No. 20-651

In The
Supreme Court of the United States

COOK CHILDREN'S MEDICAL CENTER,

Petitioner,

v.

T.L., a MINOR, *ET AL.*

On Petition for a Writ of Certiorari to the Court of Appeals of Texas, Second District

BRIEF OF *AMICI CURIAE* TEXAS ALLIANCE FOR LIFE, TEXAS CATHOLIC CONFERENCE OF BISHOPS, AMERICAN MEDICAL ASSOCIATION, AMERICAN ACADEMY OF PEDIATRICS, TEXAS MEDICAL ASSOCIATION, TEXAS NURSES ASSOCIATION, TEXAS HOSPITAL ASSOCIATION, CATHOLIC HEALTH ASSOCIATION OF TEXAS, BAYLOR SCOTT AND WHITE HEALTH, TEXAS ORGANIZATION OF RURAL AND COMMUNITY HOSPITALS, COALITION OF TEXANS WITH DISABILITIES, AND TEXAS ALLIANCE FOR PATIENT ACCESS, *ET AL.* IN SUPPORT OF PETITIONER

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INTEREST OF *AMICI CURIAE*[1]

A wide-ranging coalition collaborated for years to craft the Texas Advance Directives Act (TADA). Their ranks included pro-life groups, medical and nursing associations, hospitals, and nursing homes. The *amici curiae* joining this brief include members of the original coalition as well as other stakeholders who agree that this law is important to their distinct missions and should be defended against constitutional attack.

The *amici* also share a collective interest in preserving the ability of state legislatures to enact and continue to refine laws that offer meaningful certainty *in real time* to families, physicians, hospitals, and others confronting the most difficult end-of-life situations. This Texas statute was just such a law. It offered a clear framework to reach a resolution, in real time, with certainty offered through a grant of statutory immunity. But under the holding below, any such certainty promised by state law is a mirage. So long as private hospitals dealing with end-of-life decisions are labeled state actors for federal constitutional purposes, their medical and ethical judgments will always remain subject to judicial second guessing and to the looming *in terrorem* threat of § 1983 damages.

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[1] No counsel for any party has authored this brief in whole or in part, nor has any entity other than the named *amici curiae* made a monetary contribution to the preparation or submission of the brief. *See* Sup. Ct. R. 37.6. Timely notice was given to all parties, and each gave written consent. *See* Sup. Ct. R. 37.2(a).

The *amici* bring together different perspectives:

• Pro-life organizations: From the outset, the Texas pro-life community was deeply involved in negotiating this statute's provisions and advocating for continued refinement of its procedures through the legislative process. The groups joining this brief—Texas Alliance for Life, Texas Catholic Conference of Bishops, Texans for Life Coalition—believe the balance struck by this statute respects the dignity inherent in a natural death.

• Medical and nursing associations: Doctors and nurses will, under the court of appeals's holding, face the moral dilemma of being compelled to administer excruciatingly painful medical interventions that violate their own deeply held sense of ethics and personal conscience, with no corresponding benefit to the patient. This brief is joined by the American Medical Association, Texas Medical Association, Texas Nurses Association, Texas Osteopathic Medical Association, Tarrant County Medical Society, and Dallas County Medical Society.

• Children's hospitals and pediatricians: The facts of this case involve a young patient and a family grieving her terminal condition. Hospitals and doctors specializing in the most difficult pediatric cases may feel the precedential impacts of this decision the most acutely. This brief is joined by the American Academy of Pediatrics, the Texas Pediatric Society, and the Children's Hospital Association of Texas.

• Hospitals and hospital systems: The decision below held that hospitals are 'state actors' when performing what has traditionally been a private matter for a private committee, applying private standards of professional conduct and medical ethics. The *amici* include a range of private hospitals with a diversity of religious and secular affiliations, including the Texas Hospital Association, Catholic Health Association of Texas, Baylor Scott and White Health, and the Texas Organization of Rural and Community Hospitals. Some of their particular concerns are discussed more fully below.

• Other stakeholders in the patient care system, including the Coalition of Texans With Disabilities, LeadingAge Texas, and Texas Alliance for Patient Access.

* * *

In addition to their shared interest in defending the Texas Advance Directives Act against constitutional attack, the individual *amici* have each given thought to why preserving the dispute-resolution procedure in § 166.046 of the law furthers their diverse missions.

