IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
FORT WORTH DIVISION

BERMAN DE PAZ GONZALEZ AND EMERITA MARTINEZ-TORRES, INDIVIDUALLY AND AS HEIRS, AND ON BEHALF OF THE ESTATE OF BERMAN DE PAZ-MARTINEZ, Plaintiffs, v. THERESE M. DUANE, M.D., Defendant.	§ § § § § § § § § § § § § §	Civil Action No.: 4:20-cv-072-A

BRIEF IN SUPPORT OF
THERESE M. DUANE, M.D.'S MOTION FOR
SUMMARY JUDGMENT ON PLAINTIFFS' CLAIMS
AND ON THE DEFENSE OF QUALIFIED IMMUNITY

TABLE OF CONTENTS

TABLE OF AUTHORITIES

CASES

STATUTES

RULES

TREATISES

Defendant Therese M. Duane, M.D. ("Dr. Duane") files this brief in support of her Rule 56 motion for summary judgment on Plaintiffs' remaining § 1983 claims and on Dr. Duane's defense of qualified immunity.

INTRODUCTION

Plaintiffs are Berman De Paz Gonzalez ("De Paz Senior") and Emerita Martinez-Torres ("Torres")[1] (together, "Plaintiffs"). This case concerns the circumstances surrounding the unfortunate death of Plaintiffs' son, Berman De Paz-Martinez ("De Paz Jr."), on April 1, 2018 following injuries he sustained after jumping from a moving vehicle. Defendants' prior Rule 12(b)(6) motions and prior motion for summary judgment on qualified immunity were filed before discovery had commenced and therefore relied solely on the Plaintiffs' allegations in their live pleading. Those allegations asserted that Dr. Duane "intentionally chose to hasten [De Paz Jr.'s] death by physically extracting a breathing tube from his body" in an act Plaintiffs characterized as "euthanasia." (Doc. 46 at ¶¶ 31–33.) Plaintiffs also brazenly made the salacious accusation that Dr. Duane "improperly euthanized patients" at the Tarrant County Hospital District's ("Hospital District") public hospital, JPS Hospital, on other occasions based on patients' "race, national origin, or insurance status." (Doc. 46 at ¶¶ 27–41).

The light of discovery has now proved those sensational allegations to be entirely and categorically false. Rather, the true (and undisputed) facts show just the opposite. Dr.

[1] De Paz Senior and Torres initially brought claims in their capacities as representatives of De Paz's estate, but Plaintiffs dismissed those claims by filing a notice under Rule 41(a)(1)(A)(i). *See* Docs. 9 & 11.

Duane did not "euthanize" De Paz Jr. or intend to kill him when she removed him from a ventilator. Rather, the discovered evidence shows De Paz Jr. sustained non-survivable traumatic brain injuries when he jumped from a moving vehicle after an argument with his girlfriend. Though De Paz Jr. was in a severe coma and was assessed to have non-survivable injuries, after several days of treatment his breathing was stable. Dr. Duane therefore reasonably believed De Paz Jr. was capable of breathing on his own without the aid of a painful and invasive breathing tube and ventilator. And the determination that De Paz Jr. met criteria for removal of the ventilator was confirmed at the time by other medical providers.

Discovery has proved Plaintiffs have no competent summary judgment evidence to suggest Dr. Duane violated De Paz Jr.'s or Plaintiffs' civil rights. Nor do they have the evidence required to recover survivor or punitive damages. And even if they did, the evidence shows Dr. Duane is entitled to qualified immunity from Plaintiffs' claims. For those reasons, Dr. Duane is entitled to judgment dismissing Plaintiffs' claims as a matter of law.

FACTUAL BACKGROUND

A. Dr. Duane is an experienced and qualified trauma physician.

Dr. Duane is an experienced and qualified critical care and trauma surgeon. After graduating magna cum laude from medical school, Dr. Duane completed seven years of post-doctoral residencies and an additional fellowship in trauma and critical care, and has

over twenty years' experience practicing in those areas.[2] She is board certified by the American Board of Surgery in Surgical Critical Care and has been since October 2002.[3] Dr. Duane is also certified in Advanced Cardiac Life Support and Advanced Trauma Life Support.[4] Dr. Duane regularly participates in, and often leads, continuing medical education in critical care and life support.[5]

Dr. Duane has also written in the area of critical care and trauma, particularly with respect to end-of-life care, and she has conducted extensive clinical research in the field of critical care life support and end-of-life care.[6]

B. Overview of extubation.

Among the areas of Dr. Duane's specialty includes training, research, and experience in the criteria by which trauma patients are evaluated for use of a ventilator to assist in breathing.[7] The term "extubation" refers to the removal of the endotracheal tube from a patient's airway.[8] It is the final step in liberating a patient from mechanical ventilation so that the patient can breathe on his or her own.[9] As a general rule, the longer a patient is intubated, the more that patient is at risk for seriously adverse outcomes,

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[2] App. 84–85, Ex. D (Declaration of Therese M. Duane, M.D.) (hereinafter "Duane Decl.") at ¶¶ 3–5.
[3] App. 85, (Duane Decl.) at ¶ 5.
[4] *Id*.
[5] *Id*. at ¶¶ 5–6.
[6] App. 85–86 (Duane Decl.) at ¶¶ 6, 10.
[7] *Id*.
[8] App. 85 (Duane Decl.) at ¶ 8; App. 101, Ex. E (Expert Report of John G. O'Brien, M.D., F.A.C.S.) (hereinafter "O'Brien Report").
[9] App. 85 (Duane Decl.) at ¶ 8; App. 101 (O'Brien Report) at pg. 2.

including ventilator-associated pneumonia, increased dependence on the ventilator, and prolonged ICU stay.[10]

Generally, when a patient no longer needs assistance breathing, a patient is gradually weaned off mechanical ventilation until the patient can maintain sufficient ventilation and oxygenation.[11] Several commonly used indicators for determining the propriety of extubation include whether a patient's airway is open and clear, the respiratory rate, the presence of a cough/gag reflex, the strength of the patient's cough, and the patient's level of consciousness.[12] However, universally accepted threshold levels of cough strength, level of consciousness, and suctioning frequency have not been established.[13] Not all factors must be present, and the determination of whether to extubate is made on a case-by-case basis.[14]

One factor that has been shown to be correlated with successful extubation is the "rapid shallow breathing index" ("RSBI").[15] RSBI is the ratio of respiratory rate to tidal volume, which is a measure of the volume of air that flows into the lungs during each breath.[16] An RSBI of less than 105 breaths/min/L is associated with successful weaning from a ventilator, while an RSBI value of greater than 105 breaths/min/L is highly predictive of weaning failure.[17] Dr. Duane's research on the use of RSBI in determining

[10] App. 85 (Duane Decl.) at ¶ 8; App. 101 (O'Brien Report) at pg. 2.
[11] App. 85 (Duane Decl.) at ¶ 9; App. 101 (O'Brien Report) at pg. 2.
[12] App. 85 (Duane Decl.) at ¶ 9; App. 101 (O'Brien Report) at pg. 2.
[13] App. 86 (Duane Decl.) at ¶ 9.
[14] *Id*.
[15] App. 86 (Duane Decl.) at ¶ 10; App. 101 (O'Brien Report) at pg. 2.
[16] App. 86 (Duane Decl.) at ¶ 10; App. 101 (O'Brien Report) at pg. 2.
[17] App. 86 (Duane Decl.) at ¶ 10; App. 101 (O'Brien Report) at pg. 2.

whether to extubate a patient has been published in peer-reviewed journals, including *American Surgeon* and *The Archives of Surgery*.[18] While RSBI is widely used as an important factor in determining whether extubation is appropriate, it is not a fool-proof indicator for whether extubation will be successful.[19]

As described in the unrebutted expert report of John G. O'Brien, M.D., F.A.C.S. ("Dr. O'Brien"),[20] extubation does not equate to termination of life support when a patient meets extubation parameters.[21] Removal of a ventilator from such a patient is not the purposeful removal of life-sustaining treatment.[22] Rather, where a patient meets extubation parameters, the decision whether to extubate is one made in the exercise of a physician's medical decision-making discretion.[23]

C. De Paz Jr.'s injuries and the care he received at JPS Hospital.

Plaintiffs' son, De Paz Jr., presented to the JPS Emergency Department via ambulance early on the morning of March 29, 2018.[24] The medical records note De Paz Jr. had jumped from a moving vehicle that was traveling at approximately 45 miles per hour.[25] On arrival in the emergency department, De Paz Jr. was in a coma. His Glasgow Coma Scale ("GCS")—which is a score used to evaluate the severity of a brain injury—

[18] App. 86 (Duane Decl.) at ¶ 10.
[19] App. 86 (Duane Decl.) at ¶ 11.
[20] A party is permitted to support or dispute summary judgment through unsworn expert reports, provided their contents can be presented in admissible form at trial. *Patel v. Tex. Tech Univ.*, 941 F.3d 743, 746–47 (5th Cir. 2019) (discussing Fed. R. Civ. P. 56(c)).
[21] App. 104–105 (O'Brien Report) at pp. 5–6.
[22] App. 104–105 (O'Brien Report) at pp. 5–6.
[23] App. 105 (O'Brien Report) at pg. 6.
[24] App. 57, Ex. A (Hospital District Records) (hereinafter "Medical Records").
[25] App. 57 (Medical Records).

was 3,[26] which indicated a severe brain injury.[27] The GCS score of 3 was confirmed by multiple providers.[28] De Paz Jr. also exhibited difficulty breathing, as well as other forms of physical distress.[29] De Paz Jr. required intubation, but his breathing was spontaneous with a bag valve mask.[30] Otherwise, De Paz Jr. was generally unresponsive.[31] A CT scan obtained in the emergency department showed a skull fracture and subdural hematoma and subarachnoid hemorrhage in developing herniation.[32] De Paz Jr. showed signs of acute renal failure due to his traumatic brain injury, and was on ventilator support.[33] De Paz Jr.'s condition was categorized as "serious"[34] and his prognosis was assessed as "grim."[35]

