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Comment

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## THE MEDICAL MALPRACTICE CURE: STITCHING TOGETHER THE COLEMAN FACTORS

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### INTRODUCTION

A man enters a hospital for a routine outpatient procedure. All appears to go well, and the man is recovering at home with his wife and children when he begins to feel ill. He returns to the hospital and discovers that he has developed a post-operative infection because of unsterilized tools used during the procedure. The improper sterilization did not result from negligence on the part of a doctor or nurse but rather from the service and maintenance of the equipment used in the sterilization process. The man, a husband and a father, dies because of the infection. His family soon learns that Louisiana jurisprudence may classify the family's claim as one of “malpractice,” sweeping it under the protections of the Louisiana Medical Malpractice Act <sup>1</sup> (“MMA”) and capping recovery at \$500,000. <sup>2</sup>

The average person probably associates “malpractice” with a medical professional erring in a professional capacity. Even scholars recognize that “[t]he significance of the term ‘malpractice’ is that it is used to differentiate \*312 professionals from nonprofessionals for purposes of applying certain statutory limitations of tort liability.” <sup>3</sup> The reality, however, is that medical professional involvement is not a necessary element of “malpractice” under the MMA. <sup>4</sup>

When the Louisiana Legislature enacted the MMA, the Act gave certain advantages to health care providers, including limiting recovery for victims. <sup>5</sup> Because the Act is special legislation and deviates from the general rights of tort victims by limiting a tort victim's recovery, the Act's coverage should be construed strictly. <sup>6</sup> In an effort to assist courts in determining whether an injury constitutes “malpractice” under the MMA, the Louisiana Supreme Court in *Coleman v. Deno* set forth six factors. <sup>7</sup> Unfortunately, those factors have proven insufficient and unreliable as a test for malpractice as they are overly broad and open to varying interpretations. <sup>8</sup> In the hypothetical above, one court may apply the factors to find coverage under the MMA while another court, applying the same factors, may find general tort liability. <sup>9</sup>

Based on this determination between malpractice and general tort liability, the victim either will be limited to \$500,000 in damages or have no limit at all.<sup>10</sup> In light of Louisiana's public policy, which seeks to protect tort victims' right to recovery and construe the MMA strictly, Louisiana courts should adopt a new, narrower test for determining whether an act constitutes "malpractice" under the MMA.

Part I of this Comment discusses the MMA's enactment, including the public policy concerns behind the Act, and details the advantages and disadvantages it entails for both health care providers and tort victims. Part II introduces *Coleman*, the source of the six-factor test, and argues that these factors are an insufficient test for determining malpractice claims in \*313 Louisiana. Part III discusses two Louisiana Supreme Court cases, including the recent decision of *Dupuy v. NMC Operating Company*, as examples of the unpredictability of the *Coleman* factors and of a court's tendency to apply these factors broadly, contrary to Louisiana's public policy on interpreting the MMA. Finally, Part IV recommends legislative action to remedy the test for determining whether a certain claim constitutes malpractice and proposes an alteration of the *Coleman* factors as an interim solution for Louisiana courts.

## I. THE ENACTMENT OF THE MMA: THE ACT'S PROTECTIONS AND PURPOSES

The Louisiana Legislature enacted the MMA in 1975 in an effort to "stabilize medical malpractice insurance rates and to assure the availability of affordable medical services to the public."<sup>11</sup> The Legislature attempted to accomplish these goals by reducing the number of medical malpractice lawsuits being filed and damages being awarded.<sup>12</sup> In furtherance of this effort, the MMA provides certain advantages to qualified "health care providers"<sup>13</sup> in malpractice actions. First, the Act provides a statutory limit \*314 to recovery of \$500,000 "for all malpractice<sup>14</sup> claims for injuries to or death of a patient, exclusive of future medical care and related benefits."<sup>15</sup> Second, it requires that malpractice claims filed against health care providers covered by the MMA be reviewed by a medical review panel before the suit may be brought in a court of law.<sup>16</sup> The medical review panel consists of three Louisiana-licensed health care providers and one non-voting attorney chair-person.<sup>17</sup> The purpose of the panel is "to express its expert opinion as to whether or not the evidence supports the conclusion that the defendant or defendants acted or failed to act within the appropriate standards of care."<sup>18</sup> Once the panel issues its opinion, the plaintiff chooses whether to file a lawsuit.<sup>19</sup> If the case goes to trial and the court determines that medical malpractice occurred, recovery still is limited by the damages cap.<sup>20</sup> These protections were enacted in response \*315 to a perceived insurance crisis, but the Act, as well as the reasoning behind its enactment, continue to be questioned.<sup>21</sup>

### A. The Insurance Crisis

The Louisiana Legislature enacted the MMA in response to what many of its proponents referred to as the "insurance crisis" of the 1970s.<sup>22</sup> Nationally, malpractice insurance premiums were rising drastically as commercial insurers withdrew from covering medical liability.<sup>23</sup> In Louisiana alone, four medical malpractice insurance companies abandoned the market, leaving the state with only two providers.<sup>24</sup> As a result, insurance premiums increased by as much as 300% in Louisiana.<sup>25</sup> Commentators blamed the crisis on excessive damage awards and rising medical malpractice insurance costs.<sup>26</sup> Proponents of medical malpractice reform statutes, such as Louisiana's MMA, argued that large jury awards were causing insurance premium increases.<sup>27</sup> Others, however, believed that jury awards had nothing to do with increases.<sup>28</sup> Rather, actuaries believed the increases were a result of normal actuarial cycles.<sup>29</sup>

Decades after the purported crisis, the Louisiana Fourth Circuit Court of Appeal found in *Whitnell v. Silverman* that the Legislature enacted the \*316 Act without the benefit of actuarial evidence specifically applicable to Louisiana's

situation in 1975.<sup>30</sup> In fact, the court found it likely that such increases were part of the normal actuarial cycle and did not warrant legislative action in 1975.<sup>31</sup> This finding was based on testimony of actuary Robert E. Lowe, who testified that the insurance industry undergoes regular ten-year cycles.<sup>32</sup> A so-called “crisis” occurs every ten years because insurance companies purposefully underprice the premiums in order to cause these “crises.”<sup>33</sup> Lowe further testified that “[t]he insurance industry likes to use the term ‘crisis’ because ‘they like to get the sympathy of the consumer to support their efforts.’”<sup>34</sup> Mr. Lowe questioned the Legislature's basis for enacting the MMA, stating that “in 1975 and prior thereto, medical malpractice insurance statistics were not separately compiled or required to be separately reported to the Insurance Commissioner's Office. Thus there was no Louisiana medical malpractice information available at the time that the statute was passed.”<sup>35</sup> With critics \*317 questioning the reasoning behind the act's enactment, scholars also began questioning its constitutionality.<sup>36</sup>

### ***B. The Constitutionality of the Act***

Regardless of whether the Act's enactment was justified from a policy perspective, it has been subject to much constitutional scrutiny.<sup>37</sup> As recently as 2006, the Louisiana Third Circuit Court of Appeal in *Arrington v. ER Physicians Group, APMC* held the MMA's damages cap unconstitutional under the state constitution's “adequate remedy” clause.<sup>38</sup> The court reasoned that the cap, enacted in 1975 and never adjusted for inflation, no longer provided an injured patient with a sufficient remedy.<sup>39</sup> When the Third Circuit \*318 adjusted the statutory \$500,000 cap for inflation, that amount was only worth \$160,000.<sup>40</sup> The court noted that it did not stand alone in finding a cap unconstitutional, citing cases invalidating similar damages limitations in five other states.<sup>41</sup>

