DYING FOR DUE PROCESS: THE UNCONSTITUTIONAL MEDICAL FUTILITY PROVISION OF THE TEXAS ADVANCE DIRECTIVES ACT

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I. INTRODUCTION

In August 2006, the wife of Mr. Jimmy Givens offered testimony to the Texas legislature about how a hospital invoked a Texas statute in an effort to deactivate her husband’s pacemaker and remove him from a needed respirator even though he was fully conscious, had good health insurance, and was asking for treatment.1 Because the doctor had invoked the procedures of the statute and had received approval from the hospital’s ethics committee to remove the life-sustaining care, Mrs. Givens was shocked to find that Texas law fully supported the doctor’s decision by granting him absolute immunity from all legal consequences that might otherwise be used to protect her husband.2 As will be detailed infra,3 Mrs. Givens was able to protect her husband from the threatened treatment withdrawal, but only by bringing his case to the attention of the media. The statute itself sought to prevent any specific legal recourse.

Much has been written about the inadequacy of using the court system as a forum for resolving disputes over medical treatments.4 This criticism is especially pronounced among those who believe that doctors are being coerced into providing non-beneficial and burdensome medical interventions out of fear of being sued. They argue that threats of legal liability introduce a significant distortion into deliberation about the use of

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2 Id.

3 See infra Part II.D.1.

4 See Martin L. Smith et al., Texas Hospitals’ Experience with the Texas Advanced Directives Act, 35 CRITICAL CARE MEDIC, 1271, 1274 (2007); see also ALAN MEISEL & KATHY L. CERMINARA, THE RIGHT TO DIE: THE LAW OF END-OF-LIFE DECISIONMAKING § 3.01 (3d ed. Aspen Publ’g 2004 & Supp. 2006).
disputed medical treatments. Instead, so the argument goes, the state should empower doctors, ethics committees and hospitals to resolve disputes over such allegedly “futile” medical treatments through a dispute resolution mechanism that keeps courts out of the matter.

Texas has adopted this procedural approach to the resolution of “futility disputes” through one unique provision of its otherwise typical Advance Directives Act (Act). Under this provision, section .046 of the Act, doctors and hospitals are empowered to refuse “life-sustaining treatment”5 (LST) to those who request it, and, if they abide by a very simple set of procedures, the health care workers and hospital will be completely immunized from all potential criminal, civil, and administrative liability for the denial.6 The procedural requirements are absolutely minimal—amounting to nothing more than notice of the doctor’s decision, forty-eight hour notice and permission to attend an ethics committee meeting to review the doctor’s decision, and a ten day period to seek a transfer to another medical provider who will agree to provide the treatment.7 This ten day period may be extended by a court only if the patient can convince the court that there is a reasonable chance of finding an alternate caregiver if an extension is granted.8 At the end of the waiting period, the doctors may, with complete legal immunity, remove LST against the wishes of the patient.

Section .046 provides no protections against the arbitrary and capricious abuse of this powerful control over the life of a vulnerable patient. Most notably absent from the statute are any objective standards that will limit the discretion of the doctor or hospital. Nor is the .046 procedure limited to those cases involving terminally ill patients or those with an irreversible condition. This law applies to everyone who finds themselves in need of medical assistance to maintain one’s life, even outpatients in need of such things as dialysis or portable respirators, and regardless of whether one’s condition is expected to improve. The doctors and hospitals invoking the .046 procedure are under no legal obligation to abide by the medical standard of care or to avoid negligent, reckless, or even intentionally wrongful conduct in denying LST. All such actions are equally immunized under the statute so long as the minimal procedures are followed.

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6 Id. § 166.045(d).
7 Id. § 166.046(b)–(c).
8 Id. § 166.046(g).
However, hospitals and doctors should be aware that the “safe harbor” of legal immunity that Texas offers as an incentive to doctors who make use of the .046 procedure is not as safe as it might appear. This Article argues that a court will likely strike down the statute as a violation of the procedural due process protections of the Fourteenth Amendment, should an appropriate case come before the court. Such a case, in the clearest manner, would involve a patient being subjected to the procedure by doctors at a public hospital where state action makes a constitutional claim easiest to raise. In a related article, I also argue that patients have a colorable claim that a court should declare an ethics committee at a private hospital involved in an .046 procedure to be “state actors” who are also required to comply with constitutional guarantees.

A court would likely find the .046 procedure to violate constitutional procedural due process guarantees on three grounds. First, the statute is unconstitutionally vague because it fails to set forth any standard of “futile” or “medically inappropriate care,” and thus grants decision makers unconstrained authority to refuse LST in an arbitrary and capricious manner. Second, the statute fails to provide the patients with a neutral, unbiased forum in which to refute the doctor’s claim that the treatment is futile. The Due Process Clause is offended because the Texas legislature has placed the ultimate decision about the dispute into the hands of one of the parties to the dispute, the hospital’s own ethics committee. The statutory immunity provision further ensures that the dispute will never be reviewed by any neutral court or administrative body. Finally, under the Supreme Court’s balancing test set forth in Mathews v. Eldridge, a court would likely find that a patient’s interest in access to the full range of formal procedural protections in order to ensure a proper decision greatly outweighs the state’s interest in granting the ethics committees carte blanche regarding the procedures to be used in settling the dispute.

Even if a court does not hold the statute unconstitutional, doctors and hospitals should lobby for a complete reform of the law to place ultimate decision making about LST disputes in an independent and publicly accountable body, rather than in a hospital ethics committee. Health care

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9 Id. § 166.045(d).
10 See Nora O’Callaghan, When Atlas Shrugs: May the State Wash Its Hands of Those in Need of Life-Sustaining Medical Treatment?, ___ HEALTH MATRIX J. ___ (2008). In that Article, I also explore claims that the .046 procedure violates equal protection and substantive due process guarantees of the Fourteenth Amendment.
providers should be dubious about relying on the current statute because it places them in the unenviable position of implementing a fundamentally unfair procedure. No matter how much one could argue that the process has yielded a “proper result” in a particular case, one will never be able to deny the fact that the procedure is flawed and the patient was therefore treated improperly. At the end of the day, it makes an enormous difference whether the losing party can say, “Well, at least I had a fair hearing, and I know that I am not being singled out for bad treatment because of bias or animus. Everyone in my position will be judged the same way.” Those who are denied LST under .046 are denied this comfort and the dignity it implies by the fundamentally unfair procedures in the statute.

The law further runs the risk of undermining the doctor-patient relationship and trust, particularly among vulnerable populations. As controversial cases come to public attention, this law focuses the frustration and distrust of advocacy groups on particular doctors, ethics committees and hospitals, and the statute makes it impossible to resolve such concerns in any publicly accountable forum. In one particularly heated dispute between a hospital and family over the withdrawal of life-sustaining care from an African immigrant, a hospital went to the length of setting up an Internet web page disputing claims made by family members angry about the way a patient was treated under .046. An Internet web page is a poor substitute for a decision issuing from a fair, independent and neutral forum. In effect, the legislature has passed a hot potato to hospitals in order to avoid the political fallout from particular LST disputes.

Part II briefly explains the genesis of the Texas law and the procedure as set forth in the statute. It also sets forth some findings of a recent statistical survey on the use of the statute in Texas, and describes the experience of some patients under the statute as recounted by their family members to the Texas legislature. Part III explores the historical and moral norms of procedural due process protections and the traditional scope of absolute immunity provisions and demonstrates how the .046 procedure departs from these and other norms governing medical issues. Part IV sets forth three strong grounds upon which a court could find the .046 procedure unconstitutional. I conclude that Texas must revise its law to bring it into conformity with constitutional and moral due process requirements.

II. THE FUTILITY PROBLEM, THE TEXAS SOLUTION, AND EXPERIENCE WITH THE LAW

For over twenty years, a debate has been carried on in the medical, bioethical, and legal literature over the question of a doctor’s duty to provide “futile” medical interventions. It is generally accepted that no consensus has emerged from this prolonged scholarly engagement with the issue. Indeed, there is no generally agreed upon definition of the concept of “medical futility,” and the term is sometimes used to encompass a wide range of potential kinds of disputed cases. There is a wealth of scholarly writing on the futility debate that will not be canvassed here. For our purposes, only a brief outline of the debate will suffice in order to set forth the motives that led Texas to enact the .046 procedure, before turning to a discussion of the statutory provision, and finally setting forth some indication of patient experiences under the statute.

A. The “Futility” Problem

First, it is important to note that there are many completely non-controversial cases where almost everyone would agree that a request for treatment is physiologically futile, and thus no obligation exists to comply with the request. For instance, imagine a patient who requests massive doses of antibiotics to “cure” his congestive heart failure where there is absolutely no evidence that the patient has an infection. No state would require a doctor to provide such “care” simply because the patient requested it. In such a case, the state’s medical malpractice or tort doctrine will provide the doctor with protection from liability, since a patient seeking to sue must show that the doctor’s decision fell outside the medical profession’s standard of care. Since no plaintiff would be able to demonstrate a breach of the standard of care if the treatment offers no physiological benefit, the doctor would face no threat of legal liability in refusing the antibiotics, no matter how genuinely the patient believes that such medication would cure him.

Not all treatment disputes between a doctor and patient are this clear-cut, however. Some treatments provide a certain level of physiological benefit to a patient, for example, by prolonging a person’s lifespan for some
amount of time or by maintaining a person’s life indefinitely in a very serious condition, such as a persistent vegetative state. In such cases, a dispute about the provision of treatment often turns on the question of whether the treatment is sufficiently beneficial to the patient to justify the continued provision of care. Another class of disputes centers around a request for “long-shot” or experimental treatments that offer benefits to patients in only a relatively small percentage of cases. A patient might view such treatments as worth trying because even a small percent chance of success is worthwhile if doing nothing means inevitable death. A doctor might view such long-shot treatments as unwarranted or insufficiently beneficial in relation to the burdens of the treatment.

Unlike the case of physiologically ineffective treatments, these disputes involve treatments that either will be effective in prolonging life (perhaps indefinitely) or at least have some chance of providing a benefit for some percentage of patients. These disputes turn on a subjective assessment of how worthwhile a particular intervention is in a particular case. Subjective values of the patient, family, and doctors will almost certainly affect the weights assigned to the assessment of benefits and burdens in such cases. The futility dispute pits the patient’s interest in autonomous control over medical decisions against a physician’s judgment about whether particular treatments are appropriate or not, given each parties’ assessment of the potential benefits and burdens.

George Annas, in commenting on one of the first legal cases involving a dispute between a doctor (who wished to cease treating a patient in a persistent vegetative state) and the patient’s husband (who wished treatment to continue), argued that public debate must continue on such disputes until an empirical basis for consensus emerged. Short of such a consensus based on empirical evidence about the reliability of such a diagnosis, Annas argued the debate must continue. But no such consensus about such matters has emerged since this debate began in the late 1980s, leaving the question of legal liability for refusing to offer such care largely unresolved.

One of the persistent difficulties in achieving consensus about this issue has been an inability to define what is meant by “futile care,” particularly because the theories seem to encompass the full range of potential treatment disputes, from those that are clearly physiologically useless to those that

16 See MEISEL & CERMINARA, supra note 4, §§ 13.01—.02.
simply differ about how worthwhile a particular treatment is. For instance, the Hastings Center published the following Guidelines in 1987:

In the event that the patient or surrogate requests a treatment that the responsible health care professional regards as clearly futile in achieving its physiological objective and so offering no physiological benefit to the patient, the professional has no obligation to provide it. However, the health care professional’s value judgment that although a treatment will produce physiological benefit, the benefit is not sufficient to warrant the treatment should not be used as a basis for determining a treatment to be futile.17

This guideline accepted only the most non-controversial aspect of the futility concept, and one which no court would find a legal duty to provide.

Others argued that demanding doctors to provide care in all cases where some physiological benefit is possible constitutes a violation of physician autonomy; they would assert “[t]here are limits to physician’s obligations to provide care that they believe has no benefit . . . . [Some argue] that complete respect for patients’ autonomy reduces the physician from a moral agent to an extension of the patient’s wishes.” 18 Supporting such claims that a physician’s conscientious beliefs about “non-beneficial” treatments should be respected are horror stories about particular cases in which patient representatives demand that doctors continue to offer care in situations when such conduct seems to border on cruelty. For instance, demanding that a patient in the last throes of metastatic lung cancer be maintained on a respirator, even though his lungs are filled with tumors, or demanding repeated painful attempts at cardio-pulmonary resuscitation for a frail, terminally ill elderly woman with resulting broken bones and bruises.19

18 ALAN D. LIEBERSON, ADVANCED MEDICAL DIRECTIVES § 29:7 (Supp. 2004) (quoting Paul R. Helft et al., The Rise and Fall of the Futility Movement, 343 NEW ENG. J. MED. 293 (2000)).
19 Hearings, supra note 1 (testimony of Dr. Robert Fine) (Dr. Fine’s testimony begins at approximately 3 hours and 11 minutes into the videotape of the hearing).
Others assert that it is common for patient representatives to request painful life-prolonging care out of a sense of guilt or because they cannot “let go” of the patient, even though there are indications that the patient themselves might not have wanted the care. One ethical analysis of such a case centered on a daughter who, although she acknowledged that her terminally ill mother likely did not want the demanded continuing ventilation and dialysis, said, “I do not want to give up on my mom. I’m not ready to lose her yet.” The hospital continued the care under legal advice until the patient’s dialysis catheter ceased to function, at which time they refused to replace it.

It is far from clear whether a doctor would face legal liability for declining to provide painful interventions that offer only a few more moments of life to a terminally ill patient, but proponents of the futile care movement argue that this legal uncertainty tends to create an incentive to continue to provide such treatments rather than risk liability. In the very few reported cases dealing with “futility treatment” disputes, it appears that courts continued to side with the right of patients and their proxies to make ultimate treatment decisions, particularly given the lack of consensus over a definition of “futility.”

Some commentators have noted a progression in the dispute over the concept of futility, noting three unsuccessful stages of the futility debate: first, there was an effort to define futility as a concept; second, attempts to resolve the debate with empirical evidence; and third, when both these efforts failed, the literature turned to “discussions that cast the debate as a struggle between the autonomy of patients and the autonomy of physicians.” After these three substantive approaches failed, the scholarly literature retreated to “attempts to develop a process for resolving disputes over futility.”

Advocates of the Texas statute argue that they have simply enshrined some of the most widely accepted proposals for process-based resolutions into a statute. Its genesis began with the “Houston Citywide Policy on Medical Futility,” a policy described as acknowledging the “difficulty of

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20 LIEBERSON, supra note 18, at 1114 (quoting Robert F. Keating et al., Stopping Dialysis of an Incompetent Patient Over the Family’s Objection: Is it Ever Ethical & Legal?, 4 J. AM. SOC’Y. NEPHROLOGY 1879, 1880 (1994)).
21 Id.
22 See id. at 1090; see also MEISEL & CERMINARA, supra note 4, § 13.01[D].
23 LIEBERSON, supra note 18, at 1088 (quoting Helft et al., supra note 18).
24 Id.
trying to reach a consensus on futility [which] instead outline[s] steps for conflict resolution.”

The Houston Protocol, as it has become known, set forth a nine step procedure for resolving disputes over requests for “medically inappropriate care.” It focused on the use a multidisciplinary team of hospital employees to bring about an agreement over disputed care. If unsuccessful, it required a second opinion by another doctor who would present the case to an institutional review board about the basis for determining that the requested treatment is medically inappropriate. The patient (or surrogate decision maker) would receive seventy-two hour notice of the review board’s consideration of the case and information about how to arrange a transfer to another hospital. The patient or surrogate was permitted to attend the meeting and share their views. If the review board agreed that the requested medical treatment was “medically inappropriate” the care “may be terminated.” No other doctor at the health care facility would be permitted to provide the disputed care, but palliative care would be continued.

The Houston Protocol is similar to a procedural approach proposed by the Council on Ethical and Judicial Affairs of the American Medical Association (AMA) in 1999 for resolving futility disputes. After noting that there is no consensus about the meaning of medical futility, the Council sets out steps in a fair process for considering futility disputes. Its report, like the Houston Protocol, supports “earnest attempts” to deliberate and negotiate between the patient, family, doctor, and institution and recommends the assistance of additional consultants. If the dispute is irresolvable, the dispute moves to the institutional ethics committee. If the ethics committee decides in favor of the patient’s request, the patient may be transferred to another doctor at the hospital. If the committee agrees with the doctor that the care is futile, “arrangements for transfer to another institution may be sought.”

25 Id. at 1089.
26 Id. at 1122 (quoting A. Halev & B.A. Brody, A Multi-Institutional Collaborative Policy on Medical Futility, 276 J. AM. MED. ASS’N. 571, 571–74 (1996)).
27 Id.
28 Id.
29 Id.
31 Id.
Finally, if transfer is not possible because no physician and no institution can be found to follow the patient’s or proxy’s wishes, it may be because the request is considered offensive to medical ethics and professional standards in the eyes of a majority of the health care profession. In such a case, by ethics standards, the intervention in question need not be provided, although the legal ramifications of this course of action are uncertain.\(^{32}\)

In essence, the Texas Advance Directives Act is a statutory enactment (with slight modifications) of these two procedural approaches to resolving futility disputes. The real innovation in the Texas Act, however, and one that has not yet been tried elsewhere, lies in its provision of absolute immunity covering treatment-withdrawal decisions that are made pursuant to the statutory procedure. This immunity, as we shall see, resolves the legal uncertainty noted in the AMA’s guidance on the issue. This statutory immunity, coupled with the very weak procedural protections for patients in the Act, constitute the central procedural flaws that will likely lead this statute to be declared unconstitutional.

B. The Texas Statute

Only a few states have sought to create a legal framework for resolving disputes over allegedly futile care, and even those that have legislated generally have done so in ways that leave so many ambiguities that doctors have not relied upon these statutes.\(^{33}\) The Texas futility dispute resolution procedure, however, represents a unique approach by offering absolute immunity to doctors who refuse to provide LST if they abide by the procedures in the statute. Those involved in drafting the statute have held it up as a model piece of legislation. Dr. Robert Fine, a Texas doctor and professor at the Baylor Medical Center who was instrumental in drafting the bill, has boasted that the statute is the “first of its kind” to set out a process for resolving disputes about end of life care coupled with a legal “safe harbor.”\(^{34}\) Others have agreed that the Texas act is unique in setting forth a

\(^{32}\) Id.

\(^{33}\) See Smith, supra note 4, at 1274. Eight states suggest that a doctor has no obligation to provide futile treatment, but do not define such treatment nor provide immunity. Those states are California, Maine, Maryland, Massachusetts, New York, Tennessee, Virginia, and Washington.

procedure coupled with absolute immunity from judicial or administrative oversight.\textsuperscript{35}

1. The .046 Procedure

Most of the provisions of the Texas Advanced Directives Act are quite similar to the parallel statutes in other states setting forth orderly means for ensuring that people’s medical decisions are respected even if they become unable to speak for themselves. It sets out procedures for people to make written advance directives expressing their views about particular kinds of treatment and makes provisions for surrogates to make medical decisions in conformity with the patient’s wishes. The Act as a whole proceeds along the presumption that everyone has the right to make treatment decisions for themselves, and the dominant policy goal of the statute is to bolster and empower autonomous medical decisions for all patients. Indeed, the Act provides for criminal penalties for intentionally concealing or destroying another person’s advance directive without the patient’s consent.\textsuperscript{36}

Where Texas departs from other states is in setting forth one procedure that completely abandons the overall statutory goal of supporting autonomous decision making when a doctor disagrees with the patient’s decision. The .046 procedure is specifically designed to defeat some patients’ requests for LST.

