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## Health Care Law

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# HEALTH CARE LAW

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## I. INDIVIDUAL RIGHTS

### A. ABORTION

#### 1. *Facility Licensing*

IN *Women's Medical Center of Northwest Houston v. Bell*,<sup>1</sup> Texas physicians challenged the constitutionality of the 1999 amendments to Texas' Abortion Facility Reporting and Licensing Act<sup>2</sup> ("the Act") and three regulations promulgated under the Act. The amendments con-

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1. 248 F.3d 411 (5th Cir. 2001).

2. TEX. HEALTH & SAFETY CODE ANN. §§ 245.001-.022 (Vernon 2001 & Supp. 2002).

cerned the Act's exemption for physicians' offices, which need not comply with the licensing requirements unless the number of abortions performed in the office exceeds a certain threshold. Before the 1999 amendments, the threshold was that "at least 51 percent of patients treated in a calendar year receive abortions."<sup>3</sup> The amendments brought a physician's office within the scope of the Act if "the office is used for the purpose of performing more than 300 abortions in any 12-month period."<sup>4</sup> The regulations imposed a variety of obligations on physicians as abortion providers.<sup>5</sup> The physicians moved for a preliminary injunction to prohibit the enforcement of the statute and regulations, and the district court granted their motion, from which the State of Texas took this interlocutory appeal.

The district court concluded that the plaintiffs had shown a likelihood of prevailing on their argument that the amendments to the Act violated the plaintiffs' equal protection rights<sup>6</sup> and that the regulations were unconstitutionally vague. The Court of Appeals for the Fifth Circuit affirmed the lower court's vagueness ruling, reversed with respect to the equal-protection argument against the amendments to the Act, and remanded.<sup>7</sup>

The court of appeals approved the district court's use of rational-basis review to test the physicians' claim that the 300-abortions-per-year cutoff for the registration of physicians' offices constituted a denial of equal protection. Despite the low standard of review, the trial court nonetheless concluded that "it cannot be rational to conclude that a physician performing an average of one abortion a day as part of a general gynecological practice is thereby subjecting his patients to the 'high volume' risks cited by the state."<sup>8</sup> The court of appeals reversed on this point, stating that the greater power to regulate all abortion providers includes the lesser power to regulate a smaller number of physicians based upon the legislature's conclusion that some offices perform too few abortions to

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3. *Women's Med. Ctr.*, 248 F.3d at 414.

4. TEX. HEALTH & SAFETY CODE ANN. § 245.004(a)(2) (Vernon 2001).

5. As described by the court of appeals, the regulations, found in 25 Tex. Admin. Code, are: (1) § 139.51(1), requiring a physician licensed as an abortion provider to "ensure that all patients . . . are cared for in a manner and in an environment that enhances each patient's dignity and respect in full recognition of her individuality;" (2) § 139.51(2), requiring physicians to ensure that each patient will "receive care in a manner that maintains and enhances her self-esteem and self-worth;" and (3) § 139.51(43), which defines the standard of "quality" care as "[t]he degree to which care meets or exceeds the expectations set by the patient." *Women's Med. Ctr.* 248 F.3d at 418. After the court of appeals' decision in this case, the Texas Department of Health deleted all three offending provisions and all other uses of "quality" that appeared to be unconstitutionally vague. See 26 Tex. Reg. 9094 (Nov. 9, 2001).

6. The district court declined to enjoin enforcement of the statute on due process grounds, finding that "plaintiffs had not shown a substantial likelihood of prevailing on the merits of their claim that the 1999 amendments impose an undue burden on a woman's right to abortion." *Id.* at 416.

7. *Id.* at 423.

8. *Women's Med. Ctr. of N.W. Houston v. Archer*, 159 F. Supp. 2d 414, 465 (S.D. Tex. 1999).

require licensing.<sup>9</sup> The determination whether the line should be drawn “at ten abortions per month or three abortions per month . . . is typically a legislative function and is presumed valid.”<sup>10</sup>

The court of appeals agreed, however, with the district court’s conclusion that the challenged administrative provisions were unconstitutionally vague. The provisions included standard language such as “enhanc[ing] each patient’s dignity and respect in full recognition of her individuality . . . [and] enhanc[ing each patient’s] self-esteem and self-worth,”<sup>11</sup> which the district court observed could not be measured in any objective way and tended to vary from patient to patient and were therefore unconstitutionally vague.<sup>12</sup> The court of appeals agreed: “[E]ach of these three regulations is unconstitutionally vague on its face because it impermissibly subjects physicians to sanctions based not on their own objective behavior, but on the subjective viewpoint of others.”<sup>13</sup>

## 2. State Funding Restrictions

Texas is one of thirty states (plus the District of Columbia) that provides state funding of abortions for Medicaid recipients only when the woman’s life is endangered or the pregnancy is the result of rape or incest but not when the abortion is otherwise “medically necessary.”<sup>14</sup> The Low-Income Women of Texas (“LIWT”), in a suit brought on their behalf by physicians and abortion clinics, challenged this funding restriction<sup>15</sup> as a violation of the Equal Rights Amendment<sup>16</sup> and the rights of privacy

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9. *Women’s Med. Ctr.*, 248 F.3d at 419.

10. *Id.* at 420.

11. *Id.* at 418.

12. *Women’s Med. Ctr.*, 159 F. Supp. 2d at 467.

13. *Women’s Med. Ctr.*, 248 F.3d at 422.

14. Texas limits its Medicaid coverage to services for which the state can receive federal matching funds. See TEX. HUM. RES. CODE ANN. § 32.024(e) (Vernon Supp. 2002). Since the enactment of the Hyde Amendment, see Omnibus Consolidated and Emergency Supplemental Appropriations Act of 1999, Pub. L. No. 105-277, §§ 508(a), 509(a), 112 Stat. 2681-385 (1998), the federal government has been prohibited from paying for abortions with Medicaid matching funds except in cases of incest or rape or when the woman’s life would be threatened unless an abortion were performed. Accordingly, Texas has implicitly adopted the abortion-funding standards of the Hyde Amendment. See *Low-Income Women of Tex. v. Bost*, 38 S.W.3d 689, 692-93 (Tex. App.—Austin 2000, pet. granted). The other 29 states (plus the District of Columbia) are listed at THE ALAN GUTTMACHER INSTITUTE, STATE FUNDING OF ABORTION UNDER MEDICAID (February 1, 2002), [http://www.agi-usa.org/pubs/spib\\_SFAM.pdf](http://www.agi-usa.org/pubs/spib_SFAM.pdf) (last visited March 17, 2002).

15. Plaintiffs also challenged a similar restriction in the Maternal and Infant Health Improvement Act (“MIHIA”), TEX. HEALTH & SAFETY CODE ANN. §§ 32.001-.045 (Vernon 2001 & Supp. 2002). MIHIA provides that no funds may be used to provide abortion services unless the mother’s life is in danger. By failing to provide funding for abortion that results from rape or incest, abortion funding under MIHIA is “even more restricted” than under the state and federal Medicaid statutes. *Low-Income Women of Tex.*, 38 S.W.3d at 693. Because “the program has been unfunded and inactive since 1991,” the court of appeals concluded that this challenge was no longer ripe for adjudication. *Id.* at 695.

16. TEX. CONST. art. I, § 3A (Vernon 2001) (“Equality under the law shall not be denied or abridged because of sex, race, color, creed or national origin.”).

and equal protection of the laws<sup>17</sup> of the Texas Constitution.<sup>18</sup> Both LIWT and the state defendants moved for summary judgment. The district court granted the state's motion, and LIWT appealed. The court of appeals, though declining to reach LIWT's privacy and equal-protection arguments,<sup>19</sup> found that the state's failure to provide for abortion funding for all medically necessary procedures violates the Equal Rights Amendment.<sup>20</sup>

The appeals court held that the Equal Rights Amendment prohibits discrimination on the basis of pregnancy, because "it is biologically impossible for a man to become pregnant;" therefore, pregnancy discrimination amounts to sex discrimination.<sup>21</sup> The court then examined whether the physical characteristics of the sexes required different treatment under the law, but it concluded that the state did not offer any explanation why the physical characteristics of pregnancy justify or require funding restrictions with respect to medically necessary abortions but not with respect to any other health care services.<sup>22</sup>

In the absence of any justification based upon the physical characteristics of pregnancy, a legislative classification that discriminates based upon sex, as the court said this one does, is subject to strict scrutiny. This standard shifts the burden to the state to show that a compelling state interest is furthered by the restriction and that the restriction is "necessary" (or is "narrowly tailored") to promote the state's compelling interest. The state argued that a policy favoring childbirth over abortion advances its interest in promoting fetal and maternal health.<sup>23</sup> The court of appeals held that the state did not show how its interest in maternal health was furthered by denying abortions that protect maternal health and that the state's interest in protecting fetal health is "tempered" by the mother's rights, including her right to protect her own health first.<sup>24</sup> The court also held that there are less restrictive ways to encourage childbirth, "such as continuing to fund prenatal care and childbirth expenses and stepping-up health and education efforts to prevent unwanted pregnancies."<sup>25</sup>

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17. *Id.* § 3 ("All free men, when they form a social compact, have equal rights, and no man, or set of men, is entitled to exclusive separate public emoluments, or privileges, but in consideration of public services.").

18. The challenge was brought under the Texas constitution, because earlier challenges to the abortion-funding restriction under the federal constitution had proved futile. *Low-Income Women*, 38 S.W.3d at 696-97.

19. The court of appeals noted that LIWT's privacy and equal-protection arguments presented the court with an opportunity to decide whether the Texas constitution protects these rights more expansively than the federal constitution but—in part because the Equal Rights Amendment provided a basis for the court's decision—it declined to do so. *Id.* at 697.

20. *Id.* at 703.

21. *Id.* at 698.

22. *Id.* at 699-701.

23. *Low-Income Women*, 38 S.W.3d at 701.

24. *Id.*

25. *Id.* at 701-02. The state also argued that a judgment in favor of the plaintiffs would run afoul of the state constitution's prohibitions against drawing money from state accounts or creating new appropriations other than by legislative enactment. The court of

## B. ADVANCE DIRECTIVES

In *HCA, Inc. v. Miller ex rel. Miller*,<sup>26</sup> Karla Miller was admitted to Woman's Hospital of Texas in what was estimated to be her twenty-fourth week of pregnancy with symptoms of premature labor and a life-endangering infection. After physicians informed Karla and her husband that their child would probably suffer from severe mental and physical impairments if she survived delivery, the Millers requested that the medical staff perform no life-saving resuscitative measures on the baby after her birth. Although the Millers' treatment decision was initially accepted, physicians informed the Millers after consultation that if the baby were born alive and weighed over 500 grams, both state law and hospital policy obligated the medical staff to administer resuscitative measures even in the absence of parental consent.<sup>27</sup> Later that evening, Sidney Miller, weighing over 600 grams, survived delivery and was resuscitated over the objections of her parents. As predicted, she suffers from serious and permanent mental and physical defects.<sup>28</sup>

The Millers sued HCA and the hospital for the intentional tort of battery for treating Sidney without consent. The Millers also challenged the hospital's policy that required resuscitation for live babies over 500 grams and asserted negligence for the hospital's failure to have a policy that would prevent such treatment without consent. In accordance with a jury's verdict, the trial court entered judgment in favor of the Millers in the approximate amount of \$60,000,000 in past and future medical expenses, punitive damages, and prejudgment interest.<sup>29</sup>

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appeals rejected the characterization of its holding as a new appropriation and instead wrote that its holding simply upheld a challenge to restrictions on the use of funds that had already been appropriated by the state legislature for the Medicaid program. *Id.* at 702.

In dissent, Justice Yeakel argued that the funding restrictions have an impact on indigent women, not on women as a class, and that indigency is not a specially protected classification under the Equal Rights Amendment. Thus, Justice Yeakel rejected the majority's use of strict scrutiny to assess the constitutionality of the abortion-funding restrictions in the Medicaid statute. *Id.* at 706-07. He also contended that the majority opinion creates a constitutional right to abortion funding, a contention that the majority pointedly denied, arguing that the only right recognized by its holding is the right to be free from sex discrimination in a state program. *Id.* at 706.

26. 36 S.W.3d 187 (Tex. App.—Houston [14th Dist.] 2000, pet. granted). The author contributed research and analysis for the brief filed by the hospital defendants both in the court of appeals and the supreme court. The comments in this article are mine alone and should not be attributed in any way to the defendants.

27. *Id.* at 190.

28. As described by petitioners:

Sidney, now eleven years old, cannot sit up on her own. She cannot walk, talk, or feed herself. She cannot be toilet-trained. She is legally blind. She suffers from severe mental retardation, frequent seizures, and spastic quadriplegia in all four limbs. As a result, Sidney will always require around-the-clock care.

Petitioner's Opening Brief at 18, *Miller ex rel. Miller v. HCA, Inc.* (Tex.) (No. 01-0079) (citations to the trial record omitted), available at <http://www.supreme.courts.state.tx.us/ebrief/01/01007901.pdf> (last visited March 18, 2002).

29. *HCA*, 36 S.W.3d at 190-91.

