

TEXAS ADVANCE DIRECTIVES ACT: NEARLY A MODEL DISPUTE RESOLUTION MECHANISM FOR INTRACTABLE MEDICAL FUTILITY CONFLICTS

THADDEUS MASON POPE*

Increasingly, clinicians and commentators have been calling for the establishment of special adjudicatory dispute resolution mechanisms to resolve intractable medical futility disputes. As a leading model to follow, policymakers both around the United States and around the world have been looking to the conflict resolution provisions in the 1999 Texas Advance Directives Act ('TADA'). In this article, I provide a complete and thorough review of the purpose, history, and operation of TADA. I conclude that TADA is a commendable attempt to balance the competing goals of efficiency and fairness in the resolution of these time-sensitive life-and-death conflicts. But TADA is too lopsided. It is far more efficient than it is fair. TADA should be amended to better comport with fundamental notions of procedural due process.

I INTRODUCTION

Conflicts over the appropriateness of continuing life-sustaining medical treatment ('LSMT') at the end of life are disturbingly common.¹ Dominant among these conflicts are 'medical futility disputes.' In this type of end of life treatment conflict, intensive care unit clinicians determine that it is medically and ethically appropriate to stop LSMT and focus on comfort measures only. But the patient's surrogate decision maker will not consent to that treatment plan. Because LSMT can (or might be able to) sustain at least the patient's biological life, the surrogate wants it continued.

Fortunately, most of these medical futility disputes can be resolved through informal consensus-building approaches.² Eventually, with intensive communication, negotiation, and mediation; the parties reach agreement. Nevertheless, a significant and growing number of these medical futility conflicts remain intractable.³

Few jurisdictions in the world have developed an adequate mechanism to handle this expanding

* BA (University of Pittsburgh), JD (Georgetown University Law Center), PhD (Georgetown University), Director, Health Law Institute, Mitchell Hamline School of Law; Adjunct Professor, Australian Centre for Health Law Research, Queensland University of Technology (QUT); Adjunct Associate Professor, Albany Medical College. For valuable feedback, I thank Tom Mayo; QUT reviewers; and participants at the Loyola-DePaul Chicago Health Law Colloquium (Mar 2015), the Quinnipiac-Yale Dispute Resolution Workshop (Feb 2015), and an NYU Langone Medical Center public lecture (Feb 2015).

¹ See below Part II C.

² See below Part II D - II E.

³ See below Part III A.

subset of stalemate cases. But the few that have designed and implemented such mechanisms seem to enjoy some measure of success.⁴ Accordingly, many clinicians and commentators elsewhere are calling for the establishment of similar special adjudicatory dispute resolution mechanisms.⁵

The paradigm adjudicatory dispute resolution mechanism is a court of law. But almost nobody thinks that is an appropriate model for this type of conflict.⁶ First, litigation is cumbersome, being both time-consuming and expensive. Thus, it cannot usefully address complex, urgent medical issues. Moreover, because courts are adversarial and open to the public, they are an unwelcome forum in which to resolve sensitive medical treatment disputes worthy of privacy.

In contrast, the dispute resolution mechanism in the *Texas Advance Directives Act* ('TADA') is tailor designed for medical futility disputes. It has been in operation for over sixteen years. And policymakers both around the United States and around the world have been looking to TADA as a model to follow.⁷

Because TADA is so frequently held up as a model to follow, it merits a careful and thorough examination. The purpose of this article is to critically evaluate TADA and answer three questions. 1) How do TADA's dispute resolution provisions work? 2) Should other jurisdictions adopt them? 3) What changes are required to make TADA's dispute resolution provisions sufficiently fair?

I will proceed in seven stages. In Part II, I provide a brief background on medical futility conflicts. I describe their nature and prevalence. I explain how they can usually be prevented and resolved informally. But, as the growing attention on TADA indicates, medical futility disputes cannot always be prevented or resolved informally. In a significant subset of cases the parties can find no common ground. So, there are, and will continue to be, intractable medical futility disputes.

In Part III, I review the need and demand for dispute resolution mechanisms for these remaining stalemate cases. The status quo is for clinicians to cave-in to surrogate demands for LSMT, even when they think that the administration of such interventions is medically and ethically inappropriate, or even cruel. Clinicians are legally risk averse and reluctant to cause a patient's death without consent. But many clinicians are unhappy with this status quo. Both individual clinicians and hospitals are eager to implement adjudicatory mechanisms to resolve these cases. They see TADA as a leading model.

In Part IV, I turn from explaining the context and motivation for TADA to an examination of the statute itself. First, I provide a brief history of TADA. Second, I summarise TADA's dispute resolution provisions. I walk the reader, step-by-step, through the operation of all six stages of the dispute resolution process. Then, in Part V, I turn from the statutory text to examine TADA in operation on the ground. I describe how Texas hospitals have used TADA over the past sixteen years.

⁴ See, eg Mark Handelman and Bob Parke, 'The Beneficial Role of a Judicial Process When "Everything" Is Too Much?' (2008) 11(4) *Healthcare Quarterly* 46.

⁵ See below Part III B.

⁶ See generally, Alan Meisel, Kathy Cerminara and Thaddeus Pope, *The Right to Die: The Law of End-of-Life Decisionmaking* (Aspen Publishers, 3rd ed, 2004) section 3.26.

⁷ See below Part III C.

In Part VI, I turn from a descriptive approach to a normative approach. While *TADA* is extremely controversial, I argue neither for nor against the core idea that healthcare providers may withhold or withdraw LSMT without patient or surrogate consent. In other words, I am not evaluating ‘whether’ clinicians should be able to stop LSMT without consent. Instead, I am evaluating ‘how’ the law authorises them to do that.

Specifically, I evaluate how well *TADA* comports with notions of procedural due process, the ‘oldest of our civil rights.’⁸ This is not a constitutional analysis but rather a use of constitutional principles to evaluate fundamental fairness. The requirements of procedural due process under the Fifth and Fourteenth Amendments to the US Constitution embody ‘tenets of fundamental fairness.’ Accordingly, they provide a useful ‘template to help measure’ the propriety and fairness of *TADA*’s dispute resolution procedures.⁹

Finally, in Part VII, I conclude that *TADA* is not now sufficiently fair. But state legislatures could easily remedy these defects with modest amendments that have already garnered widespread support among relevant stakeholders.

II BACKGROUND: MEDICAL FUTILITY DISPUTES

To appreciate the motivation for, and purpose of, *TADA*’s dispute resolution provisions, it is first necessary to understand the nature of medical futility disputes. Accordingly, in this section I explain: 1) what is a medical futility dispute; 2) that they are common; and 3) that they can often be prevented. Furthermore 4) even when they cannot be prevented, medical futility disputes can almost always be informally resolved. *TADA* is designed to address the small, yet significant, subset of cases that remain intractable to communication, negotiation, and mediation.

A *What Is a Medical Futility Dispute?*

A medical futility dispute is one in which the parties disagree over whether a current or proposed medical intervention is beneficial.¹⁰ The paradigmatic medical futility dispute is one in which the patient’s substitute decision maker (surrogate) requests aggressive treatment interventions for an imminently dying or catastrophically chronically ill patient. However, that patient’s health care providers consider such treatment to be medically or ethically inappropriate.

Medical futility disputes can concern any type of medical intervention. But most of the relevant legislative and judicial activity, as well as most of the academic commentary, involve disputes over LSMT. There are three distinctive features of such disputes.

First, disputes over LSMT involve life-and-death stakes. They usually concern patients in a hospital ICU. LSMT utilises mechanical or other artificial means to sustain, restore, or supplant an individual’s spontaneous vital function. LSMT procedures include: assisted ventilation, renal

⁸ Edward L Rubin, ‘Due Process and the Administrative State’ (1984) 72 *California Law Review* 1044, 1044.

⁹ Thomas J Balch, ‘Are There Checks and Balances on Terminating the Lives of Children with Disabilities? Should There be?’ (2009) 25 *Georgia State University Law Review* 959, 963.

¹⁰ Thaddeus M Pope, ‘Dispute Resolution Mechanisms for Intractable Medical Futility Disputes’ (2014) 58 *New York Law School Law Review* 347, 351.

dialysis, cardiopulmonary resuscitation ('CPR'), antibiotics, chemotherapy, and artificial nutrition and hydration.¹¹ Typically, withholding or withdrawing LSMT will result in the patient's death.

Second, ICU patients dependent on LSMT almost never have decision making capacity. They lack the 'ability to understand the significant benefits, risks, and alternatives to proposed health care and to make and communicate a health care decision.'¹² They cannot direct their own medical treatment. Consequently, medical treatment decisions for ICU patients must be made by a substitute decision maker or surrogate.¹³

Third, the typical futility dispute is between the attending physician and the surrogate. The clinician says 'stop,' but the surrogate says 'go.' The clinician thinks that LSMT is no longer medically indicated and that the appropriate treatment plan is for comfort measures only. The surrogate, on the other hand, rejects this proposed treatment plan, and directs the clinician to continue LSMT.¹⁴

B *The Move from Definitions to Process*

Since the late 1980s, writers and policymakers have articulated four main definitions of 'medical futility.' Two are narrowly circumscribed and defined by objective clinical criteria: 1) physiological futility and 2) medical ineffectiveness. Two other positions also purport to 'appear' neutral and scientific like the first two: 3) quantitative futility and 4) qualitative futility. But they actually include value-laden criteria.¹⁵

Finding consensus on these two definitions proved problematic and elusive. Lawyers, bioethicists, health care providers, and policymakers have had enormous difficulty defining treatment that is 'futile' or 'medically inappropriate.' Years of debate have failed to produce any consensus.

So, by the mid-1990s, many institutions, professional associations, and commentators abandoned a definitional approach. They abandoned delineating clinical indications that would 'define' medical futility. Instead, paraphrasing Justice Potter Stewart's comment on pornography, many concluded that we can only 'know it' when we 'see it.'¹⁶ They instead espoused a procedural, process-based approach.¹⁷

A recent policy statement from five leading critical care medical associations reconfirms this procedural approach.¹⁸ First, the policy statement recognises that medical futility conflicts involve

¹¹ See, eg Texas Health & Safety Code § 166.002(10).

¹² Pope, above n 10.

¹³ Ibid.

¹⁴ Ibid.

¹⁵ Thaddeus M Pope, 'Medical Futility Statutes: No Safe Harbor to Unilaterally Stop Life-Sustaining Treatment' (2007) 75 *Tennessee Law Review* 1.

¹⁶ *Jacobellis v Ohio*, 378 US 184 (1964).

¹⁷ Thaddeus M Pope and Douglas B White, 'Medical Futility and Potentially Inappropriate Treatment', in Stuart Younger and Robert Arnold (eds), *Oxford Handbook on Death and Dying* (Oxford University Press, published online Sept 2015).

¹⁸ Gabriel T Bosslet et al, 'An Official ATS/AACN/ACCP/ESICM/SCCM Policy Statement: Responding to Requests for Potentially Inappropriate Treatments in Intensive Care Units' (2015) 191(11) *American Journal of Respiratory and Critical Care Medicine* 1318.

‘contested value judgments about what is appropriate treatment.’¹⁹ So, it would be problematic to give all decision-making authority either to surrogates or to individual clinicians.

Second, the statement maintains that a process-based approach can incorporate multiple perspectives to minimise the risk that the values of any one individual will carry undue weight. Third, it concludes that a process-based approach better fulfills democratic ideals for resolving conflicts involving fundamental interests. Fourth, the policy statement predicts that a process-based approach may allow mutually agreeable solutions to emerge as the conflict-resolution process unfolds over time.

In short, the multi-society policy statement agrees with *TADA* that a procedural, and not a definitional, approach is appropriate. But the policy statement specifically rejects the particular procedural approach in *TADA* as insufficiently compatible with fundamental fairness. A core objective of this article is to more fully explain why.

