No.

In the Supreme Court of the United States

COOK CHILDREN'S MEDICAL CENTER, PETITIONER

v.

T.L., A MINOR, AND MOTHER, T.L., ON HER BEHALF

ON PETITION FOR A WRIT OF CERTIORARI TO THE COURT OF APPEALS OF TEXAS, SECOND DISTRICT

PETITION FOR A WRIT OF CERTIORARI

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QUESTION PRESENTED

This case raises an important question under the state-action doctrine in a constitutional challenge to the Texas Advance Directives Act.

Under the Act, the Legislature created a safe harbor for doctors and hospitals facing the most difficult, sensitive situations in patient care—those where patients demand a course of treatment (often in end-of-life settings) contrary to the doctors' moral, ethical, and medical judgment. When such a conflict arises, the Act permits doctors to invoke an optional internal-review process before the hospital's ethics committee (consisting entirely of private actors); that committee solicits input from all stakeholders, and issues a neutral decision on the appropriate course of action. Any doctor or hospital complying with this optional process may refuse to provide care and is protected from civil or criminal liability; any patient disagreeing with the committee is free to reject the decision and pursue care elsewhere. Aside from insulating doctors and hospitals, the process does not otherwise grant or deny any rights or powers, and the Act does not influence, control, or dictate the appropriate manner of care, a decision left entirely to private actors.

In the decision below, the court of appeals invalidated the Act under Section 1983, and held that private doctors who discontinue private care for a private patient at a private hospital are state actors—simply for invoking the Act's internal-review process. The question presented is:

Whether, despite the lack of any state involvement, participation, coercion, input, or control of any kind, a private hospital is nevertheless a state actor because state law creates a safe harbor for those who conduct a private internal review to determine private medical care in a private facility.

RULE 29.6 STATEMENT

Cook Children's Medical Center is a Texas not-for-profit corporation organized under Section 501(c)(3) of the Internal Revenue Code. Its sole member is Cook Children's Health Care System, which is also a Texas not-for-profit corporation. The sole member of Cook Children's Health Care System is W.I. Cook Foundation, which is also a Texas not-for-profit corporation.

RELATED PROCEEDINGS

District Court for Tarrant County, Texas, 48th Judicial District:

[T.L.], a Minor and Mother, [T.L.], on her behalf v. *Cook Children's Medical Center*, Cause No. 048-112330-19 (Jan. 2, 2020) (order denying temporary injunction)

Court of Appeals of Texas, Second District at Fort Worth:

T.L., a Minor, and Mother, T.L., on her behalf v. *Cook Children's Medical Center*, No. 02-20-00002-CV (July 24, 2020)

Supreme Court of Texas:

Cook Children's Medical Center v. *T.L., a Minor and Mother, T.L., on her behalf*, No. 20-0644 (Oct. 16, 2020) (order denying review)

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PETITION FOR A WRIT OF CERTIORARI

Cook Children's Medical Center respectfully petitions for a writ of certiorari to review the judgment of the Court of Appeals of Texas, Second District, in this case.

OPINIONS BELOW

The opinion of the court of appeals (App., *infra*, 1a-160a) is reported at 607 S.W.3d 9. The order of the district court (App., *infra*, 161a-162a) denying injunctive relief is unreported.

JURISDICTION

The judgment of the court of appeals was entered on July 24, 2020. A petition for review in the Supreme Court of Texas was denied on October 16, 2020 (App., *infra*,

163a). The jurisdiction of this Court is invoked under 28 U.S.C. 1257(a).[1]

Because respondents' action challenges the constitutionality of a Texas statute, 28 U.S.C. 2403(b) may apply. In accordance with this Court's Rule 29.4(c), petitioner has served this petition on the Texas Attorney General, who also participated as an amicus curiae in the court of appeals.

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

The Due Process Clause of the Fourteenth Amendment to the United States Constitution provides, in pertinent part: "nor shall any state deprive any person of life, liberty, or property, without due process of law." U.S. Const. Amend. XIV, § 1.

The relevant provisions of the Texas Advance Directives Act, Tex. Health & Safety Code 166.001-166.209, are reproduced in an appendix to this petition (App., *infra*, 164a-169a).

INTRODUCTION

In a 2-1 decision, the court of appeals declared an important Texas statute unconstitutional, adopted an unprecedented theory of state action, and contravened established law in this Court. Its outlier position frustrates a state legislature's considered judgment in a sensitive area, and subjects private doctors and hospitals (as

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[1] As explained below (see Part B.2, *infra*), the judgment is "plainly final on the federal issue," which was definitively resolved below and "is not subject to further review in the state courts." *Cox Broad. Corp.* v. *Cohn*, 420 U.S. 469, 485 (1975). This Court has already granted review in another case argued this Term arising in a similar posture (*Ford Motor Co.* v. *Bandemer*, No. 19-369), and it has likewise granted review in the same context in the past. See, *e.g.*, *Organization for a Better Austin* v. *Keefe*, 402 U.S. 415, 418 n.1 (1971).

"state" actors) to novel, meritless constitutional litigation—for refusing to provide futile, harmful, and medically inappropriate private care to a private patient at a private hospital. The lower court's attempt to shoehorn this quintessential private conduct into 42 U.S.C. 1983 is legally and analytically baseless, and invents a federal constitutional right found nowhere in the Constitution.

This case implicates a central provision of the Texas Advance Directives Act, a landmark piece of legislation reflecting a delicate compromise (after six years of effort) among prominent stakeholders from all sectors of Texas life. The Act outlines an internal-review process for doctors and hospitals to invoke when they disagree with a patient's medical directive; any person or entity who complies with that optional process is protected from liability for their conduct. Aside from withholding liability, the Act does not grant any rights or powers that do not otherwise exist, and it does not involve state actors at any stage of the review—a private committee exercises its private ethical and medical judgment without any state influence, encouragement, direction, compulsion, or participation of any kind.

In the split decision below, however, the majority held that this grant of a statutory safe harbor somehow converts a doctor's private conduct into state action. The court did not identify any way in which state power is used to direct any doctor's actions, affect the hospital's decisions, compel or prevent any act (by doctors or patients), or influence any aspect of the private care provided by private professionals at a private hospital. Yet it declared that the private refusal to provide medically inappropriate, harmful, and unethical care to a dying patient is automatically state action—because the Legislature withdrew

liability for any private actor who complies with an internal ethics review before reaffirming a private medical decision.

