Tennessee General Assembly Cracks Down on “Doctor Shopping”

Prescription drug use in Tennessee ranks as one of the highest in the nation. According to a report by BlueCross BlueShield in 2007, Tennessee residents averaged 17.3 prescriptions per person compared with 11.3 prescriptions per person nationwide. Not surprisingly, Tennessee also ranks high in prescription drug abuse and accidental poisoning from prescription drugs.

In 2009, the Tennessee General Assembly added two new weapons in its arsenal in the war on prescription drug abuse — both aimed at preventing patients from “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 first law provides civil immunity to a prescriber who reports a patient who seeks a controlled substance but who has failed to disclose that he or she has obtained or has attempted to obtain the controlled substance from another practitioner within the previous 30 days. The second law imposes a civil penalty of $100 per day on any dispenser who may potentially dispense a controlled substance and who does not provide electronic access to the Tennessee Controlled Substance Database.

Reporting “Doctor Shopping.”
As of July 1, 2009, prescribers are now required to report undisclosed doctor shopping behavior if they have good reason to believe it is occurring. The term “prescriber” includes physicians, dentists, optometrists, podiatrists, veterinarians, authorized nurses, and physician assistants.

Under the law, if a prescriber has good reason to believe that a person who has obtained or who has attempted to obtain a controlled substance has deceived or failed to disclose that he or she has obtained the same controlled substance (or a drug with similar therapeutic use) from another practitioner within the previous 30 days, the prescriber “shall” report the activity within 3 business days to the local law enforcement agency for investigation. If the health care provider is acting in good faith, he or she is immune from civil liability for making a complaint, or furnishing a report, information, or records to law enforcement in compliance with the law.

In addition to providing civil immunity to the prescriber for making the report, the new legislation makes it a misdemeanor for a person to conceal “doctor shopping” activities. If a patient obtains or attempts to ob-
tain a controlled substance or a prescription for a controlled substance, the patient must disclose to the prescriber whether he or she has obtained the same controlled substance or a prescription for the controlled substance (including any with a similar therapeutic use) from another practitioner within the previous 30 days. Patients who knowingly and intentionally conceal this information may be charged with a Class A misdemeanor. The duty to report applies only if the person has violated the statute making concealment of this information a misdemeanor. Thus, if the patient openly admits to the prescriber that he or she has obtained the same controlled substance from another prescriber within the past 30 days, there is nothing to report. The new law does not make “doctor shopping,” in and of itself, a crime. The crime that must be reported is the knowing and intentional concealment of the “doctor shopping” activity.

Public Chapter No. 67, Senate Bill No. 408.

Electronic Access to the Controlled Substance Database.

Since 2006, practitioners who dispense controlled substances to patients have been required to submit monthly reports to the Board of Pharmacy regarding the controlled substances dispensed. For purposes of this law, the term “dispenser” includes not only pharmacies that fill prescriptions, but also practitioners who dispense controlled substances to their patients to take home. The law does not apply to practitioners who merely issue prescriptions for controlled substances.

A primary purpose of the database is to monitor the use of controlled substances within Tennessee and to help practitioners identify patients who may need assistance or intervention for substance abuse. For confidentiality reasons, access to the database is limited, but it may be accessed by practitioners who are currently issuing a prescription for a controlled substance and by dispensers who are dispensing controlled substances to a patient.

The new law, effective January 1, 2010, requires all practice sites where a controlled substance is dispensed to provide for electronic access to the database at all times when the dispenser provides health care services to a human patient potentially receiving a controlled substance. This law applies not just to pharmacies, but to any practitioner’s office or clinic where controlled substances that are to be consumed elsewhere are dispensed to patients.

The law does not apply to any dispenser who is not required to submit the monthly report to the database. The reporting requirements do not apply to:

(1) Any drug administered directly to a patient;
(2) Any drug dispensed by a licensed health care facility if the quantity dispensed is limited to an amount adequate to treat the patient for a maximum of 48 hours;
(3) Any drug sample dispensed; or
(4) Any facility registered by the DEA as a narcotic treatment program and is subject to the record-keeping provisions of federal law.

