01-0079 **S. A. M. by and through her next friend, Karla H. Miller, and Karla H. Miller and J. Mark Miller, Individually**
v.
HCA, Inc, HCA-Hospital Corporation of America, Hospital Corporation of America and Columbia/HCA Healthcare Corporation

From Harris County and the 14th Appellate District

KELTNER: If it pleases the Court, the issue in this case is straightforward. When adequate time for consultation exist, who gets to make the decision to resuscitate a child when the doctors have told the parents that the resuscitation measures, themselves, will cause severe and permanent disability? Is it the parents, as we have traditionally done in this state with the justifiable interest of the state intervening in the best interest of the child, or is it the hospital or healthcare provider with no input from the parents at all and no review by the court's system? That's what this case is about and let me also tell you because we have a large number of amicus briefs in this case let me tell you I think what the case is not about. It's not about opting for certain death. That's not the facts of this case. Dr. Otero, the neonatologist who delivered this child and delivered, excuse me, actually administered resuscitation testified about that issue. He was asked, "Would Sidney have died without the resuscitated treatment?" and he said "No, not at all. Might well have lived." In fact he said, "that she would have a reasonable chance for living." Additionally, Dr. Sparks, HCA's testifying non treating expert, testified to the same thing. But it was impossible to make that determination. Even during the final argument at trial Mr. Serpe, arguing for HCA, argued to the jury that this child might well have survived without

the resuscitative treatment and indicated to the jury the crucial fact in this case and that is that Sidney Miller, as a fetus, had no fetal abnormalities other than prematurity, no fetal distress before the birth and the resuscitation. The jury also heard and believed evidence in this case that the resuscitation itself caused the disabilities. That's exactly what the parents had been told when warned about the issue of doing the resuscitative treatment. They were told that there was a significant opportunity that the child could be disabled as a result of the treatment. Its case is also not about the parents choosing to end a life because of annoyance or inconvenience for caring for a child. Heavens! The facts of this case are exactly the opposite of that. The Millers on seven occasions have intervened to save Sidney's life after she was disabled because of the aggressive treatment she received at birth. Seven times at an expense of over a half million dollars out of their pocket at Texas Children's Hospital. They had an opportunity to do an abortion at this case which was done at this HCA Hospital they declined that opportunity and it was not medically indicated as well. No one has a greater interest in disabled rights than the Millers do because they face that fact daily. They have never withdrawn this trial from resuscitation (interrupted)

HECHT: The rule that you . . .

KELTNER: Yes sir.

HECHT: The rule that you proposed though wouldn't apply to people who did and people who didn't. The rule that you propose would apply to parents who

were caring and parents who were not.

KELTNER: No sir. Your Honor that is not. And let me explain. And I appreciate that question because that has been the suggestion of HCA and the suggestion of several of the amicus briefs. What we propose is that the parents get the opportunity to make the decision of what to do with their child, and I'll tell you why in just a second. But we recognize and in fact we advocate to you that any decision you write in this case ought to be true to the Family Code, what the AMA standards are, and what the United States Supreme Court has said, and that is "that the state has the right to intervene in instances in which the best interests of the child are not served by the parents decision." Tab 9 of the (interrupted)

HECHT: What I'm asking though is, take this exact case . . .

KELTNER: Yes sir.

HECHT: If the parents had, uh you say the parents were well minded toward the child, but what if they hadn't been? What if they had just callously said, "Look we don't want to put up with this the rest of our lives. We want to be rid of it."

KELTNER: The AMA standard, which is at Tab 9 of the TMA brief, answers the question the way we would answer it, your Honor. And is our position. In that situation, what the AMA says, and their ethical consideration is what you do is you let the parents make a decision; let the doctors and the parents make a decision the doctors don't agree with; you go to an ethical committee to discuss that with the parents, HCA did not have one. You discuss the policy, the written policy, with the parents, HCA did not have that either, and then

if there is a disagreement between the healthcare provider, then the healthcare provider goes to the state and seeks intervention in the best interest of the child. That's what we're saying the policy of the state ought to be, and your Honor also we believe that's what the legislature is already demonstrated the policy is in the Family Code. The United States Supreme Court in *Bowen* looked at exactly this kind of system and noted that the majority of states in this country have precisely that kind of system that represents the idea that the parents make the decision, subject justifiably, to the intervention in the best interest of the child if the parents, for some reason, are ill motivated.

HECHT: But why is it any more or less in the child's best interest to be resuscitated because of the parents motives?

KELTNER: Your Honor I think the interest, the issue of what's in the best interest of the child is a question that is difficult to decide.

HECHT: I know. But take two . . . I pray to God this doesn't happen, but if you had two situations virtually identical, one set of parents says, "Oh this is terrible, we hate to see this happen, but it's probably in the best interest of the child – no resuscitation." The other set of parents says, "We don't know. We don't care. We don't want to worry about this – no resuscitation." From the child's perspective it doesn't make any difference.

KELTNER: Absolutely right your Honor. And I could not disagree with that. And I will tell you that the AMA and the American Academy of Pediatrics do address that and by the way the American Academy of Pediatrics decision, Tab 11 of the

TMA brief, and they address those issues about what is in the best interest of the child and the things you consider and not consider. And they do address things like the financial interest of the family, whether the family is just annoyed, or it's just inconvenient. But they also address the other issue here though, your Honor, when you really get down to it is who gets to make this decision. The suggestions of HCA, and the suggestions of some of the amicus briefs says that, "The parents are not all all the time well motivated." We can see that. It's not the case here. Certainly it's not the case here. And there's no evidence to suggest to the contrary. But the American Academy of Pediatrics looks at it and they make another observation that's equally as important. Why is the healthcare provider in this case a for profit hospital corporation that runs hospitals as profit centers, which is the evidence in this case. Why are they less well motivated in terms of this decision? The American Academy of Pediatrics points out that no decision should be made for financial interest in any way in these types of cases and we certainly agree with that. The issue again is who gets to decide.

