HEALTH LAW UPDATE

By Mandy Young, Jerry Taylor and Yarnell Beatty

October 8, 2020

Tennessee Legislative Update - 2020 Sessions

Presenters' Notes on Legislative Update: The bills that your panel expects to discuss during the presentation are highlighted to help you locate them since our discussion of them will be fast-paced. We plan to follow the order in the descriptions. Finally, bills and joint resolutions mostly ceremonial in nature are not included. We hope this format is helpful and we welcome your feedback, Yarnell.beatty@tnmed.org .

BUDGET

- A proposal to repeal the Professional Privilege tax for the remaining seven professions, including lawyers and doctors, was derailed due to state funding concerns surrounding the COVID-19 impact on the state.

BUSINESS OF HEALTH CARE

PC 619 (SB 1888) Hospital Bad Debt Reporting.
Currently, pursuant to TCA § 68-1-109, Tennessee hospitals are required to report "bad debts" annually to the Department of Health. "Bad debts" means amounts considered to be uncollectible from accounts and notes receivable that are created or acquired in providing services. The new law instructs that indigence is determined by the provider's posted charity care policy pursuant to TCA § 68-11-268. It also adds that if indigence is determined and the provider concludes that there had been no improvement in the beneficiary's financial condition, then the hospital may deem the debt, or the portion of the debt, charity care without having to apply the bad debt collection criteria. Effective March 25, 2020.

PC 574 (SB 1955) Employment of Physician by FQHC or RHC
TCA § 63-6-204(e) is amended to allow federally qualified health centers and rural health centers to employ physicians (except for anesthesiologists, emergency department physicians, pathologists, or radiologists). Such employment must include a written contract, job description, or documentation containing language that does not restrict the physician from exercising independent medical judgment in diagnosing and treating patients. Effective March 19, 2020.

CRIMINAL LAW

PC 684 (SB 2629). Surrendering Custody of Infant.
The new law amends TCA §§ 36-1-142(a), 68-11-255(a)(3), and 68-11-255(b)(1) to extend the time from 72 hours after birth to two weeks during which time a mother can surrender custody of an infant at a medical facility without incurring criminal liability.

HEALTH CARE DELIVERY

PC 575 (SB 1958). Required T-CPR training for emergency communication service providers.
This new law amends various provisions of law related to required T-CPR training for emergency communication service providers. Effective March 19, 2020, it is required that the emergency communications board monitor training for emergency call takers covering recognition protocols for out-of-hospital cardiac arrest (OHCA), compression-only cardiopulmonary resuscitation (CPR) instructions, and continuous education as necessary. It also grants immunity protection from any claim, complaint, or suit of any nature against emergency communication districts, counties, municipalities, and emergency service dispatchers who maintain training requirements.

PC 573 (SB 1912) Alternative Treatments.
The new law amends the definition of "alternative treatments" in TCA § 63-1-164. The current law requires a prescriber to discuss with a patient reasonable alternatives to opioids along with the risks and benefits of the alternative treatment. Alternative treatment includes, but is not limited to, treatments such as chiropractic care, PT, acupuncture, & other such treatments that relieve pain without the use of opioids. Prescribers may now discuss interventional procedures or treatments with the patient when obtaining informed consent for treatment with opioids.

PC 739 (SB 2317) Health Care Empowerment Act.
Effective July 1, 2020, the Health Care Empowerment Act is amended at TCA § 63-1-501 et seq. The Act is expanded to allow all licensed medical professionals to use direct medical care agreements without regulation by state health insurance laws. The specific medical professions to which the law applies are not delineated but includes "legal entity." Such agreements are agreements to provide "medical care" without billing the patient's health insurance.

PC 762 (SB 1839) Prenatal and Postpartum Care or Prisoners
Requires a physician to provide prenatal and postpartum medical care to pregnant prisoners and detainees. It also requires correctional institutions to provide pregnant prisoners nutritionally appropriate meals and appropriate supplemental provisions. Amends TCA § 41-21-204 and adds a new section to Title 41, Chapter 21, Section 2. Effective July 1, 2020.

PC 764 (SB 2196) Abortion
The administration's new abortion law, referred to as the "heartbeat law," adds new sections, TCA § 39-15-214 et seq to the criminal code. Violation is a Class C felony. It prohibits abortions after six weeks gestation. Medically speaking, that is before many women realize they are pregnant. The new subsection TCA § 39-15-215(b) sets out what informed consent must be given to a woman seeking to have an abortion. Among the requirements is to determine and communicate the gestational age of the unborn child to the woman "using current medical technology and methodology applicable to the gestational age of the unborn child and reasonably calculated to determine whether a fetal heartbeat exists." An ultrasound must be displayed to the woman and she must be informed as to whether there is a fetal heartbeat. The law does not appear to address the situation where the patient refuses to consent to an ultrasound but it is clear that a physician would not be able to lawfully perform the abortion without the gestational age and heartbeat preconditions being performed. The law does not actually require the woman to look at the displayed image of the ultrasound. There is an exception to the preconditions if an emergency exists. If there is, it is an affirmative defense to criminal prosecution of the physician for a violation. To avail oneself of the affirmative defense, several other requirements must be met based upon the viability of the fetus. A physician can be prosecuted if an abortion is performed and the doctor knows the woman is seeking the abortion because of: (A) The sex of the unborn child; (B) The race of the unborn child; or (C) A prenatal diagnosis, test, or screening indicating Down syndrome or the potential

for Down syndrome in the unborn child. The woman can be prosecuted for attempting to commit or conspiring to commit a violation of the law. There are no exceptions in the law for rape or incest. It repeals a requirement that the department of children's services assign a court advocate in each judicial district to assist in the coordination of court-appointed counsel, to attend legal proceedings with a minor seeking an abortion, and to provide minors with information related to parental consent for abortions and the judicial bypass process. **Within forty-five minutes of signature by Governor Lee, the law was blocked as effectively prohibiting abortions as has been done in other states passing similar laws.**

PC 4 ES2 (SB 8003 Special Session) Telehealth.
This new law was in response to the significant uptick in the need for, and use of, telehealth during the COVID-19 pandemic. It provides for telehealth payment parity with in-person visits until April 1, 2022 for "visits" related to established physician-patient relationships. Health insurers are required to cover remote patient monitoring services if the same service is covered by Medicare; payers and providers negotiate the amount of reimbursement. The new law will include licensed alcohol and drug abuse counselors. Finally, it relaxes the definition of an originating site for telehealth delivery.

HEALTH CARE LIABILITY

PC 1ES2 (SB 8002 Special Session) COVID-19 Liability Protection.
The "Tennessee COVID-19 Recovery Act" adds a new part to Title 29, Chapter 34 and amends several other provisions related to civil lawsuits during the COVID-19 pandemic. It extends emergency liability protections to "any person" which includes entities such as doctors, health care facilities, businesses, non-profits, public institutions of higher education and their employees and contractors. Any COVID-related civil complaint filed or noticed after August 3, 2020 must plead specific facts which reasonably conclude "that the alleged loss, damage, injury, or death was proximately caused by the defendant's willful, malicious, or criminal act or omission, or performed for personal financial gain." Complaints must also include a certificate of good faith from a licensed physician from Tennessee or a contiguous state, to confirm the physician "is competent to express an opinion on exposure to or contraction of COVID-19" and believes the alleged loss, damage, injury, or death was caused by an act or omission of the defendant or defendants. The failure of a claimant to satisfy the requirements shall, upon motion, make the action subject to dismissal with prejudice. The policy reason for the new law is so Tennessee businesses would be protected from frivolous liability claims related to COVID-19 for the next two years. At the time of enactment, the standard of care for treatment and prevention of the spread of COVID-19 was emerging as health care providers learn about its transmission. With these uncertainties, businesses need to open without fear of lawsuits in order to employ more workers, open schools, and further stimulate the economy. Governor Lee had granted limited liability protection for health care workers in July via executive order but the order expired on August 29 because of passage of this law.

HEALTH INSURANCE

PC 515 (SB 645) Association Health Insurance.
Effective July 1, 2020. This amends various provisions of the insurance code to reduce regulation of association health insurance plans. It deletes the requirement that bona fide associations must have been in existence for at least five years and maintained in good faith for purposes other than obtaining insurance. Associations or business coalitions which are entering into an agreement to pool their liabilities

must have at least one substantial business purpose unrelated to offering and providing insurance coverage but allow health insurance coverage to serve as their primary purpose. Effective July 1, 2020.

PHARMACY, PRESCRIBING AND PAIN MANAGEMENT

Pharmacy

None.

Prescribing

PC 771 (SB 1938) Prescribing of Buprenorphine.
Effective August 1, 2020, a new section is added to TCA § 53-11-311 to allow APRNs and PAs holding DEA-X certificates employed by or contracted with a nonresidential office-based opiate treatment facility (OBOT), to prescribe buprenorphine. Such prescribing must be for FDA-approved medication assisted treatment or recovery and must be directly supervised by a physician who holds an active DEA-X certificate. There are significant restrictions on both the facility and the prescribing providers too numerous to list here. A new section adds restrictions on the type of payment the facility or prescriber may receive, including a provision that reimbursement for buprenorphine treatment be made only through the recipient's MCO. OBOTs offering MAT treatment using buprenorphine should become very familiar with these changes.

PC 761 (SB 1060) Prescribing of Buprenorphine.
Effective July 1, 2020, TCA 53-11-311is amended to allows APRNs and PAs with DEA-X certificates to prescribe buprenorphine under the supervision of a physician with a DEA-X number in community mental health centers, federally qualified health centers, and other enumerated facilities. There are significant restrictions on both the facility and the prescribing providers too numerous to list here.

PUBLIC HEALTH

PC 578 (SB 2007) DMHSAS Contract Authority.
Effective July 1, 2020, TCA § 33-6-103 is amended to authorize the Tennessee Department of Mental Health and Substance abuse Services (DMHSAS) to contract with any licensed community mental health agency for the provision of services under the behavioral health safety net, as long as the community mental health agency provides all of the behavioral health services that are included within adult behavioral health services for the seriously and persistently mentally ill.

PC 529 (SB 9) Smoking on Playgrounds.
Effective April 7, 2020, TCA § 39-17-1551 is amended to authorize a local government to prohibit smoking on playgrounds if it adopts a resolution or ordinance approved by a two-thirds (2/3) vote.

PC 679 (SB 1733) Maternal Mortality Review and Prevention Team.
Requires this team, created by TCA § 68-3-607, to report their recommendations to promote the safety of women and prevention of maternal deaths on an annual basis. The law previously required biennial reports. Effective June 15, 2020.

PC 732 (SB 2202) Smoking paraphernalia.

Effective January 1, 2021, various provisions of the criminal code are amended relative to smoking paraphernalia. The minimum age to purchase tobacco products is raised from 18 to 21 years old to reflect the change in federal law. It requires any person under 21 years of age who directly or indirectly purchases smoking paraphernalia or attempts to purchase smoking paraphernalia using a fake ID to be subject to the jurisdiction of the appropriate general sessions court rather than to juvenile court. It also requires anyone who sells tobacco, smoking hemp, or vaping products at retail to post warning signage.

PC 747 (SB 2552) Providers of Medication Assisted Treatment
No later than January 1, 2021, the departments of health and mental health and substance abuse services, and the bureau of TennCare are required to develop educational materials for providers and facilities at which medication assisted treatment (MAT) is prescribed or provided. The educational materials shall include the following: (1) Access to and availability of family planning services and contraception; (2) Risks and effects of neonatal abstinence syndrome; and (3) Approaches to client-centered counseling. Amends Title 53, Chapter 11, Part 3.

SCOPE OF PRACTICE AND LICENSURE

Scope of Practice

(See buprenorphine prescribing bills under *Prescribing* section above).

PC 790 (SB 1960) Physical Therapy
The new law amends several sections of the physical therapy practice act. It deletes the definitions of "electrodiagnostic tests and measures", "electrophysiologic tests and measures", and testing. It also clarifies that a licensed physical therapist may conduct an initial patient visit, rather than an initial evaluation, without a referral. "Appropriate healthcare practitioner" is substituted for "physician" with regard to healthcare professionals to whom physical therapists must refer patients to, or consult under certain circumstances. An applicant for licensure who does not pass the examination after the first attempt may retake the examination one additional time without reapplication for licensure up to a total of six attempts. Applications will remain active for 12 months. After 12 months, applicants must submit a new application with all applicable fees. It replaces the present requirement that a person must be a graduate of a professional physical therapy education program accredited by an accreditation agency approved by the board of physical therapy. A person may now be a graduate of a professional physical therapy program accredited by a national accreditation agency recognized by the United States department of education and by the board. Finally, the new law deletes the authorization for the board of physical therapy to discipline a licensee for participating in underutilization or overutilization of physical therapy services for personal or institutional financial gain.

Licensure

PC 594 (SB 2169) Summary Suspension of License.
This was an administration bill seeking to make it even easier for a state regulatory board to summarily suspend the professional licenses of health care providers. It amends TCA §§ 4-5-320, 63-1-120, and 63-1-139. An amendment to TCA § 4-5-320 changes "summary suspension" to "summary action". TCA § 63-1-120 is amended to increase the applicability of the statute to all of the health-related boards. That means that the boards added to the statute have authority to discipline in their practice acts and pursuant to TCA § 63-1-120. TCA § 63-1-139 currently requires that each board notify applicants for license and licensees "of changes in state law that impact the holder and are implemented or enforced by the entity, including newly promulgated or amended statutes, rules, policies and guidelines, upon the issuance and upon each renewal of the holder's license, certification or registration." The amendment specifies that a

board can comply with the statute by posting the change on its website 30 days before effect and for two years thereafter. This change is due to the Department of Health losing the *Sparks* case in the Court of Appeals for failure to make the licensee aware of a change in law for which she was disciplined by her licensing board. This should curtail the instances of health professional licensees disciplined by their licensing boards for unwritten rules.

(See physical therapy bill under *Scope of Practice* section above).

TENNCARE

PC 658 (SB 1469) Ground Ambulance Reimbursement.
A new section is added to the TennCare law at Title 71, Chapter 5, Part 1. TennCare MCOs are required to reimburse participating ambulance service providers for covered services to TennCare enrollees at a rate not less than sixty-seven and one-half percent (67.5%) of Medicare allowable charges. Defines "ambulance service provider." It specifies that the section does not affect the Ground Ambulance Service Provider Assessment Act under part 15 of chapter 5 and further provides that funds under this section and part 15 of chapter 5 may not be used to fund the other. Effective April 3, 2020. See also PC 643.

PC 643 (SB 2078) Ground Ambulance Assessment.
Effective April 1, 2020, there are amendments to Title 71, Chapter 5, Part 15, regarding the TennCare ground ambulance assessment. Section 1504 is amended as to how the assessment is calculated if quarterly transport data is not adequate or available. A new section 1507 is inserted which outlines the required contents of the annual cost and utilization report. There is a mandatory $100 per day penalty for late filing the report. See also PC 658.

PC 644 (SB 2123) Nursing Home Assessment Trust Fund.
Extends the annual nursing home assessment fee effective July 1, 2020.

PC 642 (SB 2022) Annual Hospital Assessment.
Renews the Annual Coverage Assessment Act of 2020, which establishes an annual coverage assessment on hospitals of 4.52 percent of a covered hospital's annual coverage assessment base.