Failure to provide for electronic access to the database

(Continued on page 5, Mammogram)

Absent Proof of Mailing, Computer-Generated Patient Reminders Were Not Admissible

At age 35 in 2001, Patient had a routine screening mammogram. In his report, Doctor did not note or report any abnormality, but recommended that Patient get a follow up mammogram in a year. This recommendation was included in the letter sent to Patient the day after the mammogram. One year later, the Breast Center claimed to have sent three additional notices to Patient, reminding her to get a follow up mammogram. Patient denied receiving the notices, and she did not get a follow up mammogram until 2004 when she noticed an indentation in her right breast and pain in the movement of her right arm. She was diagnosed with a malignancy that had spread to her liver.

She sued Doctor and the Breast Center. Doctor conceded at trial that the 2001 films contained a cluster of calcifications that he would now describe as suspicious, but he

(Continued on page 5, Mammogram)
Tweaking Tort Reform — Lose a Little, Gain . . . Maybe a Lot

In 2009, The Tennessee General Assembly tweaked the tort reform legislation of 2008 — extending the time that a plaintiff has to file a medical malpractice lawsuit, but shortening the time the plaintiff has to find a qualified expert witness. At first glance, the legislation appears to give a little to both sides of the tort reform debate. But, who really benefits from these changes that went into effect on July 1, 2009?

To understand the changes, it is necessary to review the 2008 tort reform legislation. The 2008 legislation imposed a requirement that before a complaint for medical malpractice could be filed, the plaintiff must give the potential defendants notice 60 days prior to filing the complaint. If proper notice is given, the statute of limitations1 and the statute of repose2 are extended by 90 days under the 2008 reform legislation. Thus, a plaintiff had three additional months to file the complaint during which time the claim would have been barred under pre-2008 law. Once plaintiff files a complaint, the 2008 legislation requires the plaintiff to file a Certificate of Good Faith within 90 days of filing the complaint.

The Certificate of Good Faith is a statement filed by the plaintiff that states a qualified expert has been consulted who has provided a written statement to the effect that the expert has reviewed the available medical records and has formed a good faith belief that there are reasonable grounds on which to base a medical malpractice claim. The plaintiff does not have to produce the written statement of the expert, merely a Certificate of Good Faith that such a statement has been obtained.

The 2009 tort reform legislation requires that the Certificate of Good Faith be filed with the complaint (rather than within 90 days of its filing), and it extended the statute of limitations and the statute of repose by 120 days, giving the plaintiff an additional 4 months to file the lawsuit in court as long as proper notice is given at least 60 days prior to filing the complaint.

Although extending the statutes of limitations and repose appear to benefit the plaintiff, the net effect of the two changes may actually disadvantage the plaintiff. Compare the following fact scenario analyzed under each of the 2008 and 2009 tort reform legislation.

2008 Legislation. The alleged malpractice occurs and is known to the plaintiff on June 1, 2009. The claim will be barred under the statute of limitations after June 1, 2010. Plaintiff provides the required notice to the defendants on June 1, 2010, which extends the statute of limitations for 90 days, or until August 30, 2010. Thus, the claim is not barred until after August 30, 2010. Plaintiff files the complaint on August 30, 2010. Plaintiff now has an additional 90 days to file the Certificate of Good Faith, or until November 28, 2010.

2009 Legislation. Consider the same facts given in the above example, except that plaintiff now has 120 additional days to file the complaint in court, or until September 29, 2010. But, the plaintiff must now file the Certificate of Good Faith with the complaint, so the plaintiff has lost two months that were otherwise available to search for a qualified expert witness.

Qualified Immunity Defense Available to Hospitals For Credentialing Decisions Made by a Peer Review Committee

Patient sued her surgeon for malpractice and sued the hospital for allowing the surgeon to practice in its facilities. The issue was whether the hospital was eligible for qualified immunity under the Tennessee Peer Review Act.

Patient went to see Doctor, a plastic surgeon, concerning excess skin on various parts of her body due to weight loss, and he performed several surgical procedures. Ten days later, Patient developed open wounds on her back, and Doctor sutured them. Several days later, Patient complained of pain in her left lower calf and in the wounds on her back and thigh. Doctor gave her a prescription for Avelox. Patient developed shortness of breath and increased pain in her left leg. She went to the emergency room...
In many jurisdictions, an independent medical examination (IME) cannot result in a claim for medical malpractice. When a physician is merely “evaluating” the patient, rather than “treating” the patient, no physician-patient relationship is said to exist. The physician’s duty of care arises from the physician-patient relationship, and if there is no relationship, there is no duty. Thus, there is no legal basis for a medical malpractice lawsuit. The only duty the physician owes the patient is not to harm him or her during the evaluation, and any claim for negligence against the evaluating physician is based on ordinary negligence rather than medical malpractice.