On appeal, HCA challenged the finding of liability on the basis that it owed the Millers no duty to refrain from treating Sidney, because the doctors and the hospital personnel were legally obligated to administer resuscitative treatment, and the Millers themselves had no right to withhold life-sustaining treatment from their child.<sup>30</sup> Reversing the trial court's judgment, the Court of Appeals for the 14th District of Texas at Houston agreed with HCA and concluded that under Texas law, parents have no statutory or common law right "to withhold urgently needed life-sustaining treatment from non-terminally ill children."<sup>31</sup> Their only legal right to refuse life-sustaining treatment for a minor is if the child has been certified to have a terminal or irreversible condition pursuant to the provisions of the Texas Advance Directives Act ("the Act").<sup>32</sup>

The Act provides a legal "safe harbor" from civil and criminal liability and disciplinary action for physicians, health care professionals, and institutions that follow the statutory process for withholding or withdrawing life-sustaining treatment in certain narrowly defined circumstances.<sup>33</sup> Under one such circumstance, the Act authorizes parents to execute an advance directive on behalf of their minor child.<sup>34</sup> Once the minor has been certified to be a "qualified patient"—that is, has been certified by a physician to have a terminal or irreversible condition<sup>35</sup>—life-sustaining treatment may be withheld or withdrawn by health care professionals who then are protected from liability under the Act.<sup>36</sup>

In reaching its decision, the court of appeals interpreted the Act to be the exclusive source of parents' right to refuse consent to life-sustaining medical treatment of their child. Under the court of appeals' interpretation of the Act, following the procedures of the Act when making treatment decisions for minors is mandatory, not voluntary, and the Act does not simply provide for immunities under certain circumstances; it also places substantive limits on the parties' right to make such treatment decisions at all, whether or not they are interested in securing the Act's

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30. *Id.* at 191.

31. *Id.* at 194.

32. TEX. HEALTH & SAFETY CODE ANN. §§ 166.001-166 (Vernon 2001). At the time the events in this case occurred, the Natural Death Act, *id.* ch. 674 (Vernon 1992), was in effect. Effective September 1, 1999, the Advance Directives Act replaced the Natural Death Act. *See* Tex. S.B. 1260, 76th Leg., R.S. (1999). In most respects, except as otherwise noted, the differences between the two laws are not material to the issues raised by this appeal.

33. TEX. HEALTH & SAFETY CODE ANN. § 166.045(d) (Vernon 2001).

34. *Id.* § 166.035.

35. *Id.* § 166.031(2) (defining "qualified patient"). Under the Natural Death Act, as amended in 1985, there was no such separately defined term as "irreversible condition;" the phrase was included within the definition of "terminal condition." *Id.* § 672.002(9) (Vernon 1992). The Advance Directives Act defines and uses the terms as separate and distinct concepts. *See, e.g., id.* § 166.002(9), (13) (Vernon 2001).

36. TEX. HEALTH & SAFETY CODE ANN. § 166.044 (Vernon 2001) (providing various immunities when life-sustaining treatment has been withheld or withdrawn from a "qualified patient" in accordance with subchapter of the Act that deals with living wills (or, to use the terminology of the Act, "directives to physicians")).

legal immunities.<sup>37</sup>

The court of appeals reasoned that to infer parents have a common law right to withhold such medical treatment from their children would fundamentally contradict the state's interest in the preservation of human life and the protection of minors and would present judicially intractable legal and policy issues concerning the value of life and the quality-of-life calculus.<sup>38</sup> It also noted that if parents had the right to withhold consent to life-sustaining treatment for minors who do not have a terminal or irreversible condition, the legislature would have created an anomalous situation where children who have terminal or irreversible conditions are accorded a greater degree of legal protection than children who do not.<sup>39</sup>

The court of appeals had to contend with a provision in the Act that expressly states that it "does not impair or supersede any legal right or responsibility a person may have to effect the withholding or withdrawal of life-sustaining treatment in a lawful manner."<sup>40</sup> The court interpreted this section as referring only to "a competent adult's common law right to refuse medical treatment for himself,"<sup>41</sup> not to decisions made on behalf of a minor. Consequently, the court held that "to the extent a child's condition has not been certified as terminal, a health care provider is under no duty to follow a parent's instruction to withhold urgently-needed life-sustaining medical treatment from their child."<sup>42</sup>

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37. The logic of the court of appeals' holding ought to apply to treatment decisions made on behalf of incompetent adults as well. In fact, the Act permits a surrogate decision maker and the incompetent adult's physician to make "a treatment decision that may include a decision to withhold or withdraw life-sustaining treatment from the patient." *Id.* § 166.039(a), (b). With respect to minors, on the other hand, the Act merely authorizes a surrogate to execute a "directive" (*i.e.*, a living will)—not to make a treatment decision—on behalf of the patient. *Id.* § 166.035. Thus, the structure of the Act itself would support the argument that if the treatment decisions of parents are subject to the substantive limitations of the Act (even though the Act literally addresses only "directives" for minors), then treatment decisions on behalf incompetent adults without directives are even more obviously limited by the requirements of the Act. This conclusion is not inconsistent with the court of appeals' statement that "we interpret section 166.051 [which 'states that it does not impair or supersede any legal right a person may have to withhold or withdraw life-sustaining treatment in a lawful manner,'"] *HCA*, 36 S.W.3d at 193-94] to refer to a *competent adult's* common law right to refuse medical treatment for himself." *Id.* at 194 n.18 (emphasis added). Unfortunately, this narrow interpretation of section 166.051 leaves open the possibility that a treatment decision on behalf of an *incompetent adult* patient pursuant to sections 166.038 or 166.039 must also satisfy the requirements of the Act, including the requirement that the patient has been certified to have a terminal or irreversible condition.

38. *Id.* at 194.

39. *Id.* This argument assumes that one of the purposes of the Advance Directives Act is to protect minors from their parents' medical decisions by placing substantive limits on their medical decisions, which begs the very question raised by the *HCA* appeal. The court's conclusion that the parents' reading of the Act would create an "anomaly" also assumes that children without a terminal or irreversible condition are invariably healthier than those who have such a condition, an assumption that may be undercut by the medical condition of Sidney Watson herself.

40. TEX. HEALTH & SAFETY CODE ANN. § 166.051 (Vernon 2001).

41. *HCA*, 36 S.W.3d at 194, n.18.

42. *Id.* at 195. Although the court of appeals recognized that ordinarily a court order is needed to override a parent's refusal to consent to medical treatment of their child, the court did not believe that a court order was necessary where the need for life-sustaining



The court did not consider the possible impact of the federal "Baby Doe" statute<sup>43</sup> and rule<sup>44</sup> on the case, explaining that absent "any indication that federal law either establishes parents' rights to consent to or refuse medical treatment for their children or preempts state law in that regard[, the] case is governed by state law rather than federal funding authorities."<sup>45</sup> Indeed, one view of the Baby Doe laws supports the result in this case,<sup>46</sup> and only a strained interpretation undercuts it.

In dissent, Justice Amidei rejected the majority's conclusion that the hospital was under no obligation to obtain a court order before it could override the Millers' treatment decision.<sup>47</sup> He also viewed the parents' decision as one that is protected by the U.S. Constitution, which makes the Advance Directives Act (and its predecessor statute, the Natural Death Act) upon which the majority relied irrelevant.<sup>48</sup>

The Supreme Court held oral argument in this case on April 3, 2002.

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treatment is urgent and the child is in the custody of the health care provider. *Id.* at 193 (citing *In re Dubreuil*, 629 So. 2d 819, 823-24 (Fla. 1994)).

43. 42 U.S.C.A. §§ 5101-5106i (West 1995 & Supp. 2001). These provisions were added by the Child Abuse Amendments of 1984, Pub. L. No. 98-457, tit. 1, §§ 121-28, 98 Stat. 1749 (1984), to the Child Abuse Prevention and Treatment and Adoption Reform Act, Pub. L. No. 93-247, 88 Stat. 4 (1974). The law conditions payment of federal funds for state child-protection programs upon certification by the state that it has "authority" for the state, among other things, "to prevent the withholding of medically indicated treatment from children with life-threatening conditions." 42 U.S.C.A. § 5106i(b) (West 1995 & Supp. 2001).

44. 45 C.F.R. §§ 1340.1-.20 & App. (2001).

45. *HCA*, 36 S.W.3d at 196-97.

46. Although the Baby Doe statute and rule are facially a funding mechanism, "in effect they create an obligation to administer treatment under certain circumstances." ALAN MEISEL, 2 *THE RIGHT TO DIE* 323-24 (2d ed. 1995). As Professor Meisel observes, "the basic duty is to provide medically indicated treatment." *Id.* "Withholding of medically indicated treatment" is defined as "the failure to respond to the infant's life-threatening conditions by providing treatment (including appropriate nutrition, hydration, and medication) which, in the treating physician's or physicians' reasonable medical judgment, will be most likely to be effective in ameliorating or correcting all such conditions." 42 U.S.C. § 5106g(6). This definition, and the treatment obligation that it creates, does not apply in three situations:

when, in the treating physician's or physicians' reasonable medical judgment-

(A) the infant is chronically and irreversibly comatose;

(B) the provision of such treatment would—

(i) merely prolong dying;

(ii) not be effective in ameliorating or correcting all of the infant's life-threatening conditions; or

(iii) otherwise be futile in terms of the survival of the infant; or

(C) the provision of such treatment would be virtually futile in terms of the survival of the infant and the treatment itself under such circumstances would be inhumane.

*Id.* Nothing in the court of appeals' opinion indicates that Sidney Miller's medical condition met one of these exceptions.

47. *HCA*, 36 S.W.3d at 197.

48. *Id.* at 198.

## II. PHYSICIANS

## A. GOOD SAMARITAN ACT

Even though all states except West Virginia have Good Samaritan laws, there are very few reported opinions under them. Texas' version of the Good Samaritan law<sup>49</sup> is unique, however, and that unique feature was at the center of *Ramirez ex rel. Ramirez v. McIntyre*,<sup>50</sup> in which a 2-1 majority of the Texas Court of Appeals, Third District, held that the protections afforded by the Texas Good Samaritan statute for emergency care administered in good faith are not available to a physician who could be legally entitled to remuneration for providing that care.

On April 23, 1998, Debra Ramirez ("Ramirez") was in labor at St. David's Medical Center in Austin.<sup>51</sup> Her attending physician, Dr. Patricia Gunter, had left the labor and delivery area after checking on Ramirez twice during the early stages of delivery.<sup>52</sup> The delivery progressed very rapidly after Dr. Gunter left, and an emergency page was eventually sent out for any available doctor to assist in the delivery.<sup>53</sup> Dr. Douglas McIntyre was on the labor and delivery floor when the page was sent out, and although he had never treated or seen Ramirez before and was not on call for Dr. Gunter, he immediately answered the page and completed the delivery of Colby Ramirez within about 6 minutes.<sup>54</sup> As a result of the complicated delivery process,<sup>55</sup> Colby suffered permanent neurological impairment and paralysis of his right arm and shoulder.<sup>56</sup> Ramirez sued Dr. Gunter, Dr. McIntyre, and St. David's for medical malpractice.<sup>57</sup> Raising an affirmative defense under the Good Samaritan statute, Dr. McIntyre filed a motion for summary judgment.<sup>58</sup> The trial court granted the motion, and Ramirez appealed.<sup>59</sup>

The relevant portions of section 74.001 of the Texas Civil Practice and Remedies Code protects from civil liability anyone who administers emergency care in good faith, unless the act is willfully or wantonly negligent.<sup>60</sup> The statute does not apply, however, to care given for or in expectation of remuneration, and if the caregiver would "ordinarily receive or be entitled to receive" remuneration for such services, he or she will be

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49. See TEX. CIV. PRAC. & REM. CODE ANN. § 74.001(a) (Vernon Supp. 2002).

50. 59 S.W.3d 821 (Tex. App.—Austin 2001, pet. filed).

51. *Id.* at 823.

52. *Id.*

53. *Id.*

54. *Id.*

55. Ramirez had been diagnosed with gestational diabetes (a type of diabetes that affects some women only when they are pregnant), and Colby was a macrosomic (large body size) baby. *Ramirez*, 59 S.W.3d at 827 (Patterson, J., dissenting). When Dr. McIntyre entered the delivery room, it appeared that Colby's shoulder had become lodged against his mother's pelvic bone, a condition known as shoulder dystocia. *Id.* at 823.

56. *Id.*

57. *Id.*

58. *Id.*

59. *Ramirez*, 59 S.W.3d at 823.

