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MEDICAL FUTILITY IN TEXAS: HANDLING "REVERSE RIGHT-TO-DIE" OBSTACLES WITHOUT CONSTITUTIONAL VIOLATION

I. INTRODUCTION TO THE TEXAS ADVANCE DIRECTIVES ACT

Sun Hudson was born on September 25, 2004, in Houston, Texas.[1] By September 26, the newborn laid connected to a ventilator at the neonatal intensive care unit of Texas Children's Hospital, struggling to hold on to the life he was just given.[2]

Sun was born with *thanatophoric*[3] *dysplasia*, a type of neonatal dwarfism.[4] While this fatal condition causes serious mental and physical ailments, what ultimately causes death is a dangerously narrow chest cavity that restricts the newborn's breathing capabilities.[5] In the following November, the hospital decided that Sun's condition was futile,[6] and that "allowing Sun to die naturally was medically appropriate and the most ethical course of treatment for the tragic situation."[7] In the view of the treating physicians, continuing to provide care to the baby would only increase his pain and agony.[8] Sun's mother, Wanda, did not consent to withdrawing life support from her newborn baby, believing that he would survive.[9]

The hospital notified Wanda in writing, on November 18, that it would end treatment of her son in ten days, unless she was able to find another health care facility willing to continue life support.[10] Wanda immediately sued Texas Children's, asking the court to compel the hospital to continue treatment.[11] After five months of litigation, the probate court ruled in favor of the hospital,[12] holding that "there was no reasonable expectation that another health care provider would agree to continue treatment if time

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1. *Hudson v. Tex. Children's Hosp.*, 177 S.W.3d 232, 233 (Tex. App. 1st Dist. 2005).
2. Amir Halevy & Amy L. McGuire, *The History, Successes and Controversies of the Texas "Futility" Policy*, 43 Hous. Law. 38, 40 (May-June 2006).
3. Thanatophoric literally means "bringing death." Gail M. Pfeifer & Maureen Shawn Kennedy, *Understanding Medical Futility: Two Texas Cases Illustrate the Dilemmas for Families, Hospitals—and Nurses*, 106 Am. J. Nursing 25 (May 2006).
4. Halevy & McGuire, *supra* n. 2, at 40.
5. Lance Lightfoot, *Incompetent Decisionmakers and Withdrawal of Life-sustaining Treatment: A Case Study*, 33 J.L., Med. & Ethics 851, 852 (2005).
6. *Hudson*, 177 S.W.3d at 233.
7. Lightfoot, *supra* n. 5, at 851.
8. *Id.*
9. Halevy & McGuire, *supra* n. 2, at 40.
10. *Hudson*, 177 S.W.3d at 233.
11. *Id.* at 234.
12. Halevy & McGuire, *supra* n. 2, at 40. The hospital "continued providing life-sustaining treatment throughout the judicial process." *Id.*

were further extended."[13] On March 15, the day after the court's ruling, the hospital withdrew Sun's life support and "a few breaths later"[14] he died in Wanda's arms.[15]

Wanda alleged that the hospital made a devastating mistake, and that when it came to her son, the physicians simply quit after six months.[16] According to bioethical experts, the child's death marked the first time an American court has allowed a health care facility to end a baby's life support against the wishes of a parent.[17]

The Sun Hudson case is one of several cases that have sparked a recent controversy over the Texas Advance Directives Act (Act), specifically the subsection of the statute commonly referred to as the "Futile Care Law."[18] This Act, signed by then-Governor George W. Bush in 1999, lays out the steps that are to be followed when it has been decided that a patient will not recover, and physicians and families disagree over continued health care measures.[19] With this statute, "Texas [became] the first state to adopt a law regulating end-of-life decisions, providing a legislatively sanctioned, extrajudicial, due process mechanism for resolving medical futility disputes and other end-of-life ethical disagreements."[20]

The Act permits a health care provider to discontinue life-sustaining treatment against the wishes of the patient, the patient's guardian, or the person responsible for the health care decisions of the patient (for instance, the patient's family).[21] Subsection 166.046(a) of the Act allows an "ethics or medical committee" to hear cases where a treating doctor refuses to adhere to a patient's advance directive or a health care decision made on behalf of a patient by a family member or other appropriate decision-maker.[22] Advance directives, also known as "living wills" or "directives to physicians,"[23] are "document[s] that [take] effect upon one's incompetency and [designate] a surrogate decision-maker for healthcare matters," or "[explain] one's wishes about medical treatment if one becomes incompetent or unable to communicate."[24]

In Texas, patients have the ability to make medical treatment decisions via advance

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13. *Id.* In order for the court to compel the hospital to continue treatment, "[Wanda] had the burden to show by a preponderance of the evidence that there was a reasonable expectation that another physician or health care facility would honor her directive to continue life-sustaining treatment to Sun." *Hudson*, 177 S.W.3d at 234 (quoting Tex. Health & Safety Code Ann. § 166.046(g) (2001)). The hospital "said it contacted 40 facilities with newborn intensive care units, but none would accept Sun." Leigh Hopper & Todd Ackerman, *Inside of Me, My Son is Still Alive*, Hous. Chron. A1 (Mar. 16, 2005) (available at http://www.chron.com /CDA/archives/archive.mpl?id=2005_3853325). In addition, no health care provider came forth after the case began receiving considerable publicity and media attention. Rick Casey, *No Villains in this Sad Story*, Hous. Chron. B1 (Feb. 20, 2005) (available at http://www.chron.com/CDA/archives/archive.mpl?id=2005_3845766).

14. Kenneth C. Kirk, *The Alaska Health Care Decisions Act, Analyzed*, 22 Alaska L. Rev. 213, 246 (2005).

15. Halevy & McGuire, *supra* n. 2, at 40.

16. Hopper & Ackerman, *supra* n. 13, at A1.

17. *Id.*

18. Tex. Health & Safety Code Ann. § 166.046; Pfeifer & Kennedy, *supra* n. 3, at 26.

19. Pfeifer & Kennedy, *supra* n. 3, at 26.

20. Robert L. Fine & Thomas Wm. Mayo, *Resolution of Futility by Due Process: Early Experience with the Texas Advance Directives Act*, 138 Annals Internal Med. 743, 743 (May 6, 2003).

21. Tex. Health & Safety Code Ann. § 166.046.

22. Halevy & McGuire, *supra* n. 2, at 40 (quoting Tex. Health & Safety Code Ann. § 166.046(a)).

23. Thomas Wm. Mayo, *Health Care Law*, 53 S.M.U. L. Rev. 1101, 1107 (2000).

24. *Black's Law Dictionary* 45 (Bryan A. Garner ed., 8th ed., West 2004).

directives through other sections of Chapter 166 of the State's Health and Safety Code.[25] A patient can tell his medical care provider to continue or end treatment in circumstances where he is suffering from a terminal ailment from which he anticipates to die soon, even with available life support measures.[26] An advance directive can also instruct a physician to continue care after a patient is unable to make decisions concerning his or her health care.[27] An advance directive to continue treatment, however, can put physicians in a position of continuing life support care that no longer has an effect.[28] If the Act's guidelines are followed, the Act creates a legal safe harbor for health care providers by giving immunity from any liability, civil or criminal, that may result from withdrawing life-sustaining treatment of a futile patient.[29]

The Act's guidelines state that the patient's attending physician cannot be a member of the hospital's ethics or medical committee reviewing the particular case.[30] The patient or family must receive forty-eight hours notice of the committee review process, and be allowed to attend and participate.[31] The committee must provide the patient or family a written report describing the decision and findings reached in the review process.[32] If the ethics or medical committee review process fails to resolve the dispute between the physician and the patient or family, the health care provider must "make a reasonable effort to transfer the patient to [another health care provider] who is willing to comply with the directive."[33] If no such provider is found within ten days after the day in which the patient or family received the written report from the committee, the physician and hospital may withdraw the medical treatment that has been deemed futile.[34] The "appropriate district or county 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."[35] Had Wanda Hudson shown the court that it was more likely than not that she would be able to find another health care provider willing to continue treatment for Sun, the baby would have been kept alive for an extended amount of time.[36]

History has proven that the term "medical futility" is virtually impossible to define.[37] Therefore, other states should consider codifying a concrete futile care policy,

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25. Jason B. Ostrom, *Patient's Bill of Rights*, 43 Hous. Law. 34, 34 (May-June 2006) (quoting Tex. Health & Safety Code Ann. § 166).

26. *Id.* (discussing Tex. Health & Safety Code Ann. § 166.033).

27. *Id.*

28. *Id.*

29. Fine & Mayo, *supra* n. 20, at 744.

30. Tex. Health & Safety Code Ann. § 166.046(a).

31. *Id.* at § 166.046(b)(1)–(2).

32. *Id.* at § 166.046(b)(2)(B).

33. *Id.* at § 166.046(d).

34. *Id.* at § 166.046(e).

35. Tex. Health & Safety Code Ann. § 166.046(g).

36. The Act states, "[T]he appropriate district or county 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." *Id.*

37. Council Ethical Judicial Affairs, Am. Med. Assn., *Medical Futility in End-of-life Care: Report of the Council on Ethical and Judicial Affairs*, 281 JAMA 937, 938 (1999).

as Texas did,[38] in order to limit the dangers of inconsistency and confusion among the United States' jurisdictions. Criticism of the Act, however, alleges that it violates the United States Constitution,[39] therefore implying that the Act should not exist, as is, in Texas or anywhere else in the country. The Texas Advance Directives Act is a law that fits within the bounds of the Constitution and established American common law principles. A constitutional challenge to the Act would fail.

Part II of this article will discuss in detail the controversial, and oftentimes confusing, history of medical futility, which ultimately led to the implementation of the Texas Advance Directives Act of 1999. Part III will analyze the Act under constitutional and common law principles, and will support the argument that a constitutional challenge to the Act will fail. Part IV will conclude this comment by summarizing both the history of medical futility and the constitutional analysis.

II. A BACKGROUND OF "MEDICAL FUTILITY" AND THE TEXAS ADVANCE DIRECTIVES ACT

A. *Early Conflicts between Physicians and Family Members*

American courts began addressing disagreements between health care providers and family members concerning life-sustaining treatment during the final years of the twentieth century.[40] Most of the issues the courts considered during this era revolved around one question: "What should be done when a patient or his surrogate refuses or seeks to discontinue life-sustaining medical treatment, but health care providers favor more aggressive care?"[41] In *Cruzan v. Director, Missouri Department of Health*,[42] a woman had sustained serious injuries from an automobile accident, which left her in a persistent vegetative state.[43] The parents of the woman wished to have her removed from artificial nutrition and hydration, because "it had become apparent that [she] had virtually no chance of regaining her mental faculties . . . ."[44] A friend also testified that the woman once said that she would not want to be kept alive artificially.[45] The physicians refused to honor the parents' wishes without permission from the court.[46] The United States Supreme Court ruled that artificial feeding continue, since "clear and convincing evidence" of the incapacitated woman's wishes regarding life-sustaining treatment was lacking.[47] Although the Court held in favor of the physicians, and against

38. Tex. Health & Safety Code Ann. § 166.046.

39. Maureen Kwiecinski, *To Be or Not to Be, Should Doctors Decide? Ethical and Legal Aspects of Medical Futility Policies*, 7 Marq. Elder's Advisor 313, 342–47 (2006) (arguing that the Act violates the procedural safeguards of the Due Process Clause in the Fourteenth Amendment).

