JACKSON & CAMPBELL, P.C.

VOLUME 5, ISSUE 6

Decisions

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Pennsylvania Supreme Court Finds Seven-Year Statute of Repose in State's Medical Malpractice Act is Arbitrary and Capricious, Deeming it Unconstitutional

In a decision issued on October 31, 2019, the Supreme Court of Pennsylvania ruled that a seven-year statute of repose for medical errors in the state's Medical Care Availability and Reduction of Error Act (the "Act") violated Article I, Section 11 of the Pennsylvania Constitution, which guarantees Pennsylvania citizens the right of access to the courts. *Yanakos v. UPMC*, Case No. 10 WAP 2018, --- A.3d ----, 2019 WL 5608534 (Pa. Oct. 31, 2019). Plaintiffs brought an action against their doctors and hospital after a surgery in which the plaintiff-mother received a liver donation from her plaintiff-son to cure a genetic condition. Medical tests of the son conducted prior to surgery confirmed that he suffered from the same genetic condition, making him ineligible for donation. However, he was never informed of his results and a month later he donated a lobe of his liver. Twelve years later, the mother tested positive for the same genetic condition, which should have been eliminated by the transplant. Plaintiffs mother, son, and husband filed a suit alleging battery/lack of informed consent, medical malpractice, and loss of consortium. Defendants raised an affirmative defense that the Act's seven-year statute of repose on a medical professional liability claim barred Plaintiffs' claims. The trial court agreed, holding it was bound by the plain language of the Act, which only permitted two exceptions to the seven-year period of repose: (1) injuries caused by foreign objects left in a patient's body; and (2) malpractice claims commenced by or on behalf of a minor. Plaintiffs appealed, raising several constitutional challenges, including that the Act violated Article I, Section 11 of the Pennsylvania Constitution, which provides in pertinent part: "All courts shall be open; and every man for an injury done him in his lands, goods, person or reputation shall have a remedy by due course of law, and right and justice administered without sale, denial or delay." Plaintiffs cited to many other state jurisdictions which have "open courts" provisions, arguing the exceptions to the seven-year statute of repose were "arbitrary and capricious." The Superior Court rejected the argument, citing a state Supreme Court decision in which the Court held a twelve-year statute of repose on claims against architects and builders did not violate the "open courts" provision. The Pennsylvania Supreme Court granted Plaintiffs' petition for review and Plaintiffs argued that legislation depriving medical malpractice victims of their right to file a civil action must be subjected to exacting constitutional scrutiny. According to Plaintiffs, the Act could not withstand intermediate scrutiny because the Legislature clearly recognized the harshness of the statute when it preserved access to the courts for foreign object malpractice victims. Defendants argued that Article I, Section 11 only applies when a statute extinguishes a right after the right has already accrued or vested, and because the Act went into effect a year before their allegedly negligent conduct, the Legislature was not prevented from abolishing the cause of action altogether. Defendants also argued that a rational basis test should apply. If heightened scrutiny did apply, however, Defendants argued the statute of repose should be upheld because of Pennsylvania's important interest in controlling the cost of professional liability insurance and in curtailing difficulties which arise in litigating stale claims. In analyzing the parties' arguments, the Court noted that its prior decision analyzing the "open courts" provision and a statute of repose was narrow, that it did not give the Legislature unlimited authority to modify the common law, and that it had not articulated a concrete test for measuring the lawfulness of statutes that abolish or modify common law remedies. The Court thereafter undertook an analysis of the "open courts" legislative history, holding that although a right to remedies in court is not a "fundamental right," it is an "important right" requiring intermediate scrutiny. As such, the Court concluded that the government's interest in controlling the rising costs of medical malpractice insurance and of medical care is important, but that the Act's statute of repose as enacted was not substantially related to achieving those goals. Generally, it posited, statutes of repose are intended to provide actuarial certainty to insurers in calculating insurance premium rates, and the legislative history of the Act indicated that was precisely the Legislature's purpose. Moreover, the statute of repose did not offer insurers a definite period after which there would be no liability because the Act exempted foreign objects claims and minors, still requiring insurers to account for unpredictable long-tail claims in calculating medical malpractice premiums.