60. TEX. CIV. PRAC. & REM. CODE ANN. § 74.001(a) (Vernon Supp. 2002).

deemed to be acting for or in expectation of remuneration (even if the person chooses not to charge for the occasion in question).<sup>61</sup> In address-

61. *Id.* § 74.001(b), (d). No other state has a provision that takes away the Good Samaritan law's protection if the rescuer was merely entitled to receive compensation without regard to whether he or she actually received it. Forty states and the District of Columbia simply require that the services be provided "gratuitously" or "without expectation of compensation" or some equivalent phrase, while eight states omit any mention of compensation, remuneration, or payment for emergency services rendered. A summary of the various provisions is set out in the following chart:

TABLE 1

State	Statute	"Entitlement" language? (what language is used?)
Alabama	ALA. CODE § 6-5-332(a) (2001)	no ("gratuitously")
Alaska	ALASKA STAT. § 09.65.090(b) (Michie 2001)	no ("acting as a volunteer")
Arizona	ARIZ. REV. STAT. ANN. § 32-1471 (West 2001)	no ("gratuitously")
Arkansas	ARK. CODE ANN. § 17-95-101(a) (Michie 2000)	no ("without compensation")
California	CAL. BUS. & PROF. CODE § 2395 (West 2001)	no (protection does not apply if "[a] licensee who serves on an on-call basis to a hospital emergency room": (1) received consideration for serving "on an on-call basis" in the emergency room; (2) "provided prior medical diagnosis or treatment to the same patient"; or (3) "had a contractual obligation . . . to provide obstetrical care for the patient or . . . had a reasonable expectation of payment for the emergency services provided to the patient")
Colorado	COLO. REV. STAT. ANN. § 13-21-108(1) (West 2001)	no ("without compensation" and does not apply to "any person who renders such emergency care or emergency assistance to a patient he is otherwise obligated to cover")
Connecticut	CONN. GEN. STAT. ANN. § 52-557b(a) (West 1999 & Supp. 2002)	no ("voluntarily and gratuitously and other than in the ordinary course of such person's employment or practice")
Delaware	DEL. CODE ANN. tit. 16, § 6801 (2000)	no ("voluntarily, without the expectation of monetary or other compensation from the person aided or treated")
District of Columbia	D.C. CODE ANN. § 7-401 (2001)	no ("without the expectation of receiving or intending to seek compensation")
Florida	FLA. STAT. ANN. § 768.13(2)(a) (West 1997 & Supp. 2002)	no ("gratuitously")

State	Statute	"Entitlement" language? (what language is used?)
Georgia	GA. CODE ANN. § 51-1-29 (2001)	no ("without making any charge therefor")
Hawaii	HAW. REV. STAT. ANN. § 663-1.5(c) (Michie 2000)	no ("without remuneration or expectation of remuneration")
Idaho	IDAHO CODE § 5-330 (Michie 2000)	no ("no mention of compensation/volunteering at all")
Illinois	745 ILL. COMP. STAT. ANN. 49/25 (West Supp. 2001)	no ("provides emergency care without fee to a person")
Indiana	IND. CODE ANN. § 34-30-6-1 to -2 (West 2001)	no ("does not apply to a person . . . who receives payment, or is an employee of a person who receives payment, for services rendered in connection with the emergency, from a person whose act or omission caused in whole or in part the emergency")
Iowa	IOWA CODE ANN. § 613.17 (West 1998)	no ("without compensation"; "if a volunteer fire fighter, a volunteer operator or attendant of an ambulance or rescue squad service, a volunteer paramedic . . . receives nominal compensation not based upon the value of the services performed, that person shall be considered to be receiving no compensation")
Kansas	KAN. STAT. ANN. § 65-2891(c) (1992)	no (even protects physicians who are compensated for providing emergency care "until such time as the physician employed by the patient or by the patient's family or by guardian assumes responsibility for such patient's professional care")
Kentucky	KY. REV. STAT. ANN. § 411.148 (Banks-Baldwin 1998)	no (does not apply to services performed "for remuneration or with the expectation of remuneration")
Louisiana	LA. REV. STAT. ANN. § 37:1731 (West 2000)	no ("gratuitously")
Maine	ME. REV. STAT. ANN. tit. 14, § 164 (West 1980)	no ("voluntarily [and] without the expectation of monetary or other compensation")
Maryland	MD. CODE ANN., CTS. & JUD. PROC. § 5-603 (2001)	no ("without fee or other compensation")
Massachusetts	MASS. GEN. LAWS ch 112, § 12B (1996)	no ("as a volunteer and without fee")
Michigan	MICH. COMP. LAWS ANN. § 691.1501(1) (West 2000)	no ("where physician-patient relationship . . . did not exist before the advent of the emergency")

State	Statute	"Entitlement" language? (what language is used?)
Minnesota	MINN. STAT. ANN. § 604A.01(2) (West 2000 & Supp. 2001)	no (without "compensation or the expectation of compensation . . . This subdivision does not apply to a person rendering emergency care, advice, or assistance during the course of regular employment, and receiving compensation or expecting to receive compensation or for rendering the care, advice, or assistance")
Mississippi	MISS. CODE ANN. § 73-25-37 (1999)	no (suggests that even compensated emergency care will be protected from liability)
Missouri	MO. ANN. STAT. § 334.930 (West 2001)	no ("without compensation")
Montana	MONT. CODE ANN. § 27-1-714 (2001)	no ("without compensation")
Nebraska	NEB. REV. STAT. § 25-21, 186 (2001)	no ("gratuitously")
Nevada	NEV. REV. STAT. ANN. 41.500, 41.505 (Michie 2001)	no ("'gratuitously' means that the person receiving care or assistance is not required or expected to pay any compensation or other remuneration for receiving the care or assistance"; also there must be no "preexisting relationship as a patient")
New Hampshire	N.H. REV. STAT. ANN. § 508:12 (2001)	no ("no direct compensation for the care from or on behalf of the person cared for")
New Jersey	N.J. STAT. ANN. § 2A:62A-1 (West 2000)	does not mention compensation/volunteering, although case law has clarified that the protection of this statute does not cover those with a preexisting duty to act. <i>See Velazquez v. Jiminez</i> , 763 A.2d 753 (N.J. Super. Ct. App. Div. 2000)
New Mexico	N.M. STAT. ANN. § 24-10-3 (Michie 2001)	no (does not cover care "rendered for remuneration or with the expectation of remuneration or is rendered by a person or agent of a principal who was at the scene of the accident or emergency because he or his principal was soliciting business or performing or seeking to perform some services for remuneration")
New York	N.Y. EDUC. LAW § 6527(2) (McKinney 2001)	no ("voluntarily and without the expectation of monetary compensation")

ing the issues raised on appeal, the court of appeals first stated that there was no question that Dr. McIntyre acted in good faith and did not act

State	Statute	"Entitlement" language? (what language is used?)
North Carolina	N.C. GEN. STAT. §§ 90-21.14, 90-21.16 (2001)	no ("receives no compensation"; volunteers are also covered)
North Dakota	N.D. CENT. CODE § 32-03.1-04 (2001)	no (allows physicians who render emergency care to try to recover a fee from the person injured or that person's estate, but then states that "[a]ny person rendering aid or assistance with an expectation of remuneration shall not be covered by the provisions of this chapter")
Ohio	OHIO REV. CODE ANN. § 2305.23 (West 2002)	no (does not cover aid "rendered for remuneration, or with the expectation of remuneration")
Oklahoma	OKLA. STAT. ANN. tit. 76, § 5 (West 2001)	no (just "[w]here no prior contractual relationship exists," and "voluntarily and without compensation")
Oregon	OR. REV. STAT. § 30.800 (1999)	no ("given voluntarily and without the expectation of compensation")
Pennsylvania	42 PA. CONS. STAT. ANN. § 8331 (West 2001)	does not mention compensation/volunteering at all
Rhode Island	R.I. GEN LAWS § 9-1-27.1 (2000)	no ("voluntarily and gratuitously")
South Carolina	S.C. CODE ANN. § 15-1-310 (Law. Co-op. 2001)	no ("gratuitously")
South Dakota	S.D. CODIFIED LAWS § 20-9-3 (Michie 2001)	does not mention compensation/volunteering at all
Tennessee	TENN. CODE ANN. § 63-6-218 (2001)	no ("without making any direct charge therefor")
Utah	UTAH CODE ANN. §§ 58-13-2, 78-11-22 (2001)	no (general statute: "gratuitously"; statute for health care providers: "under no legal duty to respond")
Vermont	VT. STAT. ANN. tit 12, § 519 (2000)	no ("unless [the person] will receive or expects to receive remuneration")
Virginia	VA. CODE ANN. § 8.01-225 (Michie 2001)	no ("without compensation" and, for obstetrical emergencies, only protects physicians who administer emergency care to someone "who has not previously been cared for in connection with the pregnancy by such person or by another professionally associated with such person and whose medical

willfully or wantonly.<sup>62</sup> Instead, Ramirez contended that summary judgment was improper, because Dr. McIntyre (1) acted for or in expectation of remuneration, or (2) should have been deemed to act for or in expectation of remuneration.<sup>63</sup>

In support of his summary judgment motion, Dr. McIntyre proffered his own affidavit stating that (1) he did not charge Ramirez for his services, (2) he did not expect to be compensated when performing the services, and (3) he would never charge in that type of situation.<sup>64</sup> The record on appeal also included the deposition testimony of Dr. McIntyre.<sup>65</sup> The court found that both the affidavit and the deposition testimony established that Dr. McIntyre did not receive or expect to receive

State	Statute	"Entitlement" language? (what language is used?)
Virginia (cont'd)		records are not reasonably available to such person shall not be liable for any civil damages for acts or omissions resulting from the rendering of such emergency care or assistance")
Washington	WASH. REV. CODE ANN. § 4.24.300 (West 1988)	no ("without compensation or the expectation of compensation"; but "[a]ny person rendering emergency care during the course of regular employment and receiving compensation or expecting to receive compensation for rendering such care is excluded from the protection of this subsection")
West Virginia	None	West Virginia does not have a statute protecting from civil liability physicians who render emergency aid
Wisconsin	WIS. STAT. ANN. § 895.48 (West Supp. 2002)	no ("immunity does not extend when employees trained in health care or health care professionals render emergency care for compensation and within the scope of their usual and customary employment or practice at a hospital or other institution equipped with hospital facilities, at the scene of any emergency or accident, enroute to a hospital or other institution equipped with hospital facilities or at a physician's office")
Wyoming	WYO. STAT. ANN. § 1-1-120 (Michie 2001)	no ("without compensation")

62. *Ramirez*, 59 S.W.3d at 824.

63. *Id.*

64. *Id.* at 825.

65. *Id.*

remuneration from Ramirez.<sup>66</sup>

However, the court went on to hold that Dr. McIntyre had the additional burden of establishing that he was also not entitled to remuneration for the services he provided to Ramirez.<sup>67</sup> The court reasoned that, if Dr. McIntyre was entitled to remuneration, he must then be deemed to have acted for or in expectation of remuneration.<sup>68</sup> The only evidence in the record addressing this issue was the doctor's deposition testimony that he did not think he was ethically allowed to bill Ramirez.<sup>69</sup> The court found this testimony was inconclusive on the issue of whether Dr. McIntyre was entitled to remuneration and held that Dr. McIntyre had failed to carry his summary judgment burden on this issue.<sup>70</sup> Since Dr. McIntyre did not conclusively prove that he was not entitled to remuneration, the court held that he had failed to establish his affirmative defense under the Good Samaritan statute as a matter of law.<sup>71</sup> The court reversed the summary judgment and remanded the case to the trial court.<sup>72</sup>

In dissent Justice Patterson argued that Dr. McIntyre had met his burden and was therefore entitled to summary judgment, unless Ramirez raised a fact issue.<sup>73</sup> Ramirez did offer evidence from Dr. McIntyre's deposition testimony that Dr. McIntyre could have found Ramirez's address and sent her a bill.<sup>74</sup> But the dissent found that since there was no evidence that Dr. McIntyre contemplated doing so, and since there was no evidence that he had done so before, Ramirez failed to raise a fact issue through the deposition testimony as to whether Dr. McIntyre performed the services for or in expectation of remuneration.<sup>75</sup> The dissent placed Dr. McIntyre's declaration (which the majority found inconclusive) that he did not believe he could have received remuneration for his services in the context of his affidavit and preceding testimony that neither he nor anyone he knew charged for such services.<sup>76</sup> The dissent found that the statement was uncontroverted except for the affidavit of a Maryland doctor that the trial court ruled was inadmissible and that Ramirez had failed to raise a fact issue on that point.<sup>77</sup>

The dissent went on to disagree with the majority's interpretation of the Texas Good Samaritan statute. According to the dissent, the majority's holding that the statute does not protect physicians who could be legally entitled to receive remuneration for emergency care runs contrary to the intent of the legislature and the plain meaning of the statute it-

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66. *Id.* at 826.

67. *Ramirez*, 59 S.W.3d at 826.

68. *Id.*; see TEX. CIV. PRAC. & REM. CODE ANN. § 74.001(d) (Vernon Supp. 2002).

69. *Ramirez*, 59 S.W.3d at 826.

70. *Id.* at 826-27.

71. *Id.* at 827.

72. *Id.*

73. *Id.* at 828.

74. *Ramirez*, 59 S.W.3d at 829.

75. *Id.*

76. *Id.* at 830.

77. *Id.* at 829.



self.<sup>78</sup> The dissent argued that if entitlement to remuneration were part of the test for protection under the Good Samaritan statute, no doctor would be willing to render emergency care.<sup>79</sup> Since Dr. McIntyre's testimony on the issue of whether he received or expected to receive remuneration was uncontroverted, the dissent would have affirmed the trial court's judgment.<sup>80</sup>

## B. UNAUTHORIZED PRACTICE OF MEDICINE

In *Weyandt v. Texas*,<sup>81</sup> Linda Weyandt was convicted of practicing medicine without a license. She worked as a nurse anesthetist at the Veterans' Hospital in Houston and ran an independent clinic, Associated Hypnotherapy and Pain Management Services of Texas ("Clinic").<sup>82</sup> The Clinic's yellow-pages advertisement and the signs outside the Clinic all identified the appellant as "Dr. Linda J. Weyandt."<sup>83</sup> Ms. Weyandt graduated from a medical school in Mexico, but she was not licensed to practice medicine in Texas, although she was a Certified Registered Nurse Anesthetist ("CRNA"), an advanced nurse practitioner, and a certified hypnotherapist.<sup>84</sup>

An undercover police officer visited Weyandt's clinic, and she failed to clarify that she was not licensed to practice medicine.<sup>85</sup> She examined the police officer's arm, passed electrical current through it, attempted to perform hypnosis on the officer, and charged the officer seventy-five dollars for the visit.<sup>86</sup> Upon later searching the premises, police officers found a cabinet full of prescription drugs, including lidocaine.<sup>87</sup>

After her jury conviction for practicing medicine without a license, Weyandt appealed on five grounds for reversal: (1) legal insufficiency of the evidence, (2) factual insufficiency of the evidence, (3) the trial court's decision to admit evidence of extraneous crimes, (4) the unconstitutional vagueness of the Medical Practice Act's prohibition against the unauthorized practice of medicine, as applied to Weyandt, and (5) the violation of her constitutional right to remain silent when the prosecutor inadvertently used appellant's name when he called a witness to the stand.<sup>88</sup>

The court discussed each of the points of error and ultimately affirmed

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78. *Id.* at 830-31.

