

**BEFORE THE INK IS DRY: AN INSIDER'S
LOOK AT THE NEW TORT AND INSURANCE
LEGISLATION**

**Healthcare Liability Claims After Tort Reform:
Cosmetics or CPR?**

D. Michael Wallach
Stacy R. Welch

Texas Institute for Continuing Legal Education
Austin, Texas
June 20, 2003

Before the Ink is Dry: An Insider's Look at Tort Reform – Cosmetics or CPR?

I. Scope

This paper is intended to be an introduction to those aspects of House Bill 4, recently adopted by the Texas Legislature and signed by the Governor, which are likely to be commonly encountered in the arena of medical malpractice litigation. There is a particular focus on those provisions which differ from the current law, at which points the Bill provisions are juxtaposed alongside the law currently in place. Areas of special attention include liability limits, the requirement of expert reports, and the payment of future damages in health care liability claims, which may be found under Article 10 of the Bill. The anticipated impact of the new provisions at issue are discussed as well.

II. Settlement of Claims – Article 2

Adds Chapter 42, entitled “Settlement,” to Subtitle C, Title 2, Civil Practice and Remedies Code:

By January 1, 2004, the Supreme Court is to formulate rules to implement the provisions of Chapter 42. §42.005(a). Such rules must provide the dates both before and after which a party may, or may not, make a qualifying settlement offer and the procedures for making an initial settlement offer, making successive offers, withdrawing an offer, accepting an offer, rejecting an offer, modifying the deadline for making, withdrawing, accepting, or rejecting a settlement offer. §42.005(b). The rules must also address actions in which there are multiple parties and must provide that if the offering party joins another party or designates a responsible third party after making the settlement offer, the offeree may declare the settlement offer void. §42.005(c).

Regarding the award of litigation costs, if a qualifying settlement offer is made and rejected, but the judgment rendered is “significantly less favorable” to the to the rejecting party than was the settlement offer, the offering party may recover litigation costs from the rejecting party. §42.002(a). A judgment will be deemed to be “significantly less favorable” if the “rejecting party” is a claimant and the award will be less than 80 percent of the rejected offer, or if the “rejecting party” is a defendant and the award will be more than 120 percent of the rejected offer¹. §42.002(b). Litigation costs which may be recovered include court costs, reasonable fees for up to two testifying expert witnesses, and reasonable attorney’s fees. §42.001(5). Note, however, that these provisions will be triggered by defendants and apply only to qualified settlement offers. Therefore, not every settlement offer made during the course of litigation will qualify for the application of these provisions.

Chapter 42 will not apply to class actions, shareholder’s derivative actions, actions by or against a governmental unit, actions brought under the Texas Family Code, actions to collect workers’ compensation benefits, or actions filed in justice of the peace court. §42.002(b). For

¹If litigation costs are awarded to a defendant, they will be applied as an offset against the claimant’s recovery. §42.004(g).

actions to which the Chapter does apply, for litigation costs to be awarded, settlement offers must (1) be in writing; (2) state that the offer is made under Chapter 42; (3) state the terms by which the claims may be settled; (4) state a deadline by which the settlement offer must be accepted; and (5) be served on all parties to whom the settlement offer is made. §42.003.

The costs that may be recovered by the offering party under this section are limited to those incurred after the date of the rejected settlement offer. §42.004(c). Under subsection (e) if a claimant or defendant is entitled to recover fees and costs under another law, that claimant or defendant may not recover litigation costs under Chapter 42 in addition to the fees and costs recoverable under the other law. §42.004(e). Therefore, Chapter 42 is inapplicable in such a circumstance. In spite of this effect, the legislature has also adopted subsection (f) of Section 42.004, which achieves the same goal of excluding the recovery of litigation costs where costs and fees are recoverable under other law. In this regard, subsections (e) and (f) appear to be redundant, though the language of (f) is somewhat more convoluted. More particularly, subsection (f) provides that if a claimant or defendant is entitled to recover fees and costs under another law, the court must not include fees and costs by that claimant or defendant “after the date of rejection of the settlement offer” when calculating the amount of the judgment to be rendered. Again, under subsection (c), however, the costs that may be recovered are limited only to those after the date of rejection.

Further, the total amount of the fees to be awarded cannot exceed the sum of 50 percent of the plaintiff’s economic damages, 100 percent of the noneconomic damages and 100 percent of the exemplary damages, less any liens which may be applied to recovery in the underlying claim. §42.004(d). In calculating the maximum of fees which may be awarded, the language of subsection (d) appears to prejudice defendants in those actions where the defendants would also be entitled to collect fees under subsection (a). If a plaintiff in such a case does not prevail on his or her action or recover damages, a defendant entitled to an award under (a) would not be allowed to recover under subsection (c). Simply put, if a plaintiff’s damages are zero, and the total amount of fees to be awarded is limited to a percentage of damages awarded, a prevailing defendant could not recover. Therefore, it seems that a defendant entitled to litigation costs due to a qualifying offer of settlement would benefit more from a modest plaintiff’s judgment than from an outright win under these provisions. An additional implication of subsection (d) is that the exclusion of statutory and contractual liens from bearing the risk of settlement offers may also prove to be a disincentive to settlement.

The award of litigation costs may be an illusory remedy in insurance defense cases, however, for the reason that an insurance company’s pursuit of a qualifying offer on behalf of its insured may expose the insured to uninsured losses. For example, attorney’s fees and costs of court may not be insured risks covered under a defendant’s policy. By making a qualified settlement offer, however, the opportunity that the insured may have to bear the burden of paying a claimant’s fees and costs is created.

III. Proportionate Responsibility and Designation of Responsible Parties – Article 4

Amends Section 33.004, Civil Practice and Remedies Code, and renames the section “Designation of Responsible Third Parties”:

HB4, Section 4.04:

(a) A defendant may seek to designate a person as a responsible third party by filing a motion for leave to designate that person as a responsible third party. The motion must be filed on or before the 60th day before the trial date unless the court finds good cause to allow the motion to be filed at a later date.

(b) Nothing in this section affects the third-party practice as previously recognized in the rules and statutes of this state with regard to the assertion by a defendant of rights to contribution or indemnity. Nothing in this section affects the filing of cross-claims or counterclaims.

(e) If a person is designated under this section as a responsible third party, a claimant is not barred by limitations from seeking to join that person, even though such joinder would otherwise be barred by limitations, if the claimant seeks to join that person not later than 60 days after that person is designated as a responsible third party.

(f) A court shall grant leave to designate the named person as a responsible third party unless another party files an objection to the motion for leave on or before the 15th day after the date the motion is served.

(g) If an objection to the motion for leave is timely filed, the court shall grant leave to designate the person as a responsible third party unless the objecting party establishes:

Section 33.004:

(a) Except as provided in Subsections (d) and (e), prior to the expiration of limitations on the claimant’s claim for damages against the defendant and on timely motion made for that purpose, a defendant may seek to join a responsible third party who has not been sued by the claimant.

(b) Nothing in this section shall affect the third-party practice as previously recognized in the rules and statutes of this state with regard to the assertion by a defendant of rights to contribution or indemnity. Nothing in this section shall affect the filing of cross-claims or counterclaims.

(e) A claimant may join a responsible third party, even though such joinder would otherwise be barred by limitations, if the claimant seeks to join the responsible third party not later than 60 days after a third party claim is filed under Subsection (d).

(1) the defendant did not plead sufficient facts concerning the alleged responsibility of the person to satisfy the pleading requirement of the Texas Rules of Civil Procedure; and

(2) after having been granted leave to replead, the defendant failed to plead sufficient facts concerning the alleged responsibility of the person to satisfy the pleading requirements of the Texas Rules of Civil Procedure.

(h) By granting a motion for leave to designate a person as a responsible third party, the person named in the motion is designated as a responsible third party for purposes of this chapter without further action by the court or any party.

(i) The filing or granting of a motion for leave to designate a person as a responsible third party or a finding of fault against the person:

(1) does not by itself impose liability on the person; and

(2) may not be used in any other proceeding, on the basis of *res judicata*, collateral estoppel, or any other legal theory, to impose liability on the person.

(k) An unknown person designated as a responsible third party under Subsection (j) is denominated as "Jane Doe" or "John Doe" until the person's identity is known.

(l) After adequate time for discovery, a party may move to strike the designation of a responsible third party on the ground that there is no evidence that the designated person is responsible for any portion of the claimant's alleged injury or damage. The court shall grant

the motion to strike unless a defendant produces sufficient evidence to raise a genuine issue of fact regarding the designated person's responsibility for the claimant's injury or damage.

Under the current Section 33.004, a defendant is required to join a responsible third party. As a result of the requirement of joinder, a responsible third party immune from liability or not subject to the court's jurisdiction cannot be joined and that party's liability cannot be submitted. The definition of "responsible third party" in Section 4.05 of House Bill 4, amending Section 33.011(6) of the Civil Practice and Remedies Code, includes any person who is alleged to have caused or contributed to causing the harm for which recovery for damages is sought. The requirement of the current 33.011(6) that the trial court be able to exercise jurisdiction over the third party has been removed:

HB4, Section 4.05(6)²:

(6) "Responsible third party" means any person who is alleged to have caused or contributed to causing in any way the harm for which recovery of damages is sought, whether by negligent act or omission, by any defective or unreasonably dangerous product, by other conduct or activity that violates an applicable legal standard, or by any combination of these. The term "responsible third party" does not include a seller eligible for indemnity under Section 82.002.

²For the purpose of contribution, the definition of "claimant" has also been amended to include any person who is seeking, has sought, or could seek recovery of damages. Such was likely added to prevent settlement transactions such as that described in *Utts v. Short*, 81 S.W.3d 822 (Tex. 2002).

Section 33.011(6):

(6)(A) "Responsible third party" means any person to whom all of the following apply:

- (i) the court in which the action was filed could exercise jurisdiction over the person;
- (ii) the person could have been, but was not, sued by the claimant; and
- (iii) the person is or may be liable to the plaintiff for all or a part of the damages claimed against the named defendant or defendants.