40. *E.g. Cruzan v. Dir., Mo. Dept. of Health*, 497 U.S. 261 (1990); *In re Quinlan*, 355 A.2d 647 (N.J. 1976).

41. Kwiecinski, *supra* n. 39, at 314–15.

42. 497 U.S. 261.

43. *Id.* at 266. A persistent vegetative state is "a condition in which a person exhibits motor reflexes but evinces no indications of significant cognitive function." *Id.*

44. *Id.* at 267.

45. *Id.* at 268.

46. *Cruzan*, 497 U.S. at 268.

47. *Id.* at 286–87. Clear and convincing evidence was the standard imposed by the State of Missouri when determining an incompetent person's desire in regards to being kept on life-sustaining treatment. *Id.* at 280.

the wishes of the parents, the Court did recognize that individuals enjoy a right to refuse medical treatment under the Due Process Clause of the Constitution's Fourteenth Amendment.[48]

In the landmark case *In re Quinlan*,[49] the father of a severely comatose woman wished to have her removed from life-sustaining treatment (a respirator) because the "measures . . . present[ed] no hope of her eventual recovery."[50] The woman's health care providers refused to adhere to the father's wishes, arguing "that removal from the respirator would not conform to medical practices, standards and traditions,"[51] although they agreed with the father that his daughter was beyond recovery.[52] The New Jersey Supreme Court ruled in favor of the father, holding that if the treating physicians and a consultative body of the hospital (like an ethics committee) concluded that further life-sustaining treatment was inappropriate, the treatment may be withdrawn.[53] This case "set the pattern for succeeding death and dying jurisprudence," and many "state courts echoed *Quinlan* and grounded the patient's prerogative to reject life-sustaining medical intervention in the constitutional protection of liberty."[54]

More recently, however, attention has shifted to "the other end of the spectrum . . . ."[55] An opposing question surfaced: "What should be done when health care providers contend that a life-sustaining medical intervention, such as [ventilator] support, dialysis, or artificial feeding, should be withheld or withdrawn but the patient or family members disagree?"[56]

B. *The Medical Futility Issue Addressed*

The idea of medical futility appears in ancient Hippocratic writings, which assert that three major goals of medicine are "cure, relief of suffering, and 'refus[al] to treat those who are overmastered by their diseases.'"[57] However, with substantial medical advances in the late twentieth century, "death [is] no longer final, and practitioner and patient alike could legitimately question what it meant to be 'overmastered' by illness."[58] By the 1980s and into the 1990s, futile care conflicts between medical practitioners and patients' families began multiplying across the nation, and members of the medical profession began demanding that physicians and medical facilities define "futility" and

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48. *Id.* at 278.

49. 355 A.2d 647.

50. *Id.* at 651.

51. *Id.* at 655.

52. *Id.*

53. *Id.* at 671–72. The court also stated that the withdrawal of treatment "shall be without any civil or criminal liability therefor on the part of any participant, whether guardian, physician, hospital or others." *Quinlan*, 355 A.2d at 672.

54. Norman L. Cantor, *Twenty-five Years after* Quinlan*: A Review of the Jurisprudence of Death and Dying*, 29 J.L., Med. & Ethics 182, 183 (2001).

55. Halevy, *supra* n. 2, at 39.

56. Kwiecinski, *supra* n. 39, at 315.

57. Fine & Mayo, *supra* n. 20, at 743 (quoting Nancy S. Jecker, *Knowing When to Stop: The Limits of Medicine*, 21 Hastings Ctr. Rpt. 5 (1991).

58. *Id.*

adopt guidelines for dealing with these controversial issues.[59] Most of the proposals or ideas in medical literature on dealing with futility problems, as well as how to define "futile," however, were inconsistent and caused even more confusion and bickering.[60]

As the heated debate in the health care profession and medical literature continued, a legal debate took place in the courts,[61] with similar inconsistency.[62] Courts in some jurisdictions determined that if a physician or hospital committee decided treatment was futile, families of the patients should ultimately decide if life-sustaining measures should continue, instead of the medical providers.[63] For instance, in a well-known[64] 1988 Minnesota case, *In re Wanglie*,[65] physicians determined that continued care of a severely brain damaged patient had become futile and should be withdrawn.[66] The district court, however, ruled that life support continue, as insisted on by the patient's husband.[67] In *In re Jane Doe*,[68] treating physicians concluded that it would be medical abuse to continue treatment of a teenage girl with a severe neurological ailment.[69] The trial court, although "determining that the state no longer maintained an interest in continuing treatment that was merely prolonging the child's death," ruled that the hospital could not discontinue life-sustaining treatment without the consent of both parents.[70] Kathleen Boozang[71] wrote that this opinion could be the most dominant one in supporting the rights of the family.[72]

Other jurisdictions during the 1990s decided on futility issues differently.[73] In *Gilgunn v. Massachusetts General Hospital*,[74] a court ruled in favor of health providers who asserted that treatment should not be given to a patient who was dying from multiple organ system failure (because such measures were determined to be futile) even though the patient's family asked for it.[75] In *Gilgunn*, the treating physician consulted with the

59. Robert L. Fine et al., *Medical Futility in the Neonatal Intensive Care Unit: Hope for a Resolution*, 116 Pediatrics 1219, 1220 (2005). Between 1987 and 1988, fifty percent of deaths in the U.S. that occurred in intensive care units were preceded by a decision to withdraw or withhold life support, while in 1993 the percentage was over ninety. Kwiecinski, *supra* n. 39, at 318.

60. Fine & Mayo, *supra* n. 20, at 743. One medical commentator even wrote that "although the concept could sometimes be justified, it was 'fraught with confusion, inconsistency and controversy.'" *Id.* (quoting Bernard Lo, *Resolving Ethical Dilemmas: A Guide for Clinicians* 73–81 (Lippincott Williams & Wilkins 1995)).

61. *Id.*

62. Fine et al., *supra* n. 59, at 1220.

63. *E.g. In re Baby K*, 16 F.3d 590 (4th Cir. 1994) (holding that physicians would be liable if they discontinued treatment, which they determined to be futile, of an anencephalic infant against the wishes of her parents). Anencephaly is "a congenital malformation in which a major portion of the brain, skull, and scalp are missing." *Id.* at 592.

64. Cantor, *supra* n. 54, at 185.

65. No. PX-91-283 (Minn. 4th Dist. July 1, 1991).

66. Fine & Mayo, *supra* n. 20, at 743 (discussing *Wanglie*, No. PX-91-283).

67. Cantor, *supra* n. 54, at 185.

68. 418 S.E.2d 3 (Ga. 1992).

69. Kathleen M. Boozang, *An Intimate Passing: Restoring the Role of Family and Religion in Dying*, 58 U. Pitt. L. Rev. 549, 584 (1997) (discussing *Jane Doe*, 418 S.E.2d at 4).

70. *Id.* at 585 (discussing *Jane Doe*, 418 S.E.2d at 6–7).

71. Boozang is a professor at Seton Hall University School of Law. *Id.* at 549 n. *.

72. *Id.* at 585.

73. Fine, *supra* n. 59, at 1220.

74. No. SUCV92-4820 (Mass. Super. Ct. Apr. 21, 1995).

75. Fine et al., *supra* n. 59, at 1220 (discussing *Gilgunn*, No. SUCV92-4820).

hospital's ethics committee, and received permission from the committee head to end the life-sustaining treatment.[76] Furthermore, the jury refused to award damages to the patient's daughter, who had insisted upon continued treatment.[77] These jurisdictions' conflicting decisions did not represent "a general legal acceptance of a medical prerogative to unilaterally determine qualitative futility."[78]

C. *Problems in Defining What Futile Is: "I Know It When I See It"*

To add to the confusion and inconsistency within both the judicial and medical worlds, commentators tried to present several definitions of "futile" treatment, but none of them could create a common conception or agreement.[79] Furthermore, "[t]he conceptions that they [had] produced may not [have been] sufficiently precise for a legal definition. In particular, the probabilistic nature of medicine and the value judgments inherent in evaluating any probability create problems and confusion."[80]

Some legal writers asserted that one should distinguish between medical futility, which deals with whether the benefit or advantages of the medical care is worthwhile to the patient, and economic futility, dealing with whether the care is advantageous to the community in general.[81] Commentators also attempted to define futility as either "physiologic," "qualitative," or "quantitative."[82] Physiological futility, which scholars said was the easiest to understand, involves a situation in which a patient seeks a treatment option that will ultimately *not* reach the health care goal sought.[83] Under the particular circumstances, the patient's request is "irrational," and there was little demand in the 1990s to require health care providers to give futile care of this kind.[84] Because any treatment provided will not reach a medical goal, this category of futility essentially gives the patient only *peace of mind*.[85]

The second category of futility discussed, qualitative futility, was the type that created the greatest level of controversy.[86] This type of futility "allows physicians to determine the benefits of a particular treatment and to evaluate those benefits for the patient."[87] A physician can determine that a certain life-sustaining treatment measure is futile because it will not "provide a quality of life that rises above a certain minimum level."[88] Qualitative futility involves a physician's total value-laden judgment.[89]

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76. Cantor, *supra* n. 54, at 185.
77. *Id.*
78. *Id.* at 185–86.
79. Keith Shiner, *Medical Futility: A Futile Concept?* 53 Wash. & Lee L. Rev. 803, 826 (1996).
80. *Id.*
81. *Id.* at 826–27.
82. Jerry Menikoff, *Demanded Medical Care*, 30 Ariz. St. L.J. 1091, 1095 (1998); Shiner, *supra* n. 79, at 827–32.
83. Menikoff, *supra* n. 82, at 1095.
84. *Id.*
85. *Id.*
86. *Id.* at 1096.
87. Shiner, *supra* n. 79, at 830.
88. Menikoff, *supra* n. 82, at 1097.
89. *Id.*

Quantitative futility was a third type of futility addressed in the 1990s.[90] This area involves scenarios where the benefit of the care, if it were to succeed, would definitely be worthwhile, but the chance of it being advantageous is very low.[91] A balancing of costs and benefits was also necessary here, as it was in considering qualitative futility.[92]

Medical and legal writers have commented that the "practical and theoretical differences" in the suggested definitions led to the conclusion that futility is an intangible concept,[93] and "the struggle to achieve a practical definition of 'futile treatment' is itself futile."[94] Despite this ambiguity and vagueness, proponents of futile care policy adoption have contended that the lack of an established definition is not a problem, because physicians "know it when they see it."[95]

D. *Futility Controversy Addressed by the American Medical Association*

In 1999, the Council of Ethical and Judicial Affairs of the American Medical Association (AMA) finally addressed the growing concern and controversy surrounding futility issues.[96] In this report, the AMA discussed the use of interventions in patients with life-threatening conditions, and recommended a procedural approach to futility decisions.[97] The AMA also wrote, "A fully objective and concrete definition of futility is unattainable."[98] For instance, "[one] patient may consider the physical, emotional, practical, or financial burden of aggressive intervention not worth the purpose of prolonging seemingly meaningless life,"[99] while other patients "may find even [a] short prolongation meaningful and worth the burden."[100]

The emphasis of the AMA's strategy was on a fair process for the individuals involved, as opposed to having an established, objective definition to be imposed on the interested parties.[101] The first step of the approach called for prior deliberation and negotiation among the physician, patient, and possibly the family members as to what constitutes futile care.[102] This negotiation was to take place before treatment to ensure that patient and physician agreed as to what constitutes futile, in case the patient's

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90. *Id.*

91. *Id.* at 1097–98.

