

**NURSING HOME CASES:  
PLAINTIFF'S PERSPECTIVE**

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**INTRODUCTION**

Not so long ago, insurance companies would offer several thousand dollars or "nuisance value" to get rid of a nursing home case. Many attorneys were reluctant to pursue these types of cases because a large majority of nursing home residents are in poor health, suffer from pre-existing conditions, have no earnings capacity, have a limited life expectancy, and have what some consider to be a poor quality of life. However, in the past few years, nursing home litigation has changed dramatically.

Nursing home residents are some of the most helpless and vulnerable people of our society. Like infant children, many nursing home residents are totally dependent on others for their care. This is the why quality nursing home care is so important. Unfortunately, sexual, physical, verbal, and fiduciary abuse of nursing home residents, along with neglect, is not uncommon in nursing homes today.

Since elder abuse "hits home" with virtually everyone (many people are faced with the difficult decision of having to rely on nursing homes to care for their aging parents or grandparents) juries nationwide are responding to these types

of cases. For example, in October of 1998, a Texas jury awarded 250 million dollars to the family of an 80 year-old man who died from malnutrition in a nursing home. In 1997, another Texas jury awarded 83 million dollars to the family of an 84 year-old woman who died because of an untreated bedsore. A Florida jury award 6.3 million dollars to the family of an Alzheimer's resident who wandered away from the nursing home and drowned in a pool. In February of this year, a Florida nursing home agreed to pay 1 million dollars to settle a lawsuit on behalf of Lee Anna Scurry, who is no longer able to walk because she allegedly did not receive timely and adequate physical therapy after being injured from a fall while at the facility.

#### **NURSING HOME STATISTICS**

Both nationally and in Alabama the percent of the population aged 65 and older is increasing. Persons aged 65 and older comprise a disproportionate percentage of admissions to skilled nursing care facilities.

- Nationally, 1.5 million Americans lived in 16,700 nursing facilities during the period of July through December 1995
- About 5 percent of persons aged 65 and older are in a nursing facility at any one time.
- An estimated 43 percent of persons who were aged 65 in 1990 will use nursing facilities as some point in their remaining years.
- 90 percent of the nursing facility population in the U.S. is aged 65 and older. More than 35 percent are 85 years and over.
- 75 percent of nursing facility residents are women.

- Approximately 13.5 percent of Alabama's population consists of persons aged 65 and older. This percentage is projected to increase gradually during the coming years.
- In Alabama, as of February 1997, there were 231 certified nursing facilities with 25,000 beds.
- As recently as 1995, according to a national survey, Alabama nursing facilities overall had an occupancy rate of 98.6 percent.
- According to the Alabama State Health Plan 1996-1999, as of March 1996 the average occupancy rate for the 224 licensed nursing facilities then in operation was approximately 94.8 percent for fiscal year 1995.
- In Alabama as of September 1996, Medicaid patients occupy 68 percent of the available beds, private pay patients 27 percent, and Medicare patients the remainder.

#### I. ALABAMA MEDICAL LIABILITY ACT (AMLA)

The AMLA, which applies to actions against nursing homes, was originally enacted in 1995 and codified at § 6-5-480, Ala. Code (1975), but has since been amended numerous times.

Section 6-5-548(a) of the AMLA 1996 establishes the burden of proof in nursing home cases as follows:

In any action for injury or damages or wrongful death, whether in contract or in tort, against a health care provider (nursing home) for breach of the standard of care, the plaintiff shall have the burden of proving by substantial evidence that the health care provider failed to exercise such reasonable care, skill, and diligence as other similarly situated health care providers in the same general line of practice ordinarily have and exercise in a like case.

In order to meet this burden of proof, a plaintiff must provide expert witness testimony in support of their claims.

To be qualified to testify as to the standard of care that a defendant allegedly breached, an expert witness must come within the definition of a "similarly situated health care provider" under § 6-5-548(b) or § 6-5-548(c), depending on the situation.