The procedures are fairly simple. When a physician refuses to comply with an advance directive or “treatment decision made by or on behalf of a patient, the physician’s refusal shall be reviewed by an ethics or medical committee.”\textsuperscript{37} Note that the only triggering event is the doctor’s decision to refuse to “honor a patient’s . . . treatment decision.”\textsuperscript{38} This is a completely subjective standard and does not require any prior finding of an objective state of affairs in order to trigger the patient’s loss of control over his LST. In other parts of .046\textsuperscript{39} and in the statutory notice that must be provided to

\textsuperscript{35}See Smith, supra note 4.
\textsuperscript{36}TEX. HEALTH & SAFETY CODE ANN. § 166.048(a) (Vernon 2001 & Supp. 2007).
\textsuperscript{37}Id. § 166.046(a).
\textsuperscript{38}Id.
\textsuperscript{39}For instance, section 166.046(e) says: “If the patient or person responsible for the health care decisions of the patient is requesting life-sustaining treatment that the attending physician has decided and the review process has affirmed is inappropriate treatment . . . .” Id. § 166.046(e). However, nothing in the sections discussing the doctor’s judgment or the ethics committee review directs that these parties consider whether the treatment is “inappropriate,” nor is the term defined in the statute. See id. § 166.046(e-1).
the patient, the statute suggests that the doctor and health care facility have determined that the requested care is “inappropriate,” but this is the only hint of a standard provided by the statute. The term is not defined in the statute.

The fact that only a subjectively-based futility determination by the doctor is required to trigger the .046 procedure is all the more remarkable because, while other sections of the statute impose a “reasonable care” standard on the doctor’s conduct,.046 does not impose any standard of care on the decision of the doctor or the review committee. Indeed, the statute provides that doctors who comply with a patient’s or proxy’s request to end LST will be immunized from civil and criminal liability only if the doctors exercised “reasonable care” in applying the patient’s directive. In contrast, the decision of the doctor to reject a patient’s request for LST is immunized without any requirement that the doctor exercise reasonable care. Under the statute’s immunity provision, negligent, reckless, and even intentionally malicious decisions to withhold LST pursuant to .046 are completely protected from any civil, criminal, or administrative review.

This failure to set forth a standard that must be met in order to invoke the .046 procedure is not an oversight. Dr. Robert Fine, who was instrumental in negotiating the principles that were drafted into the Act, considered the statute’s lack of a standard to be an integral part of setting forth a workable solution to the problem of treatment disputes. In an article describing the genesis of .046, he explained that two general concepts guided the interdisciplinary committee negotiating the drafting of the law. “First, negative rights to be free of unwanted treatment would be relatively stronger than rights to request LST. Second, the task force would try to

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40 Id. § 166.052.
41 That is, in the subsection setting forth the ten day period for seeking transfer, it says: “If the patient or a person responsible for the health care decisions of the patient is requesting life-sustaining treatment that the attending physician has decided and the review process has affirmed is inappropriate treatment, the patient shall be given available life-sustaining treatment pending transfer,” but only for ten days. Id. § 166.046(e). Similarly, the statutory notice to be provided to the patient or proxy set forth in section .052 says: “You have been given this information because you have requested life-sustaining treatment which the attending physician believes is not appropriate.” Id. § 166.052(a).
42 See id. § 166.044.
43 See id.; discussion infra Part II.B.2.
44 TEX. HEALTH & SAFETY CODE ANN. § 166.045(d) (Vernon 2001 & Supp. 2007); see discussion infra Part II.B.2.
45 TEX. HEALTH & SAFETY CODE ANN. § 166.045(d) (Vernon 2001 & Supp. 2007).
confront the issue of medical futility, but rather than try to define futile treatment in the law, an extrajudicial due process mechanism relying on community standards would be established to resolve disputes about futile treatment.”  

Fine consciously analogizes the impossibility of defining what constitutes “futile treatment” to the difficulty in crafting a judicial definition of obscenity. “Our experience suggests that although some find futility difficult to define, most physicians now know it when they see it (to paraphrase the late Justice Potter Stewart).”  Similarly, he argues that the procedures set forth in .046 permits the evolution of a “community standard” regarding futile care, again echoing the language used in the Supreme Court’s First Amendment test for the constitutionality of statutes regulating obscenity. Dr. Fine neglects to mention that the Court’s obscenity test requires, in addition to a community standard regarding the work’s appeal to “the prurient interest,” that the statute “specifically define” the kinds of sexual conduct that will give rise to an obscenity conviction and a determination that the work taken as a whole “lacks serious literary, artistic, political and scientific value.”  Thus, the Court’s doctrine with respect to obscenity laws actually undermines Fine’s analogy, since no law prohibiting obscene materials resting only on a subjective community standard would survive review.

This community standard on futile treatments is supposed to emerge from the fact that the futility decision is reviewed by an ethics committee, and later may be reviewed by other hospitals if the patient seeks transfer to another hospital to provide the allegedly futile treatment. Unlike the extremely restrictive judicial scrutiny of community standards regulating obscenity, however, this “community standard” again turns on the subjective and unreviewable opinions of the doctor. Fine suggests that the treating team attempts to predict whether another hospital would offer the disputed LST, and that this prediction becomes a “community standard.”

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46 Fine, supra note 34, at 67.
48 For instance, under this objective specificity requirement, the Supreme Court suggested that the statute could proscribe “patently offensive representations of ultimate sexual acts, normal or perverted, actual or simulated” and “patently offensive representations or descriptions of masturbation, excretory functions and lewd exhibition of the genitals.” Miller v. California, 413 U.S. 15, 25 (1973).
49 Id. at 24.
The conceptual boundary is that physicians must ask themselves carefully if there is another treatment team elsewhere that might provide the treatment that the first team considers futile. In essence, a community standard of futility is established.\textsuperscript{50}

Of course, this analogy is again seriously flawed because the .046 procedure does not reflect or produce any detectable means for ascertaining and applying a community standard. There may be many reasons why a patient is unsuccessful in persuading an ethics committee to agree that the treatment should be provided, and why other hospitals may not step forward to accept the patient’s transfer, that have nothing to do with the existence of a uniform community standard.

Nor is there any requirement that the patient be terminally ill or suffering from an irreversible condition\textsuperscript{51} to be subjected to the .046 procedure. Other sections of the Advance Directives Act apply only to “qualified patients” who meet certain criteria.\textsuperscript{52} For instance, a patient’s advance directive rejecting LST is only operative with respect to “qualified patients” who are suffering “with a terminal or irreversible condition that has been diagnosed and certified in writing by the attending physician.”\textsuperscript{53} In contrast, the legislature failed to place any such limit on those who are “qualified” to be refused life-sustaining care under the .046 procedure. Therefore, it is legally possible that a patient who is temporarily dependent on LST, such as a person undergoing surgery for a burst appendix who is almost certain to recover, to be subjected to the procedure outlined in .046. While some may scoff at the suggestion that a doctor or ethics committee would refuse to care for such patients, the twentieth century alone provides abundant examples of unpopular groups or individuals being subjected to medical neglect and abuse. Furthermore, the breadth of the statute’s

\textsuperscript{50} Fine, supra note 34, at 71.
\textsuperscript{51} The statute states:

“Irreversible condition” means a condition, injury, or illness: (A) that may be treated but is never cured or eliminated; (B) that leaves a person unable to care for or make decisions for the person’s own self; and (C) that, without life-sustaining treatment provided in accordance with the prevailing standard of medical care, is fatal.

\textsuperscript{52} See id. §§ 166.037–.040, 166.044–.045, 166.047.
\textsuperscript{53} Id. § 166.031(2).
coverage is relevant to an assessment of its overall fairness and constitutionality.

While the plain meaning of the first subsection of .046 suggests that the procedure is triggered whenever a doctor disagrees about any kind of treatment decision, the bulk of the provision focuses on the doctor’s disagreement over life-sustaining medical treatments only. The statutory notice that must be provided to patients whenever the procedure of .046 is invoked only speaks of the withdrawal of life-sustaining treatments. Similarly, the debate over .046 in the press, scholarly literature, and testimony in the legislature has all focused exclusively on disputes over LST. Therefore, while the statute is unclear on the scope of treatment disputes covered by the Act, this Article will likewise focus analysis of this statutory provision to situations where doctors are seeking to withdraw LST.

Life-sustaining treatment as defined in the statute means “treatment that, based on reasonable medical judgment, sustains the life of a patient and without which the patient will die.” The term “includes both life-sustaining medications and artificial life support, such as mechanical breathing machines, kidney dialysis treatment, and artificial nutrition and hydration.” “The term does not include the administration of pain management medication or the performance of a medical procedure considered to be necessary to provide comfort care or any other medical care provided to alleviate a patient’s pain.”

This definition makes it clear that the procedure applies only when there is a dispute over physiologically effective treatment, since treatment that would not be effective in sustaining the patient’s life would not fall within the boundaries of the statute. Indeed, as already noted, no state holds that a

54 See id. § 166.052.
55 Supporters of .046 also argue that the statute is balanced because the .046 procedure can be implemented regardless of who is objecting to the withdrawal of life-sustaining treatment—for instance, when a doctor refuses to accede to the wishes of a patient or proxy requesting the withdrawal of life-sustaining treatment. See Robert L. Fine & Thomas Wm. Mayo, Resolution of Futility by Due Process: Early Experience with the Texas Advance Directives Act, 138 ANN. INTERN. MED. 743, 744 (2003). However, they also acknowledge that there are additional protections for those patients who seek to terminate life-sustaining treatment than are provided to patients seeking to maintain such treatment. See Fine, supra note 34, at 67.
57 Id.
58 Id.
doctor has an obligation to provide physiologically ineffective treatments to a patient.

Once the doctor has decided to refuse to comply with a request for LST, the patient or her proxy has extremely limited available protections, mainly involving the right to receive information and to seek to transfer to another doctor or hospital. The doctor’s decision to refuse to honor the patient’s request “shall be reviewed by an ethics or medical committee”59 and the patient or proxy “may be given a written description of the ethics or medical committee process.”60 However, given the statute’s lack of a standard, it is not clear what the committee is expected to review. Presumably, the committee is to consider whether they agree with the doctor’s subjective decision to refuse compliance with the request for treatment. The patient or proxy must receive forty-eight hours notice of the ethics committee meeting61 which they may attend, a statutory notice regarding the Texas law, and a copy of the registry of health care providers and referral groups who may be willing to assist with transfer of the patient.62 Over the past twelve months, this registry has included the name of only one doctor and four or five lawyers and activist groups.63

After receiving this minimal information, the patient or proxy is entitled to “attend the meeting,” although there are no requirements that the patient or family be heard or allowed to question those present at the meeting. Some family members of patients going through the .046 procedure have complained that they believe that their concerns and views are not taken seriously in the ethics committee meeting.64 This view seems to be confirmed by Dr. Fine’s reflection on how the process affects families and patient representatives. He has written that he believes that many patient representatives have “a number of deficits as decisionmakers” and that they

59 Id. § 166.046(a).
60 Id. § 166.046(b)(1).
61 Although the statute permits either an ethics committee or a medical committee to review the decision, the assumption is that a medical committee is only used in those hospitals that do not have an ethics committee. When the term “ethics committee” is used in describing this process, the option of a medical committee is a statutory option.
63 See Registry of Health Care Providers and Referral Groups, available at http://www.dshs.state.tx.us/THCIC/Registry.shtm (last visited Apr. 6, 2008). Commentators on the law agree that the registry has been almost completely useless.
64 See infra Part II.D.
are motivated by guilt and improper values accorded to LST.  He suggests that such families secretly welcome the .046 procedure as a relief from the burden of making decisions. “For many of these families, they can make their case for continued treatment through the consultation process, and then say that they did all they could. They then walk away rather than pursue going to state court.” This statement reflects a serious bias against the validity of views of patient representatives and seems to suggest that a failure to pursue the extremely limited court proceeding available under .046 is a further confirmation that the doctor’s views are correct.

Obviously, there may be many other reasons why a family member might decline to pursue a judicial extension of the ten day period, not least the fact that the burden is on the patient representative to establish that it is likely that another hospital will agree to offer the disputed treatment.

The patient or patient representative must receive “a written explanation of the decision reached during the review process,” which must then be placed in the patient’s medical record. The fact that this notice is placed within the patient’s records has led some to fear that the notice will undermine efforts to transfer the patient to another caregiver. It is likely that these other potential caregivers will only review the medical records in determining whether to offer care, and the notice may prejudice their view about the patient’s care.

If the committee agrees with the doctor’s decision, it must provide a statutory notice to the patient or her representative thus starting the ten day waiting period. During this time, the doctor and health care facility are required to make “reasonable efforts” to find a transferring doctor or facility which would be willing to provide the requested care. As Dr. Fine has acknowledged in reflecting upon his experience implementing the law in a large hospital, however, when both the treatment team and the ethics committee come to the conclusion that further treatment is futile, it is extraordinarily unlikely that another facility will accept the patient.

The statute provides that life-sustaining medical treatment shall be provided during this ten day waiting period, but “[t]he physician and health

\[\text{\footnotesize 65 Fine, supra note 34, at 71.} \]
\[\text{\footnotesize 66 Id. at 71–72.} \]
\[\text{\footnotesize 67 See infra Part III.B.} \]
\[\text{\footnotesize 68 TEX. HEALTH & SAFETY CODE ANN. § 166.046(c) (Vernon 2001 & Supp. 2007).} \]
\[\text{\footnotesize 69 Id. § 166.046(d).} \]
\[\text{\footnotesize 70 Robert L. Fine & Thomas Wm. Mayo, Letter to the Editor, 343 NEW ENG. J. MED. 1575 (2000).} \]
care facility are not obligated to provide life-sustaining treatment after the 10th day after the written decision [of the ethics committee decision] is provided to the patient.”

There is one additional protection included in the statute. The patient or proxy may seek an extension of the ten day period from a court in order to seek a transferring hospital. The appropriate court “shall extend the time period . . . 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.”

This time-extension procedure appears to be the sole opportunity provided to the patient for seeking protections from the broader community. The statute’s use of the term “only” limits the review of the court to a consideration of whether alternative caregivers will likely be found and appears to foreclose a review of the substantive decision to withdraw the LST. Indeed, because there is no standard of care imposed on the decision and no objective criteria for “qualified patients,” the statute appears to deprive the patient of any other recourse to the courts beyond this limited time-extension procedure.

2. Texas Statutory Immunities Covering .046 Actions

The legislature’s intent to definitively close the door of the court to the patient is further confirmed by the absolute immunity which it confers on physicians and health care facilities for all decisions reached pursuant to the .046 procedure. The Texas statute provides that if a health care provider follows all of the steps laid out in .046 in denying requested LST, the health care provider will be immune from virtually all potential legal consequences for their actions.

Without this provision, the doctors and hospitals would presumably risk liability under a number of theories. Indeed, Dr. Fine suggests that the “safe harbor” from legal liability for denials of requested LST was the chief legislative goal driving his involvement in the effort to get the .046

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71 TEX. HEALTH & SAFETY CODE ANN. § 166.046(e) (Vernon 2001 & Supp. 2007).
72 Id. § 166.046(g).
73 Id. § 166.045(d) (“A physician, health professional acting under the direction of a physician, or health care facility is not civilly or criminally liable or subject to review or disciplinary action by the person’s appropriate licensing board if the person has complied with the procedures outlined in section 166.046.”).
procedure enacted into law. In a 2003 article he traces the development of futility guidelines in the 1980s and 1990s by various institutions and, most importantly by the American Medical Association’s Council on Ethical and Judicial Affairs. These efforts to address the problem of futile care would not be “effective” given the legal uncertainty, as noted above, regarding legal liability when applying institutional futility policies.

Even when ethics committees agreed that treatment was futile, treating physicians were generally unwilling to withdraw life-sustaining treatment in the face of any potential lawsuit from families who disagreed. We found no reports in the medical literature indicating the routine successful use of futility guidelines for limiting treatments deemed futile by physicians yet still requested by family members.

Nor is the threat of such liability a theoretical matter. There are a number of criminal and civil grounds of liability for causing a patient’s death against their express wishes. The Texas Advanced Directives Act sets forth several actions that will constitute crimes within the statute itself, and there are general causes of action and criminal statutes that could be used to punish doctors who withdraw LST against a patient’s wishes absent the statute’s “legal safe harbor.” Indeed, elsewhere in the Act, it provides:

A person is subject to prosecution for criminal homicide under Chapter 19, Penal Code, if the person, with the intent to cause life-sustaining treatment to be withheld or withdrawn from another person contrary to the other person’s desires, falsifies or forges a directive or intentionally conceals or withholds personal knowledge of a revocation and thereby directly causes life-sustaining treatment to be withheld or withdrawn from the other

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74 Fine & Mayo, supra note 55, at 745.
75 Id. at 743.
76 Id. at 744.
77 TEX. HEALTH & SAFETY CODE ANN. § 166.048(a). The Act provides that it is a criminal act to intentionally conceal, cancel, deface, obliterate or damage another person’s directive without the person’s consent.
person with the result that the other person’s death is hastened.  

Arguably, the doctors who invoke the procedures of .046 defeat the patient’s desires in exactly the same manner as if one had obliterated or destroyed the patient’s advance directives (and in fact may defeat a competent patient’s currently expressed intentions). While it may be that most doctors do not invoke .046 procedures with the direct intent of hastening the patient’s death, there is nothing in the statute that forbids doctors from doing so. For instance, in the case of Mr. Givens it is difficult to imagine with what intent his doctor proposed deactivating the patient’s pacemaker other than the intent to hasten Mr. Given’s death. In fact, the statute’s failure to pronounce any limiting criteria in its “legal safe harbor” seems to implicitly sanction such actions, given that elsewhere it specifically forbids such conduct outside the .046 context. Therefore, it is unlikely that the legislature was unaware of the risk that such wrongdoing might occur, yet they made no provision to prevent such conduct from being immunized so long as the procedures of the .046 provision were satisfied.

Oddly, however, the legislature included a provision specifically disowning the notion that the Texas Advance Directives Act condones mercy killing: “This subchapter does not condone, authorize, or approve mercy killing or permit an affirmative or deliberate act or omission to end life except to permit the natural process of dying as provided by this subchapter.” Notwithstanding this protestation, given the extraordinary breadth of the immunity provision of section .045, the legislature may not condone, authorize or approve mercy killing by omission, but it does immunize such conduct from civil, criminal or administrative sanctions if the doctors comply with the minimal procedures set out in .046. While a doctor could attempt to argue that deactivating a pacemaker simply permits the natural process of dying to proceed, such an explanation would hardly convince Mr. Givens or his family that his resulting death would be other than an intentional homicide.

Furthermore, even when complying with the wishes of a patient to have life-sustaining treatment withdrawn, the statute contemplates civil and

78 Id. § 166.048(b).
79 See Hearings, supra note 1 (testimony of Mrs. Givens).
81 See id. §§ 166.044–.045.
criminal liability should the doctor fail “to exercise reasonable care when applying the patient’s advance directive.”\textsuperscript{82} As previously noted, on the other hand, the immunity provision applicable to doctors who refuse to honor requests for LST is not qualified by any duty of reasonable care, nor are they required to conform their conduct to the standard of care in the medical community.\textsuperscript{83} It is thus quite a stunning contradiction that a doctor who fails to comply with a qualified patient’s advance directive request for withdrawal of LST is subject to review and disciplinary action by the appropriate licensing board.\textsuperscript{84}

C. Patient Experiences with the Texas Statute

There are no reporting requirements in the .046 statute and thus no certainty about how many times doctors and hospitals in the state have invoked the law. However, a recently published study developed some statistical data about the use of the .046 procedure.\textsuperscript{85} Less than half of the 409 Texas hospitals receiving the survey reported back to the researchers,\textsuperscript{86} and the researchers concluded that some of those reporting were not basing their answers on a reliable and uniform set of records.\textsuperscript{87} Of the 197 hospitals responding, forty-six hospitals reported having implemented the .046 procedure to resolve particular disputes with patients over treatment. Of these, only forty hospitals provided information that was consistent enough to analyze. These forty hospitals (twenty percent of those responding to the survey, representing about ten percent of all Texas hospitals) reported that 256 patients had gone through the process between 1999 and 2004.\textsuperscript{88} The patients subjected to the procedure were mainly adults (eighty-three percent).\textsuperscript{89} Of the 256 patients, the hospital ethics

\textsuperscript{82} Id. § 166.044(a) & (c).
\textsuperscript{83} Id. § 166.044(d).
\textsuperscript{84} Id. § 166.045(b).
\textsuperscript{85} See generally Smith, supra note 4.
\textsuperscript{86} Id. at 1272.
\textsuperscript{87} Id. at 1275 (“Another limitation involved the stated inability of some respondents to recall exact numbers of cases or gain access to institutional or patient records to obtain requested information. Furthermore, some hospitals had no or incomplete written records of cases for which the TADA review process had been used.”).
\textsuperscript{88} Id. at 1272–73.
\textsuperscript{89} Id. at 1272.
committees agreed with the doctor’s analysis in 178 cases (seventy percent of the 256 cases).90

Of the 178 reported cases where the ethics committee and doctors agreed about the futility of further treatment, thirty were transferred to another facility, and thirty-three had their treatment ended against the wishes of the patient or representative. Treatment was continued even after the ten day waiting period in forty-five cases. Some patients died before the end of the ten day period (seventy-eight patients) and in other cases the family agreed to discontinue treatment (seventy-one patients). The researchers noted that although there were only 178 patients whose doctors and review committees agreed to end LST, the hospitals reported 265 separate outcomes for those 178 persons, making it difficult to establish exactly how to interpret the data. For instance, perhaps some of the patients who died during the ten day period were also counted among those cases where the patients or representatives agreed to the withdrawal of treatment.

