# EMERGENCY MEDICAL CARE IN CHAPTER 74: SUBSTANTIVE DEFINITIONS AND INTERPRETIVE QUANDARIES

*Patrick Luff*,[*] *Bill Liebbe*,[**] *Jay Harvey*,[***] *and Jack McGehee*[****]



Chapter 74 of the Texas Civil Practice and Remedies Code contains the majority of the procedural and substantive provisions in Texas law affecting

* Patrick Luff is an associate at Winckler & Harvey, L.L.P., and a former professor of law at Washington & Lee University School of Law, Sandra Day O'Connor College of Law – Arizona State University, and the University of Oklahoma College of Law. The authors thank Glenn Cunningham and Zoe Taylor for their editing assistance.

** Bill Liebbe is a solo practitioner who has represented patients and their families in medical malpractice cases since 1987. He is a past President of the Dallas Trial Lawyers Association, has been board certified in personal injury law by the Texas Board of Legal Specialization continuously since 1987, and has been recognized as a Texas Super Lawyer in Plaintiff's Medical Malpractice by Thomson Reuters Service every year since 2005.

*** Jay Harvey is a partner at Winckler & Harvey, L.L.P. He is a past President of the Texas Trial Lawyers Association, is board certified in personal injury law by the Texas Board of Legal Specialization, and is a fellow of the American College of Trial Lawyers.

**** Jack McGehee is a partner at McGehee, Chang, Landgraf. He is a past President of the Texas Trial Lawyers Association, is board certified in personal injury law by the Texas Board of Legal Specialization, is a member of the American Board of Trial Advocates, and has taught courses in trial advocacy at the University of Houston Law Center and Emory Law School.

medical malpractice cases.[1] Many of the provisions of Chapter 74 are simply recodified from the 1977 Medical Liability and Insurance Improvement Act.[2] However, in addition to recodification of some provisions, the 2003 Medical Malpractice and Tort Reform Act[3] also made some significant changes and additions to the medical malpractice landscape, particularly in the area of emergency medical care.

The two versions of Chapter 74 that proceeded through the respective chambers of the Texas Legislature—House Bill 4 (H.B. 4) and Senate Bill 1 (S.B. 1)—contained some differences that were eliminated by a conference committee.[4] On the Saturday morning before the adjournment of the legislative session the following Monday, the conference committee adopted a compromise bill that contained provisions that had never been seen in either chamber.[5] Notably, neither H.B. 4 nor S.B. 1 mentioned a different standard of proof, more onerous than simple negligence, that emerged from conference committee and applied to physicians and health care providers treating patients in emergency departments, surgical suites, and obstetrical units.[6] For the first time, the words "wilful and wanton"[7] were included, and hence, for the first time under Texas law, negligent emergency health care was permitted in three physical locations in a hospital, even if such care caused serious injury or death.[8]

H.B. 4, as it ultimately passed, provided a different standard of proof for physicians and other health care providers when the care that is provided is "emergency medical care."[9] The operative section of Chapter 74 read in full:

> In a suit involving a health care liability claim against a physician or health care provider for injury to or death of a patient arising out of the provision of emergency medical care in a hospital emergency department or obstetrical unit or in a surgical suite immediately following the evaluation or treatment of a patient in a hospital emergency department, the claimant bringing the suit may prove that the treatment or lack of treatment by the physician or health care provider departed from accepted standards of medical care or health care only if the claimant shows by a preponderance of the evidence that the physician or health care provider, with *wilful and*

1. *See* TEX. CIV. PRAC. & REM. CODE ANN. § 74.001–.507 (West 2017).
2. Act of May 30, 1977, 65th Leg., R.S., ch. 817, 1977 Tex. Gen. Laws 2039, *repealed by* Act of June 2, 2003, 78th Leg., R.S., ch. 204, § 10.09, 2003 Tex. Gen. Laws 847, 884.
3. Act of June 2, 2003, 78th Leg., R.S., ch. 204, § 10.01, 2003 Tex. Gen. Laws 847, 864.
4. *See generally* Conf. Comm., Conference Committee Report, Tex. H.B. 4, 78th Leg., R.S. (2003).
5. *See generally id.*
6. *See generally id.*
7. Act of June 2, 2003, 78th Leg., R.S., ch. 204, § 10.01, sec. 74.153, 2003 Tex. Gen. Laws 847, 871 (codified at TEX. CIV. PRAC. & REM. CODE § 74.153). Throughout this Article, when the "wilful and wanton" language is quoted, it will be spelled as it appears in the statute without a [sic] annotation. CIV. PRAC. & REM. § 74.153.
8. *See* CIV. PRAC. & REM. § 74.153.
9. *See id.*

> *wanton negligence*, deviated from the degree of care and skill that is reasonably expected of an ordinarily prudent physician or health care provider in the same or similar circumstances.[10]

The inclusion of the wilful and wanton standard of proof, as well as the meaning of emergency medical care and related concepts, has led to significant confusion among Texas courts and significant obstacles to victims of medical negligence.[11] In addition, the inclusion of a jury instruction to be used in cases in which the emergency medical care statute above applied further confused the matter.[12] This particularly curious provision of Chapter 74 was not the result of the accretion of more than forty years of legislation, but rather the conscious decisions of drafters of the 2003 Medical Malpractice and Tort Reform Act.[13] This strange drafting decision, and the resulting confusion that it has caused, could be remedied by moving one of the subsections to a different section of Chapter 74.

This Article considers the interpretive difficulties surrounding emergency care under Chapter 74, contemplates how the emergency medical care statute applies in a variety of circumstances, and suggests a solution to the interpretive confusion created by the inclusion of the emergency medical care jury instruction in Chapter 74.

## I. DEFINING "EMERGENCY MEDICAL CARE"

Section 74.153 has significant implications for medical malpractice cases, since obtaining a jury finding of wilful and wanton conduct by physicians or health care providers at trial *and* having such a verdict upheld on appeal appears to be a practical impossibility.[14]

Interpreting § 74.153 requires reference to the statutory definition of "emergency medical care" from another section of Chapter 74.[15] In full, the definition states:

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10. *Id.* (emphasis added).

11. *Compare* Jaster v. Comet II Constr., Inc., 438 S.W.3d 556 (Tex. 2014) (interpreting Texas Civil Practice and Remedies Code § 150.002 to apply to claims by plaintiffs rather than defendants or third-party defendants in a professional malpractice claim), *with* Turner v. Franklin, 325 S.W.3d 771 (Tex. App.—Dallas 2010, pet. denied) (amounting wilful and wanton negligence to gross negligence). *See* Guzman v. Mem'l Hermann Hosp. Sys., No. H-07-3973, 2009 WL 780889 (S.D. Tex. Mar. 23, 2009) (equating wilful and wanton negligence as between gross negligence and malice on the tort spectrum).

12. *See Guzman*, 2009 WL 780889, at *8.

13. *See* Michael S. Hull et al., *House Bill 4 and Proposition 12: An Analysis with Legislative History, Part Three*, 36 TEX. TECH L. REV. 169, 268–69 (2005).

