IN THE SUPREME COURT OF MISSISSIPPI

THE ESTATE OF JOHN GRIMES, AND THROUGH HIS WIFE AND NEXT FRIEND, HELEN GRIMES, ON BEHALF OF THE WRONGFUL DEATH BENEFICIARIES

Appellants

v.

DR. JAMES WARRINGTON, JR.

Appellees

Case No. 2006-CA-01926

Appeal from the Circuit Court of Bolivar County, Mississippi

Brief for Appellant

OF COUNSEL:
GEORGE F. HOLLOWELL, JR.
Mississippi Bar No. [redacted]
246 South Hinds Street
Post Office Drawer 1407
Greenville, Mississippi 38702-1407
(662) 378-3103
(662) 378-3420(fax)
ATTORNEY FOR APPELLANT

IN THE SUPREME COURT OF MISSISSIPPI

THE ESTATE OF JOHN GRIMES, AND THROUGH HIS WIFE AND NEXT FRIEND, HELEN GRIMES, ON BEHALF OF THE WRONGFUL DEATH BENEFICIARIES

Appellants

v.

DR. JAMES WARRINGTON, JR.

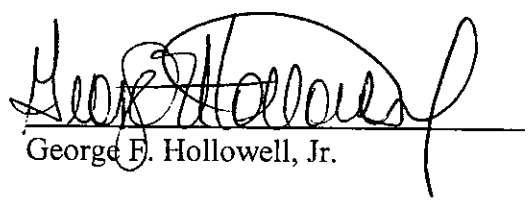
Appellees

Case No. 2006-CA-01926

CERTIFICATE OF INTERESTED PERSONS

The undersigned counsel of record certifies that the following persons have an interest in the outcome of this case. These representations are made in order that the justices of the Supreme Court and/or the judges of the Court of Appeals may evaluate possible disqualification or recusal.

1. Helen Grimes, Plaintiff/Appellant
2. George F. Hollowell, Jr, Counsel for Appellants
3. Dr. James Warrington, Jr., Appellee
4. Chris Winter, Counsel for Appellee James Warrington, Jr.
5. Honorable Charles Webster, Circuit Court Judge



George F. Hollowell, Jr.

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases

Statutes

Rules

Other Authorities

STATEMENT OF THE ISSUES

1. Whether Defendant James Warrington waived the affirmative defense of Tort Claims Act immunity under *MS Credit Ctr., Inc. v. Horton*, 926 So. 2d 167 (Miss. 2006).

2. Whether Dr. Warrington is entitled to dismissal on the theory, he is an employee of a political subdivision or of an instrumentality of a political subdivision.

STATEMENT OF THE CASE

John Grimes was sent home by Dr. Warrington after being treated in his office on August 7, 2000. On August 10, 2000, emergency surgery was performed revealing he had a perforated gallbladder, cholelithiasis, cholecystitis and choledocholithiasis. He died on August 13, 2000. (R. at p. 4)

On June 4, 2001, Helen Grimes, widow of John Grimes filed her complaint against Dr. Warrington and served the complaint, summons, and initial discovery on Dr. Warrington. (R. at first page of docket sheet; RE-1). Dr. Grimes filed his answer on June 27, 2001, listing as his seventh defense immunity under the Tort Claims Act. (R. at p. 8)

Over the next five years, Dr. Warrington served and responded to discovery requests, took and participated in depositions (including those of Grimes' experts), made a motion to dismiss for enumerating money damages prohibited by Miss. Code § 11-1-59 which was denied, designated his own experts, and otherwise participated in trial preparation resulting in at least three pre-trial orders setting deadlines for trial preparation and the filing of proposed jury instructions. (R. at docket sheet, RE-1; R. at pp. 12-17, 19-28, 53, 62-63, 86-87, 90-139)

More than seven months after the third date set for trial, Dr. Grimes filed a motion for summary judgment on August 3, 2006 claiming he was entitled to summary judgment because he was granted immunity by the Tort Claims Act as an employee of Cleveland Medical Alliance, LLP

(CMA), which he claimed qualified as either a political subdivision or an instrumentality of a political subdivision. (R. at pp. 140-145) On August 9, 2006, Dr. Warrington noticed his motion for summary judgment for hearing on August 21, 2006. (R. at p. 196) Grimes responded on August 16, 2006, raising both waiver under *MS Credit Ctr., Inc. v. Horton*, 926 So. 2d 167 (Miss. 2006) and substantive reasons for not granting the motion. (R. at pp. 198-200, 417-431).

On October 12, 2006, the Circuit Court granted Dr. Warrington's motion for summary judgment. Grimes filed a timely notice of appeal on November 6, 2006. (R. at 207-218, RE-4 to RE-14)

STATEMENT OF FACTS

John Grimes was a regular private pay patient of CMA. Part of his care was covered by Medicare as is true for most people his age, but he was not a Medicaid patient. (R. at 275, 283) His primary care physician was Dr. Austin. On August 7, 2004, Grimes' wife took him to CMA because he was experiencing right side abdominal pain. Because Dr. Austin was out of town that day, Grimes was seen by Dr. Austin's partner, Dr. Warrington. (R. at pp. 2-3, 248, 250) Dr. Warrington diagnosed the pain as resulting from bruised ribs from a fall a few days earlier an gave Grimes Celebrex and Ultram for the pain and sent him home without performing any lab tests or imaging tests. The next day, Grimes went to the emergency room at Bolivar Medical Center because he was not getting any better. Two days later, he died of a perforated gall bladder, cholelithiasis, cholecystitis and choledocholithiasis which Dr. Warrington failed to diagnose. (R. at 2-4)

It is undisputed that Dr. Warrington is a partner in CMA and that he has an employment agreement with CMA. It is also undisputed that Greenwood Leflore Hospital (GLH) is a community hospital entitled to the protections of the Tort Claims Act. What is disputed,

however, is the whether the partnership, CMA, and Dr. Warrington are entitled to the protections of the Tort Claims Act.

A medical clinic has existed at the current location of CMA for many years. It was originally named Cleveland Clinic, PA and the physician members of the professional association were Dr. Austin, Dr. Milam, Dr. Wright, Dr. Sullivan and Dr. Lindsey. Around 1990, the physicians decided to add two more doctors, Dr. Adams and Dr. Brock and they wanted to make some changes in the retirement plan. So Cleveland Clinic, PA ceased to exist and Cleveland Medical Clinic, Ltd. was formed. (R. at pp. 496-498).