The court's holding sharply conflicts with decades of this Court's controlling authority. Under settled law, private doctors are under no obligation to treat anyone, and private medical decisions are not actionable under Section 1983 or subject to the Constitution's restraints. There is no basis for saying that a statutory safe harbor converts private action into state action. Statutes regulate private conduct all the time, including imposing or limiting liability in certain circumstances. A decision to immunize certain acts is a *regulatory* decision that sets substantive rules for private conduct; it does not automatically transform that private conduct into state action, and a legislative decision to provide a complete defense—shielding private decision-making in a private setting—does not somehow attribute that private conduct to the State. The court's contrary holding runs headlong into binding precedent, and wrongly "extend[s] the protection of §1983 into areas" where it plainly does not belong. App., *infra*, 153a (Gabriel, J., dissenting).

The court's holding might make sense were this a public hospital or had a private hospital sought state intervention to *force* unwanted medical treatment on an unwilling patient. But this situation is indeed the very opposite: this is the private choice of private actors to discontinue private care, affecting only what *these* private actors are willing to provide. None of that is the product of state action or state direction; the private entity is acting independently of the State and exercising its own prerogatives in accordance with its own moral, ethical, and medical judgment. Indeed, the only state action here is a judicial directive to *compel* private doctors to provide private care

contrary to those doctors' deep personal and professional beliefs.

The factual backdrop below is devastating and tragic: it involves a two-year-old child with terminal conditions suffering daily through intensive medical interventions to stave off "dying" events. The heartbreaking consequences are very real for every person involved, including the team of doctors and nurses who have painstakingly cared for this child every minute since her birth. The continued intervention at this point simply inflicts pain and fear on a sedated child for no benefit—which is why not a single hospital, nationwide, is willing to provide the treatment that respondents seek.

The situation is exceptionally difficult, but the solution is not to upend Texas law and declare "state action" to exist where it has never been found in centuries of our nation's jurisprudence. And the ruling below is truly staggering: it held that private hospitals are "state actors"—making their medical decisions subject to due-process constraints—any time they have to make a critical decision not to provide treatment that is contrary to the wishes of a patient. That is not "state action" under any line of this Court's decisions—and there is no such thing as an independent constitutional right to *force* a private hospital to provide treatment to private patients. The court's radical expansion of the state-action doctrine wrongly invalidated a Texas statute and flouts this Court's controlling authority. This Court's review is urgently warranted.

STATEMENT

A. Statutory Background

In 1999, the Texas Legislature passed the Texas Advance Directives Act, which was intended to "set[] forth uniform provisions governing the execution of an advance

directive" regarding healthcare. Sen. Research Ctr., Bill Analysis, Tex. S.B. 1260, 76th Leg., R.S. (1999). The Act was the culmination of a six-year effort among a diverse array of stakeholders, including Texas and National Right to Life, Texas Alliance for Life, the Texas Conference of Catholic Health Care Facilities, the Texas Medical Association, the Texas Hospital Association, and the Texas and New Mexico Hospice Organization. See Hearing on H.B. 3527, Comm. on Pub. Health, 76th Leg., R.S. (Apr. 29, 1999) (statement of Greg Hooser, Texas and New Mexico Hospice Organization). The bill passed the Senate unanimously and it passed the House on a voice vote. Act of May 11, 1999, 76th Leg., R.S., ch. 450, § 3.05, 1999 Tex. Gen. Laws 2835, 2865.

A centerpiece of the Act was Section 166.046, which was designed to resolve private disagreements between patients and physicians regarding care, especially in end-of-life situations. Although the Act generally requires physicians to follow a patient's preferred course of treatment, the Legislature recognized that situations will arise where a patient's wishes may conflict with a physician's moral, ethical, or medical judgment.

When that happens, a physician can invoke a neutral review before the hospital's designated "ethics or medical committee," of which the treating physician may not be a member. Tex. Health & Safety Code 166.046(a). The patient is entitled to notice of the committee's meeting, an opportunity to attend, and notice of the committee's decision. Tex. Health & Safety Code 166.046(b). If either the patient or the physician disagrees with the committee's decision, the physician must "make a reasonable effort to transfer the patient to a physician who is willing to comply." Tex. Health & Safety Code 166.046(d). If the committee affirms a physician's decision that further life-sus-

taining treatment is medically inappropriate, "life-sustaining care" (including artificial life-support) must nevertheless be provided for at least ten days while the parties attempt to transfer the patient to a facility willing to comply with the patient's preferences. Tex. Health & Safety Code 166.046(g). Once that period expires, the facility is generally no longer required to provide the requested treatment.[2]

Although this process-based review is not mandatory (*e.g.*, Tex. Health & Safety Code 166.045(c)), the Act grants a safe harbor for physicians who comply with Section 166.046's review before refusing to carry out a patient's treatment decision:

> 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*.

Tex. Health & Safety Code 166.045(d) (emphasis added). While the Act thus provides a complete defense for certain actions, it does not specify the standards for carrying out the ethics review, dictate the substance of the medical decision, or require private actors to use the process at all. The statutory mechanism is ultimately driven by private actors and private medical judgment.[3]

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[2] That time can be extended by court order 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." Tex. Health & Safety Code 166.046(g). Respondents have never attempted to invoke this provision.

[3] The Act's process-based approach resembled one recommended years earlier by the American Medical Association. Without statutory

B. Facts And Procedural History

1. Respondent T.L. was born prematurely in early 2019 with a congenital heart defect and a host of severe health problems. 2 C.A. Rec. 90-91. Her prognosis has always been grim. *Ibid.* She was transferred immediately to petitioner's Cardiac Intensive Care Unit (CICU) in Fort Worth. *Id.* at 17-18. She has never left the hospital.

Because T.L. cannot properly oxygenate her blood, she is kept on a ventilator, has three tubes down her nose, has multiple intravenous lines for medication, and is permanently attached to four different monitors. 2 C.A. Rec. 108, 120-121, 273-274. Her body is subject to a "cascade" of inflammation, causing her blood vessels to leak. *Id.* at 145. This produces severe swelling; despite her small size, she is burdened by more than two liters of excess fluid. *Ibid.*[4]

T.L.'s multiple diseases cause life-threatening problems. She is at constant risk of so-called "dying events" that require aggressive medical intervention. 2 C.A. Rec. 277. These crashes are typically triggered by agitation, including routine CICU care such as daily chest x-rays, respiratory treatments, diaper changes, or even no reason at all. *Id.* at 133, 138, 268-269, 275. In response, her doctors have increased T.L.'s level of sedation and paralysis so she cannot get upset or move. *Id.* at 137. Her dying events have decreased as a result, but they remain a constant

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enactment, the specter of malpractice liability had limited its usefulness. See Robert L. Fine, M.D., *Medical Futility and the Texas Advance Directives Act of 1999*, 13 B.U.M.C. Proceedings 144, 145 (2000).

