No. 01-17-00866-CV

IN THE FIRST COURT OF APPEALS
AT HOUSTON, TEXAS

EVELYN KELLY, INDIVIDUALLY AND ON BEHALF OF THE ESTATE OF DAVID CHRISTOPHER DUNN,
Appellant,

v.

HOUSTON METHODIST HOSPITAL,
Appellee.

On Appeal from the 189th Judicial District Court
Harris County, Texas
Cause No. 2015-69681

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

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TABLE OF CONTENTS

INDEX OF AUTHORITIES

Cases

Statutes

Legislative Materials

Other Authorities

INTEREST OF *AMICI CURIAE*

The Amici work to improve the integrity of the medical profession, ensure high-quality medical care, promote medical liability reform, protect human life, support the dignity of patients at the end of life, and safeguard Texans with disabilities. The challenged statute—§166.046 of the Texas Advance Directives Act, Texas Health and Safety Code Chapter 166 ("TADA")—furthers these objectives. *See* TEX. HEALTH & SAFETY CODE §166.046. The Amici believe the statute easily overcomes the constitutional challenge presented here.

The Texas Alliance for Patient Access is paying all fees associated with preparing this brief.

Texas Alliance for Life (TAL). TAL opposes "the advocacy and practice of abortion (except to preserve the mother's life), infanticide, euthanasia, and all forms of assisted suicide." *The Story of Texas Alliance for Life*, https://www.texasallianceforlife.org/about-us/ (last visited Mar. 4, 2019). In 1999, TAL helped negotiate §166.046 and urged its enactment. Since 1999, TAL has supported bills to increase patient protections in TADA. However, TAL is unwavering in its support for §166.046 because it strikes a just and appropriate balance between the right of a patient to autonomy regarding decisions about a life-sustaining procedure and the conscience rights of a health-care provider to decline a medically and ethically inappropriate and harmful intervention to a dying patient.

Texas Catholic Conference of Bishops (TCCB). The TCCB is the association of the Roman Catholic Bishops and Diocese of Texas. The TCCB has been at the forefront of reforms in advance directives. It has promoted a human being's inherent dignity even in the course of suffering a natural demise. *Advance Directives Reform*, https://txcatholic.org/medical-advance-directives/ (last visited Mar. 4, 2019). "Human intervention that would deliberately cause, hasten, or ***unnecessarily prolong*** the patient's death violates the dignity of the human person." *Id*. (emphasis added). "Reform efforts should prioritize the patient, while also recognizing the emotional and ethical concerns of families, health care providers, and communities that want to provide the most compassionate care possible." *Id*. The TCCB believes that §166.046 provides a valuable process to prioritize patient needs without compromising the moral conscience and professional medical judgment of health-care providers.

Texas Baptist Christian Life Commission (CLC). The CLC is the ethics and public policy ministry of the Baptist General Convention of Texas (Texas Baptists), which includes 5,400 churches. Although the CLC does not speak for Texas Baptists, it addresses from a biblical perspective policy issues that Texas Baptists care about. In particular, Texas Baptists affirm the value of human life—from conception to natural death—and have consistently defended Americans' right to express heartfelt matters of conscience. While recognizing the inherent difficulties

of these decisions for families, medical professionals, and patients, the CLC has concluded that §166.046 strikes the right balance between patients' desires and medical professionals' rights of conscience. The statute respects the inherent dignity of those created in the image of God, in death, in medical decisions, and in the provision of treatment.

Texans for Life Coalition (TLC). TLC has promoted the sanctity of human life since 1974. Although it initially opposed TADA, TLC witnessed how the Act has prompted critical conversations among families, the medical profession, and the clergy about how to ensure compassion and dignity, while respecting matters of conscience, at the end of a person's life.

Coalition of Texans with Disabilities (CTD). Founded in 1978, CTD is a statewide, cross-disability non-profit organization. CTD has been involved in end-of-life policy discussions during multiple sessions of the Texas Legislature. People with disabilities express considerable respect and appreciation for their health-care providers, often crediting them with saving or enhancing the quality of their lives. Yet their lives are frequently devalued throughout society and particularly in health-care situations. The disability community has beseeched CTD staff to ensure that its wishes are heeded in end-of-life decisions. CTD believes TADA has answered that entreaty effectively.

