LIABILITY FOR HEALTH CARE PROVIDERS UNDER THE EMERGENCY MEDICAL CARE STATUTE

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CHAPTER 2
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LIABILITY FOR HEALTH CARE PROVIDERS UNDER THE EMERGENCY MEDICAL CARE STATUTE

I. INTRODUCTION: PROTECTING EMERGENCY ROOM HEALTH CARE PROVIDERS.

In 2003, the Texas Legislature enacted sweeping protections for defendants whose negligence is found to have caused injuries or death to others by passing House Bill 4 ("HB4"). Governor Perry signed HB4 ushering in protections for such tortfeasors which included many changes in the area of claims against health care providers for medical malpractice. The reforms in HB4 included the enactment of § 74.153 of the Texas Civil Practice & Remedies Code, entitled “Standard of Proof in Cases Involving Emergency Medical Care.”

The claimed purpose of the statute was to address certain situations in which health care providers provide emergency medical care to patients in the emergency room. Such situations often include scenarios involving acute trauma and high stress in which the health care provider may not have sufficient information to adequately diagnose and treat the patient due to the lack of a relationship with the patient, lack knowledge of the patient’s conditions, and lack of a full medical history. See H.J. of Tex., 78th Leg. R.S. 6040 (2003) (remarks by Rep. Joe Nixon). Because such emergency situations sometimes necessarily involve hurried care with very limited information on the patient, the Legislature enacted a lower standard of health care for such health care providers. This lower standard increases the evidentiary burden on victims of medical negligence, requiring them to prove that the health care provider breached the applicable standard of care with “willful and wanton” negligence, as opposed to the usual standard in medical malpractice cases in which the plaintiff must prove a breach of the standard of care with mere negligence. This article will address some of the recent legal developments concerning this Emergency Medical Care Statute.

A. Standard for invoking the Emergency Medical Care Statute.

Section 74.153 of the Texas Civil Practice and Remedies Code provides that:

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

TEX. CIV. PRAC. & REM. CODE ANN. § 74.153 (Vernon 2005) (emphasis added). The legislature may have borrowed the language defining “emergency medical care” from the federal Emergency Medical Treatment and Active Labor Act (“EMTALA”).

Under EMTALA, liability is imposed only if the patient is actually diagnosed with a emergency medical condition. Under EMTALA, a physician is not liable unless he diagnoses an “emergency medical condition.”

The willful and wanton negligence standard effectively codifies a lower standard of health care for emergency medical care. See Jackson v. Axelrad, 221 S.W.3d 650, 655 (Tex. 2006); see also Hernandez v. Lukefahr, 879 S.W.2d 137, 141 (Tex. App.—Houston [14th Dist.] 1994, no writ) (discussing how a “willful and wanton” standard diminishes the standard of care).

Under the statute, Emergency Medical Care is defined as:

1EMTALA defines the term “emergency medical condition” to mean a medical condition manifesting itself by acute symptoms of sufficient severity (including severe pain) such that the absence of immediate medical attention could reasonably be expected to result in placing the health of the individual (or with respect to a pregnant woman, the health of the woman or her unborn child) in serious jeopardy, serious impairment of bodily functions, or serious dysfunction of any bodily organ or part. 42 U.S.C. § 1399dd (e)(1).

2The standard for the imposition of liability under EMTALA is not whether the hospital fails to properly stabilize or transfer a patient after the hospital determines that the individual potentially has an emergency medical condition, it is whether it does so after determining that the individual has an emergency medical condition. The standard is a subjective one. Harris v. Health & Hosp. Corp., 852 F. Supp. 701 (S.D. Ind. 1994) (emphasis added).
Bona fide emergency care services provided after the sudden onset of a medical or traumatic condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in placing the patient’s health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ.

TEX. CIV. PRAC. & REM. CODE ANN. § 74.001(a)(7) (Vernon 2005). Thus, in order to reap the protections of the heightened standard of proof contained in the Emergency Medical Care Statute, a defendant must have been providing emergency medical care as defined in § 74.001(a)(7).

Both sides of the bar recognize that not all medical care provided in an emergency room is considered “emergency medical care.” Emergency Medicine Liability – Taking Advantage of the Wall of Protection, Susan C. Cooley, State Bar of Texas, 13th Annual Advanced Medical Malpractice Conference at 3 (2006); Emergency Care Cases: Plaintiff’s Perspective, Tommy Jacks, State Bar of Texas, 13th Annual Advanced Medical Malpractice Course at 1 (2006). Therefore, to determine whether the Emergency Medical Care Statute applies, it is necessary to ascertain if the services provided constitute “bona fide emergency care.”

