No. 02-20-00002-CV

IN THE SECOND COURT OF APPEALS
FORT WORTH, TEXAS

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

v.

COOK CHILDREN'S MEDICAL CENTER,
Appellee.

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

BRIEF OF APPELLEE

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Oral Argument Conditionally Requested

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STATEMENT OF THE CASE

Nature of the Case:	Action under 42 U.S.C. §1983 seeking a declaration invalidating Texas Health & Safety Code §166.046 under the due process provisions of the United States and Texas Constitutions, as well as temporary and permanent injunctive relief prohibiting Cook Children's Hospital from withdrawing medically inappropriate, artificial life support that hospital physicians determined was contrary to their professional ethical obligations.
Trial Court:	Hon. Sandee Bryan Marion, sitting by assignment, 48th District Court, Tarrant County.
Parties in the Trial Court:	*Plaintiffs*: T.L., a minor, and her mother, on her behalf *Defendant*: Cook Children's Medical Center
Trial Court Disposition:	Denied Plaintiffs' request for temporary injunction to prevent Defendant from withdrawing artificial life-support from T.L.

ISSUES PRESENTED

1. The United States Supreme Court has held that the withdrawal of artificial life-support from a patient does not, as a matter of law, cause the patient's death; the patient's underlying fatal disease does. Does a physician's compassionate, conscience-based refusal to provide painful and inappropriate artificial life-support nevertheless constitute a deprivation of the patient's interest in life?

2. While a patient has a right to choose her own course of medical treatment, that individual right does not include the power to force a physician to *provide* that chosen course of treatment—especially when the requested treatment violates the physician's own ethical or moral beliefs. Does a physician's compassionate, conscience-based refusal to provide painful and inappropriate artificial life-support requested by the patient or her surrogate violate the patient's interest in medical choice?

3. An unbroken line of Supreme Court cases holds that the acts of a private entity cannot be attributed to the State simply because the State regulates the entity, gives it public funding, provides it statutory safe harbor, or permits it to use a statutorily created process. Is Cook Children's—an undisputedly private hospital—nevertheless a state actor based on these factors?

STATEMENT REGARDING ORAL ARGUMENT

Cook Children's does not believe oral argument is necessary. This case is governed by precedent from the United States and Texas Supreme Courts. Oral argument would only delay disposition of the appeal, and any unnecessary delay will impose additional pain and suffering on T.L. However, if the Court sets the appeal for argument, Cook Children's wishes to participate.

INTRODUCTION

This case cannot be understood without appreciating several truths that Appellants and the State conspicuously avoid.

It is true that Appellants have a right to make personal medical decisions. But that right does not include the power to force a physician to provide care she believes she cannot ethically give. The common law regards the doctor-patient relationship as wholly voluntary. This reflects the truth that physicians, no less than their patients, possess liberty, consciences, and strongly held moral and ethical beliefs. Here, experienced pediatric nurses and doctors—who have dedicated their lives to treating the sickest children—are unable to reconcile with their ethical duties the excruciating but pointless pain they must cause T.L. every single day. These doctors' and nurses' rights of conscience are central to this case. They should not be ignored.

It is also true that T.L. has a right to life. But the tragic reality is that only her diseases, not Cook Children's, threaten to deprive her of life. The United States Supreme Court has held—and Texas law agrees—that when artificial life-support is withdrawn, it is the patient's underlying disease that causes death. The law does not regard the compassionate withdrawal of painful, medically inappropriate artificial life-support as a life-taking act.

This case is much more complicated than Appellants and the State suggest. Chief Justice Marion correctly declined to grant relief.

STATEMENT OF FACTS

T.L. was born prematurely in early 2019 at Harris Methodist Hospital in Fort Worth. 2RR17–18. She was transferred to Cook Children's Medical Center the same day. 2RR18. T.L. suffers from a host of medical problems, including a rare heart defect called Ebstein's anomaly, pulmonary atresia, chronic lung disease, and severe chronic pulmonary hypertension. 2RR89, 102–08, 119.[1] Her condition is terminal. 2RR91.

The most significant problem facing T.L. is that her body cannot properly move oxygen from her lungs into her bloodstream. 2RR108. She has undergone several high-risk, complex surgeries, 2RR113–16, 130–32, which have been unable to significantly improve her condition. 2RR140–41. No further surgical options remain. 2RR142.

T.L. is in the Cardiac Intensive Care Unit at Cook Children's ("CICU"). The CICU is a highly specialized department. The field of cardiac intensive care is a subspecialty of pediatric intensive care, born out of a realization that babies with rare heart defects require very specialized care by physicians experienced in that type of

[1] Appellants now suggest that T.L.'s diagnosis is somehow uncertain, *see* Appellants' Br. 1 ("*It is believed that* [T.L.] has congenital heart disease and chronic lung disease, which *has been said* to have caused pulmonary hypertension." (emphasis added)), but the record permits no doubt. At the temporary-injunction hearing, Appellants themselves called T.L.'s Cook Children's physician in their case-in-chief, elicited testimony as to T.L's diagnosis, did not question it, and introduced no conflicting medical testimony.

disease. 2RR102. The CICU routinely deals in rare diseases of the heart and has often treated children with combinations of heart disease, respiratory failure, and pulmonary hypertension—the same combination T.L. suffers. 2RR101–02.

A. T.L.'s health is severely compromised.

Because she cannot properly oxygenate her blood, T.L. is kept on a ventilator, has three tubes down her nose and multiple intravenous lines for the administration of medication, and is permanently attached to four additional machines to monitor her biological functions. 2RR120–21, 273–74. Her body is subject to a "cascade" of inflammation, causing her blood vessels to leak. 2RR145. As a result, she is very swollen. *Id*. Despite her small size, she carries more than two liters of excess fluid.[2] *Id*.

T.L's multiple diseases cause life-threatening problems. Almost every day, and often multiples times a day, T.L. has a "dying event" that mandates aggressive medical intervention. 2RR277. These dying events are typically brought on by agitation and can be triggered by routine CICU care such as a daily chest x-ray or respiratory treatment, or even routine baby care such as a diaper change. 2RR133, 138, 268, 275. Sometimes they occur for no apparent reason. 2RR269, 275.

[2] The photos in the record do not represent what T.L. looks like today. 2RR270–72; PX1–5. They were taken before July 2019, before her condition markedly deteriorated. *Id*. Today, her swelling has significantly increased, and her skin has a bluish tinge. 2RR272–73.

When T.L. gets upset and cries, her breathing works against the ventilator, which shuts off as a safety precaution. 2RR133–34. As a result, her oxygen levels drop precipitously. *Id*. Medical staff must immediately intervene to manually inflate her lungs. 2RR134–35. Manual inflation is very difficult because "extraordinary pressures" must be generated "to get air in to try to reestablish normal saturation." 2RR135.

To mitigate these dying events, her doctors must increase her level of sedation and paralysis so that she cannot get upset or move. 2RR137. Over time, she has developed a tolerance for these medications, so the amount must be continuously increased to have the desired effect. 2RR137. The dying events have recently decreased because of these medications but are still frequent. 2RR138.

The cost of T.L. having fewer dying events is that she must spend her days sedated and paralyzed in order to remain still and calm. 2RR150, 151. She cannot move. 2RR150–51, 275. She cannot cuddle. 2RR188. She is rarely, if ever, held. 2RR283–84. The physician who has been treating her since birth has never seen her smile. 2RR91. She is not currently capable of any of the actions Appellants describe (*e.g.*, cuddling, enjoying television shows, reaching out her hands for nail painting). *See* Appellants' Br. 1.

B. T.L. has been afforded aggressive, state-of-the-art treatment at Cook Children's.

From birth, T.L.'s prognosis was poor and her long-term survival doubtful. 2RR90–91. Still, in her first few months of life, her doctors hoped that with the help of "relatively aggressive therapies," T.L. might recover enough to leave the hospital. 2RR91. Between February and June 2019, she had several surgeries that achieved incremental gains in her condition. *See* 2RR91, 109-10, 115-18.

In July 2019, however, T.L.'s condition took a decidedly negative turn. T.L. completely crashed and, in a last-ditch effort to keep her alive, her physicians placed her on a heart-lung bypass machine. 2RR91, 126–30. Another surgery was performed to attempt to improve pulmonary blood flow in the hope that T.L.'s oxygen levels would improve, but the hoped-for recovery did not occur. 2RR140–41.

C. After the July 2019 crisis, T.L.'s already-slim hopes for recovery disappeared.

After the July 2019 surgery failed to improve T.L.'s condition, her CICU doctors discussed her condition with a multidisciplinary team that included neonatologists, cardio-thoracic surgeons, her pulmonologist, and nursing staff. 2RR141–42. Their conclusion was that "her current cardiac anatomy and physiology [was] not survivable and that to perform any other procedures and to continue painful therapies and support measures was not in [T.L.'s] best interest." *Id*.

Unfortunately, T.L.'s surgical options have been exhausted, 2RR142, and her condition will never improve. As one of her physicians explained at the temporary-injunction hearing:

Q. You mentioned a word, "hope". Is T.L.'s case hopeless?

A. Yes.

Q. But she is surviving on life-sustaining care?

A. She is alive. Her heart beats, yes.

Q. Does she know who you are?

A. No.

Q. Have you seen her smile?

A. No.

2RR91.

From early on, the CICU team had informed T.L.'s mother that T.L.'s combination of disorders would be very difficult to overcome, and those discussions intensified after T.L.'s crisis in July. After the final surgery failed to improve T.L.'s condition, her treatment team began having even more significant conversations with T.L.'s family "about the likelihood that she may not survive." 2RR91.

Even after months of conversations with the CICU physicians, T.L's mother persisted in believing that there must be some drug or surgery that would fix T.L. 2RR159–61; DX16. She did not want to talk to the CICU physicians anymore and began to avoid them. *Id*.

