CIVIL PRACTICE AND REMEDIES CODE

TITLE 4. LIABILITY IN TORT

CHAPTER 74. MEDICAL LIABILITY

SUBCHAPTER A. GENERAL PROVISIONS

Sec. 74.001. DEFINITIONS. (a) In this chapter:

(1) "Affiliate" means a person who, directly or indirectly, through one or more intermediaries, controls, is controlled by, or is under common control with a specified person, including any direct or indirect parent or subsidiary.

(2) "Claimant" means a person, including a decedent's estate, seeking or who has sought recovery of damages in a health care liability claim. All persons claiming to have sustained damages as the result of the bodily injury or death of a single person are considered a single claimant.

(3) "Control" means the possession, directly or indirectly, of the power to direct or cause the direction of the management and policies of the person, whether through ownership of equity or securities, by contract, or otherwise.

(4) "Court" means any federal or state court.

(5) "Disclosure panel" means the Texas Medical Disclosure Panel.

(6) "Economic damages" has the meaning assigned by Section 41.001.

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

(8) "Emergency medical services provider" means a

licensed public or private provider to which Chapter 773, Health and Safety Code, applies.

(9) "Gross negligence" has the meaning assigned by Section 41.001.

(10) "Health care" means any act or treatment performed or furnished, or that should have been performed or furnished, by any health care provider for, to, or on behalf of a patient during the patient's medical care, treatment, or confinement.

(11) "Health care institution" includes:

(A) an ambulatory surgical center;

(B) an assisted living facility licensed under Chapter 247, Health and Safety Code;

(C) an emergency medical services provider;

(D) a health services district created under Chapter 287, Health and Safety Code;

(E) a home and community support services agency;

(F) a hospice;

(G) a hospital;

(H) a hospital system;

(I) an intermediate care facility for the mentally retarded or a home and community-based services waiver program for persons with mental retardation adopted in accordance with Section 1915(c) of the federal Social Security Act (42 U.S.C. Section 1396n), as amended;

(J) a nursing home; or

(K) an end stage renal disease facility licensed under Section 251.011, Health and Safety Code.

(12)(A) "Health care provider" means any person, partnership, professional association, corporation, facility, or institution duly licensed, certified, registered, or chartered by the State of Texas to provide health care, including:

(i) a registered nurse;

(ii) a dentist;

(iii) a podiatrist;

(iv) a pharmacist;

(v) a chiropractor;

(vi) an optometrist;

(vii) a health care institution; or

(viii) a health care collaborative certified under Chapter 848, Insurance Code.

(B) The term includes:

(i) an officer, director, shareholder, member, partner, manager, owner, or affiliate of a health care provider or physician; and

(ii) an employee, independent contractor, or agent of a health care provider or physician acting in the course and scope of the employment or contractual relationship.

(13) "Health care liability claim" means 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. The term does not include a cause of action described by Section 406.033(a) or 408.001(b), Labor Code, against an employer by an employee or the employee's surviving spouse or heir.

(14) "Home and community support services agency" means a licensed public or provider agency to which Chapter 142, Health and Safety Code, applies.

(15) "Hospice" means a hospice facility or activity to which Chapter 142, Health and Safety Code, applies.

(16) "Hospital" means a licensed public or private institution as defined in Chapter 241, Health and Safety Code, or licensed under Chapter 577, Health and Safety Code.

(17) "Hospital system" means a system of hospitals located in this state that are under the common governance or control of a corporate parent.

(18) "Intermediate care facility for the mentally retarded" means a licensed public or private institution to which Chapter 252, Health and Safety Code, applies.

(19) "Medical care" means any act defined as practicing medicine under Section 151.002, Occupations Code,

performed or furnished, or which should have been performed, by one licensed to practice medicine in this state for, to, or on behalf of a patient during the patient's care, treatment, or confinement.

(20) "Noneconomic damages" has the meaning assigned by Section 41.001.

(21) "Nursing home" means a licensed public or private institution to which Chapter 242, Health and Safety Code, applies.

(22) "Pharmacist" means one licensed under Chapter 551, Occupations Code, who, for the purposes of this chapter, performs those activities limited to the dispensing of prescription medicines which result in health care liability claims and does not include any other cause of action that may exist at common law against them, including but not limited to causes of action for the sale of mishandled or defective products.

(23) "Physician" means:

(A) an individual licensed to practice medicine in this state;

(B) a professional association organized under the Texas Professional Association Act (Article 1528f, Vernon's Texas Civil Statutes) by an individual physician or group of physicians;

(C) a partnership or limited liability partnership formed by a group of physicians;

(D) a nonprofit health corporation certified under Section 162.001, Occupations Code; or

(E) a company formed by a group of physicians under the Texas Limited Liability Company Act (Article 1528n, Vernon's Texas Civil Statutes).

(24) "Professional or administrative services" means those duties or services that a physician or health care provider is required to provide as a condition of maintaining the physician's or health care provider's license, accreditation status, or certification to participate in state or federal health care programs.

(25) "Representative" means the spouse, parent, guardian, trustee, authorized attorney, or other authorized legal agent of the patient or claimant.

(b) Any legal term or word of art used in this chapter, not otherwise defined in this chapter, shall have such meaning as is consistent with the common law.

Added by Acts 2003, 78th Leg., ch. 204, Sec. 10.01, eff. Sept. 1, 2003.

Amended by:

Acts 2011, 82nd Leg., 1st C.S., Ch. 7 (S.B. 7), Sec. 4.02, eff. September 1, 2011

Acts 2015, 84th Leg., R.S., Ch. 728 (H.B. 1403), Sec. 1, eff. September 1, 2015.

Sec. 74.002. CONFLICT WITH OTHER LAW AND RULES OF CIVIL PROCEDURE. (a) In the event of a conflict between this chapter and another law, including a rule of procedure or evidence or court rule, this chapter controls to the extent of the conflict.

(b) Notwithstanding Subsection (a), in the event of a conflict between this chapter and Section 101.023, 102.003, or 108.002, those sections of this code control to the extent of the conflict.

(c) The district courts and statutory county courts in a county may not adopt local rules in conflict with this chapter.

Added by Acts 2003, 78th Leg., ch. 204, Sec. 10.01, eff. Sept. 1, 2003.

Sec. 74.003. SOVEREIGN IMMUNITY NOT WAIVED. This chapter does not waive sovereign immunity from suit or from liability.

Added by Acts 2003, 78th Leg., ch. 204, Sec. 10.01, eff. Sept. 1, 2003.

Sec. 74.004. EXCEPTION FROM CERTAIN LAWS. (a) Notwithstanding any other law, Sections 17.41-17.63, Business & Commerce Code, do not apply to physicians or health care providers with respect to claims for damages for personal injury or death resulting, or alleged to have resulted, from negligence on the part of any physician or health care provider.

(b) This section does not apply to pharmacists.

Added by Acts 2003, 78th Leg., ch. 204, Sec. 10.01, eff. Sept. 1,

2003.

SUBCHAPTER B. NOTICE AND PLEADINGS

Sec. 74.051. NOTICE. (a) Any person or his authorized agent asserting a health care liability claim shall give written notice of such claim by certified mail, return receipt requested, to each physician or health care provider against whom such claim is being made at least 60 days before the filing of a suit in any court of this state based upon a health care liability claim. The notice must be accompanied by the authorization form for release of protected health information as required under Section 74.052.

(b) In such pleadings as are subsequently filed in any court, each party shall state that it has fully complied with the provisions of this section and Section 74.052 and shall provide such evidence thereof as the judge of the court may require to determine if the provisions of this chapter have been met.

(c) Notice given as provided in this chapter shall toll the applicable statute of limitations to and including a period of 75 days following the giving of the notice, and this tolling shall apply to all parties and potential parties.

(d) All parties shall be entitled to obtain complete and unaltered copies of the patient's medical records from any other party within 45 days from the date of receipt of a written request for such records; provided, however, that the receipt of a medical authorization in the form required by Section 74.052 executed by the claimant herein shall be considered compliance by the claimant with this subsection.

(e) For the purposes of this section, and notwithstanding Chapter 159, Occupations Code, or any other law, a request for the medical records of a deceased person or a person who is incompetent shall be deemed to be valid if accompanied by an authorization in the form required by Section 74.052 signed by a parent, spouse, or adult child of the deceased or incompetent person.

Added by Acts 2003, 78th Leg., ch. 204, Sec. 10.01, eff. Sept. 1, 2003.

