

**PROCEDURAL DUE PROCESS AND INTRAMURAL HOSPITAL  
DISPUTE RESOLUTION MECHANISMS: THE TEXAS ADVANCE  
DIRECTIVES ACT**

THADDEUS MASON POPE\*

ABSTRACT

*Increasingly, clinicians and commentators have been calling for the establishment of special adjudicatory dispute resolution mechanisms to resolve intractable medical futility disputes. As a leading model to follow, policymakers both around the United States and around the world have been looking to the conflict resolution provisions in the 1999 Texas Advance Directives Act (TADA).*

*In this article, I provide a complete and thorough review of the purpose, history, and operation of TADA. I conclude that TADA is a commendable attempt to balance the competing goals of efficiency and fairness in the resolution of these time-sensitive, life-and-death conflicts. But TADA is too lopsided. It is far more efficient than it is fair. TADA should be amended to better comport with fundamental notions of procedural due process.*

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\* Director of the Health Law Institute and Professor of Law, Mitchell Hamline School of Law; Adjunct Professor, Australian Centre for Health Law Research, Queensland University of Technology; Adjunct Associate Professor, Albany Medical College; Visiting Professor of Medical Jurisprudence, Saint Georges University. For valuable feedback, I thank Tom Mayo; QUT reviewers; and participants at the 28<sup>th</sup> Annual Saint Louis University Health Law Symposium (April 2016), the Loyola-DePaul Chicago Health Law Colloquium (Mar. 2015), the Quinnipiac-Yale Dispute Resolution Workshop (Feb. 2015), and an NYU Langone public lecture (Feb. 2015). This is a significantly expanded and updated version of an article prepared for an Australian conference and originally published in 16 QLD. U. TECH. L.R. 22–53 (2016).

## I. INTRODUCTION

Conflicts over the appropriateness of continuing life-sustaining medical treatment (LSMT) at the end of life are disturbingly common.<sup>1</sup> Dominant among these conflicts are “medical futility disputes.” In this type of end-of-life treatment conflict, intensive care unit (ICU) clinicians determine that it is medically and ethically appropriate to stop LSMT and focus on comfort measures only. But the patient’s surrogate decision maker will not consent to that treatment plan. Because LSMT can (or might be able to) sustain at least the patient’s biological life, the surrogate wants it continued.

Fortunately, most of these medical futility disputes can be resolved through informal consensus-building approaches.<sup>2</sup> Eventually, with intensive communication, negotiation, and mediation, the parties reach agreement. Nevertheless, a significant and growing number of these medical futility conflicts remain intractable.<sup>3</sup>

Few jurisdictions in the world have developed an adequate mechanism to handle this expanding subset of stalemate cases. But the few that have designed and implemented such mechanisms seem to enjoy some measure of success.<sup>4</sup> Accordingly, many clinicians and commentators elsewhere are calling for the establishment of similar special adjudicatory dispute resolution mechanisms.<sup>5</sup>

The paradigmatic adjudicatory dispute resolution mechanism is a court of law. But almost nobody thinks that is an appropriate model for this type of conflict.<sup>6</sup> First, litigation is cumbersome. It is both time consuming and

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1. See *infra* Section II.C.

2. See *infra* Section II.D to II.E.

3. See *infra* Section III.A.

4. This article focuses on the dispute resolution mechanism in TADA. The other most notable and innovative dispute resolution mechanism for medical futility disputes is the Ontario Consent and Capacity Board. See, e.g., ONT. CONSENT & CAPACITY BD., *Welcome*, <http://www.cboard.on.ca/scripts/english/index.asp> (last visited Oct. 28, 2016); see also *Cuthbertson v. Rasouli*, [2013] 3 S.C.R. 341 (Can.); Gabriel T. Bosslet et al., *Reason-Giving and Medical Futility: Contrasting Legal and Social Discourse in the United States with the United Kingdom and Ontario, Canada*, 150 AM. C. CHEST PHYSICIANS 714 (2016); Mark Handelman & Bob Parke, *The Beneficial Role of a Judicial Process When “Everything” Is Too Much?*, 11 HEALTHCARE Q. 46 (2008); Paula Chidwick & Robert Sibbald, *Physician Perspectives on Legal Processes for Resolving End-of-Life Disputes*, 14 HEALTHCARE Q. 69 (2011).

5. See *infra* Section III.B.

6. See generally ALAN MEISEL ET AL., *THE RIGHT TO DIE: THE LAW OF END-OF-LIFE DECISIONMAKING* § 3.26 (Wolters Kluwer 3d ed., 2015); Ashley Bassel, *Order at the End of Life: Establishing a Clear and Fair Mechanism for the Resolution of Futility Disputes*, 63 VAND. L. REV. 491, 508 (2010) (“Given the inconsistency and reluctance of courts in addressing futility disputes, many medical and legal scholars recognized the need for an alternative forum.”).

expensive.<sup>7</sup> Thus, it cannot usefully address complex, urgent medical issues. Moreover, because courts are adversarial and open to the public, they are an unwelcome forum in which to resolve sensitive medical treatment disputes worthy of privacy.<sup>8</sup>

In contrast to a court of law, the dispute resolution mechanism in the Texas Advance Directives Act (TADA) is tailor designed for medical futility disputes. It has been in operation for over seventeen years, and policymakers both around the United States and around the world have been looking to TADA as a model to follow.<sup>9</sup>

Because TADA is so frequently held up as a model to follow, it merits a careful and thorough examination. The purpose of this article is to critically evaluate TADA and answer three questions: (1) How do TADA's dispute resolution provisions work?, (2) Should other jurisdictions adopt them?, and (3) What changes are required to make TADA's dispute resolution provisions sufficiently fair?<sup>10</sup>

I will proceed in seven stages. In Section II, I provide a brief background on medical futility conflicts. I describe their nature and prevalence. I explain how they can usually be prevented and resolved informally. But, as the

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7. See PRESIDENT'S COMM'N FOR THE STUDY OF ETHICAL PROBLEMS IN MED. & BIOMED. & BEHAVIORAL RESEARCH, DECIDING TO FORGO LIFE-SUSTAINING TREATMENT: ETHICAL, MEDICAL, AND LEGAL ISSUES IN TREATMENT DECISIONS 159 (1983) (describing court involvement with treatment disputes as intrusive, slow, costly, and framed in adversarial terms). In futility disputes, for example, courts typically issue a temporary injunction ordering continued treatment pending a full evidentiary hearing, but the patient often dies in the meantime, mooted the dispute. Thaddeus Mason Pope, *Involuntary Passive Euthanasia in U.S. Courts: Reassessing the Judicial Treatment of Medical Futility Cases*, 9 MARQ. ELDER'S ADVISOR 229, 254 (2008).

8. See Alice Herb & Eliot J. Lazar, *Ethics Committees and End-of-Life Decision Making*, in MEDICAL FUTILITY AND THE EVALUATION OF LIFE-SUSTAINING INTERVENTIONS 110, 111 (Marjorie B. Zucker & Howard D. Zucker eds., 1997).

9. See *infra* Section III.C.

10. I have written extensively about other aspects of medical futility disputes: impact, reasons, consequences, and other solutions. This article focuses on only this one type of solution. See generally, e.g., Douglas White & Thaddeus Pope, *Medical Futility and Potentially Inappropriate Treatment*, in THE OXFORD HANDBOOK OF ETHICS AT THE END OF LIFE 65 (Stuart Younger & Robert Arnold eds., Oxford University Press 2016); Thaddeus M. Pope, *The Texas Advance Directives Act: Must a Death Panel Be a Star Chamber?*, 15 AM. J. BIOETHICS 42 (2015) [hereinafter *Death Panel*]; Thaddeus M. Pope, *Dispute Resolution Mechanisms for Intractable Medical Futility Disputes*, 58 N.Y. L. SCH. L. REV. 347 (2014) [hereinafter *Dispute Resolution Mechanisms*]; Thaddeus M. Pope, *Medical Futility*, in GUIDANCE FOR HEALTHCARE ETHICS COMMITTEES 88 (D. Micah Hester & Toby Schonfeld eds., Cambridge University Press 2012) [hereinafter *Medical Futility*]; Thaddeus M. Pope, *Surrogate Selection: An Increasingly Viable, but Limited, Solution to Intractable Futility Disputes*, 3 ST. LOUIS U. J. HEALTH L. & POL'Y 183 (2010) [hereinafter *Surrogate Selection*]; Pope, *supra* note 7; Thaddeus M. Pope, *Medical Futility Statutes: No Safe Harbor to Unilaterally Stop Life-Sustaining Treatment*, 75 TENN. L. REV. 1 (2007) [hereinafter *Medical Futility Statutes*].

growing attention on TADA indicates, medical futility disputes cannot always be prevented or resolved informally. In a significant subset of cases, the parties can find no common ground. So, there are, and will continue to be, intractable medical futility disputes.

In Section III, I review the need and demand for dispute resolution mechanisms for these remaining stalemate cases. The status quo is for clinicians to cave-in to surrogate demands for LSMT, even when they think that the administration of such interventions is medically and ethically inappropriate, or even cruel. Clinicians are legally risk averse and reluctant to cause a patient's death without consent, but their acquiescence to surrogate demands is reluctant. Many clinicians are unhappy with this status quo. Both individual clinicians and hospitals are eager to implement adjudicatory mechanisms to resolve these cases. They see TADA as a leading model.

In Section IV, I turn from explaining the context and motivation for TADA to an examination of the statute itself. First, I provide a brief history of TADA.<sup>11</sup> Second, I summarize TADA's dispute resolution provisions. I walk the reader, step-by-step, through the operation of all six stages of the dispute resolution process. Then, in Section V, I turn from the statutory text to examine TADA in operation on the ground. I describe how Texas hospitals have used TADA over the past seventeen years.

In Section VI, I turn from a descriptive approach to a normative approach. While TADA is extremely controversial, I argue neither for nor against the core idea that health care providers may withhold or withdraw LSMT without patient or surrogate consent. In other words, I am not evaluating *whether* clinicians should be able to stop LSMT without consent.<sup>12</sup> Instead, I am evaluating *how* the law authorizes them to do that.

Specifically, I evaluate the degree to which TADA comports with notions of procedural due process, the "oldest of our civil rights."<sup>13</sup> Please note that I am not offering a constitutional analysis of TADA. Instead, I am using (or borrowing) constitutional principles to evaluate fundamental fairness.<sup>14</sup> The

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11. I have provided an even more complete history of proposed and enacted amendments in the Appendix. See *infra* Appendix: Legislative History of TADA.

12. This debate continues. For example, United Kingdom clinicians generally may refuse LSMT without consent, but Ontario clinicians may not. See Hilary Young, Physician Conscientious Professional Discretion in Canada and the United Kingdom (June 30, 2016) (unpublished article) (on file with the University of New Brunswick), [http://papers.ssrn.com/sol3/papers.cfm?abstract\\_id=2802776](http://papers.ssrn.com/sol3/papers.cfm?abstract_id=2802776).

13. Edward L. Rubin, *Due Process and the Administrative State*, 72 CALIF. L. REV. 1044, 1044 (1984).

14. Not only have other scholars made constitutional arguments, but also a lawsuit challenging the constitutionality of TADA is scheduled for trial in 2017. *Kelly v. Methodist Hosp.*, No. 2015-69681 (Harris Cty. Tex. Jun. 10, 2017) (trial scheduled). Notably, the Texas

requirements of procedural due process under the Fifth and Fourteenth Amendments to the United States (U.S.) Constitution embody “tenets of fundamental fairness.”<sup>15</sup> Accordingly, they provide a useful “template to help measure” the propriety and fairness of TADA’s dispute resolution procedures.<sup>16</sup>

Finally, in Section VII, I conclude that TADA is not now sufficiently fair. But the flaws are neither fatal nor irremediable. State legislatures could easily remedy these defects with modest amendments that have already garnered widespread support among relevant stakeholders.

## II. BACKGROUND: MEDICAL FUTILITY DISPUTES

To appreciate the motivation for, and purpose of, TADA’s dispute resolution provisions, it is first necessary to understand the nature of medical futility disputes. Accordingly, in this section I explain: (1) what is a medical futility dispute, (2) that they are common, and (3) that they can often be prevented. Furthermore, (4) even when they cannot be prevented, medical futility disputes can almost always be informally resolved. TADA is designed to address only the small, yet significant, subset of cases that remain intractable to communication, negotiation, and mediation.

### A. *What is a Medical Futility Dispute?*

A medical futility dispute is one in which the parties disagree over whether to begin or to continue medical intervention. “The paradigmatic medical futility dispute is one in which the patient’s substitute decision maker (surrogate) requests aggressive treatment interventions for an imminently dying or catastrophically chronically-ill patient. However, that patient’s health care providers consider such treatment to be medically or ethically inappropriate.”<sup>17</sup>

Medical futility disputes can (and do) concern any type of medical intervention. But almost all of the relevant legislative and judicial activity, as well as most of the academic commentary, involve disputes over just one particular type of medical intervention: life-sustaining medical treatment. There are three distinctive features of disputes over whether to begin or to continue LSMT.

First, disputes over LSMT involve life-and-death stakes. “LSMT utilizes mechanical or other artificial means to sustain, restore, or supplant an

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Attorney General supports the constitutional challenge. Amicus Brief of the State of Texas at 1, *Kelly v. Methodist Hosp.* (D. Tex. 2016) (No. 2015-69681).

15. Thomas J. Balch, *Are There Checks and Balances on Terminating the Lives of Children with Disabilities? Should There Be?*, 25 GA. ST. U. L. REV. 959, 963 (2009).

16. *Id.*

17. *Dispute Resolution Mechanisms*, *supra* note 10, at 351.

individual's spontaneous vital function."<sup>18</sup> It is usually administered in a hospital ICU. The definition of "life-sustaining treatment" in TADA is typical. It means treatment that, "based on reasonable medical judgment, sustains the life of a patient and without which the patient will die. The term includes both life-sustaining medications and artificial life support, such as mechanical breathing machines, kidney dialysis treatment, and artificially administered nutrition and hydration."<sup>19</sup> "Typically, withholding or withdrawing LSMT will result in the patient's death."<sup>20</sup>

The second distinctive feature of medical futility disputes is that ICU patients dependent on LSMT almost never have decision-making capacity. They lack the "ability to understand the significant benefits, risks, and alternatives to proposed health care and to make and communicate a health care decision."<sup>21</sup> They cannot direct their own medical treatment. "Consequently, medical treatment decisions for ICU patients [almost always] must be made by a . . . surrogate."<sup>22</sup>

The third distinctive feature of medical futility conflicts concerns the identity of the disputing parties. The typical futility dispute is between the attending physician and the surrogate. The clinician says "stop," but the surrogate says "go." "The clinician thinks that [LSMT is] no longer medically indicated and that the appropriate treatment plan is for comfort measures only. The surrogate, on the other hand, rejects this proposed treatment plan, and directs the clinician to continue [LSMT]."<sup>23</sup>

### B. *The Move from Definitions to Process*

Since the late 1980s, writers and policymakers have articulated four main definitions of "medical futility." Two are narrowly circumscribed and defined by objective clinical criteria: (1) physiological futility and (2) medical ineffectiveness.<sup>24</sup> Two other positions also purport to "appear" neutral and scientific like the first two: (3) quantitative futility and (4) qualitative futility, but they actually include value-laden criteria.<sup>25</sup>

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18. *Id.*

19. *See, e.g.*, TEX. HEALTH & SAFETY CODE § 166.002(10) (1999). The definition of "life-sustaining treatment" in TADA is typical. It means treatment that "based on reasonable medical judgment, sustains the life of a patient and without which the patient will die. The term includes both life-sustaining medications and artificial life support, such as mechanical breathing machines, kidney dialysis treatment, and artificially administered nutrition and hydration." *Id.*

20. *Dispute Resolution Mechanisms, supra* note 10, at 351–52 (quoting DEL. CODE ANN. tit. 16, § 2501(d) (West 2013)).

21. *Id.*

22. *Id.* at 352.

23. *Id.*

24. *Id.* at 364, 367.

25. *Medical Futility Statutes, supra* note 10, at 32–42.

While the former two definitions have a mostly clear and definite meaning, finding consensus on the latter two definitions has proven problematic and elusive. Lawyers, bioethicists, health care providers, and policy makers have had enormous difficulty defining treatment that is “futile” or “medically inappropriate.” Years of debate have failed to produce any consensus. So, by the mid-1990s, many institutions, professional associations, and commentators abandoned a definitional approach. They abandoned delineating clinical indications that would “define” medical futility. Instead, paraphrasing Justice Potter Stewart’s comment on pornography, many concluded that we can only “know it when [we] see it.”<sup>26</sup> They instead espoused a procedural, process-based approach.<sup>27</sup>

A recent policy statement from five leading critical care medical associations reconfirms this procedural approach.<sup>28</sup> It includes four key elements. First, the policy statement recognizes that medical futility conflicts involve “contested value judgments about what is appropriate treatment.”<sup>29</sup> So, it would be problematic to give all decision-making authority either to surrogates or to individual clinicians. Second, the statement maintains that a process-based approach can “incorporate multiple perspectives to minimize the risk that the values of any one individual will carry undue weight.”<sup>30</sup> Third, it concludes that a “process-based approach[] better fulfills democratic ideals for resolving conflicts involving fundamental interests.”<sup>31</sup> Fourth, the policy statement predicts that a process-based approach “may allow mutually agreeable solutions to emerge as the conflict-resolution process unfolds over time.”<sup>32</sup>

### C. Medical Futility Disputes Are Common

Conflicts over LSMT in the ICU are common.<sup>33</sup> Indeed, they have recently been characterized as reaching “epidemic proportions.”<sup>34</sup> A large portion of these end-of-life treatment conflicts are medical futility disputes.<sup>35</sup>

26. *Jacobellis v. Ohio*, 378 U.S. 184, 197 (1964) (Stewart, J., concurring).

27. White & Pope, *supra* note 10; AM. MED. ASS’N, CODE OF MEDICAL ETHICS § 5.5 (2016).

28. Gabriel T. Bosslet et al., *An Official ATS/AACN/ACCP/ESICM/SCCM Policy Statement: Responding to Requests for Potentially Inappropriate Treatments in Intensive Care Units*, 191 AM. J. RESPIRATORY & CRITICAL CARE MED. 1318, 1319 (2015).

29. *Id.* at 1320.

30. *Id.* at 1323.

31. *Id.*

32. *Id.*

33. See, e.g., Terrah J. Paul Olson et al., *Surgeon-Reported Conflict with Intensivists About Postoperative Goals of Care*, 148 JAMA SURGERY 29 (2013) (“[M]ore than 70% of ICU clinicians report experiencing conflict weekly.”); John M. Luce & Douglas B. White, *The Pressure to Withhold or Withdraw Life-Sustaining Therapy from Critically Ill Patients in the*

The problem has been well measured and documented in several different ways. One is from the perspective of ethics consultation services. For example, several leading U.S. medical centers have reported that medical futility disputes comprise a significant percentage of their annual ethics consults: thirteen percent at Memorial Sloan Kettering,<sup>36</sup> twenty-nine percent at the University of Michigan Health System.<sup>37</sup> Stanford's Lucile Packard Children's Hospital and the Mayo Clinic have reported similar percentages.<sup>38</sup>

The frequency of medical futility conflicts is equally high when measured from the perspective of ICU clinicians. Several recent surveys of critical care specialists demonstrate significant levels of conflict over LSMT.<sup>39</sup> For

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*United States*, 175 AM. J. RESPIRATORY & CRITICAL CARE MED. 1104, 1107 (2007) (“[D]isagreements between families and clinicians on end-of-life care are commonplace in the United States.”).

34. Ann C. Long & J. Randall Curtis, *The Epidemic of Physician-Family Conflict in the ICU and What We Should Do About It*, 42 CRITICAL CARE MED. 461, 461 (2014).

35. See, e.g., James Downar et al., *Nonbeneficial Treatment Canada: Definitions, Causes, and Potential Solutions from the Perspective of Healthcare Practitioners*, 43 CRITICAL CARE MED. 270, 280 (2015); R.D. Piers et al., *Perceptions of Appropriateness of Care Among European and Israeli Intensive Care Unit Nurses and Physicians*, 306 JAMA 2694, 2700 (2011); Linda L. Maerz et al., *Futility and the Acute Care Surgeon*, 78 J. TRAUMA & ACUTE CARE SURGERY 1216, 1217 (2015) (“[D]isagreement between the medical team and the patient or surrogate was cited as the next most common barrier . . . [to limitation in goals of care when treatment has been determined to be futile].”). See also generally, Jean-Louis Vincent, *Forgoing Life Support in Western European Intensive Care Units: The Results of an Ethical Questionnaire*, 27 CRITICAL CARE MED. 1626 (1999); V.A. Palda et al., *Futile Care: Do We Provide It? Why? A Semistructured, Canada-Wide Survey of Intensive Care Unit Doctors and Nurses*, 20 J. CRITICAL CARE 207 (2005); Robert Sibbald et al., *Perceptions of “Futile Care” Among Caregivers in Intensive Care Units*, 177 CAN. MED. ASS’N J. 1201 (2007). Cf. Michael J. Fisch, *Advance Directives: Sometimes Necessary but Rarely Sufficient*, 1 JAMA ONCOLOGY 609, 609 (2015) (discussing the trend toward using aggressive care for patients at end of life because of the conflicts inherent in patients’ need to articulate their care wishes, and the ability of both the physician and the surrogate to act accordingly).

36. Andrew G. Shuman et al., *Clinical Ethics Consultation in Oncology*, 9 J. ONCOLOGY PRAC. 240, 241 (2013).

37. Lauren B. Smith & Andrew Barnosky, *Web-Based Clinical Ethics Consultation: A Model for Hospital-Based Practice*, PHYSICIAN EXECUTIVE J., Nov.–Dec. 2011, at 62, 64.

38. David Magnus, *Organizational Needs Versus Ethics Committee Practice*, AM. J. BIOETHICS, Apr. 2009, at 1, 2; Keith M. Swetz et al., *Report of 255 Clinical Ethics Consultations and Review of the Literature*, 82 MAYO CLINIC PROC. 686, 690 (2007) (finding that futility disputes are one of the primary reasons for hospital ethics consultations).

39. See, e.g., David Cape et al., *The Impact of the Rasouli Decision: A Survey of Canadian Intensivists*, 42 J. MED. ETHICS 180, 184 (2016). A Virginia survey found that forty-four hospitals referred 274 futility cases to their ethics committees in one year. These hospitals further reported that they refer only twenty percent of futility cases to their ethics committees. Andrew Mitchell, Staff Report: Development of Life-Sustaining Treatment Guidelines 11–13, in JOINT COMM’N ON HEALTH CARE, *Meeting Archives* (Sept. 7, 2016), <http://jchc.virginia.gov/3.%20Development%20of%20Life%20Sustaining%20Treatment%20Guidelines%20CLR.pdf>.

example, a widely-discussed 2014 study from University of California at Los Angeles found that twenty percent of the medical interventions in five of its ICUs were either futile or probably futile.<sup>40</sup> Other peer-reviewed surveys have found similarly high levels of conflict.<sup>41</sup>

Furthermore, not only is the volume of futility disputes already high, but it is also likely to rise even further.<sup>42</sup> There are three main reasons for this. First, the number of patients who are the subject of futility disputes will increase with continued growth in the aging population, in the burden of chronic illness, and in the “technologies used to support vital organ function.”<sup>43</sup> Second, not only is the number of patients growing, but also the rate of conflict is increasing. Physicians are increasingly more likely to recommend comfort measures only, instead of continuing aggressive, curative treatment.<sup>44</sup> This is the result of shifts both in training and in reimbursement incentives.<sup>45</sup> Third, at the same time that physicians are increasingly recommending comfort measures only, surrogates are increasingly likely to resist those recommendations. Largely for cultural, religious, and ethnic reasons, a growing proportion of Americans say that doctors should “[d]o [e]verything [p]ossible to [k]eep [p]atients [a]live.”<sup>46</sup>

40. Thanh N. Huynh et al., *The Frequency and Cost of Treatment Perceived to be Futile in Critical Care*, 173 JAMA INTERNAL MED. 1887, 1889 (2013).