(B) The term "responsible third party" does not include:

(i) the claimant's employer, if the employer maintained workers' compensation insurance coverage, as defined by Section 401.011(44), Labor Code, at the time of the act, event, or occurrence made the basis of the claimant's suit; or

(ii) a person or entity that is a debtor in bankruptcy proceedings or a person or entity

against whom this claimant's claim has been discharged in bankruptcy, except to the extent that liability insurance or other source of third party funding may be available to pay claims asserted against the debtor.

Therefore, a defendant may now have the percentage of responsibility of a third party submitted to the jury as long as he or she files a motion for leave to designate a responsible third party on or before the 60th day before trial. As a practical matter, however, a motion of this type filed at approximately 60 days before trial will likely result in a continuance of trial for conducting discovery regarding the third party's liability. It would be advisable, then, to include the designation of third parties as an item subject to a pretrial discovery control order for the trial court's consideration.

Additionally, under subsection (e), added by House Bill 4, a claimant is not barred by limitations from seeking to join a third party designated as responsible by a defendant even if joinder would otherwise be barred by limitations as long as the claimant seeks to join that person not later than 60 days after his or her designation as a responsible third party. In health care liability claims, under Article 10 of House Bill 4, Section 74.251 of the Civil Practice and Remedies Code regarding the statute of limitations for such claims, a two year and seventy five day limitations period is set forth "notwithstanding any other law." The question then arises whether subsection (e)'s allowance of a claimant to join a designated third party is subject to Chapter 74's statute of limitations. In light of previous case law, Chapter 74 should prevail. *See e.g., Brown v. Shwarts*, 968 S.W.2d 331, 333 (Tex. 1998); *Bala v. Maxwell*, 909 S.W.2d 889, 892-93 (Tex. 1995).

House Bill 4, Article 4, Section 4.06 also amends Section 33.012, Civil Practice and Remedies Code, by rewriting the election of credit for settlement credits under Section 33.014:

HB4, Section 4.06:

(b) If the claimant has settled with one or more persons, the court shall further reduce the amount of damages to be recovered by the claimant with respect to a cause of action by a percentage equal to each settling person's percentage of responsibility.

Section 33.012:

(a) If the claimant is not barred from recovery under Section 33.001, the court shall reduce the amount of damages to be recovered by the claimant with respect to a cause of action by a percentage equal to the claimant's responsibility.

(b) If the claimant has settled with one or more persons, the court shall further reduce the amount of damages to be recovered by the claimant with respect to a cause of action by a credit equal to one of the following, as elected in accordance with Section 33.014:

(1) the sum of the dollar amounts of all settlements; or

(2) a dollar amount equal to the sum of the following percentages of damages found by the trier of fact:

(A) 5 percent of those damages up to \$200,000;

(B) 10 percent of those damages from \$200,001 to \$400,000;

(C) 15 percent of those damages from \$400,001 to \$500,000; and

(D) 20 percent of those damages greater than \$500,000. elections are made, all defendants are considered to have elected Subsection (c)(1).

(c) Notwithstanding Subsection (b), if the claimant in a health care liability claim filed under Chapter 74 has settled with one or more persons, the court shall further reduce the amount of damages to be recovered by the claimant with respect to a cause of action by an amount equal to one of the following, as elected by the defendant:

(1) the sum of the dollar amounts of all settlements; or

(2) a percentage equal to each settling person's percentage of responsibility as found by the trier of fact.

(d) An election made under Subsection (c) shall be made by any defendant filing a written election before the issues of the action are submitted to the trier of fact and when made, shall be binding on all defendants. If no

defendant makes this election or if conflicting elections are made, all defendants are considered to have elected Subsection (c)(1).

In cases other than health care liability claims, rather than having either a sliding scale or a dollar-for-dollar system available to determine the non-settling parties' credit, settlement credit will be given based only on the percentage of fault attributed to the settling parties as opposed to the remaining defendants. §4.06. This places a non-settling defendant in the position of pleading and proving a settling defendant's liability to benefit from the parties' settlement or foregoing any credit. There is a matter of timing, then, as to if and when a defendant will choose to develop a case against its co-defendant(s): Should a defendant take an adversarial position early in the litigation, or should the defendant pursue a joint defense, waiting to see if its co-defendant will settle. This is an important decision, and one in which a defendant could find itself pressed for time.

In health care liability claims, trial courts will reduce the amount of damages to be recovered by a claimant by an amount equal to the sum of the dollar amounts for all settlements or a percentage equal to each settling person's percentage of responsibility as found by the trier of fact, as elected by the defendant. *Id.* An election under this provision must be made in writing prior to the submission of the issues to the trier of fact. *Id.* In a case with multiple defendants, if no defendant makes an election, or if conflicting elections are made, all defendants are considered to have made an election applying the sum of the dollar amounts of all settlements. *Id.* This differs significantly from the current Section 33.014, which provides that if no defendant makes an election, or if conflicting elections are made, the sliding scale for credit applies. TEX. CIV. PRAC. & REM. CODE ANN. §33.014 (Vernon 2003). As mentioned above, however, the sliding scale has been eliminated.

Further, House Bill 4 does not provide any guidance regarding how the above provisions would be applied in a suit which mixes health care liability claims with non-health care liability claims. Clearly the options available to parties in each type of case conflict. Such a case could also result in a windfall to a plaintiff. For example, a combined health care liability/ non-health care liability case such as one involving products liability claims against a drug manufacturer and medical negligence claims against a physician for the prescription of a particular drug. If the physician settles and the jury does not make a finding of liability against the physician, the plaintiff would essentially receive a windfall in the amount for which he settled his claims against the physician because the non-health care liability defendant could take only a percentage of responsibility credit and would not be afforded the dollar-for-dollar settlement protection of Section 4.06(c).

Finally, Section 4.07 of House Bill 4 amends Section 33.013, Civil Practice and Remedies Code to provide for a 51 percent bar to joint and several liability for all causes of action unless the defendant acted with a specific intent to do the claimant harm as described in various designated Penal Code provisions. §4.07(b), (e)³. Currently, joint and several liability in toxic torts cases is only

³House Bill 4, Section 4.07(e) is a much more restrictive provision than the current law which simply provides that a defendant be shown to have a "specific intent to do harm." Under Section

applied where the percentage of responsibility attributed to a defendant is equal or greater than 15 percent.

IV. Products Liability⁴ – Article 5

Article 5 of House Bill 4 is relevant to the arena of health care liability claims to the extent that such covers causes of action relating to prescription drugs and medical devices.

Section 5.01(b) of House Bill 5 creates a 15 year statute of repose for products liability actions, requiring that action be brought no later than 15 years after the date of the sale of the product at issue by the defendant. This statute of repose is applicable unless the manufacturer or seller of the product at issue expressly warrants in writing that the product has a useful safe life of longer than 15 years. §5.01(c).

Section 5.02 of House Bill 4 adds Section 82.003, entitled “Liability of Nonmanufacturing Sellers,” to the Civil Practice and Remedies Code, which protects sellers who did not manufacture the product at issue in a lawsuit. Such a seller will not be liable for harm caused to the claimant by that product unless the claimant proves that the seller participated in the design of the product; that the seller altered or modified the product and the claimant’s harm resulted from that alteration or modification; that the seller installed (or had installed) the product on another product and the claimant’s harm resulted from that installation; that the seller exercised substantial control over an inadequate warning or instruction which harmed the claimant; that the seller made an express factual misrepresentation upon which the claimant relied, resulting in his injury; that the seller actually knew of a defect at the time he supplied the product and that defect harmed the claimant; or the manufacturer is insolvent and not subject to the jurisdiction of the court. §5.02(a).

Section 5.02 also adds Section 83.007, entitled “Medicines,” to Chapter 82, Civil Practice and Remedies Code. In a products liability action alleging that an injury was caused by a failure to provide adequate pharmaceutical warnings and information, there is a rebuttable presumption that the defendant or defendants (including a health care provider, manufacturer, distributor, and prescriber) are not liable with respect to the allegations involving failure to provide adequate

4.07(e), a defendant acts with specific intent to do harm with respect to the nature of his conduct and the result of his conduct when it is his conscious effort or desire to engage in the conduct for the purpose of doing substantial harm to others. House Bill 4 also adds subsection (f), which provides that a claimant’s counsel cannot refer to a violation of criminal law with regard to those Penal Code provisions which will warrant the application of joint and several liability.

⁴A "products liability action" is defined as any action against a manufacturer or seller for recovery of damages or other relief for harm allegedly caused by a defective product, whether the action is based in strict tort liability, strict products liability, negligence, misrepresentation, breach of express or implied warranty, or any other theory or combination of theories, and whether the relief sought is recovery of damages or any other legal or equitable relief. §16.012(2).

warnings or information if the warnings and information accompanying the drug in its distribution were approved by the Food and Drug Administration (“FDA”) or the warnings were those stated in the monographs developed by the FDA regarding drugs not requiring approval. §82.007(a). The question of to whom the warnings and instructions must be distributed for the presumption to apply arises. More particularly, must the distribution of the warnings and the instructions be by each defendant to a patient, or will a prescribing physician receive the benefit of the presumption if his actions fall short of distributing copies of the FDA warnings and information to each of his patients? Here, physicians may argue for the application of the learned intermediary doctrine in their favor. Under the learned intermediary doctrine, when a drug is marketed through physicians, the physician-patient relationship relieves the manufacturer of the obligation to warn the ultimate consumer (*i.e.*, the patient) of the risks associated with the drug.⁵ Extending this doctrine to the application of the presumption regarding FDA warnings and information, it could then be argued that if the warnings and information are distributed to the physician, the rebuttable presumption would be applied. Otherwise, Section 82.007's “that accompanied the product in its distribution” language could have the practical effect of requiring physicians to distribute package inserts to their patients with each written prescription in order to claim the benefit of the rebuttable presumption.

