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No. 02-20-00002-CV

In the Second Court of Appeals at Fort Worth

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

v.

COOK CHILDREN'S MEDICAL CENTER,
Appellee.

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

BRIEF OF AMICI CURIAE TEXAS ALLIANCE FOR LIFE, TEXAS CATHOLIC CONFERENCE OF BISHOPS, TEXANS FOR LIFE COALITION, COALITION OF TEXANS WITH DISABILITIES, TEXAS ALLIANCE FOR PATIENT ACCESS, TEXAS MEDICAL ASSOCIATION, TEXAS OSTEOPATHIC MEDICAL ASSOCIATION, TEXAS HOSPITAL ASSOCIATION, LEADINGAGE TEXAS, AND TARRANT COUNTY MEDICAL SOCIETY

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INTEREST OF AMICI CURIAE

The amici are groups dedicated to a variety of goals, including preserving the integrity of the medical profession, ensuring high-quality medical care, promoting medical liability reform, protecting life, assuring dignity at the end of life, and protecting Texans with disabilities. These diverse groups are united in the view that the Texas Advance Directives Act, TEX. HEALTH & SAFETY CODE ch. 166, helps achieve their essential objectives. The constitutionality of this statute is important to each of the amici.

Texas Alliance for Life (TAL). TAL is a statewide non-profit organization of people committed to protecting the fundamental right to life of all innocent human beings and to promoting respect for their value and dignity from the moment of conception until natural death. TAL opposes "the advocacy and practice of abortion (except to preserve the mother's life), infanticide, euthanasia, and all forms of assisted suicide."[1] In 1999, TAL, together with Texas Right to Life,[2] helped negotiate § 166.046 and urged its enactment. Since 1999, TAL has supported various bills to increase patient protections in the Texas Advance Directives Act. However, TAL has been and con-

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[1] https://www.texasallianceforlife.org/about-us/ (last visited December 10, 2019).

[2] Texas Right to Life now represents the Plaintiff in challenging this statute.

tinues to be unwavering in its support for § 166.046 because it strikes a just and appropriate balance between the rights of patients to autonomy regarding decisions involving life-sustaining procedures and the conscience rights of health care providers to not have to provide medically and ethically inappropriate and harmful interventions to dying patients.

Texas Catholic Conference of Bishops (TCCB). TCCB has sought reforms in advance directives to highlight—as a matter of policy—the dignity inherent in a natural death.[3] These reforms reflect the principles found in the United States Conference of Catholic Bishops' Ethical and Religious Directives, which constitute authoritative guidance on the provision of Catholic healthcare services.[4] Among other things, the Directives counsel Catholic healthcare providers to honor the sanctity of each human life by avoiding "two extremes"—"on the one hand, an insistence on useless or burdensome technology even when a patient may legitimately wish to forgo it and, on the other hand, the withdrawal of technology with the intention of causing

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[3] https://txcatholic.org/medical-advance-directives

[4] http://www.usccb.org/about/doctrine/ethical-and-religious-directives/upload/ethical-religious-directives-catholic-health-service-sixth-edition-2016-06.pdf; *see also* https://txcatholic.org/wp-content/uploads/2017/12/Conscience-Formation-2017.pdf (discussing application of Ethical and Religious Directives to end-of-life care).

death."[5] "Human intervention that would deliberately cause, hasten, or unnecessarily prolong the patient's death violates the dignity of the human person.[6]" "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."[7] The Catholic Church teaches that all human life is a gift from God, and therefore all human life is innately sacred. This respect for life is lifelong and applies to all human beings—from conception to natural death. The bishops reject medical decision–making based on flawed "quality-of-life" arguments which are often used to falsely justify euthanasia. The bishops have consistently supported the truth that decisions regarding treatment should be made through this lens of the inherent sanctity of all human life while recognizing that underlying medical conditions can have an impact on the effectiveness or appropriateness of certain medical interventions. They believe that treatment decisions should be based on whether or not the expected benefit of the

[5] http://www.usccb.org/about/doctrine/ethical-and-religious-directives/upload/ethical-religious-directives-catholic-health-service-sixth-edition-2016-06.pdf at 20.

[6] *Id.* (emphasis added).

[7] *Id.*

treatment outweighs the burden to the patient.[8] Some may claim that this is a quality of life decision, or one that allows discrimination, but they are wrong —it is an assessment of the quality or effectiveness of the treatment or intervention, not the quality of life for the patient. While TCCB supports continued legislative improvements to the act, particularly those that safeguard against any discrimination in providing necessary and effective life-sustaining treatment, TCCB generally supports the framework of § 166.046 as a balanced dispute resolution process that respects both patient dignity and healthcare provider conscience.

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

Coalition of Texans with Disabilities (CTD). Founded in 1978, CTD is a statewide, cross-disability non-profit organization. CTD has been involved

[8] https://txcatholic.org/sb-2355-support-reform-of-hospital-ethics-committees/

in end-of-life policy discussions for several Texas legislative sessions. People with disabilities express considerable respect and appreciation for their health care providers, often crediting them with their lives. Yet, people with disabilities often report experiences where their lives are devalued, throughout society and sometimes in health care situations. CTD staff has been told many times by the disability community that it wants to be sure its wishes are heard and respected in end-of-life decisions. CTD believes the Texas Advance Directives Act has advanced the rights of people with disabilities at this sensitive time.