41. Andrew M. Courtwright et al., *Experience with a Hospital Policy on Not Offering Cardiopulmonary Resuscitation when Believed More Harmful than Beneficial*, 30 J. CRITICAL CARE 173 (2015) (noting two disputes per month just regarding CPR); Whitney Huang, *Futile Medical Treatment Commonplace*, COMMONWEALTH MAG. (Nov. 13, 2014), <http://english.cw.com.tw/article.do?action=show&id=14865> (reporting rates of futilely-administered care of up to twenty-four percent among clinicians in Taiwan).

42. See Leigh Page, *Doctor Don't Give Up on Me*, MEDSCAPE (Mar. 16, 2016), <http://www.medscape.com/viewarticle/857725>.

43. Downar et al., *supra* note 35, at 271.

44. “More often . . . it is the medical team that [first] comes to the moment of declaring futility, concluding that further aggressive interventions are not accomplishing the patient’s goals of care, and often that additional medical interventions will only cause pain and suffering. When the family disagrees and insists that treatment continue, dispute arises.” CMTY. ETHICS COMM., MEDICAL FUTILITY: STRATEGIES FOR DISPUTE RESOLUTION WHEN EXPECTATIONS AND LIMITS OF TREATMENT COLLIDE 6 (2013).

45. See *Medical Futility Statutes*, *supra* note 10, at 13–19; Dana R. Lustbader et al., *Physician Reimbursement for Critical Care Services Integrating Palliative Care for Patients Who Are Critically Ill*, 141 CHEST 787, 789 (2012) (noting that “critical care codes support higher reimbursement than is available for services billed using standard E/M codes”); Sylvia M. Burwell, *Setting Value Based Payment Goals – HHS Efforts to Improve U.S. Healthcare*, 372 NEW ENG. J. MED. 897 (2015).

46. PEW RESEARCH CTR., VIEWS ON END-OF-LIFE MEDICAL TREATMENTS 1, 18 (2013); Lenworth M. Jacobs et al., *Trauma Death: Views of the Public and Trauma Professionals on Death and Dying from Injuries*, 43 ARCHIVES SURGERY 730, 732, 734 (2008); LAKE RESEARCH PARTNERS, ATTITUDES TOWARD END-OF-LIFE CARE IN CALIFORNIA 20 (2006) (noting that

*D. Many Futility Disputes Can Be Prevented*

Benjamin Franklin famously noted that “an Ounce of Prevention is worth a Pound of Cure.”<sup>47</sup> His advice applies here too. It is better to prevent futility disputes from arising in the first place than to work harder at resolving them after they have already arisen. In fact, prevention is not terribly complicated or difficult. “Most patients do not even *want* aggressive treatment at the end of life.”<sup>48</sup> Suppose that these patients still had capacity and could make their own treatment decisions. They and their clinicians would generally agree on the appropriate treatment plan. There would be no conflict.<sup>49</sup>

But such consensus is only theoretical. “[T]he patients who are the subjects of futility disputes almost always lack [decision-making] capacity and cannot make their own treatment decisions.”<sup>50</sup> Moreover, default rules are misaligned with majority preferences. Incapacitated patients are presumed to want LSMT unless they have adequately rebutted that presumption. Because most patients have not “opted out,” “they receive treatment that they would not have wanted and that their clinicians do not want to administer.”<sup>51</sup>

“Fortunately, rapidly expanding initiatives are helping patients to better understand their options and to better document their treatment preferences.”<sup>52</sup> But the needle is moving very slowly. Today, most patients still fail to adequately document their treatment preferences. If these patients had adequately documented their treatment preferences (declining LSMT when chronically critically ill), most futility disputes could be avoided.<sup>53</sup>

*E. Almost All Futility Disputes Can Be Informally Resolved*

While prevention is a first-choice approach, it is not always successful. “If prevention has failed and conflict [arises], informal [and internal] dispute resolution mechanisms [available within the hospital] work almost all of the

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twenty-seven percent of Californians believe that clinicians should “always do everything possible to save a life”).

47. Benjamin Franklin, *On Protection of Towns from Fire*, PA. GAZETTE (Feb. 4, 1735), quoted in Daniel Kiel, *An Ounce of Prevention is Worth a Pound of Cure: Reframing the Debate About Law School Affirmative Action*, 88 DENV. U. L. REV. 791, 791 (2011).

48. See LAKE RESEARCH PARTNERS, *supra* note 46, at 21.

49. *Dispute Resolution Mechanisms*, *supra* note 10, at 352–53.

50. *Id.* at 353.

51. *Id.*

52. *Id.*

53. Surrogates may not demand treatment that patients themselves have already declined. See *Surrogate Selection*, *supra* note 10, at 214. Similarly, clinicians may not administer treatments that patients themselves have already declined. Thaddeus Mason Pope, *Clinicians May Not Administer Life-Sustaining Treatment Without Consent: Civil, Criminal, and Disciplinary Sanctions*, 9 J. HEALTH & BIOMED. L. 213, 219–20 (2013).

time. Through further communication and mediation, consensus is reached in over [ninety-five percent] of medical futility cases.”<sup>54</sup>

If the treatment team is not getting anywhere with the surrogate, it can invite the intervention of ethics consultants, social workers, chaplains, palliative care clinicians, the ethics committee, external second opinions, and other experts. These other hospital resources are quite effective at achieving consensus.<sup>55</sup> Indeed, only a small portion of disputes remain intractable.<sup>56</sup>

Clinicians do not want to act contrary to their professional judgments. Nor do they want to act without patient or surrogate consent. In a medical futility dispute, these two objectives come into conflict. But they are neither irreconcilable nor mutually exclusive. Consistent with both of these objectives, there are three ways to reach consensus in a futility dispute.

54. *Dispute Resolution Mechanisms*, *supra* note 10, at 355; Thomas J. Prendergast et al., *A National Survey of End-of-Life Care for Critically Ill Patients*, 158 AM. J. RESPIRATORY CARE MED. 1163, 1163–64 (1998); Emily Ramshaw, *Bills Challenge Limits for Terminal Patients*, DALL. MORNING NEWS, reprinted in *News Archive*, SENATOR ELIOT SHAPLEIGH (Feb. 15, 2007), <http://shapleigh.org/news/1004-bills-challenge-limits-for-terminal-patients> (reporting the formal TADA process was used in only sixty-five of 974 futility disputes); Craig M. Nelson & Blanca Arriola Nazareth, *Nonbeneficial Treatment and Conflict Resolution: Building Consensus*, PERMANENTE J., Summer 2013, at 23, 24–25 (reporting consensus in eighty-seven of ninety-two cases); Daniel Garros et al., *Circumstances Surrounding End of Life in a Pediatric Intensive Care Unit*, 112 PEDIATRICS 371, 373 (2003). Cf. Ellen M. Robinson et al., *After the DNR: Surrogates Who Persist in Requesting Cardiopulmonary Resuscitation*, 47 HASTINGS CTR. REP., Jan. 2017, at 10, 12 fig. 1 (noting that nineteen of 134 conflicts were intractable).

55. Lance Lightfoot, *Incompetent Decisionmakers and Withdrawal of Life-Sustaining Treatment: A Case Study*, 33 J. L. MED. & ETHICS 851, 851 (2005) (“The vast majority of ethics consultations at Texas Children’s result in some form of compromise.”). On the other hand, some of these compromises may not be entirely knowing and voluntary. Instead of focusing on dispute prevention or dispute resolution, some clinicians focus on dispute avoidance. See David A. Asch et al., *Decisions to Limit or Continue Life-Sustaining Treatment by Critical Care Physicians in the United States: Conflicts Between Physicians’ Practices and Patients’ Wishes*, 151 AM. J. RESPIRATORY & CRITICAL CARE MED. 288, 291 (1995) (exploring how physicians withdraw LSMT on the basis of medical futility without the knowledge of the patient or family); David R. Brush et al., *Critical Care Physicians’ Approach to Negotiating with Surrogate Decision Makers: A Qualitative Study*, 40 CRITICAL CARE MED. 1080, 1083 (2012) (showing physicians deliberately misrepresent options to secure consent); Colleen Gallagher & Ryan F. Holmes, *Handling Cases of Medical Futility*, 24 HEC F. 91, 96 (2012) (recommending that clinicians not present some options).

56. This is the consensus rate not only in national studies but also in Texas. See, e.g., Ramshaw, *supra* note 54 (reporting there were “sixty five documented medical futility cases . . . in which the family disagreed with the ethics committee’s verdict” in a survey of “five years’ worth of data from eleven Texas hospitals, and two years’ worth of data from another five hospitals”); Robert L. Fine & Thomas Wm. Mayo, *Resolution of Futility by Due Process: Early Experience with the Texas Advance Directives Act*, 138 ANNALS INTERNAL MED. 743, 745 (2003) (finding that roughly six percent of futility consultations were unresolvable twenty-four months after TADA was implemented).

“First, as discussed above, the clinician might eventually get consent from the surrogate.”<sup>57</sup> With intensive communication and mediation, the physician and surrogate might find some common ground. Second, consensus might be reached by “replacing” the objecting clinician with a substitute. Sometimes, “the [treating] clinician [can] find a new health care provider willing to provide the treatment that the surrogate wants.”<sup>58</sup> While the current health care provider may be unwilling to administer the surrogate-requested treatment, it is sometimes possible to transfer the patient to another physician or facility that is willing to provide the disputed treatment. Third, if neither of these first two solutions is possible, the clinician is often able to replace the current surrogate. If the requested treatment really is harmful or non-beneficial, then the surrogate may not be complying with applicable decision-making standards. Through replacement, the clinicians obtain a new surrogate who will (hopefully) consent to the recommended treatment plan. “This is the mirror image of the second path to consensus. Instead of transferring the patient to a new *health care provider* who agrees with the surrogate, the clinician replaces the current surrogate with a new *surrogate* who agrees with the clinician.”<sup>59</sup>

But while surrogate selection is an effective mechanism for many disputes, it cannot resolve some significant categories of conflict. In many cases, it will be difficult for providers to demonstrate that surrogates are being unfaithful to patient instructions or preferences. Since too few individuals engage in adequate advance care planning, applicable instructions and other evidence regarding patient preferences are rarely available. Therefore, it is often impossible to demonstrate surrogate deviation. Other times, the available evidence shows that the surrogate is acting faithfully and making decisions consistent with the patient’s instructions, preferences, and values.<sup>60</sup>

In short, most futility disputes can be resolved through reaching consensus in one of three ways: (1) clinicians obtain consent from the current surrogate, (2) the clinicians and surrogate find another clinician or facility willing to provide the requested treatment, or (3) clinicians obtain consent from a new (replacement) surrogate.

But some conflicts are not amenable to any of these three solutions. “[E]ven impeccable communication and relational skills may not resolve conflicts that arise from fundamental difference in values between families and

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57. *Dispute Resolution Mechanisms*, *supra* note 10, at 356.

58. *Id.* See *infra* Section IV.C.5.

59. *Dispute Resolution Mechanisms*, *supra* note 10, at 356. See also *Surrogate Selection*, *supra* note 10, at 230–35; Mitchell, *supra* note 39, at 12 (reporting that ten percent of Virginia futility disputes were resolved by clinicians reaching consensus with a replacement surrogate).

60. See, e.g., *Cuthbertson v. Rasouli*, [2013] 3 S.C.R. 341, 345 (Can.). See also generally *Golubchuk v. Salvation Army Grace Gen. Hosp.*, [2008] MBQB 49 (Can. Man.) (affirming plaintiff’s argument that the surrogate was acting consistent with the patients’ values).

clinicians.”<sup>61</sup> In these intractable disputes, the clinician and surrogate are “stuck” with each other.

### III. TADA IS VIEWED AS A MODEL DISPUTE RESOLUTION MECHANISM

Unable to obtain the surrogate’s consent to the proposed treatment plan, most clinicians “cave-in” to surrogate demands. Physicians in most U.S. jurisdictions are afraid to refuse surrogate-requested treatment that they deem inappropriate or even cruel.<sup>62</sup>

In contrast, TADA has proven effective at allowing (or empowering) physicians to avoid providing medical treatment that they judge medically or ethically inappropriate. Accordingly, other jurisdictions have been looking to TADA as a model to follow.

#### A. *Clinicians Want Safe Harbor Legal Immunity*

Many medical facilities across the United States have developed policies for dealing with medical futility. Indeed, among other professional medical organizations, the American Medical Association (AMA) recommended a process-based approach. The AMA process includes seven steps: four aimed at “deliberation and resolution,” two aimed at securing alternatives in cases of “irresolvable differences,” and a final step aimed at “closure when all alternatives have been exhausted.”<sup>63</sup>

But with respect to this final step, the AMA correctly noted that “the legal ramifications of this course of action are uncertain.”<sup>64</sup> This uncertainty is “chilling” and deters clinicians from proceeding without surrogate consent.<sup>65</sup> “Immunity . . . is critical in the view of most, if not all, practicing

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61. Robert D. Truog, *Tackling Medical Futility in Texas*, 357 NEW ENG. J. MED. 1, 1 (2007).

62. See Thaddeus Mason Pope & Ellen A. Waldman, *Mediation at the End of Life: Getting Beyond the Limits of the Talking Cure*, 23 OHIO ST. J. ON DISP. RESOL. 143, 159, 189 (2007).

63. AM. MED. ASS’N COUNCIL ON ETHICAL & JUDICIAL AFFS., *Medical Futility in End-of-Life Care: Report of the Council on Ethical and Judicial Affairs*, 281 JAMA 937, 939 (1999). AM. MED. ASS’N, CODE OF MEDICAL ETHICS § 5.5 (2016).

64. *Id.* at 940.

65. *Medical Futility Statutes*, *supra* note 10, at 49–52.

physicians.”<sup>66</sup> In short, it is unclear how effective medical futility dispute resolution guidelines can be in the face of legal uncertainty.<sup>67</sup>

One Texas physician observed: “In my near [ten] year experience with consults related to medical futility, many a physician, nurse, and even hospital ethics committee member felt that certain treatments in a given case were futile and should be stopped; however, few were willing to do so in the face of potential legal jeopardy.”<sup>68</sup>

### B. Most Clinicians Accede to Surrogate Demands

In short, for clinicians, safe harbor legal immunity is not just attractive, it is essential. It allows providers to avoid practicing what they judge to be “bad” or “wrong” medicine.<sup>69</sup> In contrast, without safe harbor legal immunity, most clinicians usually “follow[] the path of least resistance”<sup>70</sup> and just provide the treatment.<sup>71</sup> Without legal protection, they “cave-in” to surrogate demands.<sup>72</sup>

66. Robert L. Fine, *Point: The Texas Advance Directives Act Effectively and Ethically Resolves Disputes About Medical Futility*, 136 CHEST 963, 965 (2009) [hereinafter *Texas Advance Directives Act*]. See also Robert L. Fine, *The Texas Advance Directives Act of 1999: Politics and Reality*, 13 HEC F. 59, 63 (2001) [hereinafter *Politics and Reality*]; Robert D. Truog, *Counterpoint: The Texas Advance Directives Act is Ethically Flawed*, 136 CHEST 968, 968 (2009) (“Clinicians are often reluctant to invoke their hospital policies without assurances of civil and criminal immunity . . .”).

67. Amir Halevy & Amy L. McGuire, *The History, Successes and Controversies of the Texas ‘Futility’ Policy*, 43 HOUS. LAW., May–June 2006, at 38, 38 (“[N]o cases went through the entire process . . . [because] residual legal uncertainty regarding the process still lingered.”).

68. Robert L. Fine, *Medical Futility and the Texas Advance Directives Act of 1999*, 13 BAYLOR U. MED. CTR. PROCS. 144, 145 (2000).

69. See Thaddeus Mason Pope, *Physicians and Safe Harbor Legal Immunity*, 21 ANNALS HEALTH L. 121, 121, 132–33 (2012) [hereinafter *Safe Harbor*]; Steve Connor, *Lord Saatchi: ‘Let New Cures be Tried out on Cancer Patients,’* INDEPENDENT (Oct. 13, 2013), <http://www.independent.co.uk/news/people/profiles/lord-saatchi-let-new-cures-be-tried-out-on-cancer-patients-8876504> (“Under current law, any deviation from standard procedure is likely to result in guilt for medical negligence, that is because current law defines medical negligence as deviation from standard procedure . . . Therefore the doctor is obliged to stick to the well-worn path even though the doctor knows that it leads to poor quality of life, followed by death.”); see also generally Emily R. Carrier et al., *High Physician Concern About Malpractice Risk Predicts More Aggressive Diagnostic Testing in Office-Based Practice*, 32 HEALTH AFFS. 1383 (2013) (supporting a need to temper deference and self-regulation with oversight without creating a distorting concern for legal risk).

70. *Texas Advance Directives Act*, *supra* note 66, at 964.

71. Tom Blackwell, *Doctors More Reluctant to Clash with Families over End-of-Life Decisions in Wake of Supreme Court Ruling*, NAT’L POST (Sept. 5, 2014), <http://news.nationalpost.com/news/canada/doctors-more-reluctant-to-clash-with-families-over-end-of-life-decisions-in-wake-of-supreme-court-ruling> (physicians are “more reticent about being aggressive in the face of family opposition”); Huang, *supra* note 41; Robert Cribb, *Stalemate: Deciding Life or Death*, TORONTO STAR (Sept. 26, 2014), <https://www.thestar.com/news/world/2014/09/26/stale>

But just because providers administer LSMT that they judge medically and ethically inappropriate does not mean that they are happy about it. Clinicians do not want to provide non-beneficial treatment.<sup>73</sup> Among other reasons, administering perceived non-beneficial treatment is a leading cause of moral distress and burnout among nurses and physicians.<sup>74</sup> So, many have been working to obtain legal safe harbor immunity like that provided by TADA.

### C. Attempts and Recommendations to Copy TADA

In a recent survey of over 700 clinicians, eighty-two percent agreed that current dispute resolution mechanisms for medical futility disputes are inadequate.<sup>75</sup> They want better and more effective mechanisms.<sup>76</sup> Specifically, most responding clinicians agreed that empowering a committee to arbitrate medical futility conflicts would be a good option.<sup>77</sup> While it is not the only option, a majority of clinicians want a non-judicial tribunal with adjudicatory power.

Many view TADA as a model or paradigm of what this type of dispute resolution mechanism should look like.<sup>78</sup> Consequently, it is no surprise that other U.S. states have been looking to copy TADA.

#### 1. Legislative and Judicial Efforts to Copy TADA

Some U.S. states have taken material, concrete steps to copy TADA. Idaho and Virginia took a legislative approach, while New Jersey tried to adopt TADA through the courts. None of these attempts were successful. But these undertakings themselves demonstrate the attractiveness of TADA.

mate\_deciding\_life\_or\_death.html; Mary Jane Dykeman, *A Year After Rasouli, End of Life Debate Continues*, LAWYERS WEEKLY, Nov. 28, 2014, at 12.

72. Thomas William Mayo, *The Baby Doe Rules and Texas's "Futility Law" in the NICU*, 25 GA. ST. U. L. REV. 1003, 1009 (2009) ("Without some measure of protection, physicians might seriously consider . . . passively going along with everything the surrogate decision maker asks for."); see also Sapna Kaul et al., *Physician Response to Patient Request for Unnecessary Care*, 21 AM. J. MANAGED CARE 823, 831 (2015).

73. See *Medical Futility Statutes*, supra note 10, at 17 ("[P]roviders resist inappropriate treatment requests out of concern for the patient.").

74. Daniel Schwarzkopf et al., *Perceived Nonbeneficial Treatment of Patients, Burnout, and Intention to Leave the Job Among ICU Nurses and Junior and Senior Physicians*, CRITICAL CARE MED. (forthcoming 2017); Annette M. Browning, *Moral Distress and Psychological Empowerment in Critical Care Nurses Caring for Adults at End of Life*, 22 AM. J. CRITICAL CARE 143, 144 (2013).

75. Downar, supra note 35, at 273.

76. See *id.* Managing conflicts of interest involves a considerable amount of staff time. Liz Forbat et al., *Conflict in a Paediatric Hospital: A Prospective Mixed-Method Study*, 101 ARCHIVES DISEASE CHILDHOOD 23, 24 (2016).

77. *Id.* at 274.

78. Fine & Mayo, supra note 56, at 746.

In February 2009, Idaho state Senator Patti Anne Lodge introduced Senate Bill (S.B.) 1114, which was closely patterned after TADA.<sup>79</sup> While the bill unanimously passed the Idaho Senate in March 2009, Idaho has a bicameral legislature. The bill was never favorably reported from a House committee.

For decades, Virginia law has provided that physicians need not “prescribe or render health care to a patient that the physician determines to be medically or ethically inappropriate.”<sup>80</sup> In cases of conflict, a Virginia physician must make a “reasonable effort” of at least fourteen days “to transfer the patient to another physician who is willing to comply with the request.”<sup>81</sup> But if no transfer is effected, it is unclear whether the physician could stop LSMT at the end of the fourteen days.

Proposed legislation sought to confirm that “the physician may cease to provide care that he has determined to be medically or ethically inappropriate.”<sup>82</sup> After that bill failed to advance, the legislature asked the Virginia Joint Commission on Health Care (VJCHC) to study the issue.<sup>83</sup> During 2016, the VJCHC considered proposals modeled explicitly on TADA.<sup>84</sup> Ultimately, the VJCHC rejected the TADA proposal and voted to “[i]nclude in the 2017 VJCHC work plan that staff form a work group to study health care decisions more broadly, focused on preventing/improving outcomes of treatment decision conflict in Virginia.”<sup>85</sup>

In New Jersey, the attempt to copy TADA did not take the form of a legislative bill as in Idaho and Virginia. Instead, it took the form of an appellate brief. The brief was authored by the New Jersey Hospital Association, the Medical Society of New Jersey, and the Catholic HealthCare Partnership of New Jersey.<sup>86</sup> These organizations asked the appellate division of the state superior court to judicially adopt provisions closely patterned on TADA.<sup>87</sup> As in Idaho, this attempt was unsuccessful. The court dismissed the case as moot after the patient died.<sup>88</sup>

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79. S. 1114, 60th Leg., 1st Reg. Sess. (Idaho 2009).

80. VA. CODE ANN. § 54.1-2990 (West 2009).

81. *Id.*

82. H.B. 2135, 2015 Leg., Reg. Sess. (Va. 2015).

83. H. J. Res. 61, 2016 Leg., Reg. Sess. (Va. 2016) (“RESOLVED by the House of Delegates, the Senate concurring, That the Joint Commission on Health Care be directed to study current legal and regulatory requirements regarding the medical appropriateness of life-prolonging care and options to clarify due diligence and the appropriate course of action when no physician can be found to carry out a patient’s requests.”).

84. Mitchell, *supra* note 39, at 27.

85. 2016 Meetings, VA. J. COMM’N ON HEALTH CARE (Nov. 9, 2016), <http://jchc.virginia.gov/meetings.asp> (under “Minutes”).

86. Brief & Appendix of Amici Curiae New Jersey Hospital Ass’n et al. at 1, *Betancourt v. Trinitas Hosp.*, 1 A.3d 823 (N.J. Super. Ct. App. Div. 2010) (No. A-003-849-08T2).

87. *Id.* at 59–64.

88. *Betancourt v. Trinitas Hosp.*, 1 A.3d 823, 825 (N.J. Super. Ct. App. Div. 2010).

## 2. Professional Organizations Endorse Copying TADA

Apart from formal judicial and legislative action to copy TADA, a significant number of professional organizations have endorsed copying TADA. These include medical associations, bar associations, and others. Medical societies in at least four states have passed resolutions calling on their legislatures to copy TADA. Medical associations in California,<sup>89</sup> North Carolina,<sup>90</sup> Washington,<sup>91</sup> and Wisconsin<sup>92</sup> considered such resolutions. Legal associations have done the same. For example, the New York State Bar Association published a similar recommendation.<sup>93</sup> And at a less formal level, major organizations in Maryland<sup>94</sup> and Connecticut<sup>95</sup> have held conferences and workshops exploring whether and how to follow TADA.

