IN THE SUPREME COURT OF GEORGIA
Case No. S23A1095

ANGELA D. WILSON, *et. al.*,

Appellants

v.

NIRANDR INTHACHAK, M.D. and RADIOLOGICAL ASSOCIATES OF SOUTH GEORGIA, P.C.,

Appellees.

AMICUS BRIEF OF THE GEORGIA DEFENSE LAWYERS ASSOCIATION IN SUPPORT OF APPELLEES NIRANDR INTHACHAK, M.D. AND RADIOLOGICAL ASSOCIATES OF SOUTH GEORGIA, P.C.

On Behalf Of:
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STATEMENT OF INTEREST OF THE *AMICUS CURIAE*

The Georgia Defense Lawyers Association ("GDLA") is an association of more than 1,000 Georgia lawyers, including sole practitioners and members of law firms of all sizes, who engage in litigation, primarily for defendants in civil lawsuits. GDLA is dedicated to, among other purposes, supporting and improving the civil defense bar, improving the adversary system of jurisprudence in our courts, eliminating court congestion and delay in litigation, and otherwise promoting improvements in the administration of justice.

Members of the GDLA also frequently represent defendants in cases involving alleged medical malpractice across Georgia and have an interest in seeing that the laws, particularly those relating to the provision of emergency medical care, are applied properly and consistently. Accordingly, GDLA writes this brief in support of Appellees here.

INTRODUCTION AND SUMMARY

This is a medical malpractice case involving the alleged misinterpretation of a head CT scan of a patient who presented to the emergency room ("ER") after falling and hitting her head and the communication of those findings to the ordering ER provider, who was told the scan showed an intracerebral hemorrhage. The Appellants contend the scan was misinterpreted and that a proper interpretation of the scan instead showed a subdural hematoma. But the parties agree on certain

key legal facts: this patient presented to an emergency department, and she was receiving care in that emergency department. Nonetheless, the Appellants seek to strip the defendant radiologist of the protections the General Assembly provided for emergency-room care because he **remotely** provided his emergency interpretive service to a critical patient while she was in an emergency department.

This case thus presents a question that will be critical to the provision of medical care in Georgia in this new, decentralized century: whether physicians who are not physically located in an emergency room—but are practicing emergency medicine for the benefit of patients in an emergency room—receive the benefits the General Assembly specifically provided for emergency practitioners. More specifically, it asks whether the provisions of O.C.G.A. § 51-1-29.5, commonly referred to as the "ER Statute", apply to Nirandr Inthachak, M.D. ("Dr. Inthachak"), a radiologist who provided care to the Appellants' decedent, Dorothy Warren ("Ms. Warren"). Dr. Inthachak was not physically present in the emergency department when he read and interpreted the CT scan remotely from his office in a neighboring county and faxed his initial interpretation to the ER provider, Physician Assistant John Steigner ("PA Steigner"). But his patient was in an emergency room: she was located within the Clinch Memorial Hospital emergency department.

The ER Statute **does not require** physicians to be physically present in the ER when rendering emergency medical care to patients, and reading such a

requirement into the statute would be inconsistent with the fundamental rules of statutory interpretation and existing Georgia law, including those related to the provision of telemedicine in this state. Interpreting the ER Statute in such a manner would also have broad policy implications that could jeopardize the advancements that telemedicine, including teleradiology, have made in increasing access to medical care. The General Assembly's plain language did not intend these perverse results and does not command them.

ARGUMENT

Dorothy Warren presented to the ER with an acute head injury requiring immediate medical intervention. Diagnostic imaging was ordered and revealed six active brain bleeds. The interpretation of that imaging was then communicated to the ordering ER provider. This provision of emergency medical care satisfied the conditions of O.C.G.A. § 51-1-29.5(c), which imposes a heightened burden of proof and which Appellants have failed to satisfy. Specifically, O.C.G.A. § 51-1-29.5(c) provides:

> In an action involving **a health care liability claim** arising out of the **provision of emergency medical care** in a hospital emergency department or obstetrical unit or in a surgical suite immediately following the evaluation or treatment **of a *patient* in a hospital emergency department**, no physician or health care provider shall be held liable unless it is proven by **clear and convincing evidence** that the physician or health care provider's actions showed **gross negligence**.