SPECIAL POINTS OF INTEREST:

- *Pennsylvania Supreme Court holds that Medical Malpractice Time Limits are Unconstitutional*
- *New Mexico Appellate Court Allows Bad Faith Claims to Continue Even In the Absence of Coverage*
- *Colorado Court Orders Disclosure of Claims File Materials Involving Attorney Discussions*
- *New York Appellate Panel Blocks Production of Hospital's Internal Investigation Documents*

New Mexico Court of Appeals Expands Scope of Bad Faith Claims, Ruling Law Does Not Foreclose Claims Against Insurers Premised on Coverage Investigations and Evaluations Even in Absence of Coverage

In a decision issued on September 5, 2019, the New Mexico Court of Appeals affirmed in part a district court's grant of summary judgment in favor of a Defendant automobile insurer who argued that the Plaintiff-insured's uninsured motorist coverage in his policy did not extend to him as a victim of an intentional tort because the injuries he sustained did not arise from the normal use of the uninsured vehicle. *Haygood v. United Services Automobile Association*, 2019 WL 4415247 (N.M. Ct. App. 2019). Although the Court agreed with the district court that there was no coverage for the underlying claim, it reversed the district court's dismissal of Plaintiff's bad faith claim. In the district court, the Plaintiff contended that regardless of whether he was entitled to coverage, he could still prevail on his bad faith claim related to the insurer and claims-handler Defendants' investigation and evaluation of the claim, offering two theories of recovery. Plaintiff first argued that Defendants exhibited bad faith in failing to pay the covered claim. He alternatively argued that Defendants intentionally delayed their coverage determination, intentionally failed to fairly evaluate the claim, and dishonestly handled the claim to their advantage. Plaintiff supported his second theory with evidence that the insurer-defendant's in-house counsel attempted to develop a conflicting account of events and suggested that the defendant-claims handler pursue various unsupported leads which extended the

length of the investigation. He further argued that the claims handler denied the claim because he made for an unsympathetic plaintiff. Defendants accepted Plaintiff's factual allegations as true for purposes of summary judgment, maintaining that the insured had no claim for bad faith in the absence of coverage. The district court agreed with Defendants, explaining New Mexico law appeared to foreclose such claims. On appeal, the Court of Appeals acknowledged that New Mexico has long recognized claims of bad faith for failure to pay cannot arise unless there is a contractual duty to pay under the policy, foreclosing Plaintiff's first theory of recovery. But on Plaintiff's second theory of recovery, the Court interpreted its decision in *O'Neel v. USAA Insurance Co.*, 131 N.M. 630 (2002) as leaving open the possibility that bad faith claims may be based on conduct other than an insurer's refusal to pay: "We note, as we did in *O'Neel*, that [Plaintiff] might establish bad faith in a variety of ways —whether by proving Defendants failed to deal fairly in handling the claim, failed to conduct a fair investigation, or failed to fairly evaluate coverage, among other possibilities." Because Defendants conceded Plaintiff's alleged facts for purposes of summary judgment, the Court held that given a fuller consideration of the record, the facts might support a trial on the merits of Plaintiff's bad faith claim. As a result, the Court reversed and remanded to the district court with instructions to determine whether Plaintiff made a sufficient showing to overcome the Defendants' summary judgment motion.