However, this data establishes that at least thirty-three patients in Texas between 1999 and 2004 had their LST removed against their wishes, with the hospitals and doctors completely immune from any societal review of their actions. Because of the limitations of this survey, (for instance only forty-eight percent of hospitals responded to the survey, and those that did report had difficulty accessing appropriate records) it is likely that there were many more.

Also of note, in eight of the 178 cases in which the doctors and review committee agreed that further treatment should be withdrawn, the patients’ conditions actually improved during the ten day waiting period.91 Presumably, treatment was not withdrawn from these patients. This suggests that the .046 procedure results in an empirically demonstrable mistaken conclusion (that there is nothing to be gained in treating a patient) in almost five percent of the cases. If one includes the fact that thirty patients were accepted by transferring hospitals (who must have concluded that the LST was warranted and that they were willing and available to offer the treatment), then the “incorrect” conclusions of the .046 consultation process increases to more than twenty percent.

These statistics do not include anecdotal evidence that suggests that simply notifying patients of the hospital’s legal power to end treatment often influences the behavior of the family without even having to invoke

90 Id. at 1273.
91 Id. at 1274.
the provision of the law. Dr. Robert Fine, in an article praising the law’s effect on ending disputes over medical care, noted that an explanation to the family about the law usually serves to end all family opposition to the doctor’s judgments about care. 92 He has found the “most striking” impact of the law to be the way it has changed the conversations between family members and doctors. 93

Even when we do not invoke the full dispute resolution process, it is explained to the family. They are often surprised to learn that there is a legally sanctioned mechanism for resolving disagreements with the treatment team. Often, within a day or two of learning of the process, they agree to withdrawing (sic) the treatment in question. 94

While one can appreciate that a doctor who has likely been involved in several LST disputes would welcome such acquiescence, this shift in the power balance raises troubling questions about the possible misuse and abuse of this newfound power. Nor should doctors and hospitals be complacent in their reliance upon this deeply flawed law.

D. Legislative Hearing Testimony

In August 2006, the Texas legislature heard almost twelve hours of testimony on the sufficiency of the .046 procedure, 95 including testimony by family members of patients whose doctors implemented the .046 procedure. All of the family members who testified at the legislative hearing noted their distrust and resentment against doctors who implemented the .046 procedure. They felt they were being ignored and that they had no real say about what was happening to their loved ones. Rather than spending time with the very ill patients, they were required to spend time and energy quickly trying to save their loved one’s life from a threat presented by the people who should be trying to help them, their own doctors. Others mentioned that they felt the procedure and the doctors had robbed them of the opportunity to spend cherished last moments with their loved ones and of the peace that comes from knowing that their family

92Fine, supra note 34 at 71.
93Id. at 70–71.
94Id. at 70.
95See generally Hearings, supra note 1; see also Tex. Health & Safety Code Ann. § 166.046 (Vernon 2001 & Supp. 2007).
member was being treated with dignity and respect. Most of them wept as they recounted their stories and spoke of the shock they felt at being put in this position because the state sanctioned this procedure and gave such power to hospitals over the life of their family member.

The patient representatives gave their testimony without naming the hospitals or doctors involved in the cases so this information is not included in these summaries. These case studies may be of limited value with regard to a specific medical analysis of the cases because the family members are simply explaining how they understood the situation in lay terminology. Nonetheless, the testimony does offer compelling insights into the human experience of those who suffered through a process in which they had almost no power to protect their loved ones from what they believed was a serious harm.

1. James Givens

Mrs. Jimmy Givens told of the treatment received by her husband at a Texas hospital. Mr. Givens, an African American bus driver, had gone to the hospital several weeks earlier for treatment of pneumonia. During the course of his treatment he had been placed on the respirator to assist his breathing. A long-standing heart ailment created complications, and he was transferred to intensive care. His doctors determined after several weeks that Mr. Givens was terminally ill, with no more than six months to live. Throughout his hospitalization, Mr. Givens was conscious and communicative, although he could not speak because a tracheotomy was necessary for placement of the ventilator.

Several weeks into her husband’s hospital stay, Mrs. Givens was notified that her husband’s doctor considered all life-sustaining treatment of her husband to be “medically inappropriate.” Therefore the hospital’s ethics committee would be meeting in two days to discuss whether to discontinue such treatment. The doctor told Mrs. Givens that he planned to take her husband off a ventilator and to disable Mr. Givens’s pacemaker, and that her husband was expected to die within a day or two after these actions were taken. The notice particularly shocked Mrs. Givens because her middle-aged husband was fully conscious with no neurological difficulties.

The hospital’s ethics committee met two days later. Although Mrs. Givens was allowed to attend the meeting, she felt that the committee had

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96 Hearings, supra note 1 (testimony of Mrs. Givens).
97 Id.
already made up its mind, and she felt that her husband’s doctor was controlling the deliberations. At the end of the meeting she was handed a statutory notice telling her that she had ten days to find an alternate caregiver who would agree to continue Mr. Givens’ treatment. If no other hospital would take over Mr. Givens’ treatment, the hospital would end all LST. Mrs. Givens never understood why the doctors and committee decided to take this action, but she believed that the hospital employees decided that since they believed he was going to die within six months, any LST in the meantime was worthless. She, on the other hand, treasured every moment she and her family had with her husband, who continued to smile, to enjoy interacting with his grandchildren, and to communicate effectively even though he could not speak.

Rather than going to court to request an extension of the ten day waiting period, Mrs. Givens did what many families have done when confronted with this law—she went to the media. Under public scrutiny for their plan to withdraw life-sustaining care from a fully conscious patient, the hospital backpedaled and agreed to grant the family more time to look for another hospital. It took three weeks to find a transferring hospital, and during that time, the family maintained a distrustful vigil beside Mr. Givens, believing that the doctors and hospital no longer were acting in Mr. Givens’ best interest. Mr. Givens became aware of the conflict, even though the family tried to shelter him from it. According to his wife, he became quite angry and distrustful of his doctors as well. After transferring to a new hospital, Mr. Givens lived another week and a half, and died in peace with his family around him, who were comforted to know that this new hospital was caring for their loved one.

2. Kalilah Roberson-Reese

Cynthia, the mother of Kalilah Roberson-Reese testified about how doctors sought to withdraw LST from her daughter using the .046 procedure. Kalilah had been hospitalized for complications during a pregnancy. After she received a C-section, subsequent complications required her to be placed on a respirator. Nonetheless, she seemed to be recovering and was able to speak with her mother in California on the telephone. During her hospitalization, her trachea tube was accidentally disconnected, and Kalilah was deprived of oxygen for twenty minutes. She

—Id. (testimony of Mrs. Cynthia Deason) (Mrs. Deason’s testimony begins at approximately 7 hours and 30 minutes into hearing).
went into a coma, and doctors informed her mother that she had experienced brain damage as a result of the accident.

Cynthia said that when she arrived at the hospital in Houston, the first thing they asked her was whether her daughter had health insurance and that this would make a big difference. They told Cynthia that her daughter was in a persistent vegetative state, but Cynthia did research on the Internet and concluded that such a diagnosis could not be made so soon after the brain had been damaged. She felt that the hospital was seeking to rush the matter. They tried to persuade her to remove Kalilah from the respirator and said that she would never be the same. Cynthia wanted to give her daughter every chance to recover, especially since she knew her daughter was a fighter and she believed she needed more time to see if her condition would improve.

Cynthia received a paper informing her that a review would take place concerning the removal of LST including the ventilator. She was not able to attend the meeting and was told it wouldn’t make any difference if she attended or not since they already knew her opinion. Then she received the statutory notice saying the committee had decided to remove her daughter’s LST. Her daughter then got a staph infection and had to be isolated, and no other hospital in Houston would take her as a transfer patient because of the infection and her need for a ventilator. She contacted Texas Right to Life, and they helped her to find a hospital that would accept and continue to care for her daughter. Kalilah had to be moved to a rural area that is very difficult for her mother to visit. Her daughter was weaned off the ventilator and is now breathing on her own. Cynthia says her daughter knows when she is in the room and tries to communicate with her, including squeezing her hand in reply to questions. She is hoping that with therapy her daughter’s condition may improve.

3. Edith Lois Pereira99

Edith Pereira’s daughter, Ms. Melvileen Klein, testified about a hospital’s efforts to end her mother’s treatment after Ms. Pereira was transferred from her nursing home to a hospital for treatment of a suspected bladder infection. Ms. Pereira’s doctor who cared for her at the nursing home suggested to Ms. Klein that that they should consider placing a feeding tube while Ms. Pereira was in the hospital.

99 Id. (testimony of Ms. Melvileen Zee Klein) (Ms. Klein’s testimony begins at approximately 7 hours and 57 minutes into hearing).
The attending physician at the hospital disagreed and told Ms. Klein that the feeding tube would do no good for her mother. While in the hospital, Ms. Pereira’s condition continued to rapidly deteriorate. The hospital staff told Ms. Klein that this was because her mother’s body wanted to die. Ms. Klein was informed that the hospital was implementing the .046 procedure and that an ethics committee would meet to determine whether to cease all LST and place her mother in hospice care.

Ms. Klein attended the meeting and said one doctor took over control of the meeting and intimidated the other members of the committee by telling them not to ask too many questions. He asked Ms. Klein questions, such as, “Can your mother dress herself?” When Ms. Klein answered, “No,” this doctor said, “Well, I think we have our answer.” Ms. Klein believed he was saying that her mother’s life was worthless because she could not dress herself. The Committee told Ms. Klein that her mother did not have an infection and that her condition was deteriorating because of fluid in her abdomen and dementia. They also said her mother’s body wanted to die.

Ms. Klein contacted Texas Right to Life, and they helped her to arrange a transfer to another hospital. Doctors at the transferring hospital concluded that Ms. Pereira had bed sores (which she had never had at the nursing home) and several severe infections. The previous hospital never diagnosed or treated these conditions to Ms. Klein’s knowledge. After her mother began receiving the proper treatment, her condition quickly improved. She received a permanent feeding tube. Her mother is now singing again, requesting food and water, and the only pain medication she needs is Tylenol.

All of the family members who testified at the Texas legislative hearings about the implementation of the .046 procedure agreed that the law was deeply flawed. They expressed shock at the fact that the law deprived their relatives of almost all legal protections and placed them in a terrible position of powerlessness. Such an appraisal is to be expected because this statute constitutes such a radical departure from typical legal protections found in the Western legal tradition.

III. THE TEXAS STATUTE IS A RADICAL DEPARTURE FROM AMERICAN MORAL AND LEGAL NORMS

Before analyzing the constitutionality of the .046 procedure, it is appropriate to point to some ways in which the statute departs from accepted moral and legal norms, from the way we normally do things. In short, .046 is unusual because it permits one set of relatively powerful
people to make a very important decision about the life of another person without the normal kinds of legal and procedural safeguards that usually surround such decisions. For instance, this .046 procedure provides fewer protections to a person facing removal of LST than Texas provides to tenants facing eviction from a rental property, see generally TEX. PROP. CODE ANN. §§ 24.001–.011 (Vernon 2000 & Supp. 2007) (providing for various procedural safeguards, such as notice to vacate prior to filing eviction suit, personal service, issuance of writ of possession, and appellate procedures). workers before their wages may be garnished, TEX. CONST. art. XVI, § 28 (“No current wages for personal service shall ever be subject to garnishment, except for the enforcement of court-ordered: (1) child support payments; or (2) spousal maintenance.”); see also TEX. LAB. CODE ANN. § 61.018 (Vernon 2006 & Supp. 2007) (prohibiting employer from withholding or diverting any part of an employee’s wages unless ordered by a court, authorized by state or federal law, or given written authorization from the employee); see also TEX. CIV. PRAC. & REM. CODE ANN. §§ 63.001–.005 (Vernon 1997 & Supp. 2005) (providing for detailed procedural requirements for a writ of garnishment). or to owners of automobiles threatened with reposition of their car. When combined with the absolute immunity from legal consequences laid out in section .045, the statute produces a virtually unheard of legal disenfranchisement of patients subjected to the .046 procedure.

The central outcome of the .046 procedure and .045 immunity provision is that the doctor and other hospital employees are made into the final and unreviewable arbiters of whether a patient’s request for LST will be honored. No judicial or societal or medical standard is allowed to intrude into this decision, even if the doctors and hospitals are acting negligently, recklessly, or with intentional malice. The statute offers no legislative findings to explain why such an important decision should be resolved in such an informal and isolated fashion, so it is difficult to understand why the state chose to adopt this procedure. Nonetheless, a review of the history and rationale supporting due process protections will demonstrate that the .046 procedure is far out of step with the Western legal tradition.

This section will proceed in four parts. First, this section provides an examination of the centrality of due process norms to the American understanding of the concept of the rule of law, followed by an analysis of how the .046 and .045 provisions departs from those traditions. Next, a brief review of the traditional scope of immunity provisions will demonstrate that the .045 immunity provision is out of step with typical rationales that support the state’s grant of immunity. Finally, I will briefly
mention a few additional ways in which the statute departs from the normal approach to medical law, which places patient autonomy, informed consent and a medical standard of care at the heart of its jurisprudence. The .046 procedure dispenses with each of these norms.

A. American Due Process Norms Are Central to Rule of Law

Before turning to a legal analysis of the constitutional sufficiency of the .046 procedures, it is important to recall the centrality and moral importance of due process norms in resolving disputes. Perhaps because we take such procedural protections for granted, they are sometimes dismissed as mere technicalities, and not as important as the substantive morality of the concrete answers proposed to various conflicts. In discussing a particular dispute over allegedly futile medical interventions, most attention is focused on the ultimate question—whether the doctors have a duty to provide the intervention when requested.

Procedural safeguards that surround the decision making process, however, are every bit as important to the morality of an action as is the ultimate decision reached. One could imagine two identical cases in which a patient is requesting LST, and two identical determinations that the intervention should be refused. In case A, the patient has the opportunity to make his case to a neutral and impartial judge, to have counsel familiar with the process, to confront the evidence offered by the doctors, to have a written determination that the intervention does not meet a set of promulgated criteria that apply to all cases, and the right to appeal the determination. All parties operate with knowledge that the doctor and hospital both face legal sanctions should they engage in negligent, reckless, or malicious conduct. Nonetheless, Patient A is unsuccessful in these efforts, is met with a determination that the requested treatment does not meet the criteria, and thus will be refused. While the patient may well be disappointed, he will at least have the satisfaction of knowing that he is not being singled out for mistreatment, that all similar cases are treated the same, that the chances are good that this is not an erroneous judgment, and that he has the comfort of knowing the reasons for the hospital’s denial of treatment.

In case B, an identical patient with an identical request for LST is subjected to the procedure laid out in .046. He gets a forty-eight hour notice that the hospital’s own ethics committee is going to review the doctor’s refusal to provide LST. No reasons need be given; there is no need to demonstrate that the requested care meets any criteria or standard, and
therefore no opportunity to try to show that the requested care does meet some objective standard.¹⁰³ The patient may go in alone to a room full of strangers who probably are familiar with his doctor but not with him. There is no duty to provide a reason for the denial and no right to appeal from the judgment.¹⁰⁴ Nor can one threaten to bring a lawsuit alleging negligent, reckless or even malicious denial of life-sustaining care, as the immunity provision forbids such review.¹⁰⁵ At most he can try to locate another doctor and medical facility with sufficient skill who will agree to provide the treatment within ten days (with the chance of a court-ordered extension if he can convince the court that it is likely that another facility can be found to offer the treatment).

The patient in scenario A is in a significantly better position than the patient in scenario B. Even though the substantive denial of treatment is the same in both cases, patient A has been afforded procedures that are consonant with human dignity and the sanctity of human life. Due process protections pay some homage to the importance of the interest at stake, and they allow Patient A and his family some comfort and security that the decision has a basis in reason and equality, rather than in the will of hospital employees who may have ulterior motives. These procedures also demonstrate that the wider society has not abandoned the patient by withdrawing societal concern from the patient’s life. All of these important moral goods are denied to Patient B. In effect, the inherent message of the .046 procedure is that Patient B’s life is not worth very much.

Justice Felix Frankfurter commented on the moral importance of the manner in which decisions are made:

> The validity and moral authority of a conclusion largely depend on the mode by which it was reached. . . . No better instrument has been devised for arriving at truth than to give a person in jeopardy of serious loss notice of the case against him and opportunity to meet it. Nor has a better way been found for generating the feeling, so important to a popular government, that justice has been done.¹⁰⁶

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¹⁰⁴ Id.
¹⁰⁵ Id. § 166.045(d).
It is important to add that the hospital and doctors in scenario A are also in a much better position than those in scenario B. No one likes to be viewed as making an arbitrary judgment in an unfair manner that imposes a terrible cost on someone else. The power granted to these doctors, hospitals, and ethics committees are unfair to those who try to implement them because they are so fundamentally flawed. They seem almost perversely designed to lead to mistrust, fear, and hostility in patients and their advocates, and they have predictably produced such reactions. Texas newspapers, blogs, and activists have been kept busy focusing attention on several high-profile disputes over .046 denials of life-sustaining care, and the hospitals and doctors are notably cast in the role of villains in each case. Even if they can successfully argue that they are substantively “correct” about the denial of some form of treatment, the lack of procedural safeguards is in itself indefensible.

Due process protections are a fundamental aspect of the American legal tradition, both as an historical matter and as a reflection of a societal respect of human dignity and equality before the law. They also recognize that it is unrealistic to assume that all those empowered to make decisions about the lives and interests of others are perfectly wise, virtuous, just, and all-knowing. Because all human beings, including judges, doctors and members of Ethics Committees are fallible, due process norms seek to minimize the possibility that these limitations will lead to unfair or erroneous decisions. In general, American procedural norms include such things as prospective laws, neutral and impartial judges, right to counsel, right to confront witnesses, rules of evidence, published decisions, and rights of appeal. Without such procedures, societal controls would merely be a matter of power rather than a matter of law. When we speak of the “rule of law,” we generally have in mind such procedural norms. Beyond their utility in minimizing erroneous decisions, they are a protection extended to the weak to equalize their position before the law with respect to those who are more powerful.

The notion of due process in the Western legal tradition was first specifically expressed in 1215 in Magna Carta.107 "No free man shall be taken or imprisoned or dispossessed or outlawed or exiled or in any way ruined, nor will we go or send against him, except by the lawful judgment of his peers or by the law of the land."108 The guarantee of due process was a

restraint on the sovereign; before the king or his officers could take action, 
certain procedures that insured fairness had to be followed.\textsuperscript{109} Due process 
emerged as a requirement to respect established rules of procedure in the 
administration of criminal justice, such as the norm that judgment must 
precede execution, that judgment was to be delivered by the equals of the 
accused, and that no free man was to be punished except in accord with the 
laws of England.\textsuperscript{110} These procedural safeguards are elaborations of the 
general concept that the government must ensure to an individual “the right 
to be heard before being condemned to suffer grievous loss of any kind.”\textsuperscript{111}
For eight hundred years the use of non-arbitrary procedure has been a part 
of the Western legal tradition.