(Emphasis added).

Georgia courts have interpreted this statute to impose three conditions before it can be applied: (1) the lawsuit must involve a health care liability claim, (2) the claim must arise out of the provision of emergency medical care, and (3) the care must have been provided to a **patient** in a hospital emergency department or obstetrical unit or in a surgical suite immediately following the evaluation or treatment of that patient. Nisbet v. Davis, 327 Ga. App. 559, 564-65 (2014). This Brief focuses on the third condition – that the care must have been provided to a **patient** in a hospital emergency department or obstetrical unit or in a surgical suite immediately following the evaluation or treatment of that patient.

I. O.C.G.A. § 51-1-29.5's plain language only requires a *patient* to be physically in an emergency department, and her treating physician need not be in that same room for the statute to apply.

The care at issue was provided to Ms. Warren while she was a patient in a hospital emergency department. Appellants argue the ER Statute does not apply because Dr. Inthachak interpreted Ms. Warren's head CT in his office located at Coffee Regional Medical Center instead of the emergency department at Clinch Memorial Hospital even though he communicated the results of his interpretation to the Clinch Memorial Hospital emergency department, where it was received by PA Steigner in the emergency department and where PA Steigner utilized Dr. Inthachak's interpretive findings and impression when developing a plan of care for Ms. Warren in the emergency department. However, this interpretation of the ER

Statute is not only contrary to the express language of the Statute itself, but it is also inconsistent with the clear legislative intent underpinning the statute and the reality of how medicine is delivered across the country and in Georgia. Adopting the interpretation urged by Appellants could also have far-reaching adverse policy implications that the legislature intended to avoid in drafting the ER Statute, and others.

A. Accepted rules of statutory construction support the interpretation of the ER Statute urged by Appellees.

The clear and unambiguous language of O.C.G.A. § 51-1-29.5 **does not require** a physician providing emergency medical care to patients to be physically present in the ER while rendering such care. The statute (and the Georgia cases interpreting it) simply requires "an action involving a health care liability claim **arising out of the provision of emergency medical care in a hospital emergency department.**" (Emphasis added).

In Nisbet v. Davis, 327 Ga. App. 559, 567 (2014), the Court of Appeals held that "the phrase 'in a hospital emergency department' refers to the physical location within the hospital where the patient arrives for emergency medical care, commonly referred to as the 'emergency room.'" Appellants rely on the Court of Appeals' decision in Kidney v. Eastside Medical Center, LLC, 343 Ga. App. 401 (2018) (physical precedent only), for the proposition that the Court later interpreted the ER Statute to impose a physical presence requirement on the physician as well as the

patient. Two of the three judges on that panel, however, disagreed with this opinion, and noted that "such a reading of the statute belies its clear and plain meaning. A patient is receiving treatment, if at all, **where he or she is located**." Id. at 415 (emphasis added). Accordingly, reading a location requirement for physicians into the ER Statute goes beyond the fundamental rules of statutory interpretation and is inconsistent with existing Georgia law.

In construing O.C.G.A. § 51-1-29.5(c) or any other statute, Georgia courts "apply the fundamental rules of statutory construction that require [them] to construe the statute according to its terms, to give words their plain and ordinary meaning, and to avoid a construction that makes some language mere surplusage." Lakeview Behavioral Health System v. UHS Peachford, 321 Ga. App. 820, 822 (2013) (quotation omitted). "[A] statute should [therefore] be read according to its natural and most obvious import of the language without resorting to subtle and forced constructions for the purpose of either limiting or extending its operation." Id. (quotation omitted).