D. Continued treatment in the CICU causes T.L. to suffer.

A physician's most sacred ethical oath, dating back to Hippocrates, is "first, do no harm." Every day that the CICU staff treat T.L., they violate this oath. T.L. cannot recover from or survive her medical conditions, yet her doctors and nurses must hurt her to provide the constant medical intervention that keeps her alive. 2RR149. Continuing the intervention in that circumstance is "not medically, ethically, or morally appropriate." *Id*.

As one of T.L.'s physicians explained, "even the most routine of ICU cares come with a price and that price is pain and that price is—is suffering." 2RR144. For T.L., "[c]hanging a diaper causes pain. Suctioning her breathing tube causes pain." 2RR146. Repositioning her—something that must be done constantly to prevent bedsores—causes pain. 2RR146.

Indeed, even just being on the ventilator causes pain. Because T.L.'s lungs are unhealthy, having air forced into them hurts. 2RR144–45, 146–47. The pain caused by this routine care triggers her dying events, which lead to even more suffering. 2RR148. Manual ventilation is still more painful because it is done in an emergency situation and must be extremely forceful. 2RR147–48. Because these crashes are a daily event, 2RR277, T.L. must endure manual ventilation on a daily basis. T.L. is in an endless, vicious cycle of suffering. *See* 2RR147.

This suffering is made worse by T.L.'s normal brain function. 2RR150. She is not brain dead or in a coma. 2RR92, 149. Though she is paralyzed and on pain medication, she feels every painful intervention and suffers the fear and anxiety that come along with it. 2RR150.

E. Performing painful intervention on T.L. with no clinical benefit conflicts with the CICU staff's ethics and conscience.

In the months since July, while discussions with the family continued, the CICU physicians had to continue painful interventions on T.L. even though they believed doing so was unethical and even "cruel." 2RR151. Inflicting pain and suffering on T.L. for no clinical benefit took a severe psychological toll on the CICU staff, as one of her doctors explained:

> [W]here a patient doesn't have any hope of surviving . . . but yet you're still providing those very painful and uncomfortable conditions and the patient is suffering, it creates a significant degree of moral distress.

2RR164.

By definition, the CICU deals almost exclusively with medically complex and fragile children. 2RR263. The professionals who work in the CICU perform painful treatments on children every day without shirking. 2RR281. They do so because they know that causing pain can be necessary to help their child patients get better and ultimately go home. *Id*.

But this calculus fails in T.L.s case. *Id*. The medical staff inflicts pain that—it is undisputed—will *not* help her get better. *Id*. From this, these seasoned

professionals naturally recoil—and they ultimately seek to refuse to cause a child needless pain despite instructions that they do so. *See id.*

This moral distress severely affects nurses in particular. 2RR280. Nurses spend more time with patients than anyone else. 2RR265. In the Cook Children's CICU, the nurse-to-patient ratio is 1:1 or 1:2. 2RR264. The nurse remains in the patient's room or just outside, keeping a line of sight on the patient at all times. 2RR263–65. The nurse provides the patient's daily care and carries out the physicians' orders. 2RR265. This includes anything from bathing and diaper changes to administering medication and responding to emergencies. 2RR268–69.

T.L.'s case mandates special rules and procedures because even a simple touch can trigger a dying event. 2RR275, 281. T.L. always has her own nurse. 2RR282. Nurses "cluster" her care around her respiratory treatments so that they need touch her as infrequently as possible. 2RR268–69. This also ensures multiple staff members are in the room in case T.L. crashes. 2RR276–78.

The nurses take extraordinary precautions to prevent T.L. from crashing. There is a one-hour window in which doses of T.L.'s sedatives, paralytics, and pain medications can be given. 2RR277–78. One nurse testified that she administers the medications at the earliest possible time, as waiting even 15 minutes into the one-hour window can precipitate a crash. 2RR278.

A nurse who has cared for T.L. since birth testified that it is "very emotionally difficult for [her] and for the nursing staff . . . [b]ecause we're inflicting painful interventions on her that we believe exacerbate her suffering for no good outcome." 2RR266, 280. Because of this moral distress, nurses are notified in advance that they will be assigned to T.L. so that they may request a change in assignment. 2RR282. Many nurses refuse to be assigned to T.L. because they "are uncomfortable in inflicting that kind of pain on her." 2RR282.

F. The CICU staff made comprehensive efforts to transfer T.L. to another hospital that would carry out her mother's wishes, but every hospital refused.

After T.L.'s crisis in July, the CICU physicians began speaking with her mother more urgently about T.L.'s dire condition and constant suffering. 2RR91. The mother expressed interest in transferring her baby to another hospital. 2RR154. At the mother's request, the CICU doctors spoke with Boston Children's Hospital and Texas Children's Hospital about transfer. 2RR154–55. Both hospitals refused. 2RR157.

The CICU physicians then asked the mother if she wanted them to contact other hospitals to continue to seek a transfer. 2RR158. She declined because she believed other hospitals would similarly refuse. 2RR158. Thus, transfer efforts ceased for a time.

G. At an impasse, the CICU physicians requested a consult from the Cook Children's Ethics Committee.

After months of discussions with the mother, T.L.'s physicians determined that they were at an impasse. A close family friend told them that the mother would never be able to decide to stop treatment and suggested that the physicians turn to the hospital's Ethics Committee. 2RR162–63. On September 27, 2019, believing that "without the hope of recovery or survival that this treatment was not beneficial and was not ethically appropriate," 2RR87, the CICU physicians requested an Ethics Committee consult. 2RR27–28.

One of T.L.'s physicians contacted the Committee's Chair. 2RR84–85. In 11 years at Cook Children's, this was the first time that this physician had requested involvement of the Ethics Committee for an impasse with a family about continuation of artificial life-support. 2RR86–88, 101.

H. The Ethics Committee determined that Cook Children's could not ethically continue to participate in providing T.L. artificial life-support.

The Ethics Committee at Cook Children's is asked to consult in connection with removing artificial life-support on average once a year. 2RR31. The committee is not a tribunal and is not intended to be one. *See* 2RR46–48. It is composed of physicians, nurses, administrators, social workers, and community members—including parents of former Cook Children's patients. 2RR64. It is largely a

consultative body and operates based on the "combined wisdom" of its members. 2RR47.

Assisting with intractable disputes about artificial life-support, or any plan of care, is only one of the Ethics Committee's functions. The Committee also provides guidance to patients, families, and medical staff on a wide range of issues, such as providing education, developing policies, or advising about ethically difficult clinical situations. 2RR36, 61–62.

Even though the committee's job in this circumstance is to determine what intervention *Cook Children's* is ethically bound to provide (or abstain from providing), 2RR83, the committee includes three members who are **un**affiliated with Cook Children's, including one physician, 2RR65, 71. The committee has disagreed with Cook Children's physicians in the past and is by no means a rubber stamp of treating physicians' opinions. 2RR76.

The committee met on October 30, 2019, to consider T.L.'s treatment. 2RR51, 69. The mother was notified about the meeting five days in advance. 2RR69. The mother, her own parents, and one of the CICU physicians were invited to speak. 2RR43, 73. All four were then excused from the meeting before the committee began its discussion. 2RR44-45. After considering all the information presented, all 22 committee members in attendance unanimously determined that continuing artificial

life-support was not medically or ethically appropriate and that Cook Children's personnel should no longer inflict such painful intervention on T.L. 2RR45–46, 74.

Immediately, the Chair verbally informed T.L.'s mother of the committee's decision and informed her that Cook Children's could discontinue artificial life-support ten days after providing her written notice of the committee's decision. 2RR51, 74. Written notice was hand-delivered to her the next day, along with T.L.'s medical records for the previous 30 days and an abstract of the records of her entire hospital stay at Cook Children's. 2RR51, 75–76; *see also* 3RRDX4. The physician team was also informed of the committee's decision. 2RR52–53.

The efforts to transfer T.L. to another facility resumed after the Ethics Committee's decision in October. 2RR54-55; DX6, 7. The CICU physicians contacted all of the top cardiac children's hospitals in the country, 2RR180, making "extraordinary efforts" to attempt to locate a hospital willing to treat T.L. in accordance with her mother's wishes, 2RR93. Every hospital refused. 2RR95, 170-71.[3]

I. T.L's mother sued Cook Children's.

T.L.'s mother filed suit under 42 U.S.C. §1983 and the Uniform Declaratory Judgments Act, alleging violations of procedural and substantive due process under

[3] At the time of the temporary-injunction hearing, Boston Children's was again reviewing the medical records. 2RR196–98. A few days later it refused the transfer. CR283.

the federal and Texas Constitutions. CR1. She obtained a temporary restraining order delaying the cessation of artificial life-support, CR25, 28, and that order was extended twice by agreement until a temporary-injunction hearing could be held, CR113, 172. The judge who entered the initial temporary restraining order was recused, CR128, and Chief Justice Hecht appointed the Honorable Sandee Bryan Marion, Chief Justice of the Fourth Court of Appeals in San Antonio, to be the trial judge, CR130.

After a full day of testimony, Chief Justice Marion took the matter under advisement and found cause to allow T.L.'s mother until January 2, 2020, to continue to seek a transfer to another hospital. 2RR349–50. On January 2, 2020, Chief Justice Marion signed an order denying the request for temporary injunction. CR307. This interlocutory appeal followed.

SUMMARY OF ARGUMENT

Appellants failed to prove two elements necessary to their request for a temporary injunction: that they had (1) a cause of action against Cook Children's and (2) a probable right to the relief sought. *Butnaru v. Ford Motor Co.*, 84 S.W.3d 198, 204 (Tex. 2002). Accordingly, Chief Justice Marion did not abuse her discretion in denying Appellants' request for temporary injunction. Because Appellants' constitutional claims fail as a matter of law, Chief Justice Marion's decision was not "so arbitrary that it exceeded the bounds of reasonable discretion"—as this Court must find to reverse her order. *Communicon, Ltd. v. Guy Brown Fire & Safety, Inc.*, No. 02-17-00330-CV, 2018 WL 1414837, at *7 (Tex. App.—Fort Worth Mar. 22, 2018, no pet.) (mem. op.).

