MEDICAL MALPRACTICE BOOTCAMP

6 CLE Hours Including
1 Professionalism Hour | 4 Trial Practice Hours

Sponsored By: Institute of Continuing Legal Education
SOLACE is a program of the State Bar of Georgia designed to assist those in the legal community who have experienced some significant, potentially life-changing event in their lives. SOLACE is voluntary, simple and straightforward. SOLACE does not solicit monetary contributions but accepts assistance or donations in kind.

How does SOLACE work?

If you or someone in the legal community is in need of help, simply email SOLACE@gabar.org. Those emails are then reviewed by the SOLACE Committee. If the need fits within the parameters of the program, an email with the pertinent information is sent to members of the State Bar.

What needs are addressed?

Needs addressed by the SOLACE program can range from unique medical conditions requiring specialized referrals to a fire loss requiring help with clothing, food or housing. Some other examples of assistance include gift cards, food, meals, a rare blood type donation, assistance with transportation in a medical crisis or building a wheelchair ramp at a residence.

Contact SOLACE@gabar.org for help.
The purpose of the SOLACE program is to allow the legal community to provide help in meaningful and compassionate ways to judges, lawyers, court personnel, paralegals, legal secretaries and their families who experience loss of life or other catastrophic illness, sickness or injury.

**TESTIMONIALS**

In each of the Georgia SOLACE requests made to date, Bar members have graciously stepped up and used their resources to help find solutions for those in need.

A solo practitioner’s quadriplegic wife needed rehabilitation, and members of the Bar helped navigate discussions with their insurance company to obtain the rehabilitation she required.

A Louisiana lawyer was in need of a CPAP machine, but didn’t have insurance or the means to purchase one. Multiple members offered to help.

A Bar member was dealing with a serious illness and in the midst of brain surgery, her mortgage company scheduled a foreclosure on her home. Several members of the Bar were able to negotiate with the mortgage company and avoided the pending foreclosure.

Working with the South Carolina Bar, a former paralegal’s son was flown from Cyprus to Atlanta (and then to South Carolina) for cancer treatment. Members of the Georgia and South Carolina bars worked together to get Gabriel and his family home from their long-term mission work.

Contact SOLACE@gabar.org for help.
Dear ICLE Seminar Attendee,

Thank you for attending this seminar. We are grateful to the Chairperson(s) for organizing this program. Also, we would like to thank the volunteer speakers. Without the untiring dedication and efforts of the Chairperson(s) and speakers, this seminar would not have been possible. Their names are listed on the AGENDA page(s) of this book, and their contributions to the success of this seminar are immeasurable.

We would be remiss if we did not extend a special thanks to each of you who are attending this seminar and for whom the program was planned. All of us at ICLE hope your attendance will be beneficial as well as enjoyable. We think that these program materials will provide a great initial resource and reference for you.

If you discover any substantial errors within this volume, please do not hesitate to inform us. Should you have a different legal interpretation/opinion from the speaker’s, the appropriate way to address this is by contacting him/her directly.

Your comments and suggestions are always welcome.

Sincerely,

Your ICLE Staff

Jeffrey R. Davis  
Executive Director, State Bar of Georgia

Tangela S. King  
Director, ICLE

Rebecca A. Hall  
Associate Director, ICLE
AGENDA

PRESIDING:  Lee Gutschenritter, Program Chair, Finch McCranie LLP, Atlanta

7:30  **REGISTRATION AND CONTINENTAL BREAKFAST**  (All attendees must check in upon arrival. A removable jacket or sweater is recommended).

8:15  **WELCOME AND PROGRAM OVERVIEW**
Lee Gutschenritter

8:30  **SHOULD I STAY OR SHOULD I GO? EVALUATING POTENTIAL MEDICAL MALPRACTICE CASES**
Lee Gutschenritter

9:15  **I THINK I HAVE A CASE ... NOW WHAT? PREPARING A PLAINTIFF’S MEDICAL MALPRACTICE CASE**
Moses Kim, The Moses Firm. LLC, Atlanta

10:00  **BREAK**

10:15  **DEFENDING A MEDICAL MALPRACTICE CASE: STRATEGIES AND TACTICS FROM THE DEFENSE PERSPECTIVE**
David C. Hanson, Weathington McGrew PC, Atlanta

11:15  **TIPS AND STRATEGIES FOR TAKING EFFECTIVE DEPOSITIONS IN MED MAL CASES**
John G. Mabrey, The Mabrey Firm, P.C., Atlanta

12:15  **LUNCH** (Included in registration fee.)
Obtain Lunch and Return to Meeting Room

12:30  **LUNCH & LEARN: OVERVIEW OF RECENT APPELLATE COURT DECISIONS IN MEDICAL MALPRACTICE CASES**
David V. “Dave” Hayes, Owen Gleaton Egan Jones & Sweeney LLP, Atlanta

1:00  **NURSING HOME CASES: DIFFERENCES AND DILEMMAS**
Katherine G. “Kate” Hughes, Wagner Hughes LLC, Atlanta

1:30  **BREAK**

1:45  **PROFESSIONALISM AND CREDIBILITY: WHY IT MATTERS AND HOW IT HELPS YOUR CASE**
Richard W. Hendrix, Finch McCranie LLP, Atlanta

2:30  **PROVING PRODUCTS LIABILITY CLAIMS IN MEDICAL MALPRACTICE CASES**
Neil T. Edwards, Childers Schlueter & Smith LLC, Atlanta

3:15  **ADJOURN**
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8:15  WELCOME AND PROGRAM OVERVIEW

Lee Gutschenritter
SHOULD I STAY OR SHOULD I GO?
EVALUATING POTENTIAL MEDICAL MALPRACTICE CASES
Lee Gutschenritter
EVALUATING POTENTIAL MEDICAL MALPRACTICE CASES

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EVALUATING POTENTIAL MEDICAL MALPRACTICE CASES

Medical malpractice cases are some of the most difficult, time-consuming, and expensive types of cases a plaintiff’s trial lawyer is likely to come across. There are several procedural matters, including obtaining an Affidavit from a qualified expert, that must be completed prior to filing a lawsuit. Simply completing the necessary steps prior to filing a medical malpractice lawsuit can quickly consume a practitioner’s time and resources. Once the case is in litigation, the practitioner is likely to face opposing counsel who has many years of experience and whose practice is devoted almost entirely to the defense of medical negligence cases. Discovery is typically lengthy and costly, and in many cases can require out-of-state travel to depose the parties’ respective expert witnesses. Additionally, almost all healthcare providers in the State of Georgia have consent provisions in their insurance policies whereby they have the option to veto any potential settlement. Many healthcare providers are reluctant to settle even in cases where there is a probable standard of care violation. This is because depending on the amount of the settlement, it must be reported and publicly listed in the National Practitioner Data Bank and the Georgia Composite Medical Board website. If the case proceeds to trial, plaintiff’s counsel must fight a substantial uphill battle in order to obtain a verdict due to the fact that the vast majority of the population will give doctors and
other healthcare providers the benefit of the doubt and will be reluctant to return a large plaintiff's verdict.

For these reasons, it is critical that plaintiff's counsel conduct a full and thorough case evaluation from the very beginning in order to identify meritorious cases, and perhaps more importantly, to identify "bad" cases quickly and prior to expending substantial amounts of time and money.

**TIME LIMITATIONS**

In most instances, medical malpractice cases are subject to a two-year statute of limitations from the date of injury or death. See O.C.G.A. § 9-3-71(a). Medical malpractice cases differ from automobile cases and other types of tort cases in that it typically takes much longer to prepare and file suit. In many instances, it takes a minimum of three months from when the case first comes in to 1) obtain certified medical records, 2) find an expert to review the case, and 3) prepare the Complaint and expert Affidavit and file and serve the defendant. In any medical malpractice case where the relevant statute of limitations will expire in six months or less, a practitioner should carefully scrutinize the potential case and act quickly in either moving forward with the case or notifying the potential client in writing, preferably via certified mail or using some other verified service method, that they will not accept the case.
While the typical medical malpractice case is subject to a two-year statute of limitations, there are exceptions:

In “foreign object” cases involving leaving objects inside patients during surgery, such as sponges, needles, broken scalpels, etc., may be brought any time within one year of discovery of the object. See O.C.G.A. § 9-3-72.

In cases involving minors, when a child is injured, the child and the child’s parents have separate and independent claims. The parents’ claims include all medical and other necessary expenses related to the injury of the child up to the age of 18, and loss of the child services. For medical malpractice occurring before a child’s fifth birthday, the child’s suit must be filed by the seventh birthday. For acts of medical malpractice occurring after the fifth birthday, the limitation period is two years from the date of malpractice. See O.C.G.A. § 9-3-73(b).

In a case involving a wrongful death claim, the lawsuit must be filed within two years of the date of death. See Hart v. Eldridge, 250 Ga. 526 (1983).

In a case decided in June of this year, the Court of Appeals held that under the proper circumstances, an amended complaint adding a new party in a medical negligence case can relate back to the original filing for purposes of the two-year statute of limitations. See Tenet Healthsystem GB, Inc. v. Thomas, 816, S.E. 2d 627 (2018) (Attached as Exhibit 1).
Georgia also has a statute of repose, which provides that even if the patient or family did not know about the malpractice, unless there is fraud, concealment, or misrepresentation, under no circumstances may a healthcare provider be sued for medical malpractice more than five years after the actual incident of malpractice. See O.C.G.A. § 9-3-71(c). The statute of repose prevents the filing of a wrongful death medical malpractice claim if five years have passed between the time of the malpractice and the filing of the claim, irrespective of the date of death. See Braden v. Bell, 222 Ga. App. 144 (1996). However, the courts have allowed the filing of a wrongful death claim outside the five-year period if it is filed as an amendment to an already filed medical negligence lawsuit. See Wesley Chapel Foot and Ankle Center, L.L.C. v Johnson, 286 Ga. App. 881 (2007).

A practitioner must be familiar with the various limitation periods described above and should obtain this information during the first contact with the potential client to determine if there is even a legal right to file suit.

**WHO IS THE PROPER “CLIENT”?**

In potential cases where the client is incapacitated or deceased, or instances where the potential client’s medical condition renders them a poor historian regarding their medical care, the practitioner is likely at the outset to hear from a spouse, child, sibling, friend, or caregiver of the potential client. It is important in
these instances to identify at the outset whether that person would be the proper party to bring suit on behalf of the potential client.

In instances where the potential client is deceased, Georgia law provides that the surviving spouse, or, if there is no surviving spouse, a child or children, either minor or adult, may bring a wrongful death action. See O.C.G.A. § 51-4-2 (Attached as Exhibit 2). But, a surviving spouse or child bringing the action must protect the interests of all children of the deceased. See O.C.G.A. § 51-4-2. If no surviving spouse or children are available to bring the claim to court, the claim may be brought by the surviving parent or parents of the deceased, or the personal representative of the deceased person's estate. If the personal representative brings a claim, any damages recovered are held by the estate for the benefit of the deceased person's next of kin.

The practitioner must possess at least a working knowledge of who may bring a wrongful death claim at the outset of the case and must ensure that the potential client's representative they are dealing with has a legal right to bring the claim. In cases involving an injured or deceased child with divorced or separated parents, the practitioner will want to seek the cooperation of both parents and be aware of their obligations in notifying the non-participating parent of the pendency of the case and may be required to seek approval from that person prior to any settlement.
WHERE DID THE ALLEGED MALPRACTICE OCCUR AND WHO ARE THE PROPER DEFENDANTS?

Another relevant fact a practitioner must consider from the outset is where the alleged malpractice occurred and who the putative defendants are. Are the putative defendants just the physician and his or her practice or are others involved? Is an independent contractor involved? Should the operating room personnel be named along with the surgeon? Is the defendant a borrowed servant or a dual agent of another practice?

In the typical malpractice case, plaintiffs are required to prove that the defendant violated the standard of care, and that this violation was the proximate cause of the client’s damages. The standard of care is defined as “what a reasonably prudent healthcare provider would do under like or similar circumstances.” However, if the case involves the provision of emergency medical care in a hospital emergency room setting, a gross negligence standard is applied, and a plaintiff must prove such negligence “by clear and convincing evidence”. See § 51-1-29.5 (Attached as Exhibit 3). Subsection (c) provides:

“In an action involving a health care liability claim arising out of the provision of emergency medical care in a hospital emergency department or obstetrical unit or in a surgical suite immediately following the evaluation or treatment of a patient in a hospital emergency department, no physician or health care provider shall be held liable unless it is proven by clear and convincing evidence that the physician or health care provider's actions showed gross negligence.” Id.
This is a more difficult burden of proof for plaintiffs. In these types of cases, the practitioner must be aware of this heightened standard and be sure that it is appropriately pled in the Complaint and included in the expert Affidavit. Again, is the E.R. doctor a Hospital employee or an independent contractor?

In cases were the alleged malpractice occurred in a U. S. Department of Veteran Affairs ("VA") Hospital, a federally funded Community Health Center, Migrant Health Center, Health Care for the Homeless Center, or Public Housing Primary Care Center, the malpractice case must be filed in accordance with the Federal Tort Claims Act. If the defendant is an employee of the VA or one of the above described facilities, the proper defendant is the United States. For those practicing in the metro area Atlanta, attached is a list of the facilities in the metro area which are subject to the FTCA. (See Exhibit 4). If an independent contractor is working with the VA, the case is different.

Under the FTCA, Georgia medical malpractice laws that would normally apply are still in effect. However, the FTCA requires the plaintiff to give proper notice to the federal agency they intend to pursue by filing a Form 95. This Notice of Claim is required before a plaintiff may file suit in federal court. The FTCA also places caps on attorney fees in contingency cases. The most one may charge in an FTCA is 25% if the case goes to trial and 20% if there is a settlement.
In cases where the alleged malpractice occurred in a nursing home or long-term care facility, the case may be governed by binding arbitration provisions. In these instances, the practitioner should obtain and thoroughly review the signed contract between the potential client or their family members and the facility at issue. Again, who is the “client”? The Power of Attorney, the son or daughter who signed the contract, or the patient, or both? Who is the proper defendant? The facility, a nurse, or a doctor? All must be considered.

**OBTAINING THE POTENTIAL CLIENT’S MEDICAL RECORDS**

Obtaining a potential client’s medical records can be costly and, in many instances takes a minimum of thirty days to obtain. Depending on the healthcare facility where the alleged malpractice occurred, a patient may be able to obtain medical records on their own quickly and for little to no cost. Therefore, a practitioner should ask the potential clients what records they currently possess and have them forward along for review. At many healthcare facilities, patients can quickly set up a log-in and password to view and obtain their medical records online. Obtaining a potential client’s login and password can be an easy and efficient means to review the records.

During the initial contact with the client, an oral history of the medical care at issue should be obtained. In many cases it is helpful to guide the client’s recollection of events in chronological order. From the outset, the practitioner should also ask
the potential client what they think the healthcare provider did wrong. If the potential client or their representative is unable to describe or pinpoint a specific instance of alleged malpractice, this should be a “red flag”, and more specific questions concerning the client’s care should be asked. If all the potential client or their representative is able to offer is something along the lines of “I was sick so I went to the hospital. The doctors tried to treat me, but I never got better,” this is likely not a case worth pursuing further.

**CONSIDERATION OF PRE-EXISTING CONDITIONS**

Another area that should be explored from the very beginning is the potential client’s medical history prior to the alleged malpractice and the existence of any preexisting medical conditions. Did the PC have a chronic illness for years preceding the alleged malpractice? Did they have any co-morbidities? Were they obese? Elderly? Diabetic? Did they comply with their doctor’s orders prior to the alleged malpractice at issue? Obviously, in medical malpractice cases your potential client will have had some sort of medical condition which necessitated the treatment at issue, so if the client falls into any of the above categories it does not mean that it is a “bad” case. However, the practitioner should look carefully to determine whether and to what extent these pre-existing medical conditions contributed to the client’s current state.
It is well settled law that a putative defendant takes the plaintiff as he or she finds them. In any medical malpractice case, the patient will likely be sick. The disease or underlying physical condition may be the cause of the injury or death and not malpractice. Obviously, this must be carefully scrutinized. In addition, even if malpractice exists and can be proven, a pre-existing condition of the plaintiff could affect claim evaluation from a damages standpoint. "Egg shell" plaintiff cases are particularly tough because if the patient's life expectancy is not that great, then the expenses of bringing a claim must be evaluated vis-à-vis damage evaluation. It is very important that counsel evaluate co-morbidities as it pertains to damages as otherwise pursuing such case may not be economical for either the client or the attorney.

**PREPARING THE COMPLAINT & AFFIDAVIT: USE OF EXPERTS**

Attached is a draft Affidavit and Complaint in a medical malpractice case that we filed (with the identity of our client and the physician involved redacted). (See Exhibit S). The draft is attached to alert the practitioner to the various requirements of an expert affidavit and Complaint under Georgia law. As an example, the courts have held that any expert providing the affidavit must have practiced in the same area of specialty as the defendant healthcare provider for at least three of the last five years or been engaged in the teaching of his or her profession for at least three of the last five years. See generally Zarate-Martinez v. Echemendia, 299 Ga.
301 (2016). Failure to adhere to this requirement could be fatal. The attached Complaint and expert affidavit contain the talismanic phrases and standard of care language which must be included in every malpractice case.

We recommend employing experts who are board-certified specialists in the same field as the putative defendant. We also recommend that counsel be very careful in dealing with experts. Make sure your expert is not simply telling you what you want to hear. **Counsel wants an objective appraisal** by a physician whether a breach of the standard of care has occurred and whether that breach was a proximate cause of the damages or death of the patient.

It can be very expensive to hire experts only to find out that one does not have a case. Many clients cannot afford the expenses necessary to hire an expert. Thus, one should consider using a nurse medical/legal reviewer to review the records to see if there is the possibility of a claim. If the case looks promising in terms of an apparent breach of the standard of care, then counsel can consider expending the money necessary to hire an expert. Any potential case should probably be abandoned if the expert does not **strongly** believe that malpractice occurred. A weak opinion may not be sufficient to pursue a case particularly when one considers that the defense is likely to have no problem finding multiple experts.

In short, retaining the right expert is important and the financial cost of doing so is also an important consideration. Unless the expert who provides an Affidavit
strongly believes in the case, the expenses of litigation are likely to be greater than the value recovered because malpractices cases are lost nine out of ten times once they reach the jury stage. Thus, it is critical that the proper expert be retained and that the Affidavit meet the minimal requirements of the standard required by the courts. The draft affidavit attached is a sample of one that would meet the legal standards of O.C.G.A. § 9-11-9.1.

