CAUSE NO. 323-112330-19

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| TINSLEE BREAUN LEWIS, A MINOR AND MOTHER, TRINITY LEWIS, ON HER BEHALF,<br><br>Plaintiffs,<br><br>v.<br><br>COOK CHILDREN'S MEDICAL CENTER,<br><br>Defendant. | §<br>§<br>§<br>§<br>§<br>§<br>§<br>§<br>§<br>§<br>§<br>§ | IN THE DISTRICT COURT<br><br><br><br><br>TARRANT COUNTY, TEXAS<br><br><br><br><br>323RD JUDICIAL DISTRICT |

**COOK CHILDREN'S MEDICAL CENTER'S BRIEF IN RESPONSE TO PLAINTIFF'S REQUEST FOR INJUNCTIVE RELIEF**

Defendant Cook Children's Medical Center respectfully files this brief to address many of the legal issues raised in Plaintiff's Request for Injunctive Relief,[1] as follows.

## INTRODUCTION

Plaintiffs' request for temporary and permanent injunctive relief should be denied. As the evidence will show at the hearing, Tinslee Lewis is a terminal patient with an irreversible condition who is suffering greatly. There is no medical benefit to continuing life-sustaining treatment for Tinslee and, as the evidence will show, such treatment causes her pain that she is forced to endure for no reason. Under all ethical medical standards, it is time to focus on controlling her pain rather than cruelly extending her life.

Under the provision of the Texas Advance Directives Act ("TADA" or "the Act") at issue in this case, the ***only*** role for the Court is to determine whether there is a reasonable expectation that an extension of time will allow Plaintiffs to find another health care facility or physician

1 This brief is not intended to be a comprehensive response to all issues that may be raised at the hearing. While a temporary injunction must be decided by the evidence presented at an open hearing, many of the issues presented in this case are purely legal in issue.

willing to take over Tinslee Lewis's treatment. *See* TEX. HEALTH & SAFETY CODE § 166.046(g). Absent such a showing, there is no basis for the Court to grant any further extension of time. The statute does not allow for an indefinite temporary injunction, let alone a permanent injunction. Moreover, Plaintiffs' claims for declaratory judgment and relief under 42 U.S.C. § 1983 fail because TADA is not unconstitutional, Plaintiffs have not been deprived of any constitutional right, and Defendant and its medical personnel are not state actors. Because Plaintiffs lack either a cause of action against Defendant or a probable right to relief, their requested injunction must be denied.

## FACTUAL BACKGROUND

This case involves the tragic medical condition of ten-month old Tinslee Lewis. Tinslee was born premature and suffers from a host of medical conditions including a rare heart defect (known as Ebstein's anomaly), pulmonary atresia, chronic lung disease, severe chronic pulmonary hypertension, and acute systolic heart failure among others. While these conditions cause numerous complications, the most significant issue is that Tinslee cannot properly get oxygen from her lungs into her bloodstream. She has undergone several complex surgeries that, unfortunately, have not been able to significantly improve her condition.

Tinslee has spent her entire life hospitalized in Cook Children's cardiac intensive care unit. She is on a tremendous amount of pharmaceutical drugs designed to keep her alive. She can only breathe with full mechanical ventilator support. Even with that support, Tinslee can only stay alive if she stays still and calm. Actions such as crying, fussing, holding her breath, or even just stress causes her to utilize oxygen much faster than she can replenish it. As a result, Tinslee must spend her days sedated, paralyzed, and sometimes restrained. Unfortunately, her condition will never improve.

More significantly, the doctors have concluded that Tinslee is suffering, with no hope of recovery and no possible surgical interventions that would improve her condition or ease her suffering. Tinslee has required artificial life support for most of her life, and has continuously been on life support since July. She is in pain. Moreover, as the evidence will show, almost every bit of medical and personal care that Tinslee receives causes her to suffer. At least 2-3 times per day, Tinslee has a "dying event," that mandates aggressive medical intervention. Events that cause Tinslee to crash include such routine things such as baths, diaper changes, positional shifts (to prevent bedsores), or nothing at all. As the Court will hear, the standard of medical care for Tinslee is to cease treatment. Indeed, to continue treatment for Tinslee mandates that doctors violate the most sacred oath of their profession: *primum non nocere* ("first, do no harm").

Cook Children's has been in constant communication with Tinslee's mother, Trinity Lewis, and has informed her of their physicians' conclusion that continuing to intervene medically is inflicting pain on Tinslee without any corresponding therapeutic benefit. Plaintiff has stated that she disagrees and believes that Tinslee will somehow recover. Cook Children's has been working with Ms. Lewis since September to see if another medical provider would choose to continue care. They have contacted dozens of doctors and hospitals across the country, and none have disagreed with Cook Children's conclusion or been willing to accept Tinslee as a patient.