Furthermore, still others are looking to copy TADA, though in a less open and transparent manner. The authors and architects of TADA report that they get calls and inquiries from lobbyists and advocates all over the country.<sup>96</sup> Plans, strategies, and bills are being drafted and devised.<sup>97</sup>

## 3. Academic Literature Recommends Copying TADA

In addition to the efforts of legislatures, policymakers, and professional organizations, a number of commentators have argued that other states should follow TADA.<sup>98</sup> For example, one author concludes that “the Texas model

89. H.D. Res. 506–09, 2009 Leg., Ref. Comm. E (Cal. 2009).

90. Arthur E. Kopelman et al., *The Benefits of a North Carolina Policy for Determining Inappropriate or Futile Medical Care*, 66 N.C. MED. J. 392, 394 (2005).

91. WASH. STATE MED. ASS’N, OFFICIAL ACTIONS OF THE 2010 HOUSE OF DELEGATES, RES. A-2 – WSMA OPINION ON MEDICAL FUTILITY IN END-OF-LIFE CARE (2010).

92. WIS. MED. SOC’Y, *2004 House of Delegates Action on Resolutions and Board Reports*, 103 WIS. MED. J. 91, 91 (2004).

93. N.Y. STATE BAR ASS’N, HEALTH LAW SECTION, SUMMARY REPORT ON HEALTHCARE COSTS: LEGAL ISSUES, BARRIERS AND SOLUTIONS 4–5 (Sept. 2009).

94. Thaddeus Mason Pope, *Medical Futility & Maryland Law*, MID-ATLANTIC ETHICS COMM. NEWSL., 1, 1–2 (2011).

95. See generally Joan W. Feldman, Hartford Hosp. Ethics Comm., Medical Futility Summit: Medicine, Law & Ethics (Oct. 21, 2010).

96. Thomas Wm. Mayo, *Medical Futility in Texas: Myths and Misconceptions*, UT SOUTHWESTERN MED. CTR. (Apr. 8, 2014), <http://repositories.tdl.org/utswmed-ir/handle/2152.5/1405>.

97. TEX. HOSP. ASS’N, KEY MESSAGES ON TEX. ADVANCE DIRECTIVES ACT (2011) (“The law that Texas passed in 1999 has been a model for other states . . .”) (on file with author).

98. Michael Mazzeffi, *The High Cost of Dying*, BALT. SUN (Oct. 27, 2015, 12:43 PM), <http://www.baltimoresun.com/news/opinion/oped/bs-ed-dying-cost-20151027-story.html> (“Other states should consider similar laws.”).

offers an excellent blueprint for other states to follow.”<sup>99</sup> Others similarly assess TADA as a “thoughtful approach” and an “admirable project.”<sup>100</sup>

Not surprisingly, the Texas lawyers and physicians who were involved in innovating TADA believe that other states should follow suit. Every mother thinks that her child is the most beautiful. These architects and builders argue that “the extra-judicial dispute resolution mechanism found in the Texas Advance Directives Act should . . . serve as a national model that appropriately balances the interests of all involved parties in these difficult cases while still leading to a defensible solution.”<sup>101</sup>

But TADA’s founding fathers are not alone. Even independent scholars have similarly encouraged “other jurisdictions in the United States [to] consider codifying a procedure similar to the one in Texas.”<sup>102</sup> These recommendations have been widely published in medical journals,<sup>103</sup> nursing journals,<sup>104</sup> law journals,<sup>105</sup> and bioethics journals.<sup>106</sup>

99. Jacob M. Appel, *What’s So Wrong with Death Panels?*, HUFFINGTON POST (Nov. 22, 2009, 11:21 AM), [http://www.huffingtonpost.com/jacob-m-appel/whats-so-wrong-with-death\\_b\\_366804.html](http://www.huffingtonpost.com/jacob-m-appel/whats-so-wrong-with-death_b_366804.html). “A national medical futility law, modeled on the Texas Advance Directives Act of 1999, is a long-overdue and life-saving measure.” *Id.*

100. Michael Kapottos & Stuart Youngner, *The Texas Advanced Directive Law: Unfinished Business*, 15 AM. J. BIOETHICS 34, 34, 37 (2015).

101. Amir Halevy, *Medical Futility, Patient Autonomy, and Professional Integrity: Finding the Appropriate Balance*, 18 HEALTH MATRIX 261, 289 (2008); Kelley Shannon, *End-of-Life Legislation Dies in Texas House*, PLAINVIEW DAILY HERALD (May 23, 2007, 7:00 PM), <http://www.myplainview.com/news/article/End-of-life-legislation-dies-in-Texas-House-85262>

59.php/ (reporting that Rep. Dianne Delisi “hopes the proposed Texas legislation will be used as a model for other states”); *Texas Advance Directives Act*, *supra* note 66, at 967 (“[O]ther states should develop similar laws.”); Robert L. Fine, *A Model for End-of-Life Care*, WASH. TIMES (Sept. 6, 2009), <http://www.washingtontimes.com/news/2009/sep/06/a-model-for-end-of-life-care/>.

102. John M. Zerwas, Jr., *Medical Futility in Texas: Handling “Reverse Right-to-Die” Obstacles Without Constitutional Violation*, 43 TULSA L. REV. 169, 198 (2007).

103. Harris C. Jacobs, *The Texas Advance Directives Act—Is It a Good Model?*, 33 SEMINARS PERINATOLOGY 384, 389 (2009); Piotr Szawarski, *Classic Cases Revisited: Mr. David James, Futile Interventions and Conflict in the ICU*, 17 J. INTENSIVE CARE SOC’Y 244, 247 (2016) (“In the USA a fine example is provided by [TADA].”). *See also* Kopelman et al., *supra* note 90. *See also generally* Matthew H. Armstrong et al., *Medical Futility and Nonbeneficial Interventions: An Algorithm to Aid Clinicians*, 8 MAYO CLINIC PROCS. 1599, 1606 (2014); John Massie, *Medical Impasse: A Problem as Big as Texas?*, 50 J. PEDIATRICS CHILD HEALTH 658 (2014).

104. Jocelyn A. Olmstead & Michael D. Dahnke, *The Need for an Effective Process to Resolve Conflicts Over Medical Futility: A Case Study and Analysis*, 36 CRITICAL CARE NURSE, Dec. 2016, at 21, 22 (describing TADA as an “important attempt” and a “starting point”).

105. Mary Johnston, *Futile Care: Why Illinois Law Should Mirror the Texas Advanced Directives Act*, ANNALS OF HEALTH L. ADVANCE DIRECTIVE, Spring 2014, at 27, 36–38; Lisa L. Dahm, *Medical Futility and the Texas Medical Futility Statute: A Model to Follow or One to Avoid?*, HEALTH LAW., Aug. 2008, at 25, 31; Kendra Norman, *Live and Let Die: The*

## IV. TEXAS ADVANCE DIRECTIVE ACT

Now that we have established the reasons for examining TADA, we can turn to an examination of the statute itself. After providing a brief history of the legislation, I walk the reader through all six steps of its dispute resolution process.<sup>107</sup>

A. *What is TADA?*

The focus of this article is on the unique dispute resolution mechanisms in the Texas Advance Directive Act. TADA is a comprehensive health care decisions statute that comprises Chapter 166 of the Texas Health and Safety Code.<sup>108</sup> Chapter 166 is itself divided into four subchapters: (1) General Provisions, (2) Directive to Physicians, (3) Out-of-Hospital Do-Not-Resuscitate Orders, and (4) Medical Power of Attorney.<sup>109</sup> These four subchapters are themselves comprised of seventy-one separate statutory sections.

The dispute resolution provisions are just a small part of TADA. They comprise just four of TADA's seventy-one sections.<sup>110</sup> And they comprise just 700 of TADA's 15,000 words. In short, TADA does far more than just resolve medical treatment conflicts. Nevertheless, for the sake of convenience, I will refer to TADA's dispute resolution provisions simply as "TADA."

B. *History of TADA: 1993 to 1999*

In 1993, representatives from most of the major hospitals in Houston, Texas, formed the Houston City-Wide Task Force on Medical Futility.<sup>111</sup> They developed a nine-step procedure for resolving futility disputes. The goal of the

*Consequences of Oklahoma's Nondiscrimination in Treatment Act*, 68 OKLA. L. REV. 585, 613–18 (2015); see also, e.g., Patrick Moore, *An End-of-Life Quandary in Need of a Statutory Response: When Patients Demand Life-Sustaining Treatment That Physicians are Unwilling to Provide*, 48 B.C. L. REV. 433, 468 (2007).

106. Laurence B. McCullough, *Professionally Responsible Clinical Ethical Judgments of Futility*, AM. J. BIOETHICS, July 2015, at 54, 54; Kapottos & Youngner, *supra* note 100, at 34–35; Thaddeus Mason Pope, *Legal Briefing: Medical Futility and Assisted Suicide*, 20 J. CLINICAL ETHICS 274, 275 (2009). See also generally, e.g., Nancy S. Jecker, *Futility and Fairness: A Defense of the Texas Advance Directive Law*, AM. J. BIOETHICS, July 2015, at 43.

107. See *infra* Appendix: Legislative History of TADA.

108. TEX. HEALTH & SAFETY CODE § 166.001 (2015) (noting that "[t]his chapter may be cited as the Advance Directives Act").

109. See generally *id.* § 166.

110. *Id.* §§ 166.045, 166.046, 166.052, 166.053.

111. Amir Halevy & Baruch Brody, *A Multi-Institution Collaborative Policy on Medical Futility*, 276 JAMA 571, 571 (1996); Amir Halevy & Baruch A. Brody, *The Houston Process-Based Approach to Medical Futility*, 14 BIOETHICS F. 10, 11 (1998); Halevy & McGuire, *supra* note 67, at 39; Elizabeth Heitman & Virginia Gremillion, *Ethics Committees Under Texas Law: Effects of the Texas Advance Directives Act*, 13 HEC F. 82, 88 (2001).

taskforce was to create a common policy because the members thought that would be more ethically and legally defensible than individual facilities proceeding on their own.

But this was still insufficient. Making the protocol citywide made it seem more reasonable, but it still did not give the protocol the force of law. The guidelines had “no legal standing,”<sup>112</sup> and without a “positive statement in the law . . . the threat of malpractice litigation would force most physicians to honor families’ requests for even the most inappropriate aggressive treatment.”<sup>113</sup> As discussed above, safe harbor legal immunity is critical.<sup>114</sup>

Four years later, the state legislature was considering comprehensive TADA legislation intended to replace three prior laws: the Texas Natural Death Act from 1977, the Texas Medical Power of Attorney Act from 1989, and the Out of Hospital Do-Not-Resuscitate Act from 1993. In replacing these three older laws, TADA was intended to coordinate and update their provisions. The Houston dispute resolution procedures were largely incorporated into this bill.

In February 1997, Senator Mike Moncrief introduced TADA in S.B. 414.<sup>115</sup> By April, the bill passed the Senate, and by May, it passed the House.<sup>116</sup> But because of various amendments, the versions of S.B. 414 passed by each chamber were not identical. So, a conference committee prepared a report that both the House and Senate quickly adopted. However, when the final version of S.B. 414 was sent to Governor Bush, in June 1997, he vetoed it.<sup>117</sup>

Governor Bush’s veto proclamation noted that S.B. 414 contained “several provisions that would permit a physician to deny [LSMT] to a patient who desires them.”<sup>118</sup> Indeed, opponents had charged that S.B. 414 would “encourage medical professionals to participate in euthanasia . . . by denying life-saving medical treatment . . . to patients whose lives they independently

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112. Heitman & Gremillion, *supra* note 111, at 90.

113. *Id.* at 88.

114. *See supra* Section III.

115. S. 75-13, 75th Sess., at 227 (Tex. 1997).

116. S.B. 414, 1997 Leg., 75th Sess. (Tex. 1997); S. 75-43, 75th Sess., at 832 (Tex. 1997); H. 75-84, 75th Sess., at 3861 (Tex. 1997);

117. Heitman & Gremillion, *supra* note 111, at 90.

118. Proclamation by the Governor of the State of Texas (June 20, 1997) [hereinafter Governor’s Proclamation].

decide are not worth living.”<sup>119</sup> The Governor was concerned about these “potentially dangerous defects.”<sup>120</sup>

To address the Governor’s concerns, at least twenty-four interested organizations formed the Texas Advance Directives Coalition (Coalition).<sup>121</sup> Its membership included advisors from the legislative and executive branches. It included medical groups like the Texas Hospital Association and the Texas Medical Association, and it even included pro-life groups like Texas Right to Life and Texas Alliance for Life.<sup>122</sup> This was a remarkable collaborative. Despite this heterogeneous composition, the Coalition was able to reach a “watershed compromise.”<sup>123</sup> The Coalition reached consensus on safeguards and protections designed to resolve the “defects” that concerned Governor Bush.<sup>124</sup>

So, when the legislature reconvened in 1999, Senator Moncrief used the Coalition’s language to amend the vetoed 1997 legislation. He again introduced TADA.<sup>125</sup> By April, it passed the Senate, and by May, it passed the

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119. TEX. H. RES. ORG., HOUSE RESEARCH ORGANIZATION BILL ANALYSIS: CONSOLIDATING STATUTES GOVERNING LIVING WILLS AND OTHER ADVANCE DIRECTIVES 2 (1997), <http://www.hro.house.state.tx.us/pdf/ba75r/sb0414.pdf#navpanes=0>.

120. Governor’s Proclamation, *supra* note 118. As discussed below, nothing in the version of TADA that was ultimately enacted mitigates these risks. *See infra* Section VI.

121. *Politics and Reality*, *supra* note 66, at 63–67; Heitman & Gremillion, *supra* note 111, at 82–92; Hanoch A. Patt, *Strange Bedfellows: The Ethics and Politics of Medical Futility in Texas*, at 25 (unpublished Ph.D. dissertation, University of Texas School of Public Health) (on file with author).

122. *See* Dennis Pacl, Presentation to the Texas Medical Association: Report of Council on Health Service Organizations 19, <https://www.texmed.org/Template.aspx?id=4858> (noting some of the organizations involved in the Texas Advance Care Directives Coalition and a recommendation the TMA continue to work with the Texas Advance Directives Coalition). Members included: AARP, ADAPT-Texas, American Cancer Society, Catholic Health Association of Texas, Free Market Foundation, Institute for Disability Access, National Right to Life Committee, Texas Alliance for Life, Texas Association for Home Care, Texas Association of Homes & Services for the Aging, Texas Attorneys for Advance Directives, Texas Center for Disability Studies, Texas Health Care Association, Texas Healthcare Trustees, Texas Hospital Association (and eleven hospital affiliates), Texas Legal Services Center, Texas Medical Association, Texas Medical Directors Association, Texas Nurses Association, Texas & New Mexico Hospice Association, Texas Partnership for End-of-Life Care, Texas Physicians’ Resource Council, Texas Right to Life Committee, and United Cerebral Palsy of Texas. Richard J. Castriotta, Am. Coll. of Chest Physicians Annual Meeting: Protecting Patients: The TADA, and the Limits of Surrogate Directives (October 2013) (PowerPoint) (on file with author).

123. Ramshaw, *supra* note 54.

124. *See id.* (noting that the “watershed compromise” created the “ten-day transfer rule”).

125. *See* S.B. 1260, 1999 Leg., 76th Sess. (Tex. 1999). An identical bill, H.B. 3527, was introduced by Representative Garnet Coleman on the very next day in March 1999, but it was laid aside after S.B. 1260 had advanced to the House floor. *See generally* H.B. 3527, 1999 Leg., 76th Sess. (Tex. 1999).

House.<sup>126</sup> Governor Bush signed the bill on June 18, 1999. TADA went into effect on September 1, 1999.<sup>127</sup>

### C. *Dispute Resolution Provisions of TADA*

The TADA dispute resolution provisions address the situation in which “an attending physician refuses to honor a patient’s advance directive or a health care or treatment decision made by or on behalf of a patient.”<sup>128</sup>

With respect to LSMT, this can happen in two basic ways. First, the surrogate may be requesting LSMT that the physician thinks is inappropriate. Second, the surrogate may be refusing LSMT that the physician thinks should be provided.<sup>129</sup> The former situation (a medical futility dispute) is the far more common situation and the one on which this article focuses.

TADA encourages the “physician’s refusal” to “be reviewed by an ethics or medical committee.”<sup>130</sup> This review process is comprised of six basic steps that proceed in a roughly chronological order: (1) The attending physician refers the dispute to a review committee, (2) the hospital provides the surrogate with notice of committee review, (3) the review committee holds an open meeting, (4) the review committee makes its decision and provides a written explanation, (5) the hospital attempts to transfer the patient to a willing facility, and then (6) the hospital may stop LSMT.<sup>131</sup>

TADA mandates that hospitals continue to administer disputed LSMT during the first five steps of this review.<sup>132</sup> In addition, TADA specifies two situations under which the process can be shortened or extended.

#### 1. The Attending Physician Refers the Dispute to a Review Committee

In a futility dispute, at some point, the attending physician determines that one or more forms of LSMT are inappropriate. Since the default presumption is that all physiologically effective LSMT will be provided, the physician

126. *See* Tex. S.B. 1260.

127. *Id.* § 3.01; *see also* TEX. HEALTH & SAFETY CODE § 166.001 (1999) (effective Sept. 1, 1999).

128. HEALTH & SAFETY CODE § 166.046(a); *see also id.* § 166.002(7) (defining “health care or treatment decision” to include “consent, refusal to consent, or withdrawal of consent to health care, treatment, service, or a procedure to maintain, diagnose, or treat an individual’s physical or mental condition”).

129. TADA’s notice provisions specify separate notice statements for each situation. *See infra* Section IV.C.2.

130. HEALTH & SAFETY CODE § 166.046(a).

131. *Id.* § 166.046(a)–(e).

132. *Id.* § 166.046(a). *But see* H.B. 3074, 2015 Leg., 84th Sess. (Tex. 2015) (Springer), (TADA was recently amended to exempt clinically assisted nutrition and hydration from the types of affected LSMT).

ordinarily seeks the consent of the patient's surrogate to a proposed plan to withhold or withdraw treatment.<sup>133</sup> The surrogate refuses consent.

TADA includes no requirement that hospitals first exhaust less restrictive alternatives before invoking its formal process.<sup>134</sup> But while not required by TADA, the attending physician will typically work on obtaining the surrogate's consent through additional family meetings and the intervention of other specialists like chaplains and ethics consultants.<sup>135</sup> Such communication and mediation typically resolve the dispute.<sup>136</sup> But if none of this works (or even if it was never tried<sup>137</sup>), then the attending physician may invoke TADA's formal dispute resolution provisions.

TADA's dispute resolution procedures are written such that they could be invoked by patients, surrogates, or physicians,<sup>138</sup> but they are typically invoked by the attending physician.<sup>139</sup> They are triggered when the attending physician "refuses to honor a patient's advance directive or a health care or treatment decision made by or on behalf of a patient."<sup>140</sup> The attending physician notifies the review committee of her refusal, effectively asking or petitioning it to adjudicate the dispute.

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133. Indeed, even when clinicians have a legal right to withhold or withdraw LSMT without surrogate consent, they must still at least consult with the surrogate. *See, e.g.,* Tracey v. Cambridge U. Hosp. NHS Found. Trust [2014] EWCA Civ. 33 (appeal taken from Eng.); *Wawrzyniak v. Chapman & Livingstone*, 95903 C.P.S.O. (2015) (Coll. of Physicians and Surgeons of Ont.) (censuring physicians for failing to "take adequate steps to discuss the proposed change [in code status] or "to have a proper discussion" with the patient's SDM); *see also* Pope, *supra* note 7, at 257–58 (discussing liability for infliction of emotional distress in some instances where physicians "unilaterally withdr[a]w LMST").

134. In the matter of DP, 2010, CanLII 42949 (Can. Ont. C.C.B) (tribunal that decided dozens of futility conflicts refused because "the health practitioner had to do more before he could determine that [the surrogate] 'did not comply'").

135. Several bills aimed to amend TADA to first require an advisory ethics consultation. *See, e.g.,* S.B. 439, 2007 Leg., 80th Sess. § 4 (Tex 2007); H.B. 3474, 2007 Leg., 80th Sess. § 6 (Tex. 2007); S.B. 303, 2013 Leg., 84th Sess. § 2 (Tex. 2013).

136. *See supra* Section II.E. Because this is so successful, many think that TADA should require a consultation before formal review. *See, e.g.,* Mayo, *supra* note 72, at 1015.

137. The chairs of several Texas hospital review committees have informed the author that clinicians sometimes move to immediately invoke the formal dispute resolution mechanism without first trying more communication or mediation.

138. *See* Mayo, *supra* note 72, at 1005 n.8. ("[I]t can be invoked by patients, surrogates and physicians alike.")

139. TEX. HEALTH & SAFETY CODE § 166.046(a) (2015) ("If an attending physician refuses to honor . . .").

140. *Id.*

## 2. The Hospital Provides the Surrogate with Notice of Committee Review

Once the attending physician refers the case to the review committee, the committee will convene a “meeting” to consider the case.<sup>141</sup> Presumably to enable the surrogate to attend and meaningfully participate at the committee hearing, the hospital must inform the surrogate of the committee review process at least two days in advance.<sup>142</sup> Specifically, this notice must be provided “not less than [forty-eight] hours before the meeting called to discuss the patient’s directive, unless the time period is waived by mutual agreement.”<sup>143</sup>

At the same time that the hospital provides notice of the review committee meeting, it must also provide the surrogate with two written documents: (1) a statutorily-mandated written “statement” of rights<sup>144</sup> and (2) a state-maintained list of health care providers and referral groups.<sup>145</sup> TADA encourages, but does not require, the hospital to provide a third document, (3) which describes its committee review process.<sup>146</sup>

### a. The hospital provides the surrogate with a written statement of rights

While not in the original 1999 TADA, a 2003 amendment added specific language that hospitals must provide to surrogates.<sup>147</sup> The required written statement basically summarizes the surrogate’s rights in plain, less legalistic language.<sup>148</sup>

In cases in which the attending physician refuses to comply with an advance directive or treatment decision requesting LSMT, the required statement shall be in “substantially” the following form:

*When There Is A Disagreement About Medical Treatment: The Physician Recommends Against Life-Sustaining Treatment That You Wish To Continue*

You have been given this information because you have requested [LSMT], which the attending physician believes is not appropriate. This information is being provided to help you understand state law, your rights, and the resources

141. *Id.* § 166.046(b)(4).

142. *Id.* § 166.046(b)(2).

143. *Id.*

144. HEALTH & SAFETY CODE § 166.046(b)(3)(A).

145. *Id.* § 166.046(b)(3)(B).

146. Since TADA provides little direction on how a review committee is to operate, the process will vary from hospital to hospital. *Id.* § 166.046(b)(1).

147. *Id.* § 166.052(a).

148. *Id.* (stating a hospital’s statement need only be “substantially” in form specified in the statute).

available to you in such circumstances. It outlines the process for resolving disagreements about treatment among patients, families, and physicians.<sup>149</sup>

A similar statement must be provided when there is a disagreement about medical treatment in which the physician recommends LSMT that the surrogate wishes to stop.<sup>150</sup>

b. The hospital provides the surrogate with the state registry list

In addition to the “statement of rights,”<sup>151</sup> the hospital must also provide the surrogate with a copy of a state-maintained list of health care providers and referral groups that have “volunteered their readiness either to consider accepting transfer or to assist in locating a provider willing to accept transfer.”<sup>152</sup>

This list is maintained by the Texas Health Care Information Council (THCIC), an agency of the Texas Department of State Health Services. THCIC was created in 1995 to collect data and report on health care activity in hospitals and health maintenance organizations operating in Texas.<sup>153</sup> TADA requires the THCIC to “maintain a registry listing the identity of and contact information for health care providers and referral groups, situated inside and outside [Texas], that have voluntarily notified the council they may consider accepting or may assist in locating a provider willing to accept transfer of a patient.”<sup>154</sup>

As of December 2016, the list includes only three health care providers.<sup>155</sup> It also includes four law firms and two advocacy groups.<sup>156</sup> While the “registry list [of] health care providers and referral groups” is maintained by the THCIC, the State of Texas does not “endorse[] or assume[] any responsibility for any representation, claim, or act of the listed providers or groups.”<sup>157</sup> Furthermore, the listing of a provider or referral group in the registry “does not obligate the provider or group to accept transfer of or provide services to any particular patient.”<sup>158</sup>

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149. HEALTH & SAFETY CODE § 166.052(a).