[4] The record contains a set of outdated photos of T.L. 2 C.A. Rec. 270-272; PX1-5. Those photos were taken before T.L.'s condition markedly deteriorated in July 2019. *Ibid.* Her swelling has since significantly increased, and her skin has developed a bluish tinge. *Id.* at 272-273.

threat. *Id.* at 138. And this treatment requires T.L. to spend her days sedated and paralyzed. *Id.* at 150, 151. She cannot move or cuddle, and she is rarely, if ever, held. *Id.* at 150-151, 188, 275, 283-284. Her treating physician since birth has never seen her smile. *Id.* at 91.

From the very beginning, the CICU team informed T.L.'s family that T.L.'s combination of disorders made her survival unlikely. Still, her doctors hoped that "relatively aggressive therapies"—including several high-risk, complex surgeries—might permit T.L. to recover enough to leave the hospital. 2 C.A. Rec. 91, 113-116, 130-132. Early surgeries achieved incremental gains, but her condition dramatically deteriorated in July 2019. *Id.* at 91, 126-130. After a life-threatening crash, her physicians put her on a heart-lung bypass machine. Her team attempted another surgery to improve pulmonary blood flow, but the results were unsuccessful. *Id.* at 140-141. Her CICU doctors discussed her condition with a multidisciplinary team that included neonatologists, cardio-thoracic surgeons, her pulmonologist, and the nursing staff. *Id.* at 141-142. They determined that all viable surgical options had been exhausted; her condition is terminal. *Id.* at 91, 142.[5]

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[5] As one of her physicians explained at the temporary-injunction hearing:

> Q. You mentioned a word, "hope". Is T.L.'s case hopeless?
>
> A. Yes.
>
> Q. But she is surviving on life-sustaining care?
>
> A. She is alive. Her heart beats, yes.
>
> Q. Does she know who you are?
>
> A. No.
>
> Q. Have you seen her smile?
>
> A. No.

2 C.A. Rec. 91.

After T.L.'s condition became worse, the CICU team began having additional conversations with her family. 2 C.A. Rec. 91. Despite the lack of any known medical options, T.L.'s mother believed a drug or surgery would somehow cure T.L. *Id.* at 159-161; DX16. Due to their different perspectives, she no longer wished to talk with T.L.'s physicians and began avoiding them. *Ibid.*

2. a. T.L.'s ongoing treatment comes with great suffering. Despite lacking any hope of survival or improvement, T.L.'s doctors and nurses must inflict great harm with the constant medical interventions that artificially maintain her life. 2 C.A. Rec. 149. As one of her physicians explained, "even the most routine of ICU cares" come with the "price" of "pain" and "suffering." *Id.* at 144. "Changing [T.L.'s] diaper causes pain"; "[s]uctioning her breathing tube causes pain"; repositioning her to avoid bedsores causes pain. *Id.* at 146.

Indeed, even her ever-present ventilator causes pain. Because her lungs are unhealthy, the act of forcing air into them hurts. 2 C.A. Rec. 144-145, 146-147. The pain from this routine care triggers dying events, which produce greater suffering. *Id.* at 148. And dying events require manual ventilation, which is even more painful due to the extreme amount of force required (*id.* at 147-148); T.L. has sometimes endured daily manual ventilation. *Ibid.* T.L. persists in an endless cycle of suffering. See *id.* at 147.

This suffering is further enhanced by T.L.'s normal brain function. 2 C.A. Rec. 150. Despite being paralyzed and medicated, T.L. is not brain dead or comatose; she feels each painful intervention and suffers the associated fear and anxiety. *Id.* at 92, 149-150.

b. Inflicting pain and suffering on T.L. for no medical benefit also imposes a psychological toll on the medical staff:

> [W]here a patient doesn't have any hope of surviving * * * but yet you're still providing those very painful and uncomfortable conditions and the patient is suffering, it creates a significant degree of moral distress.

2 C.A. Rec. 164. This moral distress severely affects nurses in particular. *Id.* at 280. CICU nurses are constantly with their patients, providing care from bathing and diaper changes to administering medication and handling emergencies. *Id.* at 265, 268-269. Because simply touching T.L. can trigger a dying event, her case mandates special rules and procedures. *Id.* at 275, 281. T.L. always has her own nurse, who "clusters" care around respiratory treatments to touch T.L. as infrequently as possible. *Id.* at 282, 268-269.

A nurse who has cared for T.L. since birth testified that it is "very emotionally difficult for [her] and for the nursing staff * * * [b]ecause we're inflicting painful interventions on her that we believe exacerbate her suffering for no good outcome." 2 C.A. Rec. 266, 280. Because of these moral challenges, nurses are notified in advance that they will be assigned to T.L. so they may request a change. *Id.* at 282. Many nurses refuse to treat T.L. because they "are uncomfortable in inflicting that kind of pain on her." *Ibid.*

3. The medical unit handling T.L.'s care is a highly specialized department. The field of cardiac intensive care is a subspecialty of pediatric intensive care, a product of the realization that babies with rare heart defects require very specialized treatment by physicians experienced in that type of disease. 2 C.A. Rec. 102. The CICU routinely deals in rare heart disease and has often treated children with combinations of heart disease, respiratory failure, and pulmonary hypertension—the same combination T.L. suffers. *Id.* at 101-102.

In assessing T.L.'s care, her expert team concluded that continued intervention is "not medically, ethically, or morally appropriate." 2 C.A. Rec. 149. The painful treatments cause suffering with no corresponding clinical benefit. CICU doctors and nurses specialize in treating medically complex, fragile children; they routinely, and unflinchingly, perform painful interventions, aware that causing pain is necessary to improve their young patients' lives. *Id.* at 263, 281. But T.L.'s situation fails this ordinary calculus. *Ibid.* The medical consensus is clear and undisputed: T.L.'s condition is permanent and terminal. Inflicting additional pain will not help her improve. *Ibid.* In the end, her medical professionals—whose efforts the court below described as "heroic" (App., *infra*, 12a)—ultimately refused to continue the futile course of treatment inflicting needless pain on a child, notwithstanding the parent's contrary instructions. *Id.* at 16a.[6]

4. a. After months of discussions with T.L.'s mother, the physicians reached an impasse. App., *infra*, 16a. In their professional opinion, there was no "hope of recovery or survival" and continued treatment "was not beneficial" or "ethically appropriate." 2 C.A. Rec. 87. Because T.L.'s mother still disagreed, the CICU physicians invoked the Act's procedures and requested a consultation with the Ethics Committee. App., *infra*, 16a.

