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DECISIONS

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PENNSYLVANIA SUPERIOR COURT UPHOLDS ENFORCEMENT OF ARBITRATION AGREEMENT IN NURSING HOME MALPRACTICE CASE

On November 25, 2015, the Pennsylvania Superior Court (en banc), issued a decision in McPherson v. Magee Hospital, et al., 2015 WL 7571937 (Pa. Sup. Ct. Nov. 25, 2015). In the decision, the Court invoked the liberal policy favoring arbitration agreements under the Federal Arbitration Act ("FAA") and state law and agreed that a valid arbitration agreement existed between Manor Care Health Services ("Manor Care") and a nursing home resident who died at the facility in 2010. The dispute began when the resident's brother sued Manor Care alleging claims of negligence, negligence *per se*, corporate negligence, wrongful death, and survivorship. Manor Care filed preliminary objections seeking to transfer the case to arbitration pursuant to an arbitration agreement the resident signed three weeks after his admission mandating the arbitration of all disputes between him and Manor Care. The

trial court overruled the objections and Manor Care appealed. On July 10, 2014, a Superior Court panel, with one judge dissenting, ruled in favor of Manor Care and reversed the trial court. Plaintiff filed a motion for re-argument *en banc*. The motion was granted and the original opinion was withdrawn. The case was briefed again and oral argument was held in March, 2015. On November 25, the Court issued an *en banc* opinion, again reversing the trial court and enforcing the arbitration agreement. The Court concluded that the trial court opinion "includes cursory findings, a lack of substantive analysis, and a failure to discuss applicable law. As such, the decision below fails to recognize and apply the standards of the FAA and its liberal policy favoring arbitration." In addition, the Court further held that the agreement was neither procedurally (font, conspicuous nature, presentation, circumstance) nor substantively (terms) unconscionable. In reaching its conclusion, the Court referenced the various provisions of the agreement and discussed how the terms were essentially fair to both parties. Through its thorough examination of the agreement, the opinion essentially creates a template for future arbitration agreements since the Court determined, as a matter of law, that the agreement was not unconscionable.

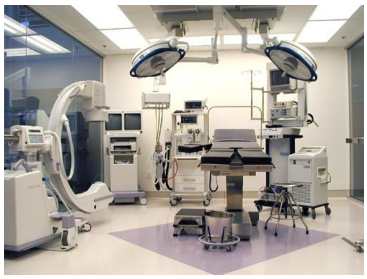
NORTH DAKOTA BOARD OF MEDICINE ISSUES PROPOSED TELEMEDICINE RULES

The North Dakota Board of Medicine issued proposed regulations designed to move the state to the list of telemedicine-friendly states. The Board held a public hearing on the proposed regulations in September 2015 and solicited comments. The Board considered the comments at its November 2015 meeting. The term "telemedicine " under the rules is defined, in part, as "the practice of medicine using electronic communication, information technologies or other means between a licensee in one location and a patient in another location, with or without an intervening healthcare provider." The rules, aimed at the quality of care delivered not the means, are designed to align with telemedicine practice rules articulated by other state medical boards.

"That is not to say, however, that the acts or treatments distinguishing 'health care' or 'health care providers' under the TMLA cannot ever encompass some element of product manufacture or sale that would implicate [the TMLA]."

Texas Appeals Court Holds That Texas Tort Reforms Do Not Bar Medical Device Claims

On November 13, 2015, in a case of first impression, the Court of Appeals of Texas, Austin, held that personal injury claims against the manufacturer of a medical device accused of promoting off-label uses with kickbacks to physicians are not subject to the same requirements Texas imposes on health care liability claims. In Verticor, Ltd. v. Wood, 2015 WL 7166024 (Tex. App.—Austin Nov. 13, 2015), plaintiff brought strict products liability, negligent marketing, and breach of implied warranty of merchantability claims against a medical device manufacturer after he suffered from complications that developed after insertion of a device into his spine. The manufacturer filed a motion to dismiss arguing that the plaintiff failed to serve expert reports as required by the Texas Medical Liability Act ("TMLA"). The trial court denied the motion and the manufacturer appealed. On appeal, the manufacturer argued that, although the plaintiff served a TMLA-compliant expert report on his treating physician, he did not serve one on the manufacturer. In this regard, the manufacturer argued that it was a "health care provider" for purposes of the TMLA because it operated under a "device manufacturer" license issued by the Texas Department of State Health Services. On Appeal, the Court noted that there is no bright-line rule that product manufacturers can never be considered health care providers under the TMLA. It further noted that Texas common law distinguishes between the tort duties owed by healthcare practitioners, which focus on specialized standards of care, and duties owed by manufacturers and sellers of products, which focus on the condition



