ADVANCED PLAINTIFF’S MEDICAL MALPRACTICE

Program Materials 2004

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The Institute is especially grateful to our outstanding Seminar Chairperson, James H. Webb, Jr., for providing the necessary leadership, organization and supervision that has brought this program into a reality. Indeed a debt of gratitude is particularly due our articulate and knowledgeable faculty without whose untiring efforts and dedication in the preparation of papers and in appearing on the program as speakers, this program would not have been possible. Their names are listed on the program at page iv of this book and their contributions to the success of this seminar are immeasurable.

I would be remiss if I 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 hope your attendance will be most beneficial as well as enjoyable. Your comments and suggestions are always welcome.

February, 2004

Lawrence F. Jones
Executive Director
Institute of Continuing Legal Education in Georgia
PROGRAM

PRESIDING:  James H. Webb, Jr., Webb, Lindsey & Wade, LLC., Peachtree City

A.M.

8:30  REGISTRATION

8:55  WELCOME AND PROGRAM INTRODUCTION
James H. Webb, Jr.

9:00  WHY DEFENDANTS LOVE EACH OTHER (AT LEAST UNTIL THE END OF THE TRIAL) AND WHAT TO DO ABOUT IT
Panelist:
Jack G. Slover, Jr., Hall, Booth, Smith & Slover, P.C., Atlanta

9:45  INTERACTION BETWEEN LAWYER, DOCTOR AND INSURER—PRACTICAL AND ETHICAL CONSIDERATIONS
Panelist:
H. Andrew Owen, Jr., Owen Gleaton Egan Jones & Sweeney, LLP, Atlanta

10:30  BREAK

10:45  INNOVATIVE TACTICS OF DEFENSE ATTORNEYS
Panelist:
Judson Graves, Alston & Bird, LLP, Atlanta

11:30  STATUTE OF LIMITATIONS TRAPS AND EXCEPTIONS
Panelist:
Jonathan C. Peters, Love Willingham Peters Gilleland Monyak, Atlanta

P.M.

12:15  LUNCHEON

1:15  PRESSURE POINTS—TURNING UP THE HEAT
Panelist:
William Q. Bird, Bird & Mabrey, P.C., Atlanta

2:15  KEYS TO NEGOTIATION AND SETTLEMENT WHEN YOU HAVE MULTIPLE DEFENDANTS
Panelist:
William L. Ballard, Scherffius, Ballard, Stills & Ayres, Atlanta

2:45  BREAK

3:00  WHAT'S THE DIFFERENCE BETWEEN INFORMED CONSENT, FAILURE TO WARN, AND FIDUCIARY DUTY?
Panelist:
Philip C. Henry, Henry, Spiegel, Fried & Milling, LLP, Atlanta

3:45  HOW WE EVALUATE CASES
Panelist:
Don C. Keenan, The Keenan Law Firm, Atlanta

4:30  ADJOURN

This seminar will be conducted primarily in a panel format with Matt Mitcham (Vice President of Claims for MAG Mutual Insurance Company), Hunter S. Allen, Jr., Allen & Weathington, PC, and the speakers listed as panel participants.
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ADVANCED PLAINTIFF’S MEDICAL MALPRACTICE

WHY DEFENDANTS LOVE EACH OTHER AND WHAT PLAINTIFFS CAN DO ABOUT IT

Jack G. Slover, Jr.
James E. Looper, Jr.
Holly M. Miller
Hall, Booth, Smith & Slover
Atlanta, Georgia
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I. Introduction

Plaintiffs’ counsel oftentimes take the “kitchen sink” approach to naming defendants in a medical malpractice suit for a number of different reasons, including an inability to determine at the beginning of litigation exactly who may have caused the alleged injury, or simply as a litigation tactic to “divide and conquer.” Paul Weber, JD, “Collegial Criticism Could Land You in Court,” Ophthalmic Risk Management and Claims Desk Reference, p. 1 (September, 1993) <http://www.omic.com/resources/risk_man/deskref/medicaloffice>. Of interest in this regard is the statistic produced by the Physician Insurers Association of America that nearly 70% of all medical malpractice claims reported against physicians emerge from hospitals, and half of those claims come out of the operating room. Id. Due simply to the operating structure of hospitals and operating rooms, patients come into contact with a wide variety and number of healthcare providers, all of whom may later be targeted as defendants in medical malpractice litigation.
II. Why Defendants Love Each Other

Several old maxims spring to mind when pondering the relationship between co-defendants in a medical malpractice case. Misery loves company. A house divided cannot stand. Many hands make light work. Circle the wagons. Safety in numbers.

The strongest relational bond all co-defendants share in a medical malpractice action is that all stand accused of professional negligence. Co-defendants may oftentimes share an “us against them” mentality. After all, to launch a medical malpractice action plaintiffs’ counsel must hire another physician to criticize the care and treatment provided by the named defendants. Such censure automatically puts the accused treaters on the defensive.

The only good thing about being a co-defendant is not being a sole defendant. At the least, co-defendants understand and empathize with being on the receiving end of the same complaint. At the most, co-defendants may join together to mount a unified defense, and may help minimize liability and spread loss.

III. Sharing the Love

Once such a case has been filed, defendants and their counsel must make the decision to either unify and mount a joint defense, or stand alone and risk a finger-pointing contest. If co-defendants choose to stand shoulder-to-shoulder, they will enter into what is known as a joint defense agreement. A joint defense agreement may be either verbal or in writing, and acts to form a joint defense group. “A joint defense group is a group of two or more separately represented parties who share a common interest and agree to cooperate with one another concerning matters relating to that
common interest.” Barbara J. Barron and Maryalyce W. Cox, “Committee Perspectives: Trial Tactics and Techniques Committee: Structure, benefits, risks: Joint Defense Agreements,” For The Defense: The magazine for defense, Insurance and corporate counsel, Vol. 42, No. 3, March 2000. The concept of the “defense group” arose from criminal law in the case Chahoon v. The Commonwealth, 62 Va. (21 Gratt) 1036 (1871). However, since its inception under criminal law, the theory behind joint defense groups has grown to include defendants in civil actions who share a common interest in the litigation, or threat of possible litigation. Id.

IV. Let the Love Flow: Benefits of the Joint Defense Agreement

After co-defendants enter into a joint defense agreement, the real lovefest begins. Joint defense agreements have great upside potential for many medical malpractice co-defendants which help make the unpleasant realities of being sued a little more tolerable. First, joint defense agreements help develop a “synergy of unique skills, experience, and defense strategies gathered from all counsel involved” in the agreement. Scott W. Sayler, Esq. and Karen A. Brady, Esq., “Joint Defense Agreements - - The Ethical and Practical Issues,” Drug and Medical Device Litigation Seminar, New Orleans, Louisiana, May 14-15, 1998). Employing a “team effort” strategy such as that envisioned by most participants in a joint defense agreement allows for the strengths, weaknesses, and expertise of each co-defendant’s attorney to be taken into consideration, and used in the most highly effective manner.

Secondly, joint defense agreements allow co-defendants to share the costs associated with litigation by eliminating duplicative work by attorneys and legal staff, as
well as by limiting out of pocket expenses such as paying for expert defense testimony, discovery costs, and document management. Id. Co-defendants in a joint defense group also more effectively use valuable resources. “By combining intangible resources such as in-house experts and witnesses, co-defendants broaden their options and can ensure that they are using the best and most effective resources available.” Id.

Another benefit of the joint defense group is peace. A joint defense agreement forces co-defendants to focus on the prize: a common defense strategy which will result in a settlement or verdict in their favor.

Finally, the cohesiveness and unified presentation that can be achieved through a joint defense agreement makes it more difficult for a plaintiff to “divide and conquer.” Id. A unified presentation can send a clear, strong message to a jury on important issues such as causation, standard of care, and damages, and also helps ensure that co-defendants do not “undermine each other’s defenses, or otherwise diffuse their message.” Id.

V. What Plaintiffs Can Do To Breakup the Happy Home

Plaintiffs who find themselves up against a joint defense have several arrows in their quiver. First, plaintiffs should pinpoint the chinks in the defendants’ armor. One of the downsides to entering into a joint defense agreement is the loss of defenses; prior to entering into a joint defense agreement, co-defendants may have agreed to forego certain defenses, including the ability to point fingers at co-defendants. Id. Plaintiffs may use defendants’ sacrifices for the greater good against them, for example, pointing out to the jury during opening and closing arguments that no such defense was made.
Another downside to joint defense arrangements is that if the court determines that the common interest rule (the common interest rule “allows co-defendants and counsel to have privileged communications and share privileged information without waiving their privileges”) does not apply, parties to the agreement will have inadvertently waived the attorney-client privilege for the documents and information shared between the co-defendants. Id. Plaintiffs may take advantage of the joint defense relationship by filing a motion to compel allegedly privileged documents and information and arguing that the relationship lacks the level of required common interest to afford protection to the information shared between co-defendants.

Plaintiffs are also benefitted by joint defense agreements by the fact that unity between defendants helps simplify plaintiffs’ case. In essence, a unified defense may make plaintiffs’ job easier by alleviating the added work and stress involved in prosecuting a lawsuit against multiple, individual defendants each with their own multiple, individual defenses, strategies, and agendas. Id.

Another positive aspect of the joint defense agreement for plaintiffs is that innocent or marginally liable defendants “share in co-defendants’ taint.” Id. This works to plaintiffs’ advantage when asking for damages by providing multi-levels of pockets to empty.

Finally, plaintiffs may allege to a jury that co-defendants taking part in a joint defense are “part of a monolithic industry or are engaged in the continuation of a conspiracy.” Id.
VI. Conclusion

Co-defendants’ love for each other is not iron clad. With the right approach, plaintiffs can divide and conquer the toughest joint defense agreement.
INTERACTION BETWEEN LAWYER, DOCTOR AND INSURER – PRACTICAL AND ETHICAL CONSIDERATIONS

H. Andrew Owen
Owen Gleaton Egan Jones & Sweeney, LLP
Atlanta, Georgia
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A major consideration in the decision making process as to whether or not to undertake representation of a plaintiff in a medical malpractice case is the prospect of effecting a financial recovery for the client. The assumption on the part of most attorneys is that a healthcare provider will have professional liability insurance available to satisfy any judgments or settlements that might be obtained on behalf of the client. This assumption is true in almost every instance, but there are factors that can have the effect of eliminating or curtailing that coverage.

A basic fact is often ignored in considering the terms of an insurance policy; it is a contract. Both the insurer and the insured are bound by the terms of the contract and certainly the plaintiff can be affected by the terms. A contract of insurance can give and take away. Most people assume that an insured is automatically covered as long as there is an insurance policy with his or her name on it. This is not necessarily the case and it is essential that attorneys representing plaintiffs in medical malpractice cases be thoroughly familiar with the policy.