During the fourteenth century in England, numerous statutes were 
enacted that protected certain liberties or rights from being taken unless by 
“process of law” or “due process of law,” phrases which came to be used as 
the equivalent to “law of the land” as used in Magna Carta.\textsuperscript{112} Sir Edward 
Coke’s view of due process as indicated by Magna Carta was that due 
process included not just the proper procedure for bringing a charged 
individual before the court but also such other civil procedures that fell 
within the “law of the land.”\textsuperscript{113} Basically, certain things could not be taken 
from an individual unless it was done according to some standing law. In 
the United States, the term “law of the land” made its way into several state 
constitutions, suggesting that the drafters of the first state constitutions 
thought of due process as relating to traditional procedural limitations on 
the government.\textsuperscript{114}

Thus from its historical roots, principles of due process have operated as 
an external moral or legal check upon the decision procedures adopted by 
authoritative adjudicators of disputes.\textsuperscript{115} Procedural due process concepts 
take some of their force from common judgments of conventional morality

\textsuperscript{109}ORTH, supra note 107, at 8.
\textsuperscript{110}CHARLES GROVE HAINES, THE REVIVAL OF NATURAL LAW CONCEPTS 104 (1930).
\textsuperscript{111}Joint Anti-Fascist Refugee Comm., 341 U.S. at 168 (Frankfurter, J., concurring).
\textsuperscript{112}LUCIUS POLK MCGHEE, DUE PROCESS OF LAW UNDER THE FEDERAL CONSTITUTION 10 (1906).
\textsuperscript{113}Jerold H. Israel, Free-Standing Due Process and Criminal Procedure: The Supreme 
Court’s Search for Interpretive Guidelines, 45 ST. LOUIS U. L.J. 303, 310 (2001).
\textsuperscript{114}HAINES, supra note 110, at 105.
\textsuperscript{115}Thomas C. Grey, Procedural Fairness and Substantive Rights, in DUE PROCESS 182, 187 
with respect to such concepts as “fundamental fairness.”\footnote{Id. at 182.} When the law of due process departs from the outlines of the morality of procedural fairness and produces results that are strongly contrary to widely shared intuitive judgment, it has gone astray.\footnote{Id. at 183.}

One of the core values that is expressed and reinforced by the centrality of the concept of due process in the Western legal tradition is respect for human dignity.\footnote{Sanford H. Kadish, \textit{Methodology and Criteria in Due Process Adjudication—A Survey and Criticism}, 66 \textit{Yale L.J.} 319, 347 (1957).} As Laurence Tribe has written, there are two strands of thought justifying the government’s duty to provide due process, one focusing on the intrinsic value of treating human beings with dignity, and the other focused on the goal of minimizing the chance of unfair or mistaken deprivations of legal interests.\footnote{Laurence H. Tribe, \textit{American Constitutional Law} § 10-7, at 666–67 (2d ed. 1988).} With regard to the intrinsic rationale, granting a meaningful hearing to an individual is required because “these rights to interchange express the elementary idea that to be a person rather than a thing, [entails the right] at least to be \textit{consulted} about what is done with one.”\footnote{Id. at 666.}

Dignity is an inherent aspect of every human. “Even the vilest criminal remains a human being possessed of common dignity.”\footnote{Furman v. Georgia, 408 U.S. 238, 273 (1972) (Brennan, J., concurring).} A State must treat its citizens in a manner consistent with their intrinsic worth as human beings.\footnote{Id. at 270 (Brennan, J., concurring).} Due process is one important mechanism by which human dignity is protected in the legal system. Respect for human dignity demands assurance that the facts upon which action by the government is based be determined by accurate and reliable means in order to prevent arbitrary, callous, and perhaps preventable mistakes or omissions.\footnote{See Richard B. Saphire, \textit{Specifying Due Process Values: Toward a More Responsive Approach to Procedural Protection}, 127 U. Pa. L. Rev. 111, 119–20 (1978).} If society tolerates arbitrary means in the legal system, it reflects a view that the individual is not important and that governmental expediency, convenience, and ease of administration are more highly valued.\footnote{See id.} In this way, due process is both a reflection of the importance of the value of the individual and human dignity and a way in which to protect that value.

\footnotetext[116]{Id. at 182.}
\footnotetext[117]{Id. at 183.}
\footnotetext[118]{Sanford H. Kadish, \textit{Methodology and Criteria in Due Process Adjudication—A Survey and Criticism}, 66 \textit{Yale L.J.} 319, 347 (1957).}
\footnotetext[119]{Laurence H. Tribe, \textit{American Constitutional Law} § 10-7, at 666–67 (2d ed. 1988).}
\footnotetext[120]{Id. at 666.}
\footnotetext[121]{Furman v. Georgia, 408 U.S. 238, 273 (1972) (Brennan, J., concurring).}
\footnotetext[122]{Id. at 270 (Brennan, J., concurring).}
\footnotetext[124]{See id.}
A particularly important part of this notion of human dignity finds expression in its political counterpart, self-determination. When decisions affect individual and group interests, democratic morality demands that people be able to participate in those decisions. State coercion therefore must be legitimized by processes that allow for this participation, because a lack of participation alienates individuals and causes a loss of dignity and self-respect that society has deemed is independently valuable. When the government fails to listen to individuals, it diminishes them and impairs their dignity; to protect individual dignity, due process must provide an opportunity to be heard. The Western legal tradition thus requires that the dignity of the individual is to be respected by ensuring fairness during interactions between individuals and their government during the decision making process.

Procedural rights in regard to a particular decision then serve several important purposes. They bolster our confidence in the accuracy of the decision, they permit an orderly and reliable mechanism for fact-finding and rule applying, and “they also serve an important symbolic function as public expressions of the affected parties’ right to demand that official acts be explained and justified.” In order to serve this function, the procedures must take the complaining party’s objections seriously “and place them on par with the claims of authority.”

Certain institutions in society, like government, schools, and businesses, give some people the power to control or intervene in the lives of others. Due process norms represent the moral conditions that justify and allow those institutions to function consistent with human dignity and self-determination values. Institutions exercising control over the lives of individuals are required by due process norms to channel that power in a manner that is morally justifiable and which ensures that these powers will

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126 Id. at 49–50.
127 Id.
129 Saphire, supra note 123, at 120–21.
131 Id.
132 Id. at 94.
be exercised only within the limits and consonant with the justification for exercising such power in the first place. 133 Due process norms direct and limit the use of such power by imposing requirements on the way in which those who have power make their decisions. 134 The right to due process is thus broader than the right to participation. It also involves the right of those subject to authority to demand justification for its uses and the entitlement to protection from its unjustified use.

B. The .046 Procedure Radically Departs from These Norms

In an article defending the Texas statute, Dr. Robert Fine argues that Texas has created a statute that protects the interests of both doctors and their patients by creating a system resting on due process norms. 135 He refers to the .046 procedure as “a legally sanctioned, extrajudicial, due process mechanism for resolving disagreements about end-of-life care between patients and providers.” 136 He asserts that the procedures set forth in the law also provide a “moral safe harbor” for determinations to deny life-sustaining treatments because they depend on the input of doctors, members of ethics committees and a community standard that is created by the possibility of review by medical teams at other hospitals. Fine says, “[T]he statute creates a ‘moral safe harbor’ . . . by providing a largely extrajudicial process of consultation with parties outside the treatment team that has been used by many institutions over the past decade to help explore and resolve disagreements about medical futility when necessary.” 137

Indeed, Dr. Fine asserts that patients are comforted by the due process protections in the statute: “By having the process specified in the law most are able to accept that they are not being singled out in some way.” 138 In an article entitled “Resolution of Futility by Due Process: Early Experience with the Texas Advance Directives Act,” Dr. Fine asserts that family members are also perhaps secretly pleased that the .046 procedure places control in the doctor and ethics committee.

133 Id. at 95.
134 Id. at 96.
135 Fine, supra note 34, at 59.
136 Id.
138 Fine, supra note 34, at 71.
Some families, even those who vigorously argued for maintenance of life-sustaining treatments, seem relieved by the process. We have had many conversations with families who said in essence, “If you are asking us to agree with the recommendation to remove life support from our loved one, we cannot. However we do not wish to fight the recommendation in court, and if the law says it is OK to stop life support, then that is what should happen.”

What Dr. Fine does not seem to take account of is the fact that the statute deprives the family members of the most effective means of using the courts to protect their loved one. The .046 procedure provides that the only role for the courts is to grant extensions to the ten day waiting period, but only if the family can convince the court that there is a reasonable expectation that a hospital willing to provide the treatment will be found if the extension is granted. Furthermore, it is slightly odd that Dr. Fine is quoting the families as believing that the “law says it is OK to stop life support.” If the family believes this is what the law says (which of course it does not say), then it is reasonable to conclude that some families believe it would be “legally futile” to seek court interventions to protect their loved one.

Since the purported goal of .046 is to create a “due process” solution to futility disputes, it is appropriate to review those procedures to see whether or not they are consonant with American due process legal norms. There appear to be four “stages” of possible procedures available in .046. First, a doctor must make a judgment that life-sustaining care is medically inappropriate, and the fact that a doctor is presumed to be acting in the best interest of his patient will create at least a presumption that this decision is not being made for crass or biased reasons. Secondly, the ethics committee at the hospital must review the decision that the intervention is medically inappropriate, and this ethics committee is another layer of decision making that may offer some assurance that the decision is not biased or arbitrary. Then a third stage of protection is provided because the patient has ten days to “appeal” his case to the broader medical community by way of seeking

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139 Fine & Mayo, supra note 55, at 745.
140 TEX. HEALTH & SAFETY CODE ANN. § 166.046(g) (Vernon 2001 & Supp. 2007) ("[The] court shall extend the [ten day] time period . . . 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.").
transfer to a hospital or medical provider willing to provide the requested life-sustaining care.

Fourth, the family may seek a court order to extend the ten day waiting period by convincing a court that there is a reasonable expectation that another facility would agree to provide the disputed treatment. Presumably, if there was a widespread acceptance that the denied life-sustaining care is “appropriate” in a particular case, then another health care provider would step forward and offer to provide this care. If no other provider does offer to provide the care, this fact could be viewed as “confirmation” that the doctor and ethics committee at the original hospital has made a proper determination that the life sustaining care in this particular instance really is medically inappropriate. This is presumably why Dr. Fine believes that the .046 procedure creates a “community standard” regarding futile treatments and a “moral safe harbor” for those denying treatment to particular patients.

Of course, such an interpretation of the .046 procedure assumes much that is disputed. First, it assumes that it is proper to have an important and disputed interest taken away from a person on the basis of a determination with absolutely no enunciated standard. This law is not merely vague in failing to set forth sufficiently clear criteria—it sets forth no criteria whatsoever. Even if one reads the provision as requiring the doctor and ethics committee to conclude that the treatment is “medically inappropriate,” this requirement would amount to nothing more than a subjective determination in the decision maker’s mind. A standardless law is per se arbitrary. Therefore, no appellate procedure would be of any use.

Thus, even if there were a neutral panel of objective and disinterested jurists to review the doctor’s determination, it is unclear what exactly they would measure the decision against. In the normal course of appellate review, the reviewing body determines whether the party with the burden of proof has established that a given state of affairs exists. For instance, a party claiming a breach of contract must establish that a legally enforceable contract exists, that the other party has breached a material provision of the contract, and that the breach has caused damages that can be redressed by the courts. The other party may argue several possible defenses to each of these claims—that there was no legal contract, there was no material breach, or that the damages have not been proved or were not caused by the breach. Each of these elements has a standard and widely accepted body of law that a reviewing court will draw upon in determining whether the plaintiff has met his burden. But in the case of the Texas statute, there is literally no “law” for a reviewing body to apply. The statute provides no
standard by which it may be determined whether a particular treatment is or is not “medically appropriate,” nor does it include any secondary provisions related to whether such a decision was made negligently or even with intentional wrongdoing.

As one legal scholar has stated however, due process protections are

[M]ost effective where there exist reasonably clear, generally understood standards for exercise of the authority in question, standards which can serve as the background for public justification and defense of decisions. As the relevant standards—and even the starting points for arguments for and against the propriety of a given decision—become less and less clear, the constraints on the decision maker in a due process proceeding become progressively weaker, and the power of these decision makers itself comes to seem more and more arbitrary.141

It is therefore inherently contradictory to suggest that there are multiple levels of review provided in the .046 procedure, for in reality such review requires that there be a standard with which to measure the initial determination. If the law does not offer any standards with which to judge such decisions, on what ground could someone appeal such determinations? The most one could say about the procedure is that it requires that the ethics committee share the doctor’s subjective belief that life-sustaining is inappropriate and that no one at a potential transferring hospital is willing to come forward and state that he or she disagrees with that subjective belief.

Suppose, for instance, that a doctor determined that a particular LST was medically inappropriate because it “smelled bad.” There is nothing in the statute to suggest that such a determination would violate Texas law. So long as the doctor was able to convince his hospital’s ethics committee that “bad-smelling” LST is “medically inappropriate,” no one would have grounds to appeal this determination on substantive or procedural ground. While some doctors may find this hypothetical insulting, it is intended to point to a legal flaw, not to suggest that doctors are currently making such arbitrary judgments. The fact that such a case will likely never occur does not cure the fundamental legal flaw in this statute. The failure to enunciate substantive standards in the statute is fatal to the argument that the statute provides any due process protections whatsoever.

141 Scanlon, supra note 130, at 99.
Some doctors might claim that any societal limits on their decision making regarding the cessation of LST is indicative of a lack of trust in their professional skills which turns doctors into mere technicians rather than skilled, trustworthy professionals. Leave to one side that every occupation that involves risk to human lives is subject to significant societal oversight. This objection misunderstands the proper role of societal protections over the lives of the most vulnerable. Rather than signaling distrust of doctors, procedural protections are necessary because society has a responsibility to enact laws that comport with human dignity, especially the dignity of the most vulnerable human beings. An analogy to a parallel situation illustrates that such societal protections are not meant as a slight aimed at doctors. Imagine that a state decides that their judges should be empowered to impose the death penalty against convicted criminals whenever the judge deems the punishment to be “legally appropriate.” In order to confirm this judgment, the sentencing judge must convince other judges in his county that the death penalty is appropriate in a particular case, and during a ten day period, judges from around the state could “veto” the sentence.

Assume further that the state places this power in the hands of judges because the legislature determines that it is too difficult to give concrete objective standards that properly reflect all the relevant factors for determining whether or not a particular criminal deserves the death penalty. The legislature concludes that trial court judges who have presided over hundreds of criminal trials have the experience, lack of bias, and professional judgment necessary to determine when it is appropriate to use capital punishment. It is also much more efficient and less costly in terms of judicial and state resource to permit this procedure than to require a jury to make this difficult decision.

No matter how accurate (meaning that all state judges reach a judgment that one hundred percent of reasonable observers would agree with) such capital punishment decisions proved to be, the Supreme Court would strike down such a law based on the inherent arbitrariness of the decision making procedure. The Court would require the state to provide an objective standard spelling out specific elements that must be found before a criminal is eligible for the death penalty, and then to provide the opportunity for trial procedures including the right to a jury, to counsel, to put on evidence, to challenge evidence, and the right to appeal the sentence. The procedures are not required simply because we distrust the skill and virtues of judges. Rather the procedural protections are required in order to demonstrate that
society takes human life seriously. Although the procedures are costly and inefficient, they accord with the human dignity that inheres even in convicted, heinous criminals. They minimize the chance of mistaken judgments, ensure that like cases are treated similarly, avoid the appearance of bias or prejudice, and bolster the community’s trust in the decisions reached.

As an aside, it should be noted that it is true that such trial-like procedures are not used in almost all decisions to end life-sustaining care. This is so, however, because it is usually possible for the doctors, patients, and caregivers to agree on a course of treatment. In those rare cases in which there are disputes, the current law in most states provides many potential legal remedies that give the patient’s decision maker the balance of power.142 It is true that many states have statutory provisions stating that no doctor is required to provide treatments that fall outside of the standard of care but such provisions are rarely relevant unless the patient’s representative is requesting care that is physiologically ineffective—such as requesting cancer-fighting chemotherapy for a heart ailment having nothing to do with cancer.143 Where the dispute is rather over a treatment that would successfully maintain the life of a patient, most doctors will not tempt fate by challenging the family’s judgment. Even if the patient’s family were not successful in obtaining a court order to maintain the treatment, the doctor and hospital would face the threat of administrative or civil liability, particularly if the medical standard of care is to provide the LST. It is the Texas statute’s provision of absolute immunity from this societal oversight that makes the law so uniquely dangerous.

Secondly, the various stages of consultation or review that do exist in the Texas statute are completely inadequate to protect against arbitrary and biased decisions in particular cases, nor do they even provide the appearance of fairness that would give patients a level of confidence that they are not being singled out for unfair treatment. Hospital ethics committees are constituted by the hospital itself, and are made up largely of hospital employees. The committee members may have long-standing relationships with doctors who are pleading their case before them. Therefore, there is at least the appearance of bias and self-interest in the committee’s decisions, including the inevitable appearance that significant

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142 See Meisel, supra note 14, § 19.2; see also Meisel & Cerminara, supra note 4, § 13.02.
143 See Meisel & Cerminara, supra note 4, § 13.02.
financial considerations are motivating the decision. Members of ethics committees, moreover, likely have no training or expertise in issuing final judgments regarding disputed factual and moral questions.

Furthermore, the statute itself fails to set out any meaningful procedural requirements binding on the ethics committee. It has already been mentioned that the failure to provide a substantive standard as fatal to the idea of a meaningful review of the futility decision. But even if there were such a standard, the statute merely provides that the patient or representative may appear at the ethics committee review, with no further procedural safeguards. They have no right to confront witnesses, review the record, challenge facts, or to put on their own case in defense of the medical appropriateness of the LST. They have no way of knowing what relationships exist between their own doctor and the members of the committee, or what ex parte communications may have passed between members of the committee and the doctors. Indeed, at a Texas legislative hearing on the statute, patient representatives complained that the committees seemed to have made up their minds before the meeting even began, and that the meetings seemed designed to convince the patient representative to agree to cessation of treatment. Some have claimed that the committee had already prepared the statutory notice regarding the ten day period before the meeting even began, and merely handed it to them at the end of the meeting. Neither of these complaints, if true, appears to violate anything in the .046 procedure.

Next, during the ten day waiting period there is an opportunity to seek review from the broader medical community by seeking to find another health care facility willing to provide the treatment. This review by other doctors outside the hospital is the basis for suggesting that a “community standard” on the appropriateness of medical treatment emerges from the .046 process.144 There could be many reasons, however, why a failure to locate an alternate caregiver during the ten day period has nothing to do with a community standard or other confirmation that the LST is inappropriate. Perhaps alternate caregivers are already overburdened and lack the resources to provide the disputed care at that particular time. Or perhaps the case has not been brought to the attention of those who would be willing to offer the care. While the original hospital is required to make “reasonable efforts” to assist in finding a transferring hospital, it is unclear what such efforts would entail.

144 See, e.g., Fine & Mayo, supra note 55, at 744.
Family members are already burdened by the anguish and distress of dealing with a loved one’s serious illness and may also be demoralized by the .046 procedure and the weight it grants to the medical profession. In seeking alternate caregivers, the families must provide the medical records from the original caregivers, and these records may be biased in reflecting the doctor’s judgment that continued LST is medically inappropriate. This judgment may color the entire medical record, leading other caregivers to steer clear of the case. Perhaps other doctors and hospitals are reluctant to question the medical judgment of their peers, knowing that someday the shoe may be on the other foot. Perhaps others are merely reluctant to enter what may have become a hotly disputed public controversy for fear of bad publicity. Perhaps a doctor who might be willing to take over the case is on vacation. The fact that no alternate caregiver is found within ten days simply provides no assurance that the decision to end LST is accepted or endorsed by the broader medical community.

