

**OUCH! THE EXPANDING DEFINITION OF  
HEALTH CARE LIABILITY CLAIMS UNDER THE  
TEXAS MEDICAL LIABILITY ACT AND WHY  
TEXAS TOOK IT TOO FAR**

Comment

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## I. AN OUNCE OF PREVENTION IS NOT A CURE: A PROFESSION INSULATED

A nurse endures months of sexually harassing comments and behavior by her boss, who happens to be a doctor.<sup>1</sup> The nurse files a Title VII claim against her employer for hostile work environment. An EMT is injured on the job when the ambulance she is driving crashes due to a mechanical failure. Because her employer chose an automobile insurance policy that does not include personal injury, the EMT sues her employer for negligence. A hospital secretary is injured when she slips and falls on negligently waxed floors. Because the hospital does not carry workers' compensation insurance, the secretary files a non-subscriber claim against the hospital. A mother is driving her children to soccer practice. Another driver in a BMW runs a red light and sideswipes her. The driver of the BMW happens to be a doctor. The attorneys retained by the nurse, EMT, secretary, and mother research the applicable statutes and procedural rules and take the necessary steps to ensure that their claims are filed properly and will not get dismissed. For example, the attorneys handling the employment-related claims familiarize themselves with Title VII and know to file a claim with the Texas Workforce Commission or the Equal Opportunity Commission to exhaust the administrative remedies before filing a suit in court. The attorney handling the car accident case knows to check the applicable statute of limitations for tort cases and to get medical records so that he can prove damages.

Claims such as these are filed every day across the nation by competent attorneys retained to represent plaintiffs with legitimate claims.<sup>2</sup> In Texas, however, the claims by the nurse, EMT, secretary, and soccer mom are all at risk of being dismissed.<sup>3</sup> This is because, according to recent case law, these claims are likely to be considered health care liability claims (HCLCs).<sup>4</sup> The problem with classifying these claims as HCLCs is that such classification imposes certain procedural requirements, which many plaintiffs do not meet because they never imagined that claims involving Title VII harassment, negligence, and non-subscriber employer negligence would qualify.<sup>5</sup> One example is the expert report requirement.<sup>6</sup> The idea behind the expert report requirement was that requiring plaintiffs to provide statements from experts in the field early in litigation regarding a physician's negligence would curb

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1. The author created the hypothetical scenarios described in this paragraph to illustrate the current, overbroad definition of health care liability claims in Texas.

2. *See Tort Trend in General Jurisdiction Courts*, CT. STAT. PROJECT, [http://www.courtstatistics.org/Other-Pages/~media/Microsites/Files/CSP/SCCS/2010/Tort\\_Trend\\_in\\_General\\_Jurisdiction\\_Courts.ashx](http://www.courtstatistics.org/Other-Pages/~media/Microsites/Files/CSP/SCCS/2010/Tort_Trend_in_General_Jurisdiction_Courts.ashx) (last visited Nov. 13, 2014).

3. *See Tex. W. Oaks Hosp., LP v. Williams*, 371 S.W.3d 171, 185 (Tex. 2012) (holding that claims against health care providers involving safety need not be directly related to the rendition of medical services in order to qualify as a health care liability claim).

4. *See id.*

5. *See* TEX. CIV. PRAC. & REM. CODE ANN. §§ 74.351–.352 (West 2011 & Supp. 2014).

6. *See id.* § 74.351.

frivolous actions, thereby helping to lower costs and solve the medical malpractice crisis.<sup>7</sup> Texas courts, however, are classifying non-medical malpractice claims as HCLCs as a result of *Texas West Oaks Hospital v. Williams, LP*, wherein the Texas Supreme Court misinterpreted and broadened the coverage of the Texas Medical Liability Act.<sup>8</sup>

In *Williams*, the court expanded the reach of a statute that imposed certain procedural requirements on plaintiffs filing certain claims against doctors.<sup>9</sup> By expanding this statute's reach, Texas has taken a law that was enacted to solve a perceived crisis in health care—thought to be caused by increasing medical malpractice—and applied it to quash claims by plaintiffs who are not patients, in claims that do not involve medical malpractice.<sup>10</sup>

This Comment discusses HCLC legislation and litigation in Texas and suggests that Texas has gone further than necessary to alleviate any pains caused by the perceived health care crisis.<sup>11</sup> Part II traces the history of Texas tort reform, beginning with Texas's first attempt to curb medical malpractice litigation in the 1970s, and ending with the enactment of the Texas Medical Liability Act (TMLA) in 2003.<sup>12</sup> Part II ends with an examination of the early interpretations of the TMLA, which differ from today's overly broad interpretation.<sup>13</sup> Part III traces the expansion of HCLCs due to the overly broad and confusing interpretation of the TMLA in *Texas West Oaks Hospital, LP v. Williams*.<sup>14</sup> Part III also examines decisions of Texas appellate courts in cases following *Williams* and suggests they represent a state of confusion with regard to the TMLA's reach over safety-related claims.<sup>15</sup> Part IV explores how the *Williams* decision's consequences were unintended by showing that HCLCs are medical malpractice claims and the legislature's intent in passing the TMLA was not to completely insulate health care providers from liability in claims unrelated to medical malpractice.<sup>16</sup> Finally, Part V proposes a solution by appealing to the Texas Legislature to clarify definitions within the TMLA to reflect the legislature's original purpose in enacting the law.<sup>17</sup>

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7. See David F. Johnson, *Exploring the Expert Report of 4590I*, 54 BAYLOR L. REV. 359, 360–61 (2002).

8. See discussion *infra* Part III.A–B.

9. See *Williams*, 371 S.W.3d at 193.

10. See discussion *infra* Part IV.

11. See *infra* Parts II–IV.

12. See *infra* Part II.

13. See *infra* Part II.

14. See *infra* Part III.A.

15. See *infra* Part III.B–D.

16. See *infra* Part IV.

17. See *infra* Part V.

## II. UNDER THE KNIFE: THE RISE OF TEXAS TORT REFORM

### A. *The Perceived Health Care Crisis and Pressure for Change*

In the 1970s, medical malpractice insurance rates increased considerably, and many insurance companies stopped offering malpractice insurance.<sup>18</sup> Doctors began limiting or abandoning their practices and organizing strikes.<sup>19</sup> These events made up what became known as America's first health care crisis and led to nationwide concern.<sup>20</sup> Many seemed to attribute the crisis, at least partially, to the aggressiveness of overzealous attorneys.<sup>21</sup> For example, in a 1971 survey, doctors cited aggressive attorneys and poor doctor–patient communication as the top two contributing factors of the medical malpractice crisis.<sup>22</sup> In the same survey, the physicians cited medical malpractice reform laws and peer review as the most effective suggested remedial measures that should be taken.<sup>23</sup>

Health care providers called upon Texas legislators for help and succeeded in convincing lawmakers that an increased incidence of medical malpractice litigation had created a health care crisis.<sup>24</sup> The providers also convinced the legislature that this crisis was on the verge of placing health care out of reach for people across the state.<sup>25</sup> Indeed, many health care providers shut their doors or narrowed the scope of their practice to escape the rising costs.<sup>26</sup>

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18. Glen O. Robinson, *The Medical Malpractice Crisis of the 1970's: A Retrospective*, LAW & CONTEMP. PROBS., Spring 1986, at 5, 5.

19. David A. Hyman & Charles Silver, *Medical Malpractice Reform Redux: Déjà Vu All Over Again?*, 12 WIDENER L. REV. 121, 121 (2005); Darrell L. Keith, *The Texas Medical Liability and Insurance Improvement Act—A Survey and Analysis of Its History, Construction and Constitutionality*, 36 BAYLOR L. REV. 265, 267 (1984).

20. See Hyman & Silver, *supra* note 19, at 121; Robinson, *supra* note 18, at 5.

21. E.g., Robinson, *supra* note 18, at 5 (citing William R. Pabst, *A Medical Opinion Survey of Physicians' Attitudes on Medical Malpractice*, in REPORT OF THE SECRETARY'S COMMISSION ON MEDICAL MALPRACTICE APPENDIX 83, 84 (1973)). A substantial body of research has shown that, contrary to popular opinion, the medical malpractice liability system “is stable and predictable [and] sorts valid from invalid claims reasonably well.” David A. Hyman & Charles Silver, *Medical Malpractice Litigation and Tort Reform: It's the Incentives, Stupid*, 59 VAND. L. REV. 1085, 1087 (2006). Additionally, there is no evidence that frivolous claims are made with enough frequency to warrant blame for the so-called medical malpractice crisis. See *id.* at 1101. In fact, one author defined the “medical malpractice myth” as follows: “Built on a foundation of urban legend mixed with the occasional true story, supported by selective references to academic studies, and repeated so often that even the mythmakers forget the exaggeration, half truth, and outright misinformation employed in the service of their greater good, the medical malpractice myth has filled doctors, patients, legislators, and voters with the kind of fear that short circuits critical thinking.” TOM BAKER, THE MEDICAL MALPRACTICE MYTH 1 (2005). A more detailed discussion about whether a medical malpractice crisis actually existed is outside the scope of this Comment.

22. Pabst, *supra* note 21, at 84.

23. *Id.* at 85.

24. Keith, *supra* note 19, at 267.

25. *Id.*

26. *Id.*

*B. The Medical Liability Insurance Improvement Act and Its Demise*

In 1975, pressured to respond, legislators enacted the Professional Liability Insurance for Physicians, Podiatrists, and Hospitals Act (PPHA).<sup>27</sup> The legislature meant for the Act to be temporary and therefore set it to expire after only two years.<sup>28</sup> “Because the legislature realized it was acting hastily in passing a transitory measure, it intended that [the PPHA] be replaced by a more detailed, comprehensive scheme of tort law reform” after its expiration.<sup>29</sup> The Act successfully established a commission to study the crisis and offer a more permanent solution.<sup>30</sup> The PPHA’s commission produced what became known as the Keeton Report, which contained findings that have been described as containing major discrepancies and flaws failing to accurately depict the facts as they really existed at the time.<sup>31</sup>

The commission’s goals were to investigate the causes for increasing medical liability insurance costs, to recommend cost-lowering measures, and to determine ways legislatures could guarantee that liability insurance would be available to health care providers.<sup>32</sup> The report listed six factors contributing to increased insurance costs: (1) technological and scientific advances in medicine; (2) the changed relationship between doctors and patients; (3) the litigious nature of society; (4) substantive changes in tort law; (5) the increased number of unmeritorious claims; and (6) the possibility for excessive damages awards.<sup>33</sup>

Curiously, the commission concluded that “[a] large percentage of the claims filed prove[d] to be unmeritorious” because “nothing [was] paid out on about 50% of the claims filed.”<sup>34</sup> The majority report included only a cursory mention of medical negligence.<sup>35</sup> Some committee members did acknowledge,

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27. *Id.*

28. *Id.* at 267–68.

29. *Id.* at 267.

30. *Id.* at 267–68.

31. *Id.* at 268.

32. *Final Report of the Texas Medical Professional Liability Study Commission to the 65th Texas Legislature* 65, Dec. 1976 (George Pletcher, Minority Report); *id.* at 70 (Harry Hubbard, Jr., Minority Report).