On March 29, 2018, De Paz Jr. was admitted to the Surgical Intensive Care Unit, or SICU.[36] On admission to the SICU, De Paz Jr.'s oxygen desaturations required that he receive continued ventilation support, and De Paz Jr. was placed on a BiLevel ventilator machine, which applies different inhalation and exhalation pressures to encourage a patient's lungs to operate more efficiently.[37] On exam, De Paz Jr.'s breathing was coarse, though unlabored, and his cough and gag reflex were noted to be absent.[38] De Paz Jr.'s

[26] App. 57 (Medical Records).
[27] App. 86 (Duane Decl.) at ¶ 13.
[28] App. 57, 60–62 (Medical Records).
[29] App. 57–60 (Medical Records).
[30] App. 57 (Medical Records).
[31] App. 58 (Medical Records).
[32] App. 68-69 (Medical Records).
[33] App. 60 (Medical Records).
[34] App. 23 (Medical Records).
[35] App. 60 (Medical Records).
[36] App. 49–56 (Medical Records).
[37] App. 55 (Medical Records); App. 88 (Duane Decl.) at ¶ 16.
[38] App. 49 (Medical Records).

respirations were 12 and his oxygen saturation level was 94% on supplemental oxygen.[39] The noted plan was to keep De Paz Jr. on the ventilator at that time, but to wean De Paz Jr. off of oxygen and the ventilator settings as tolerated.[40]

Dr. Duane first reviewed De Paz Jr.'s note and plan of care the morning on March 29, 2018 and agreed with the other providers' findings and plan.[41] Dr. Duane noted in the chart that De Paz Jr.'s GCS was 3, but that he did have a cough reflex and was breathing.[42] De Paz Jr.'s CT scans showed worsening bleeding in the brain and more edema, or fluid accumulation.[43] Dr. Duane planned to continue medications to prevent brain swelling and seizure, and the SICU continued to administer intravenous fluids.[44] De Paz Jr.'s breaths were spontaneous and the plan was to continue De Paz Jr.'s then current ventilator settings.[45] His chest X-ray was clear.[46] Dr. Duane assessed De Paz Jr.'s injury as non-survivable, but she noted that she would continue to follow De Paz Jr.'s progress.[47] At that time, the SICU team expected De Paz Jr. to progress to brain death while in the SICU.[48]

[39] App. 55 (Medical Records).
[40] App. 55 (Medical Records).
[41] App. 56 (Medical Records); App. 88 (Duane Decl.) at ¶ 17.
[42] App. 56 (Medical Records).
[43] App. 21–22, 47, 66–67, 68–69 (Medical Records); App. 88, 89 (Duane Decl.) ¶¶ 17, 19.
[44] App. 56 (Medical Records).
[45] App. 56 (Medical Records); App. 88 (Duane Decl.) at ¶ 17.
[46] App. 56 (Medical Records).
[47] App. 56 (Medical Records); App. 88–89 (Duane Decl.) at ¶ 17.
[48] App. 56 (Medical Records); App. 89 (Duane Decl.) at ¶ 17.

Later, on March 29, a neurosurgery team independently assessed[49] De Paz Jr.'s GCS as 3[50] and his injury as "non-survivable."[51] The exam noted De Paz Jr. had a worsening neurological exam and continued bleeding of the brain.[52] They believed De Paz Jr. was not a candidate for surgical intervention and had no further recommendations from a neurosurgical standpoint.[53] The neurosurgeon expected a poor outcome, but noted that the CT scan should be repeated the following morning to continue to monitor De Paz Jr.'s progression.[54]

Dr. Duane rounded on and examined De Paz Jr. on the morning of March 30, 2018 along with a nurse practitioner.[55] De Paz Jr. remained on ventilator support and had some seizure activities with stimulation and other symptoms of distress, such as swelling and increased blood pressure.[56] De Paz Jr. continued to be unresponsive with no speech and no spontaneous eye opening.[57] Though he was still intubated, his cough and gag reflex were intact.[58] He also exhibited spontaneous respirations with ventilator support.[59] His lungs exhibited reduced breath sounds, which indicated they were generally clear, and his

[49] App. 38–48 (Medical Records); App. 90 (Duane Decl.) at ¶ 21.
[50] App. 40 (Medical Records).
[51] App. 48 (Medical Records).
[52] App. 48 (Medical Records).
[53] App. 48 (Medical Records); App. 90 (Duane Decl.) at ¶ 21.
[54] App. 48 (Medical Records).
[55] App. 32–38 (Medical Records); App. 91–92 (Duane Decl.) at ¶ 24.
[56] App. 33 (Medical Records).
[57] App. 34 (Medical Records).
[58] App. 34 (Medical Records): App. 91 (Duane Decl.) at ¶ 24.
[59] App. 34 (Medical Records).

chest wall exhibited no tenderness.[60] The nurse practitioner noted in the chart that the plan was to continue to wean De Paz Jr. from the ventilator as tolerated.[61] As of that morning, his respirations had improved to 19 and his oxygen saturation level on supplemental oxygen was 99%.[62] Dr. Duane supervised the nurse practitioner's evaluation of De Paz Jr. and agreed with her recommendation and evaluation that weaning was appropriate.[63] Dr. Duane also noted, however, that De Paz Jr. exhibited more brain swelling and that this, combined with his GCS score of 3, indicated that his injuries were nonsurvivable.[64]

Dr. Duane noted in the chart a plan to have a meeting with De Paz Jr.'s family so that they would understand that we could only move forward with comfort measures due to futility of care.[65]

Another neurosurgical team independently evaluated De Paz Jr. on March 30, 2018.[66] De Paz Jr.'s GCS was again categorized as a 3.[67] The neurosurgeon's findings from a new CT scan again showed that De Paz Jr.'s brain injury was "worsening" and not survivable.[68] The team noted: "There are no surgical interventions that would improve or change the final outcome."[69]

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[60] App. 34 (Medical Records).
[61] App. 37 (Medical Records); App. 91 (Duane Decl.) at ¶ 24.
[62] App. 37 (Medical Records).
[63] App. 37 (Medical Records); App. 91 (Duane Decl.) at ¶ 24.
[64] App. 38 (Medical Records): App. 91 (Duane Decl.) at ¶ 24.
[65] App. 38 (Medical Records): App. 91 (Duane Decl.) at ¶ 24.
[66] App. 4–11 (Medical Records); App. 92 (Duane Decl.) at ¶ 25.
[67] App. 5 (Medical Records).
[68] App. 10 (Medical Records).
[69] App. 10 (Medical Records).

On the afternoon of March 30, 2018, a nurse practitioner met with De Paz Jr.'s family for a physician and pastoral care family conference.[70] The notes reflect that the nurse practitioner explained to De Paz Jr.'s family that he had suffered a severe traumatic brain injury and that his prognosis was poor. The purpose of the conference was to discuss the worsening CT findings and De Paz Jr.'s poor clinical exam with unlikely recovery. The notes show De Paz Jr.'s family asked questions, including whether De Paz Jr. would wake up, whether they should have hope, and whether he was suffering.[71] The notes reflect the nurse practitioner and De Paz Jr.'s family discussed De Paz Jr.'s wishes.[72] At the meeting, the chart also reflects that Plaintiffs determined to categorize De Paz Jr. as DNR-A.[73] "DNR-A" means that an order was put in the patient's chart stating that the patient is not to be resuscitated—either by restarting the patient's heart or by re-intubation—if the patient goes into cardio pulmonary arrest.[74] At their depositions, the Plaintiffs each testified they could not remember whether they told medical personnel to designate De Paz Jr. as "DNR-A" at that meeting and therefore could not dispute the accuracy of those notes.[75]

[70] App. 31 (Medical Records).
[71] App. 31 (Medical Records).
[72] App. 31 (Medical Records).
[73] App. 31 (Medical Records).
[74] App. 93 (Duane Decl.) at ¶ 26.
[75] App. 122–23, Ex. F (De Paz Senior Dep.) at 80:18–81:7 (testifying that De Paz Senior does not recall whether or not he authorized the "DNRA" designation for De Paz Jr. one way or the other); App. 133–34, Ex G (Torres Dep.) at 61:22–62:8 (after testifying to an understanding that "DNR" means the patient will not be resuscitated, stating: "Q. And you're not testifying that the family did not decide to make Berman a DNR-status patient. You just don't have any recollection of doing so? A. Yes.").

