What is a health care liability claim under Texas law?

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Many, including the plaintiff's bar and some members of the judiciary, do not look kindly on the special treatment health care providers are accorded under current Texas law. The strict damage caps, expert report requirements, and statute of limitations provisions of Chapter 74 of the Texas Civil Practice and Remedies Code are the most frequent targets of displeasure. While some publicly trumpet the need for legislative change, others seek redress through judicial activism. Some have openly invited judicial activism by filing federal and state lawsuits seeking declaration that the damages caps contained in Chapter 74 are unconstitutional (1). Others are more subtle in their approach. Their "indirect" efforts involve attempts to circumvent these provisions through assertions that the activity or conduct at issue is not health care and/or does not involve health care–related activities, thereby avoiding these statutory restrictions. In this issue we examine the arguments and success of the latter indirect approach.

Physicians and health care providers are entitled to the protections provided under Chapter 74 of the Texas Civil Practice and Remedies Code in "healthcare liability claims" (2). A health care liability claim is defined as

> a cause of action against a healthcare 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 services directly related to health care, which proximately results in injury or death of a claimant, whether the claimant's claim or cause of action sounds in tort or contract (3).

Based on this definition, Chapter 74 applies if three elements are met. Specifically:

1. The claim must be against a health care provider.
2. The claim must be based on
   a. Treatment,
   b. The lack of treatment, or
   c. Other claimed departures from accepted standards of
      (1) Medical care,
      (2) Health care, or
      (3) Safety or professional services directly related to health care.
3. The act or omission under element number 2 must cause injury or death to the claimant (4).

To date, there has been little focus on the first element as a method through which to argue that Chapter 74 does not apply. Under Article 4590i (5), Chapter 74's predecessor statute, this was an occasional defense because health care providers other than physicians were very narrowly defined. Specifically, Article 4590i defined health care providers other than physicians as those who practice "as a registered nurse, hospital, dentist, podiatrist, pharmacist, or nursing home" and their employees acting in the scope of their employment (6). Based on the exclusive nature of this definition, many who might professionally be considered health care providers were denied the benefits of Article 4590i (7).

This is generally not an issue in Chapter 74 matters because the Chapter 74 definition of health care providers is not exclusive. The definition of health care provider in Chapter 74 uses the terms "including" and "includes" before listing various individuals and entities (8). This change is significant. Prior decisions holding that health care providers are exclusively defined are obsolete (9). Because health care providers are now defined in a nonexclusive manner, entities that were not health care providers under Article 4590i, such as drug and alcohol treatment facilities and pathology laboratories, are now health care providers entitled to the protection of Chapter 74 (10).

The second element, setting forth the action(s) on which the claim must be based, has been the primary focus of efforts to circumvent application of Chapter 74. More specifically, the "other claimed departures from accepted standards" language is almost universally where claimants' arguments are now based.

In evaluation of this element, courts are instructed to look at the underlying nature of the claim asserted (11). Courts are not to focus on or be bound by the "form" of the pleading (11). This means that the specific cause of action pleaded is irrelevant. In practice, courts should ask one question: Is the conduct on which the claim is based "an inseparable part of the rendition of health care services" (12)? If the answer to this question is yes, the matter is a health care liability claim. If the answer is equivocal, the court can consider whether expert testimony from

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a health care professional is needed to prove the claim (11). If the answer to this question is yes, the matter is probably a health care liability claim (11).

With this guidance, courts have consistently and reasonably ruled that the physical or sexual assault of a patient by a health care provider is not a health care liability claim (13). While these claims frequently arise out of the provision of medical services, the underlying basis of the claims does not truly center on breach of the applicable standard of care and as such is not "an inseparable part of the rendition of medical services" (13).

Two interesting cases have carved out very narrow exceptions to this general rule that claims of assault are not health care liability claims. In one matter, the patient claimed that he was abused through the improper use of restraints during a psychiatric hospitalization. The patient asserted that this was not a health care liability claim because expert testimony was not required to support this claim at trial. The court held that the fact that expert testimony would not be required to support a claim at trial was not dispositive as to whether or not the matter was a health care liability claim. The focus was whether or not the "abuse" alleged was unrelated to the claimant's "course of treatment." Since there were no allegations that anyone "had turned aside from the Hospital's mission to care for and restrain [the patient] during his course of care," the matter was a health care liability claim. This result is not that surprising considering that the claim of abuse was directly related to "standards by which mental health care institutions restrain patients" (14). Further, there should be no question this was a health care liability claim since the use of restraints in this particular incident was without a doubt "an inseparable part of the rendition of health care services."