In the early 1990's, Dr. Lindsey died. In the mid 1990's Dr. Warrington joined Cleveland Medical Clinic, Ltd. (R. at pp. 499-500). In 1997, the physicians decided to change the legal format of their practice again. This time, the physicians decided to form a partnership with GLH and to make the legal form of the entity a limited liability professional partnership. Most of the physicians signed the partnership agreement on May 30, 1997. Dr. Warrington signed in an amendment the next day. But the end result was that Dr. Brock, Dr. Wright, Dr. Austin, Dr. Sullivan, Dr. Warrington and GLH became partners and co-owners of the clinic. (R. at pp. 432-452, 500-501; RE-15 to RE-31)

The business form of CMA is a partnership. It is not a subsidiary of GLH. While GLH is a partner in CMA, it does not wholly own the partnership. (R. at p. 530) The partnership agreement allows CMA to engage in any type of business in any jurisdiction that a general partnership could engage in. It does not restrict the partnership to the practice of medicine in the area served by GLH or even to business endeavors related to medicine in the state of Mississippi. The purpose and scope of the business is set out in Article I, §§ 1.02 and 1.05 of the partnership agreement which state in pertinent part:

> The Executive Committee shall take all other action required by applicable law to permit the Partnership to conduct business as a general partnership *in any jurisdiction in which the Partnership may elect to conduct business* and to register the Partnership as a limited liability partnership in any such jurisdiction where such registration is available. ...
> The Partnership is organized for the following purposes: (I) to *engage in the transaction of any and all lawful 'business* permitted under the laws of the State, (ii) to borrow money and to evidence the same by notes or other evidences of indebtedness and to secure the same by mortgage, deed of trust, pledge or other lien or security interest in furtherance of any or all of the purposes of the Partnership, (iii) to enter into, perform and. carry out contracts and agreements necessary, appropriate or incidental to the accomplishment of the purposes of the Partnership, and (iv) to do any other acts and things which may be necessary, appropriate or incidental to the carrying out of the business and purposes of the Partnership, subject to the terms and conditions of this Agreement.

(R. at p. 433; RE-16)

According to §4.01 of the Partnership Agreement, CMA is governed by an executive committee elected by the partners. (R. at pp. 436-437; RE-19 to RE-20) The doctor partners also have employment agreements with the partnership, but they do not have employment agreements with GLH. (R. at pp. 435, 453; RE-18, RE-32) There is no evidence that any of the usual indicia of employment exist between the physicians and GLH. There is no evidence that the hospital pays their employment taxes, provides them with any benefits, controls their hours, or provides them with the tools and support staff to do their work. These are obligations of the partnership, not of the hospital. (R. at p. 454; RE-33)

Moreover, the hospital cannot control the admission of doctors to the partnership. Any physician partner has the power to withhold consent and thereby prevent any other doctor from joining the partnership. The physicians partners as a group also have the authority to prevent the hospital partner from authorizing the partnership to obtain loans. They also have the power, individually, to prevent the Executive Committee from authorizing that charging of expenses to the partnership which are not directly related to the Clinic. Section 4.01 states in part:

> The Partners agree that the Partnership shall not employ additional physicians or nurse practitioners nor shall expenses not directly attributable to Partnership operations be charged to the Partnership without the consent of all Partners. It is further agreed that *unanimous* consent of the Executive Committee is required to enter into any loan or guaranty agreement pursuant to which the Partnership borrows money or creates any lien, security interest or encumbrance on Partnership assets or any agreement for sale of any substantial portion of the Partnership assets outside the ordinary course of business, contracts for nursing staff and support personnel, allocation of physician income, acquisition and selection of malpractice insurance coverage for physicians, and decisions regarding a determination of fair market value of the partnership interest of any physician partner incident to termination or disposition of a partner's interest.

(R. at pp. 436-437; RE-19 to RE-20) Article V of the Partnership Agreement states in part:

> No additional Partners will be admitted to the Partnership without the prior consent of all of the Partners, which may be withheld by any Partner in its sole and unreviewable discretion, with or without cause.

(R. at p. 438; RE-21)

The physician partners work for the clinic partnership on an as needed basis. They must work at least 46 weeks a year for the partnership clinic but there is an incentive plan for them to work more. However, they are also permitted to engage in other work, more than 75 miles outside of Cleveland, Mississippi and at designated locations within that radius, in addition to their employment by the partnership. The doctors all have admitting privileges and see patients at Bolivar Medical Center, but they rarely even go to GLH. (R. at p. 518)

Dr. Warrington testified that he does not even have admitting privileges and is not on the staff at GLH. (R. at p. 237) He was not aware that he had any privileges at GLH and he is not familiar with the bylaws, policies and regulations of GLH. He does not deal with the administration at GLH in any capacity. (R. at pp. 280-281)

The clinic partnership does the patient billings keeping track of the billings and collections for each doctor. (R. p. 455; RE-34) Each doctor's compensation is directly tied to the

collections for the patients he treated. After an initial three month period at a specific base monthly salary, the employment agreement states

> continuing thereafter, Partnership agrees to pay Employee a Base Salary of 53.6% of actual collections (net of any attorneys' fees or collection agency costs of collection) received by Partnership in the preceding calendar month as a result of professional services performed under this Agreement by Employee, payable every month by no later than the last calendar day of the month.

(R. p. 463; RE-42) Thus, Dr. Warrington was indirectly compensated by the payments received from Grimes even if Grimes paid CMA and did not pay Dr. Warrington directly. The partnership, not the hospital, sets the billing rates. Under their agreements, the doctors share 90% of the clinic's profits with the remaining 10% going to GLH. The doctors also share in the clinic's losses. (R. at pp. 285, 435[1], 455, 463-464, 527-528; RE-18, RE-34; RE-42 to RE-43) When capital contributions are needed, each partner, including Dr. Warrington, is obligated to contribute in proportion to his partnership percentage. If he does not and another partner covers for him, his capital account is docked. (R. at p. 434, 530-531; RE-17)

There is no indication that the doctor patient relationships have changed any over the years as this clinic has gone from an entirely private professional association to a partnership between the doctors and GLH. The doctors' employment agreements with the partnership require them not to discriminate against Medicare and Medicaid patients but it does not require the doctors to treat every patient, or even every needy patient, who comes through the doors. (R. at p. 455; RE-34) Nor is there any evidence that patients do not get to choose the physician of their choice but rather are treated by whomever they are assigned to by a government entity. To

---

[1]Section 3.02 of the Partnership Agreement states in part:
Partnership losses shall be allocated to the Partners in the proportion as set forth in Exhibit A attached hereto and made a part hereof. (R. at p. 435; RE-18)

the contrary, the evidence shows that Grimes was a regular patient of Dr. Warrington's partner, Dr. Austin. (R. at p. 248)

There is no evidence in the depositions or the agreements indicating that the physicians have any teaching responsibilities. There is no evidence that they are assigned any patients by GLH. There is no evidence that the physicians are required to treat any particular patient or to relate to patients in any manner that is different from the way they operated before they went into partnership with GLH. There is no requirement that these physicians must join this partnership in order to maintain some other employment relationship with GLH or the State of Mississippi or any county.

SUMMARY OF THE ARGUMENT

The Circuit Court granted summary judgment to Dr. Warrington based on the belief that the partnership agreement between GLH and CMA was virtually identical to the partnership agreement between GLH and BLMA in *Bolivar Leflore Med. Alliance, LLP v. Williams*, 938 So. 2d 1222 (Miss. 2006) *(BLMA)*. This was error for at least two reasons.