The Texas Alliance for Patient Access (TAPA). TAPA is a statewide coalition of over 250 hospitals, physician groups, charity clinics, nursing homes, and physician liability insurers.[9] TAPA promotes health care liability reform to help ensure that Texans receive high-quality, affordable medical care. TAPA supports § 166.046 because it (1) preserves a doctor's existing right to refuse to provide certain medical intervention that violates his or her ethics or conscience and (2) provides immunity from civil and criminal liability if doctors and hospitals adhere to the statutory procedures before declin-

[9] http://www.tapa.info/about-us.html (last visited December 10, 2019).

ing to provide such intervention. TAPA is paying all fees associated with preparing this brief. *See* TEX. R. APP. P. 11.

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

The Texas Medical Association (TMA) and Texas Osteopathic Medical Association (TOMA). TMA and TOMA are private, voluntary, non-profit associations. Founded in 1853, TMA is the nation's largest state medical society, representing over 53,000 Texas physicians, residents, and medical students.[10] Founded in 1900, TOMA represents more than 5,000 licensed osteopathic physicians. Both 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 nurs-

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[10] https://www.texmed.org/Template.aspx?id=5 (last visited December 11, 2019).

ing home communities.[11] The organization works extensively with the Texas Legislature on an array of issues affecting the elderly, including hospice and end-of-life matters.

Tarrant County Medical Society. Tarrant County Medical Society is an organization of more than 3800 physicians, residents and medical students dedicated to providing health care of the highest quality. The mission of the Tarrant County Medical Society is to unite physicians in the region to advocate for physician and patient rights.

[11] https://www.leadingagetexas.org/page/AboutUs (last visited December 11, 2019).

Table of Contents

Interest of Amici Curiae i

Table of Contents viii

Index of Authorities....................ix

Introduction 1

Summary of the Argument 3

Argument....................6

I. The Enactment of the Texas Advance Directives Act and How the Statute Works. 6

A. This law represents a broad consensus of stakeholders. 6

B. TADA balances several important interests, including maintaining the integrity of the medical professions. 8

C. The framework provided by the Texas statute has been beneficial, and disagreements after the conclusion of the process are exceedingly rare. 13

II. The Texas Advance Directives Act Is Constitutional. 15

A. Appellants bring a policy challenge, not a legal challenge. 15

B. TADA implements a legislative policy judgment about how to resolve otherwise intractable disagreements between patients and doctors in end-of-life situations. 18

C. Texas's process-focused approach in § 166.046 compares favorably to the approach taken in other States. 23

Prayer....................27

Certificate of Compliance....................28

Certificate of Service 29

Index of Authorities

Cases

Barshop v. Medina Cty. Underground Water Conservation Dist.,
925 S.W.2d 618 (Tex. 1996) 17

King St. Patriots v. Tex. Democratic Party,
521 S.W.3d 729 (Tex. 2017) 2, 7, 18

Smith v. Davis,
426 S.W.2d 827 (Tex. 1968) 15

Tenet Hosps. Ltd. v. Rivera,
445 S.W.3d 698 (Tex. 2014) 17

Tex. Boll Weevil Eradication Found., Inc. v. Lewellen,
952 S.W.2d 454 (Tex. 1997) 17

Tex. Mun. League v. Tex. Workers' Comp. Comm'n,
74 S.W.3d 377 (Tex. 2002) 16

Tex. Workers' Comp. Comm'n v. Garcia,
893 S.W.2d 504 (Tex. 1995) 15

Univ. of Tex. at Austin v. Garner, No. 18-0740,
63 Tex. Sup. Ct. J. 41, 2019 Tex. LEXIS 1040
(Oct. 18, 2019) (per curiam) 15

Wash. State Grange v. Wash. State Repub. Party,
552 U.S. 442 (2008)...17-18

Statutes and Rules

Ark. Code Ann. § 20-6-109(e)(2) 24

Ark. Code Ann.§ 20-6-109(e)(3)(B) 24

CAL. PROB. CODE § 4736(c) 24

TENN. CODE ANN. § 68-11-1808(f)..24

TEX. HEALTH & SAFETY CODE ch. 166 1

§ 166.044 10

§ 166.045(c) 12, 20

§ 166.046..passim

§ 166.046(b)..20, 21, 25

§ 166.046(e) 20, 21, 25

§ 166.046(g)..4-5, 23, 25

§ 166.051 ....12, 20

§ 166.052 ....4, 21, 25

§ 166.053 25

TEX. HEALTH & SAFETY CODE § 672.016(c) (repealed 1999) 19

TEX. REV. CIV. STAT. 4590h, § 7(b) (recodified 1989) 19

TEX. R. APP. P. 11..v

VA. CODE ANN. § 54.1-2990..24-25

LEGISLATIVE MATERIALS

Act of May 11, 1999, 76th Leg., R.S., ch. 450, § 3.05,
1999 Tex. Gen. Laws 2835, 2865. 6