Sec. 74.052. AUTHORIZATION FORM FOR RELEASE OF PROTECTED HEALTH INFORMATION. (a) Notice of a health care claim under Section 74.051 must be accompanied by a medical authorization in the form specified by this section. Failure to provide this authorization along with the notice of health care claim shall abate all further proceedings against the physician or health care provider receiving the notice until 60 days following receipt by the physician or health care provider of the required authorization.

(b) If the authorization required by this section is modified or revoked, the physician or health care provider to whom the authorization has been given shall have the option to abate all further proceedings until 60 days following receipt of a replacement authorization that must comply with the form specified by this section.

(c) The medical authorization required by this section shall be in the following form and shall be construed in accordance with the "Standards for Privacy of Individually Identifiable Health Information" (45 C.F.R. Parts 160 and 164).

AUTHORIZATION FORM FOR RELEASE OF PROTECTED HEALTH INFORMATION

Patient Name:_____ Patient Date of Birth:_____

Patient Address:_____

_____ Street_____ City, State, ZIP

Patient Telephone:_____ Patient E-mail:_____

NOTICE TO PHYSICIAN OR HEALTH CARE PROVIDER: THIS AUTHORIZATION FORM HAS BEEN AUTHORIZED BY THE TEXAS LEGISLATURE PURSUANT TO SECTION 74.052, CIVIL PRACTICE AND REMEDIES CODE. YOU ARE REQUIRED TO PROVIDE THE MEDICAL AND BILLING RECORDS AS REQUESTED IN THIS AUTHORIZATION.

A. I, _____ (name of patient or authorized representative), hereby authorize _____ (name of physician or other health care provider to whom the notice of health care claim is directed) to obtain and disclose (within the parameters set out below) the protected health information and associated billing records described below for the following specific purposes (check all that apply):

[ ] To facilitate the investigation and evaluation of

the health care claim described in the accompanying Notice of Health Care Claim.

[ ] Defense of any litigation arising out of the claim made the basis of the accompanying Notice of Health Care Claim.

[ ] Other - Specify:_____

B. The health information to be obtained, used, or disclosed extends to and includes the verbal as well as written and electronic and is specifically described as follows:

1. The health information and billing records in the custody of the physicians or health care providers who have examined, evaluated, or treated _____ (patient) in connection with the injuries alleged to have been sustained in connection with the claim asserted in the accompanying Notice of Health Care Claim.

Names and current addresses of treating physicians or health care providers:

1._____

2._____

3._____

4._____

5._____

6._____

7._____

8._____

This authorization extends to an additional physician or health care provider that may in the future evaluate, examine, or treat _____ (patient) for injuries alleged in connection with the claim made the basis of the attached Notice of Health Care Claim only if the claimant gives notice to the recipient of the attached Notice of Health Care Claim of that additional physician or health care provider;

2. The health information and billing records in the custody of the following physicians or health care providers who have examined, evaluated, or treated _____ (patient) during a period commencing five years prior to the incident made the basis of the accompanying Notice of Health Care Claim.

Names and current addresses of treating physicians or health care providers, if applicable:

1._____

2._____

3._____

4._____

5._____

6._____

7._____

8._____

C. Exclusions

1. Providers excluded from authorization.

The following constitutes a list of physicians or health care providers possessing health care information concerning _____ (patient) to whom this authorization does not apply because I contend that such health care information is not relevant to the damages being claimed or to the physical, mental, or emotional condition of _____ (patient) arising out of the claim made the basis of the accompanying Notice of Health Care Claim. List the names of each physician or health care provider to whom this authorization does not extend and the inclusive dates of examination, evaluation, or treatment to be withheld from disclosure, or state "none":

1._____

2._____

3._____

4._____

5._____

6._____

7._____

8._____

2. By initialing below, the patient or patient's personal or legal representative excludes the following information from this authorization:

_____ HIV/AIDS test results and/or treatment

_____ Drug/alcohol/substance abuse treatment

_____ Mental health records (mental health records do not include psychotherapy notes)

_____ Genetic information (including genetic test

results)

D. The persons or class of persons to whom the patient's health information and billing records will be disclosed or who will make use of said information are:

1. Any and all physicians or health care providers providing care or treatment to _____ (patient);

2. Any liability insurance entity providing liability insurance coverage or defense to any physician or health care provider to whom Notice of Health Care Claim has been given with regard to the care and treatment of _____ (patient);

3. Any consulting or testifying experts employed by or on behalf of _____ (name of physician or health care provider to whom Notice of Health Care Claim has been given) with regard to the matter set out in the Notice of Health Care Claim accompanying this authorization;

4. Any attorneys (including secretarial, clerical, experts, or paralegal staff) employed by or on behalf of _____ (name of physician or health care provider to whom Notice of Health Care Claim has been given) with regard to the matter set out in the Notice of Health Care Claim accompanying this authorization;

5. Any trier of the law or facts relating to any suit filed seeking damages arising out of the medical care or treatment of _____ (patient).

E. This authorization shall expire upon resolution of the claim asserted or at the conclusion of any litigation instituted in connection with the subject matter of the Notice of Health Care Claim accompanying this authorization, whichever occurs sooner.

F. I understand that, without exception, I have the right to revoke this authorization at any time by giving notice in writing to the person or persons named in Section B above of my intent to revoke this authorization. I understand that prior actions taken in reliance on this authorization by a person that had permission to access my protected health information will not be affected. I further understand the consequence of any such revocation as set out in Section 74.052, Civil Practice and Remedies Code.

G. I understand that the signing of this authorization is not a condition for continued treatment, payment, enrollment, or

eligibility for health plan benefits.

H. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal HIPAA privacy regulations.

Name of Patient

_____

Signature of Patient/Personal or Legal Representative

_____

Description of Personal or Legal Representative's Authority

_____

Date

_____

Added by Acts 2003, 78th Leg., ch. 204, Sec. 10.01, eff. Sept. 1, 2003.

Amended by:

Acts 2017, 85th Leg., R.S., Ch. 506 (H.B. 2891), Sec. 1, eff. June 9, 2017.

Acts 2019, 86th Leg., R.S., Ch. 115 (S.B. 1565), Sec. 1, eff. September 1, 2019.

Sec. 74.053. PLEADINGS NOT TO STATE DAMAGE AMOUNT; SPECIAL EXCEPTION; EXCLUSION FROM SECTION. Pleadings in a suit based on a health care liability claim shall not specify an amount of money claimed as damages. The defendant may file a special exception to the pleadings on the ground the suit is not within the court's jurisdiction, in which event the plaintiff shall inform the court and defendant in writing of the total dollar amount claimed. This section does not prevent a party from mentioning the total dollar amount claimed in examining prospective jurors on voir dire or in argument to the court or jury.

Added by Acts 2003, 78th Leg., ch. 204, Sec. 10.01, eff. Sept. 1, 2003.

SUBCHAPTER C. INFORMED CONSENT

Sec. 74.101. THEORY OF RECOVERY. In a suit against a

physician or health care provider involving a health care liability claim that is based on the failure of the physician or health care provider to disclose or adequately disclose the risks and hazards involved in the medical care or surgical procedure rendered by the physician or health care provider, the only theory on which recovery may be obtained is that of negligence in failing to disclose the risks or hazards that could have influenced a reasonable person in making a decision to give or withhold consent. Added by Acts 2003, 78th Leg., ch. 204, Sec. 10.01, eff. Sept. 1, 2003.

Sec. 74.102. TEXAS MEDICAL DISCLOSURE PANEL. (a) The Texas Medical Disclosure Panel is created to determine which risks and hazards related to medical care and surgical procedures must be disclosed by health care providers or physicians to their patients or persons authorized to consent for their patients and to establish the general form and substance of such disclosure.

(b) The disclosure panel established herein is administratively attached to the Texas Department of Health. The Texas Department of Health, at the request of the disclosure panel, shall provide administrative assistance to the panel; and the Texas Department of Health and the disclosure panel shall coordinate administrative responsibilities in order to avoid unnecessary duplication of facilities and services. The Texas Department of Health, at the request of the panel, shall submit the panel's budget request to the legislature. The panel shall be subject, except where inconsistent, to the rules and procedures of the Texas Department of Health; however, the duties and responsibilities of the panel as set forth in this chapter shall be exercised solely by the disclosure panel, and the board or Texas Department of Health shall have no authority or responsibility with respect to same.