**INSURANCE & LIEN CONSIDERATIONS**

As is true of any personal injury case, in a medical malpractice context counsel may have to deal with a lien situation. Who is responsible for paying a hospital bill if the client is on Medicaid or Medicare? What if the hospital bill is not paid at all and there is a valid hospital lien? Hospitals are entitled under Georgia law to assert a lien for unpaid medical expenses. See generally O.C.G.A. § 44-14-470. What type of insurance, if any, paid for the care or treatment related to alleged malpractice? Most types of individual private insurance are subject to the Georgia “made whole doctrine” which means that the insurance carrier would have to prove that the plaintiff was fully compensated for their injuries before the insurance company would be entitled to any recovery. Regardless of the source of payment, it is important for the practitioner to deal with this issue on the front-end and to understand their reimbursement obligations prior to any settlement negotiations, and preferably before the lawsuit is filed.
Insurance provided through a potential client’s employer should be carefully scrutinized to see if it qualifies as an ERISA plan. ERISA is governed under federal law and it pre-empts the “made whole doctrine” in Georgia. Under these types of plans, the carrier is entitled to full reimbursement for any expenses paid without deduction for case expenses and attorney fees. Because ERISA pre-empts all state laws relating to employee benefit plans, 29 U.S.C. § 1144(a), the made whole doctrine may not apply and counsel will typically have to pay a valid ERISA lien (including a self-funded plan). This is generally true for self-funded ERISA qualified plans. The Eleventh Circuit has, however, held that an injured person must be made whole before a subrogation claim can be made unless the plan specifically rejects application of the made whole doctrine. Cagle v. Bruner, 112 F. 3d 1510, 1522 (11th Cir. 1997). Since the date of the Cagle decision, the bad news is that many plans do expressly reject the made whole doctrine and thus ERISA liens must be paid. In cases where the ERISA lien is hundreds of thousands or millions of dollars, this can be a very real barrier to any settlement since the carrier has an absolute right to recover every dollar it paid. Counsel would be wise to engage in some sort of dialogue or (to the extent possible) settlement negotiations with the ERISA plan administrator well before mediation or settlement discussions with the defendant(s) begin.
If the client’s care was paid for through Medicare or Medicaid, there are statutory formulas in place for determining the amount of reimbursement that must be paid. While this is not an all-encompassing guide to addressing Medicare and Georgia Medicaid liens, we did want to provide some general information for each. If you are dealing with a Medicaid lien, the Georgia Department of Community Health (DCH) should be notified. For more information on how to notify DCH of an action, their website is https://dch.georgia.gov/third-party-liability. See also http://hms.com/ga/overview/. As for a potential Medicare lien, this process is handled through the Centers for Medicare & Medicaid Services (CMS). A case can be initiated by calling the Benefits Coordination & Recovery Center (BCRC) at 1 (855) 798-2627. CMS has also established an online portal, “Medicare Secondary Payer Recovery Portal”, to access reported cases. Information concerning the portal, creating a login, etc., can be found here:


Medicare liens are particularly problematic because Medicare has an express right to reimbursement from an attorney who has received a payment from the tortfeasor. 42 C.F.R. § 411.24(g) and § 411.26(a). Fortunately, Medicare will pay its pro-rata share of attorneys’ fees and expenses. See 42 C.F.R. § 411.37.
In almost all medical malpractice cases, defendants will require an injured plaintiff to execute a Settlement and Release Agreement stating that all medical bills arising out of an incident have been paid in full. See generally O.C.G.A. § 44-14-473. Sometimes this cannot be done because the bills have not been paid or a lien is outstanding and has not been resolved. This makes negotiation all the more difficult for counsel and must be considered in claim evaluation.

**DAMAGES**

Damages in a medical malpractice case are no different from those in a typical personal injury case. A plaintiff is entitled to recover both general and special damages. General damages, obviously, include compensation for physical and mental pain and suffering, both past and future, as well as a diminished capacity to work, labor, and earn money. These are elements encompassed in the definition of pain and suffering as well.

Because pain and suffering are considered an element of general damages, it is awarded to a plaintiff to compensate for non-pecuniary losses and hardships whether mental, physical, or both. The measure of such damages is the enlightened conscious of fair and impartial jurors. Roberts v. Chapman, 228 Ga. App. 365, 492 S.E. 2d 144 (1997). If a plaintiff can show that he or she will likely continue to suffer physical and mental pain as a result of injuries into the future, then the jury may award damages for future pain and suffering. Bennett v. Haley, 132 Ga. App.

Special damages in a medical malpractice case can be extensive. If malpractice occurs and a plaintiff is hospitalized for weeks, if not months (and we have had a case where the plaintiff was hospitalized for over a year) the medical expenses can be extraordinary. Such damages, of course, are deemed to be special damages under O.C.G.A. § 51-12-2. Special damages include medical expenses, past, present and future, lost wages, future earnings and lost profits.

With respect to future medical expenses, “An award of future medical costs must be supported by competent evidence to guide the jury in arriving at a reasonable value for such expenses.” Bridges Farm v. Blue, 221 Ga.App. 773, 774(1), 472 S.E.2d 465 (1996), rev’d in part on other grounds, 267 Ga. 505, 480 S.E.2d 598 (1997). Thus, it is often necessary in a malpractice case to retain a life-care expert and economist. Both experts can assist plaintiff’s counsel in quantifying the cost of future medical care that may arise out of the malpractice at issue. Whatever reasonable expenses have been incurred by the plaintiff in the past are recoverable and usually are easily quantifiable. However, proving future damages likely will require that counsel consider retaining an economist and/or life-care expert.
With respect to lost wages, in order to prevent speculation, a plaintiff must provide evidence as to his or her rate of compensation at the time of the malpractice and the duration of his or her absence from the workplace. A plaintiff who is not employed or otherwise earning wages or compensation on the date of the incident in question is not entitled to recover special damages for loss of earnings. *Mathis v. Copeland*, 139 Ga. App. 68-69, 228 S.E. 2d (1976).

In a wrongful death context, the measure of damages is compensation for the full value of the life of the decedent. See generally O.C.G.A. § 51-4-1. Death claims in Georgia are typically divided into two separate claims. One is for the wrongful death *per se* as measured by the “full value of the life of the decedent” without deducting for any of the necessary or personal expenses of the decedent had he or she lived. The full value of the life of the decedent consists of two elements: (1) the economic value of the deceased's normal life expectancy; and (2) an intangible element incapable of exact proof. *Department of Human Resources v. Johnson*, 264 Ga. App. 730, 592 S.E.2d 124 (2003). If a young person dies during a medical procedure and had a 50-year life expectancy and the person was employed at the time, the economist can project the economic damages. As regards the non-economic damages or the loss of the full value of the life of the decedent, damages are measured from the decedent's point of view; a child's right to recover for a parent's death is a substitution of the child in the decedent's place for the purposes
of recovering for the injury inflicted upon the decedent. The measure of damages for the wrongful death of a parent brought by such person's child, therefore, is not the child's loss from the parent's absence, but the parent's loss from not being able to raise the child. Brock v. Wedincamp, 253 Ga. App. 275, 558 S.E.2d 836 (2002). Family members and friends can testify to what the decedent enjoyed about their life and the relationships lost.

The second component of a wrongful death claim belongs to the estate. All causes of action that would have accrued to the decedent had he or she lived must be filed in the name of the Administrator or Administratrix of the estate. These include claims for medical expenses incurred prior to death, funeral and burial expenses, conscious pain and suffering prior to death and, where appropriate, punitive damages. See O.C.G.A. § 51-4-5(b); Waldon v. Archebald Memorial Hospital, 197 Ga. App. 275, 398 S.E. 2d 271 (1990). Where separate suits are instituted under wrongful death and estate claims, a defendant is entitled to joinder of the claims, even though the measures of damages are distinct for each claim. Stenger v. Grimes, 260 Ga. 838, 400 S.E.2d 318 (1991).

**PUNITIVE DAMAGES**

Recently we encountered a potential fraud claim in the context of reviewing a medical malpractice case. Anytime fraud is present in a malpractice case, there may be a claim for punitive damages. Punitive damages generally are allowed only where
it is proven by "clear and convincing evidence" that the defendant’s actions showed willful misconduct, malice fraud, wantonness, oppression or the entire want of care which would raise the presumption of conscious indifference to the consequences. O.C.G.A. § 51-12-51.1(b). Punitive damages in a tort case (such as medical malpractice) in which the cause of action does not arise from product liability are generally limited to $250,000.00. However, if a defendant’s actions occurred while under the influence of alcohol or drugs or if the defendant acted or failed to act with specific intent to cause harm, there is no limitation on the amount of punitive damages. See O.C.G.A. § 51-12-51.2. In some malpractice cases, regrettably, the doctor may be an alcoholic, or may be under the influence of drugs. If fraud is involved, there may be a claim for punitive damages in excess of $250,000.00.

The practitioner should consider early-on the appropriate damages to seek in their case and consider what evidence and witnesses will be needed to prove each category of damages at trial.

CONCLUSION

Plaintiff’s medical malpractice cases are difficult and require a significant investment of time and resources in order to be successful. Practitioners should conduct their “due diligence” on the front-end well before filing suit to ensure the case has merit and that the damages justify the time and expense involved in bringing a lawsuit. Plaintiffs’ counsel has a valuable opportunity to gain a thorough
understanding of the factual and medical issues that are likely to appear in the case well before suit is filed. Once a good case has been identified, the practitioner should use this time to their advantage:

- Carefully review the medical records;
- Get to know your client and their family and develop a good understanding of how their life has been affected by the alleged malpractice;
- Spend time researching and interviewing potential experts;
- Have your expert explain the relevant medical procedure(s) in great detail;
- Read peer-reviewed articles on the subject;
- Learn and become comfortable with the medical terminology;
- Carefully prepare the Complaint and Affidavit and ensure both comply with relevant statutes and case law;
- Interview the clients’ non-party medical providers;
- Ask the client to identify potential damages witnesses and interview those people;
- Determine whether there are outstanding liens that will need to be satisfied out of any settlement proceeds.
Remember, every medical malpractice case that is worth filing justifies this level of preparation. Best of luck!
816 S.E.2d 627  
Supreme Court of Georgia.

TENET HEALTHSYSTEM GB, INC.  
v.  
THOMAS.

S17G1021  
Decided: June 29, 2018

Synopsis
Background: Patient, who was rendered quadriplegic after cervical spine collar was removed when she was discharged from hospital, brought action including imputed liability claim against hospital. The Superior Court, Fulton County, Dempsey, J., granted hospital’s motion to dismiss simple negligence count against it. Patient filed application for interlocutory appeal, which was granted. The Court of Appeals, 340 Ga. App. 70, 796 S.E.2d 301, reversed. Hospital sought certiorari review.

[1] Courts
- Decisions of United States Courts as Authority in State Courts

Cases that cite this headnote

[2] Appeal and Error

Case that cites this headnote

[3] Limitation of Actions
- Amendment of Pleadings
In determining whether an amended complaint relates back to original complaint, court examines whether the factual allegations in original complaint and in the amended complaint are close in time, place, and subject matter, and involve events leading up to the same injury, such that there was but a single episode-in-suit.

Cases that cite this headnote

[4] Limitation of Actions
- Actions for injuries to the person
Imputed liability claim in patient’s amended complaint against hospital, asserting hospital nursing employee improperly removed patient’s cervical collar, related back to date of her original complaint alleging that hospital nurses and physicians made negligent acts and omissions, including removal of patient’s cervical collar, that resulted in quadriplegia, even if amended complaint involved conduct of different individual, where facts alleged in amended complaint occurred at same time as certain facts in original complaint and within a three-and-a-half hour time frame, facts of both complaints occurred at exact same location, and facts of both complaints involved negligent treatment of patient’s dangerously unstable spine. Ga. Code Ann. § 9-11-15(c).

Cases that cite this headnote

*628 Superior Court, Fulton County, Alford J. Dempsey
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Opinion

Hines, Chief Justice.

This Court granted a writ of certiorari to the Court of Appeals in Thomas v. Tenet HealthSystem GB, 340 Ga. App. 70, 796 S.E.2d 301 (2017), to consider whether that court properly held that a claim of imputed simple negligence against a hospital, which was asserted in a second amended complaint, related back to the original complaint pursuant to OCGA § 9-11-15 (c). Finding that the Court of Appeals was correct, we affirm that court’s judgment.

The original complaint was filed on May 6, 2014, shortly before expiration of the applicable two-year statute of limitation, OCGA § 9-3-33, and the facts alleged in that initial filing include the following. Lorraine Thomas was involved in a motor vehicle accident. Emergency personnel secured her neck with a cervical collar, or “C-collar,” placed her on a backboard, and transported her to the emergency room operated by Tenet HealthSystem GB, Inc., d/b/a Atlanta Medical Center (“hospital”). Still immobilized with the C-collar, Thomas presented to the emergency room at approximately 8:44 p.m. on May 10, 2012, was triaged by the hospital nursing staff, was examined by at least two hospital nurses, and was medically screened by Dr. Robin Lowman, who ordered a cervical CT scan. Dr. Clifford Grossman interpreted the CT scan, found no evidence of any acute fracture or subluxation of Thomas’s cervical spine, and reported his findings to Dr. Lowman. After further examination of Thomas, Dr. Lowman discharged her, and “[t]he C-collars were removed by [hospital] personnel.” Thomas was placed in a wheelchair and escorted out of the hospital at approximately 12:19 a.m. on May 11, 2012, to wait for her ride home. While waiting, however, she became unresponsive, was rushed back into the emergency room, and admitted to the hospital. After a cervical spine MRI later in the day, it was discovered that Thomas did have a cervical spine fracture that became dislocated and resulted in compression of the spinal cord, neurological damage, and quadriplegia. Nursing personnel were immediately notified to place a C-collar back on Thomas.

After setting out these facts, the original complaint asserted claims for professional negligence against Dr. Grossman and Dr. Lowman and alleged that, as a proximate result, “the injury to Ms. Thomas’s cervical spine progressed to subluxation and spinal cord injury resulting in her becoming a quadriplegic.” The original complaint then asserted a claim against the hospital of imputed liability for the negligent acts and omissions of those two doctors pursuant to the doctrines of respondeat superior, joint venture, and ostensible and apparent agency. Attached as exhibits to and referenced in the original complaint are the affidavits of two experts. Dr. Anthony Scarcella’s affidavit includes his opinion that if Dr. Lowman interpreted the cervical CT scan herself, then she breached the standard of care by, among other things, failing to stabilize, protect, and treat or cause to be treated Thomas’s dangerously unstable cervical spine prior to discharging her from the hospital. The two expert affidavits concluded that the acts and omissions of the doctors contributed to Thomas being discharged from the emergency room with a dangerously unstable spine. Dr. Joel Meyer’s affidavit concluded that due to gross negligence on the part of Dr. Grossman, “the injury to Ms. Lorraine Thomas’s cervical spine progressed to subluxation and spinal cord injury after the cervical collar was removed at discharge resulting in her becoming a quadriplegic.”
In August 2015, Thomas filed a second amended complaint that added three counts of negligence against the hospital. One of those counts asserted a claim against the hospital’s imputed liability, pursuant to the doctrine of respondeat superior or agency, for the simple negligence of a nursing employee who removed Thomas’s cervical spine collar in violation of a hospital policy that only a physician could remove a patient’s cervical spine collar. On the hospital’s motion, the trial court dismissed that count, finding that the original claim was “devoid of allegations of liability on the part of the hospital nursing staff,” that the new imputed liability claim does not arise from “the same conduct, transaction, or occurrence set forth or attempted to be set forth in the original pleading,” OCGA § 9-11-15 (c), and that the new claim therefore does not relate back to the filing of the original complaint. On interlocutory appeal, the Court of Appeals reversed, determining that, as the original complaint included the allegation that the cervical spine collar was removed by a hospital employee, as well as other allegations based on the conduct of the hospital and others related to Thomas’s emergency room visit, treatment, and discharge, her new imputed liability claim against the hospital for a nurse’s removal of the collar in violation of hospital policy arose out of the same conduct, transaction, or occurrence set forth in the original complaint. Thomas, 340 Ga. App. at 73-74, 796 S.E.2d 301.3

[1] The language of OCGA § 9-11-15 (c) is modeled after Federal Rule of Civil Procedure 15 (c), “and although there are some differences between the state and federal provisions, those differences are not material to the question presented here. We may, therefore, look for guidance in decisions of the federal courts interpreting and applying” Rule 15 (c).4 Community & Southern Bank v. Lovell, 302 Ga. 375, 377 (2). n. 6, 807 S.E.2d 444 (2017). See also Sam Finley, Inc. v. Interstate Fire Ins. Co., 135 Ga. App. 14, 16 (2), 217 S.E.2d 358 (1975). It follows that we may also look to decisions from the courts of other states that interpret and apply their own rules that are modeled after Federal Rule 15 (c). With this in mind, we turn first to the standard of review. In its opinion, the *630 Court of Appeals, after stating that “a motion to dismiss may be granted only where a complaint shows with certainty that the plaintiff would not be entitled to relief under any state of facts that could be proven in support of his or her claim,” said that its review of the ruling on the motion to dismiss in this case would be reviewed under the “de novo” standard. Thomas, 340 Ga. App. at 71, 796 S.E.2d 301.

We agree. Although the standard of review for “decisions under the same transaction or occurrence test of Federal Rule 15 (c) (1) (B) has sometimes been said to be abuse of discretion,” the better position is that decisions under the rule do not involve an exercise of discretion. See Ed. Sherman et al., Moore’s Federal Practice—Civil § 15:19 [2] (2018).

Instead, the court asks whether the facts provable under the amended complaint arose out of the conduct alleged in the original complaint. The abuse of discretion standard is suitable for decisions that balance several factors, often including equitable considerations. The relation-back issue, on the other hand, is more analogous to a dismissal on the pleadings. If facts provable under the amended complaint arose out of the conduct alleged in the original complaint, relation back is mandatory. Therefore, the proper standard of review is de novo.

1. See also Slayton v. American Express Co., 460 F.3d 215, 226-228 (2nd Cir. 2006). Accordingly, the decision of the trial court is owed no deference on appeal. See Johnson v. Burrell, 294 Ga. 301, 301 (2), n. 2, 751 S.E.2d 301 (2013).