The chart further reflects De Paz Jr.'s parents told the nurse practitioner that they wished to meet with the chaplain and with De Paz Jr.'s family before making a decision about comfort care measures.[76] The notes reflect that De Paz Jr.'s family would need additional education regarding De Paz Jr.'s condition and the goals of treatment.[77] The nurse practitioner's notes do *not* indicate that the Plaintiffs were told they would be able to take De Paz Jr. home, as they have alleged in this suit.[78]

Dr. Duane and a nurse practitioner again rounded on De Paz Jr. on the morning of March 31, 2018.[79] During their examination that day, the nurse practitioner noted there was no obvious collapsed lung and his endotracheal tube was stable.[80] He also had a stable chest x-ray with no significant changes. Though his neurological function was unchanged and he maintained his GCS of 3,[81] De Paz Jr.'s cough and gag reflex were intact and he was breathing spontaneously with the support of the ventilator.[82] Because De Paz Jr.'s repeat chest X-ray was clear, repeated chest X-rays were discontinued.[83] The chart also notes that there would be another meeting with the family.[84]

On the afternoon of March 31, 2018, the nurse practitioner met again with De Paz Jr.'s family.[85] She again explained that De Paz Jr. had a traumatic brain injury with a poor

[76] App. 31 (Medical Records).
[77] App. 31 (Medical Records).
[78] *See* App. 31 (Medical Records).
[79] App. 24–30 (Medical Records); App. 93 (Duane Decl.) at ¶ 28.
[80] App. 26 (Medical Records).
[81] App. 30 (Medical Records).
[82] App. 26 (Medical Records); App. 93 (Duane Decl.) at ¶ 28.
[83] App. 30 (Medical Records); App. 93 (Duane Decl.) at ¶ 28.
[84] App. 30.
[85] App. 19–20 (Medical Records); App. 94 (Duane Decl.) at ¶ 30.

prognosis and confirmed his DNR-A status.[86] De Paz Jr.'s mother, father, sister, and aunt were present at the meeting. They asked why De Paz Jr. was moving. The nurse explained that they were seeing non-voluntary movements as a result of the traumatic brain injury in addition to reflexive movements with stimuli.[87] De Paz Jr.'s family stated that they believed in miracles and that they did not wish to stop treatment at that time.[88] They also did not wish to pursue comfort measures and asked for more time. Again, the nurse's notes do not indicate that the Plaintiffs were told they would be able to take De Paz Jr. home.[89]

At 3:21 a.m. on April 1, the nurse practitioner rounded on De Paz Jr.[90] She first reviewed his history since he had arrived in the emergency department approximately three days prior. The nurse noted that in the past 24 hours De Paz Jr.'s neurological symptoms and prognosis were unchanged, but he showed no active sign of seizure activity.[91] He continued to receive medications and fluids. He was still intubated and unresponsive, including no speech, no spontaneous eye opening, and unequal pupils. However, De Paz Jr.'s cough and gag reflex were both intact.[92] He also exhibited spontaneous respirations with ventilator support and clearer breathing sounds in his lungs.[93] His ventilator settings were then set to pressure support ventilation to further wean De Paz Jr. off of reliance on

[86] App. 19 (Medical Records).
[87] App. 20 (Medical Records).
[88] App. 20 (Medical Records).
[89] *See* App. 19–20 (Medical Records).
[90] App. 13–19 (Medical Records).
[91] App. 13 (Medical Records).
[92] App. 14 (Medical Records).
[93] App. 14–15 (Medical Records).

the ventilator.[94] "Pressure support ventilation" is the augmentation of spontaneous breathing effort with a specific amount of positive airway pressure.[95] This allows a patient to initiate breathing and set his or her own respiration rate and the volume of each breath, which in turn decreases the ventilator's work of breathing for a patient who is being weaned from mechanical ventilation.[96] The nurse also reviewed De Paz Jr.'s extensive lab results. The nurse recommended that weaning protocols be continued as tolerated.[97]

Later that same morning, Dr. Duane reviewed the nurse practitioner's entire note and recommendations and was in agreement.[98] De Paz Jr. remained a GCS 3.[99] Dr. Duane noted that De Paz Jr. continued to have hypertension and an irregular heart beat despite best efforts to control them, further underlining that the care De Paz Jr. was receiving was not improving his extensive injuries and that his injuries were not survivable.[100] But, De Paz Jr.'s RSBI was 67[101] and he had a cough and gag reflex.[102] Those criteria were well within extubation parameters, and extubation was clinically indicated.[103] The plan of care moving forward was to continue weaning De Paz Jr. from the ventilator and to extubate him.[104] Dr. Duane met with De Paz Jr.'s respiratory therapist who agreed that De Paz Jr.

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[94] App. 15, 17 (Medical Records); App. 94 (Duane Decl.) at ¶ 31.
[95] App. 94–95 (Duane Decl.) at ¶ 31.
[96] App. 95 (Duane Decl.) at ¶ 31.
[97] App. 17 (Medical Records).
[98] App. 18–19 (Medical Records); App. 95 (Duane Decl.) at ¶ 32.
[99] App. 18 (Medical Records).
[100] *See* App. 18 (Medical Records); App. 95 (Duane Decl.) at ¶ 32.
[101] App. 63–64, 76 (Medical Records); App. 95 (Duane Decl.) at ¶ 32.
[102] App. 18 (Medical Records); App. 95 (Duane Decl.) at ¶ 32.
[103] App. 95 (Duane Decl.) at ¶ 32; App. 104 (O'Brien Report) at pg. 5.
[104] App. 17–18 (Medical Records).

met the appropriate parameters for extubation at that time.[105] The nurse practitioner also agreed with Dr. Duane's assessment.[106] Dr. O'Brien's report confirms extubation of a patient who meets extubation parameters is not equivalent to termination of life support.[107]

Dr. Duane specifically noted in the chart that, on the morning of April 1st, she discussed De Paz Jr.'s prognosis, the staff's shared findings, and the plan of care at length with De Paz Senior with the help of an interpreter.[108] Dr. Duane reemphasized to De Paz Senor that De Paz Jr. was critically injured and that all of his treating physicians and advanced care providers were in agreement that this case was not recoverable and not survivable. Dr. Duane also emphasized previous family meetings (also with an interpreter in attendance) in which the family agreed to make De Paz Jr. a DNR-A patient, and De Paz Senior agreed that this decision would stand. Dr. Duane also carefully explained to De Paz Senior that De Paz Jr. met extubation parameters and that, as with any other patient, the plan was to extubate him to allow him to breathe on his own.[109] The decision to extubate a patient who meets extubation parameters is similar to choosing which medications to administer or whether to order a particular test—it is not a decision that requires the consent of the patient's family, even under such circumstances.[110] Nevertheless, Dr. Duane did take time to explain the extubation plan and the basis for this

[105] App. 18, 63–64 (Medical Records); App. 95 (Duane Decl.) at ¶ 32.
[106] App. 17 (Medical Records).
[107] App. 105 (O'Brien Report) at pg. 6.
[108] App. 18–19 (Medical Records); App. 95–96 (Duane Decl.) at ¶ 33.
[109] App. 19 (Medical Records); App. 96 (Duane Decl.) at ¶ 33.
[110] App. 96 (Duane Decl.) at ¶ 33.

decision to extubate as a courtesy to the family.[111] Dr. Duane explained that De Paz Jr.'s remaining on the ventilator would not heal his brain and that his brain would not recover.[112] Through the interpreter, De Paz Senior voiced understanding of all of this, though he was obviously grieving, angry, and hoping for a miracle.[113] Dr. Duane offered De Paz Senior her sincere condolences and prayers for the terrible situation.[114]

De Paz Senior's deposition testimony confirms that Dr. Duane believed De Paz Jr. would survive extubation. Specifically, according to De Paz Senior, Dr. Duane told him "*that with the tube or without the tube, he [De Paz Jr.] would continue being the same*"[115] and that "*the way he was on the machine or off the machine, he would continue the same*."[116] Thus, the medical records, Dr. Duane's testimony, Dr. O'Brien's report, and De Paz Senior's own testimony all confirm this key fact: Dr. Duane did not believe extubation would cause a change in De Paz Jr.'s condition or result in his immediate death. Thus, for Dr. Duane, the decision to extubate was a reasonable exercise of her medical decision-making discretion as a licensed physician.[117] Her decision was not to purposefully remove life-sustaining treatment, but to remove an unnecessary one.[118]

At the end of the conversation with De Paz Senior, and after confirming that he understood the plan of care, the notes reflect Dr. Duane consulted with a general surgeon

[111] App. 19 (Medical Records).
[112] App. 19 (Medical Records).
[113] App. 19 (Medical Records).
[114] App. 19 (Medical Records); App. 96 (Duane Decl.) at ¶ 33.
[115] App. 124–25, Ex. F (De Paz Senior Dep.) at 88:22–89:6 (emphasis added).
[116] App. 125–26, Ex. F (De Paz Senior Dep.) at 89:23–90:3 (emphasis added).
[117] App. 105–106 (O'Brien Report) at pp. 5–6; App. 95 (Duane Decl.) at ¶ 32.
[118] *See* App. 106 (O'Brien Report) at pg. 6; App. 95 (Duane Decl.) at ¶ 32.

regarding the plan of care to confirm that Dr. Duane was following all appropriate medical procedures and protocols.[119] The surgeon confirmed that he agreed with Dr. Duane's plan of care and that Dr. Duane was in compliance with appropriate procedures and protocols.[120]

Dr. Duane, assisted by JPS personnel, then ordered De Paz Jr.'s extubation.[121] Prior to extubation, Dr. Duane administered a very low dose of Fentanyl (25 mg) to prevent De Paz Jr. from being in any pain during extubation and to prevent him from breathing too quickly following extubation. If a patient breathes too quickly, it can cause a patient to fail extubation.[122] Unfortunately, despite following appropriate protocols and procedures, De Paz Jr. soon became hypoxic after extubation and so the nurse continued to treat him with supplemental oxygen.[123] De Paz Jr. did not tolerate the supplemental oxygen and died shortly thereafter.[124] As De Paz Jr. was designated DNR-A, no chest compressions were initiated and De Paz Jr. was not re-intubated.[125]

The general surgeon pronounced De Paz Jr. dead. He also specifically noted that De Paz Jr. met extubation parameters one day prior and thus was extubated that morning at approximately 6:08 a.m. by Dr. Duane.[126] The surgeon had a conversation with De Paz Jr.'s family and they told the surgeon that they were concerned that the stories regarding

