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Health Care Law

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HEALTH CARE LAW

Thomas Wm. Mayo*

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I. HOSPITALS

A. LIABILITY FOR TORTS OF INDEPENDENT CONTRACTORS

IN *Baptist Memorial Hospital System v. Sampson*,¹ plaintiff went to the emergency room of Southeast Baptist Hospital after being bitten by a brown recluse spider. On two separate visits to Baptist's emer-

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1. 969 S.W.2d 945 (Tex. 1998), *rev'g* 940 S.W.2d 128 (Tex. App.—San Antonio 1997).

gency room, two physicians diagnosed her condition as an uncomplicated allergic reaction and prescribed pain killers and antihistamines. After her condition continued to worsen, the plaintiff went to a different hospital where the correct diagnosis was made and she received life-saving treatment. Plaintiff then sued the hospital system that included Southeast Baptist Hospital on the theory that it was vicariously liable for the second emergency room physicians' negligence.² Both parties agreed that the second physician was an independent contractor, not an employee of the hospital, and that the hospital could be liable only if the plaintiff could satisfy the elements of ostensible agency, apparent authority, agency by estoppel, or some related legal theory.

The court of appeals had ruled that two separate theories of vicarious liability applied. The first was an agency theory, either "agency by estoppel"³ or "apparent agency."⁴ According to the court, the former theory requires (i) that the hospital "hold out" (by some act or omission) the emergency-room physician as an agent of the hospital, (ii) giving rise to the plaintiff's reasonable belief that an agency relationship exists, (iii) upon which the plaintiff reasonably relied.⁵ Under "apparent agency," on the other hand, a plaintiff need only show that: (i) the plaintiff looked to the hospital, rather than to the individual physician, for her care; and (ii) the hospital held out the physician as its agent.⁶ The court concluded that, at least as to the theory of apparent agency, a sufficient factual question existed (regarding the sufficiency of the hospital's posted disclaimers of any agency relationship between the emergency room physicians and the hospital) to warrant reversal of the trial court's grant of summary judgment in the hospital's favor.⁷

The court of appeals' second theory of vicarious liability was that a hospital's operation of an emergency room creates a nondelegable duty on the part of the hospital to provide emergency medical services with reasonable care.⁸ Under this theory, a hospital may not escape liability for torts that occur in the emergency room by the simple expedient of hiring independent contractors and then delegating the operation of the emergency room to them.⁹ The court justified this conclusion by resort to "public policy and fundamental fairness [as well as] . . . the simple fact that an injured party must rely on a hospital's emergency room because there is no other place to go."¹⁰

2. Plaintiff also sued the two emergency room physicians for medical malpractice and brought other negligence claims against the hospital. After a variety of voluntary dismissals, severance of claims and parties, and partial appeals, only the vicarious liability issue was presented to the supreme court for its decision. *See id.* at 947.

3. *See Sampson*, 940 S.W.2d at 131 (relying on RESTATEMENT (SECOND) OF AGENCY § 267 (1958)).

4. *See id.* (relying on RESTATEMENT (SECOND) OF TORTS § 429 (1965)).

5. *See id.* at 132.

6. *See id.*

7. *See id.* at 134.

8. *See id.* at 136-38.

9. *See, e.g., Jackson v. Power*, 743 P.2d 1376, 1384-85 (Alaska 1987).

10. *Sampson*, 940 S.W.2d at 138.

The supreme court rejected both lines of the court of appeals' analysis and reversed.¹¹ The court ruled that the governing law in the case was provided by the three elements of "ostensible agency" as set out in the Restatement (Second) of Agency.¹² Specifically, the court rejected the idea that what the court of appeals called "apparent agency" was the law in Texas:

While a few courts of appeals have referred to section 429 [of the RESTATEMENT (SECOND) OF TORTS], it has never before been adopted in this state by any appellate court. To the extent that the [RESTATEMENT (SECOND) OF TORTS] section 429 proposes a conflicting standard for establishing liability, we expressly decline to adopt it in Texas.¹³

Applying the three-pronged test of the RESTATEMENT (SECOND) OF AGENCY, the supreme court ruled that "the [h]ospital took no affirmative act to make actual or prospective patients think the emergency room physicians were its agents or employees, and did not fail to take reasonable efforts to disabuse them of such a notion."¹⁴

The supreme court also rejected the court of appeals' suggestion that Texas should "eliminat[e] the liability loopholes currently available to hospitals in the emergency room setting . . . [and take] the full leap—imposing a nondelegable duty on hospitals for the negligence of emergency room physicians."¹⁵ The supreme court concluded that the creation of such a duty was unnecessary to protect patients, who retained the ability to sue emergency-room physicians for medical malpractice and hospitals for any breach of the tort duties that they owe directly to patients.¹⁶

The rule adopted in this case by the supreme court considerably narrows a hospital's risk of vicarious liability for the torts of their emergency room physicians. Read literally, the three elements of an ostensible agency claim will seldom be satisfied. Emergency room signs (even those the plaintiff claims she did not see or read) and consent form disclaimers (including those the plaintiff says she did not read or understand) will defeat most, if not all, claims of ostensible agency. This result appears to be based on the judicial belief that patients in an emergency room are in the right frame of mind (e.g., conscious, alert, and discerning) to appreci-

11. See *Sampson*, 969 S.W.2d at 949-50.

12. The supreme court somewhat impatiently brushed aside the notion that there are any differences among the terms "ostensible agency," "apparent agency," "apparent authority," and "agency by estoppel." See *id.* at 947 n.2.

13. *Id.* at 949.

14. *Id.* at 950. The court's reference to "no affirmative act" suggests that the mere provision of emergency medical services through emergency room physicians hired by the hospital cannot, by itself, constitute a "holding out" for purposes of the ostensible agency doctrine. In addition, the hospital included a disclaimer of any agency relationship in its informed-consent form (which the plaintiff signed without, according to her affidavit in the case, reading it) and posted signs in the emergency room stating that the physicians who worked there are independent contractors.

15. *Sampson*, 940 S.W.2d at 136.

16. See *Sampson*, 969 S.W.2d at 949.

ate the legal limitations suggested by the hospital's signs and forms. It also assumes that emergency patients are free to choose to go to another hospital if they are not happy with the legal limitations imposed by the hospital to which they have driven or been transported. With respect to emergency medicine, the analysis required by the RESTATEMENT (SECOND) OF AGENCY and adopted by the supreme court appears to take place in a sort of "Never-Never Land" that bears scant resemblance to the real world.¹⁷ In the real world, emergency patients go (or are taken to) the nearest available emergency room or, in extreme situations, to the emergency room that has the specialized (hospital-based) capabilities required to treat the patient's condition. The choice of hospital is seldom made because of the identify of individual physicians, but rather because of the (usually well advertised and promoted) capacity of the hospital to provide the needed service. In short, the real world actually resembles the picture painted by section 429 of the RESTATEMENT (SECOND) OF TORTS and by the nondelegation doctrine, but it will apparently be awhile before Texas catches up to the real world.

B. LICENSURE

On August 7, 1998, the Texas Department of Health (TDH) published in the *Texas Register* a massive repeal of most of its hospital licensing rules and adopted new rules to take their place.¹⁸ The rules' changes were intended to update TDH's hospital licensing rules and standards, to bring them into compliance with 1997 legislative changes, to streamline aspects of the licensing process, to incorporate the Medicare program's conditions of participation, and to establish new minimum standards for certain facilities. Similarly comprehensive changes were made to TDH's rules governing the licensing of abortion facilities.¹⁹

II. PHYSICIANS

A. DUTY TO THIRD PARTIES

1. *Duty to Warn*

In *Praesel v. Johnson*,²⁰ the Texas Supreme Court held that a physician

17. The court's analysis not only seems curiously out of touch with the real world, but it also contradicts its own premises. For example, the court asserts that the physicians' emergency medical services are billed by the physicians themselves, not by the hospital. *See id.* at 950. But most, if not all, patients will be ignorant of this fact until after the services have been provided; thus, the identity of the doctors as the billing entity could not possibly negate a reasonable belief as to the existence of an agency relationship between the physicians and the hospital upon which the patient relied in coming to the emergency room for care.

18. *See* 23 Tex. Reg. 8042-8089 (1998) (to be codified at 22 TEX. ADMIN. CODE § 505.11 and various sections of 25 TEX. ADMIN. CODE §§ 139.1-139.169).

19. *See id.* at 81.46-81.74 (1998) (to be codified at 25 TEX. ADMIN. CODE §§ 139.1-139.60) (Tex. Dep't of Health).