. . . if the health care provider whose breach of the standard of care is claimed to have created the cause of action is not certified by an appropriate American board as being a specialist, is not trained and experienced in a medical specialty, or does not hold himself or herself out as a specialist, a 'similarly situated health care provider' is one who meets all of the following qualifications:

- (1) Is licensed by the appropriate regulatory board or agency of this or some other state.
- (2) Is trained and experienced in the same discipline or school of practice.
- (3) Has practiced in the same discipline or school of practice during the year preceding the date that the alleged breach of the standard of care occurred.

§ 6-5-548(b) (applies to administrators, nurses, and physicians who are not board certified).

However,

. . . if the health care provider whose breach of the standard of care is claimed to have created the cause of action is certified by an appropriate American board as a specialist, is trained and experienced in a medical specialty, and holds himself or herself out as a specialist, a 'similarly situated health care provider' is one who meets all of the following requirements:

- (1) Is licensed by the appropriate regulatory board or agency of this or some other state.

- (2) Is trained and experienced in the same specialty.
- (3) Is certified by an appropriate American board in the same specialty.
- (4) Has practiced in this specialty during the year preceding the date that the alleged breach of the standard of care occurred.

§ 6-5-548(c). (applies to board certified physicians).

(Anderson v. Alabama Reference Laboratories, 2000 WL 1174214(Ala.), which pertains to expert testimony, will be discussed later.)

The AMLA affects venue, discusses the necessity for expert testimony, establishes the standard of care and burden of proof, and limits discovery as to the pattern and practice and insurance issues, among other things, and significantly affects any cause of action against a nursing home. In Ex parte Northport Health Services, Inc., 682 So.2d 52 (Ala. 1996), the Alabama Supreme Court held that the AMLA applies to nursing homes:

Furthermore, although Golden involved a patient-doctor relationship, a nursing home is, based upon § 6-5-481, considered to be a 'hospital' and thus, also covered by the provisions of the Medical Liability Act.

Finally, AMLA § 6-5-551 was amended during the 2000 Alabama Legislative Session. Act No. 00-387, (Senate Bill 422) which became effective May 9, 2000, changes the statute's applicability from applying its discovery restrictions only to plaintiffs to applying to all parties. See, Ex parte Pfizer, Inc., 746 So.2d 960,966(Ala. 1999) (Johnstone, J., concurrence

in part), for discussion of the effect of limiting applicability to plaintiffs.

Before S.B. 422 was introduced on behalf of the nursing home industry, Keith Givens, David Marsh, and other elder rights advocates, negotiated with the president of the Alabama Nursing Home Association, lawyers, and lobbyists for the Nursing Home Association, over the language of S.B. 422. There were several versions of the bill circulated among the negotiating parties before the final agreed upon compromise bill was signed into law by the Governor.

The original draft of S.B. 422 was proposed by the nursing home industry within a few weeks after the Alabama Supreme Court, in January 2000, denied the nursing home defendant's application for rehearing in Ex parte McCollough, 747 So.2d 887 (Ala. 1999). In McCollough, plaintiff alleged that negligence by the defendant nursing home in hiring, training, supervising, disciplining, and retaining its staff, as well as the home's systemic failure to provide procedures designed to minimize the risk of harm to nursing home residents (including systemic failure to provide a sufficient number of staff), proximately caused the death of plaintiff's grandmother. The Court in McCollough indicated these theories of administrative negligence were viable theories of recovery under the AMLA. The Court held that within the meaning of Ala. Code § 6-5-551, plaintiff was entitled to discovery of various categories of information relevant to proof of such

claims, and issued a writ of mandamus directing the circuit court to order the defendant to produce such discovery.

Although the original draft of S.B.422 did not say so explicitly, that draft, if enacted into law, would have legislatively overruled McCullough, in that, the language would have had the effect of making non-discoverable and inadmissible virtually all the information specifically held relevant and discoverable by the McCullough Court. Indeed, that language also potentially rendered non-discoverable and inadmissible a wide variety of documents generated in the ordinary course of nursing home business, public documents, documents obtainable from public agencies (e.g., investigation reports from the state licensing agency or a police department), and arguably even the injured or deceased resident's own medical chart.