[119] App. 19 (Medical Records); App. 96 (Duane Decl.) at ¶ 34.
[120] App. 19 (Medical Records).
[121] App. 65 (Medical Records); App. 96 (Duane Decl.) at ¶ 35.
[122] App. 95 (Duane Decl.) at ¶ 35.
[123] App. 19 (Medical Records); App. 96 (Duane Decl.) at ¶ 35.
[124] App. 2–3, 19 (Medical Records); App. 96 (Duane Decl.) at ¶ 35.
[125] App. 2, 19 (Medical Records); App. 96 (Duane Decl.) at ¶ 35.
[126] App. 12 (Medical Records).

the causative automobile incident leading to De Paz Jr.'s injury did not "add up."[127] They requested a formal autopsy. The surgeon noted in the file that he would contact the Tarrant County Medical Examiner to arrange the autopsy.[128]

After an autopsy, the Tarrant County Medical Examiner concluded De Paz Jr.'s cause of death was "BLUNT FORCE TRAUMA OF THE HEAD DUE TO FALL FROM MOVING MOTOR VEHICLE."[129] The death certificate reflected the same causes of death.[130]

D. Plaintiffs are contacted by advocacy group Direct Action Texas.

About three to five months after De Paz Jr.'s death, a person named "Aaron" with Direct Action Texas contacted De Paz Senior suggesting that his son's death may have been intended by Dr. Duane.[131] There is no indication De Paz Senior believed there had been any problem in the care provided De Paz Jr. before Direct Action Texas sought DePaz Senior out and convinced him to provide a medical waiver to obtain De Paz Jr.'s medical records. De Paz Senior authorized the release of records based on the representation that Direct Action Texas "knew that with this doctor, the same thing had happened with about ten other people. And that possibly it was only with Hispanic people and that's why she would take advantage of that, and do that to Hispanic people."[132] Apparently Direct Action Texas's information came from one or more anonymous sources, an example of which

[127] App. 12 (Medical Records).
[128] App. 12 (Medical Records).
[129] App. 78, Ex. B (Tarrant County Medical Examiner's Autopsy Report).
[130] App. 83, Ex. C (Death Certificate).
[131] App. 114–17, Ex. F (DePaz Senior Dep.) at 35:13–38:19.
[132] App. 115, 117 (De Paz Senior Dep.) at 36:9-22, 38:9-15.

was filed with the First Amended Complaint as Exhibit B. (Doc. 46 at Ex. B.) An article published by Direct Action Texas that Plaintiffs attached to their First Amended Complaint as Exhibit A makes clear Direct Action Texas was unhappy with JPS Hospital's CEO, Robert Early, and also potentially the Tarrant County Commissioners' Court, and was raising questions as "JPS prepares to ask Tarrant County taxpayers for a billion-plus dollar bond." (Doc. 46 at Ex. A, p. 3). Thus, DePaz Jr.'s parents apparently had no complaint with the care their son received from Dr. Duane until a problem was suggested by a third party activist group intent on making a point about JPS Hospital's and Tarrant County's leadership.

E. Plaintiffs sued and recovered from non-parties who Plaintiffs alleged had caused De Paz Jr.'s injuries.

On November 4, 2019, De Paz Senior and Torres filed a lawsuit in the 348th District Court of Tarrant County, Texas against Isela Guijosa, Rico Serafin, and Deyanira Guijosa (the "State Lawsuit").[133] One of those persons – Deyanira Guijosa – was apparently De Paz Jr.'s girlfriend and was driving the car from which De Paz Jr. jumped.[134] Plaintiffs, on their own behalf and on behalf of De Paz Jr.'s minor child, claimed to be "wrongful death beneficiaries" of De Paz Jr. and sought damages from the defendants "in relation to a motor vehicle accident" that "occurred in the 2000 block of W. Seminary Dr. in Fort

[133] The State Lawsuit was styled *Berman De Paz, Sr. and Emerita Martinez Torres, Individually and as Next Friends of M.D.P., a Minor, all as Wrongful Death Beneficiaries of Berman Daniel De Paz v. Isela S. Guijosa, Rico Serafin, and Deyanira Guijosa*, Cause No. 348-313058, pending in the 348th District Court of Tarrant County, Texas. App. 138–39, Ex. H (State Lawsuit Orig. Pet.).

[134] App. 118–20, Ex. F (De Paz Senior Dep.) at 58:17–59:16, 60:4–14; App. 131–32, Ex. G (Torres Dep.) at 44:14–45:11.

Worth, Tarrant County, Texas on or about March 29, 2018."[135] Plaintiffs alleged in the State Lawsuit that their injuries as "wrongful death beneficiaries" occurred "as a direct and proximate result of the [State Lawsuit] Defendants' negligence" in connection with the motor vehicle accident.[136]

On August 12, 2021, the Tarrant County District Court entered a Judgment based on a monetary settlement with the State Lawsuit defendants that awarded sums of money to De Paz Jr.'s child and to Plaintiffs.[137]

F. Dr. Duane's employment with Acclaim, a government-owned and -controlled enterprise.

At the time of De Paz Jr.'s death, Dr. Duane was an employee of Acclaim Physician Group, Inc. ("Acclaim") working as a physician at JPS Hospital.[138] Acclaim is a non-profit physician group founded and wholly owned by Tarrant County Hospital District d/b/a JPS Health Network ("JPS").[139] The Hospital District, in turn, is a county hospital district created under Chapter 281 of the Texas Health and Safety Code.[140] Tex. Health & Safety Code §§ 281.001–.124.

The Hospital District founded Acclaim as a "charitable organization" within the meaning of Texas Health and Safety Code § 281.0565 to facilitate the management of the

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[135] App. 138–39 (State Lawsuit Orig. Pet.).
[136] App. 139 at ¶ IV.
[137] Ap p. 140–44 (State Lawsuit Judgment).
[138] App. 85 (Duane Decl.) at ¶ 7; App. 182 (Thompson Decl.) at ¶ 7. The University of North Texas Health Science Center was a co-founder, but it is no longer a member, and Acclaim's sole member is JPS. *See* App. 159 (Cert. of Formation); App. 182 (Thompson Decl.) at ¶¶ 4–5.
[139] App. 85 (Duane Decl.) at ¶ 7; App. 168 (TMB Certification); App. 182 (Thompson Decl.) at ¶ 4.
[140] App. 182 (Thompson Decl.) at ¶ 4.

Hospital District's healthcare program.[141] Tex. Health & Safety Code § 281.0565. Acclaim employs and manages physicians, such as Dr. Duane, who work at Hospital District facilities, including JPS Hospital.[142] Acclaim also assists the Hospital District in developing resources for its healthcare services and provides ancillary support services through oversight and administration of various Hospital District departments, including JPS Hospital's emergency department and surgical intensive care unit.[143] Acclaim operates solely for the benefit of the Hospital District and its residents, and exists to support, promote, and advance the Hospital District's mission.[144]

At the motion-to-dismiss stage, Acclaim presented evidence of these facts and asserted that it was a unit of government for purposes of the Texas Tort Claims Act. (Docs 16 & 17.) Plaintiffs did not contest that assertion at that time. (*See* Docs. 16 & 17.) Nor did Plaintiffs contest those facts when Dr. Duane moved for summary judgment on qualified immunity before the parties had conducted discovery. (*See* Doc. 72.)

ARGUMENT AND AUTHORITIES

I. Summary-Judgment Standard

A movant is entitled to "summary judgment if the movant shows that there is no genuine dispute as to any material fact and the movant is entitled to judgment as a matter of law." Fed. R. Civ. P. 56(a). Disputes concerning material facts are genuine if "the evidence is such that a reasonable jury could return a verdict for the nonmoving

[141] App. 182 (Thompson Decl) at ¶ 5.
[142] App. 170 (Prof. Servs. Agrmt.) at ¶ 1.1; App. 182 (Thompson Decl) at ¶ 6.
[143] App. 171 (Prof. Servs. Agrmt.) at ¶ 1.2; App. 182 (Thompson Decl.) at ¶ 6.
[144] App. 182 (Thompson Decl.) at ¶ 4.

party." *Douglass v. United Servs. Auto. Ass'n*, 79 F.3d 1415, 1429 (5th Cir. 1996) (en banc) (quoting *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248 (1986)). An issue is "material" if it involves a fact that might affect the outcome of the suit under the governing law. *Anderson*, 477 U.S. at 248; *Burgos v. Southwestern Bell Telephone Co.*, 20 F.3d 633, 635 (5th Cir. 1994). "The movant bears the burden of identifying those portions of the record it believes demonstrate the absence of a genuine issue of material fact." *Triple Tee Golf, Inc. v. Nike, Inc.*, 485 F.3d 253, 261 (5th Cir. 2007) (citing *Celotex Corp. v. Catrett*, 477 U.S. 317, 322-25 (1986)).

When a movant carries his or her initial burden, the burden then shifts to the nonmovant to "designate specific facts showing that there is a genuine issue for trial." *Celotex*, 477 U.S. at 324 (quoting Fed. R. Civ. P. 56(e)); *Duckett v. City of Cedar Park, Tex.*, 950 F.2d 272, 276 (5th Cir. 1992). Although the nonmovant may satisfy this burden by tendering depositions, affidavits, and other competent evidence, "conclusory allegations, speculation, and unsubstantiated assertions are inadequate to satisfy the nonmovant's burden," *Douglass*, 79 F.3d at 1429, as "the adverse party's response ... must set forth specific facts showing that there is a genuine issue for trial." Fed. R. Civ. P. 56(e). Merely colorable evidence or evidence not significantly probative, however, will not defeat a properly supported motion for summary judgment. *Anderson*, 477 U.S. at 249–50. Furthermore, a mere scintilla of evidence will not defeat a motion for summary judgment. *Anderson*, 477 U.S. at 252; *Davis v. Chevron U.S.A., Inc.*, 14 F.3d 1082, 1086 (5th Cir. 1994).