33. *Id.* at 3 (discussing how advancements in medicine lead to an increased availability of drugs that, while helpful to society, lead patients to file claims against prescribers and manufacturers); *id.* at 3–4 (hypothesizing that, as the relationship between doctors and patients has become less close and personal, patients have become more inclined to complain following unfavorable results); *id.* at 4 (stating that, while necessary to a free society, a right to seek redress has created a society that, as a whole, is more likely to go to court to seek redress for any injury); *id.* at 4–5 (pointing out that many claims that were “once hopeless” are now feasible because the new national standard of care increases the likelihood that a patient can find a doctor willing to testify against another doctor); *id.* at 5 (discussing the general increase of claims without merit); *id.* at 3–5 (criticizing the arbitrary nature by which noneconomic damages are calculated considering experiential differences, problems with proof, and problems with the collateral source rule).

34. *Id.* at 5.

35. *Id.* at 2 (“Some are of course attributable to negligence in the sense that there was a failure to conform to standard medical procedures.”); *see also id.* at 3 (stating that “80% of the claims [against drug manufacturers or prescribing doctors] are a consequence of alleged mishaps at hospitals so that any

however, that health care providers did commit medical negligence, that such negligence could be reduced, and that one of the commission's main failings was that it did not make any recommendation regarding medical negligence or risk control.<sup>36</sup>

Following the Keeton Report's suggestions, the Texas Legislature enacted the Medical Liability and Insurance Improvement Act (MLIIA) in 1977 in an effort to curtail medical malpractice litigation by imposing certain requirements on those interested in bringing such actions.<sup>37</sup> Finding that the amount and frequency of HCLCs had increased tremendously since 1972 and that the filing of legitimate HCLCs was partly to blame for increased liability rates, this Act imposed a cap on noneconomic damages, required pre-suit notices, and shortened the statute of limitations to two years, among other things.<sup>38</sup> The Act clearly stated that its purposes were to reduce the frequency and severity of HCLCs, to decrease cost of HCLCs, to provide health care providers with reasonable rates, and to make health care more available to Texans, without "unduly restrict[ing] a claimant's rights any more than necessary."<sup>39</sup>

The MLIIA defined an HCLC as:

[A] cause of action against a health care provider or physician for treatment, lack of treatment, or other claimed departure from accepted standards of medical care or health care or safety which proximately results in injury to or death of the patient, whether the patient's claim or cause of action sounds in tort or contract.<sup>40</sup>

For the most part, the Texas Supreme Court narrowly construed the statute, resulting in somewhat plaintiff-friendly holdings in the years after the MLIIA was enacted.<sup>41</sup> Following the statute's enactment, none of the cases before the

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improvement of existing procedures at the hospital that would reduce mishaps would be of utmost importance").

36. *E.g., id.* at 65 (George Pletcher, Minority Report); *see also id.* at 70–71 (Harry Hubbard, Jr., Minority Report) (lamenting that most of the committee's efforts were "directed to the area of tort reform calculated to place health care providers beyond public accountability" and that "[o]nly in the waning days of the [s]tudy [c]ommission's existence did it consider medical negligence as a factor in the cost of liability insurance").

37. TEX. REV. CIV. STAT. ANN. art. 4590i, § 1.02 (West 1981) (repealed 2003).

38. TEX. REV. CIV. STAT. ANN. art. 4590i, §§ 1.02, 4.01, 10.01, 11.02 (West 1981) (repealed 2003). The Act also established district review committees to be overseen by the Texas State Board of Medical Examiners, prohibited plaintiffs from stating damage amounts in pleadings, limited the application of the doctrine of *res ipsa loquitur*, provided that plaintiffs may bring actions separate from HCLCs for allegations of bad faith, and provided that advance payments by health care providers should not be construed as admission of liability. TEX. REV. CIV. STAT. ANN. art. 4590i, §§ 3.01–.09, 5.01, 7.01, 8.01–9.04 (West 1981) (repealed 2003). Other portions of the Act lay out Good Samaritan policies and regulation of insurance rates. TEX. REV. CIV. STAT. ANN. art. 4590i, §§ 21.01–31.12 (West 1981) (repealed 2003).

39. REV. CIV. STAT. art. 4590i § 1.02(b).

40. TEX. REV. CIV. STAT. ANN. art. 4590i, § 1.03(a)(4) (West 1981) (repealed 2003).

41. *See, e.g.,* Schepps v. Presbyterian Hosp. of Dall., 652 S.W.2d 934, 938 (Tex. 1983) (allowing a sixty-day abatement when the plaintiff failed to provide defendant with sixty-day pre-suit notice); Hutchinson v. Wood, 657 S.W.2d 782, 783 (Tex. 1983) (per curiam) (allowing abatement for the plaintiff to correct

Texas Supreme Court concerned the definition of an HCLC.<sup>42</sup> Many plaintiffs did succeed, however, in their as-applied constitutional challenges attacking the MLIIA's damage caps.<sup>43</sup> These successful challenges, coupled with numerous extensive amendments, weakened the MLIIA and sparked a renewed interest in an examination of the legislation.<sup>44</sup>

*C. Another Try: The Texas Medical Liability Act and Early Judicial Interpretations*

In 2002, history was repeating itself.<sup>45</sup> Medical malpractice insurance had become more expensive and more difficult to obtain, and doctors were either limiting their fields of practice or closing their doors altogether.<sup>46</sup> This time, the legislature formed several interim in-house committees to evaluate the crisis, including the Senate Finance Committee, the House Committee on Insurance, and the Senate Special Committee on Prompt Payment of Health Care Providers (the Nelson Committee).<sup>47</sup>

The Nelson Committee was charged with evaluating “the effectiveness of existing state law and agency rules relating to the current medical professional liability system, [and] assess[ing] the causes of rising malpractice insurance rates in Texas, including the impact of medical malpractice lawsuits, and their impact on access to health care.”<sup>48</sup> In its evaluation, the committee noted that initial efforts toward tort reform had led to a reduction in the number of medical

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defective pleading). *But see* Hill v. Milani, 686 S.W.2d 610, 611 (Tex. 1985) (holding that the statute of limitations was not tolled by the defendant–physician’s temporary absence from the jurisdiction); Morrison v. Chan, 699 S.W.2d 205, 208 (Tex. 1985) (holding that the plaintiff’s claim was barred when it was not filed within the two-year statute of limitations period).

42. Keith, *supra* note 19, at 267–68.

43. *E.g.*, Rose v. Doctors Hosp., 801 S.W.2d 841, 847 (Tex. 1990) (holding that, although damage caps were constitutional as to wrongful death claims, they should be applied on a per-defendant basis); Lucas v. United States, 757 S.W.2d 687, 687 (Tex. 1988) (holding that the MLIIA’s limitation on damages violated the open courts provision of the Texas Constitution as applied to Lucas’s common-law causes of action). While Lucas’s holding was a fatal blow to the MLIIA, the court found other provisions unconstitutional as well. *See, e.g.*, Neagle v. Nelson, 685 S.W.2d 11, 12 (Tex. 1985) (holding that where the plaintiff could not have known about his injury until more than two years after the surgery, the MLIIA’s statute of limitations not allowing for a discovery rule violated the open courts provision of the Texas Constitution); Sax v. Votteler, 648 S.W.2d 661, 667 (Tex. 1983) (holding that the MLIIA’s provision not allowing tolling of the statute of limitations for minors until they reach the age of majority violated the open courts provision of the Texas Constitution).

44. *See* Michael S. Hull et al., *House Bill 4 and Proposition 12: An Analysis with Legislative History (Pt. I)*, 36 TEX. TECH L. REV. 1, 4–5 (2005) (discussing constitutional challenges of the MLIIA’s damages caps, statutes of limitations for minors, and the MLIIA’s amendments addressing punitive damages and expert reviews).

45. *See* David R. Schlottman, Note, *In Critical Condition: Diversicare General Partner, Inc. v. Rubio, Marks v. St. Luke’s Episcopal Hospital, and the State of Health-Care-Liability Claims in Texas*, 63 BAYLOR L. REV. 526, 531 (2011).

46. *Id.*

47. *Id.* at 532; Hull et al., *supra* note 44, at 12.

48. *Texas Senate Special Committee on Prompt Payment of Health Care Providers*, 78th Leg., Interim Report 2.3 (Nov. 2002), available at <http://www.senate.state.tx.us/75r/Senate/commit/c950/Downloads/PromptPay.pdf>.

malpractice claims, but the size of the claims had grown.<sup>49</sup> The report noted that doctors had abandoned their practices due to increased insurance costs and that “[t]he decline in patient access to care in Texas [was] alarming.”<sup>50</sup> The committee attributed much of the cause of the rising medical malpractice insurance rates in Texas to “[t]he frequency of medical malpractice claims and the growing size of jury awards and defense costs.”<sup>51</sup> The committee also noted that many claims “were dropped, dismissed or settled without a payment,” and of the cases that did go to trial, it was mostly the defendants who prevailed.<sup>52</sup> The committee’s explanation for the increased litigation involved public attitudes—resentment, distrust, and high demands of the medical profession due in part to “[c]hanges in the judicial environment.”<sup>53</sup> In 2003, with pressure for reform mounting, the Texas Legislature repealed the MLIIA and passed House Bill 4, which became known as the Texas Medical Liability Act (TMLA).<sup>54</sup>

The legislature found “a medical malpractice insurance crisis in Texas” caused by increasing insurance rates and rising costs, which could be attributed to the “inordinate[.]” increase in the number of HCLCs and insurance payouts.<sup>55</sup> The TMLA sought to remedy the “crisis” by enacting certain requirements for the filing of HCLCs, the most important of which included a limitation on damages, a short two-year statute of limitations, and a requirement that plaintiffs file an expert report.<sup>56</sup> Still in effect today, the TMLA requires that the expert report include a curriculum vitae for each expert and be served on each defendant within 120 days after the lawsuit is filed.<sup>57</sup> The penalty for not filing an expert report in accordance with these rules is harsh: the TMLA calls

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49. *Id.* at 2.4.

50. *Id.* at 2.6.

51. *Id.* at 2.7 (citing *Medical Malpractice: Verdicts, Settlements and Statistical Analysis*, JURY VERDICT RES. (Nov. 2002), [www.juryverdictresearch.com](http://www.juryverdictresearch.com) (stating the proposition that malpractice jury awards had increased by 43% from 1999 to 2000)).

52. *Id.*

53. *See id.* at 2.4 (reasoning that public distrust in the medical profession had grown as a result of medical errors and high jury awards being much more highly publicized than the subsequent court-ordered reduction of damages). The committee further hypothesized that the increased quality of care available due to increases in medical technology had led to increased patient expectations, which in turn led to increased patient demands and litigation. *Id.*

54. Act of June 2, 2003, 78th Leg., R.S., ch. 204, § 10.09, 2003 Tex. Gen. Laws 847, 884 (current version at TEX. CIV. PRAC. & REM. CODE ANN. ch. 74); Tex. H.B. 4, 78th Leg., R.S. (2003) (enacted).

55. Act of June 2, 2003, 78th Leg., R.S., ch. 204, § 10.11(a)(3), (5), 2003 Tex. Gen. Laws 847, 884 (current version at TEX. CIV. PRAC. & REM. CODE ANN. ch. 74).

