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Thomas Wm. Mayo
Southern Methodist University, tmayo@mail.smu.edu

HEALTH CARE LAW

*Thomas Wm. Mayo**

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THE most significant developments in Texas health care law during the past year (as in most odd-numbered years) came from the legislature, which in 1999 enacted hundreds of health care laws. One of these, worthy of mention in this Introduction despite the legislature's intention that the new law should effect no substantive change, is the new Texas Occupations Code.[1] The Code collects and restates, among other laws, the Medical Practice Act,[2] the Physician Assistant Licensing Act,[3] the Dental Practice Act,[4] the Nursing Practice Act,[5] and the licensing acts for optometrists and opticians, speech-language pathologists and audiologists, psychologists and other therapists and counselors, and pharmacies and pharmacists, among others.[6] The codification will take some getting used to, but even the mighty Texas Legislature may be unable to force

* Associate Professor of Law, Southern Methodist University School of Law; Of Counsel, Haynes and Boone, L.L.P., Dallas. I am grateful for the substantial assistance of Jeffrey P. King, Esq., Haynes and Boone, L.L.P.; Robert L. Fine, M.D.; Cathy Meacham, Esq., Tenet Healthcare System in Dallas; and Michelle Hartmann and Natalie Terhune, both of the SMU School of Law Class of 2001.

1. TEX. OCC. CODE (West Supp. 2000). Section 1.001(a) of the Code states: "This code is enacted as a part of the state's continuing statutory revision program, . . . [which] contemplates a topic-by-topic revision of the state's general and permanent statute law without substantive change."
2. *Id.* §§ 151.001-165.001.
3. *Id.* § 204.001.
4. *Id.* §§ 251.001-266.001.
5. *Id.* § 301.001
6. *See generally id.* title 3.

attorneys to start calling certified nonprofit health organizations "162.001(a)'s" after years of assembling (and taking apart) "5.01(a)'s".[7]

I. INDIVIDUAL RIGHTS

A. ABORTION: PARENTAL NOTIFICATION

During the Survey year, the legislature passed a parental-notice-of-abortion law, which provides that a physician may not perform an abortion on an unemancipated minor unless the physician provides forty-eight hours notice to one of her parents or her guardian, subject to certain exceptions.[8] One of these exceptions allows the minor to apply to a court for an order authorizing her to consent to an abortion.[9] Section 33.003 of the Texas Family Code permits this "judicial bypass" when the trial court determines by a preponderance of the evidence that: (1) the minor is mature and sufficiently well informed to make the decision to have an abortion performed without notification to either her parents or her managing conservator or guardian, (2) notification would not be in the best interest of the minor, or (3) notification may lead to physical, sexual, or emotional abuse of the minor.[10] Pursuant to the statute, the Texas Supreme Court promulgated "Texas Parental Notification Rules and Forms,"[11] effective January 1, 2000, to help ensure that the bypass proceeding is conducted in a confidential and expeditious manner.[12] The statute also produced a series of "In re Jane Doe" decisions in which the supreme court interpreted the bypass provisions. These were the court's first-ever forays into the abortion arena, and the results were predictably divisive.

In *In re Doe*,[13] the first case on the parental-notification law, the supreme court addressed the issue of whether a 17-year-old girl seeking a judicial bypass of the parental notification requirement had demonstrated that she was "mature and sufficiently well informed" to make the decision on her own to have an abortion. The trial court denied her application based upon the "sufficiently well informed" standard and the court of appeals affirmed. In a plurality opinion, the court concluded that the minor did not meet the standard, but nonetheless remanded the case for further proceedings "in the interest of justice."[14] Relying on United States Supreme Court decisions as well as other states with similar notifi-

7. *Compare id.* § 162.001(a) *with* Tex. Rev. Civ. Stat. Ann. art. 4495b, § 5.01(a) (West. Supp. 1999).

8. *See* TEX. FAM. CODE § 33.002(a) (West Supp. 2000) (effective September 1, 1999).

9. *See id.* § 33.003.

10. *See id.* § 33.003 (i).

11. Texas Parental Notification Rules and Forms, Tex. Sup. Ct., *available at* http://www.supreme.courts.state.tx.us/rules/pnr/index.htm.

12. *See* 76th Leg., ch. 395, § 2, 1999 Tex. Gen. Laws 2466 ("The Supreme Court of Texas shall issue promptly such rules as may be necessary in order that the process established by Sections 33.003 and 33.004, Family Code, as added by this Act, may be conducted in a manner that will ensure confidentiality and sufficient precedence over all other pending matters to ensure promptness of disposition.").

13. 19 S.W.3d 249 (Tex. 2000).

14. *See id.* at 257.

cation statutes, the court held that a minor is mature and sufficiently well informed "when the evidence demonstrates that the minor is capable of reasoned decision-making and that her decision is not the product of impulse, but is based upon careful consideration of the various options available to her and the benefits, risks, and consequences of those options."[15] This standard requires three showings by a minor seeking judicial bypass.[16] First, she must show that she has obtained information from a health-care provider about the health risks associated with an abortion and that she understands those risks, including the risks associated with the particular stage of her pregnancy. Second, she must show that she understands the alternatives to abortion and their implications, including both adoption and keeping the child. Finally, she must demonstrate that she is aware of the emotional and psychological aspects of undergoing an abortion. This showing requires the minor to show that she has considered how her decision might affect her family relations. Although it does not require her to obtain information from licensed, professional counselors, she must demonstrate that she received the information from "reliable and informed sources."[17] On the question of maturity, "the [trial] court should make specific findings concerning its determination so that there can be meaningful review on appeal."[18]

Although seven justices agreed to remand the case for further proceedings, only five justices agreed on the standard of review, holding that appellate courts should apply the "legal and factual sufficiency" review standard rather than an "abuse of discretion" standard in reviewing trial court rulings.[19] Justice Hecht (joined by Justice Abbott) dissented, criticizing the court for authorizing judges to bypass parental notification where a minor has provided minimal information and has shown no appreciation for the important family, social, moral, or religious issues involved.[20] He also accused the court of "trivializing" the abortion decision and dealing "a heavy blow to parents' fundamental, constitutional rights to raise their children, rights the Legislature had absolutely every intention of protecting by passing the Parental Notification Act in 1999."[21] Finally, although Justice Owen agreed to remand the case, she would also have required a "more substantive showing" from a minor seeking judicial bypass.[22]

After remand, the trial court denied Doe's application on the ground that she did not satisfy the second element of the sufficiently well informed standard, concluding that Doe had not thoughtfully considered her alternatives because she did not understand the intrinsic benefits of

15. *Id.* at 255.
16. *See id.* at 256-57.
17. *Id.* at 257.
18. *Id.*
19. *In re Doe*, 19 S.W.3d at 253.
20. *See id.* at 267.
21. *Id.* at 266-67.
22. *Id.* at 260.

keeping the child or adoption. The court of appeals affirmed, but the supreme court determined that Doe conclusively established the statutory requirements and that she was entitled to bypass parental notification.[23] First, the court noted that although a minor must demonstrate that she considered the "benefits, risks, and consequences" of the various options, its first decision does not require the minor to mechanically list or recite the potential benefits of her options.[24] Rather, "the focus of the inquiry is whether [she] has thoughtfully considered her alternatives."[25] Moreover, even though there may exist generally recognized benefits to an abortion alternative, those benefits must be considered in lights of the minor's particular situation.[26] In this case, Doe received information about her alternatives from several different sources, read books and did research on the Internet about her alternatives, spoke for more than an hour and a half, on two different occasions, with a counselor, and spoke to several people who had been in a similar situation.[27] In addition, the record reflected that she gave reasoned answers in response to the questions about her options. Thus, Doe demonstrated that she understood the alternatives to abortion as they applied to her and she thoughtfully considered their implications.[28] Justices Hecht, Owen, and Abbott dissented from the court's ruling, illustrating a pattern of division among the justices that repeats itself throughout most of the *Jane Doe* opinions.