First, a careful comparison of the agreements shows that unlike the BLMA partnership, GLH's majority "control" was not real control at all. The CMA physician partners made sure they retained sufficient power through provisions differing from those of the BLMA agreement requiring unanimous consent of all partners and provisions requiring unanimous consent of the Executive Committee (including the physician member) to prevent GLH's majority from being sufficient to control a long list of matters of interest to the physicians. These matter which GLH could not control included, among other things, all contracts with nurses and support personnel, the allocation of income to physicians, the borrowing of money, encumbering or sale of assets, and the selection of malpractice insurance. Although GLH was a nominal partner, through a

combination of the partnership and employment agreements, its share of income was limited to 10% of any actual profit the practice might make after paying each of the physicians more than 53% of the gross receipts directly associated with collections for care he rendered and paying all the expenses of the practice. The physicians got the other 90% of any profit the practice earned. The testimony of the clinic administrator established that the change in the clinic's business format from a professional association to a limited liability partnership with GLH as a nominal partner did not change anything about the clinic's operation except its name. The clinic clearly remained a vehicle for these particular physicians' private practice, not an entity which GLH controlled and used as its agent.

Second, even if CMA did qualify as an instrumentality of GLH, Dr. Warrington waived any Tort Claims Act defenses he had. These defenses are affirmative defenses. By participating in the ligation, including discovery and making a motion to dismiss on other grounds, for five years without bringing these defenses, which had the potential to end the litigation, to the court's attention through a motion and noticing the motion for hearing, Dr. Warrington waived these affirmative defenses under *Horton*.

ARGUMENT

Standard of Review

Summary judgment may be granted pursuant to Miss. R. Civ. P. 56(c) only if the evidence shows that no genuine issue of material fact exists, and the moving party is entitled to judgment as a matter of law. All the evidentiary matters, including admissions in pleadings, answers to interrogatories, depositions, affidavits, etc, must be viewed in the light most favorable to the party against whom the motion has been made. Summary judgment may only be granted when viewing the evidence in this light, the moving party demonstrates that he is entitled to

judgment as a matter of law. *State v. Bd. of Levee Comm'rs*, 932 So. 2d 12, ¶ 10 (Miss. 2006)

I. Dr. James Warrington Waived His Tort Claims Defenses under *Ms Credit Ctr., Inc. v. Horton*, 926 So. 2d 167 (Miss. 2006)

Tort Claims Act or governmental immunity is an affirmative defense. *City of Ellisville v. Richardson*, 913 So. 2d 973, ¶ 6 (Miss. 2005); *Lumberman's Underwriting Alliance v. City of Rosedale*, 727 So. 2d 710, 712 (Miss. 1998); *Dixon v. Singing River Hosp. Sys.*, 632 So. 2d 951, 952 (Miss. 1991) In *MS Credit Ctr., Inc. v. Horton*, 926 So. 2d 167 (Miss. 2006), the Mississippi Supreme Court held that a "defendant's failure to timely and reasonably raise and pursue the enforcement of any affirmative defense or other affirmative matter or right which would serve to terminate or stay the litigation, coupled with active participation in the litigation process, will ordinarily serve as a waiver." The *Horton* court specifically held that this holding applies to any affirmative defense with the potential to stay or terminate the litigation and is not confined to failures to pursue arbitration defenses. Tort Claims Act immunity is clearly an affirmative defense with the potential to terminate the litigation where there is only one defendant as in this case. *Horton* goes on to hold "absent extreme and unusual circumstances - an eight month unjustified delay in the assertion and pursuit of any affirmative defense or other right which, if timely pursued, could serve to terminate the litigation, coupled with active participation in the litigation process, constitutes waiver as a matter of law." *Horton* specified that in order to avoid waiver, it was necessary for a defendant to pursue the affirmative defense rights to terminate the litigation by timely asserting it in a pleading, bringing it to the court's attention by motion, and requesting a hearing in order to avoid waiver. *Id* at ¶¶ 44-45 and n.9

In this case, Dr. Warrington filed his answer in June of 2001. He raised the Tort Claims Act affirmative defense on which he based his motion for summary judgment in the Seventh

Defense. He then waited five years before bringing the defense to the attention of the court through his summary judgment motion. During this five year period, he filed a motion to dismiss on different grounds without raising the Tort Claims Act defenses in it and pursued that motion to an order. During these five years, Dr. Warrington also served and responded to discovery requests, took and participated in depositions (including those of Grimes' experts), designated his own experts, and otherwise participated in trial preparation resulting in at least three pre-trial orders setting various deadlines for various matters in preparation for trial and the filing of proposed jury instructions. (R. at docket sheet; pp. 12-17, 19-28, 53, 62-63, 86-87, 90-139) However, he did not file a dispositive motion including the Tort Claims Act defenses and notice it for hearing until August of 2006. (R. at pp. 140-145, 196) Under *Horton*, he has clearly waived his Tort Claims Act affirmative defenses.

II. Dr. Warrington Should Not Be Entitled to Dismissal on the Theory That He Is an Employee of a Political Subdivision.

In *Mozingo v. Scharf*, 828 So. 2d 1246, ¶ 26 (Miss. 2002), the court said

> An instrumentality is not specifically defined in the above code section, however, the Legislature was using "instrumentality" as an inclusive term so as not to limit the means by which the state could carry out its governmental functions. ... UAS was created to provide anesthesia services to patients at UMMC. As already noted, UMMC is a teaching hospital which functions to carry out the goal of the Legislature - to provide low cost or no cost health services to indigent persons or persons on Medicaid who live in the state. UAS is also staffed with UMMC faculty members who provide another important function to the State of Mississippi - to prepare future physicians to practice in the State. Furthermore, UAS is bound by UMMC guidelines. Actions with regard to physicians at UMMC are limited by the rights of the physicians as state employees at UMMC. UMMC has numerous divisions and practice plans under its umbrella consisting of numerous organized groups of physicians with medical school faculty appointments. Twelve of these clinical departments, including the Department of Anesthesiology, formed the plan at issue here. However, these physicians cannot moonlight on other jobs in private practice, but rather are limited to providing services at UMMC. In fact, every doctor providing clinical patient services at UMMC is required by the state to belong to the practice plan. Practically every

> case this Court has considered regarding the subject matter of immunity under the MTCA has involved one or more physician who is both a member of a practice plan and UMMC as required. Thus, UAS was created because of a direct edict from the state agency charged with the management of UMMC. We find that UAS was simply an entity created to facilitate the billing and collection of physician fees generated by state employees. It is not a private entity.

Id at ¶¶ 26-27.

This discussion of why UAS is an instrumentality of the University of Mississippi Medical Center fits with the definitions in *Black's Law Dictionary* which defines an instrumentality as "a means, medium, agency" and which discusses the instrumentality rule in terms of the alter ego rule for piercing the corporate veil. For one entity to be an instrumentality of another, it requires the instrumentality to be so dominated by the parent that it becomes indistinguishable from the parent.