Generally, our Civil Practice Act (CPA), OCGA § 9-11-1 et seq., “advances liberality of pleading.” Deering v. Keever, 282 Ga. 161, 163, 646 S.E.2d 262 (2007) (citation omitted). Under OCGA § 9-11-8 (a) (2), an original complaint, or any other pleading that sets forth a claim for relief, shall contain “[a] short and plain statement of the claim showing that the pleader is entitled to relief; and [a] demand for judgment for the relief to which the pleader deems himself entitled ....” Under this provision, “a complaint need only provide ‘fair notice of what the plaintiff’s claim is and the grounds upon which it rests.’” Mayle v. Felix, 545 U.S. 644, 655, 125 S.Ct. 2562, 162 L.Ed.2d 582 (2005) (citation omitted) (construing similar Federal Rule 8 (a)). Such notice pleading “is the hallmark of and prescribed by the CPA,” Phagan v. State, 287 Ga. 856, 859, 700 S.E.2d 589 (2010), which “abolished issue pleading.” Cotton, Inc. v. Phil-Dan Trucking, 270 Ga. 95, 95 (2), 507 S.E.2d 730 (1998). The particular section of the CPA at issue in this case, OCGA § 9-11-15,
“is liberally construed in favor of allowing amendments. Under OCGA § 9-11-15, an amendment to a complaint may raise a new cause of action.” Deering, 282 Ga. at 163, 646 S.E.2d 262 (citations omitted). And under OCGA § 9-11-15(c), the specific subsection that is relevant here, “[w]henever the claim or defense asserted in the amended pleading arises out of the conduct, transaction, or occurrence set forth or attempted to be set forth in the original pleading, the amendment relates back to the date of the original pleading.” Cf. Federal Rule of Civil Procedure 15(c)(1)(B) (formerly Rule 15(c)(2)) (“An amendment relates back to the date of the original pleading when...the amendment asserts a claim or defense that arose out of the conduct, transaction, or occurrence set out—or attempted to be set out—in the original pleading.”). “The very purpose of [OCGA § 9-11-15(c)] is to ‘qualify a statute of limitations.’” Mayle, 545 U.S. at 662, 125 S.Ct. 2562. The relation back rule is based on the notion that once litigation involving particular conduct or a given transaction or occurrence has been instituted, the parties are not entitled to the protection of the statute of limitations against the later assertion by amendment of defenses or claims that arise out of the same conduct, transaction, or occurrence as set forth in the original pleading.

6A Wright & Miller, Federal Practice & Procedure Civil § 1496 (3d ed., April 2018 Update). See also Mayle, 545 U.S. at 666, 125 S.Ct. 2562 (Souter, J., dissenting).

In OCGA § 9-11-15(c), like Federal Rule 15(c)(1)(B), “[t]he key words are ‘conduct, transaction, or occurrence.’” Mayle, 545 U.S. at 656, 125 S.Ct. 2562. The best “formulation[ ] for describing the parameters of the relation-back doctrine and focusing on its *631 underlying policies” is the standard found in the rule itself, i.e., “whether the amended pleading alleges matter that arises out of the same conduct, transaction, or occurrence as that set forth in the original pleading.” 6A Wright & Miller, supra at § 1497. See also Grange Mut. Cas. Co. v. Woodard, 300 Ga. 848, 852 (2) (A), 797 S.E.2d 814 (2017) (in construing a provision of the CPA, like other statutes, we must afford the statutory text its plain and ordinary meaning, view it in context, and read it in its most natural and reasonable way). The Supreme Court of the United States has approved a “formulation” that is closely based on the plain language of the rule: “relation back depends on the existence of a common ‘core of operative facts’ uniting the original and newly asserted claims.” Mayle, 545 U.S. at 659, 125 S.Ct. 2562. See also 6A Wright & Miller, supra at § 1497 (“As is true in a number of other contexts, such as compulsory counterclaims, crossclaims, and certain third-party claims, the search under Rule 15(c) is for a common core of operative facts in the two pleadings.”). This formulation is consistent with prior analysis by our Court of Appeals:

“[T]he question of relation back of the amendment turns on fair notice of the same general fact situation from which the claim arises. It is apparent that the strict rule of no relation back of the amendment to the time of filing the original complaint because of the assertion of a new cause of action is no longer applicable unless the causes of the action are not only different but arise out of wholly different facts.”

Jensen v. Yong Hae Engler, 317 Ga. App. 879, 883 (1), 733 S.E.2d 52 (2012) (citation omitted; emphasis in original). See also Sam Finley, 135 Ga. App. at 18, 20, 217 S.E.2d 358 (apparently the first Georgia case to use this language, based on an extensive quote from Moore’s Federal Practice).

[3] The United States Supreme Court has recognized that, in a case “where there was but one episode-in-suit,” and no “separate episodes” at a “different time and place,” an “amendment related back, and therefore avoided a statute of limitations bar, even though the amendment invoked a legal theory not suggested by the original complaint and relied on facts not originally asserted.” Mayle, 545 U.S. at 659-660, 125 S.Ct. 2562 (explaining Tiller v. Atlantic Coast Line R. Co., 323 U.S. 574, 580-581, 65 S.Ct. 421, 89 L.Ed. 465 (1945)). In Tiller, the Supreme Court emphasized that both the original and amended complaints “related to the same general conduct, transaction and occurrence which involved” the alleged injury and that the defendant “had notice from the beginning that [the plaintiff] was trying to enforce a claim against it because of the events leading up to” that injury on its property. 323 U.S. at 581, 65 S.Ct. 421. Accordingly, we will examine whether the factual allegations in Thomas’s original complaint and in the new imputed liability claim in her second amended complaint are close in time, place, and subject matter, and involve events leading up to the same injury, such that there was but a single “episode-in-suit.” See In re Olympia Brewing

[4] Thomas’s original complaint alleged that hospital nurses were involved in her care and treatment at the hospital’s emergency room following the motor vehicle accident and that the negligent acts and omissions of two doctors caused Thomas to be discharged just three and a half hours later with a dangerously unstable spine that resulted in serious injury after hospital personnel removed her cervical collar. The new imputed liability claim in Thomas’s second amended complaint alleged that this same removal of the C-collar was the negligent act of a hospital nursing employee in violation of a hospital policy. These facts alleged in Thomas’s second amended complaint occurred at the same time as certain facts in the original complaint, near the end of the three-and-a-half hour time frame of the treatment preceding the alleged injury. Thus, the relevant factual allegations were quite *632 close in time, to say the least. They also occurred at the exact same location, and they involved the same general subject matter, i.e., the negligent treatment of Thomas’s dangerously unstable spine. Finally, the allegations were part of the same events that led up to the same ultimate injury for which Thomas is seeking damages. See Porter, 317 Ill. Dec. 703, 882 N.E.2d at 593. Cf. Moore v. Baker, 989 F. 2d 1129, 1132 (11th Cir. 1993) (“The alleged acts of negligence occurred at different times and involved separate and distinct conduct.”). As a result of these close factual connections between the relevant allegations, they amounted to a single "episode-in-suit," sharing a "common core of operative facts." The fact that Thomas’s second amended complaint involved a legal theory, the imputed simple negligence of the hospital nurse who removed the C-collar, that was not in the original complaint does not prevent this new claim from relating back. See Mayle, 545 U.S. at 659, 125 S.Ct. 2562; 6A Wright & Miller, supra at § 1497 (“The fact that an amendment changes the legal theory on which the action initially was brought is of no consequence if the factual situation upon which the action depends remains the same and has been brought to defendant’s attention by the original pleading.”). Nor is relation back foreclosed by the original complaint’s omission of an allegation that a nurse’s negligent conduct caused or contributed to Thomas’s discharge with a dangerously unstable spine and to the ultimate injury that resulted, as “personal injury plaintiffs often cannot pinpoint the precise cause of an injury prior to discovery.” Mayle, 545 U.S. at 660, 125 S.Ct. 2562.

For the same reasons, relation back is not prevented by the fact that Thomas’s second amended complaint alleged that the hospital was vicariously liable for the conduct of a different individual than the individuals on whose conduct the original claim of imputed liability against the hospital was based. See Maraj v. North Broward Hosp. Dist., 989 So.2d 682, 686 (Fla. App. 2008) (where the plaintiff sued two emergency room physicians and a hospital as vicariously liable for their acts, an amended claim against a previously unnamed radiologist arose out of the same occurrence under a Florida rule very similar to OCGA § 9-11-15 (c)); Cannon v. West Suburban Hosp. Med. Center, 301 Ill.App.3d 929, 235 Ill.Dec. 158, 704 N.E.2d 731, 737 (1998) (Illinois’ very similar relation back provision was triggered by an amended complaint against a hospital for vicarious liability alleging different conduct by different persons than was alleged in support of the original claims against the hospital). See also Miller v. Warren Hospital, 2016 WL 3509305 (D.N.J. June 27, 2016) (new claim against hospital for vicarious liability for previously unnamed health providers related back under the federal rule to the original complaint that named only a single doctor); Carlson v. Countryside Manor Healthcare Facility, 2018 WL 2471283 *5 (Conn. Super. Ct. May 15, 2018) (addition of nursing staff as additional actors to a vicarious liability claim for the acts of a doctor related back because, “[a]lthough there are different actors and possibly different standards of care, ... [t]he acts committed arose out of the same factual situation[,] ... [t]he alleged events occurred during the same period of time, occurred at the same location, and resulted in the identical injury”); Lloyd v. Wollin, 2017 IL App. (1st) 162546-U (Ill. App. September 18, 2017) (applying Porter and Olympia Brewing to hold that a new vicarious liability claim against a hospital for a nurse’s conduct related back to a previous vicarious liability claim against the hospital for a doctor’s conduct during the same emergency room visit). Cf. Weber v. Freeman, 3 So.3d 825, 834 (Ala. 2008) (under Alabama’s very similar provision, no relation back where the plaintiff “was seeking to add new facts and a new claim that the surgery center was vicariously liable for a different doctor
on a different day from those actions that formed the basis of the claims asserted in the [earlier] complaint[s]).

Accordingly, we conclude that the implied liability claim in Thomas’s second amended complaint relates back to the date of her original complaint pursuant to OCGA § 9-11-15 (c) and that, as a result, that new claim is not barred by the applicable two-year statute of limitation. The Court of Appeals, therefore, correctly reversed the trial court’s dismissal of Thomas’s new implied liability claim as time-barred. We note that the hospital asserted in a brief in support of its motion to dismiss that, contrary to the allegations of the second amended complaint, the new implied liability claim actually constituted a claim of the nurse’s professional negligence rather than simple negligence and, consequently, was subject to dismissal for Thomas’s failure to file a supporting expert affidavit under OCGA § 9-11-9.1. The trial court, however, did not rule on that separate issue, instead assuming that the new claim was based on allegations of the nurse’s simple negligence, and we express no opinion on it at this time. Cf. Comman, 235 Ill.Dec. 158, 704 N.E.2d at 738 (“Having determined that the claims asserting [the hospital] is vicariously liable ... are not time-barred, we must next determine whether these claims were properly dismissed by reason of the plaintiff’s failure to comply with [the statute requiring an expert affidavit].”).

Judgment affirmed.

Melton, P.J., Benham, Hunstein, Nahmias, Blackwell, Boggs, Grant, J.J., and Judge Dean Carlos Bucci concur. Peterson, J., not participating.

All Citations
816 S.E.2d 627

Footnotes
1 OCGA § 9-11-15 (c) provides:

Whenever the claim or defense asserted in the amended pleading arises out of the conduct, transaction, or occurrence set forth or attempted to be set forth in the original pleading, the amendment relates back to the date of the original pleading. An amendment changing the party against whom a claim is asserted relates back to the date of the original pleadings if the foregoing provisions are satisfied, and if within the period provided by law for commencing the action against him the party to be brought in by amendment (1) has received such notice of the institution of the action that he will not be prejudiced in maintaining his defense on the merits, and (2) knew or should have known that, but for a mistake concerning the identity of the proper party, the action would have been brought against him.

2 In reviewing a trial court’s ruling on a motion to dismiss, an appellate court may consider any exhibits attached to and incorporated into the complaint. See Thomas v. Gregory, 332 Ga. App. 286, 287, 772 S.E.2d 362 (2015).

3 From the same trial court order that is the subject of this case, Thomas filed a separate appeal to the Court of Appeals regarding the trial court’s grant of summary judgment to the hospital on certain issues. The Court of Appeals affirmed in part, vacated in part, and remanded the case to the trial court. Thomas v. Tenet HealthSystem GB, 340 Ga. App. 78, 796 S.E.2d 307 (2017). We denied the hospital’s petition for certiorari.

4 Federal Rule 15 (c) (1) (B) provides that “[a]n amendment relates back to the date of the original pleading when ... the amendment asserts a claim or defense that arose out of the conduct, transaction, or occurrence set out—or attempted to be set out—in the original pleading.”

5 To the extent that Thomas v. Medical Center of Central Ga., 286 Ga. App. 147, 648 S.E.2d 409 (2007), which never cited OCGA § 9-11-15, much less analyzed that statute, is inconsistent with our specific holding in this case, it is hereby disapproved.
EXHIBIT 2
§ 51-4-2. Homicide of spouse or parent; survival of action

Currentness

(a) The surviving spouse or, if there is no surviving spouse, a child or children, either minor or sui juris, may recover for the homicide of the spouse or parent the full value of the life of the decedent, as shown by the evidence.

(b)(1) If an action for wrongful death is brought by a surviving spouse under subsection (a) of this Code section and the surviving spouse dies pending the action, the action shall survive to the child or children of the decedent.

(2) If an action for wrongful death is brought by a child or children under subsection (a) of this Code section and one of the children dies pending the action, the action shall survive to the surviving child or children.

(c) The surviving spouse may release the alleged wrongdoer without the concurrence of the child or children or any representative thereof and without any order of court, provided that such spouse shall hold the consideration for such release subject to subsection (d) of this Code section.

(d)(1) Any amount recovered under subsection (a) of this Code section shall be equally divided, share and share alike, among the surviving spouse and the children per capita, and the descendants of children shall take per stirpes, provided that any such recovery to which a minor child is entitled and which equals less than $15,000.00 shall be held by the natural guardian of the child, who shall hold and use such money for the benefit of the child and shall be accountable for same; and any such recovery to which a minor child is entitled and which equals $15,000.00 or more shall be held by a guardian of the property of such child.

(2) Notwithstanding paragraph (1) of this subsection, the surviving spouse shall receive no less than one-third of such recovery as such spouse's share.

(c) No recovery had under subsection (a) of this Code section shall be subject to any debt or liability of the decedent.

(f) In actions for recovery under this Code section, the fact that a child has been born out of wedlock shall be no bar to recovery.

Credits
EXHIBIT 3
§ 51-1-29.5. Health care liability claims; emergency medical care; provider liability; jury instructions; definitions

Effective: July 1, 2015
Currentness

(a) As used in this Code section, the term:

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

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

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

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

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

(6) "Emergency medical services provider" means any person providing emergency medical care.

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

(8) "Health care institution" means:

(A) An ambulatory surgical center;
(B) A personal care home licensed under Chapter 7 of Title 31;

(B-1) An assisted living community licensed under Chapter 7 of Title 31;

(C) An institution providing emergency medical services;

(D) A hospice;

(E) A hospital;

(F) A hospital system;

(G) An intermediate care facility for the intellectually or developmentally disabled; or

(H) A nursing home.

(9) “Health care liability claim” means a cause of action against a health care provider or physician for treatment, lack of treatment, or other claimed departure from accepted standards of medical care, health care, or safety or professional or administrative services directly related to health care, which departure from standards proximately results in injury to or death of a claimant.

(10) “Health care provider” means:

(A) Any person, partnership, professional association, corporation, facility, or institution duly licensed, certified, registered, or chartered by the State of Georgia to provide health care, including but not limited to:

(i) A registered nurse;

(ii) A dentist;

(iii) A podiatrist;

(iv) A pharmacist;

(v) A chiropractor;
§ 51-1-29.5. Health care liability claims; emergency medical care, GA § 51-1-29.5

(vi) An optometrist; or

(vii) A health care institution; and

(8) Any person who is:

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

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

(11) "Hospice" means a facility licensed as such under the "Georgia Hospice Law," Article 9 of Chapter 7 of Title 31.

(12) "Hospital" means a facility licensed as such under Chapter 7 of Title 31.

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

(14) "Medical care" means any act defined as the practice of medicine under Code Section 43-34-21.

(15) "Nursing home" means a facility licensed as such under Chapter 7 of Title 31.

(16) "Pharmacist" means a person licensed as such under Chapter 4 of Title 26.

(17) "Physician" means an individual licensed to practice medicine in this state, a professional association organized by an individual physician or group of physicians, or a partnership or limited liability partnership formed by a group of physicians.

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

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

(c) In an action involving a health care liability claim arising out of the provision of emergency medical care in a hospital emergency department or obstetrical unit or in a surgical suite immediately following the evaluation or treatment of a
§ 51-1-29.5. Health care liability claims; emergency medical care, GA ST § 51-1-29.5

patient in a hospital emergency department, no physician or health care provider shall be held liable unless it is proven by clear and convincing evidence that the physician or health care provider's actions showed gross negligence.