HANKINSON: Mr. Keltner, I understand from talking . . . now that we're onto the financial interest piece, um, my understanding from your brief is that you take the position that this is not a wrongful birth case. If that is your position would you explain why it is not a wrongful birth case?

KELTNER: Yes your Honor. *Nelson v. Krusen* is the wrongful death decision wrongful life decision from this court, and I think that's what you're really asking. In *Nelson v. Krusen* this court defined what that cause of action is in terms of

what was before the court. Remember, what happened there is we had a baby in neutorol that had become disabled because of a disease, because of a hereditary disease. The life was already disabled in some way and impaired. And the question was, is there a cause of action for giving birth to that child and an impaired life? That's not the issue here. Question 1 and question 2 that were submitted to the jury, don't submit that. What they submit is who caused the disability. What caused the disability? The jury found that the resuscitated treatment here caused the disability. Remember, even HCA argued to the jury at trial that there was no abnormalities in this fetus prior to the time it was born. It was simply premature. The testimony from Mark and Karla Miller was that the doctors had informed them that the resuscitated treatment, aggressive resuscitated treatment was both experimental and would cause these disabilities.

OWEN: What if we . . . let's uh . . . I just want to play this out. Let's suppose that they had gone to court and I'm the trial judge sitting there before the baby's born – what kind of order do I enter when I don't know the birth weight of the baby and there's all sorts of factors, aren't there, that would bear on the decision whether to resuscitate or not and you don't know what those factors are until the child is born. So what kind of orders does the trial court enter?

KELTNER: Justice Owen, that's a very good point. And our friends at TMA have filed a brief indicating that you always should wait 'til after the birth to be able to make that decision. And candidly, I think your decision can reflect that, if you wish it to. That's just not the facts of what happened here. Remember

(interrupted)

OWEN: Do you suggest that the hospital should have gone pre birth to a court to get an order? Now, I'm asking what would the trial court have done in those circumstances?

KELTNER: Your Honor, it is difficult to know what the trial court would have done in this case. Remember what they would have heard. They would have heard testimony from the parents, and I urge to you from one of the doctors, that the resuscitated treatment was likely to cause exactly these disabilities. Blindness and severe brain damage. They also, if they testified as they testified at trial, they would have testified that the baby otherwise had a chance to live. That is a difficult decision to make. A very difficult decision to make.

OWEN: But doesn't that depend on a lot of factors that are unknown 'til the baby is alive – is born. I mean, did the judge say "well if it weighs 658 resuscitate if it weighed 657 don't . . .

KELTNER: Your Honor . . .

OWEN: . . . or if it's at our scores . . . what would the trial court enter?

KELTNER: But that was not the facts of this case.

OWEN: But I'm asking you . . .

KELTNER: For policy purposes . . .

OWEN: . . . for policy purposes?

KELTNER: For policy purposes I think it's important to have as much information as you can. And I think you can write that in the decision in this case and still

reverse the court of appeals. Here's why. Remember, in this case it was the hospital who had dictated a policy that made anything that happened at the birth irrelevant. The hospital's policy, and this is testified by Ana Summerfield and Dr. Otero who delivered the baby as well, was if it was 500 grams or above the baby was going to be resuscitated period and para gram. Dr. Otero was asked, "Well, did these other situations have any affect on you? Did the Baby Doe regulations have any affect?" Here's what he said, "No. The baby was above the cut off weight and was gonna be resuscitated." The decision of the hospital was made seven hours prior to birth. They knew through an ultrasound that the baby was 629 grams – actually turned out to be 615 at birth. If the baby had been born dead that would have been one issue. If the baby lived, this baby was gonna be resuscitated. Again, we agree with our friends at the TMA. It is important to make these decisions. The Millers were in the obviously both the Millers were in the delivery room the entire time. There was an opportunity for other consents. They weren't given.

HECHT: Under your view, if your advocating the AMA standards, don't you have to prove that a judge would have agreed with the parent? Not even a probability in order to get to a jury on damages?

KELTNER: No sir. And there's, I think there's two reasons for that. In a battery cause of action, all we have to prove is that somebody treated without consent. That is clear here. There is no real dispute now in the record on that and you don't see a point of error I think from Columbia/HCA on that issue. The truth

of the matter is here . . . I mean, your Honor, I know you have children. Look at it . . . this hypothetical that I pose it to you could occur quite often. A child is exposed to a disease. We don't know whether the child has the disease yet or not, but there's an inoculation. If the child has the disease, there's an 80% chance of possible fatal consequences. But, there is a 30% chance with the inoculation whether the child ever gets the disease or not, there's a 30% chance that the child will be severely brain damaged. Who gets to make that decision? The Family Code says it's the parents subject to the best interest of the state. The United States Supreme Court has upheld that. Your Honor in one other thing, and I think this is very important, in *Parham v. J. R.* cited by the Texas Right to Life Committee I think lays out this issue better than anything else. And in *Parham*, what the Supreme Court said is, "In the United States years ago, we rejected the idea that the child was a ward of the state or was just an entity of the state." We recognize and western jurisprudence going back to as early as the first blackstone commentaries in the 1600's recognized that the parents were able to act in the best interest of the child.

HANKINSON: Mr. Keltner, what is the current state of the law on the relationship between the Federal Baby Doe Regulations and state law on a parents duty and right to consent to medical treatment for their child?

KELTNER: Your Honor, the Baby Doe Regulations have no prohibitions. They just require reporting and investigating on alleged child abuse. That's what they do. That's actually pretty much what the . . . even the TMA brief says as

well.

HANKINSON: So they have no impact in this type of circumstance?

