two earlier decisions, *Mitchell v. Davis* and *O.G. v. Baum*. 118 S.W.3d at 767 n.26. In *Mitchell*, by refusing the mother's application for writ of error,[21] the court had previously confirmed that the only entity with the authority to interfere with the rights and duties of parents to consent to, withhold, or withdraw medical treatment from their child is the state through its police powers. 205 S.W.2d

[21]Under Texas law, the notation "writ refused" confirms that the Supreme Court of Texas agrees with both the holding and the reasoning of the intermediate appellate court, rendering that intermediate court's decision tantamount to a decision of the Supreme Court of Texas itself. *See Hamilton v. Empire Gas & Fuel Co.*, 110 S.W.2d 561, 565–66 (Tex. [Comm'n Op.] 1937).

812, 813–14 (Tex. App.—Dallas 1947, writ ref'd). Affirming the order of the district court awarding temporary custody to a Dallas County juvenile officer to obtain lifesaving medical treatment for the mother's seriously ill child, the Dallas Court of Civil Appeals concluded,

> We have given due consideration to the argument made of the mother's natural and constitutional right to [her child's] care and custody. While a considerable amount of discretion is vested in a parent charged with the duty of maintaining and bringing up her children, the right of [the child] and his mother here to live their own lives in their own way is not absolute. "While ordinarily the natural parents are entitled to the custody and care of their child, this is not an absolute and unconditional right. The State has such an interest in the welfare of its citizens as will authorize the enactment of suitable legislation by which the State may assume the custody of children and the parents may be deprived of the custody thereof where the parents abandon the children or neglect them in such manner as to cause them to become a public charge, or where the parents otherwise prove to be unsuitable."

Id. at 815 (quoting *Dewitt v. Brooks*, 182 S.W.2d 687, 690 (Tex. 1944)). As a result, *Mitchell* stands for the proposition that even the temporary deprivation of a parent's right to make medical decisions for her child on the grounds of medical necessity implicates the state's *parens patriae* authority to protect children.

Similarly, in *Baum*, the First Court of Appeals in Houston held that the trial court did not abuse its discretion by rendering an order granting temporary managing conservatorship to Harris County Child Protective Services for the purpose of consenting to an intraoperative blood transfusion during surgery to save the arm of a sixteen-year-old Jehovah's Witness. 790 S.W.2d 839, 840–41 (Tex. App.—Houston [1st Dist.] 1990, orig. proceeding). Due to a tenet of their faith that prohibits blood

transfusions, the minor patient's parents objected to the order and sought mandamus relief on the grounds that the order deprived them of their authority to refuse a blood transfusion for their son, thereby impairing their right to freely exercise their religion and their right of privacy. *Id.* at 840.

Relying on United States Supreme Court precedent holding that the state's interest in preserving a child's health and well-being may prevail over a parent's religious liberty, the court of appeals rejected the Baums' constitutional challenge to the state's authority to supervene their decision-making authority. *Id.* at 841 (citing *Jehovah's Witnesses v. King Cty. Hosp.*, 278 F. Supp. 488, 504–05 (W.D. Wash. 1967), *aff'd*, 390 U.S. 598, 598, 88 S. Ct. 1260, 1260 (1968), and quoting *Prince*, 321 U.S. at 166–67, 64 S. Ct. at 442, with emphasis: "*The right to practice religion freely does not include liberty to expose . . . the child . . . to ill health or death.*"). By citing *Mitchell* and *Baum*, therefore, the Supreme Court of Texas confirmed in *Miller* the "either/or" nature of medical decision-making for minor patients, i.e., that such a decision can be made only by the parents or the state.

Moreover, *Miller* expressly denied treating physicians common law authority to treat a minor patient without first obtaining the consent of the parents or the state, absent emergent medical circumstances. 118 S.W.3d at 767–68. In *Miller*, physicians evaluating a mother admitted to the hospital in premature labor discovered an infection dangerous to the mother's life that could cause them to induce delivery. *Id.* at 761. Physicians informed the parents that early induction would likely result in stillbirth of

the child or severe impairments associated with prematurity including cerebral palsy, brain hemorrhaging, blindness, lung disease, pulmonary infections, and mental retardation. *Id.* at 761–62. When asked whether to treat the child upon birth, the parents informed the doctors that they wanted no heroic measures performed and asked the physicians to let nature take its course. *Id.* at 762. When asked by hospital administrators to sign a consent form allowing resuscitation per hospital policy, the father refused. *Id.* at 763. A neonatologist, whom the hospital administration had placed in the delivery room to evaluate the infant's condition upon birth, provided the premature newborn resuscitative treatment, including bagging, intubation, and ventilation to oxygenate her blood. *Id.* Although the child initially responded well to this treatment, within a few days of her birth, she suffered a catastrophic brain hemorrhage, resulting in virtually every one of the complications of prematurity predicted by the physicians. *Id.* at 763–64.

In affirming the judgment of the Fourteenth Court of Appeals, which reversed a $60 million judgment for the parents, *HCA, Inc. v. Miller ex rel. Miller*, 36 S.W.3d 187, 190–91 (Tex. App.—Houston [14th Dist.] 2000), the Supreme Court of Texas observed that the parents had argued unsuccessfully in the court of appeals that, absent a court order, neither the mother's physicians nor the hospital could supervene their refusal to consent to resuscitative treatment for their premature newborn:

> The court [of appeals] acknowledged that the Natural Death Act[22] did not "impair or supersede any legal right a person may have to withhold or withdraw life-sustaining treatment in a lawful manner." But the court noted that the parties had not cited, and the court did not find, any authority allowing a parent to withhold urgently-needed life-sustaining medical treatment from a non-terminally ill child. Thus, the court concluded that, to the extent an infant's condition is not certified as terminal, a health care provider is under no duty to follow a parent's instruction to withhold urgently-needed life-sustaining medical treatment.
>
> The court noted that when non-urgently-needed or non-life-sustaining medical treatment is proposed for a child, a court order is needed to override a parent's refusal to consent to the treatment because a determination of such issues as the child's safety, welfare, and best interest can vary under differing circumstances and alternatives. But the court held that when the need for life-sustaining medical treatment is or becomes urgent while a non-terminally ill child is under a health care provider's care, and when the child's parents refuse consent to treatment, a court order is unnecessary to override that refusal. According to the court, no legal or factual issue exists to decide about providing such treatment because a court cannot decide between impaired life versus no life at all.
>
> Given this backdrop, the court concluded that the Millers had no right to deny the medical treatment given to [their newborn daughter] and that no court order was necessary to overcome their refusal to consent.

Id. at 765 (citations omitted).

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[22]In effect at the time of the delivery, the Texas Natural Death Act (NDA) has been amended and recodified as part of the TADA. *See* Act of May 18, 1989, 71st Leg., R.S., ch. 678, § 1, 1989 Tex. Gen. Laws 2230, 2982–87 (formerly Tex. Health & Safety Code Ann. §§ 672.001–.021), *amended and renumbered by* Act of May 18, 1999, 76th Leg., R.S., ch. 450, §§ 1.02–.05, 1999 Tex. Gen. Laws 2835, 2835–63 (current version at Tex. Health & Safety Code Ann. §§ 166.001–.166). The differences between the statutes were not material to the Supreme Court of Texas's disposition because there was no evidence that, at the time of her delivery, the premature newborn suffered from an irreversible or terminal condition. *Miller* cites the TADA throughout.

Although the Supreme Court of Texas agreed with the court of appeals that a court order was not a prerequisite for supervening the parents' refusal of consent in this instance, the reasoning employed by *Miller* clarified that the only circumstances justifying a health care provider's providing medical treatment to a minor patient without the express consent of the parents—or, in the face of express refusal of consent, a court order—were those involving the provision of emergency medical care *to save the life of the child*:

> Providing treatment to a child under emergent circumstances does not imply consent to treatment despite actual notice of refusal to consent. Rather, it is an exception to the general rule that a physician commits a battery by providing medical treatment without consent. As such, the exception is narrowly circumscribed *and arises only in emergent circumstances when there is no time to consult the parents or seek court intervention if the parents withhold consent before death is likely to result to the child.* Though in situations of this character, the physician should attempt to secure parental consent if possible, the physician will not be liable under a battery or negligence theory solely for proceeding with the treatment absent consent.
>
> . . . .
>
> Further, the emergent circumstances exception acknowledges that the harm from failing to treat outweighs any harm threatened by the proposed treatment, *because the harm from failing to provide life-sustaining treatment under emergent circumstances is death.* And as we acknowledged in *Nelson v. Krusen*[, 678 S.W.2d 918, 925 (Tex. 1984) (op. on reh'g)], albeit in the different context of a wrongful life claim, it is impossible for the courts to calculate the relative benefits of an impaired life versus no life at all.

Id. at 768 (emphasis added) (citations omitted).

Having established that absent emergent circumstances necessitating life-sustaining treatment only state action in the form of a court order can supervene *the*

refusal of parents to consent to recommended treatment, *Miller* applied "these guiding principles" to find that such emergent circumstances existed upon the premature delivery of the Millers' newborn, focusing primarily on the inability of the neonatologist to assess the medical condition of the premature newborn until actual delivery. *See id.* at 768–71.

3. Federal law affirms the exclusive sovereignty of *parens patriae* as to medical decisions for minors

Although ultimately concluding in *Miller* that the common law sufficed to dispose of the issues before it, the Supreme Court of Texas briefly acknowledged the clear regulatory directives of the federal Child Abuse Prevention and Treatment Act (CAPTA), 42 U.S.C.A. §§ 5101–16i and its implementing regulations.[23] *Id.* at 771. *But cf.* 80 F.R. 16577-03 (repealing implementing regulations as unnecessary due to subsequent amendments to CAPTA). As the court acknowledged, CAPTA requires state intervention through the child protective services system when parents *withhold their consent to life-sustaining treatment* for disabled infants:

> [Appellee] HCA argues that the federal "Baby Doe" regulations are part of Texas law and forbid any denial of medical care based on quality-of-life considerations. While we do not disagree with HCA's assertion as a general proposition, HCA cites 42 U.S.C. § 5106a(b)(2)(B) as support for its contention that the Baby Doe regulations were "scrupulously followed in this case" and "faithful adherence to public policy established by the regulations should not be thwarted through civil liability in damages . . . ." But 42 U.S.C. § 5106a(b)(2)(B) provides that a federally-funded state must

[23]We similarly need not determine the extent to which CAPTA applies to the committee review process of Section 166.046, but we discuss its purpose and directives to inform our state action analysis.

implement "procedures for responding to the reporting of medical neglect" which include:

> authority, under State law, for the State child protective services system to pursue any legal remedies, including the authority to initiate legal proceedings in a court of competent jurisdiction, as may be necessary to prevent the withholding of medically indicated treatment from disabled infants with life-threatening conditions.

Assuming that this provision applies here, it states that Texas must provide a mechanism by which the child protective services system can initiate legal proceedings to prevent the withholding of medical treatment from infants. And the Family Code and Texas Administrative Code contain such provisions.

But it is undisputed that neither the Hospital nor HCA initiated or requested child protective services to initiate legal proceedings to override the Millers' "withholding of medical treatment" by refusing to consent to [their daughter's] treatment. Thus, *the federal funding regulations appear to contemplate legal proceedings to override the lack of parental consent*, and they do not answer the question of whether [the neonatologist] committed a battery by providing treatment without doing so. Further, we agree with the court of appeals' conclusion that the disposition of that issue "is governed by state law rather than federal funding authorities."

Miller, 118 S.W.3d at 771 (emphasis added) (citations omitted).

To put this discussion in context, HCA had argued that the federal regulations implementing CAPTA did not permit withholding life-sustaining treatment from the Millers' daughter—as the Millers had requested—unless the likely complications of her prematurity rendered her condition medically untreatable. *See id.*; *HCA, Inc.*, 36 S.W.3d at 192 n.10, 196–97. By way of contrast, the Millers had argued that these same regulations required HCA to seek a court order to override their refusal of consent. *See* Petitioners' Reply Brief on the Merits, *Miller ex rel. Miller v. HCA, Inc.* (No. 01-0079), at

17 ("Texas uses the Child Protective Services program to comply with Baby Doe funding prerequisites blessing the CPS process advocated by the Millers.") (accessible at http://www.search.txcourts.gov/Case.aspx?cn=01-0079&coa=cossup) (last visited July 23, 2020). But, as we explain below, CAPTA supports each of these contentions, which are not mutually exclusive.

Despite the inapplicability of CAPTA regulations to *Miller*'s circumstances, the Supreme Court of Texas's acknowledgement of the regulations' general application was in accordance with the Texas Legislature's confirmation of those regulations. After submission of *Miller* but before the court's decision, the Legislature added Section 166.010 to the TADA and made it effective June 20, 2003. Act of June 1, 2003, 78th Leg., ch. 1228, § 2, 2003 Tex. Gen. Laws 3481, 3481, 3485 (codified at Tex. Health & Safety Code Ann. § 166.010). In doing so, the Legislature expressly subjected the entirety of the TADA, including the decision-making process of Section 166.046, "to applicable federal law and regulations relating to child abuse and neglect to the extent applicable to the state based on its receipt of federal funds." Act of June 1, 2003, 78th Leg., ch. 1228, § 2, 2003 Tex. Gen. Laws 3481, 3481; *see R.R. Street & Co. v. Pilgrim Enters., Inc.*, 166 S.W.3d 232, 247–48 (Tex. 2005) (holding that provision of Solid Waste Disposal Act expressly making definitions of "solid waste" subject to federal law and regulations incorporates federal domestic sewage exclusions); *Bradley v. State ex rel. White*, 990 S.W.2d 245, 248–50 (Tex. 1999) (holding provision of Texas Government Code authorizing proceeding to remove mayor of general-law municipality, by making

proceeding "subject to the rules governing a proceeding or trial in a justice court," incorporates Texas Rule of Civil Evidence 605 thus prohibiting city aldermen from both testifying and adjudicating), *rev'g* 956 S.W.2d 725, 738–39 (Tex. App.—Fort Worth 1997) (holding phrase "subject to" means "not in conflict with"); *STS Gas Servs., Inc. v. Seth*, No. 13-05-463-CV, 2008 WL 152229, at *4 (Tex. App.—Corpus Christi–Edinburg Jan. 17, 2008, no pet.) (mem. op.) (observing phrase "subject to" means, *inter alia*, "governed or affected by" (quoting Black's Law Dictionary 1425 (6th ed. 1990))).

We presume that the Legislature's amendment of the TADA was with full knowledge of the decision of the court of appeals in *Miller* and the issues presented for the Supreme Court of Texas's review. *See Traxler v. Entergy Gulf States, Inc.*, 376 S.W.3d 742, 748 (Tex. 2012) ("We presume the Legislature is aware of relevant caselaw when it enacts or amends statutes."); *Am. Transitional Care Ctrs. of Tex., Inc. v. Palacios*, 46 S.W.3d 873, 878 (Tex. 2001) ("All statutes are presumed to be enacted by the legislature with full knowledge of the existing condition of the law and with reference to it." (quoting *McBride v. Clayton*, 166 S.W.2d 125, 128 (Tex. 1943))). Although the court of appeals held that the TADA granted parents the right to withhold or withdraw life-sustaining treatment from their terminally ill children, it did so in a manner that invited the Legislature to clarify that right in the context of prematurely born infants. *See Miller*, 36 S.W.3d at 193–95.

In apparent response, the Legislature enacted Committee Substitute Senate Bill 1320, which the House Research Organization explained sought to clarify whether the TADA applied to pediatric patients in the following manner:

> CSSB 1320 would specify that the Advance Directives Act applies to health-care treatment decisions made on behalf of a minor. The act would be subject to applicable federal law and regulations relating to child abuse and neglect, insofar as the state received federal funds.

House Research Org., Bill Digest, Tex. C.S.S.B. 1320, 78th Leg., R.S. (2003) (available at https://hro.house.texas.gov/pdf/ba78r/sb1320.pdf#navpanes=0); *see In re Dep't of Family & Protective Servs.*, 273 S.W.3d 637, 643 & n.6 (Tex. 2009) (orig. proceeding) (observing that, even when statutory language is clear by its terms, interpreting court may confirm clarity through consideration of legislative history).

The bill analysis for the identical provisions in Committee Substitute House Bill 3009 similarly clarified that a health care or treatment decision submitted to the committee review process of Section 166.046 remained subject to both the Family Code and CAPTA:

> The "definitions" section of the "general provisions" subchapter (Subchapter A) of the "Advance Directives Act," Chapter 166, Health and Safety Code, is amended by amending the definition of the term "health care or treatment decision" to clarify that the Act applies to minors as well as adults in accordance with the Texas Family Code and the federal law and regulations relating to child abuse and neglect to the extent they are applicable on the basis of the State's receipt of federal funds. The latter phrase is added to clarify that this changes [sic] is not intended to and does not alter the status quo regarding the applicability of the state or federal law.

House Comm. on Public Health, Bill Analysis, Tex. C.S.H.B. 3009, 78th Leg., R.S. (2003) (available at https://capitol.texas.gov/tlodocs/78R/analysis/html/HB03009H.htm).

Confirming the need for TADA compliance with CAPTA, the Department of Family and Protective Services (DFPS) is a recipient of federal CAPTA funds. *See* DFPS Policy Handbooks, *Child Protective Services Handbook* § 1224 (accessible at https://www.dfps.state.tx.us/handbooks/CPS/Files/CPS_pg_1200.asp#CPS_1224) (last visited July 21, 2020) ("Recipients of CAPTA funds, including DFPS, are required to submit a state assurance plan every five years specifying their use, or intended use, of funds."); *see also In re M.S.*, No. 02-18-00379-CV, 2019 WL 1768993, at *8 (Tex. App.—Fort Worth Apr. 22, 2019, pets. denied) (mem. op.) (noting that courts can take judicial notice of Handbook on appeal). Further, DFPS "is the state agency designated to cooperate with the federal government in the administration of programs" under CAPTA. Tex. Hum. Res. Code Ann. § 40.002(c)(2). DFPS is also the state agency responsible for initiating court proceedings to obtain necessary medical treatment for children neglected by their parents.[24]

Not only does CAPTA define what it means to withhold life-sustaining treatment from a disabled infant, it also delineates when such withholding by a parent constitutes medical neglect subject to exclusive state intervention:

> the term "withholding of medically indicated treatment" means the failure to respond to the infant's life-threatening conditions by providing

[24]As acknowledged by *Miller*, the Texas Family Code provides a mechanism whereby DFPS, as a recipient of CAPTA funding, "can initiate proceedings to prevent

> treatment (including appropriate nutrition, hydration, and medication) which, in the treating physician's or physicians' reasonable medical judgment, will be most likely to be effective in ameliorating or correcting all such conditions, except that the term does not include the failure to provide treatment (other than appropriate nutrition, hydration, or medication) to an infant[25] when, in the treating physician's or physicians' reasonable medical judgment --
>
> (A) the infant is chronically and irreversibly comatose;
>
> (B) the provision of such treatment would --
>
> (i) merely prolong dying;

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the withholding of medical treatment from infants." *See* 118 S.W.3d at 771. Although there are numerous cases involving proceedings initiated by DFPS to obtain possession or temporary managing conservatorship of an infant subject to medical neglect for a parent's failure to obtain other types of medical treatment, there appear to be no reported cases involving a parent's decision to withhold life-sustaining treatment from a disabled infant with a life-threatening condition *See, e.g.*, *A.L.G.A. v. Tex. Dep't of Family & Protective Servs.*, No. 03-19-00086-CV, 2019 WL 2998587, at *2 (Tex. App.—Austin July 10, 2019, pets. denied) (mem. op.) (involving petition seeking conservatorship of one-year-old infant subject to medical neglect after pediatric surgeon refused to discharge infant to mother's care); *C.S.B. v. Tex. Dep't of Family & Protective Servs.*, No. 03-18-00834-CV, 2019 WL 2127964, at *2 (Tex. App.—Austin May 16, 2019, no pet.) (mem. op.) (involving petition seeking conservatorship of one-year-old infant subject to medical neglect due to mother's refusal to place infant on waiting list for liver transplant required by genetic disorder); *C.D. v. Tex. Dep't of Family & Protective Servs.*, No. 03-17-00773-CV, 2018 WL 1354122, at *1 (Tex. App.—Austin Mar. 16, 2018, pet. denied) (mem. op.) (involving petition for possession and temporary managing conservatorship for three-month-old infant subject to medical neglect of serious eye condition); *A.R. v. Tex. Dep't of Family & Protective Servs.*, No. 03-16-00143-CV, 2016 WL 5874874, at *1, *4 (Tex. App.—Austin Oct. 4, 2016, no pet.) (mem. op.) (involving petition for temporary managing conservatorship for eleven-month-old infant subject to medical neglect of cleft palate).