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

B. Questions raised by the Emergency Medical Care Statute.

This statute spawns a number of questions, some of which have only recently begun to be addressed. For instance, in medical malpractice cases, a plaintiff must serve upon the defendant within 120 days of filing the original petition an expert report that provides a fair summary of the expert’s opinions regarding the applicable standards of care, the manner in which the defendant’s conduct did not meet those standards, and the causal relationship between that failure and the injuries claimed. TEX. CIV. PRAC. & REM. CODE § 74.351(a), (r)(16). The issue arises whether, in cases invoking the Emergency Medical Care Statute, this expert report must demonstrate that the standard of care was breached with willful and wanton negligence. Another issue concerns the meaning of willful and wanton negligence which is certainly more than mere negligence, but something less than intentional conduct. Additionally, diverging opinions are beginning to percolate through the legal system concerning under what circumstances the Emergency Medical Care Statute actually applies. Finally, another issue concerns whether the willful and wanton element can be decided on summary judgment or whether it is an issue uniquely for determination by a jury. While other issues will certainly arise in the future, this paper attempts to shed light on these particular issues in light of the relatively scant law concerning the Emergency Medical Care Statute and lack of guidance from the Texas Supreme Court.

II. CHAPTER 74 EXPERT REPORTS IN EMERGENCY MEDICAL CARE CASES.

Under the dictates of the Emergency Medical Care Statute, it is important to distinguish between the applicable standard of care and the degree to which the standard of care was not met. “As used in the context for medical malpractice actions, the phrases ‘standard of care’ and ‘standard of proof’ are not synonymous.” Bosch v. Wilbarger Gen. Hosp., 223 S.W.3d 460, 464 (Tex. App.—Amarillo 2006, pet. denied); see also Benish v. Grottie, 281 S.W.3d 184, 191 (Tex. App.—Fort Worth 2009, pet. denied).

The medical standard of care is an element of a plaintiff’s claim, setting the standard against which the factfinder measures the defendant’s conduct. Grottie, 281 S.W.3d at 191; Coan v. Winters, 646 S.W.2d 655, 657 (Tex. App.—Fort Worth 1983, writ ref’d n.r.e.). On the other hand, a standard of proof, such as that imposed by the Emergency Medical Care Statute, requires proof that the physician or health care provider’s mental state or intent at the time of any deviation from the medical standard of care was willful and wanton. Grottie, 281 S.W.3d at 191. It is the tortfeasor’s mental state that distinguishes between negligence, gross negligence, knowing acts or omissions, willful and wanton negligence, and intentional conduct. Id. The willful and wanton standard under the Emergency Medical Care Statute requires proof at trial of a mental state or state of mind beyond mere negligence at the time of the health care provider’s deviation from the medical standard of care. Id. at 192.

The Fort Worth Court of Appeals has noted that in light of the limited discovery permitted before an expert report is required to be served and in light of the proof necessary to establish a health care provider’s mental state, it is doubtful that an expert report would ever be able to contain an opinion regarding whether the health care provider acted with willful and wanton negligence. Id. The court of appeals refused to superimpose the Emergency Medical Care Statute’s standard of proof requirements onto the expert report requirements contained in section 74.351(r)(6). Id. The court noted that the Legislature made its intent clear in the Emergency Medical Care Statute by choosing the words “standard of proof” rather than “standard of care.” Id. at 193. By using this language, the Legislature prescribed a claimant’s burden of proof
at trial in a case involving emergency medical care. *Id.* The court also noted that despite the enactment of the Emergency Medical Care Statute, the Legislature did not include language in § 74.351(r)(6) which would require an expert report in an emergency medical care case to opine that the health care provider acted with willful and wanton negligence. *Id.*

Additionally in § 74.351(j), the Legislature expressly forbids the imposition of extra requirements on expert reports. *Id.* at 193. The court of appeals stated that there would be absurd consequences if a claimant was required to obtain an expert opinion on a health care provider’s mental state at the time of the negligence after only being able to review very limited discovery during the 120 day period for preparing the Chapter 74 expert report. *Id.* at 193-94. Declining the appellant’s request for the court of appeals to “judicially rewrite the statute,” the court concluded that a claimant is not required to obtain an opinion regarding the Emergency Medical Care Statute’s willful and wanton standard for inclusion in the Chapter 74 expert report. *Id.* at 194.