KELTNER: I think they do, but here's the impact they have – the Baby Doe Regulations . . . (interrupted)

HANKINSON: Finish.

KELTNER: The Baby Doe Regulations it's interesting. Governor, now President Bush, then Governor, confirmed that the Child Protective Services theory under the Family Code that we advocate to you in the brief, fulfills the Baby Doe Regulations for funding purposes. And that is the case. What you do is if you see abuse you report it. You also go to the state, if you want the state to intervene, in the best interest of the child. And interestingly, the American Academy . . . uh, no excuse me . . . the American Medical Association says, "That duty rests with the healthcare provider for the hospital."

JEFFERSON: Does the baby qualify as . . . as a qualified patient under the ADA, §166?

KELTNER: Under the ADA?

JEFFERSON: Yes.

KELTNER: . . . of the Advanced Directors Act?

JEFFERSON: Yes.

KELTNER: Your Honor, the TMA says no. We believe no. The Court of Appeals held no. I do not believe it does.

PHILLIPS: Any other questions? Thank you counsel. Court is ready to hear argument from Respondent.

HATCHELL: May it please the Court? Um, my good friend has primmed this issue in this case as a contest between a hospital administrator and parents as to who gets to decide whether a child will receive life-sustaining treatment, who can direct a course of treatment that will result in the death of that child. That is not the issue. The issue is, does anyone, parent, hospital administrator, the hospital itself, the government, have the right before a child is born to dictate a course of treatment that will result in that child's death? In order to sustain their proposition (interrupted)

ENOCH: Well let me ask you a question though . . . but somebody made a decision to do something to the child. I mean the child just wasn't sitting there. Somebody made a decision to do something to the child. So is it correct to frame the question like who makes a decision to keep something from happening. I mean, the doctor, the hospital, somebody made a decision to take some affirmative step with respect to the child and I thought that the issue here is absent parental consent for medical treatment to the child, what authority does the hospital have to have taken this affirmative step, seems to me.

HATCHELL: And the hospital has the authority because under the Family Code, Sidney Miller was entitled to receive precisely the same care that any full term infant would have if she had obligation to receive (interrupted)

HANKINSON: Mr. Hatchell what . . . as you're answering that, what in the Family Code though gave the hospital the authority to make that decision?

HATCHELL: Sidney Miller's rights to receive medical care are given by the Family Code

when she was born. Dr. Otero, who had been called in by the Miller's obstetrician to evaluate, not to treat, but to evaluate, made the decision based upon medical judgment that she was in extremist. He had approximately 60 seconds to make this determination and he made a determination that she was viable. That treatment would not be feudal. And because of the short life span that she would have had she qualifies for implied consent under the (interrupted)

HANKINSON: I go back to the question of where under the Family Code gave the hospital the authority to make the decision that their policy about resuscitation for infants born of a certain size or greater were to be resuscitated?

HATCHELL: That portion of the Family Code that gives Sidney the right to receive from the hospital the same care she would have received had she been a full term baby. Bear in mind your Honor (interrupted)

HANKINSON: I understand the right to receive care. I understand that. But you would agree that at Common Law in the context of receiving medical treatment that no treatment can be provided by a physician or a healthcare provider without the consent of the patient?

HATCHELL: I agree with that.

HANKINSON: And so consent does play a role in this case?

HATCHELL: It does play a role in (interrupted)

HANKINSON: And someone had to have the authority under the law to consent. So even if she had the right to the treatment, the question is who had the

authority under the law to consent to it on her behalf.

HATCHELL: Dr. Otero . . .

HANKINSON: Okay.

HATCHELL: Dr. Otero who had the baby in his presence has the result of a voluntary agreement by the Millers to have the child born was presented as a result of that decision with a baby that was an extremist and um . . .

HANKINSON: Wasn't that issue though decided against the hospital and answers the first question of the jury charge when the jury decided? Because I understand, it was a disputed fact issue at trial as to whether there was consent and what the consent was for by answering the first question the way the jury did that a battery had been committed. Why wasn't that decided against the hospital and we must accept it as the bases of the factual underpinnings of the case?

HATCHELL: Number one because it is established as a matter of law at the moment she was born which is the only point in time in which her constitutional right to either receive treatment or reject treatment came into being. She was an extremist and had to be resuscitated (interrupted)

HANKINSON: You don't believe she had any right to treatment before she was born?

HATCHELL: Whether she had right to treatment before she was born, um, that's a very very complex issue. Um . . .

HANKINSON: Well as I understand your argument, you're saying her right to treatment did not arise until she was born and I thought that was

contrary to the law.

HATCHELL: Her . . . yes. No her constitutional right to receive treatment and to reject treatment constitutional right comes into being the moment of birth.

HANKINSON: What authority do you have for that?

HATCHELL: That's *Roe v. Wade* and it's progeny that the constitution does not apply to the unborn.

ENOCH: Mr. Hatchell. The um, the Petitioners here assert that what you're really arguing is that there was an emergency circumstance that obviates the doctor's obligation to get the consent but that issue is an affirmative defense that the hospital didn't raise. But that's not really the emergency nature of the treatment is not an issue that the hospital has put before the court.

HATCHELL: Well I think it is. I think it's been in this case all along. And I think it's established as a matter of (interrupted)

BAKER: Isn't that an affirmative defense?

HATCHELL: I do not think it is an affirmative defense. No I think it is a right that Sidney had when she was presented to the hospital (interrupted)

BAKER: Well she may have a right, but don't you have to raise it?

HATCHELL: No. I think that . . . I do not. I think the gravest decision gives us the right to imply consent when she was placed in our care and custody for treatment through a voluntary act to have her born and not aborted.

BAKER: But they dispute that.

HATCHELL: No. No, they do not dispute the fact that the Millers gave consent for her natural birth and not be aborted.