92. *Id.* at 1097.

93. Kwiecinski, *supra* n. 39, at 325 (citing John Lantos et al., *The Illusion of Futility in Clinical Practice*, 87 Am. J. Med. 81, 83 (1989)).

94. *Id.* (citing E. Haavi Morreim, *Profoundly Diminished Life: The Causalities of Coercion*, 24 Hastings Ctr. Rpt. 33, 33 (1994)).

95. *Id.* (citing Robert L. Fine & Thomas Wm. Mayo, *Advance Directive, Due Process, and Medical Futility*, 150 Annals Internal Med. 404 (2004)).

96. Fine & Mayo, *supra* n. 20, at 744.

97. Am. Med. Assn., *supra* n. 37, at 937.

98. *Id.* at 938. The AMA wrote, "The Council finds great difficulty in assigning an absolute definition to the term *futility* since it is inherently a value-laden determination. Thus, the Council favors a fair process approach for determining, and subsequently withholding or withdrawing, what is felt to be futile care." *Id.* at 940.

99. *Id.* at 938.

100. *Id.* (The AMA referred to its approach as "the best available option.").

101. Am. Med. Assn., *supra* n. 37, at 938.

102. *Id.* at 939–40.

condition ever reached that point.[103] Secondly, if or when the physician begins to determine that treatment of the patient has become futile or inappropriate, "bedside" joint decision-making must take place between caregiver and family (or other decision maker).[104] The report stated that this step should conform to the "established standards of deliberation and informed consent."[105] If, however, physician and family deliberations did not establish an agreement, the parties could seek assistance from an individual consultant, or a representative of the patient, to help reach a resolution.[106] If disagreements remained irresolvable, an ethics committee of the hospital was to address the altercation, and make a determination as to if treatment should be continued.[107] The report stated that the family must have a voice during this committee hearing.[108]

A fifth step takes effect if the hospital committee agrees with the family, but the family and physician are still at odds.[109] In this situation, an arrangement is to be made to transfer the patient to another doctor at the hospital.[110] However, if transfer within the institution is impossible, or if the committee agrees with the treating physician instead of the family, a sixth step calls for an attempt to transfer the patient to another hospital.[111] The report stated that the transferring hospital must be helpful and supportive during this step.[112]

Finally, if there is no health care provider willing to accept the patient's or the family's wishes, the AMA stated that, "by ethics standards," the life-sustaining treatment of the patient may be withdrawn.[113] The AMA warned, however, that "the legal ramifications of this course of action are uncertain."[114]

E. *Futility in Texas*

Many Texas health care facilities and providers became interested in adopting futile care policies in order to refuse or end treatment that they felt was inappropriate.[115] The fear of possible legal ramifications and ambiguous definitions, however, discouraged the institutions from proceeding alone.[116] In Houston, individuals representing major hospitals formed the Houston Citywide Taskforce on Medical Futility.[117] The goal of this taskforce was to establish a common policy on the complicated issue that was defensible by legal and ethical standards, but also considerate to the needs of the various

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103. *Id.*
104. *Id.* at 940.
105. *Id.*
106. Am. Med. Assn., *supra* n. 37, at 940.
107. *Id.*
108. *Id.*
109. *Id.*
110. *Id.*
111. Am. Med. Assn., *supra* n. 37, at 940.
112. *Id.*
113. *Id.*
114. *Id.*
115. Halevy & McGuire, *supra* n. 2, at 39.
116. *Id.*
117. *Id.*

affected parties involved.[118] Like the medical and legal scholars, the taskforce initially attempted to define futility, and was unsuccessful.[119] The group ultimately concluded that futility was similar to "obscenity," in that physicians cannot define it, but they recognize it when they see it.[120]

Eventually, the taskforce did come up with a procedural strategy for determining inappropriate treatment matters.[121] The proposed strategy, which later became the model for the AMA guidelines,[122] included procedural safeguards to make sure that the patient or family would be kept fully informed throughout the ordeal.[123] The proposed approach reviewed all the significant information by a consultative medical body, "or some other multi-disciplinary hospital committee," and made a final determination.[124] If the committee ultimately decided that the requested treatment was medically inappropriate, the hospital would not have to provide that requested care.[125] If the committee decided that the requested care was appropriate, the provider could not end the treatment without patient or family member consent.[126]

Although this policy was implemented by most Houston hospitals, and was endorsed by the AMA, no disputes went through the process and got to the point where a review committee had to make an ultimate futility determination.[127] This lack of policy use was most likely due to the lingering fear of legal ramifications from angry family members.[128]

F. The 1999 Implementation of the Texas Advance Directives Act

During the late 1990s, the Texas legislature began recognizing problems with the state's advance directive laws.[129] Professor Thomas Mayo of Southern Methodist University in Dallas wrote, "Experience with the various advance directives over a number of years, as well as the tinkering of successive legislatures, revealed weaknesses in the laws and introduced inconsistencies among them."[130] In Austin,[131] between 1998 and 1999, Professor Mayo was a member of a "large and diverse drafting committee [that] was assembled to develop a new law that would eliminate the inconsistencies among the three existing statutes and fix some of the problems that had emerged over time."[132]

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118. *Id.*
119. *Id.*
120. Halevy & McGuire, *supra* n. 2, at 39 (quoting *Jacobellis v. Ohio*, 378 U.S. 184, 197 (1964)).
121. *Id.*
122. *Id.*
123. *Id.*
124. *Id.*
125. Halevy & McGuire, *supra* n. 2, at 39.
126. *Id.*
127. *Id.* at 39–40.
128. *Id.*
129. Mayo, *supra* n. 23, at 1108.
130. *Id.*
131. The Texas capital.
132. Mayo, *supra* n. 23, at 1108 n. 66.

A bipartisan group drafted the new legislation.[133] A significant change that took place in Austin was that one physician could make a diagnosis of a "terminal" or "irreversible" condition.[134] Other changes in the Texas code included making advance directives more user-friendly documents,[135] limitations on whom can change the documents, and broadening the audience of who advance directives can address.[136] Professor Mayo, however, writes that the most drastic change dealt with "reverse right-to-die dilemmas."[137]

The Act ended the lingering fear of legal ramifications for following the AMA's policy.[138] In fact, the statute explicitly limits the courts' ability to intervene in these futility disagreements.[139] There is no language in the statute that allows a patient, family member, or health care provider to "appeal the decision of the hospital review committee in court."[140] For the first time, a state codified a solid procedure,[141] with legal certainty,[142] for dealing with an important and intense issue that had caused so much controversy over the last decade and a half.[143]

G. *Recent Cases Arising under the Texas Act*

Wanda and Sun Hudson's story attracted national media attention and sparked a heated debate over the controversial law.[144] There were mixed opinions as to who was right and who was wrong, and one Houston reporter even expressed the idea that this was a "sad story with no villains."[145] On one end of the battlefield, there were doctors who asserted that they were attempting to practice medicine ethically, and were not trying to "play God."[146] The treating physicians at Texas Children's stated that Sun was gradually suffocating, and that his lungs and chest cavity would never grow.[147] They firmly believed that it would have gone against medical ethics to continue life support

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133. Halevy & McGuire, *supra* n. 2, at 40.

134. Mayo, *supra* n. 23, at 1109. Terminal condition is a condition in which death was "reasonably imminent and unavoidable," while an irreversible condition is one in which "death might be years or decades away." *Id.* Irreversible condition is present in the case of a patient in a "persistent or permanent vegetative state." *Id.*

135. *Id.* at 1108–09.

136. *Id.* at 1108.

137. Mayo, *supra* n. 23, at 1109.

138. Halevy & McGuire, *supra* n. 2, at 40.

139. *Id.* As stated earlier, the only action the court can take is to extend the ten-day period if the patient's family can show, by a preponderance of the evidence, that there is a reasonable expectation that they will find another health care provider who is willing to continue life-sustaining treatment for the patient. Tex. Health & Safety Code Ann. § 166.046(g).

140. Halevy & McGuire, *supra* n. 2, at 40.

141. Kwiecinski, *supra* n. 39, at 316.

142. Halevy & McGuire, *supra* n. 2, at 40.

143. Fine et al., *supra* n. 59, at 1220.

144. Lightfoot, *supra* n. 5, at 851.

145. Casey, *supra* n. 13.

146. *Id.* (quoting John Paris, a professor of bioethics at Boston College, who is a "leading expert on end-of-life issues" and a strong supporter of the Act).

147. Leigh Hopper, *No Easy Calls When Baby is Terminally Ill: Local Case Casts Light on Dilemma of Hospitals, Parents in Disputes over Ending Treatment*, Hous. Chron. A1 (Feb. 9, 2005) (available at http://www.chron.com/CDA/archives/archive.mpl?id=2005_3842407).

that was futile and only continued the child's suffering.[148]

On the other end, there was a desperate mother fighting to continue the life of her newborn baby.[149] Wanda argued, despite what the physicians stated, that Sun was conscious and showed movement, and she had every bit of confidence that he would recover and live.[150] After all, "it's just impossible for parents to grasp the idea that a child that is alive is really on a dying trajectory."[151]

To add to the controversy of *Hudson*, there were indications that Wanda was incompetent, and therefore an inadequate decision-maker for her son's medical treatment.[152] This odd situation made the Hudson ethics committee consultation particularly difficult.[153] Wanda stated that her son could never die, for the sun itself conceived him, and not another human.[154]

Hudson was only the beginning. At the end of the case, Wanda's lawyer, Mario Caballero, had another client, the family of 68-year-old Spiro Nikolouzos.[155] Spiro, a retired oil company electrical engineer, became an invalid in 2001, when a shunt in his brain caused severe internal bleeding.[156] Until 2005, Spiro's dedicated wife Jannette cared for him at their home in Friendswood, Texas,[157] and artificially fed him through a tube in his stomach.[158] Janette claimed that after the 2001 tragedy, Spiro showed recognition and emotion, although he could no longer speak.[159] In February of 2005, Spiro suffered from complications of his feeding tube, so Jannette rushed her husband to St. Luke's Hospital at the Texas Medical Center in Houston.[160] The next day, Spiro ceased breathing and had to be connected to a ventilator.[161] By the end of February, the treating physicians determined that further life-sustaining treatment of Spiro was futile, and recommended withdrawal of his ventilator support and artificial feeding.[162] The health care providers concluded that the patient was beyond recovery, and further life support was no longer in his best interests.[163] Jannette and her family objected to ending treatment, asserting that withdrawal of life support would go against the patient's

148. *Id.* Professor Paris also argued that "the notion that letting a person die may be the right thing to do is not new." Casey, *supra* n. 13. He quotes Hippocrates, stating, "To impose treatment on the patient overmastered by disease is to display an ignorance akin to madness." *Id.*

149. Lightfoot, *supra* n. 5, at 851.

150. Hopper & Ackerman, *supra* n. 13.

151. Hopper, *supra* n. 146. (quoting William Winslade, an ethicist at the University of Texas Medical Branch at Galveston).

