IN THE SUPREME COURT OF THE STATE OF GEORGIA

CAROL GLIEMMO and ROBERT GLIEMMO Appellants, vs. MARK D. COUSINEAU, M.D., EMERGENCY MEDICAL SPECIALISTS OF COLUMBUS, P.C., AND ST. FRANCIS HOSPITAL, INC. Appellees.	)	**Case No. S09A1807**

AMICUS CURIAE BRIEF ON BEHALF OF THE MEDICAL ASSOCIATION OF GEORGIA AND THE AMERICAN MEDICAL ASSOCIATION

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Pursuant to Georgia Supreme Court Rule 23, The Medical Association of Georgia and the American Medical Association respectfully submit this *Amicus Curiae* Brief in support of the position of the Appellees.

STATEMENT OF INTEREST

The Medical Association of Georgia

The Medical Association of Georgia (hereafter "MAG") is a non-profit, voluntary professional association of Georgia physicians. Founded in 1849, MAG is part of the American Medical Association Federation, and is the largest

physicians' association in Georgia. MAG has over 6,000 members and the majority of these members actively practice medicine.

MAG was founded in order to promote the improvement of public health in Georgia and advance the art and science of medicine. To achieve these goals, MAG actively advocates the positions of physicians and patients in the United States Congress, the Georgia General Assembly, state and federal courts throughout the United States, and in the private sector through large health plans, hospitals, and other entities that significantly affect patient care. Additionally, MAG publishes a widely disseminated medical journal (the "Journal of the Medical Association of Georgia"), organizes and conducts continuing medical education programs in the State of Georgia, and provides accreditation for healthcare professionals working in the Georgia prison system.

The American Medical Association

The American Medical Association (hereafter "AMA") is an Illinois non-profit corporation. It is an association of approximately 240,000 physicians, residents, and medical students and is the largest medical society in the United States. Its members practice in every state, including Georgia, and in every field of medical specialization. The AMA was founded in 1847 to promote the science and art of medicine and the betterment of public health, and these remain its core purpose.

The AMA joins this brief on its own behalf and as a respresentative of the Litigation Center of the American Medical Association and the State Medical Societies. The Litigation Center was formed in 1995 as a coalition of the AMA and private, voluntary, nonprofit state medical societies to represent the views of organized medicine in the courts.

Interest of Amici Curiae

MAG and the AMA are justifiably concerned with issues related to medical malpractice cases. MAG and the AMA support efforts to continue to improve the quality of and access to affordable health care services in Georgia and file this Amicus Curiae Brief in furtherance of this goal.

INTRODUCTION

Access to emergency and trauma care is a matter of life and death. Trauma is the number one killer of Americans between the ages of one and forty-four, and the number three cause of death across all age groups. Available at http://www.georgiaitsabouttime.com/[1]. Georgia's trauma death rate is significantly higher than the national average: 63 of every 100,000 people compared to the national average of 56 per 100,000. Id.

[1] This Web site examines trauma care in Georgia. It is sponsored by the Georgia Statewide Trauma Action Team (GSTAT), a coalition of hospitals, EMS providers, physicians, nurses and others interested in creating a statewide trauma system.

Currently, many Georgia hospitals are struggling to treat patients efficiently and effectively while their resources decline. Long waits for treatments are common, as the number of emergency room visits increase dramatically and the availability of emergency healthcare services declines. In addition to these pressures, increased expenses, and costs attributed to liability insurance has led to a further reduction in access to emergency healthcare.

The Georgia General Assembly addressed these issues in 2005 with the passage of O.C.G.A. § 51-1-29.5(c), which was designed to impact the primary obstacle to the availability of healthcare, its costs. The enactment of this statute is a legitimate exercise of legislative authority to address a pressing social issue by curbing the crisis in emergency care in the state. While it does not eliminate all of the impediments to access to emergency healthcare in Georgia, the law under consideration in the case sub judice is a major step toward that goal.

ARGUMENT AND CITATION OF AUTHORITY

I. It is a constitutional exercise of legislative authority for the Georgia General Assembly to provide access to quality healthcare for the citizens of Georgia.