The Texas Alliance for Patient Access (TAPA). TAPA is a statewide coalition comprising more than 250 physician groups, hospitals, nursing homes, charity clinics, and physician liability insurers. *About Us*, http://www.tapa.info/about-us.html (last visited Mar. 4, 2019). TAPA works to achieve high-quality, affordable medical care for Texans. TAPA supports §166.046 because it (1) preserves a doctor's existing right to decline medical intervention when incompatible with ethics or the doctor's conscience, and (2) provides immunity from liability if the medical community adheres to predetermined procedures surrounding that choice. Section 166.046's immunity protects doctors and nurses from exposing themselves to malpractice suits when adhering to professional and personal ethics.

The Texas Hospital Association (THA). THA, a non-profit trade association, represents approximately 459 Texas hospitals. THA advocates for legislative, regulatory, and judicial means to obtain accessible, cost-effective, high-quality health care. THA supports §166.046, which provides a mechanism to address situations when physicians and hospitals decline to provide medically inappropriate interventions.

The Texas Medical Association (TMA) and the Texas Osteopathic Medical Association (TOMA). TMA and TOMA are private, voluntary, non-profit associations. Founded in 1853, TMA is the nation's largest state medical society,

representing over 52,000 Texas physicians and residents. *Vision, Mission, and Goals*, https://www.texmed.org/Template.aspx?id=5 (last updated June 27, 2018). Founded in 1900, TOMA represents 5,000 licensed osteopathic physicians. *See* https://www.txosteo.org/ (last visited Mar. 4, 2019). Both organizations consider §166.046 vital to the ethical practice of medicine and the provision of high quality-care.

LeadingAge Texas (LAT). LAT provides leadership, advocacy, and education for Texas faith-based and not-for-profit retirement housing and nursing home communities. https://www.leadingagetexas.org/ (last visited Mar. 4, 2019). The organization works extensively with the Texas Legislature on an array of issues affecting the elderly, including hospice and end-of-life matters. LAT believes that §166.046 facilitates critical and productive conversations among medical professionals, families, and patients that promote dignity at the end of a person's natural life.

SUMMARY OF THE ARGUMENT

End-of-life decisions are wrenching for patients, their families, treating physicians, and all medical personnel involved. It is a medical fact that an intervention that prolongs life may also prolong—or even intensify—suffering. When a family member insists on the initiation or continuation of a meaningless medical procedure, the doctor, compelled by an ethical obligation to do no harm, must determine whether the proposed intervention would only extend or enhance suffering. As even *conversations* about the end of life are difficult to initiate, these conflicts between medical ethics and patient wishes have been historically intractable.

TADA, which the Legislature passed after emotional testimony and with high regard for patient and family concern, medical ethics, and medical science, provides a resolution. When a life-sustaining intervention conflicts with medical ethics, the physician is entitled to initiate §166.046's procedure, triggering an ethics committee's review of the patient's case and facilitating an objective evaluation of the pros and cons of further intervention. When this procedure is followed, the physician is not subject to liability.

TADA respects the patient's wishes and leaves room for good-faith differences of medical opinion. A physician and hospital that decline the desired

intervention must work with the patient and the patient's family to search for a facility willing to provide the intervention.

Section 166.046 encourages the doctor and patient to have the difficult and critical dialogue that end-of-life care requires. Life-sustaining intervention has rarely been withdrawn under the Act. Much more often, the family and hospital reach an agreement or the patient's disease runs its natural course. That is what happened here: David Christopher Dunn died of natural causes while the §166.046 procedure was underway.

Appellant claims that §166.046 unconstitutionally deprives a patient of life and an ability to make independent medical decisions. The opposite is true. The statute preserves a physician's obligation to preserve life where possible, provide comfort, and relieve pain. It also engages the patient and family in how medical care will be dispensed. Finally, it honors the physician's ethical responsibility to do no harm and to employ moral conscience in the treatment of human beings.

Medical intervention can cause a patient to suffer. Medical ethics tolerates this suffering only if the treatment provides a corresponding benefit. Physicians invoke the §166.046 process because they believe that medical intervention will no longer benefit the patient but instead will only inflict suffering. Such interventions violate the doctor or nurse's conscience because harm is being inflicted at their hand and

against their will. It violates the health care provider's ethical obligations and disrespects their medical judgment and moral conscience.