PC 626 (SB 1592) Federal Receipts Report.
This adds the TennCare Bureau to the list of state agencies required to file annual reports, pursuant to TCA § 9-1-111, of the aggregate value of federal receipts the designated state agency received and the aggregate amount of federal funds appropriated by the general assembly to the designated state agency. Effective March 19, 2020.

PC 750 (SB 2775) Intervention by Nursing Facilities to Determine Resident TennCare Eligibility
PC 750, effective June 22, 2020, amends TCA § 71-5-1424 to allow a facility to participate in any proceeding and hearing that appeals an initial determination that the individual is not financially or medically eligible. This is done through the filing of a motion to intervene in that proceeding pursuant to § 4-5-310. The administrative judge or hearing officer shall grant a facility's motion to intervene in the appeal of a resident or former resident's eligibility, absent a showing by one or more parties to the appeal that the facility's participation would cause that party to incur an undue burden or unnecessary expense.

PC 775 (SB 2585) TennCare Eligibility
Known as “Cooper’s Law,” TCA § 71-5-118 is added to the TennCare law. It requires a participating provider to strive to process hospital presumptive eligibility applications within the first twenty-four

hours of the patient's admission, when practicable. To the extent a participating provider fails to adhere to this standard, the bureau of TennCare may take remedial steps as allowed by federal law.

Workers' compensation

PC 731 (SB 2190) Increased Benefits
The new law amends several provisions of the workers' compensation law. It extends the filing time for an employee to submit a claim for benefit determination to one year after the 180 day period the employee reaches maximum medical improvement if it is later than one year after the injury is healed. It decreases the impairment rating required for an employee to be eligible for increased benefits from ten percent to nine percent. It increases the time an employee is required to report an injury and the failure by an employer to provide compensation to the bureau of workers' compensation from 60 to 180 days post injury. Finally, it removes the requirement of the court of workers' compensation claims to convene when an employee files a claim for workers' compensation benefits against their employer. Effective June 22, 2020.

PC 754 (SB 2863) Firefighters Eligible for Workers' Compensation
TCA § 7-51-201 is amended to expands compensation benefits to firefighters employed after July 1, 2019. To qualify, firefighters must obtain a physical medical examination after July 1, 2019. In order to qualify for compensation, it must be demonstrated there is no evidence of Non-Hodgkin's Lymphoma, colon, skin, or multiple myeloma cancer present at the time of the examination. Effective June 22, 2020.

EXPECTED HEALTH CARE LEGISLATIVE ISSUES FOR 2021

- Balance billing
- APRN/PA independent practice
- APRNs/PAs prescribing buprenorphine in additional settings
- APRN/PA workers' comp
- Medical marijuana
- Motorcycle helmet repeal
- Optometrists performing laser procedures
- Repeal of rest of the professional privilege tax
- Budget for state pandemic PPE and equipment arsenal
- Role for unmatched med school grads
- Corporate practice of medicine

Tennessee State Case Law Update

Presenters' Notes on Case Law Update: The cases on which your panel expects to discuss during the presentation are highlighted in order to assist you in locating the case we are discussing during the presentation. Our plan is to present the cases in order of appearance in these materials. As always, feedback on these course materials is welcome, Yarnell.beatty@tnmed.org .

I. Health Care Liability

1. *Clarissa Bidwell et al. v. Timothy Strait, MD, et al.,* No. E2018-02211-COA-R3-CV. Filed September 18, 2018.

➢ *Addition of parties not receiving pre-suit notice*

The following timeline is important for an understanding of the case.

- March 28, 2016 – Event allegedly triggering health care liability.
- March 24, 2017 – Plaintiff provides pre-suit notice to potential physician defendants whose address of record is a private employer medical practice. In fact, physicians were employed by Erlanger at all times relevant, a governmental entity. Erlanger did not receive pre-suit notice.
- July 24, 2017 – Plaintiff filed complaint against various physician defendants.
- July – September 2017 – Defendants file answers to Plaintiff's complaint. They raise comparative fault and, for the first time, identify governmental entity, Erlanger, as their proper employer for the relevant time period.
- October 19, 2017 – First of motions for summary judgments filed. They argued that since Erlanger was not included as a party to the lawsuit, TCA § 29-20-310(b) prevented a judgement to be rendered against the physicians.
- November 3, 2017 – Plaintiff filed a motion for leave to amend the complaint on the basis that Defendant did not comply with TCA § 29-26-121(a)(5) requiring them to register their current addresses which would have revealed their employer to be a governmental entity.
- September 25, 2018 - The trial court granted the motions holding that Erlanger was a necessary defendant under the GTLA (TCA § 29-20-310(b)) but the failure to provide pre-suit notice to Erlanger meant that it could not add it as a party.

On appeal, the issue for the Tennessee Court of Appeals was, "What is the result when a recipient of pre-suit notice fails to comply with § 29-26-121(a)(5), and then requests the dismissal of a matter based upon a claimant's failure to add a necessary party that was known to be the recipient of pre-suit notice and should have been identified to claimant following receipt of pre-suit notice and prior to the claimant filing the complaint, pursuant to § 29-26-121(a)(5)?" The Court of Appeals was not sympathetic to Defendants who waited to disclose that their actual employer was a governmental entity.

TCA § 29-26-121(a)(5) requires a recipient of pre-suit notice to provide the claimant with written notice of any other party who may be a properly named defendant. The physicians did not do this until their answers to the complaint. In addition, they placed comparative fault at issue in the case and did not correctly identify their employers. Per TCA § 29-26-121(c), pre-suit notice takes a "backseat" to comparative fault. "If a recipient does not identify a potential defendant, and then alleges the fault of that non-party or attempts to dismiss the complaint or receive summary judgment based on the non-party's absence, it is logical that the plaintiffs should be permitted to add that party based upon the concepts of

fairness and efficiency at the core of comparative fault." Thus, the statute of limitations was allowed tobe extended 90 days and the trial court's dismissal was vacated.

2. *Teresa M. Daffron, as Daughter…. v. Memorial Healthcare System, Inc.* No. E2018-02199-COA-CV. Filed October 7, 2019.

- Statute of limitations
- Discovery rule

The following timeline is important for an understanding of the case.

- November 2011 – Decedent began living with Plaintiff daughter so she could manage his health issues. Plaintiff was aware of Decedent's susceptibility to bed sores.
- November 1, 2013 – Decedent was admitted to Defendant facility.
- November 11, 2013 – Plaintiff observed severe pressure sores on Decedent's buttocks after being advised by a nurse that the wounds needed to be cleaned.
- December 2013 – Plaintiff is advised by the same nurse that Plaintiff should look into the care of Decedent regarding the sores.
- February 2014 – Plaintiff, through her counsel, requested Decedent's medical records from Defendant.
- April 28, 2014 – Decedent dies allegedly due to Defendant's negligent care.
- March 2015 – Plaintiff was advised by her expert physician that Defendant was negligent in its care of Decedent.
- April 21, 2015 – Plaintiff sent pre-suit notice to Defendant.
- August 24, 2015 – Plaintiff sued Defendant for health care liability for alleged negligent care of Decedent.
- July 2018 – Defendant filed a motion for summary judgement because the lawsuit was filed outside of the statute of limitations.
- November 2018 – Trial court granted Defendant's motion for summary judgement.

Plaintiff timely appealed and the issue for the Court of Appeals was whether the trial court erred in granting summary judgment in favor of Defendant on the grounds that Plaintiff knew, or should have known, of Decedent's cause of action more than a year prior to sending pre-suit notice. Plaintiff argued that the discovery rule applied to the timing of her lawsuit. She asserted that she did not know the identity of the entity responsible until March 2015 when her expert rendered his opinion. The discovery rule means a cause of action does not accrue until one discovers, or in the exercise of reasonable diligence should have discovered both that 1) he has been injured by tortious conduct and 2) the identity of the person or entity whose act caused the negligence.

The Court of Appeals held that either by December 2013 at her encounter with the nurse, or in March 2014 when she obtained medical records, Plaintiff had constructive, if not actual, notice of her father's claim against Defendant. This notice was more than one year before pre-suit notice was sent. One does not have to have all of the facts in order to have notice of a claim.

3. *Angela Dotson v. State of Tennessee,* No. E2019-00325-COA-R9-CV. Filed December 3, 2019.

- Certificate of good faith
- Statute of limitations

Plaintiff filed a claim for damages against the state in the Division of Claims Administration arising from the death of her baby on June 2, 2016, following delivery complications. Defendant in the claim was a medical resident who was a state employee. Other non-state employee defendants were sued in a separate action filed in Washington County Court. The claim was transferred to the Claims Commission which informed Plaintiff on September 6, 2017 that she must file a complaint with the Commission within thirty days. Plaintiff filed the complaint on October 6, 2017. The certificate of good faith filed in the Claims Committee action contained the caption of the Washington County case and did not mention the resident Defendant. The state filed a motion to dismiss because the certificate of good faith did not meet the requirements of TCA § 29-26-122 because it did not identify the resident. The Claims Commission denied the motion, finding the statutory requirements were not met but paragraph 22 of the complaint tracked the statute and the resident was referred to in the body of the complaint. The Claims Commission held that a claim reaches the Commission with the filing of a notice of claim rather than a formal complaint. Thus, with the addition of the 120 days because of the filing of pre-suit notice, the statute of limitations did not run. The state appealed.

The issue on appeal was whether a separate document was required to be filed in order for Plaintiff to comply with the certificate of good faith statute rather than just including the statement within the complaint. The Court of Appeals held that the plain language of the statute required that a separate document be filed and, therefore, Plaintiff was not in compliance. First, the statute states that the certificate of good faith be filed "with the complaint." Second, the statute instructs the administrative office of the courts to create a form. Thus, the Commission's ruling was reversed; the motion to dismiss should have been granted.

4. *Jennifer Moore-Pitts et al v. Carl A. Bradley, DDS, MAGD,* No. E2018-01729-COA-R3-CV. Filed December 9, 2019.

- Pre-suit notice
- HIPAA compliant authorization
- Statute of limitations

Plaintiff was allegedly injured due to complications of a dental procedure on January 13, 2017. She provided Defendant pre-suit notice on January 5, 2018 that left blank the name of the person or entity authorized to provide records to Defendant. Forty potential defendants received notice. In May 2018, one year and 118 days after the procedure, Plaintiff filed a health care liability action against Defendant. Defendant filed a motion to dismiss arguing the authorization filed with the pre-suit notice was defective because it did not permit Defendant to obtain medical records from other potential defendants. The trial court granted the motion and Plaintiff appealed.

The case turned on the sufficiency of the HIPAA authorization because Plaintiff relied on the 120-day extension of the statute of limitations afforded to her by the pre-suit notice statute. In affirming the trial court, the Court of Appeals relied on the *JAC* and *Lawson* decisions. Those cases involved blanks left in HIPAA authorization forms submitted by plaintiffs. Defendant was prejudiced by the noncompliant form because he could not obtain the medical records from the other providers who received pre-suit notice. The Court of Appeals also rejected Plaintiff's reliance on *Bray.* In that case, the Tennessee Supreme Court held that a HIPAA-compliant authorization is not required when a plaintiff sends pre-suit notice to one provider. Plaintiff could not rely on *Bray* because, although only one defendant was sued, forty potential defendants received pre-suit notice. With so many providers receiving pre-suit notice, Defendant had no way to know at the time of pre-suit notice, that Plaintiff would only sue him. Because of the deficiency and inability to show extraordinary cause, Plaintiff could not rely on the 120-day extension of the statute of limitations.

5. *Hallysay Ibsen as Administrator of the Estate of … v. Summitview of Farragut, LLC, et al.,* No. E2018-01249-COA-R3-CV. Filed December 11, 2019.

- Ex parte interview
- Qualified protective order
- Collateral order doctrine

The trial court issued an order granting Defendants a qualified protective order to conduct ex parte interviews with Plaintiff's treating health care providers on September 19, 2017. At the hearing granting the motion, the trial judge instructed the parties that Plaintiff could contact the providers and let them know participation in the interviews was voluntary but could not direct the providers not to participate. Plaintiffs sent letters to the providers to the effect that by participating in the interviews they would violate HIPAA. Defendants moved for, and were granted by order dated January 3, 2018, sanctions against Plaintiff directing Plaintiff to retract the letters and pay Defendants' costs of preparing for the motion and hearing. Plaintiff appealed the sanctions pursuant to Tenn. R. App. P. 3.

On appeal, the Court of Appeals focused on the January 3, 2018 order granting sanctions. Orders appealed pursuant to Rule 3 must be final orders, orders that resolve all of a party's claims, leaving nothing else for the trial court to adjudicate. The January 3, 2018 order did not resolve all of Plaintiff's claims; it was a contempt order regarding discovery rights. Informal ex parte interviews pertain to discovery. The order also did not impose criminal sanctions. Instead, the order required retraction and payment of a monetary fine, not imprisonment. The Court of Appeals also rejected Plaintiff's argument that the appeal was proper based on the collateral order doctrine whereby the award of sanctions separate from the merits of the underlying case is a final order. Cases interpreting that doctrine are limited to federal civil rights cases. Therefore, since the order was not a final order as it applies to Rule 3, the appeal was dismissed with the notation that Rule 10 should have been the basis.

6. *Debra Lovelace et al v. Baptist Memorial Hospital-Memphis,* No. W2019-00453-COA-R3-CV. Filed January 16, 2020.

- Waiver of argument on appeal

This involved a health care liability case wherein summary judgment was granted for Defendant hospital by the trial court. The trial court provided two independent reasons for the grant of Defendant's motion, 1) that there was no causation testimony from Plaintiff's only identified expert and 2) that the expert, a registered nurse, was not competent to testify.

On appeal, the Court of Appeals determined that through its filings, Plaintiff only raised one issue on appeal, the competence of the expert and failed to adequately raise the second issue, causation. Since causation was not adequately raised on appeal, by law, it was waived. Since it was waived, Plaintiff failed to demonstrate proof of an underlying element of the alleged cause of action – causation. Thus, the Court of Appeals affirmed summary judgment for Defendant. The Opinion noted that Plaintiff's arguments in its brief contained no citations to relevant authority or portions of the record constituting expert proof of causation.

7. *Bonnie Harmon, et al. v. Hickman Community Healthcare Services, Inc.,* No. M2016-02374-SC-R11-CV. Filed January 28, 2020.

- Summary judgment
- Standard of review for abuse of discretion

Plaintiff filed a health care liability suit against Defendant, the entity that staffed the facility in which Plaintiff was incarcerated when she alleged injuries that caused her death. The parties filed cross motions for summary judgment on the grounds of standard of care and causation. As to causation, Defendant argued Plaintiff's expert was not competent to testify as to causation. The trial court granted Defendant's motion, holding Plaintiff's sole expert on causation, Dr. Wagner, was inadmissible so there was no genuine issue of fact shown on that issue. Plaintiff then submitted a motion to alter or amend. The motion was supported by an affidavit from a different expert, Dr. Sperry, and indicated that Plaintiff had not been able to secure Dr. Sperry before the hearing. The trial court denied the motion to alter or amend. It based its decision on the criteria enumerated in *Stovall v. Clarke* for resolving motions to alter or amend.

The Court of Appeals reversed, holding the trial court abused its discretion. It too evaluated the case based on the *Stovall v. Clarke* criteria but reached the opposite conclusion.

