# Legal Issues in Health Care

## Tennessee General Assembly Clarifies “Doctor Shopping” Law

In 2009, the Tennessee General Assembly passed legislation designed to reduce “doctor shopping.” A patient “doctor shops” when he or she goes to multiple doctors in a short period of time trying to get prescriptions for the same or similar controlled substances. The legislation raised many questions and concerns among health care providers about their obligations under the new law and the potential consequences for failing to make the required reports. In an effort to clarify the legislation and address these concerns, the General Assembly passed Public Chapter 663, that become law on March 15, 2010. The table below provides a quick overview of selected differences between the two laws.

(Continued on page 2, “Doctor Shopping”)

<table>
<thead>
<tr>
<th>2010 Legislation</th>
<th>2009 Legislation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Requires report to be filed within 5 business days.</td>
<td>Required report to be filed within 3 business days.</td>
</tr>
<tr>
<td>Applies if health care provider has “actual knowledge” of the violation.</td>
<td>Applied if health care provider had a “good reason to believe” there had been a violation.</td>
</tr>
<tr>
<td>Extends good faith immunity to any person who makes the report on behalf of the provider and to any entity that has responsibility for making the report on behalf of the provider.</td>
<td>Immunizes health care provider from civil liability if the report is made in good faith.</td>
</tr>
<tr>
<td>Makes reporting optional for health care providers who are providing treatment to someone who has a mental illness (as defined by Tennessee law).</td>
<td>No similar provision.</td>
</tr>
<tr>
<td>Allows use of the information in the investigation and prosecution of the violator if the actual knowledge of the health care provider is obtained through the Controlled Substance Database, notwithstanding the confidentiality provisions.</td>
<td>No similar provision.</td>
</tr>
<tr>
<td>Does not apply in the case of a person who is enrolled in TennCare on the date of treatment.</td>
<td>No similar provision.</td>
</tr>
<tr>
<td>Imposes sanctions on a health care provider for failure to make a report only if there is a pattern of willful failure to make reports. Limits sanctions to civil penalties imposed by the provider’s licensing board.</td>
<td>Did not impose sanctions on a health care provider who failed to make the report, <em>per se</em>. However, preexisting law that was not referenced in the 2009 legislation makes it a felony if a health care provider fails to make a required controlled substance report.</td>
</tr>
</tbody>
</table>

---

**Inside this issue:**

- Pharmacists May Fill Prescriptions After Death of Prescriber
- Original Tortfeasor Can Defend by Showing Plaintiff’s Injuries Were Aggravated by Subsequent Medical Treatment
- Prescriptions for a Schedule II Controlled Substance Must Be Separate Prescription Order
- Doctor Successfully Raises Comparative Fault Defense Against Nursing Staff
- Physician Assistants Held to a Standard of Care for Physician Assistants — Not Physicians
- Supreme Court Limits Scope of Tennessee Peer Review Law
- Actual Threat Not Necessary to Trigger Duty to Protect and Warn

---

“The reportable offense is the willful deception or intentional failure to disclose [the doctor shopping activity] . . .”
If a pharmacist learns that a prescriber has died, prescriptions issued by the deceased prescriber may be dispensed under the following conditions, unless it would violate the federal Controlled Substance Act. A new prescription may be dispensed within 90 days from the date of the prescriber’s death. An authorized refill may be dispensed, but not for more than 90 days from the date of death for schedule III, IV and V drugs, and not for more than 180 days from the date of death for non-scheduled drugs. The provisions do not apply to prescriptions for schedule II drugs. However, federal regulations prohibit the dispensing of controlled substances once the practitioner has died. For controlled substances, the stricter federal law should be followed.

The law was effective on July 1, 2010. Public Chapter No. 767.