(c) The disclosure panel is composed of nine members, with three members licensed to practice law in this state and six members licensed to practice medicine in this state. Members of the disclosure panel shall be selected by the commissioner of health.

(d) At the expiration of the term of each member of the

disclosure panel so appointed, the commissioner shall select a successor, and such successor shall serve for a term of six years, or until his successor is selected. Any member who is absent for three consecutive meetings without the consent of a majority of the disclosure panel present at each such meeting may be removed by the commissioner at the request of the disclosure panel submitted in writing and signed by the chairman. Upon the death, resignation, or removal of any member, the commissioner shall fill the vacancy by selection for the unexpired portion of the term.

(e) Members of the disclosure panel are not entitled to compensation for their services, but each panelist is entitled to reimbursement of any necessary expense incurred in the performance of his duties on the panel, including necessary travel expenses.

(f) Meetings of the panel shall be held at the call of the chairman or on petition of at least three members of the panel. Notwithstanding Chapter 551, Government Code, or any other law, if any member of the panel is physically present at a meeting, any number of the other members of the panel may attend the meeting by use of telephone conference call, videoconferencing, or other similar telecommunication method for purposes of establishing a quorum or voting or for any other meeting purpose allowing a panel member to fully participate in any panel meeting. This subsection applies without regard to the subject matter discussed or considered by the panel at the meeting. A meeting held by telephone conference call, videoconferencing, or other similar telecommunication method:

(1) is subject to the notice requirements applicable to other meetings of the panel;

(2) may not be held unless the notice of the meeting specifies the location of the meeting at which a member of the panel will be physically present;

(3) must be open to the public and audible to the public at the location specified in the notice under Subdivision (2); and

(4) must provide two-way audio communication between all panel members attending the meeting during the entire meeting, and, if the two-way audio communication link with any member

attending the meeting is disrupted at any time, the meeting may not continue until the two-way audio communication link is reestablished.

(g) At the first meeting of the panel each year after its members assume their positions, the panelists shall select one of the panel members to serve as chairman and one of the panel members to serve as vice chairman, and each such officer shall serve for a term of one year. The chairman shall preside at meetings of the panel, and in his absence, the vice chairman shall preside.

(h) Employees of the Texas Department of Health shall serve as the staff for the panel.

Added by Acts 2003, 78th Leg., ch. 204, Sec. 10.01, eff. Sept. 1, 2003.

Amended by:

Acts 2005, 79th Leg., Ch. 1287 (H.B. 2476), Sec. 1, eff. June 18, 2005.

Sec. 74.103. DUTIES OF DISCLOSURE PANEL. (a) To the extent feasible, the panel shall identify and make a thorough examination of all medical treatments and surgical procedures in which physicians and health care providers may be involved in order to determine which of those treatments and procedures do and do not require disclosure of the risks and hazards to the patient or person authorized to consent for the patient.

(b) The panel shall prepare separate lists of those medical treatments and surgical procedures that do and do not require disclosure and, for those treatments and procedures that do require disclosure, shall establish the degree of disclosure required and the form in which the disclosure will be made. Each provision of a disclosure form prepared under this subsection must be made available in English and Spanish.

(c) Lists prepared under Subsection (b) together with written explanations of the degree and form of disclosure shall be published in the Texas Register.

(d) At least annually, or at such other period the panel may determine from time to time, the panel will identify and examine any new medical treatments and surgical procedures that have been

developed since its last determinations, shall assign them to the proper list, and shall establish the degree of disclosure required and the form in which the disclosure will be made. The panel will also examine such treatments and procedures for the purpose of revising lists previously published. These determinations shall be published in the Texas Register.

Added by Acts 2003, 78th Leg., ch. 204, Sec. 10.01, eff. Sept. 1, 2003.

Amended by:

Acts 2005, 79th Leg., Ch. 307 (S.B. 555), Sec. 1, eff. September 1, 2005.

Sec. 74.104. DUTY OF PHYSICIAN OR HEALTH CARE PROVIDER. Before a patient or a person authorized to consent for a patient gives consent to any medical care or surgical procedure that appears on the disclosure panel's list requiring disclosure, the physician or health care provider shall disclose to the patient or person authorized to consent for the patient the risks and hazards involved in that kind of care or procedure. A physician or health care provider shall be considered to have complied with the requirements of this section if disclosure is made as provided in Section 74.105.

Added by Acts 2003, 78th Leg., ch. 204, Sec. 10.01, eff. Sept. 1, 2003.

Sec. 74.105. MANNER OF DISCLOSURE. Consent to medical care that appears on the disclosure panel's list requiring disclosure shall be considered effective under this chapter if it is given in writing, signed by the patient or a person authorized to give the consent and by a competent witness, and if the written consent specifically states the risks and hazards that are involved in the medical care or surgical procedure in the form and to the degree required by the disclosure panel under Section 74.103.

Added by Acts 2003, 78th Leg., ch. 204, Sec. 10.01, eff. Sept. 1, 2003.

Sec. 74.106. EFFECT OF DISCLOSURE. (a) In a suit against a

physician or health care provider involving a health care liability claim that is based on the negligent failure of the physician or health care provider to disclose or adequately disclose the risks and hazards involved in the medical care or surgical procedure rendered by the physician or health care provider:

(1) both disclosure made as provided in Section 74.104 and failure to disclose based on inclusion of any medical care or surgical procedure on the panel's list for which disclosure is not required shall be admissible in evidence and shall create a rebuttable presumption that the requirements of Sections 74.104 and 74.105 have been complied with and this presumption shall be included in the charge to the jury; and

(2) failure to disclose the risks and hazards involved in any medical care or surgical procedure required to be disclosed under Sections 74.104 and 74.105 shall be admissible in evidence and shall create a rebuttable presumption of a negligent failure to conform to the duty of disclosure set forth in Sections 74.104 and 74.105, and this presumption shall be included in the charge to the jury; but failure to disclose may be found not to be negligent if there was an emergency or if for some other reason it was not medically feasible to make a disclosure of the kind that would otherwise have been negligence.

(b) If medical care or surgical procedure is rendered with respect to which the disclosure panel has made no determination either way regarding a duty of disclosure, the physician or health care provider is under the duty otherwise imposed by law.

Added by Acts 2003, 78th Leg., ch. 204, Sec. 10.01, eff. Sept. 1, 2003.

Sec. 74.107. INFORMED CONSENT FOR HYSTERECTOMIES. (a) The disclosure panel shall develop and prepare written materials to inform a patient or person authorized to consent for a patient of the risks and hazards of a hysterectomy.

(b) The materials shall be available in English, Spanish, and any other language the panel considers appropriate. The information must be presented in a manner understandable to a layperson.

(c) The materials must include:

(1) a notice that a decision made at any time to refuse to undergo a hysterectomy will not result in the withdrawal or withholding of any benefits provided by programs or projects receiving federal funds or otherwise affect the patient's right to future care or treatment;

(2) the name of the person providing and explaining the materials;

(3) a statement that the patient or person authorized to consent for the patient understands that the hysterectomy is permanent and nonreversible and that the patient will not be able to become pregnant or bear children if she undergoes a hysterectomy;

(4) a statement that the patient has the right to seek a consultation from a second physician;

(5) a statement that the patient or person authorized to consent for the patient has been informed that a hysterectomy is a removal of the uterus through an incision in the lower abdomen or vagina and that additional surgery may be necessary to remove or repair other organs, including an ovary, tube, appendix, bladder, rectum, or vagina;

(6) a description of the risks and hazards involved in the performance of the procedure; and

(7) a written statement to be signed by the patient or person authorized to consent for the patient indicating that the materials have been provided and explained to the patient or person authorized to consent for the patient and that the patient or person authorized to consent for the patient understands the nature and consequences of a hysterectomy.

(d) The physician or health care provider shall obtain informed consent under this section and Section 74.104 from the patient or person authorized to consent for the patient before performing a hysterectomy unless the hysterectomy is performed in a life-threatening situation in which the physician determines obtaining informed consent is not reasonably possible. If obtaining informed consent is not reasonably possible, the physician or health care provider shall include in the patient's medical records a written statement signed by the physician

certifying the nature of the emergency.

(e) The disclosure panel may not prescribe materials under this section without first consulting with the Texas State Board of Medical Examiners.

Added by Acts 2003, 78th Leg., ch. 204, Sec. 10.01, eff. Sept. 1, 2003.