BAKER: But they withheld their consent for any resuscitation treatment.

HATCHELL: That is a disputed issue that would have to be resolved in the Millers favor. Yes that is correct.

BAKER: Well, don't those play against each other.

HATCHELL: I don't think so.

BAKER: When the very thing that the whole argument about is that resuscitation treatment?

HATCHELL: No because again back to my principle framing of the issue, who has the right to consent before someone is born? The right for consent and the right in this particular case to refuse treatment is a constitutional liberty interest which only arises the moment she was born.

ENOCH: Okay. Let me ask you on . . . the doctor made a decision to perform treatment on the child.

HATCHELL: That's correct.

ENOCH: So I guess I go to the threshold question . . . what does the court considerate? Under ordinary scheme of things, as I understand the Family Code, if it's a minor child the parent consents. And it's not a matter of who makes the decision, it's the matter of the process that you go through. Now if the doctor in his or her medical judgment decides the parents consent is not appropriate and the doctor has, under the Family Code, some mechanisms available to go to court and get a determination, ultimately from the court, that the medical treatment will be provided. In this scheme of things it seems that the doctor can argue that even though parental consent

was necessary and even though the doctor failed to go to the court to get state intervention in the appropriate manner that under emergency circumstances the doctor is free to exercise that medical judgment to try and save the life of the child. It seems to me in this whole process of evaluation if the . . . there's a question about whether or not the life of the child really is at issue. Dr. Otero says, "Well there's no showing that the child would die without this resuscitation.

HATCHELL: That's actually incorrect your Honor.

ENOCH: Well they quote it in the brief. So if the quotes incorrect I'd appreciate it, but to be advised where that's a misquote, but obstensively there's a quote from the doctor's testimony. And so there's a question. There's a question about what would happen to this child. And then there's a question about what would happen to the child if you provide the resuscitation. And so somebody has to make a decision of which of the risks you follow. If the hospital doesn't assert that it's an emergency as an affirmative defense to touching the child, if they don't assert it's an emergency, but simply relies on the constitutional right to treatment, how does this court decide that the child should have had . . . in the face of arguments over what's the best course for the child, how does the child decide the constitutional right to have a treatment that produces arguably the damage? I mean, where's the threshold that we decide the constitutional right now absolves the hospital of the batter on the child because they lack parental consent.

HATCHELL: Your honor makes a good point because think this . . . what I see the Miller's

burden in this case is to answer three questions which they have, I think, not answered. Was there a constitutional right to receive treatment? Number two, did they have the power to enforce that right when they did? And number three, what are the standards, which your Honor raises? And I suggest that if you look through the fabric of Texas law you will find that virtually every indicator is a command to treat. The Family Code, as I have indicated, indicates that a child of premature birth is entitled to be treated; the parents in the Family Code are cast upon a duty to provide medical treatment, not as opposing counsel says, "a right to deny treatment." The Natural Death Act defines those circumstances in which life-sustaining procedures can be withheld (interrupted)

BAKER: Mister . . . Mr. Hatchell is one of your arguments that is now called the Advanced Directive Act? Is that right? Is that the linchpin of your argument on how the hospital could treat under these circumstances?

HATCHELL: No entirely your Honor, but I . . . um, in my judgment by the way, it was the Natural Death Act that was in play (interrupted)

BAKER: At the time.

HATCHELL: . . . in this particular time the Advanced Directives Act is a virtually identical act with considerable more verbiage to it. Yes. It is a linchpin in our argument to the extent (interrupted)

BAKER: Well, put it this way, are we weighing whether the statutory construction on whether an act applies or not to determine the outcome of the issue?

HATCHELL: I do not think that it is entirely determined at the available issue, your Honor,

but I will say I think that the Natural Death Act because it does speak specifically to resuscitation and life-sustaining procedures is very important. In my judgment, the Texas Legislature has occupied the field through the advance, pardon me, through the Natural Death Act. And it does specifically exclude the ability of children to issue an oral directive and it does specifically put give parents the power, but it also limits those circumstances in which that power can be exercised. It forbids the concept of mercy killing. And so I think it defines very clearly the fabric of the standard of care (interrupted)

BAKER: But it has to apply before your view gets the benefit of your argument, is that right?

HATCHELL: Yes. And in my judgment, Sidney had to be a qualified patient in order for (interrupted)

BAKER: Well as you know they argue the other way?

HATCHELL: I agree with that, but there is no doctor . . . well, I don't . . . I think we're actually in agreement on this point and that is that no doctor would certify Sidney Miller as a qualified patient in the sense that she had a terminal disease. But I think in addition to that your Honor (interrupted)

HANKINSON: Doesn't that then make the Act not applicable under these circumstances? Natural Death Act, where now it's called the Advanced Directive Act was designed to allow consent to treatment in an advance basically, in particular circumstances in which the person who might be consenting would be unable to legally give

consent.

HATCHELL: I think on a policy basis, your Honor, it is broader than that. I think it is (interrupted)

HANKINSON: In what way?

HATCHELL: It is an Act that defines those circumstances in which life-sustaining procedures can be withheld or withdrawn. You also have to look at the entire spectrum of options available to a treating doctor. At the low end of um you would have the concept of futility (interrupted)

HANKINSON: But if I have, if, for myself . . . if I had not signed an advanced directive form underneath the statute, and I am in a position to still be able to say and I'm competent to do so that I do not want to be on life support systems when I become . . . when I . . . I am free to do that without having complied with the act because I can, I can say 'I don't want medical treatment.'

HATHCELL: You can say that your Honor. But life sustaining medical treatment cannot be withdrawn from you unless you have complied with the Act. Again, except in this circumstance. If it is futile, at the one end, or two at the other end, if it is merely ameliorative and is not the denial of life-sustaining procedures. In the middle where we're talking about the withdrawal of life-sustaining procedures, the act is necessary to be applied in that judgment and in your particular circumstance an adult can make an oral directive and there are procedures for them.