The Cook Children's Ethics Committee is composed of physicians, nurses, administrators, social workers, and community members—including parents of former Cook Children's patients. 2 C.A. Rec. 64; App., *infra*, 18a. It is

[6] To be clear, her doctors and the hospital never suggested withholding or refusing all care; they were always willing to provide comfort care in addition to hydration and nutrition (as the Act itself requires, see Tex. Health & Safety Code 166.046(e)). The doctors were only opposed to providing the intensive treatment that results in tremendous suffering with no offsetting medical gain.

largely a consultative body and operates on members' "combined wisdom." 2 C.A. Rec. 47; App., *infra*, 128a. Resolving disputes over appropriate treatment—including those involving artificial-life support—is only one of its functions. 2 C.A. Rec. 36, 61-62.

The committee convened 33 days after the doctors' request to consider T.L.'s treatment. 2 C.A. Rec. 51, 69. T.L.'s mother was provided advance notice of the meeting; she attended with her own parents and spoke. *Id.* at 43, 73; App., *infra*, 18a. After considering the information presented, all 22 committee members in attendance unanimously determined that continuing artificial-life support was not medically or ethically appropriate and that petitioner's personnel should no longer take part in those treatments. 2 C.A. 45-46, 74; App., *infra*, 19a.

The committee's chair promptly informed T.L.'s mother of the committee's decision and explained that petitioner could discontinue artificial life-support ten days after providing written notice of that decision. 2 C.A. Rec. 51, 74; App., *infra*, 19a. Written notice was hand-delivered the next day, along with T.L.'s medical records for the previous 30 days and an abstract of the records of her entire stay in the hospital. App., *infra*, 19a-22a. The physician team was also informed of the committee's decision. 2 C.A. Rec. 52-53.

b. After the committee's decision, the CICU staff exhausted all efforts to transfer T.L. to another facility. 2 C.A. Rec. 54-55; DX6, 7; App., *infra*, 22a-23a. CICU physicians contacted all the top cardiac children's hospitals in the country, 2 C.A. Rec. 180, undertaking "extraordinary efforts" to identify a hospital willing to treat T.L. per her

mother's wishes. 2 C.A. Rec. 93. Every hospital refused. *Id.* at 95, 170-171; App., *infra*, 22a-23a.[7]

5. T.L.'s mother sued petitioner under 42 U.S.C. 1983 and the Uniform Declaratory Judgments Act, alleging violations of procedural and substantive due process under the federal and Texas Constitutions. App., *infra*, 23a-24a.

She obtained a temporary restraining order delaying the cessation of artificial life-support; that order was extended twice by agreement until a temporary-injunction hearing could be held. App., *infra*, 24a. After a full day of testimony, the trial court took the matter under advisement and found cause to allow T.L.'s mother until January 2, 2020, to continue to seek a transfer to another hospital. 2 C.A. Rec. 349–350. On January 2, 2020, the trial court signed an order denying the request for temporary injunction. App., *infra*, 161a-162a.

6. In a split decision, the court of appeals reversed. App., *infra*, 1a-160a.

a. As the majority explained, "[t]he allegations in this case focus on the constitutionality of the [Act]." App., *infra*, 29a. In assessing those allegations, the majority held that petitioner's conduct "constitutes 'state action' within the meaning of the Fourteenth Amendment of the United States Constitution and 42 U.S.C.A. § 1983," and it further declared that "the committee review process set forth in Section 166.046, a key component of [the Act],"

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[7] In July 2019, when CICU physicians intensified discussions with T.L.'s mother about her condition and suffering, 2 C.A. Rec. 91, the mother asked the doctors to contact Boston Children's Hospital and Texas Children's Hospital about a transfer. *Id.* at 154-155. Both hospitals refused, and transfer efforts ceased at the mother's direction. *Id.* at 157-158. At the time of the temporary-injunction hearing, Boston Children's was again reviewing T.L.'s medical records. *Id.* at 196-198. Days later it again refused the transfer. App., *infra*, 15a-16a & n.9.

violated those provisions. *Id.* at 5a, 151a. It thus concluded that "the trial court erred by denying the temporary injunction because [respondent] had shown the 'necessary elements' entitling her to that relief on her Section 1983 claim." *Id.* at 27a.

According to the majority, the private actors were engaged in state action "[b]ecause Section 166.046 delegates through [the review] process two traditional and exclusive public functions—(1) the sovereign authority of the state, under the doctrine of *parens patriae*, to supervene the fundamental right of a parent to make a medical treatment decision for her child"; and "(2) the sovereign authority of the state, under its police power, to regulate what is and is not a lawful means or process of dying." App., *infra*, 5a; see also, *e.g.*, *id.* at 32a ("Section 166.046's delegation of sovereign authority to discontinue life-sustaining treatment for T.L. over Mother's objection makes [petitioner] a state actor") (capitalization and formatting altered); *id.* at 65a ("disagree[ing]" that petitioner's decision "as affirmed by [petitioner's] ethics committee pursuant to Section 166.046" is "not a treatment decision fairly attributable to the state for purposes of Section 1983 liability"); *id.* at 96a ("the so-called 'safe harbor' provisions of the [Act] are nothing more than the traditional and exclusive exercise of the state's inherent and exclusive police power to regulate the lawful means or process of dying").

In addition to issuing this "hold[ing]" on state action (App., *infra*, 114a), the majority also declared that respondents "ha[d] shown a constitutionally actionable deprivation of rights pursuant to Section 1983" (*id.* at 115a). Because respondent "ha[d] pleaded a valid Section 1983

claim and ha[d] shown a probable right to relief," it concluded that injunctive relief was appropriate. *Id.* at 150a-151a.[8]

b. Justice Gabriel dissented. App., *infra*, 152a-160a.