(d) In an action involving a health liability claim arising out of the provision of emergency medical care in a hospital emergency department or obstetrical unit or in a surgical suite immediately following the evaluation or treatment of a patient in a hospital emergency department, the court shall instruct the jury to consider, together with all other relevant matters:

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

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

(3) The circumstances constituting the emergency; and

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

Credits

Notes of Decisions (48)
Ga. Code Ann., § 51-1-29.5, GA ST § 51-1-29.5
The statutes and Constitution are current through the 2018 legislative session. The statutes are subject to changes by the Georgia Code Commission.
FACILITIES IN METRO ATLANTA SUBJECT TO FTCA

- MERCY CARE AT GATEWAY CENTER
  Atlanta, GA, 30303-3638

- MERCY CARE MOBILE
  Atlanta, GA, 30312-1848

- MERCY CARE DECATUR STREET
  Atlanta, GA, 30312-1848

- MERCY CARE AT ST. JUDE'S
  Atlanta, GA, 30308

- OAKHURST MIDTOWN
  Atlanta, GA, 30308-2247

- HEAL AT SUNSET
  Atlanta, GA, 30314-4059

- MARTIN LUTHER KING MIDDLE SCHOOL
  Atlanta, GA, 30312-3051

- SOUTHSIDE MEDICAL CENTER - MAIN CENTER / CORPORATE HQ
  Atlanta, GA, 30315-1640

- SOUTHSIDE MEDICAL CENTER - MOBILE MEDICAL CLINIC
Atlanta, GA, 30315-1640

- **THE FAMILY HEALTH CENTER AT WEST END**
  Atlanta, GA, 30310-2750

- **MOBILE MEDICAL AND DENTAL UNIT**
  Atlanta, GA, 30310-2750

- **MERCY CARE AT ATLANTA DAY SHELTER**
  Atlanta, GA, 30318-5410

- **MERCY CARE AT CITY OF REFUGE**
  Atlanta, GA, 30314-2032

- **WHITEFOORD ELEM SCHL HLTH CLINIC**
  Atlanta, GA, 30317-1727

- **TOOMER ELEMENTARY SCHOOL**
  Atlanta, GA, 30317-2237

- **WHITEFOORD FAMILY MEDICAL CENTER**
  Atlanta, GA, 30317-1003

- **OAKHURST BUCKHEAD**
  Atlanta, GA, 30306-1314

- **SOUTHSIDE MEDICAL CENTER DECATUR**
  Atlanta, GA, 30316-2306

- **HEALING COMMUNITY CENTER**
• SOUTHSIDE MEDICAL CENTER - GRESHAM CLINIC
  Atlanta, GA, 30316-4138

• SOUTHSIDE MEDICAL CENTER - EAST POINT CLINIC
  Atlanta, GA, 30344-3602

• OAKHURST DECATUR
  Decatur, GA, 30032-3254

• THE FAMILY HEALTH CENTER AT KIDCARE
  Atlanta, GA, 30331-2156

• MILES ELEMENTARY SCHOOL
  Atlanta, GA, 30331-4401

• SOUTHSIDE MEDICAL CENTER - FOREST PARK CLINIC
  Forest Park, GA, 30297-1071

• THE FAMILY HEALTH CENTER AT COLLEGE PARK SCHOOL-BASED
  College Park, GA, 30337-2411

• RECOVERY CONSULTANTS OF ATLANTA
  Decatur, GA, 30032-1837

• SOUTHSIDE MEDICAL CENTER - FORREST PARK CLINIC
  Forest Park, GA, 30297-2134

• MERCY CARE CHAMBLEE
• RECOVERY CONSULTANTS OF ATLANTA MEDICAL
Decatur, GA, 30035-3440

• OAKHURST NORTHLAKE
Atlanta, GA, 30345-2822

• THE FAMILY HEALTH CENTER AT NORTH CLAYTON HIGH SCHOOL
College Park, GA, 30349-5403

• OAKHURST MEDICAL CENTERS-MAIN OFFICE
Stone Mountain, GA, 30083-3215

• THE FAMILY HEALTH CENTER AT KIDCARE
College Park, GA, 30349-3103

• THE FAMILY HEALTH CENTER AT LAKE FOREST
Sandy Springs, GA, 30326-5837

• SOUTHSIDE MEDICAL CENTER - RIVERDALE CLINIC
Riverdale, GA, 30274-2527

• OAKHURST HILLANDALE
Lithonia, GA, 30058-4996

• SOUTHSIDE MEDICAL CENTER - NORCROSS CLINIC
Norcross, GA, 30093-1619

• GOOD SAMARITAN HEALTH CENTER OF COBB
Marietta, GA, 30008-3855

- **CPACS/COSMO HEALTH CENTER**
  Peachtree Corners, GA, 30071-2302

- **CPACS COSMO HEALTH CENTER**
  Peachtree Corners, GA, 30071-2350

- **FOUR CORNERS PRIMARY CARE CENTERS**
  Norcross, GA, 30093-2261

- **FAMILY HEALTH CENTER AT COBB**
  Marietta, GA, 30060-1144

- **THE FAMILY HEALTH CENTER AT DOUGLAS COUNTY SCHOOLS**
  Douglasville, GA, 30134-3840

- **OAKHURST ROCKDALE**
  Conyers, GA, 30012-5357

- **YOURTOWN HEALTH**
  Palmetto, GA, 30268-1138

- **SOUTHSIDE MEDICAL CENTER - LOVEJOY MEDICAL CENTER**
  Hampton, GA, 30228-1608

- **FOUR CORNERS PRIMARY CARE CENTER AT VPH**
  Lawrenceville, GA, 30046-8457

- **YOURTOWN HEALTH - SENOIA**
- **GHMS CANTON FAMILY HEALTH CENTER**  
  Canton, GA, 30114-6413

- **HIGHLANDS MEDICAL PLAZA**  
  Cumming, GA, 30040-2478

- **GHMS CUMMING FAMILY HEALTH CENTER**  
  Cumming, GA, 30040-2467

- **SOUTHSIDE MEDICAL CENTER, SPALDING COUNTY**  
  Griffin, GA, 30223-2831

- **CARECONNECT URGENT CARE**  
  Griffin, GA, 30224-4842

- **GHMS BARTOW FAMILY HEALTH CENTER**  
  Cartersville, GA, 30120-3482

- **MEDLINK MONROE**  
  Monroe, GA, 30655-1751

- **SOUTHSIDE MEDICAL CENTER - JACKSON CLINIC**  
  Jackson, GA, 30233-2134

- **YOURTOWN HEALTH**  
  Carrollton, GA, 30117-3803

- **MEDLINK WINDER WOMEN'S CENTER**
Winder, GA, 30680-1786

- MEDLINK WINDER
  Winder, GA, 30680-1786

- FOUR CORNERS PRIMARY CARE CENTERS, HOSCHTON
  Hoschton, GA, 30548-2222

- YOURTOWN HEALTH MILBY MEDICAL CENTER
  Zebulon, GA, 30295-3380

- GHMS DAWSONVILLE FAMILY HEALTH CENTER
  Dawsonville, GA, 30534-6288

- GOOD SAMARITAN HEALTH & WELLNESS CENTER
  Jasper, GA, 30143-1964

- MEDLINK GAINESVILLE - JESSE JEWELL
  Gainesville, GA, 30501-3779

- MEDLINK GAINESVILLE - BROAD ST
  Gainesville, GA, 30501-3728
IN THE SUPERIOR COURT OF ______ COUNTY

STATE OF GEORGIA

JANE DOE,

Plaintiff,

vs.

JOHN SMITH, M.D. and
THE HOSPITAL AUTHORITY OF
______ COUNTY d/b/a
HOSPITAL

Defendants.

CIVIL ACTION FILE

NO. ____________

COMPLAINT FOR DAMAGES

COMES NOW the Plaintiff, by and through counsel, and files this Complaint against the above-named Defendants and shows the Court the following:

1.

The Plaintiff Jane Doe is a resident of _____ County, residing at ________.

2.

Defendant John Smith, M.D. is a general surgeon whose offices are located at ____. Said Defendant may be served with Summons and Complaint at his business address. When duly served with a copy of Summons and Complaint in this matter, said Defendant will subject to the jurisdiction of this Court.

3.

The Hospital Authority of ______ County is a legal entity existing under the laws of the State of Georgia. The Authority, among other business names including ____, also does
business as “Hospital” located at ______. Said Defendant may be served through the Chairman of the Hospital Authority, ______, and/or through its President and Chief Executive Officer ______, located at ______. When duly served with Summons and Complaint, said Defendant will be subject to the jurisdiction of this Court.

4.

On January 16, 2015, the Plaintiff, while under the care of the Defendant John Smith, M.D. (hereinafter Defendant Smith) did undergo an outpatient laparoscopic cholecystectomy at the Hospital. At all times relative to the medical treatment she received on January 16, 2015, while under his care, Defendant Smith had a duty to Jane Doe to provide a standard of care normally exercised by general surgeons under like conditions and similar surrounding circumstances. As set forth herein, Defendant Smith was negligent in his care and treatment of Ms. Doe and failed to comport with the requisite standard of care.

5.

Defendant Smith was negligent and failed to comport with the requisite degree of skill and care required under the facts and circumstances of the case as follows:

a) The use of an optical trocar in Ms. Doe’s case was below the standard of care since Ms. Doe had had previous abdominal surgery including a hysterectomy, which needlessly put her at considerable risk of injury during a procedure of the type performed by Defendant Smith. It was a breach of the standard of care to utilize an optical trocar in the location selected by Defendant Smith. In Ms. Doe’ case his selection of that location unreasonably increased the dangers to the Plaintiff.

b) During the laparoscopic cholecystectomy, Defendant Smith negligently
transected the left iliac common artery with the use of a trocar. As a result of negligent surgical technique, Defendant Smith not only nearly completely transected Ms. Doe’s left iliac common artery (with lacerations in multiple locations), he also lacerated the mesentery of the small bowel.

c) Having negligently lacerated the left common iliac artery in multiple locations, Defendant Smith thereafter negligently failed to properly repair the lacerations. During his attempted repair of what he described as a “small tear” of the left common iliac artery, Defendant Smith sewed shut that artery. This breach in the standard of care resulted in a near complete occlusion of artery with associated blood clots which, in turn, necessitated later emergent surgery performed at Non-Party Hospital 2 also on 1/16/15.

6.

Because of the negligence of Defendant Smith as described, after being emergently transported to Non-Party Hospital 2, the Plaintiff underwent emergent thrombectomy of the aorta, the left and right iliac system and the right leg. She also required a repair of the left common iliac artery with a bovine pericardial patch and a repair of the small bowel mesentery. Following the attempted cholecystectomy and transfer to Non-Party Hospital 2, the Plaintiff experienced a number of additional complications including high volume enterocutaneous fistulas and prolonged respiratory failure. She required numerous consultations. She later suffered from right lower leg ischemia with required a right lower extremity thrombectomy. Later she had to have a Peg gastrostomy tube for nutritional support and required treatment for abdominal pain and fever, infection, anemia and persistent entero cutaneous fistulas.

7.

The care that the Plaintiff received at the time of the laparoscopic cholecystectomy by
Defendant Smith fell below acceptable standards which violations of the standards of care were contributing factors to the described medical problems experienced by the Plaintiff.

8.

As a result of the negligence of Defendant Smith, not only has the Plaintiff required extensive hospitalization and treatment as described, she has suffered mentally and physically, has and continues to incur substantial medical expenses, and has sustained and will continue to have lost wages.

9.

Notwithstanding the fact that the laparoscopic cholecystectomy was expected to last less than an hour with minor pain and suffering associated therewith, as a result of the negligence of Defendant Smith, the Plaintiff has been hospitalized for over eight (8) months, has incurred medical expenses in excess of $1.5 million, has been in significant pain and unable to work, and continues to require medical care and treatment for the constellation of medical problems resulting from the negligent care she received from Defendant Smith.

10.

As required by O.C.G.A. § 9-11-9.1, the Plaintiff has attached hereto an Affidavit of David Jones, M.D. specifically setting forth at least one negligent act or omission claimed to exist and the factual basis for such claims against Defendant Smith.

11.

Because Defendant Smith was acting at all times pertinent to the events alleged herein within the scope of his employment as an agent and employee of The Hospital Authority of County, doing business as “Hospital”, said Defendant is vicariously liable for the acts of its agent
and employee, John Smith, M.D.

WHEREFORE, Plaintiff requests that:

a. That she be granted a jury trial as to all issues so triable;

b. That she recover an amount from the Defendants to compensate her for all of her damages alleged herein in an amount to be determined by a fair and impartial jury in an amount in excess of $10,000.00; and

c. that she be granted such other and further relief as this Court deems just and proper.

Respectfully submitted,

Richard W. Hendrix
Georgia Bar No. 346750
Steven R. Wisebram
Georgia Bar No. 771350
Attorney for Plaintiff

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225 Peachtree Street, NE
1700 South Tower
Atlanta, GA 30303
404-658-9070/800-228-9159
rhendrix@finchmccranie.com
swisebram@finchmccranie.com
AFFIDAVIT OF DAVID JONES, M.D.

STATE OF _______
COUNTY OF _______

Personally appeared before the undersigned officer duly authorized to administer oaths, DAVID JONES, M.D., who after being duly sworn, deposes and states as follows:

1.

I am DAVID JONES, M.D., a physician licensed to practice medicine in the State of Massachusetts. I am over the age of 18 and otherwise competent to give this Affidavit.

2.

This Affidavit is based upon my personal knowledge, facts to which I am competent to testify and my personal education, training and experience. My curriculum vitae is attached hereto as Exhibit “A.”

3.

I graduated from Harvard College in 1968 with a Bachelor of Arts degree and graduated in 1976 from Brown University with a Doctor of Medicine degree. I did an internship in surgery at Peter Bent Brigham Hospital in Boston, Massachusetts from 1976 until 1977; from 1977 until 1981 I was a surgical resident at Peter Bent Brigham Hospital in Boston, Massachusetts; from 1982 until 1983 I was the Chief Resident in Surgery at Brigham and Women’s Hospital, Boston, Massachusetts; from 1981 to 1982 I was a Research Fellow in surgery at Brigham and Women’s Hospital. I am licensed to practice medicine in the State of Massachusetts and I am a member of the American Board of Surgery, a Fellow in the American College of Surgeons, and have had two re-certifications from the American Board of Surgery. From 1998 until the present I have
been an Associate Professor of Surgery at Harvard Medical School and prior to that I was an Associate Professor of Clinical Surgery at Harvard Medical School and also an instructor in surgery at Harvard Medical School. From 1996 until the present I have been the Associate Chairman of Surgery, Clinical Operations, Brigham and Women’s Hospital and from 2004 until the present I have been on the consulting staff of the Dana Farber Cancer Institute.

4.

I have been on the editorial boards of The Journal of Minimally Invasive Therapy, The Journal of Minimally Invasive Therapy and Allied Technologies and Home Page, I have been the Assistant Editor of HPB, the official Journal of the I.H.P.B.A. and from 2000 to the present I have been a contributing editor to the H.M.S./I.N.T.E.L.I. Health Website.

5.


6.

From at least 1977 until the present, I have been actively involved in the practice of general surgery and for a large portion of the time I have also been an instructor in medical school in general surgery; therefore, I have been actively involved in the practice of surgery for at least three of the five years immediately preceding January of 2012. As reflected in my CV, I have written several peer reviewed articles on laparoscopic surgery.
7.

This affidavit is also based upon the facts and information shown within the medical records from the Hospital and Non-Party Hospital 2 for the admission of Jane Doe to both facilities on January 16, 2015. I have also reviewed Dr. John Smith’s dictated notes for dates that he saw Ms. Doe beforehand and have also studied and reviewed Ms. Doe’ extensive hospitalization records from Non-Party Hospital 2 following the described laparoscopic procedure of January 16, 2015. (Copies of the above-described records are attached hereto.)

8.

Based upon my review of the above-referenced records, I have found the following facts to have occurred and they are a factor and a basis upon which my opinions are founded:

(a) On December 30, 2014, Ms. Jane Doe (DOB ____ ) was evaluated by John Smith, MD. She presented with abdominal pain and an ultrasound of the gallbladder showing a slightly prominent common bile duct, and incomplete distention of the gallbladder. No stones were noted.

(b) According to her records, Ms. Doe has a documented medical history of abdominal surgery which includes a prior hysterectomy and an umbilical hernia repair. She has a degree of COPD. Her pre-surgery medications included only Synthroid. She was allergic to Sulfa. On initial examination by Dr. Smith she was of normal weight with BMI of 21.3 without significant abnormalities. Her lab studies revealed normal liver function tests.

(c) A stimulated HIDA scan performed on 1/5/12 revealed dysmotility and reproduction of her pain, prompting Dr. Smith to recommend a laparoscopic cholecystectomy as
the optimal method to treat her episodic pain.

(d) The laparoscopic surgery was performed on January 16, 2012 at Hospital by Dr. Smith. Access to the abdomen was via a 12 mm infra-umbilical incision. Dr. Smith used a 5 mm optical trocar for a near-blind approach to the peritoneum.

(e) After establishing a pneumoperitoneum and inserting his laparoscope, there was evidence of bleeding in the abdomen. As a result, Dr. Smith converted to an open laparotomy and found evidence of what he described as a "small hole" in the small bowel mesentery. Further dissection and lysis of adhesions identified a retroperitoneal hematoma. This was opened and described by Dr. Smith as a "small laceration of the left common iliac artery." Dr. Smith reported in his operative report that he repaired the "small laceration" with a 3-0 Prolene suture. Hemostasis was thought to be achieved. Further investigation, however, revealed an absence of pulses in either the right or left external iliac vessels. Dr. Smith reported blood loss of approximately 2000 ml.

(f) As a result of Ms. Doe's condition at the time, Dr. Smith contacted Dr. Katz, a vascular surgeon at Non-Party Hospital 2 to arrange transfer there because of Dr. Smith's documented concerns regarding a possible intimal flap or thrombosis of the iliac vessels. Once the patient was closed by Dr. Smith, she was emergently transferred via EMS from the Hospital to the Non-Party Hospital 2.

(g) Upon arrival at Non-Party Hospital 2, Ms. Doe was immediately taken to the ICU, intubated and resuscitated because she had bled down to a hemoglobin of 1.9 and a hematocrit of 6.3. Once stabilized and adequately resuscitated, she was emergently taken to the operating room by Dr. Katz where during exploratory laparotomy he found her to have 2 liters of blood
within the abdomen. Dr. Katz's operative notes confirm that he found not a “small tear” as described by Dr. Smith in his operative report but instead a near-complete transection of the left common iliac artery, including a secondary posterior tear of the artery not described at all by Dr. Smith in his report. Dr. Katz also noted a “large rent” in the small bowel mesentery. The attempted suture repair of the laceration performed by Dr. Smith had caused a near complete occlusion of the iliac system with active arterial bleeding from the medical aspect of the repair. As a result, Dr. Katz performed a thrombectomy of the aorta, the left and right iliac system and the right leg. He also repaired the left common iliac artery with a bovine pericardial patch. Additionally, he repaired the tear in the small bowel mesentery.

(h) Following Dr. Katz’s surgery, Ms. Doe had a long, difficult course at Non-Party Hospital 2 and was not able to be initially discharged until April 4, 2015. During this time she sustained a number of complications including a high volume entero-cutaneous fistula and prolonged respiratory failure. She required numerous consultations, courses of antibiotics and host of maneuvers to allow her to maintain her nutrition and improve her respiratory function.

(i) Following the 4/4/15 discharge Ms. Doe was re-admitted on 4/17/15 with right lower leg ischemia which required a right lower extremity thrombectomy by Dr. Katz. Additionally, a Peg gastrostomy tube was placed at that time for nutritional support. She was discharged once again on April 25th, but returned on April 27th and was readmitted with abdominal pain and fever. She was found at that time to have a superficial infection of the PEG site, COPD, anemia and the persistent entero-cutaneous fistula.

9.

It is my opinion within a reasonable degree of medical certainty that the care Ms. Doe
received at the time of the laparoscopic cholecystectomy by Dr. Smith fell below the generally acceptable standards.