A more surprising result was reached in *Vanderwerff v. Beathard*. In that case the claimant alleged that she was assaulted when her chiropractor touched her genitals "during the course of a routine examination of her knee." In his defense, the chiropractor claimed that he was "using a subjective means" of manipulating the patient's musculoskeletal system. The court held that the threshold question was whether or not the chiropractor's examination "was within the scope of a chiropractic examination." Specifically, the court held that this was a health care liability claim because the questions before it could not be answered without reference to the standard of care applicable to a chiropractor and because the conduct at issue was inseparable from the rendition of health care services since it occurred during the course of treatment by a health care provider (15). The distinction from the other assault cases appears to be the defense that the "assault" at issue was part and parcel of the medical treatment rendered, as opposed to a defense that the "assault" simply did not occur. One could reasonably argue, however, that the rubbing of someone's genitals could never be a legitimate part of a medical procedure (16) and that instead of focusing on the underlying nature of the claim, the court was persuaded by the exact artful pleading, albeit by the defense, that it has been directed to ignore.

Allegations of intentional conduct do not automatically take a claim out from under the rubric of a health care liability claim. If the underlying basis of the claim is health care that was or should have been provided, the matter is a health care liability claim, even if the claimant alleges intentional misconduct against the health care provider.

For example, in *Hunsucker v. Fustok*, the claimant alleged that her breast surgery was performed in manners outside those she and the surgeon agreed to follow. Specifically, the claimant complained that (a) the wrong surgical approach was used (through the nipple/areola), (b) new implants were not placed (her old ones were replaced), and (c) the new implants were not placed underneath the breast tissue. Despite the fact that the claimant alleged fraud and assault and battery against the surgeon based on these facts, this matter was held to be a health care liability claim because the underlying factual bases of the claim (specific elements of the surgery) were inseparable from the surgeon's rendition of health care services (17). Similarly, assertions that a psychiatric patient was held in a psychiatric hospital without authority and given psychiatric medications without her consent were held to be health care liability claims. Even though the claimant alleged that the underlying conduct was intentional, the underlying nature of the claims was the physicians' decisions to administer medications and discontinue the patient's planned discharge (18). Even claims based on misrepresentations about health care, even if alleged to be intentional in nature, are health care liability claims (19).

In contrast to ruling that assaults by health care providers are not health care liability claims, claims against the employers of those health care providers are health care liability claims. The reasoning behind these rulings stems from the 2004 case of *Garland Community Hospital v. Rose* in which the Texas Supreme Court held that negligent credentialing was a health care liability claim for two reasons: (1) physician credentialing is inseparable from the health care rendered to patients since hospitals provide physicians a place to treat patients, and (2) the evaluation of physician applications for staff privileges requires the introduction of expert testimony since that is a matter outside a juror's ordinary experience (12). Because claims against the employers of physicians and other staff alleged to have physically and/or sexually assaulted patients are essentially that they violated standards of care with respect to the hiring, instruction, retention, supervision, and training of such individuals, they are health care liability claims (20). Along similar lines, claims by patients against health care providers for failure to protect them from the intentional acts of other patients (even if styled as general negligence and/or premises liability claims) are health care liability claims (11, 21).

Some have tried to assert that this "protection" granted employers who are health care providers exists only if the employee who committed the act is a health care provider. These efforts have been unsuccessful (22). In addition to the nonexclusive language in the definition discussed above, the definition of "health care provider" also applies to "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" (23). This broad definition clearly covers the acts

of non–health care provider employees of physicians and health care providers.

The most fertile area of efforts to circumvent application of Chapter 74 has been evaluation of the "safety and professional services" element. While courts have consistently and unequivocally held that a health care provider's hiring, firing, supervision, and extension of staff privileges are health care liability claims, numerous other facets of "safety and professional services" are still open to interpretation. The key issue in these cases is whether or not the "safety and professional services" at issue are "directly related to health care."

Cases that focus on this element of Chapter 74 have primarily involved (a) interactions between staff and patients and (b) the condition and safety of the premises. The current case law addressing each of these issues is somewhat inconsistent and contradictory.