56. *Id.* at § 10.11(a)(5); TEX. CIV. PRAC. & REM. CODE ANN. § 74.251 (West 2011), *invalidated by Adam v. Gottwald*, 179 S.W.3d 101 (Tex. App.—San Antonio 2005, pet. denied) (holding § 74.251 of the Texas Civil Practice and Remedies Code unconstitutional as it applies to minors); TEX. CIV. PRAC. & REM. CODE ANN. §§ 74.301–.303, .351 (West 2011 & Supp. 2014). Other requirements under the TMLA include a notice and medical records authorization requirement, a requirement that pleadings not state a damages amount, a limited application of the doctrine of *res ipsa loquitur*, and certain discovery requirements. TEX. CIV. PRAC. & REM. CODE ANN. §§ 74.051 (West 2011), 74.052 (West 2011 & Supp. 2014), 74.053, .201, .352 (West 2011).

57. *Id.* § 74.351(a).



for a mandatory dismissal of the claim and an award of fees and costs to the health care provider defendant.<sup>58</sup>

The TMLA defined an HCLC as:

[A] cause of action against a health care provider or physician for treatment, lack of treatment, or other claimed departure from accepted standards of medical care, or health care, or safety or professional or administrative services directly related to health care, which proximately results in injury to or death of a claimant, whether the claimant's claim or cause of action sounds in tort or contract.<sup>59</sup>

This definition is substantially similar to the definition used in the MLIIA, with two major differences.<sup>60</sup> First, the TMLA replaced the word “patient” with the word “claimant.”<sup>61</sup> Second, the TMLA added another class of potential defendants by adding the language “professional or administrative services” and “directly related to health care,” presumably to ensure that a court would treat only those claims directly related to health care as HCLCs.<sup>62</sup> The foregoing language suggests that the legislature intended for HCLCs to include only those claims for negligent health care or medical malpractice.<sup>63</sup>

As a threshold question in TMLA litigation, a court must decide for itself whether a plaintiff's claim is an HCLC to ensure plaintiffs do not escape the requirements of the TMLA through artful pleading.<sup>64</sup> The Texas Supreme Court addressed this issue many times in the years following the enactment of the TMLA and concluded that the plaintiff's claim constituted an HCLC in a variety of circumstances.<sup>65</sup> Examples of claims that have constituted HCLCs include: a patient's deceptive trade practices claim against an anesthesiologist who sedated her after he said he would not;<sup>66</sup> a wrongful death claim by a patient's parents against a physician for providing insufficient post-surgical treatment;<sup>67</sup> patients' claims against a hospital for negligently credentialing a doctor as a thoracic surgeon;<sup>68</sup> and a claim by a nursing home resident's estate against the nursing home for failure to adequately protect her from harm when she died after being bitten by a spider at the home.<sup>69</sup> The Texas Supreme Court found HCLCs in all of the above cases even though the facts were varied;

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58. *Id.* § 74.351(b).

59. TEX. CIV. PRAC. & REM. CODE ANN. § 74.001(a)(13) (West 2011 & Supp. 2014).

60. Compare TEX. REV. CIV. STAT. ANN. art. 4590i, § 1.03(a)(4) (West 1981) (repealed 2003) (lacking language that would give courts guidance as to what claims constitute HCLCs), with CIV. PRAC. & REM. CODE § 74.001(a)(13) (adding explicit language to ensure a court treats only certain claims as HCLCs).

61. See *supra* note 60.

62. See *supra* note 60.

63. See *supra* note 60; *infra* Part IV.A.

64. *Yamada v. Friend*, 335 S.W.3d 192, 195–96 (Tex. 2010).

65. See *infra* notes 66–68 and accompanying text.

66. *Murphy v. Russell*, 167 S.W.3d 835, 839 (Tex. 2005) (per curiam).

67. *Carreras v. Marroquin*, 339 S.W.3d 68, 70 (Tex. 2011).

68. *In re McAllen Med. Ctr., Inc.*, 275 S.W.3d 458, 462 (Tex. 2008).

69. *Omaha Healthcare Ctr., LLC v. Johnson*, 344 S.W.3d 392, 395 (Tex. 2011).

however, the claims had more in common than the fact that they were filed against a physician or health care provider.<sup>70</sup> Each claim was filed by a patient or an individual on the patient's behalf.<sup>71</sup> Each claim was based on services rendered to that patient by the defendant—physician or health care provider.<sup>72</sup> Finally, each claim was based on alleged negligence related to the rendition of medical services.<sup>73</sup>

Since the first perceived medical malpractice crisis in the 1970s, tort reformers have been hard at work pressuring the Texas Legislature for statutory changes that would limit plaintiffs' abilities to recover in litigation with health care provider defendants.<sup>74</sup> After a few false starts, the legislature settled on the TMLA, which aimed to decrease the costs of medical malpractice insurance by imposing certain procedural requirements for malpractice claims.<sup>75</sup> After years of gradual expansion, the Texas Supreme Court went too far when it expanded the reach of the TMLA to claims that had nothing to do with medical malpractice.<sup>76</sup>

### III. A TURN FOR THE WORSE: THE SUDDEN EXPANSION OF HCLCs IN *TEXAS WEST OAKS HOSPITAL V. WILLIAMS*

The Texas Supreme Court first expanded the definition of an HCLC in 2010 when it classified a claim regarding an unsafe hospital bed as an HCLC.<sup>77</sup> In *Marks v. St. Luke's Episcopal Hospital*, Marks sued St. Luke's for injuries sustained when he fell out of his bed due to a defective footboard.<sup>78</sup> The court classified Marks's claim related to the defective bed as an HCLC, reasoning that the hospital's failure to maintain the bed related to a service provided by a professional that was integral to the rendition of health care services.<sup>79</sup> Later that year, the court also found an HCLC in a claim by a deceased water park patron's parents against a physician for negligently advising the water park on where to place defibrillators.<sup>80</sup> More expansions occurred in 2011 when, in two

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70. See *id.* at 392; *Marroquin*, 339 S.W.3d at 69; *McAllen Med. Ctr., Inc.*, 275 S.W.3d at 458; *Murphy*, 167 S.W.3d at 835.

71. See *Johnson*, 344 S.W.3d at 393; *Marroquin*, 339 S.W.3d at 69; *McAllen Med. Ctr., Inc.*, 275 S.W.3d at 462; *Murphy*, 167 S.W.3d at 836.

72. See *Johnson*, 344 S.W.3d at 393; *Marroquin*, 339 S.W.3d at 69; *McAllen Med. Ctr., Inc.*, 275 S.W.3d at 462; *Murphy*, 167 S.W.3d at 836.

73. See *Johnson*, 344 S.W.3d at 397; *Marroquin*, 339 S.W.3d at 69; *McAllen Med. Ctr., Inc.*, 275 S.W.3d at 464; *Murphy*, 167 S.W.3d at 836.

74. See *supra* Part II.

75. See *supra* Part II.C.

76. See *infra* Part III.A.

77. See generally *Marks v. St. Luke's Episcopal Hosp.*, 319 S.W.3d 658 (Tex. 2010) (discussing the supreme court's expansion of HCLCs to include claims regarding unsafe hospital beds).

78. *Id.* at 660.

79. *Id.* at 661–63 (citing *Rubio v. Diversicare Gen. Partner, Inc.*, 185 S.W.3d 842, 850 (Tex. 2005)).

80. *Yamada v. Friend*, 335 S.W.3d 192, 196–97 (Tex. 2010). This decision expanded the reach of HCLCs because the court had never before defined as an HCLC a claim against a doctor who did not render medical services directly to the plaintiff or the patient on whose behalf the plaintiffs were suing. Compare

decisions, the court found HCLCs in premises liability suits where patients sued hospitals after incurring injuries from slipping and falling in the hospital rooms during their convalescence.<sup>81</sup> Although the foregoing cases represented an expansion of the definition of HCLCs, they were all claims against health care providers.<sup>82</sup> Also, they were all claims by or on behalf of either patients or persons injured due to allegedly negligent health care decisions made by health care providers.<sup>83</sup>

#### A. *A Step Too Far*: Texas West Oaks Hospital v. Williams

In the summer of 2012, the Texas Supreme Court went too far by finding an HCLC in a claim by a non-patient against his employer for negligence when he was injured at work.<sup>84</sup> In *Texas West Oaks Hospital, LP v. Williams*, a mental health technician was injured when he had a physical altercation with a patient.<sup>85</sup> Williams worked for Texas West Oaks Hospital, a mental health hospital in Houston, and was supervising Vidaurre, a paranoid schizophrenic patient with a history of violent manic outbursts.<sup>86</sup> At one point, Vidaurre became agitated, and to help calm him down, Williams took Vidaurre outside—to an unmonitored area with no cameras or emergency notification systems—so he could smoke a cigarette.<sup>87</sup> Once the two were outside, the door locked automatically behind them.<sup>88</sup> Williams was therefore unable to escape when the altercation occurred.<sup>89</sup> While it is unclear from both the case and documents filed with the court exactly what happened, Vidaurre was killed, and Williams was injured.<sup>90</sup> Vidaurre's estate sued the hospital and Williams,

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Omaha Healthcare Ctr., LLC v. Johnson, 344 S.W.3d 392, 394–95 (Tex. 2011) (discussing a patient's HCLC against a nursing home for negligently causing the patient's death), *Carreras v. Marroquin*, 339 S.W.3d 68, 69 (Tex. 2011) (discussing a patient's parent's HCLC against the patient's physician for allegedly negligently causing the patient's death), *In re McAllen Med. Ctr., Inc.*, 275 S.W.3d 458, 463–64, 473 (Tex. 2008) (discussing a patient's HCLC against the hospital for negligent credentialing of a physician), and *Murphy v. Russell*, 167 S.W.3d 835, 839 (Tex. 2005) (per curiam) (discussing a patient's HCLC against her anesthesiologist for violation of the PPTA), with *Yamada*, 335 S.W.3d at 193 (expanding the reach of HCLCs to include claims against a doctor who was not in direct care of the patient).

81. See *St. David's Healthcare P'ship, L.P., LLP v. Esparza*, 348 S.W.3d 904, 906 (Tex. 2011) (per curiam); *Harris Methodist Fort Worth v. Ollie*, 342 S.W.3d 525, 527 (Tex. 2011) (per curiam).

82. See *Esparza*, 348 S.W.3d at 905–06; *Ollie*, 342 S.W.3d at 525–26; *Yamada*, 335 S.W.3d at 193.

83. See *Esparza*, 348 S.W.3d at 906 (finding an HCLC where a nurse dropped gel on the floor while performing a scan on the patient, which resulted in the patient's slipping on the gel and being injured); *Ollie*, 342 S.W.3d at 527 (finding an HCLC in a safety-related claim by a patient); *Yamada*, 335 S.W.3d at 193 (finding an HCLC in a claim by a non-patient related to physician's allegedly negligent advice).

84. See *Tex. W. Oaks Hosp., LP v. Williams*, 371 S.W.3d 171, 175, 193 (Tex. 2012).

85. *Id.* at 175.

86. *Id.* at 174–75.

87. *Id.* at 175.

