



January 1996

## Health Care Law

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### Recommended Citation

Thomas Wm. Mayo, *Health Care Law*, 49 SMU L. REV. 1089 (1996)  
<https://scholar.smu.edu/smulr/vol49/iss4/17>

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Thomas Wm. Mayo\*

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## INTRODUCTION

The Seventy-fourth Legislative Session proved to be yet another in which the legislature devoted a great deal of its attention to health care law. The legislature continued the practice, established in two previous sessions, of interstitial reform of health care institutions and markets and also addressed managed care, tort reform, professional licensure and regulation, HIV, and patients' rights. At the same time, the

Texas Supreme Court and the courts of appeals focused primarily upon medical liability issues (including statutes of limitations and liability rules for stillbirth). In the federal courts, the United States Court of Appeals for the Fifth Circuit decided two cases—one dealing with Medicare reimbursement issues and the other with state funding of abortion—of potential significance for indigent care in Texas. This Article surveys these and other developments within the field of health care law in Texas that occurred between October 1, 1994, and September 30, 1995.

## I. HOSPITALS

### A. MEDICAL STAFF

The legislature expanded a hospital's medical staff procedural due process requirement from a duty owed to "applicants" to one owed to each "physician, podiatrist and dentist."<sup>1</sup> In addition, the legislature continued its long-standing policy of requiring equivalent treatment of osteopathic and allopathic physicians. Thus, hospitals are now prohibited from taking a physician's academic medical degree into consideration when comparing applications for staff membership or privileges.<sup>2</sup> Hospitals may use graduate medical education as a qualification standard for staff membership and privileges, but only if the hospitals give equal recognition to programs accredited by the Accreditation Council on Graduate Medical Education and by the American Osteopathic Association.<sup>3</sup> Similarly, hospitals may use board certification as a standard for staff membership or privileges, provided they give equal consideration to certification programs approved by the American Board of Medical Specialties and the Bureau of Osteopathic Specialists.<sup>4</sup>

Hospital credentials committees are now required to "act expeditiously and without unnecessary delay" when considering applications from physicians, podiatrists and dentists for staff membership and privileges.<sup>5</sup> The credentials committee must take action not later than ninety days after receipt of the application, and the governing board must take final action within sixty days after they receive the recommendation of the credentials committee. They must notify the applicant of the final decision (including the reason for any denial or restriction of privileges) within twenty days of taking final action.

### B. PHYSICIAN PRACTICE GUARANTEES

The legislature amended the Medical Practice Act to provide that the act does not prohibit a hospital from entering into an independent contractor agreement with a physician to provide services at the hospital or

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1. TEX. HEALTH & SAFETY CODE ANN. § 241.101(c) (Vernon Supp. 1996).

2. *Id.* § 241.101(f).

3. *Id.* § 241.101(g).

4. *Id.* § 241.101(h).

5. *Id.* § 241.101(i).

other health care facilities owned or operated by the hospital.<sup>6</sup> The hospital may: (1) pay a minimum guarantee to assure the physician's availability; (2) bill and collect the physician's professional fees from patients; or (3) retain the collected fees up to the amount of the guarantee plus a reasonable collection fee.<sup>7</sup> Before this amendment, only public hospitals and hospital districts and authorities were permitted to enter into these arrangements.

### C. NONPROFIT HOSPITALS

#### 1. *Charity Care*

The legislature imposed upon "hospital systems" the charity-care obligations that formerly were applicable only to nonprofit hospitals under Chapter 311 of the Health and Safety Code.<sup>8</sup> A "hospital system" is defined as "a system of local nonprofit hospitals under the common governance of a single corporate parent that are located within a radius of not more than 125 linear miles of the corporate parent."<sup>9</sup> In addition, the definition of "unreimbursed costs" was amended so that cost-to-charge ratios would be derived from "generally accepted accounting principles for hospitals" rather than from Medicare cost reports.<sup>10</sup>

Nonprofit hospitals have available to them five different methods for the calculation of their charity-care obligation.<sup>11</sup> One such method requires that, "beginning with the hospital's or hospital system's fiscal year starting after December 31, 1995," the entities must provide charity care and community benefits in a combined amount of at least five percent of their net patient revenue.<sup>12</sup> In order to prevent hospitals from finessing this requirement through creative fiscal calendaring, the legislature has prohibited hospitals and hospital systems from changing their existing fiscal year for purposes of meeting paragraph (1)(E)'s requirements.<sup>13</sup> An exception allows an entity to change its fiscal year if it changes its ownership or corporate structure in the event of a sale or merger.

#### 2. *"Charitable Purpose"*

Pursuant to section 11.18(d) of the Tax Code, a charitable organization must be organized exclusively for the performance of religious, charita-

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6. TEX. REV. CIV. STAT. ANN. art. 4495b, § 3.06(f) (Vernon Supp. 1996).

7. Of course, not-for-profit hospitals that are exempt from federal taxation must still observe the limitations on such arrangements that are imposed by virtue of federal tax laws. See Kenneth L. Levine, *The Tax Status of Vertically Integrated Health Care Delivery Systems*, 26 J. HEALTH & HOSP. L. 257, 261-62, 264-66 (1993) (private practice income guarantees subject to scrutiny under standards that focus on community need and reasonableness).

8. TEX. HEALTH & SAFETY CODE ANN. § 311.045(a) (Vernon Supp. 1996).

9. *Id.* §§ 311.031(12), 311.042(15).

10. *Id.* § 311.031(16).

11. See *id.* § 311.045(b)(1)(A)-(E).

12. *Id.* § 311.045(b)(1)(E).

13. TEX. HEALTH & SAFETY CODE ANN. § 311.045(b)(2).

ble, scientific, literary, or educational purposes.<sup>14</sup> With an eye toward encouraging hospitals to serve low-population and low-income areas, the legislature has added two new ways for a hospital to qualify as a charitable organization. First, a hospital that is operated on a nonprofit basis and is located in a county that has fewer than 50,000 people, and has been designated as a "health professionals shortage area," is considered to be in compliance with the standards of section 11.18(d).<sup>15</sup> Additionally, a hospital that provides health care services to in- or out-patients and does not receive payment for those services from any source is deemed to be in compliance with section 11.18(d).<sup>16</sup>

### 3. Tax Exemptions

The legislature has relaxed the standards for charitable exemptions from state sales, excise, and use taxes. For example, the legislature deleted language so that a nonprofit hospital is exempted from these taxes whether or not the hospital receives any payment for the health care services it provides to patients.<sup>17</sup>

Another exemption to the sales tax requires nonprofit hospitals that are exempt from federal taxes under I.R.C. § 501(c)(3) to satisfy the same charity-care obligation that is imposed upon them by Chapter 311 of the Health and Safety Code.<sup>18</sup> In addition to the five methods prescribed by the Health and Safety Code, however, are three methods of providing charity care and community benefits not mentioned in the Health and Safety Code.<sup>19</sup> One of the Tax Code's unique methods has been amended to read as follows: "a nonprofit hospital that has been designated as a disproportionate share hospital under the state Medicaid program *in the current year* or in either of the previous two fiscal years is considered to have provided a reasonable amount of charity care and government-sponsored indigent health care" and is considered to be eligible for the exemption.<sup>20</sup> This change allows a hospital to qualify as nonprofit more quickly than before, again encouraging hospitals to function as nonprofit entities and to treat individuals who qualify for Medicaid benefits.<sup>21</sup>

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14. TEX. TAX CODE ANN. § 11.18(d) (Vernon 1992).

15. *Id.* § 11.18(d)(1)(G) (Vernon Supp. 1996).

16. *Id.* § 11.18(d)(1)(H). "Any source" includes the patient, any person legally obligated to support the patient, third-party payors, Medicare, Medicaid, or any other state or local indigent care program. It does not include charitable donations, legacies, bequests, or research grants or payments. *Id.*

17. TEX. TAX CODE ANN. § 151.310(a) (Vernon Supp. 1996).

18. *See id.* § 151.310(e).

19. *Compare* TEX. HEALTH & SAFETY CODE ANN. § 311.045(b)(1)(A)-(E) (Vernon Supp. 1996), *with* TEX. TAX CODE ANN. § 151.310(e)(1)-(8) (Vernon Supp. 1996).

20. TEX. TAX CODE ANN. § 151.310(e)(6) (Vernon Supp. 1996) (emphasis added).

21. Other amendments to the sales-tax-exemption provision of the Tax Code parallel amendments to the Health & Safety Code and the Tax Code already described in the text. *See* TEX. TAX CODE ANN. § 151.310(e)(7) (Vernon Supp. 1996) (nonprofit hospital is eligible for exemption if it is located in a county with a population under 50,000 and has been designated a "health professionals shortage area"); *id.* § 151.310(e)(8) (nonprofit hospital

## D. CONCEALED HANDGUNS

Now that it is lawful in Texas to carry a concealed handgun (after qualifying and receiving a license to do so),<sup>22</sup> it has become necessary to delineate where and when it may be unlawful to exercise this right. The legislature has made it clear that it is unlawful to carry a concealed handgun into a Chapter 241 hospital<sup>23</sup> or nursing home without the written authorization of the administration.<sup>24</sup> Hospitals and nursing homes are required to post signs, in both English and Spanish, advising persons that it is unlawful to carry a handgun on the premises.<sup>25</sup>

## II. LONG-TERM CARE

### A. ALZHEIMER'S SERVICES

The legislature has added new requirements for facilities that market services to residents with Alzheimer's disease and related disorders.<sup>26</sup> Facilities are required to display a disclosure statement that includes information concerning the facility's philosophy of care, staffing ratios, resident assessments and activities, and assessment costs. Failure to comply with this requirement will subject the facility to an administrative penalty; it may not be the basis for license revocation or suspension.<sup>27</sup>

### B. ELDERLY AND DISABLED—PROTECTIVE SERVICES

The legislature amended the Human Resources Code to expand its definitions of abuse and neglect. As a result, "abuse" includes not only the wilful infliction of harm but negligent infliction as well,<sup>28</sup> *emotional* harm or pain as well as physical harm,<sup>29</sup> and sexual abuse.<sup>30</sup> The definition of "neglect" has been amended to make it clear that failure to provide medical services constitutes neglect.<sup>31</sup> In addition, the "neglect" statute focuses upon "emotional harm or pain" rather than the previous terms of "mental anguish" or "mental illness."<sup>32</sup>

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is eligible for exemption if it provides inpatient and outpatient services and does not receive payments for these services from any source); *id.* § 171.063(a) (providing for exemption from franchise tax on same basis as sales-tax exemption); *id.* §§ 11.18(d), 151.310(e), 171.063(a) (nonprofit hospitals cannot change their fiscal year for purposes of complying with requirements for exemption, except in connection with sale or merger).

22. See TEX. REV. CIV. STAT. ANN. art. 4413(29ee) (Vernon Supp. 1996).

23. Cf. TEX. HEALTH & SAFETY CODE ANN. ch. 241 (Vernon 1992) (providing for the licensure of general and special hospitals).

24. TEX. PENAL CODE ANN. § 46.035(b)(4) (Vernon Supp. 1996).

25. TEX. REV. CIV. STAT. ANN. art. 4413(29ee), § 31(b)-(c) (Vernon Supp. 1996).

26. See TEX. HEALTH & SAFETY CODE ANN. §§ 242.204-.210 (Vernon Supp. 1996).

27. *Id.* § 242.203.

28. TEX. HUM. RES. CODE ANN. § 48.002(2)(A) (Vernon Supp. 1996).

29. *Id.*

30. *Id.* § 48.002(2)(B).

31. *Id.* § 48.002(4).

