



GEORGIA HEALTH LAW DEVELOPMENTS

A Publication of the Health Law Section of the State Bar of Georgia

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REPORT OF THE CHAIR

The Health Law Section has had another successful year with a number of programs, activities, and publications, including this latest edition of our Section's newsletter. The Section currently has approximately 500 members and is in solid financial condition.

I am delighted to report that, at its Annual meeting in June, 2002, the State Bar of Georgia recognized the Health Law Section with the "Section Award of Achievement" for the 2001-2002 Bar year. The award was presented to only four of the Bar's thirty-five sections based on programs, activities, and other achievements during the year. Thank you to our Executive Committee members, speakers, writers, attendees of Section meetings, and others who have contributed their time and talents to the Section during this year of special recognition from the State Bar.

I would also like to summarize some of the activities of the Health Law Section over the past year. In January, 2002, the Health Law Section sponsored a membership luncheon in connection with the Mid-Year meeting of the State Bar at the Swissotel in Buckhead. Gary Redding, Commissioner of the Georgia Department of Community Health, served as our featured speaker. His remarks focused on Georgia Medicaid reimbursement issues as well as efforts at the federal level to streamline health care regulations. We were honored to have Commissioner Redding with us for our luncheon.

In February, 2002, the Health Law Section co-sponsored, along with the Georgia Academy of Healthcare Attorneys, a "Fundamentals of Health Care Law" conference at the Swissotel in Buckhead. Rod Meadows, of Meadows & Lewis, served as our Chair of this conference. Apparently, we tapped into a need for this type of con-

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ference in that the seminar was so well attended. We also received excellent reviews and intend to make this seminar an annual event.

In March, 2002, the Health Law Section again co-sponsored with ICLE the Fifth Annual Health Care Fraud Institute at Callaway Gardens. Joe Whitley of Alston & Bird, Charlene McGinty of Powell, Goldstein, Frazer & Murphy, and I served as co-chairs of this successful two-day conference. Approximately 120 health care practitioners, including civil and criminal private practice attorneys, federal and state prosecutors, and others from Georgia and other states in the Southeast attended the conference. The Executive Committee of the Section met in conjunction with this program, and the Section hosted a reception for attendees. This has been a very successful effort each year, and we look forward to sponsoring this conference again in 2003.

The Section's Annual meeting is upcoming and will be held at the Swissotel in Buckhead on September 13, 2002. I would like to encourage everyone to attend. We have a wide range of topics that will be covered, including segments on the medical malpractice insurance crisis, ethical considerations in the post-Enron era, health care fraud, and key state and federal developments. You already should

have received a program brochure, but we also have included a copy of the program brochure in this issue of the newsletter. Also, please note that we will have a business meeting at lunch for the purpose of electing new officers of the Health Law Section. I hope that I will see many of you at that meeting.

The Health Law Section endeavors to respond to the different interests of its diverse membership. Our members include private practice attorneys representing various types of health care providers and payors, governmental attorneys, and others who focus on health care issues. Your continued participation in our Section and its events is of vital importance to the Section. I encourage each of you to become more involved in the Section. We are always looking for ideas for future Section projects, publications, and programs. Please feel free to contact me with any suggestions, ideas or other input. I have truly enjoyed serving as Chair of the Health Law Section this past year, and I am honored to have held the position. I look forward to working with you and the Section in the future.

Jonathan L. Rue

Parker, Hudson, Rainer & Dobbs LLP

MESSAGE FROM THE EDITOR

The Health Law Section of the State Bar of Georgia is pleased to provide a yearly publication for its members. We encourage you to send us summaries of recent cases, legislation, and agency activities which may be of interest to health law attorneys who practice in Georgia and the Southeast. Suitable short feature articles on timely topics may also be accepted for publication. Please address inquiries, submissions, and suggestions to:

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**ADVANCED HEALTH CARE LAW
AGENDA**

PRESIDING: Jonathan L. Rue, Program Chair, Chair, Health Law Section, State Bar of Georgia; Parker, Hudson, Rainer & Dobbs LLP, Atlanta

A.M.

P.M.

8:15	REGISTRATION (All attendees must check in upon arrival. A removable jacket or sweater is recommended.)	12:15	LUNCHEON AND ANNUAL MEETING Luncheon Speaker - <i>Russell E. Toal</i> , President, Georgia Cancer Coalition, Atlanta
8:55	INTRODUCTION AND PROGRAM OVERVIEW <i>Jonathan L. Rue</i>	1:30	ETHICAL CONSIDERATIONS IN THE ENRON ERA OF CORPORATE ACCOUNTABILITY <i>Bill Tillett</i> , CPA National Director of Health Care Corporate Compliance Services, Ernst & Young LLP, Atlanta
9:00	<u>UNITED STATES v. WHITESIDE: THE VIEWS OF PARTICIPATING COUNSEL</u> <i>Teresa W. Roseborough</i> , Sutherland, Asbill & Brennan, LLP, Atlanta <i>Jay D. Mitchell</i> , Nelson, Mullins, Riley & Scarborough, LLP, Atlanta	2:30	BREAK
10:00	BREAK	2:40	HIPAA UPDATE-BUSINESS ASSOCIATES AND OTHER HELPFUL INFORMATION <i>Bonnie L. Baker</i> , Meadows & Lewis, Stockbridge Temple Sellers, Regulatory/Legislative Counsel, Georgia Hospital Association, Marietta
10:15	MEDICAL MALPRACTICE INSURANCE CRISIS <i>John W. Oxendine</i> , Georgia Insurance and Safety Fire Commissioner, Atlanta <i>C. Wade Monk</i> , General Counsel, Floyd Medical Center Health System, Rome <i>David A. Cook</i> , Executive Director, Medical Association of Georgia, Atlanta	3:45	STATE UPDATE - KEY DEVELOPMENTS (MEDICAID; HOSPITAL LICENSURE; CONSUMERS' HEALTH INSURANCE PROTECTION ACT etc.) <i>Clyde L. Reese, III</i> , General Counsel, Georgia Department of Community Health, Atlanta <i>Robert M. Keenan, III</i> , King & Spalding, Atlanta
11:15	FEDERAL UPDATE - KEY DEVELOPMENTS (EMTALA; <u>RUSH PRUDENTIAL HMO v. MORAN</u>; ANTI-KICKBACK etc.) <i>Leo E. Reichert</i> , Parker, Hudson, Rainer & Dobbs LLP, Atlanta <i>Kathlynn Butler Polvino</i> , Powell, Goldstein, Frazer & Murphy LLP, Atlanta	4:30	ADJOURN

ELEVENTH CIRCUIT REVERSES HEALTH CARE FRAUD CONVICTIONS OF FORMER HCA OFFICIALS

By: *Teresa Wynn Roseborough*

Brian D. Burgoon

SUTHERLAND ASBILL & BRENNAN, LLP

Factual Context

The United States Court of Appeals for the Eleventh Circuit recently reversed the convictions of two former HCA officials, Jay Jarrell and Robert Whiteside.¹ On May 30, 2002, the Eleventh Circuit denied the federal government's motion for rehearing and motion for rehearing *en banc*, and the government then dismissed its appeal, ending the case against Jarrell and Whiteside, and clearing the way for these and other witnesses to testify in the civil actions still pending against HCA.

Jarrell is the former vice president of finance of Basic American Medical, Inc. ("BAMI"), which owned Fawcett Memorial Hospital in southwest Florida. After Columbia/HCA purchased BAMI in 1992, Jarrell became the head of the company's Southwest Florida division. In 1992, Whiteside was hired as Columbia's manager of reimbursement services.

Jarrell, Whiteside and Michael Neeb, former CFO of Fawcett, were indicted by a federal grand jury in July 1997 for conspiracy to defraud the federal government and making false statements in applications for Medicare/Medicaid benefits. A second grand jury added charges of impeding a federal auditor as well as additional false statement offenses, and also added Lynn Dick, the former controller of BAMI, to the conspiracy charge.

The case revolved around whether the four defendants had committed Medicare and Medicaid fraud by seeking reimbursement on cost report forms for interest paid on a loan originally taken out by Fawcett in 1981, and refinanced numerous times over the years (the Citizens Bank loan). While it was undisputed that the interest payments themselves were reimbursable expenses, the issue was at what rate should the interest have been reimbursed – if the interest was classified as a capital expense, it would be reimbursed at a higher rate than if it was classified as an operating expense. (Congress has since eliminated the regulation distinguishing between the different rates.)

For a period of over ten years, from the time of the initial loan in 1981, BAMI and its fiscal intermediary repeatedly differed in computing the allocation of the interest expense as between the operating and capital classifications. Fawcett ultimately determined that, over time and after multiple refinancings, the character of the interest changed from being split between capital and operating expenses to 100 percent capital-related. Therefore, on its 1992 and 1993 cost reports, Fawcett claimed that the interest for the Citizens Bank loan was 100 percent capital-related. These two cost reports formed the heart of the government's case, with prosecutors contending that Fawcett's classification of the interest expense violated reimbursement regulations.

After a two-month trial in 1999 in federal district court in Tampa, Florida, the jury found all the defendants not guilty of the obstruction charge, found Neeb not guilty on all counts, and failed to reach a verdict on the conspiracy count against Dick. However, Jarrell and Whiteside were convicted on the conspiracy and false statement charges. The court sentenced Jarrell and Whiteside to three years and two years in prison, respectively, followed by two years of supervised release. Each also received a fine and was ordered to pay restitution.

Issues on Appeal

Jarrell and Whiteside appealed on multiple grounds, the key substantive issues being whether the government proved beyond a reasonable doubt: (1) that the defendants knowingly and willfully filed false statements on cost reports and (2) that the defendants conspired to defraud the government by filing false cost reports.

The Court's discussion begins with the observation that "(t) his seemingly complex case involves a single allegedly false statement"²—classification of debt interest as 100% capital-related on cost reports submitted for Medicare and Medicaid reimbursement. The government contended that Fawcett's classification of the interest expense based on how the debt was being used at the time of filing the cost reports as opposed to how the funds were used at the time of the loan origination was inconsistent with the Medicare regulations. The defendants argued that no Medicare regulation or other authority existed that made changing the characterization of debt interest incorrect, let alone "knowingly and willfully false." They further argued

that because the government failed to prove that the statements at issue were not a reasonable interpretation of the applicable law, it failed to prove that the defendants “knowingly and willfully” made false statements.

The Eleventh Circuit agreed with the defendants and noted that where the falsity of a statement involving an interpretive question of law must be proven, the government has the burden of showing “that the defendant’s statement is not true under a reasonable interpretation of the law.”³ The court found “(t) he government cannot meet its burden in this case because, despite its contention to the contrary, no Medicare regulation, administrative ruling, or judicial decision exists that clearly requires interest expense to be reported in accordance with the original use of the loan.”⁴

The court determined that the regulation relied upon by the government to support the convictions was silent on the point, and did not prohibit the actions taken by the defendants. The court said that, although the regulation indicates that an interest expense is capital-related when the underlying debt is capital related, the regulation did not describe how to define the underlying debt or state that the initial use of the loan proceeds is the only basis for determining the nature of the debt. The court also pointed to the 1978 HCFA Administrative Bulletin number 1186, which expressly recognized that “the character of a loan may change over time” when it announced that funds that originally were determined to be “unnecessary borrowing” under the Medicare regulations (and thus non-reimbursable) can later be converted to “necessary borrowing” (and thus reimbursable) upon certain changes in the financial position of the borrower.

The court said this form over substance theory comported with the logical notion that money is fungible and concluded that the defendants’ interpretation of the Medicare regulations as authorizing treatment of debt interest as capital-related, even when the funds underlying the debt were initially used for non-capital purposes, was not unreasonable. The court found that neither the regulations nor administrative authority clearly answered the questions the defendants faced, that reasonable people could differ as to whether the loan interest in question was capital-related, and thus, that the government failed to prove the *actus reus* of the offense – actual falsity as a matter of law.

Disposition

Because the government failed to prove the actual falsity of the defendants’ statements, the court reversed their convictions and sentences. The court also overturned the defendants’ conspiracy convictions, holding that because no crime was committed by filing the cost reports, the defendants’ alleged agreement to file the cost reports could not be a criminal conspiracy as a matter of law.

Commentary

The Eleventh Circuit’s description of this case as “seemingly” complex may actually be a signal of concern about the strength of the government’s case. The Court seemed troubled that the prosecutors required a trial of two months to secure convictions in a case involving “a single allegedly false statement,” when, on appeal, the prosecutors could not show any regulation the defendants had clearly violated. The fact that the prosecutors required so much time and effort to prove the falsity of a single statement, in other words, caused the Court to focus on whether the defendants’ interpretation of the applicable regulations could even possibly not have been reasonable. Still, for health care providers, the case sends a strong message of prosecutorial willingness to pursue aggressive enforcement, which, for defendants, means a huge financial and human toll that even ultimate vindication cannot repay.

About the authors: Teresa Wynn Roseborough is a partner and member of the Health Care Group in the Atlanta office of Sutherland Asbill & Brennan, LLP. She represented the defendant, Jay Jarrell, in his appeal in this case, assisted by Brian Burgoon, an associate at Sutherland Asbill & Brennan, LLP.

¹ United States v. Whiteside, 285 F.3d 1345 (11 Cir. 2002).

² Id. at 1351.

³ Id. at 1351.

⁴ Id. at 1352.