This debate, so critical to all concerned, was resolved in the Texas Legislature. Challenges to that profound policy choice belong in the Capitol, not in the courts.

ARGUMENT

I. Texas's dispute-resolution statute was negotiated by a diverse array of stakeholders.

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

Texas Right to Life, ironically, now represents Evelyn Kelly in seeking to invalidate the very statute that the organization once wholeheartedly endorsed. During the 1999 Legislative session, TRL's Legislative Director testified: "[W]e like it and the whole coalition seems to be in agreement with this. . . . [W]e are really united behind this language." *See id.* (statement of Joseph A. Kral, IV, Legislative

Director, Texas Right to Life).[1] The bill passed the Senate unanimously. It passed the House on a voice vote. Act of May 11, 1999, 76th Leg., R.S., ch. 450, §3.05, 1999 TEX. GEN. LAWS 2835, 2865.

Among the Act's highly-negotiated reforms was to provide immunity to hospitals and health-care providers that reasonably comply with patients' advance directives. TEX. HEALTH & SAFETY CODE §166.044. The Legislature anticipated that conflicts would occasionally arise between patients and their families, on the one hand, and physicians concerned with the ethical practice of medicine. The statute thus provided a procedure by which a physician or hospital who, for medical reasons, is disinclined to proceed as the patient directed—including by withholding or withdrawing life-sustaining intervention—could act without risking malpractice liability. *Id.* §166.046. This is known as TADA's "medical futility" provision.

II. Dispute-resolution laws are necessary to maintain the integrity of the medical profession.

"Medical futility" incorporates a complex array of medical and ethical judgments. Instead of displacing physicians in determining whether a medical procedure is inappropriate, the Legislature adopted "a process-based approach" similar to one recommended years earlier by the American Medical Association

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

Council on Ethical and Judicial Affairs. Robert L. Fine, M.D., *Medical futility and the Texas Advance Directives Act of 1999*, 13 B.U.M.C. PROCEEDINGS 144, 145 (2000).[2] Yet the AMA's approach had little practical effect. Even when a physician correctly determined that additional medical intervention would not benefit the patient, the specter of potential malpractice liability propelled the medically-inappropriate fulfillment of the patient's directive. *Id*. The Texas statute solved that problem by providing a safe harbor procedure which, if followed, conferred immunity. *Id*. at 146.

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

So while patients' and families' wishes are entitled to substantial deference, they cannot and should not override conscientious medical judgment. Doctors must objectively determine if a given treatment will help or harm the patient. One physician gave the example of a terminal cancer patient whose family wished to

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

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

continue an intervention that required high-pressure intubation to force oxygen into the patient's lungs. *See* Hearing on C.S.S.B. 439 before the Senate Comm. on Health & Human Servs., 80th Leg., R.S. (April 12, 2007) (statement of Dr. Bob Fine, Texas Medical Association & Baylor Healthcare System). The intubation ruptured her lungs, inflicting severe pain. *See id.* Her pain, in turn, required substantial pain medication and paralytics. *See id.* Against her physicians' advice, the patient's family demanded this painful course of intervention—and even directed the doctor to remove the paralytics and painkillers. *See id.* It was TADA's dispute-resolution process that finally allowed the patient to pass peacefully, in a single minute, after 20 days of unrelenting agony. *See id.*

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

> Effectiveness: Whether CPR is likely to be effective depends on medical conditions and circumstances subject to medical decisionmaking. The physician must consider the patient's age, the circumstances in which the patient's cardiac arrest occurred, and the patient's other medical conditions. Some injuries or illnesses are simply not survivable. However, even in the best of circumstances, CPR is effective in only about 12 percent of cases when performed outside the hospital and in less than 25 percent of the time in a hospital setting.
>
> Possible Harm: Even when the medical circumstances are optimal and the results are good, CPR can cause pain, damage, and distress to patients. For example, chest compressions commonly result in broken ribs, and repeated attempts can cause those broken rib fragments to puncture lungs and damage other body tissues. These problems can become particularly acute when patients are elderly and frail. When

> there is no ultimate benefit to a patient, CPR can turn a tragic death into prolonged suffering or even torture.