88. *Id.*

89. See *id.*

90. *Id.* To show that Williams had not acted in accordance with safety standards, West Oaks introduced evidence that Williams kicked Vidaurre when he was on the ground and not moving. See Petitioners' Brief on the Merits, *Tex. W. Oaks Hosp., LP v. Williams*, 371 S.W.3d 171 (Tex. 2012) (No. 10–0603), 2011 WL 8603155, at \*1–3. Williams, however, claimed Vidaurre attacked him, and because there was not a camera,

asserting HCLCs under the TMLA.<sup>91</sup> Williams then filed cross-claims against West Oaks for negligence.<sup>92</sup> Because West Oaks did not subscribe to workers' compensation, Williams sued West Oaks under common-law theories of negligence.<sup>93</sup>

West Oaks filed a motion to dismiss, claiming that Williams's claims were HCLCs because they arose out of the same set of facts as the claims of Vidaurre's estate.<sup>94</sup> Both the district court and the court of appeals denied West Oaks' motion, however, finding that Williams's claims sounded in ordinary common-law negligence and were therefore not HCLCs.<sup>95</sup> The appellate court based its reasoning on the language in the TMLA's definitions section, concluding that, when the phrase "directly related to health care" appears after a series of terms, it modifies each term preceding it and not just the last listed term.<sup>96</sup> As such, the appellate court determined that, for a claim to qualify as an HCLC, it must always be directly related to health care.<sup>97</sup> Because Williams's claim was based on West Oaks' breach of its duty to provide its employees with a safe workplace, the claim was separable from Vidaurre's complaint, which was based on West Oaks' breach of its duty to provide medical care to its patient.<sup>98</sup> Thus, the court held Williams's claim was not an HCLC.<sup>99</sup>

The Texas Supreme Court reversed and held that Williams's claims were HCLCs, interpreting the language of the TMLA differently.<sup>100</sup> The court

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panic button, or other safety device, Williams was forced to take action to defend himself. *See* Respondent's Brief on the Merits, *Tex. W. Oaks Hosp., LP v. Williams*, 371 S.W.3d 171 (Tex. 2012) (No. 10-0603), 2011 WL 8603156, at \*1-2. Williams's account of the altercation, as reported by the media, is as follows: the altercation began when Williams bent down to light Vidaurre's cigarette, and Vidaurre punched Williams in the face and then hit him in the mouth. Margaret Downing, *Death at West Oaks Hospital*, HOUS. PRESS (Oct. 24, 2007), <http://www.houstonpress.com/2007-10-25/news/death-in-a-box>. Williams then tried to subdue Vidaurre by grabbing his arms and tackling him to the ground, but Vidaurre could not be stopped. *Id.* Sure that Vidaurre was about to scratch Williams's eyes, Williams punched Vidaurre once in the face. *Id.* Vidaurre then charged Williams and rammed Williams's head into the wall. *Id.* Williams was then able to subdue Vidaurre again, bringing him to the ground, where they rolled around until Williams realized Vidaurre was not moving. *Id.*

91. *Williams*, 371 S.W.3d at 175. Vidaurre's HCLCs included claims for "failure to properly treat, care for, and assess [his] medical situation." *Tex. W. Oaks Hosp., LP v. Williams*, 322 S.W.3d 349, 351 (Tex. App.—Houston [14th Dist.] 2010), *rev'd*, *Williams*, 371 S.W.3d 171.

92. *Williams*, 371 S.W.3d at 175.

93. *Id.* Williams's negligence claims against West Oaks included failure to train, warn, and adequately supervise its employees; failure to provide adequate protocol regarding altercations with patients; failure to provide employees with emergency notification devices; and failure to provide a safe workplace in general. *Id.*

94. *Id.*; *Williams*, 322 S.W.3d at 353.

95. *Williams*, 371 S.W.3d at 176.

96. *See Williams*, 322 S.W.3d at 352 (interpreting TEX. CIV. PRAC. & REM. CODE ANN. § 74.001 (West 2012)) (holding that when "directly related to health care" is preceded by "safety or professional or administrative services," directly related to health care refers to and modifies safety, professional, and administrative services, such that each listed item must be directly related to health care to qualify as an HCLC).

97. *Id.* ("The safety prong is not so broad as to apply to any injury that occurs in a medical setting.").

98. *Id.* at 352-53.

99. *Id.* at 353.

100. *Williams*, 371 S.W.3d at 183-86.

concluded that, because it had used the word “claimant,” the legislature must have intended that the TMLA’s coverage be broader than the coverage of the MLIIA, which utilized the word “patient.”<sup>101</sup> Because of this broad construction, the court classified Williams as a claimant simply because he brought a claim that the court determined was an HCLC.<sup>102</sup> The court noted that the TMLA set out different types of HCLCs: (1) claims involving treatment or other departures from standards of medical or health care, which necessarily must be brought by a patient against her health care provider and are therefore directly related to health care; (2) claims involving departures from safety standards; and (3) claims involving “professional or administrative services directly related to health care.”<sup>103</sup> The court further interpreted the statute not to require a direct relation to safety claims because the phrase “directly related to health care” in the definition of an HCLC did not directly follow “safety.”<sup>104</sup>

In determining which category Williams fell under, the court suggested that health care claims must involve a doctor–patient relationship because the TMLA defines “health care” as “*any* act or treatment . . . by any health care provider for, to, or on behalf of a *patient* during the *patient’s* medical care, treatment, or confinement.”<sup>105</sup> The court acknowledged that this interpretation conflicted with the significance it had already attributed to the legislature’s decision to use the word claimant instead of patient.<sup>106</sup> The court nevertheless determined that, while a doctor–patient relationship was required to assert a health-related claim, the claimant did not necessarily have to be a patient for the health-related claim to be an HCLC.<sup>107</sup>

For these reasons, the court held that Williams’s claims qualified as HCLCs under two of the TMLA’s categories: the health care related claims were HCLCs because there existed a doctor–patient relationship, even though the doctor–patient relationship was not between the plaintiff and the defendant.<sup>108</sup> The court also held Williams’s safety-related claims were HCLCs, despite the fact that they were not directly related to health care, because Williams alleged a departure from safety standards by a health care provider.<sup>109</sup> While the court was clear that, under its interpretation, HCLCs based on a departure from safety standards do not have to be directly related to health care, it is unclear whether the court determined that Williams’s claims were indirectly related to health care or unrelated to health care altogether.<sup>110</sup>

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101. *Id.* at 184.

102. *Id.* at 179.

103. *See id.* at 180.

104. *Id.* at 185.

105. *Id.* at 180 (emphasis added) (quoting TEX. CIV. PRAC. & REM. CODE ANN. § 74.001(a)(10) (West 2011) (internal quotation marks omitted)).

106. *Id.* at 181.

107. *Id.*

108. *Id.*

109. *See id.* at 193.

110. *See id.* at 186 (stating merely that “the safety component of HCLCs need not be directly related to the provision of health care and that Williams’ claims against West Oaks implicate this prong of HCLCs”).

Because Williams's claims were HCLCs and Williams did not file an expert report pursuant to the TMLA, the court remanded the case with instructions to dismiss all claims.<sup>111</sup> This decision opened the door to even broader interpretations and expansions of the definition of HCLCs.<sup>112</sup>

In a dissenting opinion joined by Justices Medina and Willett, Justice Lehrmann argued that the majority expanded the definition of HCLCs "[i]nterpreting a law designed to *reduce* the number of medical malpractice suits," and that "[t]he Court's strained reading of the statute runs counter to express statutory language, the Legislature's stated purposes in enacting . . . [C]hapter 74, and common sense."<sup>113</sup> Lehrmann stated that the TMLA was clearly meant to apply to claims in which a health care professional breached a duty owed to a patient.<sup>114</sup> Like the appellate court, Justice Lehrmann pointed out that Williams's claims were separate from Vidaurre's claims and had nothing to do with any allegedly negligent health care.<sup>115</sup> Additionally, she reasoned that the word claimant replaced the word patient in the TMLA not to broaden the scope of an HCLC, but rather, to merely clarify that a suit could be brought by a deceased patient's estate.<sup>116</sup> Finally, Lehrmann pointed to portions of the TMLA dealing with pre-suit *patient* authorization, expert report requirements dealing with the breach of duty of care in providing medical services, and jury instructions regarding bad results.<sup>117</sup> Although the *Williams* decision drastically broadened the definition of HCLCs, Justice Lehrmann's dissent provided a strong argument against the expansion by maintaining that the legislature could not have intended the TMLA to apply to claims by non-patients.<sup>118</sup> The Fourteenth Court of Appeals, however, followed the lead of the supreme court and continued expanding the reach of the TMLA by finding HCLCs in non-medical malpractice, safety-related claims.<sup>119</sup>

### *B. The Fourteenth Court of Appeals Follows Suit in Safety-Related Claims*

The Fourteenth Court of Appeals first had the opportunity to consider the issue of HCLCs in safety-related claims in *Memorial Hermann Hospital System v. Kerrigan*.<sup>120</sup> There, the court found that a patient's claims against a hospital

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111. *Id.* at 193.

112. *See* discussion *infra* Part III.B.

113. *Williams*, 371 S.W.3d at 193 (Lehrmann, J., dissenting).

114. *Id.* at 194.

115. *See id.*

116. *Id.*

117. *Id.* at 195–96.

118. *See id.* at 174–93 (majority opinion).

119. *See, e.g.,* *Ross v. St. Luke's Episcopal Hosp.*, No. 14-12-00885-CV, 2013 WL 1136613, at \*1 (Tex. App.—Houston [14th Dist.] Mar. 19, 2013, pet. granted) (mem. op.); *Mem'l Hermann Hosp. Sys. v. Kerrigan*, 383 S.W.3d 611, 613 (Tex. App.—Houston [14th Dist.] 2012, pet. denied).

120. *See generally Kerrigan*, 383 S.W.3d 611.

for intentional torts were HCLCs.<sup>121</sup> In that case, Kerrigan brought his daughter, Kathleen, to the emergency room because she was suffering from pain caused by sores on her feet.<sup>122</sup> The doctors diagnosed Kathleen with psychosis and mania and determined that the sores on her feet were from pacing during a manic episode.<sup>123</sup> The doctors recommended that Kathleen stay at the hospital overnight until she could be transferred to a psychiatric facility.<sup>124</sup> Sometime during the night, Kathleen became agitated and tried to leave the hospital.<sup>125</sup> Doctors requested help from a security guard, whose alleged abuse became the basis of Kerrigan's claims for assault, battery, and false imprisonment.<sup>126</sup> While the appeal was pending, the Texas Supreme Court issued its opinion in *Texas West Oaks Hospital, LP v. Williams*.<sup>127</sup> In light of the *Williams* decision, the Fourteenth Court of Appeals held that, because Kerrigan's claims centered on actions taken to ensure the safety of Kathleen and others, the claims were necessarily HCLCs, regardless of whether they were directly related to health care.<sup>128</sup> Because the court determined her claims were HCLCs and Kerrigan had not filed expert reports, the court was forced to dismiss each claim.<sup>129</sup>

Additionally, in 2013, the Fourteenth Court of Appeals held that a premises liability claim by a non-patient was an HCLC.<sup>130</sup> In *Ross v. St. Luke's Episcopal Hospital*, Ross was injured when she slipped and fell after visiting a patient at St. Luke's.<sup>131</sup> Ross was not a patient and had no doctor-patient relationship with anyone working at the hospital; she was a visitor who fell on a slippery floor in the hospital lobby.<sup>132</sup> The court reluctantly followed the dictates of the supreme court and found that Ross's claim was an HCLC because it was a claim against a health care provider that related to safety, and, because it was a safety claim, it was an HCLC despite the fact that it was wholly unrelated to health care.<sup>133</sup> Thus, the court affirmed the trial court's dismissal of Ross's claim because she had not filed an expert report.<sup>134</sup>

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121. *Id.* at 614.