**III. MEANING OF WILLFUL AND WANTON—GROSS NEGLIGENCE.**

In order for a plaintiff to prevail in a professional negligence case against a health care provider in conjunction with the providing of emergency medical care in an emergency department, a plaintiff must show by a preponderance of the evidence that the defendant deviated from the applicable standard of care with willful and wanton negligence. TEX. CIV. PRAC. & REM. CODE ANN. § 74.153. The phrase “willful and wanton negligence” is inherently contradictory. *Hernandez v. Lukefahr*, 879 S.W.2d 137, 141 (Tex. App.—Houston [14th Dist.] 1994, no writ). Yet, despite the apparent contradiction “it is obvious the legislature meant to exclude outrageous acts rising to the level of conscious indifference.” *Hernandez*, 879 S.W.2d at 142. The First Court of Appeals has described the willful and wanton negligence standard as synonymous with “gross negligence,” saying that it means an “entire want of care which would raise the belief that the act or omission complained of was the result of conscious indifference to the right[s] or welfare of the person or persons to be affected by it.” *Little v. Needham*, 236 S.W.3d 328, 334 (Tex. App.—Houston [1st Dist.] 2007, no pet.); *Wheeler v. Yettie Kersting Mem’l Hosp.*, 866 S.W.2d 32, 50 n.25 (Tex. App.—Houston [1st Dist.] 1993, writ denied) (Good Samaritan case); see also *Dunlap v. Young*, 187 S.W.3d 828, 836 (Tex. App.—Texarkana 2006, no pet.) (Good Samaritan case); *Graham v. Adesa Texas, Inc.*, 145 S.W.3d 769, 772 (Tex. App.—Dallas 2004, pet. denied).

Texas courts have also equated willful and wanton conduct with gross negligence when interpreting similar language in other statutes. See *Burk Royalty Co. v. Walls*, 616 S.W.2d 911, 916-20 (Tex. 1981) (equating willful negligence, conscious indifference to the welfare of others, and reckless disregard for the rights of others with gross negligence); *Chrismon v. Brown*, 246 S.W.3d 102, 106-07 (Tex. App.—Houston [14th Dist.] 2007, no pet.) (equating “wilfully negligent, or done with conscious indifference or reckless disregard for the safety of others” exception to immunity defense under civil practice and remedies code § 84.007(a) with gross negligence); *Moncada v. Brown*, 202 S.W.3d 794, 799-800 (Tex. App.—San Antonio 2006, no pet.) (equating willful and wanton conduct under government code § 497.096 with gross negligence); *Warren v. Medley*, 521 S.W.2d 137, 139 (Tex. Civ. App.—Beaumont 1975, no writ) (duty owed to licensee by owner of property not to injure him by “willful, wanton or gross negligence”).

The legislative history of the Emergency Medical Care Statute further indicates that the Legislature intended the willful and wanton standard to equate to a gross negligence standard. *Turner v. Franklin*, No. 05-08-00011-CV, 2010 WL 3192938, *6 (Tex. App.—Dallas Aug. 12, 2010, pet. filed). During the senate hearing adopting the conference committee report on HB4, Senator Ratliff, in response to a question concerning the language in § 74.153, stated “[n]o, the standard is the same. Both willful [sic] and wanton negligence are covered, but this is basically a gross negligence standard. You don’t have to prove intent.” S.J. of Tex., 78th Leg., R.S. 5004 (2003); see also *Turner*, 2010 WL 3192938 at *6. In light of this body of law, in *Turner*, the Dallas Court of Appeals concluded that willful and wanton as used in § 74.153 means gross negligence. *Turner*, 2010 WL 3192938 at *7.

**IV. UNDER WHAT CIRCUMSTANCES DOES THE EMERGENCY MEDICAL CARE STATUTE APPLY?**

Certain situations clearly fall within the Emergency Medical Care Statute. However, nuances arise confounding the applicability of the Emergency Medical Care Statute for a number of reasons. For instance, due to the number of people in the State that either do not have, or cannot afford, health insurance and may not have a primary care physician, some people go to the emergency room for treatment of non-emergency conditions. Such non-emergency patients may nevertheless be provided with emergency medical care, or they may be provided with non-emergency medical care. Additionally, there are situations in which a patient goes to the emergency room with an emergency condition but is not provided emergency medical care. In this latter scenario, divergent bodies
of law have developed in the state and federal legal systems.