C Medical Futility Disputes Are Common

Conflicts over LSMT in the ICU are common.²⁰ Indeed, they have recently been characterised as reaching ‘epidemic proportions.’²¹ A large portion of these end of life treatment conflicts are medical futility disputes.²²

The problem has been well measured and documented in several different ways. One is from the perspective of ethics consultation services. For example, several leading US medical centres have reported that medical futility disputes comprise a significant percentage of their annual ethics consults: 13 per cent at Memorial Sloan Kettering;²³ 33 per cent at the University of Michigan Health System;²⁴ and 50 per cent at Stanford’s Lucile Packard Children’s Hospital.²⁵ The Mayo Clinic has reported similar percentages.²⁶

The frequency of medical futility conflicts is equally high when measured from the perspective of ICU clinicians. Several recent surveys of critical care specialists demonstrate significant levels of conflict over LSMT. For example, a widely-discussed 2014 study from UCLA found that 20 per cent of the medical interventions in five of its ICUs were either futile or probably futile.²⁷

¹⁹ *Ibid* 1320.

²⁰ See, eg Terrah J Paul Olson et al, ‘Surgeon Reported Conflict with Intensivists about Postoperative Goals of Care’ (2013) 148 *JAMA Surgery* 29, 29.

²¹ AC Long and J Randall Curtis, ‘The Epidemic of Physician-Family Conflict in the ICU and What We Should Do about It’ (2014) 42(2) *Critical Care Medicine* 461.

²² James Downar et al, ‘Non-Beneficial Treatment Canada: Definitions, Causes, and Potential Solutions from the Perspective of Healthcare Practitioners’ (2015) 43(2) *Critical Care Medicine* 270.

²³ Andrew G Shuman et al, ‘Clinical Ethics Consultation in Oncology’ (2013) 9(5) *Journal of Oncology Practice* 240.

²⁴ Lauren B Smith and Andrew Barnosky, ‘Web-Based Clinical Ethics Consultation: a Model for Hospital-Based Practice’ (2011) 37(6) *Physician Executive Journal* 62.

²⁵ David Magnus, ‘Organizational Needs Versus Ethics Committee Practice’ (2009) 9(4) *American Journal of Bioethics* 1.

²⁶ Keith M Swetz et al, ‘Report of 255 Clinical Ethics Consultations and Review of the Literature’ (2007) 82 *Mayo Clinic Proceedings* 686, 689-90.

²⁷ Thanh N Huynh et al, ‘The Frequency and Cost of Treatment Perceived to be Futile in Critical Care’ (2013) 173(20) *JAMA Internal Medicine* 1887.

Furthermore, not only is the volume of futility disputes already high but it is also likely to rise even further. There are three main reasons for this. First, the number of patients who are the subject of futility disputes will increase with continued growth: 1) in the ageing population, 2) in the burden of chronic illness, and 3) in the technology used to support vital organ function.²⁸

Second, not only is the number of patients growing but also the rate of conflict is increasing. Physicians are increasingly more likely to recommend comfort measures only, instead of continuing aggressive, curative treatment. This is the result of shifts both in training and in reimbursement incentives.²⁹

Third, at the same time that physicians are increasingly recommending comfort measures only, surrogates are increasingly likely to resist those recommendations. Largely for cultural, religious, and ethnic reasons, a growing proportion of Americans say that doctors should ‘do everything possible to keep patients alive.’³⁰

D Many Futility Disputes Can Be Prevented

It is better to prevent futility disputes from arising in the first place than to work at resolving them after they have already arisen. In fact, prevention is not terribly complicated or difficult. Most patients do not even want aggressive treatment at the end of life.³¹ Suppose that these patients still had capacity and could make their own treatment decisions. They and their clinicians would generally agree on the appropriate treatment plan. There would be no conflict.³²

But the patients who are the subjects of futility disputes almost always lack decision making capacity and cannot make their own treatment decisions. In such circumstances, they are presumed to want LSMT unless they have adequately rebutted that presumption. Unfortunately, most patients have not ‘opted out’ of pro-life default rules. As a result, they receive treatment that they would not have wanted and that their clinicians do not want to administer.

Fortunately, rapidly expanding initiatives are helping patients to better understand their options and to better document their treatment preferences.³³ In short, most patients do not want continued LSMT when they are chronically critically ill. If these patients had adequately documented their treatment preferences, most futility disputes could be avoided.

E Almost All Futility Disputes Can Be Informally Resolved

While prevention is a first choice approach, it is not always successful. If prevention has failed and conflict arises, informal and internal dispute resolution mechanisms available within the

²⁸ Downar et al, above n 22.

²⁹ See Thaddeus M Pope, ‘Medical Futility Statutes: No Safe Harbor to Unilaterally Stop Life-Sustaining Treatment’ (2007) 75 *Tennessee Law Review* 1, 10-19.

³⁰ Pew Research Center, *Views on End-of-Life Medical Treatments* (21 November 2013) <<http://www.pewforum.org/2013/11/21/views-on-end-of-life-medical-treatments/>>.

³¹ *Ibid*.

³² Pope, above n 10, 353.

³³ *Ibid* 353-55.

hospital work almost all of the time.³⁴ Through further communication and mediation, consensus is reached in over 95 per cent of medical futility cases.³⁵

If the treatment team is not getting anywhere with the surrogate, it can invite the intervention of ethics consultants, social workers, chaplains, palliative care clinicians, the ethics committee, external second opinions, and other experts. These other hospital resources are quite effective at achieving consensus.³⁶ Indeed, only around five per cent of disputes remain intractable.

Clinicians do not want to act contrary to their professional judgment. Nor do they want to act without patient or surrogate consent. In a medical futility dispute, these two objectives come into conflict. But they are not irreconcilable or mutually exclusive. Consistent with both of these objectives, there are three ways to reach consensus in a futility dispute.

First, as discussed above, the clinician might eventually get consent from the surrogate. With intensive communication and mediation, the physician and surrogate might find some common ground.

Second, consensus might be reached by ‘replacing’ the objecting clinician with a substitute. Sometimes, the treating clinician can find a new health care provider willing to provide the treatment that the surrogate wants.³⁷ While the current health care provider may be unwilling to administer the surrogate-requested treatment, it is sometimes possible to transfer the patient to another physician or facility that is willing to provide the disputed treatment.

Third, if neither of these solutions is possible, the clinician is often able to replace the current surrogate with a new surrogate who will consent to the recommended treatment plan. This is the mirror image of the second path to consensus. Instead of transferring the patient to a new health care provider who agrees with the surrogate, the clinician replaces the current surrogate with a new surrogate who agrees with the clinician.³⁸

But while an effective mechanism for many disputes, surrogate selection cannot resolve some significant categories of conflict. In many cases it will be difficult for providers to demonstrate that surrogates are being unfaithful to patient instructions or preferences. Since too few individuals engage in adequate advance care planning, applicable instructions and other evidence regarding patient preferences are rarely available. Therefore, it is often impossible to demonstrate surrogate deviation. Other times, the available evidence shows that the surrogate is acting faithfully and making decisions consistent with the patient’s instructions, preferences, and values.³⁹

In short, most futility disputes can be resolved through reaching consensus in one of three ways: 1) clinicians obtain consent from the current surrogate, 2) clinicians obtain consent from a new

³⁴ Downar, above n 22.

³⁵ Pope, above n 10, 355-56.

³⁶ Lance Lightfoot, ‘Incompetent Decisionmakers and Withdrawal of Life-Sustaining Treatment: A Case Study’ (2005) 33 *Journal of Law Medicine and Ethics* 851, 851.

³⁷ See below section IV C 5.

³⁸ Pope, above n 10, 356-59; Thaddeus M Pope, ‘Surrogate Selection: An Increasingly Viable, but Limited, Solution to Intractable Futility Disputes’ (2010) 3 *St Louis University Journal of Health Law and Policy* 183.

³⁹ See, eg *Cuthbertson v Rasouli*, 2013 SCC 53.

surrogate, or 3) the clinicians and surrogate find another clinician or facility willing to provide the requested treatment.

But some conflicts are not amenable to any of these solutions. '[E]ven impeccable communication and relational skills may not resolve conflicts that arise from fundamental difference in values between families and clinicians.'⁴⁰ In these intractable disputes, the clinician and surrogate are 'stuck' with each other.

III TADA IS VIEWED AS A MODEL DISPUTE RESOLUTION MECHANISM

Unable to obtain the surrogate's consent to the proposed treatment plan, most clinicians 'cave-in' to surrogate demands. Physicians in most US jurisdictions are afraid to refuse surrogate requested treatment that they deem inappropriate or even cruel.⁴¹

In contrast, *TADA* has proven effective at allowing (or empowering) physicians to avoid providing medical treatment that they judge medically or ethically inappropriate. Accordingly, other jurisdictions have been looking to *TADA* as a model to follow.

A Clinicians Want Safe Harbor Legal Immunity

Medical facilities across the United States have developed policies for dealing with medical futility. Indeed, among other professional medical organisations, the American Medical Association ('AMA') recommended a process-based approach. The AMA process includes seven steps: four aimed at 'deliberation and resolution,' two aimed at securing alternatives in cases of 'irresolvable differences,' and a final step aimed at closure when all alternatives have been exhausted. But with respect to this final step, the AMA correctly noted that 'the legal ramifications of this course of action are uncertain.'⁴²

This uncertainty is 'chilling' and deters clinicians from proceeding without surrogate consent.⁴³ 'Immunity... is critical in the view of most, if not all, practicing physicians.'⁴⁴ It is unclear how effective medical futility dispute resolution guidelines can be in the face of legal uncertainty.⁴⁵

One Texas physician observes:

In my near 10-year experience with consults related to medical futility, many a physician, nurse, and even hospital ethics committee member felt that certain treatments in a given case were futile

⁴⁰ Robert D Truog, 'Tackling Medical Futility in Texas' (2007) 357 *New England Journal of Medicine* 1.

⁴¹ Thaddeus M Pope and Ellen A Waldman, 'Mediation at the End-of-Life: Getting Beyond the Limits of the Talking Cure' (2007) 23 *Ohio State Journal on Dispute Resolution* 143.

⁴² American Medical Association Council on Ethical and Judicial Affairs, 'Medical Futility in End-of-Life Care: Report of the Council on Ethical and Judicial Affairs' (1999) 281(10) *JAMA* 937.

⁴³ Pope, above n 29.

⁴⁴ Robert L Fine, 'Point: The Texas Advance Directives Act Effectively and Ethically Resolves Disputes about Medical Futility' (2009) 136(4) *Chest* 963, 965.

⁴⁵ Amir Halevy and Amy L McGuire, 'The History, Successes and Controversies of the Texas Futility Policy' (2006) 43(6) *Houston Lawyer* 34.

and should be stopped; however, few were willing to do so in the face of potential legal jeopardy.⁴⁶

B *Most Clinicians Accede to Surrogate Demands*

In short, for clinicians, safe harbor legal immunity is not just attractive, it is essential. It allows providers to avoid practicing what they judge to be ‘bad’ or ‘wrong’ medicine.⁴⁷ In contrast, without legal safe harbor immunity, most clinicians usually ‘follow the path of least resistance’⁴⁸ and just provide the treatment.⁴⁹ Without legal protection, they ‘cave-in’ to surrogate demands.⁵⁰

But clinicians do not want to provide non-beneficial treatment.⁵¹ So, many have been working to obtain legal safe harbor immunity like that provided by *TADA*.

C *Attempts and Recommendations to Copy TADA*

In a recent survey of over 700 clinicians, 82 per cent agreed that current dispute resolution mechanisms for medical futility disputes were inadequate.⁵² They want better and more effective mechanisms. Specifically, most responding clinicians agreed that empowering a committee to arbitrate medical futility conflicts was a good option.⁵³ While it is not the only option, a majority of clinicians want a non-judicial tribunal with adjudicatory power.

Many view *TADA* as a model or paradigm of what this type of dispute resolution mechanism should look like.⁵⁴ Consequently, it is no surprise that other US states have been looking to copy it.

1 *Legislative and Judicial Efforts to Copy TADA*

Two US states have taken material, concrete steps to copy *TADA*. Idaho took a legislative approach. New Jersey tried to adopt *TADA* through the courts. Neither attempt was successful. But these undertakings themselves demonstrate the attractiveness of *TADA*.

In February 2009, Idaho state Senator Patti Anne Lodge introduced SB 1114, which was closely patterned after *TADA*.⁵⁵ While the bill unanimously passed the Idaho Senate in March 2009, Idaho has a bicameral legislature. The bill was never favorably reported from a House committee.

In New Jersey, the attempt to copy *TADA* did not take the form of a legislative bill but rather the

⁴⁶ Robert L Fine, ‘Medical Futility and the Texas Advance Directives Act of 1999’ (2000) 13(2) *BUMC Proceedings* 144, 145.