Neither the factors described in *Mozingo* nor the level of alter ego existence described in *Black's* exists in the relationship between Cleveland Medical Alliance, LLP and GLH. Cleveland Medical Alliance was not created solely by departments of GLH. It was not created because of a direct edict from the Board of Trustees charged with managing GLH. It wasn't created solely as a means of facilitating billing for the services of employees of GLH or employee's GLH's Board. There is nothing that requires any particular doctor to join CMA as a partner. Nor can GLH order a doctor to join CMA as a partner. A new partner can only be added with the unanimous consent of all the partners, including each private physician. GLH cannot even hire nurses for CMA or allocate physician income on its own. CMA was the transformation of an existing private medical clinic into an alternate legal form of business by private for-profit physicians who were not at that time employees of GLH, GLH's Board or any of GLH's

departments but who saw personal advantages to adding GLH[2] as a partner but who also wanted to make sure GLH could not control the aspects of the practice most important to the physicians. In the words of CMA's administrator, nothing really changed except the name. (R. at p. 514)

A. CMA is Not an Instrumentality of GLH Under the Language and Reasoning of *Bolivar Leflore Med. Alliance, LLP v. Williams*, 938 So. 2d 1222 (Miss. 2006)

In *Bolivar Leflore Med. Alliance, LLP v. Williams*, 938 So. 2d 1222 (Miss. 2006) *(BLMA)*, the court held that while Bolivar-Leflore Medical Alliance, LLP was not a community hospital, it was an instrumentality of a community hospital for three reasons: 1) the purpose of the partnership was to carry out GLH's public mission of providing medical services to Mississippi citizens; 2) GLH had nearly total interest in the income and losses of BLMA, and 3) through its 2/3 majority control of the Executive Committee, GLH had total control of the partnership's operation. The *BLMA* court described its reasoning for finding BLMA to be an instrumentality of GLH saying:

> P2. On May 3, 1996, BLMA was created as a family medical clinic by an agreement between GLH ("GLH"), Dr. Don Blackwood, and Dr. Paul Warrington. The percentage interest of each was as follows: GLH - 98%; Dr. Blackwood - 1%; Dr. Warrington - 1%. The agreement provided that the distribution of all net income and losses among the individual partners was to proportionately mirror the percentage interest of each. The business affairs of BLMA were to be conducted under the authority and control of an Executive Committee created by the partners. Section 4.01 of the agreement stated, in part:
> [t]he Partners shall create an Executive Committee ... as follows: GLH shall name two individual representatives to the Executive Committee and the Physician Partners, acting by majority vote of their Percentage Interests, shall elect one representative. ... The Executive Committee *shall have full, exclusive and complete authority, discretion, obligation and responsibility* with respect to the *business* of the Partnership. The Executive Committee shall manage and control

[2]Contrary to the unsupported assertions of Dr. Warrington below, the evidence is that CMA was not funded with public funds. The partnership began with the assets that Cleveland Medical Clinic, Ltd had and has continued to be funded primarily from the receipts of the doctors from treating patients. (R. at pp. 514-515)

the affairs of the Partnership to the best of its ability and shall use all commercially reasonable efforts to carry out the business of the Partnership. The Executive Committee, acting by majority vote of its members, *shall have the sole authority to bind the Partnership by contract*, including mortgages, deeds of trust, promissory notes, or other obligations not inconsistent with the provisions of this Agreement. The Partners agree that the Partnership shall not employ additional physicians or nurse practitioners nor shall expenses not directly attributable to Partnership operations be charged to the Partnership without the consent of all Partners. (emphasis added [by *BLMA* court]...

P. 16 An instrumentality is defined as "something that serves as an intermediary or agent through which one or more functions of a controlling force are carried out: a part, organ, or subsidiary branch esp. of a governing body." Webster's Third New International Dictionary 1172 (3rd ed. 1986). In *Watts*, this Court concluded that "UAS meets the definition of 'State' because it is an instrumentality of UMMC, a state teaching hospital[,]" although this Court placed limitations on its holding, stating:

> we are not holding that all medical practice groups are per se instrumentalities of the State. However, where as here the medical practice group was created by UMMC, and is overseen by UMMC, and the purpose is to supplement the income of its faculty; when the day-to-day oversight is left to the department chair, subject to limited oversight by the vice chancellor, and its membership is composed solely of full-time UMMC faculty-physicians; where the faculty-physicians can only practice at UMMC approved sites, and the money is distributed on a point system based on factors other than mere patient service, we must conclude that the medical practice group is a State entity.

828 So.2d at 793-94.

P17. In comparing UAS and BLMA, this Court finds remarkable similarities. Just as UAS was created and overseen by UMMC, see id., BLMA was created and is overseen by GLH. Specifically, GLH appoints two-thirds (2/3) of the Executive Committee which oversees and controls the business affairs of BLMA, and maintains a 98% interest in the income and losses of BLMA. Furthermore, just as UAS physicians could "only practice at UMMC approved sites," id., Dr. Warrington was contractually required to provide services exclusively for GLH or the partnership and, should he leave the partnership, was excluded from providing medical services in the area by a covenant not to compete contained within his employment agreement. ...

P25. Defendants alternatively contend BLMA is an "instrumentality" of GLH, the "intermediary or agent through which" functions of GLH "are carried out." Since GLH is a "community hospital" and maintains 98% interest in the income and losses of BLMA and two-thirds (2/3) control over the Executive Committee membership of BLMA, they persuasively argue that BLMA functionally operates as an "instrumentality" of GLH. "As an instrumentality of GLH, created to assist GLH in performing its legitimate purpose of providing

> health care services to the public, BLMA is a 'political subdivision' as defined by Section 11-46-1(I), and accordingly is entitled to the protections, limitations and immunities of the MTCA." ...
>
> P28. This Court finds that the legislative intent and purpose of liberal construal are best supported by the latter argument and underlying facts. Finding such, we hold that BLMA is an "instrumentality" of GLH. It is uncontested that GLH is a "community hospital." GLH has nearly total interest in the income and losses of BLMA (i.e. 98%) and majority control over BLMA's Executive Committee membership (i.e. two-thirds; 2/3). Such control clearly qualifies BLMA as an intermediary or agent through which certain functions of GLH are accomplished. Therefore, this Court conclusively finds that BLMA is an "instrumentality" of GLH. As an "instrumentality," BLMA is entitled to the protections, limitations and immunities of the MTCA. See Miss. Code Ann. Section 11-46-15. Accordingly, venue is proper in the Circuit Court of Leflore County.