Here, Ms. Warren presented to the Clinch Memorial Hospital emergency department with a life-threatening head injury, and that is where she remained while Dr. Inthachak interpreted her CT scan and communicated his findings to PA Steigner. The intentionally broad language of the ER Statute should therefore "be interpreted according to its terms without resorting to a reading that forces a

limitation not appearing on the face of the statute." Kidney, 343 Ga. App. at 413-15 (Bethel, J., concurring specially) (quotation omitted).

Accordingly, interpretation of the provision begins with interpreting the word "provision" in the statutory text "provision of emergency medical care." This statute does not define the word "provision" or "provide," but both (1) grammatical context within the statute; and (2) its usage in other statutory provisions demonstrates that the "provision" of care occurs at the point care is received by the patient.

Start first with the specific provision's language. It only ever references the location of one type of party: the patient. Specifically, it discusses the provision of care "immediately following the evaluation or treatment of a patient in a hospital emergency department." O.C.G.A. § 51-1-29.5(c). No other clause in the statutory language simultaneously addresses both a geographical location and a type of person (physician, patient, administrator, etc.). The **only clause** in the statute that marries those two elements discusses a patient's location. The statute thus demonstrates its intent that any geographic focus is on the patient, not on the physician.

Analysis of the words "provision" and "provide" in other statutory contexts leads to the same result. When the Georgia Code discusses "providing" something, it generally understands that provision to occur upon receipt. Take, for example,

Section 34-9-417(a), which requires an employer to "provide all employees with a semiannual education program on substance abuse . . . ." *Id.* No ordinary speaker of English would believe that a company purchasing a DVD of such a program and locking it in a safe would have "provided" it; the provision occurs **when and where the employees receive the training**. Or take Section 31-8-106(b), which requires that upon a resident's request, a long-term care facility "must provide that resident with a current list of all services and charges." Of course this provision occurs where and when the patient actually receives the list, not when the facility begins compiling it or makes an internal decision to make it available. "Provision" occurs upon receipt.[1] And there is no reason to believe that the word "provision" suddenly varied for only this statute—as a matter of statutory interpretation, the opposite is true. A. Scalia & B. Garner, *Reading Law: Interpretation of Legal Texts* at 170 (Thompson/West 2012) ("A word or phrase is presumed to bear the same meaning throughout a text; a material variation in terms suggests a variation in meaning.").

[1] It is telling that the law has another term for when something is **sent** but not yet **received** by its intended target: dispatch. *See, e.g.*, O.C.G.A. § 33-24-47.1(b) ("…or by depositing the notice in the United States mail to be dispatched by at least first-class mail to the last address of record …"). Indeed, every attorney remembers his or her first-year contract class and entertaining hypotheticals about the "dispatch rule." *See, e.g.*, *Acceptance by correspondence*, 2 WILLISTON ON CONTRACTS § 6:33 (4th ed.). The existence of a separate term for sending something that is not yet received further emphasizes that "provide" and "provision" mean what an English speaker would assume: that the designated recipient has actually received the "provided" goods or information in the recipient's current location.

The plain meaning of "provision" grows even clearer when conjoined with what is provided – "emergency medical care." That term **is** statutorily defined:

> (5) "Emergency medical care" means bona fide emergency services provided after the onset of a medical or traumatic condition manifesting itself by acute symptoms of sufficient severity, including severe pain, such that the absence of immediate medical attention could reasonably be expected to result in placing the patient's health in serious jeopardy, serious impairment to bodily functions, or serious dysfunction of any bodily organ or part. The term does not include medical care or treatment that occurs after the patient is stabilized and is capable of receiving medical treatment as a nonemergency patient or care that is unrelated to the original medical emergency.

O.C.G.A. § 51-1-29.5(a)(5). Search this definition for any geographical limitation, or any indication that "emergency medical care" is defined in terms of geography instead of the acuteness and severity of symptoms. No such limitation exists. The pointed lack of any geographical scope on the concept of emergency medical care **itself** only reinforces that what matters is the **patient's** location. And the patient's location matters precisely because it serves as *de facto* verification of the seriousness of the condition. The patient's arrival at the emergency department signals her evaluation that her condition really is serious enough to merit emergency lifesaving measures—and thus should fall within the gross negligence standard. Any interpretation that instead focuses on the **physician's** location when treating a patient who has **herself** decided that her emergent condition merits an emergency department visit further undermines the statute.