Commentators have argued that the MMA's cap on damages also violates the Louisiana Constitution's equal protection clause.<sup>42</sup> The central argument of these commentators is that the cap divides injured patients into two categories: those who can receive an adequate remedy and those who cannot.<sup>43</sup> In fact, the more severe a victim's injuries, the less likely the victim is to recover fully.<sup>44</sup> For instance, a man whose arm is broken due to malpractice and who subsequently is awarded \$10,000 by a jury will recover his losses fully as determined by the jury. A man who is left paralyzed due to malpractice and who is awarded \$1 million by a jury, however, will be able to recover only half of his award. The greater the jury award exceeds the \$500,000 cap, the more the injured patient ultimately loses.<sup>45</sup>

Louisiana courts emphasize that, because the MMA limits tort liability for qualified health care providers, it is “in derogation of the rights of tort victims, and as such, the coverage of the [A]ct should be strictly construed.”<sup>46</sup> In addition, the MMA must be construed strictly when considering the law's questionable enactment purpose, its repeated constitutional challenges, and its limitations on a tort victim's ability to recover damages fully.<sup>47</sup> Despite the necessity of strict application, the *Coleman* factors do not lead to strict construction of the MMA; rather, the factors are easily manipulated.

## **II. THE ORIGIN OF THE COLEMAN FACTORS**

In 2002, the Louisiana Supreme Court provided six factors for courts to consider when determining whether certain conduct by a qualified \*319 health care provider constitutes malpractice as defined under the MMA.<sup>48</sup> In *Coleman v. Deno*, a 32-year-old man alleged that “patient dumping”<sup>49</sup> caused the defining delay that resulted in the need to amputate his arm to save his life.<sup>50</sup> Deciding whether this act of negligence, the alleged patient dumping, constituted “malpractice,” the Court contemplated the meaning of the MMA's definition of “malpractice.”<sup>51</sup> The MMA defines

malpractice as “any unintentional tort or any breach of contract based on health care or professional services rendered, or which should have been rendered, by a health care provider, to a patient ....”<sup>52</sup> The Act then defines a “tort” as “any breach of duty or any negligent act or omission proximately causing injury or damage to another.”<sup>53</sup> Finally, “health care,” as used in the definition of “malpractice,” is defined as “any act or treatment performed or furnished, or which 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.”<sup>54</sup> In addition to the legislative definition of “malpractice,” the Court considered three factors previously used in making malpractice determinations,<sup>55</sup> as well as three additional factors, thus providing the six factors now known as the *Coleman* factors.<sup>56</sup>

The first three factors originally were introduced in *Sewell v. Doctors Hospital*, but were not conceived by the Court.<sup>57</sup> Rather, the factors were derived from an American Law Report (“ALR”).<sup>58</sup> The first factor is “whether the particular wrong is ‘treatment related’ or caused by a dereliction of professional skill.”<sup>59</sup> The second factor is “whether the wrong requires expert medical evidence to determine whether the \*320 appropriate standard of care was breached.”<sup>60</sup> The third factor is “whether the pertinent act or omission involved assessment of the patient's condition.”<sup>61</sup>

The three additional factors came from a later version of the same annotation,<sup>62</sup> which make up the fourth, fifth, and sixth *Coleman* factors. The fourth factor is “whether an incident occurred in the context of a physician-patient relationship, or was within the scope of activities which a hospital is licensed to perform.”<sup>63</sup> The fifth factor is “whether the injury would have occurred if the patient had not sought treatment.”<sup>64</sup> Lastly, the sixth factor is “whether the tort alleged was intentional.”<sup>65</sup>

The ALR, from which the factors were derived, consists of annotations on a variety of legal topics that generally are used by attorneys to learn about an unfamiliar area of law quickly.<sup>66</sup> These annotations are written by attorneys across the country and include a full explanation of the topic along with relevant cases from every jurisdiction.<sup>67</sup> Thus, these factors, adopted word-for-word from an annotation on medical malpractice, are not tailored to Louisiana, its public policy concerns, or Louisiana's MMA.<sup>68</sup> Instead, these factors are an accumulation of arguments made by \*321 courts across the country when determining whether a claim constitutes malpractice under that particular state's medical malpractice law.<sup>69</sup>

Because these factors are not tailored to Louisiana, each factor fails to consider Louisiana's public policy of protecting tort victims' rights. The factors also represent a national interpretation of what “malpractice” means rather than the Louisiana Legislature's intended definition of the term. Thus, the arbitrary use of the ALR factors has resulted in unpredictable malpractice determinations by Louisiana courts.

### III. THE UNRELIABLE AND UNPREDICTABLE NATURE OF THE *COLEMAN* FACTORS

Following *Coleman*, Louisiana courts continue to use the six factors to evaluate whether a plaintiff's claim constitutes malpractice under the MMA.<sup>70</sup> Because of the Legislature's broad and elaborate definitions within the MMA, courts likely viewed the *Coleman* factors as a simpler, more efficient test. But an enumerated list is not better than a structured, published definition--especially when that list is not tailored to Louisiana and is as broad as the text of the MMA. In light of the factors' foundation, it is no surprise that their application has been unsuccessful in Louisiana. Because of the broad wording, there are instances when Louisiana courts have majority and dissenting opinions that apply the same six factors and reach different conclusions.<sup>71</sup> For example, the Louisiana Supreme Court did just that in *LaCoste v. Pendleton Methodist Hospital, L.L.C.*

### A. *LaCoste v. Pendleton Methodist Hospital, L.L.C.*

*LaCoste v. Pendleton Methodist Hospital* involved a claim by a patient's surviving family members after the patient, who was on life support at Pendleton Methodist Hospital, died during a power outage \*322 following Hurricane Katrina.<sup>72</sup> Chief Justice Calogero began his opinion by reiterating that the MMA “applie[s] only and strictly to cases of medical malpractice ... because the [MMA] limitations on such liability were created by special legislation in derogation of the general rights of Louisiana tort victims.”<sup>73</sup> After establishing that the hospital was a “qualified health care provider,” the Court proceeded to apply the *Coleman* factors, ultimately concluding that the claims against the hospital did not constitute malpractice but fell under general negligence.<sup>74</sup> In reversing the court of appeals' holding that these claims were malpractice under the MMA, the Court reiterated that the MMA limitations apply strictly to claims arising from medical malpractice.<sup>75</sup> Thus, the claim did not have to be presented to a medical review panel, and the plaintiffs' relief was not subject to the \$500,000 cap.<sup>76</sup> Justice Weimer agreed with Justice Knoll's dissent, which applied the *Coleman* factors more broadly to reach the opposite conclusion.<sup>77</sup>

In *LaCoste*, the plaintiffs alleged negligent and intentional acts by the defendant in

designing, constructing and/or maintaining a facility in such a manner that the hospital did not have sufficient emergency power to sustain life support systems ... by designing, constructing and/or maintaining a facility in such a manner that allowed flood waters to enter the structure, thus endangering the safety of the patients ... failure to implement an adequate evacuation plan ... failure to have a facility available for transfer of patients ... failure \*323 to have in place a plan to transfer patients in the event of mandatory evacuation.<sup>78</sup>

Evaluating the plaintiffs' claims, the Court interpreted each *Coleman* factor in favor of general tort liability, enabling the plaintiffs to file their claim in a court of law immediately without being subject to a medical review panel.