A. Situations in which the Emergency Medical Care Statute does not apply.

Pursuant to the express language in Chapter 74, the Emergency Medical Care Statute does not apply to medical care or treatment that occurs after the patient is stabilized and is capable of receiving medical treatment as a non-emergency patient or that is unrelated to the original medical emergency. TEX. CIV. PRAC. & REM. CODE § 74.001(a)(7); 74.153. The statute also does not apply to emergency care or non-emergency care to a patient that presents to the emergency department with a non-emergency condition. See TEX. CIV. PRAC. & REM. CODE § 74.001(a)(7); 74.153. Additionally, if a health care provider’s negligence causes the emergency, section 74.153 does not apply. S.J. of Tex., 78th Leg., R.S. 5004 (2003).

B. Emergency medical care provided to patient with an emergency condition.

The Emergency Medical Care Statute requires the higher standard of proof of willful and wanton negligence when a health care provider provides bona fide emergency medical care in the emergency department or obstetrical unit or in a surgical suite immediately following the evaluation of a patient in the emergency department. TEX. CIV. PRAC. & REM. CODE § 74.153. Such bona fide emergency care must be after the sudden onset of a medical or traumatic condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in placing the patient’s health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. TEX. CIV. PRAC. & REM. CODE § 74.001(a)(7).

C. No emergency care provided to a patient with an emergency condition – the federal approach.


In Guzman v. Memorial Hermann Hosp. Sys., the plaintiff moved for partial summary judgment asserting that the defendant doctor could not rely upon the Emergency Medical Care Statute because the defendant did not provide emergency medical care as defined under the statute. Id. at *1, 3. The undisputed evidence demonstrated that, even though treatment was provided in the emergency room, the defendant doctor did not diagnose the plaintiff with an emergency medical condition nor did the doctor treat the plaintiff’s condition as an emergency condition. Id. at *7. Relying upon the definition of “emergency medical care” as set forth in § 74.001 and the legislative history for the Emergency Medical Care Statute, the federal district court concluded that the Emergency Medical Care Statute does not apply to, and was not meant to address, situations in which a health care provider does not diagnose an emergency condition and does not treat the patient’s condition as an emergency condition even though such treatment occurred in the emergency department. Id. at *7-8. The district court held that, in such situations, as a matter of law, the heightened standard of proof under the Emergency Medical Care Statute does not apply. Id. at *9. The court, therefore, granted the plaintiff’s motion for partial summary judgment, concluding that the doctor could not assert the heightened willful and wanton standard of proof as set forth in the Emergency Medical Care Statute. Id. at *9.


Likewise, a federal district court in the Northern District of Texas recently stated that the heightened standard of proof under the Emergency Medical Care Statute “does not apply if the emergency room physician did not perceive the situation as an emergency or did not treat the condition as an emergency.” Id. at *16. The court also concluded that a fact issue regarding whether the defendant provided the patient with emergency medical care precluded the defendant’s motion to dismiss. Id.

D. No emergency care provided to a patient with an emergency condition – the state approach.


In Turner, the plaintiff went to the emergency room complaining of lower abdominal pain and knots on the left side of his testicles. The emergency room physician ordered a testicular ultrasound. Another doctor reviewed the radiology report remotely from his home and diagnosed the plaintiff with epididymitis which is a non-emergency inflammatory condition that is treated with antibiotics. The doctor apparently did not see evidence of testicular torsion which is an emergency condition the standard of care of which requires emergency care including consultation with a urologist and surgical detortion treatment within approximately six hours. The emergency room doctor noted in his clinical report that the ultrasound showed no torsion but instead showed epididymitis. Although the emergency room doctor suspected the possibility of testicular torsion, based in part on the other doctor’s
interpretation of the ultrasound, he diagnosed the plaintiff with epididymitis.

The emergency room doctor treated the plaintiff with pain medication and antibiotics and discharged him pursuant to the non-emergency diagnosis of epididymitis. Neither doctor consulted a urologist in conjunction with their treatment of the plaintiff. The plaintiff was instructed to contact his physician if his condition worsened and to follow up with his primary care physician within two days. The plaintiff was also provided with information regarding epididymitis.

After continued problems of pain and testicular swelling and numerous visits to his pediatrician’s office, 6 days later, the plaintiff was finally examined by a urologist who performed urgent surgical exploration and diagnosed the plaintiff with left testicular torsion. The plaintiff underwent surgery for the removal of the nonviable, necrotic left testical which was discovered to have been torsed 720 degrees.

Both doctors filed motions for summary judgment asserting the applicability of the Emergency Medical Care Statute alleging that there was no evidence that the doctors breached the applicable standard of care with willful and wanton negligence. The trial court granted the defendant’s motions for summary judgment.