⁴⁷ Thaddeus M Pope, ‘Physicians and Safe Harbor Legal Immunity’ (2012) 21(2) *Annals Health Law* 121.

⁴⁸ Fine, above n 44.

⁴⁹ Tom Blackwell, ‘Doctors More Reluctant to Clash with Families over End-of-Life Decisions in Wake of Supreme Court Ruling’, *National Post* (Canada), 5 September 2014.

⁵⁰ Thomas William Mayo, ‘The Baby Doe Rules and Texas “Futility Law” on the NICU’ (2009) 25 *Georgia State University Law Review* 1003, 1009.

⁵¹ Pope, above n 29.

⁵² Downar, above n 22.

⁵³ *Ibid.*

⁵⁴ Pope, above n 29, 68-69 and 79-80.

⁵⁵ SB 1114, 60th Leg, 1st Reg Sess § 5(7) (Idaho 2009).

form of an appellate brief. The brief was authored by the New Jersey Hospital Association, the Medical Society of New Jersey, and the Catholic Healthcare Partnership of New Jersey. These organisations asked the Appellate Division of the state Superior Court to judicially adopt provisions closely patterned on *TADA*.⁵⁶ As in Idaho, this attempt was unsuccessful. The Court dismissed the case as moot after the patient died.⁵⁷

2 Professional Organisations Endorse Copying TADA

Apart from formal judicial and legislative action to copy *TADA*, a significant number of professional organisations have endorsed copying *TADA*. These include medical associations, bar associations, and others.

Medical societies in at least four states have passed resolutions calling on their legislatures to copy *TADA*. Medical associations in California,⁵⁸ North Carolina,⁵⁹ Washington,⁶⁰ and Wisconsin⁶¹ considered such resolutions.

Legal associations have done the same. For example, the New York State Bar Association published a similar recommendation.⁶² At a less formal level, major organisations in Maryland⁶³ and Connecticut⁶⁴ have held conferences and workshops exploring whether and how to follow *TADA*.

Furthermore, still others are looking to copy *TADA*, though in a less open and transparent manner. The authors and architects of *TADA* report that they get calls from around the country from lobbyists and advocates.⁶⁵ Plans, strategies, and bills are being drafted and devised.⁶⁶

3 Academic Commentary Recommends Copying TADA

In addition to the efforts of legislatures, policymakers, and professional organisations, a number of commentators have argued that other states should follow *TADA*. For example, one author

⁵⁶ Brief of Amici Curiae New Jersey Hospital Association, Catholic Healthcare Partnership of New Jersey, and Medical Society of New Jersey, *Betancourt v Trinitas Hospital*, No. A-003-849-08T2 (NJ Super AD Aug 7, 2009).

⁵⁷ *Betancourt v Trinitas Hospital*, 1 A 3d 823 (NJ Super AD 2010).

⁵⁸ California Medical Association, 2009 House of Delegates, *Resolution 506-09: End-of-Life Care and Futile Treatment*.

⁵⁹ AE Kopelman et al, 'The Benefits of a North Carolina Policy for Determining Inappropriate or Futile Medical Care' (2005) 66(5) *North Carolina Medical Journal* 382.

⁶⁰ Washington State Medical Association, 2010 House of Delegates, Resolution A-2: WSMA Opinion on Medical Futility in End-of-Life Care.

⁶¹ Wisconsin Medical Society, *Resolution 1-2004*.

⁶² New York State Bar Association Health Law Section, *Summary Report on Healthcare Costs: Legal Issues, Barriers and Solutions* (September 2009)

<https://www.nysba.org/Sections/Health/Health_Law_Section_Report/Health_Law_Section_Reports.html>.

⁶³ Thaddeus M Pope, 'Medical Futility and Maryland Law', *Mid-Atlantic Ethics Committee Newsletter* (Maryland) Winter 2011, 1-3.

⁶⁴ Hartford Hospital Ethics Committee, *Summit - Medical Futility: Medicine, Law and Ethics* (Oct 21, 2010)

<http://www.harthosp.org/portals/1/images/6/ethics_summit_program.pdf>.

⁶⁵ Mayo, above n 50.

⁶⁶ Texas Hospital Association, Key Messages on Texas Advance Directives Act (2011).

concludes that ‘the Texas model offers an excellent blueprint for other states to follow.’⁶⁷ Others similarly assess *TADA* as a ‘thoughtful approach’ and an ‘admirable project.’⁶⁸

Not surprisingly, those involved in innovating *TADA* believe that the

extra-judicial dispute resolution mechanism found in the Texas Advance Directives Act should... serve as a national model that appropriately balances the interests of all involved parties in these difficult cases while still leading to a defensible solution.⁶⁹

But even independent scholars have similarly encouraged ‘other jurisdictions in the United States [to] consider codifying a procedure similar to the one in Texas.’⁷⁰ These recommendations have been widely published in medical journals,⁷¹ in law journals,⁷² and in bioethics journals.⁷³

IV TEXAS ADVANCE DIRECTIVES ACT

Now that we have established the reasons for examining *TADA*, we can turn to an examination of the statute itself. After providing a brief history of the legislation, I walk through all six steps of its dispute resolution process.

A What Is *TADA*?

The focus of this article is on the unique dispute resolution mechanisms in the *TADA*. But these provisions are just a small part of the *TADA*. While *TADA* spans over 15 000 words, the dispute resolution provisions consist of just around 700 words. *TADA* is a comprehensive healthcare decisions statute comprised of 71 separate statutory sections. The dispute resolution provisions

⁶⁷ Jacob M Appel, ‘What’s So Wrong with Death Panels?’ *Huffington Post* (Online), 22 November 2009 <http://www.huffingtonpost.com/jacob-m-appel/whats-so-wrong-with-death_b_366804.html?ir=Australia>.

⁶⁸ Michael Kapottos and Stuart Youngner, ‘The Texas Advanced Directive Law: Unfinished Business’ (2015) 15(8) *American Journal of Bioethics* 34.

⁶⁹ Fine, above n 44; Amir Halevy, ‘Medical Futility, Patient Autonomy, and Professional Integrity: Finding the Appropriate Balance’ (2008) 18(2) *Health Matrix* 261; Kelley Shannon, ‘End-of-Life Legislation Dies in Texas House’, *Houston Chronicle* (Houston) 23 May 2007; Robert L Fine, ‘A Model for End-of-Life Care’, *Washington Times* (Washington), 6 September 2009.

⁷⁰ John M Zerwas, ‘Medical Futility in Texas: Handling ‘Reverse Right to Die’ Obstacles without Constitutional Violation’ (2007) 43 *Tulsa Law Review* 169, 198.

⁷¹ See eg, HC Jacobs, ‘The Texas Advance Directives Act - Is It a Good Model?’ (2009) 33(6) *Seminars in Perinatology* 384; Arthur E Kopelman, ‘The Benefits of a North Carolina Policy for Determining Inappropriate or Futile Medical Care’ (2005) 66(5) *North Carolina Medicine Journal* 392; Matthew H Armstrong et al, ‘Medical Futility and Non-beneficial Interventions: An Algorithm to Aid Clinician’ (2014) 8(12) *Mayo Clinic Proceedings* 1599.

⁷² See eg Patrick Moore, ‘An End-of-Life Quandary in Need of a Statutory Response: When Patients Demand Life-Sustaining Treatment that Physicians are Unwilling to Provide’ (2007) 48 *Boston College Law Review* 433, 468; Mary Johnston, ‘Futile Care: Why Illinois Law Should Mirror the Texas Advanced Directives Act’ (2014) 23 *Annals of Health Law Advance Directive* 27; Lisa Dahm, ‘Medical Futility and the Texas Medical Futility Statute: A Model to Follow or One to Avoid’ (2008) 20(6) *Health Lawyer* 25.

⁷³ See, eg, Nancy S Jecker, ‘Futility and Fairness: A Defense of the Texas Advance Directives Law’ (2015) 15(8) *American Journal of Bioethics* 43; Laurence B McCullough, ‘Professionally Responsible Clinical Ethical Judgments of Futility’ 15(8) *American Journal of Bioethics* 54; Kappatos and Younger, above n 68; Thaddeus M Pope, ‘Legal Briefing: Medical Futility and Assisted Suicide’ (2009) 20(3) *Journal of Clinical Ethics* 274.

comprise just four sections.⁷⁴

B History of TADA: 1993 to 1999

In 1993, representatives from most of the major hospitals in Houston, Texas formed the Houston Citywide Taskforce on Medical Futility.⁷⁵ They developed a nine step procedure for resolving futility disputes. The goal of the taskforce was to create a common policy, because the members thought that would be more ethically and legally defensible than individual facilities proceeding on their own.

But this was still insufficient. Making the protocol citywide made it seem more reasonable. But it still did not give the protocol the force of law. The guidelines had ‘no legal standing.’⁷⁶ And without a ‘positive statement in the law . . . the threat of malpractice litigation would force most physicians to honor families’ requests for even the most inappropriate aggressive treatment.’⁷⁷ As discussed above, safe harbor legal immunity is critical.⁷⁸

Four years later, the state legislature was considering comprehensive *TADA* legislation. The Houston procedures were largely incorporated into this bill. In February 1997, Senator Mike Moncrief introduced *TADA* in SB 414. By April, the bill passed the Senate. By May, it passed the House. But when the final version of SB 414 was sent to Governor Bush, in June 2007, he vetoed it.⁷⁹

Governor Bush’s veto proclamation noted that SB 414 contained ‘several provisions that would permit a physician to deny [LSMT] to a patient who desires them.’ Indeed, opponents had charged that SB 414 would ‘encourage medical professionals to participate in euthanasia . . . by denying life-saving medical treatment . . . to patients whose lives they independently decide are not worth living.’⁸⁰ The Governor was concerned about these ‘potentially dangerous defects.’⁸¹

To address the Governor’s concerns, at least 24 interested organisations formed the Texas Advance Directives Coalition.⁸² Its membership included advisors from the legislative and executive branches. It included medical groups like Texas Hospital Association and Texas Medical Association. It even included pro-life groups like Texas Right to Life and Texas Alliance for Life. Despite this heterogeneous composition, the Coalition was able to reach a ‘watershed compromise.’⁸³ The Coalition reached consensus on safeguards and protections designed to resolve the ‘defects’ that concerned Governor Bush.⁸⁴

⁷⁴ Texas Health & Safety Code §§ 166.045, 166.046, 166.052, 166.053.

⁷⁵ Amir Halevy and Baruch Brody, ‘A Multi-Institutional Collaborative Policy on Medical Futility’ (1996) 276(7) *JAMA* 571.

⁷⁶ Elizabeth Heitman and Virginia Gremillion, ‘Ethics Committees under Texas Law: Effects of the Texas Advance Directives Act’ (2001) 13(1) *HEC Forum* 82, 90.

⁷⁷ *Ibid* 88.

⁷⁸ See above Part III C.

⁷⁹ Heitman and Gremillion, above n 76, 90-92.

⁸⁰ Texas House Research Organization, *Bill Analysis of SB 414* (May 23, 1997), 2.

⁸¹ Proclamation by the Governor of the State of Texas (June 20, 1997), 75th Texas Legislature, *Senate Journal* 4926.

⁸² Robert L Fine, ‘The Texas Directives Act of 1999: Politics and Reality’ (2001) 13 *HEC Forum* 59, 63-67; Heitman and Gremillion, above n 76, 92-94.

⁸³ Halevy and McGuire, above n 45.

⁸⁴ Emily Ramshaw, ‘Bills Challenge Care Limits for Terminal Patients’, *Dallas Morning News* (Dallas, Texas), 15

So, when the legislature reconvened in 1999, Senator Moncrief used the Coalition's language to amend the vetoed 1997 legislation. He again introduced *TADA*.⁸⁵ By April, it passed the Senate. By May, it passed the House. Governor Bush signed the bill on 18 June 1999. *TADA* went into effect on 1 September 1999.⁸⁶

C Dispute Resolution Provisions of TADA

The *TADA* dispute resolution provisions address the situation in which 'an attending physician refuses to honor a patient's advance directive or a health care or treatment decision made by or on behalf of a patient.'⁸⁷

With respect to LSMT, this can happen in two basic ways. First, the surrogate may be requesting LSMT that the physician thinks is inappropriate. Second, the surrogate may be refusing LSMT that the physician thinks should be provided. The former situation (a medical futility dispute) is the far more common situation and the one on which this article focuses.