Justice Gabriel explained that she disagreed with "the majority's conclusion that [petitioner's] treatment decision constitutes state action for purposes of Mother's § 1983 claim." App., *infra*, 152a. On the contrary, Justice Gabriel concluded that respondents had not even "raise[d] a bona fide issue regarding [petitioner's] status as a state actor." *Id.* at 153a. As Justice Gabriel explained, "[p]rivate action may be fairly attributed to the state 'in a few limited circumstances,' including when the state compels the private actor to take a particular action; when the private actor performs a traditional, exclusive public function; or when the state acts jointly with the private entity." *Ibid.* Justice Gabriel found none of those conditions satisfied here: (i) petitioner's "treatment decision regarding T.L. turned on professional medical judgments made by private parties, which were not dictated by standards established by the state"; (ii) while "Texas by statute has established procedures under which these decisions may be made for immunity purposes, these procedures do not dictate [petitioner's] medical judgment"; and (iii) "'hospital care, while serving the public, is not the exclusive prerogative of the State.'" *Id.* at 157a-158a.

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[8] In the proceedings below, petitioner also explained that respondents lack a protected liberty interest in this context (*i.e.*, a constitutional right to medical care from private individuals), and that the Act's procedures provide all the process that is due under the Fourteenth Amendment. Although petitioner believes that the majority wrongly rejected those points (App., *infra*, 115a-150a), it is not renewing those arguments before this Court; the state-action issue is dispositive.

Because "[s]tate action is a necessary prerequisite for any claim under § 1983," Justice Gabriel concluded, "Mother's request for a temporary injunction based on her § 1983 claim must fail based on the absence of a bona fide issue regarding state action by [petitioner]." App., *infra*, 158a.

7. The Supreme Court of Texas denied a petition for review. App., *infra*, 163a.

REASONS FOR GRANTING THE PETITION

The court of appeals declared a provision of Texas law unconstitutional by holding that a private hospital's decision on providing private medical care to a private patient is attributable to the State. This staggering expansion of the state-action doctrine is profoundly wrong, and it invites a direct conflict with this Court's controlling authority. The Act authorizes use of an optional internal-review procedure before discontinuing artificial life-support; it offers a safe harbor for potential liability, but does not otherwise dictate or affect a single aspect of a private hospital's decisions—much less constrain a patient's ability to seek his or her preferred treatment anywhere else willing to provide it.

In a long line of precedent, this Court has foreclosed any finding of state action here. Those decisions confirm that private actors are not state actors when exercising their own judgment in private settings, even if they follow state procedures, take actions against another's will, or invoke a statutory safe harbor to avoid liability. A private actor at a private hospital making private decisions is not employing state power, and the State's decision to immunize certain acts does not transform that private conduct into state action.

The court of appeals strained to avoid these binding decisions, but its novel approach is incompatible with established law and threatens to dramatically expand the range of private conduct attributable to the State—and thus subject to constitutional litigation under Section 1983. The court wrongly says a hospital acts as *parens patriae* when refusing to provide treatment; yet a hospital is not *commanding* patients to receive any given treatment or otherwise restricting any patient's choice. It is merely refusing to engage in certain actions itself, while leaving patients free to pursue their full range of options with any other willing provider. That is not *parens patriae* under any definition of the term. Nor does a hospital exercise sovereign power to decide what is lawful; it is merely making its own decisions for itself, as the governing regulatory scheme permits it to do. A contrary understanding would sweep in countless aspects of regulated industry, subjecting ordinary private decisions to constitutional attacks.

The court of appeals was confronted with a difficult, heartbreaking situation. But it erred in invalidating a Texas law on constitutional grounds and branding private doctors and hospitals as state actors. That decision, at the express urging of the state attorney general and governor (and with the acquiescence of the state high court), now sets the federal constitutional benchmark for the medical profession in one of the nation's largest States, defying the settled standards this Court has articulated for decades. The court of appeals' state-action holding is so starkly at odds with clear, bedrock law that summary reversal would be appropriate; at a minimum, the petition should be granted.

A. The Decision Below Defied This Court's Clear And Established Authority On State Action To Strike Down A Texas Statute On Constitutional Grounds

The court of appeals' decision is strikingly out of step with every strand of this Court's state-action jurisprudence. It invalidated an important state law on federal constitutional grounds, and its clear error cries out for immediate correction.

1. For well over a century, this Court has firmly "'embedded'" the principle "'in our constitutional law that the action inhibited by the first section of the Fourteenth Amendment is only such action as may *fairly be said to be that of the States*.'" *Blum* v. *Yaretsky*, 457 U.S. 991, 1002 (1982) (emphasis added). The Fourteenth Amendment "erects no shield against merely private conduct, however discriminatory or wrongful." *Shelley* v. *Kraemer*, 334 U.S. 1, 13 (1948). Unless "there is a sufficiently close nexus between the State and the challenged action of the regulated entity *so that the action of the latter may be fairly treated as that of the State itself*," there is no state action. *Jackson* v. *Metro. Edison Co.*, 419 U.S. 345, 351 (1974) (emphasis added); accord *Brentwood Acad.* v. *Tennessee Secondary Sch. Athletic Ass'n*, 531 U.S. 288, 295 (2001) ("we say that state action may be found if, though only if, there is such a 'close nexus between the State and the challenged action' that seemingly private behavior 'may be fairly treated as that of the State itself'"); *Lugar* v. *Edmondson Oil Co.*, 457 U.S. 922, 937 (1982).

This bedrock rule serves a key purpose: "to assure that constitutional standards are invoked only when it can be said that the State is *responsible* for the specific conduct of which the plaintiff complains." *Blum*, 457 U.S. at 1004 (emphasis in original). And a State is "responsible for a private decision only when it has exercised coercive

power or has provided such significant encouragement, either overt or covert, that the choice must in law be deemed to be that of the State." *Ibid.* The State, in short, must have "compelled the act." *Flagg Bros., Inc.* v. *Brooks*, 436 U.S. 149, 164 (1978).

