No. 323-112330-19

T.B.L, a minor and her mother, TRINITY LEWIS, on her behalf, Plaintiffs,	§	IN THE DISTRICT COURT OF
v.	§	TARRANT COUNTY, TEXAS
COOK CHILDREN'S MEDICAL CENTER, Defendant.	§	323rd JUDICIAL DISTRICT

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, AND TARRANT COUNTY MEDICAL SOCIETY

TO THE HONORABLE COURT:

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.

INTEREST OF AMICI CURIAE

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."[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 continues 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] "Human intervention that would deliberately cause, hasten, or *unnecessarily prolong* the patient's death violates the dignity of the human person."[4] "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."[5] While the TCCB supports continued legislative

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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.

[3] https://txcatholic.org/medical-advance-directives/ (last visited December 10, 2019).

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

[5] *Id.*

improvements to the act, the TCCB generally supports the framework of §166.046 as a balanced dispute resolution process that respects 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 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, clinics, nursing homes, and physician liability

insurers.[6] 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 declining to provide such intervention. TAPA is paying all fees associated with preparing this brief.

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 52,000 Texas physicians, residents, and medical students.[7] 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.

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

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

LeadingAge Texas (LAT). LAT provides leadership, advocacy, and education for Texas faith-based and not-for-profit retirement housing and nursing home communities.[8] 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.

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

Summary of the Argument

What the Texas Advanced 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. These conversations are a part of life, and an inevitable part of medical practice.

A medical intervention that could further prolong life can also, directly or indirectly, inflict significant suffering without proportionate benefit to the patient. When such an intervention would come near the end of life, in a situation with no meaningful prospect for cure or recovery, a treating physician might believe that further interventions would inflict only harm, violating one of the oldest and most deeply held principles of medical ethics. These ethical principles protect doctors, as well as patients. Medical providers in these end-of-life situations face not only an ethical dilemma, but also feel concrete personal anguish over being the instrument used to inflict non-beneficial suffering on a patient. Family members of patients also go through their own decision-making process as they begin to have 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.

Without a law like the Texas Advanced Directives Act, these conversations might be intractable. With the statute, 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). Indeed, the vast majority of end-of-life decisions are resolved based on conversations between physicians and families. If disagreement remains, the process continues with a review by a medical ethics committee, which the family is invited to attend. If the ethics committee determines that the requested intervention is medically inappropriate based on the patient's particular medical circumstances, the process includes an additional period of at least 10 days in which the family can make its appeal to the larger medical community to locate a medical provider willing to receive a transfer of the patient so that it can undertake the requested additional medical intervention, consistent with its own view of the ethical concerns. It is only if all of those avenues are exhausted—and only if no other medical facility is willing to provide the requested medical intervention under the circumstances—that there might actually be a withdrawal of the requested treatment.

The Legislature enacted TADA after years of work by stakeholders to reach an effective consensus on its core principles. Although one of the groups that originally joined that effort has more recently sought to rewrite the Act using litigation, rather than with proposed legislation that might not garner support,[9] the amici believe that the central balance struck by the Legislature and enacted in TADA should be defended against

[9] *E.g.*, S.B. 2089, 86th Leg. R.S. (introduced version: would have indefinitely extended the 10-day period for seeking transfer); S.B. 2089, 86th Leg. R.S. (engrossed version: would have required policies on ethics committee membership, without imposing specific qualifications).

constitutional attack. If more subtle refinements to improve the Act are needed, they are more appropriately made through the legislative process.

ARGUMENT

I. MEDICAL FUTILITY LAWS BALANCE OTHER IMPORTANT INTERESTS, INCLUDING MAINTAINING THE INTEGRITY OF THE MEDICAL PROFESSIONS.

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.[10] The bill passed without a dissenting vote.[11] In 2015, certain portions of the Act were amended, including Texas Health and Safety Code §166.046, the provision challenged as unconstitutional by the Plaintiffs. Although there was initially some disagreement among the stakeholders about those amendments, they resolved those

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[10] *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).

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

differences during the legislative process.[12] The 2015 amendment to §166.046 passed the House unanimously and passed the Senate on a voice vote.[13]

The Act provides a legal safe-harbor within which physicians and hospitals can operate in regard to advance directives. It 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 therefore 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 from providing futile intervention, without risking malpractice liability. *Id.* §166.046. This aspect of TADA is known as its "medical futility" provision.