TADA encourages the 'physician's refusal' to 'be reviewed by an ethics or medical committee.'⁸⁸ This review process is comprised of six basic steps that proceed in a roughly chronological order:

- 1) The attending physician refers the dispute to a review committee.
- 2) The hospital provides the surrogate with notice of committee review.
- 3) The review committee holds an open meeting.
- 4) The review committee makes its decision and provides a written explanation.
- 5) The hospital attempts to transfer the patient to a willing facility.
- 6) The hospital may stop LSMT.

TADA mandates that hospitals continue to administer disputed LSMT during the first five steps of this review.⁸⁹ In addition, *TADA* specifies two situations under which the process can be shortened or extended.

1 The Attending Physician Refers the Dispute to a Review Committee

In a futility dispute, at some point, the attending physician determines that one or more forms of LSMT are inappropriate. Since the default presumption is that all physiologically effective LSMT will be provided, the physician ordinarily seeks the consent of the patient's surrogate to a proposed plan to withhold or withdraw treatment. The surrogate refuses consent.

While not required by *TADA*, the attending physician will typically work on obtaining the

February 2007.

⁸⁵ Tex SB 1260 (1999).

⁸⁶ Added by Acts 1999, 76th Leg, ch 450, Sec 1.02, eff Sept. 1, 1999.

⁸⁷ Texas Health & Safety Code § 166.046(a).

⁸⁸ Texas Health & Safety Code § 166.046(a).

⁸⁹ Texas Health & Safety Code § 166.046(a). *TADA* was recently amended to exempt clinically assisted nutrition and hydration from the types of affected LSMT Tex HB 3074, 84th Legis. (2015) (Springer), enacted Tex House J 6047 (June 12, 2015).

surrogate's consent through additional family meetings and the intervention of other specialists like chaplains and ethics consultants.⁹⁰ Such communication and mediation typically resolves the dispute.⁹¹ But if none of this works (or even if it was never tried), then the attending physician may invoke *TADA*'s formal dispute resolution provisions.

TADA's dispute resolution procedures are written such that the attending physician is the only one who can invoke them.⁹² They are triggered when the attending physician 'refuses to honor a patient's advance directive or a health care or treatment decision made by or on behalf of a patient.'⁹³ The attending physician notifies the review committee of her refusal, effectively asking or petitioning it to adjudicate the dispute.

2 *The Hospital Provides the Surrogate with Notice of Committee Review*

Once the attending physician refers the case to the review committee, the committee will convene a 'meeting' to consider the case. Presumably to enable the surrogate to attend and meaningfully participate at the committee hearing, the hospital must inform the surrogate of the committee review process at least two days in advance. Specifically, this notice must be provided 'not less than 48 hours before the meeting called to discuss the patient's directive, unless the time period is waived by mutual agreement.'⁹⁴

At the same time that it provides notice of the review committee meeting, the hospital must also provide the surrogate with two written documents: 1) a statutorily mandated written 'statement' of rights⁹⁵ and 2) a state-maintained list of health care providers and referral groups.⁹⁶ *TADA* encourages, but does not require, the hospital to provide a third document, 3) that describes its committee review process.

(a) *The Hospital Provides the Surrogate with a Written Statement of Rights*

While not in the original 1999 *TADA*, a 2003 amendment added specific language that hospitals must provide to surrogates.⁹⁷ The required written statement basically summarises the surrogate's rights in plain, less legalistic, language.⁹⁸

In cases in which the attending physician refuses to comply with an advance directive or treatment decision requesting LSMT, the statement shall be in substantially the following form:

When There Is a Disagreement about Medical Treatment: the Physician Recommends against Life-Sustaining Treatment That You Wish to Continue

⁹⁰ Several bills aimed to amend *TADA* to first require an advisory ethics consultation. See, eg, SB 439 (2007) (Deuell); HB 3474 (2007) (Delisi); SB 303 (2013) (Deuell).

⁹¹ See above Part II E.

⁹² Texas Health & Safety Code § 166.046. See also Mayo, above n 50, 1005 n.8.

⁹³ Texas Health & Safety Code § 166.046(a).

⁹⁴ Texas Health & Safety Code § 166.046(b)(2).

⁹⁵ Texas Health & Safety Code § 166.046(b)(2)(A).

⁹⁶ Texas Health & Safety Code § 166.046(b)(3).

⁹⁷ Texas Health & Safety Code § 166.052. Added by Acts 2003, 78th Leg, ch 1228, Sec 5, eff June 20, 2003.

⁹⁸ Texas Health & Safety Code §§ 166.046(b)(3)(A) & 166.052.

You have been given this information because you have requested [LSMT] which the attending physician believes is not appropriate. This information is being provided to help you understand state law, your rights, and the resources available to you in such circumstances. It outlines the process for resolving disagreements about treatment among patients, families, and physicians...⁹⁹

A similar statement must be provided when there is a disagreement about medical treatment in which the physician recommends LSMT that the surrogate wishes to stop.¹⁰⁰

(b) The Hospital Provides the Surrogate with the State Registry List

In addition to the ‘statement’ of rights,¹⁰¹ the hospital must also provide a copy of a state-maintained list of health care providers and referral groups that have volunteered their readiness either to consider accepting transfer or to assist in locating a provider willing to accept transfer.¹⁰²

This list is maintained by the Texas Health Care Information Council (‘THCIC’), an agency of the Texas Department of State Health Services. *TADA* requires the THCIC to ‘maintain a registry listing the identity of and contact information for health care providers and referral groups, situated inside and outside [Texas], that have voluntarily notified the council they may consider accepting or may assist in locating a provider willing to accept transfer of a patient...’¹⁰³

As of September 2015, the list includes only three healthcare providers.¹⁰⁴ It also includes four law firms and two advocacy groups. While the ‘registry list of health care providers and referral groups’ is maintained by the THCIC, the State of Texas does not endorse or assume ‘any responsibility for any representation, claim, or act of the listed providers or groups.’¹⁰⁵ Furthermore, the listing of a provider or referral group in the registry ‘does not obligate the provider or group to accept transfer of or provide services to any particular patient.’¹⁰⁶

(c) The Hospital Provides the Surrogate with a Description of Its Review Process

While *TADA* requires hospitals to provide the ‘statement of rights’ and the ‘registry list,’ it merely suggests and recommends that the hospital provide the surrogate with a third document: ‘a written description of the ethics or medical committee review process and any other policies and procedures related to this section adopted by the health care facility.’¹⁰⁷ Since *TADA* provides almost no direction on how a review committee is to operate, the process will vary from hospital to hospital.

⁹⁹ Texas Health & Safety Code § 166.046(a).

¹⁰⁰ Texas Health & Safety Code § 166.052(b).

¹⁰¹ Texas Health & Safety Code § 166.046(b)(3)(A).

¹⁰² Texas Health & Safety Code § 166.046(b)(3)(B).

¹⁰³ Texas Health & Safety Code § 166.053(a).

¹⁰⁴ Texas Department of State Health Services, *Registry List of Health Care Providers and Referral Groups* <<http://www.dshs.state.tx.us/thcic/Registry.shtm>>.

¹⁰⁵ Texas Health & Safety Code § 166.053.

¹⁰⁶ Texas Health & Safety Code § 166.053(b).

¹⁰⁷ Texas Health & Safety Code § 166.046(b)(1).

3 *The Review Committee Holds an Open Meeting*

At this point, at least 48 hours before the review committee hearing, three things have happened. First, the attending physician has refused to honour the treatment decision for continued LSMT. Second, the physician has referred the case to the hospital review committee. Third, the surrogate has been apprised of her rights.

TADA does not authorise physicians to act unilaterally. The attending physician's refusal must be reviewed by an 'ethics or medical committee.'¹⁰⁸ But hospitals have significant discretion here. *TADA* is mostly silent as to the composition or training of the committee that reviews the dispute between the surrogate and clinician.¹⁰⁹ The statute provides only that 'the attending physician may not be a member of that committee.'¹¹⁰

With respect to the meeting itself, *TADA* provides that the surrogate is entitled to attend.¹¹¹ But it does not specify any other rules or procedures. *TADA* is silent on who else the surrogate may bring (eg an attorney, a religious adviser). It is silent on the scope of the surrogate's participation (eg right to ask questions).

While not specified in the statute, the review committee meeting typically proceeds in two stages. It 'begins with a presentation from the attending physician and other members of the health care team.'¹¹² During this presentation, clinicians 'provide reasoning and evidence to support why they believe further curative care would be medically futile.'¹¹³ Most committees then 'allow the patient and family to present their arguments and evidence.'¹¹⁴

4 *The Review Committee Makes Its Decision and Provides a Written Explanation*

After the meeting, the review committee will usually deliberate in private, separate from the treating clinicians and family. Once it reaches a decision, the committee must prepare a 'written explanation of the decision reached during the review process.'¹¹⁵ It must provide the surrogate with a copy. This 'written explanation' must also be included in the patient's medical record.¹¹⁶

The review committee consideration of a medical futility dispute results in one of three main outcomes. First, the committee can agree with the surrogate. Second, it can agree with the referring physician. Third, sometimes the conflict is mooted by the patient's death or by subsequent family-clinician agreement.

First, if the review committee agrees with the surrogate, then the physician must make a reasonable

¹⁰⁸ Texas Health & Safety Code § 166.046(a).

¹⁰⁹ Texas Health & Safety Code § 166.002(6).

¹¹⁰ Texas Health & Safety Code § 166.046(a).

¹¹¹ Texas Health & Safety Code § 166.046(b)(4)(A).

¹¹² Robert W Painter, 'Developments in Texas Advance Directives' (2009) *Houston Lawyer* 20 <http://www.thehoustonlawyer.com/aa_sep09/page20.htm>.

¹¹³ *Ibid.*

¹¹⁴ *Ibid.*

¹¹⁵ Texas Health & Safety Code § 166.046(b)(4)(B).

¹¹⁶ Texas Health & Safety Code § 166.046(c).

effort to transfer the patient to a physician who is willing to comply with the surrogate. Hospital personnel must assist the physician in arranging the patient's transfer: 1) to another physician, 2) to an alternative care setting within that facility, or 3) to another facility.¹¹⁷

Second, if the committee agrees with the referring physician (and it usually does), then the dispute resolution process may continue. Published studies indicate that review committees agree with referring physicians in more than 70 per cent of cases.¹¹⁸

Third, sometimes the conflict is mooted, because the patient dies during the review process.¹¹⁹ Other times, conflict is mooted, because surrogates are persuaded by the fact that the review process affirms the attending physician's decision that LSMT is inappropriate treatment.¹²⁰ These surrogates are happy that the committee takes the burden of decision making off their shoulders.¹²¹ On the other hand, some surrogates may consent because they experience the *TADA* process as *fait accompli*.¹²²

But while some disputes are resolved by or during the review process, others are not. Some surrogates continue to request LSMT that both the attending physician and the ethics or medical committee concluded was inappropriate.

5 The Hospital Attempts to Transfer the Patient to a Willing Facility

If the review committee agrees with the referring physician and the surrogate does not agree with that decision, then 'the physician shall make a reasonable effort to transfer the patient to a physician who is willing to comply with the directive.'¹²³ In fact, it is unlikely that another physician at the same facility will accept a transfer at this point in the process. So, *TADA* further provides: 'If the patient is a patient in a health care facility, the facility's personnel shall assist the physician in arranging the patient's transfer: 2) to an alternative care setting within that facility; or 3) to another facility.'¹²⁴

The surrogate may concurrently look for a transfer on her own. She can use the 'registry list' of health care providers and referral groups that have volunteered their readiness to consider accepting transfer, or to assist in locating a provider willing to accept transfer. Surrogates may contact providers or referral groups on the list or others of their choice to get help in arranging a

¹¹⁷ Texas Health & Safety Code § 166.046(d).

¹¹⁸ See, eg Richard J Castriotta, 'Protecting Patients: the TADA, and the Limits of Surrogate Directives' (Paper presented at the American College of Chest Physicians Annual Meeting, Chicago, Illinois, 26-31 October 2013); Becca Aaronson, 'A Texas Senate Bill Would Revise the State's End-of-Life Procedure', *New York Times* (New York) 30 March 2013.

