2020 Georgia Society of Healthcare Risk Managers Update on the Law of Medical Negligence

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I. CAUSATION

A. *Arnold v. Turbow*, 2020 WL 5757061 (Ga. Ct. App. Sept. 28, 2020)

A 30-year-old man with severe autism was admitted to the hospital for psychological evaluation after it became clear that his living situation at home was suboptimal. He required extensive day-to-day care as he had the mental age of a three-year-old and could not perform basic functions. During his hospital stay, arrangements were made for his transfer to a long-term personal care home upon discharge. But quickly after he was admitted to the home, the home's owner/CEO realized it was not an appropriate placement since the man could not perform basic functions. The owner/CEO contacted social services which began the months-long relocation process. Sadly, one morning eight months into his residency, the man snatched an extra sausage off another resident's plate and shoved it into his mouth. He choked on the link and died.

The administrator of the man's estate sued the hospital and several providers for medical malpractice stemming from their decision to discharge the decedent to a home allegedly unequipped to provide appropriate care. The plaintiff relied on deposition testimony of a psychology expert, who opined that if the defendants had consulted a psychologist and discharged the decedent to a better equipped facility, he would not have taken the extra sausage from another resident's plate and died. The defendants moved for summary judgment, arguing *inter alia*, that their conduct was not the proximate cause of the man's death. The trial court granted the motion and the plaintiff appealed.

The court of appeals affirmed summary judgment for the defendants. To begin, the plaintiff's expert could not assert causation without making numerous assumptions about the care provided at the personal care home, as well as the hypothetical result of any changes to the decedent's environment, supervision, conduct, and his receptiveness to therapy. Even more, *eight months* had passed between the decedent's discharge from the hospital and his death. Citing the Supreme Court of Georgia, the court of appeals noted that "a general rule of proximate cause is that a wrongdoer is not responsible for a consequence that is merely possible, according to occasional experience, but only for a consequence which is probable,

according to ordinary and usual experience." *Goldstein, Garber & Salama, LLC v. J.B.*, 300 Ga. 840, 842 (1) (2017). Given the length of time and the unique nature of the injury, it was too causally remote from the hospital's discharge decisions to establish approximate cause in this case.

II. DISCOVERY

A. *Advantage Behavioral Health Systems v. Cleveland*, 350 Ga. App. 511 (2019)

A few hours after he was discharged from a mental care facility, a young man committed suicide. His parents requested a copy of his records from the facility, which it produced without redaction. The parents thereafter filed a lawsuit for professional negligence. The facility filed a motion for a protective order seeking portions of its records declared as protected under the mental health privilege of O.C.G.A. § 24-5-501(a). The facility argued that communications between mental health care providers reflected in the records, and that the medical records *themselves*, were privileged and therefore inadmissible at trial. The trial court issued an order ruling that some portions of the records were privileged but that portions were not. Records concerning "goals, observation orders/levels, objectives, and plans of treatment" could not be privileged because they are not "communications." But other records, including those concerning the decedent's stress levels, were privileged since they originated from patient communications. However, the trial court held that the facility lacked standing to assert the mental health privilege. The facility appealed.

The court of appeals held that the trial court erred by ruling the facility lacked standing to assert the mental health privilege. The court noted that "[i]n the absence of a waiver by the patient, privileged material is neither discoverable nor admissible at trial, and nothing precludes [the facility] from asserting the privilege." The Supreme Court of Georgia has determined that the mental health privilege survives the death of the patient, and this rule is also embedded in the Georgia code. *See Cooksey v. Landry*, 295 Ga. 430 (2014); *see also* O.C.G.A. § 31-33-4 (providing that statutes authorizing the release of health records to a deceased patient's representative "shall not apply to psychiatric, psychological, or other mental health records of a patient"); O.C.G.A. § 37-3-166(a)(8.1)

(authorizing mental health facilities to release a deceased patient's mental health records "to the legal representative of [the] deceased patient's estate, except for matters privileged under the laws of this state"). This privilege is absolute, unless it is waived by the patient herself. The court of appeals also reasoned that prohibiting a provider from asserting the mental health privilege would contravene the privilege's purpose of encouraging free communications between patient and mental health providers. The court of appeals held that the trial court did not abuse its discretion in ruling that at least some of the disputed records were not privileged, based on factual findings that the records did not originate from patient-provider communications.

III. EXPERTS

A. *Emory University v. Willcox*, 355 Ga. App. 542 (2020)

The wrongful death complaint alleged that as a result of medical malpractice the decedent developed paraplegia during a lengthy hospitalization. Two years after that hospitalization, the decedent died from complications apparently related to her paraplegia. During discovery the plaintiff's expert testified that he believed to a reasonable degree of medical certainty that the decedent would not have died but for her paralysis. Specifically, he testified that the paralysis caused additional medical conditions which would not have otherwise developed. Interestingly, to formulate his opinions the expert had only reviewed medical records from *after* the decedent's hospitalization. So, the defendants filed a motion to exclude the testimony arguing the expert failed to base his opinions on sufficient facts or data—a requirement of O.C.G.A. § 24-7-702(b)[1]. The trial court denied the motion. In this interlocutory appeal, the defense argued the trial court abused its discretion by not excluding the expert testimony.

[1] Of course, the statute permits expert testimony if: (1) it is based on sufficient facts or data; (2) it is the product of reliable principles and methods; and (3) the witness applied the principles and methods reliably to the facts admitted into evidence. *See* O.C.G.A. § 24-7-702(b).

To begin, the court of appeals reasoned that even if the expert's testimony was based on inadequate knowledge, that would not necessarily *mandate* the its exclusion. Rather, a jury question would arise as to the weight assigned to the opinion. Generally, the factual basis of an expert's opinion goes to its credibility, not its admissibility, and it is up to the opposing party to examine the factual basis for the opinion on cross examination. On the other hand, there are instances where an expert's opinion is so fundamentally unsupported that it can offer no assistance to the jury. But here, this was not the case because the expert was only asked to opine on a connection between the decedent's paraplegia and her death. To do that the expert reviewed medical records from the time the decedent became paralyzed and thereafter. The trial court did not err in ruling that a jury could consider the opinions.