After months of trying to resolve the issue with Ms. Lewis, Cook Children's determined that no resolution was possible. Pursuant to the Texas Advance Directives Act, Cook Children's submitted the issue to its ethics committee. After hearing all of the evidence and opinions of all parties, the committee concluded that there was no medical benefit to continuing treatment for Tinslee and, to alleviate her suffering, it is in her best interest to cease medical intervention and allow her to die naturally.

Plaintiff was informed of this decision on October 30, 2019, and Tinslee was scheduled to be removed from the ventilator on Sunday, November 10. Plaintiff obtained a restraining order delaying the removal on November 10, which has now been extended twice by agreement.

## SUMMARY OF THE ARGUMENT

End-of-life decisions are wrenching for patients, their families, treating physicians, and all medical personnel involved. It is a medical fact that an intervention that prolongs life may also prolong—or even intensify—suffering. A doctor, compelled by an ethical obligation to do no harm, may cause a patient to suffer only if his intervention provides a corresponding benefit. When a family member insists on painful, yet futile, intervention, family wishes come into direct conflict with the doctor's ethics and conscience.

When the wishes of the family conflict with the ethical duties and medical judgment of doctors, the law has always allowed doctors to make the final treatment decisions. However, those decisions frequently found their way to court.

The Texas Advance Directives Act ("TADA"), which the Legislature passed in 1999 after emotional testimony and with high regard for patient and family concern, medical ethics, and medical science, provides a method of resolution. While it did not change the standard of care (or shift doctor's ability to make medical decisions), the statute gave health care providers an optional safe harbor from suit. When a life-sustaining intervention conflicts with medical ethics, the physician is entitled to initiate § 166.046's procedure, triggering an ethics committee's review of the patient's case and facilitating an objective evaluation of the pros and cons of further intervention. When a physician's ethics and conscience compel her to decline the patient's desired intervention, and this procedure is followed, the physician is not subject to malpractice liability or professional discipline. *Importantly, if a patient/family disagrees with the decision, they have the absolute right to seek treatment elsewhere.*

In the case before the Court, it is undisputed that Cook Children's properly followed all of the statutory provisions of TADA. Indeed, the evidence will show that Cook Children's greatly exceeded those requirements. Moreover, the evidence will show that no other hospital has disagreed with Cook Children's decision and – despite searching for months – no other hospital has agreed to accept Tinslee as a patient. Simply put, all doctors that have reviewed the case have agreed that further treatment of Tinslee will cause her considerable suffering for no medical benefit.

Despite this fact, Plaintiffs and the current Attorney General ask this Court to order Cook Children's to continue Tinslee's suffering. Specifically, they contend that the Act unconstitutionally deprives a patient of life and ability to make independent medical decisions. That is incorrect. The Act does not change any obligation of a physician or a hospital to provide life-sustaining intervention. And, under existing law, physicians have no constitutional obligation to provide any particular medical intervention—much less one that violates their ethics and conscience. *The Act*, therefore, does not deprive anyone of life, or of the power to direct medical care. The only deprivation the Act accomplishes is a patient's ability to sue for malpractice. But that is not a life, liberty, or property interest protected by the Due Process Clause, and Plaintiffs wisely do not assert it.[2] They have identified no constitutional right that the Act erases. Neither have they identified the "state action" required for a Section 1983 claim. The Defendant here is a private hospital, not a state actor. Therefore, their claims fail,[3] and they cannot obtain a temporary injunction.

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[2] Nor could it possibly provide the basis for injunctive relief

[3] It is also significant that neither Plaintiffs for the Attorney General have been clear as to whether they are challenging TADA as facially unconstitutional or as unconstitutional as applied to these facts.

Through a flawed constitutional suit, the Plaintiffs and the Attorney General seek to overturn the careful compromise over end-of-life care agreed to by a wide array of stakeholders, including religious authorities, right-to-life-organizations, physicians, and hospitals. This debate, so critical to all concerned, was resolved in the Texas Legislature. Challenges to that profound policy choice belong in the Capitol, not in the courts.

## ARGUMENT

To obtain a temporary injunction, Plaintiffs must plead and prove three elements: (1) a cause of action against the defendant, (2) a probable right to the relief sought, and (3) irreparable harm. *Butnaru v. Ford Motor Co.*, 84 S.W.3d 198, 204 (Tex. 2002). Plaintiffs cannot establish either of the first two elements. The statute does not authorize the relief Plaintiffs seek, and Plaintiffs' constitutional claims fail because Plaintiffs have not been deprived of any constitutionally protected interest and Defendant is not a state actor. Accordingly, Plaintiffs' request for a temporary injunction should be denied.