This signaling function is even more pronounced when examined in light of

the surrounding statutes, which are rife with provisions where the **patient's location and choice of medical care** are a proof point that the care is emergent and serious—and therefore that the physician should receive additional protections within the burden of proof. So, for example, Section 51-1-29.3 immunizes persons saving a life using a defibrillator when the recipient does not object: by her lack of objection, she demonstrates that she agrees that the situation is serious enough to merit defibrillator usage. So too are providers at free health clinics immunized from certain types of suits. O.C.G.A. § 51-1-29.4. By voluntarily attending such a clinic, the patient signaled an assent to receive care that is part of the broader medical triage of an underserved community. These are the two provisions immediately preceding the emergency-department provision in question. That statutory location is highly relevant to the Court's interpretation. *See* Scalia & Garner at 167 (an interpreter should "consider the entire text, in view of its structure and of the physical and logical relation of its many parts.").

The ER Statute does not impose a location requirement on physicians rendering emergency medical care to patients who are physically present in emergency rooms, and such a limitation should not be read into the statute as requested by the Appellants.

B. Appellees' proposed interpretation of the ER Statute is consistent with its legislative intent, as well as the reality of how medical care is provided to patients.

In interpreting statutes, Georgia courts also presume the legislature was aware of existing laws and that a statute should be interpreted harmoniously with those laws. City of Atlanta v. City of College Park, 292 Ga. 741, 744 (2013). For example, the Georgia legislature was surely aware of existing laws related to the provision of telemedicine, which also do not impose a physical location requirement on physicians rendering medical care to patients, when drafting the ER Statute:

> **(a) A person who is physically located in another state or foreign country and who, through the use of any means, including electronic, radiographic, or other means of telecommunication, through which medical information or data are transmitted, performs an act that is part of a patient care service located in this state, including but not limited to the initiation of imaging procedures or the preparation of pathological material for examination, and that would affect the diagnosis or treatment of the patient is engaged in the practice of medicine in this state. . . .**

O.C.G.A. § 43-34-31(a) (emphasis added). And as pointed out by Court of Appeals Judge Todd Markle in his opinion below, this statute can be viewed together with the ER Statute to reach the "understanding that the emergency room statute was intended to cover physicians physically located outside the hospital as long as the care provided was rendered to a patient who was present in the emergency department." Wilson v. Inthachak, Ga. Court of Appeals Case No. A23A0398, p. 13 *(Miller, P.J., Brown, Gobeil, Hodges, Pipkin, and Land, J.J. concurring)*

(quoting Gray v. State, 310 Ga. 259, 261-62 (2020)).

Judge Markle's interpretation of the ER Statute is not only sensible, it is consistent with the intent of the legislature in drafting the ER Statute as part of the 2005 Civil Justice Reform Act, also known as the Tort Reform Act of 2005. For instance, a Senate Weekly Report, announcing Governor Sonny Perdue's signing of the 2005 Civil Justice Reform Act, quotes then-Georgia Senator Preston Smith, who succinctly describes the legislative intent underpinning the 2005 Civil Justice Reform Act – Senate Bill Three:

> "Senate Bill Three is intended as a comprehensive and meaningful civil justice reform package that will make substantive changes **to ensure affordable access to quality healthcare** and create a more positive business environment in Georgia for job creation and growth," Sen. Smith said during the signing ceremony. "It **balances the important rights of litigants to redress their grievances in our courts with the need for affordable access to quality healthcare for *all* Georgians.**"

GA S. Weekly Rep., 2005 Reg. Sess. No. 5 (emphasis added) (also referencing the ER Statute as part of the legislation insofar as it "[r]ecognizes the value and different circumstances surrounding emergency care by providing a special jury charge and higher burden of proof to sue a provider of emergency care").