After the elder rights advocates informed representatives of the nursing home industry that the original proposed bill was unacceptable, lawyers for the Alabama Nursing Home Association prepared a slightly modified version of the original bill. But even with the cosmetic amendments proposed by the nursing home industry, the modified versions of the proposed bill still would have made non-discoverable and inadmissible virtually all the information held relevant and discoverable by the McCullough Court.

Eventually, after the Governor's office encouraged both sides to reach some type of agreement, the parties agreed on a version of S.B. 422 that passed both houses of the Legislature

without change and became law. (A copy of the agreed upon version of S.B. 422 is attached at the end of this paper).

There are several ways that S.B. 422 amends § 6-5-551. First, it makes explicit what was only inferable from McCullough, i.e., that the AMLA would govern all aspects of claims against a health care provider involving acts or omissions in the hiring, training, supervision, retention, or termination of care givers, so that, e.g., expert testimony generally is required to prove such a breach of the standard of care. See Ala. Code § 6-5-548. Second, it adds the requirement that in pleading a claim under the Act, a plaintiff "shall include when feasible and ascertainable the date, time, and place of the act or acts" alleged by plaintiff to render the health care provider liable to plaintiff. Finally, it provides that the Act's limitations on discovery apply to "[a]ny party," not just a "plaintiff," thereby overruling the Alabama Supreme Court's holding to the contrary in Ex parte Pfizer, 746 So.2d 960 (Ala. 1999).

In summary, S.B. 422 as passed does not overrule McCullough; instead it codifies McCullough.

## II. FORMS OF ABUSE

The following is a list of injuries or conditions that are commonly encountered as a result of neglect or omission of care and failure to properly treat, monitor, assess, and promptly notify a physician of problems with the nursing home resident.

1. Decubitus ulcers - Stage III or Stage IV (and resultant infection, septic shock, and gangrene).
2. Sexual abuse or sexual assault.
3. Physical abuse and assault.
4. Restraint injuries (physical or chemical).
5. Severe dehydration.
6. Severe malnutrition.
7. "Wander off" cases.
8. Falls and fractures (resulting from failure of staff to follow accepted protocols and implement necessary preventative measures).

### **III. CASE SELECTION AND EVALUATION CONCERNS**

Case selection is important in all cases, but especially in nursing home cases, which can be very expensive to litigate. At the least, get the nursing home resident (or their personal representative, if deceased or incompetent) to provide you with some basic information. (See requested information in "Initial Client Interview Form" attached at the end of this paper).

Here are some of the factors to consider in deciding whether to accept a nursing home case:

1. In non-death cases, whether a nursing home client with multiple impairments will be an effective or even a competent witness. (More times than not, resident will not be competent witness and therefore, case will be filed through personal representative).

2. If personal representative is filing on behalf of deceased nursing home resident's estate, what type of witness

do they make? (Did they visit loved one on regular basis before death; did they voice concerns to nursing home staff about care loved one was getting, etc.)

3. Nature and extent of injuries.

4. Can the physical injuries be separated from the resident's pre-existing disease or disability.

5. Is there evidence to support abuse? (bruises, witnesses, etc.)

6. Defendant's financial condition.

7. Harmony amongst family members/heirs.

#### **IV. PRE-SUIT INVESTIGATION**

##### **A. Getting the Records.**

Getting a copy of the resident's nursing home records, medical records, and death certificate are the first things that should be done when investigating a nursing home case. If the death certificate lists "decubitus ulcers, malnutrition, or dehydration" as the primary cause of death, you know that the case has potential.

42 C.F.R. § 483.10(b)(2) provides that a resident or his or her legal representative has the right to access all of their nursing home records within 24 hours, excluding weekends and holidays. Further, the regulation provides that the resident or legal representative may obtain copies of nursing home records upon two working days notice to the facility.

In a wrongful death case against a nursing home, obtaining the records is somewhat more complicated. First,

someone must be appointed personal representative of the resident's estate. (See Ala. Code § 43-2-43). After a personal representative has been appointed, that person may request a copy of the nursing home records.