(Continued from page 1, “Doctor Shopping”)

When is a report required? Any health care provider who has actual knowledge that a person has knowingly, willfully and with intent to deceive, obtained or attempted to obtain controlled substances in violation of the “doctor shopping” law must make a report within 5 business days of obtaining such knowledge. A person violates the “doctor shopping” law by deceiving or failing to disclose to a physician, nurse practitioner, ancillary staff, or other health care provider from whom the person obtains a controlled substance or a prescription for a controlled substance, that the person has received either the same or similar controlled substance or a prescription for the same or similar controlled substance from another practitioner within the previous 30 days. A person who violates the “doctor shopping” law commits a misdemeanor.

The offense is not the fact that the patient has obtained or attempted to obtain controlled substances from another practitioner within the past 30 days. The reportable offense is the willful deception or intentional failure to disclose that fact to a provider from whom the patient is currently seeking a controlled substance. Thus, if the patient discloses the relevant information, there is no offense, and thus, the provider is not obligated to make a report.

A report is optional if the health care provider is providing treatment to a person with a mental illness, as defined by Tennessee law. Additionally, the reporting requirement does not apply in the case of a person who is enrolled in or covered by TennCare on the date of treatment.

The report must be made to the local law enforcement agency where the health care provider is located. Or, the report should be submitted to a judicial district drug task force, if one exists. For a complete list of drug task forces in Tennessee, click on this link, http://www.narcoticnews.com/Tennesseee-Drug-Task-Force-.Drug-Task-Forces-in-Tennessee-TN.html

The form on which health care providers may make the report will be developed by the controlled substance database advisory committee and should be available in August 2010 on the department of health’s website, http://health.state.tn.us/index.htm.

Immunity. If the health care provider makes the report in good faith, he or she is immune from civil liability if a complaint, report, information, or record is furnished to a law enforcement agency. The 2009 legislation limited immunity to the health care provider. The 2010 legislation extends good faith immunity to include any person who makes the report under the direction of the health care provider and any entity that assumes responsibility for making the report for the provider.

Confidentiality. The information contained in the Controlled Substance Monitoring Database is confidential. Its primary purpose is to monitor the use of controlled substances within Tennessee and help providers identify patients who may need assistance or intervention for substance abuse. Access is limited and is not generally available to law enforcement agencies. However, the 2010 legislation creates an exception to the confidentiality provisions when the health care provider has obtained actual knowledge of a person’s violation of the “doctor shopping” law through the database.

In this case, the health care provider may provide to a local law enforcement agency or a drug task force only the pertinent information from the database for the 30 days prior to the date of treatment leading to the alleged “doctor shopping” offense. This information may be sufficient grounds for the production of complete database information for purposes of a criminal investigation or prosecution.

Sanctions for failing to make the report. If a health care provider has a pattern of willfully failing to make the required reports, the health care provider may be subject to a civil penalty assessed by the provider's licensing board.

House Bill No. 2581, Public Chapter 663.

1 “Health care provider” is defined as any physician, dentist, optometrist, podiatrist, veterinarian, advanced practice nurse with a certificate of fitness or physician assistant. Tenn. Code Ann. § 53-11-309(a).
New legislation in Tennessee requires that any written, printed, or computer-generated order for a Schedule II controlled substance prepared by an authorized prescriber must be written legibly, printed, or computer-generated as a separate prescription order.

In addition, the legislation requires that the quantity indicated on handwritten prescriptions be written either in letters or numbers, instead of both letters and numbers, as current law requires.

Senate Bill No. 1790, Public Chapter No. 795, effective January 1, 2011.
Second, the Court reaffirmed that “the doctrine of joint and several liability no longer applies to circumstances in which separate, independent negligent acts of more than one tortfeasor combine to cause a single, indivisible injury.” The Court further stated that “[t]his decision is not inconsistent with our decision to retain the ruleimposing liability on tortfeasors for subsequent negligent medical care for the injuries caused by the original tortfeasor.”

The Court reversed the holding of the trial court, allowing the defendants to assert the defense of comparative fault against the nursing home.