Acts 2003, 78th Leg., ch. 1228 (S.B. 1320), §§ 3, 4 6

Acts 2015, 84th Leg., ch. 435 (H.B. 3074), § 5 7

Hearing on H.B. 3527, Comm. on Pub. Health,
76th Leg., R.S. (Apr. 29, 1999) 6

Hearing on S.B. 2089 and S.B. 2129 before the Senate Comm
. on Health & Human Servs., 86th Leg. R.S. (April 10, 2019) ...9, 10

Other Sources

American Medical Association Code of Medical Ethics 8

Robert L. Fine, M.D., Medical futility and the Texas Advance Directives Act of 1999, 13 B.U.M.C. Proceedings 144 (2000) 11, 12

"Pro-Life Groups Embrace Bill Ensuring Food and Water at End of Life" (Apr. 23, 2015) 7

M.L. Smith, et al., Texas hospitals' experience with the Texas Advance Directives Act, 35 Crit. Care Med. 1271 (2007). 13-14

INTRODUCTION

The Texas Legislature enacted the Texas Advance Directives Act (TADA) after years of work by stakeholders to reach effective consensus on its core principles. Several of the amici joining this brief participated in those negotiations, which led to a unanimously enacted bill in 1999. After more discussions, amendments refining the law were unanimously enacted in 2003 and in 2015. The Act is now being attacked by two members of Texas's executive department, who ask this Court to "not delay" in declaring a crucial provision of the law "unconstitutional on its face" with immediate statewide effect, in the course of deciding this interlocutory appeal from the denial of a temporary order.[12]

This is a curious litigation position for state officials to take. The standard for declaring a law facially unconstitutional is proving that it is unconstitutional in *every* application, including as it was actually applied to the facts before the Court. The State does not acknowledge that standard. Instead, its brief presents a policy critique of the Legislature's design, suggesting that there is "no guarantee" how the law might be applied to hypothetical

[12] *See* State Br. 1.

circumstances not before the court on this record.[13] But that reliance on hypotheticals and counterfactuals not only fails the constitutional test—it gets the presumptions and burdens backwards. The hedging by the State about how the law *might* be applied by some state actor[14] in some future set of facts undermines, rather than supports, a true facial challenge.

The forum for policy debates about hypotheticals is the Legislature, not recasting them as a "facial" challenge. "Facial challenges are ... disfavored because they 'threaten to short circuit the democratic process by preventing laws embodying the will of the people from being implemented in a manner consistent with the Constitution." *King St. Patriots v. Tex. Democratic Party*, 521 S.W.3d 729, 741-42 (Tex. 2017). The amici believe that the central balance struck by the Legislature and enacted in TADA is a reasonable one and that it should be defended against such a constitutional attack. If refinements to the procedures set out in the Act are needed, those amendments are more appropriately and more effectively made through the legislative process.

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[13] *See* State Br. 11-13.

[14] The amici do not believe that the hospital is a "state actor" but do not brief that question because it has been fully covered by the parties.

Summary of the Argument

The amici defend this statute because it is important. What the Texas Advance Directives Act has provided, to both physicians and to families, is a structure for having difficult end-of-life conversations—and for reaching a resolution if the families and treating physician do not ultimately agree.

A medical intervention that could further prolong life can also, directly or indirectly, inflict significant suffering without proportionate benefit to the patient. A physician might conclude that making further interventions on a patient near the end of life, in a medical situation with no meaningful prospect for cure or recovery, would inflict only harm on the patient—violating one of the oldest and most deeply held principles of medical ethics. Medical providers in that position face not only an ethical dilemma but also feel moral distress over being the instrument used to inflict that non-beneficial suffering on a patient. Family members of patients also go through their own decision-making process as they begin these conversations with their doctors, and then, at their own pace and rooted in their own sincere sense of morality, come to grips with the reality of the hard choices facing them. For the vast majority of patients, a resolution is reached through conversations between physicians and families.

The framework provided by the Texas Advance Directives Act provides a structure for those conversations and, in the most difficult cases, ensures there is a process that moves toward closure. If a treating physician believes that further life-sustaining intervention would conflict with medical ethics, the Act assures the family an orderly process that begins by providing them with information about the statutory process, as well as the information that the family would need to seek a transfer of the patient to another physician or medical facility. TEX. HEALTH & SAFETY CODE § 166.052 (detailed notice). The family can then participate in an ethics committee evaluation of whether the requested interventions are medically inappropriate. If the ethics committee concurs with the physician's determination that the requested intervention is medically inappropriate, the Act provides for a minimum of at least 10 more days to seek a transfer to a medical provider willing to perform the requested additional medical intervention, consistent with its own view of the ethical concerns. If more time is needed to seek a transfer, the statute provides an orderly way to obtain one from a court based on a showing that there is "a reasonable expectation that a … facility that will honor the patient's directive will be found." *Id.* § 166.046(g). It is only once all of those

possibilities have been exhausted that the requested additional medical intervention might be withdrawn.