of the product itself and the manner it which it was sold. The Court examined the statute and noted that the manufacturer did not show evidence that it had any involvement in the plaintiff's care or treatment, or that it was licensed to be involved in his care or treatment beyond simply manufacturing the device that was used during his procedure. Consequently, the Court held that the plaintiff's claims against the manufacturer cannot be health care liability claims and, thus, the district court did not err in denying the manufacturer's motion to dismiss.

Indiana Legislature Seeks To Raise Damage Cap On Medical Malpractice Cases

On December 31, 2015, legislation was proposed in Indiana (Indiana Senate Bill No. 152) to increase the maximum amount recoverable for an injury or death in a medical malpractice action from $1.25 million to $1.65 million. The bill also seeks to increase the maximum amount recoverable from a health care provider from $250,000 to $450,000 after December 31, 2016. The legislation further proposes that the Insurance Commissioner increase these maximum amounts based on percentage increases of the Consumer Price Index beginning on January 1, 2019 and every four calendar years thereafter. In addition, the bill would increase the amount of attorney's fees that a plaintiff's attorney can recover in a medical malpractice action to 31% of any recovery – the current rate is not more than 15% of any award made from the Patient Compensation Fund. The Bill was introduced by Senator Brent Steele (R) and Senator Ed Charbonneau (R). The Bill has been referred to the Committee on Judiciary. Senate President Pro Tem David Long believes the cap has helped to hold down medical costs in Indiana but believes that the cap should increase to meet growing expenses. The current cap is being challenged in court and Senator Long believes that the cap is vulnerable to being ruled unconstitutional without allowing for increases.

New Jersey Supreme Court Upholds Cancellation of Medical Malpractice Coverage On Misrepresentation Grounds

On December 1, 2015, the New Jersey Supreme Court overturned a decision requiring an insurance group to provide medical malpractice insurance under a policy that was rescinded due to a podiatrist's misrepresentations. Thomas DeMarco v. Sean Robert Stoddard, 125 A.3d 367 (N.J. 2015). DeMarco involved a podiatrist who practiced in New Jersey and Rhode Island. To get favorable malpractice insurance rates, the podiatrist applied to the Rhode Island Joint Underwriting Association (RIJUA) and lied on his application, purporting that his practice was predominantly in Rhode Island. This coverage of $1 million from the RIJUA allowed the podiatrist to comply with a New Jersey statute mandating medical malpractice coverage for New Jersey physicians and podiatrists of $1–$3 million. One of the podiatrist's New Jersey patients was injured through malpractice and sued, ultimately adding the RIJUA into the lawsuit, seeking a declaration of coverage. The trial court and Appellate Division both found fraud in the application, but nevertheless did not allow the coverage to be rescinded, as it would harm the injured patient. Those lower courts analogized the situation to New Jersey law on automobile insurance, noting the statutory requirement of medical malpractice coverage, and would not allow rescission of the policy once an injured plaintiff has been hurt through malpractice. In a lengthy majority opinion, the New Jersey Supreme Court rejected the arguments against rescission. The Court found that the lower court's reliance "on the compulsory automobile liability insurance model was misplaced. Its reliance on that model also ignored New Jersey's longstanding rule that an insured professional cannot expect insurance coverage to respond to third-party claims when the professional liability

Misrepresentation Voids Policy

insurance has been rescinded due to misrepresentations of material fact in the application." Relying on case law from a pair of New Jersey cases decided in 2007, the court held that a legal malpractice insurance policy may be declared void from its inception due to a misrepresentation of material fact by the insured in a policy application and that upon rescission, the insurer owes no duty to defend or indemnify for any complaints or claims accrued at the time of rescission. Applying this rule, the Court held that RIJUA did not owe a duty to defend or indemnify the insured podiatrist for the Plaintiff's claims.