20. 967 S.W.2d 391, 398 (Tex. 1998), *rev'g* 925 S.W.2d 255 (Tex. App.—Corpus Christi 1996).

owes no duty to third parties to warn an epileptic patient not to drive or to report the patient's condition to state motor vehicle authorities. It reversed a lower court ruling that a physician who knew of, and treated his patient for, epileptic seizures could be liable for the wrongful death of a motorist if the physician failed to warn the patient not to drive or failed to advise his patient to notify state authorities of the patient's dangerous medical condition.²¹

Texas statute permits, but does not require, treating physicians to refer to the Texas Department of Public Safety or the Department's Medical Advisory Board patients who have had an epileptic seizure within the past three years.²² The supreme court reasoned that this regulation (and the statute that authorizes it²³) creates an exception to the traditional rule of physician-patient confidentiality but does not impose a *per se* standard of care that requires reporting.²⁴

The court also refused to create a common-law duty to third parties upon physicians to warn a patient with epilepsy not to drive.²⁵ In doing so, the supreme court continued a line of cases in which it has refused to impose duties to third parties upon physicians.²⁶ The court noted that epileptic patients themselves already have a duty to contact the Department of Public Safety to permit a determination of their fitness and safety as drivers. Against the backdrop of this legal requirement, the court continued:

The consequences of placing a legal duty on physicians to warn may subject them to substantial liability even though their warnings may not be effective to eliminate the risk in many cases. Unfortunately, many patients do not heed the admonitions of their physicians even though the consequences may be life-threatening to the patient or others.²⁷

Thus, the court concluded, "the benefit of warning an epileptic not to drive is incremental but . . . the consequences of imposing a duty are great."²⁸

21. See *Praesel*, 925 S.W.2d at 259-60.

22. See 37 TEX. ADMIN. CODE § 15.58 (1998).

23. See TEX. HEALTH & SAFETY CODE ANN. § 12.096(a) (Vernon Supp. 1999) (authorizing physicians to provide to the Department of Public Safety or the Medical Advisory Board identifying information about a patient "whom the physician has diagnosed as having a disorder . . . specified in a rule of the Department").

24. See *Praesel*, 967 S.W.2d at 394-96.

25. See *id.* at 398.

26. See *id.* at 396.

27. *Id.* at 398.

28. *Id.* The court's assumption on this factual issue is an interesting one. Apart from implicitly indulging a stereotype of patients with epilepsy, see *id.* at 399 (Enoch, J., concurring) (noting that the court's "conclusion is based upon an assumption that is wholly unsupported in the record. This Court does not know what epileptics are supposed to know about whether they should ever drive a car." *Id.*), the court further assumes that a patient who is inclined to overlook the risks posed to others by his medical condition would not be more than "incrementally" influenced by strong warnings from his or her physician. The law's hypothetical "reasonable person," even the hypothetical "reasonable person with epilepsy," ought to be held to a higher standard than is implied by the court's approach. In

The supreme court was careful to carve out of its decision the question whether mental health professionals have a so-called "*Tarasoff*"²⁹ duty³⁰ to warn identifiable third parties whom a patient has threatened to harm.³⁰ Noting that three lower courts in Texas have found the existence of such a duty to warn, the court declined to comment on the question other than to suggest that the imposition of a new tort duty turns on an close examination of the context and facts of each case.

2. *Duty to Protect*

In *Van Horn v. Chambers*,³¹ the Texas Supreme Court ruled that a physician's duty to exercise reasonable care in the diagnosis and treatment of a patient is not a duty that is also owed to third parties outside the physician-patient relationship.

The case began when a patient was taken to the Hermann Hospital emergency room and was admitted for the treatment of seizures and alcohol withdrawal. The day after his admission to the neurological critical care unit (NCCU), the patient was seen by Dr. Van Horn, a neurologist. During the patient's second day in the NCCU, Dr. Van Horn concluded that the patient no longer needed critical care services or physical restraints and ordered that the patient be transferred to a private bed on a general medical floor.

The next day, the patient tried to leave the hospital and was pursued and detained by two hospital workers and a medical student. During the ensuing struggle, all four fell through a grill that covered an air shaft and landed on the concrete floor twenty-four feet below. One employee and the medical student died; the second employee and the patient were injured.

The surviving parents of the deceased employee, along with the injured employee, sued Dr. Van Horn, alleging negligence and gross negligence. Although there were many claims in their complaint, the supreme court summed them up this way: "The gravamen of the plaintiffs' complaints is that Van Horn knew or should have known that [the patient] posed a danger to others and should have treated him accordingly."³² Specifically, they complained that Van Horn failed to perceive that the patient posed a threat to the safety of those around him and therefore, by sending the patient to an unsecured room and ordering the discontinuation of physical restraints, failed to treat the patient properly.

addition, the court's hand-wringing over the potentially great liability that would be imposed on physicians if the court were to recognize a duty to warn cuts equally against its conclusion. In light of the potentially catastrophic consequences that might result from a failure to warn, requiring the physician to warn the patient (and nothing more) would be a relatively mild response from the tort system while a simple one for physicians to satisfy.

29. See *Tarasoff v. Regents of the Univ. of Cal.*, 551 P.2d 334 (1976).

30. See *Praesel*, 967 S.W.2d at 397.

31. 970 S.W.2d 542, 544 (Tex. 1998), *rev'g* *Chambers v. Hermann Hosp. Est.*, 961 S.W.2d 177 (Tex. App.—Houston [1st Dist.] 1996), *cert. denied*, 119 S. Ct. 546 (1998).

32. *Id.* at 545.

The trial court granted Dr. Van Horn's motion for summary judgment, but the court of appeals reversed,³³ holding that the physician owed a duty to non-patient third parties on the basis of the supreme court's opinion in *Otis Engineering Corp. v. Clark*.³⁴ In *Otis*, the supreme court held that an employer owed a duty of care to third parties who were killed by an inebriated employee who was driving home from work, even though the employee was not acting within the scope of his employment, was not on the employer's premises, and was not using the employer's property.³⁵

The supreme court reversed the court of appeals, refusing to extend the rule in *Otis* to the physician-patient relationship.³⁶ In so doing, the court gave at least three reasons for agreeing with the lower courts in Texas that have refused since 1984 to apply *Otis* to physician and non-patient third parties.³⁷

1. Section 315(a) of the Restatement (Second) of Torts³⁸ requires a special relationship before there can be a duty to control the actions of a third party. Although the Texas Supreme Court has found such a special relationship between parent and child, master and servant, and independent contractor and contractee, it declined to find such a relationship between physicians and their patients.³⁹ Presumably, then, if Dr. Van Horn owed no duty to control to this patient, he owed no such duty to the plaintiffs.

2. Section 315(b) of the Restatement (Second) of Torts⁴⁰ states that some special relationships give rise to a right of protection, and subsequent sections of the RESTATEMENT give specific examples, such as parent-child⁴¹ and master-servant.⁴² The supreme court could find no evidence that Dr. Van Horn had any contact with the deceased or injured employees and therefore concluded that no special relationship could possibly have come into existence.⁴³

3. Section 319 of the Restatement (Second) of Torts⁴⁴ imposes a duty of care on those who take control of dangerous persons. The supreme court observed that "[w]e have not adopted section 319 as the law in Texas"⁴⁵ and then declined to do so in this case. The court noted that section 319 "does not apply to a case where there exists no inherent right to control another,"⁴⁶ as distinguished from the case of employers and their employees. Having already concluded that physicians have no in-

33. See *Chambers*, 961 S.W.2d at 177, 180, 193.

34. 668 S.W.2d 307 (Tex. 1984).

35. See *id.* at 311.

36. See *Van Horn*, 970 S.W.2d at 546.

37. See *id.* at 546-47.

38. RESTATEMENT (SECOND) OF TORTS § 315(a) (1965).

39. See *Van Horn*, 970 S.W.2d at 546-47.

40. RESTATEMENT (SECOND) OF TORTS § 315(b) (1965).

41. See *id.* § 316.

42. See *id.* § 317.

43. See *Van Horn*, 970 S.W.2d at 547.

44. RESTATEMENT (SECOND) OF TORTS § 319 (1965).

45. *Van Horn*, 970 S.W.2d at 547.