150. *Id.* § 166.052(b).

151. *Id.* § 166.052.

152. *Id.* § 166.046(b)(3)(B).

153. *See id.* §§ 108.001–.016.

154. HEALTH & SAFETY CODE § 166.053(a).

155. TEX. HEALTH CARE INFO. COLLECTION CTR. FOR HEALTH CARE STATISTICS, TEX. DEP’T OF STATE HEALTH SERVS., *Registry List of Health Care Providers and Referral Groups*, <http://www.dshs.state.tx.us/thcic/Registry.shtm> (last updated Dec. 14, 2016).

156. *Id.*

157. HEALTH & SAFETY CODE § 166.053(a), (d).

158. *Id.* § 166.053(b).

- c. The hospital provides the surrogate with a description of its review process

While TADA requires hospitals to provide the “statement of rights” and the “registry list,” it merely suggests and recommends that the hospital also provide the surrogate with a third document: “a written description of the ethics or medical committee review process and any other policies and procedures related to this section adopted by the health care facility.”<sup>159</sup> Since TADA provides almost zero direction on how a review committee is to operate, the process will vary (often materially) from hospital to hospital.

### 3. The Review Committee Holds an Open Meeting

At this point, at least forty-eight hours before the review committee hearing, three things have happened. First, the attending physician has refused to honor the surrogate’s treatment decision for continued LSMT. Second, the physician has referred the case to the hospital review committee. Third, the surrogate has been apprised of her rights.

TADA does not authorize physicians to act unilaterally. The attending physician’s refusal must be reviewed by an “ethics or medical committee.”<sup>160</sup> But hospitals have significant discretion here. TADA is mostly silent as to the composition or training of the committee that reviews the dispute between the surrogate and clinician.<sup>161</sup> The statute provides only that “[t]he attending physician may not be a member of that committee.”<sup>162</sup>

With respect to the meeting itself, TADA provides that the surrogate is entitled to attend,<sup>163</sup> but it does not specify any other rules or procedures. TADA is silent on who else the surrogate may bring (e.g. an attorney, a religious adviser). It is also silent on the scope of the surrogate’s participation (e.g. right to ask questions).

While not specified in the statute, the review committee meeting typically proceeds in two stages. It “begins with a presentation from the attending physician and other members of the health care team.”<sup>164</sup> During this presentation, clinicians “provide reasoning and evidence to support why they

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159. *Id.* § 166.046(b)(1).

160. *Id.* § 166.046(a).

161. *Id.* § 166.002(6) (“‘Ethics or medical committee’ means a committee established under Sections 161.031-161.033.”).

162. HEALTH & SAFETY CODE § 166.046(a).

163. *Id.* § 166.046(b)(4)(A).

164. Robert W. Painter, *Developments in Texas Advance Directives*, HOUS. LAW., Sept.–Oct. 2009, at 20 (Painter also maintains a website, *Surviving Hospitals*, at <http://www.survivinghospitals.com/>).

believe further curative care would be medically futile.”<sup>165</sup> Most committees then “allow the patient and family to present their arguments and evidence.”<sup>166</sup>

#### 4. The Review Committee Makes Its Decision and Provides a Written Explanation

After the meeting, the review committee will usually deliberate in private, separate from the treating clinicians and family. Once it reaches a decision, the committee must prepare a “written explanation of the decision reached during the review process” and provide the surrogate with a copy.<sup>167</sup> This “written explanation” must also be included in the patient’s medical record.<sup>168</sup>

A hospital review committee’s consideration of a medical futility dispute typically results in one of three main outcomes. First, the committee can agree with the surrogate. Second, it can agree with the referring physician. Third, sometimes the conflict is mooted by the patient’s death or by subsequent family-clinician agreement.

First, if the review committee agrees with the surrogate, then the physician must make a reasonable effort to transfer the patient to a physician who is willing to comply with the surrogate. Hospital “personnel shall assist the physician in arranging the patient’s transfer to: (1) another physician; (2) an alternative care setting within that facility; or (3) another facility.”<sup>169</sup>

Second, if the committee agrees with the referring physician (and it usually does), then the dispute resolution process may continue. Published studies indicate that review committees agree with referring physicians in more than seventy percent of cases.<sup>170</sup>

Third, sometimes the conflict is mooted because the patient dies during the review process.<sup>171</sup> Other times, conflict is mooted because surrogates are persuaded by the fact that the review process affirms the attending physician’s

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165. *Id.*

166. *Id.*

167. HEALTH & SAFETY CODE § 166.046(b)(4)(B). TADA does not specify any particular format or minimum length or detail. *See also infra* Section VII.E.

168. HEALTH & SAFETY CODE § 166.046(c).

169. *Id.* § 166.046(d).

170. *See, e.g.,* Castriotta, *supra* note 122 (reporting that the Memorial Hermann review committee agreed in thirty of thirty-four cases); Courtwright et al., *supra* note 41, at 4 (reporting that the Optimum Care Committee at the Massachusetts General Hospital agreed with physicians in seventy-five percent of futility cases); *see also* Becca Aaronson, *A Texas Senate Bill Would Revise the State’s End-of-Life Procedure*, N.Y. TIMES (March 30, 2013), <http://www.nytimes.com/2013/03/31/health/state-senate-bill-would-revise-end-of-life-procedure.html> (reporting seventy percent agreement in a survey of 200 Texas hospitals over six years and that this rate of agreement is not unique to Texas review committees).

171. *See, e.g.,* Mitchell, *supra* note 39, at 12 (reporting that thirty-six percent of conflicts were resolved because the patient died).

decision that LSMT really is inappropriate treatment.<sup>172</sup> These surrogates are happy that the committee takes the burden of decision making off their shoulders.<sup>173</sup> On the other hand, some surrogates may consent because they experience the TADA process as *fait accompli*.<sup>174</sup>

But while some disputes are resolved by or during the review process, others are not. Some surrogates continue to request LSMT that both the attending physician and the ethics or medical committee concluded was inappropriate.

##### 5. The Hospital Attempts to Transfer the Patient to a Willing Facility

If the review committee agrees with the referring physician and the surrogate does not agree with that decision, then “the physician shall make a reasonable effort to transfer the patient to a physician who is willing to comply with the directive.”<sup>175</sup> Moreover, in these cases in which the surrogate is requesting LSMT “that the attending physician has decided, and the [review process] has affirmed is inappropriate treatment, the patient shall be given available [LSMT] pending transfer.”<sup>176</sup>

The rationale for this “reasonable effort to transfer” requirement is a recognition of variability in medical practice. The current treating facility is unwilling to provide the treatment requested by the surrogate, but another facility might be willing to provide that treatment.

In fact, it is unlikely that another physician at the same facility will accept a transfer at this point in the process. So, TADA further provides: “If the patient is a patient in a health care facility, the facility’s personnel shall assist

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172. Robert L. Fine, *The History of Institutional Ethics at Baylor University Medical Center*, 17 PROCS. BAYLOR U. MED. CTR. 73, 80 (2004) (“[F]amilies come to understand that there is a finite limit to the time that they can avoid accepting the treatment team’s recommendation. They come to understand that they are not in control of the situation.”); Martin L. Smith et al., *Texas Hospitals’ Experience with the Texas Advance Directives Act*, 35 CRITICAL CARE MED. 1271, 1273 (2007); Regina Okhuysen-Cawley et al., *Institutional Policies on Determination of Medically Inappropriate Interventions: Use in Five Pediatric Patients*, 8 PEDIATRIC CRITICAL CARE MED. 225, 228 (2007).

173. Fine, *supra* note 172, at 81; Robert D. Truog, *Medical Futility*, 25 GA. ST. U. L. REV. 985, 999 (2009).

174. See Tom Mayo, *Medical Futility in Texas: Myths and Misconceptions* (Apr. 8, 2014), <http://repositories.tdl.org/utswmed-ir/bitstream/handle/2152.5/1405/medical%20futility%20myths%20and%20misconceptions.pdf?sequence=2> (explaining that the “[e]thics consultation ‘roundtable’ discussion may be intimidating and coercive”); see also Nora O’Callaghan, *Dying for Due Process: The Unconstitutional Medical Futility Provision of the Texas Advance Directives Act*, 60 BAYLOR L. REV. 527, 544 (2008).

175. TEX. HEALTH & SAFETY CODE § 166.046(d) (2015).

176. *Id.* § 166.046(e).

the physician in arranging the patient's transfer to: . . . (2) an alternative care setting within that facility; or (3) another facility."<sup>177</sup>

The surrogate may concurrently look for a transfer on her own. She can use the "registry list" of health care providers and referral groups that have volunteered their readiness to consider accepting transfer or to assist in locating a provider willing to accept transfer. Surrogates may contact providers or referral groups on the list or others of their choice to get help in arranging a transfer. "The patient is responsible for any costs incurred."<sup>178</sup>

Just because the hospital must search for a transfer does not mean that it will find one. It is difficult to find another facility willing to accept a patient who was the subject of TADA. Few hospitals are willing to accept the transfer of a patient after another hospital's review committee has already determined that continuing LSMT is inappropriate.<sup>179</sup>

On the other hand, transfer is not impossible.<sup>180</sup> For example, the family of Spiro Nikolouzos transferred him from St. Luke's Episcopal Hospital to Avalon Place, a long-term care facility.<sup>181</sup> More recently, a June 2011 case at Texas Children's Hospital garnered significant media attention. Fourteen year-old Jordan Allen had been diagnosed months earlier with inoperable

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177. *Id.* § 166.046(d).

178. *Id.* § 166.046(e).

179. See Bosslet et al., *supra* note 28, at 1325; Leigh Hopper & Todd Ackerman, *Inside of Me, My Son Is Still Alive*, HOUS. CHRON. (Mar. 16, 2005) (reporting that the hospital treating Sun Hudson contacted forty facilities with a newborn intensive care unit but none would accept him); Mary Ann Roser, *Time Running Out for Baby on Life Support*, AUSTIN AM.-STATESMAN, Apr. 8, 2007, at B01 ("Children's Hospital . . . contacted [thirty] hospitals on behalf of Emilio [Gonzales] . . . [but] none would take him."). Commentators have observed that transfer is not a great safeguard. See, e.g., O'Callaghan, *supra* note 174, at 568–69; *Medical Futility Statutes*, *supra* note 10, at 25. Notably, before the imposition of EMTALA, hospitals were unwilling to accept transfers of even those patients for whom they thought treatment indicated. See, e.g., Sara Rosenbaum et al., *Case Studies at Denver Health: 'Patient Dumping' in the Emergency Department Despite EMTALA, the Law That Banned It*, 31 HEALTH AFFS. 1749, 1753 (2012).

180. See Smith et al., *supra* note 172 (reporting that hospitals effected transfers in thirty of 256 futility cases); see also, e.g., Mitchell, *supra* note 39, at 12 (reporting that two percent of conflicts were resolved because the patient was transferred); Ramshaw, *supra* note 54 (reporting that eleven patients were transferred after the review committee ruled against them). Organizations like Texas Right to Life that assist families with these transfers say they can be found, but not in ten days. See, e.g., Testimony on S.B. 439, S. Comm. on Health & Human Svcs. 293:10 (Apr. 25, 2007), [http://tlchouse.granicus.com/MediaPlayer.php?view\\_id=24&clip\\_id=2724](http://tlchouse.granicus.com/MediaPlayer.php?view_id=24&clip_id=2724) (Elizabeth Graham); see also *id.* at 388:45 (testimony of Brian Potts); *id.* at 399:40 (testimony of Elizabeth Graham).

181. ASSOCIATED PRESS, *Man in Center of Life-Support Debate Dies in San Antonio*, HOUS. CHRON. (June 1, 2005, 5:30 AM), <http://www.chron.com/news/houston-texas/article/Man-at-center-of-life-support-debate-dies-1498485.php>.

glioblastoma, a particularly lethal cancer.<sup>182</sup> Jordan's parents were able to transfer him, five days into the ten-day waiting period, to Atrium Medical Center, a nearby long-term acute-care facility.<sup>183</sup>

One additional reason that transfers are rarely found and made is that the time the hospital and surrogate have to find one is limited. The transfer period is not indefinite. After being served with the review committee's "written explanation," the surrogate has only ten days to accomplish a transfer.<sup>184</sup>

#### 6. The Hospital May Stop Life-Sustaining Treatment

The patient must continue to be given LSMT until he or she can be transferred to a willing provider. But the waiting period to find a transfer lasts for only ten days from the time the surrogate was given the committee's "written explanation" that LSMT is not appropriate. If a willing provider cannot be found within ten days, then the treating facility may withdraw LSMT.

Neither the physician nor the health care facility are "obligated to provide [LSMT] after the [tenth] day after the . . . written decision" is provided to the surrogate.<sup>185</sup> The inability to transfer is intended to serve as confirmation of the review committee's decision.<sup>186</sup> The refusal of other facilities to provide the disputed LSMT supposedly indicates or confirms that the review committee was correct. Accordingly, LSMT "under this section may not be entered in the patient's medical record as medically unnecessary treatment until the [ten-day waiting period] has expired."<sup>187</sup>

#### 7. Special Adjustments to Timing

The previous six steps fully describe the TADA dispute resolution mechanism, but TADA also specifies two situations under which this standard dispute resolution process can be shortened or extended. First, the process can

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182. Todd Ackerman, *Teen's Transfer Diffuses Life Support Battle*, HOUS. CHRON. (June 30, 2011), <http://www.chron.com/news/houston-texas/article/Teen-s-transfer-defuses-life-support-battle-2078227.php>.

183. *Id.*

184. O'Callaghan, *supra* note 174.

185. TEX. HEALTH & SAFETY CODE § 166.046(e) (2015).

186. The final step of the process is illustrated by the case of Tirhas Habtegeris, one of the rare cases in which a hospital was able to circumvent patient privacy rules and explain its actions under TADA. BAYLOR HEALTH CARE SYSTEM, *Tirhas Habtegeris Case: Media Statement*, <http://www.baylorhealth.com/articles/habtegeris.htm> (last visited Feb. 16, 2006), "reprinted in Thaddeus Pope, *Tirhas Habtegeris Case: Media Statement*, [http://thaddeuspope.com/images/FN173\\_Habtegeris\\_-\\_Baylor\\_Press\\_Release\\_Feb\\_2006\\_.pdf](http://thaddeuspope.com/images/FN173_Habtegeris_-_Baylor_Press_Release_Feb_2006_.pdf) (last visited Feb. 6, 2017)." Notably, Baylor had to take extra measures to defend its decision, because it was not perceived as fair because of the state-sanctioned process itself. *Id.*

187. HEALTH & SAFETY CODE § 166.046(f).

be shortened if the patient has already been the subject of a committee review. Second, the transfer period can be extended by court order.

a. Prior committee review can shorten the process

If, during a previous admission to a facility, a patient's attending physician and the review process have determined that LSMT is inappropriate and the patient is readmitted to the same facility within six months, then that hospital does not need to follow any of the above six steps.<sup>188</sup>

This makes sense. Suppose the patient is transferred from Hospital X to a long-term care facility. Then, the patient suffers an emergent issue such as respiratory distress and returns to Hospital X.<sup>189</sup> If the patient is in substantially the same condition, why start the entire dispute resolution process all over again from scratch? The result would probably be the same.

To bypass the dispute resolution process in these cases, the patient's attending physician and a consulting physician who is a member of the facility's review committee must confirm that the previous review committee decision is still applicable. They must document on the patient's readmission that the "patient's condition either has not improved or has deteriorated since the review process was conducted."<sup>190</sup>

b. Courts can sometimes extend the transfer waiting period

Just as TADA permits special circumstances to shorten the dispute resolution process, it also permits special circumstances to lengthen the process. TADA gives the surrogate only ten days to find a facility willing to provide disputed LSMT. But the surrogate can seek an extension by asking the "appropriate district or county court" to lengthen the ten-day period.<sup>191</sup>

But getting the court to elongate the ten-day period is not easy. The surrogate's ability to obtain a judicial extension of the transfer period is extremely limited. TADA permits the court to grant such an extension only if 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."<sup>192</sup>

Procedurally, these TADA lawsuits are typically initiated by the filing of an original petition that requests a temporary restraining order preventing discontinuation of treatment. An oral hearing for a temporary injunction normally follows within fourteen days, but the temporary restraining order may

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188. *Id.* § 166.046(e-1).

189. This is exactly what happened in one of the most famous U.S. futility cases. *See, e.g., In re Baby K*, 832 F. Supp. 1022, 1025 (E.D. Va. 1993), *aff'd*, 16 F.3d 590 (4th Cir. 1994).

190. HEALTH & SAFETY CODE § 166.046(e-1).

191. *Id.* § 166.052(a)(6).

192. *Id.* § 166.046(g).

be extended once for another fourteen days upon a showing of good cause.<sup>193</sup> “The court must grant additional time only if the patient establishes by a preponderance of the evidence that there is a reasonable expectation that another physician or health care facility will accept the patient and continue care.”<sup>194</sup>

Despite these restrictive standards, in several cases surrogates have been able to obtain either temporary restraining orders or preliminary injunctions.<sup>195</sup> Hospitals have also agreed to an extension just before a pending hearing.<sup>196</sup> However, in many other cases the courts have denied requests for extensions.<sup>197</sup>

#### D. TADA Provides Safe Harbor Legal Immunity

Importantly, TADA not only outlines a dispute resolution mechanism but also offers safe harbor legal immunity for following it. The statute provides: “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

193. Tex. R. Civ. P. 680.

194. Painter, *supra* note 164.

195. See, e.g., Plaintiff’s Response in Opposition to Houston Methodist’s Special Exceptions and Motion to Dismiss at 5, *Dunn v. Methodist Hosp.* (No. 2015-69681) (noting hospital did not remove life support as planned on November 24, 2015 and patient lived until December 23, 2015); Second Extension of Temporary Restraining Order at 3, *Gonzales v. Daughters of Charity Health Services of Austin*, No. 86,427 (Travis County Prob. Ct. May 18, 2007) (after parties agreed to extend from March 20 to April 10, the court extended to June 6); *Hudson v. Tex. Children’s Hosp.*, 177 S.W.3d 232, 234 (Tex. App. 2005); Kristina Herrndobler, *Court Keeps Woman on Life Support*, BEAUMONT ENTER., Aug. 11, 2006, at A1 (reporting a temporary restraining order in the case of Daisy Conner); *In re Nikolouzos*, 179 S.W.3d 581 (Tex. App. 2005) (granting an injunction on March 12, until an appeal could be assigned, even though ultimately finding on March 15 that it had “no jurisdiction to issue a writ of injunction”); Bill Murphy, *Comatose Surgeon Would Prefer Death*, HOUS. CHRON. (Mar. 21, 2001), <http://www.chron.com/news/houston-texas/article/Comatose-surgeon-would-prefer-death-physician-1995199.php> (the family sought a temporary restraining order in the case of Joseph Ndiyob); Emily Ramshaw, *Children Fight to Save Mom*, DALL. MORNING NEWS (Aug. 18, 2006), 2006 WLNR 14340226 (temporary restraining order granted for Ruthie Webster).

196. See Todd Ackerman, *Transfer Resolves Latest Futile Care Case*, HOUS. CHRON. (Jul. 31, 2006), <http://www.chron.com/news/houston-texas/article/Transfer-resolves-latest-futile-care-case-1488717.php>; see also Todd Ackerman, *Woman’s Death Won’t End Futile-Care Law Fight*, HOUS. CHRON. (May 9, 2006), <http://www.chron.com/news/houston-texas/article/Woman-s-death-won-t-end-futile-care-law-fight-1870531.php>; *Hudson v. Texas Children’s Hosp.*, 177 S.W.3d 232, 233–34 (Tex. App. 2005) (hospital extended ten-day deadline from November 29 to December 6, 2004, before the family filed suit).

197. See Lightfoot, *supra* note 55, at 854 (citing Final Order Denying Plaintiff’s Request for an Extension of Time under the Health & Safety Code Section 166.046(f), *Hudson v. Tex. Children’s Hosp.*, No. 352,526 (Harris County Prob. Ct. Tex. Mar. 14, 2005)); *Nikolouzos v. St. Luke’s Hosp.*, 162 S.W.3d 678, 679–80 (Tex. App. 2005) (dismissing the appeal of the temporary injunction for lack of jurisdiction).

disciplinary action by the person's appropriate licensing board if the person has complied with the procedures outlined in Section 166.046."<sup>198</sup>

This legal protection is important. Without it and unable to secure surrogate consent to stopping LSMT, providers generally continue to comply with requests that they consider inappropriate.<sup>199</sup> Moreover, the requirements for earning immunity under TADA are clear, measurable, and precise. So, health care providers can be sure about when they are qualified for safe harbor protection. This clarity is important. Legal immunity is effective only when providers have confidence and certainty about when they have it.<sup>200</sup>

#### *E. The TADA Process Is Optional*

While TADA outlines a six-step dispute resolution process with specific written disclosures and other details, using that process is optional. Hospitals may refuse requested LSMT without following these six steps. And they may still have liability protection.

TADA explicitly anticipates this situation in three separate sections. First, "[i]f 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," TADA simply requires that LSMT "be provided to the patient . . . only until a reasonable opportunity has been afforded for the transfer of the patient to another physician or health care facility willing to comply."<sup>201</sup> The physician's liability is limited, so long as she complies with the professional standard of care.<sup>202</sup> But since there is significant variability in ICU medicine, it is difficult for clinicians to ascertain the standard of care.<sup>203</sup>

Second, a separate section of TADA confirms that clinicians may also have rights under common law. "This subchapter does not impair or supersede any legal right or responsibility a person may have to affect the withholding or

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198. TEX. HEALTH & SAFETY CODE § 166.045(d) (2015). *See also id.* § 166.044 ("A physician or health care facility [or "health professional, acting under the direction of a physician"] that causes life-sustaining treatment to be withheld or withdrawn from a qualified patient in accordance with this subchapter is not civilly liable . . . criminally liable or guilty of unprofessional conduct.").

199. *See supra* Section III.A.

200. *Medical Futility*, *supra* note 10, at 96; *Medical Futility Statutes*, *supra* note 10, at 78; *Safe Harbor*, *supra* note 69, at 73.

201. HEALTH & SAFETY CODE § 166.045(c).

202. HEALTH & SAFETY CODE § 166.044. The difficulty of ascertaining the standard of care makes following this process riskier than following TADA, which is not linked to the standard of care. *Medical Futility*, *supra* note 10, at 96 (discussing operation of legal safe harbors). *See also generally Dispute Resolution Mechanisms*, *supra* note 10, at 359–66 (discussing the difference between laws that operate as green lights versus yellow lights).

203. Laura Hawryluck et al., *Multi-Professional Recommendations for Access and Utilization of Critical Care Services: Towards Consistency in Practice and Ethical Decision-Making Processes*, 39 J. L. MED. & ETHICS 254, 260 (2011).

withdrawal of [LSMT] in a lawful manner.”<sup>204</sup> This section imposes only one affirmative obligation: LSMT “is required to be provided [sic] the patient . . . until a reasonable opportunity has been afforded for transfer of the patient to another physician or health care facility willing to comply.”<sup>205</sup>

Third, TADA recognizes that LSMT may be denied to a patient in a triage situation. “This chapter may not be construed to require the provision of [LSMT] that cannot be provided to a patient without denying the same treatment to another patient.”<sup>206</sup>

## V. HOSPITAL EXPERIENCE WITH TADA

Now that we have examined how TADA works, we can turn to look at how hospitals have used it. Unfortunately, TADA has never included any reporting requirements.<sup>207</sup> Consequently, no thorough and systematic data exists describing how Texas hospitals have used TADA over the past seventeen years. Nevertheless, there are some small-scale studies. Some were conducted right after TADA went into effect in 1999. Some were conducted in the 2000s. And a few more recent studies have been conducted since 2010.