On appeal, the plaintiff argued that the Emergency Medical Care Statute did not apply because the defendants had not diagnosed an emergency condition and did not provide emergency medical care. The plaintiff further argued that it would contravene public policy to allow a health care provider to not provide emergency care and at the same time be protected under the Emergency Medical Care Statute for having provided emergency care. The plaintiff argued that when a health care provider diagnoses a non-emergency condition and provides non-emergency treatment, the healthcare provider should be held to the same standard as other health care providers who provide non-emergency treatment.

In rejecting the plaintiff’s arguments, the Dallas Court of Appeals determined that even when there is a non-emergency diagnosis and non-emergency medical care is provided, the health care provider nevertheless gets the benefits of the Emergency Medical Care Statute if a patient presented to the emergency room with an emergency condition. *Id.* at *5-6. In reaching this conclusion, the Dallas Court of Appeals concluded that the “legislature’s purpose in enacting the statute [was] to provide physicians or health care providers a prospective incentive to provide emergency medical care in uncertain circumstances.” *Id.* at *5.

a. “Emergency medical care” does not actually require the medical care to have been of an emergency nature.

In a discussion of the relevant definitions, the court of appeals noted that a subcomponent of the definition of “emergency medical care” is “medical care,” which is modified by the definition of “practicing medicine,” which includes “diagnosis” and “treatment.” *Turner*, 2010 WL 3192938 at *4 (citing *TEX. CIV. PRAC. & REM. CODE ANN. § 74.001(a)(19) and TEX. OCC. CODE ANN. § 151.002(13) (Vernon Supp. 2009)). Based on this interpretation, the court of appeals concluded that even a non-emergency diagnosis and non-emergency treatment is protected by the statute if it was provided in good faith when the patient presented to the emergency room with an emergency condition. *Turner*, 2010 WL 3192938 at *4-5.

It is important to note that the relevant definition of “medical care” at issue is modified by the term “emergency.” § 74.001(a)(7). Thus, if “medical care” includes diagnosis and treatment, as the Dallas Court of Appeals held, then “emergency medical care” means “emergency [diagnosis and treatment].” *TEX. CIV. PRAC. & REM. CODE ANN. § 74.001(a)(7) (as modified by § 74.001(a)(19) as modified by TEX. OCC. CODE ANN. § 151.002(13)). Therefore, contrary to the Dallas Court of Appeals’ opinion, in order to fall within the definition of emergency medical care, the diagnosis and treatment must still be an “emergency diagnosis” and “emergency treatment,” not simply a diagnosis provided to a patient with an emergency condition. The court of appeals’ analysis and conclusion that emergency medical care includes even non-emergency diagnoses and non-emergency treatment apparently does not require courts to give effect to the word “emergency,” which expressly modifies “medical care” under the Emergency Medical Care Statute.

b. “Bona fide emergency medical services provided” does not actually require the provision of emergency services.

Emergency Medical Care is defined as:

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

*TEX. CIV. PRAC. & REM. CODE ANN. § 74.001(a)(7) (Vernon 2005) (emphasis added). The court of appeals noted, there is no indication whether the Legislature intended “bona fide” to mean “good faith” or “actual.”*
Turner, 2010 WL 3192938 at *4. Whether the definition should be interpreted as “good faith emergency services provided,” or “actual emergency services provided,” the statutory definition still requires that “emergency services [were] provided.” TEX. CIV. PRAC. & REM. CODE ANN. § 74.001(a)(7). The word “provision” means “the act or process of providing.” WEBSTER’S THIRD NEW INT’L DICTIONARY (1993). However, the court of appeals’ opinion apparently does not require the provision of emergency medical services but simply a non-emergency diagnosis and non-emergency treatment after a patient presents to the emergency department with an emergency condition.

c. Did the Dallas Court of Appeals change the medical standard of care in an emergency room?
   Under medical literature, the standard of care in an emergency room requires a health care provider to assume the worst possible emergency condition, and make a diagnosis to determine whether the emergency condition exists. If the diagnosis is not of an emergency condition the health care provider is to conduct differential diagnoses in order to determine the less urgent condition from which the patient suffers and treat the condition accordingly. Doctor defendants and medical literature agree that this is the proper standard of care in an emergency room. For instance, In EMERGENCY MEDICINE SECRETS, Vincent J. Markovick, M.D., FACEP, Director of Emergency Medical Services at Denver General Hospital, stressed that “in making decisions in emergency medicine, the first and most important question that must be answered is: What is the life threat?” In explaining decision-making in emergency medicine, he observed:

   The natural tendency in formulating a differential diagnosis is for the emergency department physician to think of the most common or statistically most probable condition to explain the patient’s initial presentation to the emergency department. If one does this, one will be right most of the time but may overlook the most serious, albeit usually most uncommon, problem. Therefore, the practice of emergency medicine involves some degree of healthy paranoia in that one must consider the most serious condition possible, and, through a logical process of elimination, rule it out and thereby arrive at the correct and generally more common diagnosis.