79. *Ramirez*, 59 S.W.3d at 831.

80. *Id.*

81. 35 S.W.3d 144 (Tex. App.—Houston [14th Dist.] 2000, pet. denied).

82. *Id.* at 148.

83. *Id.*

84. *Id.*

85. *Id.* For example, Ms. Weyandt introduced herself as "Dr. Weyandt," displayed certificates on her wall with "M.D." after her name, described herself as being "in anesthesia" for almost 20 years, and she criticized the previous work of an anesthesiologist by saying "she would not have done it that way" without clarifying that she was not an anesthesiologist. *Weyandt*, 35 S.W.3d at 148.

86. *Id.* at 148-49.

87. *Id.* at 149.

88. *Id.* at 148.

the decision of the trial court.<sup>89</sup> Of special interest, however, was the vagueness challenge to the Medical Practice Act as it applied to Weyandt. In order to be unconstitutionally vague, a statute either must fail to provide a reasonable person sufficient information to understand exactly what conduct is prohibited or it must provide insufficient notice of the prohibited conduct to law enforcement personnel.<sup>90</sup>

The relevant language of the Medical Practice Act provided:

It shall be unlawful for any individual, partnership, trust, association, or corporation by the use of any letters, words, or terms as an affix on stationery or on advertisements, or in any other manner, to indicate that the individual partnership, trust, association, or corporation is entitled to practice medicine if the individual or entity is not licensed to do so.<sup>91</sup>

Weyandt argued that the words "in any other manner" did not provide an objective standard by which to measure her conduct and that no adequate notice was given to Weyandt and law enforcement officials of what was prohibited.<sup>92</sup> The court held that the statute is not unconstitutionally vague, because it prohibits the use of the initials "M.D." and "Dr." in ways that might suggest that an unlicensed individual or entity is entitled to practice medicine, which is exactly what appellant did in this case.<sup>93</sup> Although Ms. Weyandt's evidence showed that she performed duties that were atypical of a physician, such as answering the phones,<sup>94</sup> by calling herself "Doctor," she created the impression that she was a licensed physician and thus held herself out to be licensed to practice medicine.<sup>95</sup>

### C. ESTABLISHMENT OF PHYSICIAN-PATIENT RELATIONSHIP

In *St. John v. Pope*,<sup>96</sup> the Texas Supreme Court held in 1995 that a telephone conference between a hospital's on-call board-certified internist and the emergency-room physician did not establish a physician-patient relationship between the on-call physician and the emergency-room patient. The key to the supreme court's holding was its conclusion that the on-call physician's telephonic consultation was for the purpose of determining "whether he should take the case [or refer the patient to a hospital with appropriate facilities and expertise], not as a diagnosis for a course of treatment."<sup>97</sup> A recent Dallas Court of Appeals case considered the question but concluded that on the slightly different facts before

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89. *Id.* at 157.

90. *Weyandt*, 35 S.W.3d at 155.

91. *Id.* After the date of the offense, the Legislature codified this provision of the Medical Practice Act without substantive change as TEX. OCC. CODE § 165.156 (Vernon Supp. 2002). See Act of Sept. 1, 1999, 76th Leg., R.S., ch. 388, § 1.

92. *Weyandt*, 35 S.W.3d at 155.

93. *Id.* at 156.

94. *Id.* at 153.

95. *Id.*

96. 901 S.W.2d 420 (Tex. 1995).

97. *Id.* at 424.

it, the trial court erroneously granted summary judgment in the physician's favor.

In *Lecton v. Dyll*,<sup>98</sup> Sandra Lecton came to the hospital's emergency room with a variety of neurological symptoms, including severe headache, slurred speech, partial paralysis, and dizziness. After examining the patient and reviewing her EKG and CT-scan results, the emergency-room physician consulted the on-call neurologist, Louis Dyll, by telephone. After describing the examination and test results, the emergency-room physician asked whether anything further needed to be done. Dr. Dyll "responded that 'no further treatment needed to be done for this patient at the time,' that 'it sounded like [the patient] had a hemiplegic migraine' and that 'nothing further needed to be done,' which included admission into the hospital."<sup>99</sup> At some point Lecton left the hospital with her husband; it is unclear whether that occurred before or after the telephone consultation occurred between the emergency-room physician and Dr. Dyll. Lecton suffered a stroke the next day and sued Dr. Dyll for negligence in making an incorrect diagnosis, providing the emergency-room physician with inappropriate instructions, and failing to order Lecton admitted into the hospital for further observation and possible treatment.<sup>100</sup> Dr. Dyll moved for summary judgment on the ground that no physician-patient relationship existed between the plaintiff and him, and the trial court granted his motion.<sup>101</sup>

The court of appeals reversed and remanded for trial.<sup>102</sup> The principal basis for the court's ruling, and the key fact that the court said distinguishes this case from *St. John*, was the nature of the telephone conversation between Dr. Dyll and the emergency-room physician. That conversation, held the court, was not for the sole purpose (as in *St. John*) of determining whether the patient could be safely treated in the hospital or should be transferred to a more sophisticated facility. Instead, "Dyll diagnosed Lecton's ailment, determined the necessary course of treatment (none immediately), and, instead of acknowledging a lack of competence to treat the patient, as Dr. St. John acknowledged, Dyll directed [the emergency-room physician] to send Lecton to see him the following Monday for treatment."<sup>103</sup> Combined with summary judgment evidence that the hospital's by-laws obligated on-call physicians to assist emergency room physicians and to treat all emergency room patients,<sup>104</sup> which the court said was not a factor in *St. John*, Lecton was entitled to a trial on her medical malpractice claim against the neurologist.

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98. 65 S.W.3d 696 (Tex. App.—Dallas 2001, pet. denied).

99. *Id.* at 699.

100. *Id.* at 700.

101. *Id.* at 701.

102. *Id.* at 715.

103. *Lecton*, 65 S.W.3d at 709.

104. *Id.*

## III. HOSPITALS

## A. LIABILITY FOR TORTS OF INDEPENDENT CONTRACTORS

In the 1998 case of *Baptist Memorial Hospital System v. Sampson*,<sup>105</sup> the Texas Supreme Court held that a hospital may be vicariously liable for the negligence of an independent-contractor physician under the theory of ostensible agency. The elements of ostensible agency, as the court set them out in *Sampson*, are: (1) the patient had a reasonable belief that the physician was the agent or employee of the hospital; (2) the patient's belief was based upon the hospital's holding out the physician as its agent or employee (or failed to act when the physician held herself out as the hospital's agent or employee); and (3) the patient justifiably relied on the holding out.<sup>106</sup> In the few years since *Sampson* was decided, the courts of appeals have struggled to apply its lessons in a succession of cases involving emergency department and other hospital-based physicians. A handful of cases from this Survey year will illustrate some of the points of contention.

In *Garrett v. McCuiston Community Hospital*,<sup>107</sup> Dorothy Garrett sued McCuiston Community Hospital ("MCH"), three physicians, and their professional associations for medical malpractice. Specifically, Garrett alleged that Dr. Dennis Schmidt ("Schmidt"), a radiologist, misdiagnosed a spinal mass as a cancerous lesion instead of a spinal abscess.<sup>108</sup> Even though Schmidt was an independent contractor and not an employee of MCH,<sup>109</sup> Garrett claimed that MCH was vicariously liable for the negligence of Schmidt on the basis of ostensible agency.<sup>110</sup>

MCH asserted that there was no evidence to support the second element of ostensible agency, *i.e.*, that it affirmatively held out Schmidt as its agent or employee, or that it knowingly allowed Schmidt to hold himself out as its agent or employee.<sup>111</sup> The trial court agreed and granted summary judgment in MCH's favor.<sup>112</sup>

Garrett's summary judgment evidence showed that (1) she knew MCH had a radiology department; (2) she received a magnetic resonance imaging (MRI) scan at MCH; (3) she knew that MRIs were read on site at MCH; (4) she believed a radiologist working for MCH would read her

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105. 969 S.W.2d 945 (Tex. 1998).

106. *Id.* at 949.

107. 30 S.W.3d 653 (Tex. App.—Texarkana 2000, no pet.).

108. *Id.* at 654.

109. *Id.* Schmidt is a partner in Radiology Consultants, P.A., a group of radiologists that contracted with the Hospital to provide radiologists for the Hospital's radiology department. *Id.*

110. *Id.*

111. *Garrett*, 30 S.W.3d at 656.

112. *Id.* at 654. After MCH moved for summary judgment, Garrett amended her petition, adding additional causes of action against MCH. After the trial court granted partial summary judgment for the three physicians, their associations, and the hospital on the original cause of action of medical malpractice, Garrett settled her claim with Schmidt and nonsuited the other physicians and their associations. She also nonsuited the Hospital with respect to all but the original claim of medical malpractice. *Id.*

MRI; (5) she did not choose the radiologist; (6) no one at MCH told her that the radiologist was an independent contractor; (7) the radiology department did not have signs that said the doctors were independent contractors; and (8) she could not recall seeing any forms that said the radiologists were independent contractors.<sup>113</sup>

In addressing Garrett's claims, the court of appeals stressed that the second element could only be met if MCH engaged in affirmative conduct and noted that to hold otherwise would effectively create a presumption of ostensible agency any time a hospital chose to offer radiology or other services within the hospital.<sup>114</sup> Since Schmidt was not alleged to have interacted with Garrett directly, the court affirmed the trial court's summary judgment, concluding that Schmidt's action's, omissions, or mere presence as an authoritative medical specialist did not fulfill the second element of ostensible agency.<sup>115</sup>

Justice Grant wrote a vigorous dissent. He argued that the doctrine of ostensible agency should be used to estop MCH from disclaiming responsibility for the doctor's acts.<sup>116</sup> Grant pointed out that two factors present in *Sampson* were missing from Garrett's case: (1) the hospital in *Sampson* had posted signs informing patients that the treating physicians were not agents or employees of the hospital, and (2) patients were required to sign consent forms indicating that they understood that the physicians were not hospital agents or employees.<sup>117</sup> According to Justice Grant, a proper application of *Sampson* to the instant case would mean that the hospital's actions of housing the radiologist and selecting the radiologist for the patient would need to be countered by signs and consent forms separating the radiologists' conduct from that of the hospital; without these or similar acts to inform the patients, however, MCH's provision of facilities for the radiologists and selection of radiologists to treat certain patients constituted a holding out sufficient to establish a finding of ostensible agency because they were not countered by signs, consent forms, or similar acts.<sup>118</sup>

It is often remarked that *Sampson* makes it nearly impossible for a plaintiff to succeed on an ostensible agency claim against a hospital (at least when the hospital posts a few signs and inserts disclaimers into the admissions forms). The impact of *Sampson* does indeed seem large, judging from a case like *Garrett*, in which the hospital prevailed apparently without lifting its corporate finger to negate the patient's impression that she was dealing with a physician who was an employee or agent of the hospital. Yet two unpublished opinions from the El Paso Court of Appeals offer unciteable evidence that it is still possible for a plaintiff to

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113. *Id.* at 656.

114. *Id.* at 656-57.

115. *Garrett*, 30 S.W.3d at 657.

116. *Id.* at 658 (Grant, J., dissenting).

117. *Id.*

118. *Id.*

survive summary judgment on such a claim.<sup>119</sup>

## B. PEER-REVIEW PRIVILEGE

In *In re The University of Texas Health Center at Tyler*,<sup>120</sup> the Texas Supreme Court held that the University of Texas Health Center at Tyler ("Health Center") did not waive its statutory peer review privilege created under former section 5.06 of the Medical Practice Act<sup>121</sup> and section 161.032 of the Texas Health and Safety Code.<sup>122</sup>

James McClain ("McClain") and members of his family sued the Health Center after he and several other patients contracted infections

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119. In *Moreno v. Columbia Med. Ctr.-East*, No. 08-00-00040-CV, 2001 WL 522432 (Tex. App.—El Paso May 17, 2001, pet. denied) (not designated for publication), plaintiff sought treatment for abdominal pain in the hospital's emergency room. He alleged that the independent-contractor physician negligently failed to diagnose his perforated appendix and that the hospital should be vicariously liable for the physician's negligence under an ostensible agency theory. There was evidence that the hospital posted a sign in the emergency-room lobby that stated that "billing for the ER physicians was handled separately by a different entity from Columbia" and that the plaintiff in fact received a separate bill for the physician's services. *Id.* at \*3. But there was also evidence that the plaintiff was in too much distress upon his arrival at the hospital to notice the lobby signs and that he did not attach any particular legal significance to his receipt of a separate bill for the ER physician's services. *Id.* at \*4. So far, as the court of appeals conceded, *id.*, this case sounds a lot like *Sampson*. But in *Sampson* there was no evidence of an affirmative holding out by the hospital, while in *Moreno* the plaintiff and his mother both testified that the physician wore a lab coat with the hospital's insignia on it. *Id.* The physician testified that he had never worn, and Columbia had never provided, a lab coat with the hospital's insignia on it, and this factual dispute, held the court, was enough to defeat defendant's motion for summary judgment. *Moreno*, 2001 WL 522432, at \*4.