### A. *Early Hospital Experience with TADA (1999 to 2004)*

Baylor University Medical Center reported that in the twelve months before TADA, it had fourteen futility cases.<sup>208</sup> Of these, two patients died during the consultation process even with maintenance of LSMT.<sup>209</sup> In the other twelve cases, the family agreed to withdraw LSMT, but in one case it took the family about a month to agree.<sup>210</sup>

In the first sixteen months after TADA, Baylor reported thirty-six futility cases.<sup>211</sup> In twenty-nine, the family promptly agreed to withdraw LSMT and focus on palliative care.<sup>212</sup> “Five cases were pursued through the [TADA] dispute resolution process.”<sup>213</sup> In three of these, the family agreed after

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204. HEALTH & SAFETY CODE § 166.05.

205. *Id.* § 166.051.

206. *Id.* § 166.009.

207. Several bills have tried to add such a requirement. *See, e.g.*, S.B. 303, 2013 Leg., 83d Sess. (Tex. 2013). In contrast, every state that has authorized medical aid in dying has included a detailed reporting requirement. OR. REV. STAT. § 127.865 (2015); WASH. REV. CODE § 70.245.150 (2009); VT. STAT. ANN. tit. 18 § 5293 (2015); CAL. HEALTH & SAFETY CODE § 443.19 (2016); COLO. REV. STAT. § 25-48-111 (2016).

208. Fine, *supra* note 172, at 79.

209. *Id.*

210. *Id.*

211. *Id.*

212. *Id.*

213. Fine, *supra* note 172, at 79.

receiving the review committee's report.<sup>214</sup> In the remaining two cases, the patient died during the ten-day waiting period.<sup>215</sup>

*B. Later Hospital Experience with TADA (2005 to 2010)*

By the mid-2000s, several studies went beyond the walls of a single facility and measured the use of TADA more broadly. For example, a 2007 study surveyed 200 Texas hospitals. Respondents reported reviewing 256 futility cases over the first five years of TADA (1999 to 2004).<sup>216</sup>

The families of seventy-one patients agreed to discontinue treatment.<sup>217</sup> "Thirty patients were transferred to another facility," and seventy-eight patients died before the ten-day waiting period expired.<sup>218</sup> "[Eight] patients improved, . . . and appropriateness of treatment was reassessed."<sup>219</sup> After the waiting period expired, seventy-eight patients were still alive.<sup>220</sup> Hospitals discontinued treatment for thirty-three, and despite review committee decisions, hospitals continued treatment for forty-five.<sup>221</sup>

A second study looked at five years' worth of information from eleven large hospitals and two years' worth of data from five other large hospitals. The surveyed hospitals reported a total of 974 medical futility cases, but they used TADA in only sixty-five of those cases.<sup>222</sup> The hospitals actually withdrew treatment in only twenty-seven of those cases.<sup>223</sup> Twenty-two patients died receiving treatment as they awaited transfers.<sup>224</sup>

*C. Recent Hospital Experience with TADA (2010 to 2015)*

The most recent available data suggest that hospitals rarely use TADA.<sup>225</sup> The Texas Hospital Association (THA) surveyed its members in 2009, 2010, 2011, and 2012. THA reports that in 2009, the TADA dispute resolution

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214. *Id.*

215. *Id.*; Fine & Mayo, *supra* note 56.

216. Smith et al., *supra* note 172, at 1271–72.

217. *Id.* at 1273.

218. *Id.*

219. *Id.*

220. *Id.*

221. Smith et al., *supra* note 172, at 1273.

222. *Texas Advance Directives Act*, *supra* note 66, at 967.

223. *Id.*

224. *Id.*

225. "Jeanine Graf, medical director of the pediatric intensive care unit at Texas Children's Hospital in Houston, . . . told us she has served on that hospital's bioethics committee for at least [fifteen] years. Once a year or every other year, Graf said by phone, the committee decides a child's care should end because more care would be futile." W. Gardner Selby, *Texas Right to Life Exaggerates on Claim of 'Faceless Hospital Panel' Determining Treatment*, POLITIFACT (May 30, 2014, 5:40 PM), <http://www.politifact.com/texas/statements/2014/may/30/texas-right-life/texas-law-gives-hospital-panels-sway-over-cutting-/>.

process was initiated just two times at two multi-hospital systems.<sup>226</sup> In 2010, the TADA process was initiated only one time at one hospital system.<sup>227</sup> In 2011, usage ticked up. The THA survey shows that TADA was used twenty-one times by sixteen hospitals or hospital systems.<sup>228</sup>

In 2012, THA again surveyed its member hospitals. The 202 respondents reported that TADA had been used thirty times between 2007 and 2012.<sup>229</sup> “Of those cases, [ten patients] died during the [ten-day period], six patients were transferred to another provider and four continued [to receive] treatment past the [ten-day] period.”<sup>230</sup> Extrapolating from this sample of one-third of Texas hospitals, one might estimate that TADA is used fifteen times per year statewide.<sup>231</sup> And one can estimate that treatment is actually withdrawn only five times per year.<sup>232</sup>

On the other hand, the THA data may not be accurate or representative. A single hospital study at Memorial Hermann examined its TADA experience from 2000 to 2013.<sup>233</sup> The hospital reported that it had thirty-four cases during this time period (about 2.4 per year).<sup>234</sup> The committee agreed with the referring physician in thirty of the thirty-four cases. Of these, the families of three patients agreed to discontinue treatment, four patients were transferred, and seven died during the ten-day waiting period.<sup>235</sup> The hospital discontinued treatment for fifteen.<sup>236</sup>

#### D. Summary of Hospital Experience with TADA

While available studies suggest that Texas hospitals rarely use TADA, these understate the impact and effect of TADA for two reasons. First, the more recent unpublished studies indicate far lower usage rates than the published studies. Those unpublished studies may be neither statistically valid nor reliable. For example, it is unclear whether THA member hospitals are representative of all Texas hospitals.

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226. *Id.* (citing an email from Lance Lunsford, Vice President for Advocacy Communications, Texas Hospital Association, to POLITIFACT (May 21, 2014, 12:22 PM)).

227. *Id.*

228. *Id.*

229. Aaronson, *supra* note 170.

230. *Id.*

231. If TADA were used thirty times in six years, that is five times per year. If 200 hospitals represent one-third of all hospitals, then total usage is fifteen times per year.

232. *See* Aaronson, *supra* note 170.

233. Castriotta, *supra* note 122.

234. *Id.*

235. *Id.*

236. *Id.*

Second, focusing on only hospitals' actual use of TADA fails to account for its "shadow effect."<sup>237</sup> If families know the hospital has this "weapon," then they may (reluctantly) consent to the recommended treatment plan, precluding the need to formally resort to the TADA mechanism.<sup>238</sup> Analogously, in chess, the winner prevails not by actually taking the opponent's king but instead by merely demonstrating that the king's capture is inevitable.<sup>239</sup>

#### VI. TADA FAILS TO AFFORD ADEQUATE PROCEDURAL DUE PROCESS

I have now established the purpose, operation, and usage of TADA. In this section, I turn from a descriptive account to a normative account. Specifically, I evaluate and assess whether TADA affords adequate procedural due process. I conclude that it does not; TADA is not sufficiently fair.

I am not alone. TADA is often described as a "due process" approach.<sup>240</sup> But many charge that this due process "is more illusory than real."<sup>241</sup> Some legal commentators have colorfully observed that TADA affords hospital patients with fewer protections than other Texas law affords either to tenants facing eviction from rental property or to automobile owners threatened with repossession.<sup>242</sup> Even Texas hospital lawyers have conceded TADA's weaknesses.<sup>243</sup> Even TADA's primary authors admit that the law could be improved.<sup>244</sup>

237. Pope & Waldman, *supra* note 62, at 193. Analogously, the EEOC must conciliate before filing discrimination lawsuits against employers. 42 U.S.C. § 2000e-5(b). But since employers often desire to avoid litigation, the EEOC may not always make reasonable demands and conciliate in good faith. *Cf. Mach Mining v. EEOC*, 135 S. Ct. 1645 (2015).

238. Mayo, *supra* note 174, at slide 22.

239. U.S. CHESS FEDERATION, OFFICIAL RULES OF CHESS § 4A (Tim Just ed., 6th ed. 2014). Similarly, the impact of Senator McCarthy's investigations was not limited to those actually summoned to Washington. The impact extended far more widely, to many more who never spoke out, because they were afraid of becoming the target of investigation. NORMAN H. FINKELSTEIN, WITH HEROIC TRUTH: THE LIFE OF EDMUND R. MURROW 7 (2005) ("His accusations held . . . in fear . . . and an unwritten state of self-censorship enveloped the nation."); ARTHUR HERMAN, JOSEPH MCCARTHY: REEXAMINING THE LIFE AND LEGACY OF AMERICA'S MOST HATED SENATOR 220–21 (2000).

240. *See, e.g.,* Fine & Mayo, *supra* note 56, at 743.

241. Truog, *supra* note 61, at 3; Truog, *supra* note 173, at 1000. *See also* Robert D. Truog, *Tackling Medical Futility in Texas*, 357 NEW ENG. J. MED 1558, 1559 (2007) ("The law . . . fails to provide medical patients with basic due-process protections . . ."); Diana Wray, *In Texas, a Hospital Ethics Panel - Not the Patient or Family - Decides Whether to End Care*, HOUS. PRESS (Feb. 9, 2016, 5:00 AM), <http://www.houstonpress.com/news/in-texas-a-hospital-ethics-panel-not-the-patient-or-family-decides-whether-to-end-care-8141585>.

242. O'Callaghan, *supra* note 174, at 559–61.

243. *Hearing on S.B. 439, S. Comm. on Health & Human Svcs.*, 2:50:00 (April 12, 2007), [http://tlcsenate.granicus.com/MediaPlayer.php?clip\\_id=2943](http://tlcsenate.granicus.com/MediaPlayer.php?clip_id=2943) (testimony of Michael Regier); TEX.

Despite being framed as a matter of “due process,” this is not a constitutional analysis. The focus of the present inquiry is on fundamental fairness.<sup>245</sup> As U.S. law students quickly learn, a constitutional Fourteenth Amendment procedural due process analysis requires “state action.”<sup>246</sup> So, it may not be directly applicable to private, non-governmental hospitals. To be sure, some writers have assessed whether even a private hospital’s use of TADA constitutes “state action” such that constitutional protections are triggered.<sup>247</sup> But that is not our present concern.<sup>248</sup>

In this article, I look to constitutional requirements only as guideposts to assess TADA from an ethical and public policy perspective.<sup>249</sup> The elements of due process have been well developed in hundreds of court opinions, and they provide a cogent framework for our fairness analysis.<sup>250</sup> In short, I am going to

HOSP. ASS’N, *supra* note 97 (“[S]ome clarification in state law may be appropriate to make it easier for families to understand and participate in the decision-making process.”).

244. Mayo, *supra* note 72, at 1013 (“[A] number of amendments would make the law work more effectively, more ethically, and more fairly.”); *id.* at n. 36 (TADA is “the best that could have been coaxed out of a very diverse advisory panel . . .”); *id.* at 1017 (“[T]here are still ways for the law to be improved . . .”); *Texas Advance Directives Act*, *supra* note 66, at 967 (“The Texas law is certainly not perfect . . . [it] is the worst method for resolving intractable futility disputes, except for all the others . . . [I]t can clearly be improved . . . and other states should develop . . . improvements based on the experience in Texas.”).

245. *Potvin v. Metropolitan Life Ins. Co.*, 997 P.2d 1153, 1160 (Cal. 2000) (finding that even a private entity must afford due process when it holds significant power over the physician); *Greisman v. Newcomb Hosp.*, 192 A.2d 817, 825 (N.J. 1963).

246. *See generally* *Brentwood Acad. v. Tenn. Secondary Sch. Athletic Ass’n*, 531 U.S. 288 (2001).

247. *See generally, e.g.*, Nora O’Callaghan, *When Atlas Shrugs: May the State Wash Its Hands of Those in Need of Life-Sustaining Medical Treatment?*, 18 HEALTH MATRIX 291 (2008); Zerwas, *supra* note 102, at 183–92.

248. While several litigants have briefed challenges under both the federal and Texas constitutions, plaintiffs have not pursued such cases once the patient (usually due to death) no longer had a stake in the outcome. Consequently, no court has yet ruled in the constitutionality of TADA. *See, e.g.*, Plaintiff’s Verified Complaint at § VII, *Gonzales v. Seton Fam. of Hosps.*, 1:07-cv-00267, No. A07CA267 (W.D. Tex. Apr. 4, 2007); *see also* Notice of Removal, *Aguocha-Ohakweh v. Baylor College of Med.*, No. 4:16-CV-00903 (S.D. Tex. April 4, 2016). *See also generally* Plaintiff’s Original Petition; Application for Temporary Restraining Order, Temporary Injunction, and Permanent Injunction; and Request for Disclosure, *Gonzales v. Seton Family of Hosps.*, 1:07-cv-00267, No. 86427 (Travis Cty. Prob. Ct. Tex. Mar. 20, 2007); Order of Dismissal, *In re Roberson-Reese*, No. 04:06-cv-02258 (S.D. Tex. Aug. 17, 2006). On the other hand, at least one constitutional challenge is moving forward. Plaintiff’s Original Verified Petition and Application for Temporary Restraining Order and Injunctive Relief, *Dunn v. Methodist Hosp.*, No. 2015-69681 (Harris Cty. Dist. Ct. Tex., filed Nov. 20, 2015) (“This case is about whether it is constitutional to strip plaintiff of his life without due process of law.”).

249. *See* Balch, *supra* note 15. *Cf.* Diane A. Desierto, *Rawlsian Fairness and International Arbitration*, 36 U. PA. J. INT’L L. 939, 962 (2015).

250. *See, e.g.*, O’Callaghan, *supra* note 174, at 561.

borrow constitutional notions of procedural due process because they offer a relevant and lucid measure of fundamental fairness.

Before we begin assessing the degree to which TADA satisfies specific elements of due process, we must first be mindful of two overarching principles. First, more extensive due process is required when a more significant interest is impacted.<sup>251</sup> Here, the stakes are literally “life and death.” Therefore, particularly careful due process is required.<sup>252</sup>

Second, more due process is required when the “risk of error” is high.<sup>253</sup> Due process rules are “meant to protect persons not from the deprivation [itself] but from the mistaken or unjustified deprivation of life, liberty, or property.”<sup>254</sup> Here, there is an especially high risk error for two main reasons. First, futility determinations are not purely medical judgments but are the “product of exceedingly complex value judgments.”<sup>255</sup> Second, even to the extent that they are medical judgments, there are significant limits to accurate prognostication.<sup>256</sup>

In the following six subsections, I examine the degree to which TADA comports with the following elements of procedural due process: (1) neutral and independent decision maker, (2) appellate review, (3) notice, (4) statement of decision, (5) criteria to guide decision, and (6) other due process concerns.

#### A. TADA Lacks a Neutral and Independent Decision Maker

The U.S. Supreme Court has held that “[i]t is axiomatic that a . . . ‘fair tribunal is a basic requirement of due process.’”<sup>257</sup> A fair tribunal is one with a

251. *Joint Anti-Fascist Refugee Comm. v. McGrath*, 341 U.S. 123, 161–63 (1951) (Frankfurter, J., concurring).

252. *Mathews v. Eldridge*, 424 U.S. 319, 335 (1976) (discussing a factors test for procedural due process analysis); *Woodson v. North Carolina*, 428 U.S. 280, 305 (1976) (discussing the need for case-by-case consideration of circumstances when death is at stake); CHARLES ALAN WRIGHT & CHARLES H. KOCH, JR., *FEDERAL PRACTICE AND PROCEDURE: JUDICIAL REVIEW OF ADMINISTRATIVE ACTION* § 8129(a) (April 2016 update to 1st ed.).

253. *Mathews v. Eldridge*, 424 U.S. at 344.

254. *Carey v. Phipus*, 435 U.S. 247, 259 (1978).

255. Cameron Stewart, *Futility Determination as a Process: Problems with Medical Sovereignty, Legal Issues and the Strengths and Weakness of the Procedural Approach*, 2 *BIOETHICAL INQUIRY* 155, 157 (2011). See also generally Robert M. Veatch, *What It Means to Be Dead*, *HASTINGS CTR. REP.* 45, 45 (1977); Bosslet et al., *supra* note 4; Sofia Morati, *The Development of “Medical Futility”: Towards a Procedural Approach Based on the Role of the Medical Profession*, 35 *J. MED. ETHICS* 369, 371–72 (2009).

256. Keith M. Swetz et al., *Ten Common Questions (and Their Answers) on Medical Futility*, 89 *MAYO CLINIC PROCS.* 943, 944–45 (2014); Truog, *supra* note 173, at 989; Douglas B. White & Mark Wicclair, *Limits on Clinicians’ Discretion to Unilaterally Refuse Treatment*, 21 *AM. J. CRITICAL CARE* 361, 362 (2012);

257. *Caperton v. A.T. Massey Coal Co.*, 556 U.S. 868, 887 (2009) (citing *In re Murchison*, 349 U.S. 133, 136 (1955)).

“neutral and detached judge.”<sup>258</sup> “[A]n impartial decision maker is essential.”<sup>259</sup> Indeed, the neutrality of the decision maker is widely thought to be the most important part of due process.<sup>260</sup>

Perhaps the most significant fairness problem with TADA is its delegation of decision-making power to the hospital’s very own internal review committee. Since the committee is comprised of hospital clinicians and administrators, it is hardly a neutral and independent decision maker.<sup>261</sup> It is “predisposed” to find for the hospital.<sup>262</sup>

In one survey of 200 Texas hospitals, fifty-six percent reported having a “medical appropriateness review committee distinct from their ethics committee.”<sup>263</sup> Half of these committees had five or fewer members.<sup>264</sup> Most were wholly comprised of physicians and hospital administrators.<sup>265</sup> Hardly any included community representatives.<sup>266</sup> Consequently, there is a significant risk that such committees may be biased towards the interests of hospital management.<sup>267</sup>

Harvard Professor Robert Truog has lamented the TADA review committee’s lack of neutrality in a long series of prominent articles noting, “This is hardly an impartial tribunal.”<sup>268</sup> He has observed that review committee members “are unavoidably ‘insiders.’”<sup>269</sup> Truog is concerned that TADA “gives an unwarranted amount of power to the clinicians and hospitals over patients and families who hold unpopular beliefs or values.”<sup>270</sup>

258. *Ward v. Village of Monroe*, 409 U.S. 57, 62 (1972).

259. *Goldberg v. Kelly*, 397 U.S. 254, 271 (1970).

260. *Hamdi v. Rumsfeld*, 542 U.S. 507, 509 (2004).

261. Stewart, *supra* note 255; O’Callaghan, *supra* note 174, at 597–98; Thaddeus M. Pope, *Multi-Institutional Healthcare Ethics Committees: The Procedurally Fair Internal Dispute Resolution Mechanism*, 31 CAMPBELL L. REV. 257, 294 (2009).

262. *Marshall v. Jerrico*, 446 U.S. 238, 242 (1980).

263. Smith et al., *supra* note 172, at 1272.

264. *Id.* Memorial Hermann does not use its ethics committee for TADA, but instead uses a Medical Appropriateness Review Committee (MARC) comprised of a physician chair plus three physicians appointed by the CMO and three nurses appointed by the CNO. Castriotta, *supra* note 122. While the ethics committee has some disciplinary and other diversity, the MARC has far less. Pope, *supra* note 261, at 291; E.B. Eason et al., *Withdrawal of Life Sustaining Treatment in Children in the First Year of Life*, 28 J. PERINATOLOGY 641, 641 (2008).

265. Smith et al., *supra* note 172, at 1272.

266. *Id.* See also Andrew Courtwright & Martha Jurchak, *The Evolution of Hospital Ethics Committees in the United States: A Systematic Review*, 27 J. CLINICAL ETHICS 322, 324 (2016).

267. Morten Magelssen et al., *Sources of Bias in Clinical Ethics Case Deliberation*, 40 J. MED. ETHICS 678, 678 (2014).

268. Truog, *supra* note 173, at 1000.

269. Truog, *supra* note 61, at 2.

270. Jeffrey P. Burns & Robert D. Truog, *Futility: A Concept in Evolution*, 132 CHEST 1987, 1991 (2007).

Truog argues that TADA's placement of the life-and-death decision in the hands of hospital review committees is too provider friendly because "[m]ost of these committee members are doctors, nurses, and other clinicians from the hospital community . . . [thus] involvement of the hospital ethics committee fails to bring the diversity of the community into the deliberative process."<sup>271</sup> It runs the risk of "becoming a rubber-stamp mechanism" that does not respect diversity.<sup>272</sup>

Truog is not alone. I have also warned of the dangers of giving life-and-death adjudicatory power to hospital committees.<sup>273</sup> I will not repeat those arguments here. Suffice it to say that hospital review committees are overwhelmingly internal and intramural bodies. They are comprised of professionals employed directly or indirectly by the very same institution whose decision the review committee adjudicates. When the decision maker has a pecuniary interest in the outcome, it is not sufficiently neutral and independent.<sup>274</sup>

Committee members cannot be fair and impartial when the propriety of administering expensive LSMT must be weighed against a financial loss to the very hospital that provides those committee members with privileges and a source of income.<sup>275</sup> "[A]ctual futility cases are almost always intertwined with

271. Robert D. Truog, *Counterpoint: The Texas Advance Directives Act Is Ethically Flawed: Medical Futility Disputes Must Be Resolved by a Fair Process*, 136 CHEST 968, 969 (2009).

272. Truog, *supra* note 61, at 3; Robert D. Truog, *Rebuttal from Dr. Truog*, 136 CHEST 972, 972 (2009) (suggesting that TADA is unnecessary and that ethics committees should not have unchecked decision-making power). *See also* Truog, *supra* note 173, at 988 ("[F]utility cases most commonly involve . . . the more marginalized and disadvantaged segments of our society."); Katherine Montgomery Hunter, *Limiting Treatment in a Social Vacuum: A Greek Chorus for William T.*, 145 ARCHIVES INTERNAL MED. 716, 717 (1985) (arguing for "some semblance of a community . . . to buffer . . . caretakers from social and administrative pressures").

273. *See generally* Pope, *supra* note 261; Thaddeus M. Pope, *The Growing Power of Healthcare Ethics Committees Heightens Due Process Concerns*, 15 CARDOZO J. CONFLICT RESOL. 425 (2014); Thaddeus M. Pope, *Legal Briefing: Healthcare Ethics Committees*, 22 J. CLINICAL ETHICS 74 (2011).

274. *See, e.g.*, *Ward v. Monroeville*, 409 U.S. 57, 60 (1972) (invalidating a conviction in mayor's court, because the mayor faced a "possible temptation" created by his "executive responsibilities for village finances"); *Tumey v. Ohio*, 273 U.S. 510, 531-32 (1927) (invalidating conviction where mayor had the authority to sit as a judge to try those accused of violating a state law prohibiting the possession of alcoholic beverages. Inherent in this structure were two potential conflicts. First, the mayor received a salary supplement for performing judicial duties and, second, the funds for that compensation derived from the fines assessed in a case); *Gibson v. Berryhill*, 411 U.S. 564, 579 (1973) (an administrative board composed of optometrists had a pecuniary interest of "sufficient substance" so that it could not preside over a hearing against competing optometrists).

275. Plaintiff's Original Complaint, *Gonzales v. Seton Family of Hosps.*, No. A07CA267 (W.D. Tex. 2007). At one major Houston hospital, in at least seven cases in which treatment was

questions about saving money.”<sup>276</sup> Patients without insurance or those covered by Medicaid are more likely to be perceived as receiving futile treatment.<sup>277</sup> Even TADA’s staunchest supporters concede: “I can’t promise you there’s not some rogue hospital or committee out there.”<sup>278</sup> Indeed, there have been specific allegations of corruption.<sup>279</sup>

For example, Kalilah Roberson-Reese underwent a cesarean section at Memorial Hermann Hospital in Houston, but amniotic fluid began to leak into her lungs, forcing providers to put her on a ventilator.<sup>280</sup> Later, her tracheal tube fell out and she went without oxygen long enough that she sustained serious brain damage.<sup>281</sup> Within days, the hospital initiated the TADA dispute resolution procedures, but the review committee was conflicted. The patient had exhausted her Medicaid benefits and it appeared that the hospital was trying to “bury mistakes” and avoid exposure both to liability and to uncompensated treatment.<sup>282</sup>

Another case from the same hospital involved similar allegations. The family of Sabrina Martin alleged that “Memorial Hermann and the doctors and nurses working on the case” utilized the TADA process because they “wanted

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discontinued the patient was not covered by private or public insurance but was “self-pay.” Castriotta, *supra* note 122.