End-of-life decisions are wrenching for patients, their families, and medical professionals. Often, an intervention that artificially prolongs life may also prolong—or even intensify—suffering. A doctor, bound by an oath to do no harm, may conclude that her ethics or conscience will not permit her to provide treatment that causes suffering without a corresponding benefit. The patient's surrogate may disagree. The question becomes how to resolve this conflict among private parties.

At common law, either party could leave the wholly voluntary doctor-patient relationship at will. Thus, if a patient sought treatment the physician believed unethical or that violated her conscience, the physician had a right to abstain from

providing it; her only legal duty was to give the patient a reasonable opportunity to transfer to another physician.

The Texas Advance Directives Act (the "Act") codifies these common-law principles. Additionally, it provides an optional dispute-resolution procedure for these difficult circumstances, in which the hospital's ethics committee makes the decision for the entire institution. The family is given notice of the committee's meeting and the right to attend. If the committee decides that the hospital cannot ethically provide the requested intervention, the hospital must assist the patient's attempt to transfer to a facility willing to carry out the family's wishes. The Act explicitly does not grant physicians or hospitals any power they did not have at common law. Instead, it protects their preexisting rights of conscientious refusal by ensuring that, if they use the voluntary procedure, they will not be subject to malpractice liability or other discipline.

Here, T.L.'s mother and her physicians reached an impasse. The doctors and nurses who must hurt this small child every day—towards no beneficial end—came to believe that the only way they could act consistently with their oath, medical ethics, and their consciences was to decline to participate any longer in treatment they considered unethical. Indeed, some seasoned pediatric nurses refuse to be assigned to care for T.L. because the intervention they are instructed to provide causes them extreme moral distress. 2RR280–82.

After months of discussion, T.L.'s mother disagreed, and T.L.'s physicians invoked the Act's dispute-resolution procedure. The ethics committee agreed that Cook Children's could not ethically provide further painful, inappropriate artificial life-support. Afterwards, Cook Children's—going far beyond the Act's requirements—made a herculean effort to assist T.L.'s mother in searching for an institution willing to comply with her wishes. All these efforts failed, and this lawsuit followed.

Appellants and the Attorney General ask this Court to order Cook Children's to continue inflicting medically inappropriate suffering on T.L. contrary to medical ethics and conscience. But their constitutional suit has no basis. For two critical reasons, a private hospital's use of the statutory dispute-resolution procedure cannot violate a patient's due-process rights.

First, use of the Act's process deprives a patient of no constitutionally protected interest. A patient's right to choose her treatment does not include a right to force a doctor to provide it—just as the constitutional right to an abortion does not include the constitutional right to force a particular doctor to perform one. Rather, it is a right to attempt to find a willing doctor. In refusing, a doctor exercises her own liberty interest without violating the patient's. Likewise, when artificial life-support is withdrawn, the withdrawal is not the cause of the patient's death; the underlying disease is. Both Texas law and the United States Supreme Court have

recognized this critical distinction, which Appellants and the State ask this Court to ignore.

Second, the due process clause protects only against constitutional deprivations *by the government*, and Cook Children's is not the government. A long line of United States Supreme Court decisions confirms that Cook Children's does not *become* the government as a consequence of state regulation, public funding, statutory safe harbor, or the use of a State-created statutory process.

Appellants' misguided constitutional claims ask the State to become far more involved in private disputes, eliminating—as a matter of constitutional law—physicians' and nurses' rights of conscience. And they ask this Court to overturn a careful legislative compromise between medical providers, right-to-life organizations, and religious authorities.

The policy questions this case raises belong in the Legislature, not this Court.

ARGUMENT[4]

The following facts are undisputed:

- T.L.'s condition is terminal, and there is no chance of recovery.
- T.L. suffers constant pain, which is aggravated by the artificial life-support Cook Children's is forced to provide her;
- T.L.'s medical team unanimously agree that continuing to provide her these medically inappropriate, painful support is unethical.
- Every hospital that has reviewed T.L.'s case over a period of several months is unwilling to accept transfer and comply with her mother's preferred course of treatment.
- Cook Children's is a private hospital.

From these facts, Appellants attempt to state a constitutional claim against Cook Children's. To do so, they must make numerous false—but attention-grabbing—claims about the powers §166.046 supposedly grants Cook Children's.

These claims are belied by §166.046's text, which Appellants never closely analyze, by the common law governing the physician-patient relationship; and by binding decisions from the United States Supreme Court. Section 166.046 grants none of the radical powers Appellants attribute to it. Rather, it provides a means of

[4] In the trial court, Appellants argued that an injunction was authorized by §166.046(g) of the Act, which permits a court to require a healthcare provider to maintain the status quo if it finds "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 §166.046(g). The trial court granted this relief through January 2, 2020. Appellants do not seek any further relief under this provision.

resolving purely private disputes between doctors and their patients. Properly understood, there is no constitutional infirmity.

Below, Cook Children's first lays out the historical common-law conception of the doctor-patient relationship and the concerns that animated §166.046's passage. Next, Cook Children's explains the narrow, purely private effect of §166.046. And finally, Cook Children's explains why, once §166.046's meaning is understood, Appellants' constitutional attack must be rejected.

I. The doctor-patient relationship is a voluntary arrangement between two parties each, guided by her own judgment, conscience, and ethics.

A. Physicians have a common-law right to refuse to provide care inconsistent with their conscience or ethics.

"The physician-patient relationship is 'wholly voluntary.'" *Gross v. Burt*, 149 S.W.3d 213, 224 (Tex. App.—Fort Worth 2004, pet. denied) (quoting *Fought v. Solce*, 821 S.W.2d 218, 220 (Tex. App.—Houston [1st Dist.] 1991, writ denied)). At its simplest, this means that a patient has no obligation to accept care from a physician that she does not wish to receive, while a physician has no obligation to provide care she does not wish to give.

Appellants focus heavily on the first part of this equation, observing correctly that a patient has a constitutional right to make decisions about her own treatment. Appellants' Br. 22 (citing *Cruzan v. Director, Mo. Dep't of Health*, 497 U.S. 261, 269 (1990)). Unfortunately, Appellants ignore the other side of the equation, merely

assuming—without ever demonstrating by law or logic—that once a patient makes a decision, her physician must, *as a matter of constitutional law*, carry out her instructions.

The common law has long rejected this notion. While a physician may not force treatment upon a patient, a physician has *always* been allowed to refuse to provide treatment that offends the physician's sense of conscience, ethics, or professional judgment. This right is intrinsic to the doctor-patient relationship's private, voluntary nature. Indeed, it is intrinsic to the physician's own liberty—"[n]o person can be caused, against his will, to enter into an employment contract." *N.L.R.B. v. Knoxville Pub. Co.*, 124 F.2d 875, 882 (6th Cir. 1942); *accord Texas Alcoholic Bev. Comm'n v. Live Oak Brewing Co.*, 537 S.W.3d 647, 655 (Tex. App.—Austin 2017, pet. denied) ("Among the liberty interests protected by due course of law is freedom of contract . . . .").

To protect the individual rights of each party to the bilateral, physician-patient relationship, either party may terminate it at will. AM. MED. ASS'N, COUNCIL ON ETHICAL & JUDICIAL AFFAIRS, CODE OF MED. ETHICS §1.1.5 (2016). Thus, while a physician cannot countermand a patient's wish, the physician can *abstain* from providing a particular treatment. The Code of Medical Ethics protects physicians' "right to act (*or refrain from acting*) in accordance with the dictates of conscience

in their professional practice," allowing them "considerable latitude to practice in accord with well-considered, deeply held beliefs." *Id.* §1.1.7 (emphasis added).

If a physician wishes to cease treating a patient according to the patient's wishes, ethical rules merely require a physician to "[n]otify the patient (or authorized decision maker) long enough in advance to permit the patient to secure another physician," to whom the abstaining physician must "[f]acilitate transfer." *Id.* §1.1.5. Where a physician complies with these narrow duties, the common law has traditionally protected her from liability to the patient. *E.g.*, *King v. Fisher*, 918 S.W.2d 108, 112 (Tex. App.—Fort Worth 1996, writ denied) (describing the elements of a common-law abandonment claim); *see also Tate v. D.C.F. Facility*, No. 4:07CV162-MPM-JAD, 2009 WL 483116, at *1 (N.D. Miss. Jan. 23, 2009) ("Doctors and hospitals of course have the right to refuse treatment . . . .").

In short, "[r]especting patient autonomy does not mean that" physicians must provide "specific interventions simply because they (or their surrogates) request them." CODE OF MED. ETHICS §5.5.

B. Section 166.046 was enacted to help resolve private disagreements between patients and physicians regarding care.

Disagreements between patients (or their surrogates) and physicians are most fraught when they concern end-of-life decision-making. The Texas Advanced Directives Act was passed, in part, to address these problems.

In 1999, the Legislature passed the Act, which was intended to "set[] forth uniform provisions governing the execution of an advance directive" regarding healthcare. Sen. Research Ctr., Bill Analysis, Tex. S.B. 1260, 76th Leg., R.S. (1999). The Act was the culmination of a six-year effort among a diverse array of stakeholders, including Texas and National Right to Life, Texas Alliance for Life, the Texas Conference of Catholic Health Care Facilities, the Texas Medical Association, the Texas Hospital Association, and the Texas and New Mexico Hospice Organization. *See* Hearing on H.B. 3527, Comm. on Pub. Health, 76th Leg., R.S. (Apr. 29, 1999) (statement of Greg Hooser, Texas and New Mexico Hospice Organization).