14. *See generally* Giana Ortiz, Comment, *Medical Malpractice Damage Caps – Constitutional Per Se in Texas, but at What Price? A Look at Alternative Patient Compensation Schemes*, 43 HOUS. L. REV. 1281 (2006). In fact, the authors are not aware of *any* trial verdict in favor of a plaintiff in which § 74.153 applied and was upheld on appeal, although many emergency department cases settle either before trial or while an appeal is pending. *See* CIV. PRAC. & REM. § 74.153.

15. *See* CIV. PRAC. & REM. §§ 74.001(a)(7), .153.

> 'Emergency medical care' means bona fide emergency services provided after the sudden onset of a medical or traumatic condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. The term does not include medical care or treatment that occurs after the patient is stabilized and is capable of receiving medical treatment as a nonemergency patient or that is unrelated to the original medical emergency.[16]

### *A. Texas Canons of Statutory Construction*

In order to interpret §§ 74.153 and 74.001(a)(7), it is necessary, first, to identify the tools of statutory construction that have been announced and implemented by Texas courts. It is important to remember that the judiciary will presume that a statutory provision is not intended to displace common law remedies.[17] To the contrary, abrogation of a common law claim is disfavored, and it is necessary for the express terms of the statute to so provide.[18] As to finding such implied intent by the legislature, it will be determined that the common law is abrogated only upon a finding that there exists "a clear repugnance between the common law and statutory causes of action."[19] Since the heightened burden of proof in emergency medical care cases significantly alters the common law, this general canon should instruct any interpretation of §§ 74.153 and 74.001(a)(7). Bearing this baseline rule in mind, the following canons instruct our understanding of when Chapter 74's heightened burden of proof will apply:

> 1. Although Texas does not follow the canon that statutes in derogation of the common law are to be strictly construed,[20] upon finding express terms or a clear repugnance, "it is recognized that if a statute creates a liability unknown to the common law, or deprives a person of a common law right, the statute will be strictly construed in the sense that it will not be extended beyond its plain meaning or applied to cases not clearly within its purview."[21]

16. *Id.* § 74.001(a)(7).

17. TEX. GOV'T CODE ANN. § 311.023(4) (West 2017).

18. Cash Am. Int'l Inc. v. Bennett, 35 S.W.3d 12, 16 (Tex. 2000).

19. *Id.* (quoting Holmans v. Transource Polymers, Inc., 914 S.W.2d 189, 192 (Tex. App.—Fort Worth 1995, writ denied)).

20. *See In re* Smith, 333 S.W.3d 582, 587 (Tex. 2011).

21. Satterfield v. Satterfield, 448 S.W.2d 456, 459 (Tex. 1969); *see Bennett*, 35 S.W.3d at 16–17.

2. "The meaning of a statute is a legal question, which we review *de novo* to ascertain and give effect to the Legislature's intent. Where text is clear, text is determinative of that intent. ('[W]hen possible, we discern [legislative intent] from the plain meaning of the words chosen.') This general rule applies unless enforcing the plain language of the statute as written would produce absurd results. Therefore, our practice when construing a statute is to recognize that 'the words [the Legislature] chooses should be the surest guide to legislative intent.' Only when those words are ambiguous do we 'resort to rules of construction or extrinsic aids.'"[22]

3. "[W]e must focus on what a statute says and, just as attentively, on what it does not say . . . ."[23]

4. "To determine its *common*, *ordinary* meaning, we look to a wide variety of sources, including dictionary definitions, treatises and commentaries, our own prior constructions of the word in other contexts, the use and definitions of the word in other statutes and ordinances, and the use of the words in our rules of evidence and procedure."[24]

5. Where the legislature has supplied its own definition, "[w]e do not look to the ordinary, or commonly understood, meaning of the term because the Legislature has supplied its own definition, which we are bound to follow."[25] Where, however, "words contained within the definition are not themselves defined, we apply a meaning that is consistent with the common understanding of those terms."[26]

6. Courts should not interpret a statute in such a way that renders part of it meaningless.[27]

7. "If a word is connected with and used with reference to a particular trade or subject matter or is used as a word of art, the word shall have the meaning given by experts in the particular trade, subject matter, or art."[28]

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22. Entergy Gulf States, Inc. v. Summers, 282 S.W.3d 433, 437 (Tex. 2009) (alterations in original) (citations omitted).

23. *Id.* at 464.

24. Jaster v. Comet II Constr., Inc., 438 S.W.3d 556, 563 (Tex. 2014) (footnote omitted).

25. *Summers*, 282 S.W.3d at 437.

26. *Id.*

27. *Id.* at 442.

28. TEX. GOV'T CODE ANN. § 312.002(b) (West 2017).

> 8. "[W]e will not give an undefined statutory term a meaning that is out of harmony or inconsistent with other provisions . . . ."[29]
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> 9. "In construing a statute, whether or not the statute is considered ambiguous on its face, a court may consider among other matters the . . . common law or former statutory provisions, including [those] on the same or similar subjects . . . ."[30]
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> 10."[W]hen an undefined [statutory] term has multiple common meanings, the definition most consistent within the context of the statute's scheme applies."[31]

### *B. Interpreting § 74.001(a)(7)*

This Section conducts a close reading of the definition of emergency medical care in Chapter 74 using the interpretive canons identified above in order to provide a comprehensive understanding of the definition as it applies to § 74.153.

**"Emergency medical care means bona fide . . . ."**[32]

Bona fide means "authentic" or "real."[33]

**Emergency Services.**

Although Chapter 74 does not define "emergency services," the Texas Legislature has defined the term elsewhere to mean:

> [S]ervices that are *usually and customarily* available at a hospital and that *must be provided immediately* to: (1) sustain a person's life; (2) prevent serious permanent disfigurement or loss or impairment of the function of a body part or organ; or (3) provide for the care of a woman in active labor or, if the hospital is not equipped for that service, to provide necessary treatment to allow the woman to travel to a more appropriate facility without undue risk of serious harm.[34]

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29. McIntyre v. Ramirez, 109 S.W.3d 741, 745 (Tex. 2003); *see In re* Hall, 286 S.W.3d 925, 928–29 (Tex. 2009).

30. GOV'T § 311.023(4).

31. Ritchie v. Rupe, 443 S.W.3d 856, 867 (Tex. 2014) (alterations in original) (quoting State v. $1,760.00 in U.S. Currency, 406 S.W.3d 177, 180–81 (Tex. 2013) (per curiam)).

32. TEX. CIV. PRAC. & REM. CODE ANN. § 74.001(a)(7) (West 2017).

33. *Bona Fide*, MERRIAM-WEBSTER'S DICTIONARY AND THESAURUS (3d ed. 2014).