What does a professional liability policy have to do with the topic at hand, interaction between lawyer, doctor and insurer? It is quite simple - the professional liability policy establishes the relationship among these three entities out of which the interaction arises. The benefits and the responsibilities of the insured and the insurer are delineated in the policy. It is within the parameters of these benefits and responsibilities that the defense attorney represents the client, the insured. It is important for everyone to know the extent of the benefits and responsibilities as they define the actions to be taken by all of the parties in relationship to a claim covered by a policy. It is just as important for counsel for
the plaintiff to understand and know the terms of a policy to give him or her a better understanding of the dynamics that exist among the three parties. Thus, a review of what might be contained in the policy which would impact the plaintiff and any potential recovery is appropriate.

Policy Review

As stated previously, the insurance policy is a contract and, in most instances, clearly defines the benefits and responsibilities of each party. Obviously, the purchase of professional liability insurance is a business decision of the healthcare provider who has certain options that affect the coverage provided and the price paid. Some healthcare providers are willing to reduce their coverage to obtain a better price. In most instances, the language of the policy is sufficiently clear that there is no need for judicial construction. Therefore, it would not be prudent to assume that the contract of insurance will be construed against the scrivener to provide coverage for the insured. Upon receipt of the policy, each should be carefully reviewed for a variety of terms and conditions other than just the policy limits.

Policy Period

After having established that the policy limits are such that continued pursuit of the case is worth the effort, the policy period should be reviewed. Since most professional liability policies are claims made policies, the claim must be reported during the policy year. It will be very unusual if this has not occurred, but there are instances in which this may not be the case. Oftentimes a claim may be reported to the insurer well before a lawsuit is filed. This could place the coverage within a different policy with different endorsements.
It is also necessary to ensure that the incident out of which the claim arose occurred since the retroactive date.

Duties of Insured

The conditions imposed upon the physician upon a claim being made should also be considered. Obviously, a physician is required to report a claim and failure to do so can impact coverage. Likewise, there is a provision requiring cooperation of the physician. Although an attorney may not be privy to whether or not the conditions were met, there should be an awareness of what they are as it may impact the manner in which the case is handled.

A provision that most professional liability policies have today involves a consent to settle. This simply provides that no settlement will be entered without the physician's consent. The impact of this provision on the plaintiff hardly warrants comment. However, it should be recognized that some companies interpret this as providing for a simple “yes” or “no” while other companies allow the doctors to dictate limits.

Policy Endorsements

The endorsements can have a major impact on the handling of a case and strategic decisions that are made by the attorneys involved. There can be endorsements that exclude coverage while undertaking certain procedures. For instance, there can be an exclusionary endorsement that will not provide coverage for work in an emergency department. There may be an exclusion for surgery or delivery of babies. If there is a professional corporation involved, it should be determined if the coverage for the professional corporation has shared or separate limits. There could also be a provision that provides coverage for the professional corporation only for the acts or failures to act of
certain named physicians. These are examples of the terms and conditions of a professional liability policy that should be reviewed and, if possible, understood before proceeding with a case.

**Reservation of Rights**

Obviously, there may be some conditions of the policy as to which it will be impossible to know whether or not there has been compliance. It can be determined if there are any coverage issues at the outset of the case by requesting any reservation of rights letters. Most interrogatories or requests for production of documents include an effort to determine if there are any limitations.

Knowing the parameters of the coverage should enable the plaintiff’s attorney to better understand the dynamics that exist with the healthcare provider, attorney and insurer. If counsel has insight as to some of the coverage issues, tactics and strategies may be adjusted during the course of the litigation to effect a quicker and more appropriate resolution of the case.

**Duties of Attorney**

Once the terms of the relationship between the healthcare provider and the insurer are understood, as reflected in the professional liability policy, the insertion of the attorney into the relationship and the interaction with the other two participants is governed by the terms of the policy consistent with the rules and ethical considerations of the State Bar of Georgia. The healthcare provider is the client, not the insurer. However, the insurer has certain rights and is a party to the relationship as provided in the policy. The job of the defense attorney is to defend the doctor in the best way possible. It is the attorney’s responsibility to devise tactics and strategy in developing and implementing a defense
which would include retaining experts, interviewing any and all witnesses with relevant information to the case, and filing any motions as are necessary without interference from the insurer. However, there is a responsibility to the insurer as well. In exchange for the agreement to indemnify the healthcare provider, there is an agreement to cooperate in the defense of the case and provide any information appropriate to effect a favorable outcome.

Disposition of Case

In the ideal scenario and in the vast majority of the situations, all three parties are striving for the same goal: a prompt, appropriate resolution of the case. The obvious preferred resolution would be with no payment by the insurer on behalf of the insured, if there is no liability or causation involved in the case. If there is liability and causation in the case, there is a similar mutual desire to resolve the case as soon as possible with a reasonable payment. In most cases, the insurer and the insured are in agreement as to the appropriate resolution of the claim. There are those cases in which there is no agreement as to the appropriate disposition of the case. Under this scenario, it is the role of the defense attorney to provide a thorough evaluation of the case to both parties in an effort to achieve some agreement. Quite often an insurer feels that a case should be settled for a variety of reasons, but is unsuccessful in obtaining the consent of the physician. The attorney explains the reasons to the physician why settlement is deemed appropriate by the insurer. However, the attorney’s responsibility is to the physician with continued assurance that the case will be defended to the fullest extent possible. There are occasions when the reverse is true; the healthcare provider wants the case settled, but the insurer does not enter into a settlement. Again, the attorney’s function is to make sure that both parties understand the position of the other and the reasons for their positions.
It is important that counsel for the plaintiff understand this relationship and the efforts undertaken by defense counsel in having the client and insurer reach common ground on a desired resolution of the case. It is also important that plaintiff’s counsel understand the dynamics of the relationship among these three parties inasmuch as it impacts the resolution, the timing of the resolution and the potential for an early resolution. Understanding any of the applicable considerations that arise should result in smoother relationships and more expeditious and appropriate resolutions of these cases.

**Reporting Developments**

Certain scenarios arise that can raise issues so that the progress of the case is interrupted and the orderly resolution of it is prevented. Obviously, every effort should be made to avoid such an impasse. This can best be accomplished by keeping both the client and the insurer fully apprised of everything that transpires during all of the developments that take place in the litigation. These reports should be made to the client and the insurer. Reviews by experts, whether good or bad, should be reported to both parties. Honest appraisals of the presentation of witnesses in depositions, including the doctor client, should be provided to both parties. If a particularly effective lay witness is critical of the healthcare provider’s demeanor, this should be reported. If both parties are aware of all developments that have taken place during the course of the litigation, there should not be a disagreement as to the appropriate means by which the case should be resolved when the time comes for its resolution.

Although the progress of litigation should be shared with both the insurer and the client equally, an issue could arise that could impact coverage to the detriment of the client. Obviously, the first duty is to the client and to protect him or her to the extent legally and
ethically possible. The panel and audience may want to consider some hypothetical situations that raise ethical implications. See Appendices A and B.
Assume that a physician and his professional corporation are named as defendants in a lawsuit. Included as defendants in the lawsuit are two other physicians and a hospital. One of the physicians is an employee of the professional corporation but has his own individual policy. The first physician who has the professional corporation has a valid motion for summary judgment which would remove him personally from the case. The professional corporation would remain a defendant in the case because of the other employee physician. Because of the endorsement, if the first physician is dismissed from the case, there is no coverage for the professional corporation.
APPENDIX B

Assume that a physician is one of several physicians named as defendants in a malpractice lawsuit. Among the named defendants is a professional corporation, of which the first physician is a member along with another physician who is also a member of the professional corporation. There is separate representation for the two physicians although they are members of the same professional corporation. The first physician retains personal counsel who contacts the attorney for the plaintiff in an effort to make a deal in which the first physician would implicate all of the other physicians, including his partner.
ADVANCED PLAINTIFF’S MEDICAL MALPRACTICE

INNOVATIVE TACTICS OF DEFENSE ATTORNEYS

Judson Graves
Alston & Bird, LLP
Atlanta, Georgia
INNOVATIVE TACTICS OF DEFENSE ATTORNEYS

by

Judson Graves, Esq.
Alston & Bird, LLP
1201 West Peachtree Street
Atlanta, Georgia

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INNOVATIVE TACTICS OF DEFENSE ATTORNEYS

Introduction. Trials and trial lawyers have been around a long time. Books and articles on effective courtroom skills and trial advocacy abound, and some of the old ones are still among the best ones. No one understood cross-examination better than the late Irving Younger did, for example, and he wrote and taught brilliantly on the subject.

So in preparing a case for trial nowadays it often seems difficult to come up with fresh, new and innovative ideas which will make your case presentation sparkle. Nevertheless, that is exactly what we as advocates are called upon to do: to recognize that each case is unique. Each one challenges us with its own special opportunities for creative expression of our craft. When it comes to the art of courtroom persuasion, the main constraint is that we have to remain within the applicable rules of evidence, procedure and decorum. The rest is up to us, and the only remaining limitations are the breadth and depth of our own imagination and creativity.

Practices and tactics which may sound new and innovative to some may to others sound well worn and quite routine. For example, some lawyers have been using courtroom power point presentations for years and consider them part of their regular repertoire. Others are excited because they just did their first one after resisting this basic technology for years. In this presentation I will discuss several topics which to some extent smack of innovation, but which some people would say have been around a long time. This illustrates the point that what is truly innovative is to some extent in the eyes of the beholder.
In no particular order, here are four suggested innovative trends and tactics which have regularly caught my attention in the past few years from my perspective as a malpractice defense lawyer.

**Developing A Greater Appreciation For the Entertainment Dimension of Trying Cases.** It is no secret that most jurors we encounter today have for many years been subjected to a regular diet of daily television shows, catchy advertising, movies, sound bites, music, MTV and many other forms of entertainment. We as a society thrive on entertainment, and it influences our culture in myriad ways. It often surprises me that some trial lawyers seem to forget the power inherent in entertaining a jury at the same time they are trying to persuade it. Presentations are too often long, dull, repetitive, monotonous, and unstimulating to the senses.

Many of the most effective ways to entertain a jury are intuitively obvious: show movies; pass items around the jury box; let jurors look into a microscope; do experiments; wield a scalpel; use body language and facial expressions to your benefit; vary your speech patterns; show them how to hook up a chest tube; use humor when appropriate; show big, colorful photographs; surprise them; mix videotapes with slides and power point presentations. Don’t just talk about the decedent’s accomplishments; show them through the actual trophies, the certificates and photographs evidencing the big events in his or her life. Whenever possible, don’t just tell. Show and tell. This sort of eye catching and attention holding variety is not only the stuff of entertainment; it is also the currency of persuasion.

Trial lawyers need to pay more attention to this, and the good ones already do. To help some of us less enlightened folk, the best book I have encountered on this
subject is called *Theater Tips and Strategies for Jury Trials*. A copy of the cover and copyright page is attached to this paper so you can order it. I recommend it to all of you, and I don’t get any royalties if you buy it.

**Teach The Jury The Medicine – But Really Teach It – Don’t Just Hit the Highlights.** If there is one area in which I have consistently seen the defense out-innovate the plaintiff’s camp in malpractice cases over the years, it is in teaching the medicine. And I don’t mean just hitting the highlights; I mean really teaching the fundamentals and then building on them to prove your most important points.