The district court was correct to deny the request for an injunction that would undermine this carefully balanced statute. This Court should affirm.

Argument

I. The Enactment of the Texas Advance Directives Act and How the Statute Works.

A. This law represents a broad consensus of stakeholders.

The Texas Advance Directives Act (TADA) was enacted by the Texas Legislature in 1999 as the culmination of a six-year effort by a broad array of stakeholders, including Texas and national right-to-life groups, the Texas Conference of Catholic Health Care Facilities, and professional associations including the Texas Medical Association and Texas Hospital Association.[15] The bill passed without a dissenting vote.[16] The law has been amended over time, as consensus has been reached. In 2003, the Legislature amended Texas Health and Safety Code § 166.046, the provision challenged as unconstitutional by the Plaintiffs, to refine some of its procedures.[17] And in 2015, the Legislature again amended the statute, including further refinements to

[15] *E.g.*, 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); *id.* ("[W]e like it and the whole coalition seems to be in agreement with this. . . . [W]e are really united behind this language.") (statement of Joseph A. Kral, IV, Legislative Director, Texas Right to Life).

[16] Act of May 11, 1999, 76th Leg., R.S., ch. 450, § 3.05, 1999 Tex. Gen. Laws 2835, 2865.

[17] Acts 2003, 78th Leg., ch. 1228 (S.B. 1320), §§ 3, 4, effective June 20, 2003. The 2003 amendments added what are now §§ 166.046(b)(1) and (b)(3), as well as the detailed notice given to patients at the beginning of process that is specified in § 166.052.

the notice provisions.[18] Although there was some initial disagreement among the stakeholders about proposed amendments in 2015, they resolved those differences during the legislative process.[19]

Over time, these procedures have been adjusted and improved. The amici believe that the Legislature remains the proper place to fine-tune these procedures. The Legislature is better suited to resolving the policy issues that come with modifying the duties and potential liabilities of medical professionals in end-of-life care. The legislative process has been—and will continue to be—better able to adapt and modify these procedures over time. The Court should not accept the Appellants' invitation to strike down the law in this interlocutory appeal of a temporary injunction, "short-circuit[ing] the democratic process." *King St. Patriots*, 521 S.W.3d at 741-42.

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[18] Acts 2015, 84th Leg., ch. 435 (H.B. 3074), § 5, effective Sept. 1, 2015. These 2015 amendments added what are now §§ 166.046(b)(4)(C) and (D), as well as refining the procedures in § 166.046(e) for what happens after the committee process.

[19] "Pro-Life Groups Embrace Bill Ensuring Food and Water at End of Life" (Apr. 23, 2015), *available at* http://www.christiannewswire.com/news/1278975928.html (last visited December 11, 2019) ("The Texas Alliance for Life, the Texans for Life Committee, Texas Right to Life, and Texas Catholic Conference all signed onto the legislation…").

B. TADA balances several important interests, including maintaining the integrity of the medical professions.

In enacting TADA, the Legislature made a substantive policy decision about balancing the interests involved in end-of-life medical situations. Among those interests were preserving the independence of the doctor-patient relationship and the integrity of the medical profession. A foundational principle of medical ethics is that a physician can abstain from providing a particular medical intervention when his or her medical judgment or ethics demand it. *See* AMA Code of Medical Ethics § 1.1.7 (noting that a physician can "refrain from acting" based on "dictates of conscience" and "well-considered, deeply held beliefs"); *id.* § 5.5 (Medically Ineffective Interventions). Applied to end-of-life situations, those ethics guidelines suggest an effort to transfer the patient to a provider willing to comply, but "[i]f transfer is not possible, the physician is under no ethical obligation to offer the intervention." *Id.* § 5.5.

The dilemma in end-of-life situations comes when a physician's deeply held beliefs about medical ethics conflict with a family's desire to continue life-sustaining treatment that, in the physician's judgment, is medically inappropriate. Before the adoption of TADA, the specter of liability put medical providers in a bind, in which the uncertainty about potential future legal out-

comes warped how medical and ethical decisions were made. As Dr. Robert Fine explained the background of the law:

> During this time, this pre-1998 Advance Directives Act world, when these accusations were going back and forth, physicians, my colleagues, were routinely threatened by both sides, with both civil and criminal actions.
>
> "If you don't allow my mother to die, I'm going to sue you."
>
> "If you don't keep my mother alive, I'm going to sue you."
>
> We got slammed on both sides. We also saw family relationships frayed and often frankly destroyed.