Regarding the first factor, “whether the particular wrong is ‘treatment related’ or caused by a dereliction of professional skill,”<sup>79</sup> the Court rejected the appellate court's reasoning that “the lack of sufficient back-up power is akin to a failure to have adequate equipment and, thus, a failure to provide medical treatment.”<sup>80</sup> Instead, the majority found that the allegations did not relate to “medicine, medical care, or medical treatment.”<sup>81</sup> The Court reasoned that the language used, such as “designing,” “constructing,” and “maintaining,” all suggested issues of premises liability or general negligence but not a dereliction of a professional medical skill.<sup>82</sup>

Conversely, Justice Knoll's dissent argued that “[b]ecause the wrong alleged is the failure to provide the proper ventilation care ... the allegations do relate to the patient's treatment and an alleged dereliction of the professional skill.”<sup>83</sup> In her opinion, it was “overly simplistic” to find that the plaintiffs rested their allegations on the power failure alone.<sup>84</sup> She argued that it was improper to restrict the application of the factor to the lack of power.<sup>85</sup> She instead thought it was appropriate to extend the application to the result of what the lack of electricity caused--the failure to provide treatment.<sup>86</sup>

In addressing the second factor, “whether the wrong requires expert medical evidence to determine whether the appropriate standard of care was breached,”<sup>87</sup> the Court found that, although the details of a hospital emergency

evacuation plan may call for expert medical evidence in some scenarios, the allegations at hand did not require such expert medical evidence.<sup>88</sup> The claims simply did not contain any allegations against \*324 “individuals with medical training, such as doctors and nurses, who failed to exercise proper medical skills or procedures.”<sup>89</sup>

Justice Knoll, however, found much significance in the uniqueness of health care emergency preparedness.<sup>90</sup> She argued that, because of the specialized nature of a hospital emergency plan, medical experts likely would be necessary to determine the appropriate standard of care in implementing the particular emergency plan.<sup>91</sup> She also argued that “only physicians can issue transfer and acceptance orders, and negligence regarding transfer decisions and planning in evacuations likely cannot be established without expert medical testimony.”<sup>92</sup>

In analyzing the third factor, “whether the pertinent act or omission involved assessment of the patient's condition,”<sup>93</sup> the Court recognized the defendant's argument that “the failure-to-evacuate contention and the failure-to-transfer contention [were] simply other ways of saying that the hospital was negligent in admitting and treating [Mrs. LaCoste].”<sup>94</sup> The Court found this argument unconvincing and determined that the plaintiffs' petition did not make a “failure to treat” allegation.<sup>95</sup> Based on the plaintiffs' claims, the Court concluded that “determin[ing] whether sufficient emergency power would be available or an evacuation plan should be implemented” did not require the assessment of Mrs. LaCoste's condition.<sup>96</sup>

Once again, Justice Knoll viewed the application of the factors differently. She found that, despite the wording of the allegations, “the alleged wrongdoing inherently involved a medical assessment and evaluation of Mrs. LaCoste's condition.”<sup>97</sup> Justice Knoll discussed how decisions regarding transportation of patients “necessarily includes an assessment of the patient's condition.”<sup>98</sup> In her broad interpretation of the allegations, Justice Knoll expanded the plaintiffs' claims to include allegations that were not made.<sup>99</sup> The issues at hand dealt with the building itself and the hospital's preparedness.<sup>100</sup> Mrs. LaCoste's ventilator stopped \*325 running because power was lost and the hospital's emergency plans were insufficient.<sup>101</sup> Plaintiffs did not make allegations against a doctor who failed to transfer Mrs. LaCoste.<sup>102</sup>

Regarding the fourth factor, “whether an incident occurred in the context of a physician-patient relationship, or was within the scope of activities which a hospital is licensed to perform,”<sup>103</sup> the hospital asserted that “attempting to preserve the life of a patient is an activity that a hospital is exclusively licensed to perform.”<sup>104</sup> The Court disagreed as “there [was] no allegation in the petition that a medical decision by any physician or nurse resulted in the failure to transfer this patient and that such failure resulted in her death.”<sup>105</sup> The Court concluded that the claims alleged did not involve a physician-patient relationship.<sup>106</sup>

Justice Knoll, against the majority's repeated warnings to avoid applying the factors so broadly, continued to look beyond the actual claims.<sup>107</sup> Instead of looking at the allegations of the plaintiffs, she expanded them into “failure to transport” and “failure to provide treatment.”<sup>108</sup> By transforming these allegations, she was able to argue that “[p]hysicians are exclusively licensed” to make decisions regarding transfers and that “[i]t is the failure of the treatment and care for which the hospital was licensed to perform that is at issue in this case and weighs this factor in favor the defendant's position.”<sup>109</sup>

When analyzing the fifth factor, “whether the injury would have occurred if the patient had not sought treatment,”<sup>110</sup> the Court recognized the difficulty in evaluating the factor because “any wrong that a patient suffers in a hospital or

doctor's office would not occur if the patient had not first entered the facility.”<sup>111</sup> Instead of using this type of “but-for” rationale, the Court applied this factor in relation to its determination of the other *Coleman* factors. The Court reasoned that, because it found the allegations were not treatment-related, it could not interpret this factor reasonably in favor of malpractice.<sup>112</sup> Conversely, Justice Knoll did apply \*326 a “but-for” rationale and found that “[i]f Mrs. LaCoste had not been taken to the hospital for treatment of pneumonia and placement on a ventilator, she would not have been subject to the alleged failure of lifesaving care.”<sup>113</sup>

The sixth factor, “whether the tort alleged was intentional,”<sup>114</sup> proved to be of no significance in this case. The majority and Justice Knoll agreed that the sixth factor was irrelevant considering that there was no allegation of intentional wrongdoing.<sup>115</sup>

*LaCoste* is a prime example of the uncertainty and unreliability of the *Coleman* factors. The same Court, analyzing the same set of facts, applied each factor to reach wholly contradictory conclusions. Though the majority applied the factors narrowly, in accordance with public policy, the dissent applied them broadly to find “malpractice” under the MMA. Furthermore, the *LaCoste* decision is not unique in its conflicting analysis.<sup>116</sup> Often, a majority applying the *Coleman* factors narrowly wrestles with a dissent undermining its entire argument with a broad application.<sup>117</sup> Still, other cases involve no dissent and, instead, a broad application of the factors prevails.<sup>118</sup> This broad application, as exemplified in *Dupuy v. NMC Operating Co., L.L.C.*, is contrary to Louisiana's public policy and demonstrates the need for a new malpractice test. In fact, even without a dissent exposing the flaws of such an application, the factors' glaring unreliability still shines through.