938 So. 2d 1222 at ¶¶ 2, 16-17, 25, 28.

However, there are substantial differences between the facts as described in *BLMA* and the present case in regard to all these factors, clearly demonstrating the reasoning of the *BLMA* decision is not controlling here. *BLMA* says GLH created BLMA *as a family medical clinic* to assist GLH in performing its legitimate purpose of providing health care services to the public. 938 So.2d at ¶¶ 2, 17, 25. In contrast, the partnership agreement for CMA says CMA's purpose and scope is to engage in any type of business in any jurisdiction a general partnership could engage in. It does not restrict the partnership to the practice of medicine in the area served by GLH or even to business endeavors related to medicine in the state of Mississippi. (Article I, §§ 1.02 and 1.05, R. at p. 433; RE-16) The testimony concerning the origin of CMA establishes that the changes over the years from Cleveland Clinic to Cleveland Medical Clinic and then to CMA were changes in business format made by the physicians for various private reasons, but otherwise the purpose for each change was the continuation of the private medical practice of the physician partners with business format changes decided upon by the physicians to benefit the physicians. As the testimony established, nothing really changed except the name of the clinic.

(R. at pp. 432-452, 498-501, 514; RE-15 to RE-31)

BLMA says the hospital controlled everything through the Executive Committee of BLMA. The court focused on the following language from the Partnership Agreement:

> [t]he Partners shall create an Executive Committee ... as follows: GLH shall name two individual representatives to the Executive Committee and the Physician Partners, acting by majority vote of their Percentage Interests, shall elect one representative. ... The Executive Committee shall have full, exclusive and complete authority, discretion, obligation and responsibility with respect to the business of the Partnership. The Executive Committee shall manage and control the affairs of the Partnership to the best of its ability and shall use all commercially reasonable efforts to carry out the business of the Partnership. The Executive Committee, acting by majority vote of its members, shall have the sole authority to bind the Partnership by contract, including mortgages, deeds of trust, promissory notes, or other obligations not inconsistent with the provisions of this Agreement. The Partners agree that the Partnership shall not employ additional physicians or nurse practitioners nor shall expenses not directly attributable to Partnership operations be charged to the Partnership without the consent of all Partners.

BLMA at ¶ 2. While the CMA language at first look seems similar, a close comparison shows how the physician CMA partners prevented GLH from having anywhere near the level of control GLH had over BLMA. (The quotation below uses strikeouts to show language from the BLMA agreement not present in the CMA agreement and underlining to show language in the CMA agreement not present in the BLMA agreement.)

> The Partners shall create an Executive Committee ... as follows: GLH shall name two individual representatives to the Executive Committee and the Physician Partners, acting by majority vote of their Percentage Interests, shall elect one representative. ... The Executive Committee shall have full, exclusive and complete authority, discretion, obligation and responsibility with respect to the business of the Partnership, except as provided otherwise herein, the ~~The~~ Executive Committee shall manage and control the affairs of the Partnership to the best of its ability and shall use all commercially reasonable efforts to carry out the business of the Partnership. Except as provided otherwise herein, the ~~The~~ Executive Committee, acting by majority vote of its members, shall have the sole authority to bind the Partnership by contract~~, including mortgages, deeds of trust, promissory notes, or other obligations not inconsistent with the provisions of this Agreement~~ or other obligations. The partners agree that the Partnership shall not

> employ additional physicians or nurse practitioners nor shall expenses not directly attributable to Partnership operations be charged to the Partnership without the consent of all Partners. It is further agreed that *unanimous* consent of the Executive Committee is required to enter into any loan or guaranty agreement pursuant to which the Partnership borrows money or creates any lien, security interest or encumbrance on Partnership assets or any agreement for sale of any substantial portion of the Partnership assets outside the ordinary course of business, contracts for nursing staff and support personnel, allocation of physician income, acquisition and selection of malpractice insurance coverage for physicians, and decisions regarding a determination of fair market value of the partnership interest of any physician partner incident to termination or disposition of a partner's interest.

(R. at pp. 436-437; RE-19 to RE-20)

The BLMA documents specifically gave the hospital controlled majority of the Executive Committee very broad sole authority to do almost everything important to the management of a medical practice, including entering into "mortgages, deeds of trust, promissory notes, or other obligations" with only a majority vote which could always be obtained since the hospital controlled 2/3 of the Committee. The only thing the BLMA physician partners could veto the hospital's control on was the admission of new doctors and nurse practitioners to the practice or the charging of non-Partnership expenses to the Partnership. In contrast, the CMA physicians did not grant such broad control to the Executive Committee by majority vote. The CMA physician partners excluded the language about mortgages, deeds of trust, and promissory notes. In addition, by requiring unanimous consent, instead of majority consent, from the Executive Committee, the CMA physicians partners as a group also retained the authority to prevent GLH from authorizing the partnership to enter into any loan or guaranty agreement; from borrowing money; from creating liens, security interests or encumbrances on Partnership assets; from agreeing to sell any substantial portion of the Partnership assets outside the ordinary course of business; from contracting for nursing staff and support personnel; from allocating of physician

income; from selecting and acquiring malpractice insurance coverage for physicians; and from making decisions regarding a determination of fair market value of the partnership interest of any physician partner incident to termination or disposition of a partner's interest. Similarly, the BLMA agreement allowed a majority of the Executive Committee to delegate its authority to one member of the Executive Committee while the CMA agreement requires a unanimous vote, including consent of the physician member, to delegate authority to a single member. (R. at 436-437; RE-19 to RE-20)

Because the CMA agreement requires a unanimous vote of the Executive Committee, whereas the BLMA agreement required only a majority vote, to take these actions, the physician partners can prevent GLH from controlling any of these matters where the BLMA physicians could not prevent GLH's control. In short, the physicians in CMA retained sufficient control to prevent the hospital from being able to control nearly all the major decisions relating to Partnership business. This control scenario is far different from that described in *BLMA*.

The CMA physician partners work for the clinic partnership on an as needed basis. They must work at least 46 weeks a year for the partnership clinic but there is an incentive plan for them to work more. However, they are also permitted to engage in other work, including competing medical work outside a limited geographic region, in addition to their employment by the partnership. (R. at pp. 444-445[3],453, 460-462, 509, p. 510 line 1-4; RE-32, RE-39 to RE-41)

---

[3]Section 10.01 of the Partnership Agreement states:
Except as expressly provided otherwise in this Agreement or a Partner's Employment Agreement, any of the Partners or their affiliates may engage in, or possess an interest in, other business ventures of every nature and description, independently or with others, whether or not such other enterprises shall be in competition with any activities of the Partnership; and neither the Partnership nor the other Partners shall have any right by virtue of this Agreement in and to such independent ventures or to the income or profits derived therefrom. (R. at pp. 444-445; RE-27 to RE-28)

In contrast, *BLMA* said the BLMA physicians were contractually required to provide services exclusively for GLH or the partnership and were excluded from providing medical services in the area by a covenant not to compete in their employment agreement applicable during and after termination of employment. *BLMA* at ¶17.