The plaintiff now faces a choice of either naming or not naming the nursing home as an additional defendant. If the plaintiff does not name the nursing home as an additional defendant, she runs the risk of receiving less than a full recovery for her injuries if the jury finds the nursing home partially or totally at fault. On the other hand, the Court’s opinion clearly indicates that the jury may find the original tortfeasor (the driver) liable for the full amount of her damages, even those caused by the subsequent actions of the surgeon and nursing home. How these two rules work together may need further clarification from the courts or the legislature.

What is the potential impact of this case on medical malpractice liability in general? Will it lead to frivolous claims against health care providers who provide treatment to people who are injured due to the negligence of others? Will this opinion allow the defendant in any personal injury lawsuit to obscure the issue of his or her own negligence by claiming that the treating physician aggravated the plaintiff’s injuries, and thus, should be at least partially responsible for any damages awarded by the jury? The issue of medical malpractice is rarely as clear as it appears to be in this case, and a simple car accident case could easily be converted into a complex medical malpractice case.

Recent tort reform in Tennessee may alleviate some of these concerns. A defendant who asserts a comparative fault defense against a physician or other health care provider that requires the introduction of expert testimony must file a certificate of good faith within 30 days of filing an answer to the complaint. The certificate of good faith is a sworn statement that the party has consulted a qualified expert about the case, and the expert has given a written statement that there is a good faith basis to maintain the action against the health care provider based upon the available information. If the party does not later produce a qualified expert and loses on that ground, sanctions may be imposed against the party’s attorney.

This provision has arguably reduced the number of frivolous medical malpractice lawsuits filed within the past year, and it will hopefully control the number of frivolous affirmative defenses raised against health care providers who treat personal injury victims. Nevertheless, the Court’s decision will likely motivate personal injury defense lawyers to closely scrutinize the plaintiff’s medical records looking for hints of malpractice that might reduce his or her client’s potential liability.

__________

1The surgeon in this case was in the position of being both a successor tortfeasor and an original tortfeasor because his negligence aggravated the injuries caused by the defendant driver and the additional injury caused by the surgeon was further aggravated by the negligence of the nursing home. Originally, the plaintiff sued the surgeon and the Elks Club separately. The cases were later joined into one lawsuit.

2 The author is not assuming that either the surgeon or the nursing home fell below the standard of care — a finding that requires expert testimony to establish. However, the facts on their face could sway laypeople to conclude that both the surgeon and the nursing home fell below the standard of care. If the alleged malpractice had been less obvious, would the Court have reached the same conclusion in this case?

3The plaintiff who amends his or her complaint to add the new health care provider defendant in this situation, however, is not required to file a certificate of good faith. The burden of proving the alleged malpractice is on the defendant raising the affirmative defense — not the plaintiff.
Physician Assistants Held to Standard of Care For Physician Assistants — Not For Physicians

In 2009, the Tennessee Court of Appeals held that the standard of care for physician assistants in a medical malpractice case was the same standard of care that would apply to the supervising physician. On appeal, the Tennessee Supreme court reversed the ruling of the court of appeals, and held that the standard of care for physician assistants is the standard of care expected of other physician assistants who practice in the same or similar community where the defendant physician assistant practices.

In the case of Cox v. Primary and Urgent Care Clinic, (Tenn. 2010), the patient sought care on several occasions from a clinic that was owned by a physician assistant (PA). On four visits, she complained of “progressive respiratory problems, accompanied by extreme fatigue.” She was treated for these complaints by PA, but she spoke by telephone to Doctor, the medical director of the clinic and PA’s supervising physician. She reported to Doctor her increasing concerns about her chest pressure and her inability to breathe. Her condition continued to worsen, and PA referred her to a pulmonologist. Before her appointment with the pulmonologist, she was diagnosed at Medical Center with cardiomyopathy. A mitral valve repair and a mitral valve replacement surgery were ultimately performed.