276. Truog, *supra* note 173, at 990.

277. Thanh H. Neville et al., *Differences Between Attendings’ and Fellows’ Perceptions of Futile Treatment in the Intensive Care Unit at One Academic Health Center: Implications for Training*, 90 ACAD. MED. 324, 327 (2015).

278. Selby, *supra* note 225.

279. See, e.g., Order of Abatement, *Dunn v. Methodist Hosp.*, No. 2015-69681 at 1 (Harris Cty. Dist. Ct. Tex. Dec. 4, 2015); see also Order Granting Temporary Restraining Order, *Davis v. Memorial Hermann Hosp.*, No. 2009-07079 at 2–6 (Harris Cty. Dist. Ct. Tex. Feb 4, 2009); Mimi Swartz, *Not What the Doctor Ordered*, TEX. MONTHLY, Mar. 1995, at 86, 94 (describing a case in which CIGNA pressured the HEC chair to stop expensive treatment for end-stage AIDS patient James D. Bland); *Estate of Bland v. CIGNA Health Plan of Tex.*, No. 93-052630 (Harris Cty. Dist. Ct. Tex. 1995).

280. Todd Ackerman, *Texas Law at Hub of Life Support Issue*, HOUS. CHRON. (July 8, 2006, 5:30 AM), <http://www.chron.com/news/houston-texas/article/Texas-law-at-hub-of-life-support-issue-1887343.php>.

281. *Id.*

282. *Id.*; see also *In re Guardianship of Roberson-Reese*, No. 365099-401, ¶ 28 (Harris Cty. Prob. Ct. Tex. July 6, 2006) (“Ms. Roberson-Reese is an unemployed Medicaid patient with no means of support . . . Respondents accordingly have a financial incentive to give her bed to a private insurance patient.”); *id.* ¶ 25 (“[Q]uestions exist about the quality of medical care provided . . . At the very least, there is an appearance of a conflict of interest that should preclude the ethics committee . . . from making a decision that will end her life before an independent investigation is made.”).

Sabrina to die to bury the evidence of malpractice and limit the potential damages in court.”<sup>283</sup>

To address the review committee’s lack of neutrality, some have proposed mandating certain minimum composition requirements. For example, some proposals require that the review committee include “significant membership from outside the hospital.”<sup>284</sup> One Australian court recommended that since such a hospital review committee should have “independence . . . from the treating doctors . . . it would probably need to have interstate members.”<sup>285</sup>

Other specific membership composition solutions include making at least one-quarter of the committee non-hospital staff, or mandating the inclusion of members from disability and aging advocacy organizations. More radically, hospitals could use an entirely independent and external oversight committee otherwise unconnected to the hospital.<sup>286</sup> The key goal is to “balance between embeddedness and detachment.”<sup>287</sup>

### B. TADA Lacks Appellate Review

In addition to a neutral decision maker, the U.S. Supreme Court has also held that procedural due process requires “meaningful appellate review.”<sup>288</sup> Review is deemed “meaningful” if it prevents the arbitrary deprivation of life or liberty.<sup>289</sup> If a court or state agency could review the decision of the hospital review committee, such review could largely “cure” the neutrality problem.<sup>290</sup>

283. Chris Vogel, *Doctors vs. Parents: Who Decides Right to Life?*, HOUS. PRESS (Apr. 30, 2008, 4:00 AM), <http://www.houstonpress.com/2008-05-01/news/doctors-vs-parents-who-decides-right-to-life/>.

284. Smith et al., *supra* note 172, at 1274.

285. Inquest into the death of Paulo Melo [2008] NTMC 080, 1, 34 (Austl.).

286. Diane Coleman, Disability Rights Leadership Institute on Bioethics (April 2014), <http://dredf.org/drlib/wp-content/uploads/sites/5/2014/06/DRLIB-Withholding-of-Treatment.ppt>. Some Texas hospitals have responded to bias charges by appointing disability advocates to their HECs. See Suzanne Shepherd, Dir. of Legal Svcs., Seton Fam. of Hosps., Hearing before the Texas House of Representatives Committee on State Affairs (Apr. 14, 2009), [http://tlchouse.granicus.com/MediaPlayer.php?view\\_id=25&clip\\_id=4306](http://tlchouse.granicus.com/MediaPlayer.php?view_id=25&clip_id=4306).

287. Magelssen et al., *supra* note 267, at 681. Cf. Thaddeus Mason Pope, *Unbefriended and Unrepresented: Better Medical Decision Making for Incapacitated Patients Without Healthcare Surrogates*, 33 GA. ST. U. L. REV. (forthcoming 2017).

288. Parker v. Dugger, 498 U.S. 308, 321 (1991); Spaziano v. Florida, 468 U.S. 447, 489–90 (1984); Pulley v. Harris, 465 U.S. 37, 58 (1984); Roberts v. Louisiana, 428 U.S. 325, 335–36 (1976); see also Lockett v. Ohio, 438 U.S. 586, 605 (1978).

289. See Spaziano v. Florida, 468 U.S. at 489–90.

290. Bosslet et al., *supra* note 28, at 1325 (“[T]he legitimacy of decisions that arise from a purely procedural conflict-resolution process hinges on adherence to principles of fair process, including legitimacy and freedom from conflict of interest, which some have argued cannot be guaranteed given concerns about variable expertise within institutions and financial or relational conflicts of interest . . .”).

But TADA has a real accountability problem. It denies substantive judicial or agency review, making the hospital committee the forum of last resort.<sup>291</sup> A court may only grant a definite extension of time, and it may do even that only when there is a preponderance of evidence that a transfer will be accomplished.<sup>292</sup> This means that TADA gives hospitals near-absolute (unreviewable) power over when to terminate treatment.<sup>293</sup>

Some have suggested that courts can review hospital committee decisions under TADA.<sup>294</sup> But the dominant position is that substantive judicial review is not available.<sup>295</sup> “TADA immunizes all denials of LSMT under its review process, whether they are entirely arbitrary, negligent, reckless, or made with malice and the intent of harming or killing the patient.”<sup>296</sup>

This is the better reading for two reasons. First, the legislative purpose and intent was to provide the legal certainty and finality that the Houston protocol

291. Truog, *supra* note 61, at 2 (“[T]he ethics committee is acting, under Texas law, as a surrogate judge and jury . . .”). Texas ethics committees can take justice into their own hands. While we may be prepared to trust *Batman*, we are not ready for vigilantes like those depicted in *Taxi Driver* or *Death Wish*.

292. See *supra* Section IV.C.7.

293. Painter, *supra* note 164, at 21.

294. Mayo, *supra* note 72, at 1010; Anne L. Flamm, *The Texas “Futility” Procedure: No Such Thing as a Fairy-Tale Ending*, LAHEY CLINIC MED. ETHICS J., Spring 2004, at 4, 4 (families “can challenge a provider’s adherence to Section 166.046, or more generally, the reasonableness of actions taken”).

295. See, e.g., Todd Ackerman, *Judge Denies Request to Keep Man on Life Support*, HOUS. CHRON. (Mar 10, 2005, 6:30 AM), <http://www.chron.com/news/houston-texas/article/Judge-denies-request-to-keep-man-on-life-support-1953649.php> (the trial court denied an extension, because the judge believed her duty was “to follow the law”); *In re Nikolouzos*, 179 S.W.3d 581, 582 (Tex. App. 2005) (Jenning, J., concurring) (“It is well-settled law that appellate courts have jurisdiction to consider immediate appeals of interlocutory orders ‘only if a statute explicitly provides appellate jurisdiction.’”) (citing *Stary v. DeBord*, 967 S.W.2d 325, 352–53 (Tex. 1998)); Halevy & McGuire, *supra* note 67, at 38, 39 (“The statute explicitly limits the ability of the courts to intervene in such cases.”); Lightfoot, *supra* note 55, at 854; *Politics and Reality*, *supra* note 66, at 146; Earle’s Response Brief to Plaintiff’s Third Amended Petition; Application for Temporary Restraining Order, Temporary Injunction, and Permanent Injunction, *Gonzales v. Seton Family of Hosps. et al.*, No. 86427 at 2 (Travis Cty. Prob. Ct. Tex. May 3, 2007); O’Callaghan, *supra* note 174, at 545 (“The statute’s use of the term ‘only’ limits the review of the court to a consideration of whether alternative caregivers will likely be found and appears to foreclose a review of the substantive decision to withdraw [life-sustaining treatment] . . . [T]he statute appears to deprive the patient of any other recourse to the courts beyond this limited time-extension procedure.”); Cynthia S. Marietta, *The Debate Over the Fate of the Texas “Futile-Care” Law: It Is Time for Compromise* 3, [http://www.law.uh.edu/healthlaw/perspectives/2007/\(CM\)TXFutileCare.pdf](http://www.law.uh.edu/healthlaw/perspectives/2007/(CM)TXFutileCare.pdf); Truog, *supra* note 66, at 968 (“Under TADA the family has no options for appealing the decision of the ethics committee.”).

296. Anne L. Flamm, *Is the Baby in the Bathwater? A Defining Moment for the Texas Advance Directives Act Review Process for Medical Futility Judgments*, 18 HEALTH MATRIX 229, 232 (2008).

lacked.<sup>297</sup> If the review committee's decision could be reviewed, then the process would likely become so protracted that virtually all conflicts would become moot (by the patient's death) before a decision on the merits.<sup>298</sup>

Second, this interpretation is well supported in formal executive, judicial, and legislative branch interpretations. Look first at the executive branch. When the TADA first went to Governor Bush in 1997, he vetoed the bill because it "eliminate[d] the objective negligence standard for reviewing whether a physician properly discontinued the use of [LSMT] and replace[d] it with a subjective 'good faith' standard."<sup>299</sup>

This reading is confirmed by interpretation by the judicial branch. In one of the rare cases in which a case was litigated, the court refused to reach the substantive question of whether LSMT was appropriate. It found submitted medical evidence "irrelevant" since the "hospital's ethics committee ha[d] determined the care [was] inappropriate."<sup>300</sup>

Finally, consistent with executive and judicial branch interpretations of TADA, the state legislature has also confirmed that the role for courts is a narrow one. "The court considers whether another provider who will honor the patient's directive is likely to be found; it does not address the issue of whether the decision to withdraw life support is valid."<sup>301</sup>

I am arguing for (some) judicial review of TADA review committee decisions. External oversight is essential, but that does not mean the appropriateness of LSMT should be determined by courts instead of hospital review committees.<sup>302</sup> There is broad consensus that courts lack the requisite

297. Zerwas, *supra* note 102, at 177–79.

298. *Id.* at 179 (this was key to ending "the lingering fear of legal ramifications").

299. Governor's Proclamation, *supra* note 118; *see also* H. COMM. ON PUB. HEALTH, TEX. HOUSE OF REPS., INTERIM REPORT 2006 33–34 (Nov. 15, 2006) (referencing Governor Bush's veto proclamation of the first TADA).

300. *Nikolouzos v. St. Luke's Episcopal Hosp.*, 162 S.W.3d 678, 683 (Tex. App. 2005).

301. H. COMM. ON PUB. HEALTH, *supra* note 299, at 35.

302. *See generally* Celia Kitzinger & Jenny Kitzinger, *Court Applications for Withdrawal of Artificial Nutrition and Hydration from Patients in a Permanent Vegetative State: Family Experiences*, 42 J. MED. ETHICS 11 (2016) (describing how due process entails significant costs for all involved). *Cf.* GRANT GILMORE, *THE AGES OF AMERICAN LAW* 110–11 (1977) ("The worse the society, the more law there will be. In Hell there will be nothing but law, and due process will be meticulously observed."). On the other hand, judicial review does work for medical futility conflicts in Ontario and in the UK. *See generally* Bosslet et al., *supra* note 4. *See also* Stewart, *supra* note 255, at 158 (noting a response time of Australian courts in two cases of ten days and eight days). Judicial review is also working as a stop-gap measure for medical aid in dying in Canada. *See generally* Mark Handelman, *Assisted Death: The Risks and Benefits of Tribunal Approval*, 36 HEALTH L. CAN. 138 (2016). Some have also argued that "rapid review" could work for life-sustaining treatment allocation decisions in crisis situations. MD. ATT'Y GEN., PUB. NO. 100OAG160, PUBLIC HEALTH EMERGENCY PREPAREDNESS – STATE'S AUTHORITY TO RATION VENTILATORS DURING PANDEMIC – PHYSICIAN IMMUNITY 184–85 (2015).

expertise and responsiveness necessary to engage in *de novo* review of these medical treatment decisions.<sup>303</sup> We should not replace or supplant the hospital review committee. But, we need some mechanism of review and accountability.

We must strike a balance between too much and too little review. On the one hand, TADA now provides appellate review that is too little. On the other hand, a non-deferential and more detailed review would be too much. We must aim for a middle ground. Fortunately, we can look to (and borrow) well-established rules used in judicial review of agency actions. One particularly relevant model is the Health Care Quality Improvement Act of 1986.<sup>304</sup>

When hospitals review their physicians in a manner consistent with the same procedural due process principles described here, they have immunity from civil money damages. So, if a hospital, with adequate notice and hearing procedures, took action that adversely impacted a physician's clinical privileges or membership in a professional society, that physician would have no monetary claim against the hospital. A court reviewing the hospital's actions would determine only if the hospital followed fair procedures and whether its decision is supported by substantial evidence. If so, the court would not reach the merits of the underlying matter.<sup>305</sup> Fixing TADA would simply entail hospitals giving patients the same procedural due process protections that they give physicians.

### C. TADA Affords Inadequate Notice

In addition to having a neutral decision maker and appellate review, another "elementary and fundamental requirement of due process" is notice.<sup>306</sup> Notice must be "reasonably calculated, under all the circumstances, to apprise interested parties of the pendency of the action and afford them an opportunity to present their objections."<sup>307</sup> Notice must "reasonably . . . convey [this]

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303. See generally MEISEL ET AL., *supra* note 6 §§ 3.011, 3.19A, 3.23A, 3.25. In some recent brain death cases the patient remained in the ICU for months due to preliminary injunctions and stays. See, e.g., *In re Guardianship of Hailu*, 361 P.3d 524, 525 (Nev. 2015). The same often happens in futility conflicts. *Sweiss v. Alberta Health Servs.*, 2009 ABQB 691 ¶¶ 28, 51–53 (Can.) ("There is no intention that a trial of the action will follow. Rather, the injunction is generally sought to preserve the status quo in the interim"). See also generally *Golubchuk v. Salvation Army Grace Hosp.*, 2008 MBQB 49 (Can.). Indeed, the slowness of judicial processes relative to medical treatment issues grounds the exception to mootness doctrine. See, e.g., *Roe v. Wade*, 410 U.S. 113, 125 (1973); *Compassion in Dying v. Washington*, 79 F.3d 790, 796 n. 4 (9th Cir. 1996).

304. Health Care Quality Improvement Act of 1986, 42 U.S.C. §§ 11101–52 (2012).

305. See generally *Gabaldoni v. Washington County Hosp. Ass'n*, 250 F.3d 255 (4th Cir. 2001).

306. *Mullane v. Cent. Hanover Bank & Trust Co.*, 339 U.S. 306, 314 (1950).

307. *Id.*

information, and it must afford a reasonable time for those interested to make their appearance.”<sup>308</sup> In short, the surrogate must have an “opportunity to acquaint himself with the facts . . . of the case.”<sup>309</sup>

But the mere forty-eight hours afforded by TADA does not allow the surrogate enough time: (1) to obtain the medical records, (2) to consult with an expert, and (3) to meaningfully prepare for the review committee meeting.<sup>310</sup> Federal courts have held that even substantially more notice was inadequate in situations with far less at stake.<sup>311</sup>

As a significant amount of legislative activity between 2007 and 2015 demonstrates, the short notice periods in TADA have been a central focus of reformers.<sup>312</sup> “Civil libertarians and patient rights advocates argue that [TADA fails to] provide[] sufficient time for the complicated and technical requirements that are thrust onto the patient and family.”<sup>313</sup> Those who represent patients report that the forty-eight hour period is “extremely difficult.”<sup>314</sup> Even key authors of TADA support giving surrogates more notice.<sup>315</sup>

In one case that challenged the validity of TADA under federal law, the court appointed a guardian *ad litem* for the patient. That guardian, Stephen Jody Helman, submitted a fifty-page trial brief to the court observing that TADA “is by no means perfect and could certainly be improved to make it fairer and less burdensome to patients and their representatives.”<sup>316</sup> Mr. Helman pointed specifically to the “short notice period.”<sup>317</sup>

308. *Id.*

309. *Powell v. Alabama*, 287 U.S. 45, 59 (1932) (quoting *Commonwealth v. O’Keefe*, 298 Pa. 169, 173 (Pa. 1979)); *see also Hicks v. Kentucky Unemp’t. Ins. Comm’n*, 390 S.W.3d 167, 169 (Ky. App. 2013).

310. Bob Deuell, *Respecting Every Life*, DALL. MORNING NEWS (Apr. 2, 2007, 6:42 AM) (noting that “families are thrust into a frenzied web of dismay”) (subsequently removed from website and on file with author).

311. *See, e.g., Goldberg v. Kelly*, 397 U.S. 254, 268 (1970) (more than seven days may be required before termination of welfare benefits); *Walker v. United States*, 744 F.2d 67, 70 (10th Cir. 1984) (more than five days required before termination of public employment).

312. S.B. 439, 2007 Leg., 80th Sess. (Tex. 2007); H.B. 3474, 2007 Legis., 80th Sess. (Tex. 2007); S.B. 303, 2013 Leg., 83d Sess. (Tex. 2013).

313. Painter, *supra* note 164, at 22.

314. Mary Ann Roser, *At Life’s End, It’s Kin v. Doctors*, AUSTIN AM.-STATESMAN, May 8, 2006, at A01.

315. Mayo, *supra* note 72, at 1016.

316. Guardian Ad Litem’s Trial Brief on Legal Issues at 35, *Gonzales v. Daughters of Charity Health Servs. of Austin*, No. 86,427 (Travis County Probate Court Tex. Mar. 6, 2007).

317. *Id.* at 35 n.17. Virginia gives surrogates fourteen instead of ten days. VA. CODE ANN. § 54.1-2990 (LexisNexis 2016).

To be sure, the notice period in TADA is only a minimum. In practice, hospitals may exceed the statutory notice requirements.<sup>318</sup> For example, one study suggests that the average notice given to a surrogate prior to a review committee meeting was 7.9 days.<sup>319</sup> On the other hand, nothing in TADA requires more than the forty-eight hour “floor.” Some hospitals offer no more. Indeed, hospitals sometimes provide notice on a Friday afternoon for a Monday morning review committee meeting.<sup>320</sup>

#### D. TADA Fails to Assure a Meaningful Statement of Decision

We have now examined how TADA fails to satisfy three key elements of procedural due process: (1) neutral decision maker, (2) appellate review, and (3) notice. While perhaps not quite in the same hierarchy as these three, another core element of procedural due process recognized by the U.S. Supreme Court is a “written statement” of decision.<sup>321</sup>

This requirement to set out all the relevant facts and evidence serves several purposes. First, it helps assure that a factual basis supports the

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318. Chris Tomlinson, *Right-To-Life Groups Split on End-of-Life Decision*, HOUS. CHRON. (Mar. 10, 2013) (reporting that by the time the review committee met, the patient had been in the hospital an average of forty-seven days and almost six days elapsed between when the doctor wanted to withdraw treatment and when the ethics committee met); Craig Myers, *Section 166.046 of the Texas Futile Care Law: Supplying Health Care Providers a Procedural Framework Regarding a Difficult Decision*, HEALTH INDUSTRY ONLINE, Oct. 18, 2006 (depublished report) (on file with author) (recommending that hospitals “consider providing for a more lengthy period of time”); Andy Hogue, *Hughes Bill Tackles End of Life Dilemmas*, DALL. BLOG (Apr. 20, 2009), <http://www.dallasblog.com/200904201004656/dallas-blog/hughes-bill-tackles-end-of-life-dilemmas.html> (reporting that Seton Healthcare “has voluntarily changed policies” to go “well beyond the minimum [ten] days”); *Texas Act Formalizes Ethics Committee Role in Disputes*, ACH MEDIA (Apr. 1, 2006), <https://www.ahcmedia.com/articles/128665-texas-act-formalizes-ethics-committee-role-in-disputes?trendmd-shared=1> (“[O]ne or more informal consults usually occur before the formal consultation, even though they’re not required.”); Mayo, *supra* note 72, at 1015.

319. Email from Lance Lunsford, Vice President for Advocacy Communications, Texas Hospital Association (May 21, 2014, 12:22 PM) (on file with author) (noting the following for 2010: Length of stay: one day; advance notice given to family/surrogate prior to ethics committee meeting: four days; patient passed away during ten-day period. In 2009, the process was initiated two times at two systems. Length of stay: thirty-five days; advance notice given to family/surrogate prior to ethics committee meeting: sixteen days).

320. See, e.g., Complaint at ¶ 24, *Gonzales v. Seton Family of Hosps*, No. A07CA267SS (W.D. Tex. Apr. 4, 2007); see also Petitioner’s Original Petition for Declaratory Judgment, Temporary Restraining Order, and Motion to Extend Time at 5, *Tex. Right to Life v. Memorial Hermann Healthcare System*, No. 365099-401 (Harris Cty. Prob. Ct. Tex. July 6, 2006) [hereinafter *Tex. Right to Life Original Petition*] (alleging that the mother of Kalilah Roberson-Reese was informed on Friday, June 23, 2006 about an ethics committee meeting on Monday, June 26, 2006).

321. *Morrissey v. Brewer*, 408 U.S. 471, 489 (1972).

deprivation (or dispossession) of life, liberty, or property.<sup>322</sup> Second, it enables the affected individual to understand the grounds for the deprivation.<sup>323</sup> Third, it provides a record upon which to prepare for appeal. By enabling an appellate tribunal to review the review committee's reasons, a written statement protects against arbitrary and capricious deprivations.

Unfortunately, TADA places no requirements on the extent of the explanation provided. While some hospitals provide detailed explanations,<sup>324</sup> others do not. In one case, the hospital used a preprinted, single-page form titled "Decision of the Committee for the Determination of Inappropriate/Futile Treatment."<sup>325</sup> The form includes no field or space for an explanation of *why* the review committee judged interventions to be inappropriate. And, as the form was used in at least several cases, no reasons or explanations were provided.<sup>326</sup> In another case, the family alleged that they did not know who made the decision or "what the specific grounds were for or against."<sup>327</sup>

Requiring a meaningful statement of decision would improve the TADA dispute resolution process. Hospital review committees "like judges, will give more careful consideration to the problem if they are required to state not only the end result of their inquiry, but the process by which they reached it."<sup>328</sup> Requiring a more complete written decision "sharpen[s] the decision makers' internal thought processes."<sup>329</sup> Judge Frank Coffin observes: "A remarkably

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322. *Black v. Romano*, 471 U.S. 606, 614 (1985).

323. *Haymes v. Regan*, 525 F.2d 540, 544 (2d Cir. 1975). Indeed, the basis supporting the proposed action should also be stated in the notice. *Holliday v. Fields*, 275 S.W. 642, 646 (Ky. 1925); *Moffit v. Austin*, 600 F. Supp. 295, 297–98 (W.D. Ky. 1984).

324. See, e.g., Affidavit of Catarina Gonzales at Ex. B, *Gonzales v. Seton Family of Hosps.*, No. 1:07-cv-00267-SS (W.D. Tex. Apr. 4, 2007) (the exhibit itself covers four single-spaced pages); *id.* at Ex. D (covering six single-spaced pages).

325. *Tex. Right to Life Original Petition*, *supra* note 320, at Ex. A.