**B. Records Review.**

All nursing home and medical records should be reviewed in great detail. One valuable type of documentation in the resident's nursing home records is the comprehensive assessment, which in turn is based on the Minimum Data Set ("MDS"). The MDS is a form set of documents containing comprehensive data concerning the resident. As required by 42 C.F.R. § 483.20, the comprehensive assessment must be completed within fourteen days of admission. It contains information such as the resident's prior medical status, physical and mental functioning status, sensory and physical impairments, nutritional status, activities potential, rehabilitation potential, cognitive status, and discharge potential. The comprehensive assessment must be conducted at least once every twelve months, and promptly after any significant change in a resident's physical or mental condition; and must be reviewed at least quarterly.

Medicare and Medicaid reimbursement percentages are tied to the resident's acuity level, an indicator of what type of and how much services will be required for adequate care of the resident. (This takes into account conditions such as whether the resident is ambulatory, is incontinent, is prone to pressure sores, requires assistance in activities of daily

living such as eating and bathing, etc.) In turn, the acuity level of nursing home's population will help determine the level of staffing and type of staff necessary to render the required level of care to all residents, regardless of condition. The acuity level of a resident is based on the information contained in the Minimum Data Set. Therefore, you may find exaggerations of the resident's condition in the MDS. The comprehensive assessment will be used to develop the patient's care plan, which also is required by federal law. Examine the care plan to assess the quality of the plan, to see what is being addressed by the plan and whether the goals are realistic.

Also review the Activities of Daily Living ("ADL"). These records contain information regarding out-of-bed activity, bowel movements, skin care, oral hygiene, bathing and eating, among other things. Certified nursing assistants or certified nurses' aides ("CNAs"), who deliver most of the hands-on care in a skilled nursing facility, are usually responsible for charting in these records. Despite doing most of the manual labor involving residents, CNAs are generally among the lowest paid employees of the nursing home. They are taught that one of their primary duties is to chart in these records. These records are a "hot spot" for falsification.

Other important records include the Medication Administration Records ("MAR"), sometimes referred to as the Monthly Medication Sheet. These records chart the various medications administered to the resident. In addition to the

MAR, it is important to compare all acute care hospital records to those of the nursing home for other possible discrepancies and contradictions. You will also want to assess each of the additional nursing home records such as physical therapy, occupational therapy, speech therapy, and social activities. Once all the various records have been assessed, make a comparative chart, preferably on a daily basis for each set of records. This will assist you in identifying and exposing areas of deficient care, as well as possible falsification of records.

Review of the above-mentioned records by a nursing care expert is necessary to evaluate a claim before filing suit. This type of expert, who is familiar with nursing home care, will be able to point-out deficiencies, record falsifications, and violations of the standard of care.

## **VI. SELECTED FEDERAL REGULATIONS WHICH APPLY TO NURSING HOMES**

The following list includes some specific standards promulgated under federal and state law in the areas of general policy and administration. It is intended to include some of the standards with which a lawyer representing any nursing home resident should be familiar.

1. **Quality of life:** A nursing home is required to "care for its residents in a manner and in an environment that maintains or enhances each resident's dignity

and respect in full recognition of his or her individuality." 42 C.F.R. § 483.15.

2. **Quality of Care:** This regulation spells out the "bottom line" duty the nursing has to provide appropriate nursing services to each and every resident, to maximize each resident's well being.

Under this standard: "Each resident must receive and the facility must provide the necessary care and services to attain or maintain the highest practicable physical, mental, and psychosocial well-being, in accordance with the comprehensive assessment and plan of care. 42 C.F.R. § 483.25.

3. **Facility Administration:** "A facility must be administered in a manner that enables it to use its resources effectively and efficiently to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident." 42 C.F.R. § 483.75.

Under this standard, the facility must be licensed under applicable Alabama law - 42 C.F.R. § 483.75.

4. **Resident Rights:** This standard protects a resident's right to a "dignified existence, self-determination, and communication with and access to persons and services inside and outside the facility."

The regulations protecting resident rights address such matters as access to records, refusal of treatment, notification of changes (e.g., health status, treatment, transfer or discharge), transfers, management and protection of the resident's funds, free choice (e.g., personal physician, care and treatment), grievances, and examination of survey results. These and other resident rights are spelled out in detail in 42 C.F.R. 483.10 and Ala. Admin. Code § 420-5-10-.05.