[25]An "infant or toddler with a disability" is defined as "an individual under 3 years of age who needs early intervention services because the individual . . . is experiencing [certain] developmental delays, . . . or . . . has a diagnosed physical or mental condition that has a high probability of resulting in developmental delay." 42 U.S.C.A. § 5106g(a)(2); *see also* 20 U.S.C.A. § 1432(5).

> (ii) not be effective in ameliorating or correcting all of the infant's life-threatening conditions; or
> (iii) otherwise be futile in terms of the survival of the infant; or
>
> (C) the provision of such treatment would be virtually futile in terms of the survival of the infant and the treatment itself under such circumstances would be inhumane.

42 U.S.C.A. § 5106g(5).

CAPTA requires states receiving funding to have procedures and programs in place providing "authority, under State law, for the State child protective services system to pursue any legal remedies, including the authority to initiate legal proceedings in a court of competent jurisdiction," that "may be necessary to prevent the withholding of medically indicated treatment from infants with disabilities who have life-threatening conditions." *Id.* § 5106a(b)(2)(C)(iii). As long as "medically necessary treatment" will, in the reasonable medical judgment of the treating physician, "ameliorat[e] or correct[]" the infant's life-threatening condition, such states may intervene through their child protective services system to guarantee the infant receives life-sustaining treatment, even to the point of obtaining a court order on the grounds of medical neglect to override the parents' refusal to consent. *Id.* §§ 5106a(b)(2)(C)(iii), 5106g(5); *see Stewart–Graves v. Vaughn*, 170 P.3d 1151, 1160 n.3 (Wash. 2007) (observing that CAPTA "conditions the receipt of federal funds for the prevention of child abuse and family protection on a state's willingness to establish procedures to ensure that health care providers do not withhold or withdraw lifesaving medical treatment from a disabled

infant, unless such treatment would be 'virtually futile' and 'inhumane'"). If, however, in the reasonable medical judgment of the treating physician, life-sustaining treatment would neither ameliorate nor correct the disabled infant's life-threatening condition but would instead be "virtually futile" or "inhumane" under the circumstances, CAPTA permits the treating physician to withhold such treatment without implicating the need for state intervention *but only with the consent of the parents*. *See* 42 U.S.C.A. §§ 5106a(b)(2)(C)(iii), 5106g(5). In either scenario, the reasonable medical judgment of the attending physician merely *informs* the treatment recommendation; her judgment does not supplant the decision-making authority of either the parents or the state.

This is particularly true in the context of parental refusal of life-sustaining treatment predicated upon religious conviction:

> Notwithstanding subsection (a) [acknowledging sincere religious conviction as a basis for parental medical decisions], a State shall, at a minimum, have in place authority under State law to permit the child protective services system of the State to pursue any legal remedies, including the authority to initiate legal proceedings in a court of competent jurisdiction, to provide medical care or treatment for a child when such care or treatment is necessary to prevent or remedy serious harm to the child, or to prevent the withholding of medically indicated treatment from children with life threatening conditions. *Except with respect to the withholding of medically indicated treatments from disabled infants with life threatening conditions, case by case determinations concerning the exercise of the authority of this subsection shall be within the sole discretion of the State.*

Id. § 5106i(b) (emphasis added). As the highlighted language indicates, when parents refuse to consent to medically indicated treatment for their disabled infants with life-threatening conditions, state intervention in those states receiving CAPTA funding is

mandatory, not discretionary. *See id.* Greater deference is given to parents when deciding whether to treat non-life-threatening conditions. *See id.*

Therefore, in states governed by CAPTA, such as Texas, decisions concerning the withholding of life-sustaining treatment from disabled infants, while informed by the reasonable medical judgment of treating physicians, must be made, first, by the parents or, only if the parents unreasonably refuse consent to medically indicated life-sustaining treatment, by the state. *See Bowen*, 476 U.S. at 627 n.13, 106 S. Ct. at 2113 n.13 ("The decision to provide or withdraw medically indicated treatment is, except in highly unusual circumstances, made by the parents or legal guardian."). CAPTA does not contemplate any independent authority on the part of treating physicians or the hospitals where they practice to supervene the decision-making authority of parents for their disabled infants. In other words, CAPTA does not contemplate the ability of an attending physician to unilaterally discontinue life-sustaining treatment over the objection of the parents.

Summarizing, it appears that to maintain the flow of federal CAPTA funding, the Legislature enacted Section 166.010 to make sure that the procedures set forth in Section 166.046 comport with the provisions and regulations of CAPTA, in particular those regulating the withholding of medically indicated treatment from disabled infants suffering from life-threatening conditions. The subjection of the TADA to CAPTA, therefore, strongly suggests that for disabled infants, such as T.L., the withdrawal of

life-sustaining treatment over the objections of their parents requires either the direct or delegated intervention of the state as *parens patriae* for the disabled infant.

4. Section 166.046 delegates the sovereign authority of the state to attending physicians and hospital ethics committees to supervene the refusal of parents to consent to the withdrawal of life-sustaining medical treatment from their disabled children

Based upon our detailed historical analysis of medical decision-making for minor patients, we disagree with CCMC's argument that the decision of the attending physician to discontinue life-sustaining treatment for T.L.—as affirmed by CCMC's ethics committee pursuant to Section 166.046—is not a treatment decision fairly attributable to the state for purposes of Section 1983 liability. As we have shown, only the state, acting as *parens patriae*, has the authority to supervene a parent's refusal to consent to the withdrawal of life-sustaining support for her child. There is simply no common law exception to the contrary.

Hypothetically reversing the roles of Mother and the attending physician helps to demonstrate why the current decision to discontinue life-sustaining treatment for T.L. constitutes state action. Consider if the attending physician recommended that T.L., while receiving life-sustaining treatment, undergo a cardiopulmonary transplant that, in his reasonable medical judgment, offered her a reasonable chance of full recovery.[26] If performed, the risk of death inherent in the procedure would be

[26]A cardiopulmonary transplant replaces the heart and lungs of the recipient patient with the heart and lungs of the donor. *See generally* Jonathan E. Spahr & Shawn C. West, *Heart–Lung Transplantation: Pediatric Indications and Outcomes*, 6 J. of Thoracic

significant, particularly considering the risks of infection and organ rejection. 25 Tex. Admin. Code § 601.2(b)(1)(A)(ii) (listing heart transplant as a surgical cardiovascular procedure subject to risks of infection, rejection, and death). If not performed, the attending physician's prognosis is that T.L. will likely die in the next few months. After the physician provides Mother with this information, she refuses to consent to the

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Disease 1129, 1129 (Aug. 2014) (available at http://jtd.amegroups.com/article/view/2794/3317.pdf) ("In cases where patients have end-stage lung disease associated with or causing cardiac dysfunction, congenital heart disease with pulmonary hypertension, or congenital heart disease associated with pulmonary artery/vein abnormalities, [heart–lung transplantation] may be indicated."(citations omitted)). Ebstein's anomaly is a "qualifying pediatric status 1A" congenital heart disease diagnosis approved by the Organ Procurement and Transplantation Network (OPTN). *See* http://optn.transplant.hrsa.gov/media/1255/list-of-congenital-heart-disease-diagnoses-and-qualifying-inotropes.pdf (last visited July 21, 2020).

Unfortunately, "[t]ransplant from . . . mechanical support such as . . . extracorpor[e]al membranous oxygenation (ECMO) is high risk." *Heart–Lung Transplantation*, 6 J. of Thoracic Disease at 1131. And the outcomes for pediatric heart–lung transplantation are "not great." *Id.*; *see Good v. Presbyterian Hosp.*, 934 F. Supp. 107, 108–11 (S.D.N.Y. 1996) (holding standard of care for informed consent in New York did not include informing mother of five-year-old cardiopulmonary patient of risk of contracting cytomegalovirus infection from donor of heart and lungs). Moreover, "acceptable heart/lung donor organs are rare overall, especially true for a young child where size discrepancies between the donor and the recipient may be even more difficult to reconcile." *Id.* at 111 (recounting testimony from Director of Mount Sinai Medical Center Heart/Lung Transplant Program).

The record makes no mention of whether the attending physician or CCMC's ethics committee considered the availability of a cardiopulmonary transplant when concluding that continued life-sustaining treatment for T.L. was medically inappropriate. The availability of such a procedure is assumed solely for purposes of the hypothetical and is not intended as a comment on the sufficiency of the evidence considered by the trial court.

procedure on the grounds that the risk of immediate death is too high, holding out hope that continuing T.L. on life-sustaining treatment will eventually offer a better option for recovery. Efforts to resolve the dispute by transferring T.L. to another physician or facility are unsuccessful. After invocation of the committee review process set forth in Section 166.046,[27] the ethics committee affirms the attending physician's recommendation and provides Mother with a written explanation of its decision. Tex. Health & Safety Code Ann. § 166.046(b)(4)(B).

But what does that decision mean for T.L.? Section 166.046 does not authorize the doctor to go forward with a transplant against Mother's wishes. *See id.* § 166.046(d), (e). Instead, Subsection (d) authorizes only a reasonable effort to transfer T.L. to another physician or facility to continue life-sustaining treatment without also performing a transplant. *Id.* § 166.046(d). Although Subsection (e) would absolve the attending physician and CCMC of any legal obligation to continue life-sustaining treatment after the ten-day deadline if they had deemed such treatment "medically inappropriate," that subsection does not appear to authorize discontinuing such treatment in this hypothetical situation—when the attending physician and ethics committee have determined that maintaining life-sustaining treatment for purposes of

[27]Under the plain language of the TADA, the committee review process applies to more than a decision to withdraw life-sustaining treatment; it also applies to a physician's refusal to honor any "treatment decision"—defined as "consent, refusal to consent, or withdrawal of consent to health care, treatment, service, or a procedure to maintain, diagnose, or treat an individual's physical or mental condition, including such a decision on behalf of a minor." Tex. Health & Safety Code Ann. §§ 166.002(7), .046(a).

performing a medically indicated transplant *is* medically appropriate. *Id.* § 166.046(e). And although in this hypothetical T.L.'s condition would still be clearly life-threatening, the *Miller* test for emergent treatment—when death is likely to result immediately upon the failure to perform it—does not appear to allow the transplant over Mother's objection. 118 S.W.3d at 767. Accordingly, under these circumstances, the only way the attending physician and CCMC could perform the transplant would be to report the impasse with Mother as an instance of medical neglect, *see* Tex. Family Code Ann. § 262.101(b), and to urge DFPS to intervene to obtain a court order granting it temporary managing conservatorship for purposes of consenting to the cardiopulmonary transplant. *See Baum*, 790 S.W.2d at 840–41.

Comparing the two scenarios, if state action would be the only way to override Mother's refusal of the cardiopulmonary transplant recommended by the attending physician and affirmed by the ethics committee to treat T.L.'s life-threatening condition, how is it not then implicated when Section 166.046 allows the attending physician through the ethics committee's decision to override Mother's refusal to discontinue life-sustaining treatment deemed "medically inappropriate"? CCMC never explains why state action is necessary to keep a child *alive* over a parent's objection, but not to permit a child to *die* against the parent's wishes. In either instance, the decision supervenes a parent's treatment decision, a decision traditionally and exclusively a public function of the state as *parens patriae*. Section 166.046(e) is therefore a delegation of state authority to the attending physician, who will become a state actor in conjunction with CCMC

for purposes of Section 1983 liability as soon as T.L.'s life-sustaining treatment is discontinued.

D. Additionally, only the sovereign authority of the state may define what is and what is not a lawful means or process of dying

CCMC argues that Section 166.046 does not implicate state action in two other respects: first, that it merely codifies the existing private contractual right of a physician to withdraw from the physician–patient relationship and, second, that it merely extends private medical peer review to prospective end-of-life treatment decisions to facilitate a natural and pain-free process of dying. Implicit in these arguments is that the decision to discontinue life-sustaining treatment is purely a private matter of professional medical judgment, albeit subject to state regulatory oversight. 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, we disagree.

1. The committee review process is not a mere codification or clarification of the common law tort of patient abandonment

Likening Section 166.046 to a mere codification or clarification of the common law right of a physician to withdraw from a physician–patient relationship with reasonable notice to the patient, CCMC maintains that the attending physician's refusal to honor Mother's decision to continue her daughter's life-sustaining treatment, as

affirmed through the committee review process, is solely a matter of private contract rights, not state action. CCMC infers this private contract right from one of the liability elements of the common law tort of patient abandonment that traditionally contemplates the continuation of necessary medical care and has never encompassed the termination of medically futile or otherwise inappropriate care for a terminally ill patient. CCMC's argument thereby conflates an attending physician's common law right to withdraw or disengage from a physician–patient relationship with an alleged right of a health care facility to do so in a manner that foreseeably results in the death of the patient. To demonstrate the fallacy of this argument, a discussion of the tort of patient abandonment is necessary.

In Texas, the duty of a physician to provide treatment to a patient arises from the creation of a consensual relationship:

> As is true of all callings, physicians are not obligated to practice their profession or render services to everyone who asks. It is only with a physician's consent, whether express or implied, that the doctor–patient relationship comes into being. Thus we agree with those cases that hold that the duty to treat the patient with proper professional skill flows from the consensual relationship between the patient and physician, and only when that relationship exists can there be a breach of a duty resulting in medical malpractice.

St. John v. Pope, 901 S.W.2d 420, 423 (Tex. 1995); *Childs v. Weis*, 440 S.W.2d 104, 106–07 (Tex. App.—Dallas 1969, no writ) ("The relation of physician and patient is contractual and wholly voluntary, created by agreement, express or implied."). In so contracting, the physician represents that he possesses a reasonable degree of

professional skill such as is ordinarily possessed by a member of his profession generally and agrees that he will exercise that skill with reasonable care, diligence, and judgment in treating the patient. *Graham v. Gautier*, 21 Tex. 111, 120 (1858); *Helms v. Day*, 215 S.W.2d 356, 358 (Tex. App.—Fort Worth 1948, writ dism'd).

The common law required the physician, once engaged by the patient, to obtain the informed consent of the patient to a proposed form or course of treatment by disclosing only those risks incident to the proposed treatment that a reasonable practitioner would disclose under the same or similar circumstances. *Wilson v. Scott*, 412 S.W.2d 299, 302 (Tex. 1967) (op. on reh'g). In 1977, however, the Legislature replaced this common law rule with a "reasonable person" standard that held informed consent effective only if the physician disclosed those risks of the proposed treatment that could have influenced a reasonable person in making a decision to give or withhold consent. *Peterson v. Shields*, 652 S.W.2d 929, 931 (Tex. 1983) (noting Legislature changed standard for disclosure from reasonable physician to reasonable person). Having thereby entered into a physician–patient relationship, obtained the informed consent of the patient, and then initiated the proposed form or course of treatment, the physician was prohibited by the common law from abandoning the patient by withdrawing his professional services without affording the patient a reasonable opportunity to retain another physician to continue the form or course of treatment he had initiated. *See Granek v. Tex. State Bd. of Med. Exam'rs*, 172 S.W.3d 761, 766 n.2 (Tex. App.—Austin 2005, no

pet.) (op. on reh'g); *King v. Fisher*, 918 S.W.2d 108, 112 (Tex. App.—Fort Worth 1996, writ denied).

The liability elements of a patient-abandonment claim are (1) the unilateral severance of the physician–patient relationship by the physician, (2) without reasonable notice or without providing adequate alternative medical care, (3) at a time when there is the necessity of continuing medical attention. *Granek*, 172 S.W.3d at 766 n.2; *King*, 918 S.W.2d at 112. As explained by the Amarillo Court of Civil Appeals in *Lee v. Dewbre*,

> We believe the law is well settled that a physician or surgeon, upon undertaking an operation or other case, is under the duty, in the absence of an agreement limiting the service, of continuing his attention, after the first operation or first treatment, so long as the case requires attention. The obligation of continuing attention can be terminated only by the cessation of the necessity which gave rise to the relationship, or by the discharge of the physician by the patient, or by the withdrawal from the case by the physician after giving the patient reasonable notice *so as to enable the patient to secure other medical attention*. A physician has the right to withdraw from a case, but if the case is such as to still require further medical or surgical attention, he must, before withdrawing from the case, give the patient sufficient notice *so the patient can procure other medical attention if he desires*.

362 S.W.2d 900, 902–03 (Tex. App.—Amarillo 1962, no writ) (emphasis added) (quoting *Ricks v. Budge*, 64 P.2d 208, 211–12 (Utah 1937)).

As the highlighted language demonstrates, the right of a physician to withdraw from a physician–patient relationship is not unconditional; a physician may withdraw without the permission of the patient but may do so only after giving reasonable notice to permit the patient to retain another physician to continue medically necessary care. For example, in *Urrutia v. Pitino*, the San Antonio Court of Civil Appeals acknowledged

that professional relations between a physician and his patient are contractual in nature and may ordinarily be terminated at the will of either party. 297 S.W. 512, 516 (Tex. App.—San Antonio 1927, no writ). Nevertheless, our sister court observed that the physician's right to withdraw did not encompass circumstances in which continuity of care could not be maintained and the termination of care would result in injury to or death of the patient:

> *A physician is never justified in withdrawing from a case he has once undertaken at a critical stage when his place cannot be supplied.* To withdraw means voluntarily to refuse to continue his services. If he is ever justified in so withdrawing when it is apparent that to do so must result in injury it can only be where the patient obstinately refuses to follow the treatment prescribed. It is a fact honorable to the profession that the question never seems to have been directly presented.

Id. (emphasis added) (quoting Hon. Robert G. Street, *The Law of Civil Liability for Personal Injuries by Negligence in Texas* 782 (2d ed. 1921)).[28]

[28]Judge Robert Gould Street was not only a distinguished author, but also an experienced practitioner and respected jurist. Judge Street, whose scholarly work is often cited by Texas appellate courts as Street on Personal Injuries or, as in *Urrutia*, Street on Personal Injuries in Texas, presided over the 56th District Court of Galveston County from 1903 to 1924. *See* Find A Grave, *Robert Gould Street*, https://www.findagrave.com/memorial/70213166/robert-gould-street (last visited July 21, 2020). Before taking the bench, Judge Street was one of the most prolific trial and appellate attorneys in Texas, with forty-two reported appearances before the Supreme Court of Texas and one before the Texas Court of Criminal Appeals between 1871 and 1898 (according to a Westlaw search of various iterations of his name). He also once sat by appointment as a Special Judge of the Supreme Court of Texas due to the recusal of both associate justices and authored the opinion in *Schaeffer v. Berry*, 62 Tex. 705 (1884).