326. *Id.*; see also Ex. B to Petitioner, *Davis v. Memorial Hermann Healthcare System*, No. 2009-07079 (Harris Cty. Dist. Ct. Tex. Feb. 4, 2009) (showing that the form used by the review committee did not have a space for an explanation and additionally did not state an explanation); Robert L. Painter, *Painter Law Firm, Introduction to the Texas Advance Directives Act*, YOUTUBE (Nov. 18, 2010), <https://www.youtube.com/watch?v=LEuIUaYbaw4>.

327. Plaintiff's Response in Opposition to Hous. Methodist Hosp. Second Motion to Dismiss at 2, *Kelly v. Methodist Hosp.*, No. 2015-69681 (Harris Cty. Dist. Ct. Tex. May 6, 2016) [hereinafter Response in Opposition]. Indeed, the ethics committee letter offers no reasons. Chapter 74 Motion to Dismiss and Brief in Support of Defendant's Previous Motion to Dismiss at Ex. A, *Kelly v. Methodist Hosp.*, No. 2015-69681 (Harris Cty. Dist. Ct. Tx. May 6, 2016).

328. *United States v. Merz*, 376 U.S. 192, 199 (1964).

329. Douglas E. Abrams, *But "Will It Write"?: How Writing Sharpens Decision-Making*, PRECEDENT, Spring 2009, at 61, 62. United Kingdom courts often include balance sheets summarizing benefits and disadvantages from treatment. See, e.g., *Cent. Manchester Univ. Hosps. NHS Found. Trust v. A*, [2015] EWHC (Fam) 2828 [15] (Eng.).

effective device for detecting fissures in accuracy and logic is the reduction of the results of one's thought processes."<sup>330</sup>

Moreover, written statements of decision can increase trust between families and providers. Written statements show families that the committee seriously considered their arguments and facilitates judicial review. Families are more likely to accept the result if they perceive the process as legitimate. And even beyond the index case, this will help preserve trust in health care more broadly.<sup>331</sup>

So, hospital review committees should provide the surrogate not only with the result of their decision making but also with their evidence and reasons supporting those decisions. But exactly what content requirements should apply to these statements of decision? What should review committees include? That brings us to the next due process concern.

#### *E. TADA Fails to Provide Criteria to Guide Committee Review*

Closely related to TADA's failure to assure a meaningful statement of decision is its failure to provide any criteria to guide the review committee. The Supreme Court has warned about vague statutes that fail to provide explicit standards for those who apply them. Such statutes increase the risk that the decision maker will resolve the case "on an *ad hoc* and subjective basis, with the attendant dangers of arbitrary and discriminatory application."<sup>332</sup>

The Supreme Court recognized an analogous due process problem in the capital punishment context. In 1972, the Court suspended all capital

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330. FRANK M. COFFIN, *THE WAYS OF A JUDGE: REFLECTIONS FROM THE FEDERAL APPELLATE BENCH 57* (1980) ("Somehow, a decision mulled over in one's head or talked about in conference looks different when dressed up in written words and sent out into sunlight . . . . The act of writing tells us what was wrong with the act of thinking.").

331. See generally Emily A. Largent, *Health Care Organizations and the Power of Procedure*, AM. J. BIOETHICS, Jan. 2016, at 51 (considering procedure as a way of changing the decision-making process); Frederic Romain & Andrew Courtwright, *Can I Trust Them to Do Everything? The Role of Distrust in Ethics Committee Consultations for Conflict Over Life-Sustaining Treatment Among Afro-Caribbean Patients*, 42 J. MED. ETHICS 582 (2016) (identifying ways that distrust can manifest itself in ethic committee consultations).

332. *Grayned v. City of Rockford*, 408 U.S. 104, 108-09 (1972). We would not want an "architecture committee" of firefighters to decide which buildings were worth saving and which would be left to burn. Testimony of Burke Balch, Tex. H. Comm. of Pub. Health 1:58.50 (Aug. 9, 2006), [http://tlchouse.granicus.com/MediaPlayer.php?view\\_id=23&clip\\_id=7187](http://tlchouse.granicus.com/MediaPlayer.php?view_id=23&clip_id=7187). Cf. MD. ATT'Y GEN., *supra* note 302, at 183 (arguing there is less risk of error when the criteria are clear and objective, and there is more risk of error where the criteria are complicated and allow discretion). See also generally Thaddeus M. Pope, *Is Public Health Paternalism Really Never Justified? A Response to Joel Feinberg*, 30 OKLA. CITY U. L. REV. 121 (2005) (explaining the dangers of masking illegitimate reasons under the cloak of legitimate reasons). The history of the medical futility debate is replete with declarations of "futility" without sufficient reflection or explanation of how or why any particular intervention is inappropriate for any particular patient.

punishment in the United States. Its concern was not the practice itself. The problem was not “in principle,” but it was in application.<sup>333</sup> The penalty was “wantonly and freakishly imposed” because jury discretion was not guided or limited.<sup>334</sup> The Court upheld the practice in 1976 because, by then, the states had specified factors for juries.<sup>335</sup>

The risk of arbitrariness and bias is especially high with TADA. Not only does TADA have no oversight, monitoring, or accountability, but it also has no consistency or standardization.<sup>336</sup> One recent lawsuit alleges that hospitals have “absolute authority and unfettered discretion to terminate life-sustaining treatment of any patient.”<sup>337</sup> Without any guidepost anchors or criteria, there may be significant variability not only in when but also in how hospitals invoke TADA. Enormous variability has already been well-documented across U.S. intensive care units.<sup>338</sup> Moreover, this variability is expressly presumed by TADA’s transfer requirement.

The statute neither “contain[s] [nor] suggest[s] any ascertainable standard for determining the propriety of continuing [LSMT].”<sup>339</sup> This creates three

333. *Furman v. Georgia*, 408 U.S. 238, 387 (1972).

334. *Id.* at 310 (Stewart, J., concurring).

335. *Gregg v. Georgia*, 428 U.S. 153, 206–07 (1976) (“While the jury is permitted to consider any aggravating or mitigating circumstances, it must find and identify at least one statutory aggravating factor before it may impose a penalty of death. In this way the jury’s discretion is channeled.”).

336. Testimony of Colleen Horton on Texas S.B. 439, Tex. H. of Reprs. Comm. on Pub. Health 211:10 (2007), [http://tlchouse.granicus.com/MediaPlayer.php?view\\_id=23&clip\\_id=7187](http://tlchouse.granicus.com/MediaPlayer.php?view_id=23&clip_id=7187).

337. Response in Opposition, *supra* note 327, at 7.

338. *See, e.g.*, Dominic J. Wilkinson & Robert D. Truog, *The Luck of the Draw: Physician-Related Variability in End-of-Life Decision-Making in Intensive Care*, 39 INTENSIVE CARE MED. 1128, 1131 (2013); Megan E. Romano et al., *Mandatory Ethics Consultation Policy*, 84 MAYO CLINIC PROC. 581 (2009); Thomas Fassier & Elie Azoulay, *Conflicts and Communication Gaps in the Intensive Care Unit*, 16 CURRENT OPS. IN CRITICAL CARE 654 (2010); Lawrence A. Ho et al., *Comparing Clinician Ratings of the Quality of Palliative Care in the Intensive Care Unit*, 35 CRITICAL CARE MED. 975 (2011); Arino Yaguchi et al., *International Differences in End-of-Life Attitudes in the Intensive Care Unit*, 165 ARCH. INTERNAL MED. 1970 (2005). This variability is driven by clinicians’ personal values, religion, and culture. *See generally* A. Garland & A.F. Connors, *Physicians’ Influence over Decisions to Forego Life Support*, 10 J. PALLIATIVE MED. 1298 (2007); Charles L. Sprung et al., *The Importance of Religious Affiliation and Culture on End-of-life Decisions in European Intensive Care Units*, 33 INTENSIVE CARE MED. 1732 (2007); Fathima Paruk et al., *The Durban World Congress Ethics Round Table Conference Report: III. Withdrawing Mechanical Ventilation—The Approach Should Be Individualized*, 29 J. CRITICAL CARE 902 (2014); H.H. Bülow et al., *Are Religion and Religiosity Important to End-of-Life Decisions and Patient Autonomy in the ICU? The Ethicatt Study*, 38 INTENSIVE CARE MED. 1126 (2012).

339. Affidavit of Catarina Gonzales, *supra* note 324, at 12; *see also* Maureen Kwiecinski, *To Be or Not to Be, Should Doctors Decide? Ethical and Legal Aspects of Medical Futility Policies*, 7 MARQ. ELDER’S ADVISOR 313, 349 (2006); O’Callaghan, *supra* note 174, at 529 (“[N]otably

problems. First, it means that the decisions of review committees may not be as informed or reasoned as necessary. Second, the lack of guiding standards means that a single hospital review committee may disparately treat similarly situated patients. Third, it means that review committees at different hospitals may be deciding similar cases differently.

Now, the reader may ask how TADA could possibly include substantive criteria, when its very genesis lies in the inability of clinicians and philosophers to identify any such criteria. Recall the general shift in the 1990s from substantive definitions of “futility” to process-based approaches.<sup>340</sup>

I have two responses. First, even if we cannot identify a test or algorithm for determining which treatment is inappropriate, we can still identify relevant and irrelevant factors.<sup>341</sup> We may not be able to specify sufficient reasons but we can identify “bad” reasons. For example, illegitimate bases for refusing treatment (such as the patient’s race) could be specifically excluded.<sup>342</sup>

Second, while a universal definition of “futility” has proven elusive, specific futile scenarios have garnered widespread support. For example, many clinicians deem LSMT inappropriate: (1) when the burdens of treatment significantly outweigh the benefits, (2) when treatment can never achieve the patient’s goals, (3) when death is imminent, (4) when the patient “will never be able to survive outside of an ICU,” and (5) when the patient is permanently

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absent from the statute are any objective standards . . . .”; *id.* at 530 (“fails to set forth any standard of ‘futile’”); *id.* at 543 (“not clear what the committee is expected to review”); *id.* at 564–66, 589–96; David M. Zientek, *The Texas Advance Directives Act of 1999: An Exercise in Futility*, 17 HEC F. 245, 251 (2005) (“[TADA] gives no guidance as to when it is legitimate to override the patient’s or surrogate’s wishes.”); Heitman & Gremillion, *supra* note 111 (“[TADA] offers no standards of evidence by which to judge appropriateness.”).

340. Heitman & Gremillion, *supra* note 111, at 88–89.

341. Ben White et al., *What Does “Futility” Mean? An Empirical Study of Doctors’ Perceptions*, 204 MED. J. AUSTL. 318.e1, 318.e3 (2016) (measuring conceptual consistency in definitions); M. Cardona-Morrell et al., *Non-Beneficial Treatments in Hospital at the End of Life: A Systematic Review on Extent of the Problem*, 28 INT’L J. FOR QUALITY IN HEALTH CARE 456, 459 (2016) (collecting examples of what clinicians identify as non-beneficial treatment).

342. See, e.g., H.B. 1539, 2013 Leg., 83d Sess. (Tex. 2013); S.B. 1163, 2015 Leg., 84th Sess. at 2 (Tex. 2015); H.B. 4100, 2015 Leg., 84th Sess. at 14 (Tex. 2015).

unconscious.<sup>343</sup> On the other hand, clinicians are more prepared to find treatment appropriate if it is based on religion.<sup>344</sup>

Admittedly, these five principles cannot be automatically or mechanically applied in an algorithmic fashion. But neither should they be wholly disregarded. These and similar definitions, rules, and paradigm cases can productively inform and guide review committee deliberation and analysis.

#### F. Other Due Process Concerns

While the above five elements of procedural due process are those that present the most serious problems with TADA, they are not the only ones.<sup>345</sup> The quality of TADA review committee decisions is also materially and adversely affected by: (1) the review committee's lack of diverse membership, (2) the review committee's lack of training and competence, (3) the absence of standard meeting and hearing procedures, and (4) the absence of a requirement assuring the surrogate's participation.

First, TADA omits several key issues relating to the review committee.<sup>346</sup> In stark contrast to federal regulations governing institutional review boards in the research context, TADA includes no details or guidelines concerning how a hospital composes its ethics committee.<sup>347</sup> TADA is silent as to: (1) the overall number of committee members required, (2) the inclusion of members from different professional disciplines, (3) the inclusion of lay or community

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343. Huynh et al., *supra* note 40, at 1890; Neville et al., *supra* note 277, at 326. *See also generally* Lindy Willmott et al., *Reasons Doctors Provide Futile Treatment at the End of Life: A Qualitative Study*, 42 J. MED. ETHICS 496 (2016) (describing various factors for when futile care is often provided at the end of life). Similarly, many statutes and court opinions articulate factors that should be considered in determining whether life-sustaining treatment is in a patient's best interests. *See, e.g.*, L.A. COUNTY SUPERIOR COURT RULE 7.5(h), <https://www.lacourt.org/court-rules/CurrentCourtRulesPDF/Chap7.pdf>.

344. Derek D. Ayeh et al., *U.S. Physicians' Opinions About Accommodating Religiously Based Requests for Continued Life Sustaining Treatment*, 51 J. PAIN & SYMPTOM MGMT. 971, 977 (2016).

345. The right to representation by counsel is another essential element of a fair hearing. *Thompson v. Bd. of Educ. of Henderson Cnty.*, 838 S.W.2d 390, 393 (Ky. 1992). But TADA also does not assure the surrogate a right to have legal counsel present.

346. *Statement of Michael Rieger, General Council of Seaton Family of Hosps., Hearing on H. Committee Substitute 3474 Before the Tex. H. Comm. on Public Health 7:28* (2007), [http://tlc.house.granicus.com/MediaPlayer.php?view\\_id=24&clip\\_id=2724](http://tlc.house.granicus.com/MediaPlayer.php?view_id=24&clip_id=2724); TEX. HOSP. ASS'N, *supra* note 97 ("The composition varies among hospitals . . . some . . . have only physician members."); Heitman & Gremillion, *supra* note 111, at 95 ("The open-ended definition of the review committee is a serious concern."); Fine & Mayo, *supra* note 56, at 744 ("[M]any on the task force . . . believed this was suboptimal . . .").

347. *Contrast Painter*, *supra* note 164, at 21, with 45 C.F.R. § 46.107.

members, and (4) the inclusion of members with different gender, race, and disability status.<sup>348</sup>

Second, TADA is silent as to the training or qualifications of the review committee members.<sup>349</sup> Many bioethics leaders have expressed “growing concern about [the practice of] health care ethics consultation and how it is practiced.”<sup>350</sup> The field is moving toward certification based on educational achievements and examination performance. Here, where the review committee acts as a decision maker, not as a mere advisor or consultant, the need to assure that it has the right knowledge and skills is even higher.

Third, TADA fails to define the “rules by which an ethics committee must operate.”<sup>351</sup> TADA hospital review committees have neither quorum requirements nor a system of review.<sup>352</sup> They do not report whether their decisions are unanimous or by a slim majority or whether dissent existed.<sup>353</sup> Some surrogates have even reported that they were stopped in the hall of the hospital, only to later discover that the brief and informal hallway encounter constituted the review committee meeting.<sup>354</sup>

Fourth, the “right of confrontation and cross-examination is an essential and fundamental requirement” of due process.<sup>355</sup> But TADA assures only the

348. *Id.*; Zientek, *supra* note 339, at 253–54; Selby, *supra* note 225; Bassel, *supra* note 6, at 511 (“Ethics [c]ommittee [b]ias [c]ontaminates [f]utility [d]ispute [r]esolution.”); Roser, *supra* note 314 (observing that only three of twelve utility cases were Caucasian). I have separately assessed bias issues with ethics committees. *See generally* Pope, *supra* note 261; *Dispute Resolution Mechanisms*, *supra* note 10.

349. *Texas Act Formalizes Ethics Committee Role in Disputes*, *supra* note 318 (task force could not reach consensus on “skill sets or educational requirements”).

350. Ellen Fox, *Developing a Certifying Examination for Health Care Ethics Consultants: Bioethicists Need Help*, AM. J. BIOETHICS, Jan. 2014, at 1, 1.

351. *Politics and Reality*, *supra* note 66, at 146.

352. HENRY M. ROBERT, III ET AL., ROBERT’S RULES OF ORDER NEWLY REVISED VLVII, 334–36 (Perseus Publishing, 10th ed. 2000) (commonly adopted rules of order for parliamentary authority suggest that having a quorum requirement and system of review are important considerations for due process concerns).

353. H. Comm. on Pub. Health, (2007), [http://tlchouse.granicus.com/MediaPlayer.php?view\\_id=24&clip\\_id=2724](http://tlchouse.granicus.com/MediaPlayer.php?view_id=24&clip_id=2724) Statement by Richard Mullin, General Council of Seaton Family of Hosps., on the House Committee Substitute 3474; *id.* at 1:47 (statement by Greg Hooser, Chairman of the Texas Advanced Directives Coalition, on House Committee Substitute 3474) (“[E]thics committees come in all shapes and sizes.”); *id.* at 2:46 (statement by Colleen Horton, University of Texas Center for Disabilities Studies, on House Committee Substitute 3474) (testifying about the lack of HEC oversight, monitoring, accountability, consistency, and standardization).

354. Robert Painter, Attorney, *Statement on Senate Bill 439 Before the Senate Comm. on Health and Human Serv. 4:21*, [http://www.senate.state.tx.us/75r/Senate/commit/c610/c610\\_80.htm](http://www.senate.state.tx.us/75r/Senate/commit/c610/c610_80.htm); TEX. HEALTH & SAFETY CODE § 161.031(b) (2015) (defining the term “medical committee” to include “a committee appointed ad hoc”).

355. *Lee v. Illinois*, 476 U.S. 530, 540 (1986).

surrogate's right to "attend" the meeting.<sup>356</sup> It does not assure the surrogate a right to ask questions of the attending physician or any other witness.<sup>357</sup> Admittedly, many Texas hospitals voluntarily allow confrontation and cross-examination.<sup>358</sup> But there is no provision in TADA that guarantees the right.<sup>359</sup>

## VII. CONCLUSION

Striking the right balance between efficiency and fairness is difficult. These two goals are in tension. Dispute resolution procedures that better achieve one goal entail a tradeoff that correspondingly disrespects the other. On the one hand, the cost of less process is undermining deeply held principles of fundamental fairness.<sup>360</sup> On the other hand, the cost of more process is maintenance of the status quo, the continued administration of potentially non-beneficial treatment.<sup>361</sup>

TADA is a commendable attempt to "steer a course between the Scylla of judicial review and the Charybdis of unfettered, unexamined physician discretion."<sup>362</sup> But TADA places too much weight on efficiency at the cost of fairness. Moreover, while it may have been politically expedient, striking the balance in this way was unnecessary as a matter of cost, ethics, law, or manageability.

The recalibration that I have defended in this article would not change the fundamental power of hospital review committees to authorize the withholding or withdrawal of inappropriate LSMT. Instead, the changes would be minor, affecting only: (1) who is on the review committee, (2) how the committee conducts its meeting and makes its decision, and (3) the extent to which that

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356. O'Callaghan, *supra* note 174, at 543.

357. Verified Complaint at 11, *Gonzales v. Seton Family of Hosps.*, No. 07-cv-00267-SS (W.D. Tex. April 4, 2007); Adam Black, *Texas Right to Life, Statement on Senate Bill 439 Before the Senate Comm. on Health and Human Servs.* 4:30, [http://www.senate.state.tx.us/75r/Senate/commit/c610/c610\\_80.htm](http://www.senate.state.tx.us/75r/Senate/commit/c610/c610_80.htm); O'Callaghan, *supra* note 174, at 543. Some notable proposed amendments to TADA aimed to better protect the family's right of confrontation and cross-examination. *See, e.g.*, S.B. 303, 2013 Leg., 83d Sess. § 7 (Tex. 2013).

358. Exhibit A to Affidavit of Catarina Gonzales at 12, *Gonzales v. Seton Family of Hosps.*, No. 07-cv-00267-SS (W.D. Tex. April 4, 2007) ("You will be given the opportunity to ask questions . . . and to provide input into the committee's decision making process."); Hogue, *supra* note 318 (reporting that Seton Healthcare "has voluntarily changed policies to allow attorneys to be present"); Painter, *supra* note 164, at 22; Myers, *supra* note 318 ("[I]t may be prudent to specify that the patient/decision maker has the right to actually participate and be heard . . ."); Kwiecinski, *supra* note 339, at 350.

359. Participation not only contributes to accuracy of the review committee decision but also creates the "appearance of justice." LAURENCE H. TRIBE, *AMERICAN CONSTITUTIONAL LAW* 666 (2d ed. 1988).

360. Truog, *supra* note 173, at 1001.

361. Stewart, *supra* note 255, at 158.

362. Mayo, *supra* note 72, at 1010.

decision can be reviewed. If TADA is used as infrequently as recent reports indicate, the costs of more procedural due process would be circumscribed and determinate.<sup>363</sup> This is a small price to pay to properly respect notions of due process, fundamental fairness, and fair procedure.

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363. *Death Panel*, *supra* note 10, at 41–43. Smaller rural hospitals may have a more difficult time mustering the resources to comply with more elaborate due process. *Testimony of Tom Mayo, Texas H. Comm. on Pub. Health* (Aug. 9, 2006), <http://www.house.state.tx.us/video-audio/committee-broadcasts/79/>.

## APPENDIX: LEGISLATIVE HISTORY OF TADA

Many readers will want to know more about the legislative history of TADA. How did such a statute get enacted in a state like Texas? How was it signed by a governor like George W. Bush? How did such a statute survive for over seventeen years? Did the legislature try to fix some of the procedural due process problems identified by Professor Pope? To answer these and related questions, I am providing this appendix. It describes the legislative history of TADA in a descriptive, non-normative fashion.

## I. INTRODUCTION

When TADA was first enacted in 1999, it had the broad support of hospital, medical, pro-life, and civil liberty groups. The legislation passed as the result of a consensus among a wide spectrum of stakeholders.<sup>364</sup> But within just a few years of enactment, that consensus had crumbled. Strong disagreements developed over how health care providers were implementing TADA's dispute resolution provisions.<sup>365</sup> TADA has proven very controversial and has been the subject of significant legislative activity.

Pushed largely by disability and right-to-life advocates, the Texas legislature has considered numerous bills directed at amending TADA's dispute resolution provision. These bills have been of three main types: (1) those directed at strengthening its due process protections, (2) those directed at completely eliminating the ability of clinicians to stop life-sustaining treatment without consent, and (3) those directed at narrowing the scope of the statute.

The Texas Legislature meets every other year.<sup>366</sup> More than twenty-five bills have been introduced in the last eight legislative sessions (2003, 2005, 2007, 2009, 2011, 2013, and 2015). But only two amendments were enacted. One was in 2003; the other was in 2015.

*2003 Enacted Amendments*

In 2003, Senator Jane Nelson proposed S.B. 1320. It was enacted and went into effect immediately on June 20, 2003.<sup>367</sup> S.B. 1320 amended TADA in three important ways. First, S.B. 1320 extended the dispute resolution procedures to minors as well as adults.<sup>368</sup> Second, it added the section expediting the review process for patients who have already been the subject of the review.<sup>369</sup> Third, S.B. 1320 added TADA's three written disclosures: (1) It

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364. Ramshaw, *supra* note 54.

365. Painter, *supra* note 164.

366. Kate Galbraith, *Texas Stands Against Tide in Retaining Biennial Legislature*, N.Y. TIMES, Dec. 31, 2010, § A, at 19A.

367. S.B. 1320, 2003 Leg., 78th Sess. (Tex. 2003).

368. Mayo, *supra* note 75, at 1010.

369. TEX. HEALTH & SAFETY CODE § 166.046(e-1).

specified the written language explaining a patient's right to transfer,<sup>370</sup> (2) it mandated creation of the registry for health care providers and referral groups willing to accept or assist in transfers,<sup>371</sup> and (3) it specified the optional written description of the review process.<sup>372</sup>

### *2005 Proposed Amendments*

In 2005, no bills were offered to amend TADA. But Representative Bryan Hughes offered two amendments on the House floor to an unrelated bill, S.B. 1188: Amendments 26 and 28.<sup>373</sup> Hughes later proved to be one of the central legislators involved in trying to amend TADA over the next ten years. Hughes withdrew Amendment 26, but Amendment 28 moved forward.<sup>374</sup> Amendment 28 would have required the state to pay the costs associated with transfers of Medicaid patients.<sup>375</sup> And it would have required that life-sustaining treatment continue until a transfer occurred. Ultimately, Hughes' amendment was removed in a conference committee.