This means that "[m]ere approval of or acquiescence in the initiatives of a private party" is not enough. *Blum*, 457 U.S. at 1004-1005. Nor does "[p]rivate use of state-sanctioned private remedies or procedures * * * rise to the level of state action." *Tulsa Prof'l Collection Servs., Inc.* v. *Pope*, 485 U.S. 478, 485 (1988); *Lugar*, 457 U.S. at 937. And even "[i]n cases involving extensive state regulation of private activity," this Court has "consistently held that '[t]he mere fact that a business is subject to state regulation does not by itself convert its action'" into state action. *American Mfrs. Mut. Ins. Co.* v. *Sullivan*, 526 U.S. 40, 52 (1999) (quoting *Jackson*, 419 U.S. at 350). When a decision "is made by concededly private parties," and "'turns on * * * judgments made by private parties' without 'standards * * * established by the State,'" there, again, is no state action. *Ibid.* (quoting *Blum*, 457 U.S. at 1008).

And, critically here, "the mere denial of judicial relief"—such as creating a safe harbor or withdrawing liability for private conduct—does not constitute "sufficient encouragement to make the State responsible for those private acts." *Flagg Bros.*, 436 U.S. at 165. Indeed, this Court has "never held that a State's mere acquiescence in a private action converts that action into that of the State." *Id.* at 164. On the contrary, in such circumstances, the State "has not compelled" any private action at all, but "merely announced the circumstances in which its courts will not interfere" with private conduct. *Id.* at 166. In no sense does that qualify as state action: the true complaint

"is not that the State *has* acted, but that it has *refused* to act." *Ibid.*

In sum, a private party's "exercise of the choice allowed by state law where the initiative comes from it and not from the State, does not make its action in doing so 'state action' for purposes of the Fourteenth Amendment." *Jackson*, 419 U.S. at 357 (footnote omitted). State action simply does not "inhere[] in the State's creation or modification of any legal remedy": "The most that can be said of [a] statutory scheme, therefore, is that whereas it previously prohibited [certain private acts], it no longer does so. *Such permission of a private choice cannot support a finding of state action*." *American Mfrs.*, 526 U.S. at 53 (emphasis added).

This Court has reliably applied these rules for decades to respect the "critical boundary" between private and governmental conduct, "thereby protect[ing] a robust sphere of individual liberty." *Manhattan Cmty. Access Corp.* v. *Halleck*, 139 S. Ct. 1921, 1934 (2019). "Faithful application of the state-action requirement in these cases ensures that the prerogative of regulating private business remains with the States and the representative branches, not the courts." *American Mfrs.*, 526 U.S. at 52.

2. The decision below directly flouts these established principles. The undisputed facts eliminate any conceivable basis for state action.

First, the case involves only private actors: this is a private hospital providing private medical care to a private patient; the medical team's decisions were reviewed by the hospital's ethics committee, which consists entirely of private members. Not a single state actor had any role at any stage; there was no "joint" action with the government. See *Rendell-Baker* v. *Kohn*, 457 U.S. 830, 838 n.6 (1982) ("the warehouseman's decision to threaten to sell the goods was not 'properly attributable to the State of

New York,' since no state actor was involved") (quoting *Flagg Bros.*, 436 U.S. at 156); compare, *e.g.*, *Brentwood Acad.*, 531 U.S. at 296.

Second, petitioner's exercise of private judgment is not remotely attributable to the State. The dispute "ultimately turn[s] on medical judgments made by private parties according to professional standards that are not established by the State." *Blum*, 457 U.S. at 1008. Indeed, the review process is entirely optional; it is not even mandatory. See *Jackson*, 419 U.S. at 357. It is impossible to say the State is somehow "responsible" for independent decisions of private actors reached without any state influence or participation of any kind. *Blum*, 457 U.S. at 1004-1005; see also *American Mfrs.*, 526 U.S. at 52 (no state action when "concededly private parties" exercise judgment "without 'standards * * * established by the State"); *Rendell-Baker*, 457 U.S. at 841 ("Here the decisions to discharge the petitioners were not compelled or even influenced by any state regulation."); *West* v. *Atkins*, 487 U.S. 42, 52 n.10 (1988); *Moose Lodge No. 107* v. *Irvis*, 407 U.S. 163, 175 (1972).

Third, the Act does not even compel or coerce any unwanted treatment. The committee's decision does not bind any patient: it merely determines what the hospital itself is willing to do in light of its own moral, ethical, and medical judgment. Patients remain free to disagree and seek any treatment they wish at any other facility willing to treat them. The fact that the Act *declines* to commandeer the hospital and compel it to provide involuntary care does not convert the participants into state actors. *Jackson*, 419 U.S. at 357 (a private party's "choice allowed by state law" is not state action "where the initiative comes from it and not from the State").

Finally, the background presence of state regulation is not enough (*e.g.*, *Manhattan Cmty.*, 139 S. Ct. at 1932),

nor is the Act's provision of a safe harbor (*e.g.*, *Flagg Bros.*, 436 U.S. at 164-166). Petitioner exercised its own medical judgment; it was not influenced or directed by the State, and there was no state role or state action of any kind. See, *e.g.*, *City of Cuyahoga Falls* v. *Buckeye Cmty. Hope Found.*, 538 U.S. 188, 197 (2003); *San Francisco Arts & Athletics, Inc.* v. *U.S. Olympic Comm.*, 483 U.S. 522, 547 (1987). The Act merely dictates the liability scheme for private actors in a private industry, and its grant of a safe harbor does not transform private conduct into state action. *E.g.*, *American Mfrs.*, 526 U.S. at 53; see also, *e.g.*, *White* v. *Scrivner Corp.*, 594 F.2d 140, 143 (5th Cir. 1979). This Court's decisions squarely foreclose the lower court's finding of state action.

3. The court of appeals' departure from this Court's binding precedent was unprincipled and indefensible.

First, the court of appeals invoked the "public function" test to find state action, which is meritless. This rare exception is "exceedingly difficult to satisfy." Martin A. Schwartz, *Section 1983 Litig. Claims & Defenses* § 5.14[A] (4th ed. 2020); see also *Manhattan Cmty.*, 139 S. Ct. at 1929 ("The Court has stressed that 'very few' functions fall into that category."). It requires private actors to perform a function that is "traditionally the exclusive prerogative of the state"—powers "associated with sovereignty," such as "eminent domain" and running "elections." *Jackson*, 419 U.S. at 352-353. Even traditional functions associated with government (*e.g.*, "education, fire and police protection, and tax collection") are not state action when performed by private actors. *Flagg Bros.*, 436 U.S. at 163.

It accordingly is "not enough that the federal, state, or local government exercised the function in the past, or still does." *Manhattan Cmty.*, 139 S. Ct. at 1928. On the

contrary, "to qualify as a traditional, exclusive public function within the meaning of [this Court's] state-action precedents, the government must have traditionally *and* exclusively performed the function." *Id.* at 1929.