   VINCENT J. MARKOVCHICK, ET AL., EMERGENCY MEDICINE SECRETS, 2-3 ¶¶12-13. Furthermore, in Pohlman-Parks v. Stewart, Cause No. 09-1335-C, 241st Judicial District Court, Smith County, Texas, the defendant doctor testified as follows:

   Q. The job of the emergency room doctor, the reasonable and prudent emergency room doctor, is to consider in the differential diagnoses, those illnesses or conditions that are potentially life-threatening and seek to rule those out or confirm the diagnosis?
   A. Correct.

   Additionally, James Matthews, M.D. who has practiced emergency medicine since 1973, teaches emergency medicine and is board certified by the American Board of Emergency Medicine testified as follows in the same case:

   Q. When an emergency room physician is presented with a potential life and death condition, is there an obligation and duty and a standard of care to rule out that life-threatening condition before sending the patient home?
   A. Yes.

   The Dallas Court of Appeals however, disagreed with this well known standard of care when it rejected the plaintiff’s argument because, as the court said, such an argument “would create an incentive for health care providers to assume the most dire of possibilities—and treat the patient accordingly.” Turner, 2010 WL 3192938 at *5. The obvious implication by the court of appeals is that a health care provider should not be motivated by an incentive to initially assume the worst possible condition in treating a patient who presents to the emergency room. Thus, legal and medical practitioners are left with a strange dichotomy between well established medical literature and the law in the Dallas appellate judicial district.

   2. Divergence between state and federal law regarding the applicability of the Emergency Medical Care Statute.
   As the law has developed in federal court, if a health care provider does not diagnose an emergency condition, perceive the condition as an emergency condition, and does not provide emergency medical care, the health care provider may not benefit from the protections contained in the Emergency Medical Care Statute. This approach is consistent with an analogous case involving the Good Samaritan Statute.

   In Pleasant Glade Assembly of God v. Schubert, 174 S.W.3d 388, 396 (Tex. App.—Fort Worth 2005), rev’d on other grounds, 264 S.W.3d 1 (Tex. 2008), the Fort Worth Court of Appeals did not allow a defendant
to benefit from the heightened willful and wanton standard of proof contained in the Good Samaritan Statute. The Good Samaritan Statute, which has been codified at § 74.151, is similar to the emergency room statute, in that it requires a plaintiff to prove that the defendant’s actions in providing emergency health care were willfully and wantonly negligent. TEX. CIV. PRAC. & REM. CODE ANN. § 74.151. In Schubert, the evidence demonstrated that the defendants had not treated the plaintiff’s condition as an emergency medical condition but instead treated the plaintiff’s collapse from a hypoglycemic attack as a “dramatic ploy for attention” from other members of a church youth group. Id. Because the defendants failed to demonstrate that they considered and treated the plaintiff’s hypoglycemic collapse as an emergency condition and that they provided emergency medical care, the court of appeals concluded that the defendants were not entitled to a directed verdict based on the Good Samaritan Statute. Schubert, 174 S.W.3d at 396.

However, under the Dallas Court of Appeals’s interpretation of the Emergency Medical Care Statute, even if a health care provider does not diagnose an emergency condition or provide bona fide emergency medical care, the health care provider still receives the benefit of the Emergency Medical Care Statute if the patient presents to the emergency department with an emergency condition.

Under the Emergency Medical Care Statute, if the Legislature had actually intended to give blanket protection to all medical care (emergency and non-emergency) provided in an emergency room department, it could have easily done so. However, the Legislature only provided such protection to a subset of medical care provided in an emergency department—bona fide emergency services. TEX. CIV. PRAC. & REM. CODE ANN. § 74.001(a)(7). If non-emergency medical care was protected under this statute, the words “bona fide emergency” in the statute would be meaningless. Furthermore, if the Legislature had intended the definition to include non-emergency diagnoses and non-emergency treatment, the Legislature would have used the phrase “bona fide services provided after the sudden onset . . . .” However, because the Legislature included the word “emergency” in the definition, it could not have intended the definition to include non-emergency services.