152. Lightfoot, *supra* n. 5, at 851.

153. *Id.*

154. Casey, *supra* n. 13.

155. Leigh Hopper, *Life Support to be Shut Off for Baby Today: Mother's Lawyer Says He Has No Plans to Appeal Hospital's Decision*, Hous. Chron. B1 (Mar. 15, 2005) (available at http://www.chron.com/CDA/archives/archivempl?id=2005_3852996).

156. Todd Ackerman, *Care Can End in Two Days: Family of Man on Life Support to Fight Ruling*, Hous. Chron. B1 (Mar. 10, 2005) (available at http://www.chron.com/CDA/archives/archive.mp?id=2005_3851516).

157. Friendswood is a suburb of Houston.

158. Ackerman, *supra* n. 157.

159. *Id.*

160. *Id.*

161. *Id.*

162. *Id.*

163. Kwiecinski, *supra* n. 39, at 313.

expressed wishes regarding his health and medical care.[164] The family also disagreed that Spiro was futile.[165] Jannette alleged that a neurologist subsequently informed her that her husband was in fact not brain dead, "and the part of the brain that controls breathing [was] still functioning."[166]

The physicians remained convinced in their determination, so as required by the Act,[167] the St. Luke's ethics committee heard the case.[168] Jannette was present at the consultation,[169] and over her objection, the committee agreed with Spiro's physicians that further care was inappropriate and useless.[170] On March 1, 2005, the hospital informed Jannette that it would end Spiro's life-sustaining treatment in ten days, and that she had that amount of time to find another health care facility that was willing to advance her directive and continue treatment for her husband.[171] The hospital stated that it would make a "good-faith effort" to help her locate another provider.[172]

Jannette went to the state district court to seek an injunction against the hospital after a hectic search by the family to locate another facility was unsuccessful.[173] Two days before St. Luke's was to discontinue treatment for Spiro, the district judge denied the family's request for an injunction.[174] The judge offered her "most sincere sadness and apologies," but added that she believed her "duty [was] to follow the law."[175]

Although Jannette referred to the judge's ruling as "disgusting,"[176] she stressed that the problem was not with the judge's denial.[177] The problem, she stated, was with this Act that allows a hospital to give patients and families a mere ten days notice before withdrawing life-sustaining treatment.[178] She said, "I'm so ashamed of my state that it executes civilians without criminal history."[179] Furthermore, Spiro's son stated that although he accepted that his father might never recover, the decision to end treatment should belong to their family, not a corporation.[180]

Fortunately for the Nikolouzoses, a last minute appeal to a state appellate court resulted in an immediate injunction, because a willing long-term care facility was located

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164. *Id.* at 313–14 (citing Nicole Foy, *Texas Law Gives Hospitals Right to End Life Support: It Seeks to Balance Views of Physicians and Feelings of Families*, San Antonio Exp.-News 1A (Mar. 27, 2005)).

165. *Id.*

166. Ackerman, *supra* n. 156. Jannette said that although Spiro's "eyes were open and fixed when he first was placed on the ventilator, he [had] started blinking." Todd Ackerman, *St. Luke's Postpones Removal of Life Support: Man's Family Has until 3 p.m. to Explore Any Possible Appeals*, Hous. Chron. B1 (Mar. 12, 2005).

167. The treating "physician's refusal shall be reviewed by a medical or ethics committee." Tex. Health & Safety Code Ann. § 166.046(a).

168. Rick Casey, *Right to Life Backed Law That Irks Wife*, Hous. Chron. B1 (Mar. 11, 2005).

169. Under the Act, "the person responsible for the health care decisions of the individual . . . is entitled to . . . attend the meeting." Tex. Health & Safety Code Ann. § 166.046(b)(1)–(2).

170. Casey, *supra* n. 169.

171. *Id.*

172. *Id.*

173. Kwiecinski, *supra* n. 39, at 314.

174. Ackerman, *supra* n. 156.

175. *Id.*

176. Ackerman, *supra* n. 166.

177. Ackerman, *supra* n. 156.

178. *Id.*

179. *Id.*

180. Ackerman, *supra* n. 166.

in San Antonio, Texas.[181] Shortly thereafter, the family transferred Spiro to San Antonio, where his life support was continued.[182] The family, however, continued to show extreme bitterness and anger towards St. Luke's, and remained suspicious of the hospital's motives to end treatment for financial reasons.[183] Spiro lived for about three months before he died of natural causes.[184]

Another case that received national media attention was that of Andrea Clark.[185] Andrea, who showed "minimal consciousness," was put on life-sustaining treatment after suffering complications of open-heart surgery and bleeding in the brain.[186] Andrea's treating physician determined that her care was futile, and the ethics committee agreed.[187] Andrea's family found another willing health care facility in a Chicago suburb, but the deal fell through.[188] A new doctor, however, brought uncertainty as to whether Andrea's condition was indeed futile.[189] This physician was brought in by the Texas Right to Life organization after Andrea's family started a national campaign to gain support to prolong the woman's life.[190] The hospital then agreed to continue treatment until a long-term facility could be found, but Andrea died only five days after this decision.[191]

These three well-known Houston cases brought the Act, which was previously a little-known law, into the community spotlight in 2005.[192] According to one Austin attorney, talk of these controversies will lead to changes in the Act.[193] Clark's lawyer stated, "It's unfortunate Texas has become ground-zero for this futile-care movement."[194]

III. THE ACT DOES NOT VIOLATE THE UNITED STATES CONSTITUTION

A. *Introduction to Constitutional Analysis and Argument*

A substantial criticism from opponents[195] of the Act is that it violates the United States Constitution's Due Process Clause, which is applied to the states by the Fourteenth

181. Kwiecinski, *supra* n. 39, at 314.

182. *Id.*

183. *Id.*

184. Halevy & McGuire, *supra* n. 2, at 41.

185. Todd Ackerman, *Move to Chicago Will Keep Patient on Life Support: St. Luke's Won't Pull the Plug after Reaching a Deal Amid Controversy over Futile-Care Law*, Hous. Chron A1 (Apr. 28, 2006) (available at http://www.chron.com/CDA/archives/archive.mpl?id=2006_4106704).

186. *Id.*

187. *Id.*

188. Todd Ackerman, *St. Luke's to Continue Care of Heart Patient: Decision Eases Uncertainty after Transfer to Chicago Falls Through*, Hous. Chron. B3 (May 3, 2006) (available at http://www.chron.com/CDA/archives/archive.mpl?id=2006_4109644).

189. Todd Ackerman, *Family Vows to Fight Futile-Care Law: Woman Dies After Battle to Stay on Life Support*, Hous. Chron. B1 (May 9, 2006) (available at http://www.chron.com/CDA/archives/archive.mpl?id=2006_4113149).

190. *Id.*

191. *Id.*

192. *Id.*

193. Ackerman, *supra* n. 188 (quoting Austin attorney Greg Hooser).

194. Ackerman, *supra* n. 185 (quoting Clark attorney Jerri Ward).

195. Kwiecinski, *supra* n. 39, at 342–47.

Amendment.[196] This clause states that the state cannot deprive anyone "of life, liberty, or property without due process of law."[197] The Supreme Court has held that the Fourteenth Amendment limits the states in two ways: through "procedural due process" and "substantive due process."[198] Maureen Kwiecinski[199] alleges that the Act violates procedural due process.[200] She writes, "The basic function of the due process clause is to promote fairness and justice by ensuring that any restriction or infringement on an individual's interest in life, liberty, or property is preceded by certain procedures."[201] Certain procedural safeguards, of which the Constitution requires, are notice and hearing.[202] These safeguards are present in the Act.[203] In order for a physician or hospital to end futile treatment, they must give the patient's family forty-eight hours notice of the committee hearing, and they must allow the family to attend.[204] Furthermore, the family is entitled to a written report explaining the determination reached in the hearing.[205] The Act also gives ten days notice before withdrawal, in order to allow the family to locate another physician.[206] The Supreme Court, however, would not even need to consider the constitutionality of the Act's procedural safeguards, because a challenger must first show that "state action" exists[207] and that there is a deprivation of a protected interest.[208] Kwiecinski argues that state action does exist,[209] and that a "constitutionally protected interest is at issue."[210] A constitutional challenge to the Act, however, will actually fail for lack of these two requirements.

B. A Challenge to the Act Will Not Pass the State Action Doctrine

The Supreme Court uses the "state action" doctrine as a screening mechanism.[211] The Constitution's protections, including that of due process, apply only to the government, and the constitutionality of private conduct is not addressed or heard by the Court.[212] Obviously, state legislative bodies are governmental entities, and their

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196. U.S. Const. amend. XIV, § 1.

197. *Id.*

198. Erwin Chemerinsky, *Constitutional Law: Principles and Policies* 523–24 (2d ed., Aspen 2002).

199. Kwiecinski received her law degree from Marquette University and is a registered nurse. Kwiecinski, *supra* n. 39, at 313 n. a1.

200. *Id.* at 342.

201. *Id.* at 345.

202. Chemerinsky, *supra* n. 198, at 523. Kwiecinski concedes that the Act properly includes the notice requirement, but argues that the statute does not ensure that the hearing will be constitutionally proper and fair to the patient's family. Kwiecinski, *supra* n. 39, at 350–52.

203. Tex. Health & Safety Code Ann. § 166.046.

204. *Id.* at § 166.046(b)(1)–(2).

205. *Id.* at § 166.046(b)(2)(B).

206. *Id.* at § 166.046(e).

207. Chemerinsky, *supra* n. 198, at 492. "A threshold question in any constitutional case is whether the defendant is the government." *Id.*

208. *Id.* at 534.

209. Kwiecinski, *supra* n. 39, at 347 n. 174.

210. *Id.* at 346–47.