This is ironic because the plaintiff goes first and thus has the opportunity to teach the medicine first, and to teach it in the light most favorable to the plaintiff. Too often I see plaintiff’s counsel squander this opportunity by failing initially in their case in chief to define basic terms; show the relevant instruments; put medical complications or disorders in their bigger context; distinguish what is normal from what is pathological; or even describe the basics and fundamentals of a condition before addressing the weird and the aberrational versions of that condition that are actually at issue in the lawsuit.

In light of these frequent failures by plaintiff’s counsel, in my experience the defense is more often than not afforded a wide open opportunity to teach the medicine more fully and understandably during its case in chief, or to re-teach it, as necessary, to make its points effectively. The good defense lawyers take ample advantage of these opportunities.

What is behind all this? I am convinced that most lawyers underestimate the capacity of a lay jury to learn, comprehend, absorb and apply complex matters of science and medicine, and the result is a frequent failure even to try to teach them such matters.
Too often it is the lawyer’s failure to teach, rather than the jury’s inability to learn, that takes a case down the wrong path, whether the failure is by the plaintiff or by the defense.

I often sit with experts who are describing complex subjects to me in incomprehensible terms. My strategy in assessing them as potential witnesses is simple: I just gently keep insisting that they keep “dumbing it down” until I can “get” their explanations. Sometimes it takes five or six versions to get it down to my level, but at my age I don’t care in the least if I seem intellectually slow to them. Just as true as the old trial lawyer adage that “you cannot sell what you would not buy” is the notion that you cannot teach what you do not understand. It makes sense to me that since the plaintiff has the burden of proof (and most juries try to hold them to it), inadequate teaching of the medicine will typically hurt the plaintiff more than the defense. In other words, a global lack of juror understanding may lead to a “tie,” and this translates into a failure of persuasion that ultimately benefits the defense.

Be all that as it may, I believe the defense typically does a better job of teaching the medicine accurately, and this wins lots of cases. To say that the defense typically has better access to experts, more money to fund and energize the teaching piece, and perhaps more time with the experts to develop its teaching strategy - while largely true – is really no excuse. The good plaintiff’s attorneys – and I have seen some great ones – know the importance of teaching the medicine, and they take that responsibility seriously from the outset.

How best to teach the medicine implicates the preceding section of this paper; that is, the entertainment dimension of trying cases. The need to teach the medicine
creates some of the best possible opportunities to educate and to entertain a jury about something meaningful and to enrich their experience as jurors by making them feel smarter than they were when they began the trial. While I surely concern myself more with winning the case than I do with enriching a juror’s experience, I believe the two go hand in hand.

Appreciating The Power of “Going With the Flow” and Knowing Whom to Befriend and Whom to Attack. Juries generally don’t like to witness bitter, ugly courtroom antics, offensive behavior and vituperative conduct any more than judges or most of the rest of us do. Yet, all too often I see lawyers who let their adversarial juices get the better of them and essentially attack, berate, demean, insult and belittle everything and everybody involved with the other side. For various reasons, this is to some extent understandable. Most of us trial lawyers are enthusiastic advocates and that enthusiasm can be hard to curb. There is often a lot of money at stake. Trials are physically and emotionally exhausting, so nerves and tempers fray. Most of us are highly competitive individuals who hate to lose. Some of us even have large egos.

I think it is a mistake to approach every single aspect of your opponent’s case (her witnesses; her documents; her arguments; herself; her mom; etc.) as an attack dog would, and to feel dissatisfied and unfulfilled until you have taken a big bite or two out of each of the above. In my experience, no matter how weak, flawed or unconvincing an opponent’s case is overall, there is usually some redeeming feature of it that is worthy of the jury’s respect, admiration, envy, or whatever. The failure on the part of counsel for either side to recognize such strengths, and even to acknowledge them to the jury,
diminishes one’s effectiveness and separates the advocate from the jury. In short, the attack mode is not always the best mode. It is surely not the only mode, although some of the lawyers on television make you wonder.

I view this sort of sensitivity, this ability to “go with the flow” of the evidence and the trial, as a powerful piece of effective advocacy, and I see many defense lawyers use it to their benefit. For example, it is not necessarily bad or wrong for the defense to admit the decedent was a wonderful person (if he was); who made a lot of money (if he did); who left behind a wonderful family (if he did); and who is represented by a very skilled lawyer (if he is). This is true provided you can then show convincingly and effectively that despite all these wonderful things, the decedent did not die as a result of malpractice – “and that’s what makes all the difference in this case, ladies and gentlemen.” If you have accurately “gone with the flow” of the case up to that point, then your drawing a line in the sand at that key juncture can be all the more effective. And holding that one line is enough for you to win. If you have tried to draw a line in the sand at every point along the way, however (the decedent was a selfish jerk; she inflated her income and falsified her tax returns; the family is a bunch of greedy opportunists; and their lawyer is an ambulance chaser), then all those lines may simply become too blurred for the jury to accept. They can’t distinguish between the real truth and your tough rhetoric.

Good defense lawyers know when to give ground and precisely when to stop giving it, and in medical cases this is an important line to discern. At times the best thing to do is to concede legitimate points the plaintiff is making, and even to align your
position – on those limited points – with that of the plaintiff. This is not obvious, and it is wonderful when it works.

For the plaintiff, things are a little tougher in this respect. I believe that if the plaintiff’s attorney can’t get up a head of steam in her case-in-chief, get the jury at least a little riled up, or at least a little bit righteously indignant, then the verdict probably won’t have much punch to it. Thus, the need to “go with the flow” may as a general proposition be more important to the defense than to the plaintiff.

**Innovative Use of New Technology.** I conclude with what is perhaps the most obvious courtroom innovation nowadays; namely, the use of new technology. This technology can be both a blessing and a curse. If the technology is too slick, too fast, looks too much like a cartoon, or doesn’t light up when you turn it on or push the button, it can be acutely counterproductive and embarrassing. For technology to serve your case, it must above all truly aid the jury in its absorption and understanding of the facts. It should not be a distraction, a side show, or a gimmick.

Aside from obvious suggestions such as test driving your technology with a mock jury (or even a group of friends) in advance, and triple checking all of your hardware in place before you use it in front of a jury (don’t forget the three prong adapter), some more subtle ideas about technology in the courtroom are also worth considering.

For example, not every case warrants or lends itself to the “high tech” presentation style. If a case can be easily tried with a few blowups of key medical records, a good anatomical model and a well-done medical illustration, why complicate your life with all the electronics? Most defense counsel who represent smart, confident doctors and sophisticated modern hospitals know that appearing too “flashy” is not a
particularly good characteristic for them or their client to cultivate in front of a jury. Especially if your defense is not flashy and need not be, I say it is a mistake to force the technology. It isn’t necessary or helpful in such a situation.

My other observation about the high tech issue is that many jurors – especially younger ones – now expect that complex scientific, medical or technical material will be – and should be - presented in a technologically enlightened manner. What that looks like in a given case may obviously vary widely, but surely it is not wise or persuasive to present a modern, high tech subject in an old fashioned, horse and buggy format. My bottom line on the use of technology in the courtroom is that its proper use is not only effective, but also fun. (See Part 1, supra.) The cautionary advice is simply not to overdo it or underdo it. Let the subject matter and your team’s collective technological competence drive the selection of the best technical vehicles for the effective presentation of your evidence. And if you sense that the technology threatens to outshine or overshadow your client or your overall case themes, then keep cutting it back until these critical factors are all brought back into their proper balance.

**Conclusion.** Innovation means doing something a new way. Often that is a good thing. When it comes to innovation, jury trials certainly present us with ample opportunities for changing and improving our techniques and tactics to improve our presentations and to benefit our clients. On the other hand, there are certain basic courtroom skills, traditions and other aspects of conducting jury trials that are so tried and true, and so right, that I would hesitate to dilute them with much innovation. When one rises to give the closing argument in a big case, for example, it is in my view always appropriate to pause long and hard; take a deep breath; lock on the judge’s eyes and
intone solemnly: “May it please the Court.” Then you turn to the jurors, move closer to them, and open up your calm, sincere and heartfelt conversation, with plenty of eye contact and heavy doses of logic, reason and words of wisdom. At that crucial point, innovation has very little to do with it. You do not really want to dim the lights and kill time until you start a rerun of the power point. You do not even need or want to appear too terribly clever or humorous. You no longer want to try to wow them with your use of computers or fancy medical jargon. Rather, you simply want to put together for them the pieces of the puzzle that when taken together clearly establish your theory of the case, and in doing so you want to show them absolutely that every piece fits.
THEATER TIPS and STRATEGIES FOR JURY TRIALS

Revised and Expanded
Second Edition

David Ball

Foreword By
Donald H. Beskind, Esq.
STATUTE OF LIMITATIONS IN MEDICAL MALPRACTICE
TRAPS AND EXCEPTIONS

Jonathan C. Peters
Kyle G. Wallace
Love Willingham Peters Gilileland & Monyak, LLP
Atlanta, Georgia
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By
Jonathan C. Peters, Esq.
Kyle G.A. Wallace, Esq.
Love Willingham Peters Gilleland & Monyak, LLP
Atlanta, Georgia

I. Introduction

These materials will first address the issue of exactly what claims constitute “actions for medical malpractice” falling within the two-year statute of limitation set forth in O.C.G.A. § 9-3-71(a). Next, the precise point at which this two-year statute commences will be explored in detail. After explaining the special rule that Georgia has created for foreign object cases, each of the several tolling doctrines and their applicability to actions for medical malpractice will be considered. A complete understanding of the interrelationship between the scope and proper application of the medical malpractice statute of limitation and the various tolling doctrines will give the practitioner the best chance to circumnavigate the many statute of limitation traps that persist in this area of law.

II. Failure to Properly Identify “Actions for Medical Malpractice”

Medical malpractice actions are governed by their own two-year statute of limitations. O.C.G.A § 9-3-71(a). For example, while the claims asserted in medical malpractice actions are often claims for injuries to person or wrongful death which are ordinarily governed by their own two-year statute of limitations, when these claims are based on the professional medical
negligence of the defendant, it is the medical malpractice statute of limitations that controls. This is even more significant when the theory of recovery alleged that has a longer statute of limitations, such as fraud, breach of contract, breach of warranty, and breach of fiduciary duty. Even if the plaintiff pleads a theory of recovery that has a statutory limitations period of longer than two years, if the factual allegations call into question the conduct of a medical professional in his area of his expertise, the claims will generally be held to be assertions of medical malpractice within the scope of O.C.G.A. § 9-3-71(a) and its two-year limitations. Thus, it is extremely important to know what allegations will constitute “actions for medical malpractice.”

[An] ‘action for medical malpractice’ means any claim for damages resulting from the death of or injury to any person arising out of:

1. Health, medical, dental, or surgical service, diagnosis, prescription, treatment, or care rendered by a person authorized by law to perform such service or by any person acting under the supervision and control of the lawfully authorized person; or

2. Care of service rendered by any public or private hospital, nursing home, clinic, hospital authority, facility, or institution, or by any officer, agent, or employee thereof acting within the scope of his employment.