10. Appropriate access to the peritoneum when prior surgery has been performed on a patient in or around the umbilicus is either through an open approach in which direct incision is made at each layer of the abdominal wall, or conversely using a different site for initial access such as the left upper quadrant or the subxyphoid location. Regardless, in Ms. Doe’ case, it was a breach of the standard of care to utilize an optical trocar in the location selected by Dr. Smith.

11. The use of an optical trocar at a site in which the probably of the adhesions to the anterior abdominal wall was extremely high, and the risk of injury to these structures was also extremely high, was well below the standard of care for Ms. Doe’ case and needlessly put her solid and hollow organs at considerable risk. The subsequently identified injuries confirms this. Had Dr. Smith used an open approach or had he chosen a different site for his initial access, the likelihood that Ms. Doe’ injuries would have occurred is diminishingly low.

12. Dr. Katz reported in his Discharge Summary that he found the left common iliac artery to have been sewn shut by Dr. Smith. In his operative report, Dr. Smith indicated that he had repaired what was described as a “small laceration” to the left common iliac artery. The multiple lacerations noted by Dr. Katz in his Operative Report confirms that Dr. Smith failed to properly repair the lacerations to the left common iliac artery which failure was below the standard of care for a general surgeon. It was a breach of the standard of care for Dr. Smith to sew shut the left
common iliac artery. This breach in the standard of care resulted in a near complete occlusion of the artery with associated blood clots which, in turn, necessitated the thrombectomies and additional procedures performed by Dr. Katz as described in his Operative report.

13.

It is my opinion to a reasonable degree of medical certainty that the violations of the standard of care referenced herein were contributing factors to the various medical problems experienced by Ms. Doe following the attempted cholecystectomy.

14.

This Affidavit is based upon my training, experience, personal knowledge, surgical experience and upon my review of the afore-mentioned records and documents. It is not the purpose of this Affidavit to set forth each and every opinion or to include all criticisms that I may have now or may have in the future. I may have further opinions based upon review of additional records, other records which become available and/or available information concerning the pertinent issues. The purpose of this Affidavit is to comply with O.C.G.A. § 9-11-9.1.

This _____ day of __________ 2016.

DAVID JÖ ES, M.D.
Affiant

Sworn to and subscribed before me this
_____ day of ______________, 2016.
My commission expires: ____________
I THINK I HAVE A CASE ... NOW WHAT?
PREPARING A PLAINTIFF’S MEDICAL MALPRACTICE CASE
Moses Kim, The Moses Firm. LLC, Atlanta
THE 10 COMMANDMENTS OF PREPARING A MEDICAL MALPRACTICE CASE

I. THOU SHALT CHOOSE THE RIGHT CASE

What are the damages?
Is there a theory of liability?
Is there juice?
“Can you win the case?” v. “Does the case have value?”

II. THOU SHALT FIND THE EVIDENCE

Medical Records: Are you using the Hi-Tech Act?
Certified Medical Records
Itemized Bills
Imaging
Fetal Monitoring Strips
Pathology Recuts
Autopsy
Death Certificate

III. THOU SHALT SUE THE RIGHT PEOPLE

Physician Licenses: Georgia Composite Medical Board
Nursing Licenses: Georgia SOS
TLO
Google
Facebook
Start with a shotgun
Why name a nurse individually?

IV. THOU SHALT FIND THE RIGHT EXPERTS

Academics v. In-the-Trenches
Websites
Pubmed
AAJ Listserve
Emailing Experts
Ask expert: Can you support a pt’s case?

V. THOU SHALT DRAFT THE EXPERT AFF CORRECTLY

3/5
Competent Experts/Same Specialty
Supervisors
Ordinary v. Professional Negligence: Plead both if needed

VI. THOU SHALT PERSUADE WITH YOUR COMPLAINT

Is it really just notice pleading?
Start with a bang!

VII. THOU SHALT THINK ABOUT YOUR CASE

What are the weaknesses in the case?
Create friction
Close the escape hatches (Call MD, get AFFs)
Can you find dirt? (GA Composite Medical Board)

VIII. THOU SHALT SUE IN A GOOD VENUE IF YOU CAN

GA SOS
TLO

IX. THOU SHALT AVOID PROBLEMS

An ounce of prevention is worth a pound of cure.
You MUST file within the SOL!!!
File Early if Possible
Close holes
Shotgun Defs if necessary
Have Defs ID Employers

X. THOU SHALT STAY THE COURSE

Don’t give up.
Trial Exhibits
Video Depositions
DEFENDING A MEDICAL MALPRACTICE CASE: STRATEGIES AND TACTICS FROM THE DEFENSE PERSPECTIVE

David C. Hanson, Weathington McGrew PC, Atlanta
11:15  TIPS AND STRATEGIES FOR TAKING EFFECTIVE DEPOSITIONS IN MED MAL CASES

John G. Mabrey, The Mabrey Firm, P.C., Atlanta
Depositions are the life-blood of just about every plaintiff's case. They help you obtain the necessary facts to prove your case, tie witnesses down to their version of what happened and what they remember, and they enable you to discover the opinions held by experts and treating physicians before they appear at trial to testify. Depositions also allow you to gauge the credibility and demeanor of the witnesses before they testify at trial, much like what the jurors will be doing. Well-taken depositions prevent surprises at trial or at a minimum, provide you with a tool to deal with any surprises that were not disclosed when the deposition testimony was obtained. Depositions are also helpful when you would prefer to read the deposition, as opposed to calling the witness to appear before the jury and testify.

From my perspective, the first question that needs to be answered is why you want to take a particular deposition and how will it help you pursue your case. Once that is determined, you can prepare an outline with a sequence of questions/points to help you get the information you need.

In order to become effective at taking depositions, you need to take them frequently. Like anything else, practice and making mistakes along the way will make you an effective questioner. If you are relatively new to the deposition process, I encourage you to take non-essential depositions in your case to simply familiarize yourself with the process. This will also make you comfortable hearing your own voice, and less self-conscious about asking a bad question, etc. Seeing your questions on a transcript will enable you to clean up speaking habits you may not like, and make you more efficient. Since the majority of plaintiff's lawyers do not bill by the hour, efficiency is key when it comes to taking depositions!

This paper and my talk at the seminar is intended to provide general guidelines to effectively depose a witness. I hope it is of some assistance.
Depositions are the life-blood of just about every plaintiff’s case. They help you obtain the necessary facts to prove your case, tie witnesses down to their version of what happened and what they remember, and they enable you to discover the opinions held by experts and treating physicians before they appear at trial to testify. Depositions also allow you to gauge the credibility and demeanor of the witnesses before they testify at trial, much like what the jurors will be doing. Well-taken depositions prevent surprises at trial or at a minimum, provide you with a tool to deal with any surprises that were not disclosed when the deposition testimony was obtained. Depositions are also helpful when you would prefer to read the deposition, as opposed to calling the witness to appear before the jury and testify.

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I. PRE-SUIT PREPARATION

A. Have you prepared deposition notices to serve with the Complaint for the initial people you wish to depose? Why is this important?

II. PRE-DEPOSITION PLANNING

A. The most important element of an effective deposition is clearly know why are you taking the deposition? In other words, what is the purpose? The purpose will guide you in your questions. And of course, the deposition can have more than one purpose or it can change as you discover what the witness will say.

The following are different purposes for a deposition:

1. Obtaining useful testimony;
2. Preventing harmful testimony;
3. Obtaining information (not the same thing as testimony);
4. Learning the weaknesses of your case;
5. Showing the adverse party the weaknesses of his case;
6. Crediting or discrediting other witnesses;
7. Observing the witness’s demeanor;
8. Showing the witness your demeanor, and
9. Assessing the witness’s controllability by you and by your adversary.

B. Do you have an outline for your deposition? Why is having an outline important? For your particular case, what sequence of questions do you want to use? Is chronological approach best? Do you want to begin by getting the witness relaxed, to increase chances of admissions? Or do you want to start off with a bang before the witness gets comfortable?

C. What is the likely use of the deposition transcript? Discovery and impeachment? Preserving testimony for future use at trial?

D. What demeanor you will use with the witness when asking questions?

E. Will you be using leading questions, or broad open ended questions, or a combination depending upon the point or fact you are trying to elicit?

F. Have you sent out an email out on the GTLA listerv or other type listserv requesting prior deposition transcripts of the person you are deposing? If so, and you have found a golden nugget in one of those earlier depositions, are you going to use it in your deposition or save it for trial?
G. Have you got your mind right about how you will deal with defense counsel’s speaking objections or interference with your examination, if it occurs?

H. Do you want to video the deposition?

I. Is the benefit of deposing a particular person worth the risk of that person saying something harmful about your case, i.e., treating physicians?

J. Do you want your client present at the deposition?

III. DEPOSITION EXAMINATION

A. Beginning the deposition.

To cleanly use the deposition at trial and prevent the witness from avoiding being impeached by saying he didn’t understand the question, ask a series of questions at the beginning of the deposition to ensure the witness understands your questions. I like to ask the same first series of questions for every deposition I take. It is committed to memory and I can confidently impeach a witness at trial knowing I have asked these questions. When impeaching a witness at trial, these questions serve as good lead up to the actual impeachment:

Stipulation and agreement of all counsel

Swear the witness

Introduction (I use the following the below):

“My name is John Mabrey and I represent Ms. Smith in this case. If at any time during today’s deposition I speak too fast, too softly or just ask a question that makes no sense, would you please stop me and ask me to rephrase my question?

If you do not ask me to rephrase my question, will be it be fair for me to assume that you understood my question as asked?

Have you been deposed before? Number of times/circumstances?

You understand that there is a court reporter in the room today taking down everything we are talking about today?

You understand that there will be a transcript prepared from our conversation today, and that you will have a right to review the transcript and make any changes that you deem necessary?
You understand that if your testimony at trial is different than what it is today, that the deposition transcript may be used to impeach your credibility?

What materials have you reviewed to prepare for today’s deposition? (Be prepared to list documents that you are interested in knowing if witness has ever reviewed.)

B. Random tips during the deposition.

1. Ignore the defense attorney.

2. Be persistent and get an answer to your question. Do not give up on your question, but be prepared to ask it several different ways. True/False questions are an easy way to get good sound bites.

3. Since you have a well written outline at this point, listen closely to the answers and if the witness goes off on an interesting tangent, consider exploring. After exploring, return to your outline. Your outline gives you the confidence that you will cover the important issues after chasing down the tangent.

4. Keep your questions short and simple so you can cleanly impeach the witness if necessary. Long or vague questions make it easy for a witness to evade an impeachment effort at trial.

5. If you get a good answer to a question, don’t get greedy. In other words, don’t give the deponent a chance to change his answer or qualify it somehow. Have “subject changing” type questions in your mind and ask them to change the conversation and preserve the good answer on the record you just received.

6. With inexperienced witnesses, be prepared to feed them a steady diet of leading questions at the proper times.

7. With professional witnesses, be prepared to ask open ended questions to get them speaking and explaining. Leading questions with professional witnesses (or any adverse witness) can cause them to reflexively push back and disagree with your questions, simply because you are suggesting the answer.

8. If questioning a witness about a particular document (medical records, accident report, etc.), put your questions directly on the document so you can easily go through it and ask the questions you have. The witness
will have a clean copy of the document to refer to when being questioned.

9. When deposing the defense expert, at a minimum, ask the defense expert the same substantive questions that the defense lawyer asked your expert. (example—cause of death, etc.) In a indirect manner, try to get the defense expert to agree with your expert’s opinions on issues where possible. You want to eliminate opportunities for the defense to create issues at the last minute. The more agreement the defense expert has with the plaintiff’s expert, the less chance of having a distracting issue arise.

10. At the end of the deposition, take a five minute break to go over your outline to see if there any questions you skipped, or there are any areas that you feel like you need to follow up on.

11. Do not panic if you forget to ask an important question during the deposition. You may be able to obtain the information with written discovery, or perhaps other witnesses. Keep in mind that the witness may not be ready for that particular question at trial since it is not in the transcript he is reviewing to prepare for his trial testimony.

12. When the witness doesn’t remember, or she does remember and you have exhausted her memory, lock the door. Ask, “Does that complete your entire recollection of the wreck?” When the witness responds with “So far as I can remember now, yes.”, then ask “Is there anything that could refresh your recollection?” Lock the door so she cannot come back later and change her testimony, or offer a “new” memory or recollection.

13. Consider using silent pauses at the end of the witness’s answers. Some witnesses will volunteer very helpful information during this pause.

14. If a witness says I don’t have a specific recollection, always ask for a general recollection to ensure you get what they know.

15. Use simple and easy to understand language when asking questions. In the event of an impeachment, the jury will easily understand what you were asking.

16. Avoid ambiguous questions. It will make your life easier if you have to impeach the witness at trial. The witness cannot say that she thought your question asked one thing, when you were thinking it was asking about something else.
17. At the end of every expert witness deposition, always ask if he has told you all of the opinions he intends to express to the jury at trial. Ask if there are other opinions that he holds, which were not discussed during the deposition. If he says he has no other opinions, then ask if he will agree to alert defense counsel if any new opinions are developed. Tell the expert you want to avoid any surprise opinions at trial and ask if he understands.

18. When taking an expert deposition, be very careful about trying to “win” the deposition by using your entire arsenal of questions and evidence. If you render the expert unusable at trial, the defense lawyer will simply find another expert. This new expert will be ready for your line of attack. A lot of thought needs to go into how hard you want to push the defense expert during deposition. The less a defense expert has to review in his deposition transcript, the less prepared he will be to deal with your cross-examination at trial.

END
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12:30 LUNCH & LEARN: OVERVIEW OF RECENT APPELLATE COURT DECISIONS IN MEDICAL MALPRACTICE CASES
David V. “Dave” Hayes, Owen Gleaton Egan Jones & Sweeney LLP, Atlanta
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| JORDAN V. EVERSON, ET AL. 302 GA. 364 (OCTOBER 16, 2017) | Parents filed suit against ER M.D. contending that M.D. failed to properly assess and evaluate the child’s mental status.  
M.D. instructed family to obtain assessment at nearby mental health facility and made him apt.  
Family instead decided to drive to Durham, NC for assessment when son jumped out of vehicle and was killed.  
Trail Crt denied MSJ on causation and COA affirmed. | ♦ Intervening act does not have to be wrongful or negligent.  
♦ 100 Year Old Precedent: Test as to whether intervening act of a third person will render the earlier act too remote depends simply upon whether the concurrence of such intervening act might reasonably have been anticipated by the defendant.  
Southern R. Co. v. Webb  
♦ Jury only has to determine if an intervening act was reasonably foreseeable to defendant or if it was triggered by defendant’s conduct.  
∗∗  
♦ COA relied on Goldstein v. J.B.: narrow decision addressing sexual assault that did not overrule Webb. | ♦ Family’s decision to disregard appointment with local facility and make appoint in North Carolina, thereby requiring the family drive to NC on interstate was the intervening act to break the chain of causation.  
Family’s actions did not have to be wrongful or negligent to act as a break in the chain of causation.  
♦ This was a petition for writ of certiorari and S.C. disposed of case entirely without oral argument or full briefing. |
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| GRAHAM V. REYNOLDS | 343 GA. APP. 274 (OCTOBER 23, 2017) | - Plaintiff filed suit for husband’s death against E.D. physician for negligently misdiagnosing husband’s cardiac condition.  
- Plaintiff attached affidavit of cardiologist alleging defendant misdiagnosed husband w/ panic attack.  
- Affidavit specifically alleged defendant misread EKG and husband’s symptoms, which should have led to a diagnosis of M.I.  
- Trial Court denied defendants motion to dismiss on grounds that expert was not competent to testify and affidavit did not address gross negligence. | - O.C.G.A. § 24-7-702 requires, at the time of act or omission, the expert had actual professional knowledge and experience in the area of practice or specialty in which the opinion is to be given. Knowledge and experience comes from (1) active practice for 3 of 5 years of specific procedure, condition or treatment alleged or (2) teaching of profession for 3 of 5 years of specific procedure, condition or treatment alleged.  
- O.C.G.A. § 9-11-9.1: must set forth “at least one negligent act or omission claimed to exist and the factual basis for such” (Pleading requirement, NOT evidentiary).  
- O.C.G.A. § 51-1-29.5: liability arising out of medical care in E.D., no provider shall be held liable unless it is proven by clear and convincing evidence that the provider’s actions showed gross negligence. | - Competency of Affiant:  
  o Affiant (cardiologist) was licensed physician and, as such, “part of the same profession” as defendant (ED Physician).  
  o Affiant alleged that defendant should have diagnosed husband’s cardiac condition from EKG and other symptoms. Affiant taught in the area of electrophysiology as a faculty member of a state university.  
  o Affiant not required to be an E.D. physician to opine as to diagnosing cardiac issue.  
- Contents of Affidavit:  
  o Gross negligence standard is evidentiary standard; 9-11-9.1 is a pleading standard.  
  o Only one negligent act or omission must be contained in affidavit: affiant’s statement that defendant breached applicable SOC is enough.  
  o 9-11-9.1 does not require the use of term “gross negligence.” |
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| **YUGUEROS V. ROBLES**  
343 GA.APP. 377  
(OCTOBER 26, 2017) | - Husband sued Plastic Surgeon and Practice after Wife died following liposuction, buttock augmentation, and abdominoplasty  
- Practice’s 30(b)(6) Witness—fellow Plastic Surgeon and President of Practice—testified she assumed Plastic Surgeon-Defendant ordered CT Scan during post-surgery care because that would have been standard of care  
- Trial Court excluded testimony, finding it hearsay, ambiguous, and not based on testimony to reasonable degree of medical probability under *Daubert*§24-7-702  
- Court of Appeals reversed, finding testimony was admission against interest under § 9-11-30 | - § 9-11-32(a)(2) states that deposition of deponent designated under § 9-11-30(b)(6) may be used by adverse party for “any purpose,” but that provision must be read in light of § 9-11-32(a)’s overriding requirements that deposition, so far as admissible under rules of evidence applied as though witness were then present and testifying, may be used against any party  
- § 9-11-32(a)(2) does not create rule of evidence that allows any deposition taken under § 9-11-30(b)(6) to be admitted at trial in its entirety as admission against interest, but provides for admission of depo when that admission is permitted under relevant rules of evidence  
- When testifying as to medical standard of care, § 24-7-702 is relevant rule of evidence | - Under § 24-7-702, it is role of trial court to act as gatekeeper of expert testimony. This role is not extinguished simply because depo testimony, including expert testimony, is secured under § 9-11-30(b)(6)  
- 30(b)(6) witness’s testimony could not be admitted as standard of care testimony: plaintiff was the proffering party and had the burden to establish admissibility. Testimony demonstrated that deponent had not reviewed medical records and studies and, thus, the testimony was not based upon sufficient facts or data as required by O.C.G.A. § 24-7-702. |

Plaintiffs, husband & wife, filed suit against pharmacy for injuries suffered when husband ingested improperly dispensed medication.