Texas Appellate Panel in Split Decision Holds Location of Injury in Health Care Setting Does Not Per Se Constitute a Health Care Liability Claim

In a decision issued on September 12, 2019, a Texas Court of Appeals panel denied an ambulance company and driver's interlocutory appeal from its motion to dismiss a personal injury suit seeking a dismissal on the grounds that the claims were subject to the Texas Medical Liability Act ("TMLA"), requiring service of an expert report and curriculum vitae within 120 days of Defendants' answer, which Plaintiff failed to serve. *Coci v. Dower*, 2019 WL 4316858 (Tex. App. Sept. 12, 2019). Plaintiff filed a negligence action alleging she was injured in a single-vehicle accident that occurred as she traveled by ambulance with her minor daughter. The defendant ambulance driver fell asleep while driving, causing the ambulance to leave the roadway and strike a barrier. According to Defendants, Plaintiff's claims constituted "health care liability claims" implicating the "safety" prong of the TMLA: "[A] cause of action against a health care provider or physician for treatment, lack of treatment, . . . or safety . . . services directly related to health care, which proximately results in injury to or death of a claimant, whether the claimant's claim or cause of action sounds in tort or contract." The Court evaluated Defendants' argument in conjunction with the Texas Supreme Court's decision in *Ross v. St. Luke's Episcopal Hospital.*, 462 S.W.3d 496 (Tex. 2015), which held that a safety-based claim against a health care provider constitutes a health care liability claim if there is a substantive nexus between the safety standards violated and the provisions of health care. Affirming the trial court's decision, the Court held that Defendants showed no substantive nexus, stating the cause of action failed to implicate the TMLA because it did not arise from professional duties of a health care provider and could not be classified as such merely because it occurred in a health care setting. The cause of action instead arose because the ambulance driver owed legal duties just like any other driver on the road's negligent motor vehicle operation. As such, the Court held the essence of Plaintiff's claim should proceed in ordinary negligence and Plaintiff was not required to satisfy the expert report requirements of the TMLA.

Colorado Federal Court Grants Plaintiff's Motion to Compel Insurer's Claims-Adjustment Documents, Holding Attorney Functioning as Claims Handler Not Afforded Attorney-Client or Work Product Protection

In a decision issued on June 17, 2019, the United States District Court for the District of Colorado granted in part a plaintiff's motion to compel documents relating to the handling and adjustment of his claim under his employer-provided insurance carrier's uninsured/underinsured motorist coverage. *Olsen v. Owners Insurance Company*, 2019 WL 2502201 (D. Colo. 2019). Plaintiff was involved in a traffic accident in which he alleges he sustained injuries which required medical treatment and prevented him from returning to work. In addition to accepting settlement from the at-fault party's insurer, Plaintiff sought additional benefits from his employer's uninsured/underinsured motorist insurer. When the insurer refused, Plaintiff filed suit for breach of contract, unreasonable delay or denial of insurance benefits, and bad faith breach of an insurance contract. During discovery, Plaintiff sought communications between Defendant's claims-handler and its in-house counsel that Defendant withheld on the basis of attorney-client and work-product privilege. Defendant argued that its claims-handler sought legal counsel if he had questions about whether his investigation of a suspicious claim would result in bad faith liability for Defendant, thus triggering attorney-client privilege. Defendant also argued that the work-product doctrine shielded the communications because the threat of litigation

arose immediately due to a lack of medical records and Plaintiff's counsel's notoriety in bringing bad faith claims. Plaintiff argued that Defendant must produce communications not seeking legal advice, alleging Defendant's claims-handler consulted in-house counsel in the ordinary course of the insurer's claim-handling process. After conducting an *in camera* review of the documents, the Court agreed with Plaintiff that the records did not contain legal advice or Defendant's strategy for defending against the action, but rather, consisted of administrative emails between the claims-handler and in-house counsel transmitting information about the claim, such as underlying factual information, conflicts checks, independent medical examinations, doubt over the validity of Plaintiff's claim, further factual investigations, and updates on the status and of the claim. The Court withheld two claims notes entries post-dating the filing of Plaintiff's complaint that clearly sought legal advice, but held that the remainder of the claims notes sparingly referenced legal counsel and otherwise summarized receipt of information and discussed the claims-handler's next steps in evaluating the claim. Finally, the Court held the documents were not subject to the work-product doctrine simply because Plaintiff retained counsel; the majority of communications were not prepared in anticipation of litigation and there was no indication prior to the complaint that Plaintiff's counsel made any demands to Defendant or threatened bad faith.