II. Dr. Duane is entitled to summary judgment on Plaintiffs' § 1983 claims as a matter of law.

Plaintiffs' First Amended Complaint asserts procedural and substantive due process claims against Dr. Duane under 42 U.S.C. § 1983. First, it alleges Dr. Duane violated constitutional due process by depriving De Paz Jr. of his "life and liberty interests (e.g., the right to bodily integrity) inherent in the Constitution itself, without due process of law." (Doc. 46 at ¶ 49.) Second, the Complaint alleges Dr. Duane violated De Paz Jr.'s and Plaintiffs' personal life, liberty, and property interests without due process of law by failing to follow the Texas Advance Directives Act ("TADA"). (*Id.*)

The Court dismissed Plaintiffs' claims based on alleged violations of the TADA by order dated November 18, 2021. (Doc. 58 at pp. 12-13.) Because Plaintiffs have insufficient evidence to prove their remaining claim that Dr. Duane violated De Paz Jr.'s due process right to life and bodily integrity, and because they have insufficient evidence to recover survivor damages under the Texas wrongful death and survivor statutes or punitive damages, the Plaintiffs' remaining § 1983 claim against Dr. Duane should also be dismissed as a matter of law.

A. Plaintiffs cannot meet their evidentiary burden to prove a violation of § 1983.

Plaintiffs' remaining § 1983 claim against Dr. Duane is based on the allegation that "Dr. Duane made an intentional decision to extubate [De Paz Jr.] without the informed consent of his parents, and medical records indicate that she did so with the full expectation that extubation would result in Mr. De Paz Jr.'s death." (Doc. 46 at pg. 8.) Plaintiffs' responses to interrogatories separately assert the basis of Plaintiffs' claim is the

failure to afford "notice and opportunity to be heard … before life support was removed."[145]

When responding to Defendants' Rule 12(b)(6) motions, the only cases Plaintiffs cited to support the assertion that they have a claim against Dr. Duane for the alleged withdrawal of life-sustaining treatment without notice and an opportunity to be heard were the Supreme Court's decision in *Cruzan v. Dir., Mo. Dep't of Health*, 497 U.S. 261 (1990) and the Fort Worth Court of Appeals' decision in *T.L. v. Cook Children's Med. Ctr.*, 607 S.W.3d 9 (Tex. App.—Fort Worth 2020, pet. denied). (*See* Doc. 54 at pp. 4-13.) In both cases, however, it was not disputed that the decision at issue concerned withdrawal of "life-sustaining treatment" such that, if the treatment were to be removed, the necessary result would be the patient's eventual death. *See, e.g.*, *Cruzan*, 497 U.S. at 265, 269, 281, 283 (describing the issue as "withdrawal" or "termination" of "life-sustaining treatment"); *T.L.*, 607 S.W.3d at 22–23 (noting issue concerned "discontinuation," "termination," or "withdrawal" of "life-sustaining treatment"). In *Cruzan*, for example, the guardians of a patient in a persistent vegetative state sought a court order for the "withdrawal" of "artificial feeding and hydration equipment," which it was agreed would lead to the patient's eventual death. *Cruzan*, 497 U.S. at 266–68. And in *T.L.*, a child was kept alive by "ventilation and nasogastric tubes and two IVs for purposes of oxygenation, medication, hydration, and nutrition," which measures the hospital sought to discontinue over the parents' objection. *T.L.*, 607 S.W.3d at 27. There was no dispute in these cases

[145] App. 147, Ex. J (De Paz Senior's Resp. to Interrog.) at Resp. to Interrog. No. 24; App. 153, Ex. K (Torres's Supp. Resp. to Interrog.) at Resp. to Interrog. No. 24.

that the medical interventions were "life-sustaining treatments" that were necessary for the patients' continued survival.

In contrast, there is no evidence to support the Plaintiffs' allegation that Dr. Duane believed she was removing "life-sustaining treatment" when she made the decision to extubate De Paz Jr. Rather, the overwhelming and undisputed summary evidence—from Dr. Duane, from De Paz Jr.'s medical chart, from the only expert designated by any party, John G. O'Brien, M.D. ("Dr. O'Brien"), and from De Paz Senior's own testimony[146]—proves that, for Dr. Duane and the other providers at JPS Hospital, removal of De Paz Jr.'s breathing tube was not an "end-of-life" decision. Rather, Dr. Duane reasonably believed that De Paz Jr. satisfied recognized criteria indicating that he could breathe on his own without the aid of a ventilator. The summary judgment record shows Dr. Duane reviewed De Paz Jr.'s intact cough and gag-reflex, observed his breathing, reviewed his chest x-rays and other pertinent factors, such as his RBSI below 105, consulted a respiratory therapist and a general surgeon, and reasonably concluded that De Paz Jr. likely would *survive* removal of his breathing tube, not die from lack of oxygen.[147] That is why she told De Paz Senior that "with the tube or without the tube, *he [DePaz Jr.] would continue being the same*."[148]

While Dr. Duane did believe De Paz Jr. would eventually succumb to the traumatic brain injuries he suffered when jumping from a moving vehicle, she also reasonably

[146] App. 124–26, Ex. F (De Paz Senior Dep.) at 88:22–89:6 and 89:23–90:3.
[147] *See, e.g.,* App. 5, 11, 14, 18, 19, 26, 34, 64 (Medical Records); App. 95 (Duane Decl.) at ¶ 32; App. 103–105 (O'Brien Report).
[148] App. 125, Ex. F (De Paz Senior Dep.) at 89:4-6 (emphasis added).

believed extubation would not hasten his death. Rather, she believed it would prevent or reduce the likelihood of other potential complications.[149] This decision was not an end-of-life decision, but a normal decision made in the ordinary course of care for the patient's benefit.[150] The unrebutted testimony of Dr. Duane's designated testifying expert, Dr. O'Brien, confirms that Dr. Duane's belief that De Paz Jr. would survive extubation was reasonable and an appropriate exercise of Dr. Duane's medical decision-making authority and discretion.[151]

Because the Plaintiffs did not designate any expert testimony, they cannot counter Dr. Duane's summary judgment evidence on this point. Where a matter in issue is beyond the general experience and common knowledge of a lay person, expert testimony is required. *See Johnson v. Arkema, Inc.*, 685 F.3d 452, 471 (5th Cir. 2012) (holding expert testimony necessary to determine causation of chronic injuries where issues were beyond common sense and general experience of a lay witness); *Qualls v. State Farm Lloyds*, 226 F.R.D. 551, 558 (N.D. Tex. 2005) (holding that, under Texas law, expert testimony was required to establish causation of issue that is beyond the "general experience and common sense of a lay person"). Where expert testimony is required, a jury cannot accept a lay person's opinion over that of an expert. *Qualls*, 226 F.R.D. at 558–59 (citing *Selig v. BMW of N. Am., Inc.*, 832 S.W.2d 95, 100 (Tex. App.—Houston [14th Dist.] 1992, no writ)); *Anderson v. Snider*, 808 S.W.2d 54, 55 (Tex. 1991).

[149] *See* App. 95 (Duane Decl.) at ¶ 32; App. 105 (O'Brien Report).
[150] *See* App. 95 (Duane Decl.) at ¶ 32; App. 105 (O'Brien Report).
[151] App. 104–105 (O'Brien Report).

Here, whether De Paz Jr. met the criteria for extubation, or whether Dr. Duane had a reasonable belief that that was so, is a complex issue that is the subject of specialized training and experience of the type possessed by Dr. Duane and Dr. O'Brien. It is certainly not within the common experience of a lay person. Because Plaintiffs did not designate any testifying experts in compliance with the Rules and the Court's Scheduling Order,[152] Plaintiffs cannot meet their summary judgment burden to create a genuine fact issue over whether extubation of De Paz Jr. under the circumstances constituted the withdrawal or termination of "life-sustaining treatment" as is necessary for Plaintiffs' to prove a violation of a constitutional right to notice and an opportunity to be heard under *Cruzan* or *T.L.*

Moreover, even if Plaintiffs had designated an expert who disagreed with Dr. Duane's assessment that De Paz Jr. could breathe on his own without the aid of a ventilator, the only factual dispute that would result from such evidence would be that Dr. Duane acted negligently in extubating De Paz Jr. "Unsuccessful medical treatment, however, does not give rise to a § 1983 cause of action. Nor does mere negligence, neglect or medical malpractice." *Aguocha-Ohakweh v. Harris Cnty. Hosp. Dist.*, 731 F. App'x 312, 315 (5th Cir. 2018) (citations and internal quotation marks omitted); *see also, e.g.*, *Baez v. I.N.S.*, No. 06-30112, 2007 WL 2438311, at *2 (5th Cir. Aug. 22, 2007) (per

[152] Notably, notwithstanding the Court's Order (Doc. 65) requiring the parties to (i) file a written designation identifying each proposed expert and the subject matter of the expert's testimony and (ii) serve the disclosures required by Rule 26(a)(2), Plaintiffs neither filed nor served any Rule 26(a)(2) expert designation in compliance with the Court's order or the Rules. Fed. R. Civ. P. 26(a)(2).

curium) (unpublished) (affirming denial of summary judgment because evidence simply showed disagreement with medical treatment).

For these reasons, Dr. Duane is entitled to summary judgment dismissing Plaintiffs' remaining § 1983 claims as a matter of law.

B. Plaintiffs cannot meet their evidentiary burden to prove causation necessary to recover survivor damages.

Even if Plaintiffs could establish a genuine fact issue on their allegation that Dr. Duane intended to "hasten" De Paz, Jr.'s death, they lack the evidence of causation necessary to obtain the survivor damages they seek.