46. *Id.*

herent right to control their patients, the supreme court held that section 319 could not apply to them either.⁴⁷

B. LICENSURE

In a case of apparently first impression, the Amarillo Court of Appeals held in *Attaya v. Shoukfeh*⁴⁸ that when a physician who reports what he believes to be misconduct by another physician to the State Board of Medical Examiners, the reporting physician enjoys absolute immunity from liability in a defamation action brought by the second physician. The immunity is derived from the common-law privilege for those who testify in judicial and quasi-judicial proceedings. The court acknowledged that the Medical Practice Act deems statements to the board to be privileged so long as they are made “without malice”⁴⁹ and “in good faith”⁵⁰—in short, the statute cloaks reporting physicians with a qualified immunity. The court concluded, however, that the Medical Practice Act “does not repeal, destroy, diminish or supercede common law absolute immunity.”⁵¹ The court’s only explanation for this curious statement was that qualified immunity simply does not provide sufficient protection to encourage reporting by physicians. While this is a cogent enough reason for the legislature to amend the Medical Practice Act, it is a tenuous basis for a court to ignore the Medical Practice Act. Moreover, if the legislature believed that common-law absolute immunity would survive the enactment of the Medical Practice Act, one wonders why the legislature bothered to include a rule of qualified immunity for reporting physicians. To hold that the common-law rule of absolute immunity survived flies in the face of another common-law rule: the one that requires courts to avoid construing a statute in a manner that renders the statute, or any part of it, a nullity.⁵²

In *Levy v. Texas State Board of Medical Examiners*,⁵³ the Board of Medical Examiners reversed or threw out numerous findings of fact by its administrative law judge in a disciplinary case against a physician. The version of the state Administrative Procedure Act in effect at the time of the board’s decision, however, permitted a state agency to change an ALJ’s findings and conclusions “only for reasons of policy.”⁵⁴ The board’s compliance with this provision consisted of its invocation of the

47. *See id.*

48. 962 S.W.2d 237, 240 (Tex. App.—Amarillo 1998, no writ).

49. *See* TEX. REV. CIV. STAT. ANN. art. 4495b, § 5.06(m) (Vernon 1998).

50. *Id.* § 5.06(t)(1).

51. *Attaya*, 962 S.W.2d at 239.

52. *See, e.g., Liberty Mut. Ins. Co. v. Garrison Contractors, Inc.*, 966 S.W.2d 482, 485 (Tex. 1998) (“But we do not lightly presume that the Legislature may have done a useless act.”).

53. 966 S.W.2d 813, 815 (Tex. App.—Austin 1998, no pet.).

54. *See id.* at 815 (quoting TEX. GOV’T CODE ANN. § 2001.058(e) (Vernon Supp. 1997)). In 1997, the legislature amended section 2001.058(e) to read:

A state agency may change a finding of fact or conclusion of law made by the administrative law judge, or may vacate or modify an order issued by the administrative judge, only if the agency determines:

board rule that permits the board—as a matter of policy—to change an ALJ’s findings when the board concludes, *inter alia*, that the findings are erroneous, against the weight of the evidence, based on unsound medical principles, or insufficient to protect the public interest.⁵⁵ The court of appeals held that more is required of an agency that reverses its ALJ’s findings and conclusions than a simple reference to the demands of policy:

[P]ublic policy is enhanced when the Board elaborates on why an ALJ’s finding of fact or conclusion of law is based on “unsound medical principles” or is “not sufficient to protect the public interest” because such elaboration will help guide future ALJ’s in these types of proceedings and will enhance the public’s knowledge of what constitutes inappropriate physician behavior.⁵⁶

The court’s admonition presumably has equal force in light of the legislature’s recent amendment of the Administrative Procedure Act. It will be interesting to see how the board responds to the court’s challenge in future cases.

III. NURSES: WHISTLE-BLOWER PROTECTION

Section 11 of article 4525a of the Nursing Practice Act⁵⁷ protects nurses against retaliation “for reporting under this [statute].”⁵⁸ The question in *Clark v. Texas Home Health, Inc.*⁵⁹ was whether an employer could escape liability for disciplining three nurses after they informed the employer they were going to report a nurse’s involvement in a patient’s death to the Board of Vocational Nurse Examiners, but before the report was actually filed.

The supreme court ruled that the statute’s use of the word “reporting” was broad enough to include the circumstances of this case and that the nurses therefore had a statutory claim against the employer for retaliation.⁶⁰ Specifically, the court ruled that (i) *telling the employer* that they

(1) that the administrative law judge did not properly apply or interpret applicable law, agency rules, written policies provided under Subsection (c), or prior administrative decisions;

(2) that a prior administrative decision on which the administrative law judge relied is incorrect or should be changed; or

(3) that a technical error in a finding of fact should be changed.

The agency shall state in writing the specific reason and legal basis for a change made under this subsection.

TEX. GOV’T CODE ANN. § 2001.058(e) (Vernon Supp. 1999) (applicable to contested cases before an occupational licensing agency filed on or after the effective date of the amendment (Sept. 1, 1997)).

55. See 22 TEX. ADMIN. CODE § 187.34(d) (1998).

56. *Levy*, 966 S.W.2d at 816.

57. The Nursing Practice Act is all of TEX. REV. CIV. STAT. ANN. ch. 7 (Vernon Supp. 1999), which includes articles 4512 through 4528c.

58. TEX. REV. CIV. STAT. ANN. art. 4525a, § 11(a) (Vernon Supp. 1999) (emphasis added).

59. 971 S.W.2d 435 (Tex. 1998), *aff’g in part and rev’g in part* 940 S.W.2d 835 (Tex. App.—Amarillo 1997).

60. See *id.* at 437.

intended to file the report, plus (ii) *subsequently filing the report* with the nursing board constituted *filing a report* within the meaning of the statute. The employer could not escape liability under section 11 by disciplining the nurses after step (i) but before they had a chance to perform step (ii).⁶¹ To hold otherwise, wrote the court, would “discourage an employee from informing an employer that a nurse poses a potential threat to patients”⁶² and would frustrate “the legislative intent behind the reporting requirements and the protection afforded by Section 11: ensuring a safe and monitored system of nursing care.”⁶³

The importance of the court’s broad reading of section 11 was underscored by another whistleblower case decided this past year. In *Austin v. Healthtrust, Inc.—The Hospital Co.*,⁶⁴ a nurse reported another nurse’s inappropriate use of drugs to her supervisor. According to her complaint, she was then subjected to “extreme scrutiny” and ultimately fired, allegedly in retaliation for her whistleblowing.⁶⁵ Because she did not report the nurse’s alleged misconduct to the nursing board, the plaintiff could not avail herself of the statutory retaliation claim in section 11.⁶⁶ And because she was fired in 1992, about one year before the legislature added a general protection for hospital employees who report illegal activity to their employer,⁶⁷ she had no cause of action under the new law either.⁶⁸ Thus, her only basis for a suit against her former employer was a common-law claim for retaliation, which the supreme court declined to recognize.⁶⁹

IV. MEDICAL LIABILITY

A. STATUTE OF LIMITATIONS

The Medical Liability and Insurance Improvement Act⁷⁰ (Act) contains a relatively straightforward two-year statute of limitations provision (section 10.01)⁷¹ that has caused no end of difficulty in its application. One supreme court decision during the past year confirmed an already settled point of law,⁷² while two other decisions raised interesting policy

61. *See id.*

62. *Id.* at 438.

63. *Id.*

64. 967 S.W.2d 400 (Tex. 1998), *aff'g* 951 S.W.2d 78 (Tex. App.—Corpus Christi 1997).

65. *See id.* at 400-01.

66. *See id.* at 402.

67. *See* TEX. HEALTH & SAFETY CODE ANN. § 161.134 (Vernon Supp. 1999).

68. *See Austin*, 967 S.W.2d at 402-03.

69. *See id.* at 402.

70. TEX. REV. CIV. STAT. ANN. art. 4590i (Vernon Supp. 1999).

71. *See id.* § 10.01.

72. The supreme court’s decision in *Husain v. Khatib*, 964 S.W.2d 918 (Tex. 1998) (per curiam), *rev'g* 949 S.W.2d 805 (Tex. App.—Ft. Worth 1997), came with a reminder that the three alternative beginning points for measuring the two-year limitations period are not intended to give plaintiffs their choice of the most favorable provision. If the date on which a defendant’s negligence can fairly be ascertained, then that is the date the statute begins to run. *See id.* at 919. If that date cannot be determined with any certainty, either the last day of a continuous course of treatment or the last day of a stay of hospitalization

issues.