Hearing on S.B. 2089 and S.B. 2129 before the Senate Comm. on Health & Human Servs., 86th Leg. R.S. (April 10, 2019) (testimony of Dr. Fine). Leading up to the 1999 enactment of TADA, the stakeholders who worked together to support the Act put the § 166.046 dispute-resolution procedure into place "because there were constant debates in which" doctors and medical providers "were being threatened." *Id.*

Physicians and other care providers also faced what Ellen Martin, a registered nurse testifying on behalf of the Texas Nurses Association, described as a "moral distress when we perceive a violation of one's core values or duties."[20] She testified that research in this area shows "[t]he highest

[20] Hearing on S.B. 2089 and S.B. 2129 before the Senate Comm. Health & Human Servs., 86th Leg. R.S. (April 10, 2019) (testimony of Ellen Martin).

moral distress situations, for both registered nurses and physicians, … involve those situations on which caregivers feel pressured to continue aggressive treatment that prolongs suffering."[21] This distress can be so great that it causes nurses to leave the profession.[22] As Dr. Fine put it in his testimony:

> In all my years as a geriatrician doing nursing home work, then as an internist, and now as a palliative care specialist, I've never met a patient who wanted to experience a lingering and painful death or experience a death that came too soon.

Hearing on S.B. 2089 and S.B. 2129 before the Senate Comm. on Health & Human Servs., 86th Leg. R.S. (April 10, 2019).

The Legislature balanced these concerns by providing a legal safe harbor within which physicians and hospitals can practice in regard to advance directives. The Act provides immunity to hospitals and health-care providers that reasonably comply with patients' advance directives. TEX. HEALTH & SAFETY CODE § 166.044. And it also acknowledges the potential for conflicts between patients' wishes and physicians' ethical duties. It thus offers a safe-harbor procedure by which a physician or hospital can resolve those conflicts, and in appropriate cases a physician or hospital can ultimately withdraw

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[21] *Id.*

[22] *Id.*

from providing futile intervention, without risking malpractice liability. *Id.* § 166.046. This aspect of TADA is known as its "medical futility" provision.

Medical futility necessarily involves complex medical judgments that would be difficult or impossible to prescribe with particularity in advance. Instead of enacting a rigid rule that would poorly fit some situations, substituting its judgment for medical expertise, the Legislature instead adopted "a process-based approach" similar to one recommended years earlier by the American Medical Association Council on Ethical and Judicial Affairs.[23] That approach defined medical futility in terms of the process itself, building on "the same counseling and deliberation that major ethics committees had been using for years, with attempts to transfer the patient to alternative providers if the disagreement could not be resolved. At the end of the process, if no resolution was achieved and no transfer to a willing provider could be arranged, the council noted that by ethical standards it was acceptable to halt futile treatments."[24] One shortcoming of implementing such a process-based approach solely by professional ethical guidelines, rather than

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[23] Robert L. Fine, M.D., *Medical futility and the Texas Advance Directives Act of 1999*, 13 B.U.M.C. Proceedings 144, 145 (2000), available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1312296/pdf/bumc0013-0144.pdf (last visited December 10, 2019).

[24] *Id.*

by legislative enactment, is that it would leave physicians vulnerable to potential civil liability, even if they scrupulously followed the process to completion.[25] The Texas law addressed that concern by providing a safe-harbor procedure which, if followed, would shield medical providers from liability.[26]

The safe harbor is a pivotal part of the statute. The statute does not compel a physician to personally continue to provide life-sustaining interventions that are medically inappropriate and therefore a violation of his or her ethical and moral conscience. Instead, the statute disclaims any intention 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." TEX. HEALTH & SAFETY CODE § 166.051; *id.* § 166.045(c) ("If an attending physician ... 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…") (emphasis added).

Within this framework, the Legislature's safe-harbor provision serves legitimate and important goals in allowing physicians and nurses to focus on

[25] *Id.*

[26] *Id.* at 146.

the ethical considerations of the patient's particular medical situation. It offers perhaps the only way to extricate a physician from the double bind that he or she faces if some members of a patient's family feel strongly *both* ways —demanding both that every intervention be made and that no further intervention be made.[27] And it offers perhaps the only way to assure physicians that ethical and medical judgments, reached in *agreement* with families, will not later be second-guessed by a family member who has a change of mind (or even a local prosecutor who has views that diverge from the family's own).

C. The framework provided by the Texas statute has been beneficial, and disagreements after the conclusion of the process are exceedingly rare.

The Texas statute has been effective at fostering compromise and relieving patient suffering, in part because it provides a framework for doctors and families to have these conversations. It is striking how often following this process leads to a resolution, without the ultimate step of the withdrawal of life-sustaining intervention.

A survey of Texas hospitals on their experience with the medical futility procedure in the early years of the Act found:

> Most cases were resolved before the end of the mandated 10-day

[27] *See* Testimony of Dr. Robert Fine, *supra* at page 9.

> 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).[28]

More recently, one of the amici, the Texas Hospital Association, did a survey of 202 hospitals to learn their experiences under the Act. During the period from 2007 to 2011, these hospitals accounted for almost four million patient admissions. Within that sample, the formal § 166.046 procedures were initiated only 30 times. Several of those cases resulted in a successful patient transfer. In others, the disagreement was resolved through discussions between the physician and the family. In still others, the patient passed away during the process, before any medical intervention was ever withdrawn. Within this survey sample, no patient was ultimately denied a requested life-sustaining intervention based on the statute. In the overwhelming number of cases, the process fostered the needed conversations between patients, families, and physicians.