PROTECTING THE RIGHTS OF EMPLOYEES AND THE SAFETY OF PATIENTS UNDER THE AMERICANS WITH DISABILITIES ACT

By: *Eve H. Goldstein*

JONES, DAY, REAVIS & POGUE

The views expressed herein are the personal views of the author and do not necessarily reflect those of the law firm with which she is associated.

For hospitals and other health care providers the Americans with Disabilities Act¹ (the "ADA" or the "statute") has been a multi-edged sword. On the one hand, health care providers have a professional and legal obligation not to penalize or discriminate against employees or applicants with disabilities. On the other hand, they have a professional and legal obligation to their patients to provide them with the best care possible and, consistent with the Hippocratic Oath, never to inflict harm. Balancing these conflicting obligations, while at the same time providing cost effective health care and avoiding litigation, has caused significant concern, if not consternation, since the statute's enactment in 1990.

Two recent decisions should be of significant assistance to health care providers and their counsel. The first, *Toyota Motor Manufacturing, Kentucky v. Williams*,² is a Supreme Court decision substantially restricting the types of conditions which render a person disabled within the meaning of the ADA. The second, *Waddell v. Valley Forge Dental Associates*,³ is a decision by the Eleventh Circuit affirming earlier precedent permitting employers to fire or refuse to hire a disabled individual where his disability poses even a small threat of serious injury or death to patients. In defining the scope of protected disabilities and defenses, the courts appear to be searching for a middle ground where individuals suffering serious impairments can be assured fair treatment while at the same time permitting employers to operate safely and efficiently. Such a trend can only benefit health care providers which are seeking the same goals.

DEFINING DISABILITY

A. Statutory Structure and Prior Case Law

Congress enacted the ADA with the stated purpose of providing "a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities."⁴ That it was unsuccessful in achieving clarity is evidenced by the plethora of litigation and conflicting decisions. Nonetheless, the basic statutory structure is straightforward. The ADA prohibits discrimination against a "qualified individual with a disability".⁵ A qualified individual with a disability is "an individual with a disability who, with or without reasonable accommodation, can perform the essential functions of the employment position" that he holds or for which he is applying.⁶ However, one need not reach the question of whether an employee or applicant is a "qualified individual" unless he is determined to have a disability.

The statute defines disability as

1. a physical or mental impairment that substantially limits one or more of the major life activities of such individual;
2. a record of such impairment; or
3. being regarded as having such an impairment.⁷

Key to all three is the meaning of "substantially limits" and "major life activities," and definitions of these terms are contained in regulations promulgated by the Equal Employment Opportunity Commission.⁸ "Major life activities" means "functions such as caring for oneself, performing manual tasks, walking, seeing, hearing, speaking, breathing, learning, and working."⁹ "Substantially limits" means unable or "significantly restricted as to the condition, manner or duration under which an individual can perform a particular major life activity."¹⁰ Unless a person has an impairment which substantially limits one or more of his major life activities, has a record of such impairment, or is regarded as having such an impairment, he is not disabled and therefore not protected by the statute.

Until 1999, the agencies administering the ADA and a majority of courts had held that the determination of whether

an individual was disabled was to be made without consideration of any remediation. Thus, for example, an amputee had to be evaluated without consideration of his prosthesis and a diabetic without regard to his use of insulin. All this changed with *Sutton v. United Airlines*.¹¹ There the Supreme Court considered the appeal of twin sisters whose uncorrected vision was no better than 20/200, but whose vision with corrective lenses was 20/20. United Airlines, relying on an internal standard requiring uncorrected vision of at least 20/100, refused to hire them as "global pilots," and the sisters filed suit, alleging discrimination based on an impairment that substantially limited the major life activity of working. Repudiating the position of the Equal Employment Opportunity Commission, the Court held that their impairment had to be evaluated taking into account their corrective lenses, and therefore that they did not have an impairment that substantially limited "any major life activity."¹² The Court reached a similar result in a companion case, *Albertson's, Inc. v. Kirkingburg*,¹³ finding that a truck driver with monocular vision who had compensated for his impairment so that he saw as well as people with vision in both eyes,¹⁴ was not substantially limited in the major life activity of seeing.

In reaching its decision in *Sutton*, the Court relied in large part on the Congressional finding that some 43 million Americans have one or more physical or mental disabilities. Noting that a definition of "disabled" which included correctable impairments would encompass many times that number, the Court consciously excepted a large number of individuals with impairments from the protections of the ADA. In doing so, it emphasized the necessity of evaluating the effect of the impairment on the individual in each case, rather than relying on general assumptions about the effect of a given impairment. Nor was the Court unaware of the possibly anomalous results of its decision. Under the *Sutton* standard, airlines and trucking companies may refuse, without any other reason, to hire individuals with impairments that have been corrected. However, individuals with uncorrected impairments that substantially limit major life activities (e.g., legal blindness), can only be refused a job if the employer can find an applicable exception under the ADA. As the Court noted:

...an employer is free to decide that physical characteristics or medical conditions that do not rise to the level of an impairment -- such as one's height, build, or singing voice -- are preferable to others, just as it is free to decide that some limiting, but not substantially limiting, impairments make individuals less than ideally suited for a job. (emphasis in original).¹⁵

The fact that an individual with a correctable impairment is not actually disabled, does not end the analysis. Under the ADA, the individual is protected if he is "regarded as" having an impairment that substantially limits a major life

activity, and because the Sutton sisters had alleged substantial limitation in the major life activity of working, the Court considered whether the airline "regarded" them as substantially restricted with respect to work. Although noting certain conceptual difficulty with utilizing work as a major life activity,¹⁶ the Court held that, "at a minimum," substantially limited means being barred from working in a "broad class of jobs," and that because the airline was applying the 20/100 requirement only to the job of global pilot, that standard was not met.¹⁷

What constitutes a "broad class of jobs" is not defined by the Court.¹⁸ However, in *Sutton*, the Court relied on the fact that the airline only imposed its uncorrected vision requirement with respect to a single job. Similarly, in *Murphy v. United Parcel Service*,¹⁹ a third case decided the same day as *Sutton*, the Court determined that a mechanic who was able to perform the duties of a number of mechanic positions and was only precluded by his hypertension from performing jobs requiring federal certification to operate a commercial vehicle, was not regarded as substantially limited in the major life activity of working.

B. Toyota Manufacturing, Kentucky v. Williams

Although *Sutton* and *Kirkingburg* resolved major issues under the ADA, they were, in some respects, easy cases. The sisters, with corrective lenses, had perfect vision; likewise, the truck driver in *Kirkingburg* was able to fully compensate for his monocular vision. These people were not "substantially limited" because in essence they were not limited at all.

In *Toyota*, the Court had to deal with a litigant who was in fact limited, and determine whether the limitations substantially affected a major life activity. The case was brought by Ella Williams, an assembly line worker at Toyota, who developed carpal tunnel syndrome, myotendinitis, and thoracic outlet compression as a result of her work at the plant. The company initially made some accommodations for her, but ultimately she was unable to perform the essential duties of the position, which required that she hold her hands and arms at shoulder height for several hours at a time.

The Sixth Circuit held that Williams was substantially limited in the major life area of performing manual tasks because she was unable to perform "a 'class' of manual activities affecting the ability to perform tasks at work,"²⁰ and was entitled to summary judgment on that issue. The Supreme Court reversed, holding that major life activities refers to activities "that are of central importance to daily life," not of central importance to a particular job. The Court found generally that the "manual tasks unique to any particular job are not necessarily important parts of most people's lives," and specifically that the ability to perform repetitive work with hands and arms extended at shoulder level was *not* an important part of most people's daily lives. Matters that are important to most people, according to the Court, include the ability to bathe, brush

one's teeth, and carry out personal or household chores.²¹ The Court specifically noted that there is "no support in the Act, our previous opinions, or the regulations for the ... idea that the question of whether an impairment constitutes a disability is to be answered only by analyzing the effect of the impairment in the workplace."²² Again, the Court emphasized the importance of a case by case analysis, noting that the determination of disability should turn not on the "name or diagnosis of the impairment ... but rather on the effect of that impairment on the life of the individual."²³

Although the decision dealt only with the major life activity of performing manual tasks, lower courts may well apply the same analysis to all major life activities other than working. The Court noted that the statutory phrase "major life activities" must be read as "activities that are of central importance to daily life," and that a looser, more inclusive definition would be inconsistent with the statutory finding relied on in *Sutton*, that only about 43 million Americans are disabled.²⁴

Thus, the Act no longer protects people whose conditions can be corrected so that they are able to perform the job and no longer protects a subset of people whose conditions are such that they cannot perform the job without accommodation, but whose impairments are not so severe that they substantially limit tasks that are important in most people's lives. With respect to individuals alleging substantial limitation with respect to the major life activity of working, the situation is less clear. At a minimum, the impairment must render the individual unable to perform a "broad range of jobs." Significantly, however, the Court has never ruled that a particular claimant meets that standard.

II. DIRECT THREAT DEFENSE

Even if an individual is found to be disabled and is fired or not hired for that reason, the employer may raise a number of defenses. Under the statute it is a defense to the charge of discrimination that "application of qualification standards, tests or other selection criteria that screen out or tend to screen out...an individual with a disability has been shown to be job-related and consistent with business necessity" and reasonable accommodation is not effective.²⁵ More specifically, "qualification standards" may include "a requirement that the individual...not pose a direct threat to the health and safety of other individuals in the workplace,"²⁶ and the regulations provide that this standard is met if a person poses "a significant risk... that cannot be eliminated or reduced through reasonable accommodations."²⁷ Determining the existence of a significant risk entails at least two steps. First, the determination of any risk must be based on "objective, scientific information."²⁸ Good faith belief is not enough, particularly when the employer is a health care professional. As the Eleventh Circuit has noted, this prevents a defense based on unfounded fears and prejudices that the ADA was intended to protect against.²⁹ As such, the stan-

dard is clearly right, and is easy to apply where the science is established. In cases where scientists disagree concerning the transmissibility of a disease, it is not entirely clear what the courts would do, but the Eleventh Circuit appears to come down on the side of caution and presumably would protect employment decisions made on the basis of reasonable, but unproven hypotheses.³⁰

Assuming that some level of risk is established, the next question is how to determine its significance. Here the courts use slightly different standards, but all balance the seriousness of the anticipated harm against the likelihood of its occurrence. With respect to AIDS, the Eleventh Circuit has determined that contraction of the infection inevitably leads to death, and that therefore even a remote possibility of transmission is sufficient to constitute a significant risk. Most recently, in *Waddell v. Wood Valley Dental Associates*, it affirmed the district court's entry of summary judgment in favor of the employer who fired a dental hygienist because he tested positive for HIV. The court accepted that transmission of the virus could occur through blood-to-blood contact and found persuasive that patients frequently bleed during dental prophylaxis and that the hygienist might either cut his hand or be bitten by a patient. Significantly, it ruled in favor of the employer even though "such an event [transmission of HIV during prophylaxis] has never before occurred."³¹ Presumably, similar analysis would be appropriate with respect to any HIV positive employees whose job required them to perform surgical or needle stick procedures. On the other hand, to the extent that these invasive procedures were incidental to the job, or rarely performed, a court might be expected to require reasonable accommodation in the form of exempting the employee from those duties. However, the direct danger test would likely not apply if the HIV positive employee were in a strictly clerical position.

Health care providers may also consider the "direct threat" defense in situations where the employee or applicant's disability endangers his own safety on the job. In *Moses v. American Nonwovens, Inc.*³² the Eleventh Circuit affirmed the entry of summary judgment in favor of an employer who fired an individual with uncontrolled epilepsy whose job entailed operation of machines that had fast moving press rollers and reached very high temperatures.³³ Although the decision provides little analysis, it would permit health care providers to fire or not fire persons who could not perform the essential elements of their job without posing a threat to their own safety. This would include individuals who could not safely operate machinery or automobiles, as well as immunosuppressed individuals whose jobs required exposure to infectious patients or people with bad backs who were required to do heavy lifting. The Ninth Circuit reached the opposite conclusion in *Echazabal v. Chevron USA*, holding that Chevron was required to hire an applicant with liver disease whose life might be threatened by exposure to refinery chemicals and solvents, and that an employer's concern for an applicant's health constituted a form of "paternal-

ism" prohibited by the Act.³⁴ The Supreme Court granted *certiorari* in *Echazabal*,³⁵ and its decision there will determine whether health care providers in Georgia may continue to consider risks to the health and safety of disabled employees and applicants in making placement decisions.

Conclusion

The foregoing discussion has considered only a few recent Supreme Court and Eleventh Circuit cases. Collectively, they significantly constrict the class of persons protected by the ADA and provide generous defenses against claims by those persons who remain within its protection. It would, however, be foolish to read these cases a form of judicial nullification or license to establish arbitrary job standards that adversely impact individuals with physical or mental handicaps. Rather, these cases are best read as an attempt by the courts to formulate a common sense approach to enforcement of the ADA. Clearly the Supreme Court is concerned that "disability" not be so broadly defined that most, if not all Americans, can be deemed disabled and that disability be determined with reference to the impact of the disease or condition on the particular individual, and not on the basis of a diagnosis or other label. It is only common sense that someone whose corrected vision is 20/20 is not disabled, and that only a relatively small percentage of people suffering from arthritis are. It does not go too much further to hold that inability to keep ones arms raised at shoulder level for several hours is not a substantial limitation on major life activities, even if it substantially limits the individual's ability to perform a particular job.