### **B. Dupuy v. NMC Operating Co., L.L.C.**

In March 2016, the Louisiana Supreme Court decided *Dupuy v. NMC Operating Co., L.L.C.*, which proved to be an example of a broad application of the *Coleman* factors.<sup>119</sup> A patient of the Spine Hospital of Louisiana, Richard Dupuy, allegedly developed a post-operative infection following spine surgery.<sup>120</sup> Dupuy claimed that the hospital had failed to “properly maintain and service equipment utilized in the sterilization of surgical \*327 instruments.”<sup>121</sup> The hospital filed a dilatory exception of prematurity,<sup>122</sup> arguing that the claim fell under the MMA and thus first needed to be heard by a medical review panel.<sup>123</sup>

The district court disagreed with the hospital, finding that the claim should be governed by general tort liability.<sup>124</sup> Following the First Circuit Court of Appeal's denial of the hospital's writ, the Louisiana Supreme Court granted the writ and reversed the trial court's decision.<sup>125</sup> After establishing that the hospital was a “qualified health care provider” as required by the MMA, the Court applied each *Coleman* factor and concluded that the plaintiffs' allegation of improper maintenance constituted medical malpractice under the MMA.<sup>126</sup>

Analyzing the first *Coleman* factor, the Court determined Dupuy's claim was “treatment related.”<sup>127</sup> The Court cited cases in which “infectious diseases acquired during surgical procedures [were considered] ‘treatment related.’”<sup>128</sup> The Court found that a hospital's “alleged failure to ‘properly maintain and service all equipment used in the sterilization process’ is an extension of the general duty to render professional services related to medical treatment and is ‘treatment related.’”<sup>129</sup> The claims of the *Dupuy* case and those cases cited are distinguishable, however. Unlike the cases cited by the Court,<sup>130</sup> Dupuy's claim was not of negligence on behalf of the doctor or nurses in failing to sterilize equipment; rather, Dupuy's claim concerned the hospital's failure to properly maintain and service sterilization equipment.<sup>131</sup>

Failing to maintain and service hospital equipment has been found in other cases not to be “treatment related” but to fall under general tort liability.<sup>132</sup> Thus, Dupuy's claim of failure to maintain and service \*328 sterilization equipment should have resulted in tort liability, as it was more aligned with cases like *Blevins v. Hamilton Medical Center* and *Williamson v. Hospital Service District No. 1*.<sup>133</sup> Those cases involved allegations of failing to maintain and repair equipment properly within the hospital, namely a hospital bed and a wheelchair.<sup>134</sup> Finding that such maintenance and repair were not related directly to actual treatment of the patient, the Court concluded in both cases that those actions could not be considered malpractice.<sup>135</sup>

In *Blevins*, the Court found that poor maintenance of the hospital bed, which resulted in a knee injury, was completely distinct from the treatment the patient received for his infection.<sup>136</sup> Similarly, the failure to maintain the sterilization equipment was distinct from Dupuy's surgery. Such maintenance occurred before Dupuy ever entered the hospital and could have affected any other patient receiving care at the hospital. In *Dupuy*, the Court ignored the substance of the plaintiff's claim and instead looked at the injury--an infection--to align the case with other jurisprudence.<sup>137</sup>

A Louisiana First Circuit Court of Appeal case, *Cashio v. Baton Rouge General Hospital*, arguably supports the majority's opinion in *Dupuy*.<sup>138</sup> In *Cashio*, the court held that “treatment” includes “the furnishing of a clean and \*329 sterile environment for all patients.”<sup>139</sup> The *Dupuy* Court found that “proper sterilization of surgical instruments is at the very core of the ‘treatment’ of a patient.”<sup>140</sup> The problem with this comparison, however, is that Dupuy's claim is not one of proper sterilization but one of proper maintenance and service of hospital equipment.<sup>141</sup>

Regarding “whether the wrong requires expert medical evidence to determine whether the appropriate standard of care was breached,”<sup>142</sup> the *Dupuy* Court concluded that expert medical testimony was necessary because “whether instruments were in fact properly sterilized is a question that requires medical expertise.”<sup>143</sup> Again, the Court focused on sterilization, providing an example of a medical expert being needed to explain the protocol of such maintenance.<sup>144</sup> The issue, however, was not simply whether the equipment was sterilized; rather, Dupuy's claim was for failure to maintain and service sterilization equipment.<sup>145</sup>

The Court in *Williamson* recognized that expert testimony may be required to establish the duty to maintain a wheelchair and the breach of that duty.<sup>146</sup> The Court, however, found that such evidence need not be medical.<sup>147</sup> Expert testimony is not the same as expert medical testimony. Thus, *Dupuy* is more aligned with *Williamson* in the respect that although expert evidence may be put forth, that evidence need not be supplied by a medical expert. The plaintiffs in *Dupuy* alleged that the service and maintenance was done by “plant operations.”<sup>148</sup> No expert medical evidence would be necessary to establish the proper standard of care in maintaining and servicing the sterilization equipment.

The Court did not address the third factor, “whether the pertinent act or omission involved assessment of the patient's condition,” or the sixth factor, “whether the tort alleged was intentional.”<sup>149</sup> Instead, it briefly mentioned in a footnote that it would not address these factors because the “parties agree that factors three and six do not have relevance in this case.”<sup>150</sup> This decision by the Court is confusing because the maintenance and service of sterilization \*330 equipment did not involve the assessment of the patient's condition in any way. Thus, the third factor likely would have favored the plaintiffs in this case.

The Court next addressed the fourth factor, “whether an incident occurred in the context of a physician-patient relationship, or was within the scope of activities which a hospital is licensed to perform.”<sup>151</sup> The Court discussed the Hospital Licensing Law, enacted in 1961, which “directed the Department of Health and Hospitals to adopt ‘rules,

regulations, and minimum standards' that must be met by every licensed hospital.”<sup>152</sup> Among the standards listed are those relating to “sanitary conditions, practices and environment and sanitary and sterilization procedures and practices designed to avoid sources and transmission of infections, including regulations governing the isolation of patients with communicable diseases.”<sup>153</sup> The Court found that this statute required hospitals to have clearly established sterilization procedures to maintain operating licenses.<sup>154</sup> The problem with this finding is that Dupuy's claim was not an allegation of improper hospital procedures, nor was it an allegation of improper adherence to the hospital's procedure. The allegation was that, despite having a procedure in place for properly sterilizing equipment and following that procedure, the hospital failed to service and maintain that equipment properly.

In a footnote, the Court found that, although the parties to the suit argued about the second element of the factor, the incident also “occurred in the context of a physician-patient relationship.”<sup>155</sup> Because the exact source of Dupuy's infection had not yet been determined, the Court found that the “incident” that caused the infection was ultimately the surgery itself, regardless of the origin of the initial source.<sup>156</sup> The “incident,” however, which is the subject of the claim, was the maintenance and service failure.<sup>157</sup> The first element of this factor likely was not discussed by either party because it did not seem plausible that the service and maintenance of sterilization equipment would be considered within the context of a physician-patient relationship because those actions occur before a patient even enters a hospital.

In analyzing the fifth factor, “whether the injury would have occurred if the patient had not sought treatment,”<sup>158</sup> the Court found this factor clearly favored the hospital because Dupuy's injury occurred during the treatment \*331 period.<sup>159</sup> Similarly to Justice Knoll's dissent in *LaCoste*,<sup>160</sup> the Court applied a “but-for” standard that would be difficult to overcome on any set of facts--of course a patient will not suffer the injury if he never seeks treatment at the hospital. Therefore, using a “but-for” standard always will favor the plaintiff. Consequently, with all factors leaning in favor of “malpractice,” the Court held that Dupuy's claim fell within the scope of the MMA.<sup>161</sup>

The *Coleman* factors' susceptibility to dissimilar applications of similar facts demonstrates their unpredictable and unreliable nature. Factors used to determine malpractice should result only in a narrow application of the MMA consistent with Louisiana's public policy concern for tort victims' ability to recover. The commonly used *Coleman* factors provide an insufficient means of determining whether claims constitute malpractice under the MMA. Recognizing their insufficiency, several Louisiana courts have chosen not to apply the factors in post-*Coleman* decisions.<sup>162</sup> Thus, in light of these apparent issues of inconsistency in applying the law and veering away from established public policy, a solution to this problem is necessary.