While the legislature made no changes to TADA in 2005, that year would still turn out to be a pivotal one in the statute's history. By spring, several medical futility cases had received significant attention from major newspapers and broadcast media.<sup>376</sup> This brought TADA squarely into the public spotlight for the first time.

In apparent response to this intense media coverage, the Speaker of the Texas House of Representatives included TADA in his October 2005 interim charges for House Committees. Specifically, the Speaker directed the Texas House Committee on Public Health to "[r]eview issues relating to [TADA] and assess if patients and/or their loved ones have a sufficient opportunity to obtain transfer to an alternate facility."<sup>377</sup>

On August 9, 2006, the House Committee on Public Health held a lengthy hearing in which seventy-nine witnesses offered testimony or registered opinions.<sup>378</sup> By this time, TADA had garnered even wider public attention.<sup>379</sup>

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370. *Id.* § 166.052.

371. *Id.* § 166.053.

372. *Id.* § 166.046(b)(1).

373. TADA was indirectly the subject of one 2005 amendment. *See* S.B. 1188, Amend. 26, 2005 Leg., 79th Sess. (Tex. 2005); *see also* S.B. 1188, Amend. 28, 2005 Leg., 79th Sess. (Tex. 2005).

374. *Id.* at Amend. 26.

375. *Id.* at Amend. 28.

376. Zerwas, *supra* note 102, at 182;

377. Tom Craddick, Interim Study Charges Texas House of Representatives 79th Legislature at 30 (Oct. 19, 2005), <http://www.senate.state.tx.us/75r/senate/members/dist24/assets/pdf/79thin%20interimcharges.pdf>.

378. *See generally* TEX. H. COMM. ON PUB. HEALTH, 79th Sess. Comm. Broadcast Arch. (Aug. 9, 2006), [http://tlchouse.granicus.com/MediaPlayer.php?view\\_id=23&clip\\_id=7187](http://tlchouse.granicus.com/MediaPlayer.php?view_id=23&clip_id=7187).

On November 15, 2006, the Committee delivered a sixty-five page report to the Speaker of the House.<sup>380</sup> It recommended that “the Texas Legislature consider revisions to Chapter 166.046.”<sup>381</sup>

### *2007 Proposed Amendments*

When the legislature next convened in January 2007, it followed the House Committee’s recommendations. Legislators introduced eight different bills to address the concerns that had been voiced during the August 2006 hearing. Ultimately, none of these bills were passed.

Perhaps most notable among these bills was S.B. 439, the Patient and Family Treatment Choices Rights Act. It was introduced by Senator Bob Deuell,<sup>382</sup> a physician who would be a major player in the multi-year saga to amend TADA. S.B. 439 would have made TADA more patient-friendly and fair. First, it required an advisory ethics consultation before the formal dispute resolution process.<sup>383</sup> Second, it required hospitals to provide families with a patient liaison to guide them through the process.<sup>384</sup> Third, S.B. 439 increased the notice period from two to seven days.<sup>385</sup> Fourth, it increased the transfer waiting period from ten to twenty-one days.<sup>386</sup> Fifth, it required hospitals to quickly provide medical records and to permit families to bring five or more persons for support to the review committee meeting.<sup>387</sup> Finally, S.B. 439 would have required hospitals to file reports on their use of TADA and the outcomes in those cases.<sup>388</sup> The Senate passed the bill, but time ran out before S.B. 439 reached the House floor.

Representative Garnet Coleman’s House Bill (H.B.) 3690 offered many of the same protections and safeguards as S.B. 439. Other bills, like Representative Jodie Laubenberg’s H.B. 3970, were more narrowly focused. Representative Tan Parker’s H.B. 1440 addressed how transfers were accomplished. Hospitals could convey medical facts but not opinions about the appropriateness of life-sustaining treatment.<sup>389</sup> Parker’s H.B. 3180 would

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379. See, e.g., Howard Witt, *Who Gets to Make Decisions on End of Life?*, CHI. TRIBUNE (Sept. 17, 2006), [http://articles.chicagotribune.com/2006-09-17/news/0609170386\\_1\\_patient-life-support-11th-hour-scramble](http://articles.chicagotribune.com/2006-09-17/news/0609170386_1_patient-life-support-11th-hour-scramble).

380. H. COMM. ON PUB. HEALTH, *supra* note 299, at 32–40.

381. *Id.* at 40.

382. S.B. 439, 2007 Leg., 80th Sess. at 1 (Tex. 2007).

383. *Id.* at 16.

384. *Id.* at 17.

385. *Id.* at 16.

386. *Id.* at 15.

387. S.B. 439 at 6.

388. *Id.* at 19.

389. H.B. 1440, 2007 Leg., 80th Sess. at 1 (Tex. 2007).

extend the transfer waiting period from ten days to ninety days.<sup>390</sup> Representative Dianne Delisi's H.B. 3474 would: (1) extend the ten-day transfer period to eleven business days, (2) offer a patient liaison, (3) require an "advisory consultation," and (4) assure quick provision of medical records.<sup>391</sup>

Perhaps the most radical bill of 2007 was H.B. 1094, offered by Hughes. This bill would eliminate the ten-day transfer period and instead require that the current treating facility continue treatment until the patient is transferred.<sup>392</sup> And if the patient could not be transferred, then the current facility would have to continue treatment indefinitely. H.B. 1094 also exempted artificial nutrition and hydration from the treatment covered by TADA<sup>393</sup> (a type of amendment that was later enacted in 2015).

#### *2009 Proposed Amendments*

When the Texas Legislature next convened in 2009, legislators again offered bills to amend TADA. Legislators introduced two bills: H.B. 2964 and H.B. 3325. Ultimately, neither bill was enacted.

Coleman's H.B. 2964 was the more moderate bill. It purported: (1) to exempt artificial nutrition and hydration from the sorts of treatments that can be unilaterally refused, (2) to appoint a patient liaison to assist the patient or surrogate through the dispute resolution process, and (3) to extend the transfer period from ten to fourteen days.<sup>394</sup>

In contrast, Hughes' H.B. 3325 proposed more dramatic changes. H.B. 3325 was directed, like Hughes' 2005 and 2007 amendments, at narrowing hospital authority under TADA. H.B. 3325 proposed: (1) eliminating the transfer time period altogether, thereby effectively requiring treatment until transfer, and (2) authorizing no-fee judicial review of the physician's or ethics committee's decision.<sup>395</sup>

#### *2011 Proposed Amendments*

As during both the 2007 and 2009 legislative sessions, legislators again proposed and debated TADA amendment bills in the 2011 session.<sup>396</sup> As in prior sessions, none were enacted into law.<sup>397</sup>

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390. H.B. 3180, 2007 Leg., 80th Sess. at 3 (Tex. 2007).

391. H.B. 3474, 2007 Leg., 80th Sess. at 2-3, 5, 10 (Tex. 2007).

392. S.B. 1094, 2007 Leg., 80th Sess. at 1 (Tex. 2007).

393. *Id.* at 2.

394. H.B. 2964, 2009 Leg., 81st Sess. at 3-5 (Tex. 2009).

395. H.B. 3325, 2009 Leg., 81st Sess. at 2-4 (Tex. 2009).

396. TEX. LEG. ONLINE, *Bill Stages*, <http://www.legis.state.tx.us/billlookup/BillStages.aspx?LegSess=82R&Bill=HB3520> (last visited October 6, 2016).

For the fourth legislative session in a row, Hughes introduced a bill to eviscerate hospital authority under TADA. H.B. 3520 proposed eliminating the transfer time period, effectively requiring treatment until transfer.<sup>398</sup> Hughes' bill also exempted artificial nutrition and hydration from the life-sustaining treatment covered by TADA.<sup>399</sup>

Particularly regrettable, in 2011, was the failure to enact an amendment to an unrelated bill that would have created the Texas Institute of Healthcare Quality and Efficiency. The amendment would have mandated data collection on TADA usage.<sup>400</sup> It would have required the Health and Human Services Commission to promulgate regulations requiring hospitals to report detailed statistical and demographic information concerning use of TADA.<sup>401</sup>

### 2013 Proposed Amendments

Efforts to amend TADA heated up in 2013. Legislators introduced six TADA amendment bills in the 2013 legislative session. Again, all these bills failed. But all this activity prompted a wide public discussion both in Texas and beyond.

By far, the most significant of the 2013 bills was S.B. 303.<sup>402</sup> This bill, by Deuell, reintroduced many of the safeguards and protections that Deuell included in S.B. 439 back in 2007.<sup>403</sup> S.B. 303 included a reporting requirement.<sup>404</sup> It required an "advisory ethics consultation" before the formal

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397. Chuck Lindell, *Sensitive Topic of Futile Medical Care Faces Long Road in Legislature*, AUSTIN-AM. STATESMAN (May 8, 2011, 7:12 PM), <http://www.statesman.com/news/news/state-regional-govt-politics/sensitive-topic-of-futile-medical-care-faces-long-nRZrK/>; Emily Ramshaw, *Texas End-of-Life Bills Appear Dead*, TEX. TRIBUNE (May 23, 2011, 5:49 PM), <https://www.texastribune.org/2011/05/23/texas-end-of-life-bills-appear-dead/>; Joe Tone, *How Long Should Texas Docs Treat Untreatable Patients? The Debate That Won't Go Away*, DALL. OBSERVER (July 8, 2011, 11:05 AM), <http://www.dallasobserver.com/news/how-long-should-texas-docs-treat-untreatable-patients-the-debate-that-wont-go-away-7107579>.

398. H.B. 3520, 2011 Leg., 82d Sess. at 6 (Tex. 2011).

399. *Id.* at 5.

400. H.R. Journal, 2011 Leg., 82d Sess. at 5136 (Tex. 2011).

401. S.B. 8, 2011 Leg., 82d Sess. (Tex. 2011); H.R. Journal, *supra* note 400, at 5136–37. A proposed amendment for an interim study also failed. S.B. 8 at 5138; *id.* at 5138.

402. Representative King's H.B. 1444, 2013 Leg., 83d Sess. (Tex. 2013) was a mirror companion to S.B. 303, 2013 Leg., 83d Sess. (Tex. 2013).

403. Dr. John M. Haas, President of The National Bioethics Center, commented that "[s]ignificant safeguards were developed in this proposed legislation to correct existing statutes and to protect informed consent, without forcing the health care provider to initiate or continue futile and harmful procedures." CATHOLICS FOR ADVANCE DIRECTIVES REFORM, *Bishops Articulate Church Teaching on End-of-Life Care Reform in Austin*, TEX. CATHOLIC CONF. <http://www.txcatholic-advance-directives.org/#!austin-october-2014-conference-c58f> (last accessed Oct. 1, 2016).

404. S.B. 303 at 27.

review committee meeting.<sup>405</sup> It increased the amount of notice before committee review (from two to seven days).<sup>406</sup> And it increased the amount of time in the transfer waiting period (from ten to twenty-one days).<sup>407</sup>

Furthermore, with respect to the hospital review committee meeting itself, S.B. 303 offered a special liaison to guide families through the process. It ensured that family members could be accompanied by up to five persons during the review committee meeting, and that the surrogate could not just attend but also participate.<sup>408</sup> It also guaranteed access to medical records in advance of the meeting.<sup>409</sup>

S.B. 303 even provided some substantive standards by which to judge treatment inappropriateness. For example, life-sustaining treatment is inappropriate if it: (1) “threaten[s] the patient’s life,” (2) “seriously exacerbate[s] other major medical problems,” (3) causes “pain or discomfort not outweighed by the benefit of the . . . treatment,” or (4) is “medically ineffective in prolonging the patient’s life.”<sup>410</sup>

While Deuell tried to improve TADA, Hughes again tried to kill it. Hughes offered H.B. 1464.<sup>411</sup> Like his bills in prior sessions, this bill would exempt artificial nutrition and hydration.<sup>412</sup> And it would eliminate the transfer waiting period, instead requiring treatment indefinitely until transfer.<sup>413</sup>

This year, Hughes was joined by TADA opponents Representative Stephanie Klick and Representative Charles Perry. H.B. 1889 would exempt artificial nutrition and hydration from the scope of TADA.<sup>414</sup> H.B. 1539 would disallow certain reasons for refusing treatment.<sup>415</sup> Specifically, the clinician could not refuse because she places “lesser value” on “extending the life of an elderly, disabled, or terminally ill patient.”<sup>416</sup> Nor could a clinician disagree with a surrogate’s decision to place “greater weight” on “extending the

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405. *Id.* at 14–15.

406. *Id.* at 21.

407. *Id.* at 23.

408. *Id.* at 21.

409. S.B. 303 at 22.

410. *Id.* at 13. While Senate Bill 303 was supported by a number of pro-life organizations, it was opposed by Texas Right to Life. Todd Ackerman, *Legislature Again Tries Its Hand at “Futile-Care” Reform*, HOUS. CHRON. (May. 12, 2013, 12:12 PM), <http://www.houstonchronicle.com/news/houston-texas/houston/article/Legislature-again-tries-its-hand-at-futile-care-4509741.php>; Tomlinson, *supra* note 318.

411. H.B. 1464, 2013 Leg., 83d Sess. at 1 (Tex. 2013).

412. *Id.*

413. *Id.* at 2.

414. H.B. 1889, 2013 Leg., 83d Sess. (Tex. 2013).

415. Senate Bill 675, 2013 Leg., 83d Sess. (Tex. 2013) was the mirror companion of H.B. 1539, 2013 Leg., 83d Sess. (Tex. 2013).

416. H.B. 1539 at 2.

patient's life above the risk of disability."<sup>417</sup> Of course, that is precisely what TADA permits (and was intended to permit) a clinician to do.

### *2015 Proposed and Enacted Amendments*

As the 2015 legislative session in Texas began, it was clear that legislators would again try to tackle TADA. The Texas Medical Association (TMA) observed: "In anticipation of another round of debates over end-of-life care, TMA's workgroup dedicated to the issue will work to protect physicians' ability to do what's best for patients in their final days."<sup>418</sup> Indeed, defending TADA is part of TMA's strategic roadmap for state advocacy initiatives.<sup>419</sup> Other organizations similarly expressed interest in protecting, improving, or destroying TADA.

Since no proposed changes were made in 2005, 2007, 2009, 2011, or 2013, this was "round six." Apparently, the sixth time was the charm. For the first time since 2003, Texas actually amended the "futility" provisions in TADA. Both the Texas House and Senate passed H.B. 3074, which had been introduced by Representative Drew Springer. In June, the bill was signed by the Governor.

Effective September 1, 2015, this legislation exempted "artificially administered nutrition and hydration" (AANH) from the scope of life-sustaining treatment subject to the dispute resolution procedures.<sup>420</sup> Particularly since the intense and prolonged international media attention on the legal dispute concerning Terri Schiavo, many state legislatures have tried to treat AANH differently from other forms of life-sustaining medical treatment.<sup>421</sup>

Today, clinicians can continue using TADA to stop life-sustaining medications, mechanical breathing machines, and kidney dialysis treatment. But clinicians may not use TADA to stop AANH unless it would either not

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417. *Id.*

418. Amy Lynn Sorrel, *Capitol Decisions Ahead*, TEX. MED., Jan. 2015, at 26, 31.

419. TEX. MED. ASS'N HEALTHY VISION 2020 18 (2d ed. 2014).

Legislation has been introduced over the past four legislative sessions that would instead require indefinite treatment with no provision for the physician exercising ethics or moral judgment. TMA has opposed these proposals because they would prolong unnecessary—and often painful or even torturous—care that cannot prevent but can only prolong death. They would also require physicians, nurses, and other health care professionals to provide medically inappropriate care, even if that care violates medical ethics or the standard of care. They also would set a dangerous precedent for the legislature to mandate the provision of physician services and treatments that may be medically inappropriate, outside the standard of care, or unethical.

*Id.*

420. H.B. 3074, 2015 Leg., 84th Sess. (Tex. 2015).

421. Josh Perry, *Biopolitics at the Bedside: Proxy Wars and Feeding Tubes*, 28 J. LEG. MED. 171, 182–87 (2007).

work at all or would directly harm the patient. The statute unpacks these exceptions, allowing clinicians to unilaterally withhold or withdraw AANH if it would: “(1) hasten the patient’s death; (2) seriously exacerbate[] [other major] medical problems not outweighed by the benefit of the provision of the treatment; (3) result in substantial irremediable physical pain, [suffering, or discomfort] not outweighed by the benefit of the provision of the treatment; or (4) be medically ineffective.”<sup>422</sup> Importantly, clinicians may not stop AANH under TADA because of the patient’s permanent unconsciousness or quality of life.

In addition to the AANH limitation, H.B. 3074 also clarified that TADA “does not authorize withholding or withdrawing pain management medication, medical procedures necessary to provide comfort, or any other health care provided to alleviate a patient’s pain.”<sup>423</sup> Finally, H.B. 3074 added a requirement that the hospital provide the surrogate with the portion of the patient’s medical record related to the treatment received in the facility during the current admission or during the preceding thirty calendar days.<sup>424</sup>

While only H.B. 3074 was enacted, the legislature considered five other bills in 2015.<sup>425</sup> First, consistent with his track record for over a decade, Hughes introduced H.B. 2984. Like many of Hughes’ prior bills, this one would require treatment until transfer.

With an agenda similar to Hughes, Senator Kelly Hancock introduced S.B. 1163. Described as pro-life and defending core conservative values, Hancock crafted a bill that was not designed to improve the fairness of TADA (like Deuell’s bills over the past sessions). Instead, S.B. 1163 was designed to wholly eliminate TADA’s dispute resolution provisions. Representative James Frank introduced H.B. 3414, the mirror companion to S.B. 1163.

Instead of requiring treatment until transfer like Hughes’ bills, S.B. 1163 would have added a new section (Texas Health and Safety Code Section 166.0455) that specified two reasons on which a review committee may not base a determination of medical inappropriateness.<sup>426</sup> Specifically, the bill

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422. TEX. HEALTH & SAFETY CODE § 166.046(e) (2015).

423. H.B. 3074, 2015 Leg., 84th Sess. (Tex. 2015).

424. *Id.*

425. Two other bills would have affected TADA only by changing the names of referenced state agencies. H.B. 550, 2015 Leg., 84th Sess. (Tex. 2015); S.B. 219, 2015 Leg., 84th Sess. (Tex. 2015).

426. S.B. 1163, 2015 Leg., 84th Sess. at 2 (Tex. 2015). The bill applied not only to review committees but also to health care professionals and health care facilities. Like review committees, they too would be prohibited from using the specified reasons for overriding or refusing to honor and comply with a patient’s advance directive or a health care or treatment decision made by or on behalf of a patient that directs the provision of life-sustaining treatment. *Id.*

prohibited a review committee from determining LSMT to be inappropriate under Section 166.046 based on either:

- (1) the lesser value the physician or professional, facility, or committee places on sustaining the life of an elderly, disabled, or terminally ill patient compared to the value of sustaining the life of a patient who is younger, not disabled, or not terminally ill; or
- (2) a disagreement between the physician or professional, facility, or committee and the patient, or the person authorized to make a treatment decision for the patient under Section 166.039, over the greater weight the patient or person places on sustaining the patient's life than the risk of disability.<sup>427</sup>

S.B. 1163 also specified (in a new a-1 subsection of 166.046) that the only bases on which a review committee may determine life-sustaining treatment to be inappropriate are: (1) physiological futility and (2) when "providing the treatment to the patient would clearly create a substantially greater risk of causing or hastening the death of the patient than would withholding or withdrawing the treatment."<sup>428</sup>

Coleman's H.B. 4100 would, like S.B. 1163 and H.B. 3414, narrow the scope of the review committee. Under this bill, a review committee could deny requested treatment only if it would: "(1) threaten the patient's life; (2) seriously exacerbate other major medical problems not outweighed by the benefit of the provision of the treatment; or (3) result in substantial irremediable physical pain or discomfort not outweighed by the benefit of the provision of the treatment."<sup>429</sup>

H.B. 4100 would have also prohibited the review committee from determining medical appropriateness on the basis of "permanent disability, advanced age, gender, religious or cultural differences, or financial circumstances."<sup>430</sup> The bill extended the notice period from forty-eight hours to seven days and the transfer period from ten to twenty-one days.<sup>431</sup> It required a patient liaison, quick access to the medical record, and an advisory consultation.<sup>432</sup> Finally, like S.B. 1163 and H.B. 3414, H.B. 4100 would exempt clinically assisted artificial nutrition and hydration from the scope of life-sustaining treatment that can be refused.<sup>433</sup>

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427. *Id.* This language is similar to that in an Oklahoma statute used to prohibit clinicians from overriding or refusing treatment requests. *See generally* Kendra Norman, *Live and Let Die: The Consequences of Oklahoma's Nondiscrimination in Treatment Act*, 68 OKLA L. REV. 585 (2016).

428. S.B. 1163 at 3.

429. H.B. 4100, 2015 Leg., 84th Sess. (Tex. 2015).

430. *Id.*

431. *Id.* at 9–10.

432. *Id.* at 11.

433. *Id.* at 8.

Finally, Representative Patricia Harless introduced H.B. 2351. This bill would have required review committees to adopt two types of policies: (1) “to prevent financial and health care professional conflicts of interest” and (2) “to prohibit consideration of a patient’s permanent physical or mental disability during a review . . . unless the disability is relevant in determining whether a medical or surgical intervention is medically appropriate.”<sup>434</sup>

### *2017 and Beyond*

The battle over TADA has been largely fought between those who want to improve the fairness of TADA and those who are opposed to the very concept that hospitals and physicians should be authorized to stop life-sustaining treatment without consent. The former have been thwarted in their efforts to improve TADA, because to improve it is also to preserve it.<sup>435</sup> As the 2017 legislative session draws near, familiar debates will again echo through the halls of the Texas Capitol.<sup>436</sup>

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434. H.B. 2351, 2015 Leg., 84th Sess. (Tex. 2015).

435. Since 2007, Senator Deuell has proposed and shepherded legislation that would make TADA fairer. But since his bills would preserve the core adjudicatory authority of hospital committees, he has been charged with turning his back on life and on disabled patients, earning him the nickname “Dr. Death.” *Terri Schiavo’s Brother Plea to Texas House Against Senator Deuell’s SB 303*, TEAPARTY911 (May 5, 2013), <http://www.teaparty911.com/blog/terri-schiavos-brother-plea-to-texas-house-against-senator-deuells-sb-303/>. In 2014, Deuell lost the Republican nomination for his Senate seat in the 2015 session. Ray Leszcynski, *Bob Hall Edges Out Bob Deuell in State Senate Fight to the Finish*, DALL. MORNING NEWS (May 28, 2014), <http://www.dallasnews.com/news/local-politics/2014/05/28/bob-hall-edges-out-bob-deuell-in-state-senate-fight-to-the-finish>; Michael Hashimoto, *As Bob Deuell Feared, Low Turnout Cost Him in Senate Runoff*, DALL. MORNING NEWS BLOG (May 28, 2014, 1:23 PM), <http://dallas.morningviewsblog.dallasnews.com/2014/05/as-bob-deuell-feared-low-turnout-cost-him-in-senate-runoff.html>. Moreover, as Deuell defended himself from negative attack ads, he was sued for interference with contract. *Deuell v. Texas Right to Life Committee*, No. 01-15-00617-CV (Tex. App. Sept. 15, 2016).

436. TEX. RIGHT TO LIFE, *On Human Rights Day We Stand for Life* (Dec. 10, 2016), <https://www.texasrighttolife.com/on-human-rights-day-we-stand-for-life/> (declaring intent to work with legislators to amend TADA); *Pro-Life Legislative Priorities for Texas Will Be Topic of Next Grassroots America Meeting*, TYLER MORNING TELEGRAPH (Nov. 26, 2016, 4:36 PM), <http://www.tylerpaper.com/TP-News+Local/258906/prolife-legislative-priorities-for-texas-will-be-topic-of-next-grassroots-america-meeting>.