The determination of disability is, in theory, a separate question from whether the complaining individual can perform a given job or do so with reasonable accommodation. However, hard cases make bad law, and one can imagine that a court confronted with an arbitrary job qualification -- e.g., that a typist or laboratory technician be able to lift 100 pounds -- might be tempted to find that the plaintiff's relative lack of strength constituted a substantial limit on some major life activity. In a statute where the operative terms are "substantially limits," "significant risk," "major life activity," and "reasonable accommodation," balance and good judgment are clearly the touchstones. Therefore, counsel should advise health care providers to exercise discretion in establishing physical standards -- setting them only as high as they need to be, and applying them only to positions for which they are actually necessary.

More generally, health care providers should ensure that existing position descriptions accurately describe the essential duties of the position, and revise those that do not. Employees should be given copies of their position descriptions and the position descriptions should be available to applicants. To the extent that health care employers follow these precautions and exercise judg-

ment, they are less likely to be sued and more likely to prevail if they are.

¹ 42 U.S.C. § 12101 *et seq.*

² 122 S.Ct. 2002 (Jan. 8, 2002).

³ 276 F.3d 1275 (Dec. 21, 2001).

⁴ 42 U.S.C. § 12101(b)(1).

⁵ 42 U.S.C. § 12212(a).

⁶ 42 U.S.C. § 12111(8).

⁷ 42 U.S.C. 12102(2).

⁸ The Supreme Court has expressed some question about the deference to be accorded these regulations. *Sutton v. United Airlines*, 527 U.S. 471, 479-480 (1999).

⁹ 29 C.F.R. § 1630.2(i). See also discussion in Appendix to Part 1630.

¹⁰ 29 C.F.R. § 1630.2(j). See also discussion in Appendix to Part 1630.

¹¹ 527 U.S. 471 (1999).

¹² 527 U.S. at 488-489.

¹³ 527 U.S. 555 (1999).

¹⁴ The Court cited the Ninth Circuit's acknowledgement that Kinkingburg's "brain has developed subconscious mechanisms for coping with [his] visual impairment and thus his body compensates for is disability." 527 U.S. at 565, citing 143 F.3d at 1232.

¹⁵ 527 U.S. at 490-91.

¹⁶ 527 U.S. at 492.

¹⁷ 527 U.S. at 491-493.

¹⁸ But see, discussion at 29 C.F.R. Part 1630, App. § 1632(j).

¹⁹ 527 U.S. 516 (1999).

²⁰ 122 S.Ct. at 688.

²¹ *Id.* at 693.

²² *Id.*

²³ *Id.* at 692, quoting from 29 C.F.R. Part 1630, App. § 1630.2(j).

²⁴ *Id.* at 691.

²⁵ 42 U.S.C. § 12113(a)

²⁶ 42 U.S.C. § 12113(b).

²⁷ 29 C.F.R. § 1630.2(r).

²⁸ *Bragdon v. Abbott*, 524 U.S. 624, 649 (1998).

²⁹ *Onishea v. Hopper*, 171 F.3d 1289, 1298 (1999) (*en banc*). The Eleventh Circuit was construing a provision of the Rehabilitation Act rather than the ADA, but the standard there was also "a direct threat to the health and safety of other individuals" and the Eleventh Circuit relied on *Onishea* as precedent for its decision in *Waddell*.

³⁰ See *Onishea v. Hopper*, 171 F.3d at 1298-99.

³¹ 276 F.3d at .

³² 97 F. 3d. 446 (1996) (*per curiam*), *cert. denied*, 519 U.S. 1118 (1997).

³³ See 29 C.F.R. § 1630.15(b)(2) which takes the same position.

³⁴ 226 F.3d. 1063, 1068 (9th Cir. 2000).

³⁵ 70 U.S.L.W. 3314 (U.S. Oct. 29, 2001). Oral argument was heard on February 27, 2002.

ADDENDUM

**US AIRWAYS V. BARNETT:
THE LATEST WORD ON REASONABLE ACCOMMODATIONS
AND UNDUE HARDSHIP**

On April 29, 2002 the Supreme Court announced its decision in *US Airways v. Barnett*, the first case in which it examined the concepts of "reasonable accommodation" and "undue hardship." Barnett, a former baggage handler, requested, as a reasonable accommodation, assignment to a physically less demanding position. Because a non-disabled employee was entitled to the position under the company's seniority plan, US Air denied the request.

Under the ADA an employer is obligated to make "reasonable accommodations" but only to the extent that they do not constitute an "undue hardship on the business of [the employer]." 42 U.S.C. § 12112. US Airways claimed that the Act never requires accommodations that result in violation of "disability-neutral" rules such as seniority systems. Barnett claimed that any accommodation satisfied the reasonableness standard as long as it was effective in meeting the individual's disability-related needs.

The Court rejected both parties' contentions, adopting instead what it characterized as the "practical view of the statute" taken by many lower courts. Under this approach, the plaintiff has the burden of showing that the accommodation he seeks "seems reasonable on its face, i.e., ordinarily or in the run of cases." The employer may then counter with evidence that the proposed accommodation would cause undue hardship. In determining undue hardship, the focus is on difficulties in the context of the particular employer's business operations. The Court also noted that a proposed accommodation could be unreasonable if it adversely affected the workforce -- e.g., leading to dismissals or relocations-- but would not constitute an undue hardship unless it also had a serious impact on the employer's business operations.

The decision was 5-4, with Justice O'Connor joining only so that there would be a majority rule. Significantly, how-

ever, only Justices Scalia and Thomas questioned the above analysis, arguing that employers are only obligated to provide accommodation with respect to standards that an employee's disability prevents him from complying with (e.g., limited breaks), but not rules like seniority plans that do not create obstacles to the disabled. The reservations of Justices O'Connor (who wrote a concurring opinion) and Justices Souter and Ginsburg (who dissented) related not to the standards themselves, but to their application in the context of seniority plans.

On that issue, the majority ruled that proposed accommodations which conflict with existing seniority systems will not ordinarily be considered reasonable, and that in order to avoid summary judgment, a plaintiff who proposes such an accommodation would also have to produce evidence, based on particular facts, that the accommodation was in fact reasonable. According to the Court, this could take the form of evidence that the employer frequently exercised a unilateral right to make changes under the plan or that the plan already contained so many exceptions that one more was unlikely to matter. Justice O'Connor would have preferred to limit the ruling to legally enforceable seniority systems, while Justices Souter and Ginsburg thought that the majority accorded undue deference to seniority systems generally.

Viewed narrowly, this case stands for the proposition that in most instances proposed accommodations that require violation of existing seniority plans, will not be deemed reasonable. By itself this is an important ruling, that will be of use to health care providers that have seniority systems in place. More important, the Court has, for the first time, articulated its understanding of the meaning of two terms that are central to implementation of the ADA.

GEORGIA LEGISLATIVE SUMMARY - 2002

By: *Stanley S. Jones, Jr. and Helen L. Sloat*
NELSON MULLINS RILEY & SCARBOROUGH, L.L.P.

Georgia's General Assembly held a lengthy 2002 Session – one of the longest in the State's history. Because of delays related to reapportionment, it lasted 89 days from start to finish. In its wake, a number of health-related bills passed the finish line while others lagged behind. For the most part, the General Assembly dealt with the State's budget; reapportionment; and a number of the Governor's consumer-related, election-year issues, including predatory lending, gas re-regulation, pre-certification for health insurance treatments and procedures, and identity theft and privacy protections. Major healthcare initiatives included the following bills:

State's Budget:

FY 2002

HB 1001 – Originally, the Governor set the tax revenue estimate at \$14.4 million, but these were revised to \$13.8 million because of the six-month decline in tax receipts. In total, the Budget was set for more than \$16 billion (with Tobacco funds and other carry-overs). There were some successes for healthcare providers in the FY 2002 Supplemental Budget. Primarily, huge new amounts were needed to fund increasing Medicaid and PeachCare claims: an additional \$429 million was put into the Budget to increase funding for Medicaid alone.

Additionally, \$2.4 million was added in order to provide for additional dollars for the implementation of the new healthcare information and claims payment system for Medicaid.

The Governor also proposed to increase Hospice reimbursement rates, effective April 1, 2002 to reflect October 2001 Medicare rates. This will provide an additional \$361,489 in State funds, \$885,785 with federal matching dollars.

There were also changes made to the State's coverage for pharmaceuticals. A \$.25 reduction in the dispensing fee for Generic and Preferred Brand drugs in Medicaid and PeachCare for Kids will bring a cost savings of approximately \$738,000. Also, there will be prior approval for proton pump inhibitors, which became effective February 1, 2002, resulting in savings of more than \$1 million. Also, the Department of Community Health will impose quantity level limits and require prior authorization for Oxycontin (this became effective December 1, 2001).

One of the reductions dealt with the Community Care Services Program and delayed the phase-in of 1,000 of the 2,000 new slots funded in FY 2002, saving \$4,174,655.

Some Medicaid eligibility enhancements were postponed.

FY 2003

HB 1002 - New fiscal year initiatives also generated some much needed new money for hospitals, in addition to the cash cost of increased Medicaid eligibles. The Governor proposed \$18,069,150 to "increase reimbursement rates for inpatient hospital providers using 90% of adjusted calendar year 2000 cost data plus one year of DRI inflation of 3.2%." This amount will reach \$54 million with federal matching money. The House proposed eliminating the 90% language. By the time the Budget reached the Conference Committee, it changed the language to read: "increase reimbursement rates for hospital providers using adjusted calendar year 2000 cost data plus one year of DRI inflation of 2.7% by the percentage necessary to utilize no more than the funds appropriated for this purpose." Conferees had changed the language to assure the dollars remained the same as originally proposed by Governor Barnes and that all of this amount would be used.

Nursing homes and physicians still tend to be seen in a better light by the Governor and Legislators. The Medicaid budgets reflect these priorities by larger support of nursing homes (additional money was added in Conference in excess of \$5.2 million to the Governor's original proposal bringing the total for nursing homes to \$17.2 million in order to adjust case mix reimbursement rates for nursing home providers using 2001 cost reports plus two years of DRI inflation of 2.7% each year, effective October 1, 2002) and physicians (an additional \$13.4 million was included to reimburse physicians and related providers and services using 90% of 2000 Resource Based Relative Value Scale).

PeachCare got similar boosts for inpatient hospital providers. Tobacco Dollars are also going to fund increased eligibility expansions for children over the age of 1 with incomes between 200% and 235% of the federal poverty level. One major change to PeachCare for Kids in 2003 is that State funding will be provided to fund cash obligations for current year claims rather than on an incurred cost basis. The Department of Community Health has expressed doubt that the amount of funds provided will be sufficient. Conferees provided an additional \$6.9 million

to Governor's original proposal of \$20 million for Peach-Care, and they understand that the Supplemental Budget, for FY 2003, may require further additional dollars.

Additionally, the workforce issues also got the attention of the Governor, as he recommended \$587,500, in the Department of Community Health's budget, for funding to implement programs and initiatives recommended in Code Blue: Workforce in Crisis. This Code Blue report was prepared following work conducted by the Health Strategies Council's Technical Advisory Committee on Workforce issues.

In an effort to address the growing numbers of low-income senior citizens who are not eligible for Medicaid or have no other drug benefit coverage, the State has supplied additional monies in both the Department of Community Health's Budget (for MedBank expansions) and the Department of Human Resources' Budget (for GeorgiaCares program which will be announced in the summer of 2002 and will coordinate the State's Division of Aging Offices with the HICARE program). Amounts for these respective items are \$100,000 and \$350,000.

Other Budget Highlights included:

- \$6,585,889 will come from Tobacco funds for five items: equipment for eminent cancer scholars, clinicians, and professionals; Georgia Cancer Coalition information system; contract expenses related to the Coalition; staff for Coalition; and software licenses for bioinformatics.
- \$1,530,000 in funds for applying the ICAPP advantage model to Health Professions and funding new strategic response initiatives.

Office of Governor:

- \$357,833 was added (a decrease from Governor's proposal of \$521,195) in order to provide GEMA with five positions and related operating costs for the response to terrorism effort.

Department of Human Resources ("DHR"):

Enhancements:

- \$1,596,629 was added to transition 65 kids with mental retardation from state hospitals to community placements.
- \$1,040,000 funds were added to restore State funds reduced for MHMRS mental health services for children in state custody.
- \$1,601,368 for the state's ability to react to bioterrorism (This includes three epidemiologists; funding for emergency coordinators for eight positions funded with federal dollars; state-level epidemiologist; operating expenses for expansion of the state's diagnostic testing capabilities; and funds

for hospital data collection for a statewide trauma system.)

- \$1,513,940 to fund the increasing costs of vaccinations for uninsured children including new pneumococcal conjugate vaccine.

Tobacco Dollars:

- A \$1,550,000 reduction was made to reduce expenditures for the multimedia contract for cancer education.
- A \$5,750,000 reduction was made to reduce smoking prevention and cessation related contract expenditures.
- \$2,021,660 was added for the Cancer State Aid Program to cover medical expenses for uninsured cancer patients.

Legislation Passed:

Medical Records:

HB 696 – This bill amends O.C.G.A. § 50-18-72 by expanding the number of exceptions for information protected from disclosure to the public, specifically "911" calls: "Unless the request is made by the accused in a criminal case or by his or her attorney, public records of an emergency '911' system, as defined in paragraph (3) of Code Section 46-5-122, containing information which would reveal the name, address, or telephone number of a person placing a call to a public safety answering point, which information may be redacted from such records." This bill, while passed, was vetoed by Governor Barnes.