34. TEX. HEALTH & SAFETY CODE ANN. § 311.021 (West 2017) (emphasis added).

Section 74.001(b) provides that: "Any legal term or word of art used in this chapter, not otherwise defined in this chapter, shall have such meaning as is consistent with the common law."[35] The common, ordinary meaning of emergency services can be determined by looking at a wide variety of sources, including the use and definition of the words in other statutes.[36] In construing a statute, whether or not the statute is considered ambiguous on its face, a court may consider the common law or former statutory provisions, especially those on the same or similar subjects.[37] For example, § 311.021 of the Texas Health and Safety Code had defined "emergency services" prior to the enactment of Chapter 74 and is a statutory provision on the same or similar subject—emergency services in a hospital emergency department.[38] It is, therefore, entirely appropriate to look to § 311.021 of the Texas Health and Safety Code to determine the common, ordinary meaning of the term "emergency services" and conclude that the term should be understood as services that must be provided immediately to sustain a person's life or prevent serious permanent disfigurement or loss or impairment of the function of a body part or organ. This definition of emergency services in the Texas Health and Safety Code is consistent with the plain language of § 74.001(a)(7). Section 74.001(a)(7) defines "emergency medical care" as those emergency services that the absence of which "could reasonably be expected to result in placing the patient's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part."[39]

**Provided.**

The word "provided" means to "furnish" or "supply."[40]

> **[A]fter the sudden onset of a medical or traumatic condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.**[41]

35. CIV. PRAC. & REM. § 74.001(b).
36. *See* Jaster v. Comet II Constr., Inc., 438 S.W.3d 556, 563 (Tex. 2014).
37. TEX. GOV'T CODE ANN. § 311.023(4) (West 2017).
38. HEALTH & SAFETY § 311.021.
39. *See* CIV. PRAC. & REM. § 74.001(a)(7).
40. *Provided*, MERRIAM-WEBSTER'S DICTIONARY AND THESAURUS (3d ed. 2014).
41. CIV. PRAC. & REM. § 74.001(a)(7) (emphasis added).

The medical or traumatic conditions that fall within the definition of emergency medical care must meet two criteria. First, the medical or traumatic condition must have a sudden onset.[42] Second, the

> medical or traumatic condition [must manifest] itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.[43]

If either one of these criteria is not met, then the term emergency medical care does not apply, and the affirmative defense of § 74.153 is not available.[44]

The medical or traumatic condition must be an emergency medical condition. "Standard of Proof in Cases Involving Emergency Medical Care" is the title of § 74.153. The statute applies to health care liability claims arising out of the provision of *emergency* medical care.[45] The legislative definition of "medical or traumatic condition" is a verbatim duplicate of language from the federal Emergency Medical Treatment and Labor Act (EMTALA).[46]

The phrase "such that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part" is in harmony with, and consistent with, the definition of emergency services in § 311.021 of the Texas Health and Safety Code.[47] The type of "bona fide emergency services" required to be provided are the type of services that must be provided immediately to prevent placing "the patient's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part."[48]

"Immediate" means "made or done at once."[49] If the medical or traumatic condition is not one that requires *immediate* medical attention to prevent placing the patient's health in "serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part," then the term emergency medical care does not apply, and the affirmative defense of § 74.153 is not available.[50]

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42. *Id.*
43. *Id.*
44. *See id.*; *id.* § 74.153.
45. *See id.* § 74.153.
46. *See id.*; *accord* 42 U.S.C.A. § 1395dd(e)(1)(A) (West 2019).
47. *See* CIV. PRAC. & REM. § 74.001(a)(7); TEX. HEALTH & SAFETY CODE ANN. § 311.021 (West 2017).
48. *See* CIV. PRAC. & REM. § 74.001(a)(7); HEALTH & SAFETY § 311.021.
49. *Immediate*, MERRIAM-WEBSTER'S DICTIONARY AND THESAURUS (3d ed. 2014).
50. *See* CIV. PRAC. & REM. §§ 74.001(a)(7), .153.

**"The term does not include medical care or treatment that occurs after the patient is stabilized and is capable of receiving medical treatment as a nonemergency patient or that is unrelated to the original medical emergency."**[51]

Although the Texas Legislature did not define "stabilized" in Chapter 74, EMTALA defines the term to mean "with respect to an emergency medical condition . . . that no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during the transfer of the individual from a facility."[52]

The plain language of the statute shows that the Texas Legislature intended bona fide emergency services to be of the type designed to stabilize the patient's medical or traumatic condition—to prevent deterioration of the condition so that the patient's health is not placed in "serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part."[53] Once the bona fide emergency services stabilize the patient's medical or traumatic condition and the patient is capable of receiving medical treatment as a nonemergency patient, the term emergency medical care no longer applies.[54] If the bona fide emergency services do not stabilize the patient and the patient is taken immediately to an obstetrical unit or surgical suite, § 74.153 continues to apply until the patient is stabilized.[55]

The plain language of the definition of emergency medical care, when read as a whole, applies only to a patient who arrives to the emergency department with the sudden onset of an emergency medical or traumatic condition that is unstable and, therefore, in need of immediate bona fide emergency services.[56] If the patient's medical or traumatic condition is stable on arrival to the emergency department—where "no material deterioration of the condition is likely, within reasonable medical probability, to result from or occur during" admission to the hospital—then the patient is capable of being admitted as a nonemergency patient.[57] If the medical or traumatic condition is not one that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in "serious jeopardy, serious impairment to the bodily functions, or serious dysfunction of any bodily organ or part," then the patient does not require bona fide emergency services.[58] Applying the definition of emergency medical care to such a patient who arrives to the emergency department in stable condition

51. *Id.* § 74.001(a)(7).
52. 42 U.S.C.A. § 1395dd(e)(3)(B) (West 2019).
53. *See id.*; CIV. PRAC. & REM. § 74.001(a)(7).
54. 42 U.S.C.A. § 1395dd(e)(3)(A)–(B).
55. *See* CIV. PRAC. & REM. §§ 74.001(a)(7), .153.
56. *Id.* § 74.001(a)(7).
57. M. Sean Fosmire, *Frequently Asked Questions About the Emergency Medical Treatment and Active Labor Act (EMTALA)*, EMTALA.COM, www.emtala.com/faq.htm (last updated Oct. 10, 2009).
58. *See id.*

and is capable of receiving medical treatment as a nonemergency patient would lead to the absurd result that the term emergency medical care includes patients who are stable and capable of receiving medical treatment as a nonemergency patient but not include unstable patients whose medical or traumatic conditions are stabilized by the provision of bona fide emergency services.