The second parental notification case, *In re Doe 2*,[29] addressed the "best interests" and "potential abuse" standards. The court held that the standard of review for a determination that notification would not be in the best interests of the minor should be abuse of discretion.[30] After noting that "the trial court should weigh the advantages and disadvantages of parental notification in the minor's specific situation,"[31] the court provided a list of "non-exhaustive factors" for determining a minor's best interests: (1) the minor's emotional or physical needs, (2) the possibility of emotional or physical danger to the minor, (3) the stability of the minor's home and whether notification would cause serious and lasting harm to the family structure, (4) the relationship between the parent and the minor and the effect of notification on that relationship, and (5) whether notification may lead the parents to withdraw emotional and financial support from the minor.[32] Although the trial court should consider "all relevant circumstances" surrounding the minor in question, her "generalized fear of telling her parents does not, by itself, establish that

23. *See* In re Doe, 19 S.W.3d 346 (Tex. 2000).
24. *Id.* at 359.
25. *Id.*
26. *See id.*
27. *Id.* at 359-60.
28. *See id.* at 360.
29. 19 S.W.3d 278 (Tex. 2000).
30. *See id.* at 281-82.
31. *Id.* at 282.
32. *Id.*

notification would not be in [her] best interests."[33] Finally, as with the maturity determination, the trial court must make specific findings.[34]

Regarding the "potential for abuse" standard, the trial court found no evidence that notification may lead to abuse.[35] The supreme court reviewed the trial court's finding for legal sufficiency and concluded that the record did not support the trial court's finding, in light of Doe's statements that she was afraid of her father, that he had a temper, and that he had slapped her, but never beat her.[36] The court accordingly vacated the trial court's ruling and remanded the case due to changes in the law. Accusing the court of "distorting its jurisprudence"[37] with "an interest in achieving a particular result"[38] through this holding, Justice Hecht (again joined by Justice Abbott) dissented. Justice Owen agreed with the dissent that the court's appellate-review standard was too low[39] but agreed to remand the case because the court had not previously addressed the best interest aspect of the judicial bypass provision.[40]

Less than a week after *Doe 2*, the court issued opinions in *In re Doe 3*,[41] on appeal from a trial court's denial of an application for judicial bypass. In a per curiam opinion, the court addressed the "sufficiently well informed" and "abuse of discretion" standards, ultimately vacating the trial court's order and remanding the case in the interest of justice.[42] In a concurring opinion, Justice Gonzales (joined by Chief Justice Phillips and by Justice Owen in part) addressed the standard for proving the potential for emotional abuse. Looking to the definition of "abuse" in Chapter 261 of the Family Code, he concluded that "emotional abuse contemplates unreasonable conduct causing serious emotional injury."[43] Although evidence of prior physical or emotional abuse that caused the minor to become severely depressed or self-destructive, if causally linked to notification, would likely establish this ground, mere evidence that she would be upset or have short-term feelings of guilt or anxiety would not meet the standard.[44] In this case, Doe testified that her father was an alcoholic who had been physically abusive with her mother and would likely take out disapproval of the minor's situation on her mother. She also testified that she believed she would be subject to emotional abuse if she had to tell her parents. Because this evidence did not conclusively establish that Doe would suffer emotional abuse, it failed to meet the

33. *Id.*
34. *See id.*
35. *See In re Doe 2*, 19 S.W.3d at 283.
36. *See id.*
37. *Id.* at 295.
38. *Id.*
39. *Id.* at 285.
40. *See id.* at 290.
41. 19 S.W.3d 300 (Tex. 2000).
42. *See id.* at 301.
43. *Id.* at 303-04. *See* TEX. FAM. CODE § 261.001 ("Investigation of Report of Child Abuse of Neglect").
44. *See id.* at 304.

potential for abuse standard as a matter of law.[45]

Although Justices Enoch, Baker, Hankinson, and O'Neill all agreed with the decision to set aside the court of appeals' judgment, they would have concluded that Doe proved emotional abuse as a matter of law and rendered judgment for Doe.[46] Because the legislature balanced the societal interest in having parents guide the decisions of their children with the equally strong societal interest in prohibiting child abuse, these justices rejected the notion that the courts should "differentiate among the perceived degrees or types of abuse that may occur or to consider whether the abuse would occur anyway so that one more instance doesn't matter."[47] Accordingly, Doe met the potential for abuse standard in this case, where there was "at least some evidence that notification '*may* lead to . . . emotional abuse of the minor.'"[48]

Finally, Justices Hecht, Owen, and Abbott wrote separate dissents, agreeing that Doe had failed to establish the emotional abuse standard as a matter of law and that the court should affirm the court of appeals.[49] All three justices adopted the definition of "abuse" from Chapter 261 of the Family Code, which includes "mental or emotional injury to a child that results in an observable and material impairment in the child's growth, development, or psychological functioning."[50]

In *In Re Jane Doe 4*,[51] the supreme court once again vacated and remanded a trial court order denying an application for judicial bypass. The high court found no legal error in the ruling, but it wanted to give the trial court the benefit of the *Doe 1* and *Doe 2* opinions, which set forth the controlling legal standards in the case.[52] The court further elaborated on the "best interests" standard, holding that "[a]s a matter of law, the minor's emotional well being, the family structure, and the parent-child relationship would be adversely affected if her parents withdrew support and severed all contact with her."[53] Thus, if a minor presents uncontroverted testimony to this effect that is "clear, positive, and direct," and not impeached or discredited by other circumstances, the trial court would have to accept it as fact and would abuse its discretion if it denied the minor's application."[54]

After remand, the trial court again denied the minor's application. On appeal, the supreme court held that she failed as a matter of law to establish that she was mature and sufficiently well informed to have an abortion without notifying her parents.[55] Justice Hankinson, writing the

45. *See id.* at 304-05.
46. *See id.* at 306-09.
47. *In re Doe 3*, 19 S.W.3d at 307.
48. *Id.* at 308 (emphasis added).
49. *See id.* at 309-22.
50. *See* TEX. FAM. CODE § 261.001(1)(A).
51. 19 S.W.3d 322 (Tex. 2000).
52. *See id.* at 326-27.
53. *Id.* at 325.
54. *Id.*
55. *See In re Doe 4*, 19 S.W.3d 337 (Tex. 2000).

opinion for seven members of the court, addressed only the first of the three requirements necessary to meet her burden, that she has obtained information from a health-care provider about the health risks associated with abortion and that she understands those risks. Doe testified that a past medical problem would force her to undergo a different type of abortion procedure resulting in different risks, but she was unable to explain how the procedures and risks were different, "demonstrating a lack of comprehension about the specific risks of the procedure to her."[56] Thus, although Doe spoke to a doctor about abortion, she failed to demonstrate as a matter of law that she understood the risks of having the abortion, and the trial judge could have reasonably found that she was not sufficiently well informed.[57]