1. Injury to a Fetus

In *Brown v. Shwartz*,⁷³ the supreme court applied section 10.01 to a medical malpractice claim for injuries caused to a fetus. The defendant, Dr. Shwartz, allegedly failed to notice during an in-office examination that Christina Michelle Brown's membranes had ruptured, despite her complaints of "nausea and continuing headaches, cough, and wetness in her pants."⁷⁴ Four days later, after a second physician made the correct diagnosis, Ms. Brown was admitted to the hospital, where she gave birth to Dillon, a premature baby boy who died the next day. Two years and seventy-six days later—one day after the expiration of the statutory limitations period in section 10.01⁷⁵—Ms. Brown and her husband filed wrongful death and survival claims against Dr. Shwartz. The trial court granted summary judgment to the defendant, and the court of appeals affirmed, finding that the limitations period for the wrongful death claim began to run when Dr. Shwartz allegedly failed to discover that Ms. Brown's membranes had ruptured, even though that was four days before Dillon was born (and died).⁷⁶

The supreme court affirmed with respect to the wrongful death claim but reversed as to the survival claim.⁷⁷ The court ruled that section 10.01 governed both claims but produces a different result when applied to the statutory wrongful death claim than when applied to derivative survival claim. The limitations period for the wrongful death claim, the court reasoned, could just as logically begin running when Dillon was in utero as when he was born.⁷⁸ Since there is no extension of the limitations period

will be used as an approximation of the date the negligence occurred. *See id.* In *Husain*, plaintiffs complained that their physician's failure to order tests or to involve specialists resulted in a missed diagnosis of cancer. Eventually, in August 1992, the defendant ordered a mammogram, some eleven months after plaintiff's last visit to the defendant. Since plaintiff's claim was based on the physician's nonfeasance, however, the penultimate visit in September 1991 was the last date on which defendant's negligence could have occurred, and that was more than two years prior to the filing of the medical malpractice action against the physician. *See id.* at 919-20.

73. 968 S.W.2d 331 (Tex. 1998), *aff'g in part and rev'g in part*, 929 S.W.2d 609 (Tex. App.—Waco 1996).

74. *Id.* at 333.

75. In addition to the two-year limitations period provided by § 10.01, TEX. REV. CIV. STAT. ANN. § 4.01(c) tolls the statute for 75 days if notice of the claim is provided more than 60 days prior to filing the action, as required by § 4.01(a). Ms. Brown filed the statutory notice on December 9, 1991. After settlement negotiations proved fruitless, she filed the action on February 17, 1994. The trial court ruled that the two-year statutory limitations period (including the 75-day tolling period) expired on February 17, 1994. *See Brown*, 929 S.W.2d at 611.

76. *See Brown*, 929 S.W.2d at 614. Although the survival action was not separately analyzed, the court of appeals apparently treated both of the plaintiffs' claims as wrongful death claims based on medical malpractice and intended their affirmance to include both claims.

77. *See Brown*, 968 S.W.2d at 333.

78. This conclusion required the court to hold that the fetus was a "patient" and there existed a physician-patient relationship between the fetus and Dr. Shwartz within the meaning of article 4590i. *See id.* at 334. Justice Gonzalez (in his concurring opinion)

when the decedent is a minor,⁷⁹ similarly, there is no extension when the decedent is a fetus at the time of injury.

The limitations period on the parents' survival action began to run on the same day as the wrongful death action, but because their claim is derivative of Dillon's claim, they get the benefit of the tolling provision of section 10.01, which gave Dillon until he was fourteen years old to file his claim. That tolled the running of the limitations until he died, giving his parents four more days to file their survival action than their wrongful death action.⁸⁰

2. *Misnomer and Misidentification*

In a highly contentious (6-5) ruling, the Dallas Court of Appeals ruled that a suit commenced against a neurologist did not toll the statute of limitations with respect to the neurologist's professional association (P.A.).⁸¹ Thus, although plaintiff's medical malpractice claim was timely filed against the neurologist, his later attempt to add the P.A. (which employed the physician, and of which the physician was the sole shareholder, director, and officer) more than two years after the alleged malpractice occurred was doomed. The court did not address plaintiff's argument that the late joinder should be excused on the ground of misidentification (because misidentification had not been specifically argued at trial⁸²), which leaves open the question whether the doctrine of misidentification would have been more successful than the doctrine of either misnomer or assumed name. The more difficult and interesting question turns on the Act's statement that its two-year limitations period applies "[n]otwithstanding any other law."⁸³ Rule 28 of the Texas Rules of Civil Procedure permits an "individual doing business under an assumed name [to] be sued in its . . . assumed or common name [and] on a motion by any party . . . the true name may be substituted."⁸⁴ The majority construed this rule as the type of law that the legislature intended to supersede with section 10.01.⁸⁵ The dissenters, on the other hand, mounted a valiant but losing effort to save Rule 28 from section 10.01. In their view, Rule 28 does not extend the statutory limitations period; it simply allows for pleadings to be cleaned up in actions that were timely filed against professional corporations that have been sued in their com-

pointed to the tension between this holding and the court's previous holdings that under the Texas wrongful death statute, there can be no cause of action for the death of a fetus. *See id.* at 335-36 (citing *Pietila v. Crites*, 851 S.W.2d 185 (Tex. 1993); *Blackman v. Langford*, 795 S.W.2d 742 (Tex. 1990); *Witty v. American Gen. Capital Distribs., Inc.*, 727 S.W.2d 503 (Tex. 1987); and *Tarrant County Hosp. Dist. v. Lobdell*, 726 S.W.2d 23 (Tex. 1987)).

79. *See id.* at 334 (citing *Baptist Mem'l Hosp. Sys. v. Arredondo*, 922 S.W.2d 120 (Tex. 1996)).

80. *See id.* at 335.

81. *See Hyson v. Chilkewitz*, 971 S.W.2d 563 (Tex. App.—Dallas 1998, pet. granted).

82. *See id.* at 568-69.

83. TEX. REV. CIV. STAT. ANN. art. 4590i, § 10.01 (Vernon Supp. 1999).

84. TEX. R. CIV. P. 28.

85. *See Hyson*, 971 S.W.2d at 572.

mon or assumed name.⁸⁶ The mistake made by plaintiff's counsel in *Hyson* is a common, if not everyday, mistake; often the mistake is caught before the limitations period expires. For cases, like *Hyson*, where that does not occur, the supreme court needs to tell us whether Rule 28 saves the plaintiff's action or is irrelevant.

B. TORT CLAIMS ACT

In *Dallas County Mental Health & Mental Retardation v. Bossley*,⁸⁷ the supreme court had yet another occasion to describe and apply the vexing Tort Claims Act that waives the state's sovereign immunity with respect to "personal injury and death so caused by a condition or use of tangible personal or real property."⁸⁸ In *Bossley*, the plaintiffs' decedent was hospitalized after attempting to commit suicide. The patient escaped through one unlocked door and another open one and subsequently killed himself while being pursued by hospital employees. The Dallas Court of Appeals had held that the patient's death involved the "condition or use" of the two doors and therefore sovereign immunity was waived by the Tort Claims Act.⁸⁹

The supreme court reversed, holding that the harm to the decedent was not proximately caused by the condition or use of the hospital's doors in their unlocked or open state, but rather by the failure of hospital personnel to restrain their patient once they knew he was still suicidal.⁹⁰ Justices Abbott and Spector dissented on the ground that the majority applied an inappropriate standard of proximate cause and that, under the correct standard, a question of fact was raised that could only be resolved at trial, not by summary judgment.⁹¹

C. NATURAL DEATH ACT

In the first reported case under the twenty-year-old Natural Death Act,⁹² the Houston Court of Appeals ruled that the defendants—physicians and hospitals that allegedly treated a neurologically devastated newborn in contravention of her parents' express wishes—were immune under the statute from civil liability. In *Stolle v. Baylor College of*

86. See *id.* at 575-76.

87. 968 S.W.2d 339 (Tex. 1998), *rev'g* 934 S.W.2d 689 (Tex. App.—Dallas 1995).