The Tennessee Supreme Court granted permission to appeal. On appeal, Plaintiff argued that Wagner was competent to testify on causation. Plaintiff was on notice her expert's competency was being challenged by October 2015. The matter was argued on November 2, 2015 but it was five months before the court's order was entered. According to Dr. Sperry, he was consulted in June 2013. He was contacted by Plaintiff by email on two occasions in October 2015 but he did not respond because he was out with a back injury. However, Plaintiff did not seek relief under Rule 56.07 for an extension of time. Plaintiff did not request a continuance of the November 2, 2015 hearing.

A motion to alter or amend may only be reversed for an abuse of discretion. The standard was set out in *Lee Med., Inc. v. Beecher.* Using its three criteria, the Supreme Court reversed the Court of Appeals and affirmed the trial court. According to the Court, the third *Lee Med.* criterion, whether the motion was within the range of acceptable alternative dispositions, was the real issue in the case. Based on the factors articulated by the trial court, denial of the motion was not an abuse of discretion. It was reasonable for the court to find that Plaintiff had not made strong efforts to timely secure Dr. Sperry.

8. *Trina Petty as Administrator of the Estate of Ida Mae Ewing v. Robert Burns MD D/B/A Robert Burns MD,* No. W2019-00625-COA-R3-CV. Filed March 5, 2020.

- Pre-suit notice

This case involved the sufficiency of the pre-suit notice sent in a health care liability case. It is undisputed that pre-suit notice was sent to "Robert Burns, MD." The lawsuit was filed against "Robert Burns, MD, PC, d/b/a Robert Burns, MD." Dr. Burns and Robert Burns, MD, PC filed a motion for summary judgement alleging that Plaintiff failed to provide pre-suit notice to Robert Burns, MD. The trial court granted the motion finding that the pre-suit notice letter did not allege that it was being sent to "Robert Burns, MD" as the registered agent for service of process for the corporation, Robert Burns, MD, PC nor did it allege that any agent or employee of "Robert Burns, MD, PC" was a responsible party and thus, the corporation could not have been placed on notice. Plaintiff failed to strictly comply with the pre-suit notice statute so summary judgement was granted because there was no evidence that Dr. Burns was served as the agent for the corporation. Plaintiff appealed, asserting that the pre-suit notice was sufficient to place the corporation on notice of a claim because Dr. Burns actually was the agent for the corporation.

Relying on *Shockley v. Mental Health Cooperative, Inc.* and *Runions v. Jackson-Madison County General Hospital District,* the Court of Appeals affirmed the trial court's grant of summary judgment.

Those decisions held that the language of the statute is clear that each defendant sued must receive pre-suit notice and that the inquiry for compliance is not whether the defendant knew of the lawsuit by service of notice on another potential defendant. Since pre-suit notice was sent to the individual physician rather than the actual corporate defendant, strict compliance was not adhered to and Defendant was entitled to summary judgement.

9. ***Amy Angell Tucker, et al v. Sandra Jackson Iveson et al,*** No. M2018-01501-COA-R3-CV. Filed March 11, 2020.

- Statute of repose
- Fraudulent concealment

This case involved a challenge by Plaintiff of the grant by the trial court to Defendants physician and medical practice of motions to dismiss (converted to motions for summary judgement) in a health care liability case. On December 24, 2009, Plaintiff received a prescription for antibiotics and a steroid from a nurse practitioner who never personally examined Plaintiff. Defendant nurse never told Plaintiff that one potential side-effect of the medication prescribed was tendonitis and that the risk increased if taken with steroids. Plaintiff developed painful tendonitis in her arm and shoulder. Plaintiff was told on January 25, 2010 by a physician that the most likely cause of the injury was the combination of medications prescribed by the nurse practitioner. Plaintiff filed suit on January 24, 2011. Due to incorrect information on the Board of Nursing's webpage, Plaintiff sued another defendant believing him to be Defendant nurse's supervising physician. Her actual supervising physician was Dr. Newman but Dr. Newman was not amended in as a defendant until January 17, 2013. Plaintiff conceded that the statute of limitations had run on her claim against Newman. However, she asserted she was entitled to a 90-day extension afforded by § TCA 20-1-119(a)(1). The theory of recovery against Dr. Newman and his practice was negligent hiring and supervision. The trial court granted summary judgment based on the running of the statute of limitations. Plaintiff appealed.

Plaintiff asserted that negligent hiring and supervision claims are not governed by the Health care Liability Act. The Court of Appeals concluded that the claims were substantially related to medical treatment or expertise and a duty to ensure patients receive quality care from competent clinicians. Since the Act applied, the Court reviewed the case in light of the three-year statute of repose because the cause of action arose on December 24, 2009 when the prescriptions were issued. Plaintiff did not add Defendant Newman until more than three years from accrual so he was joined after the statute of repose had run.

The Court of Appeals rejected an argument that Defendant had fraudulently concealed the injury, an exception to the statute of repose. The Court determined that the third element of the requirements for fraudulent concealment was not met – Plaintiff provided no proof that Defendants knew of the facts giving rise to the cause of action. Defendant nurse never informed Dr. Newman or the practice that she had written the prescriptions to Plaintiff. Neither defendant was aware of the case until served with process in 2013. Thus, there was no liability to conceal. Finding fraudulent concealment inapplicable, the Court of Appeals affirmed the trial court's grant of summary judgment.

10. *Ricky Lee Johnson v. Knoxville HMA Cardiology PPM, LLC D/B/A East Tennessee Heart Consultants, Inc., D/B/A Tennova Health-North et al,* No. E2019-00818-COV-R3-CV. Filed March 24, 2020.

- Pre-suit notice
- Sounding in negligence or health care liability

On February 6, 2018, Plaintiff was injured from falling off of an exam table in Defendant physician's office after suffering a fainting spell. He sued Defendants on January 7, 2019. Several theories of recovery were alleged including creating a hazardous condition by failure to provide an exam table with railings or protection on walls and floors to prevent injuries. Defendants were aware of Plaintiff's history of dizzy spells. Defendants filed motions to dismiss because Plaintiff failed to provide pre-suit notice as required by the THCLA. Plaintiff asserted the case was a simple premises liability case that did not require pre-suit notice. The trial judge ruled for Defendants and dismissed the case with prejudice, finding it was a health care liability action. Plaintiff appealed.

The only question for the Court of Appeals was whether the THCLA applied. The Court agreed with the trial judge. Plaintiff argued that he did not allege that he was receiving medical services at the time of the fall; the exam had ended and the appointment was over. The Court found that receiving medical services was the only reasonable inference from the allegations in the complaint. The case at bar was similar to the facts in *Osunde v. Delta Medical Center.* There, a patient was injured from a fall off a stool after an x-ray. The stool in *Osunde* was comparable to the table in this case. Providing an exam table was a "health care service" as defined in the Act and Plaintiff did not specifically have to plead he was receiving health care services to come under the Act. His positioning on the table was "related to the provision of health care services." Thus, the Court of Appeals affirmed the trial court but modified the order to dismiss without prejudice.

11. ***Charles Huddleston Heaton, Jr., et al v. Catherine L. Mathes et al,*** No. E2019-00493-COA-R9-CV. Filed April 3, 2020.

- Sounding in product liability or health care liability
- Seller shield defense availability in health care liability cases

Plaintiffs filed a lawsuit against several defendants alleging that they had been damaged as a result of a traumatic brain injury caused by Plaintiff's use of the prescription medication, Victoza, in 2014. The suit pled medical providers' failure to appropriately "prescribe, counsel, provide, utilize, and/or discontinue this medication." The theories of recovery were strict liability and simple negligence against Victoza's manufacturer, Novo-Nordisk, Inc., and health care liability claims against the remaining defendants, including the physician prescriber of the drug, as well as the out-of-state, mail-order pharmacies and a pharmacist who filled them: CHDP; Tel-Drug, Inc.; Tel-Drug of Pennsylvania, LLC; and pharmacist Dessender (collectively, "the CHDP Defendants"). Evidence showed that the Food and Drug Administration issued a Risk Evaluation and Mitigation Strategy ("REMS") for Victoza to warn of the risk of acute pancreatitis with the medication's use. Plaintiff asserted that he was not informed of this risk by any of the Defendants.

In 2017, the CHDP Defendants filed a motion to dismiss based on the seller shield defense, TCA § 29-28-106 of the Tennessee Products Liability Act ("TPLA"). This provides that a products liability action cannot be maintained against a product's seller, other than the manufacturer, except in certain enumerated circumstances. The CHDP Defendants took the position this statute shielded pharmacists from liability. They argued that the complaint mislabeled the alleged claims against the CHDP Defendants as health care liability claims when the case against the CHDP Defendants sounds in products liability. Defendants further claimed that the TPLA applies to failure-to-warn claims against pharmacists as sellers of drugs and, therefore, the claim should be dismissed based upon Tennessee Code Annotated § 29-28-106 because the CHDP Defendants were merely sellers and not the product's manufacturer. Finally, the CHDP Defendants argued that they had no duty to provide warnings to Plaintiff other than those provided by the manufacturer and that the complaint therefore did not state a health care liability action against the CHDP Defendants. The trial court denied the motion to dismiss relying on the case of *In re New England*

Compounding Pharmacy, Inc. Prods. Liab. Litig., and determined that the seller shield statute contained within the TPLA would not shield the CHDP Defendants from a THCLA claim and that the case should proceed as a health care liability case. Defendants were granted an interlocutory appeal.

The issue for the Tennessee Court of Appeals was whether the seller shield defense, codified at Tennessee Code Annotated § 29-28-106, should be applied to bar a claim under the THCLA. The Court held that the seller shield defense found in the Tennessee Products Liability Act is inapplicable to claims made under the THCLA. Cases have held that a pharmacist is a professional who has a duty to his customer to exercise the standard of care required by the pharmacy profession in the same or similar communities as the community in which he practices his profession, similar to the standard applicable to all medical professionals in health care liability actions. Pharmacists are subject to the THCLA. The THCLA statute and cases interpreting it emphasize that the THCLA applies to "all civil actions alleging that a covered health care provider or providers have caused an injury related to the provision of, or failure to provide health care services." The Court of Appeals relied heavily on the *New England Compounding* case where a similar conflict was addressed and it was determined that the case sounded in health care liability. TCA § 1-3-103 provides that "[i]f provisions of different titles or chapters of the code appear to contravene each other, the provisions of each title or chapter shall prevail as to all matters and questions growing out of the subject matter of that title or chapter." The plain language of TCA § 29-28-106 demonstrates that it only applies to product liability actions. The Court commented that "the CHDP Defendants' attempts to utilize the TPLA's seller shield defense to immunize themselves from liability for a claim filed pursuant to the THCLA would be akin to an attempt by a defendant in a product liability action to defend on the basis of lack of pre-suit notice, which is a defense only to a claim under the THCLA. Because the complaint states a cause of action pursuant to the THCLA, the provisions of that statute '"shall prevail as to all matters and questions growing out of the subject matter of that title or chapter."'

12. *Jessica Owens, et al. v. Gary W. Stephens, D. O., et al*., No. E2018-01564-COA-R3-CV. Filed April 16, 2020.

- Pre-suit notice
- Single parent subsidiary

This was a health care liability case in which the central issue was the sufficiency of the pre-suit notice sent by Plaintiffs. Defendants filed a motion to dismiss asserting that the HIPAA authorization form accompanying the notice only authorized the release of the mother's medical records to her own lawyer. Defendants took the position that the forms prejudiced them because they could not access and review the medical records from each of the 44 other providers being sent pre-suit notice to evaluate their case. As a result, Plaintiffs should not be able to avail themselves of the extension of the statute of limitations. Thus, the case was time barred. The trial judge dismissed the case, finding that 45 C.F.R. §§ 164.501, .502, and .506 do not permit providers to disclose medical records to other providers absent a valid HIPAA authorization and, because there was no valid HIPAA authorization permitting Defendants to obtain records from all other providers receiving notice, Defendants were prejudiced. Plaintiffs appealed.

The Court of Appeals relied on *Lawson v. Knoxville Dermatology, PC* which addressed the effect of a plaintiff's failure to identify the party authorized to disclose records on the required medical authorizations. It agreed with the trial court that Defendants were prejudiced since the authorizations were not sufficient to allow Defendants to obtain needed medical records from other providers noticed. The Court specifically rejected Plaintiffs' argument that all Defendants were part of the same parent organization. The primary case relied upon by Plaintiffs held that a HIPAA-compliant medical authorization is not required when a plaintiff sends pre-suit notice to only one provider, not when he or she ultimately files suit against only one provider. Plaintiffs sent pre-suit notice to several medical

providers. Defendants were not a "single provider"; each held individual licenses from the appropriate boards, and each provider's medical documents related only their care for the decedent. The trial court was affirmed.

13. *Vickie S. Young, Individually and as Administrator of the Estate of Randall Josh Young, Deceased v. Frist Cardiology, PLLC et al.* No. M2019-00316-SC-R11-CV. Filed April 20, 2020.

- Contiguous state rule

A health care liability case was filed following the death of Decedent following a cryoablation procedure performed by Defendant physician. After the parties' expert witnesses had been identified, Defendants moved for summary judgement on the basis that Plaintiff failed to comply with TCA § 29-26-115(a)-(b) in that the expert did not have a medical license in Tennessee or a contiguous state during the year before Decedent's heart procedure, as required by TCA § 29-26-115(b). Defendants also moved to exclude the testimony of the disputed expert. Plaintiffs countered that the Tennessee Board of Medical Examiners had granted their expert an exemption that allowed him to practice medicine without a medical license during his fellowship at Vanderbilt University. Therefore, the requirements of Section 29-26-115(b) apply only "if one is required to have a license."

The trial court denied the Defendants' motion for summary judgment and ruled that Plaintiff's expert could testify, finding that under section 29-26-115(b), an expert witness must have a license only if the expert practices in a health care profession requiring licensure in Tennessee. Because Plaintiff's expert was exempt from the licensure requirement during his fellowship at Vanderbilt, the trial court concluded that he was not practicing in a health care profession requiring licensure in Tennessee. The trial court granted the Defendants' motion for interlocutory appeal. The Court of Appeals denied the Defendants' application for interlocutory appeal.

The Tennessee Supreme Court took up the case in order to interpret the statutory provision. The facts were undisputed. The expert in question was not licensed to practice medicine in Tennessee or a contiguous bordering state during the year before the alleged injury or wrongful act. Further, he was exempt from the licensure requirement during his fellowship at Vanderbilt under Tennessee Code Annotated section 63-6-207(d)(2)(A)(i) (2017 & Supp. 2019), which exempts "medical students, interns, residents, and clinical fellows" from the requirement to have a license to practice medicine when they are participating in a training program at an accredited medical school or affiliated teaching hospital in Tennessee under the supervision of a licensed physician. The Court examined the meaning of the introductory language of section 29-26-115(b): "No person in a health care profession requiring licensure under the laws of this state . . . .".

> The phrase "requiring licensure under the laws of this state" modifies the term "health care profession" that immediately precedes it in the sentence, not "person" that comes earlier in the sentence. Thus, the statute refers to a profession that requires licensure, not to the person requiring licensure. The practice of medicine is a "profession requiring licensure under the laws of this state." See Tenn. Code Ann. § 63-6-201(a) (2017). In short, a person who practices medicine may be competent to testify as an expert witness if that person meets the license and practice requirements of section 29-26-115(b). A licensure exemption for a person who practices medicine does not eliminate the license requirement in section 29-26-115(b).