The court also addressed the "best interests" exception. Doe offered two reasons why it would not be in her best interest to notify her parents: her medical record and her parents' reaction to her older sister's pregnancy.[58] The court first explained that while her medical history "may be probative of why an abortion may be in her best interests, the statute requires her to prove . . . that notifying her parents would not be in her best interests."[59] If such health risks exist, then potential health needs and dangers to her health may in fact weigh in favor of notifying her parents.[60] Doe also testified that notifying her parents could harm their family structure and lead her parents to withdraw support. Specifically, she stated that when her sister was pregnant years earlier, her parents immediately ordered her to leave the home even though the sister was still a minor. She also stated that the parents have not spoken to the sister since. Thus, although some evidence weighed in favor of parental notification, if the trial court determined that the potential physical danger to Doe outweighed any potential disruption to Doe's family relationship, it did not abuse its discretion in finding that a judicial bypass was not in Doe's best interests.[61]

B. Advance Directives

Between 1977 and 1995, the legislature enacted three advance-directive laws for end-of-life treatment decisions in Texas. In 1977, Texas recognized "living wills" (called "directives to physicians" in the Texas Natural Death Act[62]), followed by the "durable power of attorney for health care" ("DPAHC") in 1989[63] and the "out-of-hospital do-not-resuscitate

56. *Id.* at 339.
57. *See id.*
58. *See id.* at 340.
59. *Id.*
60. *See id.*
61. *See In re Doe 4*, 19 S.W.3d at 340.
62. *See* Tex. Health & Safety Code § 672.004 (1992), *repealed by* Acts 1999, 76th Leg., ch. 450, § 1.03.
63. *See* Tex. Civ. Prac. & Rem. Code § 135.001 (1997), *repealed by* Acts 1999, 76th Leg. ch. 450, § 1.05.

["DNR"] order" in 1995.[64] These advance directives addressed three distinct situations. The directive to physicians permitted competent patients to express their nontreatment preferences in the event they were diagnosed with a terminal condition (which included, after a 1989 amendment, an irreversible condition) and were no longer competent to make their own decisions about life-sustaining treatments. The DPAHC did not convey specific instructions for treatment decisions, as the directive to physicians did, but it addressed a vastly greater number of treatment situations. It permitted competent patients to designate an agent to make all medical decisions on their behalf (not just those that concerned life-sustaining treatment) in the event they lost decision making capacity (even if they did not have a terminal condition). The out-of-hospital DNR order allowed a physician and a patient who had been diagnosed with a terminal condition to execute an order that would instruct emergency medical personnel and other health care professionals to withhold CPR in the event of cardiac or respiratory arrest outside an acute-care hospital.

Experience with the various advance directives over a number of years, as well as the tinkering of successive legislatures, revealed weaknesses in the laws and introduced inconsistencies among them. An attempt to address these problems with a single comprehensive advance directive law passed both houses in 1997[65] but was vetoed by the governor.[66] A second attempt in 1999 was more successful, resulting in a new chapter 166 of the Health and Safety Code, entitled the "Advance Directives Act."[67] Some of the more significant changes are noted in the paragraphs that follow.

The old "Directive to Physicians" has been renamed "Directive to Physicians and Family or Surrogate,"[68] a change that broadens the audience to whom the directive is addressed from physicians alone (under the old Natural Death Act) now to include family members and other surrogate decision makers as well. The new statutory form now explicitly states that no one (other than the patient) may revoke or change the directive,[69] in the apparent hope that family members and surrogates will not reject or challenge the patient's written directive without serious thought. The form also prefaces its treatment of death and terminal illness with a discussion of the importance of communication with family members and personal physicians about the patient's personal values and treatment preferences.[70] Many small changes in the form are intended to make it a

64. *See* Tex. Health & Safety Code § 674.001 (1992), *repealed by* Acts 1999, 76th Leg., ch. 450, § 1.04.

65. *See* Tex. S.B. 414, 76th Leg. (1997).

66. A large and diverse drafting committee was assembled to develop a new law that would eliminate the inconsistencies among the three existing statutes and fix some of the problems that had emerged over time. I was a member of that drafting committee, which met frequently in Austin from 1998 to 1999. The comments in this article reflect my opinions alone and should not be attributed to any other member of the drafting group.

67. *See* TEX. HEALTH & SAFETY CODE § 166.001 (West Supp. 2000).

68. *See id.* § 166.033.

69. *See id.*

70. *Id.*

more user-friendly document,[71] but perhaps the most significant change in the form is that it now permits the patient not only to refuse aggressive treatment in the face of a terminal or irreversible condition, as in the past, but also to request continued treatment for either or both conditions.[72]

Under the old law, the definition of "terminal condition" included not only conditions in which death was reasonably imminent and unavoidable but also "irreversible conditions," in which death might be years or decades away, as can be the case with patients in a persistent or permanent vegetative state.[73] By its very nature, "irreversible condition" seemed somewhat inconsistent with the notion of "terminal condition," at least in patients with some prospect for medium- or long-term survival. The Advance Directive Act separates the concepts of "terminal condition" and "irreversible condition" and provides separate definitions for each.[74] Another change in the Advance Directive Act is that the diagnosis of "terminal condition" or "irreversible condition" may now be made by only one physician, rather than two.[75]

Perhaps the most significant change in the new law is the inclusion of a process for dealing with situations in which physicians and health care entities are confronted with either "classic right-to-die" or "reverse right-to-die" dilemmas. In the "classic" situation, the incompetent patient's family asks that a particular life-sustaining treatment be withheld or discontinued and the physician refuses.[76] In the "reverse right-to-die" situation, the participants switch positions, with the family typically asking that "everything be done" to keep the patient alive and the physician

71. The new form includes instructions for completing it on the document itself, definitions of key concepts, and explanations and examples that are intended to be understandable to most lay readers. *Id.*

72. *Id.* The new form explicitly offers patients the choice of refusing or requesting certain treatments through a series of check-off boxes. In the past, a patient who wanted to express a preference to receive treatments had to write that preference somewhere on the form; no space was provided for that purpose.

73. *See, e.g.*, The Multi-Society Task Force on PVS, *Medical Aspects of the Persistent Vegetative State (Second of Two Parts)*, 330 NEW ENG. J. MED. 1572, 1575-76 (1994).

74. TEX. HEALTH & SAFETY CODE § 166.002(9), (13) (West Supp. 2000). In the new law, the phrase "terminal condition" refers to an incurable condition that is expected to bring about the patient's death within six months *even with* the provision of life-sustaining treatment. *See id.* § 166.002(13). This definition of "terminal illness" focuses more narrowly than did the old law on cases in which heroic measures are likely to be futile. The Natural Death Act referred to an incurable condition that is expected to bring about death *without* the provision of life-sustaining treatment. *See id.* § 672.002(9) (1992).

"Irreversible condition," however, is now broadly defined as a condition that is incurable, severely debilitating, and—without life-sustaining treatment—fatal. *See id.* § 166.002(9) (West Supp. 2000). This newly defined category of "irreversible condition" potentially includes a large number of conditions—for example, advanced neurodegenerative diseases (*e.g.*, multiple sclerosis, amyotropic lateral sclerosis, dementia) and progressive failures of the heart, liver, kidney, and lung.

75. *Id.* § 166.031(2).

76. This classic form of the right-to-die problem is exemplified by such cases as *In re* Quinlan, 355 A.2d 647 (N.J. 1976), and Cruzan v. Director, Mo. Dep't of Health, 497 U.S. 261 (1990).

refusing,[77] usually on the ground that initiating or continuing life-sustaining interventions would not provide a cognizable benefit to the patient.[78]

Rather than attempt a substantive resolution of such disagreements, the Advance Directives Act offers a process by which the situation may be resolved (or, if not resolved, ended), a process that has been endorsed in broad outline by the American Medical Association's Council on Ethical and Judicial Affairs.[79] The Act codifies the AMA procedure[80] (with at least one significant variation[81]) and provides a legal "safe harbor" for institutions that follow the statutory process.[82] The process includes a mandatory ethics consultation, a reasonable attempt to transfer the patient to another provider, and the continuation of life-sustaining procedures for a minimum of ten days after the ethics committee provides a written explanation of its review process to the patient's surrogate.[83] Af-

77. Relatively few "reverse right-to-die" cases have been litigated, and with few exceptions those that have gone to court have resulted in judgments that supported the family decision makers. *See* Paul R. Helft et al., *The Rise and Fall of the Futility Movement*, 343 NEW ENG. J. MED. 293 (2000).