O'NEILL: I'm curious about the procedural piece, um, how much does your argument

depend upon the emergency nature of this decision? Because I think you'd agree, but for what you claim to have been an emergency split second decision, either the parents get to make the decision or the court gets to make the decision. And where you're saying that the hospital can step in here is only in an emergency situation, is that correct?

HATCHELL: Your Honor, I say this was an emergency situation and (interrupted)

O'NEILL: I understand. And your argument depends on that, right?

HATCHELL: I know, but, but, I do not agree with the proposition that it's a contest between only the parents or only the hospital.

O'NEILL: No, but what I'm saying is you would agree that if there is not an emergency situation that there are two options: either go with the parents' wishes or go to the court?

HATCHELL: If we're talking about post birth yes, that's correct. The situation in which Sidney found herself, in this case in our judgment was an emergency and under (interrupted)

O'NEILL: So your argument does hinge on the emergency question?

HATCHELL: Yes.

O'NEILL: And you don't believe that's a factually intensive question that the jury has to decide as to what was anticipated to happen after the birth? What the predictions were that could happen?

HATCHELL: No.

O'NEILL: But that's as a matter of law that those decisions cannot be made until the moment of birth.

HATCHELL: Your Honor, when you read this record you will come to the same conclusion in my judgment.

HANKINSON: But . . .

O'NEILL: Back to my original question. Are you saying that in every case there can be no decision made from the parents or from the court until the moment of birth even if you know, let's say that you knew before hand that exactly what the fetus was going to, um, go through before birth and after birth and exactly what was going to be presented and everybody agreed on that? You'd still say no decision is made until the child is born?

HATCHELL: I absolutely do say that your Honor because at the moment of birth there is a coalescence of rights that Sidney has one of which is to refuse treatment but the other is to receive life-sustaining procedures. And I think the policy of the law needs to be that we make those determinations on the basis of a real life human being and not a statistic.

HANKINSON: Mr. Hatchell?

O'NEILL: But basically what you're saying though in answer to my question is that you leave that up to the hospital or the doctor completely in every circumstance because that would be the result. If you can only decide at birth and it's evolving that quickly so that the court can't come in, uh, then you're saying it's in the doctor's hands or the hospital's policy's hands in every situation as a matter of law?

HATCHELL: Well, first of all lets, I want to clear up the notion of hospital policy. The hospital simply has policies to ensure that physicians practicing within their

doors adhere to medical standards. So (interrupted)

O'NEILL: But without going into that analysis, it would either be the doctor or a hospital policy? It would never be the court in that situation?

HATCHELL: That is correct.

JEFFERSON: Can you provide prior to birth a procedure for court intervention? You know in anticipation that quick decisions have to be made?

HATCHELL: It's an interesting concept your Honor, um, and in this particular case I think it is probably impractical. You have probably four questions that need to be asked. Who goes to court? What court has jurisdiction? What are the standards? And is the court doing anything more than rendering an advisory opinion.

O'NEILL: But that's a different question because we have firmly imbedded in our life procedure. And my understanding is you're trying to cut an exception out from that procedure based on an emergency. Let's say you have a fetus who is going to be RH negative and is going to need a blood transfusion at birth and you know that throughout the pregnancy. The doctor knows that and the parents withhold consent for the blood transfusion and there's an established procedure that you go to court then to have that determined ahead of time that if the baby needs a blood transfusion it will be done. But under your construct, you could never make that decision until the baby was born and then it would be an emergency situation and that you could circumvent that system?

HATCHELL: I think you're correct.

HANKINSON: Well, Mr. Hatchell though, I'm uh, I'm a little bit confused by that because my understanding and I don't know if it's correct or not, but my understanding of the emergency treatment doctrine is that that doctrine would allow a healthcare provider to provide treatment without obtaining consent because it's not possible to obtain the consent because of the emergency situation of the circumstance, correct?

HATCHELL: Correct.

HANKINSON: Well, even under that circumstance we have a parent, both parents present in the delivery room with the authority under Texas Law in the Family Code to consent and they are there and they say I do not consent at this moment. Even if we adopt your construct that no rights arise nothing happens until the baby is born. And if that ends up happening, the emergency . . . as it is currently constituted in the law, the doctrine still cannot apply because the parent is present to say I do not consent. And that is only available to a healthcare provider if they are unable to obtain consent – it's not possible to get it. They know they don't have consent it doesn't apply. So we're going to have to change the emergency treatment doctrine aren't we?

HATCHELL: I do not think so your Honor. First of all from a factual standpoint, both the Millers were in the delivery room and neither uttered any objection to the treatment to the evaluation about Dr. Otero and the subsequent conduct.

HANKINSON: No. The record also indicates, and I believe it was disputed, they had

been saying for eleven hours don't resuscitate.

HATCHELL: That is correct. And that gets back to (interrupted)

HANKINSON: And, and at that point in time when they went into the delivery room apparently the jury decided that they still were of that mind set. But my point is is that just looking at a separate . . . let's look at a hypothetical case with parents in the delivery room and they say, "Do not treat that baby for on whatever it may happen to be." The way the emergency treatment doctor and is currently constituted it could not be applied then. Isn't that right? Aren't we gonna have to modify that doctrine as well?

HATCHELL: No. I don't think so your Honor because what also interplays at this point, is the Natural Death Act because you would not have a qualified patient at that point and you could not either withhold or withdraw life-sustaining procedures.

HANKINSON: But now we're under a separate legal issue. I'm just following up on what Justice O'Neill was talking with you about to the extent that we're trying to look at the policy issues related here to this type of an issue. If it is separate and apart the Emergency Doctrine, Treatment Doctrine, that applies, aren't we gonna have to modify it because that would still allow the healthcare provider to proceed because it's an emergency even when the person who is legally authorized to be the consent person says no don't treat?