B. *Dietzen v. Radiology Associates of Atlanta, P.C.*, 354 Ga. App. 279 (2020)

A physician performed a uterine fibroid embolization and left for an eight-day vacation. In the days following surgery, the patient experienced bloating, flu-like symptoms, and worsening pain. She called the practice several times and spoke with other employees reporting her pain. Around two months later, she had a hysterectomy which revealed her uterus had ruptured. She filed a medical malpractice lawsuit against the physician whom performed the uterine fibroid embolization and the clinic. After the deposition of the plaintiff's expert, the defendants moved for summary judgment arguing that the expert "testified that there was no standard of care violation attributable to [the physician]." The trial court granted the defendants' motion and the plaintiff appealed.

The plaintiff's expert affidavit alleged the defendants' failure to provide "after-care" led to the plaintiff's infection and rupture of her uterus. But in his deposition, the plaintiff's expert conceded that the defendant physician did not violate the standard of care *during* the procedure, and he could not identify any standard of care violation in the eight days following the procedure. In fact, he testified that the sole standard of care violation was when another physician at the clinic referred the plaintiff to out to her gynecologist for post-operative care. As the affidavit and the expert's deposition testimony were the sole evidence offered by the plaintiff to support her claim, the court of appeals held the trial court did not err in granting summary judgment to the defendants.

C. *Rhoades v. McCormack*, 353 Ga. App. 635 (2020), cert. denied Aug. 24, 2020.

An oral surgeon used an oscillating saw during a procedure to treat the patient's temporomandibular joint syndrome. After the surgery, the patient suffered third degree facial burns and she sued the surgeon for medical malpractice. At his deposition the surgeon testified he did not know how the burn occurred, but that the most probable cause was that the saw malfunctioned and the handpiece heated the patient's face. But the surgeon had not felt the handpiece heat up. The surgeon also testified that he was "captain of the ship," meaning it was his job to ensure the safe operation of surgical devices. The plaintiff's expert testified that the saw handpiece was known to overheat, and that the standard of care required the surgeon to take steps to prevent burns, which can include taking periodic breaks to allow the device to cool down. The expert further testified that the operator can tell if the device is overheating by touch. But he did not opine on what specific measures the surgeon should have taken and he could not conclude that the surgeon knew the handpiece was heating up. At trial, after the conclusion of the plaintiff's case-in-chief, the surgeon moved for a directed verdict arguing that the patient was, in effect, basing her case on *res ipsa loquitor*, which is not a permissible theory of liability in medical malpractice cases in Georgia. The trial court directed a verdict in favor of the surgeon and the patient appealed.

The court of appeals held that the directed verdict in favor of the surgeon was proper. The plaintiff argued that her expert testified that the surgeon fell below the standard of care because the plaintiff was most likely burned because the saw overheated, and that overheating was a known risk which required steps to prevent burns. But the expert failed to point to any specific measure the surgeon *should* have taken which would have been consistent with the standard of care. Rather, the expert had testified that the surgeon breached the standard of care by failing to prevent the injury which, in effect, inferred negligence based on an unintended result.

The plaintiff also argued that the surgeon's testimony that he was "captain of the ship" was an admission against interest, with the result being that any negligent act during the surgery should be imputed to him. But the court reasoned that the plaintiff submitted no expert testimony that anyone else in the operating room committed an act of professional negligence

resulting in the injuries, and so the court found that contention likewise unavailing.

IV. EXPERT AFFIDAVITS

A. *Giddens v. Medical Center of Central Georgia*, 353 Ga. App. 594 (2020)

Several nurses and mid-level practitioners were assisting a surgeon perform a craniotomy on a patient. The surgeon ordered for a preoperative antibiotic to be administered within an hour prior to the start of the procedure. The antibiotic was administered at 12:40 pm. The chart, however, was internally inconsistent as to whether the surgery began at 12:05 pm or 1:05 pm. Twenty days after the procedure, the patient experienced draining from the surgical site and it was ultimately determined that she had an abscess on her brain due to an infection. The patient suffered neurological deficits, allegedly resulting from the abscess, including right-sided paralysis. She sued several defendants and asserted against the hospital both claims for professional and ordinary negligence. Attached to the complaint was an expert affidavit alleging that the hospital's nurses and mid-level providers violated the standard of care by not following a direct order of a physician—to administer the prophylactic antibiotic within an hour prior to the surgery.

The defendants filed a motion for summary judgment alleging that because the antibiotic was administered at 12:40, within one hour of the surgery start time of 1:05, there was no breach of the standard care. The hospital also argued that even if the antibiotics were *not* timely administered, the nurse responsible for administering the pre-operative medications was not its employee. The trial court granted the motion. The plaintiff moved for reconsideration, this time arguing that it was a violation of the standard of care for nurses in the operating room not to *assure* that the antibiotic was administered prior to surgery. To support this motion, the plaintiffs supplemented the record with an expert affidavit arguing that "the nurses providing care to [the plaintiff], including but not limited to [a specifically named nurse], violated accepted nursing practices by failing to ensure the physician's order to administer pre-operative antibiotics to [the plaintiff] was carried out prior to surgery." The trial court denied the plaintiff's

motion. The plaintiff appealed on numerous grounds, one of which is discussed below, and one of which is discussed *infra*, in section V(A).

The plaintiff argued that the trial court erred by granting summary judgment to the hospital on her professional negligence claim. The hospital argued that the plaintiff's affidavit alleged negligence *only* on behalf of the specifically identified nurse, whom was not an agent of the hospital. The court of appeals declined to adopt the hospital's narrow reading of the affidavit, noting that the "language in the affidavit may lack the precision indicated from a literal reading of our opinions." The court of appeals held that a genuine issue of fact existed as to what time the antibiotic was administered, and there was at least some evidence to support a finding that the hospital nurses had a duty to *assure* that the plaintiff received the antibiotic prior to surgery. Although the expert affidavit was not precise, "a complete and fair reading" of it showed that the expert believed the hospital nurses breached the standard of care by failing to ensure the pre-operative antibiotic was timely administered. As such, the trial court erred in granting its motion for summary judgment on this claim.