O.C.G.A. § 9-3-70. The Court of Appeals has stated that “O.C.G.A. § 9-3-70(1) and (2) defines an ‘action for medical malpractice’ so broadly for purposes of the statute of limitation that the defendant medical doctors, psychologists, mental hospitals, and the dietician all come within the act.” Charter Peachford Behavioral Health System, Inc. v. Kohout, 233 Ga. App. 452, 455, 504 S.E.2d 514, 520 (1998). The broad statute covers not just individuals engaged in the practice of medicine, but has been held applicable to a wide range of health care providers including hospitals, St. Joseph’s Hospital, Inc. v. Mattair, 239 Ga. 674, 238 S.E.2d 366 (1977), blood

Additionally, the medical malpractice statutes cannot be avoided simply by alleging alternative theories of recovery that generally contain longer periods of limitation.


Not every claim which call into the question the conduct of one who happens to be a professional is a professional malpractice claim requiring expert testimony or an O.C.G.A. § 9-11-9.1 affidavit. It is only where the claim is based upon the failure of the professional to meet the requisite standards of the subject profession that the necessity to establish such standards and the violation thereof by expert testimony for the guidance of the jury arises.*


The distinction between an “action for medical malpractice” and those that do not come within its scope is especially important when a plaintiff seeks to increase the two-year period by relying on certain tolling provisions that are more limited in medical malpractice actions. For
example, O.C.G.A. § 9-3-90 ordinarily provides tolling for minors and those who suffer from
mental incapacity. But, section 9-3-90 is not applicable to medical malpractice actions.

O.C.G.A. § 9-3-73(b). Under section 9-3-73(b), there is no tolling for mental incapacity in
medical malpractice actions, and tolling for minors only applies when the minor is younger than
five years of age when the cause of action accrues and ceases when the minor reaches his fifth
birthday. Id, (discussed infra). Another common situation where the distinction is particular
significant is when a plaintiff has failed to file an expert affidavit with the complaint as required
by O.C.G.A. § 9-11-9.1. Often, a plaintiff will attempt to avoid a motion to dismiss for failure
to include the affidavit by arguing that the action is not one for medical malpractice because the
claims allege mere “ordinary” or “simple” negligence rather than “professional negligence.”

Illustrative Cases:

“An Action For Medical Malpractice”

plaintiff’s attempt to avoid medical malpractice statute of limitations by arguing that the claim
alleged “ordinary” or “simple” negligence for defendant’s failure to schedule follow-up
appointments following plaintiff’s cataract surgery. Held: “Medical aftercare…involves the
evaluation of the medical condition of the particular patient and thus the application of
professional knowledge; therefore, this claim is also a medical malpractice claim.” Id, at 374, 566
S.E.2d at 38.

learning that defendant physician had failed to properly remove all of her ovaries. Attempting to
avoid a dismissal based on the failure to include an expert affidavit, plaintiff asserted causes of action for breach of express medical agreement, lack of informed consent, battery, and fraudulent misrepresentation. Held: “All of these causes of action are subject to a two-year limitation period because ‘the medical malpractice statute of limitation applies to both tort and contract theories of liability when the claim ‘calls into question the conduct of a professional in his area of expertise.’” Id. at 613, 562 S.E.2d at 857.

· Ray v. Scottish Rite Children’s Medical Ctr., Inc., 251 Ga. App. 798, 555 S.E.2d 166 (2001). Plaintiff attempted to avoid medical malpractice statute of limitation by asserting claims against hospital for negligent retention of Dr. Johnson who allegedly provided negligent care to their child. Plaintiff contended that their cause of action against Scottish Rite for negligent retention is not an action for medical malpractice. Held: “An action against Scottish Rite for injuries which arose out of the care rendered by Dr. Johnson acting within the scope of her employment, constitutes an action for medical malpractice. It does not matter that the Ray’s cause of action for negligent retention raises different factual issues concerning the hospital’s conduct as opposed to Dr. Johnson’s conduct—their claim nevertheless calls into question Dr. Johnson’s professional skills, or lack thereof, and their damages are predicated upon proof that Dr. Johnson’s substandard medical care caused Cody’s injuries.” Id. at 800, 555 S.E.2d at 168-69.

· Blackwell v. Goodwin, 236 Ga App. 861, 513 S.E.2d 542 (1999). Attempting to avoid the statute of repose for medical malpractice actions, plaintiff brought claims against nurse’s employer for negligent hiring, supervision, retention, and entrustment where it was alleged that the nurse improperly administered an intramuscular injection to plaintiff. Held: Although the
claims against the employer are based upon the defendant’s own negligent employment practices, the claims nonetheless arise out of the medical services provided by its agent in the exercise of her professional skill and judgment. Id, at 864, 513 S.E.2d at 545.


- Shirley v. Hospital Auth. of Valdosta/Lowndes County, 263 Ga. App. 408, 587 S.E.2d 873 (2003). Parents brought action against hospital after nurse applied a solution to child’s penis and testicles that caused child severe pain and suffering. Held: Claim was one for professional, not ordinary negligence since conduct involved exercise of medical judgment requiring expert testimony and was not simply the negligent exercise of administrative actions by the employees, such as moving the patient, or leaving the patient unsupervised or unrestrained.

Not “An Action for Medical Malpractice”

- Moore v. Louis Smith Memorial Hospital, 216 Ga. App. 299, 454 S.E.2d 190 (1995). Held: Claim against nursing home where nursing assistant caused plaintiff to be injured when she was being moved from her wheelchair to her bed was one of ordinarily negligence, not professional negligence, since this aspect of plaintiff’s care was not required to be performed by a person with medical training and did not involve the exercise of medical judgment or required medical

· Blier v. Greene, 263 Ga. App. 35, 587 S.E.2d 190 (2003). Held: Claims of sexual assault and battery based on a sexual relationship with the defendant psychologist did not involve the exercise of professional judgment, and could not be construed as medical or professional malpractice.

· Joiner v. Lee, 197 Ga. App. 754, 399 S.E.2d 516 (1990). Held: Claim for battery based on defendant’s removal of plaintiff’s right ovary without prior consent need not meet the requisites of a medical malpractice case as the sole question is whether plaintiff’s consent encompassed what transpired.


· Boggs v. Bosley Medical Inst., Inc., 228 Ga. App. 598, 492 S.E.2d 264 (1997). Held: Fraud claim, based on defendant’s allegedly intentional misrepresentations of the number of surgical procedures required to correct plaintiff’s hair loss problem stated a cause of action separate and distinct from any claim of medical malpractice as plaintiff did not contend that defendant negligently misdiagnosed the condition, but rather contended that defendant intentionally and repeatedly misrepresented the number of treatments required in order to induce plaintiff to
undergo a series of costly treatments.

- Doe v. Hall, 260 Ga. App. 421, 579 S.E.2d 838 (2003). Held: Claim that an individual or entity tortiously violated the confidentiality provisions of O.C.G.A. § 24-9-7 does not constitute an action for medical malpractice as such a tort claim is strictly statutory in nature, and any person or entity, not just a health care provider, may be subject to such an action if confidentiality is breached.

- Bauer v. North Fulton Medical Ctr., Inc., 241 Ga. App. 568, 527 S.E.2d 240 (1999). Held: “Actions for medical malpractice” are limited to medical procedures and service offered to living patients, and the medical malpractice statutes were therefore inapplicable to claim that hospital removed eye tissue from a patient’s corpse with authorization.

III. Failing to Properly Identify the Point of Commencement of the Two-Year Limitations Period

1. General Two-Year Statute of Limitations for “Actions for Medical Malpractice”

“[A]n action for medical malpractice shall be brought within two years after the date on which an injury or death from a negligent or wrongful act or omission occurred.” O.C.G.A. § 9-3-71(a) (emphasis added). Despite the appearance of clarity in the language of the statute, the precise point at which the statute of limitation has commenced in a particular case is often a matter of great dispute among the parties. In some cases, the Georgia appellate courts have struggled to identify the point of “injury.” The difficult cases often involve unique facts where an injury occurs at some point in time subsequent to the negligent act or omission.

Except for a narrow set of cases involving the leaving of a foreign object in the patient’s
body, discussed infra, Georgia does not recognize the so-called “discovery rule” for medical malpractice actions. See, e.g., *Luem v. Johnson*, 258 Ga. App. 530, 574 S.E.2d 835 (2002). In *Luem*, in an opinion authored by Judge Phipps, the Court of Appeals provided a thorough explanation of when the statute of limitations commences under section 9-3-71(a). As explained by Judge Phipps in *Luem* “there are at least four points at which a tort cause of action may accrue.” *Id.*, at 532, 574 S.E.2d at 837 (quotation omitted). He set forth the following four points:

I. “When the defendant breaches his duty” (point of act or omission);
II. “When the plaintiff suffers harm” (point of injury);
III. “When the plaintiff becomes aware of his injury” (point of awareness of injury); and
IV. “When the plaintiff discovers the causal relationship between his harm and the defendant’s misconduct” (point of discovery of relationship between act and injury).

In most cases, the act or omission, injury, conscious awareness of the injury, and discovery of relationship between the act with the complaint and injury, will all occur at the same time. In some cases, however, the act or omission will not immediately result in an injury.

O.C.G.A. § 9-3-71 originally provided that actions for medical malpractice must be brought “within two years after the date on which the negligent act or omission occurred.” Thus, the former version of § 9-3-71 began to run at the first of the four points discussed above. In *Shessel v. Stroup*, 253 Ga. 56, 316 S.E.2d 155 (1984), the Supreme Court addressed the constitutionality of applying this provision to a situation where the plaintiff did not become injured until more than two years after the negligence of the physician. After the Supreme Court in *Shessel* struck the statute down on equal protection grounds, the Georgia legislature amended §
Section 9-3-71(a) provides for the commencement of the two-year statute of limitations from “the date on which an injury or death occurred.” In construing this language, the Georgia appellate courts have made clear that § 9-3-71(a) is not consistent with point IV and that the plaintiff need not have discovered the causal relationship between the harm and the defendant’s misconduct for the statute to commence running. See, e.g., *Luem*, 258 Ga. App. at 535, 574 S.E.2d at 839. Thus, the two-year medical malpractice statute of limitation does not commence at either point I or point IV.

The law is somewhat unresolved, however, as to whether the statute commences at point II or III. Georgia courts have apparently never quite resolved this issue in a holding. See *Jones v. Lamon*, 206 Ga. App. 842, 426 S.E.2d 657 (1992) (en banc) (splintered decision discussing but not deciding whether statute commences at point II or point III; plurality of four suggest that statute commences at point II). See also *Luem v. Johnson*, 258 Ga. App. 530, 574 S.E.2d 835 (2000) (discussing the four points, *Jones v. Lamon*, and the unresolved issue of whether the statute commences at point II or point III); *Whitaker v. Zirkle*, 188 Ga. App. 706, 374 S.E.2d 106 (1988) (stating that the date of injury occurs under the statute at point III, ‘the date the injury is discovered.’).