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[28] https://www.ncbi.nlm.nih.gov/pubmed/17414082 (last visited December 10, 2019).

II. The Texas Advance Directives Act Is Constitutional.

A. Appellants bring a policy challenge, not a legal challenge.

Disagreements about a policy decision made by the Legislature, however deeply felt, do not state a *constitutional* claim. "The wisdom or expediency of the law is the Legislature's prerogative," not that of a reviewing court. *Tex. Workers' Comp. Comm'n v. Garcia*, 893 S.W.2d 504, 520 (Tex. 1995) (quoting *Smith v. Davis*, 426 S.W.2d 827, 831 (Tex. 1968)). Courts "may not judicially revise statutes because [they] believe they are bad policy." *Univ. of Tex. at Austin v. Garner*, No. 18-0740, 63 Tex. Sup. Ct. J. 41, 2019 Tex. LEXIS 1040, at *10 (Oct. 18, 2019) (per curiam).

Appellants recite that they bring both as-applied and facial challenges, and the State's brief urges the Court to "not delay" in declaring this statute, enacted in 1999, "unconstitutional on its face." App'nt Br. 11; State Br. 1. But neither brief even acknowledges the heavy *legal* standard of proof facing a party trying to use the court system as their tool to rewrite Texas law, rather than going through the Texas Legislature.

First, this is plainly not an as-applied challenge. A party who challenges a state action on the grounds that it violates due process "as applied" must show not merely *that* the law *was* applied to them, *cf.* App'nt Br. 14, but

that the specific procedures *as applied* in their case are what resulted in an alleged deprivation of a protected interest. *Tex. Mun. League v. Tex. Workers' Comp. Comm'n*, 74 S.W.3d 377, 381 (Tex. 2002) ("we must evaluate the statute as it operates in practice against the particular plaintiff").

Appellants do not point to evidence of a violation based on how the procedural steps were actually applied here. They instead focus on hypotheticals and stretched readings of the words of the statute, imagining how those words might be applied in other cases not before the Court. *See* App'nt Br. 14-21. For example, the Appellant's attack on the notice provision of the statute is that "[t]he statute does not require a conscious patient be guaranteed notice of the hearing…." App'nt Br. 17. That surely misapprehends how the statute would ever be applied in reality—and is *not* the situation here.[29] That hypothetical cannot be the basis for a claim about the statute *as applied* to this case. Similarly, the Appellant's attack on whether the statute provides an "opportunity to be heard" is also counterfactual. The brief focuses on some testimony suggesting that, if the patient's surrogate had requested to have an attorney present in the room, that "would have to be 'discussed'."

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[29] Appellants acknowledge that notice was given "a few days in advance." App'nt Br. 17-18; *see also* RR61 (5 days in advance). The record also shows that preliminary conversations had been ongoing for weeks beforehand, including in-person meetings and the assembly of a smaller subcommittee meeting. RR151-55; RR32-33; RR35-37.

App'nt Br. 16 (discussing RR77). But what that testimony highlights is that the family did not in fact make such a request here. They attended in person, and they were heard during the process. RR43-44; RR72-73; RR77-78.

The Appellants also have not presented a valid facial challenge. When a litigant brings a facial challenge, they are asking the courts to strike down a statute for all of its possible future applications, not just the case or controversy actually before the Court. The standard for that exercise of judicial power is one of the most exacting in the law. To strike down a law as facially unconstitutional, a court must conclude that the "statute, by its terms, *always* operates unconstitutionally." *Tenet Hosps. Ltd. v. Rivera*, 445 S.W.3d 698, 702 (Tex. 2014) (emphasis added); *Barshop v. Medina Cty. Underground Water Conservation Dist.*, 925 S.W.2d 618, 631 (Tex. 1996) (noting the "burden in this facial challenge of showing that, *under all circumstances*, the Act will deprive" the plaintiff of a protected interest).

For that reason, pointing to a hypothetical situation in which the statute would be more difficult to apply is not enough. "We may not hold the statute facially invalid simply because it may be unconstitutionally applied under hypothetical facts which have not yet arisen." *Tex. Boll Weevil Eradication Found., Inc. v. Lewellen*, 952 S.W.2d 454, 463 (Tex. 1997); *Wash.*

State Grange v. Wash. State Repub. Party, 552 U.S. 442, 449-50 (2008) ("we must be careful not to go beyond the statute's facial requirements and speculate about 'hypothetical' or 'imaginary' cases").

This high burden for facial challenges protects the integrity of the legislative process. "Facial challenges are also disfavored because they 'threaten to short circuit the democratic process by preventing laws embodying the will of the people from being implemented in a manner consistent with the Constitution." *King St. Patriots*, 521 S.W.3d at 741-42. Appellants seek exactly that. They ask the Court to countermand the substantive policy choices made by the Texas Legislature, in the guise of a "facial" challenge. The Court should decline to do so.