The Fifth Circuit's earlier opinion in this proceeding noted that the Plaintiffs' standing to bring § 1983 claims for damages derives solely from § 1988's incorporation of remedies available to survivors under the Texas wrongful death and survival statutes.[153] *De Paz v. Duane*, 858 Fed. Appx. 734, 737–38 (5th Cir. 2021); *see Brazier v. Cherry*, 293 F.2d 401, 405 (5th Cir. 1961) (holding 42 U.S.C. § 1988 incorporates state wrongful death and survival statutes for those making claims under § 1983).

To recover survivor damages in Texas under § 1983, Plaintiffs must prove that De Paz Jr.'s death was caused by Dr. Duane's conduct. *Slade v. City of Marshall, Tex.*, 814 F.3d 263, 264–65 (5th Cir. 2016). The Fifth Circuit has explained a "lost chance" of survival is not enough to recover survivor damages under § 1983:

> [A] plaintiff seeking to recover under Texas's wrongful death statute must demonstrate that the defendant's wrongful actions more likely than not

[153] Plaintiffs previously voluntarily dismissed any claims they brought on behalf of Mr. De Paz-Martinez's Estate. (*See* Doc. 9 and Doc. 46 at 1 n.1.) Therefore their only claims are those asserted for their own injuries under Texas's survival statute.

> caused the decedent's death—not just that they reduced the decedent's chance of survival by some lesser degree.

Slade, 814 F.3d at 264–65 (citing *Kramer v. Lewisville Mem'l Hosp.*, 858 S.W.2d 397, 404 (Tex. 1993)). The Fifth Circuit's reasoning relied on the Texas Supreme Court's decision in *Kramer v. Lewisville Mem'l Hosp*. describing the level of causation required to recover under Texas' survival statute. *Id*. In *Kramer*, the court considered whether Texas law permits recovery for a "lost chance" of survival when a medical provider's conduct decreases a patient's chance of survival even where an adverse result probably would have occurred anyway. *Kramer*, 858 S.W.2d at 398. Evaluating Texas' existing law of causation, the *Kramer* court concluded Texas does not permit a claimant to recover under the survival statute based on a "loss of chance" where "preexisting illnesses or injuries have made a patient's chance of avoiding the ultimate harm improbable even before the allegedly negligent conduct occurs." *Id*. at 400, 404, 407.

Here, there is overwhelming evidence that De Paz Jr.'s true cause of death was the pre-existing traumatic brain injury he received when he jumped from a moving vehicle. Whether or not Dr. Duane's conduct "hastened" De Paz Jr.'s death, as Plaintiffs allege, there is no evidence De Paz Jr. had any chance of survival from his pre-existing brain injuries. The multiple physicians who evaluated De Paz Jr. agreed his injuries were not survivable.[154] The Tarrant County Medical Examiner confirmed those injuries caused De Paz Jr.'s death,[155] and Plaintiffs have designated no expert to contest that conclusion. And

[154] *See* App. 10, 38, 48, 56, 60 (Medical Records).
[155] App. 78, Ex. B (Autopsy Report).

as noted above, Plaintiffs cannot demonstrate a genuine fact issue on such a complex medical subject without qualified expert testimony. *See Johnson*, 685 F.3d at 471 (discussing the requirement in Texas law that expert testimony is required to establish complex medical facts that are beyond the common sense and experience of a lay person). Indeed, Plaintiffs' own State Lawsuit against the driver of the motor vehicle indicated Plaintiffs' belief that De Paz Jr.'s death was caused by De Paz Jr.'s "motor vehicle accident."[156]

Plaintiffs can adduce no competent summary judgment evidence to create a genuine fact issue on causation. Therefore, as a matter of law, Plaintiffs' claims for damages under § 1983 must be dismissed.

C. Plaintiffs are not entitled to punitive damages.

Plaintiffs have also asserted claims to recover punitive damages from Dr. Duane.[157] A plaintiff asserting claims under § 1983 may recover punitive damages only when the "defendant's conduct is shown to be motivated by evil motive or intent, or when it involves reckless or callous indifference to the federally protected rights of others." *Smith v. Wade*, 461 U.S. 30, 56 (1983).

Plaintiffs can produce no competent summary judgment evidence that Dr. Duane acted with any evil motive or intent, or with reckless or callous indifference to the rights of Plaintiffs. The undisputed evidence is that Dr. Duane acted as would a reasonable and

[156] App. 139 (State Lawsuit Petition) at ¶ II.

[157] Doc. 46, ¶ 51; App. 146, Ex. J (De Paz Senior's Resp. to Interrog.) at Resp. to Interrog. 17; App. 151–52 (Torres Supp. Resp. to Interrog.) at Resp. to Interrog. 17.

prudent physician in her position,[158] and that she did so in consultation with other qualified medical professionals.[159] Her judgment has been confirmed as reasonable by the undisputed expert testimony of Dr. O'Brien.[160] There is no genuine issue of fact for trial on the question of Plaintiffs' claim for punitive damages. That claim should also be dismissed.

III. Dr. Duane is entitled to summary judgment on her qualified immunity defense.

Even if the Court finds that Dr. Duane is not entitled to summary judgment on Plaintiffs' claims on the merits, now that the parties have had an opportunity to engage in discovery,[161] the summary judgment evidence demonstrates that Dr. Duane both (a) is entitled to claim the defense of qualified immunity, and (b) reasonably believed based on accepted medical criteria that De Paz Jr. was capable of breathing on his own following extubation such that there is no genuine issue of fact for trial on the question of whether Dr. Duane had any reason to believe that her order to extubate De Paz Jr., which order was given in the ordinary exercise of her medical discretion, would have violated a clearly established constitutional right.

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[158] *See* App. 94–96 (Duane Decl.) at ¶¶ 31–32, 34; App. 104–105 (O'Brien Report).

[159] *See* App. 94–96 (Duane Decl.) at ¶¶ 31–32, 34.

[160] App. 104–105 (O'Brien Report).

[161] When the Court first considered Dr. Duane's motion for summary judgment on the defense of qualified immunity, the parties had not yet engaged in discovery and the Court denied the motion, in part, because the Court was required to assume the Plaintiffs' facts were true. (Doc. 75 at pg. 16.)

A. Dr. Duane is eligible to assert qualified immunity.

As a threshold matter, Dr. Duane is eligible to assert qualified immunity. In the Fifth Circuit, privately employed doctors who provide services at public hospitals may assert qualified immunity so long as it is consistent with (1) general principles of tort immunity applicable at common law around the time of § 1983's enactment and (2) the purposes served by granting immunity. *See Perniciaro v. Lea*, 901 F.3d 241, 251 (5th Cir. 2018). Here, permitting Dr. Duane to assert qualified immunity is consistent with these objectives in light of Fifth Circuit precedent.

1. Dr. Duane's claim of qualified immunity is consistent with general principles of tort immunity existing at the time of § 1983's enactment.

"Understanding the protections the common law afforded to those exercising government power in 1871 requires an appreciation of the nature of government at that time." *Filarsky v. Delia*, 566 U.S. 377, 384 (2012). As the Supreme Court has explained, "[i]n the mid-19th century, government was smaller in both size and reach. It had fewer responsibilities, and operated primarily at the local level." *Id*. In turn, "[l]ocal governments faced tight budget constraints, and generally had neither the need nor the ability to maintain an established bureaucracy staffed by professionals." *Id*. (citing B. Campbell, The Growth of American Government: Governance From the Cleveland Era to the Present 14–16, 20–21 (1995)). Consequently, "to a significant extent, government was 'administered by members of society who temporarily or occasionally discharged public functions.'" *Id*. at 385 (quoting F. Goodnow, Principles of the Administrative Law of the United States 227 (1905)).

That is, "[p]rivate citizens were actively involved in government work, especially where the work most directly touched the lives of the people. . . . Even such a core government activity as criminal prosecution was often carried out by a mixture of public employees and private individuals temporarily serving the public." *Id.* Accordingly, "[a]t common law, courts 'did not draw a distinction between public servants and private individuals engaged in public service in according protection to those carrying out government responsibilities.'" *Perniciaro*, 901 F.3d at 251–52 (quoting *Filarsky*, 566 U.S. at 387).

For example, "Government actors involved in adjudicative activities . . . were protected by an absolute immunity from suit." *Filarsky*, 566 U.S. at 387 (citing *Bradley v. Fisher*, 13 Wall. 335, 347–348, 80 U.S. 335, 20 L.Ed. 646 (1872); J. Bishop, Commentaries on the Non–Contract Law § 781 (1889)). This absolute "immunity applied equally to 'the highest judge in the State or nation and the lowest officer who sits as a court and tries petty causes,' including those who served as judges on a part-time or episodic basis." *Id.* (quoting T. Cooley, Law of Torts 409 (1879)). To illustrate, justices of the peace "often maintained active private law practices (or even had nonlegal livelihoods), and generally served in a judicial capacity only part time." *Id*. (citing *Hubbell v. Harbeck*, 54 Hun. 147, 7 N.Y.S. 243 (1889); *Ingraham v. Leland*, 19 Vt. 304 (1847)). They "were not even paid a salary by the government, but instead received compensation through fees payable by the parties that came before them." *Id*. (citing W. Murfree, The Justice of the Peace § 1145 (1886)). Nevertheless, "the common law extended the same immunity 'to a

justice of the peace as to any other judicial officer.'" *Id*. (quoting *Pratt v. Gardner*, 56 Mass. 63, 70 (1848)).

Courts at "common law also extended certain protections to individuals engaged in law enforcement activities, such as sheriffs and constables," and "examples of individuals receiving immunity for actions taken while engaged in public service on a temporary or occasional basis are as varied as the reach of government itself." *Id*. at 387, 389. Such examples include wharfmasters, notaries, trustees of a public institution for the disabled, school board members, Board of Pilot Commissioners, and private election judges. *See id*. at 389 (collecting cases). In light of this history, in *Filarsky v. Delia*, the Supreme Court determined that the principles of tort immunity existing at the time of § 1983's enactment supported extending qualified immunity to a private attorney hired by a municipality to conduct a personnel investigation. *See id.* at 393–94.