78. As even this brief description of the problems suggests, the core dispute is usually not over a diagnosis, prognosis, or the efficacy of a particular treatment. Rather, the disagreement is over what constitutes a "benefit" to the patient, and in turn over the value judgments that underlay the positions of the respective parties and, of course, over whose value judgments are entitled to precedence.

79. *See* AMA Council on Ethical & Judicial Affairs, *Medical Futility in End-of-Life Care*, 281 JAMA 937 (1999).

80. *See* TEX. HEALTH & SAFETY CODE § 166.046 (West Supp. 2000).

81. *See* text accompanying note 83 *infra*.

82. *See* TEX. HEALTH & SAFETY CODE § 166.045(d) (West Supp. 2000) ("A physician, health professional acting under the direction of a physician, or health care facility is not civilly or criminally liable or subject to review or disciplinary action by the person's appropriate licensing board if the person has complied with the procedures outlined in Section 166.046."). The value of this safe harbor is enhanced by the Advance Directives Act's changes to the liability provisions of the old Natural Death Act. Under prior law, a physician was immune from civil and criminal liability for following a directive in good faith and was equally immune from liability for failing to follow the directive, whether or not the physician knew of the directive's existence. *See id.* § 672.016(b) (1992). The Advance Directives Act eliminates the civil and criminal immunity and adds that the physician is subject to professional discipline as well. *See id.* § 166.045(b) (West Supp. 2000).

83. *See id.* § 166.046. The "ten-day rule" provides a fixed period of time during which a transfer of the patient can be attempted. It is also a time when discussions with the surrogate decision maker (and other significant participants in the decision) should be continued and interim short-term treatment strategies attempted, if possible. It also provides an adequate window for the surrogate or family to seek judicial review in an orderly manner, *see id.* § 166.046(g), which is to say after all reasonable attempts at achieving an agreement have failed, rather than at the first sign of a disagreement. The Act specifies that the costs of transferring the patient to a different facility are to be borne by the patient. *See id.* § 166.046(e). On the other hand, the Act displays at least an implicit preference that the costs of continued treatment during the ten-day period be the responsibility of the insurer (if any). Section 166.046(f) provides: "Life-sustaining treatment under this section may not be entered in the patient's medical record as medically unnecessary treatment until [the ten-day] period . . . has expired." Although the intention behind this provision may be honorable, or at least understandable—*i.e.*, insurers should not be able to escape their obligation to pay for disputed treatment simply because it has been described in a patient's chart as "unnecessary," "futile," or "nonbeneficial")—the provision has the unfortunate effect of directing physicians to render an inaccurate or incomplete medical record. A conscientious physician who honestly believes that a disputed treatment is unnecessary,

ter ten days of continued treatment, if the disagreement persists and a transferee physician or entity has not been found, there is no longer an obligation under the statute to continue the life-sustaining treatment.[84]

If an institution chooses not to follow this somewhat extended procedure, it will forego the Act's "safe harbor" provision. The statutory alternative to the "safe harbor" procedures is simply to continue life-sustaining treatments until there has been a reasonable opportunity to transfer the patient to another physician or facility willing to comply with the directive or the surrogate's treatment decision.[85]

The Advance Directives Act also changes the process for obtaining a consent to withhold or withdraw life-sustaining treatment for a patient who is incompetent, has a terminal or irreversible condition, has not executed a directive, does not have a guardian, and has no available relatives who may, under the statute,[86] consent to the discontinuation of aggressive care. The Natural Death Act required that such a treatment decision be "witnessed" by another physician who was not involved in the treatment of the patient.[87] The Advance Directive Act continues that rule (with the modification that the second physician must "concur" in the treatment decision) and adds that concurrence may also be obtained from a physician-representative of the institutional ethics (or other medical) committee.[88]

The Advance Directives Act provides that a directive to physicians executed before the effective date of the Act (September 1, 1999) remains in effect and is governed by the Natural Death Act in effect at the time the directive was executed, rather than by the new law.[89] This provision continues the years-old trend of including a savings clause in amendments to the Natural Death Act. Unfortunately, it creates the serious potential for confusion as to the declarant's actual wishes as it assumes that lawyers, their clients, and health care providers across the state will be able to keep the nuances of the Advance Directives Act and the various incarnations of the Natural Death Act straight. In the real world, of course, that simply won't happen. Accordingly, it is in everyone's interests that directives be re-executed on forms that reflect the new law.

The advance directive formerly known as the "Durable Power of Attorney for Health Care" has a new name: the "Medical Power of Attorney."[90] In most other respects, however, the medical power of attorney resembles its predecessor, with certain exceptions noted below.[91]

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and that the medical record should reflect that judgment, should not have to choose between his or her conscience and the prohibition of the law.

84. *See* TEX. HEALTH & SAFETY CODE § 166.046(e).

85. *See id.* § 166.045(c).

86. *See id.* § 166.039(b).

87. *See id.* § 672.009(e) (West Supp. 1999).

88. *See id.* § 166.039(e) (West Supp. 2000).

89. *See* S.B. 1260, 76th Leg., ch. 450, § 3.02(a) (Tex. 1999).

90. *See* TEX. HEALTH & SAFETY CODE § 166.002(11) (West Supp. 2000).

91. There exists the same potential for disagreement between an agent with a medical power of attorney and a physician as there is between any surrogate decision maker and a

The Advance Directives Act also amends the former out-of-hospital DNR (Do Not Resuscitate) law in a number of significant ways. First, an individual no longer needs to be diagnosed with a terminal condition in order to execute an out-of-hospital DNR order.[92] This greatly expands the class of patients who may execute this directive. Any competent adult may execute this advance directive, although it still requires the signature of an attending physician to be effective.[93]

Second, the out-of-hospital DNR has always been limited to out-of-hospital locations. The prior law specified that the out-of-hospital setting included "long-term care facilities, in-patient hospice facilities, private homes, and vehicles during transport."[94] In practice, this list created confusion as to the status of other locations within a hospital, including the emergency department and outpatient departments, as well as physicians' offices. The Advance Directive Act eliminates the confusion by adding all three venues to the definition of "out-of-hospital settings."[95]

Finally, the new law permits resuscitation to be withheld when a person has an identification bracelet or an *original* out-of-hospital DNR order, as did the prior law, but it also permits resuscitation to be withheld on the basis of a photocopy of the out-of-hospital DNR order.[96] The new law also eliminates the legal immunity provisions that formerly applied when a responding health care professional knew of the existence of a valid out-of-hospital DNR order and failed to effectuate it.[97]

II. PHYSICIANS

A. COLLECTIVE BARGAINING

Often out-gunned in their negotiations with managed care organizations, physicians have started to fight back. On June 23, 1999, for example, the AMA House of Delegates voted to approve the formation of a union to facilitate collective bargaining between health insurers and two

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physician. The Advance Directives Act therefore specifies that the same procedures provided for treatment disputes in §§ 166.045 and 166.046 should be followed when the agent is acting pursuant to a medical power of attorney. *See* TEX. HEALTH & SAFETY CODE § 166.158(c) (West Supp. 2000).