In *Barragan v. Providence Mem'l Hosp.*, No. 08-99-00028-CV, 2000 WL 1731286 (Tex. App.—El Paso November 22, 2000, pet. denied) (not designated for publication), the Barragans sued in their individual capacity and as next-friend of their minor son, alleging negligence in the delayed diagnosis, treatment, and surgery of their son's torsion and atrophy of a testicle. *Id.* at \*1. The ER physician was an independent contractor; thus, the plaintiffs' prospects for summary-judgment success on their claim against the hospital once again turned on their ability to create a triable issue of fact on the *Sampson* element of holding out. The El Paso court made it clear in this opinion that it is no fan of *Sampson*. It came close to supporting the most un-*Sampson*-like idea that changes in the way hospitals and physicians are viewed by patients ought to put the burden on physicians to negate ostensible agency rather than on patients to establish it. *See id.* at \*2-3. Despite the *Sampson* precedent, the court finds numerous factual differences between the instant case and *Sampson* sufficient to defeat the hospital's motion for summary judgment as a matter of law. These differences included: (1) the absence of independent-contractor signage in the ER waiting area or examination rooms; (2) the fact that the hospital billed for ER physicians' services; (3) a consent form that perfunctorily disclaimed the existence of an employment or agency relationship with the ER physician, as opposed to the more emphatic and allegedly clearer disclaimer in the *Sampson* consent form; (4) the likelihood that the hospital's disclaimers were not particularly noticed or understood by parents who were traumatized by their son's pain and vomiting, concerned about the delay in diagnosis and treatment, and not particularly adept speakers or readers of English; and the fact that the ER nurse (an employee of the hospital) described the hospital's ER physicians to the plaintiffs as "our" doctors. *Id.* at \*6-7.

120. 33 S.W.3d 822 (Tex. 2000).

121. The Medical Practice Act was repealed and codified in the Texas Occupations Code in 1999. *See supra* note 91. Former § 5.06 is now TEX. OCC. CODE ANN. § 160.002 (Vernon Supp. 2002).

122. TEX. HEALTH AND SAFETY CODE ANN. § 161.032 (Vernon Supp. 2002).

following open-heart surgery at the Health Center.<sup>123</sup> During discovery, McClain requested production of several categories of documents, including documents that the Health Center contended were privileged because they were prepared by one of its peer review committees.<sup>124</sup> McClain asserted that the Health Center had waived its statutory peer review privilege, and the trial court agreed with McClain.<sup>125</sup> After the court of appeals refused (without opinion) the Health Center's petition for writ of mandamus, the Health Center petitioned the Supreme Court of Texas.<sup>126</sup> In a per curiam opinion, the court conditionally granted a writ of mandamus because there was no waiver of the exemption from discovery afforded by state law, and the trial court abused its discretion by ordering production of all documents.<sup>127</sup>

The court's decision to grant mandamus was based on its interpretation of the Medical Practice Act, which provides that healthcare entities may form peer review committees to review or evaluate the competence of the physician and the quality of medical and health care services.<sup>128</sup> Furthermore, all proceedings and medical peer review committee records are confidential, and all records of, determinations of, and communications to a committee are privileged and are not discoverable, with certain exceptions.<sup>129</sup> Similarly, the Health and Safety Code states that "the records and proceedings of a medical committee are confidential and are not subject to court subpoena."<sup>130</sup> The court held that the requested documents were covered by the Medical Practice Act and were therefore not discoverable.<sup>131</sup>

McClain claimed that the Health Center waived the privilege when it (1) failed to object to the second of three virtually identical deposition notices; (2) did not comply with Texas Rule of Civil Procedure 193 when making its objections; and (3) provided information about the peer review committee's evaluation in answers to interrogatories served by another patient in a suit that was consolidated with McClain's suit for discovery.<sup>132</sup> The supreme court rejected all of the three waiver theories.

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123. *In re Univ. of Tex. Health Ctr.*, 33 S.W.3d at 824.

124. *Id.* According to the Health Center, this particular committee (the Infection Control Committee) prepared the documents in question as part of an evaluation of the medical care provided to McClain and the other infected open-heart surgery patients. *Id.*

125. *Id.* The trial court first conducted an evidentiary hearing, and the Health Center submitted the documents for *in camera* inspection. Without notice to the Health Center, the trial court gave the documents to McClain a few days after the hearing. The Health Center objected after learning about this; the court ordered the documents returned, held a second hearing, and eventually entered an order requiring the Health Center to produce the documents to McClain. *Id.*

126. *In re Univ. of Tex. Health Ctr.*, 33 S.W.3d at 824.

127. *Id.* at 827-28.

128. *Id.* at 824-25. The current version of former § 1.03(a) of the Medical Practice Act is TEX. OCC. CODE ANN. § 151.002(a)(8) (Vernon Supp. 2002).

129. *Id.* at 825. The current version of former § 5.06(g), (j), (s)(3) is TEX. OCC. CODE ANN. §§ 160.007(a), (b), (e)-(g), 160.006(c) (Vernon Supp. 2002).

130. TEX. HEALTH & SAFETY CODE ANN. § 161.032(a) (Vernon Supp. 2002).

131. *In re Univ. of Tex. Health Ctr.*, 33 S.W.3d at 825.

132. *Id.* at 825-26.

In addressing the first theory, the court observed that McClain served the Health Center with three deposition notices that were identical except for the date and time of the deposition and that the Health Center asserted the privilege in its responses to the first and third notices.<sup>133</sup> Since the Health Center made its objection clear in the first response to the notice and request for documents, the court held that it was not necessary for the Health Center to reiterate its objection in its response to the second notice.<sup>134</sup> The supreme court also quickly dismissed McClain's second theory, since Rule 193 became effective on January 1, 1999, which was after McClain served the Health Center with its final notice and after the Health Center had already filed its objections.<sup>135</sup>

Finally, the court held that the Health Center's "voluntary production of information about the Infection Control Committee's recommendations in response to" another plaintiff's interrogatory also did not constitute waiver of the peer review privilege.<sup>136</sup> The court pointed out that the former Medical Practice Act provided specific means for waiving the peer review privilege<sup>137</sup> and that the party seeking the information has the burden of proving waiver.<sup>138</sup> Since the Health Center did not waive the privilege in accordance with the statute, the court held that McClain was not entitled to the documents in question.<sup>139</sup>

The court went on to state that the trial court did not waive the Health Center's privilege when it released the contested documents to McClain, since the privilege belongs to the Health Center and can only be waived voluntarily.<sup>140</sup> Furthermore, the court stated that the Health Center does not have an adequate remedy by appeal and that mandamus is appropriate to address a court order requiring production of privileged documents.<sup>141</sup> The court then granted the Health Center's petition and conditionally granted a writ of mandamus directing the trial court to vacate its order mandating the Health Center to release the documents at issue.<sup>142</sup>

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133. *Id.* at 826.

134. *Id.*

135. *Id.* The new rule provides that a "party should not object to a request for written discovery on the grounds that it calls for production of material or information that is privileged but should instead comply with Rule 193.3. A party who objects to production of privileged material or information does not waive the privilege but must comply with Rule 193.3 when the error is pointed out." TEX. R. CIV. P. 193.2(f).

136. *In re Univ. of Tex. Health Ctr.*, 33 S.W.3d at 827.

137. *Id.* (a committee must execute the waiver, and the waiver must be in writing). Former § 5.06(j) of the Medical Practice Act is now TEX. OCC. CODE ANN. § 160.007(e)-(g) (Vernon Supp. 2002).

138. *In re Univ. of Tex. Health Ctr.*, 33 S.W.3d at 827; see Act of June 1, 1987, *supra* note 129.

139. *In re Univ. of Tex. Health Ctr.*, 33 S.W.3d at 827.

140. *Id.*; see also *Granada Corp. v. First Court of Appeals*, 844 S.W.2d 223, 226 (Tex. 1992).

141. *In re Univ. of Tex. Health Ctr.*, 33 S.W.3d at 827; see also *Brownwood Reg'l Hosp. v. Eleventh Court of Appeals*, 927 S.W.2d 24, 27-28 (Tex. 1996).

142. *In re Univ. of Tex. Health Ctr.*, 33 S.W.3d at 827.



In *Poliner v. Texas Health Systems*,<sup>143</sup> a hospital peer review committee suspended Dr. Poliner from performing cardiac procedures for a period of time. Dr. Poliner filed a motion to compel to obtain information through the deposition of Dr. James Knochel regarding the manner in which the peer review committee made its decision. This information would enable Mr. Poliner to show that the committee's decision to suspend him was not objectively reasonable or that it was malicious. Dr. Knochel asserted that the requested information was privileged on the basis of the confidentiality afforded to peer review materials under the Health-Care Quality Improvement Act of 1986<sup>144</sup> ("HCQIA") and provisions of the Medical Practice Act.<sup>145</sup>

The District Court distinguished *Poliner* from recent Texas Supreme Court cases which have held that peer review materials are privileged and not subject to discovery.<sup>146</sup> Upon review of the HCQIA, the district court concluded that this statute did not create an inviolable bar to discovery of materials relating to peer review committees. The court recognized that such a privilege would exclude a wrongfully disciplined physician from showing that a peer review committee acted with malice by precluding them from proving that the data upon which the committee acted did not support the sanction imposed. In accordance with Congress' view that confidentiality serves an important public interest,<sup>147</sup> the court determined that although Mr. Poliner was not barred by any federally recognized privilege from discovery of peer review materials, some restrictions on such discovery were appropriate to protect the interests of peer reviewers and patients.

#### IV. LIABILITY: SOVEREIGN IMMUNITY

In 1993 the Legislature enacted chapter 321 of the Health and Safety Code. Section 321.002 requires the Texas Department of Mental Health and Mental Retardation ("TDMHMR") and other state health care regulatory agencies to adopt a "patient's bill of rights" for any patient who receives voluntary or involuntary in-patient "mental health, chemical dependency, or comprehensive medical rehabilitation services."<sup>148</sup> Section 321.003 authorizes a person who has been harmed by a violation of the "patient's bill of rights" to sue for injunctive relief or damages.<sup>149</sup> That section also provides that "[a] treatment facility or mental health facility that violates a provision of . . . a ['patient's bill of rights'] is liable to a person receiving care or treatment in or from the facility who is harmed

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143. 201 F.R.D. 437 (N.D. Tex. 2001).

144. 42 U.S.C.A. § 11101 (West 1995).

145. TEX. OCC. CODE § 160.007(a) (Vernon Supp. 2002).

146. See *Irving Healthcare Sys. v. Brooks*, 927 S.W.2d 12 (Tex. 1996); *Mem'l Hosp. - The Woodlands v. McCown*, 927 S.W.2d 1 (Tex. 1996).

147. See 42 U.S.C.A. § 11101 (West 1995).

148. TEX. HEALTH & SAFETY CODE § 321.002(a) (Vernon 2001).

149. *Id.* § 321.003(b).

as a result of the violation.”<sup>150</sup> The question that at least three courts of appeal have wrestled with during this Survey year is whether section 321.002 constitutes a clear and unambiguous legislative waiver of immunity from suit such that state institutions may be sued pursuant to section 321.002. The first court to decide this issue concluded that the legislature had not waived its sovereign immunity. The next two courts, however, agreed that the legislature had, in fact, done so. The Texas Supreme Court has granted review in the third of these cases, so we may get a resolution of this conflict among the appellate courts in the coming year.

In the first case, *Texas Department of Mental Health and Mental Retardation v. Lee*,<sup>151</sup> Robin Lee was sexually assaulted by an HIV-positive patient while she was under the care of Wichita Falls State Hospital. She filed suit against the hospital and other defendants under the “patient’s bill of rights” provision of the Texas Health and Safety Code for abuse, neglect, and exploitation.<sup>152</sup> The governmental defendants filed a plea to the jurisdiction based on sovereign immunity, which the trial court denied.<sup>153</sup>

Lee argued that when the Legislature enacted the Health and Safety Code’s “patient’s bill of rights” it expressly waived sovereign immunity by providing that a patient harmed by a violation of the patient’s bill of rights while under the care of a mental health facility may sue the facility for damages and other relief.<sup>154</sup> Although the terms “treatment facility” and “mental health facility” are not expressly defined in this part of the statute, the Health and Safety Code provides that “mental health facility” has the meaning assigned by section 571.003 of the Code and “treatment facility” has the meaning assigned by section 464.001 of the Code.<sup>155</sup> This incorporation of definitions by implication provided a considerable boost to Lee’s argument, because these definitions include public facilities. The court concluded, however, that mere incorporation of statutes that define treatment facilities and mental health facilities to include public facilities did not, without more, manifest a clear legislative intent to waive immunity, and sovereign immunity was not waived.<sup>156</sup>

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150. *Id.* § 321.003(a).

151. 38 S.W.3d 862 (Tex. App.—Ft. Worth 2001, pet. filed).

152. Lee also sued under the Texas Tort Claims Act, TEX. CIV. PRAC. & REM. CODE ANN. § 101.021(2) (Vernon 1997), alleging that her injuries were caused by a condition or use of tangible personal property because employees of Wichita Falls State Hospital failed to lock the interior door to her room and to provide locking devices on the door separating the women’s and the men’s wings of the hospital. *TDMHMR*, 38 S.W.3d at 864. The court of appeals concluded that the true substance of Lee’s complaint was that the sexual assault was caused, not by the condition or use of the hospital doors, but by the failure of the hospital staff to protect her from her assailant when they knew that she was hypersexual and promiscuous and that male patients had exploited her hypersexuality in the past. This conduct did not fall within the Tort Claims Act’s limited waiver of immunity for injuries caused by a condition or use of tangible property. *Id.* at 867-68.

153. *Id.* at 864.