Patient sued Doctor as supervising physician and the clinic owned by PA, but did not sue PA personally. At the trial level, the plaintiff’s expert witness testified in a deposition that PA’s services to the patient fell outside the standard of care applicable to a primary care physician, but that Doctor met the standard of care applicable to a primary care physician. Plaintiff’s expert also testified that he had never worked with physician assistants, did not know the responsibilities of a supervising physician toward a physician assistant, and was not in a position to testify about the acceptable standard of professional practice of a physician assistant.

The trial court granted the defendants’ motion of summary judgment on the grounds that plaintiff had failed to establish the standard of care for a physician assistant and that the defendants had failed to meet that standard. On appeal, the Tennessee Court of Appeals reversed the trial court, holding that the standard of care for a physician assistant was the same standard of care applicable to the supervising physician in the same or similar community in which the supervising physician practices. Because plaintiff’s expert established the standard of care for a primary care physician, and he testified that PA had failed to meet that standard of care, the court held that plaintiff had met her burden to establish a genuine issue of material fact. Thus, summary judgment for the defendants was reversed.

The Tennessee Supreme Court granted permission for an appeal to address an issue of first impression in Tennessee — which standard of care applies to a physician assistant in a medical malpractice case.

First, the Court analyzed that a physician assistant stands in an agency relationship with the supervising physician, whereby the physician assistant occupies the role of agent and the supervising physician occupies the role of principal. A nurse on duty testified that she knew that the standard of care required her to call Doctor upon a change of mental status of a patient. She further testified that she was not entirely certain that the patient had undergone a significant change. Instead of contacting Doctor, as she knew she should, she consulted with other nurses.

The jury found that Doctor had deviated from the standard of care. However, they also found that Doctor was not the legal cause of the patient’s death, resulting in a jury verdict in favor of Doctor. The jury verdict was upheld on appeal.


For your information:

Summary judgment: The court renders a judgment before a trial based upon facts not in dispute, and the application of law to those facts entitles a party to a judgment on the claim as a matter of law. If there is a dispute as to a material fact in the case, summary judgment is denied, and the case goes forward to trial.

Material fact: A fact that might affect the outcome of the case.

ing physician occupies the role of principle. Thus, in this case, Doctor could be held vicariously liable for PA’s negligence. In addition, because PA was also an employee of the clinic, the clinic could be held liable for PA’s negligence under the agency doctrine of "respondeat superior."

The Court then addressed the standard of care applicable to a physician assistant. The Court reviewed law from other jurisdictions and found that Tennessee law was similar to the law in states that held a physician assistant to a standard of care different from a physician’s standard of care. The underlying rationale for this determination included the following findings.

• Physician assistants do not have the same autonomy as physicians, and they are statutorily limited to performing "only those tasks that are within the physician assistant’s range of skill and competence."¹

• Physician assistants may be subject to disciplinary actions for practicing medicine without a license if they provide professional services inconsistent with Tennessee law.²

• Physician assistants are required only to be graduates of physician assistant training programs and to successfully complete a national examination for the certification of physician assistants.³ It would be unfair to hold a medical provider to a standard of care that he or she has not been trained to meet.

• A physician assistant’s standard of care is established, at least in part, by the written protocol developed between the physician assistant and his or her supervising physician.⁴ The Court noted that this rule clearly implies that a physician assistant’s standard of care is not the same standard of care applicable to the supervising physician.

The Court concluded that based on statute and common knowledge, physicians and physician assistants were not equivalent categories of health care providers, and thus, each should be held to a different standard of care.

Because plaintiff had failed to produce an expert that could testify as to the standard of care applicable to a physician assistant practicing in the same or a similar community as PA, the Court held that the trial court was correct in awarding summary judgment to the defendants based on the alleged negligence of PA.

---

² Id. § 63-19-108.
³ Id. § 63-19-105(a)(2).
⁴ Tenn. Comp. R. & Regs. .0880-02-.18(5)(b), (6).