The legislative history further demonstrates that § 74.153 was intended to apply only to unstable medical or traumatic conditions that are in existence when the patient is brought to the emergency department. During the Texas Senate debate over § 74.153, the following exchange occurred:

> Senator Hinojosa: Governor, on page 61, lines 12–13, the bill adds in the words "obstetrical unit" and "surgical suite" to the new section on the standard of proof now required for emergency care. Does this mean that now the higher standard applies to emergency care in these areas of a hospital, not just the emergency room?
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> Senator Ratliff: Only if the *same emergency* that brought the patient into the ER still *exists* when the patient gets to the OR Labor and Delivery area.
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> Senator Hinojosa: What about a case where a patient goes to the emergency room, is stabilized and then transferred to an OB unit or surgical suite and then another emergency occurs?
>
> Senator Ratliff: No, this does not apply to emergencies that arise during surgery or labor and delivery. *It only applies to emergencies that exist* when the patient is brought to the ER and still exists when the patient goes immediately to an OB unit or surgical suite from the ER.[59]

The house held similar discussions on § 74.153. These discussions included the following dialog:

> Representative Eiland: Chairman Nixon, on the medical malpractice Section 10 portion of the claim of the bill—you and I talked about this briefly but I want to make sure—in the section on page 61, standard of proof regarding emergency medical care, we added, basically, obstetrics to the definition. You and I talked but I want to make sure I understand. A woman goes to the hospital with preterm contractions and her physician is not there, but whoever that physician has on call for their group or whatever, sees the lady and say she is hospitalized and stabilized, but later on the baby's heart rate drops because maybe the cord is wrapped around its neck or something, and they say we have to do an emergency C-section right now. Under the bill, would that situation arise where the new higher standard would be required?

59. S.J. of Tex., 78th Leg., R.S. 5004 (2003) (emphasis added).

> Representative Nixon: No, it is the intent of this legislation that emergency situations where you do not have a prior relationship with the patient is the one given the protection. If you have a prior relationship with a patient, and you know about their medical history and their background you should not be given the protection to the same extent as someone who just shows up in the emergency room. You have no history, you have to treat them. That is why we have a different standard of care.[60]

## II. CASES APPLYING § 74.153

In *Guzman v. Memorial Hermann Hospital System*,[61] a federal district court concluded that the Emergency Medical Care Statute does not apply to, and was not meant to address, situations in which a health care provider does not diagnose an emergency condition and does not treat the patient's condition as an emergency condition even though such treatment occurred in the emergency department.[62] As a practical matter, bona fide emergency services for an emergency medical condition cannot be provided if it has not been diagnosed.[63]

This conclusion follows from the plain language of § 74.153 when it is read in context of Chapter 74's definition of "health care liability claim," which is defined to include both treatment *and* lack of treatment.[64] Thus, Chapter 74 encompasses two sets of circumstances: situations where health care *was* provided and situations where health care *was not* provided. In contrast, § 74.153 applies where "emergency service [are] *provided*."[65] To read § 74.153 as applying to provision *and* non-provision of care would not only create an interpretive conflict between §§ 74.001 and 74.153 but also do violence to the plain meaning of "provided." In directly analogous circumstances, the Texas Supreme Court has repeatedly held that the term "use" in the Texas Tort Claims Act does not include the concept of "non-use."[66] As such, "provided" cannot be read to mean "not provided." Section 74.153, therefore, does apply to health care liability claims where there was a failure to diagnose and treat an emergency medical condition. Nevertheless, Texas appellate courts have eschewed this practical and textually consistent reading of the statute.

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60. H.J. of Tex., 78th Leg., R.S. 6040 (2003).

61. Guzman v. Mem'l Hermann Hosp. Sys., 637 F. Supp. 2d 464, 464 (S.D. Tex. 2009).

62. *Id.* at 506–07.

63. *See* J.F.A. Murphy, *A Correct Diagnosis Is of Increasing Importance*, 109 IRISH MED. J. 324 (2016).

64. TEX. CIV. PRAC. & REM. CODE ANN. § 74.001(13) (West 2017).

65. *See id.* § 74.001(a)(7) (emphasis added); *supra* Section I.B (parsing the language of § 74.001).

66. *See, e.g.*, San Antonio State Hosp. v. Cowan, 128 S.W.3d 244, 245–46 (Tex. 2004); Kerrville State Hosp. v. Clark, 923 S.W.2d 582, 584 (Tex. 1996); Univ. of Tex. Med. Branch at Galveston v. York, 871 S.W.2d 175, 178–79 (Tex. 1994). For an extended discussion of cases stating that "use" does not include "non-use," *see* Patrick Luff & Jay Harvey, *Understanding the Texas Tort Claims Act*, 51 TEX. TECH L. REV. 693 (2019).

### *A. Failure to Provide Emergency Services*

In *Turner v. Franklin*, the patient awoke with sudden and severe pain in his lower left abdominal region and swelling in his left testicle—symptoms of testicular torsion.[67] Testicular torsion is an emergency medical or traumatic condition whereby the testicle becomes twisted on its own spermatic cord, cutting off the blood supply to the testicle and, if not treated within four to six hours, the testicle will become ischemic and die.[68] The emergency services that are usually and customarily available at a hospital, and that must be provided immediately to prevent loss of the testicle from testicular torsion, is an ultrasound of the scrotum to determine whether there is arterial blood flow to the testicle.[69] Dr. Franklin ordered a scrotal ultrasound that was interpreted by the technician and radiologist, Dr. Cohn, as showing arterial blood flow in both testicles without any evidence of torsion.[70] Section 74.153 applied to the health care liability claim against Dr. Franklin because following the onset of acute symptoms of testicular torsion—an emergency medical or traumatic condition—Dr. Franklin provided the emergency services that are usually and customarily available at a hospital and that must be provided immediately to prevent loss of a testicle due to testicular torsion.[71] The *Turner* court reached the correct result, but its analysis and interpretation of bona fide emergency services went unnecessarily beyond the plain language of the statute.

The Dallas Court of Appeals noted that a subcomponent of the definition of "emergency medical care" is "medical care," which is modified by the definition of "practicing medicine," which includes "diagnosis" and "treatment."[72] Based on the definitions of medical care and practicing medicine, the court concluded that even a nonemergency diagnosis and treatment is protected by the statute if there were "any actions or efforts undertaken in a good faith effort to diagnose or treat a mental or physical disease or disorder or a physical deformity or injury by any system or method, or the attempt to effect cures of those conditions."[73] The *Turner* court used the definition of medical care in § 74.001(a)(19) to develop a definition of the phrase bona fide emergency services found in the definition of the term emergency medical care to conclude that bona fide emergency services means "any actions or efforts undertaken in a good faith effort to diagnose or

67. Turner v. Franklin, 325 S.W.3d 771 (Tex. App.—Dallas 2010, pet. denied).

68. *See Testicular Torsion*, MAYO CLINIC (May 5, 2018), https://www.mayoclinic.org/diseases-conditions/testicular-torsion/symptoms-causes/syc-20378270.

69. *See id.*

70. *Turner*, 325 S.W.3d at 775.

71. *Id.* at 774.

72. *Id.* at 778 (citing TEX. CIV. PRAC. & REM. CODE ANN. § 74.001(a)(19) (West 2017); TEX. OCC. CODE ANN. § 151.002(13) (West 2017)).