A claimant may rebut this presumption as to each defendant by establishing any of the following: (1) the defendant withheld from or misrepresented to the FDA required information material and relevant to the performance of the product and causally related to the claimant’s injury; (2) the product was sold or prescribed the defendant after the effective date of an FDA withdrawal of the drug from the market; (3) the defendant recommended, promoted, or advertised the pharmaceutical product for an off-label indication (one not approved by the FDA), it was used as recommended, promoted, or advertised for this off-label use, and the claimant’s injury was causally related to the use of the product; (4) the defendant prescribed the pharmaceutical product for an off-label use, if was used as prescribed, and the claimant’s injury was causally related to the prescribed use of the product; or (5) the defendant violated 18 U.S.C. §201, regarding bribery of public officials and witnesses, which conduct caused the warnings or instructions approved for the product to be inadequate. §82.007(b).

Note that Section 82.007 provides that a claimant may rebut the above presumption as to each defendant. Therefore, it is possible that in the same lawsuit, one defendant may be entitled to the presumption while the other is not. Thus, the conduct of the manufacturer/distributor and the prescriber may result in discordant applications of the presumption

⁵*Rolen v. Burroughs Wellcome Co.*, 856 S.W.2d 607, 609 (Tex. App.—Waco 1993, *writ denied*).

V. Interest – Article 6

Amends Section 304.003(c), Finance Code, as follows:

HB 4, Section 6.01:

(c) The postjudgment interest rate is:

(1) the prime rate as published by the Federal Reserve Bank of New York on the date of computation;

(2) five percent a year if the prime rate as published by the Federal Reserve Bank of New York [auction rate] described by Subdivision (1) is less than five percent; or

(3) 15 percent a year if the prime rate as published by the Federal Reserve Bank of New York described by Subdivision (1) is more than 15 percent.

TEX. FIN. CODE §304.003(c):

(c) The postjudgment interest rate is:

(1) the auction rate quoted on a discount basis for 52-week treasury bills issued by the United States government as most recently published by the Federal Reserve Board before the date of computation;

(2) 10 percent a year if the prime rate as published by the auction rate described by Subdivision (1) is less than 10 percent; or

(3) 20 percent a year if the prime rate as published by the auction rate described by Subdivision (1) is more than 20 percent.

Therefore, the method of calculating post judgment interest will change with the enactment of House Bill 4, and this method of calculation will apply to any final judgment signed or subject to an appeal on or after September 1, 2003. The date of computation under subsection (c) is undefined, however. Presumably, the date of computation would be the date on which the judgment is signed.

Further, the Bill adds Section 304.1045, entitled “Future Damages,” to Subchapter B, Chapter 304, Finance Code to provide that prejudgment interest may not be assessed or recovered on an award of future damages. §6.02. The effective date for this provision is September 1, 2003, as well.

VI. Appeal Bonds – Article 7

Section 7.02 of House Bill 4 amends Chapter 52, Civil Practice and Remedies Code by adding Section 52.006, regarding the amount of security for a money judgment:

HB4, Section 7.02

Subject to Subsection (b), when a judgment is for money, the amount of security must equal the sum of:

- (1) the amount of compensatory damages awarded in the judgment;
- (2) interest for the estimated duration of the appeal; and
- (3) costs awarded in the judgment.

(b) Notwithstanding any other law or rule of court, when a judgment is for money, the amount of security must not exceed the lesser of:

- (1) 50 percent of the judgment debtor's net worth; or
- (2) \$25 million.

In referring to a judgment debtor's net worth, this section omits the concept of liability insurance in setting post judgment security. Therefore, if a defendant judgment debtor only has a net worth of \$100,000, but has a \$2 million liability insurance policy, the prevailing party is limited to post judgment security of \$50,000.

VII. Health Care – Article 10

Article 10 of House Bill 4 codifies Texas Revised Civil Statute Annotated, Article 4590i as Chapter 74, entitled "Medical Liability," to the Civil Practice and Remedies Code. It may appear to the reader that Chapter 74 rewrites Article 4590i in its entirety. While substantial changes have been made in a number of areas, it should be noted that Chapter 74 is a codification of a number of Article 4590i provisions which have remained unchanged. For example, Subchapter C of Chapter 74, regarding informed consent, is identical to Subchapter F of Article 4590i, regarding informed consent. Further, Section 74.352, regarding discovery procedures, providing for the promulgation of standard sets of interrogatories and requests for production of documents in health care liability claims by a Health Care Liability Discovery Panel, was added to Article 4590i in 1993. Art. 4590i, §13.02. However, the Panel never came to fruition, and standard sets of discovery were never established. Section 74.352 contains no implementing language, however, so it appears as though the provision will never be effected, even under the new law.

A. Definitions

Article 10 of House Bill 4, regarding health care litigation, adds a number of definition provisions, expanding the scope of persons covered by the act:

HB4, Section 74.001(12):

(A) "Health care provider" means any person, partnership, professional association, corporation, facility, or institution duly licensed, certified, registered, or chartered by the State of Texas to provide health care, including:

Article 4590i, Section 1.03(3):

"Health care provider" means any person, partnership, professional association, corporation, facility, or institution duly licensed, certified, registered, or chartered by the State of Texas to provide health care as a registered nurse, hospital, dentist, podiatrist,

- (i) a registered nurse; pharmacist, or nursing home, or an officer,
- (ii) a dentist; employee, or agent thereof acting in the course
- (iii) a podiatrist; and scope of his employment.
- (iv) a pharmacist;
- (v) a chiropractor;
- (vi) an optometrist; or
- (vii) a health care institution.

(B) The term includes:

- (i) an officer, director, shareholder, member, partner, manager, owner, or affiliate of a health care provider or physician; and
- (ii) an employee, independent contractor, or agent of a health care provider or physician acting in the course and scope of the employment or contractual relationship.

The term "health care institution" has also been defined by House Bill 4:

HB4, Section 74.001(11):

"Health care institution" includes:

- (A) an ambulatory surgical center;
- (B) an assisted living facility licensed under Chapter 247, Health and Safety Code;
- (C) an emergency medical services provider;
- (D) a health services district created under Chapter 287, Health and Safety Code;
- (E) a home and community support services agency;
- (F) a hospice;
- (G) a hospital;
- (H) a hospital system;
- (I) an intermediate care facility for the mentally retarded or a home and community-based services waiver program for persons with mental retardation adopted in accordance with Section 1915(c) of the federal Social Security Act (42 U.S.C. Section 1396n), as amended;
- (J) a nursing home; or
- (K) an end stage renal disease facility licensed under Section 251.011, Health and Safety Code.

By defining “health care institution” and including affiliates of a health care provider⁶ and hospital systems⁷ in the definition of “health care provider,” Section 74.001 brings the parent companies of hospitals and professional associations, whether for profit or non-profit, within the purview of Chapter 74. As a result, the corporate parents of hospital subsidiaries are afforded the benefits and protections of Chapter 74.

Further, as is evident from a comparison of the newly adopted and current provisions, House Bill 4 now covers independent contractors under the umbrella of health care providers to which Chapter 74 will apply. This should cure the sometimes inconsistent coverage under Article 4590i, which provided that only employees of a health care provider could be considered health care providers themselves. For example, under the current Article 4590i definition, a physical therapist employed by a hospital would be considered a health care provider under Article 4590i, Section 1.03, and would benefit from the Act’s provisions. A physical therapist who merely contracted with a hospital would not. Under House Bill 4, Section 74.001, each physical therapist would be considered a health care provider for the purposes of Chapter 74.

The definitions of “claimant,” “physician,” and “health care liability claim” have also been added/expanded by House Bill 4:

HB4, Section 74.001:

(2) "Claimant" means a person, including a decedent’s estate, seeking or who has sought recovery of damages in a health care liability claim. All persons claiming to have sustained damages as the result of the bodily injury or death of a single person are considered a single claimant.

(13) "Health care liability claim" means a cause of action against a health care provider or physician for treatment, lack of treatment, or other claimed departure from accepted standards of medical care or health care or safety or professional or administrative

Article 4590i, Section 1.03:

(4) "Health care liability claim" means a cause of action against a health care provider or physician for treatment, lack of treatment, or other claimed departure from accepted standards of medical care, or health care or safety, which proximately results in injury to

⁶"Affiliate" means a person who, directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with a specified person, including any direct or indirect parent or subsidiary. HB4, §74.001(1).

⁷"Hospital system" means a system of hospitals located in this state that are under the common governance or control of a corporate parent. HB4, §74.001(17).

services directly related to health care which proximately results in injury to or death of the patient, whether the patient's claim or cause of action sounds in tort or contract.

(23) "Physician" means:

(A) an individual licensed to practice medicine in this state;

(B) a professional association organized under the Texas Professional Association Act (Article 1528f, Vernon's Texas Civil Statutes) by an individual physician or group of physicians;

(C) a partnership or limited liability partnership formed by a group of physicians;

(D) a nonprofit health corporation certified under Section 162.001, Occupations Code; or

(E) a company formed by a group of physicians under the Texas Limited Liability Company Act (Article 1528n, Vernon's Texas Civil Statutes).

or death of a claimant, whether the claimant's claim or cause of action sounds in tort or contract.

(8) "Physician" means a person licensed to practice medicine in this State.

In adding the definition of "claimant," the legislature ensured that such would include, as one singular claimant, the primary injured party (or patient), as well as all persons having a derivative claim. As is discussed further below, the greatest area upon which this addition will have effect are those provisions of Chapter 74 regarding limits on liability. By expanding the definition of "physician," the legislature expanded the means through which a licensed doctor may provide medical services.

Further, the definition of "health care liability claim" now includes not only causes arising out of medical care, health care, or safety, but also include claims arising out of professional or administrative services directly related to health care. "Professional or administrative services" under House Bill 4 is defined as those duties or services that a physician or health care provider is required to provide as a condition of maintaining the physician's or health care provider's license, accreditation status, or certification to participate in state or federal health care programs. §74.001(24). Thus, House Bill 4 will overrule via statute the holdings of such cases as *Rose v. Garland Community Hospital*, 87 S.W.3d 188 (Tex. App.—Dallas 2002, *no pet. h.*), which have held that actions against hospitals for negligent credentialing of physicians are not health care liability claims for the purpose of Article 4590i. With the effective date of House Bill 4, however, such claims will be afforded the same protections and benefits available in cases alleging medical negligence.