88. TEX. CIV. PRAC. & REM. CODE ANN. § 101.021(2) (Vernon 1997).

89. See *Bossley*, 934 S.W.2d at 695-96.

90. See *Bossley*, 968 S.W.2d at 343.

91. See *id.* at 344. The majority claimed that the unlocked and open doors "permitted [decedent's] escape but did not cause his death." *Id.* at 343. It is difficult to see how the same could not be said for the staff's failure to restrain the decedent, which the majority argued was "[t]he real substance of plaintiffs' complaint" *Id.* The majority never addressed the dissenters' point that the condition or use of the hospital's doors were at least a contributing cause to the patient's death, and that serious harm was certainly a foreseeable consequence of leaving the doors unlocked or open, other than to assert that the condition or use of the hospital doors was "too attenuated from [his] death to be said to have caused it." *Id.*

92. TEX. HEALTH & SAFETY CODE ANN. art. 672 (Vernon 1992 & Supp. 1999).

*Medicine*⁹³ a child was born with a grade IV left intraventricular hemorrhage and a grade II right intraventricular hemorrhage resulting in irreversible brain damage and a neurological deficit. On that basis, the baby's attending physician ordered that she was not to receive chest compressions, intubation, or cardiac medications, after which the parents executed a directive to physicians pursuant to the Natural Death Act.⁹⁴

Despite the parents' clear and consistent pattern of requesting that no extraordinary measures be used to save their daughter's life or to keep her alive if she were determined to have a terminal condition, the baby was resuscitated when she stopped breathing and her pulse slowed after regurgitating her food. The parents sued a variety of hospitals and health care providers for eleven allegedly negligent acts or omissions,⁹⁵ all of which the court of appeals characterized as boiling down to one basic claim: the defendants failed to effectuate the directive the parents executed pursuant to the Natural Death Act.⁹⁶ Since the parents' claims all fell under the Natural Death Act, the court reasoned that the defendants were cloaked in the immunity provided by section 672.016, which provides for civil and criminal immunities for failing to effectuate the directive of a qualified patient.⁹⁷ Although there was disagreement at trial over whether the baby had a terminal condition and was therefore a qualified patient, the court observed (correctly) that defendants won either way. If she were a qualified patient, the immunity provision governed the parents' claims; if not, the precondition for withholding life-sustaining treatment in the parents' directive was not met and the defendants could not be liable for failing to effectuate the directive.⁹⁸

93. 981 S.W.2d 709 (Tex. App.—Houston [1st Dist.] 1998, pet denied).

94. TEX. HEALTH & SAFETY CODE ANN. § 672.006 (Vernon 1992) provides that parents may execute a directive on behalf of a qualified patient under the age of 18 years. A "qualified patient" is one who has been certified by two physicians (her attending physician and one other) to have a terminal condition. *See id.* § 672.002(8).

95. *See Stolle*, 981 S.W.2d at 711.

96. *See id.* at 713.

97. *See id.* at 713-14; TEX. HEALTH & SAFETY CODE ANN. § 672.016(b) (Vernon 1992). Section 672.016 is a curious provision. It begins by providing immunity from civil and criminal liability for failure to effectuate a directive the existence of which the defendant was unaware. *See id.* § 672.016(a). It then provides the same immunities for failure to effectuate a directive whose existence was known to the defendant. *See id.* § 672.016(b). In addition, while the immunities provided for effectuating a qualified patient's directive are qualified by the phrase "unless negligent," *see id.* § 672.015, and the Durable Power of Attorney for Health Care statute's immunity provision is qualified by "due care" and "good faith" requirements, *see* TEX. CIV. PRAC. & REM. CODE ANN. § 135.010 (Vernon 1997), there are no such limits on the immunities provided for failing to effectuate a patient's directive. This will change January 1, 2000, when TEX. HEALTH & SAFETY CODE ANN. § 166.045(b) takes effect. *See* 1999 TEX. S.B. 1260 § 1.03.

98. *See Stolle*, 981 S.W.2d at 713. Recall that section 672.006 specifies that parents may execute a directive on behalf of a "qualified [minor] patient." Although the appellate court notes that "[i]t is undisputed that none of the treating physicians classified [the baby's] condition as terminal," *see Stolle*, 981 S.W.2d at 713, the court does not consider whether that fact means that the baby was not a qualified patient at the time the directive was executed by her parents and that the directive was, therefore, a nullity. Since the existence of a "directive" is a prerequisite to obtaining the immunity provided by section 672.016, and "directive" is defined as "an instruction made under Section . . . 672.006,"

V. MANAGED CARE: LIABILITY

In 1997 the Texas legislature enacted Senate Bill 386,⁹⁹ the Health Care Liability Act, hailed as the first state law in the country to permit individuals to sue health insurance carriers, health maintenance organizations, or other managed care entities for damages proximately caused by the entity's negligence when making a health care treatment decision. In addition to providing for tort liability, the Act also created an independent review process to evaluate adverse benefit determinations.¹⁰⁰

The Act was almost immediately challenged in federal court, primarily on the ground of ERISA preemption.¹⁰¹ In an opinion that will be subjected to extensive appellate scrutiny at the Fifth Circuit, District Judge Vanessa Gilmore upheld the liability provision of the Act but held the independent review process to be preempted.¹⁰²

The court reasoned that the liability provision is not preempted because (a) tort liability for medical treatment decisions is an area of traditional state regulation and (b) the law excludes ERISA plans from its definition of a managed care entity.¹⁰³ The Act's independent review provisions, on the other hand, "improperly mandate the administration of employee benefits"¹⁰⁴ in violation of Congress' policy that ERISA alone be the source of a uniform, national system of benefits administration.

VI. MEDICAL RECORDS

A. CONFIDENTIALITY: HIV¹⁰⁵

Adalberto Balderas was a hemophiliac who contracted HIV infection, presumably from injections of Factor VIII, a clotting factor administered

TEX. HEALTH & SAFETY CODE ANN. § 672.002(4) (Vernon 1992), there is at least an argument that the parents' claim does not arise under the Natural Death Act and that the statute's immunity section should not be applied in this case.

99. Senate Bill 386 is codified at TEX. CIV. PRAC. & REM. CODE ANN. chap. 88 (Vernon Supp. 1999) and amends portions of the Insurance Code, including the Health Maintenance Organization Act. See TEX. INS. CODE ANN. arts. 20A.12 & 20A.12A (Vernon Supp. 1999).

100. See TEX. CIV. PRAC. & REM. CODE ANN. 88.003 (Vernon Supp. 1999).

101. The Employee Retirement Income Security Act of 1974, 29 U.S.C. §§ 1001-1461 (1994), preempts state laws that relate to employee benefits plans, including those that offer health insurance benefits. See *id.* § 1144(a). ERISA preemption is modified by a "savings clause," which preserves state laws that regulate insurance. See *id.* § 1144(b)(2)(A). Even those laws, however, are preempted to the extent they affect employer's self-insured plans, which are deemed not to be insurance companies for purposes of the savings clause. See *id.* § 1144(b)(2)(B).

102. See *Corporate Health Ins., Inc. v. Texas Dep't of Ins.*, 12 F. Supp. 2d 597 (S.D. Tex. 1998).

103. See *id.* at 610-14.

104. *Id.* at 625.

105. In addition to the case discussed in the text of this section, another significant event during the Survey year was the Texas Department of Health's (TDH) proposal to begin requiring that HIV and AIDS reporting shall include the patient's name, along with other statistical and demographic information. See 23 Tex. Reg. 7696 (1998) (to be codified at 25 TEX. ADMIN. CODE §§ 97.131-.134, 97.139, 97.146) (proposed July 31, 1998). Until now, the patient's name was reportable only for patients under the age of 13 years. The change was proposed because the TDH found the Unique Identifier reporting system,

to him in the 1980s through, but not directly from, Santa Rosa Health Care Corporation.¹⁰⁶ Between 1986 and 1989, Santa Rosa sent seven written notices to Balderas requesting that he come in to be tested for, among other things, HIV infection. Balderas did not go in for the tests but was determined to be HIV-positive in December 1989. In 1991 Balderas and his former wife, Linda Garcia (to whom he was married from 1989 to 1990), sued Santa Rosa for its failure to notify them of Balderas' possible HIV infection. Balderas died in 1993 and his estate voluntarily dismissed his claims against Santa Rosa, leaving only Ms. Garcia's claims for adjudication.¹⁰⁷ The trial court granted summary judgment to Santa Rosa, and the court of appeals reversed, holding (1) that Santa Rosa owed a duty to Garcia to warn her of the risk of infection from Balderas, and (2) that a fact issue existed as to the reasonableness of Santa Rosa's efforts to warn Garcia.¹⁰⁸