211. Chemerinsky, *supra* n. 198, at 492.

212. *Id.* at 486. "The Constitution applies to government at all levels—federal, state, and local—and to the actions of government officers at all levels. The Constitution, however, generally does not apply to private entities or actors." *Id.*

enactments classify as action by the state.[213] The actual withdrawal of medical treatment from futile patients, however, is by health care providers.[214] Today, most hospitals are private entities,[215] and physicians, acting within the scope of their own professions,[216] are private actors.[217] The Court would therefore screen out a challenge to the constitutionality of the Act, finding that there is no constitutional violation of due process, because there is no state action or actor. Although opponents may argue that implementation of the Act itself by state legislators qualifies as deprivation stemming from state action, this argument is without merit.[218] Unless a governmental entity employs the physician,[219] state action simply does not exist, and the futile care policy cannot be found unconstitutional.[220]

1. State Action Exceptions

Soon after the adoption of the Due Process Clause in 1879, the Court stated that "[t]he provisions of the Fourteenth Amendment . . . all have reference to State action exclusively, and not to any action of private individuals."[221] A few years later, *The Civil Rights Cases*[222] mandated the requirement to show state action.[223] The Court has held, however, that private conduct can constitute state action in some circumstances, and thus fulfill the doctrine's strict requirement.[224] The two main exceptions to the state action doctrine are the "public function" and "entanglement" exceptions.[225] Private health care providers and facilities do not fall into either of these two exceptions.

2. The Public Function Exception Will Not Apply

The public function exception says that state action will exist if a private individual

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213. *Id.* at 492.

214. Tex. Health & Safety Code Ann. § 166.046(e).

215. *See* Kamal R. Desai et al., *Public Hospitals: Privatization and Uncompensated Care*, 19 Health Affairs 167 (Mar.–Apr. 2000).

216. The Court has found that a physician is a state actor when he is employed by a governmental entity, like a prison. Chemerinsky, *supra* n. 198, at 494–95 (discussing *Estelle v. Gamble*, 429 U.S. 97 (1976)).

217. Kwiecinski concedes that "withdrawal itself is done by private actors," but argues that "when it is done pursuant to statutory guidelines a court is likely to conclude [that] it is state action." Kwiecinski, *supra* n. 39, at 347 n. 174. This section of this article will take the opposite approach, arguing that physicians' actions in following the Act's guidelines are *not* state action.

218. This assertion will be presented in this article's argument that the conduct of private physicians and facilities acting within the scope of the Act does not fit within the state action exception called "entanglement."

219. Chemerinsky, *supra* n. 198, at 495 (discussing *Estelle*, 429 U.S. 97).

220. *Id.* at 486.

221. *Id.* (quoting *Va. v. Rives*, 100 U.S. 313, 318 (1879)).

222. 109 U.S. 3 (1883) (holding that private acts of racial discrimination were only private wrongs in which the federal government was powerless to prevent).

223. Chemerinsky, *supra* n. 198, at 486.

224. *Brentwood Acad. v. Tenn. Secondary Sch. Athletic Assn.*, 531 U.S. 288 (2001) (holding that a private association regulating high school athletics was a state actor under the entanglement exception); *Amalgamated Food Employees Union v. Logan Valley Plaza*, 391 U.S. 308 (1968) (holding that a private shopping center could not violate constitutional free speech rights); *Evans v. Newton*, 382 U.S. 296 (1966) (holding that a private park could not racially discriminate because the park served a public function); *Terry v. Adams*, 345 U.S. 461 (1953) (holding that even private elections qualify as state action); *Marsh v. Ala.*, 326 U.S. 501 (1946) (holding that although a town was privately owned, it still operated in the same manner as any other city, and therefore could not abridge the freedoms and rights of its citizens under the Constitution).

225. Chemerinsky, *supra* n. 198, at 495–96.

or entity is engaging in a type of conduct that is "traditionally exclusively reserved to the State."[226] The famous landmark case illustrating this state action exception, and laying its foundation, is *Jackson v. Metropolitan Edison Company.*[227]

In *Jackson*, a customer petitioned against a Pennsylvania utility company who turned off her electricity because of her delinquent payments.[228] The customer alleged that the termination of her electric service was state action that deprived her of due process.[229] In this case, "the action complained of was taken by a utility company which [was] privately owned and operated, but which in many particulars of its business is subject to extensive state regulation."[230] The State, through a commission, gave the private company permission to end service to any customer upon reasonable notice of delinquent bill payments.[231] The *Jackson* Court held that the private company, although extensively regulated by the State of Pennsylvania, was not a state actor, and therefore its conduct could not be held in violation of the Due Process Clause of the Fourteenth Amendment.[232]

There is no doubt that the end-results of electric service withdrawal seem extremely trivial and minute when compared to those of life support withdrawal. This argument is an obvious one. *Jackson*, however, still positively demonstrates that the conduct and actions of health care providers will not fulfill the state action requirement that is necessary[233] to challenge the constitutionality of the Act before the Supreme Court.

Health and medical care industries are traditionally, and extensively, regulated by the states in which they operate.[234] Physicians and medical facilities alike must be licensed by the government of the state in which they practice.[235] In addition, Justice Blackmun stated in *Metropolitan Life Insurance Company v. Massachusetts*,[236] that health insurance is also "extensively regulated by the states."[237] According to Justice Rehnquist in *Jackson*, however, "[t]he mere fact that a business is subject to state regulation does not by itself convert its action into that of the State for purposes of the Fourteenth Amendment."[238] He also added that state action does not exist just because "the regulation is extensive and detailed."[239]

Hospitals and electric companies, although very different in most aspects, are

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226. *Id.* at 497 (quoting *Jackson v. Metro. Edison Co.*, 419 U.S. 345, 352 (1974)).
227. 419 U.S. 345; Chemerinsky, *supra* n. 198, at 497.
228. 419 U.S. at 346–48.
229. *Id.* at 348.
230. *Id.* at 350.
231. *Id.* at 346.
232. *Id.* at 358–59.
233. Chemerinsky, *supra* n. 198, at 492.
234. *E.g.* Tex. Health & Safety Code Ann. §§ 11.001–11.0055 (discussing the composition, requirements, and roles of the Texas Board of Health and the Texas Department of Health).
235. *E.g. id.* at § 243.003 (requiring someone who is opening a ambulatory surgical center to obtain a license from the State of Texas).
236. 471 U.S. 724 (1985).
237. *Id.* at 729.
238. 419 U.S. at 350.
239. *Id.*

comparable in that both "provide[ ] an essential public service required to be supplied on a reasonably continuous basis."[240] For this reason, the customer in *Jackson* contended that the utility company did perform a public function, and should therefore be considered a state actor.[241] Rehnquist rejected this argument, stating that "*[d]octors*, optometrists, lawyers, [and] [the utility company] . . . are all in regulated businesses, providing arguably essential goods and services, 'affected with a public interest.' We do not believe that such a status converts their every action . . . into that of the State."[242] Therefore, the fact that a hospital facility's or physician's activities are "subject to extensive state regulation"[243] (as they are in Texas[244]), and their services are necessary and beneficial to the community on a continuous basis, does not positively indicate that the Court will find that they necessarily fulfill the state actor requirement, which is mandatory for finding a constitutional violation.[245]

Finally, the *Jackson* Court rejected the customer's argument that the utility company's withdrawal of service is state action because the State had "specifically authorized and approved" the electricity termination.[246] The company's authorization to withdraw a customer's electric service came from a tariff provision filed with the state commission.[247] Although the State of Pennsylvania *authorized* the company to take action upon non-payment of bills, the company was not *required*, or even necessarily encouraged, to file a provision that allowed it to terminate service.[248] The Act[249] gives physicians and medical facilities *authorization* to end treatment,[250] despite language in an advance directive,[251] eliminating fear of legal liability.[252] The Act, however, does not *require* a medical provider to withdraw treatment if a patient's condition has been determined to be futile.[253] The Pennsylvania Public Utility Commission[254] did not say, "Electricity *must* be unilaterally withdrawn upon delinquent bill payments," just as Governor Bush and the 1999 Texas legislature did not say, "The treating physician or hospital *must* withdraw life-sustaining treatment if those health care measures no longer serve any legitimate medical purpose or achieve a health care goal."[255] The Act only

240. *Id.* at 352.

241. *Id.*

242. *Id.* at 354 (emphasis added) (brackets in original).

243. *Jackson*, 419 U.S. at 350.

244. *E.g.* Tex. Health & Safety Code Ann. §§ 11.001–11.0055 (discussing the composition, requirements, and roles of the Texas Board of Health and the Texas Department of Health).

245. Chemerinsky, *supra* n. 198, at 492.

246. *Jackson*, 419 U.S. at 354.

247. *Id.* at 354.

248. *Id.* at 355.

249. Tex. Health & Safety Code Ann. § 166.046.

250. *Id.* at § 166.046(e).

251. *Id.* at § 166.046(g).

252. Halevy & McGuire, *supra* n. 2, at 40.

253. Tex. Health & Safety Code Ann. § 166.046(e). "The physician and the health care facility are *not obligated* to provide life-sustaining treatment . . . ." *Id.* (emphasis added).

254. This commission was the governmental body that regulated the utility company in *Jackson*, and gave the company permission to withdraw electricity upon non-payment for service. 419 U.S. at 346.

255. The language of the Act states that the physician is "not obligated to provide life-sustaining treatment after the 10th day . . . ." Tex. Health & Safety Code Ann. § 166.046(e). Language indicating an *encouragement* or *requirement* to cease treatment, however, does not exist in the Act's text.

gives the guidelines to follow[256] if a physician and the treating health care facility conclude that further treatment has become useless, pointless, and unethical in the eyes of the medical profession.[257]

An argument that an individual can challenge the Act by asserting that the public function exception applies in a futility case would fail. Although medical and health care "is subject to a form of extensive regulation by the State in a way that most other business enterprises are not,"[258] the practice of medicine is not a role that has been traditionally and exclusively exercised or conducted by state governments.[259] Another method to overcome the state action doctrine, in which a constitutional challenger to the Act would have to try to use, would be the second exception, "entanglement."[260]

3. The Entaglement Exception Will Not Apply

Looking to the definition of "entanglement,"[261] it would seem that someone trying to bring a challenge to the Act before the Supreme Court would most likely use this particular exception to successfully get the case heard. Constitutional law scholar Erwin Chemerinsky defines the exception as finding state action "if the government affirmatively authorizes, encourages, or facilitates private conduct that violates the Constitution."[262] One might therefore assume that physicians' or medical facilities' actions in conjunction with the Act would qualify as state action under this exception. By analyzing the Court's cases[263] that address and lay the foundation for the exception, however, one would soon discover that health care providers still fail to meet or fulfill the criteria set forth in the doctrine, and the Act's constitutionality will remain a non-issue before the Court.

Shelley v. Kraemer[264] famously illustrates an area of the entanglement exception dealing with judicial and law enforcement actions.[265] The facts of *Shelley* differ substantially from those of a typical futility case, but an analysis of this well-known decision positively demonstrates the idea that court involvement and enforcement will create state action in the conduct of a private entity or individual.[266] This analysis will show that the Act, or actions taken by medical providers acting within the guidelines of the Act, will not satisfy the entanglement exception to the state action requirement.