For example, a claim based on a home health care nurse who placed a heavy supply bag in such a manner that it fell on and injured her patient while she provided services at his home was not a health care liability claim. Despite the fact that the "safety" issue appeared to be directly related to health care services provided to the patient, the matter was determined to not be a health care liability claim because expert testimony was not needed to establish reasonable care (24). Injury to a paraplegic patient during transfer from an examination table to a wheelchair because she fell while placed unsecured on a stool during the transfer was a health care liability claim because it was inseparable from the care the patient received during her hospitalization and because expert testimony would be needed to establish the proper method of patient transfers (25).

In *Christus Health v. Beal*, an inpatient was injured when his bed collapsed while he was asleep. The claim that the bed collapsed because it was not properly assembled was held not to constitute a health care liability claim. The court ruled that the claim was nothing more than a premises liability claim because normal use of the bed for sleeping was not directly related to the patient's treatment at the facility (26).

In contrast to *Beal*, claims surrounding the malfunction of a trapeze patient lift device were health care liability claims. This decision was based on the facts that (a) the device appeared to be a necessary part of care for the patient's condition, (b) the patient was instructed to use the device when getting in and out of bed, (c) the device was assembled by a nurse and orthopedic technician, and (d) the device had been ordered by the patient's physician. Based on these facts, the device was found to be an inseparable part of the medical services rendered to the patient (27).

In *Valley Baptist Medical Center v. Stradley*, an outpatient was injured at a medical center when he fell from a malfunctioning treadmill during "prescribed" exercise. This claim was ruled to be nothing more than a negligence or premises liability claim because a jury could understand the issues without the need of expert testimony. The fact that the patient's doctor recommended exercise did not transform the matter into a health care liability claim (28). A patient injured when she fell from a "balance board" during physical therapy, however, did allege a health care liability claim. This finding was due to the fact that at the time of the incident the patient was engaged in "therapy-exercise that was directed by the health care provider" (29).

Along the same lines of reasoning used in *Beal* to find that injury from a collapsed bed was not a health care liability claim, a hospital patient whose foot became infected from stepping on a loose paint chip at the facility during a shower did not have a health care liability claim (30).

Review of these cases appears to indicate that the key issue is how much the conduct at issue is related to a specific aspect of the patient's health care, as opposed to the patient's mere presence in a health care facility or proximity to a health care provider. The two cases discussed below issue illustrate that such a simplistic approach may not be used to blindly guide us on how these questions will be answered. These cases further illustrate that the key variable is the audience (the judge(s) to whom the argument is presented).

In 2004 in *Jones v. Ark-La-Tex,* there were claims that one of two defendant facilities was negligent because it had a "substandard air filtering system and unclean rodent-infested environment." Claimants alleged that this environment resulted in the patient's death from two rare fungal infections. Based on these underlying facts, it was held that the claimants had alleged a health care liability claim. This ruling was based on the fact that the "syntax" of the claim was for negligent treatment. Further, it was held that expert testimony would be needed to support the claimant's allegations. The court explained that testimony was needed explaining why the facilities had a duty to prevent the conditions that allowed the decedent to develop her rare infections. As such, the Texarkana Court of Appeals concluded that this type of claim was expressly a health care liability claim (31).

Four years later, in January 2008, the Texarkana Court of Appeals reached the opposite outcome under similar facts. The claims in *Omaha Healthcare Center v. Johnson* arose out of a nursing home patient who died after she was bitten by a brown recluse spider. The allegations against the nursing home focused on its failure to eradicate spiders from its facility. Based on the 2004 ruling by this same court in *Ark-La-Tex* (also considering that two judges in *Omaha Healthcare* were judges in *Ark-La-Tex*), one would anticipate a holding that this matter was a health care liability claim. From review of the *Omaha Healthcare* opinion, it appears that the court focused on the language that safety claims had to "be directly related to health care," language that was not in the predecessor statute to Chapter 74, the statute at issue in *Ark-La-Tex.* In this vein, the court held that the allegations at issue were premises liability claims, not health care liability claims, because they did not "implicate a medical duty to diagnose or treat" (32).

The "syntax" of these cases does not appear to be different. If a claim asserting a patient developed rare infections from "rodent infestation" is really a claim for negligent treatment and thus a health care liability claim, would not a claim that the patient died from bites due to a failure to "eradicate spiders" similarly be based on negligent treatment? Two other things about the *Omaha Healthcare* decision are interesting.

First, one would hope that a nursing home, treating older, often debilitated patients, would have a higher duty than owners of other non–health care-related premises to keep pests out and provide a clean environment for residents. Second, it is interesting to note the absence of any discussion or reference to the 2004 *Ark-La-Tex* decision in the *Omaha Healthcare* opinion. The factual patterns appear very similar, but the end results are opposite, notwithstanding the statutory language differences.