The Texas Supreme Court reversed and held that Santa Rosa owed no duty to Garcia to warn her of the risk of HIV infection. Texas had two different versions of an HIV confidentiality statute from 1987 to 1989 and 1989 to the present.¹⁰⁹ Under both versions of the law, AIDS test results are confidential, subject to a permissive rule that allows, but does not require, spouses to be told of a positive test result.¹¹⁰ The court held that the notices to Balderas advising him of the risk of HIV infection constituted a "test result" under both the 1987 and 1989 versions. The 1987 version defined "test result" to include "any statement . . . that any identifiable individual is . . . at risk . . . or any other statement that indicates that an identifiable individual has or has not been tested for AIDS or HIV infection,"¹¹¹ and the current (1989) law is not much different.¹¹² Thus, the question to be decided by the court was whether either version of the law permitted Santa Rosa to share the "test result" with Ms. Garcia. The court held no, based upon the requirement in both versions that a spouse may be told only if the patient tests positive for HIV.¹¹³ Since Balderas did not test HIV-positive until 1989, there could be no claim for failure to warn Ms. Garcia before that time. The court also rejected her argument that Santa Rosa owed her a common-law duty to advise her of

which lacked names, made surveillance, tracking, and follow-up difficult. See TEXAS DEP'T OF HEALTH, BUR. OF HIV & STD PREVENTION, UNIQUE IDENTIFIER REPORTING FOR HIV INFECTION SURVEILLANCE (Nov. 1997) (copy on file with author); *HIV Reporting by Name: Fact Sheet* (visited Apr. 9, 1999) <<http://www.tdh.state.tx.us/hivstd/pdf/hivname2.pdf>> (copy on file with author). Despite comments that name-reporting would deter testing and lead to breaches of confidentiality, TDH adopted the new rule, effective January 1, 1999. See 23 TEX. REG. 12669 (1998), adopted 23 TEX. REG. 7696 (1998) (codified at 25 TEX. ADMIN. CODE §§ 97.131-.134, 97.139, 97.146).

106. See *Santa Rosa Health Care Corp. v. Garcia*, 964 S.W.2d 940 (Tex. 1998), *rev'g* 925 S.W.2d 372 (Tex. App.—Corpus Christi 1996).

107. See *id.* at 942 n.1.

108. See *Garcia*, 925 S.W.2d at 378.

109. See *Garcia*, 964 S.W.2d at 942-43.

110. See *id.* at 943.

111. *Id.* at 942.

112. See TEX. HEALTH & SAFETY CODE ANN. § 81.101(5) (Vernon 1992).

113. See *Garcia*, 964 S.W.2d at 943.

the risk of infection, finding that such a duty is precluded by the confidentiality statute, which prohibited Santa Rosa from sharing a "test result" with her before Balderas had tested positive for HIV.¹¹⁴

B. SPOILIATION

When Genaro Ortega sued two physicians and a clinic for allegedly negligent care and treatment during the birth of his daughter, he discovered that the medical records he would need to prove his case had been destroyed. He then filed a separate action based upon the independent tort of spoliation of evidence. The trial court sustained the defendant's special exception, but the court of appeals reversed, holding that although there are no Texas cases allowing for the separate tort of spoliation, there should be.¹¹⁵

The supreme court disagreed and reversed, reasoning that "[i]t is simpler, more practical, and more logical to rectify any improper conduct within the context of the lawsuit in which it is relevant."¹¹⁶ The court relied upon the existence of broad remedial powers with which the trial judge may handle discovery abuses,¹¹⁷ as well as the fact that only six of the twenty states that have decided the question have chosen to recognize a separate tort for spoliation.

Hospitals are required by statute to preserve medical records for various periods of time.¹¹⁸ The plaintiff in *Trevino* argued that he should be able to pursue a claim against the clinic for breach of its statutory duty to maintain medical records. Without deciding whether such a duty in fact exists, or would be applicable to the defendant clinic, the court declined the invitation to recognize a private cause of action for a violation of the statute.¹¹⁹

VII. MEDICAL DEVICES: FEDERAL PREEMPTION¹²⁰

In *Medtronic, Inc. v. Lohr*,¹²¹ the United States Supreme Court held

114. See *id.* at 944.

115. See *Ortega v. Trevino*, 938 S.W.2d 219 (Tex. App.—Corpus Christi 1997), *rev'd*, 969 S.W.2d 950 (Tex. 1998).

116. *Trevino*, 969 S.W.2d at 953. The court was therefore noncommittal on the question whether there should be a separate tort of spoliation for the benefit of persons who are not parties to the underlying lawsuit. See *id.* at 950.

117. See *id.* at 953.

118. See, e.g., TEX. HEALTH & SAFETY CODE ANN. § 241.103 (Vernon 1992 & Supp. 1999).

119. See *Trevino*, 969 S.W.2d at 953.

120. Where the law of medical-device regulation and the rules of federal statutory preemption intersect is the LaBrea Tar Pit of American jurisprudence. This brief summary of the Texas Supreme Court's recent foray into the intersection will not attempt to explicate the intricacies of this area of the law. For a detailed analysis of the issues, the reader might just as well begin with the United States Supreme Court's opinion in *Medtronic, Inc. v. Lohr*, 518 U.S. 470 (1996). For a helpful, pre-*Medtronic* guide to the issues, see Ashley W. Warren, *Preemption of Claims Related to Class III Medical Devices: Are the Federal Objectives of Public Health and Safety Furthered or Hindered?*, 49 SMU L. REV. 619 (1996).

121. 518 U.S. 470 (1996).

that state tort claims were not preempted by federal law in the case of a Class III medical device that had been approved by the Food and Drug Administration (FDA) through the relatively undemanding "§ 510(k) process."¹²² The high court left open the question whether federal law would preempt state-law claims when the Class III device had gone through the much more rigorous premarket approval (PMA) process.¹²³ That was the question posed to the Texas Supreme Court in *Worthy v. Collagen Corp.*,¹²⁴ in which the court was required to decide whether a claim against the manufacturer of Zyderm® and Zyplast® (both injectable forms of collagen)—Class III medical devices approved through the PMA process—is preempted by the federal Medical Device Amendments of 1976 to the Food, Drug and Cosmetic Act.¹²⁵ The court held that plaintiff's claims under the Deceptive Trade Practices Act were preempted.¹²⁶ The court stopped short of holding that the PMA process automatically creates a preemptive effect, choosing instead to base its decision upon a review of the specific PMA process for Zyderm® and Zyplast® as well as the numerous decisions of other courts (both pre- and post-*Medtronic*) that concluded that the FDA's approval of Zyderm® preempted state-law claims that it was unsafe.¹²⁷

VIII. ORGAN AND TISSUE REMOVAL

Wendell Baker, Jr. was killed by police gunfire, a circumstance that required an autopsy.¹²⁸ The medical examiner, Dr. Korndorffer, consented to and did remove the decedent's corneal tissue pursuant to Texas law.¹²⁹ According to the medical examiner, he was unaware that the decedent's father had told an employee of the medical examiner that he objected to the removal of any tissue that was not absolutely required to perform the autopsy. The decedent's father, on the other hand, claimed that he had voiced his objection to the employee, an assertion that the employee denied. No one, including the decedent's father and the em-

122. Section 510(k) of the Food, Drug & Cosmetic Act, codified at 21 U.S.C. §§ 360e(b)(2), 360(k) (1994), allows the FDA to approve a medical device if it is shown to be substantially equivalent to a medical device that had been approved before Congress' enactment of the Medical Device Amendments of 1976.

123. The PMA process is described in detail in 21 U.S.C. § 360e(c)(1) (1994). As noted by the Texas Supreme Court, the FDA "spend[s] an average of 1,200 hours on each [PMA] submission." *Worthy v. Collagen Corp.*, 967 S.W.2d, 360, 363 (Tex. 1998), *cert. denied*, 118 S. Ct. 2372 (1998), *aff'g* 921 S.W.2d 711 (Tex. App.—Dallas 1996), compared to the 20 hours the FDA devotes to the average § 510(k) submission, *see id.* at 370.

124. 967 S.W.2d at 360.

125. *See id.* at 362.

126. *See id.* at 377.

127. *See id.* at 375-76.

128. *See Korndorffer v. Baker*, 976 S.W.2d 696, 697 (Tex. App.—Houston [1st Dist.] 1997, pet. filed). *See also* TEX. CODE CRIM. PROC. ANN. art. 49.25, §§ 6, 9 (Vernon Supp. 1999).

129. *See* TEX. HEALTH & SAFETY CODE ANN. § 693.012 (Vernon 1992) (permitting medical examiner to remove corneal tissue if, among other requirements, the parents of the decedent do not object).

ployee, claimed that any objection was in fact communicated to Dr. Korndorffer.