SUBCHAPTER D. EMERGENCY CARE

Sec. 74.151. LIABILITY FOR EMERGENCY CARE. (a) A person who in good faith administers emergency care is not liable in civil damages for an act performed during the emergency unless the act is wilfully or wantonly negligent, including a person who:

(1) administers emergency care using an automated external defibrillator; or

(2) administers emergency care as a volunteer who is a first responder as the term is defined under Section 421.095, Government Code.

(b) This section does not apply to care administered:

(1) for or in expectation of remuneration, provided that being legally entitled to receive remuneration for the emergency care rendered shall not determine whether or not the care was administered for or in anticipation of remuneration; or

(2) by a person who was at the scene of the emergency because he or a person he represents as an agent was soliciting business or seeking to perform a service for remuneration.

(c), (d) Deleted by Acts 2003, 78th Leg., ch. 204, Sec. 10.01.

(e) Except as provided by this subsection, this section does not apply to a person whose negligent act or omission was a producing cause of the emergency for which care is being administered. This subsection does not apply to liability of a school district or district school officer or employee arising from an act or omission under a program or practice or procedure developed under Subchapter G, Chapter 38, Education Code, other than liability arising from wilful or intentional misconduct.

Acts 1985, 69th Leg., ch. 959, Sec. 1, eff. Sept. 1, 1985. Amended by Acts 1993, 73rd Leg., ch. 960, Sec. 1, eff. Aug. 30, 1993; Acts

1999, 76th Leg., ch. 679, Sec. 2, eff. Sept. 1, 1999. Renumbered from Sec. 74.001 and amended by Acts 2003, 78th Leg., ch. 204, Sec. 10.01, eff. Sept. 1, 2003.

Amended by:

Acts 2007, 80th Leg., R.S., Ch. 705 (H.B. 2117), Sec. 1, eff. June 15, 2007.

Acts 2013, 83rd Leg., R.S., Ch. 1321 (S.B. 460), Sec. 1, eff. September 1, 2013.

Acts 2019, 86th Leg., R.S., Ch. 352 (H.B. 18), Sec. 3.01, eff. December 1, 2019.

Sec. 74.152. UNLICENSED MEDICAL PERSONNEL. Persons not licensed or certified in the healing arts who in good faith administer emergency care as emergency medical service personnel are not liable in civil damages for an act performed in administering the care unless the act is wilfully or wantonly negligent. This section applies without regard to whether the care is provided for or in expectation of remuneration.

Acts 1985, 69th Leg., ch. 959, Sec. 1, eff. Sept. 1, 1985. Renumbered from Sec. 74.002 and amended by Acts 2003, 78th Leg., ch. 204, Sec. 10.01, eff. Sept. 1, 2003.

Sec. 74.153. STANDARD OF PROOF IN CASES INVOLVING EMERGENCY MEDICAL CARE. (a) Except as provided by Subsection (b), 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, in an obstetrical unit, or in a surgical suite immediately following the evaluation or treatment of a patient in a hospital emergency department, the claimant bringing the suit may prove that the treatment or lack of treatment by the physician or health care provider departed from accepted standards of medical care or health care only if the claimant shows by a preponderance of the evidence that the physician or health care provider, with 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.

(b) Subsection (a) does not apply to:

(1) medical care or treatment:

(A) provided after the patient is:

(i) stabilized; and

(ii) receiving medical care or treatment as a nonemergency patient; or

(B) that is unrelated to a medical emergency; or

(2) a physician or health care provider whose negligent act or omission proximately causes a stable patient to require emergency medical care.

Added by Acts 2003, 78th Leg., ch. 204, Sec. 10.01, eff. Sept. 1, 2003.

Amended by:

Acts 2019, 86th Leg., R.S., Ch. 1364 (H.B. 2362), Sec. 1, eff. September 1, 2019.

Sec. 74.154. JURY INSTRUCTIONS IN CASES INVOLVING EMERGENCY MEDICAL CARE. (a) In an action for damages that involves a claim of negligence arising from the provision of emergency medical care in a hospital emergency department or obstetrical unit or in a surgical suite immediately following the evaluation or treatment of a patient in a hospital emergency department, the court shall instruct the jury to consider, together with all other relevant matters:

(1) whether the person providing care did or did not have the patient's medical history or was able or unable to obtain a full medical history, including the knowledge of preexisting medical conditions, allergies, and medications;

(2) the presence or lack of a preexisting physician-patient relationship or health care provider-patient relationship;

(3) the circumstances constituting the emergency; and

(4) the circumstances surrounding the delivery of the emergency medical care.

(b) The provisions of Subsection (a) do not apply to medical care or treatment:

(1) that occurs after the patient is stabilized and is capable of receiving medical treatment as a nonemergency patient;

(2) that is unrelated to the original medical emergency; or

(3) that is related to an emergency caused in whole or in part by the negligence of the defendant.

Added by Acts 2003, 78th Leg., ch. 204, Sec. 10.01, eff. Sept. 1, 2003.

Sec. 74.155. LIABILITY OF PHYSICIANS, HEALTH CARE PROVIDERS, AND FIRST RESPONDERS DURING PANDEMIC. (a) In this section:

(1) "Disaster declaration" means a declaration of a state of disaster or emergency by the president of the United States applicable to the entire state, a declaration of a state of disaster by the governor under Chapter 418, Government Code, for the entire state, and any amendment, modification, or extension of the declaration.

(2) "First responder" has the meaning assigned by Section 421.095, Government Code.

(3) "Pandemic disease" means an infectious disease that spreads to a significant portion of the population of the United States and that poses a substantial risk of a significant number of human fatalities, illnesses, or permanent long-term disabilities.

(b) Except in a case of reckless conduct or intentional, wilful, or wanton misconduct, a physician, health care provider, or first responder is not liable for an injury, including economic and noneconomic damages, or death arising from care, treatment, or failure to provide care or treatment relating to or impacted by a pandemic disease or a disaster declaration related to a pandemic disease if the physician, health care provider, or first responder proves by a preponderance of the evidence that:

(1) a pandemic disease or disaster declaration related to a pandemic disease was a producing cause of the care, treatment, or failure to provide care or treatment that allegedly caused the injury or death; or

(2) the individual who suffered injury or death was diagnosed or reasonably suspected to be infected with a pandemic disease at the time of the care, treatment, or failure to provide care or treatment.

(c) A physician, health care provider, or first responder may not use the showing under Subsection (b)(2) as a defense to liability under Subsection (b) for negligent care, treatment, or failure to provide care or treatment if a claimant proves by a preponderance of the evidence that the respective diagnosis, treatment, or reasonable suspicion of infection with a pandemic disease at the time of the care, treatment, or failure to provide care or treatment was not a producing cause of the individual's injury or death.

(d) Care, treatment, or failure to provide care or treatment relating to or impacted by a pandemic disease or a disaster declaration related to a pandemic disease under Subsection (b) includes:

(1) screening, assessing, diagnosing, or treating an individual who is infected or suspected of being infected with a pandemic disease;

(2) prescribing, administering, or dispensing a drug or medicine for off-label or investigational use to treat an individual who is infected or suspected of being infected with a pandemic disease;

(3) diagnosing or treating an individual who is infected or suspected of being infected with a pandemic disease outside the normal area of the physician's or provider's specialty, if any;

(4) delaying or canceling nonurgent or elective medical, surgical, or dental procedures;

(5) delaying, canceling, or not accepting in-person appointments for office or clinical visits, diagnostic tests, scheduled treatment, physical or occupational therapy, or any other diagnosis or treatment of an illness or condition not related to a pandemic disease;

(6) using medical devices, equipment, or supplies outside of their normal use, including using or modifying such

devices, equipment, or supplies for an unapproved use, to treat an individual who is infected or suspected of being infected with a pandemic disease;

(7) conducting tests on or providing treatment to an individual who is infected or suspected of being infected with a pandemic disease outside the premises of a health care facility;

(8) acts or omissions caused by a lack of personnel or staffing, facilities, medical devices, supplies, or other resources attributable to a pandemic disease that renders a physician, health care provider, or first responder unable to provide the same level or manner of care to any individual that otherwise would have been acquired in the absence of the disease; and

(9) acts or omissions arising from the use or nonuse of personal protective equipment.

(e) This section does not alter the scope of practice of a physician, health care provider, or first responder under the laws of this state.