32. *Id.*

### C. WHISTLEBLOWER PROTECTION FOR RESIDENTS

A recent change to the Human Resources Code prohibits a convalescent or nursing home from discriminating or retaliating against a resident if the resident, the resident's guardian, or any other person reports abuse or neglect.<sup>33</sup> The bill entitles a person who is retaliated or discriminated against to sue for injunctive relief, actual damages, exemplary damages, court costs, and reasonable attorney's fees.<sup>34</sup>

## III. LICENSURE AND PRACTICE

### A. PHYSICIANS

#### 1. *Scope of Licensure*

The legislature amended the Texas Medical Practice Act to except a legally qualified physician of another state from the requirements of the Act (including licensure) if the physician is in the state for consultation with Texas-licensed physicians. The out-of-state physician must not have an office in Texas or appoint a place in Texas for seeing, examining, or treating patients.<sup>35</sup> The legislature adopted a similar position on the subject of telemedicine. It amended the Medical Practice Act to provide that a person physically located in another jurisdiction is engaged in the practice of medicine in Texas if he or she, through the use of any medium (including an electronic medium), performs an act or is part of a patient-care service initiated in Texas that would affect the diagnosis or treatment of the patient.<sup>36</sup> This provision does not apply to: (1) medical specialists who provide only episodic consultation services on request to a licensed person practicing in the same medical specialty; (2) physicians providing consultation services to a medical school; or (3) physicians providing consultation services to specified educational institutions.<sup>37</sup>

#### 2. *Unaccredited Medical Schools*

The Medical Practice Act was also amended to clarify that an applicant for a medical license whose medical education in the United States (allopathic or osteopathic<sup>38</sup>) was not accredited is eligible for an unrestricted

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33. TEX. HEALTH & SAFETY CODE ANN. § 242.1335(a) (Vernon Supp. 1996).

34. *Id.* § 242.1335(b).

35. TEX. REV. CIV. STAT. ANN. art. 4495b, § 3.06(b)(11) (Vernon Supp. 1996).

36. *Id.* § 3.06.

37. *Id.*

38. The legislature has amended the Medical Practice Act in a manner that distinguishes between "medical" and "osteopathic." See *id.* § 3.04(a)(4) ("medical or osteopathic school or college"). See also TEX. HEALTH & SAFETY CODE ANN. § 102.009(c) (Vernon 1992) ("medical and osteopathic schools"). This is, one hopes, due to inadvertence and not any intention to backslide to a time when many in this state distinguished between osteopathy and "real medicine." In § 3.04(d) of the Medical Practice Act, the legislature distinguishes between "medical" and "osteopathic medical education," which is less odious but still conveys a whiff of the "real medical" vs. "osteopathic medical" distinction, particularly when compared to the language it replaced: "allopathic or osteopathic medical education."



license if the applicant: (1) received his or her medical education in a hospital or a teaching institution participating in a program of graduate medical education accredited by the American Council for Graduate Medical Education, the American Osteopathic Association, or the Board of Medical Examiners; or (2) is specialty board-certified by a board approved by the American Osteopathic Association or the American Board of Medical Specialties.<sup>39</sup>

### 3. *Impaired Physicians*

Pursuant to a recent amendment to the Medical Practice Act, the Texas State Board of Medical Examiners is authorized to impose a nondisciplinary rehabilitation order on any licensee or, as a prerequisite for issuing the license, on any applicant, based on impairment.<sup>40</sup> Any such order is confidential and not subject to the Open Records Law.

#### B. DENTISTS

After allowing the State Board of Dental Examiners to fade into the sunset in 1994,<sup>41</sup> the legislature reestablished the Board in 1995.<sup>42</sup> The bill requires the Board to set up examinations for all applicants<sup>43</sup> and mandatory continuing education requirements,<sup>44</sup> establishes procedures for handling complaints,<sup>45</sup> and provides for administrative penalties.<sup>46</sup> The Board is also required to approve and certify any health organization that employs dentists, on proof that the organization is a nonprofit section 501(c)(3) entity and a migrant, community, or homeless health center.<sup>47</sup>

#### C. PHARMACISTS

The legislature expanded the Pharmacy Act's definition of the practice of pharmacy to include performance of drug therapy management by delegation on written protocol from a physician.<sup>48</sup> The Act now provides that a physician may delegate the performance of specific acts of drug therapy management<sup>49</sup> to a pharmacist "acting under adequate physician supervision."<sup>50</sup>

39. TEX. REV. CIV. STAT. ANN. art. 4495b, § 3.04(f) (Vernon Supp. 1996).

40. *Id.* § 3.081.

41. The State Board of Dental Examiners was allowed to go out of existence pursuant to the Texas Sunset Act. TEX. GOV'T CODE ANN. ch. 325 (Vernon 1988).

42. See Act of 1995, 74th Leg., R.S., ch. 2, § 21, 1995 Tex. Gen. Laws 21 (1995).

43. TEX. REV. CIV. STAT. ANN. art. 4544, § 1 (Vernon Supp. 1996).

44. *Id.* § 5.

45. *Id.* art. 4548h, § 1.

46. *Id.* art. 4548j.

47. *Id.* art. 4551n.

48. TEX. REV. CIV. STAT. ANN. art. 4542a-1, § 5(38)(F) (Vernon Supp. 1996).

49. The specific acts must be set out in the supervising physician's order, standing medical order, standing delegation order, or other order or protocol as defined by the Texas Board of Medical Examiners. *Id.* art. 4495b, § 3.061.

50. "Adequate physician supervision" means the delegating physician: (1) must remain responsible for the formulation or approval of the order or protocol; (2) has an estab-

## D. PHYSICIAN ASSISTANTS (AND OTHER HEALTH PROFESSIONALS)

### 1. Licensure and Regulation

The legislature has now completed the slow process by which physician assistants ("P.A.s") have achieved full status as an autonomous allied health specialty. In 1993 the 73rd Legislature moved the regulatory provisions applicable to P.A.'s from the Medical Practice Act to the Physician Assistant Licensing Act.<sup>51</sup> The 74th Legislature has now established a separate State Board of Physician Assistant Examiners (rather than an Advisory Council within the Board of Medical Examiners).<sup>52</sup> In addition, the legislature shifted the legal responsibility for a P.A. employed by a physician or a group of physicians from the "employing" physician to the "supervising" physician.<sup>53</sup> The Physician Assistant Licensing Act was also amended to include provisions on confidentiality of Board files,<sup>54</sup> subpoenas,<sup>55</sup> immunity for furnishing information,<sup>56</sup> and nondisciplinary rehabilitation orders.<sup>57</sup>

### 2. Prescription Authority

The legislature has amended the Medical Practice Act to permit physicians to delegate to P.A.s the authority to sign prescription drug orders for dangerous drugs in medically underserved areas.<sup>58</sup> In addition, delegation is authorized at the delegating physician's primary practice site or, for a physician whose practice is based in a licensed hospital or long-term care facility, at the facility if the physician meets certain qualifications.<sup>59</sup> P.A.s offering obstetrical services may also be delegated the administration or providing of controlled substances.<sup>60</sup> The primary-practice-site and obstetrical delegations are limited to three P.A.s.<sup>61</sup> Finally, the phy-

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lished physician-patient relationship with the patient; (3) is geographically located to be able to be physically present daily to provide medical care and supervision; (4) periodically reviews the pharmacist's order; (5) receives periodic status reports on the patient; and (6) is available to the pharmacist for consultation, assistance, and direction. *Id.* art. 4495b, § 3.061(b). The physician may only delegate these duties to a pharmacist once the physician has established a physician-patient relationship and only if the physician is able to be present daily to provide medical care and supervision for the patient.

51. *See id.* art. 4495b-1 (Vernon Supp. 1996).

52. *Id.* §§ 1, 4-5.

53. TEX. REV. CIV. STAT. ANN. art. 4495b-1, § 17 (Vernon Supp. 1996).

54. *Id.* § 25.

55. *Id.* § 27.

56. *Id.* § 28.

57. *Id.* § 20.

58. TEX. REV. CIV. STAT. ANN. art. 4495b, § 3.06(d)(5)(A)-(B) (Vernon Supp. 1996).

59. *Id.* § 3.06(d)(6)(A), (H).

60. *Id.* § 3.06(d)(6)(J).

61. *Id.* § 3.06(d)(6)(F)(i), (J)(iv)(a). Advanced nurse practitioners are given similar authority to sign prescriptions pursuant to delegation at a physician's primary practice site, and nurse midwives are given similar authority to sign prescriptions within an obstetrical practice. *See id.* § 3.06(d)(6)(A), (J). The reference in the text to three P.A.s includes three P.A.s or advanced nurse practitioners (primary-practice-site delegation), and three P.A.s or nurse midwives (obstetrical-service delegation).

sician is not liable for the acts of the P.A.<sup>62</sup> solely on the basis of having signed an order or protocol delegating the signing or carrying out of a prescription drug order, unless the physician has reason to believe the P.A. lacked the necessary competency.<sup>63</sup>

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62. The rule also applies to the physician's liability for the acts of advanced nurse practitioners (including, presumably, nurse midwives). See TEX. REV. CIV. STAT. ANN. art. 44956, § 3.06(d)(6)(K) (Vernon Supp. 1996).

63. *Id.* § 3.06(d). Numerous other health professionals were affected by laws enacted during the last legislative session. Some of the more significant ones are noted below.

*Advanced Nurse Practitioners.* As indicated above, see *supra* note 61, advanced nurse practitioners (including nurse midwives in the context of obstetrical services) were given the same authority to sign prescriptions for either dangerous or controlled substances on the same basis as physician assistants. See *id.* § 3.06(d)(5)(A), (6)(A). Specific provisions on certified registered nurse anesthetists allow physicians to delegate the ordering of drugs and devices necessary to administer anesthesia in licensed hospitals or ambulatory surgery centers. See *id.* § 3.06(d)(6)(I)(i). The physician's order is not required to be specific as to drug, dose, or administration technique, but selection and administration must be in accord with facility policies or medical staff bylaws.

*R.N.s and LVNs.* The legislature changed the statute on "professional nursing peer review committees" to "nursing peer review committees," see TEX. REV. CIV. STAT. ANN. art. 4525b, § 1(1) (Vernon Supp. 1996), which are now authorized to review the quality of care rendered by licensed vocational nurses ("LVNs") as well as registered nurses ("R.N.s"). See *id.* § 1(3), (4). If a nursing peer review committee undertakes the review of LVNs, the law specifies the composition of the committee and when R.N.s and LVNs may vote on matters before the committee. *Id.* § 1A. The law prohibits retaliation against an RN who refuses to engage in conduct that would be reportable to the Board of Nurse Examiners. *Id.* art. 4525d. The law also revises the licensure requirements for LVNs, TEX. REV. CIV. STAT. ANN. art. 4528c, § 6(a), (d) (Vernon Supp. 1996), and allows the licensing board to temporarily suspend the license of an LVN. *Id.* § 10G.

*Podiatrists.* The legislature changed the name of the licensing agency to Texas State Board of Podiatric Medical Examiners, *id.* art. 4567, § (b)(1), and made complaint and investigation files confidential, *id.* art. 4573, § (j), among many other changes to the licensing and regulatory laws applicable to podiatrists.

*Psychologists.* The legislature amended the psychologist licensing statute and, among other things, made the licensing agency's complaint and investigation materials confidential. See *id.* art. 4512c, § 25A(e).

*Professional Counselors.* The legislature amended the Licensed Professional Counselor Act to add a definition of "counseling treatment intervention" and of the "practice of professional counseling," and modified the required applicant qualifications.

TEX. REV. CIV. STAT. ANN. art. 4512g, § 2(6), (7) (definitions), § 10 (applicant qualifications) (Vernon Supp. 1996). Additionally, the bill provides for specialization in art therapy. *Id.* § 10A.

*Perfusionists.* The legislature clarified that when a licensed perfusionist is not reasonably available to provide supervision to a provisional licensed perfusionist, the supervision may be performed by a physician certified by the American Board of Thoracic Surgeons or certified in cardiovascular surgery by the American Osteopathic Board of Surgery. *Id.* art. 4529e, § 14(b).

*Radiologic Technologists.* The legislature added a definition of "direct supervision" to the Medical Radiologic Technologist Certification Act and mandated the inclusion of training guidelines for persons who are not licensed but acting under supervision. See *id.* art. 4512m, § 2.03(13) (definition), § 2.05(f). The Texas Department of Health is required to identify radiologic procedures that may only be performed by a practitioner or medical radiologic technologist. *Id.* § 3.05(g).

*Medication Aides.* Individuals are now eligible to be certified as a medication aide once they have been employed by a licensed personal care facility for at least 90 days and have completed the required course of study and examination. See TEX. HEALTH & SAFETY CODE ANN. § 247.026(e) (Vernon Supp. 1996).