B. *Houston Hospitals, Inc. v. Reeves*, 846 S.E.2d 219 (Ga. Ct. App. 2020)

The executor of a decedent's estate filed a medical malpractice lawsuit alleging a surgeon negligently performed a cardiac catheterization on the decedent, which led to his death. In addition to suing the surgeon and his employer, the executor sued the hospital, alleging not vicarious liability, but negligence in credentialing the surgeon. The plaintiff had attached to the complaint an expert affidavit but the affidavit did not opine on whether the surgeon should have been credentialed to perform cardiac catheterization. The hospital filed a motion to dismiss the negligent credentialing claim, arguing it was subject to the expert affidavit requirement of O.C.G.A. § 9-11-9.1(a). The trial court denied the motion and the court of appeals granted the hospital's application for interlocutory review. The precise issue was one of first impression—"whether an expert affidavit regarding negligent credentialing on the part of a hospital is necessary in addition to the expert affidavit filed against an allegedly negligent defendant physician."

The court affirmed the trial court's denial of the hospital's motion to dismiss, but it made efforts to individualize the facts of the case. The court

disagreed that "in *all circumstances* a negligent credentialing claim necessarily requires an expert affidavit." (emphasis in original). Because a hospital is not a "health care professional" enumerated in O.C.G.A. § 9-11-9.1(g), the affidavit requirement does not automatically apply to claims asserted against it. But the affidavit requirement does apply to hospitals when a claim is grounded upon the additional averment of acts or omissions of a hospital's agent "professional" enumerated under subsection (g) of the statute. Here, it was not yet established which hospital employees were even involved in credentialing the co-defendant surgeon. Moreover, it was not established whether the credentialing decision was made by an administrator or a medical professional. Thus, "based on the record at this stage of the proceedings," the court could not agree that when the hospital credentialed the surgeon "it did so via the medical judgment of a professional listed in O.C.G.A. § 9-11-9.1(g)."

C. *Zephaniah v. Georgia Clinic, P.C.*, 350 Ga. App. 408 (2019)

The plaintiff, acting *pro se*, filed a lawsuit against a medical clinic after suffering injuries following a venipuncture. She did not attach to the complaint an expert affidavit. The clinic filed a motion to dismiss, arguing the complaint failed to include an expert affidavit as required by O.C.G.A. § 9-11-9.1. The trial court granted the motion and the plaintiff, at that time represented by counsel, appealed. On appeal the plaintiff argued that she did not need an expert affidavit because the employee who injured her was not a licensed professional for whom an expert affidavit was required, and that her claims were for intentional conduct did not require an affidavit.

The court of appeals held that even though the plaintiff cited O.C.G.A. § 9-11-9.1 in her complaint and alleged a violation of the standard of care, because her allegations involved the care of a *technician* (a provider not falling into the categories of professionals enumerated in O.C.G.A. § 9-11-9.1(g)) she did not have to file an expert affidavit. The court of appeals likewise agreed that the plaintiff was not required to file an affidavit to support her claim of intentional misconduct. The Supreme Court of Georgia has limited the application of O.C.G.A. § 9-11-9.1 to acts of negligence and claims based on intentional acts, even if the acts are performed by a medical professional, do not require an expert affidavit.

V. SIMPLE V. PROFESSIONAL NEGLIGENCE

A. *Giddens v. Medical Center of Central Georgia*, 353 Ga. App. 594 (2020)

Please refer to section IV(A), *supra*, for the case's factual and procedural history.

The plaintiff argued the trial court erred by granting summary judgment on the hospital's ordinary negligence claim. The court of appeals noted that whether an action lies in professional or simple negligence depends on "whether the professional's alleged negligence required the exercise of professional judgment and skill," which question is a matter of law for the court to decide. The court of appeals ultimately determined that deposition testimony established that the claim was one for professional negligence, not ordinary negligence. Of course, the plaintiff had argued that the failure to follow the surgeon's orders was simple negligence. But the court of appeals noted that, "[w]hile we agree that a hospital employee's failure to carry out instructions can constitute ordinary negligence," the question of whether the administration of a medication was timely presented a question of medical judgment. Here, the responsibility was more than a mere clerical or administrative act. Deposition testimony confirmed that a surgery will not proceed until the circulating nurse has satisfied that all pre-operative procedures have been completed. Thus, the trial court did not err in granting summary judgment to the hospital on the plaintiff's ordinary negligence claim.

B. *Lowndes County Health Services, LLC v. Copeland*, 352 Ga. App 233 (2020)

A resident at a skilled nursing facility died from complication related to aspirating fecal matter, a risk associated with bowel obstructions. The night before his death, a licensed practical nurse ("LPN") at the facility discovered vomit on the resident's clothing and noted slight abdominal distension. The resident also lacked bowel sounds in three quadrants. The LPN called a physician's assistant and asked whether the resident should be sent to the hospital for evaluation. The physician's assistant told her not to send the resident to the hospital, but he ordered labs and an abdominal x-ray. During the shift change the next morning, the LPN reported the resident's condition to an oncoming RN, whom instructed staff to "please

get something done about this resident." But the resident was not assessed for over two hours, at which time he was found with a distended abdomen and abdominal pain. He was taken to the hospital where he later died. The resident's son brought claims against several defendants, including claims for professional and ordinary negligence against the facility.

One of ordinary negligence claims was negligent staffing. Specifically, the plaintiff alleged that the facility negligently staffed the night shift by failing to staff personnel that could properly assess the resident's condition. At trial, the facility moved for a directed verdict on the negligent staffing claim, arguing its staffing decision required professional nursing judgment but the plaintiff failed to support his claim with expert testimony. The court denied the facility's motion. The jury found for the plaintiff and awarded him over $7,500,000. The facility appealed, arguing the trial court erred in denying its motion for directed verdict on the negligent staffing claim.[2]

The court of appeals found that the evidence established that the staffing claim did not sound in professional negligence but in business-related ordinary negligence. Thus, the trial court properly denied the facility's motion for a directed verdict. Most important to the court's analysis was that the scheduler was forced to choose only one shift in which to schedule an RN. The court of appeals noted deposition testimony that, as was routine at the time, RNs were not scheduled to work night shifts because government regulations only required the facility to have an RN in the facility for eight consecutive hours per day. The scheduler chose to staff the facility with an RN during the day shift, rather than the night shift "because most of the residents are asleep." Corporate representatives testified that staffing decisions were based on nursing judgment but conceded that these decisions were made in collaboration with the facility administrator. There was also evidence that RNs were more costly to staff than LPNs. As such, the weight of the evidence showed that the staffing decisions in this case were business related, and not the result of medical judgment.