HATCHELL: Well, um . . .

HANKINSON: So we're gonna have to change that?

HATCHELL: You would have to change that if you, if any credence whatsoever through the expressions of the, uh, parents before the birth. Our position is that those expressions do not have to be honored.

HANKINSON: No. I'm talking . . . I'm in the delivery room and I say, "the baby is born." And you say all these rights and duties spring up. And I say, "Do not treat." Under those circumstances, under the current law, the Emergency Treatment Doctrine is not going to be in play anymore because it applies in the circumstance where you're unable to get consent for it to be able to communicate. My child is run over by a car, needs treatment, I am nowhere around for anyone to talk to me about it, then the healthcare provider can go forward in that emergency circumstance and treat.

HATCHELL: No. I disagree with that respectfully your Honor because if we are talking about the withdrawal or withholding of life-sustaining procedures as they are defined in the Act, um, that cannot be withdrawn under the circumstances that you are talking about. The Emergency Doctrine is in full play and the (interrupted)

HANKINSON: Well, um, nobody's withdrawing anything. Let's say it's a blood transfusion circumstance. No one's withdrawing life support. It's a question of whether or not this child gets the blood transfusion and the parents for religious reasons do not believe in blood transfusions and don't want the child to have one. And so the parents says, "Do

not give my child the blood transfusion."

HATCHELL: Uh, your Honor, I, uh, in that instance, of course, you're putting the hospital in the Catch 22 because a literature is full of issues such as this and the state does have an interest, a very vital interest at the moment of birth in preserving life and so what your Honor, I think, is asking is where do we distribute the risk of being wrong.

HANKINSON: Buy why (interrupted)

HATCHELL: Do we distribute the risk of being wrong to the parents? Or do we do it to the healthcare providers? If the parents are wrong all you may well lose a life.

HANKINSON: What if the healthcare . . . what if the healthcare provider is wrong?

HATCHELL: If the healthcare providers are wrong you have essentially maintained the status quo and you have preserved life in that instance.

ENOCH: Let me . . . medical treatment can be the medical decision not to treat, right?

HATCHELL: Correct.

ENOCH: And medical treatment can be the medical decision to treat. The . . . if the evidence is as represented by the Petitioner here that there is a high probability, a reasonable medical probability, that if you provide this kind of treatment – they say it's experimental – it's not been done at this hospital before – I understand there's an argument about that. But their point is this was, this was experimental treatment that was being anticipated and a high probability, or reasonable probability, that it will produce serious injury to the child to do that. And that is balanced against a possibility that the child might survive without the treatment. And weighing those somebody makes a

decision to withhold treatment. That could be a medical decision to withhold. You could have a doctor up there saying, “On balance, it be my medical decision not to provide this service, but to withhold service.” If we decide this case based on the constitutional right to medical treatment, what treatment is the child entitled to? The treatment of the doctor who says, “You know there’s a substantial risk of injury if we do it. There’s a slight chance of survival if we don’t. Don’t treat. Or does she have the constitutional right to the treatment. This is highly experimental. We know it’s going to produce damages, but we just think it’s worth it because otherwise there’s a risk that she will die.” Which treatment is the constitutionally permitted or required treatment that the parents cannot refuse?

HATCHELL: Life-sustaining treatment and the reason for that your Honor is probably for all the reasons that you have just mentioned. These issues simply cannot be made during, I mean, cannot be decided during the 60 seconds between the time that Sidney Miller was born and the time the decision had to be made to save her life or let her die. So the, as I was trying to explain to Justice Hankinson, where do you distribute the risk is a very important policy consideration that this court must consider. And if you distribute the risk to death you of course will never know.

HANKINSON: But why isn’t the current scheme still sufficient? Why doesn’t the hospital then say, “We’ve got a parent whose not going to authorize treatment. We think the child may need treatment. We’re not sure. But we’re going to notify the state.” Then CPS goes to the courthouse

and gets a court order that says, “We’re going to give permission to the hospital to make the call based on the baby’s condition whether or not to treat or not at that point of time because that is in the best interest of the child.” As opposed to saying, “We’re authorizing you to give this medication, this blood transfusion, and this whatever, because we can’t predict.” It seems to me that there is another alternative in terms of allowing legislative policy the best interest of the child be decided by the courts as it frequently is (interrupted)

HATCHELL: Your Honor I have no (interrupted)

HANKINSON: Why won’t that work?

HATCHELL: I have no objection to what you are saying as long as it does not apply to this situation. The point that I was attempting to make with Justice Enoch was these decisions I think are best made when a child is born when you can access that child and not access statistics. The parents can then make an informed decision after consultation with their own provider. The hospital can make a decision as to its obligations under the law and you can go to court. It’s just unfortunately that could not be done in this case and you could not preserve the ability to do that unless you had done precisely what the hospital, uh, what the doctor did in this case.

HANKINSON: But doesn’t this happen all the time with medical treatment. I mean I may be – surgery may be recommended for me. And the doctor may not be able to tell it ‘til during the surgery exactly what he or she is going to need to do. And they will explain to me ahead of time, this

may happen, this may happen, here are the choices, whatever. And I make (end of tape – side A)

(beginning of tape – side B)

HATCHELL: . . . informed consent. How do you know? How do you inform yourself as to what someone needs before they are born?

O'NEILL: Well (interrupted)

HATCHELL: I would also by the way, I want to say that I do not agree that the best interest standard is applicable under the Family Code. The, uh, the Natural Death Act, uh, imposes what we call the "substituted judgment standard." And the substituted judgment standard attempts to place one self in the position of the party receiving treatment to determine that those parties desires.