A 2001 opinion from the Court of Appeals implicitly suggests in its ultimate holding that the medical malpractice statute of limitations commences at the point of injury (point II) even if the plaintiff is unaware of the injury at the time. In *Miller v. Kitchens*, 251 Ga. App. 225, 553 S.E.2d 300 (2001), the plaintiff argued that the statute of limitations should not have commenced until two and one-half months after his surgery because he was unconscious for that period of

-10-
time, and incapable of knowing of such injury. Id. at 229, 553 S.E.2d at 304. The court rejected this argument out of hand. Id. In doing so, the court apparently failed to recognize the distinction between point III and IV, and believed that the plaintiff was arguing for the so-called “discovery rule.” Also, the court seemed to mischaracterize the plaintiff’s argument as one solely for tolling, although the plaintiff appeared to also argue that commencement did not begin until point III, when he regained consciousness following the surgery and became aware of his injury for the first time. Id. While considerably questionable, this case would appear to be some authority for point II.

Practitioners should simply be aware of the fact that the precise point at which the statute of limitations in medical malpractice actions in Georgia commences is still a matter of substantial debate. And, if they are ever faced with a case that is barred under point II but survives under point III, it should be recognized that there is authority and arguments to be made on both sides. Because virtually all cases will not hinge on such a fine-line distinction, however, this particular debate is mostly academic.

2. “When Symptoms Manifest Themselves to the Patient”

As explained, the two-year medical malpractice statute of limitations commences on “the date on which an injury or death arising from a negligent or wrongful act or omission occurred.” O.C.G.A. § 9-3-71(a). The Georgia appellate courts have routinely stated that “the injury ‘occurs’ when its symptoms manifest themselves to the patient, and this rule applies even if the patient is not aware of either the cause of the pain or of the connection between the symptoms and the negligent act or omission.” Witherspoon v. Aranas, 254 Ga. App. 609, 614, 562 S.E.2d
When an injury occurs subsequent to the date of medical treatment, the statute of limitations commences from the date of the injury. 


**Illustrative Cases:**


- *Lorelli v. Sood*, 258 Ga. App. 166, 576 S.E.2d 565 (2002). Plaintiff, who suffered from a back injury, underwent a laminectomy and discectomy on July 10, 1997. After surgery, plaintiff’s pain increased and his surgery incision became infected and would not heal. Plaintiff filed suit on September 28, 1997, more than two years after first experiencing pain in July 1997. **Held:** Quoting from O.C.G.A. § 9-3-71(a), Court explained that the limitations period runs from the date of injury, pointing out that
plaintiff’s pain and suffering began immediately after the operation in July.

· Witherspoon v. Aranas, 254 Ga. App. 609, 562 S.E.2d 853 (2002). Plaintiff brought malpractice action on November 22, 2000 against Dr. Aranas for his failure to completely remove all of her ovaries in a surgery performed in November 1997. Plaintiff began experiencing severe pelvic pain in February 1998. Plaintiff attempted to argue that statute did not commence until after she learned in September 1999 from another physician that one of her ovaries might still be present. Held: Statute of limitations expired in February 2000, two years after the plaintiff began experiencing pain after the surgery.


The fact that appellant did not know the medical cause of her suffering until a later date does not affect the application of O.C.G.A. § 9-3-71(a) ‘when the evidence establishes that appellant’s injury occurred and has physically manifested itself to her’ by the earlier date. A subjective belief that symptoms were due to some other cause unrelated to the alleged negligence does not change the point at which the injury occurred….

Bryant’s own testimony establishes that she was aware of her injury as early as September 1987, the date on which she contacted Dr. Shah complaining of amenorrhea, cramps and bloating, symptoms of which she complained to various physicians from that point forward. Furthermore, Bryant testified that she attempted unsuccessfully to conceive throughout 1988. Although she did not obtain a provisional or probable medical diagnosis until 1989, and believed that there might
be some other cause for her symptoms, O.C.G.A. § 9-3-71(a) still applies, since her injury had clearly occurred and physically manifested itself to her by September 1987, or at the latest by the end of 1988.

Id. at 626, 434 S.E.2d at 164-65.

Vitner v. Miller, 208 Ga. App. 306, 430 S.E.2d 671 (1993). Plaintiff had an abortion performed on March 11, 1989. A few days later she began experiencing pain and bleeding, learned that she had retained products of conception despite the first procedure, and returned for a second suction curettage on March 15, 1989. On March 20, 1989, plaintiff began to bleed and experience pain after the second abortion. She filed suit on March 18, 1991. Although her claims arising from the first procedure were time barred, her complaint was timely filed as to alleged injuries resulting from the second abortion as the injury from this procedure did not manifest itself until March 20, 1989.

3. Misdiagnosis Cases and the Rejection of the “Continuous Tort Theory” or “Continuous Treatment Doctrine”

In 2000, the Court of Appeals in Williams v. Young, 247 Ga. App. 337, 340, 543 S.E.2d 737, 740 (2000), sitting en banc, adopted a “continuous treatment doctrine” for misdiagnosis cases. The continuous treatment doctrine provides:

If the treatment by the doctor is a continuing course and the patient’s illness, injury or condition is of such a nature as to impose on the doctor a duty of continuous treatment and care, the statute does not commence running until treatment by the doctor for the particular disease or condition involved has terminated—unless during treatment the patient learns or should learn of negligence, in which case the statute runs from the time of discovery, actual or constructive.

Id. at 340, 543 S.E.2d at 740-41. In Williams, the plaintiff had been under the care of a physician who had misdiagnosed the swelling and pain in her right ankle and foot, telling her that her
condition was lymph edema, a permanent condition that she would have to live with. Id. at 337-38, 543 S.E.2d at 738-39. After seeing the defendant physician for more than a year, plaintiff contacted another physician. That physician diagnosed her as having three dislocated bones in her foot and performed a corrective surgery. Id. at 338, 543 S.E.2d at 739. The plaintiff filed suit more than two years after she first was treated by the defendant physician, but less than two years from the point at which the care ended and she received the proper diagnosis from the second physician. Adopting the continuous treatment doctrine, the Court of Appeals held that the plaintiff’s claim was timely since it was filed less than two years after the termination of treatment by the defendant physician.

The Supreme Court granted certiorari and reversed. In Young v. Williams, 274 Ga. 845, 560 S.E.2d 690 (2002), the Supreme Court held:

The General Assembly has determined that medical malpractice actions must be filed within two years of the occurrence of injury or death arising from a negligent or wrongful act or omission. O.C.G.A. § 9-3-71(a). The legislatively-prescribed statute of limitation does not provide for the commencement of the period of limitation upon the termination of the health-care provider’s treatment of the patient, and the judicial branch is not empowered to engraft such a provision on to what the legislature has enacted. Accordingly, we reverse the judgment of the Court of Appeals that resulted from the court’s adoption of the continuous treatment doctrine, and we remand the case to the Court of Appeals for further proceedings consistent with this opinion.

Id. at 847-48, 560 S.E.2d at 693. On remand to the Court of Appeals, the court applied the general rule to the misdiagnosis case, considered when the symptoms first began to manifest themselves following the initial misdiagnosis, and held that the statute of limitations barred the claims. Williams v. Young, 258 Ga. App. 821, 575 S.E.2d 648 (2002). On May 5, 2003, the Supreme Court once again granted certiorari in this case to consider the following issue: “In a
medical malpractice action based upon the physician’s alleged misdiagnosis of the patient’s condition, what is ‘the date on which an injury…occurred’ for purposes of commencement of the two-year statute of limitations established by O.C.G.A. § 9-3-81(a)?” As of February 2, 2004, the Supreme Court had not yet issued its opinion.

For years, the Georgia appellate courts have struggled to consistently apply the statute of limitations to misdiagnosis cases like Williams where the “injury” is the defendant’s failure to properly diagnose and properly treat the plaintiff’s existing condition. “In most [misdiagnosis] cases, the applicable limitation period for a claim of misdiagnosis begins to run at the time of the alleged misdiagnosis. This is the rule because, generally, the pain, suffering, or economic loss sustained by the patient begins at the time of the misdiagnosis and continues until the medical problem is properly diagnosed and treated.” Oliver v. Sutton, 246 Ga.App. 436, 437, 540 S.E.2d 645, 647 (2000). “The misdiagnosis itself is the injury and not the subsequent discovery of the proper diagnosis; thus, the fact that the patient did not know the medical cause of his suffering does not affect the applicability of O.C.G.A. § 9-3-81(a).” Hughley v. Frazier, 254 Ga. App. 544, 546, 562 S.E.2d 821, 823-24 (2002). But, in some misdiagnosis cases, the pain, suffering, and economic loss does not occur until some point subsequent to the misdiagnosis. For example, in Whitaker v. Zirkle, 188 Ga. App. 706, 374 S.E.2d 106 (1988), the defendant misdiagnosed the presence of cancer in a mole removed from the plaintiff’s back in 1978. Id. at 706, 374 S.E.2d 106. Plaintiff remained free of cancer symptoms for seven years. But, in 1985, a biopsy of tissue from the mole revealed the presence of cancer. Id. Plaintiff brought suit in May 1986, less than a year after being diagnosed with cancer. Id. Noting that plaintiff suffered no symptoms of
cancer for several years after the misdiagnosis, this court concluded that questions of fact existed as to whether the subsequent metastasis was a separate injury. \textit{Id.} at 708, 374 S.E.2d 106.

Additionally, when the plaintiff remains under the care of the physician for an extended period of time, like in \textit{Williams}, commencing the statute upon the point of initial misdiagnosis often yields harsh results. But, the Supreme Court in \textit{Young v. Williams} foreclosed, as inconsistent with the plain language of section 9-3-71(a), the notion that the statute would not commence in these cases until the plaintiff is no longer under the defendant’s care. Therefore, under the current state of the law, unless the injury occurs subsequent to the misdiagnosis like in \textit{Whitaker}, the general rule will apply and the statute of limitation will commence at the point of misdiagnosis. Hopefully, with its upcoming decision in \textit{Williams}, the Supreme Court will provide clarity as to when the statute of limitations commences in misdiagnosis cases.

**III. Special Rule for Foreign Objects Left in Body (O.C.G.A. § 9-3-72)**

There is one type of medical malpractice claim in which Georgia does apply a “discovery rule.” The Georgia legislature has created a special one-year statute of limitations for medical malpractice cases where foreign objects are left in a person’s body that commences when the act or omission is discovered. O.C.G.A. § 9-3-72 specifically provides:

> The limitations of Code Section 9-3-71 shall not apply where a foreign object has been left in a patient’s body, but in such a case an action shall be brought within one year after the negligent or wrongful act or omission is discovered. For the purposes of this Code section, the term “foreign object” shall not include a chemical compound, fixation device, or prosthetic aid or device.

(Emphasis added). The statute explicitly provides that section 9-3-71 does not apply. This means that not only does the general medical malpractice statute of limitation in subsection (a) of
§ 9-3-71 not apply in these cases, but that the five year statute of repose in subsection (b) of § 9-3-71 also is inapplicable to foreign object cases. A plaintiff has one year from the date of discovery of the foreign object to bring an action. But, notwithstanding that this statute states that “[t]he limitations of Code Section 9-3-71 shall not apply,” the Supreme Court has held that if the object is discovered within the first year following the act or omission that caused the object to be placed in the plaintiff’s body, the plaintiff can use the general two-year statute of limitation, as it would provide a longer period under those circumstances. See Spivey v. Whiddon, 260 Ga. 502, 503-04, 397 S.E.2d 117, 119 (1990) (5-2 decision overruling their own decision in Ringewald v. Crawford W. Long Mem. Hosp., 258 Ga. 302, 368 S.E.2d 490 (1998)).