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[2] The facility also argued on appeal that the plaintiffs' explanation for striking a juror was a Batson violation. The plaintiff cross-appealed arguing the trial court erred in allowing the jury to consider whether to apportion fault to nonparties at the trial. Neither of these arguments are discussed here.

C. *Stanley v. Garrett*, 2020 WL 5554398 (Ga. Ct. App. Sept. 17, 2020)

A psychiatrist was treating a man for ongoing alcoholism and depression. He prescribed a medication for alcohol withdrawal which helped the man remain sober for several months. Unfortunately, the man relapsed during a business trip to Colorado and he cut his trip short and returned to Atlanta. His wife scheduled an emergency session with the psychiatrist for a few days later. At 11:00 a.m. on the morning of the session, the man drove to a tavern and drank five beers in 40 minutes. He then attended the session with the psychiatrist. Afterwards, he drove two miles to a pub and drank a few more beers. He drove to a burger restaurant and drank two more beers before the bartender stopped serving him. The man left, and while driving home he struck another vehicle which resulted in the decedent's death. The man's blood-alcohol content was 0.192 and anti-anxiety medication was in his system.

The decedent's wife sued the psychiatrist and his practice alleging medical malpractice in his treatment of the man, as well as ordinary negligence by failing to prevent the man from driving. As to the professional negligence claim, the psychiatrist filed a motion to dismiss for failure to state a claim arguing that physician-patient privity is required to maintain a medical malpractice claim. The trial court granted the motion. After discovery concluded on the ordinary negligence claim, the psychiatrist filed a motion for summary judgment. The trial court granted the motion, finding the psychiatrist had no duty to prevent the man from harming others. The plaintiff appealed.

First, the plaintiff argued the trial court erred in granting summary judgment on her ordinary negligence claims because genuine issues of material fact existed as to whether the psychiatrist had a duty to exercise control over the man to prevent him from harming others. The court of appeals affirmed the trial court's grant of summary judgment to the psychiatrist. The court noted that a doctor generally has no duty to control third persons to prevent them from harming others. One exception to this rule is when a special relationship exists between the doctor and another, imposing a duty on the doctor to control such person's conduct for the benefit of third persons. The Supreme Court of Georgia uses a two-part test to determine if a physician may be liable to a third party for the conduct of her mental patient: (1) the physician has control over the mental patient;

and (2) the physician knows or reasonably should have known that the patient was likely to cause bodily harm to others. *See Bradley Center v. Wessner*, 250 Ga. 199 (1982). But unless the physician has *legal authority to restrain the liberty of his patient*, the duty to control does not arise. Here, the man was a voluntary outpatient. To the extent Georgia law permitted the psychiatrist to commit the man involuntarily, he was not *required* to do so. Therefore, a duty did not arise.

The plaintiff also argued that the trial court erred in granting the psychiatrist's motion to dismiss her professional negligence claims. The court of appeals noted that "Georgia law is clear that physician-patient privity is an absolute requirement for the maintenance of a professional malpractice action." Neither the decedent nor his wife was a patient, and so the trial court did not err in dismissing the professional negligence claims.

VI. STATUTE OF LIMITATIONS

A. *St. Francis Health, LLC v. Weng*, 354 Ga. App. 310 (2020)

On August 29, 2018, an executrix filed a medical malpractice lawsuit against several of the decedent's healthcare providers, alleging that on September 4 and 5, 2016, they failed to diagnose and treat a pulmonary embolism that resulted in his death. On September 6, 2018, the hospital was served with the complaint. That same day, the hospital's attorney emailed the plaintiff's attorney informing her that she sued the wrong entity since the hospital's assets were sold on January 1, 2016. Thus, at the time of the events of the complaint the hospital was owned by a Delaware entity. Six weeks after receiving the email the plaintiff filed an amended complaint, without seeking leave of the court, naming the Delaware entity as a defendant.

The Delaware entity filed a special appearance motion to dismiss arguing that it could not be added as a party-defendant by way of an amended complaint and that the statute of limitation had run. Thereafter, the plaintiff filed a motion seeking leave of the court to dismiss the original hospital entity and add the Delaware entity as a party-defendant. The trial court denied the Delaware entity's motion to dismiss and granted the plaintiff's motion to add the Delaware entity as a defendant. The court

relied on O.C.G.A. § 9-11-15(c), which permits a plaintiff to add a new party-defendant after the statute of limitation has expired if she demonstrates: (1) the claim asserted in the amended complaint arises out of the same underlying facts set forth in the original pleading; (2) *during the applicable limitation period*, the new defendant has notice of the lawsuit such that it will not be prejudiced in maintaining its defense on the merits; and (3) the new defendant knew or should have known that, but for a mistake concerning the identity of the proper party the action would have been brought against it. The Delaware entity appealed.

The court of appeals reversed the trial court. It first noted the medical malpractice statute of limitation extinguished the claims against the hospital on September 5, 2018. And although the original complaint was filed within the limitation period, there was no evidence the Delaware entity received notice of the action until October 15, 2018, when the plaintiff filed her unauthorized[3] amended complaint naming it as a defendant. Here, the trial court only addressed whether the Delaware entity would suffer prejudice if added to the suit five months after the statute of limitation expired. But "notice" for the purpose of O.C.G.A. § 9-11-15(c) means notice of the actual lawsuit itself, not mere knowledge of the underlying facts. There was no evidence that the Delaware entity had notice or knowledge of the lawsuit prior to the limitation period expiring, and so O.C.G.A. § 9-11-15(c) was inapplicable.