73. *Id.*

treat a mental or physical disease or disorder or a physical deformity or injury by any system or method, or the attempt to effect cures of those conditions."[74]

*Turner*, in essence, rewrote § 74.153 by eliminating the word "emergency" from the phrase "arising out of the provision of emergency medical care" to reach the conclusion that § 74.153 applies to all health care liability claims "arising out of the provision of medical care in a hospital emergency department." *Turner* defined "bona fide emergency services" to mean medical care as defined in § 74.001(a)(19) so that emergency medical care means "any actions or efforts undertaken in a good faith effort to diagnose or treat a mental or physical disease or disorder or a physical deformity or injury by any system or method, or the attempt to effect cures of those conditions," provided after the sudden onset of a medical or traumatic condition.[75]

This interpretation is flawed for several reasons. First, this interpretation of bona fide emergency services extends § 74.153 beyond its plain language and applies the statute to cases clearly not within its purview. Second, this interpretation applies the statute to every emergency department case in which there are "any actions or efforts undertaken" to diagnose or treat, even if those actions or efforts do not constitute bona fide emergency services.[76] Third, it applies the statute to every "mental or physical disease or disorder or a physical deformity or injury,"[77] even though the plain language of the statute limits its application specifically to a

> medical or traumatic condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.[78]

Fourth, this interpretation applies the statute to "any system or method, or the attempt to effect cures of those conditions,"[79] even though the plain language of the statute limits its application specifically to bona fide emergency services.[80] Fifth, it applies the statute to "medical care or treatment that occurs after the patient is stabilized and is capable of receiving medical treatment as a nonemergency patient or that is unrelated to the original medical emergency,"[81] which is directly contrary to the statutory language. Sixth, this interpretation ignores the statutory definition of emergency services found in

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74. *Id.*
75. *See id.*
76. *Id.*
77. *Id.*
78. TEX. CIV. PRAC. & REM. CODE ANN. § 74.001(a)(7) (West 2017).
79. *Turner*, 325 S.W.3d at 778 (quoting TEX. OCC. CODE ANN. § 151.002(13) (West 2017)).
80. CIV. PRAC. & REM. § 74.001(a)(7).
81. *Turner*, 325 S.W.3d at 778 (quoting CIV. PRAC. & REM. § 74.001(a)(7)).

Texas Health and Safety Code § 311.021.[82] Finally, this interpretation twists the plain meaning of "provision" to mean "non-provision."[83]

In *Crocker v. Babcock*,[84] the Texarkana Court of Appeals declined to follow the *Turner* analysis, albeit without stating its reasons. Crocker presented to the emergency department with the type of medical condition—a possible stroke—that § 74.153 was designed to address.[85] Crocker argued that the hospital's stroke policies and procedures constituted the bona fide emergency services that were required, and because these emergency services were not provided, her health care liability claim arose out of the failure to provide emergency medical care and the affirmative defense provided by § 74.153 did not apply to her case.[86]

Dr. Babcock, the emergency department physician, performed a physical examination and evaluation of Mrs. Crocker and ordered a CT scan of her brain within eight minutes of her arrival.[87] In addition, he ordered a chest x-ray and an ECG.[88] The nurses "triaged Crocker's case as urgent; immediately placed [her] in an examination room for evaluation of stroke symptoms; obtained a medical and surgical history; monitored [her] vital signs; and carried out Babcock's orders relative to testing and to the administration of medication."[89]

The *Crocker* court acknowledged that, although the stroke policies and protocols of alerting the emergency department en route to the hospital and activating the stroke team so that its members can be assembled before the patient arrives were not followed, the nursing functions "were part and parcel of the actual emergency services provided to Crocker in the emergency department."[90] While the failure to initiate these stroke code protocols in the circumstances might have been poor practice, "this failure does not change the fact that the hospital took immediate action responsive to Crocker's medical condition, as outlined above."[91] Although Dr. Babcock failed to follow the stroke protocols for the treatment of possible stroke, he took "immediate action calculated to diagnose Crocker's suspected stroke" after

82. *See* TEX. HEALTH & SAFETY CODE ANN. § 311.021 (West 2017).

83. *See supra* notes 64–66 and accompanying text (interpreting Chapter 74's health care liability claim to include both provision and non-provision emergency medical services).

84. Crocker v. Babcock, 448 S.W.3d 159, 166 (Tex. App.—Texarkana 2014, pet. denied).

85. *See* CIV. PRAC. & REM. § 74.001(a)(7); *Crocker*, 448 S.W.3d at 166. Crocker had "the sudden onset of a medical or traumatic condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part." CIV. PRAC. & REM. § 74.001(a)(7).

86. *Crocker*, 448 S.W.3d at 162.

87. *Id.* at 161.

88. *Id.* at 168–69.

89. *Id.* at 167.

90. *Id.*

91. *Id.* at 168.

the sudden onset of stroke symptoms.[92] In light of the immediate actions taken by the nurses and Dr. Babcock in response to her emergency medical condition, the Texarkana Court of Appeals concluded that the standard of proof applicable to those actions is covered by § 74.153.[93]

The *Crocker* court interpreted "bona fide emergency services" to mean nursing functions taken in response to an emergency medical condition that were "part and parcel" of the actual emergency services provided.[94] The *Crocker* court interpreted "bona fide emergency services" to mean actions taken by Dr. Babcock that were "calculated to diagnose Crocker's suspected stroke after 'the sudden onset of [stroke symptoms].'"[95] The absence of these nursing functions and actions on the part of Dr. Babcock could not "reasonably be expected to result in placing [Crocker's] health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part."[96]

The opinion in *Crocker* was incorrect, however, because Crocker's health care liability claim did not arise out of nursing functions. Her health care liability claim did not allege, for example, that the nurses were negligent in triaging her as urgent, placing her in an examination room, obtaining a medical and surgical history, monitoring her vital signs, or carrying out Dr. Babcock's orders for testing and the administration of medication.[97] Likewise, Crocker's health care liability claim did not arise out of Dr. Babcock's physical examination and evaluation of her, his orders for a CT scan of her brain, chest x-ray, and ECG, or his orders for Ativan.[98] Instead, Crocker's health care liability claim arose out of the *failure* of the hospital and nurses to initiate its stroke code protocol and the failure of Dr. Babcock to order tPA.[99] Thus, for the same reasons argued in discussing *Turner*, the *Crocker* court's interpretation of Chapter 74 was incorrect.[100]

If *Turner* and *Crocker* were correct, the wilful and wanton standard would apply to *all* health care liability claims arising out of medical care in an emergency department. But had the Texas Legislature intended the wilful and wanton standard to apply to *all* health care liability claims in a hospital emergency department, it would not have included the word "emergency" in the phrase "arising out of the provision of emergency medical care" in

92. *Id.* at 169.

93. *Id.*

94. *Id.* at 166–67.

95. *Id.* at 166, 169.

96. *Id.* at 169 (alteration in original) (quoting TEX. CIV. PRAC. & REM. CODE ANN. § 74.001(a)(7) (West 2017)).

97. *See id.* at 167.

98. *Id.* at 161 n.4.

99. *See id.* at 160, 168.

100. *See supra* notes 67–83 and accompanying text (discussing *Turner* and the court's interpretation of Chapter 74).