B. Conflict with Other Law and Rules of Civil Procedure

Section 74.002(a) of House Bill 4 provides that, in the event of a conflict, including a rule of civil procedure or evidence, Chapter 74 prevails. §74.002(a). The exception to this provision, however, is any conflict between Chapter 74 and Sections 101.023, 102.003, or 108.002 of the Texas Civil Practice and Remedies Code, in which the government provisions will prevail.

C. Notice

HB 4, Section 74.051:

(a) Any person or his authorized agent asserting a health care liability claim shall give written notice of such claim by certified mail, return receipt requested, to each physician or health care provider against whom such claim is being made at least 60 days before the filing of a suit in any court of this state based upon a health care liability claim. The notice must be accompanied by the authorization form for release of protected health information as required under Section 74.052.

(b) In such pleadings as are subsequently filed in any court, each party shall state that it has fully complied with the provisions of this section and Section 74.052 and shall provide such evidence thereof as the judge of the court may require to determine if the provisions of this chapter have been met.

(c) Notice given as provided in this chapter shall toll the applicable statute of limitations to and including a period of 75 days following the giving of the notice, and this tolling shall apply to all parties and potential parties.

(d) All parties shall be entitled to obtain complete and unaltered copies of the patient's medical records from any other party within 45 days from the date of receipt of a written

Article 4590i, Section 4.01:

(a) Any person or his authorized agent asserting a health care liability claim shall give written notice of such claim by certified mail, return receipt requested, to each physician or health care provider against whom such claim is being made at least 60 days before the filing of a suit in any court of this state based upon a health care liability claim.

(b) In such pleadings as are subsequently filed in any court, each party shall state that it has fully complied with the provisions of this section and shall provide such evidence thereof as the judge of the court may require to determine if the provisions of this Act have been met.

(c) Notice given as provided in this chapter shall toll the applicable statute of limitations to and including a period of 75 days following the giving of the notice, and this tolling shall apply to all parties and potential parties.

(d) All parties shall be entitled to obtain complete and unaltered copies of the patient's medical records from any other party within 10 days from the date of receipt of a written

request for such records; provided, however, that the receipt of a medical authorization in the form required by Section 74.052 executed by the claimant herein shall be considered compliance by the claimant with this subsection.

(e) For the purposes of this section, and notwithstanding Chapter 159, Occupations Code, or any other law, a request for the medical records of a deceased person or a person who is incompetent shall be deemed to be valid if accompanied by an authorization in the form required by Section 74.052 signed by a parent, spouse, or adult child of the deceased or incompetent person.

request for such records; provided, however, that the receipt of a medical authorization executed by a claimant herein shall be considered compliance by the claimant with this section.

(e) For the purposes of this section, and notwithstanding Section 5.08, Medical Practices Act, or any other law, a request for the medical records of a deceased person or a person who is incompetent shall be deemed to be valid if accompanied by an authorization signed by a parent, spouse, or adult child of the deceased or incompetent person.

Section 74.052 requires that a claimant include a statutorily constructed medical authorization for the release of protected health care information with his or her notice of a health care claim, which notice is required by Section 74.051. §74.052(a). Failure to provide an authorization with the required notice will abate the proceedings against the defendant receiving the notice for 60 days following that defendant's receipt of the required authorization. §74.052(b). According to Section 74.052, the medical authorization required to accompany a notice of claim must provide that defendants may discover the health care information in the custody of physicians/health care providers who have examined, evaluated, or treated the claimant in connection with the injuries at issue in the claim. The authorization also extends to physicians/health care providers that may examine, evaluate, or treat the claimant in connection with the injuries at issue in the future, as well as those who examined, evaluated, or treated the claimant in the five years prior to the incident which is the basis of the claim. Claimants must provide a list of names of the physicians/health care providers to whom the authorization applies within the authorization itself, and must also list those physicians/health care providers whom the claimant asserts are excluded on the basis that such treatment is not relevant to the damages being claimed.⁸ Parties to litigation are sure to conflict over this exclusion provision, however. Under subsection (c) of Section 74.051, which states, "Notice given as provided in this chapter shall toll the applicable statute of limitations to and including a period of 75 days," indicates that any notice not accompanied by a proper medical authorization which meets the requirements of Section 74.052 will not toll the statute of limitations otherwise applicable to a health care liability claim.

It seems clear that the 60 day abatement provisions under Sections 74.051(a) and 74.052(b) are intended by the legislature to serve the same purpose as the availability of abatement under

⁸For the format required of a medical authorization under this Chapter, see attached authorization form, fashioned according to Article 10, §74.052(c).

Article 4590i, Section 4.01 – to provide time for the investigation and settlement of potential claims. Indeed, this abatement provision is critical for the reason that the statutorily-constructed medical authorization is the only means by which a health care liability defendant will be able to obtain information as to the plaintiff’s claims outside of the written discovery the plaintiff is allowed to conduct prior to the filing of his or her expert report as set forth in House Bill 4 Section 74.351(s), discussed below. It is likely that a large number of health care liability claims will be filed prior to the effective date of this Act without pre-suit notice under the current Article 4590i, Section 4.01. The typical remedy for lack of pre-suit notice under the current law – abatement upon the request of a defendant – would not be an adequate remedy for health care liability defendants in those suits filed without pre-suit notice filed in an attempt to beat the effective date of Article 10. Health care liability claims filed without proper notice which may be filed in coming weeks, by counsel eager to avoid the more limiting provisions of House Bill 4, are effectively changing the substantive rights of the parties by effectively avoiding the application of the new law. Thus, instead of abatement, it seems that a more adequate remedy for those actions filed without notice prior to the effective date of Article 10 of House Bill 4 (September 1, 2003) would be that of dismissal without prejudice, requiring the claimant to re-file his or her action after the new law has been enacted.

Section 74.051 further provides for an extended period of time in which a physician or health care provider must release his or her medical records upon a written request for records from a health care liability claimant. Under Article 4590i, a physician or health care provider must release such records within 10 days of request – a time which is often difficult to meet. Article 4590i, §4.01(d). Under Section 74.051, however, a physician or health care provider now has 45 days from the date of receipt of a written request to provide the claimant with such records. §74.051(d).

B. Emergency Care

Section 74.151, entitled “Liability for Emergency Care⁹,” provides that a person who administers emergency care in good faith is not liable in civil damages for an act performed during the emergency unless that person’s act is willfully or wantonly negligent. §74.151(a). This provision applies in any location, as opposed to only a health care facility, and applies to any individual, whether a physician, other health care provider, or layperson. *Id.* This provision does not apply, however, to (1) care administered for or in expectation of remuneration, (2) by a person who was at the scene of the emergency because he or a person he represents as an agent was soliciting business or seeking to perform a service for remuneration, or (3) by a person whose negligent act or omission was a producing cause¹⁰ of the emergency for which the care is being administered. §74.151(b), (c). Therefore, this section, which requires a threshold showing of wanton and willful negligence to hold

⁹“Emergency care” is not defined under Chapter 74.

¹⁰Note that this provision excludes persons whose acts were a producing cause of the emergency itself. Such cause is in contrast to that of “proximate cause,” which requires the element of foreseeability. Thus, a person will be excluded from the protection of this provision if he or she caused the emergency, regardless of whether the emergency was foreseeable to the actor.

the actor liable, expressly excludes physicians or health care providers who render emergency care during the emergency at issue as a part of their job or employment responsibilities for which they are being compensated. *Id.*

Interestingly, however, the legislature appears to have thwarted its own statutorily carved-out exception through the adoption of Section 74.153, entitled “Standard of Proof in Cases Involving Emergency Medical Care.”¹¹ Section 74.153 provides:

In a suit involving a health care liability claim against a physician or health care provider for injury to or death of a patient arising out of the provision of emergency medical care in a hospital emergency department or obstetrical unit or in a surgical suite immediately following the evaluation or treatment of a patient in a hospital emergency department, the claimant bringing the suit may prove that the treatment or lack of treatment by the physician or health care provider departed from accepted standards of medical care or health care only if the claimant shows by a preponderance of the evidence that the physician or health care provider, with willful and wanton negligence, deviated from the degree of care and skill that is reasonably expected of an ordinarily prudent physician or health care provider in the same or similar circumstances.

§74.153. Applying the language of Section 74.153, it applies the same standard for liability – willful and wanton negligence – to physicians and health care providers who render medical or health care to patients in emergency departments, or shortly thereafter in surgery or obstetrical departments, as a part of their professional duties for which they are compensated, as does Section 74.151 in which such health care providers are specifically excluded. The inconsistency between these provisions is fairly clear. One question which arises, however, is whether a physician or health care provider who responds to a code on a hospital floor would benefit from either of these provisions. Such would depend, therefore, on the exclusionary provisions of 74.151.