Likewise, the fact that the statute limits court involvement in the dispute to the single consideration of an extension of the ten day period on the basis of the same question suffers from the same weakness. The family has the burden of convincing the court by a preponderance of evidence that there is a reasonable chance of finding alternate caregivers if an extension is granted. It is unclear how one would demonstrate that it is reasonable to expect that an alternate caregiver will be found, given all of the possible impediments that exist to finding such alternate caregivers listed above.

By way of example, it took three weeks to find an alternative caregiver in the case of Jimmy Givens, and that case involved a man who was fully conscious, had health insurance, and a very motivated family and advocates.145 How reasonable would it be to conclude that an extension of time would likely permit a family of one with more challenging circumstances to find an alternate caregiver?

Furthermore, the Texas statute runs up against the American legal norm that legal rights should generally only be burdened based on actions rather than on status.146 The general rule is that one will be deprived of life, liberty or property only after having been found to have done something deserving of such deprivations. Most people generally know how to avoid committing a criminal act, how to avoid tort liability or an eviction from a rented apartment. The American legal tradition has found status-based laws

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145 Hearing, supra note 1 (testimony of Mrs. Givens).
146 See RODNEY JAY BLACKMAN, PROCEDURAL NATURAL LAW 70–74 (1999).
to be particularly dangerous. For instance, many states for much of the twentieth century had statutes permitting persons deemed to have socially undesirable characteristics to be sterilized against their will. One aspect of the injustice of such laws is that the disfavored groups had no opportunity to avoid the undesired legal deprivation by changing their behavior—rather they were “guilty” simply on the basis of their innate characteristics. This aspect of injustice also infects laws that impose legal burdens on people because of their race or ethnic background.

Texas has adopted a law that shares an aspect of this status-based injustice. The .046 provision makes the availability of the most basic survival protections under the law turn entirely on one’s status, with no opportunity for patients to avoid placing themselves in jeopardy. A patient will find himself deprived of the most important legal protections he would otherwise have access to simply because his doctor has concluded pursuant to the .046 procedure to deny LST to the patient. The patient has no power over whether the .046 procedure will be invoked, and no way to escape the status the .046 procedure imposes on him because of his dependence on the LST.

In effect, the Texas statute divides everyone in the state into two categories—those denied LST pursuant to .046 in category A and those who have not been made subject to the .046 procedure into category B. Everyone in category B is covered with multiple layers of societal protections over their lives, ranging from tort law to the criminal law. Anyone whose actions lead to the death of anyone in Category B will be required to answer before the law. Those in category A, however, are deprived by the .046 procedure of these same protections vis-à-vis their doctor and hospital, and a doctor may with complete impunity act to end the patient’s life by withdrawing LST without any societal oversight.

Because those in category B are particularly vulnerable, the Texas legislature is under a heavy moral burden to explain why it has withdrawn societal protections from the lives of only these particularly vulnerable persons, while maintaining those protections for all others. Our nation has a long and sad history of oppression and neglect of vulnerable populations, and this history should make us particularly reluctant to accept such laws without the most persuasive and weighty justifications.
C. The Immunity Granted in .045 Is Virtually Unheard of in Western Law

The immunity provision in .045 is integral to the operation of the .046 procedure, ensuring that doctors and hospitals will not be deterred from withdrawing LST by their fear of legal consequences. The breadth and depth of the immunity conferred in .045(d) from all criminal, civil and administrative review of the decisions reached pursuant to the procedures of .046 is virtually unheard of in Texas or American law and confirms its radical departure from traditional concepts of the rule of law. Texas has conferred a form of immunity to doctors and hospitals acting pursuant to .046 that exceeds even the broad immunity conferred on judges and public prosecutors.

Absolute immunity in general is the legal concept whereby an individual acting within the general scope of his governmental authority cannot be held liable in a suit filed against him, “regardless of his motives and whether or not he tried to exercise his judgment in good faith or not.”147 The concept has its roots in the common law treatment of public officers carrying out the commands of the king and has been extended to public officials who would otherwise be deterred in the discharge of their public duties if they were not protected in some reasonable degree from private liability.148 Courts generally hold that absolute immunity under the common law is reserved for rare and exceptional circumstances, where public policy concerns outweigh a plaintiff’s interest in access to the courts.149 Most public officials are entitled under the common law only to qualified immunity, a standard by which an official is insulated from liability unless he violates clearly established rights of which a reasonable person would know.150

147 Restatement (Second) of Torts § 895D cmt. e (1979).
148 Id. § 895D cmt. a–b.
149 See Harlow v. Fitzgerald, 457 U.S. 800, 812–13 (1982) (holding that a presidential aide is generally entitled only to qualified immunity unless he can show “that the responsibilities of his office embraced a function so sensitive as to require a total shield from liability”); Butz v. Economou, 438 U.S. 478, 507 (1978) (holding that “in a suit for damages arising from unconstitutional action, federal executive officials exercising discretion are entitled only to [qualified immunity] subject to those exceptional situations where it is demonstrated that absolute immunity is essential for the conduct of the public business”).
150 Harlow, 457 U.S. at 818.
Absolute immunity is an exception to the general rule that all are equal before the law, and that no one is above the law. Immunity is therefore sparingly granted in American law, and its use is generally limited to those instances when an important public interest necessitates that a function be performed free from the anxiety that might hamper the function if an official were constantly threatened with vexatious lawsuits. For instance, if a public prosecutor could be held civilly liable whenever he instituted a prosecution against a citizen, no one would likely agree to perform the function of public prosecutions and the common good would therefore suffer.

In light of the restricted conferral of absolute immunity upon public officials, it is shocking to compare the all-encompassing grant of immunity that covers actions taken pursuant to the .046 procedure. Unlike the case with public officials, no other checks are present against the possible abuse of the .046 provision. Doctors are neither publicly chosen nor accountable to the public at large, and impeachment proceedings are not available to remove those who might abuse the power conferred by .046. While prosecutors are immune from civil liability when performing the prosecutorial function, they still face the possibility of administrative review (a proceeding by the local bar revoking their license to practice law) and the possibility of criminal sanction. Neither of these checks restrains abuses of the .046 process.

In fact, absolute immunity for private parties under the common law is virtually unheard of. Legislatures can and do craft immunity provisions for non-public officials into statutes, but the statutes generally cover the performance of semi-public functions (such as witnesses testifying in court, persons reporting crimes to the authorities, or performing a quasi-public function such as serving as an arbiter of disputes or as a court appointed guardian ad litem). In general, it makes sense to grant some form of immunity to private parties when the risk of harm for their conduct is low and the need for encouraging or promoting some form of action is rather high. Typically, such statutory grants of immunity are limited by

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151 See Butz, 438 U.S. at 506 (quoting United States v. Lee, 106 U.S. 196, 220 (1882)).
152 See generally Yaselli v. Goff, 12 F.2d 396 (2d Cir. 1926), aff’d, 275 U.S. 503 (1927) (per curiam) (extending absolute immunity to prosecutors).
153 Id. at 404.
154 For instance, the entire public has an interest in ensuring that all children are able to go to school, even if they have medical conditions that require them to take medications at various points during the day. Therefore, the legislature has crafted an immunity provision for school
providing that they do not protect those who violate some objective standard of care, such as those acting in bad faith, with gross negligence, or with a malicious purpose.\textsuperscript{155}

Similarly, the legislature in authorizing the .045 immunity provision may be acting on the belief that the public has an interest in ensuring that patients are not provided with LST that doctors consider to be inappropriate. It is not possible to rationally argue, however, that the public has an interest in protecting the negligent, reckless or malicious denial of LST against a patient’s wishes. Yet this kind of misconduct is granted the same immunity as is granted to doctors exercising the most precise kind of careful decision making. Nor is there evidence that doctors are dissuaded from entering the profession for fear that their decisions about LST may be reviewed by outside authorities. It is particularly troubling that the statute confers immunity from administrative review by the state’s medical licensing board and immunity from criminal liability, since there is less reason to worry about vexatious or abusive uses of these procedures. Finally, a review of scores of immunity provisions in Texas statutes reveals no other immunity provision with the breadth of .046, particularly where the risk of harm and abuse is so high.\textsuperscript{156}

\textsuperscript{155} See, e.g., id. (providing that school district employees and their school districts will be immune from damages actions for dispensing such medications to students so long as they follow the instructions on the medication and avoid acting with gross negligence). Thus, the public interest in universal education is advanced, and nurses are encouraged to carefully perform a needed function free from fear that they will face civil liability for their necessary conduct.

\textsuperscript{156} I reviewed eighty-one Texas statutes conferring immunity or limiting liability. Of those, seventy granted some form of immunity to private persons, such as nurses working in public schools (e.g., id.) volunteer firefighters (e.g., \textsc{Tex. CIV. PRAC. \\& REM. CODE ANN. \textsection 101.023(d) (Vernon 2002)), and those reporting abuse or neglect of vulnerable populations (e.g., \textsc{Tex. FAM. CODE ANN. \textsection 261.106 (Vernon 2002 \\& Supp. 2007)). Almost all of the immunity provisions were qualified by a standard of care, which refuses immunity to negligent, reckless or willful misconduct. I found three statutes granting immunity to private parties without a standard of care, and in each case such conduct did not involve a serious risk of harm. First, an entity involved in administering a charitable gift annuity was granted immunity from a suit brought on behalf of a donor’s heirs alleging that the issuance of a charitable gift annuity constitutes engaging in the business of insurance. \textsc{Tex. INS. CODE ANN. \textsection 102.151 (Vernon 2007). Second, there are statutes requiring various health care entities to report on the incidence of such things as immunizations or the incidence of cancer in their practice, and the legislature conferred immunity on the reporting entities without any standard of care requirement. See \textsc{Tex. HEALTH \\& SAFETY CODE ANN. \textsections 82.010, 161.0075 (Vernon 2001 \\& Supp. 2007). Simply reporting such information in a
Interestingly, in the landmark *Quinlan* case, the New Jersey Supreme Court posited the idea of removing cases involving disputes over life-sustaining treatment from review by courts with a grant of immunity, but quickly rejected the idea as being impractical. Recall that the dispute in *Quinlan* involved a request by the patient’s parents to remove a ventilator from their comatose daughter, and the doctors’ refusal to comply for fear of malpractice and criminal liability. The court said:

We would hesitate, in this imperfect world, to propose as to physicians that type of immunity which from the early common law has surrounded judges and grand jurors . . . so that they might without fear of personal retaliation perform their judicial duties with independent objectivity. In *Bradley v. Fisher*, the Supreme Court held:

‘[I]t is a general principle of the highest importance to the proper administration of justice that a judicial officer, in exercising the authority vested in him, shall be free to act upon his own convictions, without apprehension of personal consequences to himself.’

Lord Coke said of judges that ‘they are only to make an account to God and the King [the State].’

Note that in Lord Coke’s formulary, judges are still answerable to some authorities, such that at least the king (or the state) has the power to review the judge’s performance. Such state review is explicitly foreclosed by the immunity covering actions taken pursuant to .046, which leaves only God to review the decisions of the doctors and hospitals.

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negligent or even malicious manner is unlikely to give rise to any significant harm to any individual. Third, Texas statutes confer immunity upon private parties performing quasi-judicial functions on public boards and commissions without imposing a specific standard of care. Examples include the immunity conferred on members of the Bond Review Board who make decisions about bonds for certain criminal justice, mental health or mental retardation facilities, or members of the Texas Appraiser Licensing and Certification Board. See *Tex. Gov’t Code Ann.* § 1401.002 (Vernon 2000); *Tex. Occ. Code Ann.* § 1103.059 (Vernon 2004). Again, other forms of oversight to check abuses are present in each of these cases, such as removal from the boards, and the risk of harm is relatively low even were such powers to be exercised in a negligent or malicious manner.

D. The .046 Procedure Departs from Norms of Autonomy in Medical Ethics

Many scholars would likely agree that two central principles have shaped medical law in the past fifty years: the standard of care and a patient’s autonomous control over medical decisions. The first principle, that a doctor will face liability if the plaintiff can demonstrate that a doctor’s decisions or conduct violate the standard of care in the medical profession, is specifically jettisoned by .046. The standard of care “is generally defined simply as what a reasonably prudent physician (or specialist) would do in the same or similar circumstances.” By granting absolute immunity to all .046 decisions, regardless of what other physicians would do in like circumstances, Texas has abandoned the concept of a standard of care with respect to LST denials.

The second principle, protecting a patient’s autonomy in making decisions about her own medical treatment, is also deeply rooted in American law governing medical disputes. American law has long placed the interest in autonomous control over one’s body as the central principle in deciding questions of disputes over medical care. Almost a century ago, Judge Benjamin Cardozo enunciated what is now taken to be a right with constitutional significance: “Every human being of adult years and sound mind has a right to determine what shall be done with his own body.” The centrality of this principle is most clearly seen in the line of cases establishing the principle of informed consent, imposing a duty upon doctors to provide sufficient information to patients to weigh the risks and benefits of proposed treatments. The ultimate decision regarding the proposed treatment belongs to the patient or the patient’s proxy.

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160 Id.

The autonomy principle is rooted in an individualistic philosophy that is fundamental to American culture and is often traced to the writings of John Stewart Mill:

The principle is, that the sole end for which mankind are warranted, individually or collectively, in interfering with the liberty of action of any of their number is self-protection. That the only purpose for which power can be rightfully exercised over any member of a civilized community, against his will, is to prevent harm to others... He cannot rightfully be compelled to do or forbear because it will be better for him to do so, because it will make him happier, because, in the opinion of others, to do so would be wise, or even right.162

Even more particularly, Mill argued, “Over himself, over his own body and mind, the individual is sovereign.”163 This principle is at its zenith in the Supreme Court’s abortion jurisprudence, strictly limiting the extent to which the state may limit a woman’s autonomous control over her body, even in order to protect the state’s interest in the life of another human being.164

Edmund Pellegrino, a prominent bioethicist, set forth an overview of the centrality of autonomy in a 1993 article reviewing the development of bioethics in the previous three decades.165 He focused attention on the most influential medical ethics textbook in the past forty years, “Principles of Biomedical Ethics” by Beauchamp and Childress. This book posits four broad principles to be consulted in making difficult ethical decisions about medical treatment. The first two of these four principles, non-maleficence (do no harm) and beneficence (always act in best interest of the patient), are central to the ancient Hippocratic ethic. Beauchamp and Childress add two new principles of justice and autonomy to the traditional ethic. These latter two principles marked a radical shift from the more traditional understanding that doctors would independently make judgments about

162 JOHN STEWART MILL, ON LIBERTY 13 (Watts & Co. 1929).
163 Id.
164 Planned Parenthood v. Casey, 505 U.S. 833, 879 (1992) (“[A] State may not prohibit any woman from making the ultimate decision to terminate her pregnancy before viability.”).
medical treatment without consulting with patients about risks, benefits, and ultimate goals of treatment. The Hippocratic ethic did not include any mention of a duty to include patients in clinical decisions.

Beauchamp and Childress recognized the difficulties of attaining agreement on the most fundamental question of ethics, on the nature of the good, on the ultimate sources of morality, and on the epistemological status of moral knowledge. To bypass these problems, they followed W.D. Ross and turned to principles that, on face value, should always be respected unless some strong countervailing reason exists to justify overruling them.

There is little doubt that autonomy has taken on an essential role in medical ethics and practice in this ethical system, in part because it is so consistent “with the individualistic temper of American life, which emphasizes privacy and self-determination.” Its centrality is also likely bolstered by the inability of our diverse culture to agree upon universally accepted moral principles. In fact, most would likely agree with Pellegrino’s assessment that autonomy has emerged as the dominant principle over the other three principles set forth by Beauchamp and Childress.

The autonomous control principle is so firmly embedded in American law of bioethics that it normally requires some strong justification to overcome the presumption in its favor. Autonomy is not fully controlling, for instance, in the case of those who are under-age, incompetent, or mentally retarded. But these limitations are justified by arguments that human beings in these situations are not able to effectively exercise their autonomy, and for adult incompetents it is necessary to legally demonstrate their inability to exercise autonomy. To the extent that is practicable, decision making for those in such conditions are encouraged to take into account what those in these conditions would have wanted if they could
exercise autonomy.\textsuperscript{173} The “best interest” standard also assumes that those who could exercise autonomy effectively would most likely choose to have the medical care that is in their best interest.

The movement to make advance directives legally enforceable was a further effort to protect and extend the autonomy principle into future situations when a patient has lost her ability to express her medical decisions. It is therefore ironic that the .046 procedure is embedded in a larger Advance Directives statute that is mainly intended to ensure that a patient’s autonomous decisions regarding medical treatment are given legal force.

Such protection of autonomy is pursued even where a patient has failed to execute an advance directive. For example, Texas law seeks to ensure that the patient’s wishes are respected by allowing a close family member or friend to make decisions about medical care by allowing patients to name an agent with the medical power of attorney.\textsuperscript{174} This agent has the authority to make medical decisions “according to the agent’s knowledge of the principal’s wishes, including the principal’s religious and moral beliefs.”\textsuperscript{175} Health care professionals are not civilly or criminally liable for following the directions of a health care agent appointed by the patient so long as the act or omission ordered by the agent “does not constitute a failure to exercise reasonable care in the provision of health care services” and is performed in good faith.\textsuperscript{176}

Texas takes the autonomy principle so seriously that it even includes within the Advance Directives Act criminal penalties, as well as the possibility of losing one’s medical license, for those who willfully seek to subvert the ability of the patient to control her medical decisions through her advance directives.\textsuperscript{177}

Few instances exist where the law categorically refuses to permit autonomous control over one’s medical decisions. Physician assisted suicide is one of the few examples of a medical intervention that is denied to those who wish it. The debate over this denial of autonomous control over one’s death has generated sustained debate and controversy for the past thirty years. Some of the strongest arguments against the practice are

\textsuperscript{173}Id.
\textsuperscript{174}TEX. HEALTH & SAFETY CODE ANN. § 166.152 (Vernon 2001 & Supp. 2007).
\textsuperscript{175}Id. § 166.152 (e)(1).
\textsuperscript{176}Id. § 166.160(b)(1)–(2).
\textsuperscript{177}Id. § 166.048(a).
that many vulnerable people who are undergoing the trauma of a serious illness might have their autonomy compromised by depression, subtle or overt coercion, or lack of adequate pain management. In order to protect these people, almost all states have maintained their prohibitions on assisted suicide; however, they have done so in the face of sustained debate and by offering substantial reasons for denying legal recognition to such autonomous decisions.

In the face of this strong legal protection in favor of autonomy, one could say that the law imposes the burden of proof on those who seek to limit the autonomy principle with respect to medical decisions. In this sense, the Texas law is markedly out of step with these principles. Texas lawmakers have made no serious attempt to explain or justify why people in need of LST are singled out for a denial of autonomous control over the most important decision affecting their own life.

Of course, if the Texas legislators had included any kind of standard or limiting factors about who could be subjected to the .046 procedure, one could at least draw some implicit rationales about the reasons for denying autonomous control in certain defined areas. For instance, if the law only applied when the patient was incompetent and terminally ill and the request for LST was being made by an agent who was making painful and irrational decisions on their behalf, one could conclude that the legislature was seeking to protect the true best interest of the patient against a confused or malicious proxy. But .046 applies not only to these situations, but also to a competent patient’s own requests for LST.