Ironically, Texas Right to Life was a champion of the Act it is now attempting to overturn. Its Legislative Director testified: "[W]e like it and the whole coalition seems to be in agreement with this. . . . [W]e are really united behind this language." *See id.* (statement of Joseph A. Kral, IV, Legislative Director, Texas Right to Life).[5] The bill passed the Senate unanimously and it passed the House on a voice vote. Act of May 11, 1999, 76th Leg., R.S., ch. 450, §3.05, 1999 Tex. Gen. Laws 2835, 2865.

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

One issue animating the Act's passage was what is commonly referred to as "medical futility." Simplified, this issue arises when a patient's underlying condition is fatal and incurable, but artificial intervention can allow the patient to continue living. However, that intervention often causes the patient substantial pain. Many physicians believe that "[i]t is inhumane to prolong a dying process that causes pain to a patient," and they "believe they should not be forced to provide treatment" of this type when it "violates their ethics." CYNTHIA S. MARIETTA, THE DEBATE OVER THE FATE OF THE TEXAS "FUTILE CARE" LAW: IT IS TIME FOR COMPROMISE 3 (April 2007).[6]

In testimony before the Legislature, Dr. Ann Miller, a pediatric chaplain, explained the physician's ethical imperative:

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

[6] Available at https://www.law.uh.edu/healthlaw/perspectives/2007/(CM)TXFutileCare.pdf.

Hearing on C.S.S.B. 439 before the Senate Comm. on Health & Human Servs., 80th Leg., R.S. (April 12, 2007) (statement of Dr. Ann Miller, Director of Pastoral Care, Cook Children's Medical Center).

Prior to the Act, physicians were often faced with a Hobson's choice between their consciences and professional ethics, on the one hand, and their livelihood on the other. Consider a physician who determines that further treatment is not only medically futile, but severely painful to the patient such that it violates the physician's ethical responsibility to do no harm. Yet the patient's surrogate insists that this treatment should continue.

Under the common law that governed the voluntary doctor-patient relationship, the physician would most likely be free from liability if she refused to provide further care, so long as she gave the surrogate an opportunity to find a physician who would. But there was no guarantee: the patient could file a medical-malpractice claim, or a regulatory body could investigate, and liability or discipline would depend on a complex judgment about whether the physician had appropriately followed the standard of care. As a result, physicians—fearing malpractice liability or professional discipline—often felt forced to provide care they believed to be

unethical. Robert L. Fine, M.D., *Medical futility and the Texas Advance Directives Act of 1999*, 13 B.U.M.C. PROCEEDINGS 144, 145 (2000).[7]

The Act was intended to address this problem. And, as Cook Children's explains in the next section, it did so through a process-based approach, without any need to define medical futility or dictate that physicians take any particular course in any situation.[8]

II. Appellants' constitutional claims are premised on a misreading of §166.046.

Appellants assert that §166.046 of the Act grants physicians "statutory authority" to "make a decision for" a patient. Appellants' Br. 25, 30. More hyperbolically, Appellants assert that it permits a physician to "sentence ill people to premature death." *Id.* at 21. These inflammatory assertions are flatly incorrect, and Appellants can make them only because they refuse to deal honestly with the Act's text and the common law it codifies.

[7] Available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1312296/pdf/bumc0013-0144.pdf.

[8] The Act's process-based approach resembled one recommended years earlier by the American Medical Association. Without statutory enactment, the specter of malpractice liability had limited its usefulness. *See* Robert L. Fine, M.D., *Medical futility and the Texas Advance Directives Act of 1999*, 13 B.U.M.C. PROCEEDINGS 144, 145 (2000).

A. Section 166.046 is a voluntary safe-harbor provision that does not grant physicians any rights they did not have prior to the statute's enactment.

As a whole, the Act creates a legal framework for how healthcare providers should handle and comply with advance directives, out-of-hospital do-not-resuscitate orders, and medical powers-of-attorney in the context of life-sustaining intervention. *See* TEX. HEALTH & SAFETY CODE §§166.001–.166. It does so within the common-law framework governing the voluntary physician-patient relationship. Thus, the Act does not "impair or supersede ***any*** legal right or responsibility a person may have to effect the withholding or withdrawal of life-sustaining treatment in a lawful manner." *Id.* §166.051 (emphasis added).

Generally, the Act requires physicians to follow treatment decisions made by or on behalf of a patient. At the same time, the Act—like the common law—acknowledges that a patient's wishes may conflict with a physician's conscience or judgment. Section 166.046—which Appellants contend is unconstitutional—is a tool for resolving these conflicts. It does not grant any new powers to physicians or hospitals. Instead, it provides a voluntary process by which a physician can seek to harmonize her ethical duties with the patient's wishes. It can be utilized regardless of whether the doctor wishes to *withhold* or *provide* life-sustaining intervention over a patient's wishes. *Id.* §166.046.

The first critical point to understand about §166.046 is that utilization of its process is not mandatory, even when a physician wishes to abstain from providing artificial life-support:

> If an attending physician refuses to comply with a directive or treatment decision *and does not* ***wish*** *to follow the procedure established under Section 166.046*, life-sustaining treatment shall be provided to the patient, *but only until* a reasonable opportunity has been afforded for the transfer of the patient to another physician or health care facility willing to comply with the directive or treatment decision.

Id. §166.045(c) (emphasis added). This provision is declarative of the common law. It permits a physician to rely on her common-law right to refuse to provide medical care that is inconsistent with her ethics. As she would have been before the Act, a physician who refuses to provide artificial life-support without following §166.046's procedure is civilly liable only if she "fails to exercise reasonable care." *Id.* §§166.044(a), (d).

In addition to codifying the common-law rule, the Act adds a safe harbor for a physician that complies with §166.046 before refusing to carry out a patient's treatment decision:

> 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) (emphasis added). Under that process, if a physician is unwilling to honor a patient's (or surrogate's) directive, that "refusal shall be reviewed by an

ethics or medical committee," of which the treating physician may not be a member. *Id.* §166.046(a). The patient is entitled to notice of the committee's meeting, an opportunity to attend, and notice of the committee's decision. *Id.* §166.046(b). Regardless of the committee's decision, if either the patient or the physician disagrees with it, the physician must "make a reasonable effort to transfer the patient to a physician who is willing to comply." *Id.* §166.046(d). If the committee affirms a physician's decision that further life-sustaining treatment is medically inappropriate, "life-sustaining care" (including artificial life-support) must nevertheless be provided for at least ten days while transfer to a facility willing to comply with the patient's decision is attempted. *Id.* §166.046(e).

Both before and after the Act's passage, physicians were entitled to act according to their conscience, including when that meant refusing to provide artificial life-support that a patient or her surrogate requested. The Act codifies but does not enlarge this right. It provides safe harbor when a physician *chooses* to utilize a procedure that the Legislature intended to help resolve private conflicts between physicians, patients, and families regarding end-of-life care.

The Act's plain text, and the common law it codified, repudiate Appellants' assertion that, through the Act, the Texas Legislature has authorized a health-care provider to take a patient's life. If that were the case, the religious and right-to-life

organizations that drafted the Act and worked for its passage would have spared no effort to defeat it.

B. A means of challenging §166.046's constitutionality is available, but Appellants consciously chose not to pursue it.

Section 166.046 does not impose *any* duties on Cook Children's. The hospital and its doctors are free to forego §166.046's procedure *even if* they intend to cease providing medically inappropriate artificial life-support. Section 166.046 does not deprive Appellants of any right: if §166.046 had never been enacted, T.L. would still have no constitutional right to force a physician to provide her care the physician did not wish to provide. Neither does §166.046 *grant* Cook Children's any rights it did not already have: a doctor has always been permitted to exit the doctor-patient relationship at will. Rather, §166.046's *only* effect on the parties to this case is that it bars Appellants from suing Cook Children's for malpractice.

It is because of this narrow effect that, in seeking to prevail on their §1983 claims, Appellants require this Court to legislate from the bench—to become the first court in the United States to hold:

- that the State has an affirmative obligation to provide its citizens with the medical care of their choice, *infra* §III.A.; and
- that, as a consequence of State regulation, the State becomes a party to the doctor-patient relationship, such that the physician's termination of that relationship can be imputed to the State, *infra* §III.B.

Such a holding would radically *expand* the role of the State in Texans' lives. If this is what Appellants want, their remedy is the Legislature—not a §1983 claim.

To challenge §166.046, Appellants and the State did not have to invite this Court to engage in revolutionary judicial activism. A safe-harbor statute like §166.046 prevents a plaintiff from bringing a cause of action that the law would otherwise allow. *See, e.g.*, *Newman v. Obersteller*, 960 S.W.2d 621, 622 (Tex. 1997). When the Legislature abrogates a common-law cause of action, it must do so consistent with Texas's open courts provision, which provides that "[a]ll courts shall be open, and every person for an injury done him, in his lands, goods, person or reputation, shall have remedy by due course of law." TEX. CONST. art. I, §13. This provision ensures that a person bringing a well-established common-law cause of action will not suffer an unreasonable or arbitrary denial of access to the courts. *Yancy v. United Surgical Partners Int'l, Inc.*, 236 S.W.3d 778, 783 (Tex. 2007) (citing *Jennings v. Burgess*, 917 S.W.2d 790, 793 (Tex.1996)).

Because §166.046's *only* legal effect is to abrogate a malpractice claim, the correct way to challenge its constitutionality would be for Appellants to bring a malpractice claim against Cook Children's and argue that the Act's safe-harbor provision violates the open-courts clause. To prevail on such an argument, Appellants would need to prove "(1) a cognizable, common-law claim that is statutorily restricted, and (2) the restriction is unreasonable or arbitrary when

balanced against the statute's purpose and basis." *Id*. Thus, the court would grapple with whether §166.046 is unreasonable or arbitrary, a matter within the judicial branch's competence and proper constitutional role. *See Methodist Healthcare Sys. of San Antonio, Ltd. v. Rankin*, 307 S.W.3d 283 (Tex. 2010) (considering whether statute of repose violated open-courts guarantee as applied to medical-malpractice action); *Lund v. Giauque*, 416 S.W.3d 122, 132–33 (Tex. App.—Fort Worth 2013, no pet.) (considering whether statutory grant of immunity violated open-courts guarantee in tort action).