### I. Section 166.046 does not authorize the relief Plaintiffs seek.

The plain language of TADA is clear. The Court can ***only*** grant injunctive relief if there is a reasonable probability of finding another facility or physician willing to take over the patient's care:

> "At the request of the patient or the person responsible for the health care decisions of the patient, the appropriate district or county court shall extend the time period provided under Subsection (e) ***only if the court finds, by a preponderance of the evidence, that there is a reasonable expectation that a physician or health care facility that will honor the patient's directive will be found if the time extension is granted.***"

TEX. HEALTH & SAFETY CODE § 166.046(g) (emphasis added).

In order to make the required showing under § 166.046(g), Plaintiffs must offer more than mere conclusory assertions – they must identify specific hospitals or physicians that are reasonably likely to accept a transfer. *See Nikoulouzos v. St. Luke's Episcopal Hosp.*, 162 S.W.3d 678, 683–

84 (Tex. App.—Houston [14th Dist.] 2005, no pet.) (Fowler, J., concurring) (plaintiff's stated belief that "there are doctors and hospitals who will be willing to continue treatment" was not sufficient to establish a "reasonable expectation" under § 166.046(g), where no alternative facility had been identified by the conclusion of the hearing).

When, as here, an applicant relies on a statute that defines the requirements for injunctive relief, the express statutory language supersedes common law requirements. *Hilb, Rogal & Hamilton Co. of Tex. v. Wurzman,* 861 S.W.2d 30, 33 (Tex. App.—Dallas 1993, no writ). "[T]he rules of equity control the granting of temporary-injunctive relief ***unless a particular statute provides otherwise***." *Cardinal Health Staffing Network v. Bowen,* 106 S.W.3d 230, 235 (Tex. App.—Houston [1st Dist.] 2003, no pet.) (emphasis added); *see* TEX. CIV. PRAC. & REM. CODE § 65.001 ("[T]he principles governing courts of equity govern injunction proceedings ***if not in conflict with this chapter or other law***.") (emphasis added); TEX. R. CIV. P. 693 ("The principles, practice and procedure governing courts of equity shall govern proceedings in injunctions ***when the same are not in conflict with these rules or the provisions of the statutes***.") (emphasis added).

Because Section 166.046(g) expressly limits the purpose for which the Court can grant any time extension, Plaintiffs cannot obtain an indefinite temporary injunction, let alone a permanent injunction. The only relief the Court may grant – assuming Plaintiffs prove their case at the injunction hearing – is a temporary stay for the defined period in which Plaintiffs prove they will obtain transfer. As the evidence will show, no extension is warranted here as there is no reasonable expectation of locating a new facility willing to treat Tinslee.

## II. The statute does not violate Plaintiffs' due process rights.

Plaintiffs are not entitled to declaratory judgment, and they will not succeed on their Section 1983 claim. TADA does not deprive Plaintiffs of their constitutional due process rights, and Defendant and its physicians are not state actors.

### A. Background and purpose of the Act.

#### 1. The Legislature passed the Act with the approval of a diverse array of stakeholders.

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

Texas Right to Life, ironically, now represents Plaintiffs in seeking to invalidate the very statute that the organization negotiated and wholeheartedly endorsed. During the 1999 Legislative session, TRL's Legislative Director testified: "[W]e like it and the whole coalition seems to be in agreement with this. . . . [W]e are really united behind this language." *See id.* (statement of Joseph A. Kral, IV, Legislative Director, Texas Right to Life).[4] The bill passed the Senate unanimously. It passed the House on a voice vote. Act of May 11, 1999, 76th Leg., R.S., ch. 450, §3.05, 1999 Tex. Gen. Laws 2835, 2865.

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

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

"Medical futility" incorporates a complex array of medical and ethical judgments. Instead of displacing physicians in determining whether a medical procedure is appropriate, the Texas Legislature adopted "a process-based approach" similar to one recommended years earlier by the American Medical Association Council on Ethical and Judicial Affairs. Robert L. Fine, M.D., *Medical futility and the Texas Advance Directives Act of 1999*, 13 B.U.M.C. PROCEEDINGS 144, 145 (2000).[5] Yet the AMA's approach had limited practical effect. Even when a physician correctly determined that additional medical intervention would not benefit the patient, the physician had to consider the specter of potential malpractice liability in deciding whether to follow the patient's directive. *Id.* The Texas statute solved that problem by providing a safe harbor procedure which, if followed, conferred immunity from malpractice liability and professional discipline. *Id.* at 146.