§ 74.153, and the definition of "emergency medical care" in § 74.001(a)(7) would have been unnecessary.[101]

In addition, as discussed previously, § 74.153 does not say arising out of the provision of *or failure to provide* emergency medical care.[102] Rather, § 74.153 is limited by its plain language to health care liability claims "*arising out of the provision of* emergency medical care."[103] If the health care liability claim does not "aris[e] out of the provision of emergency medical care,"[104] but *arises out of the failure to provide* emergency medical care, applying the wilful and wanton negligence standard of proof extends the statute beyond its plain meaning to cases plainly outside its purview.

### *B. Location of Treatment*

Section 74.153 only applies to health care liability claims "arising out of the provision of emergency medical care in a hospital emergency department or obstetrical unit or in a surgical suite immediately following the evaluation or treatment of a patient in a hospital emergency department."[105] In *Glenn v. Leal*, a pregnant mother was admitted directly to the hospital for induction of labor.[106] Her baby suffered a brachial plexus injury during labor and delivery, which occurs when a shoulder becomes lodged against the mother's pubic symphysis bone, resulting in shoulder dystocia.[107] In *Glenn*, the mother was neither evaluated nor treated in the hospital emergency department.[108] On appeal, the defendant argued that § 74.153 applied because the health care liability claim arose out of the provision of emergency medical care in an obstetrical unit.[109] The Houston First District Court of Appeals disagreed, concluding that the protections of § 74.153 were triggered by only the evaluation and treatment of the patient in the hospital emergency department.[110] The result was that § 74.153 did not apply to emergency medical care provided in an obstetrical unit when the patient was not evaluated or treated in a hospital emergency care department immediately prior to receiving the emergency medical care.[111]

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101. CIV. PRAC. & REM. §§ 74.001(a)(7), .153.
102. *See id.* § 74.153.
103. *Id.* (emphasis added).
104. *Id.*
105. *Id.*
106. Glenn v. Leal, 546 S.W.3d 807, 809 (Tex. App.—Houston [1st Dist.] 2018, pet. filed), *abrogated by* Tex. Health Presbyterian Hosp. of Denton v. D.A., No. 17-0256, 2018 WL 6713207 (Tex. Dec. 21, 2018).
107. *Id.*
108. *Id.*
109. *Id.* at 811.
110. *Id.* at 814.
111. *Id.*

The Texas Supreme Court, however, reached the opposite conclusion in *Texas Health Presbyterian Hospital of Denton v. D.A.*[112] As in *Glenn*, *Texas Health Presbyterian* involved a child who suffered a brachial plexus injury during delivery.[113] The mother had been previously admitted for an elective induction, and there was no question that she was admitted in stable condition.[114] Nevertheless, the Texas Supreme Court concluded that § 74.153 requires a person who receives emergency medical care in an obstetrical unit to prove wilful and wanton negligence, regardless of whether they received care in a hospital emergency department immediately prior to receiving emergency medical care in the obstetric unit or were stable on arrival.[115] Whether the opinion's reading of § 74.153 was a bad-faith, results-oriented exercise in raw judicial activism or simply a case of poor statutory interpretation, the Court's analysis was puzzling, to say the least.

The Court reached its opinion by concluding that § 74.153's language was unambiguous, contrary to the conclusions reached by the Houston First District Court of Appeals in *Glenn* and the Fort Worth Court of Appeals below in *Texas Health Presbyterian Hospital*.[116] In reading the phrase, "in a hospital emergency department or obstetrical unit or in a surgical suite immediately following the evaluation or treatment of a patient in a hospital emergency department," the Court held that the clause "immediately following the evaluation or treatment of a patient in a hospital emergency department" applies *only* to care provided in a surgical suite, with the result that if emergency medical care is provided in an obstetrical unit, it is immaterial whether the patient comes directly from a hospital emergency department.[117] The lynchpin of the Court's opinion was the fact that "in a" precedes "hospital emergency department" and "surgical suite," but not "obstetrical unit."[118] Accordingly, the Court read the clause "immediately following the evaluation or treatment of a patient in a hospital emergency department" to apply only to "surgical suite," but not "hospital emergency department" or "obstetrical unit."[119] What is particularly striking about the Court's conclusion is that it attempts to prove its point by comparing the actual language of § 74.153 to hypothetical versions of the statute that *would* be ambiguous.[120] If the statute read, "in a hospital emergency department or obstetrical unit or surgical suite immediately following the evaluation or

112. *See generally* Tex. Health Presbyterian Hosp. of Denton v. D.A., No. 17-0256, 2018 WL 6713207 (Tex. Dec. 21, 2018).

113. *See id.* at *1.

114. *Id.*

115. *Id.* at *9.

116. *Id.* at *8; *see* D.A. v. Tex. Health Presbyterian Hosp. of Denton, 514 S.W.3d 431, 444 (Tex. App.—Fort Worth 2017), *rev'd*, 2018 WL 6713207.

117. *Tex. Health Presbyterian*, 2018 WL 6713207, at *3 (alteration in original).

118. *Id.* at *5.

119. *Id.*

120. *See id.* at *6.

treatment of a patient in a hospital emergency department" or "in a hospital emergency department or in an obstetrical unit or in a surgical suite immediately following the evaluation or treatment of a patient in a hospital emergency department," *then* the statute would be ambiguous, or so the Court reasoned.[121] Yet despite this we are to believe that the simple absence of "in a" before "obstetrical unit" renders § 74.153 capable of only one linguistic meaning.[122] Putting aside the Court's bewildering attempt to demonstrate that the statute is unambiguous, its insistence on textual fidelity regarding § 74.153 must be viewed in the context of its earlier refusals to correct the interpretations of § 74.153 in *Turner* and *Crocker*, which, as discussed *supra*, were plainly unsupported by the statute's text.[123]

In addition, because the Court concluded that § 74.153 was unambiguous, it was able to ignore the clear language of legislative intent that the statute should "not apply to emergencies that arise during surgery or labor and delivery,"[124] since under Texas precedent a court need only consult extrinsic sources to aid its interpretation when the statute is ambiguous.[125] Even after dismissing the need for extrinsic sources, however, the Court went on at length in dicta about why the legislative history was unhelpful.[126] Indeed, given the Court's citation with approval of a prior decision declaring that "'[s]tatements made during the legislative process by individual legislators or even a unanimous legislative chamber are not evidence of the collective intent of the majorities of both legislative chambers that enacted a statute,'"[127] it is unclear how *any* legislative history can be instructive to a court going forward. And while the Court opined on the nature of "legislative intent," it declined to enter into any similar ontological inquiry on the concept or coherence of plain meaning.[128]

Finally, the Court disingenuously declared that "we express no opinion" on whether the acts of the defendant doctor "constituted emergency medical care."[129] In considering this statement, we must recall that the question presented was whether § 74.153 "requires the [plaintiffs] to prove wilful and wanton negligence."[130] Because the Court answered that question in the

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121. *See id.* (emphasis in original omitted).