The decedent's parents sued Dr. Korndorffer for the unauthorized removal of their son's cornea, and Dr. Korndorffer moved for summary judgment, relying primarily upon the immunity provision of section 693.014 of the Health and Safety Code.¹³⁰ The Houston Court of Appeals (First District) affirmed the decision of the trial court to deny the motion for summary judgment. The statutory immunity is available only in an action brought "by a person [such as the father of the decedent] who did not object before the removal of the corneal tissue."¹³¹ Because no one disputed the medical examiner's claim that he was not informed of the father's alleged objections to removal of his son's corneas, the medical examiner claimed that he was entitled to immunity from liability under the statute. The court of appeals disagreed and held that an objection, for purposes of defeating the claim statutory immunity, could be one of which the medical examiner personally knew, or it could be one of which, in the normal operation of the medical examiner's office, the medical examiner should have known.¹³² The court held that a fact question existed as to whether the medical examiner should have known of the father's objections, and the trial court properly denied the medical examiner's motion for summary judgment.¹³³

IX. FEDERAL DEVELOPMENTS

Although the focus of this Survey is developments in Texas law, a few federal developments are sufficiently important to health care providers and health law practitioners to warrant at least brief mention.

A. FALSE CLAIMS ACT

1. *Constitutionality*

In a one-of-a-kind holding, a federal district court in Texas has held that a *qui tam* relator in a civil False Claims Act¹³⁴ suit in which the government has not intervened lacks standing, thereby depriving the court of subject-matter jurisdiction. In *United States ex rel. Riley v. St. Luke's Episcopal Hospital*,¹³⁵ a nurse brought suit under the False Claims Act and alleged that her former employer had filed false claims for Medicare and Medicaid reimbursement.¹³⁶ The government declined to proceed

130. TEX. HEALTH & SAFETY CODE ANN. § 693.014 (Vernon 1992).

131. *Id.* § 693.014(a).

132. *See Korndorffer*, 976 S.W.2d at 701.

133. *See id.* at 702.

134. 31 U.S.C. § 3730 (1994).

135. 982 F. Supp. 1261 (S.D. Tex. 1997).

136. The False Claims Act provides that a person who "knowingly presents . . . to an officer or employee of the United States Government . . . a false or fraudulent claim for payment . . . is liable to the United States Government for a civil penalty of not less than \$5,000 and not more than \$10,000, plus 3 times the amount of damages which the Government sustains." 31 U.S.C. § 3729(a).

with the case,¹³⁷ and Ms. Riley proceeded with the action on her own. Under the False Claims Act, if Ms. Riley prevailed she would be entitled to "receive at least 15 percent but not more than 25 percent of the proceeds of the action or settlement of the claim."¹³⁸

The court dismissed the action, holding that Congress cannot create Article III standing out of whole cloth simply by "assign[ing] the Executive's potential future interest in pursuing a particular fraud claim to an unnamed, theoretical plaintiff who has suffered no injury."¹³⁹ This conclusion contradicts every other decision that squarely decides the standing question¹⁴⁰ and was quickly rejected by at least one other federal judge in the same district.¹⁴¹ The holding in *Riley* also seems plainly out of step with, if not precluded by, the United States Supreme Court's decision in *Hughes Aircraft Co. v. United States ex rel. Schumer*.¹⁴² In that case, the defendant raised constitutional issues in its petition for certiorari,¹⁴³ but the Supreme Court declined to address them.¹⁴⁴ If the Court thought that a serious question existed as to the subject-matter jurisdiction of Article III courts, it is literally inconceivable that it would have passed over the constitutional issues raised in the petition for certiorari. Indeed, even if petitioner had not raised the subject-matter jurisdiction issue, the Court would have been required to address it on its own motion.¹⁴⁵

2. *Illegal Remuneration and Stark Claims*

Medicare and Medicaid fraud and abuse, to oversimplify only a little, may be divided into two types. One type is garden-variety billing fraud that can take a number of different forms. Billing for services not rendered, double-billing for services actually rendered, billing for services rendered by a unqualified or unauthorized provider, and billing for unnecessary services are but four examples.¹⁴⁶ The harm that flows from such practices is quite real, primarily in the form of fiscal harm to the

137. After receiving notice of the case from the relator, see 31 U.S.C. § 3730(b)(2) (requiring private party to serve the government with a copy of the complaint and substantially all material evidence and information in the relator's possession), the government may either proceed with the case or decline, in which case the relator has the right to pursue the claim in the government's name, see *id.* § 3730(b)(4).

138. *Id.* § 3730(d)(1). Under some circumstances, the relator's award may be limited to 10% of the proceeds. See *id.*

139. *Riley*, 982 F. Supp. at 1268.

140. See, e.g., *United States ex rel. Hall v. Tribal Dev. Corp.*, 49 F.3d 1208, 1212-14 (7th Cir. 1995); *United States ex rel. Kreindler & Kreindler v. United Techs. Corp.*, 985 F.2d 1148 (2d Cir. 1993); *United States ex rel. Kelly v. Boeing Co.*, 9 F.3d 743 (9th Cir. 1993), *cert. denied*, 510 U.S. 1140 (1994); *United States ex rel. Robinson v. Northrop Corp.*, 824 F. Supp. 830 (N.D. Ill. 1993).

141. See *United States ex rel. Thompson v. Columbia/HCA Healthcare Corp.*, 20 F. Supp. 2d 1017, 1044-46 (S.D. Tex. 1998).

142. 520 U.S. 939 (1997).

143. See 64 U.S.L.W. 3680 (April 9, 1996).

144. See *Hughes*, 520 U.S. at 944 n.3.

145. See, e.g., *Louisville & Nashville R.R. v. Mottley*, 211 U.S. 149 (1908).

146. See 28 U.S.C. §§ 1320a-7b(a) (West Supp. 1994).

federal programs.¹⁴⁷ This is the classic type of fraud for which the federal False Claims Act was designed: “to ensure the integrity of federal programs and the Federal Treasury by deterring submission of false and fraudulent claims to the government, to provide restitution to the government for money fraudulently taken from it, and to punish those who defraud the government.”¹⁴⁸

The second type of Medicare/Medicaid fraud and abuse includes (i) illegal-remuneration offenses—relating to the payment of something of value in return for patient referrals¹⁴⁹—and (ii) self-referral offenses (also known as Stark violations, in honor of the California Congressman, Fortney “Pete” Stark, who sponsored this legislation)—making referrals to, or billing for services provided by, an entity in which the referring physician has a financial interest.¹⁵⁰ This second category of fraud and abuse is aimed at overutilization of program resources by prohibiting relationships or payments that might provide a financial incentive for referrers to order too many tests or an excessive length of stay in the hospital or the like. Thus, the primary goal of the illegal-remuneration and self-referral prohibitions is the fiscal integrity of the programs and the federal treasury, just as it is with the garden-variety fraud provisions.

To prove an offense under either the illegal-remuneration prohibition or Stark, however, it is not necessary to show that the improper payment or the prohibited financial relationship in fact resulted in overutilization or other inappropriate services or resulted in excessive charges against the Medicare or Medicaid program. Indeed, provable overutilization and similar types of misconduct fall squarely in the first category of fraud and abuse, which makes it an offense to make a “false statement or representation of a material fact in any application for any benefit or payment” to the Medicare or Medicaid program.¹⁵¹ Illegal remuneration and Stark offenses are intended to be prophylactic, not simply retrospective and remedial,¹⁵² so the mere making of an improper (with the requisite wrong-

147. Such practices may also harm program beneficiaries, who may receive unneeded services, be deprived of needed services, or find their program benefits limited because of the impact of such practices on future budgets.

148. Lisa Michelle Phelps, *Calling Off the Bounty Hunters: Discrediting the Use of Alleged Kickback Violations to Support Civil False Claims Actions*, 51 VAND. L. REV. 1003, 1007 (1998).

149. See 42 U.S.C. § 1320a-7b(b) (West Supp. 1999) (making it a crime to pay or to receive, or to offer to pay or to offer to receive, anything of value, in cash or in kind, directly or indirectly, in return for or to induce a referral for which the Medicare or Medicaid programs would be financially responsible).

150. See *id.* § 1395nn. The financial interests might be investment interests or compensation arrangements, and the statute provides numerous exceptions to the prohibitions.

151. *Id.* § 1320-7b(a)(1).

152. As I said, this is an oversimplified picture of fraud and abuse. Illegal remuneration, in addition to creating a financial incentive to overutilize, also imposes present harms on the programs and their beneficiaries. They may curtail patients' freedom of choice of provider and, on the theory that the money for kickbacks must come from somewhere, represent a misallocation of program resources that would be better spent on needed patient services rather than for bribes. Whether these harms are truly harmful, and whether they are the result of poor program design and excessive levels of reimbursement or are the result of bad apples acting badly, is a debate best left for another time and place. For a

ful intent) or of a prohibited referral—even absent a showing of harm to the public—constitutes a violation of the illegal-remuneration or self-referral prohibition.