This was good policy. The forced provision of medically-inappropriate treatment threatens the proper and ethical practice of medicine. "It is inhumane to prolong a dying process that causes pain to a patient, and physicians believe they should not be forced to provide treatment that violates their ethics." CYNTHIA S. MARIETTA, THE DEBATE OVER THE FATE OF THE TEXAS "FUTILE CARE" LAW: IT IS TIME FOR COMPROMISE 3 (April 2007).[6]

So while patients' and families' wishes are entitled to substantial deference, they cannot and should not override conscientious medical judgment. Doctors must objectively determine if a given treatment will help or harm the patient. In testimony before the Legislature, Dr. Ann Miller, a pediatric chaplain, explained the physician's ethical imperative:

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5 Available at https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1312296/pdf/bumc0013-0144.pdf.

6 Available at https://www.law.uh.edu/healthlaw/perspectives/2007/(CM)TXFutileCare.pdf.

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

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

**B. Legal standard applicable to Plaintiffs' due process claim.**

The traditional procedural due-process inquiry has two parts: (1) whether the plaintiff had a protected liberty or property interest; and (2) what process is due. *Logan v. Zimmerman Brush Co.*, 455 U.S. 422, 428 (1982); *Univ. of Tex. Med. Sch. at Hous. v. Than*, 901 S.W.2d 926, 929 (Tex. 1995).[7] The substantive due-process inquiry looks at whether the state has arbitrarily deprived the plaintiff of a constitutionally protected interest. *Patel v. Tex. Dep't of Licensing & Regulation*, 469 S.W.3d 69, 86–87 (Tex. 2015); *Simi Inv. Co. v. Harris Cty., Tex.*, 236 F.3d 240, 249 (5th Cir. 2000). Here, Plaintiffs cannot show a constitutionally protected interest. Nor can they demonstrate state action, a requirement for a Section 1983 claim. Accordingly, their suit fails.

7 The federal Due Process Clause, U.S. Const. amend. XIV, §1, and Texas's Due Course of Law Clause, Tex. Const. art. I, §19, are functionally similar, and the Texas Supreme Court routinely relies on federal precedent in interpreting the state clause. Univ. of Tex. Med. Sch. at Hous. v. Than, 901 S.W.2d 926, 929 (Tex. 1995). This is especially true of "state action issues," with respect to which the Court has explained that "[f]ederal court decisions provide a wealth of guidance." Republican Party of Tex. v. Dietz, 940 S.W.2d 86, 91 (Tex. 1997).

Cook Children's notes at the outset that – as of the moment this brief was finalized – neither Plaintiffs nor the Attorney General have stated whether they are challenging TADA's constitutionality overall or just as used here. A statute may be challenged as unconstitutional "on its face" or "as applied." *McCain v. State*, 582 S.W.3d 332, 346 (Tex. App. – Fort Worth 2018, no pet.) To say that TADA is unconstitutional "on its face" requires a showing that, by its terms, TADA always operates unconstitutionally. *Gillenwaters v. State*, 205 S.W.3d 534, 536 n.2 (Tex. Crim. App. 2006). In comparison, if they are asserting an "as applied" challenge, Plaintiffs must show that their particular circumstances render the statute unconstitutional as to them. *Id.* at n.3. Under either metric, Plaintiff's claim fails.

### C. Plaintiffs fail to identify a protected interest.

To state a due-process claim, a plaintiff must identify an interest the Constitution protects. *Patel*, 469 S.W.3d at 86–87. Plaintiff identifies two purported interests: life, and a parent's right to make medical decisions for her child. Pet. at 3. Neither of those interests are threatened by the statute the Plaintiffs challenge.

#### 1. The statute merely confers immunity; it does not deprive anyone of life or the right to make medical decisions.

Plaintiffs fundamentally misconstrue Section 166.046 of the Health and Safety Code. They complain that § 166.046 "allows doctors and hospitals the absolute authority and unfettered discretion to terminate life-sustaining treatment of any patient," regardless of the patient's or surrogate's wishes. Pet. at 3. This argument presumes that § 166.046 granted physicians "statutory authority" to withdraw life-sustaining intervention, but the Act did no such thing.

In fact, the Act explicitly disclaimed alteration of "***any*** legal right or responsibility a person may have to effect the withholding or withdrawal of life-sustaining treatment in a lawful manner." TEX. HEALTH & SAFETY CODE § 166.051 (emphasis added). It did not grant physicians any new

powers; it did not even require them to follow any procedure. It merely created a safe harbor from malpractice liability and professional discipline—by granting immunity—to physicians who choose to withhold or withdraw life-sustaining intervention in a specific manner utilizing certain procedures.

According to the United States Supreme Court, it is the patient's illness that causes death; that result is merely forestalled by life-sustaining intervention. *Vacco v. Quill*, 521 U.S. 793, 801 (1997) ("[W]hen a patient refuses life-sustaining medical treatment, he dies from an underlying fatal disease or pathology . . . ."). Following this principle, the Minnesota Supreme Court recently concluded that even if a court-appointed guardian was considered a "state actor," it was not a due process violation for that guardian to consent to the removal of life-sustaining treatment from a brain-damaged patient after his physicians and a hospital ethics committee had concluded that further medical intervention would be futile. *In re Guardianship of Tschumy*, 853 N.W.2d 728, 747 (Minn. 2014) ("There is a fundamental difference between depriving someone of life and letting disease run its course."). Here, as in *Tschumy*, the withdrawal of treatment after a medical determination of futility does not implicate any constitutional due process interest.