The Supreme Court has also recognized that the common law provided "a kind of immunity" for private doctors "who performed services at the behest of the sovereign." *Richardson v. McKnight*, 521 U.S. 399, 407 (1997) ("Apparently the law did provide a kind of immunity for certain private defendants, such as doctors or lawyers who performed services at the behest of the sovereign."). And recently, in *Perniciaro v. Lea*, the Fifth Circuit determined that two psychiatrists who were employees of Tulane University, a private institution, were eligible to assert qualified immunity in a suit brought against them by a patient at a state-run mental health facility. 901 F.3d at 255. The psychiatrists had provided services at the facility pursuant to Tulane's contract with the State of Louisiana. *Id*. at 247. The Fifth Circuit determined that the right of the psychiatrists to assert qualified

immunity was supported by general principles of immunity at common law existing at the time of §1983's enactment. *Id*. at 251–55.

In contrast, the common law existing at the time of § 1983's enactment apparently differed for private employees working in the correctional setting. "History does not reveal a 'firmly rooted' tradition of immunity applicable to privately employed prison guards." *Richardson*, 521 U.S. at 404. Although "Government-employed prison guards may have enjoyed a kind of immunity defense arising out of their status as public employees at common law," according to the Supreme Court, "correctional functions have never been exclusively public." *Id*. And the Court has "found no evidence that the law gave purely private companies or their employees any special immunity from such suits." *Id*. Therefore, in *Richardson v. McKnight*, the Supreme Court "conclude[d] that private prison guards, unlike those who work directly for the government, do not enjoy immunity from suit in a § 1983 case." *Id*. at 412.

More recently, in *Sanchez v. Oliver*, the Fifth Circuit noted that "all of [their] sister circuits to have considered the issue have found no compelling history of immunity for private medical providers in a *correctional setting*." 995 F.3d 461, 468 (5th Cir. 2021) (collecting cases) (emphasis added). But the panel, citing *Richardson*, also noted that "the Supreme Court has hinted in dicta that such a history might exist." *Id*. (citing *Richardson*, 521 U.S. at 407). The panel determined that "the key to untangling" the question in the correctional setting was to look at "the nature of the claims" being asserted against the defendant. *Id*. at 469. Noting that other "circuits have noted that there appears to have been no tradition of immunity for a doctor who acted recklessly" and observing that "a

constitutional claim under § 1983 effectively requires reckless conduct," the *Sanchez* panel determined that "there is no sufficient historical tradition of immunity at common law to support making the qualified immunity defense available to a mental healthcare provider employed by a large, for-profit company contracted by a government entity to provide care *in a correctional setting*." *Id*. (citations omitted) (emphasis added).

Turning to the present case, it is clear that Dr. Duane's assertion of qualified immunity outside of a correctional setting is consistent with general principles of tort immunity existing at the time of § 1983's enactment. Like the psychiatrists in *Perniciaro*, Dr. Duane was privately employed to provide medical care at a public facility "at the behest of the sovereign." *Richardson*, 521 U.S. at 407; *see Perniciaro*, 901 F.3d at 251–55. Important to the present case, as it was to the panel in *Perniciaro,* is that Dr. Duane's employer at the time, Acclaim, is not a large for-profit firm "systematically organized" to perform the "major administrative task" of providing care at state facilities. *See Perniciaro*, 901 F.3d at 253–54. Rather, Acclaim is owned by the Tarrant County Hospital District, a county hospital district under Chapter 281 of the Texas Health and Safety Code.[162] And Acclaim itself is a "charitable organization" under Texas Health and Safety Code § 281.0565.[163] Texas's authorizing statue states such an organization is created "to facilitate the management of a district health care program by providing or arranging health care services, developing resources for health care services, or providing ancillary

[162] *See* App. 159 (Cert. of Formation); App. 182 (Thompson Decl) at ¶ 4.

[163] *See* App. 168 (TMB Cert.); App. 182 (Thompson Decl.) at ¶ 5. As such, Acclaim is a unit of local government for purposes of the Texas Tort Claims Act. *See* Tex. Health & Safety Code § 281.0565(c).

support services for the district." Tex. Health & Safety Code § 281.0565(b). Thus, Acclaim operates solely for the benefit of the Hospital District and, by extension, the residents of Tarrant County. It does so by employing and managing physicians who provide services at Hospital District facilities such as JPS Hospital.[164] Moreover, unlike in *Sanchez,* Dr. Duane was not providing medical care to De Paz Jr. in a correctional setting but in a public hospital.

Perhaps most important, Acclaim is *not* a for-profit corporation that contracts with multiple government entities to provide care as was true in *Sanchez.* Rather, Acclaim was formed for the benefit of the Tarrant County community to provide professional medical services to the Hospital District.[165] It was formed for the administrative convenience of the Tarrant County Hospital District.[166] Therefore, its employees are more akin to direct employees of the state than to private employees who are contracting for a profit motive with governmental entities. *Perniciaro*, 901 F.3d at 253 ("Whereas the Supreme Court in *Richardson* concluded that the private prison guards there at issue 'resemble those of other private firms and differ from government employees,' 521 U.S. at 410, here we conclude just the opposite. When Drs. Thompson and Nicholl go to work at ELMHS, they act within a government system, not a private one.").

All of these factors distinguish Dr. Duane's claim of qualified immunity from that of the social worker in *Sanchez* and the prison guards in *Richardson* and demonstrate that

[164] App. 170–71 (Prof. Servs. Agrmt.) at ¶¶ 1.1-1.2; App. 182 (Thompson Decl.) at ¶ 6.
[165] *See* App. 85 (Duane Decl.) at ¶ 7; App. 182 (Thompson Decl.) at ¶ 6.
[166] *See* App. 85 (Duane Decl.) at ¶ 7; App. 182 (Thompson Decl.) at ¶ 6.

permitting Dr. Duane to assert qualified immunity in this case is consistent with general principles of tort law existing at the time of § 1983's enactment.

2. The purposes of qualified immunity are served by permitting Dr. Duane to assert qualified immunity.

The Supreme Court has identified three purposes that qualified immunity serves: "(1) preventing unwarranted timidity in the exercise of official duties; (2) ensuring that highly skilled and qualified candidates are not deterred from public service by the threat of liability; and (3) protecting public employees—and their work—from all of the distraction that litigation entails." *Perniciaro*, 901 F.3d at 253. Dr. Duane's assertion of qualified immunity is consistent with all of these purposes.

a. Preventing Unwarranted Timidity

Preventing unwarranted timidity is "the most important special government immunity-producing concern." *Id*. (quoting *Richardson*, 521 U.S. at 409) (internal quotation marks omitted). In the context of government, "where institutional rules and regulations 'limit the incentive or the ability of individual departments or supervisors flexibly to reward, or to punish, individual employees,' immunity is necessary to prevent 'overly timid' job performance." *Id*. (quoting *Richardson*, 521 U.S. at 409). By "contrast, when private entities . . . are 'systematically organized to perform a major administrative task for profit,' and do so 'independently, with relatively less ongoing direct state supervision,' then 'ordinary marketplace pressures' typically suffice to incentivize vigorous performance and prevent unwarranted timidity." *Id*. (quoting *Richardson*, 521 U.S. at 409-10). Private firms usually have more latitude to "flexibly and creatively use

rewards and punishments to encourage employees to strike the right balance between vigor and caution . . . [a]nd, unlike a state entity, any firm that fails to strike that balance risks being replaced by a ready competitor." *Id*. (quoting *Richardson*, 521 U.S. at 409-10).

Although Acclaim is nominally a private entity, the market forces assumed to be present in *Richardson* and *Sanchez* are not present here. For one thing, Acclaim is not a for-profit firm, but rather is a "charitable organization" under Texas Health & Safety Code § 281.0565 that operates solely for the benefit of JPS, employing and managing physicians who work at JPS facilities such as JPS Hospital.[167] JPS Hospital, like Acclaim, is owned by the Tarrant County Hospital District—not by a private corporation.[168] Like the psychiatrists in *Perniciaro*, when Dr. Duane went to work at JPS Hospital, she "act[ed] within a government system, not a private one." *Perniciaro*, 901 F.3d at 253 (citing *Richardson*, 521 U.S. at 409). While Acclaim's primary function is admittedly more tailored to providing health-care services than Tulane University (the employer of the psychiatrists in *Perniciaro*), given the aforementioned facts, it remains true that "[a]ny marketplace pressures influencing the performance of [Acclaim] employees . . . are likely not fine-tuned to preventing overly timid care at [JPS Hospital]." *Id*. at 254.

Along those same lines, "the pressures created by the threat of replacement are [not] at play here." *Id*. As noted, Acclaim was created and exists under the § 281.0565 for the benefit of the Hospital District and has served in that capacity since Acclaim's founding.[169]

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[167] App. 168 (TMB Cert.); App. 170–71 (Prof. Servs. Agrmt.) at ¶¶ 1.1-1.2; App. 182 (Thompson Decl.) at ¶¶ 5-6.

[168] *See* App. 159 (Cert. of Formation); App. 182 (Thompson Decl.) at ¶ 4.