HB 1481 – This was a compromise bill between the Senate and House dealing with the Tri State Crematory issue. In total, there were four bills relating to crematories introduced. Rep. Mike Snow's bill, HB 1481, which incorporated Sen. Richard Marable's SB 469, passed. It adds a new Code Section at O.C.G.A. § 31-21-44.2 to make it an offense if someone throws away or abandons any dead human body or portion of such dead human body. This will be considered an offense of "abandonment of a dead body," a felony punishable by imprisonment for not less than one nor more than three years. There are exemptions for burial and cremation, and for medical or medical laboratory personnel, hospital personnel, coroner or medical examiner, funeral director, embalmer, crematory, or cemetery operator in performing duties relating to the possession or disposition of such dead human body (either imposed by law or by lawful contract). The bill also provides an exemption for the use of a dead human body by an accredited medical school, dental school, college, or university for education, research, or advancement of medical or dental science or therapy so that these will not be considered an offense under this subsection.

All crematories must now be licensed by DHR. With respect to medical records, the bill also contains provisions

which amend O.C.G.A. § 31-33-2 to require a provider having custody and control of any evaluation, diagnosis, prognosis, laboratory report, or biopsy slide in a patient's record to retain them for a period of not less than ten years from the date such item was created in most circumstances.

There are exemptions with caveats: 1) when an individual provider has retired or sold his or her professional practice; and 2) for a hospital which must retain records in accordance with rules in O.C.G.A. § 31-7-2. The bill also allows for access to a patient's records, when the person is deceased, by the person who has a healthcare power of attorney for the patient; when such is executor or administrator of estate; or is a survivor as defined in O.C.G.A. § 51-4-2; 51-4-4; and 51-4-5. Releases of these records by a provider may only be done with a signed written authorization.

It also provides for new identification procedures for bodies of deceased persons by changing the current law in O.C.G.A. § 43-18-8(a)(1) et seq. It allows for use of DNA testing and requires serial numbers for any prosthesis. Further, it provides requirements for tagging the remains of a deceased person during the cremation and verification after release to the funeral establishment. The crematory must contain a "separate" license and at least "one operable processing station for grinding of cremated remains". The new law amends O.C.G.A. § 43-18-75 so that the Board shall provide for inspections "not less frequently than annually, of the premises of funeral establishments and crematories."

Emergency Medical Services:

SB 385 – This was Governor Barnes bioterrorism bill in the wake of September 11. It establishes a new Section at O.C.G.A. § 31-12-1.1 to define "bioterrorism" and "public health emergency."

There are new reporting requirements by providers and pharmacists for all known or presumptively diagnosed cases of persons harboring any illness or health condition that may be caused by bioterrorism, epidemic or pandemic disease, or novel and highly fatal infectious agents or toxins.

DHR is required to ascertain the existence of any illness or health condition that may be caused by bioterrorism, to identify, interview, and counsel, as appropriate, all individuals reasonably believed to have been exposed to risk; develop information relating to the source and spread of the risk; and close, evacuate, or decontaminate, as appropriate, any facility and decontaminate or destroy any contaminated materials when the Department reasonably suspects that such material or facility may endanger the public health.

The portion of the bill, which caused the most debate, relates to the Governor's powers in O.C.G.A. § 38-3-51 to

direct DHR to coordinate all matters pertaining to the response to a public health emergency.

The bill amends the Governor's powers in the event of a public health emergency to require the Governor to "issue a call for a special session of the General Assembly pursuant to Article II, Section V, Paragraph VII of the Constitution of Georgia, on the second day following the date of such." It also amends the law on when a citizen can bear arms, as found in O.C.G.A. § 38-3-51(8), which states that the Governor may suspend or limit the sale, dispensing, or transportation of alcoholic beverages, firearms, explosives, and combustibles and now includes the caveat "that any limitation on firearms under this Code section shall not include an individual firearm owned by a private citizen which was legal and owned by that citizen prior to the declaration of state of emergency."

SB 442 – Sen. Jack Hill authored this bill on disposition of grants to rural hospitals. In 1999, the General Assembly passed SB 195 which provided for the grants. No monies were appropriated until the Supplemental 2002 Budget which allocates \$5 million. This new bill authorizes the Department of Community Health ("DCH") to administer the rural health grants, rather than DHR. These grants, as outlined in O.C.G.A. § 31-7-94.1, can be granted to hospitals, whether or not they are owned by hospital authorities, under certain conditions.

Those hospitals must continue to furnish essential health care services to residents in their areas of operation, engage in long-range planning and any restructuring which may be required for those hospitals to survive; be located in a rural county (fewer than 35,000 persons); participate in both Medicaid and Medicare; provide health care services to indigent patients; and maintain a 24 hour emergency room.

Grants to rural hospitals owned or operated by hospital authorities may be for (1) Infrastructure development; (2) Strategic planning; (3) Nontraditional health care delivery systems; or (4) the provision of 24 hour emergency room services open to the general public. A for-profit facility can participate only to provide the 24-hour emergency room services

Health Insurance and Unfair Business Practices:

SB 476 – This was the Governor's bill prepared at the insistence of Consumers' Health Insurance Advocate Cathey Steinberg. It was negotiated among many sectors of the health industry and did not reach final passage until *Sine Die*.

The bill adds a new unfair insurance trade practice, (b)(8)(A)(iv) to O.C.G.A. § 33-6-4, to broadly prohibit insurance discrimination based on race, color, and national or ethnic origin. A violation of this "division" shall give rise to a civil cause of action for damages resulting from such violation, including damages for bad faith and attor-

ney's fees and costs of litigation, and may also give rise to the awarding of punitive or exemplary damages.

Further, the bill adds another unfair trade practice, (12.1) to O.C.G.A. § 33-6-5, stating that "no insurer or managed care entity subject to the licensing by the Commissioner shall violate any provision of Chapter 20A of Title 33," the four-year-old Patient Protection Act.

Sen. Price's language from his SB 378 requires that a signed acknowledgement from each enrollee must be obtained at the time of enrollment and upon any subsequent product change elected by an enrollee acknowledging that he or she has been informed about the number, mix and distribution of participating providers and the existence of limitations and disclosure of such limitations on choices of health care providers.

New provisions added in O.C.G.A. §33-20A-7.1 apply to all managed care plans as well as those offered by the State. Plans which require pre-certification shall be required to have sufficient personnel available 24/7 to provide such pre-certifications (including benefit verification) for all procedures other than non-urgent procedures and to advise of acceptance or rejection of those requests and the reasons therefor. Acceptance or rejection may be provided through a recorded or computer generated communication as long as the individual requesting pre-certification has the option to speak to an employee/representative of the health plan. The granting of pre-certification assures payment except in cases of fraud or disenrollment.

It also adds notice requirements prior to cancellation or non-renewal of an individual or group accident and sickness policy for non-payment of premiums by an insurer within 14 days of the expiration of the grace period for payment of premium.

The bill also deals with access to services on termination of a physician's contract. It establishes procedures in the event a plan terminates a physician's contract so that the enrollee has the opportunity to continue to receive health-care services from that physician, if the enrollee is receiving active healthcare services for a chronic or terminal illness or is an inpatient for 60 days from the date of the termination of the physician's contract. If the enrollee is pregnant and already receiving treatment, then she may continue with that physician throughout the remainder of that pregnancy, including six weeks post-delivery care. This continuation of care need not occur if the physician was terminated because of suspension or revocation of the physician's license or there were some issue relating to the health, safety, or welfare of the enrollee. There is also similar language for termination by the physician of his or her contract.

New language is inserted at O.C.G.A. § 33-20A-62 regarding time limits for post-payment audits and retroactive denials by insurers or requests for additional payments by providers. The fine periods vary according

to when a provider files a claim, but all disputes must be resolved within 24 months. When pre-certification has been obtained by a patient or provider, the insurer shall be prohibited from contesting, requesting payment, or re-opening such claim or any portion thereof at any time following such pre-certification except to the extent the insurer is not liable for payment under the new pre-certification provisions in Code Section 33-20A-7.1.

The bill also outlines COBRA and conversion rights for enrollees.

The bill becomes effective on July 1, 2002 and shall apply to health benefit plans issued, delivered, issued for delivery or renewed in Georgia on or after October 1, 2002 provided that the medical necessity determinations apply to all claims relating to healthcare services provided on or after July 1, 2002. There are also some limits pertaining to the post-payment audits or imposition of retroactive denials before the effective date: any health plan that is doing such on any claim initially submitted prior to July 1, 2002 shall no later than June 30, 2003, provide written notice to the claimant of the intent to conduct such an audit or impose such retroactive denial and include the specific reason for the audit or denial and shall then complete the audit or denial and provide notice to the claimant of any payment or refund due prior to January 1, 2004.

SB 505 – Sen. Brown's bill passed this Session which proposes to add as an unfair trade practice in O.C.G.A. § 33-6-5 for the non-renewal or termination of an entire line or class of business by an insurer under certain circumstances.

HB 525 – Rep. Sally Harrell's bill, introduced in the 2001 Session, finally passed the Senate and requires that every insurer provide notice to its policyholders regarding coverage for maternity benefits and limitations on hospital stays.

The Notice must be in writing or be contained in the next mailing to the policyholder, or the yearly informational packets. Additionally, the insurer must provide the Notice to the expectant mother within 30 days following the date the insurer first learns that the expectant mother covered by maternity benefits of the health benefit policy is pregnant.

Privacy and Identity Theft:

SB 475 – This bill was one of Governor Barnes' more significant consumer initiatives relating to identity theft and identity fraud concerns. It establishes new crimes for identity abuses. The bill makes it a misdemeanor for "any person to knowingly possess, display, or use any false, fictitious, fraudulent, or altered identification document." Second and subsequent offenses are considered felony charges. The bill also makes it unlawful in O.C.G.A. § 16-9-4(b)(1) for any person to knowingly manufacture, alter, sell, distribute, deliver, possess with intent to sell, deliver, or distribute, or offer for sale, delivery, or

distribution a false, fraudulent, or fictitious identification document or any identification document which contains any false, fictitious, or fraudulent statement or entry; any trademark or trade name of another; to knowingly possess the logo or legal or official seal of a government agency or any colorable imitation thereof in furtherance of a conspiracy or attempt to commit a violation of the criminal laws of this state or of the United States or any of the several states which is punishable by imprisonment and/or fines.

The bill then defines new unfair business practices under existing law. "Business victim" is defined to mean any individual or entity that provided money, credit, goods, services, or anything of value to someone other than the intended recipient where the intended recipient has not given permission for the actual recipient to receive it and the individual has suffered financial loss as a direct result of the commission or attempted commission of a violation of this article. "Consumer victim" means any individual whose personal identifying information has been obtained, compromised, used, or recorded in any manner without the permission of that individual.

If an entity illegally releases identifying information about a consumer, then the victim may request an investigation by the administrator under the fair Business Practices Act and then report it to the Governor's Office of Consumer Affairs, which keeps a repository of complaints. A person may be punishable by imprisonment for not less than one, nor more than ten years or a fine not to exceed \$100,000.00, or both. Any person who commits such a violation for the second or any subsequent offense shall be punished by imprisonment for not less than three nor more than 15 years, a fine not to exceed \$250,000.00, or both. Additionally, he or she may be ordered by the court to make restitution to any consumer victim or any business victim of such fraud.

Any business victim who is injured by reason of any violation of this article shall have a cause of action for the actual damages sustained and, where appropriate, punitive damages. Such business victim may also recover attorney's fees in the trial and costs of investigation and litigation reasonably incurred. Any consumer victim may bring an action individually or as a representative of a class, seek equitable injunctive relief and recover general and punitive damages reasonable attorney's fees and expenses of litigation. However, punitive damages shall be awarded only in cases of intentional violation. Courts may also award treble damages for an intentional violation.

A business also may not discard a record containing personal information unless it shreds the customer's record before discarding the record, erases the personal information contained in the record, modifies the customer's record to make the personal information unreadable, or takes actions to ensure that no unauthorized person will have access to the personal information. Businesses may be fined not more than \$500.00 (nor more than

\$10,000.00) for each customer's record that contains personal information that is wrongfully disposed of or discarded. The bill also establishes an affirmative defense to the wrongful disposal, if the business can show that it used due diligence in its attempt to properly dispose of or discard such records.

Guardianship Issues:

HB 360 – This was Rep. Judy Manning's bill known as the Safe Place for Newborns Act of 2002 which creates a new Chapter 10A in Title 19 of the Code to allow babies to be abandoned at certain facilities, without liability under certain conditions. Originally, the bill was introduced in 2001 and had a great deal of opposition by lawyers who focus on adoption law. Some of the concerns the lawyers raised pertained to relinquishment of father's rights. In the version that passed, a medical facility does not include a physician's or dentist's private offices. If the baby, not more than one week old, is relinquished by the mother and the baby is found not to have been abused or neglected, then the mother shall not be prosecuted for the crimes of cruelty to a child.

HB 917 – Rep. Wendall Willard and others authored this bill creating the Standby Guardianship Act, in a new Article 2 of Chapter 4 of Title 29 of the Code, to help minor children when their parents become terminally ill. The parent may designate a person to serve as the "standby guardian" but prior to such taking effect, a healthcare professional must make a healthcare determination.

Mental Health Services:

HB 498 – Speaker Murphy introduced this measure in 2001 to amend Title 37 of the Code. It stalled in 2001 due to various issues and concerns about the powers which should be relegated to Community Service Boards ("CSBs") as delivery agents for mental health, mental retardation, and substance abuse services in the community. Speaker Murphy appointed a Study Committee chaired by Rep. Roger Byrd to review this legislation and hold hearings around the State prior to the commencement of the 2002 Session.