(f) A defense under this section is in addition to any other defense, immunity, or limitation of liability provided by law. This section does not constitute a waiver of sovereign immunity of this state or governmental immunity of a political subdivision.

(g) A physician, health care provider, or first responder who intends to raise a defense under Subsection (b) must provide to a claimant specific facts that support an assertion under Subsection (b)(1) or (2) not later than the later of:

(1) the 60th day after the date the claimant serves an expert report on the physician, health care provider, or first responder under Section 74.351; or

(2) the 120th day after the date the physician, health care provider, or first responder files an original answer in the suit.

(h) This section applies only to a claim arising from care, treatment, or failure to provide care or treatment that occurred during a period beginning on the date that the president of the United States or the governor makes a disaster declaration related

to a pandemic disease and ending on the date the declaration terminates.

(i) This section does not create a civil cause of action.

Added by Acts 2021, 87th Leg., R.S., Ch. 528 (S.B. 6), Sec. 2, eff. June 14, 2021.

SUBCHAPTER E. RES IPSA LOQUITUR

Sec. 74.201. APPLICATION OF RES IPSA LOQUITUR. The common law doctrine of res ipsa loquitur shall only apply to health care liability claims against health care providers or physicians in those cases to which it has been applied by the appellate courts of this state as of August 29, 1977.

Added by Acts 2003, 78th Leg., ch. 204, Sec. 10.01, eff. Sept. 1, 2003.

SUBCHAPTER F. STATUTE OF LIMITATIONS

Sec. 74.251. STATUTE OF LIMITATIONS ON HEALTH CARE LIABILITY CLAIMS. (a) Notwithstanding any other law and subject to Subsection (b), no health care liability claim may be commenced unless the action is filed within two years from the occurrence of the breach or tort or from the date the medical or health care treatment that is the subject of the claim or the hospitalization for which the claim is made is completed; provided that, minors under the age of 12 years shall have until their 14th birthday in which to file, or have filed on their behalf, the claim. Except as herein provided this section applies to all persons regardless of minority or other legal disability.

(b) A claimant must bring a health care liability claim not later than 10 years after the date of the act or omission that gives rise to the claim. This subsection is intended as a statute of repose so that all claims must be brought within 10 years or they are time barred.

Added by Acts 2003, 78th Leg., ch. 204, Sec. 10.01, eff. Sept. 1, 2003.

Sec. 74.301. LIMITATION ON NONECONOMIC DAMAGES. (a) In an action on a health care liability claim where final judgment is rendered against a physician or health care provider other than a health care institution, the limit of civil liability for noneconomic damages of the physician or health care provider other than a health care institution, inclusive of all persons and entities for which vicarious liability theories may apply, shall be limited to an amount not to exceed $250,000 for each claimant, regardless of the number of defendant physicians or health care providers other than a health care institution against whom the claim is asserted or the number of separate causes of action on which the claim is based.

(b) In an action on a health care liability claim where final judgment is rendered against a single health care institution, the limit of civil liability for noneconomic damages inclusive of all persons and entities for which vicarious liability theories may apply, shall be limited to an amount not to exceed $250,000 for each claimant.

(c) In an action on a health care liability claim where final judgment is rendered against more than one health care institution, the limit of civil liability for noneconomic damages for each health care institution, inclusive of all persons and entities for which vicarious liability theories may apply, shall be limited to an amount not to exceed $250,000 for each claimant and the limit of civil liability for noneconomic damages for all health care institutions, inclusive of all persons and entities for which vicarious liability theories may apply, shall be limited to an amount not to exceed $500,000 for each claimant.

Added by Acts 2003, 78th Leg., ch. 204, Sec. 10.01, eff. Sept. 1, 2003.

Sec. 74.302. ALTERNATIVE LIMITATION ON NONECONOMIC DAMAGES. (a) In the event that Section 74.301 is stricken from this subchapter or is otherwise to any extent invalidated by a method other than through legislative means, the following, subject

to the provisions of this section, shall become effective:

(1) In an action on a health care liability claim where final judgment is rendered against a physician or health care provider other than a health care institution, the limit of civil liability for noneconomic damages of the physician or health care provider other than a health care institution, inclusive of all persons and entities for which vicarious liability theories may apply, shall be limited to an amount not to exceed $250,000 for each claimant, regardless of the number of defendant physicians or health care providers other than a health care institution against whom the claim is asserted or the number of separate causes of action on which the claim is based.

(2) In an action on a health care liability claim where final judgment is rendered against a single health care institution, the limit of civil liability for noneconomic damages inclusive of all persons and entities for which vicarious liability theories may apply, shall be limited to an amount not to exceed $250,000 for each claimant.

(3) In an action on a health care liability claim where final judgment is rendered against more than one health care institution, the limit of civil liability for noneconomic damages for each health care institution, inclusive of all persons and entities for which vicarious liability theories may apply, shall be limited to an amount not to exceed $250,000 for each claimant and the limit of civil liability for noneconomic damages for all health care institutions, inclusive of all persons and entities for which vicarious liability theories may apply, shall be limited to an amount not to exceed $500,000 for each claimant.

(b) Effective before September 1, 2005, Subsection (a) of this section applies to any physician or health care provider that provides evidence of financial responsibility in the following amounts in effect for any act or omission to which this subchapter applies:

(1) at least $100,000 for each health care liability claim and at least $300,000 in aggregate for all health care liability claims occurring in an insurance policy year, calendar year, or fiscal year for a physician participating in an approved

residency program;

(2) at least $200,000 for each health care liability claim and at least $600,000 in aggregate for all health care liability claims occurring in an insurance policy year, calendar year, or fiscal year for a physician or health care provider, other than a hospital; and

(3) at least $500,000 for each health care liability claim and at least $1.5 million in aggregate for all health care liability claims occurring in an insurance policy year, calendar year, or fiscal year for a hospital.

(c) Effective September 1, 2005, Subsection (a) of this section applies to any physician or health care provider that provides evidence of financial responsibility in the following amounts in effect for any act or omission to which this subchapter applies:

(1) at least $100,000 for each health care liability claim and at least $300,000 in aggregate for all health care liability claims occurring in an insurance policy year, calendar year, or fiscal year for a physician participating in an approved residency program;

(2) at least $300,000 for each health care liability claim and at least $900,000 in aggregate for all health care liability claims occurring in an insurance policy year, calendar year, or fiscal year for a physician or health care provider, other than a hospital; and

(3) at least $750,000 for each health care liability claim and at least $2.25 million in aggregate for all health care liability claims occurring in an insurance policy year, calendar year, or fiscal year for a hospital.

(d) Effective September 1, 2007, Subsection (a) of this section applies to any physician or health care provider that provides evidence of financial responsibility in the following amounts in effect for any act or omission to which this subchapter applies:

(1) at least $100,000 for each health care liability claim and at least $300,000 in aggregate for all health care liability claims occurring in an insurance policy year, calendar

year, or fiscal year for a physician participating in an approved residency program;

(2) at least $500,000 for each health care liability claim and at least $1 million in aggregate for all health care liability claims occurring in an insurance policy year, calendar year, or fiscal year for a physician or health care provider, other than a hospital; and

(3) at least $1 million for each health care liability claim and at least $3 million in aggregate for all health care liability claims occurring in an insurance policy year, calendar year, or fiscal year for a hospital.

(e) Evidence of financial responsibility may be established at the time of judgment by providing proof of:

(1) the purchase of a contract of insurance or other plan of insurance authorized by this state or federal law or regulation;

(2) the purchase of coverage from a trust organized and operating under Article 21.49-4, Insurance Code;

(3) the purchase of coverage or another plan of insurance provided by or through a risk retention group or purchasing group authorized under applicable laws of this state or under the Product Liability Risk Retention Act of 1981 (15 U.S.C. Section 3901 et seq.), as amended, or the Liability Risk Retention Act of 1986 (15 U.S.C. Section 3901 et seq.), as amended, or any other contract or arrangement for transferring and distributing risk relating to legal liability for damages, including cost or defense, legal costs, fees, and other claims expenses; or

(4) the maintenance of financial reserves in or an irrevocable letter of credit from a federally insured financial institution that has its main office or a branch office in this state.

Added by Acts 2003, 78th Leg., ch. 204, Sec. 10.01, eff. Sept. 1, 2003.