In seeking to infer a rationale for the state’s denial of respect for patient autonomy one might suspect that the real concern is to avoid the expense involved in providing expensive medical interventions. Advocates for the law, as well as the bill’s sponsor, however, vehemently deny that this law is a covert method of rationing care. If, these denials notwithstanding, this is the true rationale, the method in .046 is perhaps the least rational and fair method of reducing health care costs and rationing care the state could have devised. The ad hoc and arbitrary, case-by-case, unreviewable decision

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178 See Hearings, supra note 1 (testimony and comments denying any financial motive behind .046 procedures are scattered throughout the hearing, but particularly concentrated in the first 4 hours. For instance, at approximately 1 hour 30 minutes, a witness supporting the law, Thomas Mayo (a lawyer who serves on two hospital ethics committees), is asked by one of the Senators whether a patient’s lack of health insurance influences the ethics committees’ consideration of the appropriateness of care. He responds that ethics committees do not inquire into the question and that revenue questions do not enter into the consideration of the question.
making procedure by scattered doctors and hospitals practically ensures that like cases will not be treated alike. Nor is there any requirement that the treatment be expensive or a much-demanded resource in order for the doctors to invoke the law. Mr. Givens’ pacemaker, for instance, was certainly not costly or in great demand from other patients, yet his doctor and hospital reportedly sought to deactivate it as part of their .046 decision.

If one sought the rationale for denying patient autonomy in the .046 context from the text of the law alone, one could draw two inferences. First, because the triggering event for invoking the law is only the doctor’s subjective decision to deny life-sustaining care, one could infer that the state believes that the conflict is basically a battle of two autonomous wills. The patient or representative has a subjective wish to receive life-sustaining care, and the doctor has a subjective wish not to provide the requested care.

Thus the statute can be viewed as simply a means of resolving a dispute between two competing subjective wills. Its resolution is based on granting one side virtually limitless power to determine the outcome of the dispute. The state clearly favors the subjective will of the medical profession over the subjective will of the patients, yet it provides no reason for so favoring the doctor’s subjective will. In the hearings, some nod was given to the doctor’s medical expertise, but this is clearly not simply a question of scientifically accurate judgments about physiologically ineffective treatments. No state imposes a duty on doctors to provide physiologically ineffective treatment. As explained above, the statute itself defines “life sustaining treatment” as those interventions that will be effective in prolonging the patient’s life, and without which they will die. The dispute the statute seeks to settle then is ultimately about the value of various beneficial interventions, and can include (but need not include) a dispute about the value of the patient’s continued existence. The patient or family believes that continued LST is worth the burdens of the care, while the doctors take the opposite view.

Advocates for the right of doctors to deny futile care reinforce this characterization of the dispute between two conflicting autonomies by focusing on the right of doctors to follow their conscience, and the unfairness of forcing doctors to provide care to which they object. While it is certainly troubling to consider imposing on the conscience of doctors, there are other important values in such disputes that should be considered.

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179 See, e.g., CARL WELLMAN, MEDICAL LAW AND MORAL RIGHTS chapter 10 (Springer 2005).
For instance, if the state is a neutral judge in such a dispute, it should take into account various factors to determine which of the two disputing parties’ should prevail, such as relative power imbalances and the harm that will be imposed on the losing party. Considering these factors, one would think that a neutral judge would find that the relative power of a doctor and the ultimate cost that will be imposed on a patient whose life will be ended by respecting the doctor’s conscience would militate in favor of upholding the patient’s autonomy. After all, the burden on the doctor’s conscience in providing care to one patient in his professional career is nowhere near as weighty a matter nor as burdensome as depriving the patient of his interest in his life if the doctor’s conscience is preferred to the patient’s.

Additionally, patients in need of life-sustaining care (and their families) are particularly vulnerable, which should be a factor weighing in favor of providing additional societal protections rather than less. When first approaching a doctor for specialized or acute care, a patient will not usually have any way of evaluating whether the doctor’s values are consistent with the patient’s own values regarding LST. Therefore, the patient is not on notice that she is virtually entrusting her life into the hands of someone who might deny treatments that the patient would want. Once dependent on the doctor and hospital for life-sustaining care, she cannot simply shop around for another doctor, or drive to the next town to seek an alternate caregiver. Special needs, resources, and abilities may restrict the universe of potential alternatives, and the patient or family might lack the social resources that are needed in order to locate appropriate alternatives.

The fact that it seems fair to conclude that a neutral decision maker would have important reasons for favoring the autonomous choices of the patient suggests a further anomaly in the law. The statute sets up the dispute as one that simply resolves a conflict between two autonomous wills. Why does it favor the more powerful party concerning less weighty interests over the vulnerable party’s effort to protect his most important interest—his continued existence? The Texas legislature might be making a hidden value judgment: the lives of those who are dependent on LST are not really worth as much as the lives of other people. Multiple layers of state criminal, civil, and administrative laws protect all other people who face a conflict over behaviors that threaten their continued existence, but the statute denies such protections to those needing LST.

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State homicide laws, laws against reckless and negligent behavior, tort laws that provide incentives for people to avoid risky behaviors that might endanger someone’s life, and administrative laws that govern professions all are geared toward curbing the autonomy of those who might threaten harm to the life of another. These laws all respect human dignity by curbing behaviors that might lead to the death of a human being. But when a human being becomes dependent on LST, even if not terminally ill, the state’s interests are suddenly reversed, and the most important of these protections are removed. All of the state’s normal protections—criminal, civil and administrative—evaporate in relation to a doctor’s decision to refuse to provide LST to such a patient. Implicitly, the state is declaring that this patient’s life is no longer a concern to the wider society. This is a dehumanizing decision and one that in itself, and separate from any actual treatment decision made by a doctor pursuant to .046, is a denial of human dignity by the Texas legislature. Even before Mr. Givens’ doctors set about planning to end his life by deactivating his pacemaker, the Texas legislature effectively denied his human dignity by creating the mechanism that would permit his doctors to so act.

As I will suggest below, a battle of two autonomous wills is not the only way of characterizing disputes over LST. If one is concerned with grotesque demands on doctors by patient representatives—ones that require doctors to impose pain and suffering on an imminently-dying patient—one could develop objective criteria to describe treatments that are not obligatory even if requested. In doing so, the legislature would have to enunciate the kinds of reasons that we typically accept as justifying limitations on a patient’s (or proxy’s) autonomy. In such a debate among elected officials, a level of accountability, equality among all patients, and social responsibility over the lives of the most vulnerable would be restored to this dispute. Instead, the state has simply chosen the interests of one group over those of another to ensure that the dispute will simply end, whether justly or not.

As has been demonstrated, the .046 procedure jettisons many fundamental principles of American due process and medical law and ethics without explanation or justification. Hence, it is not surprising that the .046 provision is fraught with a cascade of policy problems, all related

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181 Infra Part IV.A.c.1.
182 Supra Part III.B.
ultimately to the basic denial of the importance of human dignity, accountability, and autonomy.

For instance, the .046 provision obviously undermines the doctor-patient relationship. One can surmise that those patient groups that already distrust the medical profession, including racial minorities and the disabled, will find this provision all the more threatening.\footnote{See Arthur L. Caplan, Odds and Ends: Trust and the Debate over Medical Futility, 125 ANN. INTERN. MED. 688, 689 (1996).} Furthermore, there is no reason to believe that doctors, with their specialized training, experiences and culture are representative of the public’s values regarding questions of life and death. Several studies have demonstrated that doctors underestimate the quality of life of persons living with medical disabilities compared to the patient’s reported self-assessment. Those doctors who believe their patient’s quality of life is low are more likely to report that they would not order aggressive interventions to save such patient’s lives.\footnote{See, e.g., K.A. Gerhart, et al., Quality of Life Following Spinal Cord Injury: Knowledge and Attitudes of Emergency Care Providers, 23 ANN. EMERGENCY MED. 807-812 (1994) (finding that emergency room doctors vastly underestimated the quality of life of those suffering from spinal cord injuries, and would discourage aggressive treatment decisions based on such misunderstanding).}

Additionally, the statute’s denial of access to the courts results in intractable and nasty public disputes in the media, on Internet web sites, and among activist groups.\footnote{See, e.g., The Sun Hudson Case, available at http://en.wikipedia.org/wiki/Sun_Hudson (last visited Feb. 22, 2008); Dignity of Life Prolife Update July 2007, available at http://www.texasrighttolife.com/documents/07-07PLU-DignityofLife.pdf (last visited Mar. 2, 2008) (discussing the death of baby Emilio Gonzalez).} In one particularly heated dispute, the family of a patient claimed that the hospital refused to maintain the life of an ill patient until her mother could be brought to the United States from Africa to say good bye to her daughter. The hospital went to the extraordinary length of creating a web page with specific denials of various charges leveled against the hospital.\footnote{See Baylor Health Care System “Tirhas Habtegiris Case: Media Statement”, available at www.baylorhealth.com/articles/habtegiris.htm.} Since none of these outlets are empowered to settle such disputes, they are poor substitutes for the courts.

Nor are doctors or ethics committee members trained or skilled at issuing authoritative judgments settling disputes over life-sustaining care. They are designed to attempt to bring parties to a consensus by pursuing the input from a multi-disciplinary perspective. Where that consensus fails, such committees have no special expertise in adjudicating disputes between
hostile positions. Therefore, their judgments lack legitimacy in the eyes of the public at large.

For all of these reasons, doctors and hospitals should be lobbying the Texas legislature for a complete overhaul of the .046 procedure, and they should refuse to be placed in the unenviable position of implementing this deeply flawed statute. As the next section will demonstrate, if such legislative reforms are not forthcoming, it is likely that a court will declare the .046 provision unconstitutional should an appropriate challenge be presented, forcing doctors, hospitals, activists and legislatures to start over with a completely new set of requirements to meet.

IV. A Strong Case the .046 Procedure Is Unconstitutional

There are at least 145 public hospitals in Texas caring for thousands of patients each year. Should one of these hospitals seek to invoke the .046 procedure, a patient could raise several powerful arguments that this provision violates the Fourteenth Amendment’s requirement that “no state shall deprive any person of life . . . without due process of law.” The lack of adequate procedural protections is sufficient to have the provision declared unconstitutional. Specifically, the statute fails constitutional procedural due process guarantees because it is unconstitutionally vague, it deprives the patient of a neutral adjudicator, and a proper balancing of relevant interests will not support the failure of .046 to set forth any formal procedural requirements governing the adjudication of the dispute.

A. The Texas Procedure Violates Due Process Requirements

The Fourteenth Amendment guarantees that “no state shall . . . deprive any person of life, liberty or property, without due process of law.” As has been shown, the .046 procedure represents a dramatic departure from


188 U.S. CONST. amend. XIV, § 1.

189 In a separate article, I explore additional constitutional challenges to the statute, including equal protection, substantive due process and state action arguments. See, O’Callaghan, When Atlas Shrugs: May the State Wash Its Hands of Those in Need of Life-Sustaining Care? ___ HEALTH MATRIX J. ____ (2008).

190 U.S. CONST. amend. XIV, § 1.
In order to bring a constitutional challenge to the statute, however, a plaintiff must show in a more specific way that the government is (1) depriving her of a constitutionally protected interest, and (2) that the governmental procedures used to effect the deprivation were not constitutionally adequate. Clearly, doctors and ethics committees at public hospitals acting pursuant to .046 are state actors whose actions are governed by the Fourteenth Amendment.  

Regarding the first matter, whether a patient denied requested, effective LST has been denied a constitutionally protected interest, there have been relatively few cases litigating the precise constitutional contours of a person’s protected interest in their life. In *Cruzan* the Supreme Court asserted, “It cannot be disputed that the Due Process Clause protects an interest in life as well as an interest in refusing life-sustaining medical treatment.” In *Roe v. Wade*, the Court assumed that the fetus would have a right to life and that the state would not be permitted to authorize the killing of a fetus if the Court agreed that the fetus was a person. Other authorities agree that while the Court has not defined the exact contours of an individual’s interest in his or her life, “the procedural due process issue would arise if the government were to authorize the removal of life support systems where the patient has not made such a request.” The Court has been particularly vigilant in requiring strict adherence to procedural norms where the State seeks to impose capital punishment on convicted criminals, which implicates the general contours of a state duty with respect to decisions to end a person’s life. Nor do cases in which the Court has rejected a governmental duty to intervene to protect a person’s life from another private individual control this situation, because, unlike those

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191 *See supra* Part III.  
192 *See* 3 RONALD A. ROTUNDA & JOHN E. NOWAK, TREATISE ON CONSTITUTIONAL LAW: SUBSTANCE AND PROCEDURE § 14 (3d ed. 1997). Public employees acting pursuant to a statute are state actors. I also argue in a related article that private hospitals acting pursuant to the .046 procedure may be deemed state actors and thus held responsible for the denial of a patient’s constitutional rights. *See* O’Callaghan, *When Atlas Shrugs*, ____ HEALTH MATRIX J. ____ (2008).  
193 ERWIN CHEMERINSKY, CONSTITUTIONAL LAW, PRINCIPLES AND POLICIES 578 (Aspen 2006).  
196 ROTUNDA & NOWAK, *supra* note 192, § 17.3.  
197 *See* id.
instances, the patient’s deprivation in a .046 proceeding is specifically authorized and executed by state actors.\footnote{See, e.g., Town of Castle Rock v. Gonzales, 545 U.S. 748, 768 (2005). In \textit{Gonzales}, the Court held that a mother whose children were killed by her husband did not, for due process purposes, have a property interest in enforcement of a restraining order. \textit{Id.} More generally, the Court recognized that “the benefit that a third party may receive from having someone else arrested for a crime generally does not trigger protections under the Due Process Clause, neither in its procedural nor in its 'substantive' manifestations.” \textit{Id. Cases like Gonzales and DeShaney v. Winnebago County Department of Social Services, 489 U.S. 189 (1989), are not on point. In DeShaney, the Court determined only that a state’s failure to intervene to save a child from his abusive father’s unauthorized violence did not implicate a governmental deprivation of the child’s interest in life within the meaning of the Fourteenth Amendment. DeShaney, 489 U.S. at 201–02 (1989). In contrast, in the .046 context, the decision to deny life-sustaining treatment is specifically authorized by .046 and, at a public hospital, is executed by a state actor. TEX. HEALTH & SAFETY CODE ANN. § 166.046(a) (Vernon 2003).}}

Texas has made clear that its statute is designed to protect doctors who refuse to provide effective LST to their patients. As noted, life sustaining treatment is defined as “treatment that, based on reasonable medical judgment, sustains the life of a patient and without which the patient will die.”\footnote{TEX. HEALTH & SAFETY CODE ANN. § 166.002(10) (Vernon 2001 & Supp. 2007).} Therefore, the legislature clearly intended the statute to apply to the removal of physiologically effective interventions that are successful in maintaining the patient’s life. Once the treatment is removed, the patient will die.\footnote{\textit{Id.}} When one considers the broad interpretation of protected liberty interests, ranging from incarceration to civil commitments to mental institutions on one end of the spectrum and to the denial of a driver’s license on the other end, a court would likely conclude that the state’s decision to terminate LST amounts to a deprivation of life for the purposes of the Fourteenth Amendment.\footnote{See \textit{DeShaney}, 489 U.S. at 200 (stating liberty interest is violated through “incarceration, institutionalization, or other similar restraint of personal liberty”); Bell v. Burson, 402 U.S. 535, 542 (1971) (holding that under a Georgia statute, the state must afford procedural due process before revoking a driver’s license).} Furthermore, the statute does not apply to all patients who are in need of LST, but only to certain patients who have been singled out by the invocation of the procedures.

The fact that the statute only applies to individualized cases, rather than across the board, bolsters the argument that procedural protections are
owed. Tribe has stated that “the case for due process protection grows stronger as the identity of the persons affected by a government choice becomes clearer, and the case becomes stronger still as the precise nature of the effect on [an] individual comes more determinately within the decision maker’s purview.”

By its terms the due process clause applies to particularized governmental decisions about whether an individual is to be granted a benefit or to be subjected to a burden. When a doctor and ethics committee of a public hospital invoke the .046 procedure to deny requested LST to a particular patient, the state is engaging in such a particularized decision making procedure that will deprive that patient of her interest in the span of life she would be able to achieve if the LST had continued. Had Mr. Givens been in a public hospital when its employees sought to disable his pacemaker and remove his ventilator, for instance, a court could easily conclude that such conduct would constitute a governmental decision of his particular case leading to a deprivation of a protected interest in life.

If a court, however, was for some reason reluctant to recognize that a governmental decision to withdraw or withhold LST amounts to a deprivation of the patient’s interest in life, one could also argue that the .046 procedure, together with the grant of immunity, constitute a deprivation of protected liberty and property interests. First, the courts have interpreted liberty to include certain fundamental rights, including the right to make certain private decisions about one’s life and medical treatment including abortion, contraception, and the right to refuse life-sustaining treatment. If the state seeks to deprive a particular person of such liberties, the state is obligated to provide due process. Secondly, the immunity provision in .045(d) means that even if the withdrawal of LST constituted negligent or even intentional wrongdoing, the patient (or his heirs) may not sue to recover damages, nor could they seek to have the doctor’s license revoked. This denial of access to the courts could be

202 See CHEMERINSKY, supra note 193, at 580 (“Perhaps most simply stated, procedural protections are required under the due process clause when there is a possible issue about how the law applies to a specific person.”).  
204 See ROTUNDA & NOWAK, supra note 192, § 17.4 (“Liberty includes the freedom of choice to engage in certain activities. When these activities have specific constitutional recognition, the liberty to engage in them is protected by the due process clause.”).  
205 Id. § 17.4(c).  
206 TEX. HEALTH & SAFETY CODE ANN. § 166.045(d) (Vernon 2001 & Supp. 2007).
held to constitute a denial of a protected fundamental liberty right (the right of access to court to petition for redress of grievances)\textsuperscript{207} and the denial of a property interest in the civil damages one would otherwise be entitled to.

While there is no precedent directly on point, it is likely that a court would conclude under one or all of these theories that a denial by a public hospital of requested, effective LST pursuant to the .046 procedure constitutes a deprivation of constitutionally protected interests, thus triggering due process protections.

Once it has been established that the due process clause applies, the next question concerns what kinds of procedures will be considered constitutionally adequate when the government seeks to deprive a person of that protected interest. A broad range of protections could potentially cloak a particular interest from governmental deprivations.

The typical elements include: (1) adequate notice of the charges or basis for government action; (2) a neutral decision maker; (3) opportunity to make an oral presentation to the decision maker; (4) an opportunity to present witnesses or evidence to the decision maker; (5) a chance to confront and cross-examine witnesses or evidence to be used against the individual; (6) the right to have an attorney present the individual’s case to the decision maker; and (7) a decision that is based on the record with a statement of reasons for the decision.\textsuperscript{208}

Two elements of due process—notice and hearing—are considered the sine qua non of the procedural requirements. While there is flexibility in the manner in which the government provides notice and hearing rights, any discretionary deprivation of a protected interest that completely denies any notice or opportunity to be heard will violate the due process clause.\textsuperscript{209} Additionally, depending on the nature of the dispute and the mandated level of formality of procedures, the government may also be required to provide such things as a right to pretrial discovery and a transcript of proceedings, and it may be required to bear the burden of proof and a heightened evidentiary burden beyond a mere preponderance of proof.\textsuperscript{210} A party may also be held to have a right to appeal an adverse judgment.

\textsuperscript{207} See Rotunda & Nowak, supra note 192, § 17.4 (“The arbitrary refusal to allow individuals to use the established state court process would seem to be invalid under even the most minimal due process or equal protection standards.”).

\textsuperscript{208} Id. § 17.8.

\textsuperscript{209} Id. § 17 (“Of course, this assumes that the deprivation is based on a reasoned judgment of some sort, rather than as the result of an emergency or accidental deprivation.”).