¹¹⁹ See below Part V.

¹²⁰ Robert L Fine, 'The History of Institutional Ethics at Baylor University Medical Center' (2004) 17(1) *Proceedings of Baylor University Medical Center* 73.

¹²¹ Fine, above n 120, 71; Robert D Truog, 'Medical Futility' (2009) 25 *Georgia State University Law Review* 985, 999.

¹²² Tom Mayo, 'Medical Futility in Texas: Myths and Misconceptions' (8 April 2014) <<http://repositories.tdl.org/utswmed-ir/handle/2152.5/1405>>.

¹²³ Texas Health & Safety Code § 166.046(d).

¹²⁴ Texas Health & Safety Code § 166.046(d).

transfer. The patient is responsible for any costs incurred.¹²⁵

After being served with the review committee's 'written explanation,' the surrogate has at least ten days to accomplish a transfer. But this is a difficult task. Few hospitals are willing to accept the transfer of a patient after another hospital's review committee has already determined that continuing LSMT is inappropriate.¹²⁶ But transfer is not impossible.¹²⁷ For example, the family of Spiro Nikolouzos transferred him from St. Luke's Episcopal Hospital to Avalon Place, a long-term care facility.¹²⁸

More recently, a June 2011 case at Texas Children's Hospital garnered significant media attention. A fourteen-year-old boy had been diagnosed months earlier with inoperable glioblastoma, a particularly lethal cancer. The boy's parents were able to transfer him, five days into the ten day waiting period, to Atrium Medical Center, a nearby long-term acute-care facility.¹²⁹

In these cases in which the surrogate is requesting LSMT 'that the attending physician has decided, and the review process has affirmed is inappropriate treatment, the patient shall be given available [LSMT] pending transfer.'¹³⁰ But the transfer period is not indefinite.

6 *The Hospital May Stop Life-Sustaining Treatment*

The patient must continue to be given LSMT until he or she can be transferred to a willing provider. But the waiting period to find a transfer lasts for only 10 days from the time the surrogate was given the committee's 'written explanation' that LSMT is not appropriate. If a willing provider cannot be found within 10 days, then LSMT may be withdrawn.

Neither the physician nor the health care facility are 'obligated to provide [LSMT] after the tenth day after the written decision' is provided to the surrogate.¹³¹ The inability to transfer is intended to serve as confirmation of the review committee's decision. The refusal of other facilities to provide the disputed LSMT supposedly indicates or confirms that the review committee was correct. Accordingly, LSMT 'under this section may not be entered in the patient's medical record as medically unnecessary treatment until the ten day waiting period has expired.'¹³²

7 *Special Adjustments to Timing*

¹²⁵ Texas Health & Safety Code § 166.046(e).

¹²⁶ See, eg Bosslet et al, above n 18, 1325; Leigh Hoper and Todd Ackerman, 'Inside of Me, My Son Is Still Alive', *Houston Chronicle* (Houston) 16 March 2005; Mary Ann Roser, 'Time Running Out for Baby on Life Support', *Austin American Statesman* (Austin) 8 April 2007.

¹²⁷ Martin L Smith et al, 'Texas Hospitals' Experience with the Texas, Advance Directives Act' (2007) 35 *Critical Care Medicine* 1271.

¹²⁸ AP, 'Man in Center of Life-Support Debate Dies in San Antonio', *Houston Chronicle* (Houston) 1 June 2005, B5.

¹²⁹ Todd Ackerman, 'Teen's Move Sidesteps Futile-Care Controversy', *Houston Chronicle* (Houston) 30 June 2011; L Frillici, 'Family Fights to Keep Teen Alive as Hospital Decides to End Life Support', *KHOU 11 News* (Houston), 30 June 2011.

¹³⁰ Texas Health & Safety Code § 166.046(e).

¹³¹ Texas Health & Safety Code § 166.046(e).

¹³² Texas Health & Safety Code § 166.046(f).

The previous six steps fully describe the *TADA* dispute resolution mechanism. But *TADA* also specifies two situations under which this standard dispute resolution process can be shortened or extended. First, the process can be shortened, if the patient has already been the subject of a committee review. Second, the transfer period can be extended by court order.

(a) Prior Committee Review Can Shorten the Process

If, during a previous admission to a facility, a patient's attending physician and the review process have determined that LSMT is inappropriate, and the patient is readmitted to the same facility within six months, the hospital does not need to follow any of the above six steps.

This makes sense. Suppose the patient is transferred from the hospital to a long-term care facility. Then, the patient suffers an emergent issue such as respiratory distress and returns to the hospital. If the patient is in substantially the same condition, why start the entire dispute resolution process all over again? The result would probably be the same.

To bypass the dispute resolution process in such cases, the patient's attending physician and a consulting physician who is a member of the facility's review committee must confirm that the previous review committee decision is still applicable. They must document on the patient's readmission that the 'patient's condition either has not improved or has deteriorated since the review process was conducted.'¹³³

(b) Courts Can Sometimes Extend the Transfer Waiting Period

Just as *TADA* permits special circumstances to shorten the dispute resolution process, it also permits special circumstances to lengthen the process. While *TADA* gives the surrogate only ten days to find a facility willing to provide disputed LSMT, the surrogate may ask the 'appropriate district or county court' to extend this ten-day period.

But the surrogate's ability to obtain a judicial extension of the transfer period is extremely limited. *TADA* permits the court to grant such an extension only if 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.'¹³⁴

Despite these restrictive standards, in several cases, surrogates have been able to obtain temporary restraining orders or preliminary injunctions.¹³⁵ Hospitals have also agreed to an extension just before a pending hearing.¹³⁶ However, in many other cases the courts have denied requests for

¹³³ Texas Health & Safety Code § 166.046(e-1).

¹³⁴ Texas Health & Safety Code § 166.046(g).

¹³⁵ See, eg, *Gonzales v Daughters of Charity Health Services of Austin*, No 86427 (Travis County Probate Court May 18, 2007) (Second Extension of Temporary Restraining Order); *Hudson v Texas Children's Hosp*, 177 SW 3d 232 (Tex App 2005); *In re Nikolouzos*, 179 SW 3d 581 (Tex App 2005); Kristina Herrndobbler, 'Court Keeps Woman on Life Support', *Beaumont Enterprise* (Texas), 11 August 2006, A.1; Bill Murphy, *Comatose Surgeon Would Prefer Death*, *Houston Chronicle* (Houston), 21 March 2001, 26; Emily Ramshaw, 'Children Fight to Save Mom', *Dallas Morning News* (Dallas), 18 August 2006.

¹³⁶ See, eg, Todd Ackerman, 'Transfer Resolves Latest Futile Care Case', *Houston Chronicle* (Houston) 31 July 2006; Todd Ackerman, 'Family Vows to Fight Futile Care Law', *Houston Chronicle* (Houston) 9 May 2006;

extensions.¹³⁷

D *TADA Provides Safe Harbour Legal Immunity*

Importantly, *TADA* not only outlines a dispute resolution mechanism but also offers safe harbour legal immunity for following it. The statute provides:

A physician, health professional acting under the direction of a physician, or health care facility is not civilly or criminally liable or subject to review or disciplinary action by the person's appropriate licensing board if the person has complied with the procedures outlined in Section 166.046.¹³⁸

This legal protection is important. Without it and unable to secure surrogate consent to stopping LSMT, providers generally continue to comply with requests that they consider inappropriate.¹³⁹ Moreover, the requirements for earning immunity under *TADA* are clear, measureable, and precise. So, healthcare providers can be sure about when they are qualified for safe harbour protection. Legal immunity is effective only when providers have confidence and certainty about when they have it.¹⁴⁰

E *The TADA Process Is Optional*

While *TADA* outlines a six-step dispute resolution process with specific written disclosures and other details, using that process is optional. Hospitals may refuse requested LSMT without following these six steps. And they may still have liability protection.

TADA explicitly anticipates this situation in three separate sections. First, '[i]f an attending physician refuses to comply with a directive or treatment decision and does not wish to follow the procedure established under Section 166.046, [the physician may].' *TADA* simply requires that LSMT 'be provided to the patient ... only until a reasonable opportunity has been afforded for the transfer of the patient to another physician or health care facility willing to comply.'¹⁴¹ The physician's liability is limited, so long as she complies with the professional standard of care.¹⁴²

Second, a separate section of *TADA* confirms that clinicians may also have rights under common law. 'This subchapter does not impair or supersede any legal right or responsibility a person may have to affect the withholding or withdrawal of [LSMT] in a lawful manner.' This section imposes only one affirmative obligation: LSMT 'is required to be provided the patient ... until a reasonable opportunity has been afforded for transfer of the patient to another physician or health care facility willing to comply.'¹⁴³

Third, *TADA* recognises that LSMT may be denied to a patient in a triage situation. 'This chapter

Hudson v Texas Children's Hosp, 177 SW 3d 232, 233 (Tex App 2005).

¹³⁷ See, eg, Lightfoot, above n 36, 854; *Hudson v Texas Children's Hosp*, No 352,526 (Probate Ct, Harris County, Tex Mar 14, 2005); *Nikolouzos v St Luke's Hosp*, 162 SW 3d 678, 679-80 (Tex App 2005).

¹³⁸ Texas Health & Safety Code § 166.045(d). See also *id* § 166.044.

¹³⁹ See above Part III A.

¹⁴⁰ Pope, above n 47; Pope, above n 29.

¹⁴¹ Texas Health & Safety Code § 166.045(c).

¹⁴² Texas Health & Safety Code § 166.044.

¹⁴³ Texas Health & Safety Code § 166.051.

may not be construed to require the provision of LSMT that cannot be provided to a patient without denying the same treatment to another patient.¹⁴⁴

V HOSPITAL EXPERIENCE WITH *TADA*

Now that we have examined how *TADA* works, we can turn to look at how hospitals have used it. Unfortunately, *TADA* has never included any reporting requirements.¹⁴⁵ Consequently, there are no thorough and systematic data on how Texas hospitals have used *TADA* over the past fifteen years. Nevertheless, there are some small scale studies. Some were conducted right after *TADA* went into effect in 1999. Some were conducted in the 2000s. And a few more recent studies were conducted since 2010.

A *Early Hospital Experience with TADA (1999 to 2004)*

Baylor University Medical Center reported that in the 12 months before *TADA*, it had 14 futility cases. Of these, two patients died during the consultation and process even with maintenance of LSMT. In the other 12 cases, the family agreed to withdraw LSMT. But in one case it took the family about a month to agree.¹⁴⁶

In the first 16 months after *TADA*, Baylor reported 36 futility cases. In 29, the family promptly agreed to withdraw LSMT and focus on comfort care. Five cases were pursued through the *TADA* dispute resolution process. In three of these, the family agreed after receiving the review committee's report. In the other two cases, the patient died during the ten day waiting period.¹⁴⁷

B *Later Hospital Experience with TADA (2005 to 2010)*

By the mid-2000s, several studies went beyond the walls of a single facility and measured the use of *TADA* more broadly. For example, a 2004 study surveyed 200 Texas hospitals. Respondents reported reviewing 256 futility cases over the first five years of *TADA* (1999 to 2004).¹⁴⁸

The families of 71 patients agreed to discontinue treatment. Thirty patients were transferred to another facility. And 78 patients died before the end of the 10-day waiting period. Eight patients improved and appropriateness of treatment was reassessed. After the 10 day period, 78 patients were still alive. Hospitals discontinued treatment for 33. And despite review committee decisions, hospitals continued treatment for 45.

A second study looked at five years' of information from eleven large hospitals and two years' worth of data from five other large hospitals. The surveyed hospitals reported a total of 974 medical futility cases. But they used *TADA* in only 65 of those cases. The hospitals actually withdrew

¹⁴⁴ Texas Health & Safety Code § 166.009.

¹⁴⁵ Mayo, above n 50. Several bills have tried to add such a requirement. See, eg, SB 439 (2007) (Deuell).

¹⁴⁶ Fine, above n 120, 79.

¹⁴⁷ Robert L Fine, 'The Texas Advance Directives Act of 1999: Politics and Reality' (2001) 13 *HEC Forum* 59, 81; Robert L Fine and Thomas William Mayo, 'Resolution of Futility by Due Process: Early Experience with the Texas Advance Directives Act' (2003) 138 *Annals of Internal Medicine* 743, 745.