Sec. 74.303. LIMITATION ON DAMAGES. (a) In a wrongful death or survival action on a health care liability claim where final judgment is rendered against a physician or health care

provider, the limit of civil liability for all damages, including exemplary damages, shall be limited to an amount not to exceed $500,000 for each claimant, regardless of the number of defendant physicians or health care providers against whom the claim is asserted or the number of separate causes of action on which the claim is based.

(b) When there is an increase or decrease in the consumer price index with respect to the amount of that index on August 29, 1977, the liability limit prescribed in Subsection (a) shall be increased or decreased, as applicable, by a sum equal to the amount of such limit multiplied by the percentage increase or decrease in the consumer price index, as published by the Bureau of Labor Statistics of the United States Department of Labor, that measures the average changes in prices of goods and services purchased by urban wage earners and clerical workers' families and single workers living alone (CPI-W: Seasonally Adjusted U.S. City Average--All Items), between August 29, 1977, and the time at which damages subject to such limits are awarded by final judgment or settlement.

(c) Subsection (a) does not apply to the amount of damages awarded on a health care liability claim for the expenses of necessary medical, hospital, and custodial care received before judgment or required in the future for treatment of the injury.

(d) The liability of any insurer under the common law theory of recovery commonly known in Texas as the "Stowers Doctrine" shall not exceed the liability of the insured.

(e) In any action on a health care liability claim that is tried by a jury in any court in this state, the following shall be included in the court's written instructions to the jurors:

(1) "Do not consider, discuss, nor speculate whether or not liability, if any, on the part of any party is or is not subject to any limit under applicable law."

(2) "A finding of negligence may not be based solely on evidence of a bad result to the claimant in question, but a bad result may be considered by you, along with other evidence, in determining the issue of negligence. You are the sole judges of the weight, if any, to be given to this kind of evidence."

Added by Acts 2003, 78th Leg., ch. 204, Sec. 10.01, eff. Sept. 1, 2003.

SUBCHAPTER H. PROCEDURAL PROVISIONS

Sec. 74.351. EXPERT REPORT. (a) In a health care liability claim, a claimant shall, not later than the 120th day after the date each defendant's original answer is filed or a later date required under Section 74.353, serve on that party or the party's attorney one or more expert reports, with a curriculum vitae of each expert listed in the report for each physician or health care provider against whom a liability claim is asserted. The date for serving the report may be extended by written agreement of the affected parties. Each defendant physician or health care provider whose conduct is implicated in a report must file and serve any objection to the sufficiency of the report not later than the later of the 21st day after the date the report is served or the 21st day after the date the defendant's answer is filed, failing which all objections are waived.

(b) If, as to a defendant physician or health care provider, an expert report has not been served within the period specified by Subsection (a), the court, on the motion of the affected physician or health care provider, shall, subject to Subsection (c), enter an order that:

(1) awards to the affected physician or health care provider reasonable attorney's fees and costs of court incurred by the physician or health care provider; and

(2) dismisses the claim with respect to the physician or health care provider, with prejudice to the refiling of the claim.

(c) If an expert report has not been served within the period specified by Subsection (a) because elements of the report are found deficient, the court may grant one 30-day extension to the claimant in order to cure the deficiency. If the claimant does not receive notice of the court's ruling granting the extension until after the applicable deadline has passed, then the 30-day extension shall run from the date the plaintiff first received the notice.

(i) Notwithstanding any other provision of this section, a claimant may satisfy any requirement of this section for serving an expert report by serving reports of separate experts regarding different physicians or health care providers or regarding different issues arising from the conduct of a physician or health care provider, such as issues of liability and causation. Nothing in this section shall be construed to mean that a single expert must address all liability and causation issues with respect to all physicians or health care providers or with respect to both liability and causation issues for a physician or health care provider.

(j) Nothing in this section shall be construed to require the serving of an expert report regarding any issue other than an issue relating to liability or causation.

(k) Subject to Subsection (t), an expert report served under this section:

(1) is not admissible in evidence by any party;

(2) shall not be used in a deposition, trial, or other proceeding; and

(3) shall not be referred to by any party during the course of the action for any purpose.

(l) A court shall grant a motion challenging the adequacy of an expert report only if it appears to the court, after hearing, that the report does not represent an objective good faith effort to comply with the definition of an expert report in Subsection (r)(6).

[Subsections (m)-(q) reserved]

(r) In this section:

(1) "Affected parties" means the claimant and the physician or health care provider who are directly affected by an act or agreement required or permitted by this section and does not include other parties to an action who are not directly affected by that particular act or agreement.

(2) "Claim" means a health care liability claim.

[(3) reserved]

(4) "Defendant" means a physician or health care provider against whom a health care liability claim is asserted.

The term includes a third-party defendant, cross-defendant, or counterdefendant.

(5) "Expert" means:

(A) with respect to a person giving opinion testimony regarding whether a physician departed from accepted standards of medical care, an expert qualified to testify under the requirements of Section 74.401;

(B) with respect to a person giving opinion testimony regarding whether a health care provider departed from accepted standards of health care, an expert qualified to testify under the requirements of Section 74.402;

(C) with respect to a person giving opinion testimony about the causal relationship between the injury, harm, or damages claimed and the alleged departure from the applicable standard of care in any health care liability claim, a physician who is otherwise qualified to render opinions on such causal relationship under the Texas Rules of Evidence;

(D) with respect to a person giving opinion testimony about the causal relationship between the injury, harm, or damages claimed and the alleged departure from the applicable standard of care for a dentist, a dentist or physician who is otherwise qualified to render opinions on such causal relationship under the Texas Rules of Evidence; or

(E) with respect to a person giving opinion testimony about the causal relationship between the injury, harm, or damages claimed and the alleged departure from the applicable standard of care for a podiatrist, a podiatrist or physician who is otherwise qualified to render opinions on such causal relationship under the Texas Rules of Evidence.

(6) "Expert report" means a written report by an expert that provides a fair summary of the expert's opinions as of the date of the report regarding applicable standards of care, the manner in which the care rendered by the physician or health care provider failed to meet the standards, and the causal relationship between that failure and the injury, harm, or damages claimed.

(s) Until a claimant has served the expert report and curriculum vitae as required by Subsection (a), all discovery in a

health care liability claim is stayed except for the acquisition by the claimant of information, including medical or hospital records or other documents or tangible things, related to the patient's health care through:

(1) written discovery as defined in Rule 192.7, Texas Rules of Civil Procedure;

(2) depositions on written questions under Rule 200, Texas Rules of Civil Procedure; and

(3) discovery from nonparties under Rule 205, Texas Rules of Civil Procedure.

(t) If an expert report is used by the claimant in the course of the action for any purpose other than to meet the service requirement of Subsection (a), the restrictions imposed by Subsection (k) on use of the expert report by any party are waived.

(u) Notwithstanding any other provision of this section, after a claim is filed all claimants, collectively, may take not more than two depositions before the expert report is served as required by Subsection (a).

Added by Acts 2003, 78th Leg., ch. 204, Sec. 10.01, eff. Sept. 1, 2003.

Amended by:

Acts 2005, 79th Leg., Ch. 635 (H.B. 2645), Sec. 1, eff. September 1, 2005.

Acts 2013, 83rd Leg., R.S., Ch. 870 (H.B. 658), Sec. 2, eff. September 1, 2013.

Acts 2021, 87th Leg., R.S., Ch. 167 (S.B. 232), Sec. 2, eff. September 1, 2021.

Sec. 74.352. DISCOVERY PROCEDURES. (a) In every health care liability claim the plaintiff shall within 45 days after the date of filing of the original petition serve on the defendant's attorney or, if no attorney has appeared for the defendant, on the defendant full and complete answers to the appropriate standard set of interrogatories and full and complete responses to the appropriate standard set of requests for production of documents and things promulgated by the Health Care Liability Discovery Panel.

(b) Every physician or health care provider who is a defendant in a health care liability claim shall within 45 days after the date on which an answer to the petition was due serve on the plaintiff's attorney or, if the plaintiff is not represented by an attorney, on the plaintiff full and complete answers to the appropriate standard set of interrogatories and complete responses to the standard set of requests for production of documents and things promulgated by the Health Care Liability Discovery Panel.

(c) Except on motion and for good cause shown, no objection may be asserted regarding any standard interrogatory or request for production of documents and things, but no response shall be required where a particular interrogatory or request is clearly inapplicable under the circumstances of the case.