\textsuperscript{210} Id.
Texas has created a procedure in .046 that is constitutionally inadequate in regard to the two essentials—notice and hearing. Specifically, the failure to set forth a standard makes both of these requirements impossible to satisfy, and the fact that the hospital itself is the ultimate judge of the case violates the requirement of an impartial hearing. Even if the state were to remedy these fundamental deficiencies, the constitution would further likely require many more procedural safeguards under the test set out in *Mathews v. Eldridge*.211

1. Notice and Hearing Requirements

Two indispensable aspects of any governmental procedures are adequate notice and hearing rights proportionate to the importance of the interests at stake. In the words of the Supreme Court:

> Many controversies have raged about the cryptic and abstract words of the Due Process Clause but there can be no doubt that at a minimum they require that deprivation of life, liberty or property by adjudication be proceeded by notice and opportunity for hearing appropriate to the nature of the case.212

The required notice must include some explanation of the basis for the government’s decision to deny a benefit or impose a burden.213 Under the .046 procedure, the patient does receive some notice (that her doctor has decided to refuse to provide requested LST, that the patient or representative may attend an ethics committee meeting, of the committee’s decision, of a right to seek transfer, etc.), but there is no requirement that the notice include the basis for the denial of the LST. This is because the statute does not include any substantive standard that the doctor and hospital must apply. Because there is no standard, the patient has no way to know the basis of the decision, and any hearing would be meaningless because one cannot present or confront evidence regarding whether this decision is erroneous or whether her case is being handled fairly without such a standard.

Perhaps the doctor and committee members simply do not like the patient’s attitude, ethnic background, or political views, and these are the...

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211 424 U.S 319, 335 (1976).
213 ROTUNDA & NOWAK, supra note 192, § 17.8.
bases of their decision to deny her LST. Nor would a patient have grounds to argue that such reasons were illegitimate under the statute, because the statute says nothing about impermissible grounds for the decision. In the absence of a standard it is impossible to conclude that any decision to deny LST is “erroneous.” Presumably doctors and hospitals in the case of Mr. Givens could assert, correctly, that their decision to deactivate the pacemaker and remove the ventilator from a conscious patient was not an erroneous judgment. The only judgment that the statute requires is that a doctor concludes, and an ethics committee confirms, that such treatments shall be denied. Therefore, a court should conclude that no procedures will be adequate unless the state sets forth a factual standard that the doctors and committee must find before a patient can be denied life-sustaining care.

a. Due Process Notice Requirements and the Void for Vagueness Doctrine

A law granting unfettered discretion to a governmental decision maker to impose burdens or deny benefits on particular persons runs afoul of the due process void for vagueness doctrine.\textsuperscript{214} The void for vagueness doctrine is related to the notice requirement and typically is relevant to criminal statutes and to regulations of fundamental rights.\textsuperscript{215} “A law is void for vagueness if persons of common intelligence must necessarily guess at its meaning and differ as to its application”\textsuperscript{216} because such laws fail to give adequate notice of what the law requires of persons. Additionally, a vague law delegates impermissibly broad discretion to government authorities to make important decisions about the lives of others without any societal control or oversight:

[I]f arbitrary and discriminatory enforcement is to be prevented, laws must provide explicit standards for those who apply them. A vague law impermissibly delegates basic policy matters to policemen, judges and juries for resolution on an ad hoc and subjective basis, with the attendant dangers of arbitrary and discriminatory application.\textsuperscript{217}

\textsuperscript{214}Rotunda & Nowak, supra note 192, § 20.9.
\textsuperscript{215}Id.
\textsuperscript{216}City of Mesquite v. Alladin's Castle, Inc., 455 U.S. 283, 290 n.12 (1982).
While both goals (notice to the public so they may conform to the demands of the law, and constraints on official discretion) are important in guiding the court in its application of the void for vagueness doctrine, the Court has said, “[W]e have recognized recently that the more important aspect of vagueness doctrine is not actual notice, but the other principal element of the doctrine—the requirement that a legislature establish minimal guidelines to govern law enforcement” 218 “in order to prevent arbitrary and discriminatory enforcement.” 219

It is important in this context to note that the two elements of the void for vagueness doctrine are directed at two different set of actors; the notice element relates to rules of conduct that regulate the general public, while the discretion-limiting element is directed at government officials and is a rule of decisions. 220 The “fair warning rationale applies exclusively to conduct rules: only when vagueness affects rules addressed to the public and meant to guide public conduct does it raise the problem of absence of fair warning.” 221

To illustrate the distinction between rules of conduct addressed to the public and rules of decisions addressed to officials, Robert Post has posited two hypothetical traffic ordinances. Imagine a law we will call “Rule 1” that tells pedestrians: “[D]o not cross the street unless the closest policeman is feeling benevolent toward you.” 222 Such a law “subjects citizens to the constraints of an uncertain and unknowable legal standard,” 223 creating a trap to the innocent, and it is thus a paradigmatically vague law. It completely fails to satisfy the notice element of the due process vagueness doctrine, which is aimed at ensuring that the general public will have an opportunity to conform their behavior to expected societal standards. This failure of notice element is especially crucial with respect to the criminal law and laws regulating free speech, but less relevant to the Texas situation. The .046 procedure is neither essentially a rule of

219 Smith, 415 U.S. at 573 (citing Grayned, 408 U.S. at 108).
221 Dan-Cohen, supra note 220, at 661.
222 Post, supra note 220, at 493.
223 Id.
conduct aimed at the general public, nor is the statute specifically designed to dissuade people from seeking LST.

Rather, the .046 procedure falls within the second category of the vagueness doctrine, because it is a rule of decision which, under due process norms, must include a sufficient level of specificity to constrain the discretion of government decision makers. “[T]he power control rationale [undergirding vagueness doctrine] pertains to the clarity of decision rules alone: only decision rules are addressed to and acted upon by officials, and only decision rules must be clear and specific in order to constrain officials’ discretion and contain their power.”224

Accordingly, Post posits another hypothetical law demonstrating how such a rule of decision could run afoul of the void for vagueness doctrine by failing to adequately control the official use of power. Imagine a second law, “Rule 2,” that tells traffic police, “Regulate traffic as you see fit.”225 Such a law would, like Rule 1, also be a paradigm of an unconstitutionally vague law because it fails to constrain the officer’s discretion by any societal standard. Rule 2 is analogous to what the .046 procedure directs doctors and ethics committees to do, granting them unconstrained and unreviewable discretion to deny LST as they see fit. That unfettered discretion is then confirmed by the absolute immunity that prevents any input from the wider medical profession or the community as checks upon their actions.

What makes the hypothetical Rules 1 and 2 and the .046 procedure so odd is that they depart so radically from the norm of how laws typically function:

The law commonly expresses itself through rules whose applications turn on the exercise of judgment. Judgments interpret and apply social standards and norms.... Compliance with [Rule 1 or Rule 2] does not require the citizen or the official to attempt to interpret and apply shared social standards. Instead these rules place the force of law entirely at the service of merely private preferences, personal likes or dislikes that make no claim to public validity. That is why courts have viewed laws like [Rule 1

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224 Dan-Cohen, supra note 220, 661.
225 Post, supra note 220, at 492.
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and 2] as especially suspect from a constitutional point of view.226

Similarly, the .046 procedure coupled with its grant of absolute immunity is unconstitutional because it fails to set forth any limiting standards for the exercise of this awesome power over a person’s life. Texas has empowered its doctors to simply exercise their will rather than to make any substantive judgments based on a standard.

Indeed, laws granting unreviewable powers to government employees without some guiding standard are all but unheard of in a country dedicated to the rule of law. One commentator has effectively summarized a common understanding of why the rule of law requires government officials to be controlled by publicly known standards:

The rule of law signifies the constraint of arbitrariness in the exercise of government power . . . . [I]t means that the agencies of official coercion should, to the extent feasible, be guided by rules—that is by openly acknowledged, relatively stable, and generally applicable statements of proscribed conduct. The evils to be retarded are caprice and whim, the misuse of government power for private ends, and the unacknowledged reliance on illegitimate criteria of selection. The goals to be advanced are regularity, and evenhandedness in the administration of justice and accountability in the use of government power.227

Most laws stricken under the void for vagueness doctrine are rules of conduct directed to the general public, such as anti-vagrancy laws, anti-loitering laws, or laws that regulate conduct protected by the First Amendment. In discussing such cases, the Court will often note how such laws undermine both goals of the void for vagueness doctrine—they both fail the notice requirement (because the public will not know that its conduct is criminalized), and they grant too much discretion to the authorities to enforce the laws in an arbitrary and capricious fashion.

Courts have also, however, struck down under the void for vagueness doctrine laws that are rules of decisions directed to government officials

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226 Id. at 494.
when those laws fail to constrain official discretion. For instance, in a series of vagueness cases the Supreme Court struck down laws that empowered local officials to deny permission for public canvassing and door-to-door solicitation permits. In *Lovell v. City of Griffin* the Court struck down a local ordinance that required written permission from the city manager before distributing literature of any kind in the town without any legitimate limitations on the manager’s discretion. In *Schneider v. New Jersey*, the Court reviewed a local ordinance:

[The ordinance] required [door-to-door canvassers] to obtain a permit, which would not issue if the chief of police decided that ‘the canvasser is not of good character or is canvassing for a project not free from fraud.’ Because the [C]ourt concluded that the canvasser’s ‘liberty to communicate with the residents of the town at their homes depends on the officer’s discretion,’ the Court held the ordinance invalid.

Courts have also found that “arbitrary and unreasonable licensing procedures are in violation of the due process . . . [clause] of the fourteenth amendment.” Such laws are rules of decision directing government officials about how to determine if a particular applicant qualifies for a license. Vague standards permit an official to deny such licenses in an arbitrary and biased manner. If a municipality establishes licensing statutes that have “no ascertainable standards . . . by which an applicant can intelligently seek to qualify for a license,” then denials of licenses will be enjoined “until a legal standard is established and procedural due process provided” to the applicants.

Similarly, the Court will strike down statutes that fail to provide meaningful limits to the discretion of juries and judges to impose the death penalty on convicted murderers:

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229 303 U.S. 444, 447 (1938).
230 308 U.S. 147, 158 (1939).
231 *Hynes*, 425 U.S. at 617 (quoting *Schneider*, 308 U.S. at 158).
232 Parks v. Allen, 409 F.2d 210, 211 (5th Cir. 1969).
233 Hornsby v. Allen, 326 F.2d 605, 612 (5th Cir. 1964).
[A state] must channel the sentencer’s discretion by clear and objective standards that provide specific and detailed guidance and that make rationally reviewable the process for imposing a sentence of death. . . . [A] death penalty system could have standards so vague that they would fail adequately to channel the sentencing decision patterns of juries with the result that a pattern of arbitrary and capricious sentencing . . . could occur.234

Thus, courts will reverse a capital punishment sentence if it is found to be the product of unconstrained discretion. For instance, Robert Godfrey was sentenced to death under a Georgia statute that made convicted murderers eligible for the death penalty “if it is found beyond a reasonable doubt that the offense was outrageously or wantonly vile, horrible or inhuman.”235 The Supreme Court held Godfrey’s sentence to be unconstitutional because this vague language permitted the “standardless and unchanneled imposition of [the] death sentence in the uncontrolled discretion of a basically uninstructed jury.”236

Nothing in these few words, standing alone, creates any inherent restraint on the arbitrary and capricious infliction of the death sentence. A person of ordinary sensibility could fairly characterize almost every murder as “outrageously or wantonly vile, horrible and inhuman.” Such a view may, in fact, have been one to which the members of the jury in Godfrey’s case subscribed.237

Applying such guidelines concerning unconstitutionally vague rules of decisions to the procedure by which Texas authorizes the denial of LST, the Court would likely find that the .046 procedure is void for vagueness under the Due Process Clause of the Fourteenth Amendment. Just as in the case of the canvassing regulations and the sentencing statutes, Texas has empowered public employees to make important decisions about the lives of private parties without providing any standard whatsoever to guide the doctor’s discretion. This defect is all the more fatal because of the absolute immunity imparted by .045(d), which ensures that society will have no opportunity to review the decision for abuse of that discretion.

235 Id. at 422.
236 Id. at 429.
237 Id. at 428–29.
Beyond the fact that the .046 procedure denies important protections to patients, vague laws that empower government officials also undermine important societal goals that rely on forthright and discernable standards in laws. Legislators, of course, might find it extremely beneficial to empower government officials to make ad hoc and unreviewable decisions in the manner suggested by “Rule 2” and the .046 procedure as a means of avoiding responsibility for legislating on controversial issues. Vague laws shift the blame for any social controversies and disagreements onto the shoulders of those making the ad hoc decisions and away from the legislature. Such discretionary empowering legislation makes it very difficult for the public to hold their legislators accountable for bad policy decisions. As one justice has stated:

[T]he [vagueness] rule is instrumental to the constitutional concept of ‘ordered liberty.’ By demanding that government articulate its aims with a reasonable degree of clarity, the Due Process Clause ensures that state power will be exercised only on behalf of policies reflecting a conscious choice among competing social values; reduces the danger of caprice and discrimination in the administration of the laws; and permits meaningful judicial review of state actions.

Since the .046 procedure is unconstitutionally vague, a court would likely strike it down on these grounds alone. There are, however additional arguments that the law is unconstitutional as a denial of procedural due process.

b. Hearing Before a Neutral Decision Maker

The Supreme Court has also held that due process requires a hearing to be held “at a meaningful time and in a meaningful manner” when a person is singled out for deprivation of a protected interest. Again, that the Texas statute contains no standard makes it impossible to provide a meaningful hearing. Implicit in the notion of a hearing is the existence of some legal or factual dispute that can be settled by a neutral decision maker. Without any requirement for the doctors to demonstrate that the provision

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of LST meets some objective standard to justify its denial, no factual or legal dispute exists to be settled at a hearing. As it stands, the ethics committee simply ratifies or disagrees with the doctor’s subjective decision to deny LST based on the members’ own subjective conclusions. Such a procedure cannot constitute a proper legal hearing.

Further, even if Texas were to remedy the statute by adding a standard, the .046 procedure would still violate constitutional due process requirements because the ethics committee is not a fair and impartial forum. One of the axioms of due process principles is that no one should be permitted to be the judge of one’s own case. In one of the first cases in which a court engaged in judicial review of a statute, a British court denied the validity of an Act of Parliament that authorized the Royal College of Physicians to adjudicate and impose a fine on a doctor for practicing medicine without a license. Lord Coke, the famous commentator on the common law, wrote at length about Dr. Bonham’s Case, which rested in part on the unfairness of allowing the college to benefit from finding Dr. Bonham guilty and collecting a fine that went into its own coffers. The physicians “cannot be judges, ministers and parties; judges to give sentence or judgment; ministers to make summons; and parties to have moiety [half] of the forfeiture.” Coke’s commentary included the Roman legal maxim: “‘aliquis non debet esse judex in propria causa’ . . . (because someone ought not to be a judge in his own cause).”

The Fourteenth Amendment carries forward this axiom by commanding the government to require an impartial adjudicator of disputes when an individual faces a governmental deprivation of a protected interest. While the specific procedures required may differ given the context of different kinds of disputes, “there is always the general requirement that the government process be fair and impartial. Therefore there must be some type of neutral and detached decision maker.”

The Court has “repeatedly . . . recognized [that] due process demands impartiality on the part of those who function in judicial or quasi-judicial capacities.” In Ward v. Village of Monroeville, Ohio, the Court

240 See ORTH, supra note 107, at 19.
242 ORTH, supra note 107, at 19.
243 Id. (citing Dr. Bonham’s Case, 77 Eng. Rep. at 652).
244 ROTUNDA & NOWAK, supra note 192, § 17.8.
determined that the petitioner, Ward, had been deprived of due process because his traffic offenses were tried before the Mayor of Monroeville, who found him guilty and imposed a fine of $100. Monroeville received a substantial part of its annual budget from such fines. The Court found that because the mayor was naturally under some pressure to keep taxes low by collecting fines and fees from those found guilty, the situation was one that created "a possible temptation to the average man as a judge to forget the burden of proof required to convict the defendant, or which might lead him not to hold the balance nice, clear and true between the state and the accused." The Court found that this financial temptation meant that the mayor lacked the necessary neutrality and impartiality that due process demanded.

Both of these cases point to constitutional deficiencies in the procedure. The doctor and ethics committee which, under the Texas procedure, are empowered to make the ultimate determinations with regard to the patient’s interest in receiving LST fall far short of constitutionally required neutrality, fairness, and impartiality. The doctor is one of the parties to the dispute, and his decision initiates the procedure against the patient. With regard to the ethics committee, the doctor is a colleague of the members of the ethics committee, and all of them are selected and employed by the same institution with its own vested institutional interests in the outcome of the dispute. Under Texas law, hospitals appoint the members of its ethics committee, all or most of whom may be employees of the hospital. Although this analysis concerns employees at a public hospital, such employees may still have a financial interest in ending LST for a particular patient analogous to a mayor’s concern to raise revenue for his town. For instance, one could imagine the particular service at the hospital under pressure to reduce costs or risk layoffs, and this pressure could create a bias regarding the judgment of a case.

Even if the ethics committee could claim some level of impartiality regarding relationships to the doctor and hospital, it cannot avoid the appearance of bias which is an equally important aspect of due process concerns. If the patient, her family, and the public believe the ethics committee is biased in favor of the doctor’s position, then one of the

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247 Id. at 60 (quoting Tumey v. Ohio, 273 U.S. 510, 532 (1927)).
248 Id.
purposes of due process—the sense that one has at least had the benefit of a fair hearing—will have been lost. As the Supreme Court said, “[T]o perform its high function in the best way ‘justice must satisfy the appearance of justice.’”

Similarly, the Court has held that when a defendant is being tried for criminal contempt of court for insulting a judge, due process requires that the proceedings on this charge be tried before a different judge, particularly when “marked personal feelings were present on both sides.” A dispute over LST would quite likely involve a level of marked personal feelings on both sides of the issue comparable to those found sufficient to require judges to recuse themselves from such contempt proceedings. One would naturally expect such disputes to arouse feelings that could predictably lead to strong animosity on the patient’s side and defensiveness on the part of hospital employees. Yet, the State of Texas has created a system in which one side of that highly charged dispute has the final say in determining the question. Thus Texas has deprived patients of due process by creating a system in which hospital employees, with their own interest in the outcome of the dispute, are the final and unreviewable arbiters between the patient and hospital employees.

Beyond the fact that doctors and ethics committees are interested parties to the dispute, the statute does not require an ethics committee constituted by hospital appointees to act as a fair tribunal. The statute includes no safeguards imposing a duty of impartiality upon the committee or preventing doctors and hospital ethics committees from colluding to undermine the fairness of the procedure. Each ethics committee is free to create whatever procedural rules it chooses to govern its decisions, or it may choose not to have any such standing procedures at all. The statute does provide that the patient or representative may be permitted to speak at the ethics committee meeting. However, while other provisions are stated in mandatory shall terms, this one provision slips into the more discretionary expression may, leaving open the possibility that in a particular case the ethics committee may not grant someone a right to speak.

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Nor do statutory duties exist with respect to the identity, skills, or training of the committee members specified in the statute. Some advocates of the .046 procedure might point to the patient’s right to appeal to the wider medical community in a bid to be transferred to another facility to receive continuing care, and that this wider community is a neutral decision maker. But all doctors and hospitals have interests in common regarding the resolution of disputes with patients. Neither is there any formal mechanism requiring all potential transferees to give serious consideration to the patient’s request. The medical community will, moreover, be making judgments about the provision of care based on the medical records created by the patient’s own physician who wishes to end LST, again undermining confidence in the fairness of the process.

This failure to provide a neutral and fair decision maker is another independent ground for holding that the .046 procedure is unconstitutional, as the Court has repeatedly stated that “a fair trial in a fair tribunal is a basic requirement of due process.”

c. Mathews v. Eldridge Balancing Test Regarding Specific Requirements

In order to comply with the Fourteenth Amendment, Texas will have to amend the .046 statute to include an objective standard that must be met before a public hospital (or a private hospital deemed to be a state actor) may lawfully deny LST to a patient who requests it. Secondly, the state must require the doctor to provide adequate notice to the patient regarding the basis of her decision and a meaningful opportunity to contest that determination before a neutral, fair, and impartial decision maker.