Another change applies when the agent is the spouse of the principal (the patient). Under the old law, the durable power of attorney for health care would be automatically revoked if the couple divorced. *See* TEX. CIV. PRAC. & REM. CODE § 135.005(a)(3) (1997). The Advance Directives Act adds that the medical power of attorney may provide that it is to remain in effect even if the principal and the agent become divorced. *See* TEX. HEALTH & SAFETY CODE § 166.155(a)(3) (West Supp. 2000).

92. *See* TEX. HEALTH & SAFETY CODE § 166.082(a) (West Supp. 2000).

93. *See id.* § 166.082(b).

94. *See id.* § 674.001(15) (West Supp. 1999).

95. *See id.* § 166.081(7) (West Supp. 2000).

96. *See id.* § 166.083(d). The Advance Directives Act states that a photocopy of the out-of-hospital DNR form may be used "for any purpose for which the original written order may be used . . . ." *Id.* § 166.083(d). This may create confusion as to whether the "original" of the order can be executed by the patient and physician on a photocopy of the original blank form. The answer should be "no," or else the word "written" in the phrase "the original written order" has no meaning.

97. *See id.* § 166.095(b).

types of physicians—medical residents and salaried employees.[98] The House of Delegates also resolved to support legislative efforts to extend protection from the antitrust laws to self-employed physicians.

The AMA's action addresses a fundamental problem confronting physicians who want to band together in their negotiations with health care payers. Although union organizations and union members acting within the legitimate objectives of the union are exempt from the antitrust laws,[99] the exemption extends only to collective bargaining by employees, not independent contractors,[100] with their employers. Texas, like a number of other states, observes a quite robust corporate-practice prohibition that makes it difficult for most physicians, other than house staff, to be employees. Moreover, the joint negotiations covered by the antitrust exemption are between physicians and third-party payers. Thus, even if Texas physicians were free to be employees, negotiations with health plans would not qualify for the antitrust exemption afforded labor organizations in their negotiations with employers.

One approach to the antitrust problem is to take advantage of the "state action" exception to the federal antitrust laws, as initially articulated by the United States Supreme Court in *Parker v. Brown*.[101] Although initially formulated in terms of the antitrust exemption enjoyed by state governments and their political subdivisions, "state action" has subsequently been expanded to include the anticompetitive conduct of private parties. To obtain the protection of the state-action doctrine, a private action must meet two tests. First, the action must be taken pursuant to a clearly stated state policy to exclude the activity from application of the antitrust laws,[102] and, second, the activity must be "actively supervised" by the state.[103] "Active supervision" requires not only that there be a structure for state involvement, but that the state act in fact, and it must act as more than a rubber stamp for private anticompetitive conduct. The "active state supervision" requirement may include not only supervision of a proposed transaction but continuing supervision and monitoring during the course of the private parties' conduct.[104]

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98. *See* Steven Greenhouse, *A.M.A.'s Delegates Vote to Unionize*, N.Y. TIMES, June 24, 1999, at A1.

99. 15 U.S.C. § 17 (1994) (§ 6 of the Clayton Act).

100. *See* Columbia River Packers Ass'n v. Hinton, 315 U.S. 143 (1942).

101. 317 U.S. 341 (1943).

102. Although the Texas legislature could hardly have been clearer about its intention to displace market forces, this prong of the state action doctrine can be a stumbling block. *See, e.g.*, Surgical Care Ctr. of Hammond, L.C. v. Hospital Serv. Dist. No. 1 of Tangipahoa Parish, 171 F.3d 231 (5th Cir. 1999).

103. *See* FTC v. Ticor Title Ins. Co., 504 U.S. 621 (1992); Patrick v. Burget, 486 U.S. 94 (1988); California Retail Liquor Dealers Ass'n v. Midcal Aluminum, Inc., 445 U.S. 97 (1980).

104. *See* North Carolina *ex rel.* Edmisten v. P.I.A. Ashville, Inc., 740 F.2d 274 (4th Cir. 1984), *cert. denied*, 471 U.S. 1003 (1985) (involving state certificate of need program). In other contexts, so-called "non-commercial" activities (*e.g.*, baseball) have been considered exempt from antitrust laws as not falling within the meaning of "trade or commerce," even though no one would deny that professional baseball involves exchanges of services and products for money. *See* Federal Baseball Club of Baltimore, Inc. v. National League of

With the requirements of the state-action doctrine clearly in mind, the 76th Legislature added a new chapter 29, entitled "Joint Negotiation by Physicians with Health Benefit Plans," to the Texas Insurance Code. The new law is premised upon certain stated findings, including that joint negotiation, if not accompanied by actual or threatened refusal to provide patient care, will result in pro-competitive effects, and that there are instances in which health plans dominate the market to such a degree that fair negotiations between physicians and plans are otherwise unobtainable. The Texas statute is an attempt to address this alleged imbalance in a way that will fit within the "state action" exemption from liability under federal antitrust laws.

The essential elements of the statute are: (1) competing physicians who comprise not more than 10 percent of the physicians in a health plan's service area[105] may jointly negotiate non-price terms of a contract;[106] (2) competing physicians may jointly negotiate pricing terms if the health

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Prof'l Baseball Clubs, 259 U.S. 200 (1922); Flood v. Kuhn, 407 U.S. 258 (1972). On this point, it is worth considering the American Medical Association's view that physicians are not driven by profits or financial considerations but are governed entirely by ethical values "'every step of the way.'" Linda Chavez, *Behind the AMA Label*, WASH. TIMES, July 1, 1999, at A17 (quoting Dr. Randolph D. Somak, Jr., AMA Chairman). The AMA's argument is unlikely to get physicians an across-the-board exemption from the antitrust laws. The Supreme Court rejected an exemption for the "learned professions" in Goldfarb v. Virginia State Bar, 421 U.S. 773 (1975), and has been consistently rejected every time the argument for such an exemption has been proferred, *see, e.g.*, Arizona v. Maricopa County Med. Soc'y, 457 U.S. 332 (1982).

105. *See* TEX. INS. CODE art. 29.09(b) (West Supp 2000). "Competing physicians within the service area of a health benefit plan" may jointly negotiate within the limits set by the statute, *see id.* art. 29.04, provided they constitute ten percent or less of the physicians in the service area, although that percentage is subject to adjustment by the Texas Attorney General. *See id.* art. 29.09(b). The ten percent limitation does not apply to the universe of *competing* physicians but to the universe of *all* physicians in the service area. There is no definition of "physician" in the new law, but elsewhere in the Insurance Code the term variously means an individual licensed by the State Board of Medical Examiners or, more broadly, an individual licensed to practice medicine in Texas, a professional association organized under the Texas Professional Association Act, a non-profit health corporation certified under section 5.01 of the Texas Medical Practice Act, a medical school as contemplated under the Education Code, or another person wholly owned by physicians. *Compare* TEX. INS. CODE art. 20.01, *with id.* art. 20A.02(r). (The former definition would not include doctors of osteopathy, while the latter would.) The phrase "competing physicians" is not defined but presumably refers to physicians in the same specialties or in specialties that have overlapping practices. A health plan's service area will be a matter of public record in connection with its obtaining a certificate of authority under the Texas Insurance Code.