5. **Access to Records:** Although often ignored by nursing facilities, the regulations clearly give "the resident or his or her legal representative" the right to review and obtain copies of that resident's records:

Upon an oral or written request to access all records pertaining to himself or herself, including current clinical records within 24 hours (excluding weekends and holidays)" and

"After receipt of his or her records for inspection, to purchase at a cost not to exceed the community standard photocopies of the records or any portions of them upon request and two working days advance notice to the facility." 42 C.F.R. § 483.10(b)(2).

For obvious reasons, this right of access to records is a critical tool in attempting to evaluate

whether a resident or her representative has a viable cause of action.

6. **Notification of Changes:** Look for this rule to be violated when a facility is trying to cover up an injury or other problem.

Federal and state regulations require a facility to "immediately notify the resident; consult with the resident's physician; and if known, notify the resident's legal representative or an interest family member when there is

- (a) An accident involving the resident which results in injury and has the potential for requiring physician intervention;
- (b) A significant change in the resident's physical, mental, or psychosocial status (i.e., a deterioration in health, mental, or psychosocial status in either life-threatening conditions or clinical complications);
- (c) A need to alter treatment significantly (i.e., a need to discontinue an existing form of treatment due to adverse consequences, or to commence a new form of treatment); or
- (d) A decision to transfer or discharge the resident from the facility . . . 42 C.F.R. § 483.10(b)(11).

7. **Staffing:** Insufficient staffing, or lack of qualified staff, often contributes to abuse, mistreatment, neglect or other substandard care. Related issues include the training, monitoring, and supervision of such staff.

**General standard for staffing (federal regulations):** "The facility must have sufficient nursing staff to provide nursing and related services to attain or maintain the highest practicable physical, mental, and psychosocial well-being of each resident, as determined by resident assessments and individual plans of care." 42 C.F.R. § 483.30(a).

"Other nursing personnel" typically refers to nurse aids, i.e., 'any individual providing nursing related services to residents in a facility who is not a licensed health care professional, a registered dietitian, or someone who volunteers to provide such services without pay. 42 C.F.R. § 483.75(e)(1).

Required Staff include (but are not limited to):

- (a) **Medical Director:** a physician designated by the facility, who is responsible for implementing resident care policies and coordinating medical care in the facility. 42 C.F.R. § 483.75(I).
- (b) **Director of Nursing:** the facility must designate a registered nurse to serve as director of nursing on a full-time basis. 42 C.F.R. 483.30(b)(2).
- (c) **Licensed Nurses:** at least one registered nurse must be used "for at least 8 consecutive hours a day, 7 days a week," 42 C.F.R. §483.30(b)(1); and the facility must designate a licensed nurse (which includes licensed practical nurses) to service as a charge nurse on each tour of duty. 42 C.F.R. § 483.30(a)(2).

**Competency requirements for nurse aids:** Among nursing facility staff, nurse aides normally have the most direct contact with facility residents; and are responsible for most

"hands-on" care in assisting residents in the basic activities of daily living (e.g., eating, bathing, grooming, bowel and bladder functioning).

The facility's general duty is to "ensure that nurse aids are able to demonstrate competency in skills and techniques necessary to care for residents' needs as identified through resident assessments, and described in the plan of care." 43 C.F.R. § 483.75(e)(4).

Generally, before allowing an individual to serve as a nurse aid, the facility must receive verification from the state nurse aide registry that the individual has met competency evaluation requirements. 42 C.F.R. § 483.75(e)(5).

**8. Reporting and investigation requirements -Suspected abuse or neglect:**

**Duty to report:**

A facility must ensure that alleged violations involving mistreatment, neglect, or abuse, including injuries of unknown source, and misappropriation of resident property are reported immediately to the administrator of the facility and to other officials in accordance with state law through established procedures (including to the State survey and certification agency)."

42 C.F.R. § 483.13(c)(2).

**Duty to investigate:**

The facility must have evidence that alleged violations are thoroughly investigated, and must prevent further potential abuse while the investigation is in progress.