Further illustrating concerns about the *Omaha Healthcare* decision is a 2006 San Antonio Court of Appeals' decision. The claims at issue in *Emeritus Corporation v. Highsmith* arose out of injuries to the claimant from resident-on-resident altercations in an assisted living facility. Unlike *Ark-La-Tex,* this case involved analysis of Chapter 74, not the predecessor statute. The claimant in *Emeritus* alleged, among other things, that the facility failed "to provide a safe and secure environment"—in essence, the same complaint made in *Omaha Healthcare*. The San Antonio Court of Appeals, however, found that because the claimant's allegations involved professional supervision, monitoring, and protection of the patient population, the matter was a health care liability claim (33).

A case even more illustrative of the inconsistency in all judicial decision-making is *Yamada v. Friend*. The claims in *Yamada* arose out of the death of a guest who had a cardiac arrest at a Fort Worth–area water park. Claimants alleged that the park's automated external defibrillators (AEDs) were improperly placed and used. In connection with their improper placement allegations, claimants alleged that an emergency physician the water park consulted regarding placement of the AEDs was negligent in the advice and services that he provided.

Interestingly, despite the fact that it appears (at least to the author) intuitive that the placement of a device that essentially brings people back from the dead would be directly related to health care (also presumably the reason a physician was consulted for this input), the Fort Worth Court of Appeals ruled that this was not a health care liability claim. This position was based on two factors. First, the court held that medical expert testimony would not be needed to establish the proper placement of the AEDs at the park. Second, the court held that the doctor's actions were not directly related to health care because the allegations against him did not "relate *directly* to acts performed or furnished by a health care provider to Sarah during her medical care, treatment, or confinement" (34).

The surprising part of the opinion was that the court of appeals also ruled that claimants' allegation that the physician breached his duty to act "as a physician of ordinary prudence would under the same or similar circumstances" in rendering his "medical consultative advice" to the water park was a health care liability claim (34). Thus, based on the same underlying facts, the court found both a health care liability claim and a non–health care liability claim. As in the *Vanderwerff* case discussed above (15), it appears the *Yamada* court did not follow the Texas Supreme Court's instruction on evaluation of this issue. The only way these two completely opposite findings could result from evaluation of the same underlying facts is if rather than properly focusing on the underlying nature of the claims before it (the facts), the court was distracted by the claimants' pleading.

For those unhappy with the limitations placed on health care liability claims, the statute will certainly be an issue in the upcoming elections. Because of that fact, we must anticipate that it will be addressed again by the Texas legislature in the relatively near future. It is important to not lose sight of the fact that judicial activism is another method of effecting change. Direct requests for judicial activism seek a swift universal decision that the statute is not valid. Because of the high-profile nature of such an action, whatever decision is reached by the trial court would then go through the appellate process. Indirect requests seek insidious erosion of the statute on a case-by-case basis. While this is a slower, less dramatic process, because of the volume of cases involved there is less chance they will go as far as the direct approach cases on appeal. Given the fact that this audience has been shown to be somewhat inconsistent in interpreting the statute, the potential effect of pleas for judicial activism through indirect efforts should not be overlooked.