IV. Using Tolling Provisions to Expand the Two-Year Statute of Limitations

1. Minors/Infants

The general tolling statute for persons under disability including minors, O.C.G.A. § 9-3-90, does not apply to actions for medical malpractice. A special rule for treatment of minors in medical malpractice actions is set forth in O.C.G.A. § 9-3-73(b). Under this statute, “[a] minor who has not attained the age of five years shall have two years from the date of such minor’s fifth birthday within which to bring a medical malpractice actions if the cause of action arose before such minor attained the age of five years.” Id. While the statute of limitation is tolled for minors who under five, there is no tolling provided for minors who are at least five years old at the time that the cause of action arises.

It must be recognized, however, when a minor under five years of age suffers an injury
from medical malpractice, some claims may belong to the parents, and those claims will not toll at all. For example, because the parents have a legal obligation to provide for the maintenance, protection, and education of their children, O.C.G.A. § 19-7-2, the parents have the sole legal right to recover for the minor’s medical expenses. See Mitchell v. Hamilton, 228 Ga. App. 850, 493 S.E.2d 41 (1997) (claim for medical expenses vested solely in parent, and thus was time-barred); Traylor v. Moyer, 199 Ga. App. 112, 404 S.E.2d 320 (1991) (applying rule in medical malpractice action); Rose v. Hamilton Med. Ctr., 184 Ga. App. 182, 361 S.E.2d 1 (1987) (physical precedent only) (holding that the right to recover medical expenses of a minor is vested with the parents). Thus, the parents cannot wait until the child’s seventh birthday to file. Rather, they must bring these claims for medical expenses within two years of the child’s injury.

2. **Mental Incapacity**

The general tolling statute of O.C.G.A. § 9-3-90 also does not apply in medical malpractice actions to toll the claims of those who are mental incapacitated. O.C.G.A. § 9-3-73(b) provides that “all person who are legally incompetent because of mental retardation or mental illness…shall be subject to the periods of limitation for actions for medical malpractice provided in this article.” The Supreme Court has held that the term “legally incompetent because of mental retardation or mental illness” in § 9-3-73(b) has the same meaning as that identical term in § 9-3-90”. Kumar v. Hall, 262 Ga. 639, 643-44, 423 S.E.2d 653, 657 (1992) (4-3 decision). Therefore, even though such injuries do not fall naturally within the traditional notions of “mental retardation” or “mental illness,” those who are incompetent due to a traumatic brain
injury, such as those who are comatose due to brain damage, fall within the statute. \textit{Id.; see also Robinson v. Williamson}, 245 Ga. App. 17, 18, 537 S.E.2d 159, 161 (2000) (“The term ‘legally incompetent because of mental retardation or mental illness’ includes those suffering from brain injury, and the tolling provisions of O.C.G.A. § 9-3-90 therefore do not apply even when such mental incapacity exists.”); \textit{Dowling v. Lopez}, 211 Ga. App. 578, 579, 440 S.E.2d 205, 207 (1993) (“Assuming, without deciding, the decedent was mentally incapacitated after the alleged malpractice, the tolling provision of O.C.G.A. § 9-3-90 during periods of legal incapacity does not apply in actions for medical malpractice.”). In actions for medical malpractice, there is simply no tolling of the statute of limitations on the basis of mental incapacity.

3. \textbf{Fraud}

O.C.G.A. § 9-3-96 provides that “[i]f the defendant or those under whom he claims are guilty of a fraud by which the plaintiff has been debarred or deterred from bringing an action, the period of limitation shall run only from the time of the plaintiff’s discovery of the fraud.” Unlike § 9-3-90 tolling for person under disabilities, section 9-3-96 tolling for fraud applies equally to medical malpractice actions. See O.C.G.A. § 9-3-73(a). But, establishing such fraud is quite difficult, as several requirements must be met.

In construing this statute, the Georgia courts have explained:

Fraud sufficient to toll the statute of limitations requires: (1) actual fraud involving moral turpitude on the part of the defendant; (2) the fraud must conceal the cause of action from the plaintiff, thereby debarring or deterring the knowing of the cause of action; and (3) the plaintiff must have exercised reasonable diligence to discover the cause of action, notwithstanding the failure to discover within the statute of limitations.

In medical malpractice actions, the fraud can be constructive. “The physician-patient relationship is a confidential one and silence or failure to disclose what should be said or disclosed can amount to fraud which tolls the statute.” Price v. Currie, 260 Ga. App. 526, 528, 580 S.E.2d 299, 302 (2003). But, to establish fraud to toll the statute of limitations, the plaintiff must present evidence that the physician knew that the plaintiff was injured in the ways plaintiff contends; that the physician knew that his violations of the standard of care caused such injuries; and that he intentionally concealed such fact.” Kane, 260 Ga. App. at 726, 580 S.E.2d at 558. Simply showing that another physician immediately recognized that the defendant physician’s efforts had been unsuccessful will not create a presumption “that the results of the treatment were fraudulently misrepresented or withheld rather than negligently or possibly without fault.” Id.

Moreover, once the plaintiff becomes aware of the true facts, any tolling ceases regardless of any continuing efforts by the physician to deter the plaintiff from learning these true facts. Kohout, 233 Ga. App. at 457, 504 S.E.2d at 521-22. Lastly, consulting with another physician apparently ceases, as a matter of law, any possible tolling on the basis of fraud even when such consultation does not reveal the fraud. “[O]nce the plaintiff seeks the diagnosis or care of
another doctor, she is no longer deterred from learning the true facts by any conduct of a
defendant even if the other doctor consulted does not diagnose the medical problem as arising
form the defendant’s improper treatment.” Price, 260 Ga. App. at 529, 580 S.E.2d at 303
(quoting Witherspoon v. Aranas, 254 Ga. App. 609, 614, 562 S.E.2d 853 (2002)). See also

On a motion for summary judgment, while the defendant has the burden of coming forth
with evidence supporting the affirmative defense of statute of limitations, once this is met, the
plaintiff has the burden to come forward with evidence of tolling. The defendant need not
establish the absence of facts showing a tolling, rather the plaintiff must present some evidence
showing that an issue exists that the statute has not run but has been tolled. Miller v. Kitchens,

For a case holding that a jury question was presented as to whether the statute of
limitations was tolled by fraud, see Boggs v. Bosley Med. Inst., Inc., 228 Ga. App. 598, 492
S.E.2d 264 (1997).

4. **Unrepresented Estate**

The time between the death of a person and the commencement of representation
upon his estate or between the termination of one administration and the
commencement of another shall not be counted against his estate in calculating any
limitation applicable to the bringing of an action, provided that such time shall not
exceed five years. At the expiration of the five years the limitation shall commence,
even if the cause of action accrued after the person’s death.

O.C.G.A. § 9-3-92. This statute will toll the claims belonging to the estate for the time period
between the death of a person and the appointment of a representative for the estate. See Dowling

The statute does not speak to and would not seem to extend to wrongful death claims belonging to the surviving spouse or child under O.C.G.A. § 51-4-5(a). See generally Childers v. Tauber, 160 Ga. App. 713, 715-16, 288 S.E.2d 5, 7-8 (1981) (holding that there was no tolling of child’s claim for mother’s wrongful death as claim belonged to daughter in her individual capacity). See also Lazenby v. Ware, 178 Ga. 463, 173 S.E. 86, 87 (1934) (statutory provision for tolling limitation against unrepresented estate held not available to decedent’s heirs suing in their own right).

But, in one case where both wrongful death and survival claims were brought in a single suit by the same person in two separate capacities (as surviving spouse and as legal representative of the estate), the court apparently held that both the estate’s survival claim as well as the surviving spouse’s individual claim for wrongful death must be tolled under the statute. See Legum, 208 Ga. App. at 187-89, 430 S.E.2d at 363-65.

If there is no surviving spouse or child, under Georgia law, the wrongful death claim is brought by the estate for the benefit of the next of kin. O.C.G.A. § 51-4-5(a). In that situation, since an representative of the estate is needed to bring the claim, tolling under § 9-3-92 would seem to apply. But, the cases are inconsistent on this issue. Compare DeLoach v. Emergency Medical Group, 155 Ga. App. 866, 868, 274 S.E.2d 38, 40 (1980) and Patellis v. King, 52 Ga. App. 118, 182 S.E. 808, 812 (no tolling) with Walden v. John D. Archibald Mem. Hosp., Inc., 197 Ga. App. 275, 279, 398 S.E.2d 271, 275 (1990) (suggesting that there would be tolling for a wrongful death claim.
brought under § 51-4-5).

Although a temporary administrator may file actions for collection of debts owed decedent, such a representative is not considered representative of the estate for purposes of section 9-3-92. Miller v. Merrill Lynch, 572 F.Supp. 1180 (1983). Tolling of statute of limitations continues as to causes of action, such as those for medical malpractice, that the temporary administrator, as opposed to the permanent administrator, is unable to assert on behalf of estate. Walden, 197 Ga. App. at 279, 398 S.E.2d at 275.

5. **Statutory Medical Records Request**

O.C.G.A. § 9-3-97.1 provides for the tolling of the statute of limitations if medical records properly sought in preparation for a possible medical malpractice action are not furnished in a timely manner. To enjoy this tolling, an injured person must make a proper request of the physician carefully following the several requirements set forth in subsection (a). These requirements include: (1) proper mailing of the request to the health care provider by certified or registered or statutory overnight delivery, return receipt requested; (2) including a medical authorization authorizing release of the requested information; (3) notice that records are needed for possible use in a medical malpractice action and that the records be mailed to the injured person or his attorney by certified or registered or statutory overnight delivery, return receipt requested; and (4) person making request must pay all fees and costs charged by health care provider for compiling, copying, and mailing such records.

If the injured person does not receive the records or a letter of response stating that the provider does not have custody or control of the records within 21 days of the date of receiving
such request, the statute of limitations shall be tolled under this statute. The medical malpractice statute of limitation as provided in §§ 9-3-71 and 9-3-72 “shall cease to run on the twenty-second day following the day such request was received and shall resume on the day following the date such medical records, or response stating that the provider does not have custody or control of the medical records, are actually received by such injured person or his attorney.” O.C.G.A. § 9-3-97.1(a).

The tolling will automatically continue, up to 90 days, until a proper response is received from the health care provider. If no response has been received in 85 days, “the injured person shall have the right to petition the court for an order tolling the period of limitation beyond the 90 days.” O.C.G.A. § 9-3-97.1(c). Unless the injured person successfully obtains such an order, the tolling will cease at 90 days notwithstanding the lack of response from the medical provider.

A complaint filed in reliance upon tolling under this statute must include, allegations stating that such tolling exists and copies of the request, medical release, and evidence of mailing must be attached as exhibits. O.C.G.A. § 9-3-97.1(b). A complaint may not be amended later to include this omitted information. Id.