Appellants consciously elected *not* to pursue a challenge of this type, telling the trial court, "[t]his is not a malpractice suit." 2RR298. To be clear, Cook Children's believes §166.046 would survive an open-courts challenge, just as it survives Appellants' misdirected due-process challenge. But by asserting the correct constitutional argument via the proper cause of action, Appellants would permit the parties and courts to have an honest discussion about whether the Legislature's policy choice was arbitrary. Appellants chose not to invoke that mechanism, and they are bound by the consequences of their decision.

Through Appellants' §1983 claim, they and the State threaten to lead this Court down a dangerous path towards statism and judicial activism. For the reasons Cook Children's explains in the next section, this Court should reject that effort.

III. Section 166.046's procedure is constitutional.

Appellants assert that §166.046 offends procedural and substantive due process. To prevail on a procedural-due-process claim, a plaintiff must prove that (1) she had a protected liberty or property interest and (2) that she was deprived of that interest with insufficient process. *Logan v. Zimmerman Brush Co.*, 455 U.S. 422, 428 (1982); *University of Tex. Med. Sch. at Hous. v. Than*, 901 S.W.2d 926, 929 (Tex. 1995).[9] The substantive due-process inquiry looks at whether the state has arbitrarily deprived the plaintiff of a constitutionally protected interest. *Patel v. Texas Dep't of Licensing & Regulation*, 469 S.W.3d 69, 86–87 (Tex. 2015); *Simi Inv. Co. v. Harris Cty., Tex.*, 236 F.3d 240, 249 (5th Cir. 2000). And under either claim, a plaintiff must demonstrate that the deprivation was the result of state action. *Lugar v. Edmondson Oil Co.*, 457 U.S. 922, 924 (1982); 42 U.S.C. §1983.

Therefore, to prevail on their claims, Appellants must show both that they have a constitutionally protected interest and that they will be deprived of this interest as a result of state action. Appellants cannot demonstrate either.

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

A. Section 166.046 does not deprive Appellants of any constitutionally protected interest.

Appellants identify three interests that they assert §166.046 will deprive them of: T.L.'s interest in life; her mother's right to make medical decisions for T.L.; and Appellants' parent-child relationship. Because each of these arguments is premised on a misunderstanding of how §166.046 operates, each fails.

1. Utilization of the §166.046 procedure does not deprive a patient of life.

According to Appellants, §166.046 "delegate[s] life[-]taking authority to a hospital's ethics committee." Appellants' Br. 21. Behind this assertion is a belief that when a physician refuses to provide artificial life-support, the physician causes the patient's death—no different than if the physician had administered a life-*taking* drug. *See id.* at 21; *see also* State's Br. 10 (asserting that "[t]he denial of life-saving medical treatment is the denial of a constitutionally protected interest").

In *Vacco v. Quill*—a decision on which Cook Children's has consistently relied but Appellants and the State tellingly fail to mention—the United States Supreme Court rejected this argument. 521 U.S. 793, 801 (1997). There is, in fact, a critical distinction between a physician's active participation in an act that causes a patient death and a physician's abstention from providing artificial life-support.

A patient has a constitutional right to refuse life-sustaining medical care. *Cruzan*, 497 U.S. at 278. Yet in most states, including Texas, physician-assisted

suicide is a crime. TEX. PENAL CODE §22.08(a). In *Vacco*, the respondents attacked this distinction, arguing that because the patient's "refusal of [life-sustaining] treatment is 'essentially the same thing' as physician-assisted suicide," there was a constitutional right to the latter. 521 U.S. at 798.

In rejecting the respondents' arguments, the Supreme Court also rejected the conflation on which Appellants' due-process claims are premised. The Court held that "the distinction between assisting suicide and withdrawing life-sustaining treatment, a distinction widely recognized and endorsed in the medical profession and in our legal traditions, is both important and logical." *Id.* at 800–01 (footnote omitted). Indeed, it "comports with fundamental legal principles of causation and intent":

> [W]hen 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. (emphasis added); *see also id.* at 801 (recognizing that the intent of a physician who withdraws life sustaining care is not to kill, but to "cease doing useless and futile or degrading things to the patient when the patient no longer stands to benefit from them" (internal quotation marks and brackets omitted)).

The Legislature, unlike Appellants and the State, understood the Supreme Court's distinction. *Compare* TEX. PENAL CODE §22.08(a) (making physician-assisted suicide a crime), *with* TEX. HEALTH & SAFETY CODE §§166.044(a)–(c)

(permitting physicians to withdraw "life-sustaining care" in accordance with a patient's directive); *accord* TEX. HEALTH & SAFETY CODE §166.050 (providing that the withdrawal of "life-sustaining care" under the Act in order to "permit the natural process of dying" is *not* an "affirmative or deliberate act or omission to end life" of the type Texas law forbids).

Vacco's reasoning, which the Act explicitly incorporates, forcefully negates Appellants' constitutional challenge. If a physician withdraws artificial life-support (whether pursuant to §166.046 or not), the physician's actions do not *cause* the patient's death. The patient's underlying disease does. *Accord* Am. Med. Ass'n, Council on Ethical and Judicial Affairs, *Physician-Assisted Suicide*, 10 ISSUES IN LAW & MEDICINE 91, 93 (1994) ("When a life-sustaining treatment is declined, the patient dies primarily because of an underlying disease."). Thus, courts have held that even where the person choosing to withdraw care is a state actor, that choice does not violate due process because there is a "fundamental" and legally crucial "difference between depriving someone of life and letting disease run its course." *In re Tschumy*, 853 N.W.2d 728, 747 (Minn. 2014);[10] *In re Quinlan*, 355 A.2d 647, 669–70 (N.J. 1976) (holding that where artificial life-support is withdrawn, "the

[10] *Tschumy* concerned a ward of the State of Minnesota who had irreversible brain damage. *In re Tschumy*, 853 N.W.2d 728, 732 (Minn. 2014). The question was whether the ward's due process rights would be violated if his guardian consented to the withdrawal of his life-sustaining medical care. *See id.* at 747. The Court assumed that the guardian was a state actor but held that there was no due-process violation because the withdrawal permitted a natural death; it did not cause it. *Id.*

ensuing death would not be homicide but rather expiration from existing natural causes"); *see also* TEX. HEALTH & SAFETY CODE §166.050.

Cook Children's does not deny that T.L. has a constitutionally protected life interest. But in refusing to continue providing medically inappropriate, artificial life-support that hurts T.L. without helping her, Cook Children's is not depriving her of life. Her disease will take her life, but there is no constitutional claim for that tragic, if natural, process. *Vacco*, 521 U.S. at 801.

2. Utilization of the §166.046 procedure does not deprive Appellants of their right to make medical decisions.

The doctor-patient relationship is a voluntary two-way street. A patient has the right to choose her course of treatment, and she effectuates this right by finding a physician willing to follow her preferred course. The physician cannot provide treatment contrary to the patient's wishes, but neither may she be commandeered into providing treatment that violates her own conscience and ethics.[11]

If the physician and patient disagree about treatment, they dissolve their relationship; the physician's only obligation in that event is to facilitate the patient's transfer to a willing provider. Thus, a physician's refusal to provide a particular course of treatment does not deny the patient her right to make medical decisions; it

[11] *Cf. Brophy v. New England Sinai Hosp., Inc.*, 497 N.E.2d 626, 639 (Mass. 1986) (holding that patient's right to refuse artificial life-support did not "justify compelling medical professionals" to participate in a decision "which [was] contrary to their view of their ethical duty").

merely requires the patient to find a different physician to treat her according to her wishes.

The due process clause *confirms* this analysis, even if Cook Children's is incorrectly treated as a state actor. Except in one narrow circumstance not applicable here,[12] a state-actor physician is not ***constitutionally*** obligated to prove ***any*** treatment, including life-sustaining treatment. Indeed, if Appellants were correct that the Constitution requires doctors to undertake treatment that ***prevents or forestalls*** illness, then patients would have a constitutional right to have ***any and all*** ailments treated by the State.

The United States Supreme Court has expressly rejected this position, which undergirds Appellants' suit. In *DeShaney*—another decision that Cook Children's relies on but Appellants and the State conspicuously ignore—the Supreme Court held that the Constitution "generally confer[s] no affirmative right to governmental aid, *even where such aid may be necessary to secure life*, liberty, or property interests of which the government itself may not deprive the individual." *DeShaney v. Winnebago Cty. Dep't of Soc. Servs.,* 489 U.S. 189, 196 (1989).

DeShaney accords with and cannot be separated from the distinction *Vacco* drew between death that results from natural processes following the withdrawal of

[12] *See infra* p. 41 (discussing the unique affirmative obligations the State owes to persons whom it has deprived of freedom, such as prisoners and the involuntarily committed).

artificial life-support and death that results from a person's affirmative, life-taking action: the government cannot *take* a person's life, but it has no affirmative obligation to provide artificial life-support. *Id.*; *accord Vacco*, 521 U.S. at 801.[13]

Appellants argue that in refusing to provide them with their desired course of treatment, Cook Children's denies Appellants the right to make their own medical decisions. Thus, Appellants believe that the substance of the right to make a medical choice includes the right to have the State *comply with and carry out* that choice. Cook Children's cannot find—and Appellants and the State have failed to cite—*any* decision from *any* American jurisdiction recognizing such an expansive substantive due-process right. *See Abigail All. for Better Access to Developmental Drugs v. von Eschenbach*, 495 F.3d 695, 710 n.18 (D.C. Cir. 2007) (en banc) ("No circuit court has acceded to an affirmative access [to medical care] claim.");[14] *Johnson ex rel. Johnson v. Thompson*, 971 F.2d 1487, 1495–96 (10th Cir. 1992) (rejecting argument that right to life includes right to receive medical care). This Court should not become the first.