1. Pro-life organizations

Texas Alliance for Life (TAL) helped negotiate the provision of TADA challenged below and has supported various bills to increase patient protections in the Texas Advance Directives Act. The group has been

unwavering in support of § 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 of health care providers to not be compelled to make medically and ethically inappropriate and harmful interventions to dying patients.

Texas Catholic Conference of Bishops (TCCB) has sought reforms in advance directives to highlight—as a matter of policy—the dignity inherent in a natural death. These reforms reflect the principles found in the United States Conference of Catholic Bishops' Ethical and Religious Directives, which constitute authoritative guidance on the provision of Catholic healthcare services. Among other things, the Directives counsel Catholic healthcare providers to honor the sanctity of each human life by avoiding "two extremes"—"on the one hand, an insistence on useless or burdensome technology even when a patient may legitimately wish to forgo it and, on the other hand, the withdrawal of technology with the intention of causing death." The bishops reject medical decision-making based on flawed "quality of life" arguments which are often used to falsely justify euthanasia. The bishops have consistently supported the truth that decisions regarding treatment should be made through this lens of the inherent sanctity of all human life while recognizing that underlying medical conditions can have an impact on the effectiveness or appropriateness of certain medical interventions. They believe that treatment decisions should be based on whether or not the expected benefit

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

Texans for Life Coalition (TLC). After previously opposing TADA, 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.

2. Medical and nursing associations

The American Medical Association (AMA) is the largest professional association of physicians, residents, and medical students in the United States. Through state and specialty medical societies and other physician groups seated in its House of Delegates, substantially all physicians, residents, and medical students in the United States are represented in the AMA's policy-making process. The AMA and Texas Medical Association join this brief on their own behalf and as representatives of the Litigation Center of the

American Medical Association and the State Medical Societies. The Litigation Center is a coalition among the AMA and the medical societies of each state and the District of Columbia. Its purpose is to represent the viewpoint of organized medicine in the courts.

Texas Nurses Association members care for patients in all clinical specialties and all practice settings. Its members serve patients' medical needs in all seasons of life, from pre-natal to birth to the last breath and struggle. Nurses experience moral distress when faced with providing interventions that harm or prolong the suffering of the very patients they took an oath to serve. The conflict resolution process in § 166.046 of the Texas Advance Directives Act takes these concerns into account.

The Texas Medical Association and the Texas Osteopathic Medical Association both consider § 166.046 vital to the ethical practice of medicine and the provision of high-quality care.

Tarrant County Medical Society and Dallas County Medical Society both believe the Texas Advance Directives Act is essential for ethically resolving conflicts regarding the treatment and care of terminally and/or irreversibly ill patients.

3. Pediatricians and pediatric hospitals

The American Academy of Pediatrics (AAP) represents 67,000 primary care pediatricians, pediatric medical subspecialists, and surgical specialists who

are committed to the attainment of optimal physical, mental, and social health and well-being for all infants, children, adolescents, and young adults. Pediatric health care is practiced with the goal of promoting the best interests of the child. AAP policy statement *Guidance on Forgoing Life-Sustaining Medical Treatment* states "it may be ethically supportable to forgo life-sustaining medical treatment without family agreement in rare circumstances of extreme burden of treatment with no benefit to the patient beyond postponement of death."

Texas Pediatric Society (TPS), The Texas Chapter of the American Academy of Pediatrics, is the statewide professional nonprofit organization of over 4,500 pediatric physician, resident and medical student members whose mission is to ensure that the children in Texas are safe and healthy, that its members are well-informed and supported, and that the practice of pediatrics in Texas is both fulfilling and economically viable. TPS supports TADA, which outlines an ethical and responsible protocol to resolve difficult end-of-life decisions in the best interest of patients and the medical judgment of physicians.

Children's Hospital Association of Texas is a nonprofit association whose mission is to advance children's health and well-being by advocating for policies and funding that promote children's access to high-quality, comprehensive health care. It represents eight free-standing, not-for-profit children's hospitals located in Texas. Children's hospitals are unique resources that benefit all children through clinical care,

research, pediatric medical education and advocacy, and they provide specialized care for the most severe and complex medical problems.