The *BLMA* decision emphasized that BLMA doctors received profits only in relationship to their 1% interest in the partnership. Dr. Warrington, however, receives more than 53% of receipts from his patients plus his share of the 90% of CMA's profits which the physician partners split among themselves. GLH receives only 10% of profits, if there are any, after the physicians have received more than 50% of what is collected from patients. (R. at pp. 285, 435, 455, 463-464, 527-528; RE-18, RE-34, RE-42 to RE-43)

The *BLMA* court held that BLMA was like University Anesthesia Services, PLLC in *Watts v. Tsang*, 828 So. 2d 785, 791 (Miss. 2002). CMA differs from University Anesthesia Services in most of the areas from the portion of *Watts* which *BLMA* quoted. CMA was not created by GLH. GLH may have acquired a substantial portion of a medical practice, but it was a practice which had been in existence for many years. GLH did not create a new medical practice. The purpose of CMA was not to supplement the income of anyone's faculty. CMA's stated purpose was to engage in any business practice inside or outside of Mississippi which a limited liability partnership could legal engage in. (R. at p. 433; RE-16)

There is no evidence any of CMA's physician employees are faculty at any medical school or have any teaching responsibilities. CMA doesn't supplement anyone's income, much less anyone's teaching income. There is no requirement that partners be otherwise connected in some way to GLH. The physicians are no different from any other private physicians in regard to their associations and duties. Dr. Warrington doesn't even have admitting privileges at GLH.

CMA's income pays the practice's expenses, each physician's compensation comprising more than half of what is collected on the services he provides to patients, and whatever is left is split with the physicians receiving 90% and the hospital receiving only 10%. (R. at pp. 285, 435[4], 455, 463-464, 527-528; RE-18, RE-24, RE-42 to RE-43) The physicians participate in losses and when capital contributions are needed, the physicians, including Dr. Warrington, are obligated to contribute. If a physician does not and another partner covers for him, his capital account is docked. (R. at p. 434, 530-531; RE-17) This is clearly very different from the point system based on factors other than mere patient services with University Anesthesia Services.

Finally, physician partners at CMA are not prohibited in engaging in medical practice elsewhere so long as it is not within a 75 mile radius of Cleveland. They are not required to obtain GLH's approval for engaging in medical practice outside that limit narrow geographic limit. (R. at pp. 460-461, 518; RE-39 to RE-40) Thus, the covenant not to compete appears to be nothing more than the normal private commercial type of covenant not to compete locally with a current employer. Neither the business model, nor the physician's compensation, nor the covenant not to compete resembles that of University Anesthesia Services, PLLC. Rather in most respects except perhaps the identity of the major investor, CMA is like any other private medical practice partnership.

Also unlike University Anesthesia Services, PLLC, there is no evidence that patients do not get to choose the physician of their choice but rather are treated by whomever they are assigned to by a government entity. To the contrary, the evidence shows that Grimes was a

---

[4]Section 3.02 of the Partnership Agreement states in part:
Partnership losses shall be allocated to the Partners in the proportion as set forth in Exhibit A attached hereto and made a part hereof.

regular patient of Dr. Warrington's partner, Dr. Austin. (R. at pp. 2-3, 248, 250)

In short, this partnership bears little or no resemblance to the University of Mississippi physician practice plans in *Watts v. Tsang*, 828 So. 2d 785 (Miss. 2002) or to the direct hospital employment relationships that existed in *Wright v. Quesnel*, 876 So. 2d 362 (Miss. 2004) and *Gilchrist v. Veach*, 807 So. 2d 485 (Miss. Ct. App. 2002). Moreover, the partnership and employment agreements in the present case are markedly different from the descriptions in *BLMA* on points directly relevant to the factual basis for the court's instrumentality finding in *BLMA*. Most importantly, CMA's physicians have sufficient control to prevent GLH from controlling many major parts of the entire operation.

Given these differences, the Circuit Court erred in holding that CMA's partnership and employment agreements are virtually identical to those in *BLMA*. The circuit court also erred in concluding that *BLMA* required the granting of Dr. Warrington summary judgment motion in this case. *BLMA* defines an instrumentality as "something that serves as an intermediary or agent through which one or more functions of a controlling force are carried out: a part, organ, or subsidiary branch esp. of a governing body." The long list of areas of CMA's operations over which the physicians prevented GLH from obtaining control by requiring unanimous approval of the Executive Committee including the physicians' representative, or requiring consent of all the partners, clearly demonstrate that CMA is not just an intermediary or agent of GLH. It demonstrates that while there may be mutual benefits to GLH joining forces with the physician partners, and while GLH may absorb more than 90% of any losses, the physician partners have not given control to GLH of the aspects of CMA which are most important to their practice: the hiring of physicians and nurse, practitioners, contracts with nursing and support staff, the allocation of physician income, the acquisition of malpractice insurance the borrowing of money,

the creation of security interests and encumbrances on Partnership assets, the sale of any major portion of Partnership assets and the valuation of partnership interests. In all these areas as well as the hiring of additional physicians and nurse practitioners and the charging of indirect expenses to the Partnership, the physicians have prevented GLH from having control by virtue of its majority ownership interest. Since it is control, not ownership, that determines status as an instrumentality, all these factors prevent CMA from being an instrumentality of GLH.

B. Significant Limitations on Control By the Political Subdivision Partner Were Overlooked in *Bolivar Leflore Med. Alliance, LLP v. Williams*, 938 So. 2d 1222 (Miss. 2006)

The *BLMA* decision does not discuss the fact that there were still significant areas under that agreement where the physicians could prevent GLH from exercising control over the partnership. Both the BLMA and CMA agreements require unanimous consent of the Executive Committee, including the physician representative to contract with a partner or an affiliate of a partner to provide goods, services, or to loan funds to the Partnership. Both the BLMA and CMA agreements require unanimous consent of all partners to employ additional physicians or nurse practitioners or to charge to the Partnership expenses not directly attributable to Partnership operations. While these provisions are not nearly as extensive as the matters over which the CMA physicians could prevent GLH from exercising control, they are substantial and significant enough to have been addressed in explaining the reasoning for the *BLMA* holding if they had been considered by the *BLMA* court as opposed to merely being mentioned in passing in relating the Defendant's argument. See *Bolivar Leflore Med. Alliance, LLP v. Williams*, 938 So. 2d 1222 (Miss. 2006)

C. Dr. Warrington is Not an Employee of a Political Subdivision

In several decisions over the last seven years, the Mississippi Supreme Court addressed

the issue of employee status for physicians who are faculty members of the University of Mississippi Medical School with faculty contracts directly with the state university and who also treat patients through practice plans which are separate entities, developing a specific fact intensive test to determine whether these physicians are employees under the Tort Claims Act when they treat private patients. *Davis v. Hoss*, 869 So. 2d 397 (Miss 2004) *Watts v. Tsang*, 828 So. 2d 785 (Miss. 2002); *Conley v. Warren*, 797 So. 2d 881 (Miss. 2001); *Miller v. Meeks*, 762 So. 2d 302 (Miss. 2000); *Owens v. Thomae*, 759 So. 2d 1117, 1122 (Miss. 1999); *Brown v. Warren*, 858 So. 2d 168 (Ct. App. 2003) Subsequently, the legislature decided the issue in regard to UMMC physicians by amending the definition of an employee under the Tort Claims Act to automatically include certain physicians in the definition of employee. But since the events at issue here occurred in 2000 and suit was filed in June of 2001, the older definition applies.