There is no plausible basis for shoehorning private medical decisions into this category. Medical care is not *exclusively* within the government's province, but overwhelmingly provided by private actors—including the private doctors and hospital here. No one confuses private medical care (even in end-of-life settings) with any exclusive sovereign function. And, indeed, this Court has already "ruled" that a subset of medical care—"operating nursing homes"—falls *outside* this narrow exception. *Manhattan Cmty.*, 139 S. Ct. at 1929; see also *Blum*, 457 U.S. at 1011-1012; *Wheat* v. *Mass*, 994 F.2d 273, 276 (5th Cir. 1993); *Hoyt* v. *St. Mary's Rehab. Ctr.*, 711 F.2d 864, 866 (8th Cir. 1983). The lower court's contrary analysis badly contravenes this settled law.

Second, the court of appeals turned to the concept of "*parens patriae*." According to the court, a hospital withdrawing life-sustaining treatment under the Act becomes a state actor because the State alone, as *parens patriae*, may override a parent's medical decisions on a child's behalf. It follows, the court reasoned, that if petitioner overrode the parent's wishes here, it was necessarily assuming an exclusive state function. This is both legally and logically baseless.

First and foremost, the court's underlying premise is wrong. *Parens patriae* applies where the State inexorably dictates a patient's treatment. Here, the hospital is not restricting T.L.'s ability to seek whatever treatment she wishes—it is merely *limiting its own services*. Tex. Health & Safety Code 166.046(d), (e), (g). T.L. was not prohibited from transferring to other facilities, where she

could dictate her chosen care. The doctor-patient relationship is a matter of private contract. App., *infra*, 32a. The fact that no hospital is willing to provide unnecessary, futile, and unethical treatment does not mean a patient has a constitutional right to force a private hospital to act against its will (*e.g.*, *DeShaney* v. *Winnebago Cnty. Dep't of Soc. Servs.*, 489 U.S. 189, 195 (1989))—and it assuredly does not mean the hospital is controlling T.L. and preventing her from pursuing alternative care elsewhere. Absent that kind of compulsion (*i.e.*, refusing to permit T.L. to receive treatment from a willing provider), *parens patriae* has nothing to do with this situation.

In any event, the court is legally wrong that an entity automatically becomes a state actor (via *parens patriae* or otherwise) by refusing to honor a patient's directive. That proposition is irreconcilable with *Blum*, which rejected state action even where facilities "discharge[d] or transfer[red]" nursing-home patients against their will. 457 U.S. at 1011-1012. And it is incompatible with involuntary-commitment cases, where private hospitals *compel* treatment (acting on their own) without becoming state actors. See, *e.g.*, *McGugan* v. *Aldana-Bernier*, 752 F.3d 225 (2d Cir. 2014); *Estades-Negroni* v. *CPC Hosp. San Juan Capistrano*, 412 F.3d 1 (1st Cir. 2005). This Court has repeatedly held that state action exists only where "it can be said that the State is *responsible* for the specific conduct of which the plaintiff complains" (*Blum*, 457 U.S. at 1004)—and there is no basis for holding the State "responsible" for the independent medical judgment of private actors. *E.g.*, *Flagg Bros.*, 436 U.S. at 163 n.11 ("The conduct of private actors in relying on the rights established under these liens to resort to self-help remedies does not permit their conduct to be ascribed to the State."). The holding below additionally conflicts with this established authority.

Third, according to the court of appeals, the Act's creation of a safe harbor effectively "delegates" to hospitals "the sovereign authority of the state, under its police power, to regulate what is and is not a lawful means or process of dying," thus rendering hospitals state actors. App., *infra*, 5a. This is profoundly mistaken.

Initially, the Act's grant of a safe harbor does not delegate regulatory authority to private hospitals; it merely withdraws liability for certain private acts in a private setting. The Legislature routinely sets substantive rules for private interactions, and it can provide statutory protections and defenses without converting private activity into state action. *E.g.*, *American Mfrs.*, 526 U.S. at 53; *Flagg Bros.*, 436 U.S. at 165; see also *Lugar*, 457 U.S. at 937 (without these limitations, "private parties could face constitutional litigation whenever they seek to rely on some state rule governing their interactions with the community surrounding them").

In any event, the Act's internal-review procedure itself sets the governing rules for Texas entities—and it recognizes that medical professionals retain the right to refuse to perform improper procedures against their will. The Act granted physicians and hospitals no new powers, Tex. Health & Safety Code 166.051, and it did not permit hospitals to dictate a patient's options at any facility besides their own—just as a patient may not dictate the medical care a hospital must provide. That does not mean that any private actor refusing to assist another in dire circumstances is exercising the State's power to decide "what is and is not a lawful means or process of dying." It simply reflects a private choice about the type of private services a private facility is willing to perform.

As this Court has repeatedly confirmed, statutory immunity does not convert a private hospital into a state actor. *E.g.*, *Flagg Bros.*, 436 U.S. at 165; *Jackson*, 419 U.S. at 357.

* * *

In sum, the decision below has no basis in this Court's jurisprudence, and it could not paper over in length what it lacked in substance. It invites a square conflict with controlling law, finds state action where it plainly does not exist, and strikes down a vital state statute in the very context in which it is needed most. It is hornbook law (literally) that "[d]ecisions invalidating * * * state statutes * * * are ordinarily sufficiently important to warrant Supreme Court review without regard to the existence of a conflict." Stephen M. Shapiro et al., *Supreme Court Practice* § 6.31(b), at 482 (10th ed. 2013). The importance here is palpable, and this Court's intervention is urgently warranted.

B. The Question Presented Is Exceptionally Important And Warrants Review In This Case

1. The question presented is of exceptional legal and practical importance. See, *e.g.*, State C.A. Amicus Br. 1 ("[t]his case presents a question of foundational importance").

a. The court of appeals struck down a vital Texas statute on federal constitutional grounds. The Act's process-based review was the centerpiece of a six-year legislative effort. See Hearing on H.B. 3527, Comm. on Pub. Health, 76th Leg., R.S. (Apr. 29, 1999) (statement of Greg Hooser, Texas and New Mexico Hospice Organization). It reflects the compromise of prominent stakeholders (including medical, hospital, and religious organizations), leading to unanimous passage. Act of May 11, 1999, 76th Leg., R.S., ch. 450, § 3.05, 1999 Tex. Gen. Laws 2835, 2865. It provides

critical guidance for doctors, hospitals, and patients confronting life's most difficult situations with fairness and compassion—securing a considered, neutral review by an expert body that respects the interests of all sides and facilitates fair resolutions to time-sensitive disputes.