VII. TRIAL

A. *Atlanta Women's Specialists, LLC v. Trabue*, 2020 WL 5752376 (Sup. Ct. Ga. Sept. 18, 2020)

Within days of giving birth to her daughter, the decedent suffered a catastrophic brain injury resulting from pulmonary edema and died. Her husband filed a medical malpractice action against one of her treating physicians ("Physician One") and that physician's employer. Vicarious liability was the sole theory of liability against the employer. The complaint

[3] *See Wright v. Safari Club Int'l*, 322 Ga. App. 486, 494 (5) (2013) (because a court order is required to add or drop parties to a lawsuit, "an amendment to a complaint adding a new party without first obtaining leave of the court is without effect").

alleged the employer was responsible, not only for the acts and omissions of Physician One, but for those of another physician not named as a defendant ("Physician Two"). After the close of evidence at trial, the defendants asked the court to assess the percentage of fault of Physician One and Physician Two for the purpose of apportioning damages between the named defendants, Physician One and his employer. The trial court denied the request. On a special verdict form, the jury found negligence by both Physician One and Physician Two, and it awarded the plaintiff nearly $46,000,000. Physician One and the employer filed a motion for a new trial and the trial court ordered a new trial on the issue of apportionment only.

On interlocutory appeal, the defendants argued that the plaintiffs did not sufficiently plead claims for vicarious liability against the employer based on the conduct of Physician Two. The plaintiffs argued that the trial court erred in ordering a new trial on apportionment as the defendants did not file a notice designating Physician Two as a nonparty at fault for the injuries, as required by O.C.G.A. § 51-12-33(d).[4] The court of appeals reversed the trial court's grant of a new trial on apportionment, in part, due to the defendants' failure to comply with § 51-12-33(d). The defendants appealed to the Supreme Court of Georgia, arguing that the plaintiffs did not sufficiently plead vicarious liability against the employer based on Physician Two's conduct.

The Supreme Court of Georgia, led by Justice Boggs, held that the court of appeals did not err in holding that the plaintiffs sufficiently pled vicarious liability against the employer based on Physician Two's conduct. The court reasoned that three factual paragraphs in the Plaintiff's complaint focused specifically on Physician Two's conduct and the complaint further identified Physician Two as an agent of the employer. On the other hand, the defendants relied on another paragraph in the complaint reserving the right to add Physician Two as a defendant if he was found to be negligent. The defendants pointed out that the complaint suggested Physician Two was negligent in one paragraph and not negligent in another. The supreme

[4] The apportionment statute requires the factfinder to consider the fault of a nonparty in two circumstances: (1) if the plaintiff entered into a settlement agreement with the nonparty; or (2) if a defending party gives notice no later than 120 days prior to the date of the trial that a nonparty was wholly or partially at fault. O.C.G.A. § 51-12-33(d).

court viewed these paragraphs as espousing alternative theories of liability, which are permitted. The defendants also argued that the complaint did not provide enough detail on the vicarious liability claim based on Physician Two's conduct to give the defendants a fair opportunity to frame a response. But the court noted the defendants had not filed a motion for more definite statement but responded to the paragraphs concerning Physician Two's conduct.

Physician One also argued that he was entitled to have the jury apportion damages between him and the hospital based on his own percentage of fault and Physician Two's percentage of fault. But the plaintiffs argued that he did not comply with subsection (d) of the apportionment statute. The court held that a defendant employee who wants to reduce a potential damages award by having the jury apportion damages between him and his defendant employer based on as assessment of the fault of a nonparty co-employee must comply with the requirements of subsection (d) of the apportionment statute. The provision requires the factfinder to consider the fault of a nonparty in two circumstances: (1) if the plaintiff entered into a settlement agreement with the nonparty; or (2) if a defending party gives notice no later than 120 days prior to the date of the trial that a nonparty was wholly or partially at fault. Here, it was undisputed that Physician Two was not a defendant, he did not enter into a settlement agreement, and the named defendants had not filed a nonparty notice of fault. The court noted that in the absence of the foregoing requirements, a defendant could simply wait until a trial was almost over and suddenly demand the jury to assess the percentage of fault between any number of people whose names came up briefly.

B. *Daly v. Berryhill*, 308 Ga. 831 (2020)

After performing a balloon angioplasty and cardiac catheter procedure, a surgeon instructed the patient not to engage in strenuous activity for a week since he was being placed on a blood thinner. There was conflicting evidence regarding the length of time specified, ranging from a day to a week. Five days after the procedure the patient was hunting, and he fainted and fell out of an 18-foot deer stand. He sued the surgeon alleging his negligent prescribing caused him to faint. At trial, the court instructed the jury on assumption of the risk and the jury returned a defense verdict. The plaintiff appealed and the court of appeals reversed, finding that the

evidence did not justify the jury instruction. Specifically the court found that the surgeon's suggestion not to engage in strenuous activity did not establish that the patient knew he risked losing consciousness if he chose to disregard the instructions. The Supreme Court of Georgia granted certiorari to consider whether at least slight evidence was presented at trial to warrant the instruction.

The supreme court, led by Justice Peterson, held that there was at least slight evidence that the patient was instructed not to engage in strenuous activity, not to lift more than ten pounds, bend, or stoop over for seven days after his procedure. One of the elements of an assumption of the risk defense is that the person had subjective knowledge of the "specific, particular risk of harm associated with the activity or condition that proximately causes injury." The court evoked a line of caselaw requiring the judiciary to consider commonsense when assessing a knowledge of the risk defense. Here, although the surgeon did not discuss *all* the possible risks of disregarding the instructions, "a competent adult . . . cannot blind himself to the obvious risk of a dangerous cardiovascular event that could result in unconsciousness if he disregards explicit physician instructions prohibiting strenuous activity immediately after major heart surgery." Since there was at least slight evidence that the patient knew that going hunting and climbing a deer stand five days after surgery posed a serious risk of physical injury, he voluntarily exposed himself to that risk. The trial court did not err in giving the jury instructions.