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

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

Id.

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

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

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

[4] https://www.texmed.org/Template.aspx?id=44569 (last updated May 9, 2017).

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

III. Texas's statutory medical-futility procedure only rarely contradicts a patient's wish for further intervention.

Texas is one of few states in which medical-futility laws have effectively fostered compromise and relieved suffering—most likely because of TADA's safe-harbor provision. Yet the data shows that Texas doctors and hospitals rarely discontinue life-sustaining intervention under the Act. After surveying 409 Texas hospitals on their experience with the §166.046 procedure between 1999 and 2004, one study found:

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

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

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

Thus, §166.046 is rarely invoked. And when it triggers, its principal impact is not halting medical intervention. Instead, the procedure fosters informal resolution among patients, families, and doctors.

IV. Section 166.046 does not mandate a specific course of action.

Physicians have long been free to choose who they treat and what treatments they provide. "The physician-patient relationship is 'wholly voluntary.'" *Gross v. Burt*, 149 S.W.3d 213, 224 (Tex. App.—Fort Worth 2004, pet. denied) (quoting *Fought v. Solce*, 821 S.W.2d 218, 220 (Tex. App.—Houston [1st Dist.] 1991, writ denied)). Once a physician-patient relationship has begun, either party may

[5] https://www.ncbi.nlm.nih.gov/pubmed/17414082 (last visited Mar. 4, 2019).

terminate it at will. AM. MED. ASS'N COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, CODE OF MED. ETHICS §1.1.5 (2016).

A physician cannot countermand a patient's wish but can *abstain* from providing a particular treatment when medical judgment, the physician's conscience, or sound ethics demands it. The Code of Medical Ethics protects physicians' right "to act (or refrain from acting) in accordance with the dictates of conscience in their professional practice," allowing them "considerable latitude to practice in accord with well-considered, deeply held beliefs." *Id.* §1.1.7 (emphasis added). The key limitation is that the physician has an ethical duty not to terminate the relationship without "[n]otify[ing] the patient (or authorized decision maker) long enough in advance to permit the patient to secure another physician." *Id.* §1.1.5. The physician must also "[f]acilitate transfer of care when appropriate." *Id.*; *accord King v. Fisher*, 918 S.W.2d 108, 112 (Tex. App.—Fort Worth 1996, writ denied) (describing elements of a common law abandonment claim); *see also Tate v. D.C.F. Facility*, No. CIVA407CV162-MPM-JAD, 2009 WL 483116, at *1 (N.D. Miss. Jan. 23, 2009) ("Doctors and hospitals of course have the right to refuse treatment . . . .").

The Legislature passed TADA to create a legal framework governing how physicians should handle and comply with advance directives, out-of-hospital do-not-resuscitate orders, and medical powers-of-attorney in the context of life-

sustaining intervention. *See* TEX. HEALTH & SAFETY CODE §§166.002(1), (10) (defining "[a]dvance directive[]" and "life-sustaining treatment").

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

Generally, TADA requires a physician to follow an advance directive or treatment decision made by or on behalf of a patient. However, it also accounts for the circumstance in which the patient's wishes conflict with the physician's conscience or assessment of medical necessity. It thus provides a procedure by which the doctor can both comply with ethical obligations and satisfy the patient's directive. *Id.* §166.046.

This procedure, the subject of Appellant's constitutional challenge, is available to a physician who declines to perform an intervention over the patient's

wishes. *Id.*; *id.* §166.052. It can also be invoked by a physician who wishes to *continue* an intervention that the patient or family wants to remove. The procedure calls for a medical review committee to evaluate the case. Life-sustaining intervention is continued during the committee's review. *Id.* §166.046(a).

The procedure gives the patient or his representative a right to notice of and to attend the committee's meeting, but it leaves to the committee the decision to concur or disagree with the physician's judgment to reject the advance directive. *Id.* §166.046(b). If the committee concurs with the physician's judgment to resist the patient's or family's wish, the physician or hospital must "make a reasonable effort to transfer the patient to a physician who is willing to comply with the directive." *Id.* §166.046(d). And if the committee sustains a decision to withdraw life-sustaining intervention, the hospital must continue the intervention for at least 10 days while efforts are made to transfer the patient. *Id.* §166.046(e).