Based on the clear intent of the Georgia legislature and Judge Markle's reasoning based on this intent, it would be improper to read a physical location requirement into the ER Statute where none exists and where related laws also do not impose such a requirement when defining what it means to provide medical care

to patients who are physically present in Georgia while the physician is not.[2]

Not only is this interpretation consistent with Georgia law and the intent of the Georgia legislature, but it is also consistent with how medical professionals view the practice of telemedicine, of which teleradiology is a subset. In a recent, comprehensive study on the impact of telemedicine on healthcare, medical authors observed that "[p]ractitioners must currently be licensed in the originating site that is the state where the patient is located at the time of care." Barbosa, William, M.D., *et al.*, *Improving Access to Care: Telemedicine Across Medical Domains*, Annual Rev. Public Health, 42:463-81, 475 (2021) ("Dr. Barbosa, *et al.*"). Specific to the delivery of teleradiology services, medical authors have also observed that "[t]eleradiologists … typically obtain state medical licenses **for each of the states that their practice provides services to**." Weinstein, Ronald, M.D., *et al.*, *Telemedicine, Telehealth, and Mobile Health Applications That Work:*

[2] In addition, at least one United States District Court in Georgia has found that an out-of-state teleradiologist provides care in Georgia when they interpret and transmit findings and impressions for imaging studies performed on patients in Georgia for purposes of exercising personal jurisdiction under Georgia's Long Arm Statute. *See* Barney v. Peters, CV420-173, 2021 WL 5291827, at *5 (S.D. Ga. Nov. 12, 2021) (finding that radiologist who provided teleradiology services from Nebraska for a patient who was receiving treatment in an emergency department in Liberty County, Georgia was subject to personal jurisdiction in Georgia, because by obtaining "**his Georgia medical license, he used that license to practice medicine in Georgia**" and, further, because the radiologist "**engages in a 'persistent course of conduct' in Georgia**" when interpreting imaging for patients situated in Georgia and transmitting findings and impressions to other providers in Georgia) (emphasis added).

Opportunities and Barriers, The American Journal of Medicine, Vol 127, No. 3, p. 185 (Mar. 2014) (emphasis added) ("Dr. Weinstein, *et al.*"). The only logical reason for such a requirement, which remains a requirement in Georgia as well (*see* Ga. R. & Reg. 360-3-.07(a)(1)), is the recognition that the "provision" of care follows the location of the patient, not the physician. Indeed, Dr. Barbosa, *et al.* further observe that "[m]ore than half of all US states are now part of the Interstate Medical Licensure Compact, an initiative to facilitate the expedition of multistate medical licensure. The initiative focuses on expanding physicians' ability **to offer care in rural and underserved areas across multiple states** through the use of telemedicine." Dr. Barbosa, *et al.* at 475 (emphasis added). Here, again, the "provision of care" is patient-centric, not physician-centric.

What the medical community acknowledges as reality is also the reality that two of three Court of Appeals' Judges in Kidney likewise appreciated – that care is provided where the patient is located. After all, the *sine qua non* of healthcare is the patient – a physician cannot provide care without a patient. Interpreting the ER Statute as requiring a healthcare provider to be physically present in the emergency department, as Appellants suggest, is not a "narrow" interpretation of the ER Statute, it is a tortured interpretation that ignores the intent of the Georgia legislature and the reality of how medical care is delivered or "provided" to patients.

C. Adopting Appellants' interpretation of the ER Statute will have adverse policy implications that will frustrate the delivery of and access to medical care for at-risk populations.

From a policy standpoint, interpreting the ER Statute in a draconian and inflexible manner will undermine the purpose of telemedicine and teleradiology, which is to increase access to medical care, particularly in rural, underserved, and poverty-stricken communities. *See* Dr. Barbosa, *et al.* (discussing how telemedicine increases access to care for rural Medicare beneficiaries (p. 464), the impact on restriction to access to care for those living below the national poverty line and in rural communities (pp. 465-466), and how telemedicine has fulfilled its fundamental aim to improve access to care (p. 473)); *see also* Dr. Weinstein, *et al.* at 184 ("Teleradiology is an example of a critically important acute care telemedicine service to rural hospitals in the rapid diagnosis of traumatic injuries and strokes.").