- Medication was given to patient by cashier at pharmacy.
- Allegations included professional and simple negligence.
- Trial Court granted summary judgment to Defendants on professional negligence claims.

“Not every suit which calls into question the conduct of one who happens to be a medical professional is a medical malpractice action. We must look at the substance of the action against a medical professional in determining whether the action is one for professional or simple negligence.” This is a question of law.

“Only when the allegations of negligence against the professional involve the exercise of professional skill and judgment within the professional’s area of expertise does the claim sound in professional negligence.”

O.C.G.A. § 26-4-85: SOC for pharm counseling. Staff must offer to discuss matters of drug therapy with patient unless patient declines. Pharmacist can delegate role to tech or cashier.

Plaintiffs’ expert admitted that he did not know if counseling had been offered by pharmacy and had no evidence to show a violation of SOC in counting, filling, labelling or providing printed info with the rx. Sole criticism was that wrong medication had been dispensed. As such, COA ruled that there was not sufficient evidence to support a professional negligence claim. Questions existed as to whether cashier took any steps to confirm patient’s identity when she handed patient the medication and this question was one of simple negligence.
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| **CURLES v. PSYCHIATRIC SOLUTIONS, INC.**<br>**343 GA. APP. 719**<br>(MARCH 15, 2018) | • Plaintiffs brought suit alleging professional negligence against psychiatrist and facility for murders committed by psychiatric patient who was released from facility.  
• Patient had hx of psychotic episodes involving violent conduct and had been admitted to subject facility at least 3 times.  
• Trial court dismissed on grounds that claim was one of medical negligence thereby barred by statute of repose and subject to affidavit rule. | **Medical negligence claims are those that arise out of care or treatment for the benefit of a patient or involve the exercise of professional judgment.** | Plaintiffs’ claims that facility should have given notice of patient’s discharge to either the court who committed the patient or law enforcement agencies having control over the patient, did not arise out of care or treatment of patient or involve the exercise of professional judgement and, thus, sounded in ordinary negligence such that action was not subject to statute of repose or affidavit rule. |
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<td>SWALLOWS V. ADAMS-PICKETT</td>
<td>• Parents of patient filed med mal claim against physician and practice on allegation that child suffered left brachial plexus injury during delivery. &lt;br&gt; • Trial Court granted defendants’ motion for partial summary judgment on parents’ lost income and medical expenses of child based on SOL grounds.</td>
<td>O.C.G.A. § 9-3-71: An action for med mal shall be brought within two years after the date on which the injury or death arising from a negligent act occurred. &lt;br&gt; • Exception for minors: O.C.G.A. § 9-3-73 – A minor younger than 5 has 2 years from the minor’s fifth birthday to file suit. &lt;br&gt; • Right to recover damages for a child’s medical expenses vests solely in the child’s parents, while the right to recover for pain and suffering vests in the child.</td>
<td>COA determined the language of OCGA § 9-3-73 to be clear and unambiguous. There is no exception listed in the statute for parents’ claims for their minor child. &lt;br&gt; Absent any specific exception listed in the statute, the parents’ claims for the minor’s medical expenses and their own ancillary claims such as loss of income are subject to the 2 year statute of limitations. &lt;br&gt; Because parents are responsible for medical expenses for their children, the right to recover damages for medical expenses incurred in such treatment is vested exclusively in a minor child’s parents.</td>
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| MACDOWELL V. GALLANT 344 GA. APP. 856 (MARCH 1, 2018) | • Patient filed suit against dentist alleging that defendant failed to inform her that prosthesis installed by oral surgeon had been installed too deep.  
• Trial Court granted SJ, COA reversed, S.C. affirmed and remanded. Trial Court granted SJ on issue of whether claim was file outside of 2 year SOL. | • O.C.G.A. § 9-3-96 SOL is tolled where the defendant is guilty of fraud: the period of limitation shall run only from the time of the plaintiff’s discovery of fraud. There must be evidence that the defendant intentionally withheld information as to the wrongful conduct.  
• SOL is tolled by fraud until plaintiff either has constructive notice or actual notice of the wrongful conduct.  
  ○ Constructive notice is obtained when a patient seeks the medical opinion of another physician.  
  ○ Actual notice is required where the second physician/dentist consulted is one who is providing services to the plaintiff jointly with the defendant. | Material issues of fact remained as to whether plaintiff had acquired actual notice of the alleged malpractice and SJ was improper.  
• Plaintiff saw a second dentist following the alleged malpractice but that second dentist was providing services to the plaintiff jointly with the defendant. |
### Case Affidavit

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| ST. MARY’S HEALTH CARE SYSTEM V. ROACH 345 GA. APP. 274 (MARCH 2, 2018) | • Parents of patient, who died as a result of aortic dissection after discharge, filed suit against hospital for negligence alleging the hospital’s imaging interpretation system improperly provider for x-rays not to be read until the next morning.  
• Plaintiff’s added hospital to case with amended complaint and did not attach an expert affidavit addressing the claims against the hospital regarding the review process for x-rays.  
• Trial Court denied hospital’s MSJ and COA reversed. | • O.C.G.A. § 9-11-9.1 requires plaintiff to file an affidavit with any action for damages alleged professional malpractice.  
• The complaint’s characterization of claims as stating professional negligence or ordinary negligence does not control. Instead, where the alleged negligence requires the exercise of professional skill and judgment the action states professional negligence.  
• If a claim goes to the propriety of a professional decision, rather than to the efficacy of conduct in the carrying out of a decision previously made, the claim sounds in professional malpractice.  
• Whether a complaint sounds in ordinary or professional negligence is a question of law for the court to decide. | • Court found the claims against the hospital were professional negligence claims.  
• Evidence established that the hospital policy allowed for an immediate consult with a radiologist, but the E.D. physician exercised her judgment and decided one was not necessary.  
• The only way to properly allege that the hospital was negligent is with expert testimony explaining how the policy fell below the standard of care. |
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| **SOUTHEASTERN PAIN SPECIALISTS v. BROWN** **303 GA. 265** **(MARCH 5, 2018)** | • Patient and husband filed suit pain management specialist after suffering brain damage due to oxygen deprivation while she underwent a procedure to relieve back pain.  
• Jury awarded over $21 million of which 50% was apportioned to the specialist.  
• Trial judge instructed the jury on ordinary and professional negligence. COA affirmed. | • Judge presiding over civil trial should charge the jury on only the legal issues raised by the complaint and answer, adjusted to the evidence introduced at trial.  
• It is a question of law whether evidence is sufficient to support the giving of a particular charge; the evidence required is only slight evidence.  
• An error in the charge that injects issues not raised by the pleadings and evidence is presumed to be harmful. | • Trial judge erred in instructing jury on ordinary and professional negligence as the allegations and evidence were that the physician failed to respond appropriately – an exercise of medical judgment – to data from monitors.  
• Instruction of ordinary negligence permitted the jury to find defendant liable based on the presumption that whether and how to respond to medical data does not require medical judgment.  
• The ordinary negligence instruction invited jurors to decide liability of the defendant without consideration of the strictures on claims for professional malpractice, such as the need for expert testimony and the bar on finding liability solely using hindsight.  
• General verdict made it impossible for Court to determine the basis of the verdict and it cannot stand. Retrial of entire case required. |
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| **CANCEL v. MEDICAL CENTER OF CENTRAL GEORGIA 345 GA. APP. 215 (MARCH 15, 2018)** | • Widespread allegations of improper behavior and treatment record alteration.  
• 4 physicians were not re-hired by medical center after their contracts were terminated. Physicians sued medical center for fraud and breach of fiduciary duty.  
• Trial Court denied Plaintiff’s requests for production of notes taken during the medical center’s review process. | • The proceedings and records of a review organization shall be held in confidence and shall not be subject to discovery or introduction into evidence in any civil action. No person who was in attendance at a meeting of such organization shall be permitted or required to testify in any such civil action as to any evidence of other matters produced or presented during the proceedings.  
• A party may seek original documents and examine witnesses who appeared before peer review committee, as long as the proceedings are not asked about.  
• Peer Review Committee is entitled to immunity for any civil or criminal proceeding unless motivated by malice. | • Plaintiff was not allowed to conduct discovery into peer review process which resulted in the termination of physician group’s contract.  
• The malice exception to the immunity defense under the peer review statute has no bearing on the confidentiality provisions. |
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<td><strong>EVANS V. ROCKDALE HOSP.</strong></td>
<td><strong>Facts</strong>&lt;br&gt;345 GA. APP. 511 (APRIL 12, 2018)</td>
<td>◆ <strong>Question of damages is ordinarily one for jury unless the damages are clearly so inadequate as to be inconsistent with preponderance of evidence.</strong>&lt;br&gt;◆ <strong>Court of Appeals has over tuned verdicts where jury awarded special damages for medical expenses but virtually nothing for pain and suffering undisputedly suffered by plaintiff as a result of the injury.</strong></td>
<td>◆ Jury awarded 100% of plaintiff’s medical expenses and the undisputed evidence shows that she underwent multiple surgeries and spent months in a rehab facility. It is undisputed that plaintiff is permanently and completely disabled.&lt;br&gt;◆ Jury’s award of zero damages for pain and suffering was so clearly inadequate under the evidence as to shock the conscience.&lt;br&gt;◆ While an appellate court can set aside a jury’s damage award and order a new trial, in cases involving comparative negligence a new trial cannot be limited to damages and the entire case must be retried.</td>
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<td>Patient suffered undiagnosed ruptured brain aneurysm.</td>
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<td>◆ Jury returned a verdict that found hospital was 51% at fault, that award the husband a post apportionment award of $33,101.95 in damages for loss of consortium, and awarded patient $586,191.60 in damages for patient’s past medical expenses, but $0 for future medical expenses and past and future pain and suffering.</td>
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<td>◆ Plaintiff appealed.</td>
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<td>Cruz Pico V. Brady</td>
<td>Patient filed suit against Doctor for injuries he suffered following a cervical node excision. Plaintiff did not attach § 9-11-9.1 Expert Affidavit, but attached affidavit from his attorney stating that the attorney had just been retained and the SOL would be expiring within 10 days. Defendant filed motion to dismiss and attached medical authorization form signed by attorney. Trial Court denied motion and COA affirmed.</td>
<td>§ 9-11-9.1 provides the contemporaneous affidavit filing requirement shall not apply to any case in which the SOL will expire within ten days of the date of the filing of the complaint and because of time constraints the plaintiff has alleged that an affidavit of an expert could not be prepared. For the extension to apply the attorney to file an affidavit that the attorney was not retained by plaintiff more than 90 days prior to the expiration of the period of limitation. If it determined that the law firm or attorney on the pleadings was retained within 90 days of the expiration of the period of limitation, the complaint shall be dismissed for failure to state a claim.</td>
<td>When an attorney is retained for purposes of O.C.G.A 9-11-9.1 is an issue of first impression. Under the GA Rules of Professional Conduct attorneys and clients can generally agree to limit the scope of representation. Medical authorization form signed by attorney indicates that the client and attorney expressly limited the scope and objective of the initial representation to obtaining the patient’s medical records. No reasonable basis to believe attorney had been retained to file suit.</td>
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## HOLMES V. LYONS

**815 S.E. 2d 252**

(JUNE 1, 2018)

- Patient sued surgeon and hospital after gynecological surgery after which the patient suffered a right distal ureteral injury and uterovaginal fistulas.
- Plaintiff alleged the physician suffered from physical impairments that negatively affected his motor skills and placed patients at increased risk of complications.
- Trial Court granted motion to dismiss finding that (1) the expert affidavit failed to specify one negligent act or omission, and (2) a physician’s failure to disclose to a patient negative life factors which might adversely affect his professional performance could not serve as a basis for separate claims of fraud, negligent misrep, and battery.

### Facts

- Affidavit rule requires affidavit to include at least one specific negligent act or omission.
- An affidavit which would not satisfy the evidentiary requirements for summary judgment purposes may nevertheless be sufficient to satisfy the pleading standards.
- When ruling on motion to dismiss, the Court must construe the affidavit in plaintiff’s favor, even if unfavorable construction may be possible.
- Generally speaking, there is no duty on physicians to disclose personal life factors which might adversely affect their professional performance and the failure to disclose such cannot be a basis for fraud or battery.
- However, the Supreme Court has not said a physician never has a duty to disclose negative information about personal life to patients.

### Legal Principles

- Affidavit generally alleges breach of standard of care and that the same resulted in injury to plaintiff. It is not required that the affidavit state the doctor’s performance of procedure resulted in specific injury alleged.
- Court distinguished current case from precedent and found plaintiff put forth specific allegations concerning the physician’s physical limitations and how they could affect his performance of the specific procedure.

### Conclusions

- While reversing the trial Court’s grant of defendant’s motion to dismiss, the Court frequently alludes to a different outcome under the summary judgment standard suggesting a suspicious view of plaintiffs’ claims.

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**POLIS V. LING**

**816 S.E. 2D 93**

(JUNE 8, 2018)

- Plaintiff filed suit on behalf of daughter who applied eczema cream which caused scar like marks on legs.
- Trial Court granted defendants’ motion for summary judgment on grounds that claims were barred by statute of limitations.

### Facts

- O.C.G.A. 9-3-71: An action for medical malpractice shall be brought within 2 years after date on which an injury or death arising from a negligent or wrongful act or omission occurred.
- Law is well established that in most misdiagnosis cases the injury begins immediately when the misdiagnosis is made. Thus, the fact that the patient does not know the medical cause of her suffering does not affect the applicability of O.C.G.A. 9-3-71. The test to determine when the cause of action accrued is to ascertain the time when the plaintiff could first have maintained her action to a successful result.
- Supreme Court rejects argument that after an initial diagnosis, a doctor’s continued failure to recognize the patient’s problems constitutes a continuing tort.

### Legal Principles

- With respect the claims that defendants negligently prescribed the cream, the relevant date is when the patient developed the marks on her legs. That was the date of the injury.
- As to the misdiagnosis claims, the latest date on which a misdiagnosis could have occurred was when the doctor told her the marks were stretch marks typical for girls her age.
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<td><strong>HOLMES V. LYONS</strong></td>
<td>• Patient sued surgeon and hospital after gynecological surgery after which the patient suffered a right distal ureteral injury and uterovaginal fistulas.</td>
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|                           | • Plaintiff alleged the physician suffered from physical impairments that negatively affected his motor skills and placed patients at increased risk of complications. | • Affidavit rule requires affidavit to include at least one specific negligent act or omission.  
• An affidavit which would not satisfy the evidentiary requirements for summary judgment purposes may nevertheless be sufficient to satisfy the pleading standards.  
• When ruling on motion to dismiss, the Court must construe the affidavit in plaintiff's favor, even if unfavorable construction may be possible.  
• Generally speaking, there is no duty on physicians to disclose personal life factors which might adversely affect their professional performance and the failure to disclose such cannot be a basis for fraud or battery.  
• However, the Supreme Court has not said a physician never has a duty to disclose negative information about personal life to patients. | • With respect the claims that defendants negligently prescribed the eczema cream, the relevant date is when the patient developed the marks on her legs. That was the date of the injury.  
• As to the misdiagnosis claims, the latest date on which a misdiagnosis could have occurred was when the doctor told her the marks were stretch marks typical for girls her age. |

| **POLIS V. LING**         | • Plaintiff filed suit on behalf of daughter who applied eczema cream which caused scar like marks on legs.  
• Trail Court granted defendants’ motion for summary judgment on grounds that claims were barred by statute of limitations. | • O.C.G.A. 9-3-71: An action for medical shall be brought within 2 years after date on which an injury or death arising from a negligent or wrongful act or omission occurred.  
• Law is well established that in most misdiagnosis cases the injury begins immediately when the misdiagnosis is made. Thus, the fact that the patient does not know the medical cause of her suffering does not affect the applicability of O.C.G.A. 9-3-71. The test to determine when the cause of action accrued is to ascertain the time when the plaintiff could first have maintained her action to a successful result.  
• Supreme Court rejects argument that after an initial diagnosis, a doctor’s continued failure to recognize the patient’s problems constitutes a continuing tort. |  |

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<td>ADAMS V. MCDONALD 816 S.E. 2d 454 (JUNE 21, 2018)</td>
<td>• Patient sued doctor for alleged misdiagnosis of heart tumor.</td>
<td>• Generally, the SOL begins to run from the misdiagnosis date. However, exception exists when misdiagnosed condition subsequently develops into a more serious and debilitating medical condition thus resulting in a new injury which did not exist at the time of the original misdiagnosis.</td>
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<td>• Trial Court granted defendants MSJ on the grounds that plaintiff’s claims were barred by 2 year SOL.</td>
<td>• If plaintiff’s symptoms were symptoms of the same injury that existed at the time of the alleged misdiagnosis, then the claim is barred by the SOL.</td>
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<td>• Court found questions of fact and cited conflicting evidence from plaintiff, defendant and the parties’ experts.</td>
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<td>• There was evidence to support an asymptomatic period between the original misdiagnosis and her subsequent stroke. Plus, the stroke resulted in brain damage which studies show was not present prior to the stroke.</td>
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<td>• There was certainly an issue of fact that should be left for a jury’s determination.</td>
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</tr>
<tr>
<td>Case Discovery</td>
<td>Facts</td>
<td>Legal Principles</td>
<td>Conclusions</td>
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<tr>
<td><strong>ADAMS V. MCDONALD</strong>&lt;br&gt;816 S.E. 2d 454 (JUNE 21, 2018)</td>
<td>- Patient sued doctor for alleged misdiagnosis of heart tumor. &lt;br&gt;- Trial Court granted defendants MSJ on the grounds that plaintiff's claims were barred by 2 year SOL.</td>
<td>- Generally, the SOL begins to run from the misdiagnosis date. However, exception exists when misdiagnosed condition subsequently develops into a more serious and debilitating medical condition thus resulting in a new injury which did not exist at the time of the original misdiagnosis. &lt;br&gt;- If plaintiff's symptoms were symptoms of the same injury that existed at the time of the alleged misdiagnosis, then the claim is barred by the SOL.</td>
<td>- Court found questions of fact and cited conflicting evidence from plaintiff, defendant and the parties' experts. &lt;br&gt;- There was evidence to support an asymptomatic period between the original misdiagnosis and her subsequent stroke. Plus, the stroke resulted in brain damage which studies show was not present prior to the stroke. &lt;br&gt;- There was certainly an issue of fact that should be left for a jury's determination.</td>
</tr>
<tr>
<td><strong>ANGLIN V. SMITH</strong>&lt;br&gt;816 S.E. 2d 426 (JUNE 21, 2018)</td>
<td>- Patient filed suit against doctor for pain and weakness suffered after back injection. &lt;br&gt;- Jury returned a defense verdict and plaintiff appealed manner in which trial court handled the affidavit of plaintiff’s expert.</td>
<td>- Duty to respond to discovery is continuing and when a party knows a previous discovery response is no longer true and does not amend the response the party is in knowing concealment. &lt;br&gt;- A party does not have to file a motion to compel in order to obtain sanctions should they later learn the answer was false or misleading. &lt;br&gt;- An interrogatory answer that falsely denies the existence of discoverable information is worse than no response.</td>
<td>- Trial Court’s exclusion of affidavit was appropriate remedy for Plaintiff’s failure to disclose the same during discovery. &lt;br&gt;- COA opinion suggests that when work product is an issue it is best to identify the responsive document and allow the court to determine the applicability of the work product doctrine to the document.</td>
</tr>
<tr>
<td>Case</td>
<td>Facts</td>
<td>Legal Principles</td>
<td>Conclusions</td>
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<tr>
<td><strong>TENET HEALTH SYSTEM, INC. V. THOMAS</strong>&lt;br&gt;816 S.E. 2d 627&lt;br&gt;(JUNE 29, 2018)</td>
<td>- Patient filed suit against hospital for delay in diagnosis and treatment after she presented to E.D. following MVA.&lt;br&gt;- Trial Court granted hospitals motion to dismiss amended complaint on grounds that new allegations did not arise from same conduct, transaction, etc.</td>
<td>- <strong>To determine relation back, Court must examine facts in original complaint and amended complaint to determine if they are close in time, place and subject matter and involve events leading up to the same injury.</strong></td>
<td>- Plaintiff’s imputed liability claim in amended complaint relates back to original complaint because it involves the same events, location and general subject matter.&lt;br&gt; New legal theories and parties can be added in amended complaints as long as they pass the common core of operative facts test.</td>
</tr>
</tbody>
</table>
Case
Relation Back
Facts
Legal Principles
Conclusions

TENET HEALTH SYSTEM, INC. V.
THOMAS
816 S.E. 2D 627
(JUNE 29, 2018)

- Patient filed suit against hospital for delay in diagnosis and treatment after she presented to E.D. following MVA.
- Trial Court granted hospital's motion to dismiss amended complaint on grounds that new allegations did not arise from same conduct, transaction, etc.