42 C.F.R. § 483.13(c)(3).

**Time of report to state licensing agency:** Results of all investigations must be reported to the administrator and the Division of Licensure and Certification within 5 working days of the incident. 42 C.F.R. § 483.13(c)(4).

## 9. Specific Standards - Areas of Nursing Care

The regulations provide specific standards of care in various areas of nursing care for conditions that occur with regularity in nursing home residents. The following is an illustrative, but not exhaustive, list.

1. **Pressure Sores:**Based on the comprehensive assessment, a facility must ensure two things:
  - (a) A resident who enters the facility without pressure sores does not develop pressure sores unless they are clinically unavoidable; and
  - (b) A resident with pressure sores "receives necessary treatment and services to promote healing, prevent infection and prevent new sores from developing.

42 C.F.R. § 483.25(c).

2. **Falls and Fractures:**A facility again has two duties in preventing falls and fractures:
  - (a) Ensuring that "the resident environment remains as free of accident hazards as possible;" and
  - (b) Ensuring "each resident receives adequate supervision and assistance of devices to prevent accidents."

42 C.F.R. §483.25(h).

3. **Misuse of chemical and/or physical restraints:** A resident "has the right to be free from any physical or chemical restraints imposed for purposes of discipline or convenience, and not required to treat the resident's medical symptoms."

42 C.F.R. § 483.13(a); see also 42 C.F.R. § 483.25(1)(1) (unnecessary medications).

4. **Dehydration, malnutrition, choking:** Again based on the resident's comprehensive assessment, the facility must ensure that a resident "maintains acceptable parameters of nutritional status, such as body weight and protein levels" unless clinically

not possible. The facility likewise "must provide each resident with sufficient fluid intake to maintain proper hydration and health.

42 C.F.R. §§ 483.25(i),(j).

5. **Care of "tubes" - catheters, feeding:** A resident who enters a facility without an indwelling catheter should not be catheterized unless clinically necessary. Similarly, a resident who has been able to eat alone or with assistance should be fed by naso-gastric tube unless clinically unavoidable. In both instances, the facility has the duty to provide appropriate treatment and services to prevent related medical problems (e.g., urinary tract infections, aspiration pneumonia) and to restore as much normal bladder function or eating skills as possible.

42 C.F.R. §§ 483.25(f),(g).

#### VI. RECENT ALABAMA CASELAW WHICH AFFECTS NURSING HOME LITIGATION

1. Ex parte Rite Aid of Alabama, Inc., 2000 WL 356335 (Ala.)

**Facts:** Wrongful death action brought by the executors of the estate of Jewell D. Deal against Rite Aid. The plaintiffs alleged that Rite Aid wrongfully caused the death of Jewell D. Deal by negligently filling for her the wrong prescription. The plaintiffs also alleged that Rite Aid had negligently trained and supervised the pharmacist who improperly filled the prescription.

In discovery, plaintiffs requested information concerning "other incidents" involving injuries to Rite Aid customers resulting from incorrectly filled prescriptions. Rite Aid objected to the requests, asserting that it was within the

definition of "healthcare provider" appearing at § 6-5-542(i), Ala. Code 1975, a portion of the AMLA, and therefore, that plaintiffs were "prohibited from conducting discovery with regard to any other act or omission," by § 6-5-551.

**Procedural Posture**: Rite Aid petitioned the Court for a writ of mandamus directing the trial court to vacate its order directing Rite Aid to answer discovery requests concerning evidence of other similar incidents or acts.

**Issue**: Whether the operator of a pharmacy is an "other health care provider" within the meaning of § 6-5-481(8), a portion of the AMLA, and therefore, entitled to the protections afforded by the AMLA's prohibitions against discovery of evidence of "other acts or omissions."

**Holding**: The Court held that based on the rationale of the Cackowski v. Wal-Mart Stores, Inc., 2000 WL 46162 (Ala.), Rite Aid, as the operator of a pharmacy, is included within the AMLA's definition of "other health care providers" and, therefore, is entitled to have evidence of other acts or omissions excluded, by the terms of § 6-5-551, Ala. Code 1975, and thus, Rite Aid's petition for the writ of mandamus was granted.