¹⁴⁸ Smith et al, above n 127.

treatment in only 27 of those cases. Twenty-two patients died receiving treatment as they awaited transfers.¹⁴⁹

C *Recent Hospital Experience with TADA (2010 to 2015)*

The most recent available data suggest that hospitals rarely use *TADA*. The Texas Hospital Association ('THA') surveyed its members in 2010, 2011, and 2012. THA reports that in 2009, the *TADA* dispute resolution process was initiated just two times at two multi-hospital systems. In 2010, the *TADA* process was initiated only one time at one hospital system. In 2011, usage ticked up. The THA survey shows that *TADA* was used 21 times by 16 hospitals or hospital systems.¹⁵⁰

In 2012, the Texas Hospital Association again surveyed its member hospitals. The 202 respondents reported that *TADA* had been used 30 times between 2007 and 2012. Of those cases, ten patients died during the ten day period, six patients were transferred to another provider, and four continued treatment past the 10-day period. Extrapolating from this sample of one-third of Texas hospitals, one might estimate that *TADA* is used 15 times per year statewide. And one can estimate that treatment is actually withdrawn only five times per year.¹⁵¹

On the other hand, the THA data may not be accurate or representative. A single hospital study at Memorial Hermann examined its *TADA* experience from 2000 to 2013.¹⁵² The hospital reported that it had 34 cases during this time period (about 2.4 per year). The committee agreed with the referring physician in thirty of the 34 cases. Of these, the families of three agreed to discontinue treatment. Four were transferred. Seven died during the ten day waiting period. The hospital discontinued treatment for fifteen.

D *Summary of Hospital Experience with TADA*

While available studies suggest that Texas hospitals rarely use *TADA*, these understate the impact and effect of *TADA*. First, the more recent unpublished studies indicate far lower usage rates than the published studies. They may be neither statistically valid nor reliable. For example, it is unclear whether THA member hospitals are representative of all Texas hospitals. Second, focusing on only hospitals' actual use of *TADA* fails to account for its 'shadow effect.'¹⁵³ If families know the hospital has this 'weapon,' they may (reluctantly) consent to the recommended treatment plan, precluding the need to formally resort to the *TADA* mechanism.¹⁵⁴

VI *TADA FAILS TO AFFORD ADEQUATE PROCEDURAL DUE PROCESS*

I have now established the purpose, operation, and usage of *TADA*. In this section, I turn from a descriptive account to a normative account. Specifically, I evaluate and assess whether *TADA*

¹⁴⁹ Fine, above n 44.

¹⁵⁰ W Gardner Selby, 'Texas Right to Life Exaggerates on Claim of "Faceless Hospital Panel" Determining Treatment', *Politifact* (Texas) 30 May 2014 <<http://www.politifact.com/texas/statements/2014/may/30/texas-right-life/texas-law-gives-hospital-panels-sway-over-cutting/>>.

¹⁵¹ Becca Aaronson, 'A Texas Senate Bill Would Revise the State's End-of-Life Procedure', *New York Times* (New York), 30 March 2013.

¹⁵² Castriotta, above n 118.

¹⁵³ Pope and Waldman, above n 41.

¹⁵⁴ Mayo, above n 122.

affords adequate procedural due process. I conclude that it does not. *TADA* is not sufficiently fair.

I am not alone. *TADA* is often described as a ‘due process’ approach.¹⁵⁵ But many charge that this due process ‘is more illusory than real.’¹⁵⁶ Some legal commentators have colourfully observed that *TADA* affords hospital patients with fewer protections than other Texas law affords either to tenants facing eviction from rental property or to automobile owners threatened with repossession.¹⁵⁷ Even Texas hospital lawyers have conceded *TADA*’s weaknesses.¹⁵⁸ So have *TADA*’s primary authors.¹⁵⁹

Despite being framed as a matter of ‘due process,’ the focus of the present inquiry is on fundamental fairness. As US law students quickly learn, Constitutional Fourteenth Amendment procedural due process analysis requires ‘state action.’¹⁶⁰ So, it may not be directly applicable to private, non-governmental hospitals. To be sure, some writers have assessed whether even a private hospital’s use of *TADA* constitutes ‘state action’ such that constitutional protections are triggered.¹⁶¹ But that is not our present concern.

In this article, we look to constitutional requirements only as guideposts to assess *TADA* from an ethical and public policy perspective. The elements of due process have been well developed in hundreds of court opinions. And they provide a cogent framework for our fairness analysis.¹⁶²

Before we begin assessing how well *TADA* satisfies specific elements of due process, we must first be mindful of two overarching principles. First, more extensive due process is required when a more significant interest is impacted.¹⁶³ Here, where the stakes are literally ‘life and death,’ particularly careful due process is required.¹⁶⁴

Second, more due process is required when the ‘risk of error’ is high.¹⁶⁵ Due process rules are ‘meant to protect persons not from the deprivation [itself] but from the mistaken or unjustified deprivation of life, liberty, or property.’¹⁶⁶ Here, there is an especially high risk error because futility determinations are not purely medical judgments but are the product of ‘exceedingly complex value judgments.’¹⁶⁷ And even to the extent they are medical judgments, there are significant limits to accurate prognostication.¹⁶⁸

¹⁵⁵ See, eg Fine and Mayo (2003), above n 147.

¹⁵⁶ Truog, above n 40, 3.

¹⁵⁷ Nora O’Callaghan, ‘Dying for Due Process: The Unconstitutional Medical Futility Provision of the Texas Advance Directives Act’ (2008) 60(2) *Baylor Law Review* 527, 555.

¹⁵⁸ Testimony of Michael Regier on SB 439 (2007) (at 170:00); Texas Hospital Association, *Key Messages on Texas Advance Directives Act* (2011).

¹⁵⁹ Mayo, above n 50, 1013, 1013-1017. Fine, above n 44.

¹⁶⁰ *Brentwood Academy v Tennessee Secondary School Athletic Assn*, 531 US 288 (2001).

¹⁶¹ See, eg Nora O’Callaghan, ‘When Atlas Shrugs: May the State Wash Its Hands of Those in Need of Life-Sustaining Medical Treatment?’ (2008) 18 *Health Matrix* 291.

¹⁶² See, eg, O’Callaghan, above n 157, 559.

¹⁶³ *Joint Anti-Fascist Refugee Comm v McGrath*, 341 US 123, 168 (1951) (Frankfurter J, concurring).

¹⁶⁴ *Matthews v Eldridge*, 424 US 319, 335 (1976).

¹⁶⁵ *Ibid*.

¹⁶⁶ *Carey v Piphus*, 435 US 247, 259 (1978).

¹⁶⁷ Bosslet et al, above n 18.

¹⁶⁸ Keith M Swetz et al, ‘Ten Common Questions (and Their Answers) on Medical Futility’ (2014) 89(7) *Mayo*

In the following six subsections, I examine how well *TADA* comports with the following elements of procedural due process.

- a) Neutral and Independent Decision Maker
- b) Appellate Review
- c) Notice
- d) Statement of Decision
- e) Criteria to Guide Decision
- f) Other Due Process Concerns

A TADA Lacks a Neutral and Independent Decision Maker

The US Supreme Court has held that ‘it is axiomatic that a . . . fair tribunal is a basic requirement of due process.’¹⁶⁹ A fair tribunal is one with a ‘neutral and detached judge.’¹⁷⁰ ‘[A]n impartial decision maker is essential.’¹⁷¹ Indeed, the neutrality of the decision maker is widely thought to be the most important part of due process.¹⁷²

Perhaps the most significant fairness problem with *TADA* is its delegation of decision making power to the hospital’s very own internal review committee. Since the committee is comprised of hospital clinicians and administrators, it is hardly a neutral and independent decision maker.¹⁷³ It is ‘predisposed’ to find for the hospital.¹⁷⁴

In one survey of 200 Texas hospitals, 56 per cent reported having a ‘medical appropriateness review committee distinct from their ethics committee.’ Half of these committees had five or fewer members.¹⁷⁵ Most were wholly comprised of physicians and hospital administrators. Hardly any included community representatives. There is a significant risk that such committees may be biased towards the interests of hospital management.¹⁷⁶

Harvard Professor Robert Truog has lamented the *TADA* review committee’s lack of neutrality in a long series of prominent articles. ‘This is hardly an impartial tribunal.’¹⁷⁷ He has observed that review committee members ‘are unavoidably “insiders”.’¹⁷⁸ Truog is concerned that *TADA* ‘gives an unwarranted amount of power to the clinicians and hospitals over patients and families who

Clinic Proceedings 943.

¹⁶⁹ *Caperton v AT Massey Coal Co*, 556 US 868 (2009).

¹⁷⁰ *Ward v Monroeville*, 409 US 57, 61-62 (1972).

¹⁷¹ *Goldberg v Kelly*, 397 US 254, 271 (1970).

¹⁷² *Hamdi v Rumsfeld*, 124 S Ct 2633 (2004).

¹⁷³ Cameron Stewart, ‘Futility Determination as a Process: Problems with Medical Sovereignty, Legal Issues and the Strengths and Weaknesses of the Procedural Approach’ (2011) 2(1) *Journal of Bioethical Inquiry* 4; O’Callaghan, above n 157, 596-99.

¹⁷⁴ *Marshall v Jerrico*, 446 US 238, 242 (1980).

¹⁷⁵ Smith et al, above n 127.

¹⁷⁶ Morten Magelssen, Reidar Pedersen and Reidun Førde, ‘Sources of Bias in Clinical Ethics Case Deliberation’ (2014) 40 *Journal of Medical Ethics* 678.

¹⁷⁷ Truog, above n 121, 1000.

¹⁷⁸ Truog, above n 40, 2.

hold unpopular beliefs or values.’¹⁷⁹

Truog argues that TADA's placement of the life-and-death decision in the hands of hospital review committees is too-provider friendly because ‘[m]ost of these committee members are doctors, nurses, and other clinicians from the hospital community... [thus] involvement of the hospital ethics committee fails to bring the diversity of the community into the deliberative process.’¹⁸⁰ It runs the risk of ‘becoming a rubber-stamp mechanism’ that does not respect diversity.¹⁸¹

Truog is not alone. I have also warned of the dangers of giving life and death adjudicatory power to hospital committees.¹⁸² I will not repeat those arguments here. Suffice it to say that hospital review committees are overwhelmingly internal and intramural bodies. They are comprised of professionals employed directly or indirectly by the very same institution whose decision the review committee adjudicates. When the decision maker has a pecuniary interest in the outcome, it is not sufficiently neutral and independent.¹⁸³

Committee members cannot be fair and impartial when the propriety of administering expensive LSMT must be weighed against a financial loss to the very hospital that provides those committee members with privileges and a source of income.¹⁸⁴ ‘Actual futility cases are almost always intertwined with questions about saving money.’¹⁸⁵ Uninsured patients are more likely to be perceived as receiving futile treatment.¹⁸⁶ Even TADA’s staunchest supporters concede: ‘I can’t promise you there’s not some rogue hospital or committee out there.’¹⁸⁷ Indeed, there have been specific allegations of corruption.¹⁸⁸

For example, Kalilah Roberson-Reese underwent a cesarean section at Memorial Hermann Hospital in Houston. But amniotic fluid began to leak into her lungs, forcing providers to put her on a ventilator. Later, her tracheal tube fell out and she went without oxygen for twenty minutes, which caused serious brain damage.¹⁸⁹ Within days, the hospital initiated the TADA dispute

¹⁷⁹ Jeffrey P Burns and Robert D Truog, ‘Futility: A Concept in Evolution’ (2007) 132 *Chest* 1987, 1991.

¹⁸⁰ Robert D Truog, ‘Counterpoint: The Texas Advance Directives Act Is Ethically Flawed: Medical Futility Disputes Must Be Resolved by a Fair Process’ (2009) 136 *Chest* 968, 969.

¹⁸¹ Robert D Truog, ‘Rebuttal from Dr. Truog’ (2009) 136 *Chest* 972, 972-73.

¹⁸² Thaddeus M Pope, ‘Multi-Institutional Healthcare Ethics Committees: The Procedurally Fair Internal Dispute Resolution Mechanism’ (2009) 31 *Campbell Law Review* 257; Thaddeus M Pope, ‘The Growing Power of Healthcare Ethics Committees Heightens Due Process Concerns’ (2014) 15 *Cardozo Journal of Conflict Resolution* 425.