Finding to the contrary would make the licensure requirement of section 29-26-115(b) "inoperative, superfluous, void or insignificant," the Court wrote. The Court reversed the trial court holding the clear

and unambiguous language of Tennessee Code Annotated section 29-26-115(b), Plaintiff's expert, who was permitted to practice medicine in Tennessee under a statutory license exemption but was not licensed to practice medicine in Tennessee or a contiguous state in the year before the alleged injury or wrongful act, was not qualified to testify as an expert witness.

14. *Josh Cathey v. William Beyer et al.* No. W2019-01603-COA-R3-CV. Filed April 24, 2020.

- Sounding in health care liability

On April 8, 2019, Plaintiff, acting pro se, filed a complaint against Nancy Plunk, a licensed professional counselor, and William Beyer, a licensed senior psychological examiner-health service provider and licensed professional counselor, alleging that Defendants falsified and concealed the counseling records of Plaintiff's minor children whom they treated. Theories of recovery included claims of: (1) falsifying healthcare records; (2) fraudulent concealment; (3) spoliation of evidence; (4) defamation of character; and (5) intentional infliction of emotional distress. Defendants filed a motion to dismiss or, in the alternative, for summary judgment asserting that Plaintiff's causes of action sounded in health care liability and subject to the pre-suit notice requirements of the THCLA, TCA § 29-26-101 et seq. The trial judge granted the motion finding the case sounded in health care liability and that Plaintiff failed to file pre-suit notice or comply with the certificate of good faith requirement. Plaintiff appealed.

On appeal, Plaintiff conceded that Defendants were health care providers. The question for the Court of Appeals was whether the alleged injuries related to the provision of health care *services*. Looking at the complaint, all of Plaintiff's claims originate from Defendants' alleged fraudulent creation and/or alteration of the children's counseling records. Specifically, Plaintiff alleged that the records showed that Defendants "intentionally falsified" some if not all of the healthcare records of the minor children, and concealed the falsifications "by failing to use transparent healthcare editing techniques." Plaintiff countered that the injuries resulting from Defendants' alteration of the children's records arose after the completion of health care services, therefore his claims are not sufficiently related to the underlying counseling services so as to qualify as a health care liability action. In upholding the trial court, the Court of Appeals reasoned that the resulting contents of health care records are generated as a direct consequence of the counseling services and constitute an aspect of a patient's care. It relied on the holding in *Ellithorpe* wherein the plaintiff suffered emotional distress after the health care service ended but the Supreme Court found it related to the service. In this case, all causes of action arose as a result of Defendants' treatment of the counseling records. Thus the case sounded in health care liability. Since Plaintiff did not file pre-suit notice, the case was properly dismissed by the trial court.

15. *Melissa Martin et al v. Rolling Hills Hospital, LLC et al.* No. M2016-02214-SC-R11-CV. Filed April 29, 2020.

- Pre-suit notice compliance burden of proof
- HIPAA compliant authorization

Survivors filed a health care liability action against several defendants as a result of the death of their daughter during treatment for suicide ideations and drug detoxification. Plaintiffs' pre-suit notice contained several deficiencies. It only included Defendant hospital as another provider receiving notice. There were two medical authorizations with each letter, but Plaintiffs failed to list on any of these four authorizations the name and address of the provider authorized to release medical records. They also left blank the space on the medical authorizations designated for an expiration or event date. Finally, while the decedent's mother signed the medical authorizations in her representative capacity, she failed to provide a description or documentation of her authority to act for the decedent. After some procedural

moves, Plaintiff's ended up filing a second identical lawsuit, relying on the savings statute for timeliness. Defendants filed motions to dismiss based on insufficient authorizations in pre-suit notices and taking the position therefore, that the claim was time barred. The trial court granted the motions finding Plaintiff failed to file HIPAA authorizations, which failure prejudiced Defendants. Therefore, Plaintiffs were not able to rely on the 120-day extension of the statute of limitations. Plaintiffs appealed.

The Court of Appeals reversed. The record showed that letters exchanged between counsel for Defendant physician and Defendant hospital did not "reflect a good faith attempt on the part of Defendants to secure the records," but instead showed "an effort by their counsel to establish a record upon which to present this argument." Defendants failed to show prejudice because Defendant physician was an "employee and/or ostensible agent" of Defendant hospital, and was merely a corporate entity (not Provider/Health Plan) and obviously had no treatment records regarding decedent. Based on its conclusions that the Plaintiffs had substantially complied with Section 121(a)(2) and that the Defendants had failed to show prejudice from the Plaintiffs' noncompliance, the Court of Appeals concluded that the Plaintiffs' first lawsuit was timely filed and that the savings statute applied to their second lawsuit. Defendants appealed.

The Tennessee Supreme Court addressed two questions:

> 1) the proper role of prejudice in the substantial compliance analysis and determination; and
>
> 2) the proper burden of production and/or proof with respect to the presence or absence of prejudice for purposes of the substantial compliance analysis and determination, including whether or not the Court should consider the adoption of a rebuttable presumption of prejudice where the pre-suit notice is not accompanied by a medical authorization which is facially compliant with HIPAA.

With respect to the first question, the Court took the opportunity to clarify the role of prejudice in a court's determination of whether a plaintiff in a health care liability action has substantially complied with Section 121. It reaffirm its earlier holding in *Stevens* and held in this case that prejudice is not a separate and independent analytical element; rather, as *Stevens* explained, prejudice is a consideration relevant to determining whether a plaintiff has substantially complied. If a plaintiff's noncompliance with Section 121 frustrates or interferes with the purposes of Section 121 or prevents the defendant from receiving a benefit Section 121 confers, then the plaintiff likely has not substantially complied with Section 121. If the plaintiff's noncompliance neither frustrates or interferes with the purposes of Section 121 nor prevents a defendant from receiving a benefit the statute confers, then a court is more likely to determine that the plaintiff has substantially complied.

As to the second question, the Court adopted the burden-shifting approach articulated in *Myers v. AMISUB (SFH), Inc.* A health care liability plaintiff bears the initial burden of establishing compliance with Section 121 by stating in the pleadings and providing "the documentation specified in subdivision (a)(2)," or of alleging "extraordinary cause" for any noncompliance. The Court held in this case that a plaintiff bears the initial burden of either attaching documents to her health care liability complaint demonstrating compliance with Section 121 or of alleging facts in the complaint demonstrating extraordinary cause sufficient to excuse any noncompliance with Section 121. A defendant seeking to challenge a plaintiff's compliance with Section 121 must file a Tennessee Rule of Civil Procedure 12.02(6) motion to dismiss for failure to state a claim. A defendant's Rule 12.02(6) motion must include allegations that identify the plaintiff's noncompliance and explain "the extent and significance of the plaintiff's errors and omissions and whether the defendant was prejudiced by the plaintiff's noncompliance." One means of satisfying this burden is to allege that a plaintiff's Section 121(a)(2)(E) medical authorization lacks one or more of the six core elements federal law requires for compliance with

the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Once a defendant files a Rule 12.02 motion that satisfies this prima facie showing, the burden then shifts to the plaintiff either to establish substantial compliance with Section 121—which includes the burden of demonstrating that the noncompliance did not prejudice the defense—or to demonstrate extraordinary cause that excuses any noncompliance.

In this case, Defendants met their burden by showing that Plaintiffs' medical authorizations lacked three of the six core elements federal law requires for HIPAA compliance. This showing shifted the burden to Plaintiffs, and they failed to establish either substantial compliance or extraordinary cause to excuse their noncompliance. As a result of this noncompliance with Section 121(a)(2)(E), Plaintiffs were not entitled to the 120-day extension of the statute of limitations. Therefore, their first lawsuit, filed after the one-year statute of limitations expired, was not "commenced within the time limited by a rule or statute of limitation," Tenn. Code Ann. § 28-1-105(a) (2017), so the plaintiffs cannot rely on the one-year savings statute to establish the timeliness of this lawsuit.

16. *Daniel Eric Cobble v. Erlanger Hospital.* No. E2019-00417-COA-R3-CV. Filed April 30, 2020.

- Pre-suit notice
- Sounding in health care liability
- Statute of repose

A pro se plaintiff sued Hospital alleging Plaintiff was negligently treated for a fever thirty-five years earlier when he was a minor patient there. The improper treatment led to Plaintiff suffering permanent brain damage according to the complaint. Defendant filed a motion to dismiss on the basis Plaintiff did not file pre-suit notice and the claim was barred by the statute of repose. The trial court granted dismissal on those bases. Plaintiff appealed.

The Court of Appeals agreed with the trial court that the claim was a health care liability claim. It stated Defendant Hospital was negligent in failing to treat Plaintiff's high-grade fever while he was a patient under Defendant's care. The Court rejected Plaintiff's argument that informing his father, and the "lead engineer for Erlanger," that he was going to sue was sufficient pre-suit notice. The claim alleged that Defendant was negligent in 1980 at the latest. The healthcare liability statute of repose extinguished Plaintiff's claim at some point in 1982 or 1983, Tenn. Code Ann. § 29-26-116(a)(3), as a matter of law and there was no evidence proffered that fraudulent concealment occurred. Further, the statute of repose is not tolled by minority or mental incompetency. Plaintiff's constitutional challenge to the pre-suit notice requirement was not addressed because he failed to serve notice of the challenge to the Attorney General. The trial court ruling was affirmed.

17. *Tammy Combs et al v. Leslie Milligan, MD, et al.* No. E2019-00485-COA-R3-CV. Filed May 1, 2020.

- HIPAA compliant authorization

In this health care liability case, pre-suit notice was sent by Plaintiffs to eight medical care providers. Some Defendants filed motions to dismiss, challenging compliance with the pre-suit notices. Defendants argued that the HIPAA release did not authorize them to obtain or use the medical records of any of the other noticed providers. Instead, they asserted that the authorization authorized each provider only to disclose and use his own records. Plaintiffs response argued that Paragraph 5 of each authorization stated, "[t]his information may be disclosed to and used by the following individual or organization for the purpose of a legal matter" and listed all the medical providers receiving a notice. Plaintiffs argued that

had Defendants attempted to obtain records, no provider would have been permitted to withhold the records based on the authorization. According to Plaintiffs, Defendants' argument was based merely on the use of the word "disclose" instead of the word "obtain." After lengthy procedural wrangling, the trial court dismissed the suit against remaining defendants.

The pre-suit notice issues for the Court of Appeals were whether Plaintiffs failed to substantially comply with the requirements of Tenn. Code Ann. § 29-26-121(a)(2)(E), which requires the provision to Defendants of a HIPAA compliant medical authorization permitting each medical provider the ability to obtain the medical records from other medical providers receiving a notice. Another issue was whether the trial court erred in dismissing Plaintiffs' complaint for failure to provide a compliant medical authorization despite not finding prejudice to Defendants. The Court of Appeals determined that the wording of the authorization did not prevent the providers from obtaining each other's medical records. Thus, there was substantial compliance. The trial court was reversed and the case could proceed.

18. *Alysia Reese McCracken Hancock v. BJR Enterprises*, *LLC, et al.* No. E2019-01158-COA-R3-CV. Filed May 14, 2020.

- Pre-suit notice
- HIPAA compliant authorization

This is another health care liability case in which the plaintiff submitted a HIPAA authorization form with blanks for Defendants to fill out. Plaintiff's response was that by construing the pre-suit notice packet materials as one cohesive document, all of the elements required by the statute are present and that the defendants had at their disposal all of the information necessary to obtain the patient's medical records. Plaintiff further asserted that the failure of Defendants to attempt to obtain the records precludes any demonstration of prejudice to them. The trial court granted Defendants' motions to dismiss for deficiency of the HIPAA authorizations.

The Court of Appeals, relying on the litany of previous blank HIPAA authorization cases well chronicled in Tennessee jurisprudence, affirmed the trial judge. A summary of existing law pertaining to failure of a plaintiff to provide a valid pre-suit HIPAA-compliant authorization is thus: Plaintiff failed to identify the individual authorized to receive the patient records. Such identification is an essential element. A medical authorization lacking an essential element is not valid. When a pre-suit medical authorization is facially invalid, the recipient is per se prejudiced and bears no burden to use or correct the form. Dismissal absent extraordinary cause is the remedy. If so, no 120-day extension of the statute of limitations applies. In this case, Plaintiff's case was not filed within the statute of limitations because she could not avail herself of the extension.

19. *Javier Carrasco v. North Surgery Center, LP et al.* No. W2019-00558-COA-R3-CV. Filed May 28, 2020.

- Pre-suit notice
- HIPAA compliant authorization
- Statute of limitations

Prior to filing a healthcare liability action, Plaintiff mailed pre-suit notice to Defendants. Plaintiff conceded that the HIPAA authorizations included did not substantially comply with the requirements in Code section 29-26-121(a)(2)(E) for authorizations. A corrected set was sent by Plaintiff after the one-year statute of limitations had expired. An enclosed letter stated that the medical authorizations provided on August 31 and September 1, 2016, were "intentionally left blank" and that counsel believed they

complied with HIPAA and Tennessee law. Enclosed with the November 2, 2016 documents was a fourth medical authorization that referenced the medical records for a "Narinder Sanwal, Deceased" instead of Plaintiff. Defendants moved to dismiss Plaintiff's complaint, arguing that the deficiencies in the authorizations prevented Plaintiff from being able to use the extension to the statute of limitations otherwise afforded in Tennessee Code Annotated section 29-26-121(c). The trial court dismissed the complaint and Plaintiff appealed.

The dispositive issue for the Court of Appeals involved the timing of Plaintiff's attempt to correct the initial non-compliant authorizations. The initial releases provided had blanks and incorrect dates, so they were not HIPAA-compliant. The attempted corrective authorization, even if HIPAA-compliant, was sent to Defendants after the one-year statute of limitations had expired. Thus, it could not be used to supplement the admittedly defective authorizations that were provided within the statute of limitations. Since Plaintiff could not avail himself of the 120-day extension of the statute of limitations because pre-suit notice was defective, the trial court properly dismissed the case.

20. ***Yebuah v. Center for Urological Treatment.*** No. M2018-01652-COA-R3-CV. Filed May 28, 2020.

- Caps on non-economic damages in health care liability action

In *Yebuah*, the healthcare provider admitted fault and the trial centered solely on damages. The jury awarded $4 million in noneconomic damages to Plaintiff for pain and suffering and lost enjoyment of life, and $500,000 in noneconomic damages to her husband for loss of consortium. The trial court initially reduced the verdict to $750,000, but then granted a motion to amend and applied the cap separately to each plaintiff, allowing an award of $750,000 for Ms. Yebuah and $500,000 her husband.

The Court of Appeals ruled that *McClay v. Airport Management Services, LLC* resolves the Plaintiffs' constitutional challenges to the caps on non-economic damages statute based on the right to jury trial, separation of powers, and equal protection. The Court of Appeals also rejected Plaintiffs' argument that application of the cap constituted a taking, which was not addressed in *McClay*. Finally, the Court of Appeals ruled that the trial court correctly applied the cap separately to each plaintiff, emphasizing that the statutory language repeats the phrase "each injured plaintiff" three times.

21. Lataisha M. Jackson v. Charles Anthony Burrell et al. No. W2018-00057-SC-R11-CV. Filed June 12, 2020.

- Common knowledge exception

Plaintiff filed suit against a massage salon alleging that a massage therapist working for the salon sexually assaulted her during a massage. In support of her claim of negligent training, supervision, and retention, Plaintiff presented evidence that before her assault, the salon had received complaints from two customers that the massage therapist had acted inappropriately and made them feel uncomfortable. The trial court granted summary judgment to the salon because no certificate of good faith had been filed. The Court of Appeals affirmed, ruling that the plaintiff had waived the common knowledge exception and that, in any event, expert testimony was necessary.