Some jurisdictions have abandoned or rejected this line of reasoning in favor of finding that a limited physician-patient relationship is created during an independent medical examination, thereby allowing a plaintiff to bring an action for medical malpractice against the evaluating physician. The Tennessee Court of Appeals has recently held that this approach to IME cases is more consistent with Tennessee law than the former approach.

In *Gentry v. Wagner*, plaintiff had been in a car accident in which he allegedly hurt his neck and lower back. As part of his lawsuit for injuries he sustained in the car accident, the court ordered plaintiff to submit to a physical examination by Doctor, a neurologist. Plaintiff claims that Doctor, after finding out that he was a paralegal, berated him about how the legal profession had negatively impacted his life. Doctor then proceeded to forcibly push and jerk plaintiff’s neck and back, causing him much pain. As a result of this exam, plaintiff sued Doctor.

The trial court granted Doctor’s motion for summary judgment on the grounds that plaintiff had failed to offer expert testimony to establish the applicable standard of care, a breach of that standard, and causation as required by the Tennessee medical malpractice statute. Plaintiff argued on appeal that the Tennessee medical malpractice statute did not apply because there was no physician-patient relationship between him and Doctor. Thus, plaintiff argued that he did not have to produce an expert witness because his claim was grounded in ordinary negligence rather than medical malpractice.

The Tennessee Court of Appeals affirmed the summary judgment.

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**Court-Ordered Medical Examination Can Be Basis for Medical Malpractice Claim**

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**Certificate of Good Faith**

If the certificate is not filed with the complaint, the complaint will be dismissed unless plaintiff shows that the failure was due to the failure of the providers to timely provide copies of the claimant’s records or demonstrates extraordinary cause. The term “extraordinary cause” is not defined.

Anecdotal evidence suggests that the requirement of a Certificate of Good Faith (coupled with fines that may be imposed on plaintiffs’ attorneys for failing to support their claims with a qualified expert) may have reduced the number of medical malpractice lawsuits filed in Tennessee since the 2008 tort reform legislation became effective. If this trend holds true, requiring the plaintiff to find a qualified expert witness within a more reasonable time frame should help to further reduce the number of frivolous medical malpractice lawsuits in Tennessee.

For a more detailed explanation of the 2008 Tort Reform Legislation, see the following newsletter article:

*July 2008, Newsletter, “Tort Reform in Tennessee, Does it Have Teeth?”*

1 Statute of limitations bars the filing of a medical malpractice lawsuit one year after the date on which the alleged injury was discovered.

2 Statute of repose bars the filing of a medical malpractice lawsuit three years after the alleged malpractice occurred.

3 The 2009 legislation clarifies that the extension does not begin to run until the expiration date of the statute of limitations or repose.

4 November 28, 2010 falls on a Sunday. For simplicity, weekends and holidays which might further extend the filing deadline will be ignored.
may result in a civil fine of $100 for each day that the violation continues. The penalty is imposed only where there is a continued pattern or practice of not providing electronic access to the database.

The dispenser may not be held civilly liable for the failure to check the database, or for actions taken after reasonable reliance on information in the database.

Access to the database enables dispensers to run an immediate check on a patient’s use of controlled substances to spot possible “doctor shopping” and other abuses. Requiring dispensers to provide electronic access to the database will facilitate these tasks.

Public Chapter No. 228, House Bill No. 151.

(Continued from page 2, Doctor Shopping)

maintained that his actions in 2001 met the applicable standard of care. Expert testimony was split as to whether the 2001 films were suspicious for cancer. Defendants argued that Patient could have mitigated her damages if she had followed their recommendations to get a follow up mammogram in 2002. However, the reminder notices that defendants claimed to have sent Patient in 2002 were computer-generated, and defendants offered inadequate proof that the reminders actually had been mailed.