The existing legal framework (unchanged by the Act) allows physicians freedom to choose who they treat and what treatments they provide. "The physician-patient relationship is 'wholly voluntary.'" *Gross v. Burt*, 149 S.W.3d 213, 224 (Tex. App.—Fort Worth 2004, pet. denied) (quoting *Fought v. Solce*, 821 S.W.2d 218, 220 (Tex. App.—Houston [1st Dist.] 1991, writ denied)).

A physician has always been allowed to ***abstain*** from providing a particular treatment when medical judgment, the physician's conscience, or sound ethics demands it. The Code of Medical Ethics protects physicians' right "to act (or refrain from acting) in accordance with the dictates of

conscience in their professional practice," allowing them "considerable latitude to practice in accord with well-considered, deeply held beliefs." AM. MED. ASS'N COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS, CODE OF MED. ETHICS §1.1.7 (2016) (emphasis added). The key limitation is that the physician has an ethical duty not to terminate the relationship without "[n]otify[ing] the patient (or authorized decision maker) long enough in advance to permit the patient to secure another physician." *Id.* §1.1.5. The physician must also "[f]acilitate transfer of care when appropriate." *Id.*; *accord King v. Fisher*, 918 S.W.2d 108, 112 (Tex. App.—Fort Worth 1996, writ denied) (describing elements of a common law abandonment claim); *see also Tate v. D.C.F. Facility*, Civ. A. No. 4:07CV162-MPM-JAD, 2009 WL 483116, at *1 (N.D. Miss. Jan. 23, 2009) ("Doctors and hospitals of course have the right to refuse treatment . . . .").

The Act, therefore, operates within the historical framework governing physician-patient relationships. The Legislature preserved patients' and doctors' rights to make decisions about care. TEX. HEALTH & SAFETY CODE §166.051. The Act requires a physician or health-care facility that "is unwilling to honor a patient's advance directive or a treatment decision to provide life-sustaining treatment" to nevertheless provide that treatment, but "only until a reasonable opportunity has been afforded for transfer of the patient to another physician or health care facility." *Id.* The Act maintains that framework, granting only immunity in addition.

Physicians already had the right to refuse to provide treatment[8] that violates their conscience and ethics. The Act did not affect that preexisting right. Therefore, the Act (which is

[8] Indeed, the implications of the rule that Plaintiffs propose is staggering to consider. Must a physician in an emergency room continue providing CPR until the family agrees with the futility decision? Do patients suddenly have the constitutional right to dictate all of their medical treatments even when such treatments are not medically indicated? Such a right would allow patients to demand almost anything and assert such treatment as protected under the Constitution.

what Plaintiffs challenge here) does not deprive the Plaintiffs of life or of the authority to direct medical care.

2. There is no constitutional right to medical care.

Moreover, a physician is not ***constitutionally*** obligated to provide ***any*** treatment, including life-sustaining treatment. A contrary holding would have severe consequences. If Plaintiff were correct that the Constitution requires doctors to undertake treatment that ***prevents or forestalls*** illness, then patients would have a constitutional right to have ***any and all*** ailments treated. Yet the United States Supreme Court has expressly rejected this position. *DeShaney v. Winnebago Cty. Dep't of Soc. Servs.*, 489 U.S. 189, 198–99 (1989); *accord Abigail All. for Better Access to Developmental Drugs v. von Eschenbach*, 495 F.3d 695, 710 n.18 (D.C. Cir. 2007) (en banc) ("No circuit court has acceded to an affirmative access [to medical care] claim.");[9] *Johnson by Johnson v. Thompson*, 971 F.2d 1487, 1495–96 (10th Cir. 1992) (rejecting argument that right to life includes right to receive medical care). Indeed, even in the unique prison context, courts have roundly rejected the notion that a patient has a right to receive "any particular type of treatment." *Long v. Nix*, 86 F.3d 761, 765 (8th Cir. 1996); *accord Jenkins v. Colo. Mental Health Inst. at Pueblo*, 215 F.3d 1337, at *1–*2 (10th Cir. 2000) (unpublished).