The issue for the Tennessee Supreme Court was whether Plaintiff's claim against a salon for negligent training, supervision, and retention of a massage therapist should be dismissed because Plaintiff did not file a certificate of good faith with her complaint. The Court analyzed the case to determine if the common knowledge exception applied. It reversed the Court of Appeals and held that Plaintiff's claim

against the salon for negligent training, supervision, and retention was within the knowledge and experience of an ordinary layperson and did not require explanation from a witness with specialized knowledge of the massage industry. Plaintiff did not allege that the employee negligently performed the massage, used improper technique or excessive force, or erred in decision-making as a massage therapist. Thus, there was no need for expert testimony about different types of massage, proper techniques for performing a type of massage, or other specialized knowledge that an expert in the massage industry would know and the average layperson likely would not. Instead, Plaintiff alleged that the employee sexually assaulted her during a massage and that the salon knew or should have known that he had previously acted inappropriately, making two other clients feel uncomfortable, and thus posed a risk of sexually assaulting Plaintiff. A layperson could understand that a salon may be negligent in its training, supervision, and retention of a massage therapist who sexually assaults a disrobed customer in a private setting during a massage when the salon knew of the massage therapist's prior inappropriate actions.

22. *Barry Charles Blackburn ex rel Briton B v. Mark A. McLean et al,* No. M2019-00428-COA-R3-CV. Filed July 31, 2020.

- Final judgements

A healthcare liability action was filed against Defendants hospital and emergency room physician. After discovery and scheduling orders, Defendant physician filed a motion for summary judgment, and Defendant hospital joined in the motion. The trial court granted each defendant partial summary judgment by dismissing 17 claims alleging Defendants breached standards of care. When Defendant hospital filed its motion to summarily dismiss the remaining claims against it, Plaintiff filed a response and a motion to substitute his physician expert witness for a different expert witness. Defendants opposed the motion, and the trial court denied the motion to substitute Plaintiff's expert witness. The court also summarily dismissed all remaining claims against the hospital, leaving only the claims against the physician for trial. Upon motion of Plaintiff, the court certified the summary dismissal of all claims against Defendant hospital as a final judgment pursuant to Tenn. R. Civ. P. 54.02.

Plaintiff appealed. On appeal, the dispositive issue for the Court of Appeals was whether the trial court erred in certifying the judgment in favor of Defendant hospital as a final judgment under Rule 54.02. Only final judgments entered by a trial court are appealable as of right. The court used a two-prong test. First was the determination of whether an order disposes of one or more but fewer than all of the claims or parties. Because the trial court's order disposed of all claims against Defendant hospital, it met the first requirement for a Rule 54.02 certification. It next considered whether the trial court properly determined that there was no just reason for delay. To do so, it considered the five factors enumerated in *Brown v. John Roebuck & Assocs., Inc.* The Court of Appeals determined that the trial court erred in certifying the order as a final judgment under Tenn. R. Civ. P. 54.02. Any decision made regarding the adjudicated claims against the hospital may encroach upon the unadjudicated claims to be tried against the emergency room physician. Thus, there was no basis on which to conclude that an injustice may result from the delay in awaiting adjudication of the entire case. Therefore, there was a just reason for delaying the expedited appeal of the summary dismissal of all claims against the hospital. Accordingly, the Court of Appeals vacated the trial court's order certifying the judgment as final under Rule 54.02 and remanded the case for further proceedings.

23. *Dorothy Eskridge, Wife and Next of Kin of Curtis Eskridge, Deceased v. NHC Healthcare Farragut, LLC, et al.* No. E2019-01671-COA-R3-CV. Filed August 5, 2020.

- Sufficiency of service of process
- Motion to dismiss

Defendants filed their answer to a health care liability claim, denying liability and asserting as one of their affirmative defenses their denial that Plaintiff had properly served Defendants with process in compliance with Rule 4 of the Tennessee Rules of Civil Procedure. They filed a motion to dismiss in accordance with Rule 12.02(4) and (5) of the Tennessee Rules of Civil Procedure. Plaintiff filed the returns of the original summonses with the court. Each acknowledged they had "served this summons and Complaint in the following manner: personal service on National Registered Agents, Inc., Samantha Sutton." Thereby, Plaintiff filed a "Motion to Dismiss or Strike Insufficiency of Service of Process or Insufficiency of Process Defense," alleging there was no basis to assert such defense, or in the alternative, that Defendants failed to set forth facts to support the affirmative defense. Defendants filed a motion to dismiss, alleging Plaintiff failed to timely serve the summonses and complaint on Defendants; Defendants were not served until eighty-nine days after the summonses were issued, which Defendants argue was not "contemporaneously with" or "soon after" the summonses were issued.

Defendants further asserted the delay was intentional. Defendants point to the fact that Plaintiff's counsel requested issuance of alias summonses on January 4, 2019, and promptly served Defendants' agent for process five days thereafter. Defendants stated that the alias summonses were served within five days and was prompt service of the alias summonses. However, Defendants argued that "because the original summonses were served within 90 days, the alias summonses are not effective to toll the one-year statute of limitations." Plaintiff countered that Defendants had to prove intent and that proving negligence or even gross negligence by Plaintiff in waiting to serve Defendants until day eighty-nine was insufficient to prove intent as required for Tennessee Rule of Civil Procedure 4.01(3). Plaintiff argued 90 days was per se prompt service. Plaintiff further argued that Defendants had waived any defense based on insufficiency of service of process because they had "cagily refused to reveal the factual basis of the defense" in their answer and only provided this factual basis after Plaintiff moved to strike the defense.

The Trial Court denied Plaintiff's motion to strike the affirmative defense and granted Defendants' motion to dismiss. The trial court found that Plaintiff's counsel intentionally delayed the issuance of service of process. The registered agent was one block from counsel's office and could have used the mail for service. Plaintiff appealed.

On appeal, the first issue was whether Defendants waived the affirmative defense of insufficiency of service of process. Defendants filed a motion to dismiss setting forth additional facts supporting their affirmative defense approximately two weeks after the returns of the summonses were filed with the trial court. Thus the court affirmed the trial court's finding that Defendants did not waive the affirmative defense of insufficiency of service of process. Next, the Court examined whether the trial court properly granted Defendants' motion to dismiss due to insufficient service of process. Because Defendants' motion to dismiss relied on Tennessee Rule of Civil Procedure 12.02(4) and (5), the trial court considered facts outside the pleadings in making its decision on the motion to dismiss. The burden was on Defendants to prove that Plaintiff's delay in completing service of process was intentional. Defendants did not present an affidavit or other evidence sufficient to establish that Plaintiff or her attorneys had intentionally delayed service of process except for the returns of the original summonses that had been personally served on the eighty-ninth day following their issuance, which provided no evidence of intent to delay. The Court reasoned that forcing Plaintiff to present evidence that a delay was not intentional without first requiring Defendants to present some actual proof and not just the Trial Court's inferences and resulting conclusions in favor of the movants that it was intentional is essentially placing the burden for Defendants. Thus, the trial court decision was affirmed in part and reversed in part.

24. *Michael Surber v. Mountain States Health Alliance,* No. E2019-01494-COA-R3-CV. Filed August 18, 2020.

- Limiting testimony on standard of care

In response to a motion in limine by Defendant hospital and during the trial of a health care liability case, the trial judge ruled to exclude testimony from Plaintiff's expert witness to the extent that hospital policies and bylaws equated to the standard of care for the hospital. Since Plaintiff was unable to prove direct liability through the expert, Defendant moved for, and was granted, a directed verdict. Plaintiff appealed.

On appeal, Plaintiff asserted that he sought to elicit the same type of testimony met with approval by the Tennessee Supreme Court in *Barkes v. River Park Hospital*. The Court of Appeals distinguished *Barkes* from the case at hand. In *Barkes,* the experts testified that the care provided fell below the standard of care as opposed to this case where the expert was only able to identify that a hospital policy was not followed and constituted a breach of the standard of care. The evidence did not support Plaintiff's assertion when Plaintiff failed to offer any expert to establish that a physician, rather than a PA, would have diagnosed Plaintiff differently based solely upon his or her status as a physician. No witness testified that Hospital's failure to ensure examination by a physician was the cause of Plaintiff's total loss of vision.

II. Evidence

25. Kenneth Ray McElroy v. Cigna, No. E2018-01038-COA-R3-CV. Filed December 12, 2019.

- Summary judgement

Plaintiff had a 50 lb. abdominal growth causing multiple other health issues. His surgeon was denied prior authorization to perform a panniculectomy to remove the growth because, according to Defendant insurance company, Plaintiff's benefit plan specifically excluded coverage of the procedure. The procedure was performed and Defendant denied payment. Plaintiff sued for breach of contract. The trial court granted summary judgement for Defendant on the basis the procedure was not covered by benefits. Plaintiff appealed.

The Court of Appeals affirmed. The language of the benefits plan was unambiguous – the procedure was specifically excluded from coverage, thus there was no contract. The evidence in the record showed that the exclusion was "regardless of the clinical indication." Plaintiff's surgeon billed for, coded for, and described the procedure in his notes as a panniculectomy.

26. Benjamin Shea Cotton, as personal …v. Jerry Scott Wilson, No. M2016-02402-SC-R11-CV. Filed June 19, 2019.

- Reasonable foreseeability
- Superseding intervening event
- Suicide rule/exceptions

This fascinating wrongful death case addressed responsibility for the suicide death of a psychiatric nurse by a non-treating psychiatrist. This was a very fact intensive case. Decedent nurse and Defendant psychiatrist had an affair in 2011 which led to the divorce of Decedent from her husband in 2012. Decedent moved in with Defendant in 2013 and she underwent treatment from a different psychiatrist for

depression and anxiety, which included the prescribing of medication. On January 26, 2014, Decedent overdosed and was admitted to a mental health treatment facility. She notified Defendant of her admission but denied to him that she had tried to commit suicide. The attending psychiatrist at the facility spoke to Defendant. The attending discharged her upon assurance by Defendant that he would make sure Decedent followed up for treatment. It was not until much later that she admitted to Defendant that she had contemplated suicide in January 2014.

Over the next ten months, the relationship was on/off. Around August 2014 Defendant broke up with Decedent and Decedent moved out of Defendant's home for a period of time but eventually moved back. In October 2014, at Defendant's home, Defendant showed Descendent and her son an antique revolver given to him by his father. The gun was stored in an unlocked drawer but the facts are disputed as to whether Decedent knew where the gun was hidden. Later that evening, Defendant informed Decedent that he wanted to pursue a relationship with another woman. Decedent stormed out of the house. On November 9, 2014, after returning from an out of town business trip, Defendant found Decedent in his home having shot herself to death with Defendant's gun.

Decedent's estate sued Defendant for wrongful death negligence asserting Defendant knew or reasonably should have known, that if Decedent had access to the gun there would be a likelihood she would harm herself due to her mental state. Defendant filed an answer, arguing that the suicide was an unforeseeable intervening, superseding act for which he was not liable and, under comparable fault, Decedent was more responsible than he.

Defendant followed up with a motion for summary judgment which was granted on October 21, 2016. The trial court held that Defendant had negated the element of proximate cause. Defendant had no reason to foresee Decedent's suicide would result from his inaction and none of the exceptions to the suicide rule that suicide is a superseding cause of death if the suicide was willful, calculated, and deliberate by one who has power of choice. Estate appealed.

The Court of Appeals reversed. It relied on the stressful events in Decedent's life and that the Defendant did not remove the gun when Decedent moved back into his house. Such evidence created a factual issue as to foreseeability.

The Tennessee Supreme Court examined the facts of the case against the established exceptions to the suicide rule. Then, the Court looked at whether there was evidence during the relevant time period that Defendant could have reasonably foreseen Decedent's suicide. There was no evidence that Decedent stayed depressed. She parented her son without restriction. Her reaction to the breakup was a normal reaction under the circumstances. There was no indication Decedent had suicidal ideations after January 2014. She carried on a relationship with Defendant for much of the time. She took her medication and functioned without restriction. Her family members were surprised by her suicide. Thus, there was insufficient facts to find Decedent's suicide was foreseeable so it was a superseding intervening event that relieved Defendant from liability to Estate. The Court reversed the Court of Appeals and upheld the summary judgment for Defendant.

27. ***Linda Bridges v. Lifford L. Lancaster, MD, et al****.,* No. M2019-00352-COA-R3-CV. Filed December 27, 2019.

- Health care liability
- Causation

This case involves an appeal from a grant of summary judgement to Defendant physician by the trial court in a health care liability lawsuit. The case turned on the content of deposition testimony proffered by Plaintiff to survive the motion. The trial court found that Plaintiff failed to demonstrate that any act or omission by Defendant caused Plaintiff's injury and there was no genuine issue of fact with respect to causation.

The Tennessee Court of Appeals affirmed the trial court's order. The issue in the lawsuit was an alleged failure by Defendant to fully investigate the causes of post-operative symptoms. The Court relied on *Stovall v. Clarke,* a 2003 Tennessee Supreme Court decision. In *Stovall,* the expert testified that had the defendant further investigated the plaintiff's symptoms, he *would have* found the underlying heart condition and *would have* diagnosed and treated it and the plaintiff *would have* survived. The expert testimony at issue in this case was not definitive. The Court did note that if Defendant had run tests to further investigate symptoms, the underlying cause would have been revealed. However, there was nothing in the expert's testimony to indicate at what point the tests would have revealed a reversible condition. The expert testified the tests "may have shown something that wasn't correctable…". Evidence of a mere possibility is not enough to withstand summary judgement and Plaintiff's expert was ambiguous and inconclusive with respect to whether additional testing would have revealed a condition that could have been treated, preventing the injury.

28. *Bonnie Harmon, et al v. Hickman Community Healthcare Services, Inc.,* M2016-02374-SC-R11-CV. January 28, 2020.

- Abuse of discretion on motion to alter or amend
- Competency of witness in health care liability action

The surviving children of a woman who died while incarcerated brought a health care liability case against the company staffing the jail for health care services. The theory of the case was that Defendant's nurse was negligent in causing the decedent's death for failure to properly treat a patient withdrawing from legal and illegal substances. Plaintiffs filed a motion for partial summary judgment on the issues of standard of care and causation. Plaintiffs relied on an affidavit of its medical expert, a board-certified neurologist/psychiatrist. Defendant challenged the physician's competency to testify arguing his testimony was irrelevant. The trial court granted summary judgment for Defendant. Plaintiffs filed a motion to alter or amend the trial court's order. The motion was supported by the affidavit of a different physician who Plaintiff asserted was previously unavailable. Plaintiffs' motion was denied so they appealed the trial court's rulings on the summary judgment and motion to alter and amend.

The Court of Appeals reversed in a split decision. The Court, as the trial court had done, applied the *Stovall v. Clarke* factors as the standard to apply to resolving motions to alter or amend. It second-guessed the trial court's conclusions based on the facts in evidence. The dissent asserted that the Court of Appeals should not have substituted its judgment for that of the trial court. It opined that Plaintiffs failed in the first *Stovall* factor, the movant's effort to procure the evidence sought to be introduced. The facts showed that Plaintiff only sent two emails to the medical expert, did not call him, did not request a continuance, and waited for the rulings to be made by the court before attempting to file a motion to alter or amend. Thus, the dissent concluded, the trial court's decision was not outside the range of acceptable alternative dispositions.