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1. See *Adriane Springs et al v Joyce Abraham, MD, et al,* United States District Court, Eastern District of Texas, Cause No 2:2008 CV 00081; *Adriane Springs et al v Joyce Abraham, MD, et al,* District Court of Dallas County Texas, 14th Judicial District, Cause No 08-00671.
2. See Tex Civ Prac & Rem Code, §74.251, 74.301, 74.303, 74.351.
3. Tex Civ Prac & Rem Code, §74.001(13).
4. *Victoria Gardens of Frisco v Walrath,* —SW3d—, 2008 WL 1822506 *2 (Tex App—Dallas) (April 24, 2008).
5. Tex Rev Civ Stat Ann Art 4590i, *repealed and codified as amended by* Act of June 2, 2003, 78th Leg, RS, ch 204, §10.01, 10.09, 2003 Tex Gen Laws 847, 865, 884 (hereinafter "former article 4590i").
6. Former article 4590i, §1.03(a)(3).
7. See *Finley v Steenkamp,* 19SW3d 533 (Tex App—Fort Worth 2000, no writ); *Townsend v Catalina Ambulance Co, Inc,* 857SW2d 791 (Tex App—Corpus Christi 1993, no writ).
8. Tex Civ Prac & Rem Code, §74.001(a)(11) and (12)(A), (B).
9. See *Brown v Villegas,* 202 SW3d 803, 805–806 (Tex App—San Antonio 2006, no pet).
10. See *Christus Health v Beal,* 240 SW3d 282, 287 (Tex App—Houston [1st Dist] 2007, no pet); *Pro Path Services, LLP v Koch,* 192 SW3d 667, 671 (Tex App—Dallas 2006, pet denied).
11. *Diversicare General Partner Inc v Rubio,* 185 SW2d 842, 847–848 (Tex 2005).
12. *Garland Community Hospital v Rose,* 156 SW3d 541, 546 (Tex 2004).
13. *Holguin v Laredo Regional Medical Center, LP,* —SW3d—, 2008 WL 312716 (Tex App—San Antonio) (Feb 6, 2008); *Jones v Khorsandi,* 148 SW3d 201 (Tex App—Eastland 2004, pet denied).
14. *Parker v CCS/Meadow Pines, Inc,* 166 SW3d 509, 513 (Tex App—Texarkana 2005, no pet).
15. *Vanderwerff v Beathard,* 239 SW3d 406, 409 (Tex App—Dallas 2007, no pet).
16. *Buck v Blum,* 130 SW3d 285, 289–290 (Tex App—Houston [14th Dist] 2004, no pet).
17. *Hunsucker v Fustok,* 238 SW3d 421, 428–429 (Tex App—Houston [1st Dist] 2007, no pet).
18. *Groomes v USH of Timberlawn, Inc,* 170 SW3d 802, 805–806 (Tex App—Dallas 2005, no pet).
19. See *Holleman v Vadas,* —SW3d—, 2007 WL 1059035 (Tex App—San Antonio) (April 11, 2007).

20. See *Holguin v Laredo Regional Medical Center, LP,* —SW3d—, 2008 WL 312716 (Tex App—San Antonio) (Feb 6, 2008); *In re Kiberu,* 237 SW3d 445, 448 (Tex App—Fort Worth 2007, no pet); *Southwest Mental Health Center v Olivo,* 2006 WL 2682245 (Tex App—San Antonio) (Sept 20, 2006); *NCED Mental Health Center, Inc v Kidd,* 214 SW3d 28 (Tex App—El Paso 2006, no pet); *Doege v Sid Peterson Memorial Hospital,* 2005 WL 1521193 (Tex App—San Antonio) (June 29, 2005); *Buck v Blum,* 130 SW3d 285, 289–290 (Tex App—Houston [14th Dist] 2004, no pet).
21. *Oak Park Inc v Harrison,* 206 SW3d 133 (Tex App—Eastland 2006, no pet).
22. *MacPete v Bolomey,* 185 SW3d 580 (Tex App—Dallas 2006, no pet).
23. Tex Civ Prac & Rem Code, §74.001(a)(12)(B)(ii).
24. *Rogers v Crossroads Nursing Services, Inc,* 13 SW3d 417 (Tex App—Corpus Christi 1999, no pet).
25. *Devereaux v Harris County Hospital District,* 2007 WL 852618 (Tex App—Houston [1st Dist]) (March 22, 2007).
26. *Christus Health v Beal,* 240 SW3d 282, 287 (Tex App—Houston [1st Dist] 2007, no pet).
27. *Espinosa v Baptist Health System,* 2006 WL 2871262 (Tex App—San Antonio) (Oct 11, 2006).
28. *Valley Baptist Medical Center v Stradley,* 210 SW3d 770, 775–776 (Tex App—Corpus Christi 2006, no pet).
29. *Clark v TIRR Rehabilitation Center,* 227 SW3d 256, 261 (Tex App—Houston [1st Dist] 2007, no pet).
30. *Shults v Baptist St. Anthony's Hosp Corp,* 166 SW3d 502 (Tex App—Amarillo 2005, pet denied).
31. *Jones v Ark-La-Tex,* 141 SW3d 790, 794 (Tex App—Texarkana 2004, no pet).
32. *Omaha Healthcare Center, LLC v Johnson,* —SW3d—, 2008 WL 339838 (Tex App—Texarkana) (Feb 8, 2008).
33. *Emeritus Corp v Highsmith,* 211 SW3d 321, 328 (Tex App—San Antonio 2006, no pet).
34. *Yamada v Friend,* 2008 WL 553690 (Tex App—Fort Worth) (Feb 28, 2008).