256. *Id.*

257. Halevy & McGuire, *supra* n. 2, at 39.

258. *Jackson*, 419 U.S. at 358.

259. Chemerinsky, *supra* n. 198, at 498. Chemerinsky writes that traditional government functions that usually fit within this exception include any type of election, management of private property in a public manner, and the regulation of schools. *Id.* at 502–05.

260. *Id.* at 505.

261. Under entanglement, "the Constitution applies if the government affirmatively authorizes, encourages, or facilitates private conduct that violates the Constitution. Either the government must cease its involvement with the private actor or the private entity must comply with the Constitution." *Id.*

262. *Id.*

263. Chemerinsky, *supra* n. 198, at 505–17. Chemerinsky writes that the entanglement exception arises "primarily in four areas: judicial and law enforcement actions, government licensing and regulation, government subsidies, and voter initiatives permitting discrimination." *Id.* at 505.

264. 334 U.S. 1 (1948).

265. Chemerinsky, *supra* n. 198, at 506.

266. 334 U.S. 1.

Shelley dealt with a African American couple who moved into a Missouri neighborhood which was governed by a restrictive covenant.[267] The covenant prevented African Americans from owning property there.[268] A white family living in the same neighborhood petitioned to the Court, seeking enforcement of the covenant against the couple.[269] The Court stated that the restrictive covenant was a private agreement between private individuals (private conduct), and the Fourteenth Amendment "erects no shield against merely private conduct, however discriminatory or wrongful."[270] The Court did find, however, that enforcement of certain conduct by state court injunctions constitutes state action in violation of Fourteenth Amendment rights.[271]

Shelley illustrates the idea that when the courts enforce private conduct that causes some sort of deprivation under the Fourteenth Amendment, government action indeed exists.[272] The private agreement in *Shelley* became invalid upon enforcement by the court.[273] The Supreme Court has found court involvement as a basis for state action in other areas.[274] Peremptory challenges[275] and prejudgment attachments[276] are two such areas.[277]

Legal and medical literature often refers to the Act's required steps as laying out an "extrajudicial process."[278] Referring to something as "extrajudicial" indicates that it is outside of judicial proceedings or beyond the action or authority of the courts.[279] The AMA's 1999 futility report[280] expressed a desire to keep the courts uninvolved with the futility controversies that began to emerge over the last decade.[281] As Dr. Amir Halevy and Amy L. McGuire[282] stated,

> The statute explicitly limits the ability of the courts to intervene in such cases. The courts' only role is the ability to grant an extension of the ten-day waiting period if the court finds,

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267. *Id.* at 4–6.

268. *Id.*

269. *Id.* at 6.

270. *Id.* at 13. Chief Justice Vinson wrote "that the restrictive agreements standing alone cannot be regarded as a violation of any rights guaranteed to petitioners by the Fourteenth Amendment." Furthermore, "it would appear clear that there has been no action by the State and the provisions of the Amendment have not been violated." *Shelley*, 334 U.S. at 13. The court conceded that the formation of the restrictive covenant was indeed private conduct. *Id.*

271. *Id.* at 19–20. The Court found that "[t]he difference between judicial enforcement and nonenforcement of the restrictive covenants is the difference to [the African American couple] between being denied rights of property available to other members of the community and being accorded full enjoyment of those rights on an equal footing." *Id.*

272. *Id.* at 19–21.

273. *Shelley*, 334 U.S. at 21–23.

274. Chemerinsky, *supra* n. 198, at 508.

275. *Lugar v. Edmondson Oil Co.*, 457 U.S. 922 (1982).

276. *Batson v. Ky.*, 476 U.S. 79 (1986).

277. Chemerinsky, *supra* n. 198, at 508.

278. Fine et al, *supra* n. 59, at 1220; Fine & Mayo, *supra* n. 20, at 744; Halevy & McGuire, *supra* n. 2, at 39.

279. *Black's Law Dictionary* at 497.

280. Am. Med. Assn., *supra* n. 37, at 937.

281. The AMA stated, "Widely publicized court cases, such as those of *Wanglie* and *Gilgunn*, indicate that patients, families, physicians, and others would benefit if the medical system could handle these situations with less need for recourse to the courts." *Id.* at 938.

282. Dr. Halevy is an associate professor at Baylor College of Medicine. Halevy & McGuire, *supra* n. 2, at 38 n. a1. Amy McGuire is also an associate professor at Baylor College of Medicine, and she serves on the ethics committee for three Houston-area hospitals. *Id.* at 38 n. a2.

"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."[283]

In addition, there is no provision in the Act that allows any party in a futility case to challenge or appeal the ethics committee decision in any court.[284]

Since the Act keeps the state courts uninvolved with the actual and physical withdrawal of life-sustaining treatment,[285] the actions of the physicians and facilities in following the Act's guidelines will not fall into this area[286] of the entanglement exception. The only provision of the Act that mentions any sort of action from the judiciary deals with *extending*, not decreasing, the amount of time a futile patient is sustained on life support.[287] In Spiro Nikolouzos's case, the Texas district court did not order that Spiro be removed from treatment.[288] The judge sadly decided that since there was no "reasonable expectation" that another health care provider would be found, the Act prevented her from issuing an injunction against the hospital.[289] The actual decision to end care still rested in the hands of the doctors and ethics committee of St. Luke's Hospital.[290]

The Supreme Court, in *Lugar v. Edmonson Oil Company*,[291] created a widely used double prong test for dealing with the "judicial and law enforcement actions"[292] area of this entanglement exception.[293] In *Lugar*, the Court found that state action existed, under the entanglement exception, when a private creditor obtained a court-enforced writ of prejudgment attachment.[294] The Court stated that, "'[f]irst, the deprivation must be caused by the exercise of some right or privilege created by the state, or a rule of conduct imposed by the state, or by a person for whom the state is responsible . . . .'"[295] An individual challenging the Act would easily be able to prove or fulfill this first part of the famous *Lugar* test. The Act, implemented by the Texas state legislature,[296] clearly creates a privilege that allows doctors to cease treatment of patients whom they believe to be beyond recovery, even if an advance directive requests otherwise.[297]

The second prong of the test, however, would keep the Act's constitutionality a non-issue. The *Lugar* Court further stated that "the party charged with the deprivation must be a person who may be fairly said to be a state actor 'because he is a state official,

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283. *Id.* at 40 (quoting Tex. Health & Safety Code Ann. § 166.046(g)).

284. *Id.*

285. *Id.*

286. This area is described by Chemerinsky as finding state action when such action is enforced by a judicial or law enforcement entity. Chemerinsky, *supra* n. 198, at 506.

287. Tex. Health & Safety Code Ann. § 166.046(g) (emphasis added).

288. Ackerman, *supra* n. 156.

289. *Id.*

290. *Id.*

291. 457 U.S. 922.

292. Chemerinsky, *supra* n. 198, at 505.

293. *Id.* at 506-08.

294. *Id.* (discussing *Lugar*, 457 U.S. 922).

295. *Id.* (quoting *Lugar*, 457 U.S. at 937).

296. Mayo, *supra* n. 23, at 1108–12.

297. Tex. Health & Safety Code. Ann § 166.046.

because he has acted together with or has obtained significant aid from state officials, or because his conduct is otherwise chargeable to the state.'"[298] Physicians, again, are not state actors or officials.[299]

The Supreme Court has contemplated entanglement in circumstances where governmental licensing or regulation of an activity exists.[300] According to Chemerinsky, "government licensing or regulating is insufficient for a finding of state action, unless there is other government encouraging or facilitating."[301] Although the State of Texas sets out a procedure[302] for dealing with the complicated area of medical futility,[303] there is no encouraging on the part of the State to deny the treatment to patients.[304] The decision rests solely with the treating physicians.[305]

A final area of the entanglement exception deals with finding government action when a private entity receives government subsidies.[306] Most hospitals today are private entities,[307] but some hospitals do receive payment for their services through state government subsidies, like Medicaid.[308] Chemerinsky, however, writes that later decisions of the Court make it very unlikely that subsidies, even large ones, by themselves will cause a private entity to pass the state action requirement.[309] *Blum v. Yaretsky*[310] is one of these cases.[311]

In *Blum*, Medicaid patients alleged that they were deprived of procedural due process when their nursing home transferred them to another home, which "provid[ed] less extensive . . . medical care than the former."[312] The defendants in this case, however, were New York state officials who decreased government benefits to the patients in response to the lower level transfers.[313] The patients were not "challenging particular state regulations or procedures, and their arguments concede[d] that the decision to discharge or transfer a patient originates not with state officials, but with nursing homes that are privately owned and operated."[314] The Court found that state

298. Chemerinsky, *supra* n. 198, at 508 (quoting *Lugar*, 457 U.S. at 937).

299. *See Jackson*, 419 U.S. at 354 (asserting that physicians and optometrists are not state actors just because they offer necessary and vital services).

300. Chemerinsky, *supra* n. 198, at 510–13 (discussing *Burton v. Wilmington Parking Auth.*, 365 U.S. 715 (1961)).

301. *Id.* at 510.

302. Tex. Health & Safety Code Ann. § 166.046.

303. Fine & Mayo, *supra* n. 20, at 744.

304. The language of the Act states that the physician is "not obligated to provide life sustaining treatment after the 10th day . . . ." Tex. Health & Safety Code Ann. § 166.046(e). Language indicating an *encouragement* or *requirement* to cease treatment, however, does not exist in the Act's text.

305. *Id.*

306. Chemerinsky, *supra* n. 198, at 513.

307. Desai et al., *supra* n. 215, at 167.

308. *E.g.* Tex. Health & Human Servs. Commn., *Texas Medicaid Program*, http://www.hhsc.state.tx.us/medicaid/med_info.html (last updated Mar. 19, 2008).

309. Chemerinsky, *supra* n. 198, at 513.

310. 457 U.S. 991 (1982).

311. Chemerinsky, *supra* n. 198, at 514–15.

312. 457 U.S. at 994.

313. *Id.* at 995–96.

314. *Id.* at 1003.

action did not exist, and therefore there was no due process violation.[315]

Justice Rehnquist, in the *Blum* majority opinion, rejected the patients' argument that "state subsidization of the operating and capital costs"[316] of the nursing homes, as well as state licensing for the facilities, converted the medical decisions of the health care providers to those of the State.[317] He further wrote that "[t]he decisions about which [the patients] complain are made by physicians and nursing home administrators, all of whom are concededly private parties."[318] These decisions were made by a review committee, which consisted of doctors whose duties were to periodically determine whether each patient was receiving the appropriate amount of care, and therefore decided if a particular patient's continued residence at the facility was necessary.[319]

Several factual comparisons can be drawn between a typical futility case under the Act and *Blum*. Nursing homes are considered health care facilities,[320] just as hospitals treating severely ill patients are. *Blum* deals with patients objecting to the decreased level of health care and health benefits they are receiving,[321] while Wanda Hudson and Jannette Nikolouzos objected to the withdrawal of health care given to their loved ones, who were also patients.[322] Nursing homes, like other private entities in the health care industry, "are extensively regulated" by the state.[323] Similar to the provision of the Act requiring a hospital ethics committee to decide if further treatment of a futile patient is necessary,[324] in *Blum*, the government required a "utilization review committee" of doctors to decide if a patient's continued health care at the home is necessary and appropriate.[325]

The *Blum* Court found that the decisions made by the physicians and committees at the nursing home did not qualify as action by the state, and were thus not subject to a constitutional challenge.[326] Therefore, the Court would also find that no state action exists in the decisions of the physicians and ethics committees acting within the

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315. *Id.* at 1012. Justice Rehnquist wrote, "We conclude that respondents have failed to establish 'state action' in the nursing homes' decisions to discharge or transfer Medicaid patients to lower levels of care. Consequently, they have failed to prove that petitioners have violated rights secured by the Fourteenth Amendment." *Id.*

316. *Blum*, 457 U.S. at 1011.