106. *See id.* art. 29.04. The statute provides a list of sixteen terms and conditions of contracts with health plans with respect to which physicians may jointly negotiate. These non-price items include:

> '(1) practices and procedures to assess and improve the delivery of effective, cost-efficient preventive health care services, including childhood immunizations, prenatal care, and mammograms and other cancer screening tests or procedures;
> (2) practices and procedures to encourage early detection and effective, cost-efficient management of diseases and illnesses in children;
> (3) practices and procedures to assess and improve the delivery of women's medical and health care, including menopause and osteoporosis;
> (4) clinical criteria for effective, cost-efficient disease management programs, including diabetes, asthma, and cardiovascular disease;

benefit plan has substantial market power, as found by the Texas Attorney General, and the pricing terms "have already affected or threatened to adversely affect the quality and availability of patient care";[107] (3) joint negotiations shall be conducted through a representative.[108] The physician representative will often need to provide the necessary information through a series of filings, as facts and circumstances change. For example, as physicians enter and depart from the jointly negotiating group, the

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(5) practices and procedures to encourage and promote patient education and treatment compliance, including parental involvement with their children's health care;
(6) practices and procedures to identify, correct, and prevent potentially fraudulent activities;
(7) practices and procedures for the effective, cost-efficient use of outpatient surgery;
(8) clinical practice guidelines and coverage criteria;
(9) administrative procedures, including methods and timing of physician payment for services;
(10) dispute resolution procedures relating to disputes between health benefit plans and physicians;
(11) patient referral procedures;
(12) formulation and application of physician reimbursement methodology;
(13) quality assurance programs;
(14) health service utilization review procedures;
(15) health benefit plan physician selection and termination criteria; and
(16) the inclusion or alteration of terms and conditions to the extent they are the subject of government regulation prohibiting or requiring the particular term or condition in question; provided, however, that such restriction does not limit physician rights to jointly petition government for a change in such regulation.'

Id. art. 29.04(1)-(16). These areas of permissible joint negotiation purportedly address non-price factors. With the possible exception of the inclusion of reimbursement methodology, it is unlikely that joint communications on any of these issues would prompt antitrust enforcement action. Interestingly, the list does not include some non-price factors that are often cited as important to physicians, such as coverage decisions. It is also not clear how the legislature can be sure that joint negotiation on these listed points will not be used as a proxy for joint negotiation as to pricing matters.

107. *Id.* art. 29.06(a). The statute requires the Attorney General to "make the determination of what constitutes substantial market power," but curiously fails to require the Attorney General to make the determination on the second factor. *Id.* The statute also provides no guidance to the Attorney General as to the standards for determining whether substantial market power exists.

108. *See id.* art. 29.07(3). Before acting as a representative under this statute, the representative is required to submit to the Attorney General a report that provides information concerning (i) the representative and the represented physicians, (ii) the relationship of the physicians requesting joint representation to the total population of physicians in a geographic service area, (iii) health plans with which the representative intends to negotiate, (iv) the projected subject matter of the negotiations, (v) the representative's plan of operation and procedures to ensure compliance with this applicable section, (vi) the expected impact of the negotiations on the quality of patient care, and (vii) the benefits of the contract between the health plan and physicians. *See id.* art. 29.08(1)(A)-(H).

If the representative, acting on behalf of the physicians, and the health plan reach agreement, the physicians' representative is required furnish to the Texas Attorney General a copy of the proposed contract and the above-referenced plan of action. *See id.* art. 29.08(2). In the event that a health plan declines to negotiate or terminates negotiations, or simply fails to respond, the representative is required to report that fact to the Attorney General and the filing regarding those negotiations is terminated, subject to renewal if negotiations with the health plan arise again within 60 days after the notification. *See id.* art. 29.08(3).

physicians' representative will presumably be able to supplement its prior filing. The representative can be one of the involved physicians. who must register with the Texas Attorney General;[109] An approval of the initial filing by the Attorney General is effective for all subsequent negotiations between the parties specified under the initial filing. The statute makes no distinctions between initial filings and supplemental filings, so the Attorney General presumably will have to approve or disapprove supplemental filings as well. and (4) the jointly negotiated contract, if any, must be approved by the Attorney General.[110] The statute applies only to health benefit plans and does not apply to employers. The statute also does not apply to certain specialty coverage plans such as a specific disease or limited-benefit coverage, to certain supplemental health insurance plans that do not pay for physician services (specifically, dental or vision care, coverage for hospital expenses or hospital confinement), to workers' compensation coverage, or to a long-term care policy (unless the policy is so comprehensive that the Attorney General finds that the should be deemed to be a health benefit plan).[111]

Jointly negotiating physicians are not authorized "to jointly coordinate any cessation, reduction, or limitation of health care services."[112] Since the physicians' refusal to provide services if their price or other demands are not met is a necessary consequence of failing to reach agreement with a health plan, the precise impact of this provision is unclear. The physicians are not permitted to require participation in all products within a health care plan as a condition to participation in any particular product.[113] Finally, the physicians may not negotiate to exclude non-physician providers. In effect, non-physician providers (which are the subject of other state laws that prohibit health plans from discriminating on the basis of licensure) will obtain some benefit from the negotiations by the

109. *See id.* art. 29.08. The Attorney General is required to approve or disapprove a filing or a contract within 30 days. *See id.* art. 29.09(a). If the Attorney General does not meet the deadline for approval or disapproval, an applicant can petition a state district court in Travis County, Texas, for an order requiring the Attorney General to act. *See id.* art. 29.09(d).

If the Attorney General disapproves a contract, the Attorney General must furnish a written explanation of deficiency together with a statement of remedial measures as to how deficiencies could be corrected. *See id.* art. 29.09(a). The Attorney General is required to approve a request if the Attorney General finds that the benefits resulting from the joint negotiation or proposed contract outweigh the disadvantages attributable to a reduction in competition, specifically taking into account the distribution of physicians by specialty. *See id.* art. 29.09(b).

110. *See id.* arts. 29.08(2), 29.09(a).

111. *See id.* art. 29.03(b).

112. *See id.* art. 29.10.

113. *Id.* This provision is an interesting twist on the usual scenario in which physicians withdraw from plans that had required them to participate in all products. Under the new law, it would presumably be futile for a health plan to attempt to get jointly negotiating physicians to agree to such a term, since the physicians would be prohibited from meeting and discussing it. It is not clear from the statute, however, whether the legislature thought it was protecting the plans or the physicians with this prohibition.

physicians.[114]

Both the Texas Attorney General and the Insurance Commissioner have the authority to promulgate rules to implement this new chapter of the Insurance Code.[115]

B. Duty to Warn

In *Thapar v. Zezulka*,[116] Freddy Ray Lilly had a history of mental health problems and was treated by Dr. Thapar, a psychiatrist. Thapar treated Lilly for several years, both on an inpatient and outpatient basis for a variety of problems, including severe post-traumatic stress disorder, alcohol abuse and paranoid and delusional beliefs concerning his stepfather, Henry Zezulka. In August of 1988, Lilly was admitted to the hospital and during that stay indicated to Thapar that he felt like killing Henry Zezulka. After a seven-day inpatient treatment, Lilly was discharged and within a month shot and killed Zezulka. Ms. Zezulka, Henry's wife and Lilly's mother, sued Thapar for negligence resulting in her husband's wrongful death. Ms. Zezulka claimed that Thapar was negligent in diagnosing and treating Lilly and in failing to warn of Lilly's threats toward Henry Zezulka.[117]

In the district court, Thapar moved for summary judgment on the ground that Zezulka had not stated a claim for medical negligence because Thapar owed no duty to Zezulka in the absence of a doctor-patient relationship. The trial court granted summary judgment for Thapar based on the Supreme Court's decision in *Bird v. W.C.W.*,[118] which held that a psychologist owes no duty to a third party to nonnegligently diagnose a patient's condition. The Court of Appeals held that the no-duty ground asserted in Thapar's motion for summary judgment was a defense to the cause of action pleaded by Zezulka.