This raises the question whether a violation of either of these prohibitions can also be a False Claims Act violation when the claim submitted for payment accurately describes medically appropriate care that was actually provided by an appropriate provider. In other words, can an otherwise proper claim for payment be, in the words of the False Claims Act, “a false or fraudulent claim for payment”¹⁵³ simply because a payment or a financial interest constituted an illegal remuneration or self-referral? Or does the False Claims Act require that the government or *qui tam* relator show that the defendant’s conduct resulted in financial harm to the Medicare or Medicaid program?

In *United States ex rel. Thompson v. Columbia/HCA Healthcare Corp.*¹⁵⁴ the district court ruled that financial harm to the government was required for a relator to state a claim under the False Claims Act: “[The relator] has not stated a claim unless he has sufficiently alleged that the defendants have submitted claims that are false or fraudulent (i.e., claims or claim amounts that the government would not have had to pay but for the fraud).”¹⁵⁵

The Court of Appeals for the Fifth Circuit reversed on this point, holding that “where the government has conditioned payment of a claim upon a claimant’s certification of compliance with, for example a statute or regulation, a claimant submits a false or fraudulent claim when he or she falsely certifies compliance with that statute or regulation.”¹⁵⁶ Thus, the question for the district court to answer on remand was whether submission of claims for payment under Medicare necessarily entails certification of compliance with the illegal-remuneration and Stark laws.¹⁵⁷ On remand, the district court held that Medicare payments are conditioned upon a certification of compliance with all applicable federal laws and without such a certification, the provider would not be paid.¹⁵⁸ The result of the *Thompson* case will be to lower the pleading requirements in the Fifth Circuit for False Claims Act cases based upon violations of the ille-

version of that debate, see James F. Blumstein, *Rationalizing the Fraud and Abuse Statute*, 15 HEALTH AFF. 118 (1996); Timothy Stoltzfus Jost & Sharon Davies, *The Fraud and Abuse Statute: Rationalizing or Rationalization?*, 15 HEALTH AFF. 129 (1996).

153. 31 U.S.C. § 3729(a) (1994).

154. 938 F. Supp. 399 (S.D. Tex. 1996), *aff’d in part and vacated in part*, 125 F.3d 899 (5th Cir. 1998).

155. *Id.* at 405. At least one other district court has ruled otherwise. See *United States ex rel. Pogue v. American Healthcorp., Inc.*, 914 F. Supp. 1507 (M.D. Tenn. 1996).

156. *Thompson*, 125 F.3d at 902.

157. The district court was also instructed to consider whether a Stark violation renders false or fraudulent an otherwise valid claim in light of the Stark law’s prohibition of both the self-referral and the submission of a bill for services rendered in violation of the Stark law. See *id.* at 903. Cf. 42 U.S.C. § 1395nn (West. Supp. 1999).

158. *United States ex rel. Thompson v. Columbia/HCA Healthcare Corp.*, 20 F. Supp. 2d 1017, 1036 (S.D. Tex. 1998).

gal-remuneration and self-referral prohibitions and increase the utility of *qui tam* actions as a tool against health care fraud.

B. EMTALA

In 1986 Congress passed the Emergency Medical Treatment and Active Labor Act (EMTALA)¹⁵⁹ to deal with the problem of “patient dumping” – a practice by which a private hospital would arrange to transport patients who lack health insurance (usually coming in through the hospital’s emergency department) to a public hospital. As Texas did three years later,¹⁶⁰ Congress prohibited hospitals from transferring patients in need of emergency care for nonmedical reasons,¹⁶¹ but it also created two duties that go beyond the hospitals’ transfer obligations. First, hospitals are required to “provide for an appropriate medical screening examination”¹⁶² for all patients who come to the emergency department. Second, if the patient is found to have an emergency medical condition,¹⁶³ the hospital must “provide . . . such treatment as may be required to stabilize the medical condition”¹⁶⁴ or provide for an appropriate transfer.¹⁶⁵

These statutory duties, however, are not explicitly or even conceptually limited to “patient dumping” (*i.e.*, transferring patients for economic rather than medical reasons). Read literally, the statute may create a cause of action any time a hospital fails to provide an “appropriate medical screening examination” or fails to stabilize the patient’s emergency medical condition—in short, any time a hospital’s emergency room physicians commit certain acts of medical malpractice.

Most federal courts agree that Congress did not intend to create a fed-

159. Emergency Medical Treatment and Active Labor Act, Pub. L. No. 99-272, § 9121(b), 100 Stat. 82, 164 (1986), *codified at* 42 U.S.C. § 1395dd (1994). Compliance with EMTALA is an undertaking that is included in every hospital’s provider agreement with the Medicare program, a condition of participation in the Medicare program. *See* 42 U.S.C. §§ 1395f(a), 1395cc(a)(1)(I) (1994); 42 C.F.R. §§ 482.11(a), 489.20(l), 489.24 (1998).

160. *See* TEX. HEALTH & SAFETY CODE ANN. §§ 241.027-.028 (Vernon 1992 & Supp. 1999).

161. *See* 42 U.S.C. § 1395dd(c) (1994).

162. *Id.* § 1395dd(a).

163. EMTALA defines “emergency medical condition” as:

- (A) a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in -
 - (i) placing the health of the individual (or, with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy,
 - (ii) serious impairment to bodily functions, or
 - (iii) serious dysfunction of any bodily organ or part; or
- (B) with respect to a pregnant women [*sic*] who is having contractions -
 - (i) that there is inadequate time to effect a safe transfer to another hospital before delivery, or
 - (ii) that transfer may pose a threat to the health or safety of the woman or the unborn child.

Id. § 1395dd(e)(1).

164. *Id.* § 1395dd(b)(1)(A).

165. *See id.* § 1395dd(b)(1)(B).

eral emergency medical malpractice law,¹⁶⁶ but they do not agree how to avoid that result in light of the plain language of EMTALA. In *Roberts v. Galen of Virginia, Inc.*¹⁶⁷ the plaintiff alleged that the defendant hospital had transferred her to a lower level health care facility before her emergency medical condition had been stabilized in violation of subsection (b) of EMTALA. Affirming the district court's grant of summary judgment in favor of the hospital, the United States Court of Appeals for the Sixth Circuit held that, in addition to pleading and proving that the hospital transferred her before her emergency medical condition had been stabilized, the plaintiff was also required to show that the hospital acted with an improper motive, such as the plaintiff's "indigency or lack of insurance[,] . . . race, sex, politics, occupation, education, personal prejudice, drunkenness, or spite; that is, anything except medical negligence."¹⁶⁸

The United States Supreme Court disagreed with the Sixth Circuit's reading of EMTALA and reversed.¹⁶⁹ In its first-ever opinion to consider EMTALA (a brief *per curiam*), the Court acknowledged the court of appeals' desire to avoid reading EMTALA as a federal medical-malpractice statute for emergency care but held that "there is no question that the text of § 1395dd(b) does not require an 'appropriate' stabilization, nor can it reasonably be read to require an improper motive."¹⁷⁰

166. The same point was made by the Houston Court of Appeals during the Survey year. See *Watts v. Hermann Hosp.*, 962 S.W.2d 102, 104 (Tex. App.—Houston [1st Dist.] 1997) ("The duty created by EMTALA is a 'limited' one in a very critical sense: 'EMTALA is not a substitute for state law malpractice actions, and was not intended to guarantee proper diagnosis or to provide a federal remedy for misdiagnosis or medical negligence.'" (quoting *Vickers v. Nashville Gen. Hosp., Inc.*, 78 F.3d 139, 142 (4th Cir. 1996))). The *Watts* court did not need to address what limitations, if any, should be imposed on the statutory duty to stabilize, because it concluded that the plaintiff's emergency condition had, in fact, been stabilized prior to his discharge from the hospital. See *id.* at 107.

167. 111 F.3d 405 (6th Cir. 1997), *rev'd*, 119 S. Ct. 685 (1999) (*per curiam*).

168. *Id.* at 409, *relying on* *Cleland v. Bronson Health Care Group, Inc.*, 917 F.2d 266 (6th Cir. 1990).

169. See *Roberts v. Galen of Virginia, Inc.*, 119 S. Ct. 685 (1999) (*per curiam*).

170. *Id.* at 687.