#### IV. THE MEDICAL MALPRACTICE CURE

Because of Louisiana's concern with denying tort victims full recovery,<sup>163</sup> the Louisiana Legislature should provide courts with a reliable test for determining whether a claim constitutes malpractice under the MMA. Although the Louisiana Supreme Court attempted to solidify the malpractice analysis by implementing the *Coleman* factors, that attempt was in vain. As a statutorily governed area of law, defining “malpractice” entails much more than establishing an easy-to-apply test. To prevent divergent opinions, courts need more than broad definitions for guidance when dealing with complicated and specific facts. The Legislature should provide Louisiana courts with a narrow definition of malpractice that construes the MMA strictly. This definition should explain clearly what claims constitute malpractice so that Louisiana courts can make these determinations with consistency.

As an intermediate solution, Louisiana courts deciding malpractice claims should apply an altered version of the current *Coleman* factors that emphasizes a narrow application. The first *Coleman* factor should be altered \*332 from “whether the particular wrong is ‘treatment related’ or caused by a dereliction of professional skill”<sup>164</sup> to “whether the particular

wrong alleged is related to the treatment the patient received or caused by a dereliction of professional skill.” Including the word “alleged” will steer the courts toward focusing on the actual allegations before them. Modifying a plaintiff’s allegations, as was done in *Dupuy* and in Justice Knoll’s *LaCoste* dissent,<sup>165</sup> is not the duty of the courts. Rather, courts must focus on the language of the plaintiff’s allegations, and to not do so is insupportable.<sup>166</sup> Moreover, amending the phrase “treatment related” to “related to the treatment that patient received” will help the court focus on the particular patient’s actual treatment rather than going down the chain of causation as Justice Knoll did in *LaCoste*.<sup>167</sup>

The second *Coleman* factor should be amended from “whether the wrong requires expert medical evidence to determine whether the appropriate standard of care was breached”<sup>168</sup> to “whether the wrong alleged requires expert medical evidence to determine whether the appropriate standard of care was breached.” Again, incorporating “alleged” will help the courts focus on the actual claim presented. This change will aid in preventing scenarios similar to that of *LaCoste*, in which Justice Knoll discussed the need for expert medical evidence in determining the standard of care for transferring patients when “failure to transfer” was not the plaintiff’s claim.<sup>169</sup> Further, placing emphasis on the medical nature of expert testimony will remind the court that a medical expert, rather than any individual employed by a hospital, must be required.<sup>170</sup>

The third factor, “whether the pertinent act or omission involved assessment of the patient’s condition,”<sup>171</sup> should be amended to “whether the alleged act or omission occurred as part of the assessment of the patient’s condition.” Once again, replacing “pertinent” with “alleged” will help the court focus on the actual claim in the case. Additionally, substituting “involved” with “occurred as part of” stresses that the “act or omission” needs to be part of assessing the patient--not merely somehow involved in the eventual care of the patient.

**\*333** The fourth factor, “whether an incident occurred in the context of a physician-patient relationship, or was within the scope of activities which a hospital is licensed to perform,”<sup>172</sup> should be modified to read “whether the alleged incident occurred in the context of the physician-patient relationship, or was within the scope of activities which a hospital is licensed to perform.” Inserting “alleged” ensures yet again that the court’s focus remains on the actual claim at hand.

The fifth factor, “whether the injury would have occurred if the patient had not sought treatment,”<sup>173</sup> should be removed altogether. As the Court has discussed, this factor suggests a “but-for” analysis that almost always will be satisfied.<sup>174</sup> If a patient suffers an injury in a hospital, it is likely that the patient would not have suffered the injury if he had never entered the hospital. The unreliability of this fifth factor was made clear in *LaCoste*.<sup>175</sup> As the majority indicated, there are very few scenarios in which a patient could suffer an injury in a hospital that would have occurred even if he had not sought treatment there.<sup>176</sup> The only exception to this factor leaning in favor of malpractice established by jurisprudence is when the injury could have occurred to a visitor of the hospital.<sup>177</sup> In that scenario, however, the previous four factors would lead to the conclusion of general tort liability considering the victim was not a patient of the hospital.

Similarly, the sixth factor, “whether the tort alleged was intentional,”<sup>178</sup> also should be removed because it carries no weight, considering the MMA’s **\*334** definition of malpractice begins with “any unintentional tort.”<sup>179</sup> When determining whether the MMA applies, the analysis begins with the definitions established within the MMA. As the Court found in both *LaCoste* and *Dupuy*, these factors simply provide assistance in determining malpractice,<sup>180</sup> making this factor wholly unnecessary.<sup>181</sup>

Use of these altered *Coleman* factors by Louisiana courts provides a starting point, but ultimately the Legislature should amend the MMA to provide a clearer definition of malpractice that is aligned with the state’s public policy concerns for

avoiding derogation of tort victims' rights. Additionally, incorporating the above-amended factors into the MMA may assist the Legislature in achieving that objective.

## CONCLUSION

Louisiana courts have applied these non-Louisiana based, broad, unreliable factors with little consistency since 2002. When addressing the vital public policy concern with limiting tort victims' right to recovery, Louisiana courts should have a straightforward, Louisiana-based approach to making malpractice determinations. The *Coleman* factors, though sometimes applied with Louisiana's public policy in mind, are susceptible to varying interpretations. This susceptibility shows that the *Coleman* factors are an insufficient test that fails to accomplish the public policy goals of Louisiana under the MMA.

The ideal solution is to amend Louisiana's MMA to provide a clearer definition of "malpractice" so courts will achieve non-conflicting results. Considering courts' familiarity with the *Coleman* factors, an alteration of those factors that emphasizes construing the MMA strictly would be a simple and efficient starting point.

## Footnotes

<sup>1</sup> J.D./D.C.L., 2018, Paul M. Hebert Law Center, Louisiana State University. Many thanks to Professors John Church and Bill Corbett for their guidance and feedback during the writing of this Comment.

<sup>1</sup> See *Dupuy v. NMC Operating Co.*, 187 So. 3d 436 (La. 2015).

<sup>2</sup> LA. REV. STAT. § 40:1231.2(B)(1) (2017).

<sup>3</sup> *Coleman v. Deno*, 813 So. 2d 303, 314-15 (La. 2002) (citing FRANK L. MARAIST & THOMAS C. GALLIGAN, JR., LOUISIANA TORT LAW § 21-22 (1st ed. 1996)).

<sup>4</sup> In *Dupuy v. NMC Operating Co., L.L.C.*, the Court rejected the plaintiff's argument that Dupuy's injury was not treatment-related because the "maintenance and service of sterilization equipment" was performed by "plant operations rather than physicians." Instead, the Court found that "[t]he use of the broad term 'health care provider,' rather than simply 'physician' or 'medical doctor,' necessarily includes actions which are treatment related and undertaken by the Hospital in its capacity as a health care provider--even if those actions are not performed directly by a medical professional." *Dupuy*, 187 So. 3d at 443.

<sup>5</sup> See § 40:1231.2(B)(1).

<sup>6</sup> *Blevins v. Hamilton Med. Ctr., Inc.*, 959 So. 2d 440, 444 (La. 2007).

<sup>7</sup> *Coleman*, 813 So. 2d at 315.

<sup>8</sup> See, e.g., *LaCoste v. Pendleton Methodist Hosp., L.L.C.*, 966 So. 2d 519 (La. 2007).

<sup>9</sup> See discussion *infra* Part III.

<sup>10</sup> § 40:1231.2(B)(1).