The GDLA urges this Court to heed the research and observations of the medical community, as the General Assembly has, and avoid interpreting the ER Statute in a manner that is inconsistent with its purpose and ordinary meaning as doing so could have far-reaching unintended consequences. The Dr. Barbosa, *et al.* authors found that "projections indicate that there will be a growing shortage of practicing physicians, estimated between 46,900 and 121,900, by the year 2032" and "[l]ess than 12% of physicians in the United States practice in rural

communities." Dr. Barbosa, *et al.* at 466. This shortage and its disparate impact only underscore the importance of the remote provision of healthcare, including telemedicine and teleradiology.

In this connection, it is not hard to imagine a neurologist from Memorial Health in Savannah (a Level 1 Trauma Center) being unwilling to accept a telemedicine consult for a patient in the emergency department at Clinch Memorial Hospital in Homerville, Georgia, because he or she cannot walk to the emergency department to physically examine the patient. This would be particularly troubling for a patient in the same emergency department where Ms. Wilson received treatment in view of the findings of the Dr. Barbosa, *et al.* authors relating to the positive impact of telestroke, including teleradiology components of treatment, on patient outcomes. Dr. Barbosa, *et al.* at 467-469 (discussing positive outcomes for "underserved patient populations, including rural and ethnically diverse communities."); *see also* Dr. Weinstein, *et al.* at 184 ("Telestroke is a model urgent telemedicine service because of its documented improvements in patient outcomes and the strong economic case that can be made for implementing the service.").[3]

[3] The fact that a neurologist may arguably have a "face-to-face" encounter with a patient via remote means does not elevate the importance of the care provided compared to a radiologist, whose practice is to interpret imaging studies from a remote location (either inside the hospital or outside the hospital) and report findings and impressions to clinicians. To this end, it would be categorically unfair to exclude radiologists from the benefits the General Assembly intended to confer with the ER Statute merely because they are diagnosticians and not clinicians. And such a

Distorting the clear meaning of the ER Statute to require physical presence of a healthcare provider in the emergency department would not enhance the quality of the care provided to patients who present to the Clinch Memorial Hospital emergency department, as Ms. Wilson did. The only and most reasonably logical way to interpret the ER Statute is to hold that "[a] patient is receiving treatment, if at all, **where he or she is located**." Kidney, 343 Ga. App. at 415 (emphasis added).

CONCLUSION

The GDLA respectfully requests that this Court adopt the interpretation of the ER Statute suggested by Appellees and as outlined in the well-reasoned opinion penned by Judge Markle and joined by Presiding Judge Miller, and Judges Brown, Gobeil, Hodges, Pipkin, and Land, and hold that O.C.G.A. § 51-1-29.5(c) properly applies to telemedicine providers, i.e., those physicians who provide care from a location other than the emergency department where the patient is located at the point of care. *See* Wilson v. Inthachak, Ga. Court of Appeals Case No. A23A0398, pp. 9-14.

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conclusion would be inconsistent with the real impact of teleradiology outlined by the Dr. Weinstein, *et al.* authors, discussed *supra.*

RESPECTFULLY SUBMITTED THIS 13th DAY OF OCTOBER, 2023.

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CERTIFICATE OF SERVICE

This is to certify that I have this day served a true and correct copy of the foregoing **BRIEF OF THE GEORGIA DEFENSE LAWYERS ASSOCIATION AS AMICUS CURIAE IN SUPPORT OF APPELLEES NIRANDR INTHACHAK, M.D. AND RADIOLOGICAL ASSOCIATES OF SOUTH GEORGIA, P.C.** by depositing a copy of the same in the United States Mail, with sufficient postage affixed thereto to ensure delivery, addressed to the following:

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