The same analysis dooms Plaintiffs' stated interest in the individual right to make medical decisions. That right is not diminished by the Act. Rather, the Act protects individuals' right to make their own medical decisions, confirming the longstanding rule that before terminating a patient-physician relationship, the physician must give the patient reasonable notice so that he can find someone who will comply with his wishes. But an individual's right to make a decision does

9 In *Abigail Alliance*, the *en banc* D.C. Circuit held that the Due Process Clause does not give terminally ill patients a right of access to potentially life-saving experimental drugs that have not been approved by the FDA. 495 F.3d at 711.

not compel a physician to implement it against the physician's own will. The patient's right is to make her choice, but this right does not overpower the physician's ethics and conscience. *See Harris v. McRae*, 448 U.S. 297, 318 (1980) ("Whether freedom of choice that is constitutionally protected warrants federal subsidization is a question for Congress to answer, not a matter of constitutional entitlement.").[10]

Plaintiffs' claims of constitutional injury are predicated on the notion that a patient has a constitutional right not only to receive medical care, but to receive medical care of a specific type. But there is no constitutional right to medical care, let alone specific types of care, even if the care would save a person's life. Therefore, Plaintiffs' claims fail.

**D. A private physician's treatment decision does not constitute state action.**

To bring a Section 1983 claim, Plaintiffs must also demonstrate state action. *Shelley v. Kraemer*, 334 U.S. 1, 13 (1948) (holding that the Constitution "erects no shield against merely private conduct, however discriminatory or wrongful"); *Republican Party of Tex.*, 940 S.W.2d at 90–91 (applying same doctrine to the Texas Constitution).

Here, Defendant – a private hospital – is indisputably a private actor. The case of *Klavan v. Crozer-Chester Medical Center*, 60 F. Supp. 2d 436 (E.D. Pa. 1999), is instructive on this point. In *Klavan*, doctors at a private hospital took aggressive measures to resuscitate a patient and then kept him alive in a persistent vegetative state even though his advance medical directive

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10 *Harris* illustrates the danger in Plaintiffs' conception of constitutional rights. If a constitutional life interest conferred an affirmative right to the medical care of its choice, so would the constitutional abortion right confer an affirmative right to have the state provide abortions. Yet Harris rejected precisely such an argument, explaining:

> It cannot be that because government may not prohibit the use of contraceptives or prevent parents from sending their child to a private school, government, therefore, has an affirmative constitutional obligation to ensure that all persons have the financial resources to obtain contraceptives or send their children to private schools.

*Harris v. McRae*, 448 U.S. 297, 318 (1980) (citations omitted).

expressly prohibited such treatment. *Id.* at 439–40. The patient's guardian sued under § 1983, alleging a violation of his due process right to refuse unwanted medical treatment. *Id.* at 440. The court dismissed the claim, finding that the hospital and doctors were not "state actors," even though they were regulated by a Pennsylvania statute that required them to either comply with the patient's advance directive or transfer him, as well as by other state and federal statutes that required them to inform patients of their right to refuse treatment. *Id.* at 443–44. Although the situation in *Klavan* was essentially the inverse of the facts here, the conclusion is the same: the existence of a statute regulating advance directives and end-of-life decisions does not make a private hospital into a state actor.

Plaintiffs rely on two limited doctrines in which the Supreme Court has found state action by a private party in unique circumstances:

- The *state compulsion test* attributes a private actor's conduct to the state when the state "exerts coercive power over the private entity or provides significant encouragement." *Id.* at 549–50 (citing *Adickes v. S.H. Kress & Co.*, 398 U.S. 144, 170–71 (1970).
- The *public function test* asks "whether the private entity performs a function which is 'exclusively reserved to the State.'" *Cornish v. Corr. Servs. Corp.*, 402 F.3d 545, 549 (5th Cir. 2005) (quoting *Flagg Bros., Inc. v. Brooks*, 436 U.S. 149, 158 (1978).

1. Section 166.046 does not satisfy the state-compulsion test.

Supreme Court precedent firmly refutes any notion that a hospital or physician invoking Section 166.046's safe harbor is a state actor. In the first place, § 166.046 provides a discretionary, not mandatory, procedure; it issues no directives to any physician or hospital. *See* TEX. HEALTH & SAFETY CODE §166.045(c) (providing that if an attending physician does *not* wish to follow the procedure established under §166.046, life-sustaining treatment must be provided until the patient is transferred). The Supreme Court has repeatedly held that "[a]ction taken by private entities with the ***mere approval or acquiescence*** of the State is not state action." *Am. Mfrs. Mut. Ins. Co. v. Sullivan*, 526 U.S. 40, 52 (1999) (emphasis added); *accord Blum v. Yaretsky*, 457 U.S. 991, 1004–

05 (1982); *Flagg Bros.*, 436 U.S. at 154–65; *Jackson v. Metro. Edison Co.*, 419 U.S. 345, 357 (1974).