"It is well established in this state that a professional who has made a misrepresentation of material fact in an application for professional liability insurance can expect that the policy may be rescinded."

Florida Supreme Court Holds That Evidence of Future Medicare Benefits Should Be Excluded From Personal Injury Trial

On October 15, 2015, the Florida Supreme Court addressed the issue of whether a defendant could introduce evidence of collateral source benefits to which the developmentally-disabled plaintiff was entitled, including discounted benefits under Medicare and Medicaid, in a case involving injuries he sustained after getting struck by a car while riding his bike. Joerg v. State Farm Mut. Auto Ins. Co., 176 So.3d 1247 (Fla. 2015). Since 1984, Florida courts allowed limited admission of evidence that pertained to free or low-cost collateral source benefits. This generally included things like Medicare and Medicaid benefits, which the court held were relevant to the issue of plaintiff's future expenses. The trial court precluded State Farm from introducing evidence of plaintiff's future Medicare or Medicaid benefits. The jury awarded approximately $1.5 million in damages, including $469,076 for future medical expenses. On appeal, the Second District Court of Appeal reversed the award for future damages, concluding that Plaintiff's Medicare benefits should not have been excluded by the collateral source rule. The Florida Supreme Court quashed the decision below, holding that the trial court properly excluded evidence of plaintiff's eligibility for future benefits from Medicare, Medicaid, and other social legislation as collateral sources. In so holding, the Court noted that future benefits through Medicare were both a liability and uncertain, due to the right of reimbursement retained by the program. These payments are not necessarily free and thus not admissible in court. The Court also held that calculating damage awards based on benefits plaintiff has not yet and might never receive is "absolutely speculative."

Florida Supreme Court Disallows Evidence of Future Medicare Benefits As Impermissible Collateral Source

"The Court must compare the allegations of the complaints with the allegations of the AG lawsuit, not for the truth of the matters asserted, but to see if they 'have as a common nexus, or are casually connected by reason of, any fact, circumstances, situation, event or decision.'"

Tennessee Federal Court Rejects Coverage For Lawsuit on Grounds It was "Related" To Pre-Policy Complaints

In a decision issued on November 4 2015, the United States District Court for the Middle District of Tennessee granted an insurer's motion for summary judgment in a coverage action finding that consumer complaints filed against the insureds that preceded the effective date of their policy were "related" to a lawsuit filed by the state's attorney general against the insureds during the policy's effective dates. Hale v. Travelers Cas. and Sur. Co. of America, 2015 WL 6737904 (M.D. Tenn. Nov. 4, 2015). The Plaintiff insureds were principals and directors of a medical-based business that provided "bio-identical hormone replacement therapy" in Tennessee and elsewhere. Plaintiffs were sued by the Tennessee Attorney General in state court alleging that they had saturated the commercial marketplace in Tennessee with false and misleading statements and material omissions about the safety, efficacy, benefits, side effects, and risks of their hormone replacement therapy. Plaintiffs tendered the lawsuit to their insurer but the insurer denied coverage on the grounds that the lawsuit was not covered because the lawsuit constituted a "related wrongful act" to certain complaints and demands first made prior to the issuance of the policy. The policy at issue provided that "all Related Wrongful Acts shall be deemed to have occurred at the time the first of such Related Wrongful Acts occurred." The term "Related Wrongful Acts" was defined as "All Wrongful Acts that have as a common nexus, or are casually connected by reason of, any fact, circumstances, situation, event or decision." Prior to the issuance of the policy, the Plaintiffs were subjected to 65 complaints to the Better Business Bureau, numerous consumer affairs complaints, a t.v. investigation, and ten demand letters. The insureds argued that the claims were meritless and constituted only a small fraction of their customers. The Court rejected this argument and noted that the policy does not require more than one complaint or that the complaint be meritorious. The Court also rejected Plaintiffs' argument that it could not consider the content of the complaints. The Court noted that it must compare the allegations of the complaints with the allegations of the AG lawsuit to see if they "have as a common nexus, or are casually connected by reason of, any fact, circumstances, situation, event or decision." The Court concluded that there was no coverage under the policy because the previously filed complaints were "related wrongful acts" deemed to have been first made prior to the policy period.