New York Appellate Panel Denies on Statutory Grounds Request for Hospital Internal Review Documents and Statements in Infant Injury Suit

In a decision issued on July 5, 2019, a New York appellate panel reversed the Supreme Court's order granting a mother's motion to compel statements made by defendant doctors and nurses as part of the quality assurance and peer review process related to her infant son's severe brain injury while in the care of the defendants and intervenor-hospital. *Nowelle B. v. Hamilton Medical, Inc.*, 2019 WL 2896807 (N.Y. App. Div. 1st Dep't Jul. 5, 2019). Plaintiff commenced the action for personal injuries sustained by her infant son after he suffered severe brain injury from bilateral pneumothoraxes. During discovery, Plaintiff requested Defendants and Intervenor produce all documents related to the evaluation of what occurred to her son. Defendants and Intervenor objected, contending any documents responsive to the request would have been made as part of the Intervenor's quality assurance program, which are privileged and exempt from disclosure pursuant to New York statute, which shields from disclosure "the proceedings [and] the records relating to performance of a medical or a quality assurance review function or participation in a medical . . . malpractice prevention program." Plaintiff then moved to compel, relying on a statutory exemption for statements made by any person "in attendance" at a quality assurance meeting who is a party to an action or proceeding, the subject matter of which was reviewed at such meeting. The Supreme Court granted Plaintiff's motion in relevant part, ordering Defendants to produce any statements made by a physician or other health care professional named in the action who made statements within the quality assurance process that concerned the facts and circumstances of Plaintiff's claim. The Appellate Panel disagreed, interpreting the statutory exception more narrowly. Relying on Court of Appeals precedent, the Panel held that Plaintiff's proposed construction of the statutory exception would render the phrase "in attendance" meaningless, or rather, would swallow the general rule that materials used by a hospital in the quality review and malpractice prevention process are strictly confidential. Plaintiff sought statements provided shortly after the incident that were obtained as part of Intervenor -hospital's quality assurance investigation, but were not made at a quality assurance committee meeting nor made in response to any inquiries of the committee. Indeed, the Panel found none of the Defendants were ever "in attendance" at the meetings. In reversing, the Panel also declined to follow Second Department precedent which expanded the exception to the statements Plaintiff sought to compel.

Florida Court Interprets Claim Under Vulnerable Adult Statute as Inappropriate Duplicative Remedy for Medical Malpractice Claims

In a decision issued on July 19, 2019, a Florida appellate district court held that the complex issues of medical negligence cannot also be permitted to be litigated under a Florida statute designed to address protection of vulnerable adults. *Specialty Hospital -Gainesville, Inc. v. Barth*, 2019 WL 3070046 (Fl. Dist. Ct. App. Jul. 15, 2019). Plaintiff filed a complaint alleging a long-term acute-care facility he attended after suffering permanent paralysis during an aortic-aneurism operation caused a deep-tissue sacral pressure ulcer requiring extensive treatment, procedures, and hospitalization. Count I alleged that the care facility committed medical malpractice by failing to reposition Plaintiff or otherwise prevent avoidable ulcers, causing catastrophic injuries. Count II alleged the care facility abused and neglected him in violation of a vulnerable adult statute, by improperly restraining him and not responding to his calls for assistance, even when he believed he was suffocating or choking. A jury found the care facility liable on both Counts and the trial court denied the care facility's motion to set aside the verdict. The care facility filed an appeal from the final judgment seeking to set aside the verdict as to Count II. Relying on its precedent and express legislative intent, the District Court held that the Florida Legislature did not intend to provide an alternative cause of action for medical negligence when it created the vulnerable adult statute. The entire legislative scheme, it held, was to punish "perpetrators" of abuse, neglect or exploitation, recognizing that many people in the state, because of age or disability, are in need of protective services. Even though the Legislature recognized that the remedies provided under the vulnerable adult statute were in addition to and cumulative with other legal and administrative remedies, the Court stated that the type of wrongful conduct considered by the statute was entirely different than the medical negligence chapter of the Florida Statutes, which includes separate, distinct, and extensive procedures, investigations, protections, and remedies. Looking to the facts alleged, the Court found all of the allegations were species of medical negligence, as the care facility improperly used restraints and failed to timely respond to calls for help in the process of providing medical treatment. In this case, restraints were placed on Plaintiff so he was unable to remove his feeding and respiratory tubes, but they required individualized orders each day from a doctor. The Court distinguished the instant facts from cases in which non-medical staff were authorized to employ restraints on a judgment call basis. The Court also found the nurses' failure to answer Plaintiff's distress calls were derived from his need for medical treatment, as Plaintiff's alleged suffocation or choking was related to his breathing anxiety on a new ventilator: "[T]he responses and restraints were *part* of Plaintiff's medical treatment, and they required a degree of medical skill or judgment." In reversing the appeal and remanding with directions to enter a directed verdict for the care facility, the Court left open the possibility that a health-care provider could, in certain circumstances, become subject to claims under the vulnerable abuse statute, citing as examples a sexual offense or attempt against a vulnerable adult and/or any person who knew of the abuse and failed to report it to law enforcement officials.