(d) Failure to file full and complete answers and responses to standard interrogatories and requests for production of documents and things in accordance with Subsections (a) and (b) or the making of a groundless objection under Subsection (c) shall be grounds for sanctions by the court in accordance with the Texas Rules of Civil Procedure on motion of any party.

(e) The time limits imposed under Subsections (a) and (b) may be extended by the court on the motion of a responding party for good cause shown and shall be extended if agreed in writing between the responding party and all opposing parties. In no event shall an extension be for a period of more than an additional 30 days.

(f) If a party is added by an amended pleading, intervention, or otherwise, the new party shall file full and complete answers to the appropriate standard set of interrogatories and full and complete responses to the standard set of requests for production of documents and things no later than 45 days after the date of filing of the pleading by which the party first appeared in the action.

(g) If information or documents required to provide full and complete answers and responses as required by this section are not in the possession of the responding party or attorney when the answers or responses are filed, the party shall supplement the answers and responses in accordance with the Texas Rules of Civil Procedure.

(h) Nothing in this section shall preclude any party from taking additional non-duplicative discovery of any other party. The standard sets of interrogatories provided for in this section shall not constitute, as to each plaintiff and each physician or health care provider who is a defendant, the first of the two sets of interrogatories permitted under the Texas Rules of Civil Procedure.

Added by Acts 2003, 78th Leg., ch. 204, Sec. 10.01, eff. Sept. 1, 2003.

Sec. 74.353. PRELIMINARY DETERMINATION FOR EXPERT REPORT REQUIREMENT. (a) On motion of a claimant filed not later than 30 days after the date each defendant's original answer is filed, a court may issue a preliminary determination regarding whether a claim made by the claimant is a health care liability claim for the purposes of Section 74.351.

(b) If a court determines under Subsection (a) or (c) that a claim is a health care liability claim for purposes of Section 74.351, the claimant shall serve an expert report as required by Section 74.351 not later than the later of:

(1) 120 days after the date each defendant's original answer is filed;

(2) 60 days after the date the court issues the preliminary determination under Subsection (a) or (c); or

(3) a date agreed to in writing by the affected parties.

(c) If a court does not issue a preliminary determination under Subsection (a) before the 91st day after the date that a claimant files a motion under that subsection, the court shall issue a preliminary determination that the claim is a health care liability claim for the purposes of Section 74.351.

(d) A preliminary determination under this section is subject to interlocutory appeal by either the claimant or defendant.

(e) If on interlocutory appeal an appellate court reverses a trial court's preliminary determination that a claim is not a health care liability claim, the claimant shall serve an expert

report as required by Section 74.351 not later than 120 days after the date that the appellate court issues an opinion reversing the preliminary determination.

(f) A preliminary determination under this section applies only to the issue of whether a claimant is required to serve an expert report under Section 74.351.

Added by Acts 2021, 87th Leg., R.S., Ch. 167 (S.B. 232), Sec. 3, eff. September 1, 2021.

SUBCHAPTER I. EXPERT WITNESSES

Sec. 74.401. QUALIFICATIONS OF EXPERT WITNESS IN SUIT AGAINST PHYSICIAN. (a) In a suit involving a health care liability claim against a physician for injury to or death of a patient, a person may qualify as an expert witness on the issue of whether the physician departed from accepted standards of medical care only if the person is a physician who:

(1) is practicing medicine at the time such testimony is given or was practicing medicine at the time the claim arose;

(2) has knowledge of accepted standards of medical care for the diagnosis, care, or treatment of the illness, injury, or condition involved in the claim; and

(3) is qualified on the basis of training or experience to offer an expert opinion regarding those accepted standards of medical care.

(b) For the purpose of this section, "practicing medicine" or "medical practice" includes, but is not limited to, training residents or students at an accredited school of medicine or osteopathy or serving as a consulting physician to other physicians who provide direct patient care, upon the request of such other physicians.

(c) In determining whether a witness is qualified on the basis of training or experience, the court shall consider whether, at the time the claim arose or at the time the testimony is given, the witness:

(1) is board certified or has other substantial training or experience in an area of medical practice relevant to

the claim; and

(2) is actively practicing medicine in rendering medical care services relevant to the claim.

(d) The court shall apply the criteria specified in Subsections (a), (b), and (c) in determining whether an expert is qualified to offer expert testimony on the issue of whether the physician departed from accepted standards of medical care, but may depart from those criteria if, under the circumstances, the court determines that there is a good reason to admit the expert's testimony. The court shall state on the record the reason for admitting the testimony if the court departs from the criteria.

(e) A pretrial objection to the qualifications of a witness under this section must be made not later than the later of the 21st day after the date the objecting party receives a copy of the witness's curriculum vitae or the 21st day after the date of the witness's deposition. If circumstances arise after the date on which the objection must be made that could not have been reasonably anticipated by a party before that date and that the party believes in good faith provide a basis for an objection to a witness's qualifications, and if an objection was not made previously, this subsection does not prevent the party from making an objection as soon as practicable under the circumstances. The court shall conduct a hearing to determine whether the witness is qualified as soon as practicable after the filing of an objection and, if possible, before trial. If the objecting party is unable to object in time for the hearing to be conducted before the trial, the hearing shall be conducted outside the presence of the jury. This subsection does not prevent a party from examining or cross-examining a witness at trial about the witness's qualifications.

(f) This section does not prevent a physician who is a defendant from qualifying as an expert.

(g) In this subchapter, "physician" means a person who is:

(1) licensed to practice medicine in one or more states in the United States; or

(2) a graduate of a medical school accredited by the Liaison Committee on Medical Education or the American Osteopathic

Association only if testifying as a defendant and that testimony relates to that defendant's standard of care, the alleged departure from that standard of care, or the causal relationship between the alleged departure from that standard of care and the injury, harm, or damages claimed.

Added by Acts 2003, 78th Leg., ch. 204, Sec. 10.01, eff. Sept. 1, 2003.

Sec. 74.402. QUALIFICATIONS OF EXPERT WITNESS IN SUIT AGAINST HEALTH CARE PROVIDER. (a) For purposes of this section, "practicing health care" includes:

(1) training health care providers in the same field as the defendant health care provider at an accredited educational institution; or

(2) serving as a consulting health care provider and being licensed, certified, or registered in the same field as the defendant health care provider.

(b) In a suit involving a health care liability claim against a health care provider, a person may qualify as an expert witness on the issue of whether the health care provider departed from accepted standards of care only if the person:

(1) is practicing health care in a field of practice that involves the same type of care or treatment as that delivered by the defendant health care provider, if the defendant health care provider is an individual, at the time the testimony is given or was practicing that type of health care at the time the claim arose;

(2) has knowledge of accepted standards of care for health care providers for the diagnosis, care, or treatment of the illness, injury, or condition involved in the claim; and

(3) is qualified on the basis of training or experience to offer an expert opinion regarding those accepted standards of health care.

(c) In determining whether a witness is qualified on the basis of training or experience, the court shall consider whether, at the time the claim arose or at the time the testimony is given, the witness:

(1) is certified by a licensing agency of one or more

states of the United States or a national professional certifying agency, or has other substantial training or experience, in the area of health care relevant to the claim; and

(2) is actively practicing health care in rendering health care services relevant to the claim.

(d) The court shall apply the criteria specified in Subsections (a), (b), and (c) in determining whether an expert is qualified to offer expert testimony on the issue of whether the defendant health care provider departed from accepted standards of health care but may depart from those criteria if, under the circumstances, the court determines that there is good reason to admit the expert's testimony. The court shall state on the record the reason for admitting the testimony if the court departs from the criteria.

(e) This section does not prevent a health care provider who is a defendant, or an employee of the defendant health care provider, from qualifying as an expert.

(f) A pretrial objection to the qualifications of a witness under this section must be made not later than the later of the 21st day after the date the objecting party receives a copy of the witness's curriculum vitae or the 21st day after the date of the witness's deposition. If circumstances arise after the date on which the objection must be made that could not have been reasonably anticipated by a party before that date and that the party believes in good faith provide a basis for an objection to a witness's qualifications, and if an objection was not made previously, this subsection does not prevent the party from making an objection as soon as practicable under the circumstances. The court shall conduct a hearing to determine whether the witness is qualified as soon as practicable after the filing of an objection and, if possible, before trial. If the objecting party is unable to object in time for the hearing to be conducted before the trial, the hearing shall be conducted outside the presence of the jury. This subsection does not prevent a party from examining or cross-examining a witness at trial about the witness's qualifications.