Second Circuit Court of Appeals: Policy Language Trumps "Factual Nexus" Test When Determining Whether Claims Are "Related"

On October 21, 2015, the United States Court of Appeals for the Second Circuit, applying New York law, held that a "related claims" provision should be interpreted and applied pursuant to the plain language of the contract. Nomura Holding America, Inc. v. Federal Ins. Co., 2015 WL 6161487 (2nd Cir. Oct. 21, 2015). The insureds were involved in the issuance of mortgage-backed securities and were named as defendants in a lawsuit in 2008 alleging that misrepresentations were made in the offering documents. Five additional lawsuits were filed in 2011 and 2012 and the insureds sought coverage under a D&O policy covering the 2011-2012 policy period. The insurer denied coverage on the grounds that the lawsuits related back to the 2008 lawsuit and were deemed first made before the inception of the policy. The policy defined "related claims," in part, as "all claims for wrongful acts based upon, arising from, or in consequence of the same or related facts, circumstances, situations, transactions or events …" The trial court, applying a "factual nexus," test concluded that the denial was proper because the claims related back to the 2008 suit. The test required a "sufficient factual nexus exist where the claims are neither factually nor legally distinct, but instead arise from common facts and where the logically connected facts and circumstances demonstrate a factual nexus among the claims." Although the Second Circuit affirmed the trial court's decision, it held that the trial court erred in employing the "factual nexus" test instead of interpreting the policy pursuant to its "plain language as required by New York law," which includes an analysis under the definition of "related claims." The Court held that the later claims were "related" to the claim first made in 2008.

New York's Highest Court Rules That Medical Providers Must Warn Patients When Drugs Might Impair Ability to Drive

On December 16, 2015, the Court of Appeals for New York, in a 4-2 decision, held that medical providers must warn patients when drugs they have administered might impair the patient's ability to drive. Edwin Davis v. South Nassau Communities Hospital, 2015 WL 8789470 (N.Y. Dec. 16, 2015). The case involved a lawsuit brought by a bus driver against physicians and a hospital seeking to recover for personal injuries he sustained when a patient became unconscious as a result of medications administered at the hospital, . The patient's vehicle crossed a double yellow line and struck the bus plaintiff was driving. The trial court dismissed the complaint on the grounds that there was no patient-physician relationship between the plaintiff and the defendants. The Supreme Court, Appellate Division, affirmed the ruling in a July 2014 decision where it held that the plaintiff failed to state either a medical malpractice claim or a negligence claim against the defendants. The Court of Appeals reversed and held that the treating physicians and hospital owed the plaintiff a duty to warn the patient that medications she received could impair her ability to operate a motor vehicle and that the claim sounded in medical malpractice, rather than ordinary negligence. In so holding, the Court held that "to take the affirmative step of administering the medication at issue without warning about the disorienting effect of those drugs was to create a peril affecting every motorist in [the patient's] vicinity. Defendants are the only ones who could have provided a proper warning of the effects of that medication. Consequently, on the facts alleged, we conclude that defendants had a duty to plaintiffs to warn that the drugs administered to her impaired her ability to safely operate an automobile." The Court supported its decision by noting that its decision imposed no additional obligation on a physician who administers prescribed medications. Instead, the Court noted, it was "merely extending the scope of persons to whom the physician may be responsible for failing to fulfill that responsibility. "

Florida Appellate Court Allows Bad Faith Claim In $43 Million Malpractice Case

In a December 1, 2015 decision, a panel of the First District Court of Appeal held that, contrary to a trial court's ruling, an insurer is not shielded from its insured's bad faith claim under a safe-harbor provision contained in section 766.1185(1)(a) of the Florida Bad Faith statute. Mohamad Samiian v. First Professionals Ins. Co., 2015 WL 7731744 (Fla. Dist. Ct. Dec. 1, 2015). The insured, a plastic surgeon, was hit with a $43 million judgment in a case involving the death of a patient following liposuction. The insurer tendered the full $250,000 policy limits prior to the expiration of the pre-suit period. Several days after offering the policy limits, the insurer offered to submit the case to binding arbitration. The offer to arbitrate was not contingent upon any limitation of damage. The plaintiff accepted the offer and the arbitration panel awarded the plaintiff over $35 million in damages, plus attorneys fees, interest and costs. The insured subsequently filed a breach of contract action against his insurer alleging that it acted in bad faith in handling the claim. The insurer filed a motion for summary judgment contending that, because it tendered its policy limits promptly, the claim was therefore barred by the safe harbor provision of 766.1185(1)(a). The trial court granted summary judgment and held that the safe harbor provision applied because the insurer offered its policy limits within the safe harbor period. On appeal, the panel held that the insurer was not shielded from the bad faith claim because the insured's bad faith claim did not allege that the insurer failed to tender the policy limits. Instead, a different section of the statute applies, and there are disputed factual issues regarding whether the insurer acted in bad faith regarding the arbitration offer. "Whether [the insurer] acted in bad faith as alleged in the complaint depends on numerous factual questions that cannot, on this record, be resolved by summary judgment." In this regard, the claim fell within the section of the statute which specifies ten factors that must be considered in determining whether an insurer acted in bad faith.