122. *Id.* at 612.

123. *Id.*

124. *Id.*

125. *Id.*

126. *Id.* at 612–13.

127. *Id.* at 614.

128. *Id.*

129. *Id.* at 612.

130. *Ross v. St. Luke's Episcopal Hosp.*, No. 14-12-00885-CV, 2013 WL 1136613, at \*1 (Tex. App.—Houston [14th Dist.] Mar. 19, 2013, pet. granted) (mem. op.).

131. *Id.*

132. *Id.*

133. *Id.* (stating that the court was “[c]ompelled by stare decisis” to hold that the claim was an HCLC, that the supreme court deemed certain facts irrelevant even though those facts suggested the TMLA should not apply to this situation, and that “Ross likely never imagined that, under the Texas Supreme Court’s construction, the plain language of the Texas Medical Liability Act would swallow her garden-variety slip and fall case. But it has”).

134. *Id.* at \*1–2.

Thus, the Texas Supreme Court's overly broad interpretation in *Williams* led to absurd results, as the Fourteenth Court of Appeals felt compelled to find HCLCs in intentional tort claims and premises liability claims that were not related to health care.<sup>135</sup> Not all Texas courts are willing to embrace such expansion, however.<sup>136</sup>

### C. Other Appellate Courts React

The Sixth Court of Appeals refused to expand the definition of an HCLC to negligence per se claims filed under the Occupational Safety and Health Act (OSHA) in *Good Shepherd Medical Center-Linden, Inc. v. Twilley*.<sup>137</sup> In that case, Twilley sustained two on-the-job injuries while performing his duties as Director of Plant Operations for the hospital: First, he fell from a ladder attached to the hospital building, and second, he tripped and fell over hardened cement on the hospital's premises.<sup>138</sup> Twilley asserted general negligence claims, and the hospital moved for dismissal because Twilley had not filed an expert report under the TMLA.<sup>139</sup> The court interpreted the Texas Supreme Court's decision in *Williams* narrowly, concluding *Williams* did not hold that the TMLA applies to all safety claims "completely untethered from health care."<sup>140</sup> The court held that not requiring *any* relation to health care to find an HCLC would produce absurd results:

[W]hen [the hospital's] argument is taken to its logical extreme, a suit against a health care provider for negligence in causing a car accident in a hospital parking lot would involve a safety claim and thus would require a report from a health care practitioner expert. A safety claim must involve a more logical, coherent nexus to health care. The simple fact that an injury occurred on a health care provider's premises is not enough.<sup>141</sup>

Because the court found that non-patient Twilley's general negligence claims were not HCLCs, the court allowed the claim to proceed.<sup>142</sup>

Likewise, the Thirteenth Court of Appeals refused to expand the definition of an HCLC and, unlike the Fourteenth Court of Appeals in *Ross v. St. Luke's Hospital*, it held that a premises liability claim by a non-patient against a hospital was not an HCLC.<sup>143</sup> In *Doctors Hospital at Renaissance, Ltd. v.*

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135. See *id.* at \*1; *Mem'l Hermann Hosp. Sys. v. Kerrigan*, 383 S.W.3d 611, 614 (Tex. App.—Houston [14th Dist.] 2012, pet. denied).

136. See discussion *infra* Part III.C.

137. *Good Shepherd Med. Ctr.-Linden, Inc. v. Twilley*, 422 S.W.3d 782, 789 (Tex. App.—Texarkana 2013, pet. denied).

138. *Id.* at 783.

139. *Id.* at 783–84.

140. *Id.* at 789.

141. *Id.* at 788.

142. *Id.* at 788–89.

143. *Doctors Hosp. at Renaissance, Ltd. v. Mejia*, No. 13-12-00602-CV, 2013 WL 4859592, at \*4 (Tex.



*Mejia*, Mejia was visiting her father in the hospital when she slipped and fell on a freshly waxed floor inside the hospital.<sup>144</sup> Mejia sued the hospital alleging safety violations; she did not file an expert report.<sup>145</sup> Noting that the supreme court had not provided clear guidance, the Thirteenth Court of Appeals narrowly interpreted *Williams* to find an HCLC where the claims involved safety “indirectly related to health care.”<sup>146</sup> The court agreed with the Sixth Court of Appeals’ decision in *Twilley* that the *Williams* decision did not bring all safety claims totally unrelated to health care within the reach of the TMLA.<sup>147</sup> Reasoning that Mejia was not a patient, the court found that her case was a “garden variety” premises liability claim, thus having no relation, directly or indirectly, to health care.<sup>148</sup> As such, the court determined Mejia’s claims could proceed without the filing of an expert report.<sup>149</sup>

In decisions following *Williams*, Texas appellate courts seemed to take notice of the expanded definition of HCLCs.<sup>150</sup> Texas courts seemed confused, however, about whether *Williams* expanded the reach of HCLCs to all safety-related claims against physicians, or only to those claims that were indirectly related to health care.<sup>151</sup> The Texas Supreme Court had the chance to clarify its decision in August of 2013.<sup>152</sup>

#### *D. The Texas Supreme Court Affirms Its Expansion of HCLCs but Fails at Clarification*

In *Psychiatric Solutions, Inc. v. Palit*, the Texas Supreme Court once again found a safety-related claim by an employee against its health care provider employer to be an HCLC.<sup>153</sup> In that case, Palit was a psychiatric nurse at a mental hospital operated by Psychiatric Solutions.<sup>154</sup> Palit asserted negligence claims against Psychiatric Solutions after he was injured while restraining a patient, and Psychiatric Solutions moved to dismiss because Palit had not filed an expert report.<sup>155</sup> Although the court was unclear about whether the claims in *Williams* constituted HCLCs under the health care prong, the court said that, as in *Williams*, Palit’s claims were HCLCs under the health care prong and the safety prong.<sup>156</sup> *Palit* was distinguishable from *Williams*

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App.—Corpus Christi Aug. 1, 2013, pet. filed) (mem. op.).

144. *Id.* at \*1.

145. *Id.*

146. *Id.* at \*2, \*4.

147. *Id.* at \*3.

148. *Id.* at \*3–4.

149. *Id.* at \*4.

150. *See supra* text accompanying notes 120–149.

151. *See supra* text accompanying notes 120–149.

152. *See Psychiatric Solutions, Inc. v. Palit*, 414 S.W.3d 724, 727 (Tex. 2013).

153. *Id.* at 724–25.

154. *Id.* at 725.

155. *Id.*

156. *Id.* at 726.

because, in addition to claiming that Psychiatric Solutions negligently failed to maintain a safe work environment, Palit also claimed the hospital was negligent in failing to provide proper security for a dangerous patient.<sup>157</sup> Because the court held Palit's claims were HCLCs and Palit had not filed an expert report, the court dismissed his claims.<sup>158</sup>

Justice Lehrmann, who dissented in *Williams*, joined Justice Boyd in a concurring opinion.<sup>159</sup> Noting their agreement with the majority that Palit's claims were HCLCs and should therefore be dismissed, the justices wrote separately to express their disagreement with the majority's broad construction of the definition of HCLCs.<sup>160</sup> The concurring opinion insisted that the legislature meant for "directly related to health care" to modify "safety" for three reasons.<sup>161</sup> First, the principle of *ejusdem generis* requires a narrow construction of the term safety because it is followed by the specific, narrowing phrase "directly related to health care."<sup>162</sup> Second, the legislature's decision not to add a comma after the word safety shows that it intended that safety be included with "professional or administrative services directly related to health care."<sup>163</sup> Finally, limiting safety claims to those related to health care is consistent with the legislative purpose behind the TMLA.<sup>164</sup> Boyd argued that the purpose of enacting the TMLA was to address the crisis affecting medical care and medical malpractice insurance costs; not requiring safety claims to be related to health care "takes the statute far beyond the Legislature's stated purpose."<sup>165</sup> Justice Boyd expressed concern that this was a slippery slope.<sup>166</sup> He agreed that the TMLA applied in this case because Palit's claims were related to health care, albeit indirectly.<sup>167</sup> He cautioned the court, however, to take care not to allow the application of the TMLA when a plaintiff asserts a safety claim wholly unrelated to health care.<sup>168</sup>

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157. Compare *id.* (discussing a situation where the plaintiff's claims included both improper supervision of patients and failure to provide a safe work environment), with *Tex. W. Oaks Hosp., LP v. Williams*, 371 S.W.3d 171, 175 (Tex. 2012) (discussing a situation where the plaintiff's claims involved the hospital's breach of a duty of care it owed to Williams as its employee, including failure to train employees, failure to supervise employees, failure to provide emergency protocol for employees, failure to provide employees with emergency notification devices, failure to warn employees of dangers, and failure to provide a safe workplace for employees).

158. *Palit*, 414 S.W.3d at 727.

159. *Id.* at 727–31 (Boyd, J., concurring).

160. *Id.* at 727.

161. *Id.*

162. *Id.* at 729.

163. *Id.* at 727–28 (quoting Act of May 30, 1977, 65th Leg., R.S., ch. 817, § 1.03(a)(4), 1977 Tex. Gen. Laws 2039, 2041, repealed by Act of June 2, 2013, 78th Leg., R.S., ch. 204, § 10.09, 2003 Tex. Gen. Laws 847, 884) (internal quotation marks omitted).

164. *Id.*

165. *Id.* at 730 (hypothesizing that under the *Williams* majority's construction, a non-patient's claim for injuries sustained after being assaulted in the parking lot after visiting the hospital due to poor lighting and inadequate security would be an HCLC).

166. See *id.* at 730–31.

167. *Id.*

168. See *id.*

Pressured for change due to increased medical malpractice liability insurance costs, the Texas Legislature has been working tirelessly for years to statutorily limit plaintiffs' abilities to recover in actions against health care providers.<sup>169</sup> While the TMLA seems free from the defects that led to the downfall of the MLIIA, the Texas Supreme Court's interpretation in *Williams* has caused immense confusion regarding the definition of HCLCs.<sup>170</sup> The majority opinion in *Palit* did not help to clarify matters.<sup>171</sup> The court's expansion of the definition of HCLCs has had unintended consequences, as the TMLA now reaches claims by non-patients under a statute intended to curb medical malpractice litigation.<sup>172</sup>

#### IV. ADVERSE REACTION: THE STATEWIDE CONSENSUS THAT THE RESULTS OF *WILLIAMS* WERE UNINTENDED

Many practitioners across the state agree that the Texas Supreme Court's decision in *Williams* was unexpected.<sup>173</sup> The original legislative intent behind the TMLA was to address the perceived medical malpractice crisis by imposing certain procedural requirements and limitations.<sup>174</sup> As a result of the Texas Supreme Court's interpretation of the TMLA, as laid out in *Williams*, plaintiffs with valid claims that have nothing to do with medical malpractice may be deprived of their day in court.<sup>175</sup> This is because, when plaintiffs filed their claims, their attorneys never imagined they would have to meet procedural requirements specific to a statute designed to solve a perceived problem involving medical malpractice claims.<sup>176</sup> Faced with the decision to either drop their claims or have them dismissed with an order to pay their opponents' attorney's fees, these plaintiffs have no redress for their injuries merely because health care providers were the source of the injuries.<sup>177</sup> Even with notice that

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169. See discussion *supra* Part II.