4. Hospitals and hospital associations

The Catholic Health Association of Texas is a voluntary, professional association that represents and advocates on behalf of Catholic hospitals in Texas and supports its mission through collaboration, advocacy, involvement, education and inspiration. The association generally supports the dispute resolution process in § 166.046 of the Texas Advance Directives Act as a tool to assist our member hospitals to provide care that is respectful of the life and dignity of patients as articulated in the Ethical and Religious Directives.

Texas Organization of Rural and Community Hospitals. Rural and community hospitals must often immediately and expertly stabilize their most critically ill or injured patients so they can be quickly transferred to larger and better equipped urban hospitals. Rural hospitals fear that the dismantling of TADA will not only impact the treatment they are able to give patients at their own facilities but also affect the willingness of urban hospitals to accept the transfer of their most critical patients.

The Texas Hospital Association (THA) is a nonprofit trade association that 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 inappropriate interventions.

Baylor Scott & White Health including HealthTexas Provider Network and Scott & White Clinic (collectively, BSWH), is the largest not-for-profit healthcare system in Texas and often cares for the "sickest of the sick"—terminally and/or irreversibly ill patients. BSWH believes § 166.046 provides an essential ethical process to resolve conflict about the treatment and care of terminally and/or irreversibly ill patients. BWSH sees § 166.046 as critical to its ability to provide the best care possible for the patients it serves and for honoring the moral foundations of the medical profession to serve for the benefit of the sick and to do no harm.

5. Other important stakeholders in patient care

Coalition of Texans with Disabilities (CTD). 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.

LeadingAge Texas provides leadership, advocacy, and education for Texas faith-based and not-for-profit retirement housing and nursing home communities. The organization works extensively with the Texas Legislature on an array of issues affecting the elderly, including hospice and end-of-life matters.

The Texas Alliance for Patient Access (TAPA) is a statewide coalition of over 250 hospitals, physician groups, charity clinics, nursing homes, and physician liability insurers. 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 right to refuse to provide certain medical interventions that violate 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 interventions.

SUMMARY OF THE ARGUMENT

This constitutional claim against a private hospital fails at the threshold because it challenges private, not state, action. The determination by a private hospital that it could no longer ethically participate in requested but medically inappropriate interventions was a private decision. The Texas statute did not compel the outcome of this ethics determination, either way.

Quite the opposite. Texas's advance-directives act creates a zone for private liberty in which private determinations about end-of-life questions can be made without the specter of state intrusion by prosecutors or locally elected judges.

The court of appeals turned the statute's limits on state power into a cage for private liberty. By classifying this private hospital as a state actor, the court created an ongoing role for itself—and future state and federal courts—in second-guessing these most private end-of-life decisions. And because its state-action holding is of federal constitutional dimension, there is nothing that the Texas Legislature, or any state legislature, could do to restore the full protective effect of this statute. Only this Court can hold the line on state action.

State laws about advance directives depend on certainty. The Texas statute offers that certainty through detailed procedures and a robust immunity provision. But under the court of appeals's decision, that certainty has vanished. Now medical providers face a trap. If they act within the protections set up under state law, the court of appeals reasons, then they become state actors subject to federal constitutional claims seeking injunctive relief or money damages. App. 84a, 86a-87a, 114a.

Classifying private hospitals and doctors as state actors reduces them for constitutional purposes to cogs in the machine of the state, leaving no room for independent medical ethics or diversity of individual

conscience. The Texas statute carefully balances those private interests and, as a matter of state policy, provides a path for medical providers to withdraw from providing an intervention that violates their ethics or deeply held sense of morality, while also providing a highly structured framework for the patient to seek a transfer to another medical provider who is willing to provide that requested intervention.

The Court should reverse on state action. This claim against a private hospital is simply not a valid federal *constitutional* claim. Drawing that line with clarity will allow state political branches to continue to fine-tune and improve the details of their advance-directives statutes in response to the expressed concerns of stakeholders, including the *amici*. Failing to draw a clear line against this misuse of 42 U.S.C. § 1983 sows doubt about the very premise of state advance-directives laws: whether they can truly offer certainty to hospitals, medical providers, and patients who rely on them.

ARGUMENT

I. The certainty necessary to state advance-directives laws is undermined if private hospitals and private doctors are classified as state actors.