Further, observe that subsection (b) of Section 74.154, regarding jury instructions involving emergency medical care appears to be misplaced. Subsection (a) provides that, in an action for damages arising from the provision of emergency medical treatment under Section 74.154, the trial court must instruct the jury to consider (with all other relevant matters) whether the person providing care did or did not have the patient’s medical history or was able or unable to obtain same, including knowledge of preexisting medical conditions; the presence or lack of a preexisting physician/health

¹¹"Emergency medical care" means bona fide emergency services provided after the sudden onset of a medical or traumatic condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in placing the patient’s health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. The term does not include medical care or treatment that occurs after the patient is stabilized and is capable of receiving medical treatment as a nonemergency patient or that is unrelated to the original medical emergency. §74.001(7).

care provider-patient relationship; the circumstances constituting the emergency; and the circumstances surrounding the delivery of the emergency medical care. §74.154(a). Section (b) then proceeds to state that the provisions of subsection (a) do not apply to medical care or treatment that occurs after the patient is stabilized and is capable of receiving medical treatment as a nonemergency patient, that is unrelated to the original medical emergency, or that is related to an emergency caused in whole or in part by the negligence of the defendant. §74.154(b). By placing these exclusions under the section regarding jury instructions, the legislature has effectively made inapplicable those instructions in the enumerated circumstances. It has not, however, excluded such circumstances with regard to the application of the standard of care.¹²

C. Statute of Limitations

Under Section 74.251 added by House Bill 4, the statute of limitations applicable to health care liability claims remains two years, or, with proper notice, two years and 75 days from the occurrence of the breach or tort or from the date the medical/health care or treatment that is the subject of the claim of the hospitalization for which the claim is made is completed. §74.251(a). Minors under the age of 12 years still have until their 14th birthday in which to file the claim or have a claim filed on their behalf. *Id.*

However, subsection (b) of Section 74.251 creates a statute of repose for health care liability claims, which provides that a claimant must bring such a claim no later than 10 years after the date of the act or omission that gives rise to the claim. §74.251(b). Failure to bring a claim within 10 years will bar the claim and eliminate the claimant's cause of action. *Id.* A statute of repose differs from a statute of limitations in that it may cut off a claimant's right of action before the injured party discovers or reasonably should have discovered the injury. *Dallas Mkt. Ctr. Dev. Co. v. Beran & Shelmire*, 824 S.W.2d 218 (Tex. App.—Dallas 1991, *writ denied*). Prior to House Bill 4, Texas had two statutes of repose, one for architects and engineers and one for persons furnishing construction or repairs to improvements (*i.e.*, contractors), which also apply 10 year repose periods. TEX. CIV. PRAC. & REM. CODE ANN. §§16.008-.009 (Vernon 2003). While the statute of limitations under Article 4590i in the past has often come under fire by the plaintiff's bar for violation of the Texas Constitution's open court provision, the statutes of repose previously established under Texas law have survived state constitutional challenge. *See Suburban Homes v. Austin-Northwest Dev. Co.*, 734 S.W.2d 89 (Tex. App.—Houston [1st Dist.] 1987, *no writ*). It is unclear, however, how the statute of repose will be applied as to minors.

¹²The exclusion of a defendant who caused the emergency at issue is the exception here because such exclusion is expressly stated in Section 74.153.

D. Liability Limits

HB 4, Section 74.301

Article 4590i, Section 11.02:

(a) In an action on a health care liability claim where final judgment is rendered against a physician or health care provider other than a health care institution¹³, the limit of civil liability for noneconomic damages of the physician or health care provider other than a health care institution, inclusive of all persons and entities for which vicarious liability theories may apply, shall be limited to an amount not to exceed \$250,000 for each claimant¹⁴, regardless of the number of defendant physicians or health care providers other than a health care institution against whom the claim is asserted or the number of separate causes of action on which the claim is based.

(b) In an action on a health care liability claim where final judgment is rendered against a single health care institution, the limit of civil liability for noneconomic damages inclusive of all persons and entities for which vicarious liability theories may apply, shall be limited to

¹³*i.e.*, an ambulatory surgical center; an assisted living facility; an emergency medical services provider; a health services district; a home and community support services agency; a hospice; a hospital; a hospital system; a nursing home; or an end stage renal disease facility. §74.001(a)(11).

¹⁴"Claimant" means a person, including a decedent's estate, seeking or who has sought recovery of damages in a health care liability claim. All persons claiming to have sustained damages as the result of the bodily injury or death of a single person are considered a single claimant. §74.001(a)(2).

an amount not to exceed \$250,000 for each claimant.

(c) In an action on a health care liability claim where final judgment is rendered against more than one health care institution, the limit of civil liability for noneconomic damages for each health care institution, inclusive of all persons and entities for which vicarious liability theories may apply, shall be limited to an amount not to exceed \$250,000 for each claimant and the limit of civil liability for noneconomic damages for all health care institutions, inclusive of all persons and entities for which vicarious liability theories may apply, shall be limited to an amount not to exceed \$500,000 for each claimant.

HB 4, Section 74.303:

(a) In a wrongful death or survival action on a health care liability claim where final judgment is rendered against a physician or health care provider, the limit of civil liability for all damages, including exemplary damages, shall be limited to an amount not to exceed \$500,000 for each claimant, regardless of the number of defendant physicians or health care providers against whom the claim is asserted or the number of separate causes of action on which the claim is based...¹⁵

(c) Subsection (a) does not apply to the amount of damages awarded on a health care

(a) In an action on a health care liability claim where final judgment is rendered against a physician or health care provider, the limit on civil liability for damages of the physician or health care provider shall be limited to an amount not to exceed \$500,000.

(b) Subsection (a) of this section does not apply to the amount of damages awarded on a health care liability claim for the expenses of necessary medical, hospital, and custodial care received before judgment or required in the future for treatment of the injury.

¹⁵Though not outlined here, in adjusting the liability limit prescribed in (a), Section 74.303(b) establishes that the consumer price index is to be determined as published by the Bureau of Labor Statistics of the United States Department of Labor. This had been previously unspecified under Article 4590i.

liability claim for the expenses of necessary medical, hospital, and custodial care received before judgment or required in the future for treatment of the injury.

(d) The liability of any insurer under the common law theory of recovery commonly known in Texas as the "Stowers Doctrine" shall not exceed the liability of the insured.

(e) In any action on a health care liability claim that is tried by a jury in any court in this state, the following shall be included in the court's written instructions to the jurors:

(1) "Do not consider, discuss, nor speculate whether or not liability, if any, on the part of any party is or is not subject to any limit under applicable law."

(2) "A finding of negligence may not be based solely on evidence of a bad result to the claimant in question, but a bad result may be considered by you, along with other evidence, in determining the issue of negligence. You are the sole judges of the weight, if any, to be given to this kind of evidence."

(c) This section shall not limit the liability of any insurer where facts exist that would enable a party to invoke the common law theory of recovery commonly known in Texas as the "Stowers Doctrine."

(d) In any action on a health care liability claim that is tried by a jury in any court in this state, the following shall be included in the court's written instructions to the jurors: Do not consider, discuss, nor speculate whether or not liability, if any, on the part of any party is or is not subject to any limit under applicable law.

"A finding of negligence may not be based solely on evidence of a bad result to the patient in question, but such a bad result may be considered by you, along with other evidence, in determining the issue of negligence; you shall be the sole judges of the weight, if any, to be given to any such evidence." (Art. 4590, §7.02(a)).

The difference in the damage caps reflected in House Bill 4, as opposed to those of Article 4590i is clear. Note, however, that the new caps are to be applied per claimant, as opposed to each defendant, as is the current state of the law. Further, the noneconomic damages caps will be applied to health care liability claims regardless of whether House Joint Resolution 3, which proposes a constitutional amendment to the open courts provision to allow damage caps on noneconomic damages in health care liability claims. If House Joint Resolution 3 passes, however, the noneconomic damage caps set forth in Section 74.301 will be secure against all open courts challenges. If the Resolution does not pass, the caps under 74.031 will be subject to constitutional challenge, which may result in the application of the alternative limitation on noneconomic damages set forth in Section 74.302. The provisions in Section 74.302 are largely the same as those found in Section 74.301, with the addition of Section 74.302's inclusion of *quid pro quo* provisions regarding defendants' evidence of financial responsibility. See §74.302(b), (c).

Nevertheless, in any event, the caps set forth in Section 74.303 will apply in all death cases. The application of these caps to wrongful death and survival claims is permitted because the legislature created those causes of action. As such, the legislature may modify the statutorily-created causes of action without constitutional challenge. *See Rose v. Doctors Hosp.*, 801 S.W.2d 841, 848 (Tex. 1990). Further, note that this cap incorporates punitive damages, which had not been previously incorporated under Article 4590i.

Thus, under subsection (a), there is a \$250,000 cap per claimant on noneconomic damages in actions against a physician or health care provider regardless of the number of such defendants. Under subsection (b), if a health care institution is a defendant (including any persons or entities for which vicarious liability may apply), an additional \$250,000 will be added to the cap for that institution. However, if there are multiple health care institution defendants, under subsection (c), the cap on noneconomic damages will be limited to \$500,000 total per claimant. There is no provision in Section 74.301 which offers any guidance as to how the noneconomic damages are to be allocated between plaintiffs, or among defendants. It seems logical that such would be allocated to plaintiffs in proportion to each plaintiff's rights to the total judgment and that such would be allocated between defendants in proportion to each defendant's percentage of responsibility.

Under subsection (d) above, note that claimants can no longer use the Stowers doctrine to try to obtain a greater recovery from a defendant's insurer where the recovery against the defendant would otherwise be capped.

E. Expert Reports

HB, Section 74.351

(a) In a health care liability claim, a claimant shall, not later than the 120th day after the date the claim was filed, serve on each party or the party's attorney one or more expert reports, with a curriculum vitae of each expert listed in the report for each physician or health care provider against whom a liability claim is asserted. The date for serving the report may be extended by written agreement of the affected parties. Each defendant physician or health care provider whose conduct is implicated in a report must file and serve any objection to the sufficiency of the report not later than the 21st day after the date it was served, failing which all objections are waived.

Article 4590i, Section 13.01

(d) Not later than the later of the 180th day after the date on which a health care liability claim is filed or the last day of any extended period established under Subsection (f) or (h) of this section, the claimant shall, for each physician or health care provider against whom a claim is asserted:

(1) furnish to counsel for each physician or health care provider one or more expert reports, with a curriculum vitae of each expert listed in the report; or

(2) voluntarily nonsuit the action against the physician or health care provider.

(b) If, as to a defendant physician or health care provider, an expert report has not been served within the period specified by Subsection (a), the court, on the motion of the affected physician or health care provider, shall, subject to Subsection (c), enter an order that:

(1) awards to the affected physician or health care provider reasonable attorney's fees and costs of court incurred by the physician or health care provider; and

(2) dismisses the claim with respect to the physician or health care provider, with prejudice to the refiling of the claim.

(c) If an expert report has not been served within the period specified by Subsection (a) because elements of the report are found deficient, the court may grant one 30-day extension to the claimant in order to cure the deficiency. If the claimant does not receive notice of the court's ruling granting the extension until after the 120-day deadline has passed, then the 30-day extension shall run from the date the plaintiff first received the notice.