### 3. Determination and Pronouncement of Death

The legislature added P.A.s to a statute that had given registered nurses authority to determine and pronounce a person dead if their place of employment has a policy permitting this.<sup>64</sup> The law requires that if such a policy exists, it "must include physician assistants who are credentialed or otherwise permitted to practice at the facility, institution, or entity."<sup>65</sup>

#### E. CHEMICAL DEPENDENCY PROGRAMS—EXEMPTIONS

The legislature added certain "twelve-step programs" to the list of programs that are exempt from the licensure requirements of the Texas Commission on Alcohol and Drug Abuse.<sup>66</sup> In order to qualify for the exemption, the program must: (1) not offer or purport to offer a chemical dependency treatment program; (2) not charge program participants; and (3) allow participants to maintain anonymity.

## IV. MEDICAL RECORDS

### A. DISCLOSURE

The legislature has provided that hospitals may not disclose patient health care information without a written patient authorization except under certain limited circumstances,<sup>67</sup> and that the authorization is valid

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64. TEX. HEALTH & SAFETY CODE ANN. § 671.001(d) (Vernon Supp. 1996). *See also id.* § 671.002 (adding P.A.s to limitation of liability provision).

65. *Id.* § 671.001(d).

66. *Id.* § 464.003(7).

67. TEX. HEALTH & SAFETY CODE ANN. § 241.152(a) (Vernon Supp. 1996) (prohibiting disclosure). The statute describes ten exceptions in which the patient's written authorization is not required, including disclosure: (1) to a health care provider who is rendering health care to the patient at the time the request is made; (2) in connection with hospital peer review, quality assurance, or the hospital's compliance with statutory, regulatory, accreditation, or certification requirements (subject to certain conditions); (3) to a governmental agency or authority, to the extent authorized or required by law; (4) for use in a research project approved by an institutional review board under federal law; (5) to facilitate payment by a health benefit plan; and (6) pursuant to a court order or subpoena. *Id.* § 241.153.

By tightening up on the disclosure of medical information, the legislature has, perhaps unintentionally, set the stage for some very difficult interpersonal conflicts, and it may have created an incentive to depart from the prevailing standard of care. Absent the patient's authorization (or, if the patient is incompetent, the authorization of the legal representative), the request of parents, adult children, and others who ask for medical information must be denied. Thus, if a patient's "significant other" is named as the patient's agent in a durable power of attorney for health care, only that person may be given medical information about the patient unless that person gives permission for others (e.g., parents, adult children, or others) to be told. Ironically, it is those "others"—next of kin—who will be responsible for making burial arrangements if the patient dies, even though they may never be told medical information about the disease or accident that was the cause of death. Family members who will be responsible for caring for the incompetent patient at home are not included within the statute's list of persons who may be told medical information about the patient. Moreover, many nursing specialties emphasize that the patient and the patient's family all must be "treated" when there is a medical crisis. Family therapy in these circumstances usually means providing enough information and comfort that the family can begin to understand and then to cope with the medical crisis at hand. Absent

for only ninety days unless it provides otherwise.<sup>68</sup> Within fifteen days of the request, the hospital must disclose the information or make the information available for inspection and copying.<sup>69</sup> The legislature has established a maximum fee schedule, and hospitals may insist on prepayment before disclosure or inspection and copying, unless there is a medical emergency.<sup>70</sup> In addition, hospitals are now statutorily obligated to implement reasonable safeguards for the security of health care information.<sup>71</sup> In the event of unauthorized release, the statute now provides for a private cause of action for injunctive relief and for damages.<sup>72</sup>

The legislature also revised provisions of the Medical Practice Act relating to disclosures. The statute now requires physicians to release copies of records received from another physician or health care provider, as well as their own.<sup>73</sup> Physicians may charge a reasonable fee for copying medical records, and the Board of Medical Examiners is required to promulgate a rule that prescribes what constitutes reasonable fees.<sup>74</sup>

### B. SEX OFFENDERS

The legislature has provided for "sex offender information exchange," which allows certain health care professionals to release information to law enforcement agencies regarding the treatment of a sex offender.<sup>75</sup> A health care provider who releases information to law enforcement agencies is not liable for damages arising from the disclosure.<sup>76</sup>

### C. MEDICAL RECORD FEES

The legislature amended the Health and Safety Code to provide that a health care provider (including a health care facility) may not charge a fee to a patient: requesting medical or mental health records for use in: (1) applying for disability benefits or assistance under certain federal or state programs; or (2) appealing the denial of those benefits or assistance.<sup>77</sup> Fees may be charged if the agency requests the records.

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express written authorization from the patient's legal representative, this kind of communication may be unlawful.

68. *Id.* § 241.152(c).

69. *Id.* § 241.154.

70. TEX. HEALTH & SAFETY CODE ANN. § 241.154(b)(1) (Vernon Supp. 1996).

71. *Id.* § 241.155.

72. *Id.* § 241.156.

73. TEX. REV. CIV. STAT. ANN. art. 4495b, § 5.08(k) (Vernon Supp. 1996). The legislature clarified that a patient cannot maintain a cause of action against a physician for improper disclosure if the physician did not have written notice that the authorization was revoked. See TEX. HEALTH & SAFETY CODE ANN. § 611.007(c) (Vernon Supp. 1996).

74. TEX. REV. CIV. STAT. ANN. art. 4495b, § 5.08(o), (p) (Vernon Supp. 1996).

75. *Id.* art. 4512g-1. A "sex offender" is defined as "a person who has been convicted or has entered a plea of guilty or nolo contendere for" any of a number of sex offenses in the Penal Code. *Id.* § 1(3); TEX. CODE CRIM. PROC. ANN. art. 42.12, § 9(m) (Vernon Supp. 1996).

76. TEX. REV. CIV. STAT. ANN. art. 4512g-1, § 5 (Vernon Supp. 1996).

77. TEX. HEALTH & SAFETY CODE ANN. § 161.202 (Vernon Supp. 1996).

#### D. PODIATRISTS

The legislature created a new health care provider privilege. Communications between a podiatrist and patient, and records created or maintained by a podiatrist concerning professional services rendered to the patient, are confidential and privileged and may not be disclosed except as authorized by the statute.<sup>78</sup> Either the patient or the podiatrist acting on a patient's behalf may claim the privilege.<sup>79</sup> The statute provides for numerous exceptions, including various civil, criminal, and administrative proceedings.<sup>80</sup>

#### E. BLOOD DONORS

In *Tarrant County Hospital District v. Curry*,<sup>81</sup> the Supreme Court of Texas conditionally granted mandamus to prevent the disclosure of a blood donor's birth date. The underlying wrongful death suit against a blood bank and a physician alleged that inadequate screening procedures allowed HIV-contaminated blood to be used in a transfusion. Deposition testimony and medical records suggested that the donor knew she was HIV-positive when she donated the blood. Plaintiffs sought the birth date of the donor on the theory that it would add to a sequence of facts tending to show that the defendants should have known that the donor was HIV positive.

The Court held that disclosure of the birth date would effectively identify the donor in violation of the Health & Safety Code, which provides that a court "may not disclose to any other person the name of the donor or any other information that could result in the disclosure of the donor's identity."<sup>82</sup> The statute overturns old case law that had allowed the disclosure of the identity of blood donors unless: (1) there was a societal interest which would override a plaintiff's right to discover; (2) the plaintiff could not prosecute the cause of action without the information; or (3) the defendant could show that the plaintiff intended to use the information improperly.

### V. MEDICAL LIABILITY

#### A. RECUSAL—TEXAS SUPREME COURT

In *Rogers v. Bradley*,<sup>83</sup> the Texas Supreme Court denied the petitioner's (Rogers') motion to recuse four of the justices<sup>84</sup> from participating in a medical malpractice case. Rogers' basis for the recusal motion was that the four justices were depicted (albeit without their agreement)

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78. TEX. REV. CIV. STAT. ANN. art. 4547d, § 2(a) (Vernon Supp. 1996).

79. *Id.* § 3(a).

80. *Id.* §§ 4-5.

81. 907 S.W.2d 445 (Tex. 1995).

82. TEX. HEALTH & SAFETY CODE ANN. § 162.101(e) (Vernon 1992).

83. 909 S.W.2d 872 (Tex. 1995).

84. The motion to recuse named Justices Hightower, Hecht, Cornyn, and Enoch. *Id.* at 879.

in a video produced by TEX-PAC, the Texas Medical Association's political action committee. The video was an attempt by TEX-PAC to convince viewers to elect the four justices (among others) because, TEX-PAC asserted, these justices would ultimately help the professional and personal lives of Texas physicians.

Of particular concern to Rogers was the fact that his opponent in the case, Brian Bradley, also appeared in the TEX-PAC video. In the video, Bradley, a physician, discussed Rogers' case against him, and Bradley was portrayed as being hopeful, even though the case was potentially damaging to his career, because he "ha[d] a Supreme Court he can appeal to" if TEX-PAC's chosen judicial candidates were elected.<sup>85</sup>

The four justices who were the subject of Rogers' recusal motion denied the motion; Justice Gammage, who was not one of the four (but who was portrayed favorably by TEX-PAC), did recuse himself from the case.<sup>86</sup> According to Justice Gammage, "a reasonable member of the public . . . would doubt that the justices portrayed favorably in the TEX-PAC video are actually impartial."<sup>87</sup>

In a concurring opinion, Justice Enoch explained his reasons for denying the recusal motion. Pointing out that it was TEX-PAC's unilateral act that placed the justices' images in the video, Justice Enoch stated that in the tests for recusal used by all jurisdictions, "[i]t is the conduct of the judge that is being examined, not the conduct of some third party."<sup>88</sup> If a judge has not taken any action that provides a basis for recusal, then recusal is not only unnecessary but unacceptable, because "[a]ll judges have a duty to sit and decide matters brought before them, unless there is a basis for disqualification or recusal."<sup>89</sup>

Justice Enoch wrote that in Texas, where judges are elected to office, it is unavoidable that citizen groups will support judicial candidates for office, and if judges recuse themselves merely because they have been endorsed by politically active groups, the result will be a chilling effect on citizen involvement in the political process: "Citizens' political speech would be unacceptably regulated if they had to fear that their efforts in support of a political candidate, even for judicial office, would remove that candidate from his or her official duties if elected."<sup>90</sup> Although Justice Enoch expressed his disapproval of Texas' judicial selection system,<sup>91</sup> he argued that the system would be unworkable if Justice Gammage's approach were adopted by the court: "Under [Justice Gammage's] rea-

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85. *Id.* at 887 (statement of Kim Ross).

86. *Id.* at 874.

87. *Id.*

88. *Rogers*, 909 S.W.2d at 880.

89. *Id.* at 879.

90. *Id.* at 882.

91. *Id.* (stating that he "deplores" the system) and *id.* at 884 (blaming the system for "plac[ing] intolerable tensions between the process by which judges are chosen and the obligations they must discharge once in office"); see also Justice Craig Enoch, 1995 *Annual Survey of Texas Law: Foreword*, 48 SMU L. REV. 723 (1995) (discussing problems inherent in politicization of the judiciary).

soning, only judges who faced no election opposition would be able to fully perform the functions of their office. Judges who defeated well-financed election opposition with strong broad-based support would be virtually removed from the duties of the office to which they were elected."<sup>92</sup>

#### B. EXISTENCE OF PHYSICIAN-PATIENT RELATIONSHIP

The threshold inquiry in any medical malpractice case is whether the health care provider owed a duty to the plaintiff. To prove the existence of a duty when the defendant in a malpractice case is a physician, the plaintiff must first establish that there was a physician-patient relationship. When no prior relationship exists between the doctor and patient, as is often the case with on-call doctors, a physician-patient relationship is established only if the physician takes some affirmative act toward the patient. For example, the physician must see or talk to the patient, or must discuss the patient's condition with other medical professionals and recommend a treatment, before the courts will find that a physician-patient relationship exists. The mere fact that a physician is "on call" is not sufficient to establish a professional relationship between the on-call physician and a patient who enters the hospital.

Accordingly, Texas courts have held that there is no physician-patient relationship between a patient who enters a hospital emergency room (the "ER") and a physician who is on call when the patient is treated but who does not participate in the patient's treatment.<sup>93</sup> The extent of participation required does not have to involve the physician going to the ER to see the patient; rendering medical treatment over the telephone is sufficient to establish a professional relationship. Thus, if the telephone conversation between the physician and the ER staff involves the physician discussing the patient's medical condition and then rendering a medical opinion about how the patient should be treated, the courts will find that a physician-patient relationship has been established.<sup>94</sup> But if the telephone conversation consists of the physician merely receiving information that a certain patient has entered the ER, and the physician does not recommend how the patient should be treated and does not go to the ER to treat the patient, no professional relationship will be found.