This case reaches the Court when many Americans are contemplating the unwelcome possibility that they may need to make directives about their own

medical care or that of loved ones. The statute in question is Texas's advance-directives act, the law promising certainty about whether directives can be honored by medical providers. Texas's version of this statute authorizes medical powers of attorney, out-of-hospital DNR (do not resuscitate) orders, and in-hospital DNR orders, along with other directives to physicians by patients or surrogates.[2] For each type of directive, this law authorizes physicians and other medical providers to follow a patient's directive and refrain from making certain life-sustaining medical interventions, with the effect that a natural death may occur.[3] And for each, this law offers protection from liability for physicians and other medical providers, even when refraining from a life-sustaining medical intervention might lead to a natural death.[4]

Advance-directive statutes depend on a promise of certainty. They are enacted against a background in which prosecutors, local officials, and some state officials might seek for their own reasons to intervene in these inherently private end-of-life decisions. These statutes establish a zone for that private liberty in which—so long as the requirements of the statute are scrupulously followed (as it is conceded they were followed here)—private decisions are shielded from state meddling.

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[2] Tex. Health & Safety Code §§ 166.032-037, 166.040, 166.082, 166.154, 166.203.

[3] *Id.* §§ 166.047, 166.096; *see also id.* §§ 166.048, 166.097.

[4] *Id.* §§ 166.044, 166.094, 166.160, 166.166, 166.207.

The procedures of the Texas Advance Directives Act also help structure these very difficult end-of-life conversations—and provide the certainty of a resolution if the family members and treating physician cannot ultimately reach a consensus.

The Legislature's approach was to define specific steps that a physician and hospital can follow to satisfy their own duties as a matter of law, shielding them from the risk of civil or criminal liability. These steps include an ethics committee review that the family can attend, assistance with the process of seeking a transfer to another physician, at least 10 more days to obtain such a transfer, and a streamlined procedure to have a court further extend that 10-day period if it would help secure a such transfer.[5] By taking those steps, the physician and hospital are deemed to have fulfilled their duties as a matter of law and are thus shielded from further liability.[6]

Yet the court of appeals held that even assiduously following the Act cannot provide certainty. The court of appeals reasoned that, because only the State can define homicide or wrongful death, private physicians become state actors when death might be a consequence of their action or inaction. App. 70a, 87a, 114a. The court of appeals analogized a natural death in the medical context to homicide, noting that "consent has never been a defense to the crime of homicide." App. 89a.

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[5] Tex. Health & Safety Code §§ 166.046, 166.052, 166.053.

[6] *Id.* §§ 166.045(c) & (d).

As persuasively argued in the Petition for Certiorari, the court of appeals's framing is flat wrong. By enacting § 166.046 and the rest of TADA, the Texas Legislature was exercising its own sovereign power to regulate duties of private parties—not delegating that power. Pet. 26. A private hospital and private doctors reaching their own ethical choices consistent with a set of procedures in a statute do not thereby become state actors. *Am. Mfrs. Mut. Ins. Co. v. Sullivan*, 526 U.S. 40, 58 (1999); *Flagg Bros., Inc. v. Brooks*, 436 U.S. 149, 165 (1978) ("It is quite immaterial that the State has embodied its decision not to act in statutory form.").

Private hospitals should not be subjected to the ruinous risk of § 1983 claims such as this one seeking money damages along with injunctive relief—even when, as here, there is no dispute that the hospital followed state law. Allowing this kind of federal constitutional bypass would significantly undermine the ability of hospitals, doctors, and ultimately patients to rely on advance directives. This Court should hold the line on the state-action doctrine.

II. This expansion of state action undermines medical ethics and overrides existing legal protections for the personal conscience of medical providers.

For the vast majority of patients near the end of life, difficult conversations and counseling lead to a consensus about how to proceed. But sometimes the

disagreements prove intractable. These strong disagreements often arise within families, such as when siblings might disagree about how to proceed for a parent.[7]

This case involved a disagreement between a treating physician and a family member that was not resolved after months of discussions and counseling. Pet. 12. The treating physician invoked § 166.046 after determining that continuing painful and intrusive interventions on a patient near the end of life, in a medical condition with no effective prospect for cure or recovery, would inflict only harm on the patient—violating one of the oldest and most deeply held principles of medical ethics.