Regardless of which definition applies, it is clear that Dr. Warrington does not fit in any of the automatic categories. He is not "under contract to provide health services with the State Board of Health, the State Board of Mental Health or any county or municipal jail facility." He is not a faculty member "employed by the University of Mississippi Medical Center (UMMC) and its departmental practice plans ... provid[ing] health care services only for patients at UMMC or its affiliated practice sites." He is not "employed by any university under the control of the Board of Trustees of State Institutions of Higher Learning who practices only on the campus of any university under the control of the Board of Trustees of State Institutions of Higher Learning." He is not "employed by the State Veterans Affairs Board ... provid[ing] health care services for patients for the State Veterans Affairs Board." Conspicuously absent from this list of special categories of physicians is any mention of physicians who have some sort of

contractual relationship with community hospitals or who have entered into partnerships ventures with community hospitals to operate traditional medical practices. If the legislature had intended to include physicians like Dr. Warrington in the definition of employees, it would have addressed that category when it addressed these other special categories of physicians. Instead the legislature added certain very specific categories of physicians who would qualify as employees leaving the clear impression that those physicians who do not fall into those specific categories are not employees.

The clear intent of the legislature in enacting the Tort Claims Act was to immunize the state and its political subdivisions from certain tortious conduct. *City of Grenada v. Whitten Aviation, Inc.* 755 So. 2d 1208 (Miss. Ct. App. 1999). It was not to immunize private individuals who enter into business relationships with community hospitals which are not even restricted in their operations to this state. Nor was it the legislature's intent to immunize those who bring in political subdivisions as partners in their private practices in order to buy Tort Claims Act defenses at the expense of unsuspecting citizens harmed by the negligence of the private individuals with no disclosure to the patients of the affiliation with a government entity. If immunity can flow down through multiple levels of contracts between the political subdivision and the person harming a patient and through an entity that is not even limited in purpose to the purposes of a community hospital, then there is no logical end to how far immunity can extend and there will be no meaning left to the independent contractor exclusion in Miss. Code § 11-46-1(f) or to the definitions of employee or political subdivision in Miss. Code § 11-46-1.

Moreover, if this court were to go through the *Miller v. Meeks*, 762 So.2d 302, 310 (Miss. 2000) analysis, the result would still be that Dr. Warrington would not have immunity. There was nothing about the nature of the services Dr. Warrington provided to Grimes that was different in

any way from the services provided by any private physician to any private patient. The clinic administrator testified that when the clinic went from being an entirely private professional association to a limited liability partnership with GLH, nothing changed as to the characteristics of the clinic or how things were managed and financed. Nothing changed except the name. The state had little interest in his treatment. Grimes was not a poor uninsured patient with no means of securing health care other than through subsidized state care. He was not a Medicaid patient. Like many affluent Americans who worked long years, he had Medicare coverage. His treatment was not used as a teaching function to teach new doctors. He didn't walk into GLH or even into CMA and expect to be treated by whoever was assigned to him. Grimes went to this clinic because Dr. Austin was his primary care physician of choice with whom he had a long standing relationship. He was treated by the physician partner of his physician of choice because his regular physician was out of town. Neither GLH nor CMA exercised any control over Dr. Warrington's treatment of Grimes. Dr. Warrington wasn't even aware of any policies that GLH or CMA might have. He used his own discretion and judgment in treating Grimes. And contrary to his assertions in the court below, there is evidence that he was at least indirectly, if not directly, compensated from Grimes for his services. Grimes was a Medicare recipient. Medicare does not pay all the amount. It has deductibles and copays which Grimes would have paid. Moreover, there is evidence that what Dr. Warrington got paid was based on a percentage of what CMA collected from or on behalf of specific patients for services rendered by Dr. Warrington. Thus, he was indirectly compensated by Grimes for his services. (R. at pp. 248-250, 275, 283, 455, 463) There is at least some evidence for finding that each of the *Miller* factors weighs against finding immunity under the Tort Claims Act.

What Dr. Warrington and his physician partners seek to do here is to buy Tort Claims Act

immunity and defenses for the practice of private physicians while continuing their private practice with all the benefits the practice had before changing its business format and without informing patients or making publicly available information that would disclose GLH's participation in the legal format of the business. In short, they have taken affirmative action which has created a trap for their unwary patients.

D. Diligent Pre-Suit Research Would Not Have Revealed Greenwood LeFlore's Ownership Interest or Level of Control and Need for Notice Because the Information is Not Publicly Available

Davis v. Forrest Royale Apts., 938 So. 2d 293 (Miss. App. 2006) and *Ray v. Keith*, 859 So. 2d 995 (Miss. 2002) hold that a plaintiff has a duty to exercise due diligence in ascertaining the proper defendant. Both cases upheld dismissals for failure to ascertain the existence of a Tort Claims Act defendant and to properly comply with the Act in regard to that defendant.

Davis was a premises liability case in which the plaintiff was injured at an apartment complex owned by the County. In rejecting an argument that the Tort Claims Act statute of limitations should not begin to run until the plaintiff discovered that the apartment complex was owned by the County, the court said:

> The warranty deed, which listed Forrest County as the owner of the property, was available to Davis during this entire period, had she chosen to exercise due diligence by examining it. Her own failure to exercise due diligence does not excuse her duty to comply with the procedural requirements of the MTCA.

Davis at ¶ 7.

In *Ray*, the plaintiff was injured when an employee of the County ran a stop sign and hit him. The plaintiff originally sued only the employee and the action was dismissed. When he later sued both the county and the employee, summary judgment was granted on the statute of limitations. The *Ray* court also focused on the plaintiff's lack of diligence in determining the

true parties to the lawsuit and who the driver's employer was, pointing out that the information was plainly and easily available in the accident report. *Ray* at ¶ 15.

The converse of the emphasis in *Ray* and *Davis* on the lack of diligence and the sorts of publicly available information on the proper defendant is that where examination of publicly available information would not lead to discover of the State or a political subdivision as a true party, a plaintiff who lacks knowledge of who the true defendant should be and of that defendant's Tort Claims Act status should not lose his or her claim because of information that was not readily discoverable prior to filing suit.

In terms of ownership of businesses, the repository of public information is the Secretary of State's office which makes its database available via the web. In the case of Cleveland Medical Alliance, LLP, as with most limited liability partnerships, a search of the Secretary of State's web site reveals the date of creation, the business address, and usually one officer. In this case the officer was listed as Terrell Cobb with no other affiliating information. See www.sos.state.ms.us The partnership agreement, which is necessary to determine the identity of partners and the interests of GLH and the extent of its control are generally private documents not available from the Secretary of State's office. See Miss. Code § 79-13-1001 (limited liability partnership need only file a statement of qualification which does not reveal who the owners are or what the control or management structure is). Such a search does not reveal any inkling that GLH might be a partner or a controlling partner in CMA.