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92. *Rogers*, 909 S.W.2d at 884.

93. See, e.g., *Ortiz v. Shah*, 905 S.W.2d 609 (Tex. App.—Houston [14th Dist.] 1995, writ denied) (holding that no professional relationship existed between an on-call physician and an ER patient when the physician merely received information that the patient was in the ER and agreed to see the patient, but the patient died before the physician could see, talk to, or recommend treatment for the patient); *Wheeler v. Yettie Kersting Memorial Hosp.*, 866 S.W.2d 32 (Tex. App.—Houston [1st Dist.] 1993, no writ) (holding that the mere fact that a physician is on call does not create a duty, but ultimately finding a physician-patient relationship under the facts of that case).

94. See *Ortiz*, 905 S.W.2d at 611 (absence of advice-giving or other affirmative act disproves physician-patient relationship); cf *Hand v. Tavera*, 864 S.W.2d 678 (Tex. App.—San Antonio 1993, no writ) (finding a physician-patient relationship where the physician was under a contract with an HMO to treat ER patients, and where he discussed a patient's condition with the ER staff and then recommended a pain reliever for the patient).



The line in Texas appeared reasonably clear before 1995: the mere receiving of information that a patient was in the ER was not enough of an affirmative act to create a physician-patient relationship; the discussion of the patient's medical condition and the recommending of a course of treatment for the patient was enough. However, in the 1995 case of *St. John v. Pope*,<sup>95</sup> the Texas Supreme Court appears to have blurred that line.

In that case, the plaintiff ("Pope") went to the ER at Central Texas Medical Center in San Marcos ("Center") suffering from back pain and fever.<sup>96</sup> After examining Pope, the ER physicians called Dr. Holland St. John ("St. John"), an internist on call. St. John discussed Pope's condition with the ER physicians and learned that Pope had recently undergone back surgery and epidural injections, and that he had a very high white blood cell count. St. John recommended that the ER physicians send Pope either to a hospital with a neurosurgeon (the Center did not have such a specialist) or to the physician who had performed Pope's back surgery.<sup>97</sup>

The Center's ER physicians then contacted the hospital where Pope's back surgeon practiced, but that hospital refused to accept Pope. Pope left the Center, against the advice of the ER physicians, and went to another hospital the following day. At the second hospital, physicians performed a lumbar puncture and discovered that Pope had meningitis. Pope developed permanent disabilities from the meningitis, and he sued the Center ER physicians, including St. John, for failing to exercise professional care. Pope presented evidence showing that St. John should have recognized that Pope might have meningitis, that St. John was qualified to perform the lumbar puncture himself, and that he was therefore negligent in recommending that Pope be referred to another hospital instead of treating Pope.<sup>98</sup> This evidence did not sway the Supreme Court, however, which found that no physician-patient relationship existed between Pope and St. John.<sup>99</sup>

The Court explained that physicians, like all professionals, are not obligated to render services to anyone who asks, and that a professional relationship is established only when the physician consents to its establishment.<sup>100</sup> If the physician declines to treat a patient, he has clearly not consented to the establishment of a professional relationship, and therefore none exists. Because St. John declined to treat Pope, the Court concluded that no physician-patient relationship was established.

That St. John was qualified to treat Pope was immaterial to the Court; it stated that "a physician may decline treatment and thereby decline to create a physician-patient relationship, even on the basis of an erroneous

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95. 901 S.W.2d 420 (Tex. 1995).

96. *Id.* at 421.

97. *Id.* at 422.

98. *Id.*

99. *Id.* at 424.

100. *Pope*, 901 S.W.2d at 423.

conclusion that the patient's condition is beyond his or her ability to treat."<sup>101</sup> The Court also noted that St. John's discussion of Pope's medical condition with the ER physicians was not enough to establish a professional relationship. In the Court's view, St. John's discussion of Pope's condition served only to help St. John determine if he should take or decline the case; the discussion was not intended to lead St. John to a diagnosis of Pope's condition.<sup>102</sup>

Before *Pope*, the content of the physician's telephone call with the ER staff easily determined whether or not a physician-patient relationship was established. The mere reception of information was not enough to create the relationship, but the discussion of the patient's medical condition, combined with the making of a recommendation about the patient, was enough. According to this pre-*Pope* line of cases, the facts of *Pope* fit into the latter category. St. John did more than simply receive information about Pope—he discussed Pope's medical condition and also recommended that Pope be treated by a specialist. Indeed, in *Ortiz*, the Houston Court of Appeals classified *Pope* as belonging in the latter category, describing *Pope* as a case where the on-call physician "discussed [the] case over the telephone with [the ER] physician, and gave advice on how [the] patient should be treated."<sup>103</sup>

It can also be argued that *Pope* fits just as easily into the first category because, as the Supreme Court stated, St. John did not diagnose Pope and did not affirmatively agree to take medical responsibility for Pope; instead, St. John refused to see Pope. The determinative factor may be the definition of "rendering medical advice." The Supreme Court clearly regarded St. John's suggestion of a transfer as not constituting medical advice. It is apparent, however, that the ER physicians gave credence to St. John's suggestion that Pope see a specialist. After all, once they heard that St. John felt Pope needed a specialist, the ER physicians did not attempt to convince Pope to stay for more tests. Arguably, St. John's suggestion served as medical advice to the ER physicians to cease their inquiry into Pope's problems. If St. John had not made his suggestion, it is possible that the ER physicians would have continued to examine Pope and would have ultimately tested him for meningitis. Obviously, it is not certain that the ER physicians would have discovered Pope's meningitis: what does seem certain, though, is that the physicians discontinued testing Pope and allowed him to leave because St. John advised that there was nothing the Center could do for Pope.

### C. STATUTE OF LIMITATIONS

#### 1. Wrongful Death—Choice of Statute

Before the Texas Supreme Court's decision this past year in *Bala v.*

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101. *Id.*

102. *Id.* at 424.

103. *Ortiz*, 905 S.W.2d at 611 (citing the court of appeals opinion in *Pope v. St. John*, 862 S.W.2d 657 (Tex. App.—Austin 1993), *rev'd*, 901 S.W.2d 420 (Tex. 1995)).

*Maxwell*<sup>104</sup> there was a division among the courts of appeals on the issue of whether, in a wrongful death suit that involved health care liability, the governing statute of limitations was to be found in the Medical Liability and Insurance Improvement Act<sup>105</sup> ("Medical Liability Act") or the Civil Practice and Remedies Code<sup>106</sup> ("CPRC"). The former statute provides that limitations start to run at the time of the alleged medical negligence, while the latter provides that limitations do not run until the date of death of the decedent who is the subject of the wrongful death action.

Of the courts of appeals that addressed the issue before *Bala*, all but one court held that the Medical Liability Act governed because of its provision that, "notwithstanding any other law", it applies to all cases involving health care liability.<sup>107</sup> The Houston Court of Appeals for the Fourteenth District was the one court that held to the contrary. According to the Houston court's opinion in *Wilson v. Rudd*,<sup>108</sup> the CPRC governed such cases because the legislature intended to provide an absolute two-year period of limitations in wrongful death cases.<sup>109</sup> This conflict meant that in a case where the act of medical negligence occurred more than two years before the patient's death, the beneficiaries' wrongful death cause of action was barred by limitations in courts except for the Houston court.

In *Bala v. Maxwell*,<sup>110</sup> the Texas Supreme Court resolved the conflict by reversing the Houston Court of Appeals, which had held that the CPRC provided the applicable limitations period for wrongful death cases involving medical malpractice. The Supreme Court held that the argument that the CPRC provides an absolute two-year limitations period in wrongful death cases "ignores the clear language of section 10.01 [of the Medical Liability Act], which applies to all health care liability claims *notwithstanding any other law*."<sup>111</sup> Therefore, in all Texas courts, "[a] wrongful death plaintiff suing on a medical negligence theory therefore does not necessarily have two full years from time of death to bring a lawsuit. Rather, the statute of limitations expires at the same time it would have for the decedent, two years after the alleged negligence occurred."<sup>112</sup>

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104. 909 S.W.2d 889 (Tex. 1995).

105. TEX. REV. CIV. STAT. ANN. art. 4590i, § 10.01 (Vernon Supp. 1996).

106. TEX. CIV. PRAC. & REM. CODE ANN. § 16.003(b) (Vernon 1986) provides the limitations period for claims brought under the Wrongful Death Act, *id.* § 71.004(b). For an example of the conflict among the courts of appeals, compare *Wilson v. Rudd*, 814 S.W.2d 818 (Tex. App.—Houston [14th Dist.] 1991, writ denied) (holding that § 16.003(b) governs), with *Goode v. Shoukfeh*, 863 S.W.2d 547 (Tex. App.—Austin 1993, no writ) (holding that article 4590i, § 10.01 governs); see also *Todd v. Planned Parenthood*, 853 S.W.2d 124 (Tex. App.—Dallas 1993, writ denied) (same as *Goode*); and *Shidaker v. Winsett*, 805 S.W.2d 941 (Tex. App.—Amarillo 1991, writ denied) (same).

107. See TEX. REV. CIV. STAT. ANN. art. 4590i, § 10.01 (Vernon Supp. 1996).

108. 814 S.W.2d 818 (Tex. App.—Houston [14th Dist.] 1991, writ denied).

109. See *id.* at 822.

110. 909 S.W.2d 893 (Tex. 1995).

111. *Id.* at 892 (emphasis in original).

112. *Id.* at 893.

This rule may lead to a harsh result in certain situations. If, for example, the medical negligence occurs more than two years before the decedent's death, the decedent's beneficiaries will be barred from bringing a wrongful death action unless they file the action within two years of the medical negligence. That is, they must file the action while the decedent is still alive. There is an obvious problem here: it is illogical, not to mention distasteful, to expect a person's family members to file a wrongful death cause of action before the person has actually died.

It is notable that a plaintiff who finds himself in the situation just described will be unable to remedy his situation by invoking the "open courts" provision of the Texas Constitution.<sup>113</sup> That provision prohibits the applicable limitations period from cutting off a plaintiff's common law cause of action before the plaintiff knew or should have known the cause existed.<sup>114</sup> However, "the open courts provision offers no protection to purely statutory causes of action."<sup>115</sup> Because wrongful death and survival actions are purely statutory,<sup>116</sup> the open courts provision does not protect plaintiffs who bring such claims.

## 2. *Minors—Constitutionality*

The Texas Supreme Court, in *Weiner v. Wasson*,<sup>117</sup> held that the statute of limitations contained in the Medical Liability Act<sup>118</sup> is unconstitutional as applied to minors. The statute provides that minors under the age of twelve shall have until their fourteenth birthday to file, or have filed on their behalf, a medical malpractice claim. In 1983, a previous version of the statute, which required minors under the age of six years to file by their eighth birthday, had been held unconstitutional under the open courts provision of the Texas Constitution.<sup>119</sup> The court agreed with the reasoning of the previous decision and concluded that the child's lack of legal capacity, coupled with the possibility that an adult might fail to act on the child's behalf, effectively abrogated the child's right to pursue a claim.<sup>120</sup> Furthermore, the child's right to redress outweighed the statute's stated legislative purpose halting the rising costs of medical liability insurance.<sup>121</sup>

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113. See TEX. CONST. art. I, § 13.

114. See, e.g., *Hellman v. Mateo*, 772 S.W.2d 64, 66 (Tex. 1989); *Morrison v. Chan*, 699 S.W.2d 205, 207 (Tex. 1985).

115. *Moreno v. Sterling Drug, Inc.*, 787 S.W.2d 348, 355-56 (Tex. 1990).

116. *Id.* at 356.

117. 900 S.W.2d 316 (Tex. 1995).