<sup>11</sup> *Hutchinson v. Patel*, 637 So. 2d 415, 419 (La. 1994).

<sup>12</sup> Felicia Scroggins, *Differentiating Medical Malpractice and Personal Injury Claims in the Context of Statutory Protections: Lacoste v. Pendleton Methodist Hosp., L.L.C.*, 3 J. HEALTH & BIOMEDICAL L. 367, 367 (2008).

<sup>13</sup> § 40:1231.1(A)(10) (defining "health care provider" as "a person, partnership, limited liability partnership, limited liability company, corporation, facility, or institution licensed or certified by this state to provide health care or professional services as a physician, hospital, nursing home, community blood center, tissue bank, dentist, a licensed dietician or licensed nutritionist

employed by, referred by, or performing work under contract for, a health care provider or other person already covered by this Part, registered or licensed practical nurse or certified nurse assistant, offshore health service provider, ambulance service under circumstances in which the provisions of R.S. 40:1237.1 are not applicable, certified registered nurse anesthetist, nurse midwife, licensed midwife, nurse practitioner, clinical nurse specialist, pharmacist, optometrist, podiatrist, chiropractor, physical therapist, occupational therapist, psychologist, social worker, licensed professional counselor, licensed perfusionist, licensed respiratory therapist, licensed radiologic technologist, licensed clinical laboratory scientist, or any nonprofit facility considered tax-exempt under Section 501(c)(3), Internal Revenue Code, pursuant to 26 U.S.C. 501(c)(3), for the diagnosis and treatment of cancer or cancer-related diseases, whether or not such a facility is required to be licensed by this state, or any professional corporation a health care provider is authorized to form under the provisions of Title 12 of the Louisiana Revised Statutes of 1950, or any partnership, limited liability partnership, limited liability company, management company, or corporation whose business is conducted principally by health care providers, or an officer, employee, partner, member, shareholder, or agent thereof acting in the course and scope of his employment”).

14 § 40:1231.1(A)(13) (defining “malpractice” as “any unintentional tort or any breach of contract based on health care or professional services rendered, or which should have been rendered, by a health care provider, to a patient, including failure to render services timely and the handling of a patient, including loading and unloading of a patient, and also includes all legal responsibility of a health care provider arising from acts or omissions during the procurement of blood or blood components, in the training or supervision of health care providers, or from defects in blood, tissue, transplants, drugs, and medicines, or from defects in or failures of prosthetic devices implanted in or used on or in the person of a patient”). Subsection (A)(22) defines “tort” as:

[A]ny breach of duty or any negligent act or omission proximately causing injury or damage to another. The standard of care required of every health care provider, except a hospital, in rendering professional services or health care to a patient, shall be to exercise that degree of skill ordinarily employed, under similar circumstances, by the members of his profession in good standing in the same community or locality, and to use reasonable care and diligence, along with his best judgment, in the application of his skill.

§ 40:1231.1(A)(22).

15 *Id.* § 40:1231.2(B)(1).

16 *Id.* § 40:1231.8(A)(1)(a).

17 § 40:1231.8(C).

18 § 40:1231.8(G).

19 *See* Allison B. Lewis, *Unreasonable and Imperfect: Constitutionality of the Louisiana Medical Malpractice Act's Limit on Recovery*, 69 LA. L. REV. 417, 420 (2009).

20 § 40:1231.2(B)(1) (“The total amount recoverable for all malpractice claims for injuries to or death of a patient, exclusive of future medical care and related benefits as provided in R.S. 40:1231.3, shall not exceed five hundred thousand dollars plus interest and cost.”).

21 *See* Leonard J. Nelson et al., *Medical Malpractice Reform in Three Southern States*, 4 J. HEALTH & BIOMEDICAL L. 69, 71 (2008); Lewis, *supra* note 19 (arguing the damages cap is unconstitutional); *see also* W. Taylor Hale, *A Critical Misdiagnosis: Re-Evaluating Louisiana's Medical Malpractice*, 53 LOY. L. REV. 463 (2007) (arguing that the Act violates Equal Protection by not affording every patient with an adequate remedy); *Arrington v. ER Physicians Group, AMPC*, 940 So. 2d 777, 784 (La. Ct. App. 2006), *vacated sub nom. Arrington v. Galen-Med, Inc.*, 947 So. 2d 727 (La. 2007) (finding “the \$500,000.00 cap on medical malpractice damages unconstitutional as failing to provide the plaintiffs an ‘adequate remedy’ as guaranteed under the provisions of La. Const. art. 1, § 22”).

22 *See* Nelson et al., *supra* note 21, at 71.

23 *Id.* (discussing the 500% increase in premiums in some states).

24 Emily Townsend Black Grey, *The Medical Malpractice Damages Cap: What is Included?*, 60 LA. L. REV. 547, 547 (2000).

25 *Id.*

26 *See* Lewis, *supra* note 19, at 418.

27 *Id.*

28 *Whitnell v. Silverman*, 646 So. 2d 989, 994 (La. Ct. App. 1994), *rev'd*, 686 So. 2d 823 (La. 1996).

29 *Id.*

30 *Id.*

31 *Id.*

32 *Id.*

33 *Id.*

34 *Id.*

35 *Id.* The court discussed the testimony of actuary Robert Lowe:

We agree. Perhaps the best explanation is given by actuary Robert E. Lowe. ... Mr. Lowe testified that the insurance industry undergoes regular 10 year cycles which include a 'crisis' every ten years. We have had insurance crises in 1975, 1985, and are due one in 1995. These cycles are well known in the literature and have been discussed by academic writers and industry analysts for decades. The cycles are caused by underpricing by the industry itself. In order to compete for the premium dollar while still maintaining market share, insurance companies will underprice premiums for a period of time. Because they are all competing with each other for the same premium dollar and market share, they will all underprice at the same time. Mismanagement of pricing by the companies themselves creates a depletion of surplus, of loss reserves, such that pricing must increase over a short period to make up for the reserve depletion. As the pricing increases, it places strain on the insurance companies to absorb business. There is a relationship between the amount of business a company can write and the size of its surplus. When the surplus is depleted, its capacity to write new business decreases drastically. In order to add increasing prices in a short period of time at a rapid rate, the insurance companies must dispose of some business. Which business they dispose of is entirely within their control and entirely arbitrary, but the companies dispose of the business which they perceive to be more troublesome, such as medical malpractice and environmental. This disposal of business is a commonly recognized phenomenon in the insurance business and has been written about by many industry commentators. The insurance companies dispose or dump certain kinds of business by simply refusing to write certain lines. ... The insurance 'crisis' is never a crisis to the insurance companies, who are in fact raising their rates rapidly.

*Id.*

36 *See* Lewis, *supra* note 19 (arguing the damages cap is unconstitutional); *see also* Hale, *supra* note 21 (arguing that the Act violates Equal Protection by not affording every patient with an adequate remedy); *Arrington v. ER Physicians Group, AMPC*, 940 So. 2d 777, 784 (La. Ct. App. 2006), *vacated sub nom. Arrington v. Galen-Med, Inc.*, 947 So. 2d 727 (La. 2007) (holding "the \$500,000 cap on medical malpractice damages unconstitutional as failing to provide the plaintiffs an 'adequate remedy' as guaranteed under the provisions of La. Const. art. 1, § 22").

37 *See* Lewis, *supra* note 19 (arguing the damages cap is unconstitutional); *see also* Hale, *supra* note 21 (arguing that the Act violates Equal Protection by not affording every patient with an adequate remedy); *see also Arrington*, 940 So. 2d at 784 (holding "the \$500,000 cap on medical malpractice damages unconstitutional as failing to provide the plaintiffs an 'adequate remedy' as guaranteed under the provisions of La. Const. art. 1, § 22").