Similarly, in *Lee v. Moore*, the Dallas Court of Civil Appeals held that "a physician who leaves a patient in a critical stage of the disease, without reason or sufficient notice to procure another medical attendant, is guilty of a culpable dereliction of duty, and is liable therefor." 162 S.W. 437, 440 (Tex. App.—Dallas 1913), *rev'd on other grounds*, 211 S.W. 214 (Tex. 1919). Again, as articulated by this decision, the physician's right to withdraw is subject to a reasonable notice requirement intended to permit the patient to retain another physician to continue medically necessary care. Although the Supreme Court of Texas ultimately reversed on other grounds, it neither rejected the lower court's articulation of this element of the claim nor suggested that the reasonable notice requirement contemplated anything other than maintaining continuity of medically necessary care for the patient. *See* 211 S.W. at 215–17.

As observed by CCMC, Section 166.045(c) of the TADA appears to track the liability elements of the abandonment tort:

> 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.

Tex. Health & Safety Code Ann. § 166.045(c). Section 166.051 similarly provides that

> if an attending physician or health care facility is unwilling to honor a patient's advance directive or a treatment decision to provide life-sustaining treatment, life-sustaining treatment is required to be provided the patient, but only until a reasonable opportunity has been afforded for transfer of the patient to another physician or health care facility willing to comply with the advance directive or treatment decision.

Id. § 166.051.

CCMC argues that because this language effectively codifies the common law, Sections 166.045(c) and 166.051, and by extension Section 166.046, merely clarify that the common law right of an attending physician to withdraw from a physician–patient relationship—to terminate the relationship at will—extends to and includes the right to discontinue life-sustaining treatment adjudged by the physician to be medically futile or otherwise inappropriate. *Compare Granek*, 172 S.W.3d 766 n.2, *with* Tex. Health & Safety Code Ann. § 166.045(c) (withdrawal without ethics committee affirmation), § 166.046(d), (e) (withdrawal with ethics committee affirmation), § 166.051 (withdrawal by any lawful means). CCMC reasons that, by affirming nothing more than the attending physician's private professional medical judgment, the decision of its ethics committee to affirm the treatment decision of the attending physician is not a decision fairly attributable to the state. We disagree for four reasons.

First, when asked to provide this court with any Texas authority extending the right to withdraw implied by the abandonment tort to the circumstances of this particular case, CCMC conceded that it could find no such decision. Neither have we found such a decision. Absent such authority, the hospital nevertheless asks us to simultaneously extend the right to withdraw where it has never before been extended and to conclude that such extension has always been the common law of this state. This we cannot do.

Second, and relatedly, CCMC's argument conflates the common law right to withdraw from the physician–patient relationship, with which we take no issue, with an alleged common law right of an attending physician to involuntarily, albeit passively, euthanize his terminally ill patient, with which the entire history of the TADA takes issue. Had there existed such a common law right, the State Bar of Texas and the Baylor Law Review need not have published their seminal series of articles on passive euthanasia in 1975, and the Legislature need not have enacted the NDA and TADA in serial response thereto.

Simply put, no Texas court has ever held that an attending physician has a common law right to unilaterally withdraw from a physician–patient relationship with a terminally ill patient by discontinuing life-sustaining treatment over the objection of the patient—to quite literally terminate the private contractual relationship by causing the death of the other contracting party. Even with the "codification" of the common law in 1999, there has been not a single reported decision so holding, let alone articulating what constitutes a "reasonable opportunity" for transfer pursuant to Sections 166.045(c) and 166.051.

And what constitutes a reasonable opportunity for transfer when a diligent search for another physician or health care facility to continue life-sustaining treatment is unavailing? The TADA is utterly silent. If codifying or clarifying the common law, the TADA should track the following instruction from the pattern jury charge for patient abandonment: "'Reasonable notice' means such notice as would normally give

the patient reasonable time to secure other medical attention if desired." Comm. on Pattern Jury Charges, State Bar of Tex., *Texas Pattern Jury Charges: Malpractice, Premises & Products* PJC 51.7 (2016). Again, the liability elements for patient abandonment contemplate the necessity of continued medical care, the wrongful termination of which causes injury to or the death of the patient. They do not contemplate passively causing the death of a patient when a transfer of care is impossible. In another health care liability context, the Supreme Court of Texas has held that granting a patient a reasonable opportunity to act is meaningless when the purpose of the opportunity is impossible to accomplish. *See Nelson*, 678 S.W.2d at 921 (holding that parents did not have a reasonable opportunity to discover and prosecute a health care liability claim against the defendant physician and hospital for misdiagnosis of the mother that excluded her as a genetic carrier of Duchenne muscular dystrophy when the possibility of her child's suffering from a neuromuscular defect did not become detectable to the trained eye until well after the statute of limitations had expired; the statute thereby imposed an impossible condition). Accordingly, it cannot be said that the common law right of an attending physician to withdraw from a physician–patient relationship included at any time a right to involuntarily euthanize a terminally ill patient for whom a transfer of care was impossible, nor that such a right finds support among the liability elements of the patient abandonment tort.[29]

[29]To the extent CCMC argues that the common law right to withdraw merely recognizes a private right of conscience on the part of the attending physician to

Third, contrary to CCMC's argument, the committee review process of Section 166.046 does not actually authorize the attending physician to withdraw from the physician–patient relationship but instead maintains the relationship even beyond the ten-day deadline for the purpose of providing the terminally ill patient with palliative care, including hydration, nutrition, and pain medication if medically appropriate. Tex. Health & Safety Code Ann. § 166.046(e)(1)–(5). In this manner, Section 166.046 clearly contemplates the maintenance of the physician–patient relationship through the natural death of the terminally ill patient, not its termination through the unilateral withdrawal of the attending physician.

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disengage from providing treatment deemed medically futile or otherwise inappropriate, no decisional authority so holds under these circumstances. Additionally, when a state creates a right for doctors to conscientiously object to certain medical procedures, such as abortion, the statute ordinarily provides that this privilege does not extend to cases in which a patient's life is at risk. In such cases, the state imposes a duty to save the patient's life, even if the only way of doing so is by requiring the doctor to perform the objectionable procedure. *See* Nora O'Callaghan, *Dying for Due Process: The Unconstitutional Medical Futility Provision of the Texas Advance Directives Act*, 60 Baylor L. Rev. 527, 608 (Spring 2008); *see also* Tex. Occ. Code Ann. § 103.004 ("A private hospital or private health care facility is not required to make its facilities available for the performance of an abortion unless a physician determines that the life of the mother is immediately endangered."). Moreover, to the extent Sections 166.045(c), 166.046(e), and 166.051 can be interpreted to "codify" the individual rights of conscience of the attending physician, they create a conflict of interest that impeaches the impartiality of his professional medical judgment, as well as the committee review process itself. *See In re Dubreuil*, 629 So.2d 819, 823 (Fla. 1993) (recognizing potential conflict of hospital's private interests with best interest obligations of the state in supervening patient's refusal of life-sustaining treatment).

Fourth and finally, the tort of patient abandonment has no application whatsoever to the committee review process established by Section 166.046 because the common law never authorized the practice of medicine by a health care facility such as CCMC, and the Medical Practice Act expressly prohibits such facility from making any treatment decision absent the statutory authority granted by Section 166.046. The Texas Medical Practice Act[30] generally prohibits the corporate practice of medicine. *See Gupta v. E. Idaho Tumor Inst., Inc.*, 140 S.W.3d 747, 752 (Tex. App.—Houston [14th Dist.] 2004, pet. denied) (discussing the statutory prohibition of the corporate practice of medicine). "The purpose of [the Medical Practice Act] is to preserve the vitally important doctor–patient relationship and prevent possible abuses resulting from lay control of corporations employing licensed physicians to practice medicine." *Id.* Accordingly, contracts that facilitate the corporate practice of medicine by a hospital or clinic are illegal. *See Cmty. Health Sys. Prof'l Servs. Corp. v. Hansen*, 525 S.W.3d 671, 678 n.1 (Tex. 2017); *Doctors Hosp. at Renaissance, Ltd. v. Andrade*, 493 S.W.3d 545, 548 (Tex. 2016);

[30]The Medical Practice Act, which provided a comprehensive statutory scheme governing the licensing, regulation, and discipline of physicians by the Texas Board of Medical Examiners, was in 1999 repealed and recodified as part of the Texas Occupations Code. *See* Act of July 28, 1981, 67th Leg., 1st C.S., ch. 1, § 1, 1981 Tex. Gen. Laws 1, 30 (formerly Tex. Rev. Civ. Stat. Ann. art. 4495b), *repealed and recodified by* Act of May 13, 1999, 76th Leg., R.S., ch. 388, §§ 1, 6(a), 1999 Tex. Gen. Laws 1431, 1462–63, 1503–08, 2440 (effective Sept. 1, 1999) (current version at Tex. Occ. Code Ann. §§ 151.001–165.060); *see In re Univ. of Tex. Health Ctr. at Tyler*, 33 S.W.3d 822, 824 (Tex. 2000) (orig. proceeding) (recognizing repeal and recodification).

Watt v. Tex. State Bd. of Med. Exam'rs, 303 S.W.2d 884, 887–88 (Tex. App.—Dallas 1957, writ ref'd).

The common law reflects this prohibition by imposing a nondelegable duty upon an attending physician to obtain the informed consent of his patient to any proposed form or course of treatment. *See Espalin v. Children's Med. Ctr. of Dallas*, 27 S.W.3d 675, 686 (Tex. App.—Dallas 2000, no pet.) ("Hospitals have no such duty of disclosure of medical or surgical risks, nor are they required to secure a patient's informed consent prior to surgery."); *Boney v. Mother Frances Hosp.*, 880 S.W.2d 140, 143 (Tex. App.—Tyler 1994, writ denied) (same); *Ritter v. Delaney*, 790 S.W.2d 29, 31 (Tex. App.—San Antonio 1990, writ denied) (op. on reh'g) (same); *Nevauex v. Park Place Hosp., Inc.*, 656 S.W.2d 923, 925 (Tex. App.—Beaumont 1983, writ ref'd n.r.e.) (same). As discussed above, the process of obtaining a patient's informed consent to a form or course of treatment is a negotiation of the critical term of the physician–patient relationship. *See Wilson*, 412 S.W.2d at 302. A health care facility like CCMC is, quite literally, a third-party to this relationship; it has no common law duty to obtain or right to make a treatment decision from or for a terminally ill patient because it cannot practice medicine or enter into the underlying physician–patient relationship.

Nevertheless, Section 166.046 not only makes a health care facility such as CCMC responsible for statutory disclosures concerning the committee review process, it authorizes the facility—through the committee review process—to affirm the treatment decision of the attending physician; without the committee's approval, the

attending physician must continue to provide life-sustaining treatment. Tex. Health & Safety Code Ann. § 166.046(a), (e). Through its committee review process, the health care facility, not the attending physician, decides whether to continue life-sustaining treatment for its terminally ill patient. *See id.* And by absolving and immunizing both the attending physician and the health care facility of any legal obligation to continue and from any civil or criminal liability for discontinuing life-sustaining treatment to their terminally ill patient, Sections 166.045(d) and 166.046(e) recognize that the health care facility has an independent duty to provide such treatment with the invocation of Section 166.046, as well as independent discretion to either continue or discontinue such treatment upon the expiration of the ten-day deadline for transfer. *See id.* §§ 166.045(d), .046(e).

By way of contrast, both the common law tort of patient abandonment and Section 166.045(c) are attending-physician specific; the attending physician alone is responsible for reasonable notice and a reasonable opportunity to transfer. Thus, Section 166.046 does not merely clarify the common law. It completely reworks the consensual elements of the physician–patient relationship by delegating control of this treatment decision to the committee review process of the health care facility, authorizing what is quintessentially the corporate practice of medicine and clothing the facility with absolute, unqualified immunity from civil liability and criminal prosecution for so practicing. There is simply no common law antecedent for the committee review process established by Section 166.046(e).

Summarizing, the liability elements for the patient abandonment tort have never been applied to the unilateral withdrawal of an attending physician from providing life-sustaining treatment to a terminally ill patient when the withdrawal will, within reasonable medical probability, result in the patient's death. Nor do such elements apply to health care facilities such as CCMC. Accordingly, Sections 166.045(c), 166.046(d) and (e), and 166.051 do not merely codify a physician's private contractual right to withdraw from treating a terminally ill patient but instead create new, statutory authority for both an attending physician and a health care facility to withdraw from their private contractual obligations by discontinuing life-sustaining treatment and thereby facilitating the death of their patient from terminal illness or injury.[31] Again, that is authority that is traditionally and exclusively a public function of the state.

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[31] Although not material to our analysis, we note a potential conflict in the TADA involving the now-statutory duty to afford the terminally ill patient a reasonable opportunity for transfer. Section 166.046(e) absolves the attending physician of any "legal obligation" to provide life-sustaining treatment upon the expiration of ten days from written notice of an affirmation through the committee review process. Tex. Health & Safety Code Ann. § 166.046(e). Section 166.046(g) authorizes the extension of that deadline by a district or county court only upon a showing by the terminally ill patient, "by a preponderance of the evidence, that there is a reasonable expectation that a physician or health care facility that will honor the patient's directive will be found if the time extension is granted." *Id.* § 166.046(g).

Nevertheless, the proviso of Section 166.051 mandates the provision of life-sustaining treatment "until a reasonable opportunity has been afforded for transfer of the patient to another physician or health care facility willing to comply with the advance directive or treatment decision." *Id.* § 166.051 (applying to "[t]his subchapter," including Sections 166.045 and 166.046). Moreover, an attending physician commits a prohibited medical practice if, "in complying with the procedures outlined in Sections 166.045 and 166.046, Health and Safety Code, [he] *wilfully* fails to make a reasonable effort to transfer

2. State regulation of the lawful means or process of dying, naturally or otherwise, is distinguishable from state regulation of private medical practice

CCMC argues that, by creating the committee review process and immunizing treatment decisions made thereby from civil liability and criminal prosecution, the Legislature merely established a "safe harbor" for private medical peer review decisions that the courts have already found do not implicate state action. We disagree because the committee review process of Section 166.046 involves the exercise of the state's police power to regulate the lawful means or process of dying, naturally or otherwise; thus, it is fundamentally different from ordinary medical peer review.

a. State regulation of private medical peer review does not ordinarily constitute state action

In *Goss v. Memorial Hospital System*, upon which CCMC relies, the Fifth Circuit rejected a physician's Section 1983 procedural-due-process claim for the wrongful revocation of his staff privileges at two private hospitals because although the Texas

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a patient to a physician who is willing to comply with a directive." Tex. Occ. Code Ann. § 164.052(a)(22) (emphasis added). These provisions suggest that the ten-day deadline of the committee review process remains subject to reasonableness and willfulness standards.

We need not resolve this potential conflict to determine the issue of state action, but we note its existence leaves the granting of immunity from civil liability as potentially the sole distinction between Sections 166.045(c) and 166.046(e). *Compare* Tex. Health & Safety Code Ann. § 166.044(d) (granting immunity from civil liability and criminal prosecution for treatment decision affirmed by committee review process), *with id.* § 166.047 (granting immunity from criminal prosecution to treatment decisions made pursuant to either Section 166.045(c) or Section 166.046(e)).

Medical Practice Act authorizes and regulates medical peer review activity throughout the state, including by immunizing medical peer review committees and their members from civil liability, such private decisions cannot be characterized as actions taken under color of state law. 789 F.2d 353, 356 (5th Cir. 1986). In so holding, the court reasoned that, although the Medical Practice Act authorized a medical peer review committee to report its findings of a physician's incompetency to the Texas State Board of Medical Examiners and immunized its members from civil liability arising from the consequences of such report or investigation, the immunity granted did not make the committee generating the report an investigatory arm of the state. *Id.*; *see also Wong v. Stripling*, 881 F.2d 200, 201–02 (5th Cir. 1989) (considering similar Mississippi regulatory law in holding that private hospital's suspension of physician's staff privileges was not state action); *Cole v. Huntsville Mem. Hosp.*, 920 S.W.2d 364, 368–71 (Tex. App.—Houston [1st Dist.] 1996, writ denied) (holding private hospital's denial of physician's reapplication for staff privileges was not state action), *disapproved of on other grounds by Brown v. De La Cruz*, 156 S.W.3d 560, 567 nn.40, 41 (Tex. 2004). When the Legislature subsequently repealed and recodified the Medical Practice Act in 1999, *see* note 30 *supra*, at 76, it retained the civil immunity for private medical peer review activities and effectively codified *Goss* by expressly disclaiming that such activities constitute state action. Tex. Occ. Code Ann. § 160.010 (civil immunity), § 160.011 ("The reporting or assistance provided for in this subchapter does not constitute state action on the reporting or assisting medical peer review committee or its parent organization.").

The private medical peer review contemplated by *Goss* is easily distinguishable, however, from the medical peer review involved in overriding a patient's refusal to consent to the withdrawal of life-sustaining treatment. The former regulates the private practice of medicine generally for purposes of public health; the latter, despite being informed by the private practice of medicine, specifically regulates what constitutes a lawful means or process of dying for purposes of civil liability and criminal prosecution.

Although not exclusively created for medical peer review purposes, *see* note 8 *supra*, at 8, an ethics or medical committee created pursuant to Section 161.0315(a) and authorized by Section 166.046(a) to review an attending physician's refusal to comply with a patient's or patient representative's directive to continue life-sustaining treatment may conduct medical peer review. *See Mem'l Hosp.–The Woodlands v. McCown*, 927 S.W.2d 1, 3 (Tex. 1996) (orig. proceeding) (observing "medical committee" is one of two types of medical review committees created by statute). Medical peer review is generally retrospective in nature and has the intended purpose of improving standards of medical care in the future through "exacting critical analysis" of the competence and past performance of physicians and other health care providers in "an atmosphere of confidentiality" promoting "candid, uninhibited communication" within the medical profession to facilitate such critical analysis. *See id.* Much of the critical analysis anticipated by Section 166.046(a) is retrospective, particularly concerning how a patient came to be subject to and sustained by life-sustaining treatment.

By way of contrast, the critical aspect of the committee review process under Section 166.046 is one of prospective prognosis, i.e., given the patient's terminal or irreversible condition, is continued life-sustaining treatment medically inappropriate? Tex. Health & Safety Code Ann. § 166.046(e) (creating a ten-day deadline for transfer only if the ethics committee affirms that continued life-sustaining treatment is "medically inappropriate"). Indeed, the entire purpose of this statutory process is to make a *prospective* treatment decision, not to review one retrospectively, and thereby to establish the means by which a terminally ill patient may lawfully die. The mechanism provided by Section 166.046 is therefore distinguishable from the process described in the cases cited by CCMC that hold medical peer review does not constitute state action.

b. State regulation of what is and what is not a lawful means or process of dying is a traditional and exclusive public function

i. Homicide and suicide

"The Legislature, unless it is limited by constitutional provisions imposed by the State and Federal Constitutions, has the inherent power to define and punish any act as a crime, because it is [u]ndisputedly a part of the police power of the State." *Ex parte Smith*, 441 S.W.2d 544, 547 (Tex. Crim. App. 1969) (quoting *State v. Hales*, 122 S.E.2d 768, 770 (N.C. 1961)). The penal statutes of this state have always criminalized homicide in all its many forms, even when the crime occurred during the alleged provision of medical care. *See, e.g.*, *Grotti v. State*, 273 S.W.3d 273, 275–79 (Tex. Crim. App. 2008) (affirming reversal of criminally-negligent-homicide conviction of attending physician

who occluded hospital patient's breathing tube with her finger), *aff'g*, 209 S.W.3d 747, 753 (Tex. App.—Fort Worth 2006); *Smith v. State*, 132 S.W.2d 868, 870–72 (Tex. Crim. App. 1939) (reversing murder-by-abortion conviction of nurse when circumstantial evidence failed to demonstrate her responsibility for perforation of patient's uterus); *Jones v. State*, 141 S.W. 953, 955–66 (Tex. Crim. App. 1911) (affirming homicide conviction of attending physician who first delivered newborn infant, then brutally crushed the child's skull and broke its neck); *Saenz v. State*, 479 S.W.3d 939, 952–54 (Tex. App.—San Antonio 2015, pet. ref'd) (affirming capital murder conviction of nurse who injected bleach into dialysis lines of multiple patients who died of cardiac arrest); *Davis v. State*, 955 S.W.2d 340, 342–46 (Tex. App.—Fort Worth 1997, pet. ref'd) (affirming involuntary-manslaughter conviction of oral surgeon who oversedated patient); *Jones v. State*, 751 S.W.2d 682, 683–87 (Tex. App.—San Antonio 1988, no pet.) (affirming injury-to-a-child conviction of pediatric intensive care nurse who gave infant patient massive overdose of Heparin and was on duty when inordinate number of infant fatalities occurred in the hospital PICU); *Jones v. State*, 716 S.W.2d 142, 144–45 (Tex. App.—Austin 1986, pet. ref'd) (affirming murder conviction of pediatric nurse who injected patient with an unprescribed overdose of muscle relaxant); *Showery v. State*, 690 S.W.2d 689, 691–96 (Tex. App.—El Paso 1985, pet. ref'd) (affirming homicide conviction of attending physician who suffocated newborn infant after botched abortion); *see also Atteberry v. Nocona Gen. Hosp.*, 430 F.3d 245, 250 (5th Cir. 2005) (describing allegations that nurse killed as many as twenty-two hospital patients by

injecting them with paralytic drug); *James v. Nocona Gen. Hosp.*, Nos. 7:02-CV-0291-KA, 7:03-CV-004-KA, 7:03-CV-005-KA, 7:03-CV-006-KA, 7:03-CV-008-KA, 7:03-CV-009-KA, 7:03-CV-0022-KA, 7:03-CV-0034-KA, 7:03-CV-0040-KA, 7:03-CV-0042-KA, 2006 WL 3008105, at *1, *5 (N.D. Tex. Oct. 23, 2006) (mem. & order) (confirming capital murder conviction of nurse who "ran amok on the wards" resulting in deaths of multiple hospital patients).