Because Patient denied receiving the reminders and because the defendants failed to adequately prove their mailing, the trial court excluded the reminders from evidence. During jury deliberations, the jury sent a question to the court asking whether reminders had been sent to Patient. Because the reminders had been excluded from evidence, the jury was never told that the defendants claimed to have sent Patient three reminders in 2002. The jury returned a verdict of $2,780,000 in favor of Patient, which was upheld on appeal. The jury reduced their original verdict of $3,475,000 by 20% based on the fault of the Patient.

On appeal, the issue was whether defendants presented “proof from the appropriate witness to establish that the computer version of the letters was deposited in the mail.” Although the burden was on defendants to prove Patient had received the reminders, receipt may be presumed from competent proof of mailing without return. Mailing may be proved by a witness with personal knowledge that the letters had been deposited in the mail, or by showing a routine practice of sending out correspondence. The defendants offered proof of mailing using an employee of the Breast Center, but this employee testified that the reminders had been delivered to the hospital for mailing. The employee of the hospital who was charged with the mailings was not called as a witness, and thus, the defendant’s evidence of mailing fell short.

The Tennessee Court of Appeals upheld the ruling of the trial court to exclude the reminders, finding that the rules of evidence required that the “habit or routine practice proven must be the habit or the practice of the mailer, and not some person once removed from the mailer.”

Whether the admission of these reminder letters would have reduced the jury verdict beyond the 20% is purely speculative, and the defect in evidence resulted from the defense attorneys’ failure to call the necessary witness. Nevertheless, the court’s holding should put the medical community on notice that if reminders are mailed to patients, a routine practice of mailing the reminders must be established and maintained.

room where a test showed deep vein thrombosis (a blood clot). She was found to have a pulmonary embolism and was prescribed Coumadin (a blood thinning medicine). After her discharge, she again saw Doctor who again closed the wound on her back. Several days later, she was back in the emergency room complaining of shortness of breath and chest pain. Examination showed that she was bleeding into her lungs and that her blood had become too thin. Patient continued to have problems with the open wounds on her back and thigh.

Patient sued Doctor for medical malpractice, and she also sued the hospital for granting surgical privileges to Doctor and for not revoking his privileges because he was incompetent and dangerous. The trial court denied the hospital’s motion for summary judgment, finding that it did not have immunity under the Tennessee Peer Review Act. The Tennessee Court of Appeals reversed, finding that the decision of the hospital peer review committee to recommend renewal of Doctor’s surgical privileges is protected by the qualified immunity provided under the Peer Review Act.

In so holding, the court of appeals distinguished several Tennessee cases that held hospitals owed patients a duty of reasonable care in selecting and retaining competent physicians. The cases were inapplicable either on their facts or because they had been decided prior to the passage of the Peer Review Act. The court emphasized that the hospital was immune because the credentialing decision had been made by a peer review committee, which falls squarely within the protection of the Act.


Tennessee Peer Review Act, § 63-6-219(d)(1).

### 2009 Medical Malpractice Claims Report for Tennessee

The Tennessee Department of Commerce and Insurance has recently published its annual report on medical malpractice statistics in Tennessee.

#### Malpractice Claims Closed in 2008:

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>2008 Totals</th>
<th>2008 %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Claims resolved through judgment</td>
<td>425</td>
<td>13.48</td>
</tr>
<tr>
<td>Claims resolved through settlement</td>
<td>549</td>
<td>14.55</td>
</tr>
<tr>
<td>Claims resolved through ADR*</td>
<td>43</td>
<td>1.36</td>
</tr>
<tr>
<td>Claims Otherwise Resolved</td>
<td>2,227</td>
<td>70.61</td>
</tr>
<tr>
<td>Total Number of Claims Closed</td>
<td>3,154</td>
<td>100.00</td>
</tr>
</tbody>
</table>

* Alternative Dispute Resolution (arbitration, mediation, private trial, etc.)*

Of the 425 claims resolved through judgment, 420 resulted in a judgment in favor of the defendant, with no damages awarded to the claimant. The number of claims pending as of December 31, 2008 was 5,780.