Section 166.046 does not authorize removal of:

- comfort care;
- pain relief; or
- artificially administered nutrition and hydration, unless medically inappropriate or against the patient's wishes.

Id. §166.046(e). And, nothing in TADA condones euthanasia. *Id*. §166.050 ("This subchapter does not condone, authorize, or approve mercy killing or permit an

affirmative or deliberate act or omission to end life except to permit the natural process of dying as provided by this subchapter.").

TADA immunizes from civil, criminal, and disciplinary liability the physician who withdraws (or continues) life-sustaining intervention by following its provisions, "unless the physician or health care facility fails to exercise reasonable care when applying the patient's advance directive." *Id.* §§166.044(a), (c). Section 166.046 goes further, providing a safe harbor to physicians who follow it when abstaining from compliance with a patient's wishes. *Id.* §166.045(d).

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

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

Id. §166.045(c) (emphasis added). A physician who elects not to comply with the §166.046 procedure will lose the benefit of the safe-harbor provision but will retain TADA's immunity unless the doctor withdraws life-sustaining intervention while "fail[ing] to exercise reasonable care when applying the patient's advance directive." *Id.* §166.044(a).

V. Appellant's arguments are based on a misconception about §166.046.

Appellant argues that §166.046 "violated David Christopher Dunn's [substantive and procedural] due process rights under the Texas Constitution and the U.S. Constitution," and she seeks a declaration to this effect. CR183. She complains that §166.046 "allows doctors and hospitals the absolute authority and unfettered discretion to terminate life-sustaining treatment of any patient," regardless of the patient's or his surrogate's wishes. *Id.*

Appellant's arguments misread §166.046. The core of her argument is that by "delegati[ng] [] decision-making authority to hospital systems in Texas, the state has authorized the deprivation of life to Texas patients." CR463. This argument presumes that §166.046 granted physicians "statutory authority" to withdraw life-sustaining intervention. CR469. In fact, TADA delegated no such authority.

TADA explicitly *did not* alter "*any* legal right or responsibility a person may have to effect the withholding or withdrawal of life-sustaining treatment in a lawful manner." TEX. HEALTH & SAFETY CODE §166.051 (emphasis added). It did not grant physicians any new powers; it did not even require them to follow any procedure. It merely created a safe harbor—by granting immunity—to physicians who withhold or withdraw life-sustaining intervention in a specific manner.

For this reason, Kelly's suit does not satisfy the "capable of repetition yet evading review" exception to mootness, as she asserts. Specifically, the

constitutionality of §166.046 does not "evade review." A plaintiff such as Kelly could bring a malpractice claim against a physician or hospital, seeking damages. When the defendant asserts §166.046's immunity, the plaintiff could then challenge that statute's constitutionality.

An issue does not "evade review" if a damages claim could be brought. *Alvarez v. Smith*, 558 U.S. 87, 93-94 (2009) ("[S]ince those who are directly affected by the forfeiture practices might bring damages actions, the practices do not 'evade review.'"); *Memphis Light, Gas & Water Div. v. Craft*, 436 U.S. 1, 8–9 (1978) (holding that damages claim saves case from mootness). In *Alvarez*, the Supreme Court dismissed as moot a claim challenging a state's seizure of property as violative of due process. *Id*. Like Kelly here, the plaintiffs in *Alvarez* sought only declaratory and injunctive relief. *Id*. at 92. This case is analogous and moot, and dismissal is warranted.

CONCLUSION AND PRAYER

For physicians, patients, and families, no aspect of health care is more fraught than end-of-life decision-making. In many instances, physicians face a difficult choice between their desire to carry out their patients' wishes and their ethical duty, as medical professionals, not to increase or prolong their patients' suffering without proportionate benefit to the patient. TADA's §166.046 appropriately balances these competing concerns.

Appellant's constitutional challenge misapprehends both the statute and its purpose. As a consequence, the constitutional challenge fails. Amici request that this Court affirm the trial court's judgment.

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

Based on a word count run in Microsoft Word 2016, this brief contains 4,347 words, excluding the portions of the brief exempt from the word count under Texas Rule of Appellate Procedure 9.4(i)(1).

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