C. *Evans v. Rockdale Hospital, LLC*, 355 Ga. App. 33 (2020)

A husband a wife sued a hospital for medical malpractice and loss of consortium for its alleged failure to assess and treat a catastrophic brain aneurism suffered by the wife. At trial, the hospital argued the wife's fault exceeded that of the hospital's, because she had not obtained treatment for longstanding uncontrolled hypertension despite being aware of it. To support their damages claim, the plaintiffs presented medical bills reflecting total past medical expenses of $1,196,288.97. They also presented evidence of future medical expenses, past and future lost wages, and the extent of the wife's impaired condition. The jury returned its verdict on a special verdict form awarding the wife the precise amount she requested for past medical expenses ($1,196,288.97), but zero damages for future medical expenses, past and future lost wages, and past and future pain and

suffering. The jury apportioned fault among the parties finding the hospital 51% at fault and the wife 49% at fault, and the court reduced the damages in proportion to the percentages of fault. The plaintiffs filed a motion for additur or for a new trial on the issue of damages arguing that the award was so clearly inadequate that it was inconsistent with the preponderance of the evidence. The trial court denied the motion and the plaintiffs appeals.

Ultimately, the case went up to the Supreme Court of Georgia and back down. Initially, the court of appeals had ordered a retrial assessing whether the award of zero damages for pain and suffering "was so clearly inadequate under a preponderance of the evidence as to shock the conscience and necessitate a new trial under O.C.G.A. § 51-12-12(b)."[5] The Supreme Court of Georgia granted certiorari and determined the court of appeals applied the wrong standard. Appellate courts are limited in determining whether the trial court abused its discretion in deciding a claim under O.C.G.A. § 51-12-12. The supreme court offered three instances where an appellate court can determine that the trial court abused its discretion in reviewing a verdict under O.C.G.A. § 51-12-12: (1) if the trial court failed to exercise any discretion at all; (2) if the trial court's discretion "was infected by a significant legal error or a clear error as to a material factual finding;" or (3) where the verdict was "so excessive or inadequate as to be irrational and thus the apparent result of jury bias, prejudice, or corruption." *See Rockdale Hospital v. Evans*, 306 Ga. 847, 851-52 (2019).

Here, guided by the standard of review articulated by the supreme court, the court of appeals found that the trial court acted within its discretion by denying the plaintiff's motion for a new trial on the issue of damages. First, it was clear the trial court indeed used its discretion to review the verdict and the plaintiffs had not pointed to any errors of material fact made by the court. Next, the trial court had relied on governing legal principles in exercising its discretion, namely that an award for pain and suffering is a matter for the enlightened conscience of the jury. Finally, the court of appeals could not say the jury verdict was irrational, evidencing bias,

[5] O.C.G.A. § 51-12-12(a) holds that the question of damages is ordinarily for the jury "and the court should not interfere with the jury's verdict unless the damages awarded by the jury are clearly so inadequate or excessive as to be inconsistent with the preponderance of the evidence in the case."

prejudice, or corruption. Indeed, the supreme court had noted the threshold for an appellate court to set aside a jury verdict approved by a trial court under O.C.G.A. § 51-12-12 is "extremely high" considering the presumption of correctness.

The supreme court had noted that the question of whether a verdict was *inconsistent* is a separate question from whether it was *inadequate* under O.C.G.A. § 51-12-12, and that a contrary verdict is entirely void. But the supreme court had not granted certiorari on the question of whether the verdict was inconsistent. The parties disputed whether the verdict was void as inconsistent, and so the court of appeals vacated the lower court's order to the extent it denied the plaintiffs' challenge that the verdict was inconsistent and remanded on that issue.

D. *Haskins v. Georgia Neurosurgical Institute, P.C.*, 355 Ga. App. 781 (2020)

A patient underwent a lumbar discectomy to treat a protruding disc in his lumbar spine. In the operating room after surgery he was able to move his feet, and so he was moved to a recovery room. About 30 minutes later, he could no longer move his feet. The patient was diagnosed with cauda equina syndrome ("CES") based upon symptoms indicating a possible spinal nerve injury. A subsequent MRI showed stenosis of the spinal canal, and the surgeon performed a laminectomy. After this second operation, the patient could still not move his feet and he continued to suffer neurological problems. He sued the surgeon and his employer alleging the surgeon negligently caused nerve damage during the initial lumbar discectomy. At trial, the jury returned a verdict for the defendants and the patient moved for a new trial, which was denied. The plaintiff appealed on numerous bases, some of which are discussed below.

First, on cross examination of the plaintiff's expert, defense counsel had questioned him about an article written by the defendant surgeon's colleagues. The plaintiffs argued that the trial court erred in permitting this questioning, as the article was hearsay and not established as a learned treatise under O.C.G.A. § 24-8-803(18). The plaintiff argued the article's use was *not* harmless error because it bolstered the defense's claim that the patient suffered a stroke which caused the CES. The court of appeals noted that the article did not even mention strokes as a cause of CES, and that its

use was equally beneficial to the plaintiff because it supported their expert's opinions as to why no over-retracted nerve damage was shown on the subsequent MRI. Under these circumstances, it was "highly probably that the brief questioning about the article did not contribute to the verdict." As such, its admission was harmless error.

Next, the plaintiffs argued that the trial court erred in allowing the defense to introduce evidence of the patient's signed informed consent. On direct examination, the patient's wife testified that prior to the discectomy the surgeon called the procedure "simple" and "easy." On cross examination, defense counsel questioned her about that appointment and showed her the informed consent form signed by her husband. The trial court charged the jury that informed consent was not a defense to medical malpractice. The court of appeals held that the lower court did not abuse its discretion in permitting the use of the consent form during trial. Although the form was not relevant to the issue of liability, it was admissible to impeach the witness on her testimony that the surgeon had described the surgery as "simple."

Next, the plaintiffs argued that the trial court erred by not permitting them to introduce rebuttal deposition testimony of an expert witness. The trial court excluded the testimony because the plaintiffs identified the expert after the deadline set in the scheduling order. Of note, the Supreme Court of Georgia holds that when a court excludes a witness "based solely upon a party's failure to meet a deadline in a scheduling order without considering any other factors, that court will have abused its discretion." *Lee v. Smith*, 307 Ga. 815, 821-22 (2020). The plaintiffs argued they were harmed because they needed to rebut the defense expert's testimony that an MRI is not the "gold standard" for diagnosing a spinal stroke, and that the imaging in this case may have been consistent with a stroke. The court of appeals held the error was harmless. The brief testimony did not address or even rebut the defense expert because the statements were generalized and did not compare MRIs to examination methods discussed by the defense expert. Likewise, the plaintiffs' expert did not opine on whether the subsequent MRI was consistent with a stroke. At best, the court said, the testimony was cumulative and parroted that an MRI is a good test to show a stroke and that if the patient suffered a stroke it would have shown up on an MRI.