In 2005 the Georgia General Assembly determined that there was a crisis affecting the provision and quality of healthcare services in the state. To address that crisis, the 2005 Tort Reform Act was passed. GA Laws 2005, p. 1. The basis

for and the desired results of such an undertaking were clearly delineated in the preamble to the statute.

> The General Assembly finds that there presently exists a crisis affecting the provision and quality of healthcare services in this state. Hospitals and other healthcare providers in this state are having increasing difficulty in locating liability insurance and, when such hospitals and providers are able to locate such insurance, the insurance is extremely costly. The result of this crisis is the potential for a diminution of the availability of access to healthcare services and a resulting adverse impact on the health and well-being of the citizens of this state. The General Assembly further finds that certain civil justice and health care regulatory reforms as provided in this Act will promote predictability and improvement in the provision of quality healthcare services and the resolution of healthcare liability claims and will thereby assist in promoting the provision of healthcare liability insurance by insurance providers. The General Assembly further finds that certain needed reforms affect not only healthcare liability claims but also other civil actions and accordingly provides such general reforms in this Act.

Ga. L. 2005, p.1 §1.

Thus, within this preamble, the General Assembly specifically identified problems facing the State of Georgia and explained its plan to address them. Included in this statute is O.C.G.A. § 51-1-29.5(c) as it pertains to the provisions of medical care in the context of medical emergencies.

This statute is now under attack as a constitutionally impermissible "special" law. The characterization of the alleged constitutional infirmity is inapposite. What is important is that this Court has recognized the authority of the General Assembly to address these unique societal issues head on and to create solutions.

Assuming but not conceding that O.C.G.A. § 51-1-29.5(c) is a "special" law, it is a permissible special law because the legislature may enact special laws when the classification of those affected is reasonable. The Court has applied this principle consistently and has upheld special laws where there is a reasonable justification for the law. See e.g., McAllister v. American Nat. Red Cross, 240 Ga. 246, 240 S.E.2d 247 (1977), Black v. Blanchard, 227 Ga. 167, 179 S.E.2d 228 (1971).

Specifically, this Court has confirmed the General Assembly's unique ability to address issues involving medical malpractice cases. In Smith v. Cobb County-Kennestone Hosp. Auth., the Court upheld a 1987 amendment to O.C.G.A. § 9-3-73 changing the provision for tolling of the statute of limitations applicable to minors in medical malpractice cases. 262 Ga. 566, 423 S.E.2d 235 (1992). In doing so, this Court acknowledged the stated purpose of the legislature of providing quality healthcare, by "stabilizing insurance and medical costs," and observed further that "[i]t is not disputed that the objectives recited in [the statute] are legitimate goals." Id. Moreover, this Court held that the General Assembly's goals of "providing quality healthcare, assuring the availability of physicians, preventing the curtailment of medical services, stabilizing insurance and medical costs, preventing stale medical malpractice claims, and providing for the public safety, health, and welfare as a whole" were legitimate. Id. at 570. The goals

approved by the Court in Smith are consistent with the General Assembly's legislative findings in 2005 with regard to the protections needed to preserve and improve the safety and efficacy of emergency medical services in Georgia. There is no reason to conclude that these legislative goals are any less legitimate today than they were in the 1987 statute.

Here, the legislature was uniquely situated to identify the crisis in emergency healthcare and act on it appropriately. As such, "a legislature must have substantial latitude to establish classifications that roughly approximate the nature of the problem perceived." Phyler v. Doe, 457 U.S. 202, 216, 102 S. Ct. 2382, 72 L.Ed. 786 (1982). Furthermore, "when social or economic legislation is at issue, the Equal Protection clause allows the states wide latitude." Cleburne v. Cleburne Living Center, 473 U.S. 432, 439, 105 S. Ct. 3249, 87 L.E.2d 313 (1985). A statute aimed at improving emergency healthcare for all Georgia residents certainly qualifies as social or economic legislation and thus the legislature took the initiative to conduct the appropriate research and react accordingly with the enactment of O.C.G.A. § 51-1-29.5(c).