Supreme Court Limits Scope of Tennessee Peer Review Law

Following an audit, a hospital system made a business decision to stop outsourcing the provision of vascular access services to patients in its member hospitals and to begin providing these services using nurses employed by its own hospitals. After several of the member hospitals canceled their vascular access services contracts, the vendor that had been providing those services filed suit against a number of defendants who had been involved in the audit and decision to terminate the contracts, alleging improper interference with its business contracts.

During discovery, the vendor requested copies of documents and records relating to the audit of its services. The defendants refused to produce the requested records, claiming that they were protected from discovery under the privilege in Tennessee Peer Review Law of 1967, which protects confidential information even pursuant to a court order. The trial court determined that most of the requested records were protected by the privilege, and thus, not discoverable by the plaintiff. The Tennessee Supreme Court agreed to hear the appeal after the Tennessee Court of Appeals declined to accept the appeal. The Tennessee Supreme Court ruled that the records were not protected by the privilege and were discoverable by the plaintiff.

The Tennessee Supreme Court agreed to hear the appeal because of the ambiguity and internal conflicts created by the statutory language. The issue addressed by the Court is whether the peer review privilege extends to proceedings involving a hospital’s business decisions that affect the quality and cost of patient care. The Court held that the privilege only extends to peer review proceedings before a peer review committee as defined by Tennessee statute that involve a physician’s conduct, competence, or ability to practice medicine.

(Continued on page 7, Peer Review)
Tennessee law defines a “peer review committee” as “any committee . . . of any licensed health care institution . . . the function of which, or one (1) of the functions of which, is to evaluate and improve the quality of health care rendered by providers of health care service[s].” The Court acknowledged that the quality management committees that had considered the audit and made the decision to stop outsourcing the vascular access services fell within the statutory definition of “peer review committee.” However, the Court stated that failing within the definition was only part of the inquiry. The Court must also determine whether these committees were engaging in a “peer review function” when they received the audit report and other disputed records.

The Tennessee Supreme Court held that these proceedings were not peer review proceedings for the purposes of Tenn. Code Ann. § 63-6-219(e) because they did not involve a physician’s professional conduct, competence, or ability to practice medicine.

Two of the Supreme Court Justices filed a dissenting opinion, disagreeing with the holding of the majority on several grounds. First, although the privilege created by the statute is quite broad, the language is neither ambiguous nor conflicting. Second, the term “peer review proceeding” is not found in the statute and was created by the majority solely to limit the scope of the privilege to those committee deliberations that involve a physician’s conduct, competence, or ability to practice medicine.

The majority was concerned that a hospital could avoid all production of documents and records in civil proceedings simply by placing all of its regular business functions under the umbrella of a committee that meets the definition of “peer review committee.” The dissent noted that this concern about hypothetical abuse of the peer review privilege was not the question before the Court, and that any remedy for such abuse should be addressed by the General Assembly.

The purpose of the privilege is to encourage frank and open discussion without fear of reprisal about issues that affect the quality of patient care. With this case as precedent, how many people will offer a negative opinion as to the quality of services provided by a medical vendor if they risk being sued for libel, slander, defamation, or tortious interference with a business contract? The Tennessee General Assembly should consider this issue and clarify the scope of the privilege. Is the majority correct — or the dissent?


Actual Threat of Harm Is Unnecessary to Trigger “Duty to Protect and Warn”

A man receiving outpatient treatment from a psychiatrist shot and killed his wife and himself. Patient’s daughter filed suit against the psychiatrist and his medical practice on the grounds that he “negligently failed to provide reasonable care to his patient . . . and negligently failed to protect [patient’s] family from harm.” The trial court granted summary judgment for the defendants, and the plaintiff appealed. On appeal, the defendants argued that summary judgment was appropriate because there was no evidence to establish that the patient had communicated to the psychiatrist any actual threat to harm the mother or daughter, and in the absence of any actual, communicated threat, the psychiatrist had no duty to protect the patient’s family under Tenn. Code Ann. § 33-3-206.¹

The Tennessee Court of Appeals disagreed with the defendants’ interpretation of the statute, finding that the statute was not the exclusive source of law for imposing a duty to protect on a mental health care provider. The court looked to see what duties a psychiatrist might owe to a non-patient under common law (law created by judges).