154. *Id.* at 870.

155. *Id.*

156. *TDMHMR*, at 870-71.

In the second of the three cases, *Central Counties Center for Mental Health & Mental Retardation Services v. Rodriguez*,<sup>157</sup> the Austin Court of Appeals had two consolidated appeals that raised the same issue of sovereign immunity. In one case, Karen Rodriguez had sued the Central Counties Center for Mental Health & Mental Retardation Services ("Center") for personal injuries, including sexual exploitation by a Center employee.<sup>158</sup> In the other case, Debbie Fiske and Raymond Rodriguez sued the Austin State Hospital ("Hospital") for damages they suffered and on behalf of their son, Christopher Roy Rodriguez, who committed suicide while he was a patient there.<sup>159</sup> The Center and the Hospital brought these interlocutory appeals from two district courts' orders that denied their pleas to the jurisdiction.

As in *TDMHMR*, the issue on appeal was whether the legislature clearly and unambiguously waived sovereign immunity when it enacted section 321.003 of the Health and Safety Code. This time, however, the court ruled that the legislature did waive sovereign immunity. The court based its ruling primarily upon the definition of "mental health facility" and what the court viewed as a "straightforward" construction of words that have a "plain and ordinary meaning."<sup>160</sup> Both the Center and Hospital invited the court to consider contrary legislative history.<sup>161</sup> The Code Construction Act plainly provides that "whether or not the statute is considered ambiguous on its face, a court may consider among other matters the . . . legislative history;"<sup>162</sup> the court of appeals declined the invitation, "[b]ecause the legislature has spoken clearly, we will look no further than the statute itself."<sup>163</sup>

In the third action in this series, *Wichita Falls State Hospital v. Taylor*,<sup>164</sup> "Deborah Taylor filed a wrongful death and survival action against Wichita Falls State Hospital and a doctor employed by the Hospital after her husband committed suicide following his discharge from the Hospital."<sup>165</sup> Taylor asserted that the hospital discharged her husband in a manner contrary to *TDMHMR*'s "patient's bill of rights."<sup>166</sup> The hospital asserted that it was immune from the suit, because chapter 321 of the Health and Safety Code does not constitute a legislative waiver of immunity from suit.<sup>167</sup> The trial court denied the hospital's plea to the jurisdiction.<sup>168</sup> The Waco Court of Appeals decided to follow the Austin court and held that, for the reasons set forth in *Rodriguez*, section 321.003 con-

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157. 45 S.W.3d 707 (Tex. App.—Austin 2001, pet. filed).

158. *Id.* at 709.

159. *Id.*

160. *Id.* at 711.

161. *Id.* at 712-13.

162. TEX. GOV'T CODE § 311.023 (Vernon 1998).

163. *Cent. Counties Ctr. for MH & MR Servs.*, 45 S.W.3d at 713.

164. 48 S.W.3d 782 (Tex. App.—Waco 2001, pet. granted).

165. *Id.* at 783.

166. *Id.*

167. *Id.* at 783-84.

168. *Id.* at 784.

stitutes a clear and unambiguous legislative waiver of immunity from suit.<sup>169</sup>

## V. HEALTH CARE FINANCE

### A. SUBROGATION

In *Franks v. Prudential Health Care Plan, Inc.*,<sup>170</sup> Mr. Franks joined a Prudential health maintenance organization (“HMO”) through his employer, ATC Long Distance. The contractual document between Prudential and Mr. Franks’ employer provided that Prudential was entitled to be reimbursed “the reasonable cash value” of the medical services it provided to Mr. Franks for injuries caused by third-parties.<sup>171</sup>

In 1996, Mr. Franks was in a traffic accident and settled with the other driver’s insurance company for his personal injury claims. Subsequently, Prudential requested, through its collection agent, that Mr. Franks reimburse them \$2,074.98—the value of the medical services Prudential had already provided to him<sup>172</sup>—out of his settlement proceeds.<sup>173</sup> Mr. Franks complied with Prudential’s request but later filed suit claiming that Prudential had no right to reimbursement, since they would receive a windfall by collecting twice, once from the member who prepaid Prudential and again from the member’s tort settlement. In response, Prudential claimed that it was actually Franks who would obtain a double recovery, once from Prudential for medical care and again from the tortfeasor with whom he settled.

In 1999, Mr. Franks filed a class action suit in federal court seeking a declaratory judgment that Prudential lacked enforceable rights of reimbursement and that Prudential recovered more in reimbursement for his medical treatment than they had to pay for that treatment.<sup>174</sup> The defendants renewed a motion to dismiss under 12(b)(6) claiming that plan documents conferred upon Prudential the “unequivocal right” to recover the reasonable value of medical treatment from the settlement proceeds of enrollees injured by a third-party.<sup>175</sup> Prudential contended that the terms of Mr. Franks plan documents should be enforced as written, and he could not demonstrate a reason for those documents to be invalidated. Mr. Franks argued that the defendants have no right to pursue and obtain reimbursements from plan members. Alternatively, Mr. Franks con-

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169. *Cent. Counties Ctr. For MH & MR Servs.*, 45 S.W.3d at 785. The hospital also argued that section 321.002 is an unconstitutional delegation of legislative authority to MHMR, an executive agency. The court, however, stated that the constitutionality of section 321.002 had “no bearing on the trial court’s jurisdiction to entertain Taylor’s suit. Thus, it [was] not the proper subject of a plea to the jurisdiction.” *Id.*

170. 164 F. Supp. 2d 865 (W.D. Tex. 2001).

171. *Id.* at 869.

172. The amount was apparently based upon the typical charges for such medical services, not the actual amount paid by Prudential. *Id.* at 870.

173. *Id.*

174. *Id.* at 869-70.

175. *Franks*, 164 F. Supp. 2d at 870-71.

tended, if Prudential can seek reimbursement, "Prudential is at most entitled only to the amount it actually paid on Mr. Frank's behalf."<sup>176</sup>

The Fifth Circuit has determined that where an ERISA plan's language sets out plain and unambiguous terms for subrogation and reimbursement, those terms must be enforced as written.<sup>177</sup> Applying this circuit precedent, the district court concluded that "the terms which appear in Mr. Franks' plan, including the provision allowing Prudential to recover the reasonable value of medical services in the event a member receives funds from a third-party tortfeasor," should be enforced.<sup>178</sup>

Since the Fifth Circuit had not addressed the issue of whether the language of "reasonable cash value" is enforceable in a subrogation provision, the court considered other federal and state appellate courts that have enforced contractual rights of subrogation and reimbursement in HMO plan documents. The court followed decisions from the First<sup>179</sup> and Eighth<sup>180</sup> Circuits that comported with Fifth Circuit precedent, supporting the argument that reimbursement rights, including "reasonable value" subrogation provisions, under the terms of an ERISA plan, are valid and enforceable. The district court also rejected Mr. Franks' argument that the federal Health Maintenance Organization Act prevents an HMO from seeking subrogation and reimbursement. The court looked at the legislative history of the HMO Act and concluded that Congress did not intend to limit third-party recoveries.<sup>181</sup>

The district also dismissed Mr. Franks' claim that an HMO should be limited to the prepayments it receives from its members for providing health care.<sup>182</sup> The court ruled that Prudential is not getting a windfall, since the money it receives from reimbursement could go to the reasonable cost of doing business or to keep membership fees down.<sup>183</sup> The court therefore appeared to accept Prudential's argument that, in an accounting sense, Mr. Franks has probably already received a financial benefit from the operation of this reimbursement provision, and a judgment in his favor would simply have amounted to reaping a benefit while refusing to contribute to its cost.

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176. *Id.* at 870.

177. *Sunbeam-Oster Co. Group Benefits Plan v. Whitehurst*, 102 F.3d 1368, 1374 (5th Cir. 1996).

178. *Franks*, 164 F. Supp. 2d at 880-81.

179. *See Harris v. Harvard Pilgrim Health Care, Inc.*, 208 F.3d 274, 278-79 (1st Cir. 2000) (enforcing strict language of an HMO reimbursement clause).

180. *Ince v. Aetna Health Mgmt., Inc.*, 173 F.3d 672, 676 (8th Cir. 1999) (enforcing an HMO's "reasonable value" language in subrogation provision).

181. *Franks*, 164 F. Supp. 2d at 883.

182. *Id.* at 888.

183. *Id.* at 887-88.

B. UNCOMPENSATED CARE FOR UNDOCUMENTED ALIENS<sup>184</sup>

On July 10, 2001, Texas Attorney General John Cornyn offered a legal opinion in response to a question posed by the Harris County Hospital District.<sup>185</sup> Specifically, the Harris County Hospital District asked whether it could provide free or discounted non-emergency health care to persons residing within its boundaries, without regard to their immigration or legal status. In brief, the Attorney General responded that the hospital district was barred from using public funding for such purposes by the Personal Responsibility and Work Opportunity Reconciliation Act of 1996 ("PRWORA").<sup>186</sup> Furthermore, Cornyn noted that while PRWORA itself imposes no sanction specified for violations, the hospital district could face consequences under state and federal laws for using public funds for purposes specifically barred by PRWORA." The Attorney General's opinion has implications for all hospital districts, hospital authorities, county hospitals, other public hospitals, and non-public hospitals.

Under the Texas Health and Safety Code, the Harris County Hospital District ("Harris County") is required to provide medical care to indigent and needy persons residing in the district.<sup>187</sup> The state code further defines the responsibilities of hospital districts through the Indigent Health Care and Treatment Act, which states that when a patient residing in the county cannot pay for the hospital care, the district must provide the necessary care to the patient without charge.<sup>188</sup> A patient's status as an alien does not preclude the patient from being considered a state or county resident for purposes of public benefit programs; however, the hospital district must comply with the federal immigration law and policy when it comes to provision of services.<sup>189</sup>

While the federal government has broad constitutional powers regarding the admission, naturalization, and residence of aliens, states have no such power. State laws that are inconsistent with federal immigration policy are preempted by federal law." Therefore, Harris County's provision of services cannot be inconsistent with federal immigration policy.

The PRWORA is a federal act that deems undocumented or illegal aliens to be ineligible for state and local public assistance.<sup>190</sup> This eligibility requirement has a number of exceptions. First, the hospital district must provide necessary treatment for the emergency medical conditions

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184. Much of the analysis in this section was prepared by Lewis Lefko, Esq. of Haynes and Boone.

185. Op. Tex. Att'y Gen. No. JC-0394 (2001).

186. 8 U.S.C.A. §§ 1601-1646 (West 1999).

187. TEX. HEALTH & SAFETY CODE ANN. § 281.002 (Vernon 2001).

188. See generally § 61.001.

189. See Op. Tex. Att'y Gen. Nos. JM-962 (1988) at 3, 8 & WW-1274 (1962) at 3.

190. 8 U.S.C.A. § 1621(a) (West 1999). Under PRWORA, aliens ineligible for such public assistance include those who are not qualified aliens (as defined in *id.* § 1641), non-immigrants under the Immigration and Nationality Act (*id.* § 1101 *et seq.*), or aliens paroled into the United States under *id.* § 1182(d)(5) for less than one year.

of aliens, regardless of immigration or legal status.<sup>191</sup> This requirement for providing emergency care is found not only in PRWORA but is required by the federal Emergency Medical Treatment and Active Labor Act ("EMTALA").<sup>192</sup> The hospital district may also provide public health assistance for immunizations with respect to immunizable diseases and for testing and treatment of symptoms of communicable diseases whether or not such symptoms are caused by a communicable disease.<sup>193</sup> Finally, PRWORA allows for the provision of public benefits to undocumented aliens through the enactment of a state law after August 22, 1996, which "affirmatively provides for such eligibility."<sup>194</sup> By "affirmatively provides," this section requires that the state law expressly state the legislature's intent that undocumented aliens are to be eligible for certain public benefits.<sup>195</sup>

Texas enacted a law in 1997 that allows for greater eligibility of undocumented aliens for certain public assistance. The law, which amends the Texas Family Code,<sup>196</sup> states that the Department of Protective and Regulatory Services may use state and federal funds to provide child protective services and related benefits to eligible children and families "without regard to the immigration status of the child or the child's family."<sup>197</sup> In the same law, the Texas Legislature amended another section of the Family Code, providing that the commissioners court of a county may provide for services to and support of children in need of protection and care "without regard to the immigration status of the child or the child's family."<sup>198</sup>

While both provisions expand the eligibility of undocumented aliens for public assistance, Cornyn concluded that the Texas Legislature clearly stated its intent to limit the expansion to publicly-funded child protective services. No Texas law has been enacted that would allow Harris County Hospital District, or any other public hospital or hospital district, to provide public funds for nonemergency health care for undocumented aliens.

One argument made against the Attorney General's conclusion is that House Bill 1398 of the Seventy-sixth Texas Legislature, which amended a provision of the Indigent Health Care and Treatment Act, allows undocumented aliens to receive public benefits from Harris County.<sup>199</sup> However, Cornyn responded that the amended law does not expressly refer to the immigration status of aliens.<sup>200</sup> Cornyn further stated that there is no

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191. 8 U.S.C.A. § 1621(b) (West 1999).

192. 42 U.S.C.A. § 1395dd (West 2001).

193. 8 U.S.C.A. § 1621(b) (West 1999).

194. *Id.* § 1621.

195. Op. Tex. Att'y Gen. No. JC-0394 (2001) at 4.

196. TEX. FAM. CODE ANN. § 264.004(c) (Vernon Supp. 2002).

197. *Id.* § 264.004(c); see also Act of May 19, 1997, 75th Leg., R.S., ch. 575, § 23, 1997 Tex. Gen. Laws 2012, 2020.