38 *Arrington*, 940 So. 2d at 784; *see also* LA. CONST. art. I, § 22 ("All courts shall be open, and every person shall have an adequate remedy by due process of law and justice, administered without denial, partiality, or unreasonable delay, for injury to him in his person, property, reputation, or other rights.").

39 *Arrington*, 940 So. 2d at 781, in which the court discussed the insufficiency of the cap:

The balance has been weighed heavily in favor of the health care providers, their insurers, and The Patient's Compensation Fund by the two-thirds erosion in "the dollar" from 1975 to date which limits the value of the claim to one-third if [sic] its value in 1975, thereby violating the equal protection laws guaranteed by The Louisiana Constitution.

*Id.*

40 *Id.*

41 *Id.* at 784 (citing cases finding medical malpractice caps unconstitutional in Texas, Alabama, New Hampshire, Ohio, and Florida).

42 See Lewis, *supra* note 19 and accompanying text.

43 Lewis, *supra* note 19, at 425-28; Hale, *supra* note 21.

44 E.g., Taylor v. Clement, 940 So. 2d 796, 797 (La. Ct. App. 2006) (discussing how the plaintiff's award was initially an amount above \$500,000, but was reduced to the cap amount of \$500,000).

45 *Id.*

46 See Blevins v. Hamilton Med. Ctr., Inc., 959 So. 2d 440, 444 (La. 2007); see also Sewell v. Doctors Hosp., 600 So. 2d 577, 578 (La. 1992).

47 See discussion *supra* Part I.

48 Coleman v. Deno, 813 So. 2d 303, 315 (La. 2002).

49 "Patient dumping" is the "refusal to treat patients with emergency medical conditions who are uninsured and cannot pay for medical treatment or the transfer of such patients to a public hospital." Spradlin v. Acadia-St. Landry Medical Found, 758 So. 2d 116, 117 n.1 (La. 2000).

50 Coleman, 813 So. 2d at 307-10.

51 *Id.* at 314-15.

52 LA. REV. STAT. § 40:1231.1(A)(13) (2017).

53 § 40:1231.1(A)(22).

54 § 40:1231.1(A)(9).

55 Coleman, 813 So. 2d at 315.

56 *Id.* at 316.

57 Sewell v. Doctors Hosp., 600 So. 2d 577, 579 n.3 (La. 1992).

58 *Id.* (quoting Holly P. Rockwell, Annotation, *What Patient Claims Against Doctor, Hospital, or Similar Health Care Provider Are Not Subject to Statutes Specifically Governing Actions and Damages for Medical Malpractice*, 89 A.L.R.4th 887 (1991)).

59 Coleman, 813 So. 2d at 315-16 (citing Sewell, 600 So. 2d at 579 n.3 (La. 1992)).

60 *Id.*

61 *Id.*

62 *Id.* at 316.

63 *Id.* at 315-16.

64 *Id.*

65 *Id.*

66 AMERICAN LAW REPORTS, WESTLAW, <http://legalsolutions.thomsonreuters.com/law-products/westlaw-legal-research/litigator/alr> [<https://perma.cc/3MGS-Y8GY>].

67 *Id.*

68 Rockwell, *supra* note 58 discusses courts' various considerations when defining the scope of medical malpractice statutes: In defining the scope of the medical malpractice statutes as applied to tort claims, the courts have weighed various considerations, including the statutory language and legislative history, and the factual basis and context of a claim. When focusing on statutory language, the courts have tended to either define the breadth of coverage intended, as reflected in general statutory terms or the legislative history, or to determine whether a patient's claim fell within the statutory definition of 'treatment related,' 'health care,' 'malpractice, error, or mistake,' or like term, as a factual matter. In analyzing the factual basis of a claim, the courts may consider whether a particular wrong is 'treatment related' or was caused by a dereliction of professional skill or duty, whether the wrong can be evaluated based on common knowledge or requires expert evidence to determine whether the appropriate standard of care was breached, or whether the act at issue involved assessment of the patient's condition. In addition, courts have considered factors such as whether an incident occurred in the context of a physician-patient relationship, or was within the scope of activities which a hospital is licensed to perform, whether the injury would have occurred if the patient had not sought treatment, and whether the tort alleged was intentional.

*Id.*

69 *Id.*

70 *E.g.*, [LaCoste v. Pendleton Methodist Hosp., L.L.C., 966 So. 2d 519, 524-25 \(La. 2007\)](#).

71 *See, e.g., id.*; *see also* [Billeau v. Opelouses Gen. Hosp. Auth., 189 So. 3d 562 \(La. Ct. App. 2016\)](#).

72 [LaCoste](#), 966 So. 2d at 521.

73 *Id.*

74 *Id.* at 519.

75 *Id.* at 524. The court discussed Louisiana's public policy interest in avoiding derogation of tort victims' rights: This court has steadfastly emphasized that the [MMA] and its limitations on tort liability for a qualified health care provider apply *only* to claims 'arising from medical malpractice,' and that all other tort liability on the part of a qualified health care provider is governed by general tort law. ... This is so because, as we have oft repeated, the [MMA's] limitations on the liability of health care providers were created by special legislation in derogation of the rights of tort victims. ... In keeping with this concept, any ambiguity should be resolved in favor of the plaintiff and against finding that the tort alleged sounds in medical malpractice. The limitations of the [MMA], therefore, apply strictly to cases of malpractice as defined by the [MMA].

*Id.*

76 *See* LA. REV. STAT. § 40:1231.8(A)(1)(a) (2017); *see also id.* § 40:1231.2(B)(1).

77 [LaCoste](#), 966 So. 2d at 530.

78 *Id.* at 521.

79 [Coleman v. Deno](#), 813 So. 2d 303, 315 (La. 2002).

80 [LaCoste](#), 966 So. 2d at 526.

81 *Id.*

82 *Id.*

83 *Id.* at 530 (Knoll, J., dissenting).

- 84 *Id.* at 531.
- 85 *Id.*
- 86 *Id.*
- 87 *Coleman v. Deno*, 813 So. 2d 303, 315 (La. 2002).
- 88 *LaCoste*, 966 So. 2d at 527.
- 89 *Id.*
- 90 *Id.* at 531 (Knoll, J., dissenting).
- 91 *Id.*
- 92 *Id.*
- 93 *Coleman v. Deno*, 813 So. 2d 303, 315 (La. 2002).
- 94 *LaCoste*, 966 So. 2d at 527.
- 95 *Id.* at 527-28.
- 96 *Id.* at 528.
- 97 *Id.* at 531-32 (Knoll, J., dissenting).
- 98 *Id.* at 532.
- 99 *Id.* at 530.
- 100 *Id.* at 521 (majority opinion).
- 101 *Id.*
- 102 *Id.*
- 103 *Coleman v. Deno*, 813 So. 2d 303, 316 (La. 2002).
- 104 *LaCoste*, 966 So. 2d at 528.
- 105 *Id.*
- 106 *Id.*
- 107 *Id.* at 532 (Knoll, J., dissenting).
- 108 *Id.*
- 109 *Id.*
- 110 *Coleman v. Deno*, 813 So. 2d 303, 316 (La. 2002).
- 111 *LaCoste*, 966 So. 2d at 528-29.
- 112 *Id.* at 529.
- 113 *Id.* at 532 (Knoll, J., dissenting).
- 114 *Coleman*, 813 So. 2d at 316.