**Dissent** (Johnstone, J.): Justice Johnstone points out that this case is controlled by Ex parte McCollough, 747 So.2d 887 (Ala. 1999), "which expressly required the trial court to enforce discovery of other acts or omissions by a medical provider sued on, among other theories, a theory of negligent hiring, training, or staffing."

**Dissent** (Lyons, J.): Justice Lyons recognizes that "the majority opinion in McCullough negates any 'clear legal right' in Rite Aid to a writ of mandamus requiring the trial court to vacate its order for discovery of the other acts and omissions by Rite Aid.

2. **Anderson v. Alabama Reference Laboratories, 2000 WL 1174214 (Ala.)**

**Facts:** On September 13, 1995, Thomas Mark Anderson was diagnosed with pneumonia by his physician (Dr. Keith Fuller) and treated with antibiotics. Anderson returned to his physician two days later complaining of fatigue and high fever. Dr. Fuller collected a sputum specimen and sent it to ARL for testing. The results were normal. On November 5, Dr. Fuller received another report from ARL concerning the results from the testing of Anderson's specimen, which stated that Anderson's specimen was positive for tuberculosis.

Dr. Fuller told Anderson, in the presence of his pregnant wife, that persons with tuberculosis may also be infected with HIV, and recommended that Anderson submit to an HIV test. Anderson then reported to the local community health department, where he was required to sign a form promising to take the drugs for treatment of tuberculosis for one year. As a result of taking these drugs, Anderson suffered a rash, dizziness, fatigue, nausea, and vomiting. On November 21, Dr. Fuller received another report from ARL which again stated that Anderson tested positive for tuberculosis, and that ARL's

finding had been confirmed by the Alabama Department of Health state laboratory.

Approximately six weeks later, Dr. Fuller received a call from either ARL or the State Health Department and was informed that DNA testing had been performed on Anderson's specimen. As a result of the DNA testing, it was discovered that Anderson's specimen had been contaminated with another donor's specimen and that the tuberculosis had come from that other person. Dr. Fuller then informed Anderson that the results of the test had been incorrect and that he did not have tuberculosis.

On October 7, 1997, Anderson and his wife filed suit against ARL, alleging that ARL had negligently, wantonly, or recklessly performed the tuberculosis testing and had thereby caused him to suffer severe emotional distress and economic losses, and had caused his wife to suffer a loss of consortium. (The claim was subject to the AMLA).

At the hearing on ARL's motion for summary judgment, the trial court granted ARL's motion and ruled that Dr. Linda Pifer, plaintiffs' expert witness, was not competent to testify concerning the alleged breach of the applicable standard of care. The plaintiffs appealed.

**Issues:** The Andersons' appeal presents three issues:

**I. Whether ARL falls within the definition of "other health care provider" for purposes of the AMLA.**

**II. Whether Andersons' proffered expert witness, Dr. Linda Pifer, was a "similarly situated health care provider"**

for purposes of the AMLA and, thus, competent to testify as to the alleged breach of the applicable standard of care.

III. Whether the Andersons' action falls within one of the recognized exceptions to the requirement that the plaintiff in a medical-malpractice action present expert medical testimony on the alleged breach of the applicable standard of care.

**Holding:**

I. The Court held that ARL falls within the AMLA's definition of "other health care provider."

Section 6-5-548(b) defines a "similarly situated health care provider" as "one who meets all of the following qualifications":

- (1) Is licensed by the appropriate regulatory board or agency of this or some other state.
- (2) Is trained and experienced in the same discipline or school of practice.
- (3) Has practiced in the same discipline or school of practice during the year preceding the date that the alleged breach of the standard of care occurred.

The Court held that Dr. Pifer did not meet the requirement of (b)(3) because she had no training or experience in the specific field of tuberculosis testing. In addition, the Court held that Dr. Pifer did not practice in the specialty of tuberculosis testing in the year preceding the testing of Anderson's specimen. The trial court properly entered summary judgment for ARL.