The Tennessee Supreme Court agreed with the dissent by the Court of Appeals. It held that the Court of Appeals should not have merely re-applied the *Stovall* factors. A trial court ruling on a motion to alter or amend may only be reversed for an abuse of discretion using the *Lee Medical, Inc. v. Beecher* criteria for determining abuse of discretion. The Supreme Court looked at the third question in the *Lee Medical*

analysis, whether the trial court's denial of the motion to alter or amend was within the range of acceptable alternative dispositions. The Court agreed with the facts noted by the COA dissent and held that the trial court's decision was within the acceptable range.

The Supreme Court also upheld the trial court and Court of Appeals' determinations that Plaintiffs' expert was not competent to testify. Plaintiffs' expert had an impressive CV but they failed to put forth any evidence that his testimony would be relevant. The evidence did not demonstrate experience with drug withdrawals or other testimony why a neuro-psychiatrist's testimony would be relevant to the issue of causation.

29. ***Rhonda Willeford, et al v. Timothy Klepper, MD et al,*** No. M2016-01491-R11-CV. Filed February 28, 2020.

- Constitutionality of ex parte communications statute
- Separation of powers
- Doctrine of elision

During the course of discovery in a health care liability case, Defendants moved for a qualified protective order pursuant to TCA § 29-26-121(f) to allow Defendants to interview decedent's non-party treating health care providers outside the presence of Plaintiff's counsel. Plaintiff's opposed the motion by arguing that the statute is an unconstitutional violation of the separation of powers clause, Article 2, sections 1 and 2 of the Tennessee Constitution. The trial court granted the motion. Plaintiff sought an interlocutory appeal by permission. The Court of Appeals denied but the Tennessee Supreme Court granted permission.

The issue for the Court was whether the ex parte communication statute violates the separation of powers clause. The Court analyzed the question based on the distinction between substantive law and rules of practice and procedure. The purpose of the Health Care Liability Act is both procedural and substantive. It noted that some legislatively proscribed procedure such as limitations of actions have been upheld. The creation or denial of privilege, such as the covenant of confidentiality is substantive law and thus within the purview of the Legislature. Since the purpose of the statute is within the purview of the Legislature, the Court sought to preserve the purpose so it next turned to the procedural aspect of the statute – the removal of the courts' discretion to grant protective orders.

The statute removes trial court discretion over a discovery matter. Pre-trial matters rest exclusively with the judiciary. So, the statute as written was determined to be unconstitutional based on separation of power between the legislative and judicial branches. Since the Court intended to preserve the substantive policy purpose of the statute, noting the State's general severability statute, TCA § 1-3-110, it utilize its power of elision to re-write the statute to make it compliant with the State Constitution. It eliminated the mandate that judges grant motions for protective orders and made it permissive. As re-written, the statute is constitutional.

30. *Thomas K. Ballard III, MD et al v. Tennessee Department of Health,* No. No. M2019-01101-COA-R3-CV. Filed May 8, 2020.

- Substantial and material evidence

The Department of Health brought charges against a physician and his licensed pain management clinic after Department audits revealed a litany of violations of the state pain management clinic laws and improper prescribing by the physician medical director. An administrative Law Judge assessed Appellants

$3,500.00 in civil penalties and ordered that the Clinic's Pain Management Clinic certificate be permanently revoked. Dr. Ballard was also ordered to pay all court costs for the matter not to exceed $5,000.00. The Department appealed under the theory that the civil penalty was not enough. The Commissioner's designee affirmed the ALJ's finding and also found three additional violations and so she increased the civil penalty. Physician and Clinic appealed. The Chancellor affirmed the Designee's decision. Physician and Clinic again appealed.

On appeal, the issue for the Tennessee Court of Appeals was whether the additional findings and penalties assessed by the Designee were arbitrary and capricious. Appellants first challenged whether substantial and material evidence existed to find a failure to establish a means of evaluating and monitoring the quality of patient care, identifying and correcting deficiencies, or opportunities to improve quality of care. Appellants argued that their absence of written policies is only evidence of not having written policies, not that care was substandard. The evidence showed that the auditor asked questions about quality of care. After repeated attempts, Appellants could never show compliance with the policy requirements. The next challenge was to the findings regarding billing practices. Evidence showed that billing records were not kept on site and that the Clinic's statements did not list the amounts paid for co-pay or the remainder of services. Instead, the billing statements only listed insurance coverage and the date of any insurance payment. The records were also prepared electronically, and statements were only sent to insurers, not patients. In addition, the Clinic accepted cash payment which was strictly forbidden by statute. The Court rejected Appellant's argument that it had cured the billing defects from the audit. Appellants provided no caselaw or citations to statutes or regulations to support a claim that an admitted, but later corrected, violation of relevant directives cannot serve as a basis for discipline. Appellants also challenged whether substantial and material evidence existed for the Commissioner's Designee to find that Dr. Ballard dispensed controlled substances to his patients. Physician admitted to the auditor that he sometimes engaged in that conduct.

The Court found the Designee's order set out specific violations and factors considered in assessing penalties. It rejected Appellants' claims that the increase in potential costs was arbitrary and capricious under the UAPA. Agencies have the discretion to require that license or certificate holder "to pay the actual and reasonable costs of the investigation and prosecution of the case." Tenn. Code Ann. 63-1-144(a). In this case, the Commissioner's Designee increased the maximum that Appellants could pay in costs from $5,000.00 to $10,000.00. By the time the case reached the Commissioner's Designee, the Department's costs for investigating and prosecuting the case was $7,048.03, which was nearly 50% more than the cap imposed by the ALJ. Moreover, the Department was successful in its appeal of the initial order, which resulted in additional discipline to Appellants. Given the Department's success, it was within the Commissioner's Designee's discretion to order Appellants to pay the additional costs incurred on review. Thus, the Designee did not abuse her discretion in any of the additional findings or penalty assessment amount.

31. *Mitzi Bayne Ruth, et al v. Home Health Care of Middle Tennessee LLC, et al.* No. E2019-01178-COA-R3-CV. Filed May 26, 2020.

- Breach of contract

This was a breach of contract case in which Plaintiffs sought to recover the balance of a promissory note executed to secure payment for of a deceased owner's interest in the Defendant home health company and to recover on a guaranty to secure the note. Defendants answered the complaint, admitting to nonpayment, and filed a counterclaim, asserting that Plaintiffs breached two sections of a Settlement Agreement, which addressed how the parties would proceed regarding tax matters. The parties filed cross

motions for summary judgment. The trial court granted Plaintiffs' motion and dismissed Defendants' counterclaim, and denied Defendants' motion.

Defendants appealed, arguing that Plaintiffs were not entitled to summary judgment because there was a genuine issue of fact as to whether they filed a required amended tax return and paid the taxes. In addition, Defendants contended that they were entitled to judgment on their counterclaim. The common question presented by both motions to the Court of Appeals was whether the Estate filed the amended return and paid the appropriate taxes in accordance with the Agreement; the question was whether the evidence as to that question was conflicting. The evidence submitted by Plaintiffs showed that they filed the amended tax return, made the necessary payment for the year at issue, and that the IRS rejected their payment. Such evidence demonstrates that there was no issue of material fact for trial and effectively negated the essential element of Defendants' counterclaim, that Plaintiffs breached the Settlement Agreement. In their answer to the complaint, in their response to Plaintiffs' Requests for Admission, and in their response to Plaintiffs' Rule 56.03 statement, Defendants admitted that they did not make the required payment. Thus, there was no issue of fact for trial as to their breach of the Promissory Note and Guaranty Agreement, and Plaintiffs were entitled to judgment on both motions. The trial court's decision was affirmed.

32. *Martha Gilmore, Executrix of the Estate of Nannie Susan Carpenter v. NOL, LLC A/K/A Premier Radiology.* No. M2019-01308-COA-R3-CV. Filed May 27, 2020.

- Comparative fault
- Thirteenth Juror

An 84 year old patient was injured when an automatic door closed on her after her physical therapy appointment. Plaintiff filed a lawsuit against Defendant building owner under the theories of negligence and premises liability as a result of an unreasonably dangerous condition. Defendant filed an answer denying liability and asserted comparative fault as an affirmative defense. The case went to trial and the jury returned a verdict finding that both Defendant and Plaintiff were negligent and that Plaintiff had sustained damages in the amount of $500,000. The jury allocated fault between the parties, finding Plaintiff 77% negligent and Defendant 23% negligent. Because the jury found Plaintiff's fault to be over 50%, the trial court entered a judgment in favor of Defendant and dismissed Plaintiff's complaint. Plaintiff appealed the trial court's denial of her motion for a new trial and raised the following arguments: (1) that the trial court applied an incorrect standard in its role as the thirteenth juror and committed manifest error; and (2) that Defendant offered no evidence in support of its affirmative defense of comparative fault, so Plaintiff was entitled to a new trial. Plaintiff made the additional alternative argument that if material evidence supported the jury's verdict finding her negligent, the trial court committed reversible error in excluding testimony of her expert regarding whether she did anything before her fall that would have caused the door to close on her.

The Court of Appeals first considered the motion for a new trial. During the hearing on Plaintiff's motions, the trial judge stated that he "must consider whether the record contains any material evidence to support the verdict, [and if there is,] the jury's findings must be affirmed." His statement does not recite the proper standard for a trial judge to apply when faced with a motion for a new trial and acting as the thirteenth juror. Plaintiff had to show that the trial judge "was not satisfied with the verdict or misconceived his role as the thirteenth juror." The trial judge followed up his misstatements with a written order in which he recited the proper standard of review and stated that he was denying Plaintiff's motion for a new trial because he was "satisfied with the jury's verdict." That part of the trial judge's ruling was affirmed.

The next question for the Court of Appeals regarded the sufficiency of the evidence that Plaintiff was 77% negligent. To prove Plaintiff was negligent, Defendant was required to present some material evidence that the conduct of Plaintiff was a proximate cause of the accident. Surveillance camera evidence presented at trial showed Plaintiff stopped in the path of the sliding door and placed her hand on the doorjamb for close to ten seconds before she continued through the doorway. She then stopped just past the threshold and was standing close to the doorjamb for about two seconds when the sliding door began closing and came into contact with her, causing her to fall. Plaintiff's expert witness testified that the presence detection sensors located above the doorway did not detect someone standing immediately adjacent to the doorjamb. This did not satisfy the industry standard in at least two ways. The Court agreed with Plaintiff that no evidence was introduced at trial that Plaintiff was negligent. It rejected Defendant's argument that the jury could conclude from the tape that she was negligent. The evidence showed that the industry standard required the automatic door to remain open for thirty seconds when a presence sensor is triggered, and in this case the door was open for less than thirty seconds when it began to close and knocked Plaintiff over. No evidence was introduced that Defendant had posted any notices near the doors warning visitors against standing in any particular blind spots near the automatic door to avoid being struck by the door. No evidence was introduced that Plaintiff knew or should have known that the automatic door would close if she stood too close to the doorjamb. The Court vacated the trial court's decision finding Plaintiff liable for comparative fault and remanded the case for a new trial.

III. Worker's Compensation

33. Sharee Clay v. Signature Healthcare, et al, No. 2015-06-0977. Filed October 21, 2019.

- Expert testimony

Employee, a nursing assistant, injured her left shoulder and neck assisting a patient in a shower chair on November 15, 2014. She was diagnosed with muscle strain and assigned to light duty. Four days later, Employee was injured in a car wreck, suffering pain in her left leg, left wrist, and left elbow. She denied any increased symptoms to her left shoulder and neck. She received treatment for all of her injuries over time. In the meantime, she left her job with Employer and worked as a hair stylist. In addition to the car accident, Employee had a pre-existing degenerative cervical condition and was not forthcoming about her medical history with some of her treating physicians.

The trial judge excluded the written medical opinion of Employee's treating orthopedist who originally attributed Employee's shoulder pain as a work-related injury during his deposition. On cross-examination, the expert admitted that he did not have all of Employee's medical records. After reviewing additional records, the expert sent a letter opining that the shoulder injury was not a result of the work injury. The expert was deposed a second time after reviewing additional records and went back to his original conclusion that Employee's injury was work related. Despite the fact both parties agreeing to the admissibility of the letter, there was no formal stipulation so at trial Employee objected to it and it was excluded by the trial judge. The trial judge found that Employee suffered a left shoulder and neck injury

arising out of her employment and ordered Employer to pay temporary disability, permanent partial disability, and ongoing benefits. Employer appealed.

The Tennessee Bureau of Workers' Compensation Appeals Board affirmed the trial court. As to the issue of the exclusion of the expert's letter at trial, the Appeals Board did not find an abuse of discretion by the trial judge based on the hearsay rule. There was no stipulation.

As to the issue of compensable injury vs. pre-existing conditions, the Appeals Board found that the preponderance of the evidence supported the conclusion the injury arose out of Employee's employment. The trial court gave more weight to Employee's three experts rather than those proffered by Employer. One of Employee's expert was a board-certified neurosurgeon. Employee's preexisting conditions were asymptomatic before the time of her work injuries. The trial court discounted the testimony of Employee's expert who vacillated in his opinion of causation.

34. *Marsha Wright v. Tennessee CVS Pharmacy, LLC, et al,* No. 94867-2015. Filed October 31, 2019.

- Increased benefits
- Increased benefit for extraordinary cases

Pharmacy employee was injured during a robbery of the pharmacy while she was on duty. As a result, she suffered from physical injuries to her leg which reached maximum medical improvement with no permanent impairment. In addition, she was diagnosed with PTSD and insomnia. She was no longer able to perform work in public settings and was largely confined to her home and suffered panic attacks and migraines. She reached maximum medical improvement and was assigned a permanent impairment rating of 15 %. Her treating psychiatrist certified that she was unable to perform her pre-injury occupation. Following trial, the trial judge awarded her 67.5 weeks pf permanent disability based on the 15% impairment rating; increased disability based on her age, and extraordinary benefits; and permanent disability. Employer appealed.

There were two issues on appeal to the Tennessee Bureau of Workers' Compensation Workers' Compensation Appeals Board. The first was whether Employee was entitled to increased permanent disability benefits pursuant to TCA § 50-6-207(3)(B) because she could not return to work. Employer based its argument against the award on the fact there was no evidence she attempted to find a job. The Board upheld the award. It relied on a Tennessee Supreme Court Special Workers' Compensation Appeals Panel decision holding employee failure to seek employment is not an automatic bar to benefits beyond the original award. In this case, Employee suffered from PTSD, she could not perform her pre-injury occupation, and she could not work in public. Thus, facts were sufficient not to overturn the trial court's findings.

The second issue surrounded the award of additional benefits in "extraordinary cases" pursuant to TCA § 50-6-242(a)(2). The basis for Employer's objection to the award was a statement made by Employee's treating psychiatrist in his deposition indicating that Employee's condition was not permanent. The doctor stated that Employee's ability to return to work "might happen later." Again, the Board upheld the trial judge. The psychiatrist had certified that Employee could no longer perform her pre-injury occupation and questioned whether she would ever work again. Cases have held that suggestions that an employee

"may improve" do not automatically render a physician's opinion of permanency invalid. The doctor's statement fell short of rebutting the presumption of permanence by clear and convincing evidence.

35. *Vera Adiole v. Logan Senior Care, LLC, et al.,* No. 2018-06-0451. Filed December 16, 2019.