- 115 *LaCoste*, 966 So. 2d at 529.
- 116 See, e.g., *Billeau* v. Opelouses Gen. Hosp. Auth., 189 So. 3d 562 (La. Ct. App. 2016).
- 117 See, e.g., *id.*
- 118 See, e.g., *Dupuy v. NMC Operating Co.*, 187 So. 3d 436 (La. 2016).
- 119 See *id.*
- 120 *Id.* at 437.
- 121 *Id.* at 436-37.
- 122 In Louisiana, the dilatory exception is a means of defense aimed at retarding the progress of an action. A dilatory exception of prematurity may be brought by a defendant when the action is filed too early. LA. CODE CIV. PROC. art. 921, 923, 926 (2017).
- 123 *Dupuy*, 187 So. 3d at 437-38.
- 124 *Id.* at 438.
- 125 *Id.*
- 126 *Id.*
- 127 *Id.*; *Coleman v. Deno*, 813 So. 2d 303, 315-16 (La. 2002).
- 128 *Dupuy*, 187 So. 3d at 440.
- 129 *Id.* at 441.
- 130 See *Cashio v. Baton Rouge Gen. Hosp.*, 378 So. 2d 182 (La. Ct. App. 1979); see also *McBride v. Earl K. Long Mem'l Hosp.*, 507 So. 2d 821 (La. 1987).
- 131 *Dupuy*, 187 So. 3d at 438.
- 132 See *Blevins v. Hamilton Med. Ctr., Inc.*, 959 So. 2d 440, 446 (La. 2007); see also *Williamson v. Hosp. Serv. Dist. No. 1*, 888 So. 2d 782, 789-90 (La. 2004); *LaCoste v. Pendleton Methodist Hosp., L.L.C.*, 966 So. 2d 519, 525 (La. 2007).
- 133 *Blevins*, 959 So. 2d 440; see also *Williamson*, 888 So. 2d 782.
- 134 *Blevins*, 959 So. 2d 440; *Williamson*, 888 So. 2d 782.
- 135 See *Blevins*, 959 So. 2d at 444; see also *Williamson*, 888 So. 2d at 790-91.
- 136 *Blevins*, 959 So. 2d at 446.
- 137 See *Dupuy v. NMC Operating Co.*, 187 So. 3d 436, 445 (La. 2015). By the end of the opinion, the court concluded that “the plaintiff’s allegations regarding failure to sterilize the equipment used to sanitize surgical instruments fall under the MMA.” *Id.* This wording is a clear alteration of the plaintiff’s claim. This type of alteration is exactly what the *LaCoste* Court cautioned against:  
[P]laintiffs do not allege a “failure to transfer,” but rather, they allege that the defendant failed to implement an adequate evacuation plan, failed to have in place a plan to transfer patients in the event of a mandatory evacuation, and failed to have a facility available for the transfer of patients. While a failure to transfer may relate to medical malpractice in another case, [the claims alleged here are] not “treatment related” or the result of the dereliction of professional medical skill, based on the factual allegations to which our review is limited. ... As we cautioned in *Williamson*, “[a]n expansive reading of the definition of medical malpractice contained in the MMA runs counter to our previous holdings that coverage of the Medical Malpractice Act should be strictly construed.”

- 138 *LaCoste*, 966 So. 2d at 526.
- 139 *Cashio v. Baton Rouge Gen. Hosp.*, 378 So. 2d 182 (La. Ct. App. 1979).
- 140 *Id.* at 184.
- 141 *Dupuy*, 187 So. 3d at 442.
- 142 *Id.* at 436-37.
- 143 *Coleman v. Deno*, 813 So. 2d 303, 315-16 (La. 2002).
- 144 *Dupuy*, 187 So. 3d at 443.
- 145 *Id.*
- 146 *Id.* at 436-37.
- 147 *Williamson v. Hosp. Serv. Dist. No. 1*, 888 So. 2d 782, 790 (La. 2004).
- 148 *Id.*
- 149 *Dupuy*, 187 So. 3d at 443.
- 150 *Coleman v. Deno*, 813 So. 2d 303, 315-16 (La. 2002).
- 151 *Dupuy*, 187 So. 3d at 444 n.10.
- 152 *Coleman*, 813 So. 2d at 315-16.
- 153 *Dupuy*, 187 So. 3d at 444 (quoting LA. REV. STAT. § 40:2109 (2017)).
- 154 § 40:2109(B)(2).
- 155 *Dupuy*, 187 So. 3d at 444.
- 156 *Id.* at 444 n.11.
- 157 *Id.*
- 158 *Id.* at 436-37.
- 159 *Coleman v. Deno*, 813 So. 2d 303, 315-16 (La. 2002).
- 160 *Dupuy*, 187 So. 3d at 445.
- 161 *LaCoste v. Pendleton Methodist Hosp.*, 966 So. 2d 519, 532 (La. 2007) (Knoll, J., dissenting).
- 162 *Dupuy*, 187 So. 3d at 440-45.
- 163 *See, e.g., Gayden v. Tenet Healthsystem Mem'l Med. Ctr., Inc.*, 891 So. 2d 734 (La. Ct. App. 2004).
- 164 *See Blevins v. Hamilton Med. Ctr., Inc.*, 959 So. 2d 440, 444 (La. 2007); *see also Sewell v. Doctors Hosp.*, 600 So. 2d 577 (La. 1992).
- 165 *See Coleman v. Deno*, 813 So. 2d 303, 315-16 (La. 2002).
- 166 *See discussion supra* Part III.
- 167 *See discussion supra* Part III.A.

- 168 *See Coleman*, 813 So. 2d at 315-16.
- 169 *LaCoste v. Pendleton Methodist Hosp.*, 966 So. 2d 519, 531 (La. 2007) (Knoll, J., dissenting).
- 170 *See discussion supra* Part III.B.
- 171 *See Coleman*, 813 So. 2d at 315-16.
- 172 *Id.*
- 173 *Id.*
- 174 *See LaCoste*, 966 So. 2d at 529; *see also Williamson v. Hosp. Serv. of Jefferson*, 888 So. 2d 782, 791 (La. 2004) (discussing “a ‘but for’ rationale that may be overly facile”).
- 175 *See discussion supra* Part III.A.
- 176 *LaCoste*, 966 So. 2d at 528-29; *see also Williamson*, 888 So. 2d at 791 (discussing “a ‘but for’ rationale that may be overly facile”).
- 177 *Williamson*, 888 So. 2d at 791, where the Court discussed the impracticability of a but-for standard in this context: This factor initially weighs to some extent in favor of the defendant, because the plaintiff likely would not have been transported in the wheelchair had she not sought treatment at the hospital. Such reasoning, however, employs a ‘but for’ rationale that may be overly facile. It is just as reasonable to say that any visitor to the hospital, even those not seeking treatment, who used this particular wheelchair could have suffered injury.  
*Id.*
- 178 *Coleman*, 813 So. 2d at 315-16 (citing *Sewell v. Doctors Hosp.*, 600 So. 2d 577, 579 n.3 (La. 1992)).
- 179 LA. REV. STAT. § 40:1231.1(A)(13) (2017).
- 180 *See Coleman*, 813 So. 2d at 315-16; *LaCoste*, 966 So. 2d at 524-25; *Dupuy v. NMC Operating Co.*, 187 So. 3d 436, 439 (La. 2015).
- 181 *See discussion supra* Part III.

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