The plaintiffs also argued that the trial court erred by not allowing them to use the deposition of a subsequent treating physiatrist. On appeal, the court of appeals noted that the witness did not testify as to causation or liability but only to the nature and extent of the injuries. Even more, the witness was not even licensed to perform surgery and he had no opinions about what was done during the operation or any criticisms of the providers. The plaintiffs argued the testimony contraindicated trial evidence that the patient was able to move his feet in the operating room after the discectomy. But the witness had no personal knowledge of what occurred in the operating room. The court held that the exclusion was harmless error since there was no reasonable probability that the testimony's omission contributed to the verdict.

Finally, during cross examination of the patient, defense counsel asked a single question about his deposition testimony that he went "to the black quarters to find help" with farm work after the procedure. The plaintiffs moved for a mistrial on the grounds that the question was prejudicial. The judge denied the motion but directed defense counsel to move forward with their examination without mentioning race again, which defense counsel did. The plaintiffs argued the court erred by failing to take additional corrective action. On appeal, the court of appeals found that it was "highly probable" that the alleged error of "not taking further corrective action concerning the single unanswered question" did not contribute to the judgment. In other words, a mistrial was not essential to preserve a fair trial.

E. *Moore v. WellStar Health System. Inc.*, 349 Ga. App. 834 (2019)

A patient with a small bowel obstruction aspirated while being placed under anesthesia for surgery and died several days later. His wife brought a medical malpractice claim against various defendants and at trial the jury returned a defense verdict. The plaintiff appealed claiming she was entitled to a new trial because the trial court erred in allowing inadmissible and prejudicial hearsay evidence during the cross-examination of a plaintiff's expert and the friendly (i.e. co-defendant's) cross-examination of a defense expert. The case centered around the standard of care as to when an NG tube should be placed to treat a bowel obstruction, which presumably prevents aspiration. The claimed hearsay evidence was a committee opinion from the American Society of Anesthesiologists regarding expert

witness testimony of a physician who was not involved in the case. This committee opinion showed that in 2011 the American Society of Anesthesiologists sanctioned the uninvolved physician for offering similar standard of care testimony given by that plaintiff's expert. Here, the plaintiff contended that these findings in a wholly different case against an unrelated expert constituted inadmissible and prejudicial hearsay. The defendants argued the committee opinion fell within the learned treatise exception to the hearsay bar, O.C.G.A. § 24-8-803(18).

The court of appeals reversed the trial court's ruling and held the plaintiff was entitled to a new trial. It reasoned that there was no question the committee opinion was hearsay but disagreed it fell within the "learned treatise" exception. O.C.G.A. § 24-8-803(18) limits its scope to statements contained in published "treaties, periodicals or pamphlets" which are established as a reliable authority. The court of appeals held that the committee opinion did not fit into this exception because even assuming it was "published," which was questionable, there was no evidence the committee opinion was a reliable authority. There was testimony that the ASA spoke "with some authority" on some issues and provided some guidelines, but there was no testimony that the ASA spoke with reliable authority on the topic at issue.

XIII. MISCELLANEOUS

A *Brown v. Board of Regents of the University System of Georgia*, 355 Ga. App. 478 (2020)

In October 2016, a physician employed by the Augusta University Medical Center ordered a chest x-ray in response to a patient's complaints of shortness of breath. The radiologist reviewing the images ordered a follow-up chest CT scan, but it was not performed until May 2017. The subsequent CT revealed a lung malignancy. Preparing to sue the university system of Georgia, the patient filed an *ante litem* notice on March 9, 2017. On May 18, 2018, the patient filed a second *ante litem* notice setting forth the same allegations, but with corrected typographical errors. In October 2018, the patient filed a medical malpractice lawsuit against the Board of Regents (among other defendants), alleging a failure to timely diagnose his lung cancer. The Board of Regents filed a motion to dismiss the complaint,

arguing that the second *ante litem* notices failed to state the place of the transaction or occurrence, as required by O.C.G.A. § 50-21-26(a)(5)(c).[6] The plaintiff responded that the medical records attached to the notice clearly indicated that he received treatment at Charlie Norwood Veterans Administration Medical Center ("CNVAMC"). The State filed a brief pointing out that, in fact, the medical records had only been attached to the first notice, not the second one, and that they indicated the treatment occurred at Augusta Medical Center. The trial court granted the Board of Regents' motion to dismiss for failure to follow procedural requirements of the *ante litem* statute.

The court of appeals affirmed. The first *ante litem* had attached to it the October 2016 x-ray report, which showed the patient's location was the "AUG Emergency Dept (ED/UC)," but also indicted the records were printed at Augusta VAMC. Both notices failed to indicate precisely where the transaction occurred. The court held that the complete omission of one of the six categories of information required by the *ante litem* notice statute renders the notice insufficient. Notably, actual notice of the location is irrelevant. And although the court can consider the claimant's good faith mistakes, here there was no evidence that the plaintiff was unaware of the location where he underwent the October 2016 x-ray. Despite minimal prejudice to the State, the court was simply not authorized to ignore an element wholly absent from an *ante litem* notice.

B. *Hunter v. Lowndes County Health Services, LLC*, 355 Ga. App. 367 (2020)

An 11-year-old girl with characteristics of severe autism, developmental delays, and impaired decision making was admitted as a resident in a long-term care facility. At the time of her admission, the resident's mother signed multiple documents on her behalf, including an arbitration agreement. The two-page agreement had blanks for initials on each page,

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[6] A plaintiff suing the state of Georgia must file notice of the claim to the state setting forth "to the extent of the claimant's knowledge": (1) the name of the state government entity, the acts or omissions of which are asserted as the basis of the claim; (2) the time of the occurrence out of which the loss arose; (3) the place of the occurrence; (4) the nature of the loss; (5) the amount of loss claimed; and (6) the acts or omissions which caused the loss. O.C.G.A. § 50-2-26(a)(5)(A)-(F).

which were left blank but the mother signed the signature line at the end although she did not date it. No one on behalf of the facility signed the agreement. When the resident was 21 years old, she choked in the facility dining room and died. Thereafter, the mother sent the facility a settlement demand which noted the arbitration agreement was unenforceable for lack of consideration and because it was not signed on the facility's behalf. The letter also noted that the mother was withdrawing her earlier assent to arbitrate based on the arbitration agreement. The facility filed a motion to compel arbitration, and the trial court granted the motion but issued a certificate of immediate review.