170. See discussion *supra* Parts II.C–III.A.

171. *Palit*, 414 S.W.3d at 727–29.

172. See discussion *infra* Part IV.

173. See, e.g., E. Dale Burrus, *The Ever-Widening Net—How Far Will the Texas Supreme Court Extend Chapter 74?*, KROGER BURRUS (Aug. 26, 2012), <http://www.krogerlaw.com/blog/2012/08/the-ever-widening-net-how-far-will-the-texas-supreme-court-extend-chapter-74/>; Russell Frost, *Texas West Oaks Hospital v. Williams*, LAW OFF. RUSSELL FROST (July 15, 2013), <http://www.russellfrostlaw.com/texas-west-oaks-hospital-v-williams>; Jay Pate, *Texas Supreme Court Expands Reach of Medical Malpractice “Expert Report” Requirements to Claim by Employee Against Employer*, HEYGOOD, ORR & PEARSON BLOG (July 7, 2012), <http://www.hop-law.com/texas-supreme-court-expands-reach-of-medical-malpractice-expert-report-requirements-to-claim-by-employee-against-employer/>.

174. See discussion *supra* Part II.C.

175. See *The Scope of a Health Care Liability Claim: Hearing on H.B. 2644 Before the House Comm. on Judiciary & Civil Jurisprudence*, 2013 Leg., 83rd Sess. (2013), available at [http://tlchouse.granicus.com/MediaPlayer.php?view\\_id=28&clip\\_id=6893](http://tlchouse.granicus.com/MediaPlayer.php?view_id=28&clip_id=6893), at 3:02:42 [hereinafter *Hearing*] (testimony by practitioners revealed that, since *Williams*, health care provider defendants are seizing the opportunity by threatening to countersue the plaintiffs for attorneys fees, forcing plaintiffs to abandon their claims).

176. *Id.*

177. See *id.*

their claims may constitute HCLCs, acquiring expert reports is problematic in these cases, not just because they are costly, but also because attorneys are confused—and rightfully so—about what is required in an expert report for a case that does not involve medical malpractice.<sup>178</sup> Additionally, the overly broad interpretation of the TMLA under *Williams* burdens the court systems, tying up parties in litigation for years and using valuable judicial resources on interlocutory rulings and appeals.<sup>179</sup>

The purpose of the TMLA was to help solve a perceived medical malpractice crisis by reducing the frequency and severity of medical malpractice lawsuits in Texas.<sup>180</sup> The Texas Supreme Court's overly broad interpretation of the Act has resulted in unintended consequences, as the TMLA is now being applied to claims that have absolutely nothing to do with medical malpractice.<sup>181</sup> This section explores the definition of medical malpractice and its application under Texas case law, which is necessary to show that HCLCs are medical malpractice claims, and claims that are wholly unrelated to medical malpractice are being called HCLCs.<sup>182</sup> This section also argues that the legislature did not intend for the overly broad definition applied to the word “claimant” by the supreme court in *Williams*, and that the legislature needs to take action to provide clarity for courts and practicing attorneys in the state.<sup>183</sup>

### A. Defining Medical Malpractice

Prior to any attempts at health care reform, the well-settled definition of medical malpractice was based on common-law negligence, proof of which depended on expert reports due to the specialized nature of treatment and healing.<sup>184</sup> For example, in *Bowles v. Bourdon*, a patient's parents brought a medical malpractice suit against the patient's doctor, claiming that the doctor negligently treated the patient's broken arm.<sup>185</sup> The court ruled in favor of the defendant-physician because the plaintiff's expert failed to show that the defendant's “want of skill or attention” proximately caused the patient's

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178. *Id.* at 3:10:47 (statement of Attorney Susan Hutchison).

179. *See id.*

180. Act of June 2, 2003, 78th Leg., R.S., ch. 204, § 10.11(a)–(b), 2003 Tex. Gen. Laws 847, 884.

181. *See, e.g.*, *Tex. W. Oaks Hosp., LP v. Williams*, 371 S.W.3d 171, 174 (Tex. 2012); *Ross v. St. Luke's Episcopal Hosp.*, No. 14-12-0085-CV, 2013 WL 1136613, at \*1 (Tex. App.—Houston [14th Dist.] Mar. 19, 2013, pet. granted) (mem. op.); *Mem'l Hermann Hosp. Sys. v. Kerrigan*, 383 S.W.3d 611, 613–14 (Tex. App.—Houston [14th Dist.] 2012, pet. denied); *see also Hearing, supra* note 175, at 3:02:52.

182. *See* discussion *infra* Part IV.A–B.

183. *See* discussion *infra* Part IV.C.

184. *See, e.g.*, *Bowles v. Bourdon*, 219 S.W.2d 779, 782 (Tex. 1949) (“It is definitely settled with us that a patient has no cause of action against his doctor for malpractice, either in diagnosis or recognized treatment, unless he proves by a doctor of the same school of practice as the defendant: (1) that the diagnosis or treatment complained of was such as to constitute negligence and (2) that it was a proximate cause of the patient's injuries.”).

185. *Id.*

injuries.<sup>186</sup> Thus, the court held that because the plaintiff's expert could not prove that the patient's injuries were caused by the negligent execution of the specialized duties of a physician, there was no negligence and, therefore, no medical malpractice.<sup>187</sup>

Medical malpractice can also be defined by an examination of liability insurance law.<sup>188</sup> The insurance market is segmented, and different policies cover different types of liability.<sup>189</sup> Because of this segmentation, many policies have exclusions to avoid an overlap with other policies, and many professionals have many policies at once.<sup>190</sup> Commercial general liability (CGL) insurance is the most commonly obtained liability policy; almost every business has a CGL policy.<sup>191</sup> CGL insurance policies typically cover the insured's liability for injuries and property damage caused on the insured's premises or arising out of the insured's business activities.<sup>192</sup> Commercial professional liability (CPL) policies, on the other hand, are policies professionals obtain to cover their liability for wrongful conduct in the rendition of professional services.<sup>193</sup> The terms "professional liability insurance" and "malpractice insurance" are often used interchangeably.<sup>194</sup> CPL policies "bridge[] a 'gap'" by providing coverage for types of liability the CGL policies exclude.<sup>195</sup> Coverage questions often arise when a professional service could be at issue and litigation ensues that focuses on the definition of professional services.<sup>196</sup> The first Texas case to address the issue defined professional

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186. *Id.* at 782, 785.

187. *See id.* at 785.

188. *See infra* text accompanying notes 189–214.

189. TOM BAKER & KYLE D. LOGUE, *INSURANCE LAW & POLICY: CASES, MATERIALS, AND PROBLEMS* 422 (Wolters Kluwer Law & Business, 3d ed. 2013).

190. *See* *Utica Nat'l Ins. Co. of Tex. v. Am. Indem. Co.*, 141 S.W.3d 198, 203–05 (Tex. 2004).

191. AMY ELIZABETH STEWART, *TEXAS INSURANCE COVERAGE LITIGATION: THE LITIGATOR'S PRACTICE GUIDE* 13 (2012).

192. *Id.* at 14 (footnote omitted) ("In common parlance, CGL insurance generally covers premises liability claims such as slip-and-fall injuries, damage to tangible property caused by the insured's operations, and invasion of privacy, as well as claims for defamation, libel and slander." (emphasis omitted)).

193. *Id.* at 37–38.

194. *See, e.g., id.*

195. *Id.* at 37.

196. *See generally* *Nat'l Cas. Co. v. W. World Ins. Co.*, 669 F.3d 608 (5th Cir. 2012) (involving insurance disputes in which the issue centered on whether the alleged negligence involved the rendition of professional services); *Allstate Ins. Co. v. Disability Servs. of the Sw., Inc.*, 400 F.3d 260 (5th Cir. 2005) (considering whether providing adequate communication to a patient was a professional service); *Royal Ins. Co. of Am. v. Hartford Underwriters Ins. Co.*, 391 F.3d 639 (5th Cir. 2004) (centering on whether the insurer's professional liability clause covered the underlying claim); *Potomac Ins. Co. of Ill. v. Jayhawk Med. Acceptance Corp.*, 198 F.3d 548 (5th Cir. 2000) (deciding that referring patients for elective procedures is not a professional service); *Guar. Nat'l Ins. Co. v. N. River Ins. Co.*, 909 F.2d 133 (5th Cir. 1990) (considering whether professional services included failure to effectively maintain a window); *Big Town Nursing Homes, Inc. v. Reserve Ins. Co.*, 492 F.2d 523 (5th Cir. 1974) (determining whether restraint of a patient being treated for alcoholism fell within professional judgment); *Utica Nat'l Ins. Co. of Tex. v. Am. Indem. Co.*, 141 S.W.3d 198 (Tex. 2004) (contemplating whether health services triggered the requirement of duty in performing a professional service); *Duncanville Diagnostic Ctr., Inc. v. Atl. Lloyd's Ins. Co. of Tex.*, 875 S.W.2d 788 (Tex. App.—Eastland 1994, writ denied) (deciding whether administering drugs and providing medical diagnosis

services as services pertaining to the profession, which uses special knowledge in its services for others.<sup>197</sup> A non-medical professional services case expanded on that definition in 1998 by adding that a professional act is not merely incidental to the profession but must “arise out of acts particular to the individual’s specialized vocation.”<sup>198</sup>

Applying Texas law, the Fifth Circuit determined that a CGL policy’s medical malpractice and professional services exclusion did not avoid coverage for a premises liability action by a patient’s estate.<sup>199</sup> In that case, Margaret Wagner opened a window and jumped to her death at Texarkana Memorial Hospital, where she had been admitted just one day earlier for psychiatric care.<sup>200</sup> Wagner’s estate sued the hospital, and the court found the hospital negligent in failing to properly monitor and observe Wagner, failing to properly maintain the window in Wagner’s room to prevent escape or suicide, and failing to properly maintain and train the staff in the psychiatric unit.<sup>201</sup> The court found in favor of the plaintiffs because the hospital’s negligence did not fall under the CGL policy’s medical malpractice and professional services exclusion.<sup>202</sup> The court interpreted North River’s exclusion to apply only to “actions taken on behalf of a patient that are based on professional medical judgment.”<sup>203</sup> The court determined that the hospital was not negligent in its rendering of a professional service because the hospital’s liability was based on its negligence in failing to maintain the window in such a way that would prevent Wagner’s suicide, not on any negligently trained professional medical judgment made pursuant to some established medical policy.<sup>204</sup> In the end, because the hospital’s nonprofessional administrative decision regarding the security of the windows in Wagner’s room did not constitute professional medical services, the court did not consider it professional negligence or malpractice.<sup>205</sup>

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fell under professional services); *Md. Cas. Co. v. Crazy Water Co.*, 160 S.W.2d 102 (Tex. Civ. App.—Eastland 1942, no writ) (discussing whether a “tuber,” an employee who prepared baths at the hotel, was rendering professional services).