118. TEX. REV. CIV. STAT. ANN. art. 4590i, § 10.01 (Vernon Supp. 1996).

119. See *Sax v. Votteler*, 648 S.W.2d 661 (Tex. 1983).

120. *Weiner*, 900 S.W.2d at 318. The court found little difference between the two provisions, other than dictating different ages by which minors must bring a claim. *Id.* The court stated that "[w]hether a statute compels a child to bring suit by age eight or by age fourteen is inconsequential because in either instance a minor child is legally disabled from pursuing a suit on his own." *Id.*

121. *Id.* The court declined to determine the constitutionality of the statute on a case-by-case basis, finding it to be an unworkable standard which would require the court to "inquire whether the minor's parent was 'incompetent' or had a 'conflict of interest' that

The court went on to hold that a minor has until two years after reaching age eighteen to bring a claim for malpractice arising during his minority.<sup>122</sup> In so holding, the court rejected defendant's assertion that a minor should have only a "reasonable time" after the age of majority in which to file suit.<sup>123</sup>

#### D. OFFICIAL IMMUNITY

In *Kassen v. Hatley*<sup>124</sup> the patient was brought to the hospital by a police officer after the patient had threatened to harm herself. The patient had experienced chronic mental health problems and received regular outpatient mental health treatment at the Dallas County Mental Health and Mental Retardation System ("Dallas County MHMR"). The physician who examined the patient decided not to admit her for inpatient treatment based on her "difficult patient file," which recommended that the patient be declined admission and referred to Dallas County MHMR unless she displayed different symptoms from those experienced previously. The physician and head nurse decided not to return the patient's medication to her after it was apparent she had already taken more than her prescribed dosage. The patient committed suicide a short time after leaving the hospital. Her parents then brought a wrongful death action against the hospital (Parkland Memorial Hospital, which is owned by the Dallas County Hospital District), the nurse, the physician, and the physician's affiliated medical school (University of Texas—Southwestern Medical Center).<sup>125</sup>

In analyzing the defense of official immunity raised by the physician and the nurse, the Texas Supreme Court distinguished between governmental and medical discretion.<sup>126</sup> Under this aspect of its ruling, government-employed medical personnel cannot obtain official immunity for tort liability that arises from the exercise of medical, as distinguished from governmental, discretion.<sup>127</sup> The court held that the physician and nurse did not conclusively establish that they exercised governmental discretion in this case because they did not claim governmental concerns influenced their decision to decline admission to the patient in this

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prevented the parent from acting in the minor's best interests." *Id.* at 320. The dissent argued that the rationale of *Sax* should be applied to the present case and found the statute of limitations "is not unconstitutional where the minor is at least twelve years of age, his or her parent knew of the injury and potential claim within the limitations period, and the parent or legal guardian was competent and had no conflict of interest that would preclude him or her from acting in the best interest of the child." *Weiner*, 900 S.W.2d at 321-22.

122. *Id.* at 321. In this case, the defendant first performed surgery on the plaintiff and last treated him when the plaintiff was fifteen years old. *Id.* at 322. The undisputed facts showed that the plaintiff was aware that he had a claim against his physician in that same year, yet suit was not filed until more than four years after the defendant last treated the patient. *Id.*

123. *Id.* at 321.

124. 887 S.W.2d 4 (Tex. 1994).

125. *Id.* at 7.

126. *Id.* at 11.

127. *Id.*

case.<sup>128</sup>

The court also considered the applicability of the defense of sovereign immunity to the hospital. An entity waives sovereign immunity under the Texas Tort Claims Act for "personal injury and death so caused by a condition or use of tangible personal or real property if the governmental unit would, were it a private person, be liable to the claimant according to Texas law."<sup>129</sup> The court held that information contained in medical records does not qualify as tangible personal property under the Texas Tort Claims Act (following *University of Texas Medical Branch v. York*<sup>130</sup>) and extended this reasoning to include the difficult patient file and the emergency room procedures manual.<sup>131</sup> The court further held that the *non-use* of prescription drugs by the patient after she was denied admission will not support a claim under the Texas Tort Claims Act, which requires that the *use* of tangible personal or real property cause the alleged injury.<sup>132</sup>

#### E. STILLBIRTH

In *Krishnan v. Sepulveda*,<sup>133</sup> the Texas Supreme Court held that the mother of a stillborn infant may recover mental anguish damages as a result of her injury caused by the alleged negligent diagnosis, supervision, and treatment of her physician.<sup>134</sup> The trial court had dismissed the case, sustaining the physician's special exception that Texas law does not recognize damages for the death of an unborn fetus. The court of appeals reversed and remanded, finding that the plaintiffs alleged that the physician was negligent in caring for the mother, not the fetus. The Supreme Court affirmed, holding that the mother may recover mental anguish damages for her injuries.<sup>135</sup> The father, however, could not recover mental anguish damages, because the physician owed no duty to the father.<sup>136</sup> Despite its willingness to award damages for the stillbirth of plaintiffs' child, the Court made it clear that it did not intend to overrule prior opinions in which it had held that "there is no wrongful death or survival cause of action for the death of a fetus."<sup>137</sup>

#### F. ADMISSIBILITY OF SCIENTIFIC EVIDENCE

In *North Dallas Diagnostic Center v. Dewberry*,<sup>138</sup> the Dallas Court of Appeals noted that Texas civil case law is unhelpful in guiding a trial

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128. *Id.* at 12.

129. TEX. CIV. PRAC. & REM. CODE ANN. § 101.021(2) (Vernon 1986).

130. 871 S.W.2d 175, 176 (Tex. 1994).

131. *Kassen*, 887 S.W.2d at 14.

132. TEX. CIV. PRAC. & REM. CODE ANN. § 101.021(2) (Vernon 1986).

133. 38 Tex. Sup. Ct. J. 806 (June 15, 1995).

134. *Id.* at 808.

135. *Id.* at 808-09.

136. *Id.* The court awarded damages to the mother on the grounds that Texas authorizes recovery of mental anguish damages in almost all personal injury actions. *Id.* at 808.

137. *Krishnan*, 38 TEX. SUP. CT. J. at 808.

138. 900 S.W.2d 90 (Tex.App.—Dallas 1995, writ denied).

court's determination about the admissibility of scientific evidence.<sup>139</sup> The court further observed that Texas law is consistent with federal law with respect to expert testimony on causation and that the relevant Texas and federal rules of evidence are identical.<sup>140</sup> The court therefore adopted the factors set out by the United States Supreme Court in *Daubert v. Merrell Dow Pharmaceuticals, Inc.*,<sup>141</sup> which are: (1) whether the theory or technique can be and has been tested; (2) whether the theory or technique has been subjected to peer review and publication; (3) the known or potential rate of error and the standards controlling a technique's operation; and (4) general acceptance in the scientific community.<sup>142</sup>

The court noted that as a consequence of its adoption of the *Daubert* factors, parties will be required to "develop more evidence at the preliminary *voir dire* examination of an expert [in order to allow] the trial court to perform its 'gatekeeping' role."<sup>143</sup> The court added that this may result in more time and expense in the litigation process, but the test "provides necessary safeguards against admitting testimony ungrounded in scientific validation."<sup>144</sup>

#### G. INDEMNIFICATION BY STATE

To encourage physicians to provide charity care, or at least to decrease the malpractice premiums of those who do,<sup>145</sup> the legislature in 1989 enacted chapter 110 of the Civil Practice and Remedies Code, which obligated the state to provide indemnification for malpractice to doctors who devote at least ten percent of their practice to charity care.<sup>146</sup> Although the statute obligates the state to indemnify "a health care professional" in connection with "a health care liability cause of action,"<sup>147</sup> it also limits the state's exposure to "\$100,000 for a single occurrence in the case of an eligible medical malpractice claim arising as a result of prenatal care, care during labor and delivery, and care given to a mother or infant during the 30-day period immediately following delivery, or as a result of emergency care."<sup>148</sup> In *Texas v. Pruett*,<sup>149</sup> two physicians were sued for malpractice in connection with the death of a patient during childbirth. Each settled

139. *Id.* at 95.

140. *Id.* Compare TEX. R. CIV. EVID. 702 with FED. R. EVID. 702.

141. 113 S. Ct. 2786 (1993).

142. *North Dallas Diagnostic Ctr.*, 900 S.W.2d at 95 (quoting *Daubert*, 113 S. Ct. at 2796-97).

143. *North Dallas Diagnostic Ctr.*, 900 S.W.2d at 96.

144. *Id.*

145. See *Texas v. Pruett*, 900 S.W.2d 335, 337 (Tex. 1995) (purpose of bill was, "in part, to encourage physicians and other health care professionals to provide charity care;" additional incentive was to "mandate[] reductions in professional liability insurance premiums" to "reflect the reduction in the insurer's liability exposure based on the state's indemnification").

146. See TEX. CIV. PRAC. & REM. CODE ANN. § 110.002 (Vernon Supp. 1996).

147. *Id.*

148. *Id.* § 110.04(a)(1) (emphasis added).

149. 900 S.W.2d 335 (Tex. 1995).

separately with the decedent's estate for the full policy limit of \$100,000 and sought reimbursement from the state. The state interpreted the "single occurrence" language as a "per case" limit, regardless of the number of physicians involved, and argued that its obligation to indemnify in this case was \$100,000. A trial court agreed with the doctors, and the Texas Supreme Court affirmed.<sup>150</sup>

The court construed the "single occurrence" language as creating a "per claim/per physician" limit of \$100,000. If the legislature had intended to create a global limit of \$100,000 with respect to all physicians' claims arising out of a single occurrence, wrote the court, it would have applied the limit to "a single occurrence in the case of eligible medical malpractice claims" rather than the singular "eligible medical malpractice claim."<sup>151</sup> The court found itself on somewhat firmer ground when it noted that insurers were directed to reduce malpractice insurance premiums for each qualifying physician based upon the indemnification obligation, and the reduction obviously could not take into account whether one or more physicians were sued in connection with a single occurrence. Of course, if the Supreme Court has misconstrued the statute, the legislature can fix the damage in 1997. Without any action on the part of the legislature, the indemnification program will expire on September 1, 1997.<sup>152</sup>

## H. TORT REFORM

### 1. Medical Malpractice

The legislature amended the cost bond provision of the Medical Liability and Insurance Improvement Act. It now requires a health care liability claimant to file a \$5,000 cost bond or escrow account or an expert report for each physician or health care provider named in the lawsuit within 90 days of filing.<sup>153</sup> A court order may be entered for failure to file, raising the cost bond to \$7500 to be filed within 21 days and providing for dismissal for want of prosecution for continued noncompliance.<sup>154</sup> The claimant must also furnish an expert report for each physician or health care provider within 180 days after the date of filing or voluntarily nonsuit the action.<sup>155</sup> If the claimant fails to do so, the court shall, upon the defendant's motion, enter an order sanctioning the claimant or attorney, awarding reasonable attorney's fees and court costs incurred by that

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150. *Id.* at 337.

151. *Id.* *But cf.* TEX. GOV'T CODE ANN. § 311.012(b) (Vernon 1988) (Code Construction Act: "The singular includes the plural and the plural includes the singular"). The legislature's choice of singular or plural does not seem to decide much in this case. If, for example, the legislature had used the plural ("eligible medical malpractice claims"), the court would hardly have been precluded from concluding that the \$100,000 limit applies to all claims against a single physician, as long as the claims arose out of a single occurrence, and that if more than one physician is sued the \$100,000 limit applies to each physician.

152. TEX. CIV. PRAC. & REM. CODE ANN. § 110 (Vernon Supp. 1996).

153. TEX. REV. CIV. STAT. ANN. art. 4590i, § 13.01(a) (Vernon Supp. 1996).

154. *Id.* § 13.01(b).

155. *Id.* § 13.01(d).



defendant, forfeiting any cost bond to the extent necessary to pay the award, and dismissing the action with prejudice.<sup>156</sup> The law also now provides requirements for the expert report<sup>157</sup> and sets out requisite qualifications for an expert.<sup>158</sup>

## 2. Punitive Damages

The legislature amended the Civil Practice and Remedies Code, which now requires, to recover exemplary damages in a civil action, that the claimant prove by "clear and convincing evidence" that the harm results from fraud, malice, a wilful act or omission, or gross neglect in certain wrongful death actions.<sup>159</sup> Exemplary damages may not exceed the greater of (1) \$200,000 or (2) two times the amount of economic damages, plus an amount equal to any non-economic damages found by the jury not to exceed \$750,000.<sup>160</sup> The law also delineates the evidence the trier of fact shall consider in determining exemplary damages.<sup>161</sup>

## 3. Joint and Several Liability

Through another amendment to the Civil Practice and Remedies Code, the legislature has provided for "proportionate responsibility" rather than "comparative responsibility."<sup>162</sup> The law now allows a defendant to be jointly and severally liable for damages with respect to a cause of action if the percentage of responsibility attributed to the defendant is greater than 50 percent (increased from 20 percent).<sup>163</sup> The bill also allows a defendant to bring in other responsible parties not included in the lawsuit so that the jury may assign a percentage of the fault to these parties, thereby affecting the amount of damages assigned to the defendant.<sup>164</sup> These provisions apply to all causes of action filed or accrued after September 1, 1995. If a cause of action accrues before this date, the plaintiff will have until September 1, 1996, to file a lawsuit that will be subject to the current threshold limits.<sup>165</sup>

156. *Id.* § 13.01(e).