- Causation

A home health employee injured her back while maneuvering a patient in a wheelchair. She received treatment from several health care providers. Employer filed, and was granted by the trial court, its motion for summary judgment because Employee did not come forward with sufficient evidence that her injuries arose from the work incident.

On appeal, the Bureau's Appeals Board reviewed Employer's evidence submitted by three physicians who treated Employee. Dr. Hazelwood initially attributed the injury to the work incident but released her a couple of months later indicating he had done everything he could do for her. Dr. Shibayama opined that her current back and hip conditions were less than fifty percent related to the work injury. Dr. Elalayli found MRI results were "benign" and the hip injury was less than fifty percent related to the work incident. Employee's evidence consisted of an opinion from a physician assistant that Dr. Hazlewood's treatment caused "further harm" and that the symptoms "may" be related to the work injury. Based on the weight of the evidence, summary judgment for Employer was proper.

36. *Mary Denson v. VIP Nursing Home and Rehabilitation Service, LLC,* No. M2019-02145-SC-R3-WC. Filed July 21, 2020.

- Attorney's fees

In 2004, the parties settled Employee's workers' compensation claim. Pain treatment was paid for by Employer until 2017, when Employer refused to pay for pain management medication prescribed by Employee's treating physician so Employee filed a Petition for Contempt to Compel Compliance with Court Order. Two years later, Employer reversed its decision and Employee sought attorney's fees in the amount of $9116.69 pursuant to TCA § 50-6-204(b)(2). After a hearing, the trial court ordered Employer to pay $7500 in attorney's fees, finding it in contempt. Employer appealed the award and its reasonableness.

The Special Workers' Compensation Panel found that there was no transcript of the hearing filed and no witnesses were called during the hearing. The court's order, however, listed its considerations in its order and found that the evidence was "undisputed" that the injury was causally related to Employee's work. Thus, the award was proper. Next the Panel considered the appropriateness of the amount. It reviewed the award using the ten factors set forth in Rule 8. Employer did not demonstrate any abuse of discretion by the trial court.

IV. Miscellaneous

37. *Steven Shao ex rel Elizabeth Shao v. HCA Health Services of Tennessee, Inc. et al,* No. M2018-02040-COA-R3-CV. Filed September 16, 2019.

- Sanctions

The Tennessee Court of Appeals upheld sanctions imposed on a party's lawyer by a trial judge during the course of a health care liability case. Plaintiff's counsel sent threatening emails to opposing counsel, including a threat to the child of one of the defense attorneys. In another, Plaintiff's counsel accused another lawyer of falsifying a certificate of service.

The Court rejected counsel's argument that the trial judge exceeded his authority in enjoining free speech and association in the sanction orders. The restrictions imposed by the court mirrored restrictions on counsel's law license by the Supreme Court. The Supreme Court's restrictions overrode those of the trial court and rendered that issue moot. Further, the Court of Appeals ruled there were facts supporting the trial judge's award of attorneys' fees. It found he had acted "reckless" throughout the proceedings, ignoring the trial court's admonishments. Since the practice of law is a privilege, not a right, and there was clear authority to regulate the conduct and ethics of licensees, the Court of Appeals held the sanctions were not unconstitutional.

38. *Dr. Victor W. McLaughlin, MD v. Elizabeth King McLaughlin,* No. E2018-01319-COA-R3-CV. Filed October 28, 2019.

- Asserting an affirmative defense

Plaintiff physician sued Defendant daughter-in-law for payment of $31,085.15 in loans. Defendant filed an unsworn answer denying the substantive allegations but asserting no affirmative defenses in the answer. At a pre-trial hearing of the matter, a Stipulated Exhibit based partially on responses to requests for admissions was entered in which Defendant acknowledged receiving twenty-seven loans from Plaintiff over a two-year period. The trial court later entered a final judgment award for Plaintiff. Defendant filed a motion to vacate the judgment asserting that during the previous hearing Defendant was prepared to orally deny the complaint pursuant to TCA § 24-5-107 and proceed to trial. The trial court denied the motion because Defendant was required by Rule 8.03 of the Rules of Civil Procedure to assert any affirmative defenses but did not do so. Thus, she was precluded from asserting that the loan was a gift. Defendant appealed.

On appeal, the issue for the Court of Appeals was whether the trial court erred by failing to follow the procedure outlined in TCA § 24-5-107 for an action brought upon a sworn account when the court found Defendant had waived any affirmative defenses by failing to raise them in her answer. The case turned on the interpretation of the statute versus the presumption under the Rule that failure to plead an affirmative defense generally results in a waiver of the defense. The Court of Appeals held that the allowance of a § 24-5-107 oral denial of the account under oath does not come into play unless the defendant has not filed a sworn denial. In this case, she filed an answer with no affirmative defenses. She responded to requests for admissions and agreed to the entry of the Stipulated Exhibit all without asserting an affirmative defense. Thus, there was no error by the trial court.

39. *Walter Joshlin et al v. Hollis H. Halford, III, MD et al,* No. W2018-02290-COA-R9-CV. Filed November 6, 2019.

- Substitution of party

Plaintiff sued Defendant for health care liability and Plaintiff's wife sued for loss of consortium. During the pendency of the case, Plaintiff died of causes unrelated to the case in February 2014. Plaintiff's counsel filed a notice of death. In May 2014, an estate was opened for the decedent. On June 26, 2015, Defendant filed a motion to dismiss for Plaintiff's failure to timely substitute a proper party (Plaintiff's estate). Plaintiff defended the motion by asserting that according to Tenn. R. Civ. P. 25.01(2), no

substitution of party was required. The trial court ruled for Plaintiff, denying the motion based on Rule 25.01(2) and TCA § 20-5-106 whereby the action passed to Plaintiff's surviving spouse who was already a plaintiff in the case. Defendants appealed.

The issue before the Tennessee Court of Appeals was whether Plaintiff's claims passed automatically to his surviving spouse without need to substitute parties pursuant to TCA § 20-5-106 and Rule 25.01(2). The wrongful death survival statute relied upon by Plaintiff did not apply in this case. Plaintiff's death was not a result of the underlying injury. Based on *Timmins v. Lindsey,* wrongful death statutes are inapplicable in unrelated personal injury actions. The existing action was eligible, therefore, to be revived. To find otherwise would result in a case where a plaintiff dies of unrelated cause becoming a wrongful death action. The manner in which a pending action is revived is dictated in TCA § 20-5-103 to 105. Since an estate was open, the co-executors were the proper parties to revive the action. The case had to be dismissed because Plaintiff failed to comply with Rule 25.01. Plaintiff's surviving spouse's claim was different from Plaintiff's malpractice action even if she were a plaintiff in the underlying case. Rule 25.01(1) applied which required a substitution of parties within 90 days of the filing of a suggestion of death. Since Plaintiff waited over a year, the case should have been dismissed. Thus, the Court of Appeals reversed the trial court.

40. *Lytoniona Lee et al v. Quince Nursing and Rehabilitation, LLC,* No. W2019-00093-COA-R3-CV. Filed November 7, 2019.

- Res judicata

In September 2012, employees of a nursing home allegedly dropped Plaintiff's aunt while attempting to dress her for a dialysis appointment allegedly contributing to her death. Plaintiff niece filed a lawsuit against the nursing home alleging several theories of recovery on January 27, 2014. The case went to arbitration and the arbitrator dismissed the case based on the running of the statute of limitations in a health care liability action and ruled that Plaintiff lacked standing to sue on behalf of her aunt's estate. The trial court adopted the arbitrator's order on October 15, 2015. Plaintiff did not appeal. On September 25, 2018, Plaintiff sued the nursing home again, this time for breach of contract based on the same underlying facts as the healthcare liability case dismissed earlier. The trial court dismissed the case based on res judicata and Plaintiff appealed.

The Tennessee Court of Appeals affirmed the trial court. The case met all of the *Jackson v. Smith* elements of res judicata – first case was resolved by a court of competent jurisdiction; same parties in both suits; plaintiff asserted the same claim in both suits with same facts and circumstances as the first case; and the judgement in the first suit was final and on the merits. In addition, the breach of contract case could reasonably have been litigated in the first suit.

41. ***Dora Nesbitt Jones et al v. Allenbrooke Nursing and Rehabilitation Center, LLC.,*** No. W2019-00448-COA-R3-CV. Filed December 16, 2019.

- Power of attorney
- Arbitration agreement

Nesbitt granted her daughter, Jones, a power of attorney (POA) in 2007 to handle property issues. The POA specifically excluded health care decisions and no instrument was ever executed giving Jones decision-making authority. As of June 2013, Nesbitt was incompetent. She was admitted to Defendant nursing home that month. As part of her admission, Jones signed an arbitration agreement. In September

2016, Nesbitt was injured from a fall at the nursing home. She sued Defendant and Defendant filed a motion to compel arbitration, which was denied by the trial court because the POA was not sufficient to bind Nesbitt, therefore, there was no valid contract for arbitration. Defendant appealed.

Unfortunately for Defendant, its arguments on appeal were recycled arguments previously rejected by the Court of Appeals. First, Defendant argued that the trial court failed to apply the Federal Arbitration Act which governs the enforceability of arbitration agreements. However, this argument had been rejected in the case of *Edwards v. Allenbrooke Nursing & Rehabilitation Center, LLC* in 2017, wherein Defendant was a party. This case was not about enforceability but one of authority to bind Nesbitt. As *Edwards* found, the trial court resolves issues of formation of arbitration agreements.

Since contract formation was the issue, the Court of Appeals looked at the specific language of the POA. Its construction only conferred specifically enumerated powers and excluded health care decisions. Admission documents to a health care facility is a health care decision under *Owens v. National Health Corp.* decided in 2007. Even the arbitration agreement in question this case specifically stated admission to Defendant "is a health care decision." Thus, the POA did not authorize Jones to enter into the arbitration agreement on behalf of Nesbitt. The Court of Appeals also rejected Defendant's contention that Jones had apparent authority to enter into the agreement. The Court cited the 2008 *Barbee* case, another arbitration clause case, finding that if the principal is incompetent, she cannot act on her own behalf so she cannot take action to "clothe" the agent with apparent authority. The same facts apply here; Nesbitt was incompetent at the time the agreement was signed. Finally, the Court rejected Defendant's assertion that the agreement was binding because Nesbitt was a third-party beneficiary. That argument had been rejected in another 2008 case, *Ricketts.* It held that there must be a valid agreement before a court can apply third party beneficiary concepts. Thus, the trial court decision was affirmed because Jones had no authority to bind Nesbitt. The arbitration agreement was not enforceable.

42. *Donna Felecia Watson v. Quince Nursing & Rehabilitation Center, LLC,* No. W2019-00261-COA-R3-CV. Filed December 17, 2019.

- Arbitration agreement
- Authority to bind

The facts in this case, as well as the parties' arguments, were similar to those made in the previous case. This time, however, the nursing home patient's son did have authority to bind his mother to an admission arbitration agreement. In this case, the mother gave her son permission to sign all documents related to the nursing home admissions process. The *Watson* court also relied heavily on *Owens,* as well as *Necessary v. Life Care Centers on America, Inc.* Those cases stand for the proposition that if a person has authority to sign admission documents (health care decision), such person had authority to sign an arbitration agreement included in the admissions process. Here, as opposed to *Watson* above, the patient's son had express authority to sign admission documents presented as part of the admissions process. Thus, the Court of Appeals reversed the trial court's order denying Defendant's motion to compel arbitration. Arbitration was compelled.

43. *Kingston Springs Medical, LLC v. Karl Francis et al.,* No. M2018-01617-COA-R3-CV. Filed February 25, 2020.

- Contracts
- Right of first refusal

In 2005, Physician entered into a lease with Karl Francis to lease building space on his property for his medical clinic. A provision was included a right of first refusal provision that would allow Physician to match any offer from an unrelated third party to purchase the fee simple interest in the leased premises and purchase the property on the same terms and conditions. After signing the lease, Physician constructed his clinic building on the property. In 2011, Physician learned that in 2008 the property owners had conveyed the land to a two-party partnership owned equally by both partners. Believing such conveyance triggered the right of first refusal, Physician proposed to purchase the land at the same price as the 2008 conveyance but the owners refused. Physician's medical practice sued the property owner partners as well as the individuals party to the original lease (and members of the property owner partner organizations) for breach of lease and sought damages based on misrepresentation by concealment by failing to provide notice to Plaintiff regarding the sale as required by the lease as well as unjust enrichment and other claims. Defendants moved for summary judgement denying the conveyance triggered the right of first refusal provision in the lease. The motion was based on the argument that the conveyance was not a bona fide offer or, since the original owners were members of the partners who received the conveyance, there was no "unrelated third-party" involved. The trial court granted summary judgment for Defendants. It held that the lease created a garden-variety type of first refusal triggered by a third-party offer. Plaintiff appealed.

The Court of Appeals affirmed the grant of summary judgment for Defendants. The Court focused on how the term "agreement" was used in the lease. In the last sentence of the opportunity to purchase provision, the term meant the right of first refusal such that any transfer of the fee simple interest is subject to the right of first refusal. However, elsewhere in the provision, the term refers to the parties' lease, not just the right of first refusal. The Court interpreted the provision to be a garden variety right of first refusal whereby the price terms and conditions were determined by reference to a third-party offer. But, there was no third-party offer because the property was merely transferred.

44. ***Jodi McClay v. Airport Management Services, Inc.,*** No. M2019-00511-SC-R23-CV. Filed February 28, 2020.

- Constitutionality of caps on non-economic damages in civil tort cases
- Right to trial by jury
- Separation of powers doctrine
- Equal protection

This is not a health case but it has such an important bearing on health care, namely health care liability cases, which the presenters thought it important to include in these materials. The bottom line is that the statutory caps on non-economic damages, TCA § 29-39-102, are constitutional in Tennessee. In health care liability actions, courts will apply the caps unless a statutory exception applies.

A civil trial jury in US District Court for Middle Tennessee returned a verdict in a personal injury case that included a $930,000 award to Plaintiff for non-economic damages. Defendant moved the trial court to apply Tennessee's statutory cap on non-economic damages pursuant to TCA § 29-39-102. Plaintiff challenged the constitutionality of the caps statute. The District Court certified three constitutional questions of law to the Tennessee Supreme Court. The Supreme Court answered them pursuant to Rule 23. As to all three challenges, the cap statute was held by the majority to be constitutional.

The first challenge posed to the caps was that the statute violated a plaintiff's right to a trial by jury guaranteed by Article 1, Section 6 of the Tennessee Constitution. The statutory cap is not disclosed to juries; the court applies the caps to any award over the statutory amount. Juries still determine the underlying fact questions of civil cases and determines the amount of the award. A cap is a policy

decision applied after a jury's determination, not a re-examination of the factual question of damages. That right is not violated when the court, not jury, applies the cap. The Court relied on precedent holding that the Legislature has the authority to legislatively alter common law and those holding remedies are matters of law subject to the Legislature's determination.

The second challenge was that the cap was unconstitutional because it violated the separation of powers doctrine on Article 2, section1 of the Tennessee Constitution. The argument was that the legislative branch had intruded upon the judicial branch's authority over procedural rules of the courts. The Court did not consider the cap to be a procedural rule, rather, it was considered a substantive law over which the Legislature has authority. It does not change procedural operations of the judiciary. Courts can still interpret and apply the law.