3. **Hall v. Chi, et al.**, 2000 WL 1990253 (Ala.)

**Facts:** On October 17, 1996, James Hall was anesthetized and underwent hip-replacement surgery. As a result, Hall was paralyzed from the waist down and died several months later. Marian Hall, as personal representative of James Hall, sued the hospital, Hall's treating physicians, and fictitious defendants alleging that they had wrongfully caused the death of her husband.

**Procedural Posture:** Trial court entered judgment on the pleadings, concluding that any action should have been filed within two years, after the surgery had occurred. Hall appealed.

**Issue:** Whether Marian Hall's complaint was timely filed.

**Holding:** The court reversed the trial court citing McMickens v. Waldrop, 406, So.2d 867 (Ala. 1981), which held that "an administrator could file a wrongful death action within two years of the decedent's death, even though the period allowed by the medical malpractice statute of limitations had already ran." If the decedent had a viable medical malpractice claim when he died, the decedent's personal representative could, within two years after the decedent's death bring a wrongful death action alleging medical malpractice.

4. **Mock v. Allen, WL 869601 (Ala.)**

**Facts:** In September 1991, Mock was involved in an automobile accident in Austin, Texas, and suffered injuries to his head, neck, back, left hip/groin, and left knee. When

Mock returned home to Alabama, he was eventually referred to Dr. Robert Allen, a neurologist for treatment.

Mock was treated by Dr. Allen for approximately one month, and during that time, Mock alleges that Dr. Allen fondled his genitals on several occasions while treating him. After Mock complained to the hospital about Dr. Allen's conduct, Dr. Allen denied that he had touched Mock improperly. Dr. Alan Prince, another neurologist from whom Mock sought treatment, testified that an examination of Mock based on his complaints would not have required touching his genitals.

At trial, Mock objected to the trial court's ruling that his action against Dr. Allen was governed by the AMLA. In addition, the trial court disallowed evidence that Dr. Allen had had improper contact with five other male patients. The court also prohibited Mock's attempt to offer evidence of Dr. Allen's alleged sexual preference. The jury returned a verdict in favor of Dr. Allen and Mock appealed.

**Issues:**

**I. Whether the trial court erred in ruling that Mock's claims against Dr. Allen were governed by the AMLA.**

**II. Whether the trial court erred in ruling that evidence of other similar wrongful acts allegedly committed by Dr. Allen was inadmissible.**

III. Whether the trial court erred by refusing to allow Mock to offer evidence concerning Dr. Allen's alleged sexual preference.

**Holding:**

I. Mock argued that the AMLA does not apply to his case because the acts of intentional sexual assault that the complained of were for no medical reason. The Court disagreed, stating that the "alleged sexual misconduct occurred while Dr. Allen was providing professional services and/or treating Mock's physical injuries" and held that the alleged misconduct falls within the AMLA.

II. Mock argued that the AMLA does not provide a blanket prohibition on the discovery or admissibility of "similar acts" evidence, and relied on McCullough to support his position. However, the Court held that McCullough was factually distinguishable from Mock's case and held that Mock was entitled to introduce only evidence concerning Dr. Allen's alleged wrongful acts against him personally.

III. Mock sought to provide evidence that Dr. Allen was a homosexual, but the Court held that this evidence would have focused the jury's attention away from what actually happened between Mock and Dr. Allen, and that the probative value of this evidence was substantially outweighed by the danger of unfair prejudice.

**Dissent** (See, J.): Justice See pointed out that Dr. Allen himself testified that "there was no medical reason for him to engage in the conduct of which he is accused," and

therefore, Justice See was of the opinion that the AMLA would not apply.

## VII CONCLUSION

The Court apparently put nursing home plaintiffs on more even footing with defendants with its decision in McCullough. However, defendants are attempting to misconstrue the recently amended AMLA § 6-5-551 (Act. No. 00-387; S.B. 422) as an overruling of McCullough, when agreement to the bill in final form was premised on the understanding that the legislature did no such thing. It is very important that plaintiff attorneys continue to present to the courts the true intended meaning of § 6-5-551: that the 2000 amendment actually codifies McCullough.