HANKINSON: Well . . . but, if, if the hospital were to go to CPS and say, "We've got this circumstance . . ." they would be claiming that the neglect or abuse by the parent under the Family Code and so the decision by the court under the Family Code on whether or not to allow CPS to become the guardian of the child for purposes of making medical decisions would be made on the best interest determination wouldn't it?

HATCHELL: I do not think so your Honor. I think under that instance because the Baby Doe Regulations are in the CPS handbook that decision should be made if those standards are followed on the concept of medically indicated treatment. Uh, and there is no question Professor Mayo at SMU says, you,

I believe the colorful term he used is, "You must be legally blind to believe that the Baby Doe Regulations were not fully intended to supplant the best interest standard."

O'NEILL: Okay. Let me ask you just (interrupted)

BAKER: Uh, I want to ask you a question on that. Uh, the Millers cite the *Bowen* case that discusses the Baby Doe Regulations, but I noticed that you didn't either cite it or distinguish it. Can you tell me why?

HATCHELL: Well because it's not applicable your Honor. The *Bowen* . . . the only importance of the *Bowen* case, uh, is that, as I understand their briefing, is that it recognizes the, um, the concept that uh you cannot treat someone except in limited circumstance without their consent. *Bowen* was a precursor of what are now the Baby Doe Regulations. And what the courts real holding in that case was that Congress didn't, and the Administrative Agencies did not have the authority to promulgate the Baby Doe Regulations under the Rehabilitation Act. So when *Bowen* was decided, Congress amended the Child Abuse and Treatment Reform Act, Baby Doe Implica . . . um, Baby Doe Regulations were implicated and um promulgated under that Act and therefore became law. So I really don't need to deal uh with the *Bowen* case because it is essentially obsolete in so far as the ineffectiveness (mumbling) then of uh the Baby Doe Regulations.

O'NEILL: Okay.

BAKER: But on the other hand you rely on *Krusen* for part of your argument?

HATCHELL: Your Honor, we rely on *Krusen* uh to this extent. We need the Millers to

make a stand as to what this cause of action is and I uh my good friend uh Mr. Keltner is is very cagy and not revealing that. Is this a personal action for Sidney Miller through battery? If it is, if we are dealing with her personal action, battery issues, personal action then she must be complaining and seeking damages because she is alive and that gets us to *Nelson v. Krusen*.

O'NEILL: All right. Let me get um, make sure I understand the construct that you've put forth under an emergency situation. So you've got an emergency presented and what what you believe should happen then is an involving situation that should be up to the position to make that decision?

HATCHELL: That's correct.

O'NEILL: Okay now. So then if there's some evidence in the case that the hospital made the decision before the birth and imposed that decision on that doctor and took away that discretion – oh, well, uh, I understand you're saying there's not any evidence. But I suppose the other side of that coin is is there if there is evidence to that effect then there is some evidence to uphold the verdict?

HATCHELL: Well (interrupted)

O'NEILL: It's my understanding is their arguing that the hospital had a policy and that was determined before the birth. And under your construct that you can't decide until the moment of birth and it's up to the physician to deal with an evolving situation which I understand that, that premise. But if the evidence is that the hospital didn't do that that they imposed a resuscitate no matter what on the doctor then you would, you'd have to concede that there would

be some evidence to support this verdict.

HATCHELL: Will not have to concede that your Honor because I think if you'll look DX 144 which is the only written policy that the hospital had. You will see that what the hospital's policy is is to follow the law. I don't believe (interrupted0

O'NEILL: Well oh uh, again. I want to make sure you understand my question. I think you're arguing the evidence here. If we were to review and find that there was some evidence that that policy was imposed on the doctor. I hear ya. You don't think there is any. But if the record has any, then you lose.

HATCHELL: No, we do not lose your Honor because no such policy was implemented in this case. Now Dr. Jacobs who is the (interrupted)

O'NEILL: Again, you're arguing evidence.

HATCHELL: Well, we have to understand the evidence I think to get to the issue because doctor uh Dr. Jacobs who ordered Dr. Otero to be present did not order him there to resuscitate. He ordered him there to evaluate which is the medical standard.

O'NEILL: And there is evidence on both sides of that. I mean there's evidence that, and I don't want to get into an evidentiary debate, but I understand there's evidence that he was told that he would be subject to possible discipline if he didn't obey the resuscitate (interrupted)

HATCHELL: That is not correct your Honor.

O'NEILL: We have to look at the record.

HATCHELL: He was told and he knows that if he performed below the standard of care in the hospital he was subject to peer review and that's all the record shows.

PHILLIPS: Are there any other questions? Thank you counsel.

KELTNER: If it please the court. I think there are two issues there are two fictions that HCA argues to you. One legal and one factual. First off, they have to admit that one of the things that they have to rely on is United States Supreme Court decision in *Roe v. Wade*. In what they advocate to you is that holding should be extended. Now we're not here to argue what *Roe v. Wade* was correctly or incorrectly decided and I'm not suggesting that to you, but what I am suggesting is they extend *Roe v. Wade* past where the majority opinion, no matter what you might think of it, says. The majority opinion *in Roe v. Wade* recognized that a fetus had rights. And in fact it just said that the mother's rights overcame the fetus' and the fetus had to bow to that right until the third trimester. Also, the majority opinion in *Roe v. Wade* also noted that there were a number of state statutes just like in Texas that gave rights to the fetus. Heavens, this Court, in *Brown v. Schwartz* by Justice Hecht decided that a fetus was a patient for purposes of malpractice cases. In the Family Code, the public policy of this state is that a fetus is protected. You can terminate the parent-child relationship in utero. Additionally, you can determine parentage in utero. The Probate Code allows a fetus to inherit. The Property Code allows a fetus to transfer and receive property. All of these rights are the public policy of Texas about what the right of the fetus is.