B. TADA implements a legislative policy judgment about how to resolve otherwise intractable disagreements between patients and doctors in end-of-life situations.

At the heart of the Texas Advance Directives Act is the Legislature's substantive policy decision about how to resolve intractable disagreements between patients or families and medical providers in end-of-life situations. Texas law permits medical providers to withdraw rather than be compelled to continue providing inappropriate medical interventions that violate their

conscience or sense of medical ethics, while providing the patient with a reasonable opportunity to transfer to another medical provider.

Early efforts at model laws dealing with end-of-life situations, such as the Natural Death Act, recognized the need to balance those interests. When Texas enacted its version of that law, it included a provision absolutely shielding medical providers from civil or criminal liability for "failing to effectuate the directive" and noting that it "may constitute unprofessional conduct" if they "refuse[] to make the necessary arrangements or take[] the necessary steps to effect the transfer…" TEX. REV. CIV. STAT. 4590h, § 7(b) (recodified 1989). And when Texas's Natural Death Act was later recodified into Chapter 672 of the Health and Safety Code, this language was clarified to say, "If an attending physician refuses to comply with a directive or treatment decision, the physician shall make a reasonable effort to transfer the patient to another physician." TEX. HEALTH & SAFETY CODE § 672.016(c) (repealed 1999).

The Texas Advance Directives Act was enacted in 1999 to replace and improve the Natural Death Act. In so doing, the Legislature preserved the same fundamental policy decision about the role of physicians, but with added clarity. As the background rule, which applies in the rare situations

where a physician does not invoke the formal § 166.046 procedures, he must continue making life-sustaining interventions "but only until a reasonable opportunity has been afforded for the transfer of the patient to another physician or health care facility willing to comply with the directive or treatment decision." TEX. HEALTH & SAFETY CODE § 166.045(c); *id.* § 166.051. This duty is, by its text, expressly limited in duration. *Id.* ("but only until"). And like so many duties in the law, this background catch-all duty is framed in terms of what is "reasonable" under the circumstances.

What the § 166.046 safe-harbor procedures offer is a way to ensure, in real time, that a reasonable opportunity for transfer has been provided. The State's brief calls the phrase "reasonable opportunity" as used in the background-rule provisions "undefined" and "inherently vague." State Br. 15. But those are the provisions that apply when § 166.046 is *not* invoked. TEX. HEALTH & SAFETY CODE § 166.045(c). Once § 166.046 is invoked, there are well-defined procedures and extremely detailed requirements. *Id.* §§ 166.046(b), -(e). And through § 166.046(g), there is the opportunity for immediate judicial review of the precise question whether more time is needed to seek a transfer.

At every step, the patient is advised about the transfer process and provided with information and materials to pursue one. When the formal process begins, the family is provided not just notice of the upcoming hearing but also: (A) a copy of a statement prescribed by § 166.052 of the statute explaining the process, including how the patient can seek a transfer, and (B) "a copy of the registry list of health care providers and referral groups that have volunteered their readiness to consider accepting transfer or to assist in locating a provider…" *Id.* § 166.046(b)(3). The family is also entitled to copies of the patient's medical records and diagnostic results and reports. *Id.* § 166.046(b)(4). Advising the family about a transfer, and making efforts to facilitate the transfer, are at the heart of § 166.046.

This opportunity for a transfer then extends, after the committee's decision, for a period of at least 10 days, providing at total of at least 12 days since the formal § 166.052 notifications were given. *Id.* § 166.046(e). The medical provider is obligated, both by professional standards and by the provisions of the statute, to assist in these efforts. *Id.* § 166.046(e). It is only if all efforts at transfer are unsuccessful—if no other medical facility is ethically willing and able to offer the requested interventions in this particular med-

ical case—that the original medical facility can withdraw the interventions and receive the statutory safe harbor.

Section 166.046 has been criticized for offering judicial review of whether more time is needed at the end of the process while not offering a distinct judicial review of the committee action that comes in the middle of the process. *See* State Br. 14; Appellant Br. 24. But this distinction precisely promotes the substantive balance struck by the Legislature. The question of medical futility is, in this process-based approach,[30] left to the medical community—the physician who makes that initial determination; the medical institution's ethics committee that reviews that decision in a formal process in which the family can participate; and, through the transfer process, the outcome of that one institution's committee process is effectively "appealed" to the larger medical community. That is what happened here. And, through that "appeal" to the larger medical community, in which numerous facilities were contacted including "a very comprehensive list of the top cardiac children's hospitals in the country," RR180, no medical facility was found that was willing and ethically able to accept the transfer to provide these requested medical interventions. RR95; RR155-58; RR165-70; RR256-59.

[30] *See* pp. 11-12, *supra*.

This focused judicial review also makes the process of obtaining an extension easier for patients than it would be without § 166.046. To obtain an extension, patients need only demonstrate "a reasonable expectation that a … facility that will honor the patient's directive will be found." TEX. HEALTH & SAFETY CODE § 166.046(g). They need not allege or prove some other cause of action to get into court but can focus on this narrow question about an extension of time.[31] By the same token, the narrow focus also protects the balance struck by the Legislature. It ensures that, when there is no longer a reasonable expectation of a transfer, the extension will be denied and the physician who has followed the process can withdraw. *Id.* ("shall extend the time … only if the court finds, by a preponderance of the evidence, that there is a reasonable expectation…").