These requirements would fundamentally change the nature of a proceeding under .046. Under this reformed approach, in order to refuse LST, the doctor would have to present objective evidence to a neutral, impartial decision maker that the treatment should not be provided because it does not meet the state’s standard for appropriate medical care. The patient or her representatives would receive notice of the doctor’s determination and would be able to offer evidence to show that the treatment does satisfy the standard or that other relevant factors counsel against the doctor’s decision to end treatment. Of course, several questions remain about the nature of such procedures. Courts determine what

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253 TEX. HEALTH & SAFETY CODE ANN. § 166.046(d) (Vernon 2001 & Supp. 2007).

254 In re Murchison, 349 U.S. at 136.
additional kinds of procedures are constitutionally required in particular disputes by applying a balancing test laid out in *Mathews v. Eldridge*.\(^{255}\)

In *Mathews v. Eldridge* the Supreme Court set forth a flexible, three-part balancing test to determine what procedures are required with respect to any proposed governmental deprivation of protected interests.\(^{256}\) In *Mathews*, the question was whether the due process clause requires the government to provide a pre-termination hearing before ending payments to a recipient of Social Security disability benefits.\(^{257}\) In answering the question, the Court set forth a balancing test to determine the kinds of procedures the constitution will require when a person is deprived of a protected interest by the government. The test is designed to determine the “scope of the trial-like procedures required by balancing the worth of the procedure to the individual against its cost to society as a whole.”\(^{258}\) The Court set forth the following factors to weigh in determining what procedures would be required: first, the private interest that will be affected by the official action; second, the risk of an erroneous deprivation of such interest through the procedures used, and the probable value, if any, of additional or substitute procedural safeguards; and finally, the Government’s interests, including the function involved and the fiscal and administrative burdens that the additional or substitute procedural requirements would entail.\(^{259}\)

Using this method in *Mathews v. Eldridge*, the Court determined that the government did not have to provide a pre-termination hearing before ending medical disability Social Security benefits because, on balance, the social costs of providing such hearings were too weighty in comparison to the potential benefits to the individual.\(^{260}\)

Commentators have attempted to categorize the kinds of procedural questions that are typically determined by a court applying the *Mathews v. Eldridge* test in a constitutional challenge to a government process. According to Erwin Chemerinsky, at least five procedural questions can arise in such cases:

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\(^{255}\) See generally 424 U.S. 319 (1975).

\(^{256}\) *Id.* at 334–35.

\(^{257}\) *Id.* at 323.

\(^{258}\) ROTUNDA & NOWAK, supra note 192, § 17.8.

\(^{259}\) *Mathews*, 424 U.S. at 335.

\(^{260}\) *Id.*
First, what type of notice is required? Second, when must the hearing be provided: must it be before the deprivation or can it be after the deprivation? Third, what type of hearing is required? For instance, must it be an adversarial hearing and must the government provide an attorney? Fourth, who has the burden of proof and what is the standard of proof (i.e. preponderance of the evidence, clear and convincing evidence, or proof beyond a reasonable doubt) to be applied? Fifth, who should be the decision maker?261

Nowak and Rotunda say that courts typically use the Mathews v. Eldridge test to answer three questions: whether there is an entitlement to a hearing before the government can act to deprive him of his personal interest rather than a post-deprivation remedy; the level of formality or informality of the required hearing; and the standard of proof the government must meet to justify the deprivation.262

A broad range of possible answers exists to solve to these kinds of due process issues, from simple and informal measures on one end of the spectrum, to formal trial-like procedures on the other end. “[D]ue process is flexible and calls for such procedural protections as the particular situation demands.”263 For instance, the Court has held that due process requires only a very informal procedure before a public utility may discontinue service to a customer for nonpayment of bills.264 The public utility must give a written notice of the reasons for terminating service and must include notice of a procedure for challenging disputed charges, which could consist of a phone number to a responsible employee with the power to correct billing mistakes.265 The most stringent protections and formal procedures, including those laid out in the Bill of Rights, are required in criminal cases where the state is threatening a definitive loss of life or liberty.266

261 CHEMERINSKY, supra note 193, at 583.
262 ROTUNDA & NOWAK, supra note 192, § 17.8.
265 Id. at 18.
266 Foucha v. Louisiana, 504 U.S. 71, 95 (1992) (“[P]rocedural protections afforded in a criminal commitment surpass those in a civil commitment; indeed, these procedural protections are the most stringent known to our law.”).
Thus, applying this analysis to the Texas futility provision, a court considering what procedures the constitution requires would apply the balancing test laid out in *Mathews v. Eldridge* to the following three factors: (1) the weight of the patient’s interest in continuing to receive LST and thus his interest in continued life, (2) whether additional protections would lessen the risk of erroneous deprivations of LST, and (3) the state’s interest in avoiding complex procedures in permitting doctors and hospitals to deny LST they deem inappropriate. Generally, more stringent procedures are required when there is a weighty personal interest, a greater chance of erroneous decisions, and a less important state’s interest.

The *Mathews v. Eldridge* test is notoriously unpredictable with regard to the detailed answers to the possible procedural requirements because it rests on a subjective balancing test. Different judges assign different weights to the various interests and differ about the projected benefits of additional procedures. However, some judicial agreement likely exists about the far reaches of possible procedures that fail to satisfy the balancing test.

For instance, it is almost certain that, given the personally weighty and irreplaceable nature of a person’s life, the government will be required to hold a pre-deprivation hearing, rather than providing post-deprivation review of the justification for the deprivation.267 The presumption is that pre-deprivation notice and hearing are preferred unless the government can demonstrate sufficiently weighty interests against such procedures. The Court has stated, “We tolerate some exceptions to the general rule requiring pre-deprivation notice and a hearing, but only in extraordinary situations where some valid governmental interest is at stake that justifies postponing the hearing until after the event.”268

The additional questions, relating to the precise nature of the hearing (formal adversarial hearing or informal, right to counsel, to confront witnesses, to put on evidence), adequate time for notice and preparation, and questions regarding the burden of proof, will depend upon the weight a judge assigns to the three *Mathews v. Eldridge* factors.

Presently, the Texas statute specifies an extremely informal hearing to decide this question. Each ethics committee in every hospital in the state has complete freedom to adopt whatever procedures it chooses in deciding the question. The statute does not assign any burden of proof to either side, and again this anomaly is likely due to the statute’s refusal to set forth a

268 Id.
standard for deciding the case. And the statute provides a very limited period to prepare for the hearing—a mere forty-eight hours to find experts and evidence to support the patient’s request for LST.  

Would these statutory procedures be found sufficient under the Mathews v. Eldridge test? While this question cannot be answered with certainty, it is possible to set forth a summary of the relevant interests of the patient and the government that a court will weigh in deciding the question. In all likelihood, a correct balancing of these factors would lead a court to find that the statute’s procedures are unconstitutional with respect to every relevant procedural question.

First, a court would have to determine the weight of the personal interests at stake in the decision. Some might argue that the personal value is low because we typically think of those in need of LST as being terminally ill or in some kind of extremely disabled state. Because the patient’s quality of life in such cases is imagined to be relatively low, the argument goes, the patient has little interest in maintaining her life. Of course, even assuming that the statute only applies to terminally ill or extremely disabled people, it does not follow that their lives are less precious to them—indeed, many people find that life becomes more precious as the end approaches or vulnerabilities must be accepted.

Even those who are terminally ill or who are radically disabled have an interest in continuing to receive life-sustaining treatments. Human beings have long believed that human life has an intrinsic worth and dignity that does not fluctuate with changing conditions. There is a value in the comfort of knowing that one is cared for and valued even in straitened conditions. Those in such vulnerable conditions can be loved and cared for by family and friends, and many philosophies of life find these to be the most noble and valuable human interactions in a life. Others may live in the hope of a miraculous cure, or that medical science will develop new treatments in the future. All people also have an interest in having their autonomous choices about what happens to their bodies respected.

But the real problem with this argument is that the statute applies equally to those with only passing illnesses and otherwise functional people in need of life-support to maintain their lives. As previously noted, the statute does not limit the application of the statute to the terminally ill or

269 TEX. HEALTH & SAFETY CODE ANN. § 166.052(a) (Vernon 2003).
270 See supra note 51.
those with irreversible conditions. People with only a transient need for such treatments or those recovering from a serious accident are often in need of LST in order to recover, and many others live long, active, and fulfilling lives with such treatments. Since the state has chosen to give doctors the power to withdraw treatment from such patients (no matter how unlikely it may be that such patients would be subjected to the law), a court must include the interests of these kinds of patients in the overall weight of the personal interests at stake.

Others may fear that their doctors have made medical mistakes about their condition or are overlooking available therapies. Further, all patients and their loved ones have a strong interest in ensuring that they are not being treated poorly or unfairly. The Texas procedure includes no checks upon negligent, reckless, or even intentionally wrongful behavior on the part of the doctors and hospitals. Nor does the statute provide any mechanism to ensure that patients are not subjected to arbitrary or discriminatory treatment decisions or simply to personal animus. Lack of procedural safeguards will likely magnify the sense of patients that they are being unfairly singled out for poor treatment. Coupled with the fact that the law’s absolute immunity provision prevents all recourse to the courts, the .046 procedure seems perversely designed to instill fear and distrust in patients.

In sum, extremely weighty personal interests are at stake in regard to the withdrawal or denial of life-sustaining treatments. Particularly given the extremely broad coverage of the Texas statute’s definition of life-sustaining treatment, a court would very likely find that the interests at stake are of the highest order.

Next, the court would consider the state’s interest in maintaining an extremely informal procedure for settling disputes over the provision of life-sustaining treatment. The state could claim that it has an interest in granting hospitals complete control to determine all procedures in the .046 context in order to advance several state interests. The state could claim these informal procedures are necessary to advance its interests in protecting the well-being of patients by preventing them from being subjected to futile treatments, protecting the conscience rights of doctors who object to being required to provide futile treatments, avoiding the social costs of providing futile life-sustaining treatments, or avoiding the costs of more formal adjudications of these disputes.

271 See id.
Each of these interests has some merit. The state has an interest in protecting patients from painful or burdensome treatments that will offer them no benefits in return. This is why the government tests and bans certain quack treatments that are peddled to desperate and gullible people. Some patients might be motivated by ignorance, fear or sheer desperation to request LST far out of proportion to the benefits provided—for instance, someone who is actively dying of chronic congestive heart failure might make an advanced request for repeated cardio-pulmonary resuscitation even when it is clear that his heart will no longer function no matter what is done. Or a proxy may demand the provision of food to a patient whose body is no longer able to assimilate the food, thereby risking the concentration of toxic substances in the body that may hasten the patient’s death. In these cases, the provision of LST might actually be harmful to the patient, and the state will have an interest in protecting the patient from such treatment.

While some patients’ genuine interests would be advanced by having an effective means of denying such treatments, another wide universe of patients are vulnerable to the .046 procedure because their genuine interest is arguably best advanced by maintaining LST. Having conceded that the futility statute is not a rationing or cost-saving provision, the state could not have an interest in creating a mechanism that subjects such patients to wrongful denials of treatment. Additional procedural safeguards are necessary to ensure that unless they are genuinely being harmed, patients are not deprived against their wishes of LST. Therefore, this interest does not support the state’s chosen informal procedures.

In this context, some argue that it is a violation of a doctor’s conscience rights to require him to provide certain treatments that he believes are futile.272 One could imagine the doctors who are asked to give CPR to a frail, elderly, imminently dying woman, perhaps breaking bones and bruising the patient in order to comply, would balk at such a request. Some commentators have argued that “health care professionals ought not, and in fact, cannot be coerced to treat when such treatment affronts their sense of ethics.”273


In weighing the state’s interest in protecting the doctor’s conscience rights, it is important to once again look to the breadth of the state’s definition of LST. The provision applies to treatments that would be effective in maintaining a patient’s life, not to those that are ineffective. If the treatment is simply not effective in maintaining the patient’s life (such as repeated CPR on a brain dead patient), the doctor is under no obligation to provide the treatment regardless of .046. Even without the .046 procedure, medical malpractice liability will not be imposed on a doctor who refuses to provide treatment that falls outside the standard of care in the medical community.

What .046 adds to the protections provided by the medical standard of care is protection for doctors whose consciences are offended by providing care that falls within the Texas statute’s definition (and is therefore effective at sustaining life) and treatments that are also presently within (or close to the edge of) the standard of care in the medical community. In such cases where the doctor objects to the standard of care, or is unclear about what the standard of care would be for a particular case, .046 provides a safe harbor of absolute immunity in withdrawing life-sustaining care. The state’s interest in protecting the conscience of a doctor who objects to providing treatments that are effective in maintaining life and which are arguably within the standard of care would seem to be at least debatable, especially when compared to the interests of the patients in receiving such care. But such borderline cases are not the only ones covered by .046.

Again, the breadth of cases that fall within the ambit of .046 undermines the weight of the state’s interest in protecting the conscience rights of all possible .046 decisions made by doctors, including those involving non-terminal patients, those who could recover with proper care, the chronically ill, and terminal patients whose lives may be extended in an incremental but meaningful degree. Furthermore, some doctors might have idiosyncratic consciences that the state has no interest in protecting. For instance, presumably the doctor who got approval from his hospital’s ethics committee to deactivate the fully-conscious Mr. Givens’ pacemaker and respirator was no doubt acting on his conscientious beliefs. But Texas has no clearly legitimate interest in surrounding this doctor’s conscience with such ironclad protection and absolute immunity. Indeed, a doctor who acted on similar grounds in another state would likely face murder charges.

Ordinarily, when a state creates a right for doctors to conscientiously object to certain medical procedures, such as abortion, the statute provides
that this privilege does not extend to cases in which a patient’s life is at risk. In such cases, the state imposes a duty to save the patient’s life, even if the only way of doing so is by requiring the doctor to perform the objectionable procedure.\footnote{See, e.g., The Illinois Health Care Right of Conscience Act, widely acknowledged to be the broadest health care conscience statute in the nation, does not relieve physicians of a duty to provide emergency medical care. 745 ILL. COMP. STAT. 70/6 (West 2002).} Similarly, a state would not likely argue that its interest in protecting a doctor’s conscience extends to other cases in which doing so would cost another person her life.

Regardless, the statute does not limit the .046 procedure to cases where a doctor claims to have a conscientious objection to treatment. Any reason—or even no reason at all—for his decision to deny treatment will suffice. Furthermore, the state seemingly has no interest in protecting the conscience rights of doctors when their treatment decisions are based on misdiagnoses or negligence. Other doctors might be motivated by animus toward a patient or base their decisions on invidious discrimination toward various groups. The statute’s informal procedures provide no protection against medical mistakes or from intentional or negligent wrongdoing.

Third, the state may claim an interest in avoiding the social costs involved in providing life-sustaining care when a doctor objects to such care. Indeed, care for patients in need of life-sustaining care can be quite costly. Legislators have repeatedly stated, however, that they did not intend the statute to be a cost-saving measure. The statute applies whether a patient has insurance or can pay for medical care, and it applies even if there is relatively little cost or demand for the resources involved in providing the treatment. While the state may have an interest in controlling medical costs, it does not have a legitimate interest in subjecting patients’ interest in sustaining their lives to an ad hoc and unfair procedure for limiting such costs.

The state may also argue that additional procedures are themselves too costly and burdensome to provide. Requiring more formal procedures, approaching those that one might find in a typical courtroom, costs the state money and resources it could use to achieve other goals. Additionally, the withdrawal of the LST would be delayed, entailing more costs for the medical care. Courts are reluctant to forego necessary procedural protections, particularly those involving fundamental rights, simply because a state claims they are too costly. Nonetheless, \textit{Mathews v. Eldridge} specifically instructs courts to consider among the state’s interests “the
fiscal and administrative burdens that the additional or substitute procedural requirements would entail." 275

Finally, the court would be required to consider “the risk of an erroneous deprivation of such interest through the procedures used, and the probable value, if any, of additional or substitute procedural safeguards." 276 A cardiologist appearing before the Texas House Committee testified about reviewing the records of a patient being subjected to the .046 procedure in which he concluded that the patient had been misdiagnosed for two years as having congestive heart failure, and that his doctors (who wished to end LST) had overlooked the fact that the patient’s condition was actually improving even with the wrong care being provided. 277 He had also reviewed twenty other cases in the .046 context and found that the cases were entirely too complex to handle in a simple ethics committee meeting. 278 Misdiagnoses with regard to persistent vegetative state are also common. In one study, an expert in the diagnosis of PVS found that forty percent of those found to be in this condition were misdiagnosed and could benefit from available therapies. 279 Indeed, even for those who have been correctly diagnosed, there have been recent reports of therapies that can restore such patients to consciousness, and some patients have inexplicably recovered on their own. 280 Additional procedures would likely be helpful in minimizing wrongful deprivations of LST based on a misdiagnosis or in cases in which a doctor is unaware of available treatments.

As argued in this Article, a fair judge would likely find that the current procedures in .046 present an unacceptable risk of erroneous deprivations of life-sustaining treatments. The current procedure provides no safeguards to

275 424 U.S. 319, 335 (1976).
276 Id.
277 See Hearings, supra note 1 (testimony of Doctor Vincent Freiderwall, Clinical Professor of Medicine, University of Notre Dame) (testimony of Dr. Freiderwall begins at approximately 6 hours, 47 minutes, 31 seconds).
278 Id.
279 Ronald Cranford, Misdiagnosing the Persistent Vegetative State, 313 BRIT. MED. J. 5, 5–6 (July 6 ed. 1996), available at http://www.bmj.com/cgi/content/full/313/7048/5.
prevent the statute from being used to deprive patients of their interests in life based on idiosyncratic values, discrimination, misdiagnosis, animus, or negligence. Therefore, a court would likely conclude that the present procedures are a violation of the Fourteenth Amendment’s Due Process Clause.

A court would also likely conclude that a patient’s interest in access to a full range of formal procedural protections in order to ensure a proper decision greatly outweighs the state’s interest in granting the ethics committees carte blanche regarding the procedures to be used in settling the dispute. Additional procedures would all be extremely useful to protect against erroneous deprivations, and a court may well conclude that *Mathews v. Eldridge* would require such things as: the imposition of the burden of proof on the doctor to demonstrate that the patient’s case satisfies an objective standard; a neutral and impartial decision maker (either at the administrative or judicial level); regularized rules of evidence and rights of confrontation; the right to put on one’s own case; the right to counsel; and the right to have a reasoned opinion based on the evidence. A court might also conclude that, in the interest of uniformity, a right to appeal should be required.

V. CONCLUSION

Notwithstanding all the understandable criticism of resort to the courts in cases involving disputes over medical treatment, it is difficult to conceive of alternative means of protecting the important societal, dignitary and personal interests at stake in the futility procedure against abusive or negligent deprivations. Looking closely at the costs of foregoing the use of courts and related legal protections, as Texas has done, it becomes clear that, for all of their difficulties and shortcomings, courtroom procedures offer an important and valuable forum for sorting out disputes over LST. Furthermore, the constitution requires that state provide some of these traditional protections when it seeks to deprive individuals of their constitutionally protected interests in life and liberty.

As part of those constitutionally required procedures, the legislature must honestly confront the lack of a consensus about the meaning of the medical futility concept. The legislature should return to the most extreme and clearly persuasive cases used by advocates of the futility concept to argue that some treatment decisions are actually harmful to patients; therefore, doctors should not be legally obligated to provide such extreme interventions. The legislature should also strictly limit the application of
any denial of LST to instances in which the patient is terminally ill, is no longer able to speak for herself, and has not left a clear indication of her wishes.

Some commentators have argued that the proper standard for denial of requested care should attempt to put forward an anti-cruelty standard.281 Such standards would apply to patients who are not competent to decide upon their own treatment and who had not left any directions that would indicate that they would request such treatment. Such an approach could invoke the state’s parens patriae power to protect vulnerable persons from harm. Such an approach suggests a starting point for an objective standard that sets forth relevant criteria responsive to the most compelling instances in which the state may have an interest in ensuring that doctors are not required to legally provide LST. In a related paper, I have suggested how the state could develop such a standard by analogizing to a federal child abuse prevention act.282

In any case, the Texas approach of granting virtually unlimited discretion to the health care sector in denying LST to persons requesting it is an illegitimate approach that will likely be found to violate the constitutional rights of those subject to the law.

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