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[13] The State's decision to ignore *DeShaney* is telling. Elsewhere, it has recognized that under *DeShaney*, "there is *no* freestanding constitutional obligation for the government to provide services to its citizens under *any* circumstances." Brief of the State of Texas, *Planned Parenthood of Austin Family Planning, Inc. v. Suehs*, No. 12-50377, 2012 WL 1878694, at *22–23 (5th Cir. filed May 11, 2012) (emphasis added).

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

Were this Court to do so, the consequences would be severe and far-reaching. Not only the refusal to provide artificial life-support, but the refusal to treat *any* illness is capable of causing injuries of constitutional dimensions. Thus, in ruling for Appellants, this Court would be creating a substantive-due-process entitlement to *any* desired medical care, at least where its non-provision might cause cognizable harm. A person with active alcoholism could demand a liver transplant; a patient could demand opioids for mere headaches; or a patient could demand illegal or unproven drugs or surgeries—and in each instance, the State would be constitutionally obligated to provide the requested treatment. *Contra Abigail All.*, 495 F.3d at 710 n.18; *People v. Privitera*, 591 P.2d 919, 925–26 (Cal. 1979) (rejecting substantive-due-process right of access to drug of patient's choice).

But that is only the beginning. The due process clause has long been understood to "afford[] protection against unwarranted government interference with freedom of choice in the context of certain personal decisions," but not to confer an obligation on the government to ensure that the person "realize[s] all the advantages of that freedom." *Harris v. McRae*, 448 U.S. 297, 317–18 (1980). Accordingly, the substantive-due-process right to use contraceptives does not imply "an affirmative constitutional obligation to ensure that all persons have the financial resources to obtain contraceptives." *Id.* at 318.

To rule for Appellants would be to overrule not only *DeShaney*, but *Harris* as well. It would be to command that where a person has a substantive-due-process right—be it to life, travel, or an abortion—the government is not only prohibited from interfering with the exercise of that right, it must affirmatively assist citizens in "realiz[ing] all the advantages of" it. *Id.*

Putting aside the question of state action,[15] a claim similar to Appellants' was addressed in *Disability Rights Wisconsin v. University of Wisconsin Hospital & Clinics*, 859 N.W.2d 628 (Wisc. App. 2014) (unpublished). Like Appellants, the *Disability Rights* plaintiffs argued that a state hospital violated their due process rights by refusing to provide them certain desired treatments. The court rejected that claim, finding no authority "that doctors have an obligation, deriving from patients' fundamental constitutional rights, to begin or continue medical treatment." *Id.* at *6. Following *DeShaney*, the court concluded that there was no "substantive due process right to medical care from the government" because such a right would "run contrary to the fundamental principle that the government is not under a constitutional duty to affirmatively protect persons or to rescue them from perils 'that the government did not create.'" *Id.* at *8 (quoting *DeShaney*, 489 U.S. at 195).

[15] Unlike this case, *Disability Rights* concerned a public hospital that was unquestionably a state actor.

The single exception to *DeShaney*'s rule is a telling one. The *only* persons whom the state owes a constitutional duty to provide medical care are those the state has deprived of their freedom—typically, prisoners and the involuntarily committed. *DeShaney*, 489 U.S. at 198–99 (citing *Youngberg v. Romeo*, 457 U.S. 307, 314–15 (1982) (involuntary commitment); *Estelle v. Gamble*, 429 U.S. 97, 103–04 (1976) (prisoners)).[16] But even in this unique context, the right to state-provided care is narrowly circumscribed. Courts have roundly rejected the notion that prisoners and the involuntarily committed have a right to receive "any particular type of treatment." *Long v. Nix*, 86 F.3d 761, 765 (8th Cir. 1996); *accord Jenkins v. Colorado Mental Health Inst. at Pueblo*, 215 F.3d 1337, at *1–2 (10th Cir. 2000) (unpublished).

DeShaney decides this case. Even if Cook Children's were a state actor, the Constitution would not require it to provide T.L. care it does not wish to provide—care it believes is contrary to its professional and ethical duties.[17] Because Cook

[16] This narrow exception to *DeShaney*'s rule explains the court's holding in *Baby F.*, on which Appellants rely. That case concerned the proper standard for the withdrawal *by the state* of life-sustaining care for a child *in the state's custody*, when that decision was contrary to the wishes of the child's decision-making surrogate. *See Baby F. v. Oklahoma Cnty. Dist. Ct.*, 348 P.3d 1080, 1082–84 (Okla. 2015). Notably, even in this state-custody situation, the court did not hold that the State had an insuperable obligation to comply with the surrogate's wishes, let alone that a specific private physician or hospital did. Instead, the court held that life-sustaining care could be removed if clear and convincing evidence demonstrated that it was in the child's best interests. *Id.* at 1088; *see also In re Wendland*, 28 P.3d 151, 169 (Cal. 2001).

[17] Plaintiffs' citation, at the injunction hearing, of the Emergency Medical Treatment and Labor Act, 42 U.S.C. §1395dd, harms rather than helps their constitutional arguments. *See* 2RR348–49. Plaintiffs are correct that, under certain circumstances, EMTALA requires emergency rooms to

Children's has no affirmative obligation to provide medical care, §166.046 *cannot* violate due process in granting Cook Children's safe harbor for abstaining from such care.

3. Utilization of §166.046's procedure does not deprive T.L.'s mother of her parental rights.

Finally, Appellants and the State assert that Cook Children's use of §166.046 will deprive T.L.'s mother of her constitutional liberty interest in making decisions about the care of her child. As with her right to make medical decisions, the mother's right to make decisions about her child does not extend to forcing physicians to participate in providing artificial life-support against their will. *See DeShaney,* 489 U.S. at 198–99. Neither Appellants nor the State cite *any* contrary authority.

Similarly, if the mother's parental rights are terminated by T.L.'s death, the cause of that termination is the severe medical conditions from which T.L. suffers, not Cook Children's conscientious refusal to provide artificial life-support or its use of §166.046's procedure.

B. Cook Children's is not a state actor.

Cook Children's is an indisputably private entity. *E.g.*, 2RR314. Nevertheless, Appellants and the State attempt to characterize Cook Children's as a state actor with

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provide a statutory level of care to patients before releasing them. But the fact that this affirmative obligation is a *statutory* mandate underscores the lack of *constitutional* obligation at issue here. Plaintiffs have never made an EMTALA claim.

respect to its use of §166.046's procedure. Private conduct is attributable to the State only in the most remarkable circumstances. This is because the sharp division between private and governmental conduct "preserves an area of individual freedom by limiting the reach of federal law and federal judicial power." *Lugar*, 457 U.S. at 936. Thus, courts that have considered facts similar to those of this case have emphatically rejected state-action arguments.

Klavan v. Crozer-Chester Medical Center, 60 F. Supp.2d 436 (E.D. Pa. 1999), is instructive. In that case, a patient's advance medical directive prohibited doctors from taking aggressive life-saving care or keeping him in a persistent vegetative state. *See id.* at 439–40. The patient's doctors, working at a private hospital, ignored that directive and took action the patient forbade. *Id*.

Like Appellants, the patient's guardian sued under §1983, alleging a violation of his due process right to refuse unwanted medical treatment. *Id*. at 440. The court dismissed the claim, finding that the hospital and doctors were not "state actors"—even though a Pennsylvania statute compelled the hospital to either comply with the patient's advance directive or attempt to transfer him. *Id*. at 443–44. Like *Klavan*, this case concerns a private hospital, regulated by State law, that is accused of acting contrary to the patient's surrogate's wishes. The same result should obtain: Cook Children's actions are *not* attributable to the State.

Klavan is especially instructive because the Supreme Court has explained that "examples may be the best teachers" in determining whether a particular private person can be deemed a state actor. *Brentwood Acad. v. Tennessee Secondary Sch. Athletic Ass'n*, 531 U.S. 288, 296 (2001). It is thus telling that for all the cases Appellants and the State cite, they describe *none* of their facts in detail. Indeed, they cannot point to any case whose *facts* support their state-action argument:

- Appellants can point to no case in which a private hospital's provision or withholding of medical treatment made it a state actor. *Contra Klavan*, 60 F. Supp.2d at 443–44.

- Appellants can point to no case in which a medical provider's action pursuant to a statutory or regulatory scheme made it a state actor. Several cases establish the contrary. *E.g.*, *Blum v. Yaretsky*, 457 U.S. 991 (1982) (transfer of patients pursuant to Medicaid utilization requirements was not state action).

- Appellants can point to no case in which a private hospital was deemed to be a state actor simply because it received public funding. Many cases establish the contrary. *E.g.*, *id.* at 1008; *Hodge v. Paoli Mem'l Hosp.*, 576 F.2d 563, 564 (3d Cir. 1978) (per curiam) (collecting cases).

- Finally, Appellants can point to no case (whether in a medical context or otherwise) in which a private party's benefiting from a statutory immunity scheme made it a state actor. Many cases explicitly reach the opposite conclusion. *E.g.*, *Goss v. Memorial Hosp. Sys.*, 789 F.2d 353, 356 (5th Cir. 1986) (immunity for medical peer review committees did not make them state actors).