Indeed, the "[p]rivate use of state-sanctioned private remedies or procedures does not rise to the level of state action." *Tulsa Prof'l Collection Servs., Inc. v. Pope*, 485 U.S. 478, 485–86 (1988); *accord Flagg Bros.*, 436 U.S. at 161–62. A physician or hospital making use of § 166.046 is doing no more than using a state-provided remedy; the physician or hospital does not receive the type of "overt, significant assistance of state officials" that creates state action. *Pope*, 485 U.S. at 485–86; *cf. id.* at 487 (finding state action in private use of probate procedure, where probate court was "intimately involved" throughout each stage of the procedure's operation); *Lugar v. Edmondson Oil Co.*, 457 U.S. 922, 941 (1982) (holding that private use of prejudgment-attachment procedure constituted state action, where acts by sheriff and court clerk showed "joint participation with state officials in the seizure of disputed property"); *Georgia v. McCollum*, 505 U.S. 42, 51–52 (1992) (finding state action in criminal defendant's use of racially-discriminatory peremptory challenges because the court enforces them); *Edmonson v. Leesville Concrete Co.*, 500 U.S. 614, 615 (1991) (same, in a civil case).

Plaintiffs' reliance on *Lugar*, *McCollum*, and *Edmonson* is misplaced. *See* Pet. at 11. In contrast to those cases, here the Act contemplates ***no*** involvement or participation by state officials aside from the very limited role of the Court in determining whether there is a reasonable expectation that an alternative facility or physician willing to take over the patient's care can be found if a time extension is granted. *See* § 166.046(g).

In reality, Plaintiffs' claim of state action amounts to no more than a private party "acting pursuant to the procedures of section 166.046." Pet. At 11. But in the absence of overt assistance from or coercion by the State, even compliance with a ***mandatory*** procedure does not implicate

state action. Consider *Blum v. Yaretsky*, in which "a class of Medicaid patients challeng[ed] decisions by the nursing homes in which they reside to discharge or transfer [them] without notice or an opportunity for a hearing." 457 U.S. at 993. Federal law ***required*** nursing homes to establish utilization review committees to "periodically assess[] whether each patient is receiving the appropriate level of care, and thus whether the patient's continued stay in the facility is justified." *Id.* at 994–95. The *Blum* plaintiffs were found by their respective URCs to not require a higher level of care and were therefore transferred to other institutions in accordance with the statutory procedure. *Id.* at 995. Yet even so, the Supreme Court held that there was no state action: the nursing homes, not the state, initiated the reviews and judged the patients' need for care on their own terms, not on terms set by the state. The nursing homes' decisions "ultimately turn[ed] on medical judgments made by private parties according to professional standards that are not established by the State." *Id.* at 1008.[11]

The decision to abstain from following a patient's wishes—and thus whether to initiate the § 166.046 procedure—originates with the physician, who acts according to her own conscience, expertise, and ethics. *Cf. id.* at 1009 (noting that nursing homes' transfer decisions were based on judgments that "the care [the patients] are receiving is medically inappropriate"). As in *Blum*, the State does not determine when or for what reasons a physician may invoke the §166.046 procedure. Moreover, unlike in *Blum*, use of § 166.046 is permissive, even for physicians wishing to abstain. This case thus fits easily within *Blum*'s no-state-action holding.

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11 Following *Blum* and *Flagg*, the Fifth Circuit has held that private psychiatric hospitals do not become "state actors" when they hold patients pursuant to civil commitment statutes. *Bass v. Parkwood Hosp.*, 180 F.3d 234, 241–43 (5th Cir. 1999) (private hospital acting pursuant to Mississippi involuntary commitment statute was not "state actor" for purposes of § 1983 action); *see also Lewis v. Law-Yone*, 813 F. Supp. 1247, 1254 (N.D. Tex. 1993) (patient's § 1983 claim against private psychiatric hospital and doctors failed because they were not "state actors," even though suit concerned their compliance with voluntary commitment procedures established by Texas statute). "Merely because a state provides a scheme by which private parties can effectuate a process does not mean that the private parties become state actors by implementing such a process." *Lewis*, 813 F. Supp. at 1254.

Another consideration cutting strongly against state action is that §166.046 does no more than immunize a physician who employs it. A similar issue arose in *Flagg Brothers*, in which the plaintiff sued to stop a warehouse from selling, pursuant to a warehouseman's lien, goods she had abandoned at the warehouse. *See* 436 U.S. at 153–54. State law provided the warehouse a procedure for making the sale and absolved it from liability if it complied. *See id.* at 151 n.1. The Court rejected the argument that the statute, or the state's decision to deny relief, constituted state action. *Id.* at 165.