O'NEILL: Do you agree if there's an emergency situation it should be up to the doctor to deal with it on an evolving basis?

KELTNER: Um, I'm sorry your Honor?

O'NEILL: You agree that if it is an emergency situation, with no opportunity to go to the court before hand, that it should be left up to the physician to deal with the situation presented on an on going basis?

KELTNER: I think that's what Texas Law is under *Gravis* and *Moss* is those decisions are written. But I think *Gravis* indicates while there is no emergency here. And I disagree with my very good friend Mike Hatchell on that issue, uh, both factually and legally. In *Gravis*, Ruel Walker, one of the best writers this Court ever had, pointed out that the issue of emergency is a intensely factual question. And it was something that you had looked at because otherwise a physician or healthcare provider in this case a hospital could always create an emergency by withholding decisions until the absolute last minute. The testimony here, as you said, from Ana Summerfield directly at trial actually it was here deposition read into trial shortly after the case was initiated was that the hospital's policy was 500 grams. Above it we resuscitate. 499 we do not. Ultrasound proved it was 629. Dr. Otero, and I'll give you his quotes on this because I evidently this is going to be factually important, says first off, "The nursing staff, rather than the treating physicians told him to attend the delivery." That's volume four page 191.

O'NEILL: I, I, I didn't mean to get you into evidentiary (interrupted)

KELTNER: I'm sorry. Your Honor, I am going to far and I'm sorry. But I'm passionate about this part.

O'NEILL: We'll read this record. I (interrupted)

KELTNER: The emergency . . . the emergenc . . . there's no complaint that the emergency issue was not submitted to the jury in this case. It's factual. It is gone now to HCA. They have to establish it as a matter of law and this record doesn't establish it at all. Not even close. And that's crucial here. You know the other, the other fiction is, is, is, is a factual fiction. It's as if we didn't know this baby was going to be born and going to be born prematurely. That's all the conversations were about throughout the hospital, throughout the day.

BAKER: Then we didn't know what would happen though.

KELTNER: Your Honor? I'm sorry?

HECHT: We didn't, we didn't know what would happen once the child was born.

KELTNER: Your Honor treatment decisions are made by physicians constantly based on what is going to happen in the future. Heavens, the public policy of this state under the ADA is to make treatment decisions for yourself not knowing what those instances are going to be in the future.

HECHT: If Dr. Otero had been standing there holding an infant that he was he had every confidence would be, would be one of those cases that would um, uh turn out all right. Everybody would be for resuscitation and doing anything that you could to make the child stronger wouldn't it?

KELTNER: No your Honor. And that (interrupted)

HECHT: It wouldn't?

KELTNER: No sir. And that's why the facts of this case are so terribly important to your decision. The truth of the matter is that the testimony is the Jacobs the only

doctor that we hired that my people had uh, uh, uh a physician-patient relationship with. It told them that the resuscitation itself would cause this disability. Additionally your Honor, the testimony at trial was it was almost guaranteed that this kind of resuscitated treatment would cause this kind of risk. The issue I put to you is the facts don't raise the issue uh that you propose. I do think in policy this Court ought to take those kinds of things into consideration. It's just. You can still reverse the Court of Appeals decision based on the factual context submitted to this court. The last thing I would say to you in ending (interrupted)

OWEN: But wouldn't had they gone to court, don't you think the court probably would have said, "I'm gonna leave this up to the doctor. When the baby is born, I give the doctor the authority to make the decision whether to resuscitate or not."

KELTNER: Heavens no. And I think they wouldn't for this reason. If they had listened to the people who testified at trial and the people that were there would know two things. Dr. Otero came in minutes before this baby was delivered. He came in because of the hospital. He was told he was there to resuscitate because of the baby was over 500 grams. Do you think that a, a, uh, I, I don't it defies description to me that a probate court hearing an arbitrary policy of 500 grams and we're gonna resuscitate otherwise no other consideration is important knowing that the situation was it would cause horrible and permanent disabilities to this child is a problem? The other thing they would have heard was this policy was not announced by a doctor. It

was done by a hospital administrator who was a nurse.

OWEN: Well how long does it take for us to get to a probate court and get all these experts up on the stand and get all the testimony about the policy decision and then have the probate court make a call on who makes the decision once the baby is here and all the facts are known to resuscitate or not?

KELTNER: Your Honor we do this all the time in Texas, in the Jehovah's Witness blood transfusion cases. And we have instances in which probate courts and judges and juvenile court judges get the courts very quickly. In fact, in many hospitals there's room set aside for them.

OWEN: But that's a little bit different issue then this specific child by child analysis isn't it?

KELTNER: Well it is. Your Honor I understand that. And I think that's a good point. HCA interestingly tried to put on evidence on this case how a probate proceeding would go and incredibly what the probate court would have ruled, and the court kept that out. But what the judge said is he'd come to the hospital. He also said, because of *Roe v. Wade* considerations, he would make no decision before birth. I think that's flat wrong. But he said he would come to the hospital and make that decision. Remember, eleven hours before birth we are asked, the Miller's are asked to make the decision about whether to resuscitate their child. All this stuff about waiting for birth was born on appeal. The doctors asked them to make the decision. They made it. It was a decision no one ought to be able to make. Seven hours before the hospital says you might wanna change your mind we want to bring this

issue up. This was everybody knew that this was coming. We had seven hours when they absolutely knew there was a refusal based on medical advice of their doctor exactly like the AMA provisions at Tab 9 of the TMA brief. And Tab 11 of the TMA brief what the American Academy of Pediatrics says it ought to be done. In this circumstance I think it works. I wanted (interrupted)

PHILLIPS: Any other questions? Thank you counselor.

KELTNER: Thank you your Honor. I appreciate it.

PHILLIPS: That concludes the argument in the first cause and the court will now take a brief recess.