198. TEX. FAM. CODE ANN. § 264.006 (Vernon Supp. 2002); see also Act of May 19, 1997, 75th Leg., R.S. ch. 575 § 25, 1997 Tex. Gen. Laws 2012, 2020.

199. Op. Tex. Att'y Gen. No. JC-0394 (2001) at 4 n.3.

200. *Id.* at 5.

indication that the Legislature intended to provide state or local public benefits for which undocumented aliens are ineligible under PRWORA.<sup>201</sup> Since the amended law does not “affirmatively provide” such expanded public benefits for undocumented aliens, Harris County is not allowed to provide such public assistance to undocumented aliens.<sup>202</sup>

The opinion also considers the argument that PRWORA violates the Tenth Amendment of the United States Constitution.<sup>203</sup> The Supreme Court has held that Congress cannot force federal regulatory programs directly on states.<sup>204</sup> It is argued that such action infringes upon state sovereignty—which is generally the ability of the states to establish their own legislative decision-making process—because PRWORA requires a state that wishes to allow the benefits for undocumented aliens to pass a law rather than use any other means the state might choose.<sup>205</sup> Cornyn responded that PRWORA does not force the state to take action but rather prohibits the state from allowing undocumented aliens to receive most public benefits.<sup>206</sup> In other words, PRWORA does not coerce the states to legislate in a particular area, but if a state wishes to depart from federal restrictions, Congress offers the state the ability to do so by enacting a statute in compliance with PRWORA. While Congress may be seen as influencing the states’ actions through PRWORA, the Tenth Amendment does not bar Congress from encouraging a state to regulate in a particular way. The United States Supreme Court has historically allowed Congress to urge a state to adopt legislation which follows a federal interest, allowing Congress to provide incentives as a method of influence or to use a number of similar methods, “short of outright coercion.”<sup>207</sup>

While PRWORA itself has no specific enforcement procedures for violations, the Attorney General’s opinion notes that Harris County Hospital District may face consequences under state or federal law for spending public funds for a purpose specifically barred by PRWORA. The consequences under state or federal law could significantly affect the amount of funding Harris County is granted for the future.

Under Texas law, a violation of PRWORA could lead to an audit of Harris County’s financial records. The district is subject to accounting and control procedures under authority delegated by the commissioners court.<sup>208</sup> In approving the budget, the commissioners court may take into account the unauthorized expenditures made by the hospital district

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201. *Id.*

202. *Id.* at 4.

203. *Id.*

204. *N.Y. v. United States*, 505 U.S. 144, 157 (1992) (holding that Congress cannot directly compel a state to act or enforce a federal regulatory program); *see also* *Printz v. United States*, 521 U.S. 898 (1997) (stating that Congress cannot circumvent this prohibition by directly conscripting state officers).

205. *Id.* at 5.

206. *Tex. Att’y Gen. Op. No. JC-0394* (2001) at 5.

207. *N.Y.*, 505 U.S. at 166.

208. *TEX. HEALTH & SAFETY CODE ANN. § 281.049* (Vernon 2001).



board. Additionally, the hospital district board could be subject to a taxpayer's suit to enjoin future unauthorized expenditures.<sup>209</sup>

Harris County may also face consequences related to other state or federal funding. As a condition of receiving funding from Medicare and Medicaid, Harris County must comply with applicable federal laws related to the health and safety of patients.<sup>210</sup> The Attorney General further noted that some state-funded grants allocated to Harris County may require the district to comply with applicable state and federal laws.<sup>211</sup> If PRWORA is considered to be an "applicable federal law" for the purposes of such grants, then violations of PRWORA may compromise Harris County's receipt of certain state or federal funding. Such consequences related to state or federal funding may affect non-public hospitals as well if they have received state-funded grants and treat immigrant patients with such funds.

Many hospital districts are concerned that the Attorney General's opinion will greatly affect treatment policies, fearing the impact that denial of treatment to thousands of undocumented immigrants will have on the people and the health system. Several hospital districts have noted that the denial of preventive care to undocumented aliens may eventually lead to more expensive emergency care,<sup>212</sup> which is required to be provided by EMTALA. The danger, therefore, would not only lie in the health and welfare of the immigrants, but also on the effectiveness of the health system itself.

While many Texas hospital districts and other hospitals are concerned about the impact of this opinion, some have noted that the opinion might not have a practical impact. Many hospitals have a policy under which patients are not even asked about their immigration or legal status. Patients are asked only if they reside in the county. Such a "don't ask, don't tell" policy, common among many Texas hospitals, could make the restrictions imposed by PRWORA nearly impossible to enforce. Also, as with all Texas Attorney General opinions, the opinion does not have the force of law. Until a lawsuit is brought and a court enters a judgment reflecting the Attorney General's opinion, no legal precedent exists to support the Attorney General's opinion.

## VI. FEDERAL DEVELOPMENTS: FALSE CLAIMS ACT

In *Riley v. St. Luke's Episcopal Hospital* ("Riley II"),<sup>213</sup> the en banc Fifth Circuit Court of Appeals reversed its previous ruling<sup>214</sup> and held

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209. See Op. Tex. Att'y Gen. No. JM-79 (1983) at 3 (acknowledging the authority of commissioners court to reject hospital district's budget).

210. 42 C.F.R. § 482.11 (2001).

211. See Op. Tex. Att'y Gen. No. JC-0394 (2001) at 6, 7.

212. See Ed Housewright, *Immigrants could lose preventive care: AG's opinion may affect Parkland*, DALLAS MORNING NEWS, July 16, 2001, at 6A.

213. 252 F.3d 749 (5th Cir. 2001).

214. *Riley v. St. Luke's Episcopal Hosp.*, 196 F.3d 514 (5th Cir. 1999) ("Riley I").

that the provisions of the False Claims Act ("FCA")<sup>215</sup> that allow a *qui tam* relator to pursue a claim when the government has chosen not to intervene do not violate the separation of powers. In so doing, the Fifth Circuit has finally fallen in step with other federal courts that have decided that same issue.

In *United States ex rel. Riley v. St. Luke's Episcopal Hospital*,<sup>216</sup> a nurse brought suit against her former employer under the *qui tam* provisions of the FCA and chose to pursue the suit although the government exercised its right not to intervene. The district court dismissed the lawsuit on standing grounds. Although the Fifth Circuit in *Riley I* held that Riley did have standing, the court further held that "solo" *qui tam* actions pursued under the FCA violate the separation of powers. The Fifth Circuit decided to rehear the case en banc but delayed the rehearing until after a ruling by the Supreme Court on the standing of *qui tam* relators in *Vermont Agency of Natural Resources v. United States ex rel. Stevens*.<sup>217</sup> In May of 2000, the 7-2 majority in *Stevens* held that the federal government's injury in fact conferred standing on a *qui tam* relator bringing suit under the False Claims Act even when the government chooses not to intervene in the suit.<sup>218</sup> However, the majority explicitly declined to decide whether such suits were in violation of the "appointments" clause or the "take care" clause of Article II, sections 2 and 3 of the Constitution.<sup>219</sup>

The standing issue thus resolved, in *Riley II* the Fifth Circuit, sitting en banc, turned to the question of separation of powers—specifically the "take care" clause and the "appointments" clause—in *qui tam* suits brought under the FCA where the government chooses not to intervene. The court first looked at the role of history in *qui tam* law suits, essentially agreeing with the dissent in *Stevens* that the important historical role played by *qui tam* jurisprudence was one argument supporting the view that *qui tam* suits brought under the FCA do not violate Article II.<sup>220</sup> Secondly, the court determined that the Executive Branch "retains sufficient control" over such law suits to carry out its constitutional duty to take care that the laws are faithfully executed.<sup>221</sup> Reaching the opposite conclusion, the *Riley I* panel had relied heavily on four factors listed

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215. 31 U.S.C.A. §§ 3729-3731 (West 1998 & Supp. 2001).

216. 982 F. Supp. 1261 (S.D. Tex. 1997).

217. 529 U.S. 765 (2000).

218. *Id.* at 774.

219. *Id.* at 778 n.8. The dissent, however, ventured that the historical evidence used by the majority to determine the standing issue was also dispositive in resolving the Article II questions. *Id.* at 801 (Stevens, J., dissenting).

220. *Riley II*, 252 F.3d at 753; see *supra* note 218 and accompanying text.

221. *Id.* at 753-54; U.S. CONST. art. II, § 3. The court cites the following examples: the government retains the right to veto settlements by a *qui tam* relator, may take over the case within 60 days of notification (and after 60 days, upon a showing of good cause), may dismiss the FCA action over the objections of the *qui tam* relator, may request copies of the pleadings and deposition transcripts, and, perhaps most importantly, receives the larger percentage of any recovery, up to 70%. *Riley II*, 252 F.3d at 753-54; see also 31 U.S.C.A. § 3730 (West 2002).

by the Supreme Court in *Morrison v. Olson*<sup>222</sup> that demonstrated sufficient executive control over the Ethics in Government Act ("EGA").<sup>223</sup> The court in *Riley II* explained that *Morrison* is inapplicable in determining the constitutionality of the FCA, because: (1) under the EGA, the independent counsel acts as the United States itself, while under the FCA, the *qui tam* relator merely brings a lawsuit in the name of the United States; and (2) the EGA deals with criminal prosecution while the FCA deals with civil litigation.<sup>224</sup> The court went on to say that were *Morrison* applicable, there is a "credible argument" that since the Supreme Court upheld the independent counsel provisions in *Morrison*, it would similarly uphold the *qui tam* provisions of the FCA.<sup>225</sup> The court stated further that any infringements on executive power by the *qui tam* provisions of the FCA are relatively small seen in the greater context of the American judicial system as a whole.<sup>226</sup> Finally, the court quickly dismissed the contention that the *qui tam* provisions of the FCA violate the "appointments" clause, since "qui tam relators are not United States officers."<sup>227</sup>

The dissent in *Riley II* for the most part reiterated what the *Riley I* panel held. First, the dissent attacked the conclusions of the majority regarding the amount of control retained by the executive in *qui tam* lawsuits brought under the FCA, using the four factors in *Morrison* as a

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222. 487 U.S. 654 (1988). In *Morrison*, the Supreme Court upheld the constitutionality of the independent counsel provisions of the Ethics in Government Act.

223. These factors are: (1) the Attorney General retains the power to remove the independent counsel for "good cause"; (2) the Attorney General's decision not to request appointment of an independent counsel is committed to his unreviewable discretion, giving the Executive a degree of control over the power to initiate an investigation by the independent counsel; (3) the Attorney General defines the jurisdiction of the independent counsel; and (4) once appointed, the independent counsel must abide by Justice Department policy. *Riley I*, 196 F.3d at 527-28 (quoting *Morrison*, 487 U.S. at 696).

224. *Riley II*, 252 F.3d at 755.

225. *Id.* at 756. All other circuits that have decided this issue have come to the same conclusion about *Morrison*, albeit through slightly different reasoning. The Ninth Circuit has given the most complete comparison of the FCA and *Morrison*, concluding that the four *Morrison* factors were not intended as a determinative test, and instead that the infringements on Executive power found in *Morrison* should be compared "in toto" with the infringements on Executive power under the *qui tam* provisions of the FCA. *United States ex rel. Kelly v. Boeing Co.*, 9 F.3d 743, 752 (9th Cir. 1993). Finding that the *qui tam* provisions infringed less on the Executive power than the independent counsel provisions, the *Kelly* court held that the FCA *qui tam* provisions did not violate the "take care" clause. *Id.* Other courts confronted with the same issue have explicitly or impliedly followed the reasoning in *Kelly*. See *United States ex rel. Taxpayers Against Fraud v. Gen. Elec. Co.*, 41 F.3d 1032, 1041 (6th Cir. 1994); *United States ex rel. Downy v. Corning, Inc.*, 118 F. Supp. 2d 1160, 1167-68 (D.N.M. 2000); *United States ex rel. Wright v. Cleo Wallace Ctrs.*, 132 F. Supp. 2d 913, 919 (D. Colo. 2000); see also *United States ex rel. Kreindler & Kreindler v. United Tech. Corp.*, 985 F.2d 1148, 1155 (2nd Cir. 1993) (holding that the *qui tam* provisions of the FCA do not violate the "take care" clause, but without referring to *Kelly* or *Morrison*).

226. *Riley II*, 252 F.3d at 757.

227. *Id.* at 757-58; U.S. CONST. art. II, § 2; accord *Taxpayers Against Fraud*, 41 F.3d at 1041; *Kelly*, 9 F.3d at 758; *United States ex rel. Robinson v. Northrop Corp.*, 824 F. Supp. 830, 836 (N.D. Ill. 1993).

determinative test instead of as an analogy.<sup>228</sup> Finding none of the factors in *Morrison* present in the *qui tam* provisions of the FCA, the dissent determined that the FCA violates the “take care” clause. Second, the dissent raised a paradox regarding the *qui tam* relator’s status in reference to the “appointments” clause,<sup>229</sup> since the Supreme Court has twice held that “persons litigating on behalf of the United States are officers of the United States,”<sup>230</sup> *qui tam* relators must be “officers who have not properly been appointed or . . . non-officers who therefore are not qualified to sue on behalf of the government,” either of which, concluded the dissent, violates the “appointments” clause.<sup>231</sup> The dissent then pointed out that the Article II question was explicitly left open in *Stevens* and stated that at least two (and possibly three) members of the Supreme Court have expressed reservations regarding *qui tam* actions under Article II.<sup>232</sup> Finally, the dissent asserted that history is not necessarily conclusive on the Article II issues as it is on the Article III issue, because (1) special deference must be given to history in an Article III standing inquiry,<sup>233</sup> and (2) the history of *qui tam* law suits is ambiguous.<sup>234</sup>

Although the dissent in *Riley II* raised some compelling concerns, every court (with the sole exception of the *Riley I* panel) faced with the same issue has agreed with the *Riley II* majority. Were the question to reach the Supreme Court, it is clear that Justices Stevens and Souter agree with the *Riley II* court that the *qui tam* provisions of the FCA do not violate Article II.<sup>235</sup> However, as the dissent in *Riley II* pointed out, Justices Scalia and Thomas (and possibly Justice Kennedy) appear to have reservations regarding Article II and the FCA.<sup>236</sup> In other words, the fate of *qui tam* lawsuits brought under the FCA, especially those in which the government chooses not to intervene, is not altogether certain. Absent a split among the circuits, however, it is anyone’s guess whether four justices believe the issue is sufficiently important to warrant *certiorari* review.