### Top Ten Provider Types Ranked by Number of Claims Closed in 2008:

<table>
<thead>
<tr>
<th>Provider Type</th>
<th>No. of Claims</th>
</tr>
</thead>
<tbody>
<tr>
<td>Physicians</td>
<td>1,888</td>
</tr>
<tr>
<td>Nursing</td>
<td>211</td>
</tr>
<tr>
<td>Other</td>
<td>158</td>
</tr>
<tr>
<td>Dentist</td>
<td>73</td>
</tr>
<tr>
<td>Nursing Home Administrator</td>
<td>61</td>
</tr>
<tr>
<td>Nursing APN Specialties</td>
<td>36</td>
</tr>
<tr>
<td>Osteopathic Medicine</td>
<td>24</td>
</tr>
<tr>
<td>Podiatry</td>
<td>24</td>
</tr>
<tr>
<td>Emergency Medical Personnel</td>
<td>20</td>
</tr>
<tr>
<td>Pharmacy</td>
<td>18</td>
</tr>
</tbody>
</table>

TOTALS: 2513

(Continued on page 8, Malpractice Report)
Patient developed an infection from a surgical procedure, and she sought treatment from Doctor for her pain from the infection. Patient saw Physician Assistant, but not Doctor, who was the supervising physician at the clinic. Physician Assistant prescribed Patient nausea medicine and enough Demerol to take four pills a day for three weeks. Patient had a history of seizures and was also suspected of drug abuse. Physician Assistant did not schedule a follow-up visit. Two weeks later, Patient called the clinic complaining of nausea and vomiting. She was told to go to the emergency room, but she did not go. Later that day, she died as a result of acute combined drug intoxication. Patient’s husband brought suit for wrongful death and medical malpractice.

After Doctor was disciplined administratively by the Tennessee Board of Medical Examiners for failing to comply with regulations that required Doctor to personally review Physician Assistant’s prescription of controlled medication within 10 days, plaintiff moved to add a claim for negligence per se (a claim based upon violation of a statute or regulation). The regulations also impose a duty on a physician for “active and continuous overview of the physician assistant’s activities.”

The trial court denied plaintiff’s motion to amend his complaint to add the claim for negligence per se. The trial court also granted the defendants’ motion for summary judgment after finding that plaintiff had failed to produce expert testimony sufficient to establish the standard of care or that the alleged negligence had caused Patient’s death.

The Tennessee Court of Appeals affirmed summary judgment on the medical malpractice claim, agreeing with the trial court that plaintiff had failed to produce competent expert testimony on the standard of care. However, the appeals court reversed the trial court on its denial of the negligence per se claim, finding that the statutory and regulatory requirements under the Physician Assistant Act established a standard of care that Doctor had breached. The case was sent back to the trial court for a determination of whether the violation of the statute and regulation had caused Patient’s death. Thus a claim that is essentially a medical malpractice claim was repackaged as negligence per se, eliminating the need for plaintiff to prove negligence by expert testimony. Plaintiff must still prove causation by expert testimony, but negligence is established by virtue of Doctor’s failure to comply with the supervisory requirements of the Physician Assistant Act.

A violation of a statute or regulation does not, in and of itself, support a claim for negligence or negligence per se. For example, the Physician Assistant Act requires a written protocol that outlines the standard of care for the physician assistant and supervising physician. The protocol must be signed and dated, maintained at the physician’s practice location, reviewed and updated every two years, and be made available to the Board of Medical Examiners upon request.

The court noted that this regulation was more an administrative tool, rather than substantive in nature, and would not by itself support a claim for negligence per se.

On the other hand, the obligations imposed by the regulations on the physician to personally review the patient’s chart within 10 days after the examination of the patient for whom a controlled drug is prescribed and to engage in an “active and continuous overview of the physician assistant’s activities” are more than perfunctory administrative tasks. The court found that the legislature “intended to mandate that the supervising physician’s ‘active’ oversight include exercise of the physician’s independent judgment as to whether the physician assistant’s actions were appropriate.” The statute and regulation, taken together, “appear to be substantive,” a

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.
The report highlights that the major cost of medical malpractice is in attorney’s fees, particularly the cost of defending a lawsuit. Jury awards make up less than 1% of the total amount of damages paid to claimants on claims closed in 2008. This percentage is consistent with reports dating back to 2005.