The bill changes the name from the Division of Mental Health, Mental Retardation, and Substance Abuse in DHR to the Division of Mental Health, Developmental Disabilities, and Addictive Diseases within the Department of Human Resources. Regional Boards will now become mere planning boards and community service board powers are redefined. New provisions deal with the Olmstead Supreme Court case on de-institutionalization.

HB 1400 - Reps. Jimmy Skipper and Buddy Childers authored this bill to amend current law on transportation of the mentally ill. The intent is to help with facility-to-facility transfers of these patients so that counties do not always bear the costs of such transfers and to allow patients to be transferred by their families.

Pharmacy Issues:

HB 585 – Initially, this legislation by Rep. Bobby Parham, which was introduced in 2001, was extremely harmful to pharmacy benefit managers and was fought by the DCH's own pharmacy benefit manager, Express Scripts. The bill changes the number of certified pharmacy technicians under the direct supervision of a pharmacist from two to three.

The bill also adds a new Code Section at O.C.G.A. § 36-4-110.1 which requires that every pharmacy benefit manager providing services or benefits in this state which constitutes the practice of pharmacy as defined in Code Section 26-4-4 shall be licensed to practice as a pharmacy in this state and shall comply with those provisions of Code Section 26-4-110.

One of the more interesting aspects of the bill, added in Conference, is in Section 3 which amends O.C.G.A. § 26-4-115(c). DCH is authorized to promulgate rules and regulations to require that all wholesale drug distributors make adequate provision for the return of outdated drugs for up to six months after the labeled expiration date for prompt full credit or replacement.

Healthcare Workforce Shortages:

HB 652 – This bill, introduced by Rep. Ron Dodson at the request of the Georgia Hospital Association, will create the Health Care Work Force Planning Act in new Code Section at O.C.G.A. § 43-1-30. This bill will attempt to gather data concerning various healthcare professionals who are licensed in Georgia. It requires healthcare related boards to distribute survey questions for the purpose of gathering data related to work force supply and demographics.

The bill also outlines uses for the data collected: “along with identifying information required for analysis of the data collected, including social security number, shall be provided by the agency responsible for administration of the professional licensing functions to the University of Georgia Office of Information Technology Outreach Services. The information and data shall be used solely for the purpose of analyzing the supply and demand of health care personnel and projecting trends and needs for the state’s health care work force.”

Hospital Lien Law Amendments:

SB 451 – Sen. Carol Jackson introduced this bill to amend O.C.G.A. § 44-14-470(b) and O.C.G.A. § 44-14-471. It requires a notice to be sent to persons before a hospital lien may be filed. Such written notice must be provided “within 30 days after the person has been discharged.... to the patient and, to the best of the hospital claimant’s knowledge, the persons, firms, corporations, and their insurers claimed by the injured person or the legal representative of the injured person to be liable for damages arising from the injuries.” It clarifies that a hospital lien

filed is against a cause of action and not against an individual and that such lien cannot be filed “sooner than 15 days” of the delivery of such notice to the interested parties. The bill also requires that Superior Court Clerks maintain a separate docket book for hospital liens in O.C.G.A. § 44-14-472.

HB 1040 – Rep. Alan Powell successfully proposed this bill to allow a traumatic specialty burn medical practice also to file a lien against a cause of action.

Licensure:

HB 69 – Reps. David Graves and others introduced this bill to license clinical perfusionists. The Board overseeing these clinical perfusionists will be the Composite State Board of Medical Examiners.

HB 828 – Rep. Bobby Parham introduced this amendment to Chapter 34 of Title 43 which establishes that orthotics and prosthetics personnel be licensed to practice. This will also be overseen by the Composite State Board of Medical Examiners.

HB 1083 – Rep. Louise McBee and others introduced this bill early in this year’s Session, to change the licensing requirements for athletic trainers in Title 43. An applicant no longer is required to hold a degree in physical therapy (or corrective therapy) with a minor in physical education or health, and two academic years working under the direct supervision of an approved athletic trainer. Now, such an applicant must have met the athletic training curriculum requirements of a college or university approved by the board and give proof of graduation. Current law states that athletic trainers shall be entitled to receive reimbursement for services under such policies or contracts regardless of whether such services are rendered by a duly licensed doctor of medicine or by an athletic trainer as long as the person is qualified pursuant to paragraph (1) or (2) of subsection (a) of Code Section 43-5-8. Further, the current law states that an insurer is required to offer such coverage.

HB 1344 – Rep. Pinholster’s bill repeals the sunset provisions in the Georgia Volunteers in Health Care Specialties Act; Georgia Volunteers in Dentistry Act; and the Georgia Volunteers in Medicine Health Care Act. These allow the provision of healthcare services to the indigent by retired professionals as long as these professionals (such as physicians and dentists) do not obtain fees for their services.

HB 1352 – Rep. Buddy Childers introduced this bill as a result of a court opinion on the confusing nature of current law governing supervision of physicians’ assistants. It increases the number and deals with group practice settings. It specifically amends O.C.G.A. § 43-34-102 and establishes definitions for an “alternate supervising physician” for which an assistant may work. Further, the bill clarifies law on situations of “on-call” practice issues and provides that a primary supervising physician the ability

to designate, in writing, an “alternate supervising physician.” No primary supervising physician shall have more than four physician’s assistants licensed to him or her at a time; provided, however, that no physician may supervise more than two physician’s assistants at any one time.

Insurance Mandates:

HB 1100 – This was Governor Barnes’ initiative on requiring health plans to provide for coverage for colorectal cancer screening. This will be found in O.C.G.A. § 33-24-56.3.

HB 1492 – Rep. Bobby Parham introduced this bill dealing with health insurance coverage for diabetics. New language in O.C.G.A. § 33-24-59.2 requires that on or after July 1, 2002 health insurance plans “shall provide” for coverage for medically necessary equipment, supplies, pharmacologic agents, and outpatient self-management training and education, for individuals with insulin-dependent diabetes, insulin-using diabetes, gestational diabetes, and non-insulin-using diabetes who adhere to the prognosis and treatment regimen prescribed by a licensed physician.

Indigent Care Trust Fund:

HB 1402 – Governor Barnes introduced this legislation with Rep. Kathy Ashe to create a breast cancer prestige tag. The funds generated shall be deposited in the Indigent Care Trust Fund in order to fund cancer screening and treatment related programs for those persons who are medically indigent. Such prestige tags will be available on or after January 1, 2003.

State’s Health Plans:

SB 408 - SB 408 allows employees of the Federal-State Shipping Point Inspection Service and the Georgia Firefighters’ Pension Fund to participate in Georgia’s flexible employee benefit plan. This expands current law on who may participate found in O.C.G.A. § 45-18-50.

HB 1049- This bill allows for 30 days paid leave for State employees who wish to serve as organ donors and seven days paid leave for those State employees who serve as bone marrow donors. This bill amends current provisions pertaining to State employees’ leave time found at O.C.G.A. § 45-20-31. The bill becomes effective on July 1, 2002.

Tax Initiatives:

HB 1444 – This bill includes a provision for use of Special Local Option Sales Tax (“SPLOST”) dollars by a county for certain hospital facilities. The specific language authorizes a capital outlay project or projects for a hospital or hospital facilities that are owned by a county or a hospital authority and operated by the county or hospital authority or by an organization which is tax exempt under Section 501(c)(3) of the Internal Revenue Code,

which operates the hospital through a contract or lease with the county or hospital authority.

HB 1565 – This amends O.C.G.A. § 48-7-29 so that certain tax credits could be given for qualifying rural hospitals and rural physicians beginning January 1, 2003. The bill redefines “rural hospital” and “rural physician” so that a “rural hospital” is an acute care hospital located in a rural county that contains fewer than 100 beds (the current law requires 80 beds) and a “rural physician” is a physician licensed to practice medicine in Georgia in a rural county who resides in a rural county or a county contiguous to the rural county and work in the fields of family practice.

Patient Protection Initiatives:

HB 1413 – Reps. Buddy Childers and Larry Walker were behind this initiative. It establishes that criminal record checks must be completed on employees of personal care homes who either handle funds of residents or have direct personal contact with the residents. A director must have fingerprint records check as well. Additionally, each potential employee of a facility shall request a criminal record check from a local law enforcement agency and submit the results of the criminal record check to the facility. See O.C.G.A. § 31-7-250 et seq.

HB 1585 – This bill strengthens the law in O.C.G.A. § 16-5-100 on cruelty to the elderly. A person who is the guardian or who is supervising the care or custody of a person age 65 or older will be guilty of cruelty when such person willfully deprives the elderly person of healthcare, shelter, or necessary sustenance to the extent that the person’s wellbeing is jeopardized. There are some exemptions for a person acting under a physician’s guidance and to a hospital, skilled nursing facility, hospice, and their agents/employees who are in good faith following a course of treatment developed in accordance with accepted medical standards or are acting in good faith in accordance with a living will or durable healthcare power of attorney. The provisions of this bill become effective on July 1, 2002.

Other Consumer Initiatives Impacting Healthcare:

HB 1568 - Natural gas regarding regulation caused a great deal of anxiety within the Governor’s Office, as well as with Legislators, advocates and even hospitals. HB 1568 created a Universal Service Fund for low-income consumers funded by a surcharge on “interruptible service” users. Some of Georgia’s hospitals are “interruptible service” users who will be required to pay to the fund. Amendments were hammered out for exemptions from these surcharges will be based upon a hospital’s indigent and other free care as a percentage of its expenses.

2002 GEORGIA HEALTH CARE LAW UPDATE

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Agency

Palladino v. Piedmont Hospital Inc., No. A01A1884, 2002 Ga. App. LEXIS 273 (Mar. 4, 2002). Plaintiff alleged respondeat superior liability where the hospital's employee allegedly touched and later fondled plaintiff's genitals after surgery. Addressing the respondeat superior claim, the Court found it a question of fact whether the employee deviated from his accepted duties in touching the patient's genitals, because at least one of the defendant's duties was to examine the plaintiff's genitals.

Williamson v. Coastal Physician Servs. of the Southeast, Inc., 251 Ga. App. 667, 554 S.E.2d 739 (2001), cert. denied (Mar. 11, 2002). A widow whose husband died several weeks after being treated in a hospital emergency room sued the physician service company at the ER for the physician's medical malpractice. The court ruled that in order for vicarious liability to be imputed from an employee to an employer, the employer must have assumed the right to control the time, manner, and method of executing the work, including the hours of work and how to perform the details of the job. In this case, the physician was an independent contractor who worked in the emergency room pursuant to a staffing agreement. The agreement allowed the doctor to notify the hospital on a monthly basis of when he was available to work; allowed the hospital to schedule him only during those times; and allowed the hospital no control over the manner or method by which the physician diagnosed or treated patients in the emergency room. The physician and hospital demonstrated to the court that the contract language was followed. Therefore, the court ruled the physician was not an employee or agent of the physician service company, and the vicarious liability malpractice claim was dismissed.

Mantooth v. American National Red Cross. See description of this case on page 7.

Americans With Disabilities Act

Waddell v. Valley Forge Dental Associates, Inc., 276 F.3d 1275 (11th Cir. 2001).

A dental hygienist with HIV was not considered a "qualified individual" under the Americans with Disabilities Act and thus his discrimination claim was dismissed. Rather, the plaintiff hygienist was considered a direct

threat to the health and safety of the patients because the procedures she used to clean teeth are "exposureprone" based upon the Center for Disease Control's definition of the term and reliable medical opinion. As such, the hygienist could not claim protection of the ADA, and his employer could properly refuse to allow him to continue treating patients.

Bankruptcy

Cochran v. Emory University, 251 Ga. App. 737, 555 S.E.2d 96 (2001), cert. denied (Feb. 25, 2002). Here's an interesting twist on a typical malpractice claim. The Cochrans filed a bankruptcy petition in March of 1997. In that petition, Cochran was required to list all "contingent and unliquidated claims of every nature." The Cochrans left this section blank, failing to disclose Cathy Cochran's potential malpractice claim as an asset. The bankruptcy court discharged the Cochran's debts and closed the bankruptcy. Cochran subsequently filed a medical malpractice suit against a hospital. The hospital successfully filed a motion for summary judgment, contending Cochran was judicially estopped from bringing the medical malpractice claim. Cochran claimed she told her attorney about her claim and her bankruptcy attorney advised her not to list the asset because the suit was not yet filed. Cochran moved to reopen the bankruptcy case, and then filed a motion for reconsideration in light of the reopened bankruptcy case. The trial court denied the motion, finding Cochran's attempts to amend her petition were untimely and made only after receiving an unfavorable order on summary judgment. The Court of Appeals affirmed the trial court, holding the debtor was judicially estopped from asserting the claim. It was clearly within the discretion of the trial court to find the plaintiff did not act with the requisite diligence after the bar of judicial estoppel was raised.

West v. Men's Focus Health Centers of Georgia, Inc., 251 Ga. App. 202, 553 S.E.2d 379 (2001), cert. denied (Jan. 9, 2002). Married couple sought to renew an earlier malpractice suit alleging that the medical center's and physician's malpractice caused the patient to become totally impotent. The original action was filed when the medical center was involved in a federal bankruptcy proceeding. The bankruptcy court granted the plaintiff's motion for relief from the bankruptcy court's automatic stay, allowing the plaintiffs to prosecute their medical malprac-

tice action. Subsequently, the Wests dismissed the action without prejudice. Several days later, the Wests filed a new complaint. This court ruled the bankruptcy court's previous actions annulled the stay normally in place during bankruptcy proceedings; therefore, the couple was free to pursue their renewed malpractice claim.