A. The core balance struck by the Texas statute is consistent with the rules of medical ethics.

The code of ethics adopted by the American Medical Association provides that a physician can abstain from providing a requested medical intervention when his or her own medical judgment or ethics demands it.

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[7] "[P]hysicians, 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. (Tex. April 10, 2019) (testimony of Dr. Robert Fine).

See AMA Code of Medical Ethics § 1.1.7 (noting that, although the freedom is not unlimited, a physician can "refrain from acting" in accordance with "dictates of conscience" and "well-considered, deeply held beliefs"); *id.* § 5.5 (Medically Ineffective Interventions). In regard to end-of-life situations, the AMA guidelines further suggest that physicians strive to transfer the patient to a different medical provider who is ethically willing to comply, but "[i]f transfer is not possible, the physician is under no ethical obligation to offer the intervention." *Id.* § 5.5.

The balance struck by the Texas statute respects these principles of medical ethics. Under Texas law, a physician facing this dilemma has a limited duty to provide a requested intervention, "*but only until* a reasonable opportunity has been afforded for the transfer of the patient to another physician or health care facility willing to comply with the directive or treatment decision." Tex. Health & Safety Code § 166.045(c) (emphasis added); *id.* § 166.051. That background rule, echoing the AMA guidance, is what applies even when a physician elects not to request a committee review to resolve the dispute. *Id.*

Other states have also enacted statutes that echo the same AMA ethical guidance. These statutes provide that a physician's duty in these intractable situations is linked to the possibility of a transfer. In California, a physician's duty extends only "until a transfer can be accomplished or until it appears that a transfer cannot be accomplished." Cal. Prob. Code § 4736(c). In Arkansas, the statute provides for

"continuing care . . . until a transfer can be effected or until a determination has been made that a transfer cannot be effected." Ark. Code Ann. § 20-6-109(e)(2). "If a transfer cannot be effected, the healthcare provider or institution shall not be compelled to comply." *Id.* § 20-6-109(e)(3)(B). Tennessee law has the same provisions. Tenn. Code Ann. § 68-11-1808(f). And in Virginia, the law provides that, at the end of a short period defined by statute, "the physician may cease to provide" a medical intervention "that the physician has determined to be medically or ethically inappropriate . . . " Va. Code Ann. § 54.1-2990.

This substantive policy decision at the heart of the Texas Advance Directives Act is consistent with medical ethics and the practice of other states.

B. Following the steps of § 166.046 offers certainty about whether "a reasonable opportunity has been afforded for the transfer of the patient."

Texas law does not require a physician facing this dilemma to always invoke the ethics-review procedures of § 166.046. The statute says, if the physician "does not wish to follow the procedure established under Section 166.046," the default duty rule discussed above is what applies to their conduct: "life-sustaining treatment shall be provided to the patient, *but only until* a reasonable opportunity has been afforded for the transfer of the patient to another physician or health care facility willing to comply with the directive

or treatment decision." Tex. Health & Safety Code § 166.045(c) (emphasis added).

The incentive to go through § 166.046 is certainty. Defining "reasonable opportunity" can be fraught in any circumstance. Guessing how a future, potentially skeptical judge might read that phrase entails extraordinary risk. *E.g.*, App. 77a. The Legislature's solution was § 166.046. When a physician complies with § 166.046, including its detailed framework for facilitating a possible transfer of the patient, that physician will know with legal certainty that she has fulfilled her legal duty in this regard. The statute makes that link explicit. Once a physician completes this process, she is shielded from civil, criminal, or professional liability, as a matter of law. *Id.* § 166.045(d) (" . . . is not civilly or criminally liable or subject to review or disciplinary action . . . if the person has complied with the procedures outlined in Section 166.046").

C. The court of appeals brushed aside the statute's protection of individual conscience.

Under the court of appeals's view that they are state actors, private hospitals and medical providers could be subjected to suit under § 1983 for refraining from actions that violate deeply and sincerely held beliefs.