317. *Id.*

318. *Id.* at 1005. Justice Rehnquist also echoed the theme in *Jackson*, asserting that "although it is apparent that nursing homes in New York are extensively regulated, '[t]he mere fact that a business is subject to state regulation does not by itself convert its action into that of the State for purposes of the Fourteenth Amendment.'" *Id.* at 1004 (quoting *Jackson*, 419 U.S. at 350).

319. *Id.* at 994–95. The Court stated, "There is no suggestion that those decisions were influenced in any degree by the State's obligation to adjust benefits in conformity with changes in the cost of medically necessary care." *Blum*, 457 U.S. at 1005.

320. Rehnquist stated, "Nursing homes chosen by Medicaid patients are directly reimbursed by the State for the reasonable cost of health care services." *Id.* at 994. Furthermore, the two types of nursing homes discussed in *Blum* were referred to as either "skilled nursing facilities" or "health related facilities." *Id.*

321. *Id.* at 995.

322. Wanda objected to withdrawal of life support from her baby, Sun. Casey, *supra* n. 13. Jannette objected to life withdrawal of her husband, Spiro. Ackerman, *supra* n. 156.

323. *Blum*, 457 U.S. at 1005; *Jackson*, 419 U.S. at 350.

324. Tex. Health & Safety Code Ann. § 166.046(a).

325. *Blum*, 457 U.S. at 994–95.

326. Rehnquist wrote, "We conclude that respondents have failed to establish 'state action' in the nursing homes' decisions to discharge or transfer Medicaid patients to lower levels of care." *Id.* at 1012.

guidelines of the Texas Act, and a constitutional challenge would still fail under this "subsidization"[327] area of the entanglement exception.

Physicians and medical facilities are clearly not state actors.[328] Furthermore, their actions in conjunction with the Act will not surpass the strict state action doctrine, via the public function exception or the entanglement exception.

C. *Futile Medical Treatment Is Not a Constitutionally Protected Right*

In order to show the State of Texas, through implementation of the Act, has violated the Due Process Clause, one must show that there has been a deprivation of "life, liberty, or property."[329] One argument is that the right to make medical decisions for one's self is a fundamental right, and is a constitutionally protected aspect of self-determination or patient autonomy.[330] Other writers, however, have asserted that patient autonomy is actually a negative right to refuse unwanted treatment, and this right cannot automatically establish a positive right to access of medical treatment.[331]

1. Lack of a Benefit

Physicians, because of their expertise and thorough education, are best able to determine when a patient is no longer benefiting from life-sustaining measures. A survey shows that ninety percent of patients feel that doctors are accurate decision-makers as to end-of-life care.[332] After a physician makes a judgment, an ethics committee further examines the futility determination.[333] Because a concrete, and agreed upon[334] definition for the term "futile" appears to be unattainable,[335] physicians should be the primary, if not sole, judges, and decide when continued treatment is unnecessary, unethical, and no longer serves any purpose. Their judgments and decisions should be recognized and respected as legitimate, thoughtful, and final. *Quinlan*,[336] a case that has been followed by numerous other American jurisdictions,[337] advocates this assertion, stating,

> Doctors . . . to treat a patient, must deal with medical tradition and past case histories. They must be guided by what they do know. The extent of their training, their experience, consultation with other physicians, must guide their decision-making processes in providing care to their patient. The nature, extent and duration of care by societal standards is the responsibility of a physician. The morality and conscience of our society places this responsibility in the hands of the physician. What justification is there to

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327. Chemerinsky, *supra* n. 198, at 513–15.
328. *Blum*, 457 U.S. at 1005; *Jackson*, 419 U.S. at 354.
329. U.S. Const. amend. XIV, § 1.
330. Kwiecinski, *supra* n. 39, at 342–43.
331. Shiner, *supra* n. 79, at 837–38.
332. Darren P. Mareiniss, *A Comparison of* Cruzan *and* Schiavo*: The Burden of Proof, Due Process, and Autonomy in the Persistent Vegetative Patient*, 26 J. Leg. Med. 233, 256, 258 (June 2005).
333. Tex. Health & Safety Code Ann. § 166.046(a).
334. Shiner, *supra* n. 79, at 826.
335. Am. Med. Assn., *supra* n. 37, at 938.
336. 355 A.2d 647.
337. Cantor, *supra* n. 54, at 183.

> remove it from the control of the medical profession and place it in the hands of the courts?[338]

Therefore, when a physician and a professional ethics committee follows the Act's procedures and concludes that the patient is beyond recovery and further medical care has become useless, withdrawal of treatment should *not* be considered a deprivation of an interest.

Chemerinsky discusses several cases that have illustrated and explained what it means to deprive an individual of "life, liberty, or property" interests.[339] Unlike medical treatment measures that no longer serve a health care purpose for a patient, all of the interests described in these landmark constitutional law cases *benefit* the individuals in some aspect.[340] For instance, in *Board of Regents v. Roth*,[341] Justice Stewart stated that property interests, in regards to due process, are created by "rules or understandings that secure certain benefits and that support claims of entitlement to those benefits."[342] This phrase has been interpreted to mean that an individual possesses a right to an interest if there is a "reasonable expectation to a continued receipt of a *benefit*."[343]

It cannot be reasonably expected that further life-sustaining treatment would have served any benefit to the unfortunate Sun Hudson.[344] *Thanatophoric dysplasia*[345] is rare and fatal.[346] Babies born with this horrible disease often die soon after birth.[347] As opposed to a benefit, keeping the child alive would actually have given him "a continued receipt"[348] of *suffering*.[349] Sun would have slowly suffocated to death as his body grew and his lungs became more and more restricted.[350] Even the trial judge at Wanda Hudson's injunction hearing stated that he was concerned over the child's ongoing pain.[351] Skilled physicians,[352] members of a competent ethics committee,[353] and forty other hospitals all agreed that there was no reasonable expectation that continued

338. *Quinlan*, 355 A.2d at 665 (quoting *In re Quinlan*, 348 A.2d 801, 818 (N.J. Super. Ch. Div. 1975)).

339. Chemerinsky, *supra* n. 198, at 534–55.

340. *Id.* Some of the liberty interests discussed include the right "to engage in any of the common occupations of life, to acquire useful knowledge, to marry, establish a home and bring up children, . . . and generally to enjoy those privileges long recognized . . . as essential to the orderly pursuit of happiness by free men." *Id.* at 542 (quoting *Bd. of Regents v. Roth*, 408 U.S. 564, 572 (1972)).

341. 408 U.S. 564 (holding that a professor had no protected interest in continued employment at a state university, and therefore, there could be no Fourteenth Amendment protection).

342. *Id.* at 577; Chemerinsky, *supra* n. 198, at 537.

343. Chemerinsky, *supra* n. 198, at 537 (emphasis added). Chemerinsky further states that the *Roth* Court "would find a property interest only if state law creates a reasonable expectation to receipt of a benefit, regardless of the importance of the interest." *Id.*

344. *Hudson*, 177 S.W.3d at 233.

345. Lightfoot, *supra* n. 5, at 852. This disease has been referred to as a "lethal genetic condition." *Id.* at 851.

346. *Id.* at 852.

347. Casey, *supra* n. 13.

348. Chemerinsky, *supra* n. 198, at 537.

349. Casey, *supra* n. 13. Sun's treating physicians "came to the conclusion . . . that keeping Sun on a ventilator would only delay his death, possibly painfully." *Id.*

350. *Id.*; Lightfoot, *supra* n. 5, at 852.

351. *Hudson*, 177 S.W.3d at 234.

352. *Id.* at 233.

353. *Id.* A "vast majority of ethics consultations at Texas Children's result in some form of compromise and resolution . . . ." Lightfoot, *supra* n. 5, at 851.

treatment would serve any beneficial interest to this ill-fated child.[354]

Perhaps the most famous futility-like case of recent years is that of Terri Schiavo.[355] Terri's condition was a "persistent vegetative state."[356] Nancy Beth, the patient in *Cruzan*, was in this same condition.[357] According to Dr. Darren P. Mareiniss,[358] "[Terri] and other patients in persistently vegetative states have no hope of recovery or improvement. Rather, their futures hold further physical deterioration, decubitus ulcers, and contractures."[359] Since keeping a person in a permanent vegetative state alive serves no medical purpose (because they will *never* recover[360]), one should not reasonably expect that continued forms of life-sustaining treatment create any sort of benefit to these unfortunate individuals. The parents of Nancy Beth Cruzan agreed to this assertion, and wished to have life support removed when it became obvious that she would never regain her "cognitive faculties."[361] Furthermore, the *Quinlan* court also agreed that if the physicians determined that there was "no reasonable possibility" that any benefit would ever be served, ongoing treatment should end.[362]

In the California case of *Barber v. Superior Court*,[363] two physicians were charged with murdering a severely comatose patient.[364] The patient suffered a heart episode in the recovery room after a surgery.[365] Several examinations proved that the man suffered brain damage that would leave him in a permanent vegetative state, and the physicians determined that he was beyond recovery.[366] The patient's family requested that he be removed from life-sustaining treatment.[367] He died shortly thereafter.[368] Euthanasia was illegal in California.[369]

The *Barber* court found the physicians' withdrawal of treatment as an omission, instead of an affirmative act, and therefore the physicians would have to have had a legal duty to continue treating the patient in order to have committed murder against him.[370] The court's main issue became "one of determining the duties owed by a physician to a patient who has been reliably diagnosed as in a comatose state from which any meaningful recovery of cognitive brain function is exceedingly unlikely."[371] The *Barber* court acknowledged that continued life-sustaining treatment does not always serve a

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354. Hopper & Ackerman, *supra* n. 13.
355. *Schiavo ex rel. Schindler v. Schiavo*, 357 F. Supp. 2d 1378 (M.D. Fla. 2005).
356. Mareiniss, *supra* n. 332, at 240.
357. *Cruzan*, 497 U.S. at 266.
358. Dr. Mareiniss received his medical degree from New York University School of Medicine. Mareiniss, *supra* n. 332, at 233 n. a1.
359. *Id.* at 252.
360. *Id.*
361. *Cruzan*, 497 U.S. at 265.
362. 355 A.2d at 671–72.
363. 147 Cal. App. 3d 1006 (Cal. App. 2d Dist. 1983).
364. *Id.* at 1010.
365. *Id.*
366. *Id.*
367. *Id.*
368. *Barber*, 147 Cal. App. 3d at 1011.
369. *Id.* at 1012.
370. *Id.* at 1017.
371. *Id.*

benefit,[372] and furthermore stated,

> A physician has no duty to continue treatment, once it has proved to be ineffective. Although there may be a duty to provide life-sustaining machinery in the *immediate* aftermath of a cardio-respiratory arrest, there is no duty to continue its use once it has become futile in the opinion of qualified medical personnel.[373]

Barber is a state court case, like *Quinlan*, but it still nevertheless advocates the assertion that when a skilled medical provider concludes that treatment is no longer creating a benefit to a patient beyond recovery, there is no legal duty to continue.[374] Because a duty to give medical care no longer exists after a patient is no longer benefiting from it in any way, it should be argued that the patient is no longer *entitled* to receive that care.