Some argue that it would contravene public policy to allow a health care provider to not provide emergency medical care and at the same time be protected for having provided emergency medical care. They further assert that when a health care provider diagnoses a non-emergent condition and provides non-emergent treatment, the healthcare provider should be held to the same standard as other health care providers who provide non-emergent treatment.

Given the development of the law concerning the Emergency Medical Care Statute and the Good Samaritan Statute with a similar standard, litigants in Texas federal courts and perhaps in the Fort Worth appellate judicial district can anticipate that if a health care provider does not diagnose an emergency condition and does not provide emergency medical care, the health care provider may not benefit from the heightened willful and wanton standard of proof contained in the Emergency Medical Care Statute. However, litigants in the Dallas appellate judicial district now know that the protections of the Emergency Medical Care Statute are available even in light of a non-emergency diagnosis and the provision of non-emergency treatment.

V. IS THE EMERGENCY MEDICAL CARE STATUTE A STANDARD OF PROOF OR A STANDARD OF CARE.

Under the dictates of the Emergency Medical Care Statute, it is important to distinguish between the applicable standard of care and the degree to which the standard of care was not met. The Amarillo Court of Appeals has stated that “[a]s used in the context for medical malpractice actions, the phrases ‘standard of care’ and ‘standard of proof’ are not synonymous.” Bosch v. Wilbarger Gen. Hosp., 223 S.W.3d 460, 464 (Tex. App.—Amarillo 2006, pet. denied). The applicable standard of care is a threshold issue to be established by expert testimony. Bosch, 223 S.W.3d at 463; McCombs v. Children’s Med. Center of Dallas, 1 S.W.3d 256, 259 (Tex. App.—Texarkana 1999, pet. denied); see also Mills v. Angel, 995 S.W.2d 262, 268 (Tex. App.—Texarkana 1999, no pet.); Rodriguez v. Reeves, 730 S.W.2d 19, 21 (Tex. App.—Corpus Christi 1987, writ ref’d n.r.e.); Coan v. Winters, 646 S.W.2d 655, 657-58 (Tex. App.—Fort Worth 1983, writ ref’d n.r.e.). The degree to which the standard of care was not met (e.g., by mere negligence or by willful and wanton negligence) is a question of fact to be determined by the jury. Bosch, 223 S.W.3d at 463; McCombs, 1 S.W.3d at 259; see also Mills, 995 S.W.2d at 268; Mathis v. Bocell, 982 S.W.2d 52, 56 (Tex. App.—Houston [1st Dist.] 1998, no pet.) (reversing a summary judgment based on fact issue concerning breach of the standard of care); Connor v. Waltrip, 791 S.W.2d 537, 539 (Tex. App.—Dallas 1990, no writ); Rodriguez, 730 S.W.2d at 28.

As the Fort Worth Court of Appeals has stated:

Testimony by a medical expert of whether a defendant doctor was negligent, or of what constitutes negligence or malpractice on the part of a defendant doctor, or what the
medical expert would have done, is inadmissible in a medical malpractice suit. An expert witness in a medical malpractice case should state what the standard of care for the specific disease or condition is in a given locality and then state what conduct of the defendant doctor violated or breached that standard of care. Then, unless evidence shows as a matter of law that the doctor is not negligent or that his negligence, if any, was not a proximate cause of his patient’s injury, the jury is to determine whether the doctor met the standard of care.

Coan, 646 S.W.2d at 657-58 (citations omitted); see also Boone v. Fisher, No. 13-96-001-CV, 2000 WL 34410138, *1-2 (Tex. App.—Corpus Christi June 22, 2000, no pet.) (not designated for publication); Carter v. Roy, No. A14-90-00346-CV, 1991 WL 140955, *2 (Tex. App.—Houston [14th Dist.] Aug. 1, 1991, no writ) (not designated for publication). Therefore, as long as the applicable standard of care has been sufficiently articulated and there is expert testimony of a breach of the standard of care, whether a defendant failed to comply with the standard of care and to what degree such standard of care was not met is usually an issue for the jury to decide. Likewise, whether a defendant failed to comply with a particular standard of care with willful and wanton negligence is generally an issue to be determined by the jury.