Conflict Of Interest

Georgia Baptist Health Care System, Inc. v. Hanafi, 253 Ga. App. 540, 559 S.E.2d 746 (2001). In 1994, Dr. Hanafi was denied reapplication of privileges to a hospital and filed suit. In 1996, Dr. Hanafi terminated his relationship with his original law firm and retained new counsel. In that same year, one of Hanafi's former attorneys from his original law firm joined the law firm that represented the hospital. The hospital's firm put up a firewall and sent notice to Dr. Hanafi stating the conflict and expressing its understanding Dr. Hanafi waived any objections. Dr. Hanafi did not object. Seventeen months later, and after again obtaining new counsel, Dr. Hanafi decided to object to the conflict. The trial court ruled in favor of Dr. Hanafi. On appeal, the court reversed the trial court's decision, stating the alleged conflict of interest issue was untimely and the conflict was apparently waived. In general, courts consider the length of the delay, whether the movant was represented by counsel during the delay, why the delay occurred, and whether disqualification would result in prejudice to the nonmoving party contrary to the administration of justice. Here, the conflict issue was not raised by Dr. Hanafi until many months after the notice; there was a hint of delay tactic or harassment in the delay; and disqualifying counsel would have deprived the hospital of its longstanding counsel and delayed resolution of the case. Additionally, public trust was not undermined by the decision. Therefore, the court ruled no conflict existed.

Employment Issues

O'Neal v. Garrison, 263 F.3d 1317 (11th Cir. 2001). Terminated executive of Master Health Plan, Inc. (MHP) brought a whistleblower suit against MHP, its outgoing president, and other executives asserting various federal and state claims. As an at-will employee, the plaintiff cooperated with the government in the criminal investigation and testified before the grand jury. The grand jury returned an indictment against MHP and some of its executives. Subsequently, the plaintiff was placed on administrative leave with pay and later terminated. Plaintiff filed suit on federal civil rights conspiracy claims, Georgia RICO, and tortious interference claims, and the trial court entered summary judgment for the defendants. The jury returned a verdict for one of the executives on a breach of contract claim. The plaintiff appealed. The Court of Appeals reversed, holding that (1) the plaintiff's at-will status did not preclude the civil rights conspiracy claim or the state RICO claim; (2) alleged retaliatory termination of employment satisfied the "predicate acts" requirement for state RICO claims; (3) a question of fact existed as to whether the incoming president possessed

the authority to terminate the executive; and (4) the fact that the outgoing president was angry with the plaintiff did not make the outgoing president potentially liable for tortious interference.

Evidence

Hospital Corporation of Lanier v. Doster, A01A2240, 2002 Ga. App. LEXIS 302 (Mar. 8, 2002). After admitting negligence and proceeding to trial upon the issues of causation and damages, the defendant hospital appealed the jury's damage award, complaining evidence of negligence offered during the causation and damages trial was cumulative and prejudicial. The Court of Appeals disagreed, concluding because such evidence was required to show causation, there was no abuse of discretion by the trial court in allowing the testimony.

Brown v. Macheers, 249 Ga. App. 418, 547 S.E.2d 759 (2001), *cert. denied* (Oct. 22, 2001). This case was fraught with evidentiary issues including relevance, impeachment, the right to question reactions during testimony, and the availability of insurance. A patient died from excessive bleeding following heart surgery, and the administrator of the estate brought a medical malpractice claim against the surgeon. The jury found for the defendant. The appellate court reversed this decision, ruling the trial court should have allowed plaintiff to question defendant about his surprised reaction to testimony, because a party's conduct is relevant to the case. Also, costs of medications and their influence on the physician's decision-making is a proper line of questioning and should have been permitted. The appellate court also ruled that, under the fairness doctrine, the defendant is required to introduce all portions of plaintiff's expert's deposition relevant to the matter on which the expert was being impeached. Finally, the court found that raising issues of costs of medications does not necessarily open the door to the admission of evidence of insurance coverage.

Chambers v. Gwinnett Community Hospital, Inc., 253 Ga. App. 25, 557 S.E.2d 412 (2001). Evidence that defendants' expert witnesses were policyholders in the defendant's mutual insurance company was properly excluded, as mere policyholder status represents too attenuated a connection with any type of insurance company to outweigh the potential prejudice to the jury's deliberations. Further, the trial court has sound discretion to determine whether an expert has the experience necessary to testify and to determine what areas, if any, the expert could address in his testimony.

Cannon v. Jeffries, 250 Ga. App. 371, 551 S.E.2d 777 (2001). The plaintiff's expert affidavit stated that the physician was negligent in failing to test for chlamydia in the mother, which "may have contributed to the premature rupture of membranes," and the physician negligently delayed an emergency caesarian section that contributed to the death of the newborn child. However, the expert substantially qualified her opinions in her deposition, testify-

ing she could not state with a reasonable degree of medical certainty that chlamydia caused the pre-term labor. The Court of Appeals found, although it is not necessary to use the magic words "reasonable degree of medical certainty" in describing the prospect of survival for appropriate treatment, such prospect must be more than a mere chance for speculation. Thus, the Court of Appeals affirmed the trial court's grant of summary judgment.

Latimore v. Department of Transportation, 250 Ga. App. 360, 552 S.E.2d 439 (2001). This case clarifies the rules regarding impeachment of an expert witness. A negligence action was filed against the DOT after an employee allegedly backed into a pedestrian. The plaintiff's treating physician testified as an expert on the plaintiff's condition, treatment, medical record and medical expenses. On cross-examination, the physician was asked whether his medical license had ever been suspended or placed on probation, and the expert answered "no." The defense then proved otherwise. The court recognized that normally, after being qualified as an expert, the credibility of one's record is not impeachable; however, a witness may always be impeached on a collateral issue indirectly material to the issue in the case. The physician was suspended due to failure to perform appropriate tests and evaluations and failure to maintain proper records – evidence material to the case. Therefore, the evidence was admissible.

Fraud & Abuse

United States v. Whiteside, No. 99-15197, 2002 WL 448494 (11th Cir. Mar. 22, 2002). This opinion represents a huge setback for the government in its celebrated prosecution of Columbia/HCA. Defendants were convicted on conspiracy and false statement charges for classifying debt interest as 100% capital-related on hospital Medicare/Medicaid cost reports submitted to the government. The government contended this classification of interest expenses based on how the debt was being used at the time of the filing of the cost report, rather than how the funds were used at the time of the loan, was inconsistent with Medicare regulations. The court noted the verification/certification statement on the cost report only specified "intentional misrepresentation or falsification of any information contained in this cost report may be punishable by fine and/or imprisonment under federal law." The court held the government could not meet its burden of proof because no Medicare regulation, administrative ruling or judicial decision clearly requires interest expense to be reported in accordance with the original use of the loan. Therefore, the government could not prove the defendants knowingly and willfully made false statements, and the Eleventh Circuit reversed the convictions.

United States v. Liss, 265 F.3d 1220 (11th Cir. 2001). Defendants were convicted of participating in a scheme to defraud Medicare by receiving kickbacks, including lease and office furniture payments, for referrals to an independent laboratory. In affirming their sentences, the court

found a physician abuses his position of trust when receiving a kickback for a referral even where the referrals were medically necessary and the physician did not falsify patient records or submit fraudulent claims. However, the doctor could not be ordered to pay restitution for the medically necessary referrals because there was no actual loss to the government.

Culver v. State, Nos. A01A2319, 2002 WL 316029 (Ga. Ct. App. Mar. 1, 2002). In a Fulton County bench trial, defendant was found guilty of Medicaid fraud for overcharging and unnecessarily charging Medicaid for certain drug tests. The Court of Appeals reversed defendant's conviction, finding venue was not proper in the case. Under O.C.G.A. § 49-4-146.1(b)(1)(A)-(C), venue for improperly obtaining or attempting to obtain benefits from Medicaid occurs in the county to which the Medicaid billing forms are submitted. In this case, proper venue for the Medicaid charge was DeKalb rather than Fulton County. [NOTE: see also Cash v. State, No. A01A2371, 2002 WL 387474 (Ga. Ct. App. Mar. 13, 2002) for a similar ruling.]

Hospital Authorities

Caudell v. City of Toccoa, 153 F. Supp. 2d 1371 (N.D. Ga. 2001). The plaintiff had served continuously on the Stephens County Hospital Authority since 1978 and on the City Commission since 2000. Act No. 163 by the 2001 General Assembly amended the municipal charter of the City of Toccoa to prohibit "any member of the City Commission . . . [from] serv[ing] simultaneously as a member of the board of any hospital authority." The plaintiff was the only person in the state affected by the Act. The plaintiff alleged the Act violated (a) the Voting Rights Act of 1965; (b) the Equal Protection Clause of the Fourteenth Amendment and Article I of the Georgia Constitution; (c) the right to freedom of association under the First Amendment and Article I of the Georgia Constitution; (d) the Bill of Attainder Clause in the United States and Georgia Constitutions; and (e) provisions of the Georgia Constitution and Code prohibiting local or special legislation on matters previously addressed through general legislation. The court held the Act was unconstitutional under each of these federal and state provisions. Because plaintiff had been singled out as the only person affected by the Act, and since no legitimate state purpose had been shown justifying the Act, it was declared illegal and unconstitutional.

Turpen v. Rabun County Board of Commissioners, 251 Ga. App. 505, 554 S.E.2d 727 (2001), cert. denied (Feb. 11, 2002). Citizens sued seeking, among other things, a declaration that defendants' pending acquisition of a nonprofit hospital was void for failure to comply with the Hospital Acquisitions Act. Although their requested relief was ultimately granted, it was impossible to undo the already finalized acquisition. Following remand, the citizens moved to enjoin defendants from selling or making payments on any revenue bonds relating to the hospital acquisition. Because the citizens did not file their

appeal in a timely manner, the Superior Court's decision was binding, and payment could be made.

Immunity

Martin v. Fulton-DeKalb Hospital Authority, 250 Ga. App. 663, 551 S.E.2d 415 (2001), cert. denied (Mar. 11, 2002). This case interprets the scope of the ambulance immunity law. A premature baby was transferred by a Grady Health Systems ("Grady") transport team to Crawford Long Hospital. Grady allegedly administered an overdose of blood thinner that caused excessive brain damage. The trial court granted Grady's motion for summary judgment under O.C.G.A. § 31-11-8(c), which provided immunity for certain ambulance services performing emergency services for no remuneration. The plaintiff appealed, arguing Grady was paid for its emergency services and therefore § 31-11-8 did not apply. Grady contended the Medicaid payments did not cover medical services rendered while the patient was aboard but was instead analogous to "transportation fees," which should not revoke immunity. The Court of Appeals agreed with the plaintiff, finding no immunity because Grady had contracted to provide Medicaid services and had agreed to be reimbursed by Medicaid as payment in full. The court rejected the argument the reimbursement was not specifically for "medical care," and therefore was not "remuneration." The court found there was no requirement under § 31-11-8(c) that the emergency services rendered specifically denote medical intervention. In dicta, however, the Court noted this decision would not change prior decisions providing for charitable immunity in cases where Medicaid had paid only part of the patients' care.

Washington v. Clark, 250 Ga. App. 242, 550 S.E.2d 671 (2001), cert. denied (Nov. 30, 2001). This case applies the Good Samaritan law applicable to volunteer physicians. A malpractice claim was brought by a plaintiff who, during an unsuccessful burglary attempt, was shot in the chest. Emergency technicians applied inflatable military anti-shock trousers to the plaintiff. Subsequently, the plaintiff was transported to a hospital where an on-call vascular surgeon was summoned from home to perform emergency surgery on the plaintiff. Ten days later, due to allegedly negligent use and negligent monitoring of the trousers, plaintiff experienced renal failure, resulting in an infection in his legs requiring amputation of both legs. The court upheld previous rulings finding the surgeon statutorily immune from malpractice claims based on O.C.G.A. § 51-1-29.1(a)(1), which immunizes a provider "who voluntarily and without the expectation or receipt of compensation provides professional services ... at the request of a hospital." The physician's assistance as an on-call surgeon was voluntarily provided with no expectation of payment, and neither he nor his professional corporation received any payment from any private person or public entity in connection with the services provided. The fact substantial portions of patient's medical charges

were paid by Medicaid did not bar application of statutory immunity because the hospital, not the physician, received the money.

Satilla Community Serv. Bd. v. Satilla Health Serv., Inc., 251 Ga. App. 881, 555 S.E. 2d 188 (2001). A psychiatric patient stabbed and killed her Community Service Board caseworker after discharge from a psychiatric hospital. The deceased caseworker's guardian filed an action for contribution and implied indemnity against the patient's psychiatrist and the psychiatric hospital which had contracted with the Community Service Board to provide psychiatric services. In turn, the hospital brought an action against the Community Service Board who employed the social worker. The court found that the Community Service Board was a state agency or department within the state and therefore was subject to sovereign immunity for tort liability. Nonetheless, that immunity did not extend to claims sounding in breach of contract and indemnity as a contract right. The Community Service Board's failure to properly screen a patient with a criminally violent past prior to admission constituted a breach of contract with the hospital and grounds for a claim. Additionally, the Worker's Compensation Act did not bar claims against the Community Service Board because the contract between the Board and the hospital implied indemnity for the hospital for negligent acts by the Board, its agents and employees.