The decision below eviscerates that six-year legislative process. It subjects private doctors and hospitals to constitutional litigation, and binds the Legislature's hands, wrongly "constitutionaliz[ing] issues of legislative policy" that only this Court can now correct. *Supreme Court Practice* § 6.31(b), at 482 (explaining why this sort of error carries "extraordinary public importance" justifying this Court's review).

The harm from this decision sweeps well beyond this litigation. Without the Act's guidance, doctors and hospitals are left in an untenable position. See, *e.g.*, State C.A. Amicus Br. 6 ("a ruling on the provision's constitutionality is necessary to guide the hospital's permissible conduct"). They can no longer refuse treatment they believe medically, morally, and ethically wrong without risking civil and criminal liability. And this conflict will predictably arise in the situation where this legislative guidance is needed most: those where patients are unable to find any other willing provider due to significant problems with the desired treatment. Doctors in those situations often face conflicting directives from different family members—with some urging to continue treatment and others urging to stop—exposing medical professionals to potential liability no matter what they do. See, *e.g.*, Hearing on S.B. 2089 and S.B. 2129 before the Senate Comm. on Health &

Human Servs., 86th Leg. R.S. (April 10, 2019) (testimony of Dr. Fine).[9]

And the ironic result is that most doctors will be coerced *by the State's threat of liability* into providing private treatment to private patients in a manner starkly at odds with their deepest personal and professional beliefs. That is the only actual "state action" in this case, and it flips the appropriate constitutional holding on its head.

b. Nor is there any doubt that the proceedings below have effectively wiped out this key statute. The court of appeals flatly declared the provision unconstitutional in its most important context. The state attorney general and governor filed an amicus brief expressly declaring the statute unconstitutional: "Section 166.046 is a facially unconstitutional affront to procedural due process." C.A. Amicus Br. 5. And the State's highest court refused to step in and revive the statute (App., *infra*, 163a), an unmistakable indication of the Court's views (a fact apparent to all sophisticated Texas litigants).

No rational actor in the State will now rely on the Act's safe harbor in the face of (i) an exhaustive opinion declaring it unconstitutional, (ii) the express declarations of unconstitutionality from the State's highest executive officers, and (iii) the state supreme court's acquiescence in those views. This decision thus undeniably sets the federal constitutional standard in this vital setting in one of the nation's largest States. It short-circuits the range of policy options in this exceptionally important context (contra,

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[9] The decision may also invite unintended consequences: In light of the inability to terminate inappropriate care, doctors and hospitals may be reluctant to take on at-risk patients in the first place (out of fear of being forced to continue, indefinitely, a course of ineffective and inappropriate treatment). That threatens to leave those patients most in need of evaluation and aggressive treatment with the least access to medical care.

e.g., *Cruzan* v. *Director, Missouri Dep't of Health*, 497 U.S. 261, 293 (1990) (Scalia, J., concurring)), and it guts a statutory scheme that functioned effectively for years for medical professionals and patients alike. This Court's immediate review is warranted.[10]

2. This case is also an ideal vehicle for deciding the question presented. The federal constitutional question has been finally and exhaustively resolved at the state level. The state-action declaration was a necessary predicate to relief under Section 1983, which was the sole ground of decision. The issue arises as a pure question of law: the pertinent facts are undisputed, and the legal question was analyzed over 150-pages of a split appellate decision. As the attorney general and governor themselves reaffirmed, "[a] ruling on the constitutionality of section 166.046 is necessary to a decision in this case," and "[t]he constitutionality of section 166.046 is central to the family's request for injunctive relief." State C.A. Amicus Br. 6, 14 (formatting omitted). There is no conceivable obstacle to the Court resolving this important legal question.[11]

Nor does it matter that the case arose on a request for a temporary injunction. The factual record on the federal

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[10] Indeed, the need for this Court's review is extraordinarily timely: In light of the expanding pandemic, doctors and hospitals need clarity more than ever; the decision below obliterates the key legislative mechanism designed to provide guidance in the hardest situations.

[11] While respondents also advanced constitutional claims under the *state* constitution, the holding below was grounded exclusively in federal law, the injunction was sought pursuant to 42 U.S.C. 1983, and certain categories of relief are available solely under that federal claim. So while there was no "alternative" ground at all—the sole disposition was the federal constitutional issue—even a *hypothetical* disposition of the state issue would not stand "independent[ly]" of the federal question. See, *e.g.*, *Michigan* v. *Long*, 463 U.S. 1032, 1044 (1983).

question is complete, and the court of appeals' disposition squarely resolved each aspect of the federal constitutional inquiry—there is nothing left to adjudicate on remand. See, *e.g.*, *Supreme Court Practice* § 3.7, at 165 (explaining that the Court "look[s] beyond the mere fact that further proceedings are contemplated, and assess[es] the finality of the ruling on federal questions in terms of the likely impact of the subsequent proceedings on that ruling or on the federal policies at stake"). Put simply, "the federal issue is conclusive [and] the outcome of further proceedings preordained." *Cox Broad.*, 420 U.S. at 479. The federal issue is appropriately "deemed final," and declining review "would not only be an inexcusable delay of the benefits Congress intended to grant by providing for appeal to this Court, but it would also result in a completely unnecessary waste of time and energy"—in proceedings that continue despite the obvious lack of state action, and during which the patient endures relentless agony. *Ibid.*; see also, *e.g.*, *Keefe*, 402 U.S. at 418 n.1.[12]

[12] While the dissent suggested that the majority overstepped by definitively resolving the legal questions at a preliminary stage (App., *infra*, 159a-160a), the dissent *was a dissent*—and the majority unquestionably announced its definitive holding on the federal issue, including the core question of state action. See, *e.g.*, *id.* at 160a (admitting that "the majority's holdings * * * essentially constitute final and binding decisions on the merits of Mother's § 1983 claim"). There is no need to read between the lines to understand that the majority's extensive opinion meant exactly what it said: petitioner is a state actor and the statute is unconstitutional under the Fourteenth Amendment.

CONCLUSION

The petition for a writ of certiorari should be granted. The Court may wish to consider summary reversal of the decision below.

Respectfully submitted.

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