Therefore, when reviewing the constitutionality of O.C.G.A. § 51-1-29.5(c), it is important to remember, "it is a fundamental principle that 'the legislature, and not the courts, is empowered by the Constitution to decide public policy and to implement that policy by enacting laws, and the courts are bound to follow such

laws if constitutional.'" Housing Auth. of Macon v. Ellis, 288 Ga. App. 834, 836, 655 S.E.2d 621, 623 (2007), citing Commonwealth Inv. Co. v. Frye, 219 Ga. 498, 499, 134 S.E.2d 40 (1963). Additionally, the issue of health policy is "more properly suited to legislative action as the legislature offers a forum wherein all the issues, policy considerations and long range consequences involved...can be thoroughly and openly debated and ultimately decided." Atlanta Obstetrics and Gynecology Group v. Abelson, 260 Ga. 711, 718-19, 398 S.E.2d 557, 563 (1990). See also C.W. Matthews Contracting Co. v. Gover, 263 Ga. 108, 428 S.E.2d 796 (1993). Accordingly, the General Assembly acted within the scope of its power by identifying a specific problem and enacting a law to address it.

II. The state of emergency medicine in Georgia not only made the General Assembly's passage of O.C.G.A. 51-1-29.5(c) reasonable, it made it essential.

Certainly, the foundation of any effort by the General Assembly to address a societal need is a clear description of that need. By enacting O.C.G.A. § 51-1-29.5(c), the General Assembly clearly saw a need that must be addressed.

The need to address issues involving emergency medicine is evidenced in a report released in June 2006 by the Institute of Medicine (IOM) entitled, "Future of Emergency Care." This report was prepared by the IOM's 40-member board and is considered by IOM to be the most comprehensive national review of emergency

procedures in 40 years. It analyzes three specific areas: 1) hospital emergency rooms, 2) pediatric emergency care, and 3) pre-hospital care given by ambulance services. According to the report, long waits for treatments are common, with ambulances sometimes waiting for hours to unload patients. Once in the emergency room, patients may wait for up to two days before being admitted to a hospital bed.

The study cited three contributing problems to the rise in emergency room visits: the aging of the baby boomers, the growing number of uninsured and underinsured patients, and the lack of access to primary care physicians. In 2003, 114 million people, including 30 million children, visited emergency rooms, compared with 90 million visits a decade ago. In that same period, the number of U.S. hospitals decreased by 703, the number of emergency rooms decreased by 425, and the total number of hospital beds dropped by 198,000. Ken Krizner, Report shows rise in emergency room visits puts pressure on hospitals, Managed Healthcare Executive, Sept. 1, 2006.

The stress encountered in an emergency setting should be obvious. Life or death decisions made in an instant under the pressure of a mounting number of patients necessarily exacts a toll. In a study published in the July 2009 issue of the "Annals of Emergency Medicine,"[2] one-third of emergency physicians surveyed

[2] This study was available February 3, 2009 online.

showed signs of career burnout. The study was conducted through a mail survey sent to a random sample of members of the American College of Emergency Physicians. A large percentage of emergency physicians in this study, 32.1%, exhibited emotional exhaustion, which is the core symptom of burnout. High anxiety caused by concern for bad outcomes of patients was the strongest predictor of burnout. Gloria Kuhn, Richard Goldberg, and Scott Compton, Tolerance for Uncertainty, Burnout, and Satisfaction With the Career of Emergency Medicine, 54 Ann. of Emerg. Med. 106 (2009). Underlying this stress is the potential for being named in a malpractice lawsuit and the expense of defending it, missing time from work and the substantial cost of maintaining malpractice insurance.

It is important to note that one of the reasons for decreased availability of healthcare is that physicians limit their practices to exclude high-risk procedures and services in order to avoid exposure to lawsuits. See, e.g., Joint Economic Committee, United States Congress, Liability for Medical Malpractice; Issues and Evidence 15-17 (May 2003). Another reason is that some physicians simply stop practicing entirely or exclude entire categories of services from their practice. See, e.g., Current Issues Related to Medical Liability Reform, Before the Committee on Energy and Commerce Subcommittee on Health, U.S. House of Representatives 3-4 (statement for the record of the American Medical Association).

It is these types of facts on which the Georgia General Assembly relied in enacting O.C.G.A. § 51-1-29.5(c). Within the reality of budget constraints, the General Assembly cannot legislate into existence additional emergency rooms adequately staffed with qualified healthcare providers. Nor can it legislatively eliminate or reduce the number of patients seen in emergency rooms each year. However, it can address the financial strain and the stress that emanates from malpractice lawsuits and this is precisely what it has endeavored to do. Obviously, it does not eliminate the problem completely, but it does undertake to address it and contribute to the alleviation of an emergency healthcare crisis.