Florida Appellate Court Finds that Insurer Safe-Harbor Provision Does Not Apply to Shield Bad Faith Claim

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Recent Notable Defense Verdicts

Notable Verdicts

Baltimore, MD — September, 2015. A Baltimore City jury awarded $28.3 million to a plaintiff in medical malpractice case filed against numerous physicians and Sinai Hospital of Baltimore, Inc. in a case involving the alleged misdiagnosis of an ulcer that resulted in severe bowel injury to a 47-year old man. The plaintiff alleged the defendants were negligent in failing to order an upper endoscopy and failing to continue use of a protonic pump inhibitor. The damage award included $1 million in past medical expenses, $14 million in future medical costs, $5 million loss of consortium, and $8 million in pain and suffering.

Philadelphia, PA — November, 2015. A Philadelphia County jury returned a verdict for $10.1 million in a medical malpractice case against The Children's Hospital of Philadelphia in a case involving the alleged failure of the hospital to diagnose a 6-year old boy with bacterial mengingitis when he was an infant in 2009. The boy suffered developmental and learning delays as a result of his condition.

Cook County, IL— December 2015. A Cook County jury awarded $22 million to a family of a woman with six children who suffered brain damage leaving her disabled and dependent on the care of others. Her injuries resulted from the alleged lack of medical attention to a tracheostomy blocked by blood clots. The award included $14 million in future medical expenses, $686,000 in past medical expenses, $1 million in emotional distress, $2.5 million in disfigurement, and $2 million loss of normal life.

Queens County, NY— December, 2015. A Queens County jury awarded $134 million in damages in a case against a physician involving a baby born blind and with cerebral palsy allegedly caused by tachysystole and decelerations. The verdict included a bad faith claim against the physician's insurer.

Notable Defense Verdicts

Westchester County—June, 2015. A Westchester County jury found for the defendant, Westchester Medical Center, in a case involving alleged negligence in failing to adequately turn and reposition a 17-month old infant admitted through the emergency room for treatment of necrotizing pneumonia. The infant suffered deep tissue injury/pressure sores to the back of the skull which required subsequent surgery. The defendant maintained that it adhered to appropriate pressure ulcer prevention.

Allegheny County, PA - 2015. An Allegheny County jury concluded that defendant nursing home's alleged negligent conduct in causing decedent to suffer a urinary tract infection did not act in an outrageous manner with wanton or willful indifference to the decedent. The jury, therefore, declined to award punitive damages against the facility. A jury had previously awarded $193,000 in damages in favor of the decedent's estate.

Palm Beach County, Florida—June, 2015. A Palm Beach County jury concluded that an orthopedic surgeon, two physician's assistants and the medical practice group that employed them were not negligent in a case in which a 77-year old female alleged that the defendants failed to timely diagnose and treat subluxation following hip replacement surgery. Plaintiff alleged that the hip implants displaced immediately after surgery and went undiagnosed for two weeks. Defendants argued that that surgeon was aware of the condition but made the medical decision to wait in hopes that it would realign without surgery.

Norfolk, VA—July, 2015. A Norfolk City jury held in favor of the defendants in a case involving alleged damages and pain and suffering to a newborn after an elective traverse low incision caesarian section resulted in disruption of the placenta. Plaintiff alleged that the procedure resulted in the newborn's anemia and required 30 days of hospitalization. The defendants denied malpractice and argued that the incision and all other aspects of delivery complied with the standard of care.