The Fifth Circuit has applied these principles to a medical peer-review committee. In *Goss v. Memorial Hospital System*, 789 F.2d 353, 356 (5th Cir. 1986), the court considered a provision of the Texas Medical Practice Act that immunized hospitals' medical peer review committees from civil liability for reporting physician incompetency to the Board of Medical Examiners.[12] The plaintiff argued "that this immunity granted appellees by the State of Texas provided such encouragement to appellees that the peer review committee acted as an investigatory arm of the state." *Id.* Relying on *Flagg Brothers*, the Fifth Circuit rejected this argument, writing that the conferral of immunity "did not make the action of appellees state action." *Id.*[13]

Similarly, in *White v. Scrivner Corp.*, 594 F.2d 140, 141 (5th Cir. 1979), the Fifth Circuit considered whether a grocery store security guard's detention of a shoplifter constituted state action. The plaintiff relied on a Louisiana statute "insulating merchants from liability for detention of persons reasonably believed to be shoplifters." *Id.* at 143. The court held that *Flagg Brothers*

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12 An amended version of this statute is codified at Tex. Occ. Code §160.010.

13 A California court applied the same principle in *Thomas v. Chadwick*, a § 1983 action brought by parents against a private hospital and doctor who had reported them for child abuse after a mistaken diagnosis of "shaken baby" syndrome. 224 Cal. App. 3d 813 (Cal. App. 1990). The court concluded that the hospital and doctor were not "state actors" even though they were acting pursuant to a mandatory-reporting statute that gave them absolute immunity. *Id.* at 823 n.12.

"require[d] rejection of this argument." *Id.* Noting that the statute allowed, but did "not compel merchants to detain shoplifters," the court held that the immunity statute could not constitute state action. *Id.*

Because §166.046 is a permissive statute, initiated at a physician's sole option, and because it does no more than withhold a cause of action, there is no coercion or participation rising to the level of state action.

2. Section 166.046 does not satisfy the public-function test.

Plaintiffs also rely on the public-function test. *See* Pet. at 11–12. The Supreme Court holds that state action exists when a private entity performs a function that is "traditionally the *exclusive* prerogative of the State." *Jackson*, 419 U.S. at 353 (emphasis added). These are powers "traditionally associated with sovereignty." *Id.* The public-function test is "exceedingly difficult to satisfy." MARTIN A. SCHWARTZ, SECTION 1983 LITIG. CLAIMS & DEFENSES §5.14[A]. The Court has "rejected reliance upon the doctrine in cases involving":

> coordination of amateur sports, the operation of a shopping mall, the furnishing of essential utility services, a warehouseman's enforcement of a statutory lien, the education of maladjusted children, the provision of nursing home care, and the administration of workers' compensation benefits.

*Id.* (footnotes omitted).

Plaintiff argues that hospital ethics committees exercise the "traditionally exclusive state function of a court." Pet. at 12. That is incorrect. Ethics committees, as their name suggests, opine on questions of medical practice and ethics. They have no judicial function, and do not apply the law. Moreover, medical decision-making is a quintessentially ***private*** function. *See Blum*, 457 U.S. at 1011 ("We are also unable to conclude that the nursing homes perform a function that has been traditionally the exclusive prerogative of the State." (quotations omitted)). Even when overlaid with state regulations, a hospital's decisions are its own. *See id.* 1011–12 (holding that even if the

state were obligated to provide nursing home services, "it would not follow that decisions made in the day-to-day administration of a nursing home are the kind of decisions traditionally and exclusively made by the sovereign").

Decisions about when to enter into and leave doctor-patient relationships are governed by the desires of the doctor and patient. A doctor's decision to terminate that relationship is left to his medical judgment and conscience, provided that he conforms to a non-statutory code of medical ethics. These private, personal decisions are not—and never have been—regarded as public functions. The doctors and hospital ethics committees who make these decisions are not state actors, and no due process interest is implicated. Accordingly, Plaintiffs' constitutional claims fail.

### E. Plaintiffs have not been deprived of due process.

Finally, Cook Children's notes that even if TADA somehow could be constitutionally challenged in the method Plaintiffs assert – which it cannot – due process has not been violated here. As the evidence will show at the hearing, Plaintiffs have been properly treated under any standard.

## CONCLUSION AND PRAYER

For the reasons set forth above, Plaintiffs' request for injunctive relief should be denied. Section 166.046(g) does not permit the indefinite temporary injunction or the permanent injunction that Plaintiffs seek, but instead allows an extension of time for a limited period ***only*** if the Court finds by a preponderance of the evidence presented at the hearing that there is a reasonable expectation that another facility or physician will be found to take over Tinslee Lewis's treatment. Furthermore, Plaintiffs' constitutional challenge misapprehends both the Act and its purpose. Because the Plaintiffs have shown neither a cause of action nor a probability of prevailing on the merits, their request for a temporary injunction should be denied.

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Respectfully submitted,

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## CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of the above and foregoing document has been served on Plaintiff's counsel via their emails as noted below on December 11, 2019.

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