Washington Supreme Court Rules Certificate of Insurance Can Create Additional Insured Coverage, Binding Insurer to Agent's Representations

In a decision issued on October 10, 2019, the Washington Supreme Court held that an insurance company was bound by the apparent authority of its agent in its issuance of a certificate of insurance naming the insured's parent company as an insured despite its absence from the policy and despite preprinted general disclaimers in the certificate of insurance. *T-Mobile USA Inc. v. Selective Insurance Company*, Case No. 96500-5, 2019 WL 5076647 (Wa. Oct. 10, 2019). This action arose out of a project owner's decision to hire a contractor to assist it in constructing a cell phone tower on a building in New York City. The parties signed a contract under which the contractor obtained a liability policy and provided the project owner with annual certificates of insurance evidencing the coverage and the project owner's status as an additional insured under the policy. The project owner's parent company was not a party to the contract, but over the course of seven years, was named by the insurer's agent, along with its subsidiaries and affiliates, as additional insureds on the certificates of insurance. The parent company then brought an action against the contractor's insurer seeking to obtain declaratory relief and breach of contract damages for the insurer's failure to provide a defense in an action by the building owner alleging faulty construction of the tower. The Ninth Circuit held that the agent acted with apparent authority when it issued the certificate of insurance, clearly listing the parent company as an insured. The Ninth Circuit also held that the agent's representations were inconsistent with the policy and that the certificate included additional text broadly disclaiming that the certificate could be used to "amend, extend or alter the coverage afforded by" the policy. The Ninth Circuit then certified the following question to the Washington Supreme Court: Is an insurance company bound by its agent's written representation—made in a certificate of insurance—that a particular corporation is an additional insured under a given policy? The Court answered in the affirmative, finding issuance of a certificate and the specific representations within it would be pointless if a court were to give effect to general disclaimers in the certificate as opposed to the specific representations of the insurer (or its agent). The Court distinguished this case from its prior holding that certificates of insurance are not the equivalent of an insurance policy, reasoning that in its prior decision the certificates stated that the construction company had obtained coverage for construction cranes, not that the crane owner was an additional insured under the construction company's policy. In addition, the insurer's agent there made no representations as to coverage. Finally, the Court ruled that as a matter of public policy, enforcing authorized representations of an insurer's agent incentivizes insurers to ensure that its agent's representations are true.

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Jury Verdicts/Settlements

DeKalb County, GA — November, 2019. A DeKalb County awarded more than $6.4 million to a child and her parents over claims that an obstetrician-gynecologist allowed the mother to keep taking a blood pressure medication after she became pregnant despite the drug's well-known risk of causing fetal and neonatal side effects. The girl, now 8, suffered brain damage and other injuries allegedly as a result of the drug. The defendant and its insurer rejected a $1 million settlement demand prior to trial.