157. *Id.* § 13.01(r)(6).

158. TEX. REV. CIV. STAT. ANN. art. 4590i § 14.01(a) (Vernon Supp. 1996).

159. TEX. CIV. PRAC. & REM. CODE ANN. § 41.003(a), (b) (Vernon Supp. 1996).

160. *Id.* § 41.008(b).

161. *Id.* § 41.011(a). The factors include:

- (1) the nature of the wrong;
- (2) the character of the conduct involved;
- (3) the degree of culpability of the wrongdoer;
- (4) the situation and sensibilities of the parties concerned;
- (5) the extent to which such conduct offends a public sense of justice and propriety; and
- (6) the net worth of the defendant.

*Id.*

162. TEX. CIV. PRAC. & REM. CODE ANN. ch. 33 (Vernon Supp. 1996).

163. *Id.* § 33.013(b).

164. *Id.* § 33.004.

165. See Act of 1995, 74th Leg., R.S., ch. 136, §§ 3-4, 1995 TEX. GEN. LAWS 976 (1995).

## VI. PATIENTS' RIGHTS

## A. OUT-OF-HOSPITAL DO-NOT-RESUSCITATE ORDERS

The legislature has created a new type of advance directive—an “out-of-hospital do not resuscitate order”<sup>166</sup> (“out-of-hospital DNR”). The procedures of executing an out-of-hospital DNR are similar to the procedures provided under the Natural Death Act for directives to physicians.<sup>167</sup> “Out-of-hospital setting” is defined as any setting outside of a licensed acute care hospital in which health care professionals are called for assistance, including long-term care facilities, in-patient hospice facilities, private homes, and vehicles during transport.<sup>168</sup> The new law requires the Texas Department of Health to promulgate a rule that establishes a standard form for this purpose.<sup>169</sup> Orders are limited to persons with a “terminal condition” and may be used to govern the use of cardiopulmonary resuscitation and “other life-sustaining procedures designated by the [Texas Board of Health].”<sup>170</sup> Significantly, the concept of “death that is imminent” or “death that will occur within a relatively short time” (both of which limit the use of the directive to physicians under the Natural Death Act<sup>171</sup>) is missing from the out-of-hospital DNR law. Another difference between the two statutes is that out-of-hospital DNR orders do not require the second-physician certification of a terminal condition, as is required in the Natural Death Act.<sup>172</sup> Additionally, the bill provides for “DNR identification devices” (such as a bracelet or a necklace) that can be worn by the patient subject to an out-of-hospital order.<sup>173</sup> Health care professionals or health care facilities are afforded protection from civil and criminal liability where the professional or facility unknowingly fails to effectuate an out-of-hospital DNR order.<sup>174</sup>

## B. INFORMED CONSENT

## I. Abortion

The Texas courts' refusal to adopt the “mature minor” doctrine was reaffirmed by the Waco Court of Appeals in *Powers v. Floyd*.<sup>175</sup> In 1974, a physician (Dr. Floyd) performed a surgical abortion on a patient

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166. TEX. HEALTH & SAFETY CODE ANN. ch. 674 (Vernon Supp. 1996).

167. See *id.* ch. 672 (Vernon 1992).

168. *Id.* § 674.001(15) (Vernon Supp. 1996).

169. *Id.* § 674.003(a).

170. *Id.* § 674.002(a).

171. See TEX. HEALTH & SAFETY CODE ANN. § 672.002(6) (Vernon 1992) (defining “life-sustaining procedure”).

172. See *id.* § 672.002(8) (defining “qualified patient”). Two bills—1995 S.B. 497 and 1995 H.B. 1430—that would have deleted the second physician certification requirement in the Natural Death Act did not pass.

173. *Id.* § 674.001(7) (defining “DNR identification device”), § 674.023(d) (requiring Texas Board of Health to promulgate standard design for DNR identification devices) (Vernon Supp. 1996).

174. *Id.* § 674.017.

175. 904 S.W.2d 713 (Tex.App.—Waco 1995, writ denied).

(Tammy Powers) without informing her that he was doing so.<sup>176</sup> Tammy was sixteen at the time, and her mother consented to the abortion.<sup>177</sup> Tammy learned about the abortion in 1990 and sued Dr. Floyd for failing to disclose the nature of the procedure to her, for failing to obtain her informed consent for the procedure, and for fraudulently concealing that a surgical abortion had been performed.<sup>178</sup>

The Waco court affirmed summary judgment for Dr. Floyd, holding that in 1974 Dr. Floyd owed no legal duty to Tammy to obtain her informed consent for the abortion.<sup>179</sup> The court explained that, while physicians must make reasonable disclosures to, and obtain consent from, patients before performing medical procedures, "certain classes of people, such as the insane, the mentally deficient and minors in general have been regarded as incompetent to give legally binding consent."<sup>180</sup> Because a minor cannot give legally binding consent for medical procedures, the court added, such consent must come from someone who is authorized to give consent on behalf of the minor.<sup>181</sup> In this case, Tammy's mother was legally authorized to consent to the abortion, and the mother indeed gave such consent to Dr. Floyd.

The court rejected Tammy's argument that in 1974 she was sixteen and should therefore have been treated as a "mature minor." The court pointed out that the common law made no distinction "between the infant and the mature teenager, [and] treat[ed] them both as the 'property' of their parents, who could make all decisions affecting them."<sup>182</sup> The court acknowledged that the federal government and some states now recognize the rights of "mature minors" to make their own decisions about medical care. The court declared, however, that "the general rule in Texas was that a minor patient could not consent to medical or surgical treatment, and Texas has never adopted or recognized the 'mature minor' exception."<sup>183</sup> The court remarked that disclosure to Tammy would have been "a vain or useless act" because she was a minor in 1974 and, under Texas law, her consent would not have been legally binding.<sup>184</sup>

The court's holding was based in part upon the notion that one who cannot legally consent to receive a certain medical treatment does not even deserve to be apprised of the nature and risks of that treatment. Although the legal duty to disclose relevant information is predicated

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176. *Id.* at 714-15.

177. *Id.*

178. *Id.* at 715.

179. *Id.* at 718.

180. 904 S.W.2d at 717 (quoting DEPARTMENT OF HEALTH, EDUCATION & WELFARE, PUB. NO. 74-16001, FAMILY PLANNING, CONTRACEPTION AND VOLUNTARY STERILIZATION: AN ANALYSIS OF LAWS AND POLICIES IN THE UNITED STATES, EACH STATE AND JURISDICTION 70 (1974)).

181. *Id.*

182. *Id.*

183. *Id.* at 718.

184. *Id.*

upon the legal duty to obtain informed consent,<sup>185</sup> it is likely that this principle will continue to be challenged in Texas until the courts finally adopt some form of the "mature minor" doctrine.<sup>186</sup> The court also relied upon the "therapeutic privilege" exception to the informed consent doctrine and assumed "complete disclosure could be severely disturbing to a minor . . . [because even where adult patients are concerned] 'some disclosures may so disturb that patient that they serve as hindrances to needed treatment.'"<sup>187</sup> As a blanket justification for refusing to find a duty to disclose relevant details to a minor patient, this comment flies in the face of existing professional norms and, presumably, experience.<sup>188</sup> If there is any excuse for this position in the *Powers* case, it might be in the court's focus on 1974 duties and norms (although there is no evidence that the court would reach a different conclusion in a 1996 case) and on the fact that Tammy Powers had been classified as "slightly above 'retarded' by the [Belton Mental Health and Mental Retardation Clinic]."<sup>189</sup> In this part of the opinion, however, the court does not explicitly rely on either explanation.

## 2. Minors

The legislature amended the Family Code to allow a peace officer with custody of a minor to consent to medical, dental, surgical, and psychological treatment if the officer has reasonable grounds to believe immediate medical treatment is needed and the parent cannot be contacted.<sup>190</sup> A peace officer, as well as an adult responsible for the care of a minor under juvenile court jurisdiction, is immune from liability for damages resulting from the treatment except as to negligence.<sup>191</sup> A physician, dentist, hospital, or medical facility treating under this non-parental consent provision is not liable except for negligence.<sup>192</sup> A parent appointed as a conservator may consent to non-invasive care (and all necessary medical, dental, and surgical care during an emergency) when the parent has possession.<sup>193</sup> Finally, unmarried minors are authorized to consent to treatment of their biological child in their custody.<sup>194</sup>

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185. See *Wilson v. Scott*, 412 S.W.2d 299, 301 (Tex. 1967).

186. The standard of care is certainly evolving toward recognition of a duty to disclose relevant details to minor patients. See, e.g., Committee on Bioethics, American Academy of Pediatrics, *Informed Consent, Parental Permission & Assent in Pediatric Practice*, 95 PEDIATRICS 314 (1995) (minors are entitled to age- and maturity-appropriate disclosure of the nature of the procedure, risks, and alternative treatments).

187. 904 S.W.2d at 718.

188. See *Informed Consent, Parental Permission & Assent in Pediatric Practice*, *supra* note 186.

189. *Powers*, 904 S.W.2d at 715.

190. TEX. FAM. CODE ANN. § 32.001(a)(8) (Vernon Supp. 1996).

191. *Id.* § 32.001(d).

192. *Id.*

193. *Id.* § 153.074(3)-(4).

194. *Id.* § 32.003(a)(6).

## C. ORGAN AND TISSUE REMOVAL

The legislature amended the Health & Safety Code to allow a medical examiner to release a person's organs to a qualified organ procurement organization where the person died under circumstances requiring an inquest with consent.<sup>195</sup> If an autopsy is required and removal will not interfere, the organs may be removed before the autopsy.<sup>196</sup> A medical examiner denying the removal of organs must provide a written statement to the qualified organ procurement organization explaining the reasons for denial.<sup>197</sup>

## VII. HIV

The legislature amended the Health and Safety Code to require a physician or other person attending a pregnant woman during gestation or at a delivery to take and submit a sample of the mother's blood on the first examination or visit for a standard HIV test.<sup>198</sup> Before a blood sample is taken, the physician must provide the mother with printed materials about AIDS and HIV and "verbally"<sup>199</sup> notify the woman of the test. The woman must also be provided pre-test counseling to the effect that test results are confidential but not anonymous.<sup>200</sup> The patient's medical record must reflect the fact that written materials and verbal notification were provided and the results maintained for nine months. If an HIV test is positive, the mother must be provided with information about AIDS and HIV and post-test counseling.<sup>201</sup> The law also requires testing within twenty-four hours of delivery of the woman's blood or a sample from the umbilical cord.<sup>202</sup> Neither first-visit nor postnatal testing may be required if the woman objects.<sup>203</sup>

## VIII. INDIGENT CARE

## A. MEDICARE—REIMBURSEMENT

In *Harris County Hospital District v. Shalala*<sup>204</sup> the United States Court of Appeals for the Fifth Circuit affirmed a district court decision that the Department of Health and Human Services' ("HHS") refusal to reimburse the Harris County District Hospital ("hospital") for uncollected debts was a violation of the Omnibus Budget Reconciliation Act of 1989 ("OBRA").<sup>205</sup> In 1989 the hospital submitted a reimbursement claim for

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195. TEX. HEALTH & SAFETY CODE ANN. § 693.002(a)(1)-(2) (Vernon Supp. 1996).

196. *Id.* § 693.002(a)(3).

197. *Id.* § 693.002(a)(4).

198. *Id.* § 81.090(a)(1), (2)(B).

199. *Id.* § 81.090(k).

200. TEX. HEALTH & SAFETY CODE ANN. § 81.090(k) (Vernon Supp. 1996).

201. *Id.* § 81.090(m).

202. *Id.* § 81.090(c)(2)(B).