¹⁸³ See, eg, *Ward v Monroeville*, 409 US 57, 61-62 (1972); *Tumey v Ohio*, 273 US 510, 523 (1927); *Gibson v Berryhill*, 411 US 564, 579 (1973).

¹⁸⁴ *Gonzales v Seton Family of Hospitals*, No. A07CA267 para 47 (WD Tex Filed 4 April 2007).

¹⁸⁵ Truog, above n 121, 990.

¹⁸⁶ Thanh H Neville et al, ‘Differences Between Attendings’ and Fellows’ Perceptions of Futile Treatments in the Intensive Care Unit at One Academic Health Center: Implications for Training’ (2015) 90(3) *Academic Medicine* 324, 327.

¹⁸⁷ Selby, above n 150.

¹⁸⁸ See, eg *Davis v Memorial Hermann Hosp*, No 2009-07079 (Harris Cty Dist Ct, Tex Feb 4, 2009) (Order granting TRO); *Dunn v Methodist Hosp*, No 2015-69681 (Harris Cty Dist Ct, Tex Dec 4, 2015) (Order of abatement); Mimi Swartz, ‘Not What the Doctor Ordered’, *Texas Monthly* (Texas) March 1995; *Estate of Bland v CIGNA Health Plan of Texas*, No 93-52630A (Harris Cty, Tex 1995).

¹⁸⁹ Todd Ackerman, ‘“Texas” Patient Care Law at Hub of Houston Dispute’, *Houston Chronicle* (Houston), 9 July 2006, A1.

resolution procedures. But the review committee was conflicted. The patient had exhausted her Medicaid benefits and it appeared that the hospital was trying to ‘bury mistakes’ and avoid exposure both to liability and to uncompensated treatment.¹⁹⁰ Another case from the same hospital involved similar allegations. The family of Sabrina Martin alleged that ‘Memorial Hermann and the doctors and nurses working on the case utilised the *TADA* process because they ‘wanted Sabrina to die to bury the evidence of malpractice and limit the potential damages in court.’¹⁹¹

To address the review committee’s lack of neutrality, some have proposed mandating certain minimum composition requirements. One example is to require that the review committee include ‘significant membership external to and outside the hospital.’¹⁹² One Australian court recommended that since such a hospital review committee should have ‘independence ... from the treating doctors ... it would probably need to have interstate members.’¹⁹³

Other specific membership composition solutions include making at least one quarter of the committee non-hospital staff, or mandating the inclusion of members from disability and aging advocacy organisations. More radically, hospitals could use an entirely independent and external oversight committee otherwise unconnected to the hospital.¹⁹⁴ The key goal is to balance between embeddedness and detachment.¹⁹⁵

B *TADA Lacks Appellate Review*

In addition to a neutral decision maker, the US Supreme Court has also held that procedural due process requires ‘meaningful appellate review.’¹⁹⁶ Review is deemed ‘meaningful’ if it prevents the arbitrary deprivation of life or liberty. If a court or state agency could review the decision of the hospital review committee, such review could largely ‘cure’ the neutrality problem.¹⁹⁷

But *TADA* has a real accountability problem. It denies substantive judicial or agency review, making the hospital committee the forum of last resort.¹⁹⁸ A court may only grant a definite extension of time. And it may do even that only when there is a preponderance of evidence that a transfer will be accomplished.¹⁹⁹ This means that *TADA* gives hospitals near-absolute (unreviewable) power over when to terminate treatment.²⁰⁰

¹⁹⁰ *Texas Right to Life v Memorial Hermann Healthcare System*, No 365099-401 para 17 (Harris County Probate Court, Tex, July 5, 2006) (Petitioner’s Original Petition for Declaratory Judgment, Temporary Restraining Order and Motion to Extend Time).

¹⁹¹ Chris Vogel, ‘Doctors v Parents: Who Decides Right to Life?’ *Houston Press* (Houston), 29 April 2008 <<http://www.houstonpress.com/2008-05-01/news/doctors-vs-parents-who-decides-right-to-life/>>.

¹⁹² Smith et al, above n 127, 1274.

¹⁹³ Inquest into the death of Paulo Melo [2008] NTMC 080.

¹⁹⁴ Diane Coleman, *Disability Rights Leadership Institute on Bioethics* (April 2014) <<http://dredf.org/drlib/wp-content/uploads/sites/5/2014/06/DRLIB-Withholding-of-Treatment.ppt>>.

¹⁹⁵ Magelssen, Pedersen and Førde, above n 176.

¹⁹⁶ *Parker v Dugger*, 498 US 308, 321 (1991).

¹⁹⁷ Bosslet et al, above n 18, 1325.

¹⁹⁸ Truog, above n 40, 2.

¹⁹⁹ See above IV C 7.

²⁰⁰ Painter, above n 112.

Some have suggested that courts can review hospital committee decisions under *TADA*.²⁰¹ But the dominant position is that substantive judicial review is not available.²⁰² ‘*TADA* immunises all denials of LSMT under its review process, whether they are entirely arbitrary, negligent, reckless, or made with malice and the intent of harming or killing the patient.’²⁰³

This is the better reading for two reasons. First, the legislative purpose and intent was to provide the legal certainty and finality that the Houston protocol lacked. Second, this interpretation is well-supported in formal executive, judicial, and legislative branch interpretations.²⁰⁴

When *TADA* first went to Governor Bush in 1997, he vetoed the bill because it ‘eliminate[d] the objective negligence standard for reviewing whether a physician properly discontinued the use of [LSMT]. And replaces it with a subjective good faith standard.’²⁰⁵ In one of the rare cases in which a case was litigated, the court refused to reach the substantive question of whether LSMT was appropriate. It found submitted medical evidence ‘irrelevant’ since the ‘hospital’s ethics committee has determined the care is inappropriate.’²⁰⁶

The state legislature has also confirmed that the role for the courts is a narrow one. ‘The court considers whether another provider who will honor the patient’s directive is likely to be found; it does not address the issue of whether the decision to withdraw life support is valid.’²⁰⁷

External oversight is essential. But that does not mean the appropriateness of LSMT should be determined by courts instead of hospital review committees. There is broad consensus that courts lack the requisite expertise and responsiveness necessary to engage in *de novo* review of these medical treatment decisions.²⁰⁸

On the one hand, *TADA* provides appellate review that is too little. On the other hand, a non-deferential and more detailed review would be too much. We must aim for a middle ground. Fortunately, we can look to well-established rules used in judicial review of agency actions. One particularly relevant model is the Health Care Quality Improvement Act (‘HCQIA’).²⁰⁹

²⁰¹ Mayo, above n 50, 1010-13; Anne L Flamm, ‘The Texas “Futility” Procedure: No Such Things as a Fairy-Tale Ending’ (2004) *Lahey Clinical Medical Ethics Journal*.

²⁰² Todd Ackerman, ‘Care Can End in Two Days: Family of Man on Life Support to Fight Ruling’, *Houston Chronicle* (Houston) 1 March 2005; *In re Nikolouzos*, 162 SW 3d 678, 682 (Tex App 2005) (Fowler J, concurring); Halevy and McGuire, above n 45; Lightfoot, above n 36, 854; Fine, above n 46, 146; *Gonzales v Daughters of Charity Health Services of Austin*, No 86247 (Travis County Probate Court, Tex May 4, 2007) (Medical Defendants’ Reply Brief in Further Support of their Opposition to Application for Temporary Restraining Order) 2; O’Callaghan, above n 157, 539 and 545; Cynthia S Marieta, *The Debate Over The Fate of the Texas ‘Futile-Care’ Law: Is It Time for Compromise* 3 <law.uh.edu/healthlaw/perspectives/2007>; Truog, above n 121.

²⁰³ Anne L Flamm, ‘Is the Baby in the Bathwater? A Defining Moment for the Texas Advance Directives Act Review Process for Medical Futility Judgments’ (2008) 18 *Health Matrix* 229.

²⁰⁴ Zerwas, above n 70, 179.

²⁰⁵ *Tex Legis J* 4926 (June 20, 1997), vetoing *Tex S Bill* 414, 76th Leg (1997); see also House Committee on Public Health, Texas House of Representatives, Interim Report 2006 (Nov 15 2006) 33, 34.

²⁰⁶ *Nikolouzos v St Luke’s Episcopal Hosp*, 162 SW 3d 678, 683 (Tex App 2005).

²⁰⁷ Interim Report, above n 205, 35.

²⁰⁸ Meisel, Cerminara and Pope, above n 6.

²⁰⁹ 42 USC §§ 11101-52.

When hospitals review their physicians in a manner consistent with the same procedural due process principles described here, they have immunity from civil money damages. So, if a hospital, with adequate notice and hearing procedures, took action that adversely impacted a physician's clinical privileges or membership in a professional society, that physician would have no monetary claim against the hospital. A court reviewing the hospital's actions would determine only if the hospital followed fair procedures and whether its decision is supported by substantial evidence. If so, the court would not reach the merits of the underlying matter.²¹⁰

C TADA Affords Inadequate Notice

In addition to having a neutral decision maker and appellate review, another 'elementary and fundamental requirement of due process' is notice.²¹¹ Notice must be 'reasonably calculated, under all the circumstances, to apprise interested parties of the pendency of the action and afford them an opportunity to present their objections.'²¹² Notice must reasonably convey this information. And it must afford a reasonable time for those interested to make their appearance.²¹³

The surrogate must have an opportunity to acquaint herself with the facts of the case.²¹⁴ But *TADA*'s 48 hours allows insufficient time for the surrogate: (a) to obtain the medical records, (b) to consult with an expert, and (c) to meaningfully prepare for the review committee meeting.²¹⁵

As significant legislative activity between 2007 and 2015 demonstrates, the short notice periods in *TADA* have been a central focus of reformers.²¹⁶ 'Civil libertarians and patient rights advocates argue that [*TADA* fails to] provide sufficient time for the complicated and technical requirements that are thrust onto the patient and family.'²¹⁷ Those who represent patients report that the 48-hour period is 'extremely difficult.'²¹⁸ Even key authors of *TADA* support more notice.²¹⁹

In one case that challenged the validity of *TADA* under federal law, the court appointed a guardian *ad litem* for a patient, Stephen Jody Helman. Mr Helman submitted a fifty-page trial brief to the court observing that *TADA* 'is by no means perfect and could certainly be improved to make it fairer and less burdensome to patients and their representatives.'²²⁰ Mr Helman pointed specifically to the 'short notice period.'²²¹

In practice, hospitals may exceed the minimum notice requirements.²²² For example, one study

²¹⁰ *Gabaldoni v Washington County Hospital Association*, 250 F 3d 255 (4th Cir 2001).

²¹¹ *Mullane v Central Hanover Bank & Trust*, 339 US 306, 314 (1950).

²¹² *Ibid.*

²¹³ *Ibid.*

²¹⁴ *Powell v Alabama*, 287 US 45, 59 (1932).

²¹⁵ Bob Deuell, 'Respecting Every Life', *Dallas Morning News* (Dallas) 2 April 2007.

²¹⁶ See, eg SB 439 (2007) (Deuell); HB 3474 (2007) (Delisi); SB 303 (2013) (Deuell).

²¹⁷ Painter, above n 112.

²¹⁸ Mary Ann Roser, 'Futility Law Gives Doctors too Much Power, Groups Charge', *Austin American Statesman* (Austin) 8 May 2006.

²¹⁹ Mayo, above n 50, 1016.

²²⁰ *Gonzales v Daughters of Charity Health Services of Austin*, No 86,427 (Travis County Probate Court, Tex Mar 6, 2007) (Guardian Ad Litem's Trial Brief on Legal Issues, 35).

²²¹ *Ibid* 35, n 17.

²²² Craig Myers, 'Section 166.046 of the Texas Futile Care Law: Supplying Health Care providers a Procedural

suggests that the average notice given to a surrogate prior to a review committee meeting was 7.9 days.²²³ But nothing in *TADA* requires more than the 48-hour ‘floor.’ Some hospitals offer no more. Indeed, hospitals sometimes provide notice on a Friday afternoon for a Monday morning meeting.²²⁴

D *TADA Fails to Assure a Meaningful Statement of Decision*

While perhaps not in the same hierarchy as a neutral decision maker, appellate review and notice; another core element of procedural due process recognised by the US Supreme Court is a ‘written statement’ of decision.²²⁵

This requirement serves several purposes. First, it helps assure that a factual basis supports the deprivation (or dispossession) of life, liberty, or property.²²⁶ Second, it enables the affected individual to understand the grounds for the deprivation.²²⁷ Third, it provides a record upon which to prepare for appeal. By enabling an appellate tribunal to review the review committee’s reasons, a written statement that sets out all the relevant facts and evidence protects against arbitrary and capricious deprivations.