197. *Md. Cas. Co.*, 160 S.W.2d at 104–05.

198. *Atl. Lloyd’s Ins. Co. of Tex. v. Susman Godfrey, L.L.P.*, 982 S.W.2d 472, 476–77 (Tex. App.—Dallas 1998, pet. denied).

199. *Guar. Nat’l*, 909 F.2d at 137–38.

200. *Id.* at 134.

201. *Id.* The negligence in maintaining the window was based on the decision to use screws in the window sashes rather than a more fixed solution, such as a permanent window screen. *Id.* at 136.

202. *Id.* at 137.

203. *Id.* at 135.

204. *Id.* at 136–37 (holding that the hospital’s mistake was not that it negligently made the medical decision not to protect the patient from unsecured windows, but that once it decided to do so, it executed the plan poorly through the administrative decision to inadequately secure the windows).

205. *Id.* at 135–36. The court found that only one of the plaintiffs’ claims—the claim regarding inadequately secured windows—fell outside the medical malpractice and professional services exclusion on the North River CGL policy. *Id.* at 137. Texas insurance law, however, provides for coverage in this situation because the claims were independent of one another. *Id.* (citing *Cagle v. Commercial Standard Ins. Co.*, 427 S.W.2d 939, 944 (Tex. Civ. App.—Austin 1968, no writ)) (“Where a loss . . . is caused by a covered peril and an excluded peril that are independent causes of the loss, the insurer is liable.”).

On the other hand, the Fifth Circuit held that the negligence at issue in *Big Town Nursing Homes, Inc. v. Reserve Insurance Company* did involve professional services.<sup>206</sup> In that case, Big Town Nursing Homes, Inc. (Big Town) had a policy that included a malpractice endorsement.<sup>207</sup> The endorsement provided that the policy included damages caused by malpractice and defined malpractice as “malpractice, error or mistake . . . in rendering or failing to render to such person, or to the person inflicting the injury, medical, surgical, dental or nursing care, including the furnishing of food or beverages in connection therewith.”<sup>208</sup> The underlying case was based on a claim of false imprisonment after nurses restrained a patient who attempted to leave an alcohol treatment facility—an action taken in accordance with hospital policy.<sup>209</sup> The Fifth Circuit determined that the nurses’ decision to restrain Newman was neither merely administrative nor purely physical; it was “the exercise of a trained nursing judgment in obedience to an established medical policy.”<sup>210</sup> Therefore, because the negligent acts involved professional services, the court found that they were covered by the malpractice insurance policy.<sup>211</sup>

The foregoing examination of malpractice in the context of insurance law shows that malpractice cases arise in situations where professionals breach a duty owed based on the rendition of professional services.<sup>212</sup> In the case of medical malpractice, the duty is owed to patients because patients consult doctors for their professional expert medical services.<sup>213</sup> In light of this definition, it is clear that an HCLC is a medical malpractice claim because HCLCs are applied in cases that have traditionally been defined as malpractice.<sup>214</sup>

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206. See *Big Town Nursing Homes, Inc. v. Reserve Ins. Co.*, 492 F.2d 523, 525 (5th Cir. 1974).

207. *Id.* at 524.

208. *Id.* at 525.

209. *Id.* at 524–25 (citing the district court’s opinion, which noted, “there is a general policy among the treating doctors that when a patient is irrational or is apt to hurt himself the nurses are to restrain the patient until the doctor performs an examination and orders otherwise”).

210. *Id.* at 525.

211. *Id.* Other medical malpractice liability insurance cases are instructive on the question of whether an act constitutes professional services and, therefore, malpractice. *E.g.*, *Utica Nat’l Ins. Co. of Tex. v. Am. Indem. Co.*, 141 S.W.3d 198, 204–05 (Tex. 2004) (holding that the negligent administration of a drug constitutes a professional service, while the negligent storage of a drug is a mere administrative task); *Duncanville Diagnostic Ctr., Inc. v. Atl. Lloyd’s Ins. Co. of Tex.*, 875 S.W.2d 788, 791–92 (Tex. App.—Eastland 1994, writ denied) (holding that the administration of an overdose of a sedative and failure to correctly diagnose a patient’s ailment were professional services, while negligent training and hiring and failure to institute adequate policies and procedures were mere administrative tasks).

212. See discussion *supra* notes 206–211 and accompanying text.

213. See, *e.g.*, *Guar. Nat’l Ins. Co. v. N. River Ins. Co.*, 909 F.2d 133, 136–37 (5th Cir. 1990) (concluding that the hospital was not exercising its professional medical judgment but rather making an administrative decision when it failed to secure the windows in a patient’s room).

214. See discussion *infra* Part IV.B.

### B. An HCLC Is a Malpractice Suit

The Texas Legislature's attempts at tort reform have been aimed at solving Texas's so-called medical malpractice crisis.<sup>215</sup> Doctors and other proponents of tort reform convinced the legislature to act to reduce the filing of medical malpractice claims.<sup>216</sup> Under the TMLA, courts have typically found claims to be HCLCs where a plaintiff alleges a doctor departed from the accepted standards of care in the profession in a way that is inseparable from the rendition of medical services.<sup>217</sup> Prior to the supreme court's expansion of the definition of HCLCs in *Williams*, every supreme court case that found claims to be HCLCs involved a claim against a health care provider, by a patient or someone on a patient's behalf, based on the alleged negligence in a health care provider's rendition of medical services to the patient.<sup>218</sup>

Medical malpractice has been defined as the negligent rendition of medical services by a trained medical professional that resulted in the injury of a patient to whom the medical professional owed a duty.<sup>219</sup> Courts deciding insurance cases have defined medical malpractice claims as claims against a health care provider, by a patient or someone on the patient's behalf, based on the alleged negligent acts of the health care provider, stemming from the provider's allegedly negligent professional medical judgment involving patient care.<sup>220</sup>

The fact that tort reform legislation has been aimed at solving America's so-called medical malpractice crisis—which was largely blamed on aggressive plaintiffs filing too many medical malpractice claims—indicates that the TMLA was meant to apply to medical malpractice claims.<sup>221</sup> Additionally, the definitions of HCLCs, based on early case law interpreting the TMLA, and the definitions of medical malpractice, based on judicial interpretations of insurance law, are strikingly similar.<sup>222</sup> Therefore, it is clear that HCLCs are medical malpractice claims.<sup>223</sup> The argument that the TMLA was not meant to apply in cases by non-patients is strengthened by the following analysis, which

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215. See Act of June 2, 2003, 78th Leg., R.S., ch. 204, § 10.11, 2003 Tex. Gen. Laws 847, 884; Act of May 30, 1977, 65th Leg., R.S., ch. 817, § 1.02(a)(5), 1977 Tex. Gen. Laws 2039, 2040.

216. See Keith, *supra* note 19, at 267.

217. *E.g.*, *Diversicare Gen. Partner, Inc. v. Rubio*, 185 S.W.3d 842, 848 (Tex. 2005) (finding that the plaintiff's claim against a nursing home for negligently failing to protect her from an attack by another resident constituted an HCLC because such claims were inseparable from the health care and medical services provided to her).

218. See discussion *supra* notes 70–73 and accompanying text.

219. See discussion *supra* Part IV.A.

220. See *Guar. Nat'l Ins. Co. v. N. River Ins. Co.*, 909 F.2d 133, 137–37 (5th Cir. 1990); *Big Town Nursing Homes, Inc. v. Reserve Ins. Co.*, 492 F.2d 523, 525 (5th Cir. 1974); *Md. Cas. Co. v. Crazy Water Co.*, 160 S.W.2d 102, 104 (Tex. Civ. App.—Eastland 1942, no writ).

221. See discussion *supra* Part II.A.

222. See *supra* notes 215–218 and accompanying text.

223. See discussion *supra* Part IV.B.



shows that the *Williams* court's interpretation of the word claimant was also overly broad.<sup>224</sup>

### C. The Meaning of "Claimant": A Comparative Analysis

The Texas Legislature's decision to use the word claimant in the TMLA did not indicate an intention for the statute to have broader coverage than the MLIIA, which used the word patient.<sup>225</sup> An examination of other specialized Texas statutes shows that the purpose of using the word claimant in the TMLA was not to include non-patients' claims that are wholly unrelated to health care, but instead to ensure that claims could be filed on behalf of patients if the patient herself was unable to file the claim.<sup>226</sup>

One statute that uses the word claimant is the Crime Victims Compensation Act, which the legislature passed to afford innocent individuals harmed by criminal acts an opportunity to recover what they could not recover from insurance.<sup>227</sup> The Act defines claimant as an individual who acts on behalf of a victim, an individual responsible for expenses a victim incurs as a result of being a victim to a crime, or an individual who is personally affected financially by the death or injury of a victim.<sup>228</sup> The Act defines "victim" as someone who is injured or killed as the result of a criminal act.<sup>229</sup> Thus, the legislature used the word claimant in addition to the word victim to ensure that those close to and affected by the victim's injury or death, as well as the victims themselves, would have some recourse under the statute.<sup>230</sup>

Similarly, the child support lien provisions of the Texas Family Code define claimant as the person to whom child support is owed, an attorney representing that person, the agency providing support to the child, a local registry or domestic relations office, or an appointed friend of the court.<sup>231</sup>

On the other hand, at least one statute defines claimant broadly: the Insurance Code defines claimant as "a person having any claim against an insurer, whether the claim is matured or not, liquidated or unliquidated, secured or unsecured, absolute, fixed, or contingent."<sup>232</sup> There are no cases, however, in which an employee of an insurer or a plaintiff whose claim is wholly unrelated to any insurance policy was deemed a claimant under Texas insurance

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224. See discussion *infra* Part IV.C.

225. *Contra* Tex. W. Oaks Hosp., LP v. Williams, 371 S.W.3d 171, 184 (Tex. 2012).

226. See discussion *infra* Part IV.C.

227. TEX. CODE CRIM. PROC. ANN. art. 56.32(a)(2) (West 2006 & Supp. 2014); Senate Comm. on Criminal Justice, Bill Analysis, Tex. S.B. 1049, 74th Leg., R.S. (1995).

228. CODE CRIM. PROC. art. 56.32(a)(2).

229. *Id.* art. 56.32(a)(11). As originally introduced, the Act defined claimant as simply "a victim or an authorized person acting on behalf of a victim." Tex. S.B. 248, 73d Leg., R.S. (1993). In 1995, however, the legislature clarified the definition by adding a numbered list of individuals who would qualify as claimants, all of which required a connection to the victim. Tex. S.B. 1049, 74th Leg., R.S. (1995).

230. See discussion *supra* notes 223–225.

231. TEX. FAM. CODE ANN. § 157.311(2) (West 2014).

232. TEX. INS. CODE ANN. art. 443.004(a)(3) (West 2013).

law.<sup>233</sup> Similarly, there are no cases in which a plaintiff with a claim wholly unrelated to child support was deemed a claimant under the Family Code simply because the defendant was someone who owed child support under the Code.<sup>234</sup> Finally, there are no cases of record in which a plaintiff was deemed a claimant under the Texas Code of Criminal Procedure simply because the defendant participated in a criminal act and injured someone else who was not a party to the pending suit.<sup>235</sup>

These examples may seem extreme, but the Texas Supreme Court's decision in *Williams* has had a similar effect by applying the TMLA to causes of action that are wholly unrelated to medical malpractice.<sup>236</sup> Because of *Williams*'s unintended effect, it is imperative that the Texas Legislature clarify the definitions in the TMLA to avoid further unwanted results and undeserved dismissals.