2. Positive Right vs. Negative Right

Cruzan established the right to *refuse* unwanted medical treatment as an interest protected under the Fourteenth Amendment.[375] This liberty interest has been referred to as a constitutionally protected "negative right."[376] Futility issues, conversely, deal with patients or family members *demanding* treatment.[377] Currently, there is no constitutionally protected "positive right" that entitles an individual to medical care or treatment.[378]

An analysis of *DeShaney v. Winnebago County Department of Social Services*[379] can demonstrate that a state is not required to give demanded health care, even though such measures can be vital in preserving the constitutionally protected interest of "life."[380] Joshua DeShaney, the petitioner, was admitted to a Wisconsin emergency room three different times with injuries that gave clear indications that he was being abused by his father, with whom he lived.[381] Each time the child was hospitalized, the physicians notified the Department of Social Services (DSS) of possible child abuse.[382] The father's ex-wife also advised the DSS that the father violently hit the child.[383] The DSS, however, took no action to remove the boy from his father's custody, even though a caseworker who visited the home monthly was suspicious of abuse.[384] Joshua was eventually beaten so severely that he suffered serious brain damage that left him in a coma.[385]

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372. *Id.* at 1016.
373. *Barber*, 147 Cal. App. 3d at 1017–18.
374. *Id.*
375. *Cruzan*, 497 U.S. at 278.
376. Mareiniss, *supra* n. 332, at 258–59; Shiner, *supra* n. 79, at 837–38.
377. Fine & Mayo, *supra* n. 20, at 744.
378. Mareiniss, *supra* n. 332, at 59; *see* Shiner, *supra* n. 79, at 837–38.
379. 489 U.S. 189 (1989).
380. U.S. Const. amend. XIV, § 1.
381. *DeShaney*, 489 U.S. at 192–93.
382. *Id.* at 192.
383. *Id.*
384. *Id.* at 192–93.
385. *Id.* at 193.

Joshua, through his mother, brought action against the State and employees thereof, alleging violation of the child's rights under the Due Process Clause.[386] The boy's mother argued that "by failing to intervene to protect him against a risk of violence at his father's hands of which they knew or should have known,"[387] the DSS deprived the child's liberty interest.[388]

One could certainly argue that the State should not have stood by while this child was being hurt.[389] Justice Rehnquist, however, stated that the Court's past decisions "have recognized that the Due Process Clauses generally confer no affirmative right to governmental aid, even where such aid may be necessary to secure *life*, liberty, or property interests of which the government itself may not deprive the individual."[390]

After analyzing *DeShaney*, it is apparent that an individual has no "affirmative right" to receive certain aid, like medical care, from the State.[391] The State may not deprive a person of life,[392] yet in a futility case, the ending of treatment by doctors ultimately ends the patient's life.[393] Applying the *DeShaney* rationale, however, indicates that although the futile patient will die shortly after withdrawal of care, the State will not be in violation of the Fourteenth Amendment.[394] The Court has ruled before that the government has an obligation to give medical care, but this ruling dealt with incarcerated patients who had no choice but to rely on the government for aid and health assistance.[395]

Individuals do enjoy a protected right to refuse unwanted medical treatment.[396] A withdrawal, withholding, or denial of treatment from a futile patient who is beyond any recovery, however, is not a deprivation of a constitutionally protected interest or right.[397] Aside from the fact that an analysis of case law demonstrates that there is no constitutionally protected right of entitlement to medical care from the State,[398] ongoing health treatment of a futile patient serves no continued benefit like other protected interests do.[399] Therefore, the Act's provisions[400] should not be held in violation of due process.

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386. *DeShaney*, 489 U.S. at 193.

387. *Id.*

388. *Id.*

389. *Id.* at 203. Rehnquist wrote, "The people of Wisconsin may well prefer a system of liability which would place upon the State and its officials the responsibility for failure to act in situations such as the present one." *Id.*

390. *DeShaney*, 489 U.S. at 196 (emphasis added).

391. *Id.*

392. U.S. Const. amend. XIV, § 1.

393. Kwiecinski, *supra* n. 39, at 346–47.

394. *DeShaney*, 489 U.S. at 196.

395. *Estelle*, 429 U.S. at 103.

396. *Cruzan*, 497 U.S. at 278.

397. Mareiniss, *supra* n. 332, at 258–59. Mareiniss writes that a futility procedure such as the Act "would provide for much needed expertise and objectivity in deciding end-of-life care." *Id.* at 259.

398. *See e.g. DeShaney*, 489 U.S. 189.

399. Chemerinsky, *supra* n. 198, at 534–55 (discussing the Court's cases that have defined constitutionally protected interests).

400. Tex. Health & Safety Code Ann. § 166.046.

IV. CONCLUSION

No mother ever wants to experience the horrible pain and anguish that Wanda Hudson faced.[401] Most mothers will never face it. Wanda, as well as the families of other futile patients, like the Nikolouzoses, the Clarks, the Schindlers,[402] and the parents of "Baby K,"[403] deserve heart-felt sympathy. Medical futility cases are truly tragic, and there will never be an easy way to address them.

There comes an unfortunate time, however, when further life-prolonging measures are serving no legitimate health care goal.[404] At that moment, the parties involved in these scenarios, like the physicians and family members, can disagree over "values or goals."[405] Families will ask the physicians to do everything they can,[406] while the health care providers believe that further treatment is inappropriate,[407] unethical,[408] non-beneficial,[409] or believe a "goal of comfort care,"[410] or palliative care,[411] is all that is left to be done before an inevitable death.[412] The American Medical Association writes, "Some interventions must eventually be stopped."[413]

To add to the difficulty surrounding futility dilemmas, an objective definition of "futile" appears to be impossible to achieve.[414] With today's medical technology, two disagreeing parties could legitimately argue over if death is certain.[415] The decisions of *Wanglie*, *Gilgunn*, *Jane Doe*, and *Baby K* failed to produce clarity as to which party should make these end-of-life decisions,[416] and prompted the AMA to suggest an extrajudicial process for dealing with medical futility.[417] The Texas Advance Directives Act[418] is such a process.[419]

The Act sets out procedural guidelines, which must be scrupulously followed, to guarantee that the rights of patients and families are considered during futile treatment disagreements.[420] Although it has been alleged that the Act violates the Fourteenth

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401. Hopper & Ackerman, *supra* n. 13.

402. *See Schiavo*, 357 F. Supp. 2d. 1378. The Schindlers were Terri Schiavo's parents. *Id.* at 1382.

403. *See Baby K.*, 16 F.3d 590. "Baby K" was an anencephalic infant. *Id.* at 592.

404. Am. Med. Assn., *supra* n. 37, at 937.

405. *Id.*

406. Fine & Mayo, *supra* n. 20, at 744. "A 'medical futility' conflict is a situation in which the physician is asked to 'do everything' but feels that withdrawal of treatment is most appropriate; a 'right to die' conflict is a situation in which the physician is asked to stop all treatment but feels that it should be maintained." *Id.*

407. *Id.*

408. *Id.*

409. Halevy & McGuire, *supra* n. 2, at 39.

410. Am. Med. Assn., *supra* n. 37, at 937.

411. Palliative care is "effective pain relief [that] is increasingly viewed as an integral part of medical responsibility to patients." Cantor, *supra* n. 54, at 186.

412. Am. Med. Assn., *supra* n. 37, at 937.

413. *Id.* at 938.

414. *Id.*

415. Fine & Mayo, *supra* n. 20, at 743.

416. Boozang, *supra* n. 69, at 584–91.

417. Am. Med. Assn., *supra* n. 37, at 938.

418. Tex. Health & Safety Code Ann. § 166.046.

419. Fine & Mayo, *supra* n. 20, at 743.

420. Pfeifer & Kennedy, *supra* n. 3, at 25.

Amendment,[421] a constitutional challenge would ultimately fail for a lack of state action[422] and a lack of a deprivation of a protected interest.[423]

State action does not exist because the withdrawal of treatment is by health care providers, who are private individuals.[424] *Jackson*, a landmark state action case, demonstrates that the actions of physicians and hospitals do not fall into the public function exception, because their actions are not those "traditionally exclusively reserved to" the State of Texas. *Shelley* demonstrates that because the Act limits judicial action as to the withdrawal of treatment,[425] the conduct of doctors will not fall into the entanglement exception to state action. An analysis of *Blum* and the *Lugar* test also show that the Act's constitutionality will not be scrutinized via the entanglement exception.

A constitutional challenge to the Act would also fail because a constitutionally protected interest is not at stake. Because futile medical care does not serve any beneficial purpose to a patient, the Court should not view the withdrawal as a deprivation. Physicians, because of their "expertise and objectivity,"[426] should be the sole decision-makers when determining if any reasonable benefit is continually being served.[427] Furthermore, although discontinuing life-sustaining treatment ends life, which *is* an interest protected by the Constitution,[428] there currently exists no positive right to receive medical care.[429] An analysis of *Roth* supports this assertion.

Because the constitutionality of the Act, and the fear of a challenge, should not be an issue of concern, other jurisdictions in the United States should consider codifying a procedure similar to the one in Texas. These codifications could aid other states in handling an ambiguous "I know it when a see it" definition,[430] which can be expected to arise when dealing with the difficult obstacles of medical futility in America.

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421. Kwiecinski, *supra* n. 39, at 342.
422. Chemerinsky, *supra* n. 198, at 491.
423. *Id.* at 534.
424. Tex. Health & Safety Code Ann. § 166.046(e); Kwiecinski, *supra* n. 39, at 347 n. 174.
425. Halevy & McGuire, *supra* n. 2, at 40.
426. Mareiniss, *supra* n. 332, at 259.
427. *Barber*, 195 Cal. App. 3d at 1020; *Quinlan*, 355 A.2d at 656.
428. U.S. Const. amend. XIV, § 1.
429. Mareiniss, *supra* n. 332, at 259.
430. Halevy & McGuire, *supra* n. 2, at 39; Kwiecinski, *supra* n. 39, at 325.

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