C. Texas's process-focused approach in § 166.046 compares favorably to the approach taken in other States.

Texas's procedures compare favorably to other States that have enacted statutes covering the same subject area as the Texas Advance Directives Act. The suggestion in the State's brief that Texas is an "outlier" in regard to due

[31] This case is an example. In the same order that the district court (properly) denied the request for a temporary injunction based on Appellants' meritless constitutional claims, it granted several weeks more time to seek a transfer under § 166.046(g). CR239-240.

process is simply wrong. Other States have taken a variety of approaches to these difficult end-of-life questions. While some specific details of Texas's statute are of course unique to Texas, that is to be expected when a law was hammered out through the legislative process and has subsequently been amended to refine and improve its procedures.

Texas certainly does not stand alone on the substantive policy judgments embedded in the statute. Several states have joined Texas in clarifying their own statutes to make the limited scope of a physician's duty in these intractable situations more explicit. For example, in California the duty extends "until a transfer can be accomplished or until it appears that a transfer cannot be accomplished." CAL. PROB. CODE § 4736(c). In Arkansas, the statute provides for "continuing care ... until a transfer can be effected or until a determination has been made that a transfer cannot be effected." ARK. CODE ANN. § 20-6-109(e)(2). It goes on to say: "If a transfer cannot be effected, the healthcare provider or institution shall not be compelled to comply." *Id.* § 20-6-109(e)(3)(B). Tennessee has the same provisions. TENN. CODE ANN. § 68-11-1808(f). And in Virginia, the statute provides that, at the end of a period defined by statute, "the physician may cease to provide" the medical in-

tervention "that the physician has determined to be medically or ethically inappropriate…" VA. CODE ANN. § 54.1-2990.

The detailed procedures that Texas makes available through § 166.046 also compare favorably to the generality of other States' statutes regulating these end-of-life situations. The State's brief suggests that Texas's precise procedures are inferior to Virginia's. *See* State Br. 1 ("Virginia provides a longer timeframe and, unlike Texas, ensures the patient's right to seek meaningful judicial review."). But the timeline differences are not material here. Virginia begins its 14-day clock from the physician noting the determination in the medical records. VA. CODE ANN. § 54.1-2990(B). TADA provides at least 10 days after the *committee* has delivered its written decision, which is at least 48 hours after a formal notice is provided along with information about Texas's registry of groups that have indicated they are willing to assist in the transfer process.[32] TEX. HEALTH & SAFETY CODE §§ 166.046(e), 166.053. With regard to judicial review, Virginia's statute speaks in generalities. Texas's statute offers a streamlined procedure to get an extension from a district or county court. *Id.* § 166.046(g). And as demonstrated by the district court's order below, Texas's approach allows a district court to provide

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[32] Appellants were actually notified of the hearing 5 days, not 48 hours, in advance. RR61.

such an extension even when (as here) a patient cannot show an entitlement to relief on any other freestanding cause of action. CR239-40.

Other aspects of Texas's law also compare favorably to its peers. Under § 166.046(b), patients are provided with detailed medical records and other information that might assist them in obtaining a transfer. TEX. HEALTH & SAFETY CODE § 166.052 (a model statement to provide to patients); § 166.046(b)(4)(C)-(D) (medical records and diagnostic reports); *id.* § 166.046(b)(3) (this registry is provided at the outset). These precise requirements have been fine-tuned by the Legislature over time.[33] Among those amendments, Texas has created an infrastructure to facilitate those transfers, by maintaining a central formal registry that includes groups that "may assist in locating a provider willing to accept transfer of a patient under Section 166.045 or 166.046." *Id.* § 166.053. Suggestions of how to fine-tune these procedures should be heard by the Legislature, not recast as constitutional issues that will be forever beyond the reach of future legislatures to resolve.

The balanced approach chosen by the Texas Legislature offers certainty to medical providers about when their duty has been fulfilled while also ensuring that a patient who needs more time to seek a transfer can obtain an

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[33] Acts 2003, 78th Leg., ch. 1228 (S.B. 1320), §§ 3, 4, effective June 20, 2003 (adding what are now §§ 166.046(b)(1) and (b)(3), 166.052, and 166.053).

appropriate extension based on a streamlined evidentiary showing. And Texas's detailed procedures in § 166.046 compare favorably to other States that have confronted the same difficult questions.

Prayer

The amici believe that the framework provided by the Texas Advance Directives Act is constitutional. If the State amici wish to offer refinements to those procedures for future cases, the forum to do so is the Legislature, rather than by asking a Court to rewrite the law on dubious yet sweepingly broad constitutional grounds that would tie the hands of a future Legislature. The Court should affirm the district court's order.

Respectfully submitted,

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CERTIFICATE OF COMPLIANCE

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