Moreover, the consent of the decedent has never been a defense to the crime of homicide. *See Walter v. State*, 581 S.W.3d 957, 969 (Tex. App.—Eastland 2019, pet. ref'd) (affirming murder conviction and rejecting consensual sexual asphyxia defense). *But cf.* Tex. Penal Code Ann. § 22.06(a)(2)(B) (stating "victim's effective consent or the actor's reasonable belief that the victim consented to the actor's conduct is a defense to prosecution" for assault, aggravated assault, or deadly conduct if the victim knew the conduct was a risk of "recognized medical treatment"). Indeed, although suicide is not and has never been a crime in this state, actively assisting an individual in committing suicide remains a homicide. *Id.* § 19.02(b)(1) (defining murder as "intentionally or knowingly caus[ing] the death of an individual"); *see Mullane v. State*, 475 S.W.2d 924, 925–27 (Tex. Crim. App. 1971) (affirming murder with malice conviction despite victim's having both paid defendant $900 and provided him with the murder weapon to assist him in committing suicide); *Carew v. State*, 471 S.W.2d 860, 861–62 (Tex. Crim. App. 1971) (affirming conviction for accomplice to murder arising from same suicide-for-hire scheme).

For example, in *Sanders v. State*, the Court of Criminal Appeals described the distinction between passive and active assistance thusly,

> It is not and has not been a violation of law in Texas for a person to take his or her own life.
>
> Whatever may have been the law in England, or whatever the law may be there now with reference to suicide, or in any of the states of the federal Union, where they have so provided by statute with reference to suicide, the punishment of persons connected with the suicide, by furnishing means or agencies or affording an opportunity to the suicide to take his or her life, has not obtained and does not obtain in Texas. So far as our law is concerned, the suicide is innocent of any criminality. Therefore the party who furnishes the means to the suicide is also innocent of violating the law. It may be a violation of morals and ethics, and reprehensible, that a party may furnish another poison, or pistols, or guns, or any other means or agency for the purpose of the suicide to take his own life, yet our law has not seen proper to punish such persons or such acts. A party may furnish another with a pistol, knowing such party intends to take his own life, yet neither would be guilty of violating any statute of Texas. So it may be said of furnishing poison to the suicide. *However, a party would not be justified in taking the life of the party who desires to forfeit his life by shooting the would-be destroyer at his request, for in that case it would be the direct act of the accused, and he would be guilty of homicide, although he fired a shot at the request of the would-be suicide. So it would be with reference to poison. If the suicide obtains the poison through the agency of another, that other knowing the purpose of the suicide to take his own life, the party furnishing it would not be guilty, yet if the party furnishing it know the purpose of the suicide, and he himself gives the medicine or poison by placing it in the mouth or other portions of the body, which would lead to the destruction of life, then it would be the act of the party giving, and he would not be permitted to defend against the result of such act.*

112 S.W. 68, 70 (Tex. Crim. App. 1908) (emphasis added), *overruled in part on other grounds by Aven v. State*, 277 S.W. 1080, 1083 (Tex. Crim. App. 1925) (op. on reh'g); *see also Aven*, 277 S.W. at 1081–82 (quoting emphasized language from *Sanders* and affirming capital-murder-by-poison conviction because evidence supported defendant's administration,

not mere preparation, of arsenic for victim's alleged voluntary ingestion with intent to end her own life); *Grace v. State*, 69 S.W. 529, 530–31 (Tex. Crim. App. 1902) (reversing murder conviction because charge permitted jury to convict if defendant merely placed firearm within reach of suicide who undisputedly grabbed it thereafter and killed herself); *Wyler v. State*, 25 Tex. 182, 187–88 (1860) (affirming murder conviction after jury properly charged concerning distinction between homicide and suicide). Accordingly, the active killing of another individual, even with the individual's consent, has always been subject to the regulation of the state through its criminal or penal statutes.

The Legislature eventually criminalized even the passive assistance of suicide, leaving no room for one individual, including a treating physician, to assist another individual, including any patient, in taking the person's own life. *See* Act of May 24, 1973, 63rd Leg., R.S., ch. 399, § 1, 1973 Tex. Gen. Laws 883, 920, *amended by* Act of May 29, 1993, 73rd Leg., R.S., ch. 900, § 1.01, 1993 Tex. Gen. Laws 3586, 3624 (current version at Tex. Penal Code Ann. § 22.08 ("Aiding Suicide")). Section 22.08(a) of the Texas Penal Code states, "A person commits an offense if, with intent to promote or assist the commission of suicide by another, he aids or attempts to aid the other to commit or attempt to commit suicide." Tex. Penal Code Ann. § 22.08(a). Aiding suicide, therefore, "encompasses action which indirectly contributes to another's voluntary suicide, such as providing access to poison or a gun." *Goodin v. State*, 726 S.W.2d 956, 958 (Tex. App.—Fort Worth 1987), *aff'd*, 750 S.W.2d 789 (Tex. Crim. App. 1988). The

crime does not include "action on the part of an accused which directly causes the death of another, even if done at the deceased's request." *Id.* (also quoting *Sanders*, 112 S.W. at 70, for same proposition). As a result, aiding suicide is a crime distinct from, but complementary to, the crime of homicide because passive assistance as defined by Section 22.08(a) is a distinct element not shared by the active assistance described by *Sanders* as homicide, even though in both instances the victim intends to take her own life. *See id.*

ii. Wrongful death

As with criminal prohibitions and their consequences, civil liability for the wrongful death of another is exclusively a creation of the Legislature. *See* Tex. Civ. Prac. & Rem. Code Ann. § 71.002. The Supreme Court of Texas has repeatedly confirmed that there was no recognized common law cause of action for wrongful death. *Kallam v. Boyd*, 232 S.W.3d 774, 776 (Tex. 2007); *Horizon/CMS Healthcare Corp. v. Auld*, 34 S.W.3d 887, 903 (Tex. 2000); *Rose v. Doctors Hosp.*, 801 S.W.2d 841, 845 (Tex. 1990) (op. on reh'g); *Moreno v. Sterling Drug, Inc.*, 787 S.W.2d 348, 356 (Tex. 1990). This is likely because at common law any civil remedy available to the victim died with him and thereby merged into the criminal felony, which upon conviction resulted in the forfeiture of the felon's property to the state, rendering that property unavailable for execution for damages by the victim's estate. *See Galveston, Harrisburg & San Antonio R.R. Co. v. Le Gierse*, 51 Tex. 189, 199 (1879). The fact that the statutory wrongful death cause of action incorporated common law "elements" made it no less an exclusive creation

of the state, subject solely to the amendment, modification, or repeal of the Legislature. *See Moreno*, 787 S.W.2d at 356.

Nothing demonstrates this more than the decades-long refusal of the Supreme Court of Texas to interpret the Wrongful Death Act to include a cause of action for the death of an unborn child. In *Magnolia Coca Cola Bottling Company v. Jordan*, an opinion adopted from the Texas Commission of Appeals,[32] the Supreme Court of Texas held that the parents of an infant mortally injured *in utero* could not recover damages for his wrongful death even though the infant was subsequently born alive because, the infant's not being a "person" at the time of the wrongful conduct, the defendant owed no duty of care to him and, even had he survived, he could not have maintained a common law cause of action for his prenatal injuries. 78 S.W.2d 944, 945–50 (Tex. [Comm'n Op.] 1935), *overruled by Leal v. C. C. Pitts Sand & Gravel, Inc.*, 419 S.W.2d 820, 822 (Tex. 1967).

In so holding, the court looked by analogy to the criminal law concerning homicide:

> If we are to support a rule of present civil liability by analogy to criminal law, we should look to the law of this state rather than to a law said to exist in ancient days. Article 1205, Penal Code of 1925, being part of the chapter entitled "Homicide," has been in effect at least from the time of the adoption of the Penal Code of 1857. It provides: "The person upon whom the homicide is alleged to have been committed must be in existence by actual birth."

[32]Adopted opinions of the Commission "are given the same force, weight, and effect as the opinions written by the members of the Supreme Court itself." *Nat'l Bank of Commerce v. Williams*, 84 S.W.2d 691, 692 (Tex. 1935).

> In view of this statute, it has been held that one cannot be convicted of homicide of a newly born child unless it is shown that at the time the offense is alleged to have been committed the child had been completely expelled from its mother, and that, after being thus born, it had an independent existence; "that is, that the child breathed, and its blood circulated independent of its mother." *Wallace v. State*, 10 Tex. [Ct.] App. 255[, 274 (1881)]. *See*, *also*, *Cordes v. State*, 54 Tex. Cr[im]. [] 204, [211,]112 S.W. 943[, 947 (1908)]. Another article of the Penal Code (article 1195), a part of the chapter entitled "Abortion," prescribes severe penalties for the destruction of the vitality or life of a child in a state of being born and before actual birth. This state, therefore, has not brought unborn children within the protection of its penal statutes defining and prescribing penalties for homicide. In other words in its laws with respect to homicide, it treats the child as having no independent existence as a human being until it has been actually and completely born.

Id. at 948. C*ompare Wallace*, 10 Tex. Ct. App. at 270–77 (holding that full-term newborn infant found with string knotted around its neck was not born alive despite evidence of spontaneous respiration because hydrostatic test employed by medical experts could not establish whether respiration had occurred before or after infant was completely expelled from mother's body), *with Wheeler v. Yettie Kersting Mem'l Hosp.*, 761 S.W.2d 785, 785–86 (Tex. App.—Houston [1st Dist.] 1988, writ denied) (holding newborn infant of eight months' gestational age not born alive despite initial vitality during near complete breech delivery because prolonged entrapment of head and neck by cervix and umbilical cord resulted in prenatal oxygen deprivation and postnatal resuscitation efforts never induced spontaneous respiration and circulation).

In *Leal v. C.C. Pitts Sand & Gravel, Inc.*, the Supreme Court of Texas subsequently modified this interpretation to the effect that as long as the unborn child was born alive, only to die of its prenatal injuries postnatally, the parents could maintain a wrongful

death action because the child became a "person" through live birth. 419 S.W.2d at 821–22; *see also Yandell v. Delgado*, 471 S.W.2d 569, 570 (Tex. 1971) ("[A] cause of action does exist for prenatal injuries sustained at any prenatal stage provided the child is born alive and survives."). Over the course of the next half century, however, the Supreme Court of Texas adamantly refused to interpret the statute to apply to the stillborn death of an unborn child because it was the Legislature that possessed the exclusive authority to amend the statute to define "person" or "individual" to include an unborn child never born alive. *See Witty v. Am. Gen. Capital Distribs., Inc.*, 727 S.W.2d 503, 504, 506 (Tex. 1987) (defining the issue as one purely of legislative intent); *see also, e.g.*, *Blackman v. Langford*, 795 S.W.2d 742, 743 (Tex. 1990); *Tarrant Cty. Hosp. Dist. v. Lobdell*, 726 S.W.2d 23, 23 (Tex. 1987).

Finally, in 2003, the Legislature amended the Wrongful Death Act to expand the definition of actionable deaths to those of unborn children. Act approved June 20, 2003, 78th Leg., R.S., ch. 822, §§ 1.01–.02, 2003 Tex. Gen. Laws 2607, 2608 (current version at Tex. Civ. Prac. & Rem. Code Ann. §§ 71.001, .003); *see Fort Worth Osteopathic Hosp., Inc. v. Reese*, 148 S.W.3d 94, 96–97 (Tex. 2004) (upholding constitutionality of Wrongful Death Act as interpreted by *Witty* while acknowledging amendments thereto). Not only did the Legislature expand the term "individual" to include "an unborn child at every stage of gestation from fertilization until birth," it also correspondingly expanded the term "death" to include the failure of an unborn child "to be born alive." Tex. Civ. Prac. & Rem. Code Ann. § 71.001(3) ("Death"), § 71.001(4) ("Individual").

And as part of the same enactment, the Legislature similarly amended the Texas Penal Code to expand the crime of homicide to include the death of unborn children. *See* Act of June 20, 2003, 78th Leg., R.S., ch. 822, §§ 2.01–.02, 2003 Tex. Gen. Laws 2607, 2608 (current version at Tex. Penal Code Ann. § 1.07(a)(26) ("Individual"), § 1.07(a)(49) ("Death"), § 19.06). Critically, though expanding the homicide and wrongful death statutes to include the death of an unborn child, the Legislature exempted from criminal prosecution and civil liability a death arising from a lawful medical or health care procedure or the lawful dispensation or administration of a drug. Tex. Civ. Prac. & Rem. Code Ann. § 71.003(c)(2)–(4); Tex. Penal Code Ann. § 19.06(2)–(4); *see Reese*, 148 S.W.3d at 97 (discussing statutory exemptions).

Viewed in the context of this background, the so-called "safe harbor" provisions of the TADA are nothing more than the traditional and exclusive exercise of the state's inherent and exclusive police power to regulate the lawful means or process of dying by not only defining what constitutes a penal offense subject to criminal prosecution but also what constitutes a wrongful means of causing another individual's death subject to civil liability. Only the state can define homicide and wrongful death to exclude the consensual—and therefore the nonconsensual—discontinuation of life-sustaining treatment from a terminally ill patient; the fact that the statutory lawfulness of the conduct depends on and is informed by the private practice of medicine makes it no less the exclusive act of the state. *See Moreno*, 787 S.W.2d at 356.

iii. Natural death and "mercy killing"

CCMC finally contends that an attending physician's passively permitting a terminally ill patient to die a "natural death" does not implicate state action, citing the reasoning of the United States Supreme Court in *Vacco v. Quill* and recognizing—as the Court had implicitly in *Cruzan ex rel. Cruzan v. Director, Missouri Department of Health*, 497 U.S. 261, 280, 110 S. Ct. 2841, 2852 (1990)—"the distinction between letting a patient die and making that patient die." 521 U.S. 793, 807, 117 S. Ct. 2293, 2301 (1997). But the determination of by what means or process an individual succumbs to a terminal illness and by whose authority, if not voluntarily—although informed by private medical practice—clearly implicates the exclusive police power of the state to determine what constitutes a lawful means or process of dying and what constitutes a criminal homicide subject to prosecution.

In *Vacco*, the Court observed that "when a patient refuses life-sustaining medical treatment, he dies from an underlying fatal disease or pathology; but if a patient ingests lethal medication prescribed by a physician, he is killed by that medication." *Id.* at 801, 117 S. Ct. at 2298. Upholding the constitutionality of New York's criminalization of assisting suicide against an equal protection challenge, the Court found this distinction rationally related to "valid and important public interests," such as "prohibiting intentional killing and preserving life; preventing suicide; maintaining physicians' role as their patients' healers; protecting vulnerable people from indifference, prejudice, and psychological and financial pressure to end their lives; and avoiding a possible slide

towards euthanasia." *Id.* at 803–09, 117 S. Ct. at 2300–02. And in *Glucksberg,* the companion case to *Vacco*, the Court upheld Washington's criminalization of assisted suicide against a substantive-due-process challenge on essentially the same basis. 521 U.S. at 728–35, 117 S. Ct. at 2271–75.

Thus, contrary to CCMC's argument, *Vacco* and *Glucksberg* implicitly acknowledge that when a state legislatively authorizes a terminally ill patient to refuse life-sustaining treatment on the one hand but criminalizes physician-assisted suicide on the other, the drawing of this statutory distinction is a valid exercise of a state's police power to determine what is and what is not a lawful means or process of dying. It is simply not possible that the former is purely a matter of private medical practice, albeit regulated by the state, while the latter is an exercise of the state's police power, albeit informed by private medical practice, particularly when the end result of the physician assistance in both instances is involuntary. This is consistent with the development of the concept of "natural death" in Texas.

As discussed above, Texas's homicide statutes clearly include within their ambit any proactive aiding of an individual in taking her own life, even if justified as a "mercy killing" due to the victim's terminally ill condition. *See Hislop v. State*, 64 S.W.3d 544, 544–46 (Tex. App.—Texarkana 2001, no pet.) (affirming murder conviction of forty-two-year-old disabled caretaker son despite claim that death of his eighty-year-old mother was "mercy killing" due to poor bone cancer prognosis). With the development of mechanical ventilation and other means of advanced life support, however, it was

not clear before passage of the TADA whether simply discontinuing life-sustaining treatment for a terminally ill patient would subject a merciful health care provider to criminal prosecution for homicide. *See* C. Anthony Friloux, Jr., *Death, When Does It Occur?*, 27 Baylor L. Rev. 10, 16 (Winter 1975) ("The recent ability of physicians to control the functions of organs by external devices over which the patient has no control, and the recognition of limitations on the cessation of heart beat and respiration as signs of death, force a re-evaluation and re-examination of the entire concept of 'medical death.'").

In the 1975 Baylor Law Review forum on passive euthanasia, renowned criminal defense attorney Percy Foreman accurately and rather presciently described the legal conundrum of the attending physician:

> The distinction between involuntary euthanasia by a positive act and involuntary euthanasia by omission is not always easy to discern. Suppose a patient is alive only because he is connected to a mechanical respirator. Without the machine, he would die. Attempts are made by the physician to revive him to a self-sufficient state, while the machine artificially keeps him breathing. After a period of time, the doctor concludes his efforts are futile and decides to unplug the machine. The patient dies. Is the doctor's act of unplugging the life-supporting machine an "external manifestation of the doctor's will," that is, a positive act? Or is the act to be considered an omission by the doctor in that he is omitting to provide further lifesaving medical care? If it is an affirmative act, and without the patient's consent, theoretically the doctor would be liable for murder. On the other hand, if it be deemed an omission, then the criminal liability of the doctor would turn on the question of duty. Although the doctor has a duty to administer ordinary means to preserve life, there is not a duty to administer "extraordinary" means.
>
> Ordinary treatment has been defined as "all medicines, treatments and operations which offer a reasonable hope of benefit, and which can

be obtained and used without excessive expense, pain or other inconvenience. Extraordinary means are considered those which do not involve the above factors, or which, if used would offer no reasonable hope of benefit." Once the doctor, after trying in vain to revive the patient, concludes that any further attempts are futile, then the use of the mechanical respirator is arguably "extraordinary means." However, one writer has pointed out that such an argument is invalid in that it is clouded by a moral-legal confusion.