#### V. KICKING THE HABIT: AN ATTEMPT AT CLARIFICATION AND A PLEA FOR ACTION

As recent case law clearly demonstrates, it is imperative that the Texas Legislature take action to end the confusion about the definition of HCLCs.<sup>237</sup> Taking action is necessary to prevent more unintended results and to ensure that injured parties have an opportunity to be heard without unfair dismissals stemming from misunderstandings of the law.<sup>238</sup> There are a couple of different ways the legislature could achieve this end.<sup>239</sup> First, the legislature could reintroduce a bill, similar to House Bill 2644, which clarifies the language in the TMLA by redefining claimant in terms of the injured patient, and by clarifying that all types of HCLCs must be directly related to the rendition of medical services.<sup>240</sup> Alternatively, supporters and opponents of the bill could commit to brainstorming a mutually acceptable alternative solution.<sup>241</sup>

In April 2013, during the Regular Session of the 83rd Texas Legislature, Representative Chris Turner of Tarrant County introduced House Bill 2644 in an effort to end the confusion that was plaguing Texas courts after the Texas Supreme Court's decision in *Williams*.<sup>242</sup> House Bill 2644 was intended to clarify the definition of claimant by stating that it included only patients and

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233. *But see* Tex. W. Oaks Hosp., LP v. Williams, 371 S.W.3d 171, 184 (Tex. 2012) (holding that, partly because the TMLA used the word claimant instead of patient, the TMLA's coverage should extend to an employment claim by a non-patient).

234. *But see id.*

235. *But see id.* at 174.

236. *See supra* note 175 and accompanying text.

237. *See supra* note 175 and accompanying text.

238. *See supra* Part IV.

239. *See infra* notes 240–241 and accompanying text.

240. *See* Tex. H.B. 2644, 83d Leg., R.S. (2013).

241. *See Hearing, supra* note 175, at 3:24:30.

242. *See id.*

people bringing claims on behalf of a patient.<sup>243</sup> The Bill replaced the word person with the word patient and added the following sentence: “In a cause of action in which a party seeks recovery of damages related to injury to another person who is a patient, or other harm to the patient, ‘claimant’ includes both the patient and the party seeking recovery of damages.”<sup>244</sup> These changes represented an attempt to clarify that the legislature’s purpose in changing the word patient to the word claimant in the TMLA was not to broaden the field of potential plaintiffs, but rather to clarify that a patient’s guardian or estate could bring the action as well as the patient.<sup>245</sup> Additionally, by inserting the phrase “directly related to health care” immediately after the word safety, the Bill sought to clarify that safety claims, like all other types of HCLCs, must be related to the rendition of medical or health care services.<sup>246</sup>

Representative Turner brought House Bill 2644 before the Texas Committee on Judiciary and Civil Jurisprudence “to showcase some of the real impact that this broad interpretation is having on claimants in a wide variety of scenarios.”<sup>247</sup> This impact included dismissals of premises liability, non-subscriber employment, sexual harassment, intentional tort, and negligence claims.<sup>248</sup> None of the dismissed claims discussed at the hearing were directly related to the rendition of medical services.<sup>249</sup> Indeed, none of the plaintiffs were patients, and none of the claims were for malpractice or involved the professional services of health care providers.<sup>250</sup> Because of this, none of the attorneys ever imagined their claims would be dismissed for failure to file expert reports.<sup>251</sup> Despite compelling testimony regarding the consequences of

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243. *See id.*

244. Tex. H.B. 2644.

245. *See Hearing, supra* note 175, at 3:02:52 (statement of Rep. Chris Turner, Fort Worth).

246. *See* Tex. H.B. 2644.

247. *Hearing, supra* note 175, at 3:02:52 (statement of Rep. Chris Turner, Fort Worth).

248. *Id.* Attorneys Stuart Andrew “Drew” Gibbs, Susan Hutchison, Kern Lewis, and Jay Harvey testified at the hearing in favor of House Bill 2644. *Id.* Gibbs, a personal injury attorney, testified about his client, Ana Solis. *Id.* at 3:05:01 (statement of Attorney Stuart Andrew “Drew” Gibbs). Solis was a nursing home employee who slipped and fell because the hospital was engaged in a floor-stripping project. *Id.* Solis claimed that the hospital was negligent in failing to provide Solis with a safe work environment. *Id.* Gibbs testified that, because of the *Williams* decision, he was forced to drop Solis’ claim to avoid being counter-sued by the nursing home for attorney’s fees. *Id.* Similarly, Hutchison, who testified on behalf of the Texas Employment Lawyers Association, was forced to drop claims on behalf of at least three clients for the same reason. *Id.* at 3:10:47 (statement of Attorney Susan Hutchison). These dropped claims included (1) a phlebotomist’s claim against her boss for sexual harassment; (2) a nurse’s claim against a nursing home under the whistleblower statute after she was fired for reporting abuse of a patient; and (3) a claim of racial discrimination in the workplace by an employee of a mental health facility. *Id.* Lewis testified that he was forced to dismiss his case involving a home health nurse who was injured on the job and whose employer did not carry workers compensation insurance. *Id.* at 3:16:21 (statement of Attorney Kern Lewis). Finally, Harvey testified regarding a claim by a subcontractor injured while working on pumps in a hospital. *Id.* at 3:21:12 (statement of Attorney Jay Harvey).

249. *See* discussion *supra* note 248.

250. *See* discussion *supra* note 248.

251. *See, e.g., Hearing, supra* note 175, at 3:10:47 (statement of Attorney Susan Hutchison). In fact, these attorneys cannot even make sense of the need for expert reports in their situations because without the rendition of medical services, expert reports are not necessary for a determination of the standard of care. *See,*

*Williams*, the Committee on Judiciary and Civil Jurisprudence left the Bill pending, and without any explanation, the legislature allowed the Bill to die.<sup>252</sup>

Opponents of House Bill 2644 argue that the solution is not as simple as the proponents suggest.<sup>253</sup> They maintain that there are certain situations where a claim that should be an HCLC would not be considered an HCLC under the Bill.<sup>254</sup> Only one witness, Michael Hull, testified at the hearing in opposition to the Bill, however, and he was only able to describe one narrow set of circumstances in which House Bill 2644 would be problematic.<sup>255</sup> Even as an opponent, he acknowledged the *Williams* interpretation created a problem that needs to be addressed.<sup>256</sup> Hull testified that he opposed the Bill “in the softest, softest way,” claiming the Bill’s solution was problematic in that, under the Bill, if a health care provider negligently administered an overdose of medication to a patient, and the patient then injured a third party, the third party’s claim against the physician would not be an HCLC despite its basis in the negligent rendition of medical services.<sup>257</sup> When pressed by the House Judiciary Committee, Hull conceded that non-medical malpractice claims such as premises liability claims should not be considered HCLCs.<sup>258</sup>

Hull’s hypothetical scenario is not a cause for concern. In cases where a third party is injured because of a doctor’s negligence to a patient and the third party sues the patient, the patient can implead the health care provider claiming medical malpractice and that claim would qualify as an HCLC under the proposed definition.<sup>259</sup> Additionally, because of the ample evidence that medical malpractice lawsuits were not the cause of the perceived medical malpractice crisis, the threat of claims not qualifying as HCLCs when they should qualify is not nearly as great as the threat of claims qualifying as HCLCs when they should not be.<sup>260</sup> At the very least, to the extent the legislature deems this solution unworkable, the legislature should engage in a discussion of potential alternatives on which the interested parties may be able to reach a compromise.<sup>261</sup> Regardless of the chosen solution, commentators agree that *Williams* created a problem that needs to be addressed.<sup>262</sup>

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*e.g., id.*

252. See TEX. LEGISLATURE ONLINE, <http://www.capitol.state.tx.us/BillLookup/History.aspx?LegSess=83R&Bill=HB2644> (last visited Nov. 18, 2014).

253. *E.g., Hearing, supra* note 175, at 3:24:30 (statement of Attorney Michael S. Hull).

254. *E.g., id.*

255. *Id.*

256. *Id.*

257. *Id.* at 3:24:57.

258. *Id.*

259. See FED. R. CIV. P. 14(a); Tex. H.B. 2644, 83d Leg., R.S. (2013). The third-party claim by the defendant in this scenario would qualify as an HCLC under the proposed definitions because it would be a claim by a patient for negligence related to the rendition of health care services. See Tex. H.B. 2644.

260. See discussion *supra* note 21.

261. See *Hearing, supra* note 175, at 3:24:30 (statement of Attorney Michael S. Hull).

262. See *Hearing, supra* note 175.

VI. A CLEAN BILL OF HEALTH: A FUTURE FREE FROM THE MEDICAL MALPRACTICE MESS

The Texas Supreme Court went too far in *Texas West Oaks Hospital, LP v. Williams* with its overly broad interpretation of HCLCs under the TMLA.<sup>263</sup> The TMLA was enacted to solve a perceived medical malpractice crisis and is now being used to insulate doctors from liability in claims that have absolutely nothing to do with medical malpractice.<sup>264</sup> For Texas practitioners, this result was unexpected and means the dismissal of many meritorious claims despite the attorneys' knowledge and diligence.<sup>265</sup> Medical malpractice claims are based on common-law theories of negligence and require expert reports to show that a health care provider breached a duty owed to a patient by negligently rendering health care services.<sup>266</sup> Claims that are being defined as HCLCs under the TMLA, however, involve such non-medical issues as employment and premises liability.<sup>267</sup> Despite widespread surprise at such an overly broad interpretation of the TMLA, the Texas Legislature has chosen not to clarify the TMLA's original intent, thereby confusing and burdening Texas practitioners and courts.<sup>268</sup>

Texas can kick the habit by passing a bill clarifying the language of the TMLA in order to ensure the statute is not used to place hurdles on meritorious claims that do not involve medical malpractice.<sup>269</sup> The solution is simple: the legislature should pass a statute superseding *Williams*, clarifying the reach of the TMLA by explicitly stating that safety claims must be directly related to health care.<sup>270</sup> If an original intent of the TMLA was to classify non-medical malpractice safety claims as HCLCs, the legislature should clarify that as well so that valid claims are not cut off at the knees.<sup>271</sup> Whatever direction the legislature decides to take, all agree that steps must be taken to clear up the current medical malpractice mess in Texas.<sup>272</sup>

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263. See discussion *supra* Part III.A.

264. See *supra* notes 55–56 and accompanying text.

265. See *supra* note 173 and accompanying text.

266. See discussion *supra* Part IV.A.

267. See, e.g., *Tex. W. Oaks Hosp., LP v. Williams*, 371 S.W.3d 171, 174 (Tex. 2012); *Harris Methodist Fort Worth v. Ollie*, 342 S.W.3d 525, 525 (Tex. 2011) (per curiam).

268. See discussion *supra* Part IV.

269. See discussion *supra* Part V.

270. See discussion *supra* Part V.

271. See *Hearing*, *supra* note 175.

272. See *id.*