[169] App. 168 (TMB Cert.); App. 170–71 (Prof. Servs. Agrmt.) at ¶¶ 1.1-1.2; App. 182 (Thompson

Acclaim's subservient relationship to the Hospital District shows that it is not a private contractor facing the threat of replacement pursuant to market forces, but rather is more an extension or appendage of the Hospital District. Therefore, Acclaim's employees need immunity to avoid unwarranted timidity in carrying out their duties.

b. Deterrence of Candidates from Public Service

The second purpose of qualified immunity "is ensuring that the threat of litigation and liability does not deter talented candidates from public service." *Perniciaro*, 901 F.3d at 254. In theory, "employees of private firms generally do not need immunity because private firms can offset the risk of litigation and liability with higher pay or better benefits." *Id.* (citing *Richardson*, 521 U.S. at 411). But "highly skilled individuals," such as those "who have the freedom to select other opportunities that carry less risk of liability" are "likely to decline public service if not given the same immunity as their public counterparts." *Id.* (citing *Filarsky*, 566 U.S. at 391).

According to the *Perniciaro* panel, "[t]his is particularly so where . . . the private individuals work in close coordination with government employees who may leave them 'holding the bag—facing full liability for actions taken in conjunction with government employees who enjoy immunity for the same activity.'" *Id.* (citing *Filarsky*, 566 U.S. at 391).

Decl.) at ¶¶ 5-6. The University of North Texas Health Science Center was a co-founder, but it is no longer a member, and Acclaim's sole member is JPS. *See* App. 159 (Cert. of Formation); App. 182 (Thompson Decl.) at ¶¶ 4-5.

Here, physicians who accept employment with Acclaim are engaging in a form of public service because they will be working at Tarrant County Hospital District facilities, such as JPS Hospital.[170] Employment with Acclaim is by definition a form of public service.

Dr. Duane, during the period in question, worked for Acclaim at the public JPS Hospital, alongside public employees.[171] The purpose of ensuring that threat of litigation and liability does not deter talented candidates from public service supports allowing Dr. Duane to assert qualified immunity in this case.

c. Protecting Against Distraction

The third purpose of qualified immunity "is protecting public employees from frequent lawsuits that might distract them from their official duties." *Perniciaro*, 901 F.3d at 254–55 (citing *Richardson*, 521 U.S. at 411). This "interest in protecting those who perform public duties from distraction applies regardless of whether they are full-time public employees or contractors." *Id*. (citing *Filarsky*, 566 U.S. at 391). And "where private individuals work alongside public employees, the interest in extending qualified immunity to those individuals is far greater." *Id.* at 254–55. This purpose counsels in favor of permitting Dr. Duane to assert qualified immunity.

[170] *See* App. 85 (Duane Decl.) at ¶ 7; App. 182 (Thompson Decl.) at ¶ 6.
[171] App. 85 (Duane Decl.) at ¶ 7; App. 182 (Thompson Decl.) at ¶ 7.

B. Dr. Duane is entitled to qualified immunity because Plaintiffs cannot show that she violated a "clearly established" right.

"The doctrine of qualified immunity shields officials from civil liability so long as their conduct 'does not violate clearly established statutory or constitutional rights of which a reasonable person would have known.'" *Mullenix v. Luna*, 577 U.S. 7, 11 (2015) (quoting *Pearson v. Callahan*, 555 U.S. 223, 231 (2009)). "Once invoked, a plaintiff bears the burden of rebutting qualified immunity by showing two things: (1) that the officials violated a statutory or constitutional right and (2) that the right was 'clearly established' at the time of the challenged conduct." *Perniciaro*, 901 F.3d at 255 (quoting *Ashcroft v. al-Kidd*, 563 U.S. 731, 735 (2011)).

Based on the discovery produced or obtained by the parties, Plaintiffs cannot meet either element. As shown above, Dr. Duane did not violate a statutory or constitutional right of De Paz Jr. But even if she did, Plaintiffs cannot prove that such a right was "clearly established" at the time. "Law is 'clearly established' for these purposes only if 'the contours of the right were sufficiently clear that a reasonable official would understand that what he was doing violated that right.'" *Id.* (quoting *Anderson v. Creighton*, 483 U.S. 635, 640 (1987)). This standard does "not require a case directly on point, but existing precedent must have placed the statutory or constitutional question beyond debate." *Mullenix*, 577 U.S. at 12 (quoting *Ashcroft*, 563 U.S. at 741) (internal quotation marks omitted).

As demonstrated by the unrebutted testimony of Dr. O'Brien, a reasonable physician in the same circumstances would reasonably believe that De Paz Jr. met

established extubation criteria such that such a physician would reasonably believe that De Paz Jr. was likely to survive extubation.[172] Thus, it was not clearly established at the time that Dr. Duane's conduct in removing De Paz Jr. from a ventilator violated a right to life, bodily integrity, or notice and an opportunity for a hearing.

Even if, however, there is a fact issue over whether Dr. Duane could have reasonably believed such was true, the case law existing at the time of Dr. Duane's alleged actions reasonably could have been interpreted as *supporting* their lawfulness. In *Reynolds v. Parkland Hospital*, for example, the court determined that doctors at Parkland hospital—who had "refused to meet with [the patient's] family, made the decision to withhold life support without consulting the family, and made 'inappropriate' medical decisions that resulted in his death"—did not owe an applicable constitutional duty to the patient. *Reynolds v. Parkland Mem'l Hosp. & Doctors*, No. 3:12-CV-4571-N-BN, 2012 WL 7153849, at *1, 3 (N.D. Tex. Dec. 28, 2012), adopted, 2013 WL 607152 (N.D. Tex. Feb. 19, 2013).

The *T.L.* case cited in Plaintiffs' briefing was not decided until July 2020, years after the events at issue here. *T.L.*, 607 S.W.3d 9. The only other case Plaintiffs claim directly speaks to this issue, *Cruzan,* was not about a governmental entity's decision to withdraw life support, but of the parents' right to withdraw life support for their adult child. *Cruzan*, 497 U.S. at 265. There was no existing authority in April 2018 that should have alerted Dr. Duane that her conduct—the alleged intentional withdrawal of life-

[172] App. 104–105 (O'Brien Report).

sustaining treatment from a patient with non-survivable traumatic brain injuries—violated a known existing *constitutional* right. Much less so under the admissible summary judgment evidence, which shows Dr. Duane reasonably believed De Paz, Jr. met extubation criteria and was likely to survive the procedure.

Other controlling precedent further raises questions that show the Plaintiffs' alleged rights were not "clearly established" such that a reasonable physician would have been aware. For example, existing law does not recognize a constitutional right to continued medical care, such as artificial life support.[173] It would have been reasonable for Dr. Duane to extrapolate from this rule and conclude that the law permitted her to remove De Paz Jr. from life support under the circumstances. Relatedly, there is a robust body of case law establishing that allegations of improper medical treatment are redressed through state tort law—not the United States Constitution.[174] Dr. Duane would have had no reason to

[173] *See, e.g.*, *Vacco v. Quill*, 521 U.S. 793, 801 (1997); *City of Revere v. Mass. Gen. Hosp.*, 463 U.S. 239, 244 (1983); *Estelle v. Gamble*, 429 U.S. 97, 103 (1976); *Johnson ex rel. Johnson v. Thompson*, 971 F.2d 1487, 1495–96 (10th Cir. 1992); *Abigail All. for Better Access to Dev. Drugs v. von Eschenbach*, 495 F.3d 695, 711 (D.C. Cir. 2007) (en banc).; *see also* Mem. Op. & Order, Nov. 18, 2021, at 10 ("The law is clear that a person like Berman, who is not incarcerated or otherwise in custody of defendants, does not have a constitutional right to medical care.").

[174] *See, e.g.*, *Baez v. INS*, No. 06-30112, 2007 WL 2438311, at *1 (5th Cir. Aug. 22, 2007) (per curiam) (unpublished) ("Unsuccessful medical treatment, acts of negligence, neglect, or medical malpractice are insufficient to give rise to a constitutional violation. Disagreement with one's medical treatment is not sufficient to state a cause of action under § 1983." (citing *Varnado v. Lynaugh*, 920 F.2d 320, 321 (5th Cir. 1991))); *see also, e.g.*, *Collins v. City of Harker Heights*, 503 U.S. 115, 128 (1992) (noting that "the Due Process Clause does not purport to supplant traditional tort law in laying down rules of conduct to regulate liability for injuries that attend living together in society"); *Aguocha-Ohakweh v. Harris Cnty. Hosp. Dist.*, 731 F. App'x 312, 315 (5th Cir. 2018) (stating that unsuccessful medical treatment "does not give rise to § 1983 cause of action"); *Wilson v. Dall. Cnty. Hosp. Dist.*, 715 F. App'x 319, 323 (5th Cir. 2017) (affirming dismissal of federal claims against a hospital for an alleged "custom or policy of committing medical errors"); *Kinzie v. Dall. Cnty. Hosp. Dist.*, 106 F. App'x 192, 194 (5th Cir. 2003) (affirming dismissal under *Collins* of § 1983 claims against health care provider based on

believe that, if she misjudged De Paz Jr.'s chances of survival for extubation, her exercise of ordinary medical judgment would necessarily implicate any federal constitutional right.

Even if there is a genuine issue of material fact over whether Dr. Duane did indeed violate Plaintiffs' rights, the evidence conclusively shows that a reasonable physician in Dr. Duane's circumstances would not have believed that extubation when extubation is clinically indicated would violate a patient's right to life, bodily integrity, or to receive notice and an opportunity to be heard. Dr. Duane is therefore entitled to judgment as a matter of law on her qualified immunity defense.

CONCLUSION

Based on the foregoing, Dr. Duane asks the Court to grant her motion for summary judgment based on qualified immunity and dismiss with prejudice all of Plaintiffs' remaining claims against her.

patient's receipt of HIV-positive blood").

Respectfully submitted,

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CERTIFICATE OF SERVICE

I hereby certify that all counsel of record were served July 20, 2022, with a copy of the foregoing document via the Court's CM/ECF system.

Katherine R. Hancock