To answer this question, the court looked to a case decided by the Tennessee Supreme Court in 1997 (Turner v. Jordan, 957 S.W.2d 815). In Turner, the Supreme Court held that a psychiatrist has a duty of care where the psychiatrist knows or should know that a patient poses an unreasonable risk of harm to foreseeable, readily identifiable third persons. In Turner, a patient injured a nurse, and the nurse sued the psychiatrist, arguing that her injuries were caused by the psychiatrist’s failure to protect her from the intentional and violent acts of a patient.

Using Turner as precedent, the court of appeals found a common law duty to protect foreseeable, readily identifiable third persons that was independent of the Tennessee statute. Thus, the fact that patient did not communicate an actual threat of harm to the psychiatrist was not dispositive of the case. Nor was the fact that the victims knew of the risk of harm posed by the

(Continued on page 8, Duty to Protect)
patient. These facts are for the jury to consider. Summary judgment for the defendants was reversed, and the case was sent back to the trial court.

To bolster its holding that the statute does not apply, the court of appeals emphasized the fact that the duty to protect was not the only claim made by the plaintiff — she had also claimed that the psychiatrist’s failure to treat her father according to the accepted standards of psychiatric care resulted in the death of her mother and her own emotional injuries. The court distinguished between a claim for failure to warn family members and a claim of negligent diagnosis and treatment that led to the harm suffered by family members.

However, negligent diagnosis and treatment are claims of medical malpractice that are brought on behalf of a patient. The claims in this case were brought on behalf of non-patients — the daughter and mother. The court reasoned that the claims were not medical malpractice because they weren’t brought on behalf of a patient, and thus, they were simply claims for ordinary negligence, even though medical expert testimony would be needed to prove them. It is difficult to reconcile this language with recent Tennessee cases that clearly define medical malpractice as “negligent conduct that constitutes or bears a substantial relationship to the rendition of medical treatment by a medical professional.” If the alleged negligence falls within the definition of medical malpractice, the Tennessee Medical Malpractice Act applies. The court’s willingness to permit a non-patient to assert these claims in an ordinary negligence action is troubling and appears to significantly extend the duty owed by a health care professional to a non-patient in Tennessee.

The court relied on Turner to justify this conclusion, but the court’s reliance on this case appears misplaced. A careful reading of Turner reveals it does not recognize a separate claim for negligent diagnosis and treatment. The issue determined in Turner was whether a psychiatrist owed a duty of care to protect a nurse from the violent and intentional acts of a hospitalized mentally ill patient. A jury could find such a duty breached by finding that the psychiatrist deviated from the standard of care by failing to medicate, restrain, seclude, or transfer the patient. While the standard of care applicable to the psychiatrist’s treatment of patient is necessarily part of the plaintiff’s proof, the claim is for failure to protect — not for negligent diagnosis and treatment which is clearly a claim for medical malpractice that may be brought only on behalf of a patient.

The decision of the court in this case raises questions that justify clarification from either the Tennessee Supreme Court or the General Assembly.

1 Tenn. Code Ann. § 33-3-206 states:
“IF AND ONLY IF
(1) a service recipient has communicated to a qualified mental health professional or behavior analyst an actual threat of bodily harm against a clearly identified victim, AND
(2) The professional, using the reasonable skill, knowledge, and care ordinarily possessed and exercised by the professional’s specialty under similar circumstances, has determined or reasonably should have determined that the service recipient has the apparent ability to commit such an act and is likely to carry out the threat unless prevented from doing so, THEN
(3) The professional shall take reasonable care to predict, warn of, or take precautions to protect the identified victim from the service recipient’s violent behavior.”

The mental health professional can discharge his or her responsibility under the statute in several ways, including warning the intended victim. The court interpreted the statute to apply only if there is an actual threat communicated. If there is no actual threat, then common law applies.