...

(l) A court shall grant a motion challenging the adequacy of an expert report only if it

(e) If a claimant has failed, for any defendant physician or health care provider, to comply with Subsection (d) of this section within the time required, the court shall, on the motion of the affected physician or health care provider, enter an order awarding as sanctions against the claimant or the claimant's attorney:

(1) the reasonable attorney's fees and costs of court incurred by that defendant;

(2) the forfeiture of any cost bond respecting the claimant's claim against the defendant to the extent necessary to pay the award; and

(3) the dismissal of the action of the claimant against that defendant with prejudice to the claim's refiling.

(f) The court may, for good cause shown after motion and hearing, extend any time period specified in Subsection (d) of this section for an additional 30 days. Only one extension may be granted under this subsection.

(g) Notwithstanding any other provision of this section, if a claimant has failed to comply with a deadline established by Subsection (d) of this section and after hearing the court finds that the failure of the claimant or the claimant's attorney was not intentional or the result of conscious indifference but was the result of accident or mistake, the court shall grant a grace period of 30 days to permit the claimant to comply with that subsection. A motion by a claimant for relief under this subsection shall be considered timely if it is filed before any hearing on a motion by a defendant under Subsection (e) of this section.

...

appears to the court, after hearing, that the report does not represent an objective good provider departed from accepted standards of health care, an expert qualified to testify under the requirements of Section 74.402;

(f) In this section:

...

(5) "Expert" means:

(A) with respect to a person giving opinion testimony regarding whether a physician departed from accepted standards of medical care, an expert qualified to testify under the requirements of Section 74.401;

(B) with respect to a person giving opinion testimony regarding whether a health care provider departed from accepted standards of health care, an expert qualified to testify under the requirements of Section 74.402;

(C) with respect to a person giving opinion testimony about the causal relationship between the injury, harm, or damages claimed and the alleged departure from the applicable standard of care in any health care liability claim, a physician who is otherwise qualified to render opinions on such causal relationship under the Texas Rules of Evidence;

(D) with respect to a person giving opinion testimony about the causal relationship between the injury, harm, or damages claimed and the alleged departure from the applicable standard of care for a dentist, a dentist or physician who is otherwise qualified to render opinions on such causal relationship under the Texas Rules of Evidence; or

(E) with respect to a person giving opinion testimony about the causal relationship between the injury, harm, or damages claimed and the alleged departure from the applicable standard of care for a podiatrist, a podiatrist or physician who is otherwise qualified to render opinions on such causal relationship under the Texas Rules of Evidence.

(f) In this section:

...

(5) "Expert" means:

(A) with respect to a person giving opinion testimony regarding whether a physician departed from accepted standards of medical care, an expert qualified to testify under the requirements of Section 14.01(a) of this Act; or

(B) with respect to a person giving opinion testimony about a nonphysician health care provider, an expert who has knowledge of accepted standards of care for the diagnosis, care, or treatment of the illness, injury, or condition involved in the claim.

(6) “Expert report” means a written report by an expert that provides a fair summary of the expert’s opinions as of the date of the report regarding applicable standards of care, the manner in which the care rendered by the physician or health care provider failed to meet the standards, and the causal relationship between that failure and the injury, harm, or damages claimed....

(6) “Expert report” means a written report by an expert that provides a fair summary of the expert’s opinions as of the date of the report regarding applicable standards of care, the manner in which the care rendered by the physician or health care provider failed to meet the standards, and the causal relationship between that failure and the injury, harm, or damages claimed.

(s) Until a claimant has served the expert report and curriculum vitae as required by Subsection (a), all discovery in a health care liability claim is stayed except for the acquisition by the claimant of information, including medical or hospital records or other documents or tangible things, related to the patient’s health care through:

(1) written discovery as defined in Rule 192.7, Texas Rules of Civil Procedure;

(2) depositions on written questions under Rule 200, Texas Rules of Civil Procedure; and

(3) discovery from nonparties under Rule 205, Texas Rules of Civil Procedure.

...

(u) Notwithstanding any other provision of this section, after a claim is filed all claimants, collectively, may take not more than two depositions before the expert report is served as required by Subsection (a).

The most obvious change in the requirement of expert reports under House Bill 4 is the reduction of the time period in which a health care liability claimant has to serve an expert report from 180 days to 120 days. However, defendants must now file objections to the claimant’s report under this section within 21 days of its date of service or waive any such objection. §74.351(a). Note also, however, that House Bill 4 has eliminated the double opportunity system of a claimant’s ability to gain an extension of time in which to file an adequate and compliant expert report currently found in Article 4590i, Section 13.01(f) and (g). Under the current law, a claimant may be granted a one-time 30 day grace period for filing an expert report if the claimant shows, upon motion and after

hearing, good cause for such extension. Art. 4590i, §13.01(f). Additionally, a claimant may be granted a 30 day grace period to file a sufficient report if the claimant failed to comply with the requirements of Section 13.01 and such was the result of accident or mistake, as opposed to conscious indifference.

Since the addition of these provisions of Article 4590i in 1995, there has been much debate over the manner in which subsections (f) and (g) should be interpreted in relation to one another. Under Section 74.351(a), the 120 day deadline for serving an expert report may be extended by written agreement of the parties. Under 74.351(c), the court may grant one 30 day extension if an expert report is not considered served because elements of the report are deemed deficient. While subsection (c) lacks any threshold determination that the court must make in order to grant such an extension, such as good cause, accident, or mistake, it is significant to note that in doing so the legislature did not provide a means for a claimant who has altogether failed to file an expert report to receive an extension of time.

Section 74.351(r) also expands the current Article 4590i definition of an “expert” in health care liability claims. Experts are currently defined only as to claims against physicians as to standard of care requirements. The provisions of House Bill 4 take the physician standard of care and create analogous provisions for experts against other health care providers. These new provisions also add requirements for experts regarding the issue of causation. Such requirements are phrased under the new provisions as being those set forth under the Texas Rules of Evidence. Thus, for example, in a case against a dentist for failure to recognize a spot on a patient’s gums which is later diagnosed as cancer, a fellow dentist would be qualified as an expert to testify regarding the standard of care applicable to the defendant-dentist. A dentist would not be qualified, however, by virtue of his knowledge, skill, experience, training, or education, to testify regarding the issue of causation, as such would be better evaluated by an oncologist. *See* Tex. R. Evid. 702; *Broders v. Heise*, 924 S.W.2d 148, 152 (Tex. 1996).

Further, there appears to be an internal conflict in the provisions (s) and (u) of Section 74.351 above. Subsection (s) provides that all discovery is stayed in a health care liability claim until such time as the claimant’s expert report is served, with the exception of written discovery allowed under the Texas Rules of Civil Procedure (*i.e.*, interrogatories, requests for disclosure, requests for production, depositions by written questions). Meanwhile, Subsection (u) provides that notwithstanding any other provisions, claimants may not take more than two depositions before the expert report is served. Taking the provisions collectively, and in light of the “[n]otwithstanding any other provision of this section,” language contained within Subsection (u), it appears that initial discovery in health care liability claims will be limited to written discovery requests, depositions upon written questions, and written discovery from nonparties. The “two deposition” limit will probably generate litigation as to whether that means oral or written depositions. Note also that the discovery allowed in the litigation of health care liability claims under this section is limited to that conducted by the claimant. §74.351(s). Further, the scope of such discovery is limited to those matters related to the patient’s health care. *Id.* Thus, a claimant may not attempt to discovery other

matters, such as the net worth of a defendant, policies and procedures, personnel files, and administrative matters.

F. Payment for Future Losses

Under Section 74.501 *et seq.*, in health care liability actions against a physician or health care provider in which the present value of the award of future damages equals or exceeds \$100,000, a defendant physician or health care provider or a claimant may request that medical, health care, or custodial services awarded be paid in whole or in part in periodic payments rather than by a lump-sum payment. §74.503(a). Upon such request the court must enter an order to that effect. Further, a defendant physician or health care provider or a claimant may request that future damages¹⁶ other than medical, health care, or custodial services awarded in a health care liability claim be paid in whole or in part in periodic payments rather than by a lump sum payment. §74.503(b). Entering an order on this type of request is within the court's discretion.

If periodic payments are to be applied, the court must make a specific finding of the dollar amount of periodic payments that will compensate the claimant for the future damages. §74.503(c). The court must also require a defendant who is not adequately insured to provide evidence of financial responsibility in an amount adequate to assure full payment of damages awarded by the judgment, and judgment entered by the court must provide for payments to be funded by (1) an annuity contract issued by a company licensed; (2) an obligation of the United States; (3) applicable and collectible liability insurance from one or more qualified insurers; or (4) any other satisfactory form of funding approved by the court. §74.505.

On the death of the recipient, money damages awarded for loss of future earnings continue to be paid to the estate of the recipient of the award without reduction, and periodic payments, other than future loss of earnings, terminate on the death of the recipient. §74.506(a), (b). The impact of these provisions is likely to be especially significant in cases such as birth injury cases, where the patient may die within a few years of the initial injury. Further, if the recipient of periodic payments dies before all payments required by the judgment are paid, the court may modify the judgment to award and apportion the unpaid damages for future loss of earnings in an appropriate manner. §74.506(c).

G. Organization Liability of Hospitals

Section 10.06 of House Bill 4 amends Chapter 84, Civil Practice and Remedies Code, by adding Section 84.0065, entitled "Organization Liability of Hospitals." This section provides that where a hospital does not have an expectation of compensation for health care services rendered to

¹⁶"Future damages" means damages that are incurred after the date of judgment for medical, health care, or custodial care services; physical pain and mental anguish, disfigurement, or physical impairment; loss of consortium, companionship, or society; or loss of earnings. §74.501(1).

a patient, the liability of the hospital or hospital system is limited to money damages in the amount of \$500,000, if the patient makes certain written acknowledgments. Section 84.0065 states:

(a) Except as provided by Section 84.007, in any civil action brought against a hospital or hospital system, or its employees, officers, directors, or volunteers, for damages based on an act or omission by the hospital or hospital system, or its employees, officers, directors, or volunteers, the liability of the hospital or hospital system is limited to money damages in a maximum amount of \$500,000 for any act or omission resulting in death, damage, or injury to a patient if the patient or, if the patient is a minor or is otherwise legally incompetent, the person responsible for the patient signs a written statement that acknowledges:

- (1) that the hospital is providing care that is not administered for or in expectation of compensation; and
- (2) the limitations on the recovery of damages from the hospital in exchange for receiving the health care services.