Subsection (d) of the statute specifically provides that “[i]t is intended that the provisions of this Code section tolling the statute of limitations for medical malpractice under certain circumstances by strictly complied with and strictly construed.”

As you can see, this statute requires a lot and provides little relief in return. Therefore, there has been little use of it since its enactment. To date, there is only a single reported decision by the Georgia appellate courts applying its provisions. See Ajayi v. Williams, 248 Ga. App.
325, 546 S.E.2d 537 (2001).
WHAT’S THE DIFFERENCE BETWEEN INFORMED CONSENT, FAILURE TO WARN, AND FIDUCIARY DUTY?

Philip C. Henry
Wendy G. Huray
Henry, Spiegel, Fried & Milling, LLP
Atlanta, Georgia
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Philip C. Henry, Esquire
Wendy G. Huray, Esquire
Henry, Spiegel, Fried & Milling, LLP
Suite 2450
Atlanta, GA  30326
(404) 832-8000

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Introduction

The duty to obtain informed consent, the duty to warn, and fiduciary duty all relate to a physician’s duty to provide patients with necessary and accurate information during all phases of a physician-patient relationship. The duty to obtain informed consent arises prior to undertaking a diagnostic or treatment procedure. One component of informed consent, the duty to disclose the known material risks of proposed procedures, could fairly be categorized as a duty to warn.

Georgia case law also requires physicians to warn patients after treatment, such as where patients have received defective medical devices and harmful drugs. The concept of fiduciary duty affirmatively requires physicians to speak truthfully rather than withhold information throughout the relationship, including while trying to obtain consent, during treatment, and when the physician has injured the patient through medical negligence.

This paper will first address the duty to obtain informed consent and conclude with a discussion of fiduciary duty and failure to warn. Before analyzing physicians’ common law and statutory duty to obtain informed consent in Georgia, it is helpful to initially explain the two distinct legal principles of “consent” in the medical context.

Types of Consent In The Medical Malpractice Context

The first principle is “basic” consent, or that consent to a touching that avoids a battery. A medical “touching” without consent constitutes the intentional tort of battery for which an action will lie. Pope v. Davis, 261 Ga. App. 308, 309 (2003); Ketchup v. Howard, 247 Ga. App. 54, 55-56 (2000).

The second principle is “informed” consent, which addresses the autonomy of a competent patient to determine what medical treatment he will allow or refuse. Informed
consent involves a medical professional fully informing a patient of the risks of and alternatives to proposed diagnostic procedures or treatment so that the patient’s right to decide is not diminished by a lack of relevant information. Pope, 261 Ga. App. at 310; Ketchup, 247 Ga. App. at 56.

Physicians’ Common Law Duty to Obtain Informed Consent – Ketchup v. Howard

The common law doctrine of informed consent provides that physicians have a duty to inform patients of (1) the known material risks of a proposed treatment or procedure and (2) available treatment alternatives. Ketchup v. Howard, 247 Ga. App. 54, 54 (2000). Prior to the year 2000, Georgia was the only state that did not recognize this common law doctrine. A brief summary of the history of the informed consent doctrine in Georgia helps illustrate the potential consequences of the Ketchup decision.

In Young v. Yarn, 136 Ga. App. 737 (1975), the Georgia Court of Appeals found that the General Assembly had defined physicians’ duty of disclosure to patients in the Georgia Medical Consent Law, now O.C.G.A. § 31-9-6 (d). This Code section provides:

> A consent to surgical or medical treatment which discloses in general terms the treatment or course of treatment in connection with which it is given and which is duly evidenced in writing and signed by the patient . . . shall be conclusively presumed to be a valid consent in the absence of fraudulent misrepresentations of material facts in obtaining same.

O.C.G.A. § 31-9-6 (d). The Court determined that a duty to disclose the treatment “in general terms” does not include a duty to disclose or warn of the risks of treatment. Young, 136 Ga. App. at 738-39.

Therefore, between 1975 and 2000, Georgia did not recognize any common law duty for medical professionals to advise patients of the known material risks of a proposed procedure or the available and reasonable alternatives. In fact, evidence of a failure to reveal the risks

In 1988, the General Assembly enacted O.C.G.A. § 31-9-6.1, a limited codification of the common law doctrine of informed consent. This statute, which is discussed fully below, imposes a duty on physicians to provide patients undergoing specified procedures with specified information. Prior to the Ketchup decision, if the procedure did not fall within the confines of O.C.G.A. § 31-9-6.1, a physician could still obtain valid consent by disclosing the general terms of treatment under O.C.G.A. § 31-9-6. Further, even if the procedure was covered by O.C.G.A. § 31-9-6.1, the physician was required only to disclose the information outlined in the statute.

Ketchup v. Howard, 247 Ga. App. 54 (2000), presented the Court of Appeals with an opportunity to revisit the issue of informed consent. The case dealt with a dentist’s duty to disclose the risks of and alternatives to a root canal. The Court overruled Young v. Yarn, joining the other 49 states in recognizing the common law doctrine of informed consent. Ketchup, 247 Ga. App. at 54.

The Court first determined that the 1971 Georgia Medical Consent Law on which the Young court relied was intended to address only the “basic” consent that avoids a battery, not informed consent. Id. at pp. 56-58. The Court then found that Young likely would have been declared unconstitutional if considered in light of subsequent United States Supreme Court and Georgia Supreme Court decisions identifying individuals’ constitutionally protected liberty interests regarding their medical treatment. Id. at 58.
For example, after Young the Georgia Supreme Court held that all legally competent persons have a liberty interest, protected by the Georgia Constitution, to make all decisions regarding their medical care. This interest includes the right to refuse medical treatment, even where necessary to save the patient’s life. See Zant v. Prevatte, 248 Ga. 832 (1982); State of Ga. v. McAfee, 259 Ga. 579 (1989). See also Cruzan v. Director, Mo. Dept. of Health, 497 U.S. 261 (1990) (a competent person has a liberty interest under the Due Process Clause to refuse unwanted medical treatment). The Court correctly reasoned that this constitutionally protected liberty interest to make all decisions regarding medical treatment is rendered meaningless in the absence of the common law doctrine of informed consent. Id. at 59.

The Court also found that Young had essentially substituted the judiciary’s judgment for that of the medical profession for the standard of care on the issue of informed consent. Id. By contrast, the Ketchup Court recognized that the American Medical Association’s Code of Medical Ethics sets forth the medical profession’s standard on informed consent. Id. at 60. The Court cited several AMA statements in support of its decision.

Section 1 of the 1998-1999 Edition, entitled Fundamental Elements of the Patient-Physician Relationship, provides “[t]he patient has the right to receive information from physicians and to discuss the benefits, risks, and costs of appropriate treatment alternatives.” Id. Section 8.08 of the AMA Code of Medical Ethics, entitled Informed Consent, provides “[t]he patient’s right of self-decision can be effectively exercised only if the patient possesses enough information to enable an intelligent choice.” Id.

Similarly, the 1992 Code of Medical Ethics, as prepared by the Council on Ethical and Judicial Affairs of the American Medical Association, goes further to read as follows:

The patient should make his own determination on treatment. The physician’s obligation is to present the medical facts accurately to
the patient or to the individual responsible for his care and to make recommendations for management in accordance with good medical practice. The physician has an ethical obligation to help the patient make choices from among the therapeutic alternatives consistent with good medical practice. Informed consent is a basic social policy for which exceptions are permitted (1) where the patient is unconscious or otherwise incapable of consenting and harm from failure to treat is imminent; or (2) when risk-disclosure poses such a serious psychological threat of detriment to the patient as to be medically contraindicated. Social policy does not accept the paternalistic view that the physician may remain silent because divulgence might prompt the patient to forego needed therapy. Rational, informed patients should not be expected to act uniformly, even under similar circumstances, in agreeing to or refusing treatment.

Id. at 60-61.

The doctrine of informed consent recognized in Ketchup requires a physician to "inform a patient of the material risks of a proposed treatment or procedure which are or should be known," and "inform a patient of available alternatives to the proposed procedure or treatment." Id. at 59. By adding material risks that are or should be known, the Court slightly expanded the common law doctrine as defined in the beginning of the decision.

As with O.C.G.A. § 31-9-6.1, expert testimony is required to establish that the risk either was known or should have been known, but expert testimony is not required to establish that the patient’s decision to have or reject the proposed treatment because of the risk would have been affected. Instead, the jury would, as in general tort cases, be asked to determine whether an ordinary, reasonable, and prudent person in the patient’s position would have rejected the proposed treatment or procedure using lay standards. Id. at 63.

Importantly, contrary to O.C.G.A. § 31-9-6.1, Ketchup appears to create an independent cause of action for a medical professional’s failure to obtain informed consent. The Court noted that under Young v. Yarn, a physician could induce or encourage a patient to undergo a risky yet
unnecessary surgery without making known either the attendant risks or available alternatives.  
Id. at 59. “This would leave the uninformed patient without a remedy, even if the procedure resulted in death or disfigurement, unless the physician negligently performed the surgery.  Contrary to the holding in Young v. Yarn, the law in Georgia cannot leave such a patient with no recourse.”  Id.

The Ketchup Court adopted a purely prospective application of the duty to obtain informed consent.  Id. at 64. The Court therefore held that Dr. Howard was not liable for medical malpractice based on his failure to warn of the risks of and alternatives to the root canal under the common law as it existed at the time, and affirmed the trial court’s grant of summary judgment.  Id.

Several judges concurred in the judgment only. Judge Andrews, Blackburn, Ruffin and Miller joined a special occurrence contending that the majority’s recognition of common law informed consent beyond that set forth in O.C.G.A. § 31-9-6.1 invaded the province of the General Assembly and ignored contrary Supreme Court authority, primarily Albany Urology Clinic v. Cleveland, 272 Ga. 296 (2000), which is discussed below.

The Supreme Court did not review Ketchup. Certiorari was dismissed on January 19, 2001.

Physicians’ Statutory Duty to Obtain Informed Consent

In 1988 the General Assembly adopted the Informed Consent Doctrine, O.C.G.A. § 31-9-6.1, which became effective on January 1, 1989. The statute applies in a limited context and requires only limited disclosures.

The disclosure requirements apply only to physicians obtaining consent for patients undergoing the following procedures:
1. Any surgical procedure under general, spinal, or major regional anesthesia;
2. An amniocentesis diagnostic procedure; or
3. A diagnostic procedure which involves the intravenous or intraductal injection of a contrast material.


If the procedure falls into one of these categories, the statute sets forth six categories of information that physicians must disclose “in general terms” to their patients before they undergo the specified procedures:

1. The patient’s diagnosis requiring the procedure;
2. The nature and purpose of the procedure;
3. The material risks generally recognized and accepted by reasonably prudent physicians of infection, allergic reaction, severe loss of blood, loss or loss of function of any limb or organ, paralysis or partial paralysis, paraplegia or quadriplegia, disfiguring scar, brain damage, cardiac arrest, or death associated with the procedure which, if disclosed to a reasonably prudent person in the patient’s position, could reasonably be expected to cause such prudent person to decline such proposed procedure on the basis of the material risk of injury that could result from such proposed procedure;
4. The likelihood of the procedure’s success;
5. The practical alternatives to the procedure which are generally recognized and accepted by reasonably prudent physicians; and,
6. The patient’s prognosis if the procedure is rejected.