> It is submitted that once life support equipment has begun to operate on a patient, it is [fallacious] to argue that a cessation of such treatment is a mere "omission to provide the therapeutic treatment," and not an "act" in a legal sense. The physician must physically turn the switch to the "off" position. That is, in fact, positive action. This conclusion, however, is a legal one only, and is not to make a moral judgment quite so dramatic as "equating the physician's turning off a mechanical respirator with the gunman's killing for hire."

One further anomaly concerning involuntary euthanasia is that homicide cannot be committed on a person who is dead. Thus criminal liability for turning off a mechanical life-support machine may rest upon the legal definition of death. In the legal sense, this does not give the doctor much grace. The traditional definition of death is:

> the cessation of life . . . defined by physicians as a total stoppage of the circulation of the blood and a cessation of the animal and vital functions consequent thereon, such as respiration, pulsation, etc.

Doctors have argued that the traditional definition is impractical in light of modern artificial means of continuing heartbeat and respiration almost indefinitely, and have suggested the adoption of the "functional" death, i.e. the absence of functional brain activity. However, the Texas courts adhere to the traditional definition. Therefore, although a patient's electroencephalograph may reflect an isoelectric or flat wave pattern over a period of time, if his heart beat and respiration continue by artificial means, he is legally alive and the act of terminating the artificial means is technically the act that causes death.

Percy Foreman, *The Physician's Criminal Liability for the Practice of Euthanasia*, 27 Baylor L. Rev. 54, 56–58 (Winter 1975) (citations omitted).

Significantly, concluding that any exercise of the state's police power to exclude involuntary euthanasia or "mercy killing" from the definition of criminal homicide would trigger due-process and equal-protection complications, Foreman wrote,

> The law surrounding criminal liability for acts of euthanasia is grounded on the State's police power. In practice, the exercise of the police power by the states exhibits a more liberal attitude toward euthanasia, whether self-inflicted or brought about by another. Despite evidence that euthanasia is widely practiced, at least by omission, there have been few prosecutions in this country. Perhaps from the view point of the terminally ill who desire a premature death, the practice is just. It is at least accommodating. *But from the perspective of euthanasia victims unwilling or unable to give consent to the premature termination of their lives, the practice of not dealing with perpetrators as the law provides might be viewed as inadequate protection of life by state action—arguably a violation of both due process and equal protection.*
>
> The gap between criminal liability in theory and in practice gives neither the physician nor the patient much comfort. While there have been no convictions in Texas for voluntary euthanasia, we end where we began—euthanasia is a euphemism for criminal homicide.

Id. at 61 (emphasis added).

To address these concerns, in 1977 the Legislature enacted the NDA—the predecessor of the TADA, *see* note 22 *supra*, at 51—authorizing, for the first time, a terminally ill patient to *voluntarily* refuse life-sustaining treatment, thereby relieving the attending physician from any legal obligation to provide such treatment over the patient's refusal. *See* Act of May 28, 1977, 65th Leg., R.S., ch. 398, §§ 1–12, 1977 Tex. Gen. Laws 1085, 1085–89 (formerly Tex. Rev. Civ. Stat. Ann. art. 4590h, §§ 1–11). The

NDA carefully defined the terms "life-sustaining procedure," "qualified patient," and "terminal condition" and expressly limited the remedy to competent adult patients with terminal conditions who *voluntarily* executed—in the exact form set forth therein—a written directive to withhold life-sustaining procedures. *See id.* §§ 2(2)–(3), (5)–(6), 3, 7. There was no provision whatsoever for the *involuntary* removal of life-sustaining treatment.

If the patient properly executed a written directive refusing treatment, the NDA further provided that no physician or health care facility causing the withholding or withdrawal of life-sustaining procedures pursuant to the directive would be subject to civil liability "unless negligent" and expressly disclaimed that such conduct would, for any purpose, constitute a criminal act under the Texas Penal Code. *Id.* §§ 6, 8(a). Nevertheless, the NDA categorically stated that "[n]othing in this Act shall be construed to condone, authorize, or approve mercy killing, or to permit any affirmative or deliberate act or omission to end life other than to permit the natural process of dying as provided in this Act." *Id.* § 10. The TADA retains a virtually identical prohibition against mercy killing. Tex. Health & Safety Code Ann. § 166.050.

Although the NDA disclaimed any intent to "impair or supersede any legal right or legal responsibility a person may have to effect the withholding or withdrawal of life-sustaining procedures in a lawful manner,"[33] neither Texas common law nor any statute

[33]Act of May 28, 1977, 65th Leg., R.S., ch. 398, § 11, 1977 Tex. Gen. Laws 1085, 1089.

provided other lawful means or process for withholding or withdrawing life-sustaining treatment. *See Stolle v. Baylor Coll. of Med.*, 981 S.W.2d 709, 713–14 (Tex. App.—Houston [1st Dist.] 1998, pet. denied) (holding NDA exclusive lawful means for effectuating removal of life support from terminally ill patients). When considered *in para materia* with the specifically referenced homicide statute, the NDA created the very type of statutory distinction held by *Vacco* and *Glucksberg* to be a constitutional exercise of the state's police power to determine what is and is not a lawful means or process of dying.

As anticipated by Foreman's forum commentary, the Legislature soon thereafter supplemented the NDA with an expanded definition of legal death:[34] "A person is dead when, according to ordinary standards of medical practice, there is irreversible cessation of the person's spontaneous respiratory and circulatory functions." Tex. Health & Safety Code Ann. § 671.001(a). But when such a determination is precluded by "artificial

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[34]*Compare* Act of May 4, 1979, 66th Leg., R.S., ch. 165, § 1, 1979 Tex. Gen. Laws 368, 368 (formerly Tex. Rev. Civ. Stat. Ann. Art. 4447t) (adding neurological or brain death to cardiopulmonary death), *repealed and recodified by* Act of June 14, 1989, 71st Leg., R.S., ch. 678, § 13(1), 1989 Tex. Gen. Laws 2230, 2981, 3165 (current version at Tex. Health & Safety Code Ann. §§ 671.001–.02), *with Prichard v. State*, 533 S.W.3d 315, 321 (Tex. Crim. App. 2017) (observing Penal Code does not define term "death" other than to include failure of unborn child to be born alive and acknowledging cardiopulmonary definition of Section 671.001(a) in holding term contemplates only human, not animal, death), *Glover v. Davis*, 366 S.W.2d 227, 232 (Tex. 1963) (holding reliable evidentiary attributes of death include "lack of pulse or heartbeat, lack of breathing, sensitivity of the eyes to light, or other medically accepted tests"), *and Sanger v. Butler*, 101 S.W. 459, 462 (Tex. App.—Dallas 1907, writ ref'd) (interpreting "death" as used in will to include "cessation of life; that state of a being, animal or vegetable, in which there is a total and permanent cessation of all the vital functions").

means of support," a person "is dead when, in the announced opinion of a physician, according to ordinary standards of medical practice, there is irreversible cessation of all spontaneous brain function. Death occurs when the relevant functions cease." *Id.* § 671.001(b). Finally, a physician or other authorized health care provider who determines death in compliance with Section 671.001(a) "is not liable for civil damages or subject to criminal prosecution . . . based on the determination of death." *Id.* § 671.002(a).

As this court has reason to know, the determination of whether a person is legally dead or alive when life-sustaining treatment is withdrawn is not purely a matter of private medical practice; such a determination always implicates the exclusive police power of the state to determine the lawfulness of an individual's death, albeit informed by private medical practice. For example, in *Grotti v. State*, this court reversed the criminally-negligent-homicide conviction of an intensive care physician who used her finger to "occlude" or block a patient's endotracheal tube after discontinuing the patient's mechanical ventilation and pronouncing her dead because the evidence was factually insufficient to establish that the patient was actually alive at the time of the occlusion. 209 S.W.3d at 753. In holding that the evidence was factually insufficient to support the conviction, we applied the statutory definition of "death" set forth in Section 671.001, and in doing so, observed that the definition "provides guidance to physicians, and others relying on those physicians' pronouncements, as to when death legally occurs in this state." *Id.* at 759–61 & n.16. Agreeing with our application of this

definition, the Court of Criminal Appeals ultimately affirmed our decision. 273 S.W.3d at 281–84.

From an evidentiary standpoint, *Grotti* is an excellent example of how Texas exclusively regulates the lawful means of dying in end-of-life circumstances instead of merely regulating private medical practice generally. Grotti experienced both criminal prosecution and licensure revocation for allegedly the same treatment decision involved here, i.e., causing the death of a terminally ill patient without that patient's or the patient's representative's consent. *Compare* 209 S.W.3d at 754–57, *with Grotti v. Tex. State Bd. of Med. Exam'rs*, No. 03-04-00612-CV, 2005 WL 2464417, at *3–11 (Tex. App.—Austin Oct. 6, 2005, no pet.) (mem. op.) (affirming Board of Medical Examiner's revocation of Grotti's license to practice medicine in Texas). But it was the alleged unlawful death of the patient, not Grotti's alleged failure to adhere to appropriate standards of care in her private practice of medicine, that triggered the State's prosecution. *See Grotti*, 209 S.W.3d at 779–82. In fact, when she attempted to equate the two by arguing that for double jeopardy purposes the Board's imposing an administrative penalty with the revocation of her license was indistinguishable from her homicide prosecution, we categorically disagreed. *See id.* The *Grotti* case exemplifies why the state's regulation of the lawful means of dying is clearly distinct from the state's regulation of the private practice of medicine.

In urging us to follow the reasoning of *Goss*, CCMC asks us to determine that the treatment decision to discontinue life-sustaining treatment for a terminally ill infant,

affirmed through the committee review process set forth in Section 166.046, is nothing more than state regulatory "oversight" of a private treatment decision through private medical peer review. *Grotti* conclusively demonstrates to the contrary. The immunization of such a decision from *both* criminal prosecution and civil liability is not merely a "safe harbor" for private medical peer review but is exclusively an exercise of the state's police power in determining whether medical treatment resulting in the death of a terminally ill patient will be lawful. *See* Tex. Health & Safety Code Ann. §§ 166.045(d), .047.[35]

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[35]One final aspect of Grotti's conduct implicates the state's police power. By discontinuing the mechanical ventilation in the manner she did, Grotti arguably violated both the determination-of-death statute and the TADA. First, a report from the Texas Department of Health found that Grotti did so without consulting with the patient's husband as required by both state law and the hospital's advance directive policy, despite the husband's immediate presence with other members of the family in the ER waiting room. *See Grotti v. Belo Corp.*, 188 S.W.3d 768, 776, 784 (Tex. App.—Fort Worth 2006, pet. denied). Second, deposition testimony from the attending ER physician confirmed that the hospital's ER was not equipped with any diagnostic mechanism to test or otherwise confirm Grotti's pronouncement of the patient's death due to irreversible cessation of all spontaneous brain function. *See id.*

Although arguably presenting two prosecutable violations, Grotti's conduct reveals a potential area of statutory conflict. On the one hand, Section 671.001(c) expressly prohibits the termination of "artificial means of supporting a person's respiratory and circulatory functions" absent a pronouncement of neurological death by the attending physician. Tex. Health & Safety Code Ann. § 671.001(b), (c). On the other hand, Section 166.046(e) authorizes an attending physician to withdraw life-sustaining treatment, including mechanical ventilation, even when there is no irreversible cessation of all spontaneous brain function. *Id.* §§ 166.002(10), .046(e).

At least one court has held that these statutes should be read together to require both confirmation of neurological death and a surrogate decision maker's consent before life-sustaining treatment may be withdrawn from a terminally ill patient. *See*

Moreover, other jurisdictions have held that the state's *parens patriae* interest in assuring the voluntariness of a decision to withdraw life-sustaining treatment implicates the state's police power in defining what is and what is not a lawful means or process of dying. In *Cruzan*, the United States Supreme Court implicitly recognized that the decision to discontinue life-sustaining treatment for even an incompetent adult patient invoked the *parens patriae* authority of the state: "Missouri relies on its interest in the protection and preservation of human life, and there can be no gainsaying this interest." 497 U.S. 280, 110 S. Ct. at 2852. Both the majority and the dissent acknowledged that the state's *parens patriae* authority extended to assuring that the process through which such a decision is made results in a factually accurate and legally transparent determination of the patient's own treatment decision. *Id.* at 281–82, 110 S. Ct. at 2852–53 (recognizing Missouri's interests in setting evidentiary and procedural standards that confirm the decision is the patient's and not the result of abuse); *id.* at 315, 110 S. Ct. at 2871 (Brennan, J., dissenting) (agreeing with majority that "Missouri has a

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Andrade Garcia v. Columbia Med. Ctr. of Sherman, 996 F. Supp. 605, 611 (E.D. Tex. 1998) (order) (interpreting Section 671.001(c) in conjunction with former Section 672.009 of the NDA). *But cf. Jones v. United States*, No. SA-82-CA-346, 1985 WL 3487, at *3 (W.D. Tex. Apr. 17, 1985) (concluding that attending physician's disconnection of mechanical ventilation before pronouncing neurological death was not medical negligence because diagnostic testing revealed complete cessation of all spontaneous brain function). The fact that Section 166.046(e) of the TADA now authorizes involuntary withdrawal before pronouncement of death, when the NDA did not, raises a question of reconciliation that we need not address other than to observe that the potential conflict clearly implicates the exercise of the state's police power in determining when death legally occurs.

parens patriae interest in providing Nancy Cruzan, now incompetent, with as accurate as possible a determination of how she would exercise her rights under these circumstances"). Indeed, the majority and dissent clearly anticipate that the state will assert its *parens patriae* interests either directly or through the appointment of a guardian ad litem, even when the decision involves discontinuing life-sustaining treatment in a private hospital setting. *See id.* at 281 n.9, 318, 110 S. Ct. at 2853 n.9, 2872.

By implicitly holding that the liberty interest an incompetent adult has in *voluntarily* refusing life-sustaining treatment is of constitutional dimensions subject only to the *parens patriae* protection of the state, *Cruzan* strengthened the precedential authority of three earlier state decisions holding that the refusal of private physicians and hospitals to discontinue such treatment constitutes state action subject to federal due-process constraints. For example, in *In re Colyer*, the Supreme Court of Washington held that there was a sufficiently close nexus between the state's exercise of its police power criminalizing homicide—which clearly informed the hospital's refusal to discontinue life-sustaining treatment without a court order—and the state's general prohibitions against withdrawing or discontinuing life-sustaining treatment to find that the encroachment on the patient's privacy interest was fairly attributable to the state. 660 P.2d 738, 741–42 (Wash. 1983). In so finding, the court held that "an adult who is incurably and terminally ill has a constitutional right of privacy that encompasses the right to refuse treatment that serves only to prolong the dying process." *Id.* at 742. In essence, the court held that the state's regulation of the process of dying is a traditional

and exclusive public function because the state, and only the state, defines what is and is not a lawful process of dying through its homicide statute; its licensure and regulation of physicians responsible for treating the dying; and its supervision of the mentally incompetent as *parens patriae*, including the judicial appointment of guardians. *See id.* The court had previously observed that such regulation of the process of dying included both the state's exclusive determination of when death occurred for purposes of removing life support and its provision, through its Natural Death Act, for (1) a competent adult to anticipate and effectuate by a signed, witnessed directive such removal when death appeared imminent due to an incurable injury, disease, or illness and (2) civil and criminal immunity for physicians and other health care providers who assisted in the lawful execution of said directive. *Id.* at 740–41. Taken together, these factors showed a sufficient nexus between the state and the prohibitions against withholding or discontinuing life-sustaining treatment "to call into play the constitutional right of privacy." *Id.* at 742.

Relying in part on the reasoning in *Colyer*, in *Rasmussen v. Fleming*, the Supreme Court of Arizona held that the state's regulation of the process of dying through its Medical Treatment Decision Act, prohibiting the withdrawal or discontinuation of life support from a terminally ill adult without the execution of a written declaration, both implicated the federal constitutional right to privacy and constituted "state action" due to the regulatory authority of the state over the practice of medicine and the supervisory

authority of the state over the guardianship of incapacitated persons. 741 P.2d 674, 681–82 & n.9 (Ariz. 1987).

Finally, in *In re Eichner*, the Supreme Court, Appellate Division, of New York held that the refusal of a private hospital to withdraw life-sustaining treatment from a mentally incompetent adult patient constituted "state action" in violation of the Fourteenth Amendment, reasoning that the trial court

> was of the view that the constitutional right to privacy was not involved in this proceeding for want of the requisite element of "state action", i. e., that Nassau Hospital was acting as a "private" entity within the meaning of the Fourteenth Amendment, and its refusal to withdraw the respirator could never trigger constitutional ramifications. We cannot abide by [the trial court]'s analysis with respect to this question. True, there is case authority for the proposition that actions by a hospital are not state action. But, in determining whether "state action" is present, the test does not focus on the entity qua entity. Rather, the existence of "state action" for Fourteenth Amendment purposes depends on "whether there is a sufficiently close nexus between the State and the challenged action of the regulated entity so that the action of the latter may be fairly treated as that of the State itself[."] Thus, in *Schlein v. Milford Hosp.*, [561 F.2d 427 (2d Cir. 1977)], where the challenged activity was the rejection of staff privileges for a physician[,] an "activity" having minimal if any connection with the State[,] the court had little difficulty in rejecting the [f]ederally based due process claim. In stark contrast, it is the implied presence of the State, potentially capable of imposing criminal penalties and civil liability upon the hospital or medical staff, that has prompted this controversy. That the District Attorney has asserted what is essentially an adversary position in support of the hospital reflects this. State action was found to be present in *Roe* [*v. Wade*, 410 U.S. 113, 93 S. Ct. 705 (1973)] because the Texas statute imposed criminal sanctions for the performance of an abortion. Similarly, if the District Attorney's views prevail, the homicide statutes of this State would impose criminal penalties upon those who discontinue life-sustaining measures for [the proposed ward]. Furthermore, physicians are licensed by the State Board of Regents and, hence, their continued right to practice may be jeopardized by State action taken as a consequence of their conduct in termination-of-treatment situations.

> *Indeed, the State's* parens patriae *responsibility to provide continuing supervision over the affairs of an incompetent pursuant to the Mental Hygiene Law is sufficient to establish the existence of State action herein.* Consequently, we find that Nassau Hospital's rejection of [the proposed guardian]'s request constituted State action within the meaning of the Fourteenth Amendment.

426 N.Y.S.2d 517, 540 (N.Y. App. Div. 1980) (emphasis added) (citations omitted), *modified sub nom. by In re Storar*, 420 N.E.2d 64 (N.Y. 1981) (retaining part of order allowing removal of artificial respiration but deleting procedures delineated by intermediate appellate court in its opinion).

Earlier in the opinion, anticipating the police power distinction acknowledged by *Vacco* and *Glucksberg*, the court had articulated how the state's exclusive regulatory authority over the lawful means or process of dying implicated the decision to withdraw or discontinue life-sustaining treatment:

> Conduct which results in the death of a human being who is medically alive quite obviously implicates criminal homicide statutes. Such conduct may take the form of an act, or an omission to act where an affirmative duty to act is imposed by law. The actor's motive, no matter how kindly, is legally irrelevant, and this remains true notwithstanding the fact that the consent of the deceased had been obtained, or that the actor firmly believed his conduct to be morally justified. Euthanasia, referred to colloquially as "mercy killing[,"] is consequently proscribed by the criminal law, and any physician who, acting on his own, removes a life-sustaining respirator arguably commits some form of homicide.

Id. at 533 (footnoted omitted) (citations omitted).