Intentional Infliction Of Emotional Distress

Mantooth v. American National Red Cross, 253 Ga. App. 587, ___ S.E.2d ___ (2002). This case involves several different issues, each of which is discussed separately. A woman's estate sought recovery for emotional distress because she received a blood transfusion from a donor who was in a part of Africa where a rare undetectable strain of HIV existed. Shortly after receiving the transfusion, Red Cross notified the hospital it had supplied substandard blood. The woman did not test positive for HIV and her death was in no way associated with HIV. Nonetheless, the decedent claimed she was in constant fear (when alive) that she had the virus and would pass it on to family members. The decedent did not seek medical treatment for her "severe emotional distress" nor did she seek treatment for the physical damage allegedly caused by the transfusion. In fact, she did not incur any transfusion-related medical expenses.

Exposure to HIV Claim: The court ruled that, although Red Cross breached a duty by failing to follow its own standards, the decedent's estate could not recover because it did not demonstrate the damage was proximately caused by the breach of duty, and the mere fear of exposure after an allegedly negative event is not enough to prove actual exposure for purposes of establishing emotional distress damages.

Agency Claim: The court ruled the hospital was not vicariously liable for the acts of the physicians who alleg-

edly negligently gave the blood transfusion. The record showed the physicians were not employees of the hospital; rather, the hospital merely granted them active medical staff privileges. The hospital did not compensate either doctor for medical services performed at the hospital and did not reserve the right to control their time, manner, or method of patient care. The recruiting agreement between the hospital and physician did not transform him into an employee of the hospital. The agreement did not provide a salary, and a loan to finance his practice was insufficient to make him an employee. Therefore, partial summary judgment on the issue of vicarious liability was rightfully granted by the trial court.

Apparent Agency Claim: Similarly, there was no evidence to hold the hospital vicariously liable for the doctors' conduct based on apparent agency. Under apparent agency theory, a hospital may be liable for the actions of a doctor who is an independent contractor when (1) the hospital holds the doctor out as its agent and (2) the patient's justifiable reliance on that holding out leads to injury. There was no evidence of either element in this case. In fact, the consent form signed by decedent explicitly stated she understood all physicians furnishing services to her were independent contractors and not employees or agents of the hospital.

Northside Hospital, Inc. v. Routanen, 246 Ga. App. 433, 541 S.E.2d 66 (2000). Here's one we missed last year, so we're including it in this year's outline. Child of a deceased patient brought an action against hospital alleging intentional infliction of emotional distress arising out of the disposition of her father's body. The plaintiff claimed the morgue's reference to the father as "the body" and the hospital's delay in the disposition of the body were unreasonable and outrageous. The court ruled the definition of intentional infliction of emotional distress is conduct so outrageous in character and so extreme as to go beyond all possible bounds of decency as to be regarded as outrageous and utterly intolerable in the civilized community. Although calling the woman's deceased father "the body" could be considered rude and insensitive, it cannot be considered outrageous. Furthermore, prior to his death, the deceased had executed a document giving his fiancé power of attorney. Although the document lacked many of the legal requirements for a proper power of attorney, the fact such a document was executed meant it was not unreasonable for the hospital to be deliberative in the disposition of the body. Therefore, although comments made and procedures taken may have been rude and insensitive given the nature of the situation, they were not outrageousness.

Medical Malpractice

Bradford v. Rossi, 249 Ga. App. 325, 548 S.E.2d 70 (2001). Patient brought a medical malpractice suit against his physician for alleged abandonment. The Court of Appeals dismissed the complaint, holding a claim of abandonment against a medical physician amounts to a claim

for medical negligence, which requires filing an expert affidavit under Georgia law.

Bowling v. Foster, A01A2094, 2002 Ga. App. LEXIS 384 (Mar. 21, 2002). Plaintiff sued her orthopedic surgeon for medical malpractice, fraud, battery and breach of fiduciary duty resulting from his failure to properly treat her condition, failure to inform her the initial treatment had failed, not documenting the treatment had failed, and not disclosing such failure to a doctor sought out for a second opinion. Because plaintiff presented no expert testimony the orthopedic surgeon had deviated from the standard of care, defendant was entitled to summary judgment on the malpractice claim. Moreover, the patient's execution of an informed consent form negated her fraud, battery and breach of fiduciary duty claims for his pre-operative treatment. However, because the doctor actively misled the plaintiff by concealing the cause of her post-operative pain and providing misleading information to her second doctor, the claims for fraud and breach of fiduciary and private duty were allowed to proceed.

Rockefeller v. Kaiser Foundation Health Plan of Georgia, 251 Ga. App. 699, 554 S.E.2d 623 (2001). Under O.C.G.A. § 43-34-103 and § 43-34-105, each physician's assistant must be supervised by a doctor approved to supervise such physician's assistant by the Composite State Board. In this medical malpractice case, a physician's assistant misdiagnosed plaintiff's condition and prescribed drugs while under the supervision of a physician who was not approved by the Composite State Board. On this basis, plaintiff alleged negligence *per se*, and the Court agreed, rejecting defendants' argument that a member of a group practice can supervise the physician's assistant of another group member without Composite Board approval. [NOTE: In response to this ruling, House Bill 1354 was enacted by the 2002 General Assembly allowing a "primary" supervising physician to designate with the Composite Board any number of "alternate" supervising physicians as long as such alternate supervises no more than 4 PAs at any one time.]

Byrne v. Nezhad, 261 F.3d 1075 (11th Cir. 2001). Plaintiff brought a medical malpractice case as part of a multi-count Georgia Racketeer Influence and Corrupt Organization's Act ("RICO") prosecution. Based on similar prior litigation in state court and suspecting the plaintiff's claims lacked factual basis, the District Court took an unusual step and granted defendant leave to conduct discovery for the purpose of determining whether the plaintiff had violated Rule 11 of the Federal Rules of Civil Procedure. Plaintiff then moved for the court to recuse, but the court denied the motion. After discovery was complete, the defendants moved to sanction the plaintiff contending that, with the exception of one of the medical malpractice claims, none presented a factual basis and the claims were brought in bad faith for the sole purpose of harassment. The trial court agreed, dismissed all claims except for the malpractice claim, and required the plaintiff and his attorney

ney to pay attorney's fees and costs incurred in defending the dismissed claims. In an exhaustive 52-page opinion with 116 footnotes (ugh!), the 11th Circuit held: (1) the plaintiff's motion for recusal was unfounded; (2) the claims against the hospital were barred by the statute of limitations; (3) all but the malpractice claims against the physician defendants were frivolous, baseless and subject to dismissal; (4) it was proper to impose monetary sanctions against plaintiff's counsel; but (5) the trial court abused its discretion in imposing sanctions against the client. The opinion then ends with an interesting piece of advice to judges and defense counsel confronted with "shotgun" pleadings. It is clear the courts are becoming less tolerant of harassment litigation.

Kodadek v. Lieberman, 247 Ga. App. 606, 545 S.E.2d 25 (2001). Parents of a child who had a portion of a needle left in his throat during a tonsillectomy filed an action against the physician. Of the many claims lodged, including fraud, the jury returned only one against the doctor. A verdict was then entered in favor of the child for compensatory and punitive damages. The trial and appellate court both agreed the J.N.O.V. in favor of the defense on the issue of punitive damages was appropriate. In order for there to be a finding for punitive damages, there must be evidence of a high degree of willful misconduct, malice, wantonness, or oppression—a very high standard which was not proved here. There was no clear and convincing evidence, testimony from both sides conflicted, and the jury found for the defendant on all other issues. Therefore, punitive damages were inappropriate.

McCombs v. Synthes, 250 Ga. App. 543, 553 S.E.2d 17 (2001). Plaintiff appealed a grant of summary judgment finding in favor of the defendant, a spinal implant manufacturer. Affirming the trial court's ruling, the Court of Appeals found, according to the learned intermediary doctrine, that the duty to warn rests not with the manufacturer, designer or distributor, but solely with the treating physician in light of that physician's knowledge of a patient's particular needs.

Shortnacy v. North Atlanta Internal Medicine, 252 Ga. App. 321, 556 S.E.2d 209 (2001). A driver collided head-on with the plaintiff's car while driving the wrong way on Georgia 400. Immediately preceding the accident, the driver had been administered Demerol and Phenergan for back pain by his physician. The injured plaintiff filed a complaint against the physician alleging breach of common law duty of ordinary care, as well as medical negligence.

Reopening Default: Incredibly, the complaint had been inadvertently stored in the physician's insurance company's Christmas decorations and only discovered a year later when the decorations were being unpacked. Meanwhile, a default judgment had been entered by the court. The Court of Appeals upheld the trial court's decision to reopen the default judgment based on the circumstances.

Liability: The plaintiff also appealed the trial court's finding that the defendant owed no duty of care to plaintiff as a matter of law. The plaintiff argued that either (1) a general common law tort or ordinary negligence extended to this situation or (2) a duty was owed by the doctor to the general public, similar to the duty created by the Dram Shop Act. The court noted that generally, there is no duty to control the conduct of third parties to prevent them from causing physical harm to others. Two exceptions exist, where (a) a special relationship exists between the actor and the third person imposing a duty upon the actor to control the third person or (b) a special relationship exists between the actor and the other which gives the other a right to protection. The court refused to extend the Dram Shop Act to physicians and ruled there was no duty based on these exceptions to the general rule.

Purcell v. Breese, 250 Ga. App. 472, 552 S.E.2d 865 (2001), cert. denied (Jan. 10, 2002). It is ordinarily a question of fact whether a doctor acted in "good faith," defined as "a state of mind indicating honesty and lawfulness of purpose; belief that one's conduct is not unconscionable or that known circumstances do not require further investigation." While summary judgment is appropriate in cases where no evidence supports a finding of lack of good faith, in this case there was sufficient evidence of defendant's bad faith to defeat summary judgment. Further, where a doctor-patient relationship was voluntarily terminated by a patient prior to his death but not before the allegedly negligent acts occurred, the defendant doctor cannot claim termination of the physician-patient relationship as a defense.

Thompson v. Zwiren, No. A01A1931, 2002 WL 378134 (Ga. Ct. App. Mar. 12, 2002). The trial court charged the jury as follows: "Plaintiff must present expert medical testimony showing that within a reasonable degree of medical certainty as proven by a preponderance of the evidence that the injury in question was proximately caused by the negligence of the defendant." The Court of Appeals granted the plaintiff a new trial, holding the jury charge was harmful error. The standard of proof required to establish an injury for negligence is the preponderance of the evidence, which is not functionally equivalent to requiring certainty. Certainty is not required, but the plaintiff must show probability rather than a possibility that the alleged negligence caused the injury or death. The charge given was inconsistent and self-contradictory with the burden of proof; therefore, the case was reversed.

Medical Malpractice - Affidavit Requirement

Georgia Dermatology Clinic v. Nesmith, No. A01A2445, 2002 WL 342154 (Ga. Ct. App. Mar. 6, 2002). The plaintiff filed a complaint availing itself of O.C.G.A. § 9-11-9.1(b), which gives the plaintiff an automatic right to file a supporting affidavit within 45 days of filing the complaint when the following requirements are met: (1) the statute of limitations period will expire within 10 days of the date of filing the complaint,

and (2) the plaintiff alleges that, because of time constraints, an expert affidavit could not be prepared. Notwithstanding the plaintiff's full compliance with the statutory requirements, the defendants moved to dismiss the complaint. The Court of Appeals held that, where a complaint otherwise meets the statutory requirements, the plaintiff need not file an additional affidavit stating that an expert affidavit could not be obtained and need not demonstrate good faith in order to receive an automatic extension.

Memorial Hospital of Adel, Inc. v. Dunn, 251 Ga. App. 399, 554 S.E.2d 548 (2001). Plaintiffs filed medical malpractice and loss of consortium actions alleging improper placement of equipment used to administer anesthesia during surgery in 1998. Plaintiffs failed to file an expert affidavit with their complaint as required by O.C.G.A. § 9-11-9.1, but invoked provisions of subsection (b) allowing a plaintiff to file the required affidavit 45 days later. Plaintiffs did not file the affidavit within 45 days, but rather filed a request for an additional 45 days several days before the expiration of the original 45-day time period. Plaintiffs stated they were unable to procure an affidavit because the treating physician had notified plaintiffs 2 days before the affidavit was due that he was no longer willing to execute an affidavit. Defendants opposed the plaintiffs' request for an additional 45 days, but agreed to give the plaintiffs an additional 30 days. However, the plaintiffs did not file their affidavit until several days after the 30-day extension. Defendants filed a supplemental brief contending time should not be extended to allow for this filing. The trial court found good cause existed and justice required extending the time for the filing of the affidavit. The Court of Appeals affirmed the trial court's ruling, stating it would not substitute its judgment for that of the trial court when there is no obvious and apparent abuse of discretion by the court.

Cabey v. DeKalb Medical Center, 252 Ga. App. 313, 555 S.E.2d 742 (2001). Where the *pro se* plaintiff did not properly invoke the portions of O.C.G.A. § 9-11-9.1(b) granting an extension of time to file an expert affidavit in support of her complaint in either her original or amended complaint, the defendant was entitled to summary judgment.