O.C.G.A. § 31-9-6.1(a)(1)-(6). The Georgia Supreme Court has held that this statute does not impose a general requirement of disclosure on physicians, but requires physicians to disclose only the factors listed in O.C.G.A. § 31-9-6.1(a). *Albany Urology Clinic v. Cleveland*, 272 Ga. 296, 299 (2000).
Under O.C.G.A. § 31-9-6.1(d), failure to comply with the informed consent statute shall not constitute a separate cause of action but may give rise to an action for medical malpractice upon a showing of the following:

1. That the patient suffered an injury which was proximately caused by the surgical or diagnostic procedure;

2. That requisite information concerning the injury suffered was not disclosed; and,

3. That a reasonably prudent patient would have refused the surgical or diagnostic procedure or would have chosen a practical alternative to such proposed surgical or diagnostic procedure if such information had been disclosed.

O.C.G.A. § 31-9-6.1(d).

Physicians’ Duty (or Lack Thereof) to Disclose Personal Facts Affecting Their Performance

In Albany Urology Clinic v. Cleveland, 272 Ga. 296 (2000), the Supreme Court of Georgia examined whether a physician had a duty to disclose to his patients factors of his life, namely his illegal drug use, which might adversely affect his performance of a surgical procedure in order to obtain valid consent. There was no evidence that the physician was under the influence of cocaine while treating this patient, but he was subsequently admitted to a rehabilitation facility for drug treatment. Albany Urology, 272 Ga. at 297. The Supreme Court decided this case several months prior to the Court of Appeals’ recognition of the common law doctrine of informed consent.

The Court found no common law or statutory (O.C.G.A. § 31-9-6.1) duty for physicians to disclose “unspecified life factors which might subjectively be considered to adversely affect the professional’s performance,” but did note that physicians have a common law duty to truthfully answer a patient’s questions regarding medical or procedural risks. Id. at 296-297, 298. Failure to truthfully respond may invalidate a patient’s consent, leaving the physician liable
for battery. Id. at 301. Under these circumstances, however, the Court found that the unknown factor (cocaine use outside of work) that the patient claimed would have caused him to withhold consent was “too attenuated from the subject matter of the professional relationship to support a battery claim.” Id.

Albany Urology contains several statements that support the special concurrences in Ketchup. The Supreme Court noted that prior to the informed consent statute, physicians were under no common law duty to disclose procedural risks to patients. Id. at 298. The Court went on to state that this common law rule could only be changed by legislative act, which occurred with the limited informed consent law in O.C.G.A. § 31-9-6.1. Id. Being in derogation of common law (as it existed at the time), O.C.G.A. § 31-9-6.1 must be strictly construed. Id. at 299. Therefore, “in situations not covered by the statute’s language, the common law rule must still govern, as courts are without authority to impose disclosure requirements upon physicians in addition to those requirements already set forth by the General Assembly.” Id.

The Ketchup court fully acknowledged Albany Urology, rationalizing that the Supreme Court’s mention of the common law doctrine of informed consent was dicta, and that it had the right to correct its error in Young v. Yarn and its progeny. Ketchup, 247 Ga. App. at 64-65.

The issue in Albany Urology was whether the failure to make such a disclosure constitutes fraud or vitiates basic consent or consent to avoid a battery. It remains to be seen whether the doctrine of informed consent recognized in Ketchup would require the disclosure of such personal information to obtain valid informed consent. As noted by Justice Carley in her dissent, which was joined by Justices Huntstein and Thompson:

The concept of valid consent to undergo a medical procedure encompasses more than the procedure itself, and includes the qualifications or lack thereof of the one who is proposing himself as the professional who will perform that procedure. . . . Certainly,
the qualifications of the particular physician, no less than the
general and inherent risks of the suggested medical procedure, are
of concern to the patient whose authorization is being sought.

Albany Urology, 272 Ga. at 304.

**Fiduciary Duty**

A physician’s fiduciary duty to accurately and truthfully inform his patient arises out of
the trust and confidence of the physician-patient relationship. Where a person sustains toward
another a relation of trust and confidence, his silence when he should speak or his failure to
disclose what he ought to disclose is as much a fraud in law as an actual affirmative false

Most of the breach of fiduciary duty cases we found in the medical malpractice context
dealt with a physician’s fiduciary duty to inform a patient of an injury or negligent mistreatment.
226 (2001). This issue usually arises when a patient claims that a physician’s fraud deterred him
from bringing a medical malpractice action, thereby tolling the statute of limitation until the
patient’s discovery of the fraud.

Fraud sufficient to toll the statute of limitation under these circumstances requires (1)
actual fraud involving moral turpitude on the part of the defendant; (2) the fraud must conceal
the cause of action from the plaintiff, thereby debarring or deterring the knowing of the cause of
action; and (3) the plaintiff must have exercised reasonable diligence to discover the cause of
action, notwithstanding the failure to discover within the statute of limitation. *Miller v.
Further, while a physician has a fiduciary duty to inform his patient of any injury or negligent mistreatment, to establish fraud a plaintiff must present evidence that the physician knew that the plaintiff was injured in the ways the plaintiff contends; that the physician knew that his violations of the standard of care caused such injuries; and that he intentionally concealed such fact. Miller, 251 Ga. App. at 226-27. Proof of these elements is obviously difficult. A plaintiff must show not just a misdiagnosis, but a “known failure to reveal negligence in order to show fraud.” Price, 260 Ga. App. at 529.

Georgia case law does address physicians’ fiduciary duties in other contexts. For example, in Breyne v. Potter, 258 Ga. App. 728, 732 (2002), the Court of Appeals held that the trial court erred in granting summary judgment to a physician on a breach of fiduciary duty claim. The physician, a maternal-fetal medicine specialist, misread the results of genetic tests and provided inaccurate information to his patient regarding her baby, after which the patient had an abortion. The physician here admitted that he owed a fiduciary duty to the patient, but unsuccessfully contended that the patient’s decision to abort the pregnancy severed the causal link between breach and damages as a matter of law. Breyne, 258 Ga. App. at 731.

In Petzelt v. Tewes, 260 Ga. App. 802 (2003), a patient sued an anesthesiologist for, among other things, breach of fiduciary duty based in part on his allegation that the anesthesiologist fraudulently obtained his consent to perform medical procedures by assuring him that his referring physician was aware and approved of her treatment plans. The trial court granted summary judgment on this claim based on the anesthesiologist’s argument that there was no evidence she made false statements or intentionally misled or deceived the patient to obtain consent.
The Court of Appeals reversed, noting that in cases of fraud a patient’s consent may be vitiated if a physician fails to respond truthfully to the patient’s questions about a diagnosis or treatment. Pezelt, 260 Ga. App. at 804-05. The Court found evidence on which a jury could infer that the anesthesiologist recklessly misrepresented that the referring physician acquiesced to her treatment plan, and that the anesthesiologist intended to deceive the patient. Id. at 805-06.

Failure to Warn


Additionally, the learned intermediary doctrine is similar to a physician’s basic duty to obtain informed consent. Under this doctrine, the manufacturer of a prescription drug or medical device does not have a duty to warn the patient of dangers involved with a product, but instead has a duty to warn the patient’s doctor, who acts as a learned intermediary between the patient and the manufacturer. Williams v. American Medical Systems, 248 Ga. App. 682, 685 (2001). The rationale for the doctrine is that the treating physician is in a better position to warn the patient than the manufacturer, in that the decision to employ prescription medication or medical devices involves a professional assessment of medical risks in light of the physician’s knowledge of a patient’s particular need and susceptibilities. McCombs v. Synthes, 587 S.E.2d 594 (Ga.) (2003).
One other interesting area of failure to warn cases involves a mental health professional’s duty to warn third parties of a threat of serious bodily harm. At least two Georgia cases touch on this issue.

In Bradley Center v. Wessner, 250 Ga. 199 (1982), the Supreme Court recognized a duty to control a hospitalized patient in order to prevent harm to third parties. The Court approved the Court of Appeals’ description of this duty as follows: “[w]here the course of treatment of a mental patient involves an exercise of ‘control’ over him by a physician who knows or should know that the patient is likely to cause bodily harm to others, an independent duty arises from that relationship and falls upon the physician to exercise that control with such reasonable care as to prevent harm to others at the hands of the patient.” Bradley Center, 250 Ga. at 201 citing Bradley Center, 161 Ga. App. at 581. This duty arises out of the general duty that one owes to all the world not to subject them to an unreasonable risk of harm, not a physician-patient relationship. Id. at 201. Bradley Center was a duty to control, not a duty to warn, case.

The Court of Appeals was next presented with an opportunity to define a duty to warn in Jacobs v. Taylor, 190 Ga. App. 520 (1989), but somewhat dodged the issue. In Jacobs, a released mental patient killed his former wife, against whom he had made specific threats, and two others, who were strangers. The children of the victims sued the patient’s former psychiatrists.

As to the former wife, the Court found that even if the physicians had a duty to warn her about the danger her former husband posed, the wife’s subsequently acquired knowledge of that precise danger absolved them of any liability in their failure to warn. Jacobs, 190 Ga. App. at 527. The evidence showed that the former wife was fully aware of the danger and had instituted
criminal proceedings against the patient for terroristic threats. Id. There was therefore no duty to warn her of the obvious, or what she knew or should have known. Id.

As to the strangers, there was no evidence that they were foreseeable or readily identifiable targets of the patient’s unspecified threats. Id. The Court declined to impose blanket liability on doctors for failing to warn members of the general public of the risk posed by a patient with a history of violence who made generalized threats. Id.
MED/MAL CASE INTAKE EVALUATION

Don C. Keenan  
The Keenan Law Firm  
Atlanta, Georgia
ICLE SEMINAR

13 February, 2004

MED / MAL CASE INTAKE EVALUATION

DON C. KEENAN

“You only have one time to make a first impression”

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I. Initial Case Triage Intake
   A. Telephone Intake
   B. Secondary Review
   C. Obtain Outside Materials if Merited

II. Different Procedure for Attorney Referral
   A. Importance of Impressions
   B. Value of Teamwork

III. Track your Statistics
   A. Keenan Law Firm
      1. 70% Attorney Referral Cases
      2. 75% Out of State Referrals
      3. Intake v. Acceptance

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B. Chart by Years and Months
      a. Chart attached as “A”

IV. Don’t Swim Upstream
   A. Knowledge of National / Local Verdicts / Settlements
   B. Prior Focus Group Findings
   C. Value Paradigm
      1. Attached as “B”

V. The Key Elements
   A. Damages 1-10 Scale
   B. Liability 1-10 Scale
   C. Causation 1-10 Scale
   D. Venue 1-10 Scale
   E. Assessment of Plaintiff 1-10 Scale
   F. Assessment of Defendant 1-10 Scale
   G. Budget
      1. Attached as “C”
   H. Focus Group if necessary

VI. ELEMENTS THAT DON’T MATTER
   A. The Insurance Company
   B. The Defense Attorney
**BUDGET SHEET**

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## VALUE PARADIGM

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