Unfortunately, *TADA* places no requirements on the extent of the explanation provided. While some hospitals provide detailed explanations, others do not.²²⁸ In one case, the hospital used a preprinted single-page form titled ‘Decision of the Committee for the Determination of Inappropriate/Futile Treatment.’ The form includes no field for an explanation of why the review committee judged interventions to be inappropriate. And no reasons or explanations are provided.²²⁹

Hospital review committees ‘like judges, will give more careful consideration to the problem if they are required to state not only the end result of their inquiry, but the process by which they reached it.’²³⁰ Requiring a more complete written decision sharpens the decision makers’ internal

Framework Regarding a Difficult Decision’ Health Industry Online (Strasburger) 18 October 2006; Andy Hogue, ‘Hughes Bill Tackles End of Life Dilemmas’, Dallas Blog (Dallas), 20 April 2009; ‘Texas Act Formalizes Ethics Committee Role in Disputes’, Medical Ethics Advisor, 1 April 2006; Mayo, above n 50, 1015.

²²³ Email from Lance Lunsford, vice president for advocacy communications, Texas Hospital Association, 21 May 2014, cited and linked as a source; W Gardner Selby, ‘Texas Right to Life exaggerates on claim of “faceless hospital panel” determining treatment’ 30 May 2014, <<http://www.politifact.com/texas/statements/2014/may/30/texas-right-life/texas-law-gives-hospital-panels-sway-over-cutting-/>>.

²²⁴ *Gonzales v Seton Family of Hospitals*, No. A07CA267SS para 24 (WD Tex Apr 4, 2007) (Complaint); *Texas Right to Life v Memorial Hermann Healthcare System*, No. 365099-401 para 7 (Harris County Probate Court, Tex, July 6, 2006) (Petitioner’s Original Petition for Declaratory Judgment, Temporary Restraining Order, and Motion to Extend Time).

²²⁵ *Morrissey v Brewer*, 408 US 471, 489 (1972).

²²⁶ *Black v Romano*, 471 US 606, 614 (1985).

²²⁷ *Haymes v Regan*, 525 F2d 540, 544 (2d Cir 1975).

²²⁸ *Gonzales v Seton Family of Hospitals*, No A07CA267 (WD Tex Filed 4 April 2007) (Complaint) (Exhibit B to Affidavit of Catarina Gonzales (Feb 19, 2007)) & Exhibit D to Affidavit of Catarina Gonzales (Mar 9, 2007)).

²²⁹ *Texas Right to Life v Memorial Hermann Healthcare System*, No 365099-401 (Harris County Probate Court, Tex, July 6, 2006) (Exhibit A to Petitioner’s Original Petition for Declaratory Judgment, Temporary Restraining Order, and Motion to Extend Time). See also *Davis v Memorial Hermann Healthcare System*, No 2009-07079 (Harris County District Court, Tex (Feb 4, 2009) (Petition); see also Robert L Painter, ‘Introduction to the Texas Advance Directives Act’ <<https://www.youtube.com/watch?v=TIX4J0TQFwY>>.

²³⁰ *United States v Merz*, 376 US 192, 199 (1964).

thought processes.²³¹ Moreover, written statements of decision show families that the committee seriously considered their arguments and facilitates judicial review.

What exactly review committees should include in their written statements of decision brings us to the next due process concern.

E *TADA Fails to Provide Criteria to Guide Committee Review*

Closely related to *TADA*'s failure to assure a meaningful statement of decision is its failure to provide any criteria to guide the review committee. The Supreme Court has warned about vague statutes that fail to provide explicit standards for those who apply them. Such statutes increase the risk that the decision maker will resolve the case 'on an ad hoc and subjective basis with the attendant dangers of arbitrary and discriminatory application.'²³²

This risk is especially high with *TADA*. Not only does *TADA* have no oversight, monitoring, or accountability but it also has no consistency or standardisation.²³³ Without any guidepost anchors or criteria, there may be significant variability both in when and how hospitals invoke *TADA*. Enormous variability has already been well-documented across US intensive care units.²³⁴ Moreover, this variability is expressly presumed by the transfer requirement.

The statute neither contains nor suggests any ascertainable standard for determining the propriety of continuing LSMT.²³⁵ This creates three problems. First, it means that the decisions of review committees may not be as informed or reasoned as necessary. Second, the lack of guiding standards means that a single hospital review committee may disparately treat similarly situated patients. Third, it means that review committees at different hospitals may be deciding similar cases differently.

Now, the reader may ask how *TADA* could include substantive criteria, when its very genesis lies in the inability of clinicians and philosophers to identify any such criteria. First, illegitimate bases for refusing treatment (such as the patient's race) could be specifically excluded. Second, while a universal definition of 'futility' has proven elusive, specific futile scenarios have garnered widespread support.

For example, many clinicians deem LSMT inappropriate: 1) when the burdens of treatment significantly outweigh the benefits, 2) when treatment can never achieve the patient's goals; 3) when death is imminent, 4) when the patient will never be able to survive outside of an ICU, and

²³¹ Douglas E Abrams, 'But "Will It Write?" How Writing Sharpens Decision-Making' (2009) 3(2) *Precedent* 61.

²³² *Grayned v City of Rockford*, 408 US 104, 108-09 (1972).

²³³ Testimony of Colleen Horton on SB 439 (2007) (211:10).

²³⁴ Dominic J Wilkinson and Robert D Truog, 'The Luck of the Draw: Physician-Related Variability in End-of-Life Decision-making in Intensive Care' (2013) 39(6) *Intensive Care Medicine* 1128.

²³⁵ *Gonzales v Seton Family of Hospitals*, No A07CA267 para 48 (WD Tex Filed 4 April 2007); Maureen Kwicinski, 'To Be or Not to Be, Should Doctors Decide? Ethical and Legal Aspects of Medical Futility Policies' (2012) 7(2) *Marquette Elder's Advisor*, 313, 349; O'Callaghan, above n 157, 529, 543, 564-66 and 589-96; David M Zientek, 'The Texas Advance Directives Act of 1999: An Exercise in Futility' (2005) 17(4) *HEC Forum* 245; Heitman and Germillion, above n 76.

5) when the patient is permanently unconscious.²³⁶

These principles cannot be automatically or mechanically applied in an algorithmic fashion. But neither must they be wholly disregarded. These and similar definitions, rules, and paradigm cases can productively inform and guide review committee deliberation and analysis.

F *Other Due Process Concerns*

While the above five elements of procedural due process are those that present the most serious problems with *TADA*, they are not the only ones.²³⁷ The quality of *TADA* review committee decisions is also materially adversely affected by: 1) the review committee's lack of diverse membership, 2) the review committee's lack of training and competence, 3) the absence of standard meeting and hearing procedures, and 4) the absence of a requirement assuring the surrogate's participation.

First, *TADA* omits several key issues relating to the review committee.²³⁸ In stark contrast to federal regulations governing Institutional Review Boards in the research context, *TADA* includes no details or guidelines concerning how a hospital composes its ethics committee.²³⁹ *TADA* is silent as to: a) the overall number of committee members required, b) the inclusion of members from different professional disciplines c) the inclusion of lay or community members, and d) the inclusion of members with different gender, race, and disability status.²⁴⁰

Second, *TADA* is silent as to the training or qualifications of the review committee members.²⁴¹ Many bioethics leaders have expressed "growing concern" about the practice of healthcare ethics consultation and how it is practiced.²⁴² The field is moving toward certification based on educational achievements and examination performance. Here, where the review committee acts as a decision maker, not as a mere advisor or consultant, the need to assure that it has the right knowledge and skills is even higher.

Third, *TADA* fails to define the 'rules by which an ethics committee must operate.'²⁴³ Committees have neither quorum requirements nor a system of review.²⁴⁴ They do not report whether their decisions are unanimous or by a slim majority or whether dissent existed.²⁴⁵ Some surrogates have

²³⁶ Thanh N Huynh et al, 'The Frequency and Cost of Treatment Perceived to Be Futile in Critical Care' (2013) 173(20) *JAMA Internal Medicine* 1887.

²³⁷ The right to representation by counsel is another essential element of a fair hearing. *Thompson v Board of Education of Henderson County*, 838 SW 2d 390, 393 (Ky 1992). But *TADA* also does not assure the surrogate a right to have legal counsel present.

²³⁸ Testimony of Michael Rieger before House Committee (April 25, 2007) (446:00); Texas Hospital Association, *Key Messages on Texas Advance Directives Act*; Heitman and Gremillion, above n 76, 95; Fine and Mayo, above n 147, 744.

²³⁹ 45 CFR § 46.107.

²⁴⁰ Painter, above n 112, 20; Zientek, above n 235, 253-54.

²⁴¹ Texas Act Formalizes Ethics Committee Role in Disputes, Medical Ethics Advisor (1 April 2006).

²⁴² Ellen Fox, 'Developing a Certifying Examination for Health Care Ethics Consultants: Bioethicists Need Help' (2014) 14(1) *American Journal of Bioethics* 1.

²⁴³ Fine, above n 46, 146.

²⁴⁴ Robert's Rules of Order Newly Revised (11th ed Da Capo Press, 2011).

²⁴⁵ Hearing before Texas HR Comm on Public Health Interim Rep, 80th Legis (2006) (Statement of Richard Mullin).

even reported that they were stopped in the hall of the hospital, and later learned that brief and informal encounter constituted the review committee meeting.²⁴⁶

Fourth, the ‘right of confrontation and cross-examination is an essential and fundamental requirement’ of due process.²⁴⁷ But *TADA* assures only the surrogate’s right to ‘attend’ the meeting. It does not assure the surrogate a right to ask questions of the attending physician.²⁴⁸ Many hospitals voluntarily allow this.²⁴⁹ But there is no provision in *TADA* that guarantees the right.

VII CONCLUSION

Striking the right balance between efficiency and fairness is difficult. These two goals are in tension. Dispute resolution procedures that better achieve one goal entail a tradeoff that correspondingly disrespects the other. On the one hand, the cost of less process is undermining deeply held principles of fundamental fairness.²⁵⁰ On the other hand, the cost of more process is maintenance of the status quo, the continued administration of potentially non-beneficial treatment.²⁵¹

TADA is a commendable attempt to ‘steer a course between the Scylla of judicial review and the Charybdis of unfettered, unexamined physician discretion.’²⁵² But *TADA* places too much weight on efficiency at the cost of fairness.

The recalibration that I have defended in this article would not change the fundamental power of hospital review committees to authorise the withholding or withdrawal of inappropriate LSMT. Instead, the changes would be minor, affecting only 1) who is on the review committee, 2) how the committee conducts its meeting and makes its decision, and 3) the extent to which that decision can be reviewed. If *TADA* is used as infrequently as recent reports indicate, the costs of more process are circumscribed and determinate. This is a small price to pay to properly respect notions of due process, fundamental fairness, and fair procedure.

See also, Hearing before Texas HR Comm on Public Health, 80th Legis (2007) (Statement of Gregory Hooser); Hearing before Texas HR Comm on Public Health, 80th Legis (2007) (Statement of Colleen Horton, Univ of Tex Ctr for Disabilities Studies).

²⁴⁶ Testimony of Robert Painter on SB 439 (2007) (261:20); Texas Health & Safety Code § 161.031(b).

²⁴⁷ *Lee v Illinois*, 476 US 530, 540 (1986).

²⁴⁸ *Gonzales v Seton Family of Hospitals*, No A07CA267 para 46 (WD Tex Filed 4 April 2007); Testimony of Adam Black on SB 439 (2007) (269:30).

²⁴⁹ *Gonzales v Seton Family of Hospitals*, No A07CA267 (WD Tex Filed 4 April 2007) (Complaint, Exhibit A to Affidavit of Catarina Gonzales).

²⁵⁰ Truog, above n 121.

²⁵¹ Stewart 2011, above n 173.

²⁵² Mayo, above n 50, 1010.