203. *Id.* § 81.090(l).

204. 64 F.3d 220 (5th Cir. 1995).

205. *Id.* at 221.

\$1,168,022 for uncollected Medicare copayments, or "bad debts."<sup>206</sup> The hospital's claim was denied on the basis that the hospital had not complied with Medicare requirements regarding the verification of indigency of patients.<sup>207</sup> The Fifth Circuit's decision hinged on a provision in OBRA, which provides that "[t]he Secretary may not require a hospital to change its bad debt collection policy if a fiscal intermediary, in accordance with the rules in effect as of August 1, 1987, with respect to criteria for indigence determination procedures . . . has accepted such policy before that date."<sup>208</sup>

The hospital pointed out that, prior to 1989, Blue Cross/Blue Shield of Texas ("BCBS"), the fiscal intermediary, had reimbursed the hospital for bad debts, thereby accepting the Hospital's indigence determination policy.<sup>209</sup> The Hospital's indigence determination policy was the same then as it is now.<sup>210</sup> Accordingly, argued the Hospital, HHS' refusal of the hospital's reimbursement claim was tantamount to requiring the hospital to change its policy in violation of OBRA.<sup>211</sup> HHS argued that OBRA applies only if there has been a "formal" acceptance and that BCBS had never "formally" accepted the Hospital's indigence determination policy.<sup>212</sup>

The Fifth Circuit sided with the hospital, holding that BCBS evinced acceptance of the hospital's indigence determination policy when it reimbursed the hospital for prior bad debts.<sup>213</sup> Finding the violation of OBRA was enough reason to affirm the district court's ruling, the Fifth Circuit did not even reach HHS's claim that the Hospital had failed to comply with Medicare regulations.<sup>214</sup>

Hospitals in Texas can use this case to protect themselves against attempts by the HHS to require the hospitals to make changes to their indigence determination policies. In fact, after this case, HHS cannot even require hospitals to change policies that do not meet Medicare requirements; if HHS has reimbursed a hospital under the hospital's policy, HHS must continue to do so, even if that policy violates the Medicare requirements. The case offers this protection, however, only for those hospitals that received Medicare reimbursements before August 1, 1987. Hospitals that did not receive reimbursements until after that date will have to conform their policies to meet Medicaid requirements if HHS orders them to do so.

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206. *Id.*

207. *Id.* The specific complaint of the fiscal intermediary (Blue Cross/Blue Shield of Texas) was that the hospital had not considered patients' assets when determining their indigent status. On appeal, HHS claimed that the hospital had also failed to verify income statements submitted by patients. *Id.*

208. 64 F.3d at 222 (quoting OBRA, 42 U.S.C. § 1395f note (1994)).

209. *Shalala*, 64 F.3d at 227.

210. *Id.*

211. *Id.*

212. *Id.*

213. *Id.*

214. *Shalala*, 64 F.3d at 223, n.11.

## B. MEDICAID—ABORTION FUNDING

In *Hope Medical Group for Women v. Edwards*<sup>215</sup> the Fifth Circuit affirmed the district court's injunction against the state of Louisiana, enjoining the state from enforcing a statute that prohibited the state's Medicaid program from paying for abortions except when necessary to save the mother's life, thereby prohibiting Medicaid-funded abortions in the case of rape or incest.<sup>216</sup>

The plaintiffs offered two reasons for the court to affirm. First, because the current Hyde Amendment permits states to use federal Medicaid funds for abortions to terminate pregnancies caused by rape or incest,<sup>217</sup> plaintiffs argued that states are required to use state Medicaid funds for abortions in those situations.<sup>218</sup> The court disagreed and followed the Tenth Circuit's recent holding in *Hern v. Beye*,<sup>219</sup> which held that state restrictions on abortions are subject to the requirements of the Medicaid statute ("Title XIX")<sup>220</sup> and its accompanying regulations, not to the Hyde Amendment, which purports only to restrict federal expenditures.

The plaintiffs' second argument was that the Louisiana statute violates Title XIX by unreasonably prohibiting abortions without regard to medical necessity.<sup>221</sup> Title XIX, which established the Medicaid program, describes the medical services that states participating in Medicaid must provide to "categorically needy" individuals.<sup>222</sup> While states have broad discretion to determine the scope of medical services they will provide under Medicaid, Title XIX requires that the states' standards must be "reasonable."<sup>223</sup> The court agreed with plaintiffs that "reasonableness"

215. 63 F.3d 418 (5th Cir. 1995), *petition for cert. filed*, 64 U.S.L.W. 3540 (U.S. Feb. 13, 1996) (No. 95-1164).

216. *Id.* at 420.

217. This current (1993) version tracks the original 1976 Hyde Amendment. *Id.* at 421. Congress amended the Hyde Amendment in 1981, however, and from 1981 to 1993 the Hyde Amendment prohibited the states' use of Medicaid funds "except where the life of the mother would be endangered if the fetus were carried to term." *Id.* The version of the Louisiana statute at issue in *Hope Medical Group* mirrored the 1981-1993 version of the Hyde Amendment. *Id.*

218. *Hope Medical Group*, 63 F.3d at 418.

219. 57 F.3d 906 (10th Cir. 1995), *cert. denied*, 116 S. Ct. 569 (1995).

220. 42 U.S.C. ch. 7, subch. XIX (1994).

221. *Hope Medical Group*, 63 F.3d at 423.

222. *Id.* at 421. Title XIX sets out eight categories of medical services that states are required to provide through their Medicaid programs:

- (1) inpatient and outpatient hospital services;
- (2) other laboratory or X-ray services;
- (3) nursing facility services;
- (4) early and periodic screening, diagnostic and treatment services for recipients under the age of 21;
- (5) family planning services and supplies;
- (6) physicians' services and supplies;
- (7) services furnished by a nurse-midwife;
- (8) services furnished by a certified pediatric nurse practitioner or certified nurse practitioner.

*Id.* See also 42 U.S.C. § 1396d(a) (1994). The parties agreed that abortion fits into the first, fifth and sixth categories. *Hope Medical Group*, 63 F.3d at 425.

223. *Hope Medical Group*, 63 F.3d at 427.

requires that state programs must "provide 'health-sustaining' medical services to eligible recipients."<sup>224</sup>

The plaintiffs' evidence convinced the court that abortions were often "medically necessary" in rape and incest cases.<sup>225</sup> The court was particularly persuaded by a December 1993 letter that the Health Care Financing Administration ("HCFA") sent to the Medicaid directors of each state.<sup>226</sup> The letter expressed HCFA's opinion that the broadening of the 1993 Hyde Amendment means that Title XIX requires participating states to fund medically necessary abortions in rape and incest cases.<sup>227</sup> The court viewed HCFA's letter as suggesting that in at least some rape and incest cases, abortions are medically necessary and are therefore required to be provided through state Medicaid programs.<sup>228</sup> Because the Louisiana statute "categorically prohibits funding for abortions in cases of rape or incest without regard to whether the procedures might be medically necessary,"<sup>229</sup> the Court found that the statute violates the requirements of Title XIX.

This is a significant case for Texas. Like the Louisiana statute at issue in *Hope Medical Group*, the Texas Maternal and Infant Health Improvement Act also restricts the use of public funds to abortions performed because "the mother's life is in danger."<sup>230</sup> *Hope Medical Group* provides solid support against the state's denial of Medicaid reimbursement for abortions in cases of incest or rape.

### C. MEDICAID—GENERAL

#### 1. Medicaid Fraud

The legislature enacted the Medicaid Fraud Prevention Act,<sup>231</sup> which establishes a mechanism for the Office of the Attorney General (OAG) to investigate, prosecute, enjoin, and obtain civil penalties from any person who knowingly or intentionally engages in Medicaid fraud. The act provides for venue in Travis County and allows the OAG to seek injunctive relief.<sup>232</sup> A person who commits an unlawful act is liable to the state

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224. *Id.* (quoting *Hodgson v. Board of County Comm'rs*, 614 F.2d 601, 608 (8th Cir. 1980)).

225. *Id.* This evidence included research reports and expert testimony explaining that there can be health problems (both physical and mental) related to pregnancies that result from rape and incest. *Id.*

226. *Id.*

227. *Hope Medical Group*, 63 F.3d at 427.

228. *Id.* The defendants did not controvert the plaintiffs' evidence that abortions in rape and incest cases can often be medically necessary, nor did the defendants dispute the plaintiffs' contention that the Louisiana statute is not related to the medical or health needs of patients. *Id.*

229. *Id.* at 428. The court rejected defendants' argument that the Louisiana statute should be upheld because it promotes the state's interest in encouraging childbirth, which the court held was an insufficient interest to allow a state to ignore Title XIX's objective of providing necessary medical services to eligible recipients. *Id.*

230. TEX. HEALTH & SAFETY CODE ANN. § 32.005 (Vernon 1992).

231. TEX. HUM. RES. CODE ANN. ch. 36 (Vernon Supp. 1996).

232. *Id.* § 36.003(a).



for restitution, interest, a civil penalty of not less than \$1,000 or more than \$10,000 for each unlawful act committed, and two times the value of the payment or monetary or in-kind benefit provided under the Medicaid program directly or indirectly as a result of the unlawful act.<sup>233</sup> The OAG is afforded investigative power similar to that granted the Consumer Protection Division and Antitrust Division under the Deceptive Trade Practices Act as to a person it believes has information relevant to the subject matter of an investigation, including requiring statements under oath, examination of a person, and issuance of a "civil investigative demand." State agencies are required to provide the OAG with access to all documentary materials of persons and Medicaid recipients under the Medicaid program to which that agency has access. Immunity is granted to any person providing access to documentary materials as authorized in the Act.<sup>234</sup> Finally, the act authorizes suspension or revocation of a Medicaid provider agreement or permit, license, or certification of a person found liable under the act.<sup>235</sup>

## 2. *Managed Care*

The legislature passed a package of bills relating to the development of a state Medicaid managed care program. Under the most comprehensive of these new laws, the Health and Human Services Commission ("Commission") is required to develop a health care delivery system that restructures the delivery of health care services provided under the state Medicaid program if a federal waiver is obtained.<sup>236</sup> The law specifies minimum requirements for health care delivery plan agreements, including: (1) uniform eligibility criteria; (2) uniform description and provision of services; (3) adequate access to quality care through a sufficient provider network; and (4) grievance and appeal procedures for recipients and providers. It also authorizes the formation of "intergovernmental initiatives" to operate the systems within a geographical area and requires contracts between the initiatives and managed care organizations to meet certain standards. The Commission and intergovernmental initiatives are required to contract for at least three years with each health care provider who: (1) previously provided care to Medicaid and charity patients at a significant level as prescribed by the Commission; (2) meet the credentialing criteria; and (3) agree to accept the reimbursement rate set by the Commission, the intergovernmental initiative or the multiple managed care organizations. Finally, the law includes a whistleblower provision that provides an award for reporting Medicaid fraud, misuse, or overcharges. The award must equal at least 10 percent of the savings to the state that result from the individual's disclosure.<sup>237</sup> Other Medicaid/

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233. *Id.* § 36.004(a).

234. *Id.* § 36.008.

235. *Id.* § 36.009(a).

236. TEX. GOV'T CODE ANN. ch. 531 (Vernon Supp. 1996).

237. *Id.*

managed care amendments are noted below.<sup>238</sup>

## IX. MENTAL HEALTH

### A. ADMISSIONS

As amended by the legislature, the Health and Safety Code allows the required physician's order for admission of a voluntary patient to be issued orally, electronically or in writing, signed by the physician.<sup>239</sup> In the case of an oral or electronically transmitted unsigned order, a signed original must be presented to the mental health facility within twenty-four hours of the initial order. The order must be from an admitting physician who has personally conducted an in-person physical and psychiatric examination within seventy-two hours of the admission or who has consulted with a physician who has conducted an in-person examination within seventy-two hours of the admission. Another amendment authorizes a person younger than sixteen years of age who is or has been married to consent to voluntary inpatient mental health services.<sup>240</sup>

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238. The Texas Department of Health is required to establish performance, operation, and financial standards for Medicaid managed care organizations. *See* TEX. HEALTH & SAFETY CODE ANN. §§ 12.017, 533.045 (Vernon Supp. 1996).