To determine relation back, Court must examine facts in original complaint and amended complaint to determine if they are close in time, place and subject matter and involve events leading up to the same injury.

- Plaintiff's imputed liability claim in amended complaint relates back to original complaint because it involves the same events, location and general subject matter.
- New legal theories and parties can be added in amended complaints as long as they pass the common core of operative facts test.

1:00 NURSING HOME CASES: DIFFERENCES AND DILEMMAS
Katherine G. “Kate” Hughes, Wagner Hughes LLC, Atlanta
NURSING HOME CASES
DIFFERENCES AND DILEMMAS

Katherine “Kate” Hughes
Wagner Hughes, LLC
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Atlanta, Georgia 30305
(404) 900-6979
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I. Medical Malpractice versus Nursing Home Litigation

A. Theories of Recovery

Traditional medical malpractice cases and nursing home cases can overlap and include the same injuries and theories of recovery. However, nursing home litigation is inherently different and can encompass numerous additional causes of action than traditional medical malpractice cases. The most common nursing home cases arise out of:

1. Pressure Ulcers or Decubitus Ulcers, “Bedsores”
2. Falls and Drops
3. Failure to diagnose and treat (UTIs, sepsis, strokes, pneumonia, and more)
4. Improper restraints, chemical or physical
5. Physical abuse
6. Neglect (dehydration & malnutrition)
7. Emotional, sexual or psychological abuse
8. Financial abuse
9. Fraud/whistleblower
10. Wrongful death

The term “nursing home” has come to encompass several different types of long term care facilities, including skilled nursing facilities, assisted living facilities, personal care homes and other different types of rehab and long-term acute care facilities. Most skilled nursing facilities in Georgia participate in Medicare and Medicaid and are therefore subject to Federal Regulations, which require them to meet minimum standards. The State of Georgia has also implemented its own set of regulations for skilled nursing facilities, assisted living facilities and personal care homes. Georgia has a Residents’ Bill of Rights for Nursing Home Residents, which provides additional requirements for skilled nursing facilities. In nursing home litigation, violations of Federal and State regulations can be used to create independent causes of action and even establish negligence per se. Traditional medical malpractice laws can also be utilized to bring a cause of action against a long-term care facility involving the care of doctors and nurses.
### Applicable Law

<table>
<thead>
<tr>
<th>Medical Malpractice</th>
<th>Nursing Home</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Professional negligence by a nurse or doctor.</td>
<td>1. Professional negligence: O.C.G.A. §51-1-27</td>
</tr>
<tr>
<td>- O.C.G.A. §9-11-9.1</td>
<td></td>
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<tr>
<td>- Requires duty, breach, causation &amp; damages</td>
<td>3. Georgia Regulations:</td>
</tr>
<tr>
<td>- Requires expert on standard of care, not defined by statute or regulations</td>
<td>- Nursing Homes: Ga. Comp. R &amp; Regs. R. 111-8-56 et al</td>
</tr>
<tr>
<td></td>
<td>- Personal Care Homes: Ga. Comp. R &amp; Regs. R. 111-8-62 et al</td>
</tr>
<tr>
<td></td>
<td>4. Georgia Bill of Rights: O.C.G.A §31-8-100 et al</td>
</tr>
</tbody>
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1. O.C.G.A. §51-1-27
A person professing to practice surgery or the administering of medicine for compensation must bring to the exercise of his profession a reasonable degree of care and skill. Any injury resulting from a want of such care and skill shall be a tort for which a recovery may be had.

2. O.C.G.A. §9-11-9.1
(a) In any action for damages alleging professional malpractice against: (1) A professional licensed by the State of Georgia and listed in subsection (g) of this Code section; (2) A domestic or foreign partnership, corporation, professional corporation, business trust, general partnership, limited partnership, limited liability company, limited liability partnership, association, or any other legal entity alleged to be liable based upon the action or inaction of a professional licensed by the State of Georgia and listed in subsection (g) of this Code section; or (3) Any licensed health care facility alleged to be liable based upon the action or inaction of a health care professional licensed by the State of Georgia and listed in subsection (g) of this Code section, the plaintiff shall be required to file with the complaint an affidavit of an expert competent to testify, which affidavit shall set forth specifically at least one negligent act or omission claimed to exist and the factual basis for each such claim. . . . (g) The professions to which this Code section shall apply are: ... (8) Dietitians;... (11) Medical doctors; (12) Nurses; (13) Occupational therapists ... (17) Physical therapists; (18) Physicians’ assistants...(25) Speech-language pathologists...
### Potential Causes of Action

<table>
<thead>
<tr>
<th>Medical Malpractice</th>
<th>Nursing Home</th>
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<tbody>
<tr>
<td>1. Professional negligence by a nurse or doctor or other professional listed under O.C.G.A. §9-11-9.1 (O.C.G.A. §51-1-27)</td>
<td>1. Professional negligence by a nurse or doctor or other professional listed under O.C.G.A. §9-11-9.1 (O.C.G.A. §51-1-27)</td>
</tr>
<tr>
<td>2. Simple negligence (non-professional negligence and corporate malfeasance, such as understaffing and skimming resources, etc.)</td>
<td>2. Simple negligence (non-professional negligence and corporate malfeasance, such as understaffing and skimming resources, etc.)</td>
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</table>
| 5. Negligence Per Se for violation of Georgia Regulations:  
  - Nursing Homes: Ga. Comp. R & Regs. R. 111-8-56 et al  
  - Personal Care Homes: Ga. Comp. R & Regs. R. 111-8-62 et al | 5. Negligence Per Se for violation of Georgia Regulations:  
  - Nursing Homes: Ga. Comp. R & Regs. R. 111-8-56 et al  
  - Personal Care Homes: Ga. Comp. R & Regs. R. 111-8-62 et al |
Medical Malpractice cases tend to focus on the negligence of an individual nurse or doctor, whereas in a nursing home case, there is a greater focus on systematic negligence and corporate malfeasance. These systematic issues can include anything from understaffing to siphoning resources away from the nursing home residents so that the nursing home can make a greater profit. For example, one Georgia nursing home was accused of not buying sufficient food and supplies for the nursing home to operate properly and nurses and nurse aids were buying adult diapers with their own money to try to care for the residents. In that instance, one would not want to blame the nurses and aides for failing to change the residents frequently enough, one would blame the nursing home management for trying to make a greater profit by not spending sufficient money on supplies that would be necessary to run the nursing home within acceptable standards.

**B. Documentation**

A background in medical malpractice will provide a good foundation for handling nursing home cases. However, nursing homes have an additional sub-culture of their own, including different terms of art, documentation, staffing and lingo. [See the attached Nursing Home Documentation Checklist for a comprehensive list of a typical nursing home documentation]

One of the typical documents found uniquely in a nursing home chart will be the Minimum Data Set, or “MDS.” [See MDS front page] Federal regulations require nursing homes accepting Medicare and or Medicaid to periodically submit comprehensive assessments of each resident's functional capabilities and health issues. These reports help the nursing home identify each resident’s specific problem areas, which in turn trigger the nursing home to formulate a plan to resolve and prevent those problem areas. There is a 1400+ page manual on the CMS website that can provide insight to each section of the MDS3. The following is a brief guide to the information contained in the MDS4.

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<tbody>
<tr>
<td>A</td>
<td>Identification Information</td>
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<tr>
<td>B</td>
<td>Hearing, Speech, and Vision</td>
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<tr>
<td>C</td>
<td>Cognitive Patterns</td>
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<tr>
<td>D</td>
<td>Mood</td>
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<td>E</td>
<td>Behavior</td>
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<tbody>
<tr>
<td>F</td>
<td>Preferences for Customary Routine and Activities</td>
<td>Obtain information regarding the resident’s preferences for his or her daily routine and activities.</td>
</tr>
<tr>
<td>G</td>
<td>Functional Status</td>
<td>Assess the need for assistance with activities of daily living (ADLs), altered gait and balance, and decreased range of motion.</td>
</tr>
<tr>
<td>GG</td>
<td>Functional Abilities and Goals</td>
<td>Assess the need for assistance with self-care and mobility activities.</td>
</tr>
<tr>
<td>H</td>
<td>Bladder and Bowel</td>
<td>Gather information on the use of bowel and bladder appliances, the use of and response to urinary toileting programs, urinary and bowel continence, bowel training programs, and bowel patterns.</td>
</tr>
<tr>
<td>I</td>
<td>Active Diagnoses</td>
<td>Code diseases that have a relationship to the resident’s current functional, cognitive, mood or behavior status, medical treatments, nursing monitoring, or risk of death.</td>
</tr>
<tr>
<td>J</td>
<td>Health Conditions</td>
<td>Document health conditions that impact the resident’s functional status and quality of life.</td>
</tr>
<tr>
<td>K</td>
<td>Swallowing/Nutritional Status</td>
<td>Assess conditions that could affect the resident’s ability to maintain adequate nutrition and hydration.</td>
</tr>
<tr>
<td>L</td>
<td>Oral/Dental Status</td>
<td>Record any oral or dental problems present.</td>
</tr>
<tr>
<td>M</td>
<td>Skin Conditions</td>
<td>Document the risk, presence, appearance, and change of pressure ulcers as well as other skin ulcers, wounds or lesions. Also includes treatment categories related to skin injury or avoiding injury.</td>
</tr>
<tr>
<td>N</td>
<td>Medications</td>
<td>Record the number of days that any type of injection, insulin, and/or select medications was received by the resident.</td>
</tr>
<tr>
<td>O</td>
<td>Special Treatments, Procedures, and Programs</td>
<td>Identify any special treatments, procedures, and programs that the resident received during the specified time periods.</td>
</tr>
<tr>
<td>P</td>
<td>Restraints and Alarms</td>
<td>Record the frequency that the resident was restrained by any of the listed devices at any time during the day or night; record the frequency that any of the listed alarms were used.</td>
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</tr>
<tr>
<td>Q</td>
<td>Participation in Assessment and Goal Setting</td>
<td>Record the participation of the resident, family and/or significant others in the assessment, and to understand the resident’s overall goals.</td>
</tr>
<tr>
<td>V</td>
<td>Care Area Assessment (CAA) Summary</td>
<td>Document triggered care areas, whether or not a care plan has been developed for each triggered area, and the location of care area assessment documentation.</td>
</tr>
<tr>
<td>X</td>
<td>Correction Request</td>
<td>Request to modify or inactivate a record already present in the QIES ASAP database.</td>
</tr>
<tr>
<td>Z</td>
<td>Assessment Administration</td>
<td>Provide billing information and signatures of persons completing the assessment.</td>
</tr>
</tbody>
</table>

C. Cast of Characters

In addition to new lingo and documentation, nursing homes have different staff than hospitals and other healthcare facilities:

- Administrator
- Administrative Staff
- Medical Director
- Director of Nursing “DON”
- Assistant Director of Nursing “ADON”
- Registered Nurses “RNs” (can fill different positions, such as DON)
- Nurse Supervisors
- Floor Nurses
- Licensed Practical Nurses “LPNs” (can fill different positions, such as floor nurses or med techs)
- Certified Nurse Aides “CNAs”
- MDS Coordinator
- Care Plan Coordinator
- Dietician
- Therapists (PT, ST, OT, RT)
- Wound Care Team
- Social Services Director/Activities Director
Not all nursing homes will fill every position listed above and some employees fill more than one role, usually depending on the size and resources of the facility. Federal and state regulations set forth minimum staffing levels for nursing staff at nursing homes. Assisted Living Facilities and Personal Care Homes do not provide around the clock nursing care and do not have the same level of nursing and other staff. Sometimes these individual staff members are included in a lawsuit against the facility, depending on the situation.

II. Dilemmas

A. Peeling the Corporate Onion

Many nursing homes use a management company in addition to the regular onsite staff who oversee the day to day operations of the facility. This is just the tip of the iceberg. One of the biggest dilemmas faced in nursing home litigation is corporate nursing home chains, which have multiple layers of corporate structure designed to separate and insulate corporate assets and liabilities. Some nursing home chains incorporate each separate facility location through the use of hundreds of separate companies, while other companies make the decisions and reap the profits from those individual locations. Then, when litigation occurs, these separate entities try to insulate themselves from liability claiming they are a separate company.

Sifting through the corporate structure and red tape can require a lot of leg work. There are a few things you can do before filing suit to make sure you include the appropriate parties:

1. CMS Nursing Home Compare Ownership Information: Go to the CMS nursing home compare website at https://www.medicare.gov/nursinghomecompare. Once you have found the specific nursing home you are researching you will be able to access a link to the names of all entities and individuals with the ownership and control of that nursing home. This website is also very useful in providing copies of recent surveys and nursing home ratings.

2. Form 855 A, Medicare Enrollment Application: Submit a Freedom of Information Act request to CMS for the Form 855 A for the facility you are researching (include the years you are interested in). This form will have information about the nursing home, including changes in ownership, operation and control, corporate organization and structure and other helpful information.

3. Cost Report Form CMS-2540-10: Submit a Freedom of Information Act request to CMS for the Cost Report Form CMS-2540-10 Form for the facility you are researching (6 years is recommended to analyze patterns and changes). These Cost Reports are a valuable tool in many areas of nursing cases, especially identifying when resources are being siphoned away from the nursing home by related entities, but they can also help identify when resources are

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flowing to and from related entities to help determine if those entities should be included in your case.

B. Getting the Records

Obtaining a full set of nursing home records can be arduous, for both the Plaintiff’s attorney and the attorney representing the nursing home. Records get thinned out and moved. Some records are maintained only in electronic format and never reduced to paper. Even a well-meaning nursing home will likely miss many documents in their production of the chart and related documents. It is important to have some mechanism in place to ensure that you have everything. If you represent the nursing home, you have the benefit of driving over to the facility itself and walking the staff through all the categories of records they may have that they didn’t even know they had until you get everything. [See the attached Nursing Home Documentation Checklist, for a start] If you represent the nursing home resident or their family, it will be more difficult. However, there are ways to improve your chances of getting all the records:

1. **RPDs:** Once suit is filed served opposing counsel with RPDs requesting all the documents you would like.

2. **30(b)(6) Document Deposition with Notice to Produce:** In addition to obtaining the documents, the purpose of the 30(b)(6) corporate representative document deposition with a Notice to Produce is to find out more information about the following topics:

   - additional documents that may available that have not been produced
   - objections to producing documents (such as production of certain documents would be unduly burdensome or other similar objections)
   - missing documents that the nursing home claims cannot be located (what was done to locate the documents?)
   - record destruction policies
   - electronic records systems and audit trails

Some attorneys use this in lieu of an RPD. It can also be used in conjunction with RPDs. These deposition transcripts can be useful if it becomes necessary to file Motions to Compel against the nursing home.

3. **Federal Regulations:** If your client still resides at the subject nursing home, there is a limited Federal regulation, which would allow access to the resident’s nursing home file within 24 hours and a copy within an additional 2 working days:

   §42 C.F.R. §483.10(b)(2) The resident or his or her legal representative has the right:

   (i) Upon an oral or written request, to access all records pertaining to himself or herself including current clinical records within 24 hours (excluding weekends and holidays); and
(ii) After receipt of his or her records for inspection, to purchase at a cost not to exceed the community standard photocopies of the records or any portions of them upon request and 2 working days advance notice to the facility.

C. Arbitration Agreements

Many nursing home residents and their families are presented with a large package of documents to sign upon admission into the nursing home. Often these papers include an agreement to arbitrate any dispute with the nursing home in lieu of traditional jury trial. Many families are not even aware of what they are signing.