On appeal, the mother agued that the trial court erred by granting the motion to compel arbitrating since it was unenforceable. The court of appeals agreed. The facility had argued the parties had mutual assent even though it did not sign the agreement. The fact that the agreement was undated and that the facility did not sign it was important to the court. Since there was no meeting of the minds, and since the mother withdrew her assent to the agreement, the agreement was unenforceable at the time when the facility sought to compel arbitration. The trial court thus erred by granting the facility's motion to compel arbitration.

C. *OB-GYN Associates, P.A. v. Brown*, 2020 WL 6253453 (Ga. Ct. App. Oct. 23, 2020)

A midwife encountered shoulder dystocia during spontaneous vaginal delivery of a baby. The delivery notes indicated that during the 40-second shoulder dystocia, the midwife performed standard alleviation measures including the McRoberts maneuver, suprapubic pressure, a rotational maneuver of the anterior shoulder, delivery of the posterior arm, and she used a lateral traction. As a result of the traction, the newborn suffered a broken clavicle, caput succedaneum, bruising, as well as permanent injury to the right brachial plexus. The plaintiffs filed a medical malpractice lawsuit arising from the midwife's handling of the shoulder dystocia. The complaint alleged that the injuries were due to the midwife's application of excessive traction during the 40 seconds after the shoulder dystocia was encountered. The defendants filed a motion for partial summary judgment on the applicable standard of care, arguing that a heightened gross negligence standard applied under O.C.G.A. § 51-1-29.5 (the emergency

medical care statute).[7] The trial court denied the motion, holding that an issue of material fact existed as to whether the shoulder dystocia constituted a medical emergency since the midwife was able to resolve the issue within 40 seconds. The court of appeals granted the defendants' application for interlocutory appeal.

The language of the emergency medical care statue reads, in part, that for claims "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 health care provider shall be held liable unless the plaintiff proves gross negligence by clear and convincing evidence. O.C.G.A. § 51-1-29.5(c). The defendants argued the gross negligence standard applied because the alleged malpractice occurred while the mother was receiving emergency medical care in an obstetrical unit at a hospital. The defendants further argued that the statute's limiting phrase, "immediately following the evaluation or treatment of a patient in a hospital emergency department" applied *only* to emergency care provided "in a surgical suite"—the phrase directly preceding the limitation. The plaintiffs argued for a broader reading whereby the limiting phrase applied to obstetrical units as well.

Using canons of statutory construction, the court of appeals held that the limiting phrase acts as a "spatial and temporal modifier that clearly applies only to care rendered in a surgical suite in an effort to distinguish from routine and planned care provided in a surgical suite." Applying the limiting phrase to all locations in the series would result in an absurd application of the statute (for example, applying it to care provided "in a hospital emergency department . . . immediately following the evaluation or treatment of a patient in a hospital emergency department.") As such, the emergency medical care statute applies to the provision of medical care in an obstetrical unit. The court of appeals reversed the trial court's denial of the motion partial motion for summary judgment, noting that the jury

[7] The emergency medical care statute raises a plaintiff's burden for establishing liability arising from the provision of certain emergency medical care by requiring them to prove gross negligence by clear and convincing evidence (instead of simple negligence by a preponderance of the evidence). *See* O.C.G.A. § 51-1-29.5(c).

would have to determine whether the defendants' conduct was, in fact, grossly negligent.

D. *Pneumo Abex, LLC v. Sheila Long*, 2020 WL 5904450 (Ga. Ct. App. Oct. 6, 2020)

A woman's husband died from pulmonary adenocarcinoma, allegedly as a result of constant exposure to certain products containing asbestos. The wife filed a lawsuit against the product manufacturer alleging numerous theories of liability, including negligence. During discovery it became evident that the defendants were exploring the possibility of assigning liability to alleged medical malpractice of the late husband's doctors, whom were not parties to the case.

The plaintiff filed a partial motion for summary judgment "regarding various affirmative defenses and alternative causation," arguing that there was no evidence that any medical malpractice occurred and, therefore, that she was entitled to summary judgment as to those potential defenses.[8] The defendants submitted an expert affidavit that the husband's physicians were professionally negligent. The trial court granted the plaintiff's motion, holding, *inter alia*, that the defendants' expert affidavit did not meet the required causation standard of expressing his opinion with a reasonable degree of medical certainty. The defendants appealed, arguing the trial court erred by granting summary judgment as to their "non-party fault defense" that the husband's physicians committed malpractice.

The court of appeals looked to the apportionment statute of O.C.G.A. § 51-12-33(c). The court held that when defendants allege nonparty tortfeasors committed the tort of medical malpractice, such nonparties can only be included on the verdict form for apportionment if there is "some competent evidence" that they committed malpractice and proximately caused the injuries.

[8] The plaintiff also moved for summary judgment on an "alternative carcinogens" theory—that the decedent's lung cancer was caused from exposure to something else, namely second-hand smoke, radon, or fuel exhaust.

Here, the defendants' expert averred that the cancer was susceptible to a new class of therapeutic agents called tyrosine kinasc inhibitors ("TKIs"), and when the husband was diagnosed with cancer "the *possibility* of adding TKI to chemotherapy was routinely *considered*" by oncologists and pulmonologists. The expert caveated that the medical records he reviewed were incomplete, but they did reveal that the husband was not treated with a TKI until at least two years after his diagnosis. This delay allegedly deprived the decedent of "potential" benefits of early TKI treatment, "probably meaningfully" contributing to his pain and suffering. The court of appeals concluded that the expert's medical testimony was too vague to express the kind of reasonable degree of medical certainty or probability necessary to establish causation in a medical malpractice claim. Testimony that TKI was often *considered* did not bear on how often TKI was actually administered, and the expert also failed to specify the type of pain and suffering early TKI treatment would have reduced and the likelihood that the treatment would have reduced such pain.