122. *See id.* at *6–7. And this is without even scratching the surface of the broader question of whether plain meaning as a concept is any more coherent than other theories of statutory interpretation.

123. *See supra* notes 64–85 and accompanying text (analyzing the courts' approach in Chapter 74 emergency services cases).

124. *Tex. Health Presbyterian*, 2018 WL 6713207, at *8 n.14; *see supra* note 59 and accompanying text (outlining the debate in the Texas Senate concerning § 74.153's scope); *supra* note 60 and accompanying text (outlining the debate in the Texas House concerning § 74.153's scope).

125. *See, e.g.*, Sullivan v. Abraham, 488 S.W.3d 294, 299 (Tex. 2016).

126. *Tex. Health Presbyterian*, 2018 WL 6713207, at *7.

127. *Id.* at *8 (quoting Molinet v. Kimbrell, 356 S.W.3d 407, 414 (Tex. 2011)).

128. *See id.* at *7.

129. *Id.* at *1 n.3.

130. *Id.* at *3–4.

affirmative, reinstating the trial court's opinion on that issue,[131] it implicitly must have concluded that the plaintiffs *had* received emergency medical care. Otherwise, § 74.153 would not require the application of a wilful and wanton standard of proof as the Court concluded. Thus, despite the Court's avowal that it expressed no opinion on the matter, the case's subsequent disposition showed otherwise.

## III. PRACTICAL APPLICATIONS OF § 74.153

Airway, breathing, and circulation are the three things required to sustain a person's life, prevent serious or permanent disfigurement, or loss or impairment of the function of a bodily part or organ. The emergency medical or traumatic conditions referred to in § 74.001(a)(7), therefore, include such things as airway obstruction, respiratory arrest, cardiac arrest, hemorrhaging, and blockage of circulation to a bodily part or organ.[132] When a patient has the sudden onset of symptoms of an emergency medical or traumatic condition, bona fide emergency services must be provided immediately to sustain the patient's life, prevent serious or permanent disfigurement, or loss or impairment of the function of a bodily organ or part.[133] Bona fide emergency services stabilize the patient so that no material deterioration of the emergency medical or traumatic condition is likely to occur and the patient is capable of receiving medical treatment as a non-emergency patient.[134]

### *A. Respiratory Arrest*

A patient arrives to the emergency department in respiratory arrest. The bona fide emergency service required is immediate intubation to stabilize the patient. The absence of immediate intubation "could reasonably be expected to result in placing the patient's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part."[135] If, while providing the bona fide emergency service of intubation, the endotracheal tube is misplaced in the esophagus, the health care liability claim arises out of the "provision of emergency medical care,"[136] i.e. intubation, and § 74.153 would apply. If the patient is not immediately intubated and the patient suffers brain injury or death, the affirmative defense provided by § 74.153 would not apply because the health care liability claim arises not out of the *provision* of emergency medical care, but out of the

131. *Id.* at *9.
132. *See* TEX. CIV. PRAC. & REM. CODE ANN. § 74.001(a)(7) (West 2017).
133. *See id.*
134. *See id.*
135. *Id.*
136. *Id.* § 74.153.

*failure* to provide emergency medical care.[137] The Texas Legislature specifically limited § 74.153 to health care liability claims "arising out of the *provision* of emergency medical care" and did not say that § 74.153 applies to health care liability claims "arising out of the [*failure* to provide] emergency medical care."[138]

Health care liability claims arising out of the failure to provide emergency care are clearly not within the purview of § 74.153. Interpreting emergency medical care to include "any actions or efforts,"[139] including nonemergency services and actions taken in immediate response to the patient's emergency medical condition, would effectively extend § 74.153 to health care liability claims arising out of the failure to provide emergency medical care. This interpretation would provide a physician or health care provider who fails to intubate a patient in respiratory arrest with the affirmative defense of § 74.153, as long as some actions or efforts were undertaken, such as the physician ordering a chest x-ray and arterial blood gases, and the nursing staff triaging the patient as urgent, placing the patient in an examination room for evaluation of respiratory arrest, obtaining a medical and surgical history, monitoring the patient's vital signs, and carrying out the physicians orders for a chest x-ray and arterial blood gases.

### *B. Suspected Myocardial Infarction*

A patient arrives to the emergency department with signs and symptoms of myocardial infarction. Expert testimony establishes that the bona fide emergency services required are found in the ACCF/AHA Guideline for the Management of ST-Elevation Myocardial Infarction.[140] If these guidelines are not followed and the patient is discharged and dies of a myocardial infarction, bona fide emergency services were not provided and the affirmative defense of § 74.153 would not apply. If these bona fide emergency services stabilize the patient and the patient is capable of being admitted to the CCU as a nonemergency patient, the term emergency medical care no longer applies and the affirmative defense of § 74.153 is no longer available. If these bona fide emergency services do not stabilize the patient and the patient is immediately taken to the surgical suite, § 74.153 applies to the care provided in the surgical suite until the patient is stabilized.

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137. *See id.*

138. *Id.* (emphasis added).

139. Turner v. Franklin, 325 S.W.3d 771, 778 (Tex. App.—Dallas 2010, pet. denied).

140. Patrick T. O'Gara et al., *2013 ACCF/AHA Guideline for the Management of ST-Elevation Myocardial Infarction*, 61 J. AM. C. CARDIOLOGY e80 (2013), http://www.onlinejacc.org/content/61/4/e78.

### *C. Abdominal Pain*

A twenty-seven-year-old woman presents to the emergency department with acute onset of severe abdominal pain. Following examination, the differential diagnoses include (a) medical or traumatic conditions that require immediate surgery because material deterioration of the condition is likely to result in, among other things, placing the patient's health in serious jeopardy without immediate surgery; (b) medical or traumatic conditions that do not require immediate surgery because material deterioration of the condition is not likely to result during admission for further evaluation and testing before surgery; and (c) medical or traumatic conditions that do not require admission.[141] Expert testimony establishes that the bona fide emergency services required to confirm or rule out conditions (a) and (b) include an abdominal sonogram, followed by a STAT CT[142] of the abdomen if the sonogram fails to diagnose the medical condition causing the abdominal pain. A physician who orders a STAT CT of the abdomen following a negative sonogram is providing emergency medical care. A physician who does not order a STAT CT of the abdomen following a negative sonogram is not providing emergency medical care. If the patient suffers injury or death because the patient was discharged with undiagnosed medical or traumatic condition (a) or (b), § 74.153 would not apply.

### *D. The Stable Medical or Traumatic Condition*

If the patient's medical or traumatic condition is such that "the absence of immediate medical attention could [not] reasonably be expected to result in placing the patient's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part," the patient is stable and capable of receiving medical treatment as a nonemergency patient.[143] These patients do not need to go immediately to the obstetrical unit or surgical suite. These patients are capable of being admitted to the hospital by the appropriate medical specialist for nonemergency care. The term emergency medical care and § 74.153 do not apply to these patients.

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141. *See generally Five Steps of Emergency Care*, ST. MARY'S REGIONAL MED. CTR., https://www.stmarysregional.com/services/emergency-services/emergency-care-what-to-expect (last visited Apr. 19, 2019).