A foundational principle of medical ethics is that a physician can abstain from providing a particular medical intervention when 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 principles recommend an effort to transfer the patient, but "[i]f transfer is not possible, the physician is under no ethical obligation to offer the intervention." *Id.* §5.5. Patients,

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[12] "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…").

[13] Acts 2015, 84th Leg., ch. 435 (H.B. 3074), § 5, effective September 1, 2015.

similarly, retain the right to seek a new medical provider of their choice. "The physician-patient relationship is 'wholly voluntary.'" *Gross v. Burt*, 149 S.W.3d 213, 224 (Tex. App. —Fort Worth 2004, pet. denied).

The dilemma 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. As Dr. Robert Fine explained the history of the Act:

> 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. Robert 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."[14] She testified that research

[14] 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).

in this area shows "[t]he highest moral distress situations, for both registered nurses and physicians, … involve those situations on which caregivers feel pressured to continue aggressive treatment that prolongs suffering."[15] This distress can be so great that it causes nurses to leave the profession.[16] As Dr. Robert 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) (testimony of Dr. Robert Fine).

Medical futility necessarily involves complex medical judgments that would be difficult or impossible to prescribe in advance. Instead of applying 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.[17] One shortcoming in the AMA's approach was that it would have left physicians vulnerable to potential civil liability, even if they scrupulously followed the process to completion. *Id.* The Texas statute addressed that concern by providing a safe-harbor procedure which, if followed, would shield medical providers from liability. *Id.* at 146.

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[15] *Id.*

[16] *Id.*

[17] 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).

The safe harbor is an essential part of the statute. The statute does not compel a physician to personally continue to provide life-sustaining interventions that violate his or her ethical and moral beliefs as a doctor. 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;" further, it contemplates that a physician who wishes to personally withdraw from treatment may do so *without* following those formal procedures. *See* 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).

The Legislature's provision of a safe harbor serves legitimate and important goals in allowing physicians and other health care professionals to focus on 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.[18] 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).

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[18] *See* Testimony of Dr. Robert Fine, *supra* at page 5.

II. 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. What is striking is 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 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).[19]

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.

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

Within this survey sample, no patient was ultimately denied a requested life-sustaining intervention based on the statute. What these surveys underscore is that the effect of having this resolution process and safe-harbor, in the overwhelming number of cases, is to foster the needed conversations between patients, families, and physicians.

III. THE COMMITTEE PROCEDURE DOES NOT RESULT IN ANY DEPRIVATION OF A PROTECTED INTEREST.

Statutes of course begin with a presumption of constitutionality. "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).

Plaintiffs focus much of their constitutional challenge on the committee procedure in isolation, arguing that step of the process should be more legalistic in nature rather than focused on the medical and ethical concerns of prolonging life-sustaining intervention. Plaintiffs do not establish how the committee decision itself would deprive them of a protected interest. Under the statute, even after the committee decision, a family has the opportunity to seek a transfer to another medical facility that is ethically willing to make the requested life-sustaining intervention. TEX. HEALTH & SAFETY CODE §166.046(d)-(e).

Plaintiffs have also hedged on whether they are bringing a facial challenge or an as-applied challenge to the committee process. They appear to bring neither. They do not

focus on how any alleged defect in the statute actually affected the committee's resolution of this specific ethics case, as would be needed to frame an as-applied challenge. *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"). Nor do their arguments show how the "statute, by its terms, *always* operates unconstitutionally." *Tenet Hosps. Ltd. v. Rivera*, 445 S.W.3d 698, 702 (Tex. 2014) (emphasis added). When an alleged deprivation is merely conjectural or speculative—such as the Plaintiffs' insinuation that some members of a hospital ethics committee might not have suitable "qualifications" or that some could hypothetically be "conflicted"—they have failed to "meet their burden in this facial challenge of showing that, *under all circumstances*, the Act will deprive them" of a constitutionally protected interest. *Barshop v. Medina Cty. Underground Water Conservation Dist.*, 925 S.W.2d 618, 631 (Tex. 1996) (emphasis added). This is a heavy burden, but it is what the law requires to strike down a statute.