(b) Subsection (a) applies even if:

- (1) the patient is incapacitated due to illness or injury and cannot sign the acknowledgment statement required by that subsection; or
- (2) the patient is a minor or is otherwise legally incompetent and the person responsible for the patient is not reasonably available to sign the acknowledgment statement required by that subsection.

§84.0065.

H. Legislative Findings

Finally, note that Article 10 of House Bill 4 ends with legislative findings regarding the state of health care, professional liability insurance, and other matters related to the enactment of the provisions included in Article 10. §10.11. Such findings are for the purpose of setting forth the State's interest in enacting the various provision, which will be cited in response to any constitutional challenge made under the new law.

VIII. Claims Against Employees or Volunteers of a Governmental Unit – Article 11

Section 11.01 of House Bill 4 amends Sections 108.002(a) and (b), Civil Practice and Remedies Code to expand the definition of “public servant” to include health care providers, including employees and independent contractors. This is important for the reason that, under Section 108.002 of the Civil Practice and Remedies Code, public servants are not personally liable for damages in excess of \$100,000 arising from personal injury, death, or deprivation of a right,

privilege, or immunity if the damages are the result of the servant's acts or omissions in the course and scope of his employment and if the amount up to \$100,000 is covered through enumerated means (including liability insurance). §108.002(a).

Further, Section 11.02 of Article 11 adds Sections 261.051 and .052 to Chapter 261, Civil Practice and Remedies Code, to provide that nonprofit corporations, partnerships or proprietors which manage or operate a hospital or provides services under contract with a municipality is considered a governmental unit and will receive the same protection afforded a governmental unit with regard to liability under the provisions of Chapters 101, 102, and 108 of the Civil Practice and Remedies Code.

Finally, Section 11.05 adds Section 101.106(a)–(d) to the Civil Practice and Remedies Code, regarding election of remedies to provide that, in a state law claim, a claimant filing suit under Chapter 101 against a governmental unit constitutes an irrevokable election by the plaintiff and bars any suit or recovery against any individual employee¹⁷ of the governmental unit on the same subject matter. §101.106(a). Similarly, the filing of a suit against any employee of a governmental unit constitutes an irrevokable election by the plaintiff and bars any suit or recovery against the governmental unit on the same subject matter unless the governmental unit consents. §101.106(b). In addition the settlement of a claim arising under Chapter 101 will bar the claimant from any suit or recovery from any employee of the same governmental unit; and a judgment against an employee of a governmental unit will bar the plaintiff from obtaining judgment from any suit or recovery from the governmental unit. §101.106(c), (d).

IX. Damages – Article 13

Section 13.02 of House Bill 4 amends the definition of “economic damages” under Section 41.001, Civil Practice and Remedies Code. Under this provision, “economic damages” are defined as compensatory damages intended to compensate a claimant for actual economic or pecuniary loss, not including exemplary damages or noneconomic damages¹⁸. §41.001 (4).

The concept of gross negligence has also been restored to the determination of exemplary damages via Section 13.04 of House Bill 4, which amends Section 41.003, Civil Practice and Remedies Code:

¹⁷Note that only employees, not contractors, are included here.

¹⁸“Noneconomic damages” are defined as damages awarded for the purpose of compensating a claimant for physical pain and suffering, mental or emotional pain or anguish, loss of consortium, disfigurement, physical impairment, loss of companionship and society, inconvenience, loss of enjoyment of life, injury to reputation, and all other nonpecuniary losses of any kind other than exemplary damage. §41.001(12).

HB4, Section 13.04:

(a) Except as provided by Subsection (c), exemplary damages may be awarded only if the claimant proves by clear and convincing evidence that the harm with respect to which the claimant seeks recovery of exemplary damages results from:

- (1) fraud;
- (2) malice; or
- (3) gross negligence

(d) Exemplary damages may be awarded only if the jury was unanimous in regard to finding liability for and the amount of exemplary damages.

(e) In all cases where the issue of exemplary damages is submitted to the jury, the following instruction shall be included in the charge of the court: "You are instructed that, in order for you to find exemplary damages, your answer to the question regarding the amount of such damages must be unanimous."

“Gross negligence” under the new provision will have the same meaning as the two part objective/subjective test which is currently part of the definition of malice: “an act or omission (A) which when viewed objectively from the standpoint of the actor at the time of its occurrence involves an extreme degree of risk, considering the probability and magnitude of the potential harm to others; and (B) of which the actor has actual, subjective awareness of the risk involved, but nevertheless proceeds with conscious indifference to the rights, safety, or welfare of others.” §41.001(11), HB4, §13.02. Accordingly, the definition of “malice” under the new provisions means only a specific intent by the defendant to cause substantial injury or harm to the claimant. §41.001(7), HB4, §13.02. Exemplary damages must still be supported by clear and convincing evidence, and must now be supported by a unanimous finding of liability and the amount of such damages.

The cap applicable to exemplary damages is also unchanged; however, the “cap-busting” provision of Section 41.008(c)(7), regarding Section 22.04 of the Penal Code, providing that the cap will not apply in cases of criminal injury to a child, elderly person, or disabled individual, has been

Current Section 41.003:

(a) Except as provided by Subsection (c), exemplary damages may be awarded only if the claimant proves by clear and convincing evidence that the harm with respect to which the claimant seeks recovery of exemplary damages results from:

- (1) fraud;
- (2) malice; or
- (3) wilful act or omission or gross neglect in wrongful death actions brought by or on behalf of a surviving spouse or heirs of the decedent’s body...

modified. Under the provisions enacted by House Bill 4, the exemplary damages cap will not be eliminated in cases involving injury to such persons if the conduct at issue occurred as part of the provision of health care.

Section 13.08 of House Bill 4 adds Section 41.0105, entitled “Evidence Relating to Amount of Economic Damages,” to Chapter 41, Civil Practice and Remedies Code to provide that the recovery of medical or health care expenses incurred is limited to the amount actually paid or incurred by or on behalf of the claimant. Under the current law, an injured plaintiff is typically entitled to recover reasonable and necessary expenses. Therefore, it has been arguable that a claimant’s damages should be limited, when the claimant received medical care and treatment from a provider who rendered such services for compensation in amounts predetermined under an insurance, Medicaid, Medicare or Workers’ Compensation agreement, to those rates at which the provider was paid, as opposed to the provider’s standard charges. This provision in House Bill 4 recognizes, now, that third party payors do not typically pay, nor providers receive, the standard rates at which physicians or health care providers bill their services. Limiting a claimant’s recovery to the medical expenses actually paid on behalf of the claimant should help to more clearly determine what medical expenses will be considered recoverable.

Chapter 18, Civil Practice and Remedies Code, is amended by adding Subchapter D, Section 18.091, entitled “Proof of Certain Losses; Jury Instruction,” which provides that if any claimant seeks recovery for loss of earnings, loss of earning capacity, loss of contributions of a pecuniary value, or loss of inheritance, the evidence to prove the loss must be presented in the form of a net loss after reduction for income tax payments or unpaid tax liability pursuant to any federal income tax law. This provision will effectively result in a substantial reduction of damages. By requiring that these losses, such as loss of earnings, be demonstrated by and awarded to a claimant in an after-tax fashion, the legislature has eliminated the economic windfall to claimants which exists under the current law. Further, if the claimant seeks recovery for loss of earnings, loss of earning capacity, loss of contributions of a pecuniary value, or loss of inheritance, the court must instruct the jury as to whether any recovery for compensatory damages sought by the claimant is subject to federal or state income taxes.

X. School Employees – Article 15

Section 15.01 of House Bill 4 adds Section 22.051 to the Education Code, providing that, among other enumerated individuals, any other person employed by a school district whose employment requires certification and the exercise of discretion is to be considered a professional employee of a school district. Such definition would include school nurses. This inclusion is important for the reason that, under Section 22.0511 of the Education Code, professional employees of a school district, including nurses, are not personally liable for any act that is incident to or within the scope of the duties of the employee’s position and that involves the exercise of judgment or discretion on the part of the employee, except in instances of excessive force in the discipline of students.

XI. Admissibility of Certain Evidence in Civil Action – Article 16

Section 16.01 of House Bill 4 amends Chapter 32 of the Human Resources Code, regarding nursing facilities, by adding Section 32.060, regarding the admissibility of certain evidence relating to nursing institutions:

- (a) The following are not admissible as evidence in a civil action:
 - (1) any finding by the department that an institution licensed under Chapter 242, Health and Safety Code, has violated a standard for participation in the medical assistance program under this chapter; or
 - (2) the fact of the assessment of a monetary penalty against an institution under Section 32.021 or the payment of the penalty by an institution.
- (b) This section does not apply in an enforcement action in which the state or an agency or political subdivision of the state is a party.
- (c) Notwithstanding any other provision of this section, evidence described by Subsection (a) is admissible as evidence in a civil action only if:
 - (1) the evidence relates to a material violation of this chapter or a rule adopted under this chapter or assessment of a monetary penalty with respect to:
 - (A) the particular incident and the particular individual whose personal injury is the basis of the claim being brought in the civil action; or
 - (B) a finding by the department that directly involves substantially similar conduct that occurred at the institution within a period of one year before the particular incident that is the basis of the claim being brought in the civil action; and
 - (2) the evidence of a material violation has been affirmed by the entry of a final adjudicated and unappealable order of the department after formal appeal; and
 - (3) the record is otherwise admissible under the Texas Rules of Evidence.