Added by Acts 2003, 78th Leg., ch. 204, Sec. 10.01, eff. Sept. 1,

2003.

Sec. 74.403. QUALIFICATIONS OF EXPERT WITNESS ON CAUSATION IN HEALTH CARE LIABILITY CLAIM. (a) Except as provided by Subsections (b) and (c), in a suit involving a health care liability claim against a physician or health care provider, a person may qualify as an expert witness on the issue of the causal relationship between the alleged departure from accepted standards of care and the injury, harm, or damages claimed only if the person is a physician and is otherwise qualified to render opinions on that causal relationship under the Texas Rules of Evidence.

(b) In a suit involving a health care liability claim against a dentist, a person may qualify as an expert witness on the issue of the causal relationship between the alleged departure from accepted standards of care and the injury, harm, or damages claimed if the person is a dentist or physician and is otherwise qualified to render opinions on that causal relationship under the Texas Rules of Evidence.

(c) In a suit involving a health care liability claim against a podiatrist, a person may qualify as an expert witness on the issue of the causal relationship between the alleged departure from accepted standards of care and the injury, harm, or damages claimed if the person is a podiatrist or physician and is otherwise qualified to render opinions on that causal relationship under the Texas Rules of Evidence.

(d) A pretrial objection to the qualifications of a witness under this section must be made not later than the later of the 21st day after the date the objecting party receives a copy of the witness's curriculum vitae or the 21st day after the date of the witness's deposition. If circumstances arise after the date on which the objection must be made that could not have been reasonably anticipated by a party before that date and that the party believes in good faith provide a basis for an objection to a witness's qualifications, and if an objection was not made previously, this subsection does not prevent the party from making an objection as soon as practicable under the circumstances. The court shall conduct a hearing to determine whether the witness is qualified as

soon as practicable after the filing of an objection and, if possible, before trial. If the objecting party is unable to object in time for the hearing to be conducted before the trial, the hearing shall be conducted outside the presence of the jury. This subsection does not prevent a party from examining or cross-examining a witness at trial about the witness's qualifications.

Added by Acts 2003, 78th Leg., ch. 204, Sec. 10.01, eff. Sept. 1, 2003.

SUBCHAPTER J. ARBITRATION AGREEMENTS

Sec. 74.451. ARBITRATION AGREEMENTS. (a) No physician, professional association of physicians, or other health care provider shall request or require a patient or prospective patient to execute an agreement to arbitrate a health care liability claim unless the form of agreement delivered to the patient contains a written notice in 10-point boldface type clearly and conspicuously stating:

UNDER TEXAS LAW, THIS AGREEMENT IS INVALID AND OF NO LEGAL EFFECT UNLESS IT IS ALSO SIGNED BY AN ATTORNEY OF YOUR OWN CHOOSING. THIS AGREEMENT CONTAINS A WAIVER OF IMPORTANT LEGAL RIGHTS, INCLUDING YOUR RIGHT TO A JURY. YOU SHOULD NOT SIGN THIS AGREEMENT WITHOUT FIRST CONSULTING WITH AN ATTORNEY.

(b) A violation of this section by a physician or professional association of physicians constitutes a violation of Subtitle B, Title 3, Occupations Code, and shall be subject to the enforcement provisions and sanctions contained in that subtitle.

(c) A violation of this section by a health care provider other than a physician shall constitute a false, misleading, or deceptive act or practice in the conduct of trade or commerce within the meaning of Section 17.46 of the Deceptive Trade Practices-Consumer Protection Act (Subchapter E, Chapter 17, Business & Commerce Code), and shall be subject to an enforcement action by the consumer protection division under that act and subject to the penalties and remedies contained in Section 17.47, Business & Commerce Code, notwithstanding Section 74.004 or any

other law.

(d) Notwithstanding any other provision of this section, a person who is found to be in violation of this section for the first time shall be subject only to injunctive relief or other appropriate order requiring the person to cease and desist from such violation, and not to any other penalty or sanction.

Added by Acts 2003, 78th Leg., ch. 204, Sec. 10.01, eff. Sept. 1, 2003.

SUBCHAPTER K. PAYMENT FOR FUTURE LOSSES

Sec. 74.501. DEFINITIONS. In this subchapter:

(1) "Future damages" means damages that are incurred after the date of judgment for:

(A) medical, health care, or custodial care services;

(B) physical pain and mental anguish, disfigurement, or physical impairment;

(C) loss of consortium, companionship, or society; or

(D) loss of earnings.

(2) "Future loss of earnings" means the following losses incurred after the date of the judgment:

(A) loss of income, wages, or earning capacity and other pecuniary losses; and

(B) loss of inheritance.

(3) "Periodic payments" means the payment of money or its equivalent to the recipient of future damages at defined intervals.

Added by Acts 2003, 78th Leg., ch. 204, Sec. 10.01, eff. Sept. 1, 2003.

Sec. 74.502. SCOPE OF SUBCHAPTER. This subchapter applies only to an action on a health care liability claim against a physician or health care provider in which the present value of the award of future damages, as determined by the court, equals or exceeds $100,000.

Added by Acts 2003, 78th Leg., ch. 204, Sec. 10.01, eff. Sept. 1, 2003.

Sec. 74.503. COURT ORDER FOR PERIODIC PAYMENTS. (a) At the request of a defendant physician or health care provider or claimant, the court shall order that medical, health care, or custodial services awarded in a health care liability claim be paid in whole or in part in periodic payments rather than by a lump-sum payment.

(b) At the request of a defendant physician or health care provider or claimant, the court may order that future damages other than medical, health care, or custodial services awarded in a health care liability claim be paid in whole or in part in periodic payments rather than by a lump sum payment.

(c) The court shall make a specific finding of the dollar amount of periodic payments that will compensate the claimant for the future damages.

(d) The court shall specify in its judgment ordering the payment of future damages by periodic payments the:

(1) recipient of the payments;

(2) dollar amount of the payments;

(3) interval between payments; and

(4) number of payments or the period of time over which payments must be made.

Added by Acts 2003, 78th Leg., ch. 204, Sec. 10.01, eff. Sept. 1, 2003.

Sec. 74.504. RELEASE. The entry of an order for the payment of future damages by periodic payments constitutes a release of the health care liability claim filed by the claimant.

Added by Acts 2003, 78th Leg., ch. 204, Sec. 10.01, eff. Sept. 1, 2003.

Sec. 74.505. FINANCIAL RESPONSIBILITY. (a) As a condition to authorizing periodic payments of future damages, the court shall require a defendant who is not adequately insured to provide evidence of financial responsibility in an amount adequate to

assure full payment of damages awarded by the judgment.

(b) The judgment must provide for payments to be funded by:

(1) an annuity contract issued by a company licensed to do business as an insurance company, including an assignment within the meaning of Section 130, Internal Revenue Code of 1986, as amended;

(2) an obligation of the United States;

(3) applicable and collectible liability insurance from one or more qualified insurers; or

(4) any other satisfactory form of funding approved by the court.

(c) On termination of periodic payments of future damages, the court shall order the return of the security, or as much as remains, to the defendant.

Added by Acts 2003, 78th Leg., ch. 204, Sec. 10.01, eff. Sept. 1, 2003.

Sec. 74.506. DEATH OF RECIPIENT. (a) On the death of the recipient, money damages awarded for loss of future earnings continue to be paid to the estate of the recipient of the award without reduction.

(b) Periodic payments, other than future loss of earnings, terminate on the death of the recipient.

(c) If the recipient of periodic payments dies before all payments required by the judgment are paid, the court may modify the judgment to award and apportion the unpaid damages for future loss of earnings in an appropriate manner.

(d) Following the satisfaction or termination of any obligations specified in the judgment for periodic payments, any obligation of the defendant physician or health care provider to make further payments ends and any security given reverts to the defendant.

Added by Acts 2003, 78th Leg., ch. 204, Sec. 10.01, eff. Sept. 1, 2003.

Sec. 74.507. AWARD OF ATTORNEY'S FEES. For purposes of computing the award of attorney's fees when the claimant is awarded

a recovery that will be paid in periodic payments, the court shall:

(1) place a total value on the payments based on the claimant's projected life expectancy; and

(2) reduce the amount in Subdivision (1) to present value.

Added by Acts 2003, 78th Leg., ch. 204, Sec. 10.01, eff. Sept. 1, 2003.