## VII. LEGISLATIVE UPDATE

As is usually the case, the 2001 Legislative session produced literally hundreds of new health care related laws—far more than can be usefully reviewed and analyzed in the space allocated for any Survey article. By way of compromise, I am appending a list of the most significant bills that were enacted by the 77th Legislature together with a brief synopsis of the

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228. *Riley II*, 252 F.3d at 760-67 (Smith, J., dissenting).

229. *Id.* 252 F.3d at 767-69.

230. *Morrison*, 487 U.S. at 671 n.12; *Buckley v. Valeo*, 424 U.S. 1, 126 (1976).

231. *Riley II*, 252 F.3d at 768-69 (Smith, J., dissenting).

232. *Id.* at 770; see *Friends of the Earth, Inc. v. Laidlaw Envtl. Servs., Inc.*, 528 U.S. 167 (2000).

233. *Riley II*, 252 F.3d at 771-72 (citing *Stevens*, 529 U.S. at 766 (2000)).

234. *Id.* at 772-74.

235. *Stevens*, 529 U.S. at 801 (Stevens, J., dissenting.)

236. See *supra* text accompanying note 213.

major features likely to be of interest.<sup>237</sup>

#### A. HEALTH BENEFITS COVERAGE/INSURANCE REGULATION:

1. H.B. 2127 - Amends Insurance Code, adding Article 21.52L, providing that the issuer of a health benefit plan may not refuse to enroll a person in the plan solely because the person is enrolled in another health benefit plan at the time the person applies for the coverage; applies to plans offered by insurers, HMOs, 5.01(a)'s, and MEWAs, among others; violation constitutes unfair discrimination under Article 21.21-8, which provides for an award of compensatory damages, court costs and attorneys fees plus, for knowing violations, a civil penalty of up to \$25,000 per claimant, and injunctive relief.

2. S.B. 8 - Omnibus Women's Equal Health Care Act amends the Insurance Code prohibiting discrimination in health care rates and reimbursement for women's services; providing administrative and civil penalties.

3. S.B. 544 - Amends Insurance Code Article 20A to add to "basic health care services" periodic health assessments for adult enrollees, including annual well-woman examinations; requires the Insurance Commissioner to require an HMO to verify that a physician's license to practice medicine and any other certificate the physician is required to hold, including a certificate issued by the Department of Public Safety or the DEA or a certificate issued under the Medicare program, is valid as of the date of initial credentialing and on the date of each recredentialing; prohibits the Commissioner from requiring recredentialing more than once every three years; authorizes the Commissioner to promulgate a standardized form to be used by a public or private hospital, HMO, or PPO for verification of physician credentials.

#### B. INDIGENT/CHARITY CARE

1. H.B. 2419 - Amends the Health and Safety Code to permit a non-profit hospital or hospital system that contracts with a local county to provide indigent health care services under the Indigent Health Care and Treatment Act to credit unreimbursed costs from direct care provided to an eligible county resident toward meeting the hospital's or system's charity care and government-sponsored indigent health care requirement; requires each hospital to publish annually a notice of the hospital's charity care program and policies in a local newspaper; and requires the TDH to publish annually a manual that lists each nonprofit hospital in this state with a brief summary of the hospital's charity care policies.

2. H.B. 2602 - Amends the Health and Safety and Government Codes to make clarifying changes to the Indigent Health Care and Treatment Act enacted in 1999; provides that if a county and health care provider or

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237. The full text of all bills can be found at <http://www.capitol.state.tx.us/tlo/billubr.htm>; disposition tables are at <http://www.lrl.state.tx.us/isaf/>.

a public hospital and health care provider disagree on a patient's eligibility, they are authorized to submit the matter to the Texas Department of Health; authorizes rather than requires TDH to adopt rules governing the distribution of state assistance that establish a maximum annual allocation for each county eligible for assistance; specifies the allocation of the amount in the tertiary care account that is not held in reserve for reimbursement of unpaid tertiary medical services; provides that minimum eligibility standards for indigent health care must incorporate a net income eligibility level equal to 21 rather than 25 percent of the federal poverty level.

### C. LONG-TERM CARE AND ASSISTED LIVING FACILITIES

1. H.B. 482 - Amends the Health and Safety Code protecting persons who report abuse or neglect from retaliation by nursing homes or intermediate care facilities.
2. S.B. 355 - Amends the Health and Safety Code relating to a nursing home resident's right to informed consent regarding the prescription of psychoactive medications.
3. S.B. 1839 - Amends the Health and Safety Code to address quality of care issues in long-term care facilities.

### D. MANAGED CARE

1. H.B. 606 - Amends Article 3.70-3C, Insurance Code, by adding Section 3B prohibiting certain health benefit plans from requiring the use of hospitalists by participating physicians.
2. H.B. 2382 - Amends the Insurance Code to prohibit exclusion of contraceptive drugs, devices and related services by a health plan.
3. H.B. 2828 - Amends Insurance Code Article 20A.11 to require HMO's that delegate functions to any entity to execute a written agreement with each such entity and file a copy with the Department of Insurance; specifies that delegation agreements shall give the HMO authority to monitor solvency requirements (if any) applicable to the delegated entities and shall obligate the delegated entities to permit the Insurance Commissioner to examine records relevant to solvency requirements and the ability of the delegated entity to fulfill its contractual obligations; adds reserve requirement for delegated networks; requires contracts between a limited provider network or delegated entity and physicians to provide for notice to enrollees before their physician is terminated from the network or entity, for continuity of care for certain enrollees even after the physician is terminated; requires networks to allow referrals to out-of-network providers for covered services that are not available from network physicians and providers and to pay for such services at the usual and customary or agreed-upon rate.

### E. MEDICAL/PATIENT RECORDS

1. H.B. 398 - Amends the Occupations Code to include billing records in medical record provisions related to physician-patient communication; requires TSBME to promulgate a rule regarding appointment of temporary or permanent guardian of physician's billing or medical records.

2. S.B. 11 - Subject to a number of exceptions, requires covered entities to comply with HIPAA Privacy Standard; permits disclosure of protected health information to health researchers only upon the express written consent of the patient or upon documentation that a waiver has been approved by either an IRB or a privacy board; prescribes the membership and activities of privacy boards; prohibits reidentification of individual from protected health information or use of protected health information for marketing purposes without individual's consent; provides enforcement provisions for injunctive relief, civil penalties, disciplinary action, and exclusion from state-funded health programs.

### F. MENTAL HEALTH

1. H.B. 1072 - Authorizes a peace officer or health officer to take into custody, detain, and return to a treatment facility a patient or client under a court order for treatment at the facility.

2. H.B. 1887 - Amends the Health and Safety code regarding the competency of patients receiving mental health services to consent to research.

3. S.B. 22 - "JoJo's Law" amends the Health and Safety Code regarding the admission of minors to facilities and the right of minors to consent to treatment and rehabilitation for chemical dependency.

4. S.B. 684 - Amends the Health and Safety Code expanding the definition of nonphysician mental health professional for purposes of a proceeding or evaluation under the Mental Health Code.

5. S.B. 1588 - Amends Health and Safety Code relating to a preliminary examination for emergency detention because of mental illness.

6. S.B. 1767 - Amends Section 574.021(e) of the Health and Safety Code relating to the issuance of a protective custody order by a magistrate.

### G. NONPROFIT ORGANIZATIONS

1. S.B. 731 - Amends the Texas Non-Profit Corporation Act to exempt a nonprofit corporation officer from liability concerning any action taken or omission made, unless the officer's conduct was not made in good faith or in the best interest of the corporation.

### H. PHARMACY/DRUGS

1. S.B. 65 - Authorizes a Class A or Class C pharmacy located in Texas to provide pharmacy services, including the dispensing of drugs, through a telepharmacy system in a facility that is not at the same loca-

tion as the Class A or Class C pharmacy; provides that a telepharmacy system is required to be under the continuous supervision of a pharmacist as determined by rule of the Texas State Board of Pharmacy; provides that the pharmacist is not required to be physically present at the site of the telepharmacy system to qualify as continuous supervision; requires the pharmacist to supervise the system electronically by audio and video communication; authorizes a telepharmacy system to be located only at a health care facility in Texas that is regulated by this state or the United States; requires the board to adopt rules regarding the use of a telepharmacy system under this section, including certain rules; prohibits a telepharmacy system from being located in a community in which a Class A or Class C pharmacy is located; authorizes the telepharmacy system to continue to operate in the community if a Class A or Class C pharmacy is established in a community in which a telepharmacy system has been located under this section.

2. S.B. 768 - Amends Section 562.008(a) of the Occupations Code to require the pharmacist, if a practitioner certifies on the prescription form that a specific prescribed brand is medically necessary, to dispense the drug as written by the practitioner; allows the State Board of Pharmacy to comply, by rule, with certain federal labeling requirements; allows pharmacy students to work as interns outside of their college-assigned programs; allows academic pharmacists to serve on the board; increases continuing education requirements for pharmacists from 24 hours to 30 hours during the preceding 24 months; limits the use of the word "apothecary".

#### I. PHYSICIANS/HEALTHCARE PROFESSIONALS

1. H.B. 1183 - Amends Section 1 Subtitle C, Title 3 of the Occupations Code relating to the regulation of surgical assistants; granting rulemaking authority; providing an administrative penalty.

2. H.B. 3152 - Amends the Health and Safety Code to authorize a physician, podiatrist, or dentist (medical professional) to require a hospital to participate in alternative dispute resolution procedures or binding arbitration if the hospital's credentials committee has failed to take action on a completed application as required or a medical professional is subject to a professional review action that may adversely affect his medical staff membership or privileges and the medical professional believes that mediation of the dispute is desirable.

3. H.B. 3421 - Amends Section 204.155(b), Occupations Code relating to the licensure of physician assistants.

4. H.B. 3600 - Amends the Occupations Code relating to the confidentiality of records regarding the compliance monitoring of physicians by the TSBME.

5. S.B. 1024 - Amends the Occupations Code concerning immunity in connection with investigations under and enforcement of the law regulating the practice of podiatry.



6. S.B. 1166 - Amends Subsection (e), Section 157.053 of the Occupations Code relating to the authority of certain advanced practice nurses and physician assistants to prescribe drugs.

7. S.B. 1264 - Amends the Occupation Code relating to the scope of practice of a physician assistant acting in a delegated practice.

#### J. REPORTING REQUIREMENTS

1. H.B. 3335 - Amends Section 48.051(c), Human Resources Code, relating to duties and immunities of certain persons reporting that an elderly or disabled person is in a state of abuse, neglect, or exploitation.

#### K. TELEMEDICINE, TELEPHARMACY AND TELEDENTISTRY

1. H.B. 2700 - Amends Government Code by adding Sections 531.02171 and 531.02172 relating to certain services provided through telemedicine; requires pilot program for services near the Texas-Mexico border.

2. S.B. 65 - Authorizes a Class A or Class C pharmacy located in Texas to provide pharmacy services, including the dispensing of drugs, through a telepharmacy system in a facility that is not at the same location as the Class A or Class C pharmacy; provides that a telepharmacy system is required to be under the continuous supervision of a pharmacist as determined by rule of the Texas State Board of Pharmacy; provides that the pharmacist is not required to be physically present at the site of the telepharmacy system to qualify as continuous supervision; requires the pharmacist to supervise the system electronically by audio and video communication; authorizes a telepharmacy system to be located only at a health care facility in Texas that is regulated by this state or the United States; requires the board to adopt rules regarding the use of a telepharmacy system under this section, including certain rules; prohibits a telepharmacy system from being located in a community in which a Class A or Class C pharmacy is located; authorizes the telepharmacy system to continue to operate in the community if a Class A or Class C pharmacy is established in a community in which a telepharmacy system has been located under this section.

3. S.B. 789 - Amends the Government Code, the Health and Safety Code, the Insurance Code, the Utilities Code, and the Human Resources Code relating to the regulation and reimbursement of telemedicine medical services and teledentistry under the Medicaid program.

#### L. MISCELLANEOUS

1. H.B. 100 - Amends the Occupations Code relating to the regulation of certain health care activities using the Internet.

2. H.B. 1922 - Creates an individual's right to be informed regarding personal data collected by a state government body.

3. H.B. 2408 - Authorizes the Health Professions Council to conduct a study relating to the complaint procedures of certain health care regulatory entities.

4. H.B. 2600 - Amends the Labor Code relating to the provision of workers' compensation benefits and to the operation of the workers' compensation insurance system; providing penalties.

5. S.B. 583 - Authorizes hospital lien to include reasonable and necessary charges for emergency hospital care provided by physicians during first seven days of hospitalization minus charges for which the physician has received or is entitled to receive insurance benefits.