The Supreme Court reviewed the issue and determined that a mental health professional has no duty to a third party non-patient for negligent misdiagnosis or negligent treatment.[119] This holding was consistent with *Bird* and the post-*Bird* holdings of the Supreme Court on related issues. The Supreme Court also determined that, in Texas, a mental health professional owes no duty to identifiable third parties to warn them of a pa-

114. "Non-physician health care provider" would include, for example, chiropractors, doctors of osteopathy, and podiatrists. Under the statute, the Attorney General and the Commissioner of Insurance may by rule authorize podiatrists to participate in the joint negotiations permitted by this chapter. *See id.* art. 29.11. On June 2, 2000, the Attorney General proposed a rule that would clarify that podiatrists may participate in joint negotiations without joining in with physicians. *See* Proposed Rule, Chapter 58, Physician Joint Negotiation, 25 Tex. Reg. 4977 (2000).

115. *See* Tex. Ins. Code art. 29.11 (West Supp. 2000). On June 2, 2000, the Attorney General promulgated final rules. *See* Adopted Rule, Chapter 58, Physician Joint Negotiation, 25 Tex. Reg. 5324 (2000).

116. 994 S.W.2d 635 (Tex. 1999).

117. *See id.* at 636.

118. 868 S.W.2d 767 (Tex. 1994).

119. *Thapar*, 994 S.W.2d at 638.

tient's specific threats. This duty has never been recognized in Texas despite the holding in *Tarasoff v. Regents of University of California*,[120] in which the California courts recognized a cause of action against a mental health professional for failing to warn third parties of a patient's threats. The Texas Supreme Court stated that the Legislature has chosen to closely guard patient communications with mental health professionals through a statute governing the disclosure of communications during the course of mental health treatment.[121] This statute classifies communications between mental health professionals and their patients as confidential and prohibits disclosure to third parties unless an exception applies. While there is an exception for disclosure to medical or law enforcement personnel where the professional determines there is a probability of imminent physical injury by the patient to himself or others, or where there is a probability of immediate mental or emotional injury to the patient, this exception is permissive rather than mandatory. The Supreme Court refused to impose a duty that it considers to be in contradiction to legislative enactments evidencing the adoption of a public policy against disclosure of mental-health-professional/patient communications.[122]

III. LIABILITY

A. DECEPTIVE TRADE PRACTICES ACT

In *MacGregor Medical Association v. Campbell*,[123] Mr. Campbell became violently ill after ingesting a drink containing formaldehyde at his office. He was immediately taken to the MacGregor Clinic and treated by Dr. Berlin who failed to pump his stomach, perform blood tests to determine the level of formaldehyde contamination in his body, or treat him with activated charcoal. Subsequently, after eight months of continuing problems, Mr. Campbell underwent two unsuccessful stomach surgeries, resulting in the need to completely remove his stomach. Following his death four and a half years after his initial visit with Dr. Berlin, Mr. Campbell's wife sued the professional association of physicians who operated the clinic that treated her husband alleging negligence, Deceptive Trade Practices Act violations, breach of contract, and breach of warranty.[124]

The clinic filed a motion for summary judgment alleging that the two-year statute of limitations in article 4590(i) of the Insurance Code, the Medical Liability and Insurance Improvement Act, barred the Campbell's claim.[125] The trial court granted the summary judgment for the clinic. The court of appeals determined that although the limitations ap-

120. 551 P.2d 334, 345-47 (Cal. 1976).
121. TEX. HEALTH & SAFETY CODE § 611.002 (1996).
122. *Thapar*, 994 S.W.2d at 639-40.
123. 985 S.W.2d 38 (Tex. 1998).
124. *See id.* at 39.
125. *See id.* at 39-40.

plied and barred Campbell's negligence claim, it did not bar her DTPA, breach of contract, or breach of warranty claims.

On appeal, the Texas Supreme Court stated that the article 4590(i) limitations protection applied to professional associations of physicians as well as individual physicians,[126] and it determined that Campbell's claims of breach of contract and breach of warranty were barred by those limitations. In language that sweeps even more broadly, the court stated that a negligence claim could not be recast as a DTPA claim to avoid the standards set forth in Article 4590(i). The court further distinguished Campbell's DTPA claim from that of the plaintiff in *Sorokolit v. Rhodes*,[127] which allowed a DTPA claim against a physician when the doctor guaranteed that, following breast surgery the patient's breasts would look like a picture she had selected. The court said that Dr. Sorokolit "knowingly breached his express warranty of a particular result and knowingly misrepresented his skills and the results he could achieve" which gave rise to a DTPA claim.[128] Ms. Campbell's claim was based on representations regarding the clinic's ability to provide qualified personnel and resources for medical treatment, which are more akin to claims regarding quality of medical care than claims in which a doctor specifically guarantees and warrants a particular result. Accordingly, the court concluded that "Article 4590i, Sorokolit, and its progeny prohibit the assertion of this DTPA claim."[129]

B. Statute of Limitations

In *Earle v. Ratliff*,[130] Michael Ratliff, a 38-year-old freight handler who injured his back on the job, was treated and operated on in November 1991 by Dr. Earle, who performed various surgical procedures including the insertion of a metal bone plate and pin screws. After the surgery Ratliff's condition continued to decline. In November 1993 Dr. Earle operated again to remove and replace the devices he had implanted in the first surgery. Ratliff's condition declined even further, leaving him unable to walk, talk or care for himself. Ratliff then sued Dr. Earle for: negligence, fraudulent concealment, strict liability and violations of the DTPA.[131]

Dr. Earle moved for summary judgment on several grounds, including that Ratliff's claims relating to his 1991 surgery were barred by limitations, that Earle did not breach the standard of care owed to Ratliff in the second surgery in 1993, and that Dr. Earle had obtained from Ratliff the consent to treatment and surgery required by statute.[132] Finally, Dr. Earle also argued that Ratliff's healthcare liability claims could not be

126. *See id.* at 40.
127. 889 S.W.2d 239 (Tex. 1994).
128. *MacGregor Med. Ass'n*, 985 S.W.2d at 40 (quoting *Sorokolit*, 889 S.W.2d at 242).
129. *Id.* at 40-41 (emphasis added).
130. 998 S.W.2d 882 (Tex. 1999).
131. *See id.* at 884.
132. *See id.* at 885.

recast as DTPA violations. Although the court of appeals found it difficult to ascertain when the limitations period began because the case included elements of both misdiagnosis and mistreatment, the court found that under the circumstances the limitations period did not begin to run on Ratliff's claim until the date of Earle's last treatment, which was less than two months before Ratliff filed his lawsuit.[133] Upon review, the supreme court found that because Ratliff did not allege that Dr. Earle misdiagnosed or mistreated his condition after surgery, the limitations period began to run on Ratliff's complaint concerning the 1991 surgery on the date the surgery was performed.[134] The Supreme Court also Ratliff's Open Courts argument because Ratliff had ample opportunity to learn of any negligence by Dr. Earle in performing his 1991 surgery and "the fact that he waited more than two years to do so does not [extend the limitation period or] raise constitutional concerns."[135]

Regarding claims for Dr. Earle's alleged negligence and failure to disclose the risks associated with the 1993 surgery, the Supreme Court held that the claim is governed by the Medical Liability Insurance Improvement Act[136] and that if a physician makes disclosures as required by the panel created by that act which determines what risks should be disclosed for a given procedure, then the physician cannot later be found negligent for not disclosing other risks and hazards associated with the procedure. Thus, because Ratliff produced no evidence that his written consent was ineffective due to incapacity or was otherwise invalid, he raised no issue that Dr. Earle was negligent in disclosing the risk of surgery.[137]

C. HOSPITALS

In *NME Hospitals, Inc. v. Rennels*,[138] the Texas Supreme Court held in a case of first impression that "a plaintiff may . . . maintain standing to sue under the Texas [Commission on Human Rights] Act [("TCHRA")[139]] in the absence of a direct employment relationship with the defendant"[140] as long as the plaintiff can show that the defendant interfered with plaintiff's employment relationship.