With regard to the composition of the committee, Plaintiffs suggest that the Legislature's design is unconstitutional because "[t]here are no specific restrictions under the act regarding the qualifications of the persons serving on the committee." Amended Pet. at 6. In part, this is because Texas has such a wide variety of hospitals, in both urban and rural settings, some of which may have specific religious or other affiliations. A survey conducted in 2012 by amicus Texas Hospital Association[20] showed that, among hospitals that had formed a formal ethics committee such as the one described by §166.046, a significant majority included social workers and chaplains, along with chief

[20] *See* page 8, *supra.*

nursing officers. The committees also included a range of other specialists (including psychologists, ethicists, and medical specialists). A majority of the surveyed committees also included community members, for a broader context on the ethical implications of the committee's deliberations. In any event, it is unclear how the Plaintiffs believe they were harmed, on these specific facts, by the actual composition of the Cook Children's ethics committee—let alone how allowing hospitals to form ethics committees consistent with medical practice and tailored to the needs of their community and the specific medical specialities implicated in a case would "under all circumstances" deprive a person of some protected interest. *Barshop*, 925 S.W.2d at 631.

Plaintiffs also attack the motives of those who serve on hospital ethics committees, arguing that a hospital forming such a committee is unconstitutional because there is a "conflict of interest inherently present when the treating physician's decision is reviewed by the hospital 'ethics committee' to whom the physician has direct financial ties." Amended Pet. at 6. Implying an "inherent" inability to separate ethical concerns from financial ones does a disservice to the medical and other professionals who agree to serve on such a committee. Moreover, in practical terms, prohibiting any member of an ethics committee from having links to the entity itself could be a severe restriction on the ability of more rural hospitals to even form such a committee. It may also make it extraordinarily difficult for an ethics committee to include specialists with the appropriate medical expertise, when specialists would tend to have admitting privileges.

Plaintiffs and the Attorney General would have every ethics committee become rigidly legalistic, demanding a "record" and "evidentiary" standards toward meeting pre-

defined legislated criteria to which a lawyer might formulate a "reasoned objection." But if legal formalities were imposed onto every ethics committee as a matter of constitutional law, the effect would burden families already going through a medical crisis with the need and expense of hiring legal counsel. That burden would fall most heavily on families grappling with the ethical considerations for the first time or whose own ethical and moral views may not map neatly onto those of a legal advocacy group.

These attacks on the formality of the committee procedures also ignore that, in the statutory design, the committee is merely one institution's ethics-evaluation process—not necessarily the last institution that will consider the question. Under TADA, if a committee ultimately determines that further life-sustaining intervention would not be appropriate, there is at least a 10-day additional window of time provided for the family with the help of the attending physician and the hospital to secure a transfer of the patient to another facility that does believe the requested life-sustaining to be medically appropriate. TEX. HEALTH & SAFETY CODE §166.046(e).

It is also not entirely clear what additional legal review might reasonably follow from adopting more formalities at the committee stage. Would a court second guess the committee's determination of medical ethics? Would a court readily conclude—even when no other medical facility is willing to accept a transfer so that it can administer the requested life-sustaining intervention in the same circumstances—that the original ethics committee's decision failed to meet whatever deferential standard of review would be applied to a medical-ethics decision?

The family's option to seek a transfer is, in some meaningful sense, already an appeal to the broader medical community on the underlying question of medical ethics. And in that type of "appeal," rather than a legalistic one, the family does not need to persuade a majority of that community but merely to find one institution willing and able to accept the transfer. Plaintiffs have had that opportunity here. Indeed, it has been more than 40 days since the ethics committee made its determination. No institution has been located that is willing, ethically and morally, to make these requested interventions.

PRAYER

Through the Texas Advanced Directives Act, the Legislature has provided families and physicians with a framework for resolving difficult end-of-life decisions. This design includes a safe harbor encouraging physicians and medical institutions to provide multiple layers of review, culminating in a period of time for families to secure a transfer to another medical facility, during which life-sustaining intervention will continue to be provided. The amici believe that the framework created by TADA is essential and constitutional.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I certify that on December 11, 2019, this Brief of Amici Curiae was served on counsel of record by electronic mail:

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