Franklin County, MO — October, 2019. A Missouri Appellate Court affirmed a Franklin County jury's $14.2 million verdict in a lawsuit accusing two physicians of causing a patient's severe bowel injuries, concluding that there was ample evidence supporting the jury's decision against both physicians. The Court also rejected the defendants' arguments challenging the verdict-directing instructions.

Lee County, AL — October, 2019. A Lee County jury awarded $9 million to the family of a college student who died after visiting an urgent care facility for treatment of chest pains, difficulty breathing, and coughing. She was sent home with an inhaler and died the next day of a blood clot. The family sued the facility and two physicians for medical malpractice and wrongful death accusing the facility of providing negligent care. Plaintiffs' argued that the patient's condition was critical and that she should have been taken to a medical center or hospital for treatment.

Cook County, IL — November, 2019. A Cook County jury awarded a $101 million verdict in a case involving brain damage suffered by a boy at birth due to the alleged malpractice of a hospital in failing to induce labor and ignoring warning signs from external fetal monitors. The boy was ultimately delivered via a C-section but suffered severe brain damage which left him unable to speak and confined to a wheelchair. A settlement deal, however, will reduce the payment by half.

Middlesex County, MA — July, 2019. A Middlesex County jury awarded $11.6 million in damages in a lawsuit accusing a radiologist of misinterpreting an X-ray, which led to a toddler suffering cardiac arrest resulting in permanent brain damage. Plaintiff alleged the radiologist was negligent in not diagnosing her enlarged heart.

Notable Defense Verdicts

Cook County, IL — October, 2019. An Illinois Appellate Court affirmed a Cook County Circuit Court jury's verdict in favor of a physician in a medical malpractice case accusing him of malpractice in conducting the patient's leg surgery. In upholding the defense verdict, the Court held that the patient was not able to show that she was not adequately informed of the surgery's risks. The Court also rejected the appeal on other grounds.

Bossier Parish, LA — September, 2019. A Louisiana Appellate Court affirmed a defense verdict issued by a Bossier Parish jury in a case alleging that a long-term care hospital was negligent in causing a patient's death. The patient was a 63-year-old man suffering from throat cancer who had been sent to the facility to gain weight so he could undergo chemotherapy. The Court held that the jury's verdict was not plainly erroneous given the patient's condition.

San Bernardino County, CA — September, 2019. A California Appellate Court affirmed a San Bernardino County's verdict in favor of a surgeon in a lawsuit in which a patient alleging that the surgeon had performed a medical procedure without her consent. Although the jury concluded that the surgeon did not have consent to perform the knee surgery procedure, they concluded that the lack of consent was not a substantial factor in causing her injury. The Court rejected the patient's arguments that the verdict was irreconcilably inconsistent.

DeKalb County, GA — September, 2019. A DeKalb County jury found in favor of a physician defendant in a case involving the death of a 51-year-old man. In the lawsuit, the estate of the man alleged that the physicians failed to diagnose the man with Deep Vein Thrombosis during care provided to the man.

Florence County, SC —July, 2019. A South Carolina Appellate Court upheld a defense verdict entered by a Florence County jury in a lawsuit accusing a physician of negligently delivering a baby, causing a shoulder nerve injury. In upholding the verdict, the Court rejected the Plaintiff's arguments that the Court should not have instructed the jury that it needed to find that the obstetrician acted with gross negligence when faced with an emergency situation pursuant to § 15-32-230 of South Carolina Code.

Maricopa County, AZ — July, 2019. An Arizona Appellate Court upheld a Maricopa County jury's verdict in favor of a physician in a lawsuit alleging that the physician's negligence caused her spleen and liver damages. The Court held that the trial court did not err by concluding that the evidence was insufficient to permit the jury to infer the injury would not have occurred absent negligence.