Based on these reports, tort reform efforts focusing on runaway jury awards and capping noneconomic damages would fall far short of meaningful reform. In 2008, Tennessee passed tort reform that was a disappointment to many doctors because it did not address these issues. However, the 2008 tort reform legislation penalizes plaintiffs’ lawyers for bringing a medical malpractice lawsuit without the support of a qualified expert witness. Initial observations show that this legislation has had a “chilling” effect on the willingness of plaintiffs’ lawyers to file frivolous medical malpractice lawsuits. Anecdotal evidence from risk managers indicate that in the past year there has been a significant reduction in the number of medical malpractice lawsuits filed in Tennessee. Because of the large backlog of pending cases, it may take several years before the yearly report reflects the financial impact of the 2008 tort reform legislation.

<table>
<thead>
<tr>
<th>2008 Totals</th>
<th>2008 %</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Damages Paid by Settlements</td>
<td>$83,035,550</td>
</tr>
<tr>
<td>Total Damages Paid by Judgments</td>
<td>$790,000</td>
</tr>
<tr>
<td>Total Damages Paid by ADR</td>
<td>$35,492,893</td>
</tr>
<tr>
<td>Total Damages Paid</td>
<td>$119,318,443</td>
</tr>
</tbody>
</table>

Fees paid to claimants’ counsel for closed claims in 2008 totaled $38,802,022, roughly 33% of the total damages paid to claimants.

The total defense costs on closed and pending claims as of December 31, 2008 since the inception of such claims was $214,222,964. The total medical malpractice premiums paid in 2008 was $220,117,000. The total amount paid by insurance companies on closed and pending malpractice claims in 2008 was $229,301,025.


See also, the article on “Tweaking Tort Reform . . .” on page 3 of this Newsletter

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(Continued from page 7, Negligence per se)

legislative judgment as to the standard of care,’ establishing a floor below which the standard of care for a supervising physician may not fall.” After concluding that the Patient’s injury was of a type which the statute and regulation was designed to prevent, the court remanded the case to the trial court to allow the plaintiff to amend his complaint to include the claim for negligence per se.


Tenn. Comp. R. & Regs. 088-2-.18(7).
judgment granted by the trial court, noting that a claim for medical malpractice is appropriate “when a claim alleges negligent conduct which constitutes or bears a substantial relationship to the rendition of medical treatment by a medical professional.” Under Tennessee law, a physician-patient relationship is implied when a physician affirmatively undertakes to diagnose and/or treat a person, or affirmatively participates in such diagnosis and/or treatment even if the physician never meets or examines the patient.

The appellate court found that Doctor had affirmatively undertaken to diagnose a medical condition of plaintiff as a part of the independent medical examination. The court also noted that a physician has a duty not to hurt the examinee during an independent medical examination. The court reasoned that such a duty can only be justified if there is an implied physician-patient relationship. Based on these findings, the court of appeals held that the medical malpractice statute applied, and because plaintiff had failed to offer expert testimony, summary judgment in favor of Doctor was appropriate.


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**Legislative Update Notes**

**Public Chapter 384, HB 93:** All nursing homes must complete a criminal background check before employing any person who will provide direct care to a resident or patient. Prior law required the check to be done within 7 days of employment.

**Public Chapter 403, SB 9:** This bill creates a new category of health care provider known as “medication aide certified.” This is a trained person who administers medications under the general supervision of a licensed nurse, and who has received a medication aide certificate that is valid for two years. Under the new law, nursing homes or assisted care living facilities may use one or more medication aides certified to administer medications to its patients.

**Public Chapter 468, SB 772:** This bill recognizes that the requirement of having mental health patients transported to psychiatric hospitals by law enforcement criminalizes mental health. Under the new law, people with a mental illness who are not a danger to themselves or who are not in need of vehicular security may be transported by non-law enforcement people who are willing to provide the transport, providing all requirements of the statute have been met.

**Public Chapter 46, SB 442:** The Tennessee Peer Review Law of 1967 grants peer review committees certain immunities relating to their actions undertaken to review, discipline, and educate the medical profession. This bill clarifies that a “peer review committee” also includes a “medical group practice” and their staff personnel. Thus, a medical group practice has the immunity provided under present law for peer review activities.

**Public Chapter 264, HB 465:** Under this law, nurse practitioners and physician assistants may certify disability or deafness to the department of revenue for the purpose of obtaining disabled license tags, provided such authority is expressly included in the written protocol developed jointly by the supervising physician and nurse practitioner or physician assistant.