Dr. Margaret Rennels was employed as a pathologist for Sierra Laboratory Associates ("Sierra"). Sierra Medical Center ("the Hospital") was Sierra's primary client. Under its "Pathology Agreement" with the Hospital, Sierra had the exclusive right to set up the Hospital's pathology department and to perform all pathology work for the Hospital.[141] Sierra terminated Dr. Rennels on September 9, 1993, citing difficulties between

133. *Id.*
134. *See id.* at 886.
135. *Id.* at 890.
136. TEX. REV. CIV. STAT. ANN. art 4590i, § 6.01-.08 (Vernon Supp. 1999).
137. *See Earle*, 998 S.W.2d at 892.
138. 994 S.W.2d 142 (Tex. 1999).
139. TEX. LABOR CODE § 21.055 (West Supp. 1999).
140. 994 S.W.2d at 146.
141. *See id.* at 143.

Dr. Rennels and another associate pathologist. Dr. Rennels alleged that the termination constituted sex discrimination.[142]

Dr. Rennels returned to work later that year, and in early 1994, Sierra informed her by letter that she would be made a shareholder once the necessary paperwork was completed. On April 4, 1994, however, Dr. Rennels overheard a conversation between the Hospital's chief executive officer and a Sierra shareholder concerning their desire to prevent Dr. Rennels from becoming a shareholder. Sierra's attorney later informed Dr. Rennels that she would not be made a shareholder, and that Dr. Rennels could continue her employment as a salaried associate only if she signed a release. Dr. Rennels then filed a discrimination claim with the Equal Employment Opportunity Commission, was terminated by Sierra on May 25, 1994, and sued the Hospital for retaliatory discharge and conspiracy under the THRCA.[143]

The Hospital moved for summary judgment on the ground that Rennels lacked standing to sue the Hospital under the THRCA in the absence of a direct employment relationship between Rennels and the Hospital, and that because she did not have standing to sue under the THRCA she lacked standing to bring the conspiracy claim The trial court granted summary judgment in favor of the Hospital on both claims.[144] The court of appeals reversed the summary judgment and remanded the case to the trial court.[145]

Affirming the court of appeals judgment, the Texas Supreme Court concluded that the THRCA is modeled after federal civil rights law to the extent that it purports to correlate "state law with federal law in the area of discrimination in employment."[146] In doing so, it looked to the decisions of many courts that have held that while a Title VII plaintiff must show an employment relationship to sue under Title VII, a direct employment relationship between a plaintiff and defendant is not necessary, so long as the plaintiff can show that the defendant-employer controlled access to the plaintiff's employment opportunities and denied or interfered with that access based on unlawful criteria.[147] In order to harmonize federal and state common law, the court concluded that a plaintiff may likewise maintain standing under the THRCA in the absence of a direct employment relationship with the defendant. Furthermore, the THRCA does not expressly require an employment relationship between the employer who violates the statute and the "person"—not the "employee"—who is harmed by the violation.[148] Relying on the express wording of the Act, and construing the remedial statute liberally and in conformity with analogous federal precedent, the court therefore recognized that the Act

142. *See id.*
143. *See id.* at 144.
144. *See id.*
145. *See id.*
146. *Id.* (quoting Schroeder v. Texas Iron Works, Inc., 813 S.W.2d 483, 485 (Tex. 1991).
147. *See id.* at 145.
148. *Id.*

affords a claim to people who do not stand in a direct employment relationship with the defendant-employer.[149]

In *St. Joseph Hospital v. Wolff*,[150] an allegedly negligent resident/surgeon was employed by a foundation in Austin instituted by St. Joseph to give its residents "extensive experience in general surgery."[151] The case against St. Joseph was initiated after the resident failed to notify the chief surgeon that one of his patients was losing a significant amount of blood following a tracheostomy. The patient suffered brain damage as a result of the blood loss and the medical-malpractice claim followed. At trial, the jury found the resident's conduct to be negligent and awarded damages against St. Joseph.[152]

On appeal, St. Joseph challenged the district court's jury instruction regarding "joint enterprise" as well as the jury's finding that the hospital was engaged in a joint enterprise with the foundation. In addition, St. Joseph alleged that it owed no duty to the patient and that an instruction should have been given regarding the borrowed servant doctrine. The court of appeals rejected all points raised by the hospital.[153] As to the joint enterprise instruction, the court of appeals held that the district court properly defined a joint enterprise as requiring a "common business or pecuniary interest."[154] The court continued by finding that this requirement (as well as the common purpose requirement) was met through evidence that St. Joseph and the foundation shared a "mutual desire to provide extensive training through patient care" as well as the "financial benefits and costs" of the program.[155]As to the remaining element of an integrated enterprise – that the parties have an equal right to direct and control the enterprise – the court cited the fact that St. Joseph maintained control over residents and consulted in the academic aspects of the program as evidence that the requirement was met.[156]

In finding a joint enterprise, the court of appeals rejected the remaining issues on appeal. The court first explained that St. Joseph's argument that it owed no duty to the patient was irrelevant in light of the joint enterprise finding. Put another way, St. Joseph's liability for negligence was established through the foundation and thus there was no need for a direct relationship between the hospital and patient.[157] Similarly, the court held that arguments regarding a borrowed servant instruction were immaterial once a joint enterprise was found.[158]

149. *See id.* at 147.
150. 999 S.W.2d 579 (Tex. App.—Austin 1999, no pet.).
151. *Id.* at 583.
152. *See id.*
153. *See id.* at 584.
154. *Id.* at 586-87.
155. *Id.* at 587.
156. *See id.* at 589-90.
157. *See id.* at 591-92.
158. *See id.* at 592.

IV. HEALTH INSURANCE: THIRD-PARTY ADMINISTRATION

In *Toranto v. Blue Cross and Blue Shield of Texas, Inc.*,[159] a patient had assigned her health insurance benefits to her physician. Blue Cross and Blue Shield ("Blue Cross"), acting as a third-party claims administrator for her insurance plan, nonetheless paid the patient directly and refused to pay her out-of-network physician because the health plan's documents contained an anti-assignment clause. Although the Texas Insurance code broadly prohibits insurers from including anti-assignment provisions in their policies,[160] Blue Cross successfully argued in the lower court that the Insurance Code prohibition did not apply to a third-party administrator because it was not an "insurer."[161]

The Texas Supreme Court reversed. The court reasoned that when a third party is acting as the claims administrator for an insurer, such a third party is an insurer because it is authorized to act as the insurer's claims administrator under Chapter 3 of the Texas Insurance code. Because the anti-assignment clause in the plan documents violates the Texas Insurance Code, Blue Cross as an insurer is subject to and must comply with the Insurance Code's anti-assignment prohibition.[162]

159. 993 S.W.2d 648 (Tex. 1999).

160. TEX. INS. CODE art. 21.24-1, § 3(a) (1998), provides: "An insurer may not deliver, renew. or issue for delivery a health insurance policy in this state that prohibits or restricts the written assignment by a covered person of benefits provided by the policy for health care services to the physician or other health care provider that furnishes those health care services to the covered person."

161. *Id.* art. 21.24-1, § 1(6) (Vernon 1998), defines "insurer" as "an insurance company, association, or organization authorized to do business in this state under Chapter 3 . . . of this Code."

162. *See Toranto*, 993 S.W.2d at 649.