Despite the fact that the Court of Appeals of New York subsequently modified the lower court's opinion to vacate its discussion of "state action" and the right of privacy in its entirety, *see Storar*, 420 N.E.2d at 74, both *Colyer* and *Rasmussen* found its

reasoning persuasive. *Rasmussen*, 741 P.2d at 681–82 & n.9, 686; *Colyer*, 660 P.2d at 742. And, ultimately, although the United States Supreme Court did not articulate the right to privacy as encompassing a right to refuse life-sustaining treatment, *Cruzan* clearly agreed with the conclusion that the right to refuse such treatment was a liberty interest subject to constitutional protection: "It cannot be disputed that the Due Process Clause protects an interest in life as well as an interest in refusing life-sustaining medical treatment." 497 U.S. at 281, 110 S. Ct. at 2853.

Taken together, *Colyer*, *Rasmussen*, and *Eichner*—and, implicitly, *Cruzan*, *Vacco,* and *Glucksberg*—recognize that the determination of what is and is not a lawful means or process of dying, naturally or otherwise, is traditionally and exclusively subject to the police power of the state, especially when the individual dying is subject to the *parens patriae* protection of the state. Adopting their reasoning in conjunction with the reasoning of *Miller*, we therefore hold that the treatment decision of an attending physician to unilaterally discontinue life-sustaining treatment for a terminally ill minor patient, over the objection of her parents, as affirmed by an ethics or medical committee through the statutory authority of Section 166.046, constitutes the exercise of (1) the sovereign authority of the state, under the doctrine of *parens patriae*, to supervene the fundamental right of a parent to make a medical treatment decision for her child and (2) the sovereign authority of the state, under its police power, to regulate what is and is not a lawful means or process of dying, naturally or otherwise. Accordingly, the treatment decision made by the attending physician and affirmed by CCMC's ethics

committee constitutes "state action" within the meaning of the Fourteenth Amendment of the United States Constitution and 42 U.S.C.A. § 1983, as well as Article I, Section 19 of the Texas Constitution. *See Tex. Workers' Comp. Comm'n v. Patient Advocates of Tex.*, 136 S.W.3d 643, 658 (Tex. 2004) (noting that although Article I, Section 19 and the Fourteenth Amendment are textually different, we generally construe Article I, Section 19—the due course of law clause—in the same way as the Fourteenth Amendment).

VII. By Demonstrating a Lack of Reasonable Notice and a Meaningful Opportunity to Be Heard, Mother Has Shown a Probable Right to Relief on Her Procedural-Due-Process Claim

Having established that Section 166.046 constitutes a delegation of traditional and exclusive public functions to private physicians and health care facilities, we must decide whether Mother has shown a constitutionally actionable deprivation of rights pursuant to Section 1983. Mother argues that the unilateral decision to withdraw life-sustaining treatment from T.L. pursuant to Section 166.046, overriding her refusal to consent, deprives her daughter of a vested fundamental right to life and deprives Mother of a derivative, yet vested, fundamental right to make medical decisions for her daughter in violation of federal and state due-process guarantees, both facially and as applied. We agree that Mother has shown a probable right to relief on these facts.

A. Terminally ill patients and their surrogate decision makers, including the parents of terminally ill children, have vested constitutional rights protected by due process

A Section 1983 analysis requires us to identify the right that the plaintiff claims was infringed. *Baker v McCollan*, 443 U.S. 137, 140, 99 S. Ct. 2689, 2692 (1979). Mother contends that the threatened action of withdrawing T.L.'s life-sustaining treatment implicates T.L.'s right to life and Mother's parental right to care, custody, and control of her child.

CCMC argues that T.L.'s right to life is not implicated here because even if it were to discontinue the medical treatment that is keeping her alive, her death would be caused by her underlying disease process, not the discontinuation of medical treatment. We have already rejected this argument in discussing the implications of *Cruzan*, *Vacco*, and *Glucksberg*.

Not only do terminally ill patients have a vested, fundamental right to decide whether to discontinue life-sustaining treatment, either individually or through surrogate decision makers, this right is subject solely to the state's exercise of its *parens patriae* and police power functions to assure the circumstances prompting and ultimately effectuating the decision are lawful. Moreover, we have also shown that parents of terminally ill children have a derivative, yet just as vested, fundamental right to make such decisions for their children, again, subject solely to the same exercise of state authority.

Accordingly, when the state's asserted *parens patriae* and police power interests conflict with a parent's rights, the state's interests may prevail only if strict procedural safeguards are followed. *See, e.g.*, *Troxel*, 530 U.S. at 65–66, 120 S. Ct. at 2060; *Santosky*, 455 U.S. at 753–54, 102 S. Ct. at 1395; *Stanley v. Illinois*, 405 U.S. 645, 651, 92 S. Ct. 1208, 1212 (1972); *In re J.W.T.*, 872 S.W.2d 189, 194–95 (Tex. 1994) (op. on reh'g) (noting that "the rights of the natural parent are of high importance and due process properly requires that the burden of proof to show forfeiture of parental rights rests upon [whomever challenges those rights]"—quoting *Gunn v. Cavanaugh*, 391 S.W.2d 723, 727 (Tex. 1965)—while recognizing that those rights are not absolute because "protection of the child is paramount"); *see also A.B.*, 412 S.W.3d at 609 (applying *Mathews v. Eldridge* test[36] to procedures used to terminate parental rights and citing *Rodarte v. Cox*, 828 S.W.2d 65, 79 (Tex. App.—Tyler 1991, writ denied)). Stated differently, before the state can assert its *parens patriae* interest in opposition to a parent's highly protected liberty interest in making life-preserving medical decisions for her terminally ill infant—as codified in Family Code Section 151.001(a)(6); as acknowledged in the TADA's provision allowing a parent to execute an advance directive for a minor child with a

[36]Under this test, determining what process is due in a particular proceeding involves the consideration of three factors: (1) the private interest affected by the proceeding or official action; (2) the risk of an erroneous deprivation of such interest through the procedures employed, and the probable value, if any, of additional or substitute safeguards; and (3) the governmental interest, including the function involved and the fiscal and administrative burdens that the additional or substitute procedural safeguards would entail. 424 U.S. 319, 335, 96 S. Ct. 893, 903 (1976).

terminal or irreversible condition, Tex. Health & Safety Code Ann. §§ 166.031, .035; and as acknowledged by CAPTA in the context of overriding a parent's decision to forego life-sustaining treatment—it must provide sufficient procedural-due-process protections to the parent.

We can easily distinguish the out-of-state authorities CCMC cites for the proposition that facilitating a natural death does not implicate a vested right. All involve mentally incompetent adult patients whose court-appointed guardians sought court orders authorizing the withdrawal of life-sustaining treatment as representatives of the patient's wishes; thus, they are hardly supportive of a conclusion that the withdrawal of life-sustaining treatment *against* a patient's or patient representative's wishes does not implicate a terminally ill patient's right to life. *See Woods v. Commonwealth*, 142 S.W.3d 24, 40, 42 (Ky. 2004) (affirming constitutionality of statute allowing court-appointed guardian ad litem to make decision to withdraw life-sustaining treatment from permanently unconscious adult patient because statute recognized "a distinction between an affirmative intent to kill and a passive decision[—through a third party acting in good faith and in patient's best interest—]to allow a natural death to occur in accordance with a patient's constitutional liberty interest and common law right of self-determination"); *In re Guardianship of Tschumy*, 853 N.W.2d 728, 731–32, 747 (Minn. 2014) (noting, in case in which mentally incompetent adult patient's court-appointed guardian desired to withdraw his life-sustaining treatment and "all interested parties" agreed, that to do so would not result in due-process deprivation because the disease

process, not the state's action through the "lawful authority" of guardian, caused the death); *Quinlan*, 355 A.2d at 654, 669–70 (noting that removal of life-sustaining treatment from adult patient in persistent vegetative state in accordance with court-appointed surrogate's decision would not be homicide but rather a lawful death from natural causes). But regardless of the mechanism that ultimately causes T.L.'s death, when a terminally ill patient or her surrogate decision maker (especially a parent of a minor patient with her own individual liberty interest) actively opposes the withdrawal of life-sustaining treatment, the right to life is clearly implicated.

CCMC confuses a patient's initial consent to health care treatment with the continuation of that treatment in the life-sustaining treatment context. If T.L. dies after CCMC, through her attending physician, discontinues her life-sustaining treatment—and if no action or inaction of CCMC, its staff, or any other person "hastens her death" in violation of the TADA—presumably, she will die of the natural disease process. But because the life-sustaining treatment has already begun with Mother's consent and has continued for some time, there is no dispute that life-sustaining treatment is what is keeping her alive currently in accordance with Mother's wishes. CCMC's and the attending physician's belief that T.L.'s life now is being harmed more than it is being helped by such treatment does not change this fact.[37]

[37]For this reason, we also disagree with CCMC's argument that Mother's right to make this medical decision is not implicated here because a physician cannot "be commandeered into providing treatment that violates her own conscience and ethics." This is not a case in which Mother is insisting upon *initiating* treatment against the

The issue in these types of cases is not that the life-sustaining treatment has no effect because "[s]trictly speaking, if a physician can keep the patient alive, such care is not medically or physiologically 'futile;' however, it may be 'futile' on philosophical, religious or practical grounds." *See Causey v. St. Francis Med. Ctr.*, 719 So.2d 1072, 1074 (La. Ct. App. 1998). This concept is implicit in the holdings of *Vacco*, *Woods*, and *Quinlan* and was expressly acknowledged in *Tschumy* by that court's emphasizing what it was *not* holding: "Nothing we say in this opinion should be viewed as prohibiting any interested family member or employee of the hospital or other health care facility from looking to the courts if there is a dispute over what is in the ward's best interest." 853 N.W.2d at 748.

By enacting the TADA with Section 166.046(e), the Legislature knowingly moved from authorizing *voluntary* passive euthanasia, as originally contemplated by the

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physician's wishes; instead, Mother wishes to continue treatment that the physician had initially agreed with and willingly provided and now wants to discontinue. It is undisputed that the life-sustaining treatment is the only means to maintain T.L.'s life and that it is Mother's right to make decisions for T.L. while she is alive. Therefore, to discontinue this ongoing course of treatment over Mother's objection would deprive Mother of a constitutionally protected right. For that reason, *DeShaney* is distinguishable and does not compel a different result under these particular facts. Moreover, because this alleged deprivation is limited solely to these particular facts, we are not concerned that the far-reaching effects envisioned by CCMC—forcing physicians to provide medical treatment for minor children in many other contexts against the physicians' conscience and ethics—would inevitably result from a holding that Mother's parental right to make medical decisions for her child is implicated in this distinct context.

NDA, to authorizing *involuntary* passive euthanasia.[38] *See* O'Callaghan, *supra*, at 529–31, 538, 567 (observing that the point of advance directives and surrogate decision makers is to respect the individual autonomy of terminally ill patients and to facilitate their

[38]As observed by Percy Foreman, it is questionable how "passive" euthanasia is when it contemplates the act, not the omission, of disconnecting the patient from mechanical ventilation or other life support. Foreman, *Physician's Criminal Liability*, 27 Baylor L. Rev. at 57 ("The physician must physically turn the switch to the 'off' position." (quoting Cannon, *The Right to Die*, 7 Hous. L. Rev. 654 (1970))). Indeed, the heading for the statutory notice required for the committee review process is anodyne to the point of subterfuge—"The Physician Recommends Against Certain Life-Sustaining Treatment That You Wish To Continue"—suggesting through its use of the term "recommends" that the choice remains that of the patient. Tex. Health & Safety Code Ann. § 166.052. Even the heading of Section 166.052—"Statements Explaining Patient's Right to Transfer"—suggests that the statutory notice merely explains the patient's right to transfer in the event the committee review process affirms the attending physician's refusal to honor the patient's request for continued life-sustaining treatment. *Id.*; *see TIC Energy & Chem., Inc. v. Martin*, 498 S.W.3d 68, 75 (Tex. 2016) ("[T]hough a statutory heading does not limit or expand a statute's meaning, the heading can inform the inquiry into the Legislature's intent."). If terminally ill patients were to consider these headings in conjunction with the heading for Section 166.050—"Mercy Killing Not Condoned"—they would be hard pressed to anticipate the finality of the authority granted to their attending physicians in the event a transfer is not forthcoming. Tex. Health & Safety Code Ann. § 166.050. And the phrase "are not obligated to provide life-sustaining treatment after the 10th day" never actually tells the patient that his attending physician can unilaterally and involuntarily euthanize him, even if passively, if the patient cannot arrange for a transfer to save himself. *Id.* § 166.046(e). *Compare* Senate Comm. on State Affairs, Bill Analysis, Tex. C.S.S.B. 1260, 76th Leg., R.S. (1999) ("Requires other life-sustaining treatment for a patient until a facility transfer is successful if the patient request[s] inappropriate treatment."), *with* House Research Org., Bill Digest, Tex. C.S.S.B. 1320, 78th Leg., R.S. (2003) ("If the patient or surrogate had requested life-sustaining treatment that the attending physician and the [committee] review process affirmed was inappropriate, the patient's life would have to be sustained until a transfer in care was complete."). "As some have said, the devil is in the details." *Priel v. State*, No. 07-09-00349-CR, 2010 WL 445287, at *3 (Tex. App.—Amarillo Feb. 9, 2010, no pet.) (mem. op., not designated for publication).

voluntary decision to discontinue life-sustaining treatment). CCMC essentially argues that, because both types of euthanasia passively result in a natural death, the voluntariness of the decision does not implicate the patient's right to life. Nothing could be further from the truth. The entire constitutional premise of *Cruzan*, as confirmed by *Vacco* and *Glucksberg*, is that the liberty interest a terminally ill patient has in individual *autonomy* may overcome a state's interest in preserving her life and thereby her right to *voluntarily refuse* life-sustaining treatment. There is simply no constitutional equivalent for involuntarily depriving a terminally ill patient of her life against her wishes.[39]

[39]It is the unilateral and involuntary nature of the treatment decision authorized by Section 166.046(e) that distinguishes this type of case from others in which the courts have determined that no procedural due process in the form of court intervention is necessary, i.e., when a guardian or other state-authorized decision maker exercises substitute judgment, without objection, to *voluntarily* withdraw life-sustaining treatment. *See In re Guardianship of Tschumy*, 834 N.W.2d 764, 773 (Minn. Ct. App. 2013) (exploring authority from other jurisdictions), *aff'd*, 853 N.W.2d at 748; *see also Woods*, 142 S.W.3d at 50 (recognizing that in the event of a disagreement between surrogate decision maker and health care provider, "resort may be had to the courts" with the burden of proof on one seeking to withhold or withdraw life support from the patient to show "by clear and convincing evidence that the patient is permanently unconscious or in a persistent vegetative state, or that death is imminent, and that it would be in the best interest of the patient to withhold or withdraw life-prolonging treatment"); *Quinlan*, 355 A.2d at 671–72 (concluding that if Quinlan's guardian and family agreed with the "responsible attending physicians" and hospital ethics committee that "there [was] no reasonable possibility of [her] ever emerging from her present comatose condition to a cognitive, sapient state and that the life-support apparatus now being administered to [her] should be discontinued," such a withdrawal would not subject anyone involved to civil or criminal liability).

Indeed, the very form prescribed for an advance directive[40] contemplates solely a *voluntary refusal* of life-sustaining treatment by a terminally ill patient: "This is an important legal document known as an Advance Directive. It is designed to help you communicate *your wishes* about medical treatment at some time in the future when you are unable to make *your wishes* known because of illness or injury." Tex. Health & Safety Code Ann. § 166.033 (emphasis added). And Section 166.037 states categorically that "[t]he desire of a qualified patient, including a qualified patient younger than 18 years of age, supersedes the effect of a directive." *Id.* § 166.037.

By giving the deciding "vote" to an ethics or medical committee in the event of a conflict between an attending physician and his terminally ill patient or surrogate decision maker about whether to continue life-sustaining treatment if no other provider will accept a transfer for continued treatment, Section 166.046(e) unquestionably trumps the patient's or surrogate decision maker's decision to continue living for whatever additional amount of time she may have before the natural disease process overcomes the life-sustaining treatment.[41] Thus, for the purposes of due-process

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[40]"'Directive' means an instruction made under Section 166.032, 166.034, or 166.035 to administer, withhold, or withdraw life-sustaining treatment in the event of a terminal or irreversible condition." Tex. Health & Safety Code Ann. § 166.031(1).

[41]The Attorney General puts it this way:

> When a patient has requested [the continuation of] life-sustaining treatment, only to have it denied by a physician or health care facility, the physician and health care facility are denying the patient life *for the period of*

analysis, the patient's right to life is at stake and, derivatively, the right of a parent to decide whether to preserve her child's life. *See Parham*, 442 U.S. at 600, 99 S. Ct. at 2503 (observing, because interest of a minor patient in treatment decision "is inextricably linked with the parents' interest in and obligation for the welfare and health of the child, the private interest at stake is a *combination* of the child's and parents' concerns" (emphasis added)).

B. The process afforded T.L. and Mother

Having determined that vested fundamental rights are at stake, we must next examine whether T.L. and Mother were afforded sufficient process by comparing what they received with what was due. *See Logan v. Zimmerman Brush Co.*, 455 U.S. 422, 428, 102 S. Ct. 1148, 1154 (1982); *Brokaw v. Mercer Cty.*, 235 F.3d 1000, 1020 (7th Cir. 2000) (explaining that state action depriving a constitutionally protected interest in life, liberty, or property "is not in itself unconstitutional; what is unconstitutional is the deprivation of such an interest without due process of law" (quoting *Doe by Nelson v. Milwaukee Cty.*, 903 F.2d 499, 502 (7th Cir. 1990))); *Cty. of Dallas v. Wiland*, 216 S.W.3d 344, 356 (Tex. 2007) (noting that intent of procedural due-process rules is not to protect from

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time that he or she would have lived had the life-sustaining treatment been provided." [Emphasis added.]

deprivation of constitutional rights but the mistaken or unjustified deprivation of those rights).

The parties do not dispute that at least the minimum procedure set forth in Section 166.046 was followed.[42] But the fact that a state procedure was followed—even under a constitutional statute—does not preclude Section 1983 liability if the plaintiff was not afforded sufficient notice and a meaningful opportunity to be heard in accordance with the Fourteenth Amendment. *See, e.g.*, *Doyle v. Schultz*, 97 F. Supp. 2d 763, 768–69 (W.D. La. 2000); *State, Cty. of Bexar v. Southoaks Dev. Co.*, 920 S.W.2d 330, 336 (Tex. App.—San Antonio 1995, writ denied) (op. on reh'g). Because CCMC largely followed the Section 166.046 procedure, we analyze the process T.L. and Mother received in terms of that procedure.