III. Legislation addressing medical litigation issues has been effective in improving healthcare and should not be curtailed.

It is clear that legislation addressing medical malpractice litigation has been effective across the medical landscape. A recent study conducted by the Carl Vinson Institute reveals that the number of physicians in Georgia increased by 1,000 since 2004. This increase obviously coincides with the passage of the 2005 legislation now at issue. Additionally, The 2009 edition of the American College of Emergency Physicians' National Report Card on the State of Emergency Medicine, states that, "Georgia has made great progress in improving its 'Medical Liability Environment.'" National Report Card at 37. It further states, "it is vital

that policymakers do not roll back this progress as a result of the continuous pressure from medical liability reform opponents." Id.

Recent studies in other states also show that medical tort reform acts have led to an increased supply of physicians. Carol and David Emmons, The Impact of Liability Pressure and Caps on Damages on the Healthcare Market: An Update of Recent Literature, American Medical Association Chicago, Ill, 2007, at 1. For example, the 2003 tort reform bill in Texas led to a resurgence of a competitive malpractice insurance industry in which premiums have been lowered by as much as 35% in some cases. Joseph Nixon, Why Doctors are Heading for Texas, The Wall Street Journal, May 17, 2008. This has "allowed doctors and hospitals to cut costs and even increase the resources devoted to charity care." Id.

It is worth noting that many other states have enacted statutes using nearly identical language to that challenged by the Appellants. See e.g., S.C. Code Ann. § 15-32-230 (1976) (establishing a "grossly negligent" standard for liability in claims arising out of emergent medical care in South Carolina); K.S.A. § 8-1506 (providing immunity for drivers of emergency vehicles in Kansas absent evidence of "reckless disregard" for the safety of others); F.S.A. § 768.13 (providing that gratuitous providers of emergency medical care in Florida shall not be liable for damages absent evidence of "reckless disregard"); A.R.S. § 9-500.02 (granting

immunity to emergency medical personnel in Arizona absent evidence of "gross negligence or intentional misconduct.")

Additionally, Michigan has a statute that prescribes a gross negligence standard for liability on the part of "emergency medical services personnel," MCL 333.20901 et seq. Michigan courts upheld this statute in Jennings v. Southwood, stating:

> If emergency personnel are liable for ordinary negligence, then the EMSA immunity provision is rendered void. Before the statutory immunity, emergency personnel were liable for their ordinary negligence. The Legislature, dissatisfied with this situation, enacted the EMSA limiting liability to situations of gross negligence or wilful misconduct. Undoubtedly, by providing this limited immunity, the Legislature intended to shield emergency medical personnel from the very liability they were previously exposed to-liability for ordinary negligence...[I]t is a comfort to current EMS field personnel that they at least have a statement of legislative support recognizing the difficulty inherent in their jobs. Removing the exemption could affect the morale of EMS workers or make them reluctant to perform certain parts of their jobs for fear of being sued, and could discourage persons from entering EMS occupations.

446 Mich. 125, 133-34, 521 N.W.2d 230 (1994). Thus, experience demonstrates that these statutes do not simply define the issues and make futile attempts at addressing them, they actually produce the desired results.

CONCLUSION

Providing quality healthcare by stabilizing insurance and medical costs is a legitimate goal of the General Assembly and has previously passed constitutional muster before this Court. The state of emergency healthcare in Georgia was such

that nothing short of legislative attention was required. The General Assembly in 2005 enacted legislation which improved the quality of healthcare by stabilizing costs. It was a constitutional exercise of legislative power to do so in 1987 and was likewise constitutionally appropriate in 2005. O.C.G.A. § 51-1-29.5(c) is not an unconstitutional special law.

Respectfully submitted, this 1st day of October, 2009.

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CERTIFICATE OF SERVICE

This is to certify that I have this 1st day of October, 2009, served a true and correct copy of the within and foregoing ***Amicus Curiae Brief On Behalf Of The Medical Association Of Georgia And The American Medical Association*** upon all counsel of record by placing same in the United States Mail, postage prepaid addressed to:

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