Texas is not alone in protecting these rights of conscience. A number of federal statutes also respect the conscience of medical providers who refuse to perform,

accommodate, or assist with certain health services on religious or moral grounds.[8] Other sections of Texas law also reflect the legislature's desire to protect medical providers' religious beliefs.[9]

The protection of conscience and medical ethics is also a key part of this statute. The Texas Legislature heard testimony about what Ellen Martin, testifying on behalf of the Texas Nurses Association, called a "moral distress when we perceive a violation of one's core values or duties."[10] She explained that research in this area indicates "[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."[11]

The testimony received by the district court made those abstract concerns concrete. *See* 2 C.A. Rec. 280 ("we're inflicting painful interventions on her that we believe exacerbate her suffering for no good outcome."); *see also* 2 C.A. Rec. 164; 2 C.A. Rec. 266, 268-69, 282.

The court of appeals praises these medical providers as "heroic," App. 12a, but it steadfastly refuses to give their deeply and sincerely held ethical and moral

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[8] *See*, *e.g.*, 42 U.S.C. § 300a-7 (The Church Amendment); 42 U.S.C. § 238n (Public Health Service Act § 245).

[9] *E.g.*, Tex. Occ. Code § 551.008.

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

[11] *Id.*

objections any weight. To the contrary, the court of appeals reasons that, if medical providers are state actors, then their own ethical concerns must be subjugated to their role as gears in the machinery of the state. App. 79a n.29. The court of appeals calls any attempt to protect those individual rights of conscience by statute—as this Texas statute plainly does—"a conflict of interest" that would "impeach[] the impartiality of . . . professional judgment, as well as the committee review process itself." *Id.*

Classifying private doctors, nurses, and hospitals of varying religious and secular affiliations as state actors has a profound ethical cost. The court of appeals's holding casts a shadow over every invocation of the statute. It used this rationale to compel a hospital and its medical providers to administer excruciatingly painful medical interventions that violate their own deeply held sense of ethics and personal conscience, with no corresponding benefit to the patient. And other Texas hospitals have, in the months since this decision, been threatened with § 1983 suits should they use the statute.

As this Court has explained, "the state-action doctrine enforces a critical boundary between the government and the individual, and thereby protects a robust sphere of individual liberty." *Manhattan Cmty. Access Corp. v. Halleck*, 139 S. Ct. 1921, 1934 (2019). The court of appeals, by treating private hospitals and private medical providers as parts of the state, has overstepped that boundary at the cost of individual liberty.

III. Constitutionalizing these questions could undermine future legislative refinements to the statute.

The *amici* believe that the state legislature remains the right forum for addressing policy disagreements about how to best balance these private interests.

Constitutionalizing these questions not only threatens the Texas Advance Directives Act as it exists today but threatens to "short circuit the democratic process" that has led to statutory refinements in recent years and would otherwise be expected to lead to improvements in the future. *Wash. State Grange v. Wash. State Republican Party*, 552 U.S. 442, 451, 128 S. Ct. 1184, 1191 (2008) (making this observation about facial challenges).

Texas's legislature has been responsive, crafting over time an advance-directives statute with clearer and more detailed steps than many of its peers. Under § 166.046(b), patients are provided with detailed medical records and other information that might assist them in obtaining a transfer. Tex. Health & Safety Code § 166.052 (a model statement to provide to patients); § 166.046(b)(4)(C)-(D) (medical records and diagnostic reports); *id.* § 166.046(b)(3) (this registry is provided at the outset). As concerns have been raised, the Legislature has fine-tuned these procedures over

time.[12] Texas has also set up an infrastructure to ease transfers of patients in end-of-life situations, with a registry for groups that "may assist in locating a provider willing to accept transfer of a patient under Section 166.045 or 166.046." *Id.* § 166.053.

Only a robust statute can offer this level of clarity or certainty. If the protections of this statute are subjected to second-guessing by state and federal courts under the guise of state action, then private hospitals and doctors will be left, once again, vulnerable to threats of ruinous lawsuits made by grieving family members.[13]

And once these private disputes are framed as constitutional absolutes, there is less flexibility for future legislative improvements and accommodations of personal conscience. Suggestions to further fine-tune aspects of the § 166.046 process should be presented to the legislature, not recast as federal constitutional claims on the mistaken premise that private hospitals are state actors.

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

[13] *E.g.*, Hearing on S.B. 2089 and S.B. 2129 before the Senate Comm. on Health & Human Servs., 86th Leg. R.S. (Tex. April 10, 2019) (testimony of Dr. Fine).

CONCLUSION

The Court should grant the Petition and, as urged by the Petition, consider issuing a summary reversal.

Respectfully submitted,

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December 2020