Section 166.046 was expressly designed to bypass the courts in these specific types of disputes. *See* O'Callaghan, *supra*, at 537, 540–41 (noting that doctor "instrumental in drafting" the TADA described Section 166.046 as an "extrajudicial due process mechanism relying on community standards"). Thus, its procedures allow court

[42]Despite setting forth what appears to be a detailed decisional process, Section 166.046 has been widely criticized for failing to provide sufficient procedural due-process protections for terminally ill patients who do not wish to discontinue life-sustaining treatment, particularly in light of their medical and emotional vulnerability, and the likely absence of medical sophistication on their parts and the parts of their surrogate decision makers. *See, e.g.*, Thaddeus Mason Pope, *Procedural Due Process and Intramural Hospital Dispute Resolution Mechanisms: the Texas Advance Directives Act*, 10 St. Louis Univ. J. Health L. & Pol'y 93, 129–30, 139 (2016); O'Callaghan, *supra*, at 529–31, 568–70, 584–610.

involvement in only a very narrow circumstance: when the terminally ill patient or surrogate decision maker resisting withdrawal of the life-sustaining treatment seeks a court order directing the attending physician to continue life-sustaining treatment beyond the ten-day deadline upon a finding, "by a preponderance of the evidence, that there is a reasonable expectation that a physician or health care facility that will honor the patient's directive will be found if the time extension is granted." Tex. Health & Safety Code Ann. § 166.046(g). Otherwise, before depriving any patient, including T.L., of the right to life and any parents, including Mother, of the right to make medical decisions for their children, Section 166.046 provides that the attending physician and ethics or medical committee employ the following procedures:

• Give the patient or patient's surrogate decision maker a written description of the ethics or medical committee review process and the health care facility's policies and procedures related to the law;

• Give the patient or surrogate decision maker at least forty-eight hours' notice before the committee's meeting to resolve the conflict, along with (1) a statutory notice of the right to transfer, *see id.* § 166.052, and (2) a copy of the registry of health care facilities and referral groups ready to consider accepting a transfer or to assist in finding one;

• Give the patient or surrogate decision maker a copy of "the portion of the patient's medical record related to the treatment received by the patient" in the facility

for a limited time frame: the lesser of the preceding thirty calendar days or the amount of time the patient has been admitted to the facility;

• Give the patient or surrogate decision maker a copy of the patient's "reasonably available diagnostic results and reports related to the medical record provided";

• Allow the patient or surrogate decision maker to "attend" the ethics or medical committee's meeting;

• Make a determination that the life-sustaining treatment urged by the patient or surrogate decision maker but opposed by the physician is "medically inappropriate," an undefined term;

• Provide the patient or surrogate decision maker with a written explanation of the committee's decision;

• Allow the patient or surrogate decision maker to seek a transfer to a new facility at the patient's cost;

• Reasonably assist the patient or surrogate decision maker in trying to find "a physician who is willing to" provide the requested treatment;

• Provide life-sustaining treatment during the committee process and up to ten days from the time the patient or surrogate decision maker is given "both the

[committee's] written decision" that life-sustaining treatment is not medically appropriate and the patient's medical record;[43]

• Continue to administer "pain management medication, medical procedures necessary to provide comfort, [and] any other health care provided to alleviate a patient's pain" pending the review process, through transfer, or until death; and

• Continue to administer artificially administered nutrition and hydration for the same time period unless it would hasten the patient's death or be medically ineffective in prolonging life, be medically contraindicated, result in substantial irremediable physical pain, or be contrary to the patient's or surrogate's clearly documented desire.

Id. § 166.046.[44]

Beyond the requirements of Section 166.046, CCMC gave Mother formal notice five days before the hearing and had both attempted to persuade her to voluntarily discontinue her daughter's life-sustaining treatment and to assist her in arranging for a transfer some time before giving formal notice. But the committee chair testified that,

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[43]CCMC is still providing life-sustaining care in accordance with this court's stay order; thus, the last two procedures outlined in Section 166.046 are not currently applicable.

[44]We are reminded by the amici supporting the constitutionality of Section 166.046, *see* note 17 *supra*, at 25, that its enactment was the result of painstaking negotiations, deliberative compromise, and unanimous consensus—none of which may be anticipated should this court hold otherwise. Nevertheless, whether Section 166.046 was enacted unanimously or by the margin of a single vote in each house, our due-process analysis does not change. *See In re J.G.*, 495 S.W.3d 354, 364–65 (Tex. App.—Houston [1st Dist.] 2016, pet. denied) (reciting law that although statutes are presumed to be constitutional, that presumption is rebuttable).

until CCMC delivered formal notice of the hearing to Mother, no one had told her that the ethics committee would make the final decision as to whether T.L. would continue to receive life-sustaining treatment at CCMC. Mother received formal notice on a Friday that the ethics committee would meet the following Wednesday to consider her daughter's fate. At best, Mother had two full business days and a portion of another to prepare for the meeting at which this final decision would be made.

The ethics committee chair described the purpose of the ethics committee's involvement in the process as "explor[ing] all opportunities to resolve disagreements" and facilitating communication among the parties. No one involved in the direct care of the patient is allowed to be on the ethics committee. The chair said that if Mother had brought an attorney, patient advocate, or medical expert to the meeting, the committee would have "talked about" allowing such persons to attend, but the chair also admitted that the committee's practice had not been to allow a medical expert to attend.

When describing the committee's consideration of the attending physician's recommendation, the chair stated, "We consider what the physicians or the care team have said and we consider what the family has said and we consider the combined wisdom of the people who have served on the committee and we use that as we have our conversation." When asked what evidentiary standard or burden of proof the committee employed to make its decision, after stating that no written policy articulated such a standard, she testified that the committee considered "the burdens and the

benefits for [the] patients." Describing her personal support for the decision, she stated, "I look at things that are both burdensome and beneficial to children, to patients[,] and I believe that we are burdening [T.L.] and that we are allowing her to suffer." She characterized the ethics committee's approval of the attending physician's recommendation as a "binding decision."

C. Mother has shown a probable right to relief because CCMC did not provide T.L. and Mother sufficient procedural due process

1. T.L. and Mother did not receive reasonable notice or a meaningful opportunity to be heard

"An elementary and fundamental requirement of due process in any proceeding which is to be accorded finality is notice reasonably calculated, under all the circumstances, to apprise interested parties of the pendency of the action and afford them an opportunity to present their objections." *Mullane v. Cent. Hanover Bank & Tr. Co.*, 339 U.S. 306, 314, 70 S. Ct. 652, 657 (1950); *In re E.R.*, 385 S.W.3d 552, 558 (Tex. 2012) ("We measure the constitutionality of notice using *Mullane*'s analytic framework, rather than *Mathews v. Eldridge*'s balancing test."). Notice must reasonably convey the nature, manner, and timing of the action to be taken or the decision to be made, and it must afford a reasonable time for those interested to make their appearance with due regard to "the practicalities and peculiarities" of the case. *See Mullane*, 339 U.S. at 314–15, 70 S. Ct. at 657 (citing *Grannis v. Ordean*, 234 U.S. 385, 397, 34 S. Ct. 779, 784 (1914)). "But when notice is a person's due, process which is a mere gesture is not due process." *Id.*

More particularly, the constitutional adequacy of both notice and the opportunity to be heard depends upon the nature of the case. *Id.* at 313, 70 S. Ct. at 656–57; *E.R.*, 385 S.W.3d at 559. For example, when the action or decision turns on the evaluation of evidence, reasonable notice and a meaningful opportunity to be heard require that interested parties be permitted time to obtain and present witnesses and documentary evidence in support of their interests, as well as an opportunity to cross-examine and rebut witnesses and documentary evidence adverse to their interests. *See City of Arlington v. Centerfolds, Inc.*, 232 S.W.3d 238, 250–52 (Tex. App.—Fort Worth 2007, pet. denied) (identifying direct and cross-examination of witnesses as critical components of procedural due process in administrative hearings). "Denial of such an opportunity affects the ability of the fact-finder to ascertain the truth of the dispute." *Id.* at 251.

The determination of whether the continuation of life-sustaining treatment for a patient with a terminal condition or irreversible condition is "medically inappropriate" is a question of "reasonable medical judgment" requiring a diagnosis of a terminal or irreversible condition by the attending physician, with the former including a prognosis of death within six months even with continued life-sustaining treatment and the latter a prognosis of fatality upon the discontinuation of life-sustaining treatment. *See* Tex. Health & Safety Code Ann. §§ 166.002(9), (13), .040(a), .046(e). In the malpractice context, the diagnosis of a terminal or irreversible condition, including a prognosis of death within a certain time frame, requires expert medical testimony. *See Columbia Rio Grande Healthcare, L.P. v. Hawley*, 284 S.W.3d 851, 859–62 (Tex. 2009) (holding diagnosis

of terminal illness and survival prognosis a matter of reasonable medical probability); *Wyatt v. Longoria*, 33 S.W.3d 26, 29–30 (Tex. App.—El Paso 2000, no pet.) (reversing summary judgment in favor of gastroenterologist due to expert testimony demonstrating misdiagnosis of terminal metastatic breast cancer as cause of liver and peritoneal cancer with survival prognosis of three to six months); *Fence v. Hospice in the Pines*, 4 S.W.3d 476, 481–85 (Tex. App.—Beaumont 1999, pet. denied) (reversing summary judgment in favor of hospice and its medical director due to expert testimony demonstrating misdiagnosis of decedent with terminal brain cancer with a survival prognosis of six months or less). In the context of the Section 166.046 process, it follows that in order to meaningfully object to or otherwise contest an attending physician's refusal to continue life-sustaining treatment, a terminally ill patient must have a reasonable opportunity to obtain and present a "second opinion" in the form of expert medical testimony to refute her terminal or irreversible condition diagnosis, confirm continued life-sustaining treatment as medically appropriate, or otherwise demonstrate a more optimistic survival prognosis. *See Sloan v. Molandes*, 32 S.W.3d 745, 747–48 (Tex. App.—Beaumont 2000, no pet.) (affirming health care liability judgment for gestational diabetes patient who obtained second opinion critical of her prescribed steroid treatment, leading to her seek emergency treatment for acute necrotizing pancreatitis); *Columbia Rio Grande Reg'l Healthcare, L.P. v. Hawley*, 188 S.W.3d 838, 868 (Tex. App.—Corpus Christi–Edinburg 2006) (Castillo, J., dissenting) (observing that patient learned of intestinal cancer diagnosis from earlier hospitalization only when she

sought a second opinion), *rev'd on other grounds*, 284 S.W.3d at 865–66. Here, Mother had a mere two business days and a portion of another day to prepare for a meeting at which a "binding decision" would be made.[45]

[45]By way of comparison, in 2017, according to one study of fifteen metropolitan areas, the earliest a new patient could expect to get an initial appointment with a cardiologist—let alone a cardiopulmonary specialist with experience treating Ebstein's anomaly—in Dallas or Houston was, on average, twelve days. *See* Merritt Hawkins, 2017 Survey of Physician Appointment Wait Times & Medicare and Medicaid Acceptance Rates, at 7 (https://www.merritthawkins.com/uploadedFiles/MerrittHawkins/Content/Pdf/mha2017waittimesurveyPDF.pdf) (last visited July 21, 2020). The average wait time for initial cardiology appointments in Boston—the home of Boston Children's Hospital—was forty-five days. *Id.* Given the likely overlap of physicians and health care facilities willing to give a more favorable second opinion and those willing to accept a terminally ill patient for transfer, and even assuming the prompt consideration and cooperation evidenced by this record between CCMC and Boston Children's, Texas Children's Hospital in Houston, and Children's Medical Center of Dallas, *see supra*, at 15–16 & n.9, forty-eight hours is inadequate when considering "the practicalities and peculiarities" of the action to be taken or the decision to be made.

The concurrence in *Nikolouzos v. St. Luke's Episcopal Hospital* describes the "procedural problems that threaten to sabotage a family's attempt to obtain additional time under Section 166.046(g) to locate alternate care for its loved one." 162 S.W.3d 678, 683 (Tex. App.—Houston [14th Dist.] 2005, no pet.) (Fowler, J., concurring). First, the only procedure available under the transfer-extension provision is to seek a temporary restraining order, but that decision is not appealable. *Id.* Second, the provision requires an evidentiary finding that "there is a reasonable expectation that a physician or health care facility that will honor the patient's directive will be found if the time extension is granted," but temporary-restraining-order hearings are not evidentiary hearings. *Id.* Justice Fowler thus concluded that "the lack of a specific procedure leaves already bereaved families with no clear procedure to secure alternate care for their loved one." *Id.* at 684.

Moreover, a meaningful opportunity to be heard contemplates actual patient participation in the committee review process.[46] No greater ethical issue exists for a terminally ill patient than the question of whether to continue life-sustaining treatment. But Section 166.046 makes no provision whatsoever for *how* the committee will review or otherwise consider the attending physician's decision, other than to employ the term "ethics or medical committee," which "means a committee established under Sections 161.031–161.033" of the Health & Safety Code. Tex. Health & Safety Code Ann. §§ 166.002(6), .046(a)–(b), (e). How, then, is a patient or patient representative such as Mother—on a few days' notice—able to prepare for advocating her position in opposition to the physician, other than being able to merely state her opinion, such as Mother was able to do here?[47]

Mother and her parents were excused from the meeting before the committee began its deliberations on whether they agreed with the doctor's opinion or Mother's.

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[46]The Texas Administrative Code mandates that all Texas hospitals "adopt, implement, and enforce a policy to ensure patients' rights" including "the right of the patient or the patient's designated representative to participate in the consideration of ethical issues that arise in the care of the patient." *Cf.* 25 Tex. Admin. Code Ann. § 133.42(a)(1)(F) (available at https://www.sos.texas.gov/tac/index.shtml) (last updated Dec. 15, 2019). And to effectuate the right to participate, each hospital must "have a mechanism for the consideration of ethical issues arising in the care of patients and provide education to care givers and patients on ethical issues in health care." *Id.*

[47]CCMC's policy document outlining the ethics committee's functions in case reviews describes this particular category of cases: "[c]ases involving intractable differences of *opinion* between the physician and the patient or the person responsible for the patient's health care decisions regarding the patient's advance directive or a health care or treatment decision made by or on behalf of a patient." [Emphasis added.]

Health and Safety Code Section 161.032(b)(1) provides that the proceedings of an ethics or medical committee "may be held in a closed meeting following the procedures prescribed by Subchapter E, Chapter 551" of the Texas Government Code, better known as the Texas Open Meetings Act (TOMA). *Id.* § 161.032(b)(1); *Suarez v. Silvas*, No. 04-19-00836-CV, 2020 WL 2543311, at *7 (Tex. App.—San Antonio May 20, 2020, no pet. h.). Subchapter E of the TOMA permits a closed meeting only if (1) a quorum of the committee "first convenes in an open meeting for which notice has been given as provided by [the TOMA] and during which the presiding officer publicly . . . announces that a closed meeting will be held"; (2) the committee keeps either "a certified agenda or . . . a recording of the proceedings of [the] closed meeting, except for a private consultation [with legal counsel] permitted under [the TOMA]"; and (3) the committee reconvenes in an open meeting to take a "final action, decision, or vote" on the matter deliberated in the closed meeting. Tex. Gov't Code Ann. §§ 551.101–.103. Unless a district court renders a final judgment concluding that the committee conducted the closed meeting in violation of the TOMA, neither the certified agenda nor a recording of the closed meeting is subject to public disclosure. *Id.* § 551.104; *see In re Smith Cty.*, 521 S.W.3d 447, 453–54 (Tex. App.—Tyler 2017, orig. proceeding) (discussing statutory restrictions on public disclosure of closed meeting recordings). Here, although the ethics committee's secretary took notes of the meeting, the chair testified that she had not seen or reviewed those notes.

In *Goldberg v. Kelly*, the United States Supreme Court held that a state that terminates public assistance payments to a particular recipient without affording him the opportunity for an evidentiary hearing before termination denies him procedural due process and thereby deprives him "of the very means by which to live." 397 U.S. 254, 264–71, 90 S. Ct. 1011, 1018–22 (1970). In so holding, the Court held that when considering the state's potential deprivation of existential necessities—such as food, clothing, housing, and medical care—the recipient's participation in the evidentiary hearing must include (1) "an effective opportunity to defend by confronting [and cross-examining] any adverse witnesses and by presenting his own arguments and evidence orally"; (2) the right to counsel, though not to the appointment of counsel; (3) the right to an impartial decision maker; and (4) a statement of the decision and the evidence upon which the decision maker relied. *See id.* As long as the decision was subject to full administrative and judicial review, the Supreme Court observed that the evidentiary hearing could remain informal and need not take the form of a judicial or quasi-judicial trial; nor did due process require "a particular order of proof or mode of offering evidence." *See id.* at 266–69, 90 S. Ct. at 1020–21; *see also Univ. of Tex. Med. Sch. at Hous. v. Than*, 901 S.W.2d 926, 932–33 (Tex. 1995) (holding that absence of a record of the ex parte proceedings, subject to administrative or judicial review, contributed to conclusion that ex parte proceedings violated due process).

Because the discontinuation of life-sustaining treatment may deprive an unwilling terminally ill patient of the very means by which to live, *Goldberg* suggests that,

at a minimum, the patient or her surrogate decision maker be afforded the opportunity to participate in the committee review process by evidentiary hearing, either individually or through counsel, with the right to present documentary evidence and expert medical testimony to contest the attending physician's decision and to confront and cross-examine any witnesses presented in favor of the decision, including the attending physician. *Compare Texaco, Inc. v. Cent. Power & Light Co.*, 925 S.W.2d 586, 588, 590–91 (Tex. 1996) (interpreting the word "participate" as employed in the predecessor to Texas Rule of Appellate Procedure 30 providing for restricted appeals to mean active involvement in the hearing of evidence leading to rendition of a final and appealable judgment, either in person or through counsel, including the examination of witnesses, presentation of evidence, and argument of the issues before the trier of fact), *with Kirby v. State*, No. 12-01-00081-CR, 2002 WL 1163795, at *2 (Tex. App.—Tyler May 31, 2002, pet. ref'd) (not designated for publication) ("'The word 'attend' means 'to be present at.'" (quoting The American Heritage College Dictionary 88 (3d ed. 2000))). In the absence of such an evidentiary hearing, the "reasonable medical judgment" contemplated by the statute could well rest on nothing more than the physician's *ipse dixit* opinion leaving the reviewing committee without probative evidence that the continuation of life-sustaining treatment is medically inappropriate. *See Windrum v. Kareh*, 581 S.W.3d 761, 769 (Tex. 2019) (citing law denying *ipse dixit* medical testimony probative value).

Concerning the right to counsel, in particular, the United States Supreme Court held after *Goldberg* that, even in cases involving the permanent termination of parental rights, procedural due process does not always require the appointment of counsel for indigent parties in evidentiary hearings, but in so holding the Court nevertheless warned of the importance of legal counsel for parents lacking education or sophistication when the decision to be made requires consideration of expert medical testimony:

> [T]he ultimate issues with which a termination hearing deals are not always simple, however commonplace they may be. Expert medical and psychiatric testimony, which few parents are equipped to understand and fewer still to confute, is sometimes presented. The parents are likely to be people with little education, who have had uncommon difficulty in dealing with life, and who are, at the hearing, thrust into a distressing and disorienting situation. That these factors may combine to overwhelm an uncounseled parent is evident from the findings some courts have made.

Lassiter v. Dep't of Soc. Servs. of Durham Cty., N.C., 452 U.S. 18, 30, 101 S. Ct. 2153, 2161 (1981). Although some terminally ill patients in this situation may be just as likely to be uneducated and unsophisticated, many more are likely to be medically and emotionally vulnerable, and no less likely to be overwhelmed and in need of legal counsel to present their defense.[48]

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[48]In contrast to the committee review process of Section 166.046, in civil litigation generally, a party is entitled to counsel of her choice. And an indigent party may qualify for appointed counsel if the trial court—in its discretion under exceptional circumstances—determines that because of the public and private interest at stake, the administration of justice would best be served by the appointment of counsel. Tex. Gov't Code Ann. § 24.016 ("A district judge may appoint counsel to attend to the cause of a party who makes an affidavit that he is too poor to employ counsel to attend to the cause."); *Gibson v. Tolbert*, 102 S.W.3d 710, 712 (Tex. 2003) (using exceptional circumstances standard for appointment of counsel to indigent party).

Mother's lack of a meaningful opportunity to participate in the committee meeting resulting in a binding decision to discontinue T.L.'s life-sustaining treatment thoroughly frustrates the purpose of both the notice and the committee review process. *See Peralta v. Heights Med. Ctr., Inc.*, 485 U.S. 80, 84–86, 108 S. Ct. 896, 899 (1988); Pope, *supra*, at 140–42, 146–47; O'Callaghan, *supra*, at 596–97.