Because the degree to which a standard of care was not met is generally a fact issue for the jury, the question remains whether such issue is proper for disposition by summary judgment. The First Court of Appeals’ opinion in Wheeler v. Yette Kersting Mem’l Hosp., 866 S.W.2d 32 (Tex. App.—Houston [1st Dist.] 1993, writ denied) (Good Samaritan case) is instructive on this issue. In Wheeler, emergency medical technicians (“EMT”) defendants moved for summary judgment seeking to prove that their actions in treating the plaintiff were not willfully or wanton negligent as a matter of law. Wheeler, 866 S.W.2d at 50 n.25. The court noted that, among other evidence, there was deposition testimony by a doctor expert providing that:

1. the action of EMT Davis in tearing the amniotic sac open was “completely wrong” and speeded up the delivery; (2) the proper procedure when the water breaks is to have the patient lie quietly and avoid rupturing the membranes; (3) in reasonable medical probability, had the EMTs followed the proper procedure, there would have been time for Life Flight to arrive and take Mrs. Wheeler to John Sealy; (4) as Mrs. Wheeler's labor became more intense, the EMTs should have stopped at one of the several other hospitals en route to have Mrs. Wheeler rechecked.

Id. at 51. Additionally, an EMT expert testified by affidavit that “the failure of the EMTs to attempt to maintain an airway for the infant was beneath the standard of care for EMTs.” Id. Another medical expert testified by affidavit that “the EMT’s failure to attempt to establish an airway for the baby or deliver its head was beneath the standard of care for an EMT.” Id. Noting that, in order for the EMTs to obtain a summary judgment, they were required to establish as a matter of law that they were not willfully or wantonly negligent in caring for the plaintiff, the court of appeals reversed in part concluding that the summary judgment proof raised fact issues which precluded summary judgment. Id.

It is important to note that, in Wheeler, the expert testimony offered in support of the plaintiff’s claims only addressed whether the defendant’s actions fell below the applicable standard of care. There was no testimony or evidence addressing the degree to which the standard of care was not complied. That is to say, there was no summary judgment evidence concerning whether the defendant’s conduct was willfully or wantonly negligent. Nevertheless, the court of appeals concluded that the evidence was sufficient to raise a fact issue concerning whether the defendants’ actions were willfully or wantonly negligent and, thus, the defendants could not, as a matter of law, establish otherwise.

This has been a fairly common rule of law for some time. For instance, in Hood v. Phillips, 554 S.W.2d 160 (Tex. 1977), expert medical testimony characterizing “carotid surgery as an unaccepted mode of treatment for emphysema, a controversial procedure, as a treatment not supported by medical evidence, and as a surgical procedure which had been tried by a number of physicians, found ineffectual, and abandoned.” Id. at 166. The supreme court concluded that, based on the expert testimony concerning the defendant’s deviation from the applicable standard of care, this testimony was sufficient to support the submission of issues to the jury regarding ordinary negligence, gross negligence, and punitive damages. Id. at 166. It is important to note that the expert testimony in Hood addressed the applicable standard of care and how the defendants deviated from the standard of care but at no time did the experts offer opinions regarding whether the defendants’ actions rose to the level of gross negligence. See id.

Furthermore, by analogy, the heightened standard of proof for gross negligence is in fact submitted to the jury for determination. See Texas Pattern Jury Charge Malpractice 85.1c. Moreover, PJC 51.18C provides
that an issue should be submitted to the jury regarding whether a doctor’s rendition of emergency medical care was done with willful or wanton negligence.

In *Turner v. Franklin*, the Dallas Court of Appeals noted that the willful and wanton standard, which is essentially a gross negligence standard, contains a subjective component concerning the actor’s actual, subjective awareness of the risk involved and choice to proceed with conscious indifference to the rights, safety, or welfare of others. *Turner*, 2010 WL 3192938 at *7. The court further stated that “[b]ecause willful and wanton negligence . . . has a subjective element inquiring into the defendant’s state of mind and because issues of intent are usually best left to the trier of fact” for resolution, determining the issue by summary judgment usually will be improper. *Id.* at *7*. Nevertheless, the Dallas Court of Appeals concluded that there was nothing under section 74.153 that categorically precludes resolution by summary judgment. *Id.* at *8*. The court then proceeded to review the summary judgment evidence concerning both doctor defendants and concluded that, under a traditional summary judgment standard, one doctor failed to prove as a matter of law that he did not violate the standard of care with willful and wanton negligence. However, the court concluded that the evidence as to the other doctor was insufficient under a no evidence standard to raise a fact issue on the willful and wanton standard. *Id.* at *9-10*.

VI. CONCLUSION

This area of the law related to the Emergency Medical Care Statute is fluid and developing. It will be interesting to see how the diverging interpretations in the state and federal systems continue to develop. It will also be interesting to see if the Texas Supreme Court grants the Petitions for Review in the *Turner* case in order to clarify some of the uncertainty with the application of the statute.