A call to CMA to determine who Dr. Warrington's employer was would be just as unlikely to turn up the necessary information to suspect the involvement GLH in CMA. The truthful answer would be that Dr. Warrington was employed by CMA which again would not have provided any information indicating the presence of a political subdivision or

instrumentality of a political subdivision as a proper defendant. Even if one suspected that CMA was affiliate with GLH, a search of GLH's web site does not show CMA listed among GLH's clinics.[5]

In situations where a political subdivision joins with private parties in forming a business entity that appears to the public to be a private business entity and where a search of the Secretary of State's online database would not reveal the interest or level of control of the operation by a political subdivision, an injured claimant ought not to lose his claim because he did not discover until after the defendant filed his answer that there was any possibility that a Torts Claim Act defendant was a proper party. The situation is especially egregious when the named defendant merely raises the defense in his answer and then sits on it for over five years without prosecuting the defense which could lead to early termination of the lawsuit by raising it in a motion and requesting a hearing. See *Horton.*

As the court recognized in *Arceo v. Tolliver*, 949 So. 2d 691, ¶ 13 (Miss. 2006), our Constitution requires "a reasonable right of access to the courts - a reasonable opportunity to be heard." While that right is couple with a duty of diligence, when acting with diligence would not put a plaintiff on notice of the need to comply with a particular rule or on notice of the involvement of an entity requiring compliance with special procedures, then equitable principles may be applied to avoid the loss of a claim without a reasonable opportunity to be heard. In *Puckett v. State*, 834 So. 2d 676, ¶¶ 11, 13 (Miss. 2002), the court held that equitable tolling may be applied when a party's untimeliness is the result of extraordinary circumstances which are

---

[5]There is a Cleveland Family Medical Clinic listed, but it is not the same entity. The Dr. Warrington listed there is Paul Warrington, not James Warrington, Jr. Based on the names of the physicians listed, including Paul Warrington and Don Blackwood, Cleveland Family Medical Clinic appears to be successor to BLMA. See http://www.glh.org/clinics.asp .

both beyond his control and unavoidable even in the exercise of due diligence. It should be applied when a party is prohibited from exercising his right to proceed by circumstances which are clearly beyond his control and rise to such a dimension as to implicate due process and fundamental fairness. When a political subdivision enters into a business venture with private parties and the documents on file with the Secretary of State and the information made publicly available to clients or patients of either the business venture or the political subdivision do not reveal the political subdivision's ownership or other interest in the business venture, the business venture and its employees should not be allowed to hide behind the shield of Tort Claims Act immunity or other Tort Claims Act defenses, particularly when they sit on those defenses for years. This case rises to such a level.

CONCLUSION

This is a typical medical malpractice wrongful death case involving an elderly gentleman who had Medicare coverage that paid a portion of his medical expenses. He went to the clinic where his regular doctor practiced, but saw his doctor's partner that day because his doctor was out of town. Dr. Warrington mis-diagnosed his problem in August of 2000 with fatal consequences. His estate and wrongful death beneficiaries sued Dr. Warrington less than a year later in 2001. After participating in the litigation for five years, Dr. Warrington, who derives his income from a typical agreement between a doctor and his professional limited liability partnership, now seeks to avoid liability by claiming that he is entitled to immunity under the Tort Claims Act because one of the partners in the partnership just happens to be a community hospital.

This partnership bears little or no resemblance to the University of Mississippi physician practice plans or to the direct hospital employment relationships that existed in *Wright v.*

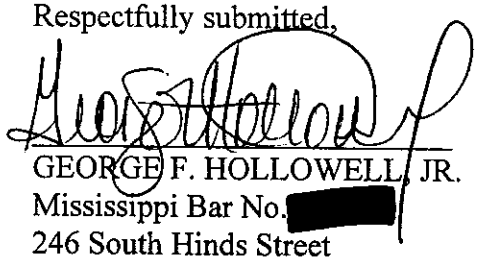
Quesnel, 876 So. 2d 362 (Miss. 2004) and *Gilchrist v. Veach*, 807 So. 2d 485 (Miss. Ct. App. 2002). It is materially different from the partnership in *BLMA* because here the doctors made sure the things that concerned them most about their practice (like hiring nurses and support staff, allocating income to physicians and malpractice insurance) could not be controlled by GLH despite GLH's nominal ownership of a majority of the partnership and nominal majority on the Executive Committee. Majority control is worth little and is not control at all where a vote or consent of more than a majority is needed for a decision or to act. CMA was not "a means, medium, agency" for GLH to control and use for its purposes. Instead, Dr. Warrington and his physician partners used CMA and GLH's participation in CMA to carry out their purposes of a more friendly business and liability environment for their private practice of medicine. Thus, CMA was not an instrumentality of a political subdivision.

Dr. Warrington is not an employee of GLH under GLH's control either directly, or through CMA as its instrumentality. He is a physician partner in an ordinary private medical practice which has changed its legal format repeatedly over the years when it was in the best interests of the physicians.

Even if Dr. Warrington were an employee and CMA was an instrumentality of a political subdivision, Dr. Warrington would still not be entitled to immunity or any other Tort Claims Act defenses because he waited five years after mentioning those defenses in his answer before bringing these defenses, which had the potential to terminate the litigation early, to the attention of the court through a motion and noticing the motion for hearing. That constitutes waiver under *Horton*.

Accordingly, the Circuit Court's entry of summary judgment in Dr. Warrington's favor should be reversed.

Respectfully submitted,



GEORGE F. HOLLOWELL, JR.
Mississippi Bar No. [redacted]
246 South Hinds Street
Post Office Drawer 1407
Greenville, Mississippi 38702-1407
(662) 378-3103
(662) 378-3420(fax)
ATTORNEY FOR APPELLANT

CERTIFICATE OF SERVICE

Pursuant to M.R.A.P. Rule 25(a), I hereby certify that I have mailed the original and three (3) true and correct copies of the above and foregoing Brief of Appellant via First Class U.S. Mail to:

Hon. Betty W. Sephton
Clerk, Supreme Court of Mississippi
P.O. Box 249
Jackson, Mississippi 39205-0249

I further certify that I have mailed a true and correct copy of the above and foregoing Brief of Appellant via First Class U.S. Mail to:

Chris Winter, Esquire
UPSHAW WILLIAMS BIGGERS BECKHAM & RIDDICK, LLP
P.O. Drawer 8230
Greenwood, MS 38935-8230

Honorable Charles Webster, Circuit Court Judge
Coahoma County Courthouse
Post Office Box 998
Clarksdale, MS 38614-0998

I further certify that pursuant to M.R.A.P. 28(m), that I have also mailed an electronic copy of the above and foregoing on an electronic disk and state that this brief was written in Adobe Acrobat format.

This the 7th day of May, 2007

GEORGE F. HOLLOWELL, JR.
ATTORNEY FOR APPELLANT