Unable to find a single case supporting their state-action position, Appellants and the State resort to cherry-picking favorable one-liners from Supreme Court decisions. Removed from their factual context, these quotations make Appellants' and the State's state-action arguments appear superficially plausible. There is a good

reason Appellants and the State avoid these cases' facts: when they are closely examined, Appellants' and the State's state-action arguments fall apart.[18]

1. A private party's use of a State-created procedure is not state action.

Appellants focus their state-action arguments on the fact that the State created the §166.046 procedure. In analyzing this argument, this Court must remember that §166.046 provides a discretionary, not mandatory, procedure; it issues no directives to any physician or hospital. *See* TEX. HEALTH & SAFETY CODE §166.045(c) (providing that if an attending physician does *not* wish to follow the procedure established under §166.046, life-sustaining treatment must be provided, but only until a reasonable time has been afforded for the patient's transfer). The Supreme Court has repeatedly held that "[a]ction taken by private entities with the ***mere approval or acquiescence*** of the State is not state action." *American Mfrs. Mut. Ins. Co. v. Sullivan*, 526 U.S. 40, 52 (1999) (emphasis added); *accord Blum*, 457 U.S. at 1004–05; *Flagg Bros., Inc. v. Brooks*, 436 U.S. 149, 154–55 (1978); *Jackson v. Metro. Edison Co.*, 419 U.S. 345, 357 (1974).

[18] The state-action inquiry has two parts. First, the deprivation must have been "caused by the exercise of some right or privilege *created* by the State"; and second, "the party charged with the deprivation must be a person who may fairly be said to be a state actor." *Lugar v. Edmondson Oil Co.*, 457 U.S. 922, 937 (1982) (emphasis added). Appellants and the State focus mostly on the second prong, but their argument fails at the first. Here, even assuming there is a deprivation, it is not caused by a State-created right. Rather, it is caused by a private healthcare provider's preexisting right not to provide services to another private person she deems inconsistent with her conscience, judgment, or ethics. Cook Children's may exercise this right regardless of §166.046's safe-harbor process.

Indeed, the "[p]rivate use of state-sanctioned private remedies or procedures does not rise to the level of state action." *Tulsa Prof'l Collection Servs., Inc. v. Pope*, 485 U.S. 478, 485–86 (1988); *accord Flagg Bros.*, 436 U.S. at 161–62. A physician or hospital making use of §166.046 is doing no more than using a State-provided remedy; the physician or hospital does not receive the type of "overt, significant assistance of state officials" that creates state action. *Pope*, 485 U.S. at 485–86; *cf. id.* at 487 (finding state action in private use of probate procedure, where probate court was "intimately involved" throughout each stage of the procedure's operation); *Lugar*, 457 U.S. at 941 (holding that private use of prejudgment-attachment procedure constituted state action, where acts by sheriff and court clerk showed "joint participation with state officials in the seizure of disputed property"); *Georgia v. McCollum*, 505 U.S. 42, 51–52 (1992) (finding state action in criminal defendant's use of racially discriminatory peremptory challenges because, without the court's participation and enforcement, there would be no peremptory challenges); *Edmonson v. Leesville Concrete Co.*, 500 U.S. 614, 615 (1991) (same, in a civil case).

Even compliance with a *mandatory* procedure does not implicate state action. Consider *Blum v. Yaretsky*, which both Appellants and the State cite without mentioning its close similarity to this case. In *Blum*, "a class of Medicaid patients challeng[ed] decisions by the nursing homes in which they reside[d] to discharge or

transfer [them] without notice or an opportunity for a hearing." 457 U.S. at 993.[19] Federal law ***required*** nursing homes to establish utilization review committees to "periodically assess[] whether each patient is receiving the appropriate level of care, and thus whether the patient's continued stay in the facility is justified." *Id.* at 994–95. The *Blum* plaintiffs were found by their respective URCs to not require a higher level of care and were therefore transferred to other institutions in accordance with the statutory procedure. *Id.* at 995.

Even so, the Supreme Court held that there was no state action: the nursing homes, not the state, initiated the reviews and judged the patients' need for care on their own terms, not on terms set by the state. The nursing homes' decisions "ultimately turn[ed] on medical judgments made by private parties according to professional standards that are not established by the State." *Id.* at 1008; *id.* at 1010 ("[T]hose regulations themselves do not dictate the decision to discharge or transfer in a particular case.").[20]

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[19] *Blum*, which concerned Medicaid patients and regulations, refutes Appellants' argument that, by providing Medicaid-funded care, "Cook [Children's] is an arm of the State." Appellants' Br. 31 n.26. Consistent with *Blum*, courts have consistently rejected the argument that a hospital is a state actor because it receives Medicaid, Medicare, or other public funding. *E.g.*, *Wheat v. Mass*, 994 F.2d 273, 275–76 (5th Cir. 1993); *Hodge v. Paoli Mem'l Hosp.*, 576 F.2d 563, 564 (3d Cir. 1978) (per curiam); *see also Rendell-Baker v. Kohn*, 457 U.S. 830, 840 (1982) (holding that private school was not state actor despite receiving most of its funding from the State).

[20] Following *Blum* and *Flagg Brothers*, the Fifth Circuit has held that private psychiatric hospitals do not become "state actors" when they hold patients pursuant to civil commitment statutes. *Bass v. Parkwood Hosp.*, 180 F.3d 234, 241–43 (5th Cir. 1999) (private hospital acting pursuant to Mississippi involuntary commitment statute was not "state actor" for purposes of section 1983 action); *see also Lewis v. Law-Yone*, 813 F. Supp. 1247, 1254 (N.D. Tex. 1993) (patient's section

As in *Blum*, the decision to abstain from providing medically unnecessary artificial life-support —and thus whether to initiate the §166.046 procedure— originates with the physician, who acts according to his own conscience, expertise, and ethics. *See Blum*, 457 U.S. at 1009 (noting that nursing homes' transfer decisions were based on judgments that "the care [the patients] are receiving is medically inappropriate"). As in *Blum*, the State does not determine when or for what reasons a physician may invoke the §166.046 procedure, nor does it "dictate the decision to" withdrawal or continue artificial life-support. *Id.* at 1010. And *unlike* in *Blum*, use of §166.046 is permissive, even for physicians wishing to abstain. This case thus fits easily within *Blum*'s no-state-action holding.

West v. Akins, which the State also briefly mentions, State's Br. 23, provides a useful counterpoint to *Blum* and demonstrates the unusual circumstances that must be present to deem a private healthcare provider a state actor. *West* concerned a "private physician" who "provided orthopedic services to inmates" pursuant to a contract with the State. 487 U.S. 42, 44 (1988). The patients he treated were "not free to employ or elect to see a different physician." *Id.*

1983 claim against private psychiatric hospital and doctors failed because they were not "state actors," even though suit concerned their compliance with voluntary commitment procedures established by Texas statute). "Merely because a state provides a scheme by which private parties can effectuate a process does not mean that the private parties become state actors by implementing such a process." *Lewis*, 813 F. Supp. at 1255.

The Court held that the doctor was a state actor, but it did so on extremely narrow grounds. Because the plaintiff was incarcerated, meaning that the plaintiff could only receive care from the doctors the state chose, the state owed the plaintiff "an affirmative obligation to provide adequate medical care. *Id.* at 55–56. Even though the physician was not a state employee, the state used him to "fulfill [*its own*] obligation" to the prisoner. *Id.* at 55. Thus, the plaintiff's "deprivation was caused, in the sense relevant for state-action inquiry, by the *State's exercise of its right to punish* [the plaintiff] by incarceration *and to deny him a venue independent of the State* to obtain needed medical care." *Id.* (emphasis added). In other words, in treating the patient, the physician was a tool of the state.

This case resembles *Blum*, not *West*. Appellants are free to seek medical care outside of Cook Children's, which has in fact provided them enormous assistance in their search for a different facility. More important, Cook Children's is in no sense acting in the State's stead. The State is not even constitutionally obligated to provide T.L. medical care, much less is Cook Children's providing such care on the State's behalf.

Cook Children's is a private hospital that has utilized a State-created *voluntary* remedy. No precedent holds that, in doing so, it becomes a state actor.

2. The State's provision of safe harbor does not make Cook Children's a state actor.

Both Appellants and the State place great emphasis on the fact that a healthcare provider that utilizes §166.046's procedure has safe harbor from civil, criminal, and professional liability. Indeed, the State characterizes this as a type of "encouragement" that further state action. Again, the cases Appellants and the State cite do not support their arguments.

In *Flagg Brothers*, the Supreme Court held that a person does not become a state actor because he uses a state-provided remedy that gives him safe harbor. In that case, the plaintiff sued to stop a warehouse from selling, pursuant to a warehouseman's lien, goods she had abandoned at the warehouse. *See* 436 U.S. at 153–54. Like in this case, state law provided the warehouse a procedure for making the sale and absolved it from liability if it complied. *See id.* at 151 n.1. The Court rejected the argument that the statute, or the state's decision to deny relief against the warehouse, constituted state action:

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

Id. at 165. As in *Flagg Brothers*, the Legislature's mere "denial of judicial relief" where a physician complies with §166.046 does not "convert[]" the physician's decision "into [a] public act[]." *Id.*

Coming even closer to this case's precise facts, the Fifth Circuit has applied *Flagg Brothers* to a medical peer-review committee. In *Goss*, 789 F.2d at 356, the court considered a provision of the Texas Medical Practice Act that immunized hospitals' medical peer review committees from civil liability for reporting physician incompetency to the Board of Medical Examiners.[21] The plaintiff argued "that this immunity granted appellees by the State of Texas provided such encouragement to appellees that the peer review committee acted as an investigatory arm of the state." *Id.* The Fifth Circuit rejected this argument, writing that the conferral of immunity "did not make the action of appellees state action." *Id*.

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

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

The State's "encouragement" argument adds nothing to this analysis. According to the State, the safe-harbor provision is an "incentive" that "strongly encourages providers to follow section 166.046's committee-review procedure." State's Br. 21–22. The State relies foremost on *Blum*, which—when its facts are considered—actually negates the State's argument. In *Blum*, unlike here, the nursing homes' use of the utilization-review-committee procedure was *mandatory*. It *still* did not constitute state action because the decision when to invoke the procedure belonged exclusively to the hospital, and the "State is simply not responsible for *that* decision." *See* 457 U.S. at 1008 n.19. Likewise, here, Cook Children's alone decides when the surrogate's desires and the physicians' conscience are sufficiently in conflict to initiate the procedure, and the committee makes a decision for the private hospital using its own private criteria. The State has no role in, and is not responsible for, these decisions.