The Health and Human Services Commission ("Commission") is required to develop educational-program, support-service, and complaint-system guidelines for clients and providers in managed care Medicaid programs and a bill of rights and responsibilities for clients. *See* TEX. GOV'T CODE ANN. ch. 531 (Vernon Supp. 1996).

The Commission is required to develop a system to coordinate and integrate state Medicaid databases to facilitate the analysis of Medicaid data and reduce fraud in the Medicaid program by December 1, 1995. *See id.*

Act of 1995, 74th Leg., R.S., ch. 576, 1995 TEX. GEN. LAWS 3371 (1995), requires the Commission to develop a plan for a pilot program that uses Medicaid funds to establish medical savings accounts for recipients of acute care services under the Medicaid program by December 1, 1995.

The Texas Department of Mental Health and Mental Retardation is required to evaluate and, if necessary, revise its sliding fee schedules at least once every five years beginning by January 1, 1996. *See* TEX. HEALTH & SAFETY CODE ANN. §§ 552.017(e), 593.075(e) (Vernon Supp. 1996).

Act of 1995, 74th Leg., R.S., S. Con. Res. 55 requires the Medicaid federal waiver to include certain provisions including: (1) exempting pre-natal and well child visits from co-payments; (2) eligibility period guaranteed for 12 months; and (3) integrated managed care pilot model for long-term care, mental health and substance abuse services. Act of 1995, 74th Leg., R.S., S. Con. Res. 56 provides that the Medicaid office continue to administer the Vendor Drug Program and accelerate computer-based rebate monitoring and utilization review. Act of 1995, 74th Leg., R.S., S. Con. Res. 57 provides that the Medicaid office ensure that the federal waiver application does not waive the requirement that services provided by federally qualified health centers are mandatory. Act of 1995, 74th Leg., R.S., S. Con. Res. 58 authorized the Medicaid office with Texas Department of Mental Health and Mental Retardation and others to structure a range of service and delivery options for Level I ICF-MR program recipients, as well as feasibility studies by Texas Department of Health on the use of cost-effective home care services. Act of 1995, 74th Leg., R.S., S. Con. Res. 60 directed the Medicaid office to develop a pilot project plan for use of Medicaid funds to establish medical savings accounts for recipients of acute care services and use of Medicaid funds for the Texas Health Insurance Risk Pool.

239. TEX. HEALTH & SAFETY CODE ANN. § 572.002(3)(A)(ii) (Vernon Supp. 1996).

240. *Id.* §§ 572.001(a), (d), 572.002(3).

## B. MEDICATIONS

Recent changes to the Health and Safety Code authorize the administration of psychoactive medication to a patient who refuses the treatment and who is receiving court-ordered mental health services authorized under article 46.03 of the Code of Criminal Procedure.<sup>241</sup> Also, a physician may now petition a probate court on behalf of the state to authorize the administration of psychoactive medication.<sup>242</sup> Similarly, a physician may apply for court authorization to administer a psychoactive medication if the patient is receiving court-ordered mental health services or an application for court-ordered mental health services has been filed.<sup>243</sup> The court must hold a hearing on the application within thirty days. The legislature eliminated the requirement that the patient be in a Texas Department of Mental Health and Mental Retardation facility for issuance of the order.<sup>244</sup>

## X. MANAGED CARE

### A. HEALTH MAINTENANCE ORGANIZATIONS

The legislature settled a long-standing debate by amending the Health Maintenance Organization ("HMO") Act to allow HMOs to contract for services through other HMOs as well as through contracts with physicians and providers.<sup>245</sup> The Act was also amended to provide that it does not apply to: (1) a physician who is engaged in care within the definition of medical care; or (2) a provider engaged in health care services other than medical care as a part of a "health maintenance organization delivery network."<sup>246</sup> The term "health maintenance organization delivery network" is defined as "a health care delivery system in which a [HMO] arranges for health care services directly or indirectly through contracts or subcontracts with providers and physicians."<sup>247</sup> The bill also authorizes contracts or subcontracts within an HMO delivery network on a fee-for-service, risk-sharing or capitated risk arrangement: (1) by a physician with other physicians for medical care or with other providers for services

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241. *Id.* § 576.025(a)(5).

242. *Id.* § 574.104(a).

243. *Id.* § 574.104.

244. TEX. HEALTH & SAFETY CODE ANN. § 574.102 (Vernon Supp. 1996).

245. TEX. INS. CODE ANN. art. 20A.06, § 6(a)(3) (Vernon Supp. 1996).

246. *Id.* art. 20A.26(f)(1)(A). The legislature also amended the definition of the term "physician" to include a professional association, a 5.01(a) nonprofit health corporation, *see* TEX. REV. CIV. STAT. ANN. art. 4495b, § 5.01(a) (Vernon Supp. 1996), and a limited liability company or partnership wholly owned by physicians. TEX. INS. CODE ANN. art. 20A.02, § 2(m) (Vernon Supp. 1996).

247. TEX. INS. CODE ANN. art. 20A.02, § 2(u) (Vernon Supp. 1996). The definition of the term "provider" was also amended to mean: (1) any person other than a physician, including institutions, organizations or persons licensed or otherwise authorized to provide a health care service; (2) a person wholly owned or controlled by a provider or group of providers who are licensed to provide the same health care service; or (3) a person wholly owned or controlled by one or more hospitals and physicians, including a physician-hospital organization. *Id.* § 2(n).

ancillary to the practice of medicine other than hospital or other institutional or inpatient provider services; (2) by a provider with similarly licensed providers for health care services that those providers are licensed to provide other than medical care; and (3) by a provider with other providers for health care services that the provider is not licensed to provide, other than medical care, if those services constitute less than fifteen percent of the total amount of services to be provided or arranged for by that provider.<sup>248</sup> Finally, the Act was amended to provide that the utilization review agent statute<sup>249</sup> does not apply to utilization review by a physician or provider in the ordinary course of treatment of patients pursuant to a joint or delegated review agreement with a HMO on services rendered by the physician or provider.<sup>250</sup> These amendments became effective on September 1, 1995, and are applicable to contracts entered into or renewed on or after January 1, 1996.<sup>251</sup>

#### B. 5.01(A) CERTIFIED NONPROFIT HEALTH CORPORATIONS

The legislature amended the Insurance Code to require certification for 5.01(a) nonprofit health corporations<sup>252</sup> that arrange for or provide a health care plan to enrollees on a prepaid basis.<sup>253</sup> Certification requires compliance with the HMO certificate of authority criteria as well as accreditation by National Committee on Quality Assurance, Joint Commission for Accreditation of Healthcare Organizations, or an accrediting organization recognized by Insurance Commission rule. Certificate holders "may not engage in unfair and disruptive provider hiring or contracting, the purpose of which is to limit competition from traditional community providers."<sup>254</sup> The Board of Medical Examiners is required to implement this provision by rule. The certification requirement is not applicable to a 5.01(a) corporation that provides health care services on a risk sharing or capitated risk arrangement on behalf of an HMO.<sup>255</sup>

#### C. SMALL EMPLOYERS

The legislature has provided more insurance options to small employers by amending the Small Employer Health Insurance Availability Act.<sup>256</sup> The legislature lowered the required minimum level of eligible employee participation from ninety percent to seventy-five percent and eliminated the requirement that the employer pay at least 75 percent of the premium for those employees' coverage.<sup>257</sup> The Act now requires a

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248. *Id.* art. 20A.26, § 26(f)(6)-(9).

249. *See id.* art. 21.58A.

250. *Id.* art. 20A.26, § 26(f)(4).

251. Act of 1995, 74th Leg., R.S., ch. 874, § 4, 1995 TEX. GEN. LAWS 4355 (1995).

252. *See* TEX. REV. CIV. STAT. ANN. art. 4495(b), § 5.01 (Vernon Supp. 1996).

253. TEX. INS. CODE ANN. art. 21.52F, § 2(a) (Vernon Supp. 1996).

254. *Id.* § 5.

255. *Id.* § 2(c).

256. *Id.* art. 26.21.

257. *Id.* art. 26.21(b).

31-day (rather than 30-day) annual open enrollment period and allows exclusion of a late enrollee until the next open enrollment period.<sup>258</sup> Finally, the small employer carrier is required to offer a catastrophic plan and a basic coverage plan (instead of three prior plans—preventive/primary, in-hospital, and standard).<sup>259</sup>

#### D. PHARMACIES

The legislature amended the Insurance Code to add "managed care plan" to the "any willing pharmacy" requirement currently applicable to insurers.<sup>260</sup> The Code defines "managed care plan" as an HMO, preferred provider organization, or other organization that provides health care benefits and requires or encourages participants to use health care providers designated by the plan.<sup>261</sup>

#### E. INSURANCE FRAUD

The legislature amended the Penal Code to include insurance fraud as a criminal offense.<sup>262</sup> A person commits an offense if the person intentionally presents a statement for payment that the person knows contains false or misleading information that is material to the claim and the matter affects a person's right to payment.<sup>263</sup> Information that is material to a claim includes: (1) whether health care services were provided; (2) whether health care services were medically necessary; and (3) information concerning the condition treated or diagnosis made.<sup>264</sup> Soliciting, offering, paying, or receiving a benefit in connection with the furnishing of health care with the intent to defraud or deceive is also an offense.<sup>265</sup>

#### F. PATIENT PROTECTION ACT VETO

House Bill 2766,<sup>266</sup> which was passed by both houses with the support of the Texas Medical Association<sup>267</sup> but vetoed by Governor Bush,<sup>268</sup> would have added the Patient Protection Act to the Insurance Code. The bill provided for wide-ranging consumer protections and would have required managed care entities to provide prospective enrollees a written plan and description of the terms and conditions of a managed care plan and to use certain procedures for the selection of a primary care physician or dentist if the plan uses capitation. The bill also provided numerous

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258. TEX. INS. CODE ANN. art. 26.21(h), (j) (Vernon Supp. 1996).

259. *Id.* art. 26.42(a).

260. *Id.* art. 21.52B, § 2.

261. *Id.* § 1(6).

262. TEX. PENAL CODE ANN. ch. 35 (Vernon Supp. 1996).

263. *Id.* § 35.02(a).

264. *Id.* § 35.02(c).

265. *Id.* § 35.02(b).

266. Tex. H.B. 2766, 74th Leg., R.S. (1995).

267. See *Governor Vetoes Legislation to Increase Managed Care Regulation*, 4 HEALTH L. REP. (BNA) 25, d27 (June 22, 1995).

268. See Proclamation of the Governor (June 16, 1995) (veto message for H.B. 2766) (copy on file with author).

requirements concerning the selection of participating providers and placed limitations on the use of economic practice profiles to exclude providers from the plan.

The governor criticized the bill for impos[ing] numerous new regulations on managed care organizations, add[ing] potentially significant costs to state and local governments and private employers, and contain[ing] exemptions which may give a competitive advantage to some managed care organizations. The result was too little protection for patients and much too much protection for special interests combined with too little competition and too much cost.<sup>269</sup>

Notwithstanding these criticisms, there were things in the Patient Protection Act the governor liked, and he instructed

the Commissioners of Insurance and Health to promulgate the following rules: (1) require disclosure of information concerning plan terms and conditions to allow enrollees and employers to make informed decisions when selecting among managed care plans; (2) allow evaluation of managed care plans to ensure consumers are receiving quality care at an affordable price; (3) where possible, expand HMO patient choice to allow for continuity of treatment should a patient's treating physician be terminated; (4) implement reasonable due process procedures to ensure providers are given reasons if they are turned down or terminated from a managed care plan; and (5) prohibit retaliatory actions by HMOs against patients for filing complaints or appealing decisions.<sup>270</sup>

The rules have been promulgated.<sup>271</sup> While the Department of Insurance rules became effective on December 6, 1995,<sup>272</sup> the Department of Health withdrew its proposed rules on December 6, 1995.<sup>273</sup>

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269. *Id.*

270. *Id.*

271. See Tex. Dep't of Ins., Proposed Rule, 20 Tex. Reg. 5475 (July 25, 1995); Tex. Dep't of Health, Proposed Rule, 20 Tex. Reg. 5990 (August 8, 1995).

272. See Dep't of Ins., Adopted Rule, 20 Tex. Reg. 9697 (Nov. 21, 1995) (effective date); *id.* at 9866 (Nov. 24, 1995) (text of adopted rules).

273. See *id.* at 10755 (Dec. 15, 1995).