142. Robert Painter, *'Stat' Means 'Now': How Hospitals Bungle Urgent CT and MRI Orders*, PAINTER L. FIRM (July 2, 2010), http://www.painterfirm.com/a/41/Stat-means-now-How-hospitals-bungle-urgent-CT-and-MRI-orders#tab-1.

143. CIV. PRAC. & REM. § 74.001(a)(7).

## IV. EMERGENCY MEDICAL CARE AND STATUTORY JURY INSTRUCTIONS

Section 74.154 contains jury instructions that must be given in cases involving emergency medical care. The first subsection reads as follows:

> (a) In an action for damages that involves a claim of negligence arising from the provision of emergency medical care in a hospital emergency department or obstetrical unit or in a surgical suite immediately following the evaluation or treatment of a patient in a hospital emergency department, the court shall instruct the jury to consider, together with all other relevant matters:
>
> (1) whether the person providing care did or did not have the patient's medical history or was able or unable to obtain a full medical history, including the knowledge of preexisting medical conditions, allergies, and medications;
>
> (2) the presence or lack of a preexisting physician-patient relationship or health care provider-patient relationship;
>
> (3) the circumstances constituting the emergency; and
>
> (4) the circumstances surrounding the delivery of the emergency medical care.[144]

Regardless of the wisdom of the policy decisions that motivated this provision, the statute itself is easy enough to apply. "Emergency medical care" and "hospital" are defined in Chapter 74,[145] and "obstetrical unit"[146] and "surgical suite"[147] are sufficiently precise that they present no major interpretive obstacles.

### *A. Substantive Definitions Affecting Jury Instructions in Emergency Medical Care*

Section 74.154 becomes peculiar in subsection (b), which in effect modifies the definition of emergency medical care as it applies in § 74.154(a) by providing a substantive limitation on the types of cases to which § 74.154(a) applies. According to § 74.154(b):

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144. *Id.* § 74.154(a).

145. *Id.* §§ 74.001(a)(7), (16) (defining "hospital" by reference to Chapters 241 and 577 of the Texas Health and Safety Code).

146. *Id.* § 74.154(a).

147. *Id.*

> The provisions of Subsection (a) do not apply to medical care or treatment:
>
> (1) that occurs after the patient is stabilized and is capable of receiving medical treatment as a nonemergency patient;
>
> (2) that is unrelated to the original medical emergency; or
>
> (3) that is related to an emergency caused in whole or in part by the negligence of the defendant.[148]

As we have seen *supra*, the opening section of Chapter 74 defines "emergency medical care" as:

> [B]ona fide emergency services provided after the sudden onset of a medical or traumatic condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part.[149]

In addition, we have seen that this definition "does not include medical care or treatment that occurs after the patient is stabilized and is capable of receiving medical treatment as a nonemergency patient or that is unrelated to the original medical emergency."[150]

### *B. The Interpretive Dilemma Created by § 74.154*

The limiting language from § 74.154(b)—stating when the jury instruction from § 74.154(a) need not be given—is rendered largely superfluous when read in conjunction with the definition of emergency medical care from § 74.001(a)(7). By its own terms, the jury instruction is only given when two necessary conditions are present. First, the case must arise "from the provision of emergency medical care."[151] Second, such care must have been given in either a hospital emergency department, an obstetrical unit, or a surgical suite immediately following the patient's evaluation or treatment in a hospital emergency department.[152] Yet the first necessary condition is not satisfied if the treatment complained of occurred when the patient was stabilized or was unrelated to the original medical

148. *Id.* § 74.154(b).
149. *Id.* § 74.001(a)(7).
150. *Id.*
151. *Id.* § 74.154(a).
152. *Id.*

emergency since, pursuant to § 74.001(a)(7), such treatment is not emergency medical care. As a result, it is unnecessary for subsection (b) to repeat that the instruction in subsection (a) need not be given when the treatment complained of occurred when the patient was stabilized or was unrelated to the original medical emergency. The instruction would not be given in any case because the case would not be one where the claim of negligence "ar[ose] from the provision of emergency medical care."[153]

The only language from § 74.154(b) that is not contained in the definition of emergency medical care from § 74.001(a)(7) is the proviso that the jury instruction from § 74.154(a) also need not be given when the care or treatment "is related to an emergency caused in whole or in part by the negligence of the defendant."[154] Curiously, although a similar provision occurs in § 74.151, which prescribes a higher standard of proof for Good Samaritans or volunteers providing emergency care,[155] such a provision is absent from § 74.153, which prescribes the standard of proof that applies in cases where emergency medical care was provided in a hospital emergency department, an obstetrical unit, or a surgical suite immediately following the patient's evaluation or treatment in a hospital emergency department.[156]

### *C. Proposed Solutions*

The cleanest, simplest fix to the statutory confusion described above would be two-fold. First, the language from § 74.154(b)(3) would be added to the definition of "emergency medical care" from § 74.001(a)(7), with the result that the last sentence of that definition would read

> this term does not include medical care or treatment that occurs after the patient is stabilized and is capable of receiving medical treatment as a nonemergency patient or that is unrelated to the original medical emergency or that is related to an emergency caused in whole or in part by the negligence of the defendant.[157]

Second, § 74.154(b) would then be removed entirely. Superfluous language would be omitted from Chapter 74, and the definition of "emergency medical care" would be clarified.

For those who prefer to keep the language from § 74.154(b), another possible fix would be to move that subsection to § 74.153, which provides a wilful and wanton negligence standard of proof for cases involving an injury

153. *Id.*

154. *Id.* § 74.154(b)(3).

155. *Id.* § 74.154(e). Also curious is that the drafters chose to leave the phrase as "emergency care" rather than "emergency medical care." The language comes from a 1961 act protecting good samaritans.

156. *Id.* § 74.153.

157. *Id.* §§ 74.001(a)(7), .154(b)(3).

caused during the provision of emergency medical care in a hospital emergency department or obstetrical unit, or in a surgical suite immediately following the evaluation or treatment of a patient in a hospital emergency department.[158] Because § 74.154 deals only with jury instructions, whereas § 74.153 contains substantive provisions relating to the standard of proof, it would be more congruous to have the substantive provisions from §§ 74.153 and 74.154(b) together. The result would be a two-part section. Subsection (a), containing the current language from § 74.153, would first explain which cases receive a wilful and wanton negligence standard of care. Subsection (b) would contain the language from § 74.154(b) and limit the universe of cases to which subsection (a) applies. This is already the substantive *effect* of §§ 74.153 and 74.154(b) when read together; placing them in the same section would merely clarify Chapter 74.

## V. CONCLUSION

This Article has attempted to untangle the interpretive muddle created by §§ 74.153 and 74.154 of the Texas Civil Practice and Remedies Code. The basic tools of statutory construction show that the "wilful and wanton" standard of proof should only apply in limited circumstances, although in practice that has not proven to be the case.

158. *Id.* § 74.153.