In 2016, the Center for Medicare and Medicaid Services (CMS) issued a regulation setting forth that long term care facilities were not permitted to enter into pre-dispute arbitration agreements with their residents. However, in November of 2016 this proposed regulation was stayed before it ever went into effect. In 2017 CMS submitted a new proposed regulation, which removed the provision that prohibited pre-dispute arbitration agreements. There are certain limited exceptions to the enforcement of arbitration agreements, such as instances where the signor did not have the legal authority to sign for the nursing home resident, but as a whole, they are currently enforceable.
MEDICAL MALPRACTICE BOOTCAMP
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NURSING HOME DOCUMENTATION CHECKLIST

Administrative (not considered to be the “chart” but should be requested)

- Admission Face Sheet
- Advance Directives:
  - CPR Directive
  - DNR Order from physician
  - Resident Self Determination Act Acknowledgement
  - Living Will
  - Durable Power of Attorney
  - Power of Healthcare
  - Guardianship/Conservator
  - Legal incapacitation
- Consents & Acknowledgements:
  - Physical Restraints
  - Admission Consents
  - Consent to Treat
  - Consent to Photograph
  - MDS Consent
  - MDS Acknowledgement
  - Release of Information Consent
  - Release of Responsibility/Leave of Absence
- Personal inventory Sheet
- Pre-admission Screening (PASARR)
- Admission Agreement
- Arbitration Agreement
- Death Certificate/Record of Death
- Billing Records
- Financial Records

Nursing Home Chart

- Discharge Summary
- Physician Orders
- Physician Telephone Orders
- History & Physical
- Hospital Discharge Summary
- Hospital Transfer Form
- Outside Medical Records
- Immunization Records
- Physician Progress Notes
Consults (Dentist, Podiatrist, Ophthalmologist, Vascular, Hospice, Wound Care Physician, etc.)

Minimum Data Set “MDS”

Care Area Assessments “CAA” (formerly Resident Assessment Protocols “RAPS”)

Care Plans

Admission Nursing Assessment

Nurses Notes [Narrative Notes, Daily Nursing Summaries, Weekly Nursing Summaries, Bi-Monthly Nursing Summaries, Monthly Nursing Summaries]

ADL Flowsheets [bathing, grooming, toileting, etc.]

Intake and Output Record

Vital Sign Flow Sheets

Other flow sheets [Diabetic, etc.]

24 Hour Reports

Medication Administration Record “MAR”

Treatment Administration Record “TAR”

Skin Breakdown Assessments [Braden Scale, Norton Risk, etc.]

Wound Documentation

Skin Assessments [Daily, Weekly]

Fall Risk Assessments

Restraint Assessments

Restraint Consent Forms

Pain Assessments

Behavioral Monitoring Records

Antipsychotic Monitoring Records

Abnormal Voluntary Movement Scale “AIMS”

Bowel & Bladder Assessments “B&B”, Toileting Program Assessment

Physical Therapy Records [Evaluations, Care Plans, Notes]

Occupational Therapy Records [Evaluations, Care Plans, Notes]

Speech Therapy Records [Evaluations, Care Plans, Notes]

Restorative Therapy Records [Evaluations, Care Plans, Notes]

Nutrition/Dietary Assessment/Records

Meal Consumption Records

Social Services Assessment/Records

Activity Records

Pharmacy Reviews, Pharmacy Consultant Sheets, Pharmacy Communication Record

Labs

Radiology

Photos

Transfer Forms

Misc. [FLU Shot record, etc.]
MINIMUM DATA SET (MDS) - Version 3.0
RESIDENT ASSESSMENT AND CARE SCREENING
Nursing Home Comprehensive (NC) Item Set

### Section A

#### Identification Information

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<td>1. Add new record</td>
<td>→ Continue to A0100, Facility Provider Numbers</td>
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<tr>
<td>2. Modify existing record</td>
<td>→ Continue to A0100, Facility Provider Numbers</td>
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<tr>
<td>3. Inactivate existing record</td>
<td>→ Skip to X0150, Type of Provider</td>
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<th>A0100. Facility Provider Numbers</th>
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<td>B. CMS Certification Number (CCN):</td>
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<tr>
<td>C. State Provider Number:</td>
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<tr>
<td>1. Nursing home (SNF/NF)</td>
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<td>2. Swing Bed</td>
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<tr>
<td>A. Federal OBRA Reason for Assessment</td>
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<tr>
<td>01. Admission assessment (required by day 14)</td>
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<tr>
<td>02. Quarterly review assessment</td>
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<td>03. Annual assessment</td>
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<td>04. Significant change in status assessment</td>
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<td>05. Significant correction to prior comprehensive assessment</td>
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<tr>
<td>06. Significant correction to prior quarterly assessment</td>
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<tr>
<td>99. None of the above</td>
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<tr>
<th>B. PPS Assessment</th>
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<td>PPS Scheduled Assessments for a Medicare Part A Stay</td>
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<td>01. 5-day scheduled assessment</td>
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<tr>
<td>02. 14-day scheduled assessment</td>
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<tr>
<td>03. 30-day scheduled assessment</td>
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<tr>
<td>04. 60-day scheduled assessment</td>
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<td>05. 90-day scheduled assessment</td>
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<tr>
<td>PPS Unscheduled Assessments for a Medicare Part A Stay</td>
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<tr>
<td>07. Unscheduled assessment used for PPS (OMRA, significant or clinical change, or significant correction assessment)</td>
<td></td>
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<tr>
<td>Not PPS Assessment</td>
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<td>99. None of the above</td>
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| C. PPS Other Medicare Required Assessment - OMRA |  |
| Enter Code |  |
| 0. No |  |
| 1. Start of therapy assessment |  |
| 2. End of therapy assessment |  |
| 3. Both Start and End of therapy assessment |  |
| 4. Change of therapy assessment |  |

| D. Is this a Swing Bed clinical change assessment? |  |
| Enter Code |  |
| 0. No |  |
| 1. Yes |  |

| E. Is this assessment the first assessment (OBRA, Scheduled PPS, or Discharge) since the most recent admission/entry or reentry? |  |
| Enter Code |  |
| 0. No |  |
| 1. Yes |  |
1:45 PROFESSIONALISM AND CREDIBILITY: WHY IT MATTERS AND HOW IT HELPS YOUR CASE
Richard W. Hendrix, Finch McCranie LLP, Atlanta
IS PROFESSIONALISM AN OLD-FASHIONED IDEAL?

BY:
RICHARD W. HENDRIX

FINCH McCRANIE, LLP
225 PEACHTREE STREET, NE
1700 SOUTH TOWER
ATLANTA, GA 30303
IS PROFESSIONALISM AN OLD-FASHIONED IDEAL?

At times it seems like we as a profession have lost our way. Similarly, as a country, it sometimes seems we have collectively lost our way. Values such as character, civility, virtue, honesty, integrity, and patriotism are increasingly being called into question as archaic or “old-fashioned” ideals – and, as such, are no longer in vogue or sufficiently “modern”. The “modern” mentality seems to be that we no longer need to rely on these ideals. In today’s “modern” society, we are encouraged to believe that everything is open to a secular humanistic interpretation regardless of what the issue may be. Indeed, moral relativism, writ large, occupies the public domain.

Is there good and evil? Is there right and wrong? Such concepts no longer matter according to some, rather we simply need to look at each situation and apply our own relative ideals in addressing them. The problem with this mentality, however, is that such logic when applied in actual life simply does not work. There is good and evil in the world. There are absolutes. There is right and wrong. And there are principals and standards – freedom, ethics, love and social responsibility – by which we, as a society, and particularly as professionals, should live by. Character, civility, integrity, honor, virtue, selflessness, sacrifice, service: these are
terms that must be embodied by our profession. (May I include kindness, morality and manners as well?) If not, we will continue to be lost in the wilderness which permeates the moral relativism of the new information “modern” age.

To be clear, much has been achieved in today’s world. We are a more prosperous and egalitarian society and have achieved a collective standard a living unparalleled in human history. Groups, long disadvantaged and discriminated against, now, have more opportunity than ever before to share in this prosperity, and Civil Rights, once denied, are available to more than ever before. This is not to say our society currently rests in a cradle of perfected equality and opportunity; rather, it is to acknowledge how far we have come together as Group. But in enjoying these rightly won Civil Rights, I fear our society is, nonetheless, increasingly losing its civility and its connection to many of the “old-fashioned” values necessary for both civility and these only recently-won Civil Rights to thrive. I fear we may have “thrown the baby out with the bathwater,” and will be unable to continue the necessary work of Civil Rights, tackle the pressing problems of today and tomorrow, or fulfill our roles as professionals in the practice of law.
Recently a famous actor was awarded a Tony Award for his stage performance. In receiving his award, in the presence of all those in attendance, the actor used crass vulgarity to describe our sitting President. Regardless of one’s politics, it occurred to me when I was watching this that we really have lost our way in society. It used to be that using vulgarity (the F word no less) in public was shunned and discouraged by society – if not career threatening altogether. Now, however, such vulgarity is portrayed by some to be fashionable and “modern.” Only a few years ago, dishonoring the Office of the President – even if the President may himself behave inappropriately – with such vulgarity would have been considered to be completely out of the bounds of civil behavior and totally inappropriate. There is a reason why Congress stands and applauds when the President walks into the House of Representative’s chamber during the State of the Union – it is out of respect for the Office, not necessarily the individual who holds it.

Now, in today’s modern society, such behavior is considered “acceptable” as a form of political “resistance.” It as if the conviction of one’s beliefs empowers an individual to express those beliefs in a manner proportionate to how strongly they are held. The reality, however, is often the opposite and, we owe it to ourselves and
our causes to express strongly held beliefs and criticisms in a manner in which they are likely to be listened to, and not just simply heard.

Ultimately, the referenced actor received an ovation for his very public display of vulgarity. To even criticize anyone who uses such terms is today considered by some to be provincial and out of step with the new “normal”: the new moral and civil normal of our depressingly “modern” society. Obviously, in the context of the article being written, the question arises – how does this social commentary apply to us lawyers?

Now, I would submit, more than ever, we lawyers need to embrace the time-honored tradition of Professionalism. Certainly, this requires competency, and scholarship. But, more importantly, if we are to embody these traditions today, I suggest we must also engage in a degree of professional introspection. Have we as a profession lost our way like so many in society seem to have done? Are we committed to excellence? Are we truly committed to pursuing justice? Must we adhere to the timeless standards of selflessness, service and even sacrificial devotion to cause regardless of the political conflicts omnipresent in society? Are we instead and as a profession more focused on the almighty dollar and accompanying
narcissistic rewards? Should our professional ideals be subordinate to our desire for economic, financial and social “success”? Are we honest enough to even admit that these are issues that must be critically examined by all lawyers in today’s progressive society?

I hope so, and I would submit that we as lawyers must hold ourselves to higher standards than the general public. We are on the front lines every day, called to ethically solve problems for our clients and, as best we can, achieve justice in the process. We are the infantry. In order that justice might be achieved in our progressive world, it has become imperative that we as a profession subordinate our own needs for the greater good of our clients and society. Money will come if we do it right, but we cannot focus solely on money. We must focus on what I refer to as “old-fashioned” ideals. Indeed, our own professional rules acknowledge that they alone cannot “exhaust the moral and ethical considerations that should inform a lawyer, for no worthwhile human activity can be completely defined by legal rules, [and that these] . . . [r]ules simply provide a framework for the ethical practice of law.” Bar Rule, Pt IV, Ch. 1, Scope § 14. If we are to let our “conscience” and “approbation of professional peers” guide us, Bar Rule, Pt IV, Ch. 1, Preamble § 14, what is to guide our consciences and those of our peers? Not only, therefore, must
we be competent, prepared, honest and forthright, in our journey towards professionalism we must rediscover virtues that many today call old-fashioned, out-of-step ideals: character, competency, virtue, integrity, steadfastness, loyalty, sacrifice, fidelity, and (dare I say it or is it too old-fashioned to even express: love for our fellow man?)

We as lawyers know that we will not always agree with our adversaries. However, it is important that we as lawyers always be courteous to our adversaries. We must agree to disagree in a civil way. At the heart of the Prussian enlightenment lay a belief in the transformative powers of conversation – civil conversation – and a deep-seated belief and practice in what Immanuel Kant termed the “cautious language of reason.” These individuals avoided vulgarity or “immoderate speech,” and they eschewed satirical or mocking remarks. They believed that if reason and progress were to blossom, civility was necessary to ensure that issues took prominence over individuals and their passions. We can see these sentiments echoed in our current rules where despite our duty to diligently and “zealously assert” our client’s position, we are nonetheless encouraged not to engage in

1 Christopher Clark, Iron Kingdom: The Rise and Downfall of Prussia, 1600-1947, pp. 247-52 (First Harvard University Press ed. 2008.)
“offensive tactics” and to treat “persons involved in the legal process with courtesy and respect.” Bar Rule, Pt IV, Ch. 1, Preamble § 14; Bar Rule 1.3 cmt. 1.

As was so famously asked by Rodney King following the Los Angeles riots, years ago: “Why can’t we all just get along?” Why we cannot, I do not know; nevertheless, we must aim to do so. I submit that we lawyers must return to old-fashioned ideals in our dealings with our clients, with our adversaries and with society in general. Respectfully, in order to adhere to our duty to “remain[] an upright person” and to “help[] maintain the legal profession’s independence from government domination,” we have a professional duty to do so. Bar Rule, Pt IV, Ch. 1, Preamble §§ 8, 10.

The simple fact is that we are all brothers and sisters. We must learn to love each other, care for each other, be courteous to one another and as the Golden Rule states: “Do unto others as we would have done unto ourselves.” Respectfully, only in so doing will our quest for justice be achieved. We must return to our roots, otherwise we will fail in our duty as lawyers to ourselves, to our fellow bar members, and to society. We lawyers have a professional duty which we must fulfill. As members of the infantry and being on the frontline of dealing everyday with a
plethora of societal and legal issues, we must pursue justice as professionals, and we must embody these time-honored, old-fashioned standards and principles for the greater good of our civil society. In a very real sense, as professionals, I would submit we have a fiduciary duty to do so. We cannot forget that the failure of others to fulfill their duties does not excuse us from fulfilling ours. Indeed, it makes it all the more important that we do so.

I heard a colleague recently remark upon one of the older and more venerated law firms in our state. The remark was made that partners at this firm are no longer internally rewarded for community work or even for service within State or local bar organizations. After all, time devoted to State or local bar organizations is time away from billable hours! Given that the Bar encourages us to devote a certain amount of time each year to pro bono work, and seeks to reminds us that “[e]very lawyer, regardless of professional prominence or professional work load, has a responsibility to provide legal services to those unable to pay, and personal involvement in the problems of the disadvantaged can be one of the most rewarding experiences in the life of a lawyer,” this news was particularly discouraging. Bar Rule 6.1; Bar Rule 6.1 cmt. 1. Unfortunately, partners who devote time to serving their profession or communities, without pay, risk financial punishment in this “modern” yet venerated
law firm because their “realization rates” are diminished by the lack of time they spend on billable hours.

Is this reported disregard for the ideals of our Profession not a siren call for all of us? Is this something that we can tolerate as a Profession? The salient question arises again: have we lost our way? Where is our sense of duty? Where are the leaders in the Bar and in our law firms? Is this who we are: businessmen only, focused on the bottom line and not on our duties as Professionals? Should we simply follow the trend lines of modern civil society? Here, I suggest we all consider the wisdom of the following well-known Bible verse: “For whosoever will save his life shall lose it; but whosoever shall lose his life … shall save it. For what shall it profit a man, if he shall gain the whole world, and lose his own soul.” Matthew 16:26.

I will end this rant, polemic or epistle (however it is viewed) with two vignettes which hopefully will leave us all on a more positive note. Not long ago I represented a client, a small company, who impressed me with something that they did which I really thought was quite beautiful. They began their Board meetings with the Pledge of Allegiance to the United States of America. (Yes, everyone stood before the flag.) They also opened their meetings with a prayer, seeking guidance
and wisdom in their business decisions. Is there something wrong with this? Is this too “old-fashioned” for the rest of us? I would submit these practices, rooted in “old-fashioned” notions are a great way to start any meeting when discussing important business matters. And yes, we lawyers will not be harmed in honoring a higher power, our Country, and our fellow man, which includes our clients, each other, and especially adversaries with whom we may disagree. There must be civil discourse. And yes, there must be a renewed fidelity to the traditions of selfless service that make our Profession a noble and honorable one.

With respect to honoring each other, I will close this article with another vignette which is also emblematic of why it is that we can end this discussion on a positive note. Recently, I attended a calendar call in Bartow County. An established lawyer was seeking to admit a new lawyer in her office to the local Bar. The presiding Judge, in the presence of all the lawyers present for a very busy calendar call and motions calendar, then administered the oath and welcomed the new lawyer to the local Bar. Thereafter, without any prompting, all the members of the local Bar formed and stood in line and each and every lawyer present (and there were many) proceeded to shake the hand of the newly admitted lawyer and to welcome her to the Bar. It was wonderful and gratifying to see, and kudos to the Bartow
County Bar for doing it! And perhaps this too was old-fashioned, but it nevertheless epitomized old-fashioned professionalism.

For all you trial lawyers, the next time you try a case and lose it, don’t forget to shake your opponent’s hand and congratulate them on their hard-won victory. Don’t forget to remember who you are. You are graced to be in a profession where you may be of service to others. You are blessed to be able to assist clients with their problems. Do not squander this privilege. Instead, return to the old-fashioned values of honor, integrity, virtue, honesty and duty. Yes – to be professional we must practice our craft and develop competency – but being a true professional requires much more than scholarship or avoiding sophistry.

I simply suggest that it is not old-fashioned to be courteous. It is not old-fashioned to stop using vulgarity in public. It is not old-fashioned to show respect to our civic leaders regardless of how we feel about their individual political views. It is not “old-fashioned” to focus on selfless service without focusing on the almighty dollar. If we began showing respect to one another and indeed, loving and serving one another as we are called to do, perhaps the vignettes set forth herein may serve
as an example for ourselves, our clients and society. This is our calling as lawyers and, I submit, a pre-requisite to being professional.

We as lawyers can and must do better than some of our more famous, "modern" friends. We must lead the way – out of the wilderness – back to this country’s and our profession’s time-honored roots of honor, respect, virtue, character, integrity, duty and patriotism. These are the principles that make our profession great and the standards of conduct our country desperately needs us to embody – now more than ever.

Can I even say it? I will: Amen!
2:30   PROVING PRODUCTS LIABILITY CLAIMS IN MEDICAL MALPRACTICE CASES
       Neil T. Edwards, Childers Schlueter & Smith LLC, Atlanta
Appendix
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GEORGIA MANDATORY CLE FACT SHEET

Every “active” attorney in Georgia must attend 12 “approved” CLE hours of instruction annually, with one of the CLE hours being in the area of legal ethics and one of the CLE hours being in the area of professionalism. Furthermore, any attorney who appears as sole or lead counsel in the Superior or State Courts of Georgia in any contested civil case or in the trial of a criminal case in 1990 or in any subsequent calendar year, must complete for such year a minimum of three hours of continuing legal education activity in the area of trial practice. These trial practice hours are included in, and not in addition to, the 12 hour requirement. ICLE is an “accredited” provider of “approved” CLE instruction.

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