Finally, by way of comparison, consider the procedural-due-process protections afforded the subjects of two analogous situations: the involuntary termination of parental rights and the proceedings of a medical peer review committee. As to the former, if Mother's refusal to consent to the discontinuation of her daughter's life-sustaining treatment met the statutory definition of medical neglect, the Texas Family Code itself would mandate compliance with the detailed procedural framework applicable when a parent's rights to a child are at risk of being terminated as a result of state action. *See generally* Tex. Fam. Code Ann. chs. 101–10, 161, 262–63; *In re Gordon*, No. 03-14-00072-CV, 2014 WL 1279740, at *2 (Tex. App.—Austin Mar. 28, 2014, orig. proceeding) (mem. op.) ("The family code sets out very specific procedures and time lines to which parties to a termination suit must adhere."). Whether those procedures provide sufficient due process in a particular proceeding is fact specific and determined by "considering any relevant precedents and then . . . assessing the several interests that are at stake." *See In re B.L.D.*, 113 S.W.3d 340, 352, 354 (Tex. 2003) (quoting *Lassiter*, 452 U.S. at 25, 101 S. Ct. at 2158, and recognizing that *Lassiter* due-process analysis is fact specific); *In re K.L.*, 91 S.W.3d 1, 6 (Tex. App.—Fort Worth 2002, no pet.)

(concluding that once the state has granted a procedural right in the Family Code, that right must be administered consistently with the Fourteenth Amendment's Due Process Clause). Included in the constitutional and statutory procedural safeguards are the statutory right to counsel for an indigent parent and the right to effective assistance from that counsel, Tex. Fam. Code Ann. §§ 107.013, 262.201(c)–(e); *In re M.S.*, 115 S.W.3d 534, 544 (Tex. 2003); *K.L.*, 91 S.W.3d at 5–6 & n.16, the right to actual notice of permanency hearings and trial, *In re K.M.L.*, 443 S.W.3d 101, 119–20 (Tex. 2014), the right to nonsubstituted service when the parent's identity is known and the state did not make a sufficiently diligent inquiry, *E.R.*, 385 S.W.3d at 565–66, and the right to a meaningful appeal when appeal is permitted, *In re B.G.*, 317 S.W.3d 250, 253–58 (Tex. 2010); *In re J.O.A.*, 283 S.W.3d 336, 342–43, 347 (Tex. 2009); *M.S.*, 115 S.W.3d at 547–48. And implicit in the right to counsel contemplated by *Lassiter* is the right to present evidence through the direct examination and cross-examination of witnesses:

> If, as our adversary system presupposes, accurate and just results are most likely to be obtained through the equal contest of opposed interests, the State's interest in the child's welfare may perhaps best be served by a hearing in which both the parent and the State acting for the child are represented by counsel, without whom the contest of interests may become unwholesomely unequal.

452 U.S. at 28, 101 S. Ct. at 2160. For the *exact same refusal of consent*, the Family Code would afford Mother more due-process protection had CCMC simply reported her for medical neglect. *See* Tex. Fam. Code Ann. § 261.101(b) (imposing a duty upon doctors

and nurses to report suspected abuse or neglect of a child within forty-eight hours of first suspicion).

Considering the second comparison, a physician against whom a "professional review action" is proposed by a medical peer review committee is entitled under federal and state law to the following due process:

• a notice giving reasons for the proposed action and no less than thirty days to request a hearing before the action can be taken;

• if the physician requests a hearing, no less than thirty days' notice before that hearing, and a list of the witnesses expected to "testify" at the hearing on the committee's behalf;

• a mutually-acceptable arbitrator, or a hearing officer or panel of persons appointed by the health care provider who do not directly compete economically with the physician, as the decision maker;

• the right to be represented by an attorney of the physician's choice;

• the right to a record of the proceedings;

• the right to call witnesses and cross-examine witnesses;

• the right to present relevant evidence; and

• the right to submit a written statement.

See Health Care Quality Improvement Act of 1986, 42 U.S.C.A. § 11112(a)–(b) (hereinafter HCQIA); *see also id.* § 11111 (granting immunity from damages for medical peer review conducted in compliance with federal requirements); Tex. Occ. Code Ann.

§§ 160.001, .010 (incorporating HCQIA medical peer review due-process protections and immunity and creating additional civil immunity); *see also Huntsville Mem'l Hosp. v. Ernst*, 763 S.W.2d 856, 859 (Tex. App.—Houston [14th Dist.] 1988, orig. proceeding) (holding physician subject to private medical peer review is "entitled to know who will participate as decision makers on behalf of the hospital at both the hearing and appellate stages, what witnesses will appear, and what documents will be offered into evidence").

In other words, if the *exact same treatment decision* urged by the attending physician were made the basis of a professional review action by CCMC, the Occupations Code would afford him every one of the due-process protections guaranteed by HCQIA. *See Ching v. Methodist Children's Hosp.*, 134 S.W.3d 235, 240–43 (Tex. App.—Amarillo 2003, pet. denied) (affirming summary judgment on pediatric cardiothoracic surgeon's common law and statutory due-process claims due to his failure to rebut presumption of reviewing committee's compliance with HCQIA); *Maewal v. Adventist Health Sys./Sunbelt, Inc.*, 868 S.W.2d 886, 891–94 (Tex. App.—Fort Worth 1993, writ denied) (affirming summary judgment on surgeon's contract and tort claims due to his failure to rebut presumption of reviewing committee's compliance with HCQIA). By comparison, Section 166.046 provides an unwilling terminally ill patient with only the right to attend the meeting, which presents a viable denial-of-due-process claim. *See In re A.M.B.*, 640 N.W.2d 262, 268–69, 298–99, 311 (Mich. Ct. App. 2001) (determining that parents of child in state custody were denied procedural due process when, without

adequate notice of and no opportunity to participate in hearing, court ordered their child to be taken off life support).

2. Mother has shown a probable right to relief because 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

Finally, the "medically inappropriate" standard employed by Section 166.046(e) to authorize the unilateral withdrawal of life-sustaining treatment from an unwilling terminally ill patient, even when informed by reasonable medical judgment, fails to articulate an objective standard by which to decide that the patient's natural death is either her chosen or best treatment option. When addressing this decision in mentally competent adult patients, the courts generally hold that the subjective decision of the patient to refuse life-sustaining treatment overrides any interest the state may have in her continued life, as long as her objective medical and emotional circumstances demonstrate that the decision is an informed and rational one. *See Cruzan*, 497 U.S. at 270, 110 S. Ct. at 2847 (acknowledging right to refuse treatment as "logical corollary" of doctrine of informed consent); *cf. Miller*, 118 S.W.3d at 766 (same for parents of minor patients). When the patient is mentally incompetent, the courts generally hold that the evidence must objectively demonstrate that the patient—if she were capable of articulating her subjective informed decision—would choose to refuse life-sustaining treatment, thereby permitting a designated representative to exercise "substituted judgment" to so refuse. *See Cruzan*, 497 U.S. at 270–78, 110 S. Ct. at 2847–51 (discussing

"substituted judgment" and "best interest" standards). And when the patient is a terminally ill child legally incompetent to make a subjective decision to refuse treatment on her own and legally deprived of parents to make the decision for her, the courts uniformly hold that the evidence must objectively demonstrate that the withdrawal of life-sustaining treatment is in the "best interests" of the child. *See*, *e.g.*, *In re Christopher I.*, 131 Cal. Rptr. 2d 122, 133 (Cal. Ct. App. 2003); *In re Truselo,* 846 A.2d 256, 269–70 (Del. Fam. Ct. 2000); *In re K.I.*, 735 A.2d 448, 455–56 (D.C. 1999); *Baby F. v. Okla. Cty. Dist. Ct.*, 348 P.3d 1080, 1086–88 (Okla. 2015).

While reasonable medical judgment may inform the decision, the deciding factor is ultimately the individual liberty interest of the patient in deciding that a natural death is the best treatment option. By limiting the evidentiary standard for the committee's decision solely to an ad hoc determination of whether the continuation of life-sustaining treatment is "medically inappropriate," Section 166.046(e) excludes from the committee review process any consideration of the subjective interests of the patient or, when dealing with a terminally ill child whose parent's rights have not been temporarily or permanently terminated, that parent's determination of what medical treatment is in the child's best interests—both of which are procedural-due-process prerequisites.

As the United States Supreme Court observed in *Cruzan*, "The choice between life and death is a deeply personal decision of obvious and overwhelming finality." 497 U.S. at 281, 110 S. Ct. at 2852. To effectuate this deeply personal decision, the Legislature enacted first the NDA and then the TADA, with the primary focus of both

being to create a lawful means or process by which a terminally ill individual could *voluntarily* refuse life-sustaining treatment and thereby facilitate that person's natural death. In this context, reasonable medical judgment clearly informs the volitional decision of the patient, and the processes created by both the NDA and TADA guard against medical coercion in any form, altruistic or otherwise.

When, however, the TADA extended the process to permit involuntary withdrawal of life-sustaining treatment without the consent of either the patient or her designated representative, the "medically inappropriate" standard left complete discretion to the reasonable medical judgment of the attending physician with the only check on less-than-altruistic medical coercion coming in the form of the committee review process. Suddenly, a deeply personal decision of overwhelming finality was no longer a deeply personal decision. In fact, Section 166.046 purposefully excludes any consideration of the patient's personal decision.

How then to decide that natural death is the preferred treatment decision? On two separate occasions, the Supreme Court of Texas has recognized the impossibility of fashioning an objective evidentiary standard for Texas courts to calculate the subjective relative benefits of living an impaired life versus having no life at all. In *Nelson*, the Supreme Court of Texas refused to recognize a wrongful life cause of action due to the impossibility of that calculation when, but for the medical negligence of the defendant physician, the minor patient would never have been born. 678 S.W.2d at 925. Similarly, in *Miller*, the court refused to recognize a duty to withhold life-sustaining

treatment from a newborn infant, as urged by the parents, when the calculation could not even be attempted without first evaluating the child's postnatal medical condition. 118 S.W.3d at 768 (citing *Nelson*). Significantly, while reasonable medical judgment clearly informed both decisions, the court implicitly held that reasonable medical judgment alone could not complete the relative-benefits calculation to the exclusion of the individual interests of the children and their parents. Indeed, neither decision contemplated granting private medical practitioners the unilateral authority to decide for both infant and parents whether the infant was to live or die. Even CAPTA, the applicability of which *Miller* considered and Section 166.010 contemplates, places the sole authority for deciding to withhold life-sustaining treatment in the hands of either a disabled infant's parents or the state, informed by the reasonable medical judgment of the attending physician. 42 U.S.C.A. § 5106g(5) (contemplating parental consent to withholding life-sustaining treatment when neither ameliorative nor curative of disabled infant's terminal condition).

Here, the individual wishes of the patient, expressed either personally or through a designated representative, never become part of the calculation because Section 166.046(e) authorizes the discontinuation of life-sustaining treatment solely upon the *ipse dixit* opinion of the attending physician. Stated differently, the statutorily-mandated committee review process decides whether a natural death is the best treatment option for the patient without reference to the opinion of either the unwilling patient or her unwilling designated representative.

And without any requirement holding the attending physician to an objective evidentiary standard that includes consideration of the patient's wishes, there is no evidentiary "dispute" to be settled at the meeting. O'Callaghan, *supra*, at 596–97. Or as the doctor "instrumental in drafting" the TADA has described, the committee's decision is based solely on "community standards" of what is medically appropriate for patients, including minor children, despite their assertions of important life and liberty interests to the contrary. *See id.* at 537, 540–41. That is the description of an ad hoc, not an objective, standard that can change depending on what particular ethics or medical committee conducts the review. *See id.* at 590 ("In the absence of a standard it is impossible to conclude that any decision to deny [life-sustaining treatment] is 'erroneous.'"). That appears to be exactly what happened here: the attending physician expressed his medical opinion that continuation of life-sustaining treatment for T.L. was medically inappropriate; Mother and her parents expressed their opinions that they wanted the treatment to be continued until T.L. could come home; and the committee, in the words of its chair, decided that in its opinion the treatment was more of a burden than a benefit to T.L.

Critically, as noted above, medical decisions involving minor patients whose parents cannot legally make those decisions for them require a judicial, rather than a parental, determination of their best interests. And those courts from other jurisdictions that have considered how to confirm that the withdrawal of life-sustaining treatment is in the best interest of a terminally ill child do so by applying objective evidentiary

standards and a heightened clear-and-convincing burden of proof. *See Baby F.*, 348 P.3d at 1088–89; *see also Christopher I.*, 131 Cal. Rptr. 2d at 128, 133–35 (mandating determination of decision to withdraw life-sustaining treatment according to best-interest standard proven by clear and convincing evidence and adopting twelve factors—some of which give voice to family members' and child's preferences, if ascertainment is possible—in determining whether continued treatment was in best interest of ventilator-dependent infant in persistent vegetative state); *Hunt v. Div. of Family Servs.*, 146 A.3d 1051, 1064–65 (Del. 2015) (holding same and adopting nonexclusive list of factors for mentally incompetent adult patient set forth in *In re Guardianship of Grant*, 747 P.2d 445, 457 (Wash. 1987), to be employed in making the decision);[49] *Truselo*, 846 A.2d at 272 (adopting *Grant* factors); *K.I.*, 735 A.2d at 455–56 (affirming best-interests finding by clear and convincing evidence in favor of withdrawing life-sustaining treatment from comatose infant).

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[49]Those factors include

> evidence about the patient's present level of physical, sensory, emotional, and cognitive functioning; the degree of physical pain resulting from the medical condition, treatment, and termination of the treatment, respectively; the degree of humiliation, dependence, and loss of dignity probably resulting from the condition and treatment; the various treatment options; and the risks, side effects, and benefits of each of those options.

Hunt, 146 A.3d at 1064–65.

In the analogous situation of involuntarily terminating parental rights for medical neglect, a district court must determine that such termination is in the best interest of the child by clear and convincing evidence. *See* Tex. Fam. Code Ann. § 161.001(b)(2); *see also In re E.N.C.*, 384 S.W.3d 796, 802 (Tex. 2012). The Family Code defines clear and convincing evidence as "the measure or degree of proof that will produce in the mind of the trier of fact a firm belief or conviction as to the truth of the allegations sought to be established." *E.N.C.*, 384 S.W.3d at 802 (quoting Tex. Family Code Ann. § 101.007). And this heightened standard of review is mandated not only by the Family Code but also by the Due Process Clause. *Id.* (citing *Santosky*, 455 U.S. at 753–54, 102 S. Ct. at 1394–95).

While it is true that Section 166.046 gives a health care provider the power to overcome only one parental right—the right to make medical decisions on behalf of a child—in this limited circumstance, the effect of the removal of a child's life-sustaining treatment on a parent's liberty interest is the same and therefore just as grave. Thus, by allowing an attending physician and ethics or medical committee to make a decision of this consequence on less than a clear-and-convincing-evidence standard—indeed, on no more than the *ipse dixit* opinion of the attending physician—the committee review process gives parents who are facing a physician's and committee's decision to withdraw life-sustaining treatment from their child less due-process protection than parents from whom the state seeks the same result by terminating their parental rights. *See Baby F.*, 348 P.3d at 1088 n.4 ("Since a child's death after the issuance of a DNR order would

function in a very real sense as a severance of the parental bond, it would be absurd not to apply the clear and convincing evidence standard to the determination from the viewpoint of the parent's rights, let alone those of the minor child.").

D. Mother has pleaded a cause of action with a probable right of relief

Based on the foregoing, Mother has pleaded a probable right to relief that under the flexible standard of *Mathews v. Eldridge*, the committee review process established by Section 166.046 and provided to T.L. and Mother did not provide sufficient procedural due process. First, the private interests that Mother has identified as being affected are of the highest concern and jealously protected under the law: the rights to life and medical autonomy of a terminally ill patient and, when the patient is a minor, the right of her parent to make that medical decision for her. Second, she has shown that the risk of erroneous deprivation of these fundamental life-and-liberty interests under the procedures employed is substantial because she had no opportunity to meaningfully contest the attending physician's decision.[50] Third, and finally, to the extent the state's interests include the fiscal and administrative burdens that such additional procedural requirements would entail, Mother has shown that it is at least arguable that those

[50]In contrast, requiring a patient's or patient's representative's expressed wishes to be overridden by only a defined standard taking into account the patient's best interest and requiring proof of that best interest by clear and convincing evidence would benefit terminally ill patients and their designated representatives by ensuring a more accurate and just decision that is already held to comport with procedural due process in closely analogous contexts.

interests are substantially mitigated by the fact that the state's interests also extend to affirmatively protecting terminally ill patients, including minors, from the unlawful deprivation of their lives and that the fiscal and administrative burdens that additional procedural requirements would entail are not significant in comparison to the private interests at stake. *See M.S.*, 115 S.W.3d at 548 (discounting the state's interests in economy and efficiency in comparison to the rights of parents to maintain their relationships to their children). This is not to say that the interests urged by CCMC are unimportant,[51] but in determining the propriety of a temporary injunction, we are not concerned with whether CCMC's asserted interest would ultimately prevail. *See, e.g.*, *Martinez v. Mangrum*, No. 02-13-00126-CV, 2014 WL 1389566, at *4 (Tex. App.—Fort Worth Apr. 10, 2014, no pet.) (mem. op.). We therefore conclude that Mother has shown a probable right to relief on her claim that she was denied meaningful notice and an opportunity to heard.[52] *See Mathews*, 424 U.S. at 335, 96 S. Ct. at 903; *Mosley v. Tex. Health & Human Servs. Comm'n*, 593 S.W.3d 250, 265 (Tex. 2019); *Univ. Interscholastic*

[51] *See* Pope, *supra*, at 147 ("TADA is a commendable attempt to 'steer a course between the Scylla of judicial review and the Charybdis of unfettered, unexamined physician discretion.' But TADA places too much weight on efficiency at the cost of fairness.").

[52] Thus, we need not determine—as urged by Mother in her first two issues and by the Attorney General—that Section 166.046 violates substantive and procedural due process, both facially and as applied, as a matter of law. *See, e.g.*, *VanDevender*, 222 S.W.3d at 432–33; *Henson*, 546 S.W.2d at 900; *see also* Tex. R. App. P. 47.1.

League v. Hatten, No. 03-03-00691-CV, 2004 WL 792328, at *3 (Tex. App.—Austin Apr. 15, 2004, no pet.) (mem. op.).

VIII. Mother is entitled to temporary injunctive relief pending trial on the merits

Mother has pleaded a valid Section 1983 claim and has shown a probable right to relief. If CCMC were allowed to withdraw life-sustaining treatment from T.L. before a trial on the merits can be had, Mother and T.L. will suffer permanent, irreparable damage. *See Cruzan*, 497 U.S. at 283, 110 S. Ct. at 2854 ("An erroneous decision not to terminate results in a maintenance of the status quo . . . . However, an erroneous decision to withdraw [life-sustaining] treatment is not susceptible of correction."). Thus, we conclude that the trial court abused its discretion by denying Mother's request for a temporary injunction.

IX. Conclusion

"[T]he decision to withdraw life-sustaining medical care from a desperately ill child is one that should rarely involve the courts. . . . '[T]he decision-making process should generally occur in the clinical setting without resort to the courts, but . . . courts should be available to assist in decision making *when an impasse is reached*.'" *A.M.B.*, 640 N.W.2d at 311 (emphasis added) (quoting *In re Rosebush*, 491 N.W.2d 633, 637 (1992)). On these facts, Mother has presented a bona fide complaint that CCMC, in invoking and following Section 166.046's committee review process, failed to provide her adequate procedural due process for the ultimate encroachment on the paramount

individual interests at stake. Therefore, Mother has shown a probable right to relief on her Section 1983 claim.

We reverse the trial court's denial of Mother's application for a temporary injunction, and we remand this case to the trial court to render an order granting the requested temporary injunction pending a final trial on the merits consistent with this opinion. Our previously issued stay order remains in effect until the trial court renders such an order complying with this court's judgment or until superseded by a higher court.

/s/ Wade Birdwell

Wade Birdwell
Justice

Delivered: July 24, 2020