Therefore, investigations of a nursing home conducted by the Texas Department of Health and Human Services are not admissible in civil litigation unless such violation regards the particular instance and particular individual at issue in the litigation or unless such regards substantially similar

conduct which occurred within one year prior to the incident in question in the litigation. Further, evidence of a violation must have been affirmed by a final order and must be admissible under the Rules of Evidence. Under Section 16.02 of House Bill 4, Section 242.017 of the Health and Safety Code is added, adopting similar provisions regarding hospitals and other health care institutions.

XII. Charitable Immunity and Liability – Article 18

House Bill 4, Section 18.01 amends Section 84.004(a) and (c), Civil Practice and Remedies Code, regarding volunteer liability as follows:

HB4, Section 18.01:

(a) Except as provided by Subsection (d) and Section 84.007, a volunteer of a charitable organization is immune from civil liability for any act or omission resulting in death, damage, or injury if the volunteer was acting in the course and scope of the volunteer's duties or functions, including as an officer, director, or trustee within the organization.

(c) Except as provided by Subsection (d) and Section 84.007, a volunteer health care provider who is serving as a direct service volunteer of a charitable organization is immune from civil liability for any act or omission resulting in death, damage, or injury to a patient if:

(1) the volunteer commits the act or omission in the course of providing health care services to the patient;

(2) the services provided are within the scope of the license of the volunteer; and

Current Section 84.004:

(a) Except as provided by Subsection (d) and Section 84.007, a volunteer who is serving as an officer, director, or trustee of a charitable organization is immune from civil liability for any act or omission resulting in death, damage, or injury if the volunteer was acting in the course and scope of his duties or functions, including as an officer, director, or trustee within the organization.

(c) Except as provided by Subsection (d) and Section 84.007, a volunteer health care provider who is serving as a direct service volunteer of a charitable organization is immune from civil liability for any act or omission resulting in death, damage, or injury to a patient if:

(1) the volunteer was acting in good faith and in the course and scope of the volunteer's duties or functions within the organization;

(2) the volunteer commits the act or omission in the course of providing health care services to the patient;

(3) the services provided are within the scope of the license of the volunteer; and

(3) before the volunteer provides health care services, the patient or, if the patient is a minor or is otherwise legally incompetent, the person responsible for the patient signs a written statement that acknowledges:

(A) that the volunteer is providing care that is not administered for or in expectation of compensation; and

(B) the limitations on the recovery of damages from the volunteer in exchange for receiving the health care services.

(4) before the volunteer provides health care services, the patient or, if the patient is a minor or is otherwise legally incompetent, the patient's parent, managing conservator, legal guardian, or other person with legal responsibility for the care of the patient signs a written statement that acknowledges:

(A) that the volunteer is providing care that is not administered for or in expectation of compensation; and

(B) the limitations on the recovery of damages from the volunteer in exchange for receiving the health care services.

With these changes, a volunteer no longer has to be a serving as an officer, director, or trustee of a charitable organization to benefit from the provisions of Section 84.004.

XIII. Community Benefits and Charity Care – Article 22

Section 22.02 of House Bill 4, amends Chapter 311 of the Health and Safety Code by adding Section 311.0456, entitled "Eligibility and Certification for Limited Liability":

(a) In this section, "department" means the Texas Department of Health.

(b) This section applies only to a nonprofit hospital or hospital system that is certified by the department under Subsection (d).

(c) To be eligible for certification under Subsection (d), a nonprofit hospital or hospital system must provide:

- (1) charity care in an amount equal to at least eight percent of the net patient revenue of the hospital or hospital system during the preceding fiscal year of the hospital or system; and
- (2) at least 40 percent of the charity care provided in the county in which the hospital is located.

(d) To be certified under this subsection, a nonprofit hospital or hospital system must submit a report based on its most recent completed and audited prior fiscal year to the department not later than April 30 of each year stating that the hospital or system is eligible for certification. The department must verify the information in the report not later than May 31 of the year in which the department receives the report by checking

the information against the report filed by the hospital or system under Section 311.046. After the department has verified the information in the report, the department shall certify that the hospital or hospital system has met the requirements for certification. The certification issued under this subsection to a nonprofit hospital or hospital system takes effect on May 31 of that year and expires on the anniversary of that date.

(e) For the purposes of Subsection (b), a corporation certified by the Texas State Board of Medical Examiners as a nonprofit organization under Section 162.001, Occupations Code, whose sole member is a qualifying hospital or hospital system is considered a nonprofit hospital or hospital system.

(f) Notwithstanding any other law, the liability of a nonprofit hospital or hospital system for noneconomic damages as defined by Section 41.001, Civil Practice and Remedies Code, for a cause of action that accrues during the period that the hospital or system is certified under this section is subject to the limitations specified by Section 101.023(b), Civil Practice and Remedies Code, and Subsection (c) of that section does not apply. This subsection establishes the total combined limit of liability of the nonprofit hospital or hospital system and any employee, officer, or director of the hospital or system for noneconomic damages for each person and each single occurrence, as described by Section 101.023(b), Civil Practice and Remedies Code.

Thus, Section 311.0456 will apply governmental limits to hospital liability for noneconomic damages when a nonprofit hospital or hospital system meets the enumerated requirements. The liability of a qualifying hospital or hospital system will be limited to \$100,000 in noneconomic damages. *See* Tex. Civ. Prac. & Rem. Code Ann. §101.023(b). This liability limit is to be considered the combined limit of liability for the hospital or hospital system, including any employee, officer, or director of the hospital or system.

**APPENDIX 1 – ATTORNEY COVER LETTER TRANSMITTING MEDICAL AUTHORIZATION TO
CLAIMANT’S HEALTH CARE PROVIDERS**

September 1, 2003

Terry S. Treater, M.D.
4444 Main Street
Fort Worth, Texas 76102

Re: Anne D. Claimant

Dear Dr. Treater

I have been retained as counsel to represent a defendant physician in a health care liability claim instituted by your patient, Anne D. Claimant. In her Medical Authorization for the release of protected health information, which accompanied her notice of health care liability claim, she identified you as a physician who has examined, evaluated, or treated her in connection with the injuries she allegedly sustained in connection with the claim asserted against my client.

Therefore, under Section 74.051 of the Texas Civil Practice and Remedies Code Annotated, as an attorney representing a physician to whom notice of claim was provided, I am entitled to obtain from you the protected health information set forth in the attached authorization executed by Ms. Claimant for the purposes set forth therein. Likewise, you are authorized to release such information. Please forward to me any and all authorized documents regarding Ms. Claimant which you may have in your possession which are authorized under the attached. I will, of course, provide you with payment for reasonable copying fees.

If you have any questions, comments, or concerns regarding the attached, please do not hesitate to contact me directly.

Very truly yours,

D. Fence Attorney

APPENDIX 2 – MEDICAL AUTHORIZATION SET FORTH IN HB4, SECTION 74.052

AUTHORIZATION FORM FOR RELEASE OF PROTECTED HEALTH INFORMATION

A. I, _____(name of patient or authorized representative), hereby authorize _____(name of physician or other health care provider to whom the notice of health care claim is directed) to obtain and disclose (within the parameters set out below) the protected health information described below for the following specific purposes:

1. To facilitate the investigation and evaluation of the health care claim described in the accompanying Notice of Health Care Claim; or
2. Defense of any litigation arising out of the claim made the basis of the accompanying Notice of Health Care Claim.

B. The health information to be obtained, used, or disclosed extends to and includes the verbal as well as the written and is specifically described as follows:

1. The health information in the custody of the following physicians or health care providers who have examined, evaluated, or treated _____ (patient) in connection with the injuries alleged to have been sustained in connection with the claim asserted in the accompanying Notice of Health Care Claim. (Here, list the name and current address of all treating physicians or health care providers.)

_____.

This authorization shall extend to any additional physicians or health care providers that may in the future evaluate, examine, or treat _____ (patient) for injuries alleged in connection with the claim made the basis of the attached Notice of Health Care Claim;

2. The health information in the custody of the following physicians or health care providers who have examined, evaluated, or treated _____ (patient) during a period commencing five years prior to the incident made the basis of the accompanying Notice of Health Care Claim. (Here, list the name and current address of such physicians or health care providers, if applicable.)

_____.

C. Excluded Health Information - the following constitutes a list of physicians or health care providers possessing health care information concerning _____ (patient) to which this authorization does not apply because I contend that such health care information is not relevant to the damages being claimed or to the physical, mental, or emotional condition of _____ (patient) arising out of the claim made the basis of the accompanying Notice of Health Care Claim. (State "none" or list the name of each physician or health care provider to whom this authorization does not extend and the inclusive dates of examination, evaluation, or treatment to be withheld from disclosure.)

_____.

D. The persons or class of persons to whom the health information of _____ (patient) will be disclosed or who will make use of said information are:

1. Any and all physicians or health care providers providing care or treatment to _____ (patient);
2. Any liability insurance entity providing liability insurance coverage or defense to any physician or health care provider to whom Notice of Health Care Claim has been given with regard to the care and treatment of _____ (patient);
3. Any consulting or testifying experts employed by or on behalf of _____ (name of physician or health care provider to whom Notice of Health Care Claim has been given) with regard to the matter set out in the Notice of Health Care Claim accompanying this authorization;
4. Any attorneys (including secretarial, clerical, or paralegal staff) employed by or on behalf of _____ (name of physician or health care provider to whom Notice of Health Care Claim has been given) with regard to the matter set out in the Notice of Health Care Claim accompanying this authorization;
5. Any trier of the law or facts relating to any suit filed seeking damages arising out of the medical care or treatment of _____ (patient).

- E. This authorization shall expire upon resolution of the claim asserted or at the conclusion of any litigation instituted in connection with the subject matter of the Notice of Health Care Claim accompanying this authorization, whichever occurs sooner.
- F. I understand that, without exception, I have the right to revoke this authorization in writing. I further understand the consequence of any such revocation as set out in Section 74.052, Civil Practice and Remedies Code.
- G. I understand that the signing of this authorization is not a condition for continued treatment, payment, enrollment, or eligibility for health plan benefits.
- H. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal HIPAA privacy regulations.

Signature of Patient/Representative

Date

Name of Patient/ Representative

Description of Representative's Authority