Similarly, the Court explained in *American Manufacturers* that while the State's creation of a remedy and incentives for using it can "be seen as encourag[ement]" in some sense, "this kind of subtle encouragement is no more significant than that which inheres in the State's creation or modification of any legal remedy." 526 U.S. at 53. But the Court has "never held that the mere availability of a remedy for wrongful conduct, even when the private use of that remedy serves important public interests, so significantly encourages the private activity as to make

the State responsible for it." *Id.*; *accord Flagg Bros.*, 436 U.S. at 165 ("If the mere denial of judicial relief is considered sufficient encouragement to make the State responsible for those private acts, all private deprivations of property would be converted into public acts whenever the State, for whatever reason, denies relief sought by the putative property owner.").

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

3. There is no State coercion sufficient to deem Cook Children's actions those of the State.

Relying again on *Blum* and *American Manufacturers*, the State argues that §166.046's procedure "is predicated on the State's exercise of coercive power over the provider," namely its requirement that a provider maintain the status quo (i.e., continue to provide artificial life-support) while it utilizes the §166.046 procedure or otherwise gives the patient a reasonable time to seek transfer. State's Br. 21. Neither case the State cites supports its argument, which would convert a vast array of private conduct into State action.

It is true that *Blum* mentioned in passing that the State "can be held responsible for a private decision" if "it has exercised coercive power . . . [such] that the choice must in law be deemed to be that of the State." 457 U.S. at 1004. Yet the circumstances in *Blum*, which resemble those in this case more than any other

Supreme Court decision, were deemed *not* to constitute coercion of that level despite the fact that the procedure at issue was mandatory.

No less than the §166.046 procedure, the utilization-review-committee procedure in *Blum* could be seen as "use[of] the coercive power of [federal] law to control the provision of care." State's Br. 21. After all, the effect of the regulations in that case was to determine whether the nursing homes' patients would continue to receive care or would be discharged. *See* 457 U.S. at 1005. Thus, the federal government "insert[ed] itself into the dispute" between the patient and the nursing home without converting the home's private conduct into state action. State's Br. 21.

The State's coercion argument ultimately fails because it misunderstands what the Supreme Court means by the term "coercion." Coercion does not occur because the State has regulated a private party or given it the power to take some optional action. It exists when the private party was coerced into making the specific decision for which it is sued—here, withdrawing medically unnecessary artificial life-support. *See, e.g.*, *San Francisco Arts & Athletics, Inc. v. U.S. Olympic Committee*, 483 U.S. 522, 547 (1987) (holding that the Olympic Committee's enforcement of its government-granted trademark rights was not state action because there was "no evidence that the Federal Government coerced or encouraged the [Committee] in the *exercise* of its right" (emphasis added)); *S.P. v. City of Takoma Park, Md.*, 134 F.3d

260, 270 (4th Cir. 1998) (holding that use of involuntary-commitment statute did not constitute coercion because the statute, "while providing guidelines to mental health care providers, does not coerce, or even encourage, physicians to involuntarily commit individuals"). *Contra Sanchez v. Pereira-Castillo*, 590 F.3d 31, 52 (1st Cir. 2009) (holding that coercion sufficient to attribute a private party's action to the state existed where a private physician was conscripted by the State to perform exploratory surgery on a person in State custody).

This case is devoid of coercion of this type: the State did not coerce Cook Children's into invoking §166.046's procedure; more important, the State did not coerce the ethics committee into deciding that providing further medically inappropriate artificial life-support was unethical.[22] Those decisions—which are the basis for Appellants' claims—belong exclusively to Cook Children's.

As *Blum*'s holding suggests, the State's coercion argument proves far too much. Nearly every private transaction is shaded in some way by State regulation, which (as in this case) may provide minimum standards or limits that the parties' private contract may not cross. What the State argues—remarkably—is that when it

[22] The so-called coercion the State identifies is the Act's requirement that Cook Children's maintain the status quo (i.e., provide life-sustaining care) while the §166.046 procedure is utilized or while it seeks to transfer a patient. Appellants do not sue Cook Children's for maintaining the status quo. Furthermore, that provision of the Act is merely declaratory of the common law, which likewise required a physician to give a patient a reasonable opportunity to transfer before the physician terminated the doctor-patient relationship.

sets a minimum standard with which a party must comply in dealing with other private persons, the State "becomes a party" to that transaction such that the regulated party's actions are attributable to the State. *See* State's Br. 21. If this argument were taken seriously, nearly all private actors in regulated professions would become state actors, from doctors regulated by the Texas Medical Board, to attorneys governed by the State Bar and the Rules of Professional Conduct—and even to hairstylists, dieticians, and tow truck operators regulated by the Texas Department of Licensing and Regulation.

Because Cook Children's decision to refuse to provide medically inappropriate artificial life-support was not coerced, the State's argument fails.

4. Cook Children's has not been delegated a unique governmental function.

A private party's conduct can be attributed to the State when the private actor performs a function that is "traditionally the *exclusive* prerogative of the State." *Jackson*, 419 U.S. at 353 (emphasis added). For somewhat different reasons, Appellants and the State argue that this test has been met. It has not.

The functions that satisfy this test for state action are those "traditionally associated with sovereignty." *Id.* The test is "exceedingly difficult to satisfy." MARTIN A. SCHWARTZ, SECTION 1983 LITIG. CLAIMS & DEFENSES §5.14[A]. The Court has "rejected reliance upon the doctrine in cases involving":

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

Id. (footnotes omitted). Nothing Cook Children's does satisfies this exceedingly difficult standard.

The State primarily argues that in utilizing the §166.046 procedure, a hospital ethics committee "mimics a state adjudicatory body." State's Br. 23; *see also* Appellants' Br. 30–31. What the State means is that the committee reviews the circumstances and makes a decision. In doing so, however, the committee acts nothing like a court—because it was not intended to be one. Rather, ethics committees—fixtures in most hospitals—opine on questions of medical practice and ethics, which is what the committee does under §166.046. They have no judicial function and do not apply the law—a fact that remains true under §166.046, which does not ask the committee to resolve any legal question, only medical and ethical ones.

Importantly, medical decision-making—which is what this case and section 166.046 more generally involves—is a quintessentially ***private*** function. *See Blum*, 457 U.S. at 1011 ("We are also unable to conclude that the nursing homes perform a function that has been traditionally the exclusive prerogative of the State." (internal quotation marks omitted)). Even when overlaid with state regulation, a hospital's

decisions are its own—especially when they concern the ethics or medical appropriateness of providing care. *See id.* 1011–12 (holding that even if the state were obligated to provide nursing home services, "it would not follow that decisions made in the day-to-day administration of a nursing home are the kind of decisions traditionally and exclusively made by the sovereign").

Section 166.046 is a voluntary process for determining whether to terminate the doctor-patient relationship in a particularly fraught context. Decisions about whether to enter into and leave doctor-patient relationships represent a private negotiation between doctor and patient.[23] The state has not "traditionally" had a hand in defining that relationship's contours, must less has it been the state's "exclusive prerogative." Rather, a doctor's decision to terminate that relationship is left to his medical judgment and conscience, provided that he conforms to a non-statutory code of medical ethics. These private, personal decisions are not—and never have been—regarded as public functions. The doctors and hospital ethics committees who make these decisions are not state actors, and no due process interest is implicated.

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[23] The State recognizes that this decision is made by a private party—Cook Children's—without the State's involvement. It thus attempts to cast the State's *exclusion* from this decision as a form of state *action* by labeling Cook Children's private decision-making a form of "exclusive jurisdiction." State's Br. 23. This is pure sophistry. Private parties always have "exclusive jurisdiction" over whether to enter into or exit relationships with other private parties, but this does not convert their decision-making process about whether to do so into state action.

Furthermore, because the physician-patient relationship has traditionally been regarded as *private*, the State has not "outsource[d] adjudication" of that private dispute to private parties. State's Br. 24. It never had a role in the dispute in the first place, let alone an *exclusive* role.

Furthermore, adjudication in the sense in which the State uses it—an entity reviewing a person's decision, affirming it or not, and explaining its reasoning—is not in any sense exclusive to the State. To take just one example among thousands, every corporate human-resources department uses a similar process in determining whether an employee should face discipline. They are not state-actors for doing so. *See Klunder v. Brown Univ.*, 778 F.3d 24, 32–33 (1st Cir. 2015) (holding that a private university's "internal disciplinary" process did not constitute state action). Indeed, even the adjudication of *legal* disputes—which this case does not present—is often done by private parties, such as mediators and arbitrators, who are not state actors. *See Davis v. Prudential Secs., Inc.*, 59 F.3d 1186, 1191 (11th Cir. 1995) ("agree[ing] with the numerous courts that have held that the state action element of a due process claim is absent in private arbitration cases"); *accord Tulsa Prof'l*, 485 U.S. at 485 ("Private use of state-sanctioned private remedies or procedures does not rise to the level of state action.").[24]

* * *

Cook Children's is using a traditionally private mechanism (a hospital ethics committee) to make a traditionally private decision (whether to provide medical

[24] In more inflammatory fashion, Appellants argue that Cook Children's is a state actor because, in withdrawing medically unnecessary care, it acts as an "executioner[]." Appellants' Br. 33. Beyond misunderstanding how §166.046 functions, this argument fails for the same reason as the State's: whether and when to withdraw care is a traditionally private function.

care) using traditionally private standards (medical judgment and ethics). That it is doing so using a voluntary statutory procedure does not make it a state actor. *Blum*, 457 U.S. at 1011–12.

PRAYER

Appellee respectfully requests that the Court affirm the trial court's denial of a temporary injunction.

Respectfully submitted,

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Based on a word count run in Microsoft Word 2016, this brief contains 14,384 words, excluding the portions of the brief exempt from the word count under Texas Rule of Appellate Procedure 9.4(i)(1).

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