The final challenge was pursuant to the equal protection clauses of the Tennessee Constitution found at Article 1, section 8 and Article XI, section 8. Violation requires evidence of a discriminatory purpose. In this case, Plaintiff conceded that the caps statute was facially neutral. However, Plaintiff argued that it had disparate impact on women. Without evidence of a discriminatory purpose on the part of the Legislature, the Court held that disparate impact alone does not violate equal protection.

45. ***Roy Franks et al v. Tiffany Sykes et al.*** No. W2018-00654-SC-R11-CV. Filed May 1, 2020.

- Tennessee Consumer Protection Act of 1977

Plaintiffs were injured in car accidents and received treatment at hospitals. The hospitals did not bill Plaintiffs' health insurance companies. Instead, they filed hospital liens against Plaintiffs' claims for damages arising from the accidents. The hospital liens were for the full amount of the hospital bills with no reduction for Plaintiffs' health insurance benefits. Plaintiffs sued the hospitals, asserting the filing of undiscounted hospital liens was an unlawful practice under the Tennessee Consumer Protection Act of 1977. Defendants filed motions to dismiss. The trial court granted the motions to dismissed, ruling that Plaintiffs had failed to state a cause of action.

On appeal, the Tennessee Court of Appeals affirmed, holding that the Act did not apply to a claim in which the underlying transactions involved medical treatment. Defendants appealed. The filing of a hospital lien constitutes a debt collection activity, and the Act does not apply unless the underlying transaction is a consumer transaction as defined by the Act. It determined the underlying transaction was the treatment of Plaintiff Franks' injuries from a motor vehicle accident. It constituted a doctor's practice of his profession and therefore did not fit within the Act's definition of a "consumer transaction".

The issue for the Tennessee Supreme Court on appeal was whether the Act applies to the business aspects of a health care provider's practice. The U.S. Supreme Court has recognized that learned professionals, such as lawyers, engage in business roles as well as professional roles. This includes health care providers. The Court analyzed whether a consumer has stated a cause of action under the Act against a health care provider by looking at whether the health care provider was acting in a business or in a professional capacity. The Court held that the Act applies to health care providers when they are acting in their business capacities. In this case, no medical care was involved in the controversy. The controversy involved debt collection, which is money for commerce. A hospital lien filing is a debt collection activity. The plaintiffs, who were consumers of medical services, may state a claim under the Act against the hospitals for conduct arising out of the hospitals' business practices. The case was reversed and remand.

46. *Jeffrey Clay Davis v. Vanderbilt University Medical Center,* No. M2019-01860-COA-R3-CV. Filed August 5, 2020.

- Tennessee Public Protection Act
- "Illegal act" requirement

Plaintiff medical center employee sued Defendant medical center under the Tennessee Public Protection Act ("the TPPA") asserting that his employment was terminated because he refused to remain silent about the medical center's failure to enact policies to safeguard its employees from workplace violence. Employer filed a motion to dismiss the complaint for failure to state a claim upon which relief can be granted, and Employee filed a motion to amend his complaint to add allegations that the "illegal activities" referenced in his complaint included violations of the Patient Safety and Quality Improvement Act of 2005 ("PSQIA"), Tenn. Code Ann. §§ 63-1-150 and 68-11-272, as well as assault and battery. Employee amended his complaint. The trial court granted Employer's motion to dismiss. The court determined that the OSHA guidelines are not mandatory and found that "the failure to employ best practices, or follow OSHA recommendations, does not equate to illegal activity." Employee appealed.

The issue for the Tennessee Court of Appeals was whether the trial court erred in granting Employer's motion to dismiss. The TPPA defines "illegal activities" as "activities that are in violation of the criminal or civil code of this state or the United States or any regulation intended to protect the public health, safety or welfare." Tenn. Code Ann. § 50-1-304(a)(3). Thus, under the TPPA, illegal activity requires violation of a state or federal statute or regulation. The court first looked at the complaint in reference to 2015 OSHA workplace violence guidelines. Because they are not statutory provisions or regulations but non-mandatory guidance only, their violation did not constitute illegal activity under TPPA. It then looked at the general duty clause of the Occupational Safety and Health Act. The Court noted federal precedence for the proposition that an employer may violate the general duty clause by failing to have sufficient policies in place to prevent workplace violence. Thus, it determined that the trial court erred in dismissing Employee's complaint on the basis that it did not allege activity related to a statute or regulation. Based on Tenn. Code Ann. § 50-3-102(b), the court further determined that workplace safety, including the prevention of workplace violence, is a matter of public concern in the State of Tennessee. Finding therefore, that the complaint stated a sufficient claim under, TPPA, the Court of Appeals reversed the trial court's dismissal of the case.

47. *Earle J. Fisher, et al v. Tre Hargett, et al,* No. M2020-00831-SC-RDM-CV. Filed August 5, 2020 and *Benjamin Lay et al v. Mark Goins, et al.,* No. M2020-00832-SC-RDM-CV. Filed August 5, 2020.

- Injunction
- Construction of the eligibility requirements for absentee voting

On the surface, this case might be understood to be about absentee voting statutory interpretation but since the underlying reason for the case being brought is the current worldwide pandemic, the nexus to health care cannot be ignored. Here, the trial court issued a temporary injunction enjoining the State from enforcing its construction of the eligibility requirements for absentee voting stated in Tennessee Code Annotated section 2-6-201(5)(C) and (D) (2014 & Supp. 2019). The injunction temporarily mandated the State to provide any eligible Tennessee voter, who applies to vote by mail in order to avoid transmission or contraction of COVID-19, an absentee ballot in upcoming elections during the pendency of pandemic circumstances. The injunction further mandated the State to implement the construction and application of Tennessee Code Annotated section 2-6-201(5)(C) and (D) that any qualified voter who determines it is impossible or unreasonable to vote in-person at a polling place due to the COVID-19 situation shall be

eligible to check the box on the absentee ballot application that "the person is hospitalized, ill or physically disabled and because of such condition, the person is unable to appear at the person's polling place on election day; or the person is a caretaker of a hospitalized, ill or physically disabled person," and have that absentee voting request duly processed by the State in accordance with Tennessee law. The State interpreted the statute such that a voter in fear of becoming ill or of spreading COVID-19 was not eligible to vote absentee. Plaintiffs wanted those in fear of becoming ill or of spreading COVID-19 to be able to vote absentee – basically anyone who wanted to vote absentee. Other plaintiffs who had an auto-immune deficiency and were particularly vulnerable to contracting COVID-19 sought to be eligible to vote absentee.

The case got to the Tennessee Supreme Court State via expedited review when the Court of Appeals granted the State permission to appeal pursuant to Rule 9 of the Tennessee Rules of Appellate Procedure. The Court reviewed two distinct categories of plaintiffs and persons within the scope of the trial court's temporary injunction: 1) persons with special vulnerability to COVID-19 and persons who are caretakers for persons with special vulnerability to COVID-19; and 2) persons who neither have special vulnerability to COVID-19 nor are caretakers for persons with special vulnerability to COVID-19.

During oral argument, the State conceded that plaintiffs and persons with special vulnerability to COVID-19 or who are caretakers of persons with special vulnerability to COVID 19 are eligible to vote absentee by mail pursuant to the statutory eligibility requirements for absentee voting by mail set forth in Tennessee Code Annotated section 2-6-201(5)(C) and (D). Therefore, the Court held that as to plaintiffs and persons with special vulnerability to COVID-19 or who are caretakers of persons with special vulnerability to COVID 19, injunctive relief is not necessary as they may vote absentee:

> (5) Persons Over 60--Persons Hospitalized, Ill or Disabled. . . .
> (C) The person is hospitalized, ill or physically disabled, and because of such condition, the person is unable to appear at the person's polling place on election day; or
> (D) The person is a caretaker of a hospitalized, ill or disabled person

With respect to the plaintiffs who do not have any special underlying vulnerability to COVID-19, the Court determined that the case had characteristics of both an as-applied challenge and a facial constitutional challenge. First, the Court had to determine the appropriate standard for reviewing right to vote challenges. The Court reviewed under the same standard as the trial court, the *Anderson-Burdick* framework; whereby courts weigh the burden against "'the precise interests put forward by the State as justifications for the burden imposed by its rule,' taking into consideration 'the extent to which those interests make it necessary to burden the plaintiff's rights.'"

The first step was to determine the extent of the burden imposed by the State on the right to vote. It found that the risk to the non-vulnerable category of voters is significantly less than the risk to voters with special vulnerability to COVID-19 or voters who are caretakers for persons with special vulnerability to COVID-19. It refused to say that in-person voting is foreclosed for non-vulnerable plaintiffs, or that they are excluded or virtually excluded from voting. The State's Plan for in-person voting includes detailed measures for their protection and the protection of the poll workers, including social distancing, screening questions for poll workers before entry into the polling places, plexiglass shields for check-in procedures, mandatory masks and gloves for poll workers and recommended masks for voters, single use pens for voters to use to sign poll books, single use styluses for voters to use to ensure touchless voting, and frequent and regular sanitation of surfaces. Thus the Court did not classify the burden on the right to vote of this category of plaintiffs as severe but rather, the burden "best characterized as moderate."

Next, the Court weighed the moderate burden against the precise interests put forward by the State as justification for the burden imposed, the burden resulting from the statutory eligibility requirements for absentee voting by mail set forth in Tennessee Code Annotated section 2-6-201(5)(C) and (D), in the context of the COVID-19 pandemic. The State identified three specific interests: 1) prevention of fraud; 2) fiscal responsibility; and, 3) feasibility. The Supreme Court rejected fraud but found that the State's interests in the efficacy and integrity of the election process are sufficient to justify the moderate burden placed on the right to vote of those plaintiffs and persons who neither have special vulnerability to COVID-19 nor are caretakers for persons with special vulnerability to COVID-19 and concluded that those plaintiffs are unlikely to succeed on the merits of their claims. The trial court erred in granting the temporary injunction with respect to non-vulnerable voters.

48. *Blount Memorial Hospital v. Eric Glasgow,* No. E2019-00776-COA-R3-CV. Filed August 18, 2020.

- Quantum meruit

Plaintiff Hospital sued Defendant seeking to recover payment for medical services received by Plaintiff on December 29, 2013 and on January 3, 2014, in the amount of $31,595.55. At issue during the trial was the value of the medical services. Plaintiff introduced the value of services and patient consent to pay form through its financial counselor as well as the fact Defendant's primary and secondary health insurance coverage refused to pay the bills. The counselor also testified the amount was based on hospital charges in the area. Defendant did not present evidence to the contrary. The bills submitted to Defendant did not include contractual discounts that would have applied pursuant to Blount Memorial's agreements with Defendant's health insurance. Thus, Defendant took the position the discounts would have made the amount owed lower. The trial court decided in favor of the amount asserted by Plaintiff Hospital. It reasoned that $31,595.55 was a customary charge for the services because "the amount that was billed in this case was the amount that was and is set by Medicare and . . . [it] is the same amount as any hospital that accepts Medicare patients and gets paid by Medicare[.]" Defendant appealed.

The sole issue for the Court of Appeals was whether Plaintiff proved by a preponderance of the evidence that the amount it charged for medical services represented the actual and reasonable value of those services under a quantum meruit theory. The court relied on the case of *Doe v. HCA Health Services of Tennessee, Inc.,* it was not necessary that Plaintiff's financial counselor have experience in setting the prices for hospital services in order to provide competent testimony regarding what was reasonable and customary rates. The counselor had 14 years' experience, testified as to community hospital rates, and there was no controverting testimony on rates from Defendant. A prima facia case on rates was established but not rebutted by Defendant. Thus, the trial court was affirmed.

Attorney General Opinion Update

TENNESSEE ATTORNEY GENERAL OPINIONS ON HEALTH ISSUES

1. *Governor's Emergency Management Executive Orders.* Opinion No. 20-07. April 27, 2020.

The question posed by the Speakers was whether executive orders issued by the Governor addressing the COVID-19 pandemic serve as the exclusive regulation of the State's emergency management in response to the pandemic, and to what extent, if any, may local governmental entities take actions or issue orders that conflict with the Governor's executive orders? The question arose as local mayors and counties

contemplated orders that were either more or less restrictive than executive orders issued by the Governor during the COVID-19 pandemic. The Attorney General responded yes.

The Governor declared the COVID-19 outbreak an emergency in Tennessee. Absent an express delegation of power by the Governor, local governmental entities may not take actions that are either more restrictive or less restrictive with respect to the subjects addressed in the Governor's executive orders governing the State's emergency response to COVID-19. The Governor has exclusive responsibility and authority to assume control over all aspects of the State's response to an emergency such as the COVID-19 pandemic pursuant to TCA § 58-2-107(a)(1). The statute indicates that the executive orders issued pursuant to that authority have the force and effect of law.

2. *Potential Legal Consequences for Pharmacists under the Proposed Cannabis Act.* Opinion No. 20-11. June 5, 2020.

Considering marijuana is federally classified as a Schedule I controlled substance, the Attorney General was asked to opine as to whether pharmacists would face any adverse legal consequences if they provided counsel and guidance to patients regarding the medical use of cannabis if medical cannabis was authorized. This was asked based on pending legislation in the General Assembly.

The Attorney General responded that the Cannabis Act would immunize pharmacists acting in good faith from adverse administrative actions and civil liability under state law. As for criminal liability, the proposed Cannabis Act would not immunize pharmacists from state criminal liability and would not—and could not—immunize pharmacists from adverse administrative and criminal punishment under federal law. The AG went the further and opined that pharmacists who acted in good faith pursuant to the state medical cannabis program would be highly unlikely to face criminal prosecution or adverse administrative action by the federal government.

3. *Constitutionality of Governmental Mandate to Wear Face Covering.* Opinion No. 20-14. July 24, 2020.

Addressing a polarizing, often politicized, issue with passion on both sides, the Attorney General was asked to opine on the question of whether it is constitutional for a governmental edict to be issued mandating citizens wear face coverings during a pandemic such as COVID-19. The AG responded that a governmental mandate that requires the general population to wear face coverings in public due to the health emergency caused by COVID-19 would be constitutionally defensible. In 2020, Tennessee Governor Bill Lee issued executive orders #38 and 54 which encouraged the populace to wear masks with some exceptions during the COVID-19 emergency and authorizing county mayors to mandate that citizens wear masks within their jurisdictions.

The AG applied the two-pronged test enumerated by the U.S. Supreme Court in *Jacobson v. Massachusetts*. First, a governmental mandate to wear face coverings in public has a "real or substantial relation" to the COVID-19 health crisis. In considering whether a governmental measure has a "real or substantial relation" to a public health crisis, the inquiry is whether the measure is arbitrary or unreasonable. The governmental decision as to how best to protect the public is afforded great deference. Unless the measure adopted by the government is arbitrary or unreasonable, a court's interference is not justified. Face coverings reduce the chances that respiratory droplets containing the virus will infect others. Even though some may be unconvinced that wearing face coverings is an effective way to thwart the spread of COVID-19, courts may not second-guess governmental officials when the measures they enact in response to a public health emergency are not arbitrary or unreasonable. As to the second prong,

under the minimal scrutiny required by *Jacobson*, a governmental mandate to wear face coverings in public during the current COVID-19 health crisis does not amount to a "plain, palpable" invasion of clearly protected rights.

The AG likened a mask mandate to other liberty restrictions that have been upheld such as the seat belt and motorcycle helmet requirements. The AG addressed common arguments against mandates backed by the Fourteenth Amendment and First Amendment and concluded both would be overcome by the state interest in preventing the spread of the virus.