Sullivan v. Fredericks, 251 Ga. App. 790, 554 S.E.2d 809 (2001), cert. denied (Feb. 25, 2002). Patient filed a medical malpractice suit against his surgeon for allegedly failing to insert the necessary screws during surgery, which resulted in additional corrective surgery. The trial court, and subsequently the appellate court, granted the surgeon's motion to dismiss because the patient failed to comply with expert affidavit requirements. The plaintiff failed to file an expert affidavit contemporaneously with his complaint as required by O.C.G.A. § 9-11-9.1, and the complaint did not contain the required language in subsection (b) that time constraints prevented preparation of an affidavit. Plaintiff failed to raise either grounds for

failure to submit the professional affidavit; therefore, the suit was dismissed.

Medical Malpractice - Statute Of Limitations

Young v. Williams, No. S01G0589, 2002 WL 372958 (Ga. Mar. 11, 2002). Here's the most important medical malpractice decision in the past year. As noted in last year's outline, the Court of Appeals had created a "continuous treatment doctrine" for any action based on an alleged misdiagnosis. The continuous treatment doctrine modified the statute of limitation by changing its commencement from the date on which the injury occurred to the date on which the "treatment by the doctor for the particular disease or condition involved has terminated -- unless during the treatment the patient learns or should learn of the negligence, in which case the statute runs from the time of discovery." In adopting this doctrine, the Court of Appeals overruled cases in which it had previously declined to adopt the continuous treatment doctrine for medical malpractice cases. The Supreme Court overruled the Court of Appeals, stating the General Assembly had determined the statute of limitations for medical malpractice actions; therefore, the judicial branch was not empowered to engraft the continuous treatment doctrine standard onto what the legislature had already enacted. (Now, if we can just get the Supreme Court to review the Court of Appeals' unfounded creation of the "common law" informed consent doctrine!)

Hughley v. Frazier, Nos. A01A2462, A01A2463, 2002 WL 461102 (Ga. Ct. App. March 27, 2002). Plaintiff brought a medical malpractice action against a doctor alleging a misdiagnosis resulted in surgery that left him permanently incontinent. The doctor first treated plaintiff in early April 1996. Visits also occurred in late April and early May. On May 16, plaintiff saw a different doctor who noted the severity of the situation, provided the patient with a correct diagnosis, and referred him to a surgeon for immediate surgery. On May 21, plaintiff underwent surgery, which left him incontinent due to the severity of the previously misdiagnosed sores. The complaint was filed on May 18, 1998, was dismissed shortly thereafter, and was refiled on April 17, 2000. The defense argued this action was not filed within the two-year statute of limitations. Plaintiff tried to invoke the continuous treatment doctrine; however, the court ruled the doctrine is no longer recognized in this state as applied to these facts. Further, the court explained that the anal sores were present when the plaintiff first went for treatment and remained thereafter despite the misdiagnosis. Therefore, although the plaintiff claimed the incontinence was a new injury, the court disagreed because the injury related back to the misdiagnosis. The period of limitation commenced on the date the negligence or wrongful act occurred, which was in late April or early May. Because the claim was not filed within two years of the act, the case was dismissed.

Ray v. Scottish Rite Children's Medical Center, 251 Ga. App. 798, 555 S.E.2d 166 (2001). Plaintiffs' claim of negligent hiring and retention, at its heart, was a claim involving the performance of an expert in his area of expertise and, as such, a claim for medical malpractice. Because it was a claim for medical malpractice, it was subject to the two year statute of limitations in medical malpractice cases, not the statute of limitations applicable to general negligence cases.

Miscellaneous

Ferguson v. City of Charleston, 532 U.S. 67 (2001). A state-owned hospital instituted a plan to test pregnant women suspected of using cocaine. Later, a hospital employee volunteered the hospital's services to the state prosecutor who developed an initiative to prosecute women who tested positive for cocaine while pregnant. The purpose was to deter pregnant women from abusing cocaine. An affected woman sued, contending the policy was an unconstitutional search. The hospital and state argued the policy should fall under the "special needs" exception to the Fourth Amendment. Because the primary purpose of the program was to use the threat of arrest and prosecution to force women into treatment and given the extensive involvement of law enforcement officials at every stage of the policy, the case did not fit within the category of the special needs exception -- a category reserved for cases where the individual has consented to the search though the voluntary analysis is altered because of the potential for adverse consequences. As such, the Fourth Amendment's general prohibition against nonconsensual, warrantless, and suspicious searches applied, and the practice was declared invalid.

Insurance Department of Georgia v. St. Paul Fire & Casualty Ins. Co., 253 Ga. App. 551, 559 S.E.2d 754 (2002). The Commissioner of Insurance argued the decision of the insurance companies not to renew over a thousand medical malpractice policies was an unfair trade practice under Georgia law limiting an insurer's ability to cancel an entire line or class of business. The Court of Appeals disagreed. Because it was clear the meaning of cancel did not encompass the definition of nonrenew, the insurance company was not required to continue providing coverage to the "stand alone" doctors who had previously held policies with the company.

Noncompete Clauses

New Atlanta Ear, Nose & Throat Associates, P.C. v. Pratt, ___ Ga. App. ___, 560 S.E.2d 268 (Ga. Ct. App. 2002). Five employee-shareholder physicians had restrictive covenants in their employment and shareholder agreements with a professional corporation. Included in the covenants were listings of facility names where the physicians were prohibited from practicing within 8 miles in the event they left the current practice. The facilities were only listed by name, and no addresses were given. The physicians left the practice and announced they intended to violate the covenants, which resulted in this lawsuit. The court ruled that in determining the enforceability of restrictive covenants, three different levels of scrutiny could be applied: strict scrutiny for employment contracts, middle scrutiny for professional partnership agreements, and much less scrutiny for sale-of-business agreements. Because there were two different types of contracts, differing levels of scrutiny were applied to each contract. The employment contract fell under strict scrutiny and the shareholder agreement fell under a middle level of scrutiny. The Court of Appeals concluded the lack of specific addresses in either contract meant the medical facility could change location, thereby allowing the prohibited areas to shift during the course of the employment. The court ruled both covenants were too vague to be enforceable under either level of scrutiny.

Open Meetings/Open Records Act

The Claxton Enterprise v. Evans County Board of Commissioners, 249 Ga. App. 870, 1 FCDR 1915 (2001). Although it doesn't involve a hospital authority, this case contains some important rulings on Open Meetings Act compliance. A newspaper filed suit alleging a county Board of Commissioners violated the Georgia Open Meetings Act. Among the raised issues were: the Board's closed meeting to discuss impending litigation; whether phone calls constitute a "meeting" under the Act; whether preprinted multi-choice affidavit forms used by the Board were permissible; when meeting minutes must be made available; and the availability of attorney fees for violation of the Act.

Litigation Exception: The court ruled that mere threats of legal action are not sufficient to justify a closed meeting. There must be a realistic and tangible threat of legal action against the county, the government entity, its officers or employees. Among those factors that should be considered are (1) a formal letter demanding or some comparable writing that presents the party's claim and manifests a sound intent to sue; (2) previous or preexisting litigation between the parties or proof of ongoing litigation concerning similar claims; (3) proof that a party has both retained counsel with respect to the claim at issue and has expressed an intent to sue. Here, an idle threat, standing alone, was insufficient to justify closing a meeting under O.C.G.A. §50-14-2.

Other Issues: The court ruled that a series of phone calls, even ones between members discussing official business, do not constitute a "meeting" under the Act. The legislature chose to define a meeting as one that occurs "at a designated time and place." The court also ruled it is sufficient under the Act to use preprinted multi-choice affidavit forms containing spaces to check all boxes that might apply to why the meeting could be closed. However, review of such form affidavits should be done with heightened scrutiny because they conveniently leave open the possibility that an individual could check every box that might apply and later say, "I inadvertently checked the wrong exception." Additionally, the court ruled that minutes from meetings must be made available as soon as they are made official but in no case later than immediately following the next regular meeting of the agency. Finally, a court must award attorney fees under the Act only if it finds an agency acted "without substantial justification" in failing to comply with the Open Meetings Act. Here, the Board was in violation of the Act; however, it was not proven such non-compliance lacked substantial justification.

Moon v. Terrell County, 249 Ga. App. 567, 548 S.E.2d 680 (2001). The County Board of Commissioners went into executive session and terminated plaintiff based on a letter received from the Department of Corrections. Since reviewing this letter amounted to "receiving evidence or hearing argument on charges filed to determine disciplinary action" against a public employee, such meeting was in violation of the Open Meetings Act and was void. Further, because the minutes of that meeting did not reflect the names of the persons who voted to close the meeting, the meeting was in violation of the Open Meetings Act.

Georgia Department of Natural Resources v. Theragenics Corp., 273 Ga. 724, 545 S.E.2d 904 (2001). Defendant designated approximately 1/3 of its information filed with the Department of Natural Resources as "proprietary" or "confidential." Pursuant to an Open Records Act request, the Department sought to provide all of defendant's information to a third party. The Court ruled where defendant had attempted to prevent competitors or the public from obtaining the proprietary information, the Department could not contend the compelled government disclosure authorized it to make a future disclosure of the information which defendant had at all times tried to protect.

Payment Issues

Liberty National Life Insurance Company v. Radiotherapy of Georgia, P.C., 252 Ga. App. 543, 557 S.E.2d 59 (2001). This is a wonderful case for providers in disputes with payors over payment amounts. Liberty National sold cancer insurance policies which agreed to pay providers their "usual and customary charges." In this case, Liberty Mutual claimed defendant oncologists were violating this provision because their charges were in excess of Medicare fee schedules for the same cancer ser-

vices. In effect, Liberty National claimed any billing in excess of the Medicare fee schedule was in excess of reasonable and customary charges. Because plaintiff had been aware of this practice for a number of years and had paid the bills without complaint, it had not met its burden of due diligence; thus, its claim for misrepresentation or fraud failed. The same result would have been achieved under the voluntary payment doctrine, where a payment made through ignorance of law and in the absence of fraud is deemed voluntary and not recoverable.

Peer Review

McCall v. Henry Medical Center, Inc., 250 Ga. App. 679, 551 S.E.2d 739 (2001) cert. denied (Jan. 9, 2002). Plaintiff filed a medical malpractice action against a hospital for negligently granting medical privileges to a surgeon who operated on the plaintiff. The hospital objected to several discovery requests on the grounds the requested materials were privileged peer review materials. Declining to rule on the plaintiff's motions to compel discovery, the trial court granted the hospital's motion for summary judgment. The Court of Appeals found the General Assembly never intended the peer review statutes to be used to bar a tort action for negligent credentialing. The court noted the definition of "peer review" in § 31-7-131(1) only covered the evaluation of "actual medical care services" rendered in the hospital by a physician; but here, since the plaintiff was applying for initial appointment to the medical staff, there were no "actual" cases reviewed. Thus, summary judgment was not warranted in this case merely because a peer review committee had approved the physician. [NOTE: A 2001 amendment to § 31-7-131(3)(B)(vi) expands the definition of "review organization" to include credentialing of initial applicants seeking medical staff privileges, hopefully curing this problem.]

University Health Services v. Long, No. 501A1658, 2002 WL 372964 (Ga. Mar. 11, 2002). A hospital instituted proceedings to review the care provided by an obstetrician/gynecologist and suspended the physician's privileges until the review was complete. The physician obtained an interlocutory injunction permitting him to continue practicing. After the review, the hospital permanently revoked the privileges and petitioned the court to dissolve the injunction. The physician filed an amended complaint asking the trial court to continue the injunction, reverse the revocation of his privileges, and rule the hospital's fair hearing plan violated due process. The trial court extended the injunction and prohibited the hospital from revoking the physician's privileges. In a unanimous opinion, the Supreme Court reversed the trial court, finding that the court's role "is not to substitute [its] judgment for that of the hospital's governing board or to reweigh the evidence regarding the renewal or termination of staff privileges." The Supreme Court concluded the harm to the patients greatly outweighed any potential harm to the physician, and the trial court should have deferred to the medical judgment of the hospital's governing body.

Katz v. Hospital Authority of Rabun County, No. A01A2191, 2002 Ga. App. LEXIS 320 (Mar. 12, 2002). The hospital's chief of staff called a meeting to discuss a physician's performance. As a result of this meeting, the physician was sent a letter indicating his privileges had been revoked under the Medical Staff's Bylaws and informing him of his right to an appeal. His contract to perform services was also terminated. The hospital violated its own bylaws in a number of ways, including failing to provide the physician with copies of the complaints, failure to conduct a hearing, and failure to provide a written report. Because of these violations of the Medical Staff Bylaws, the hospital's motion for summary judgment was denied.

Psychiatrist-Patient Privilege

Cornelius v. Hutto, 252 Ga. App. 879, 558 S.E.2d 36 (2001). A psychiatrist had treated both the husband and his wife, and had signed an affidavit supporting the wife's custody claim for the couple's son. However, the trial

court never considered the affidavit because an agreement on custody was reached between the parties, and later issued an order granting the parents' motion to withdraw and expunge the affidavit from the record. The husband subsequently sued the psychiatrist alleging a violation of psychiatrist-patient privilege and invasion of privacy. The trial court granted the psychiatrist's motion for directed verdict on the invasion of privacy claim, and the jury returned a defense verdict on the other claim. The Court of Appeals reversed the trial court's grant of a directed verdict on the invasion of privacy claim. The court found the psychiatrist based his affidavit on information received from the husband during therapy, which could not be released without the husband's consent. Under Georgia libel and slander laws, material information contained in regular pleadings filed in a court are normally privileged, but that privilege does not apply to psychiatrist-patient communications. Therefore, the court reversed the trial court, concluding the invasion of privacy claim presented a jury question.

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