Jackson &Campbell
Attorneys and Counselors at Law

DECISIONS

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THE CENTERS FOR MEDICARE AND MEDICAID SERVICES ENACTS NEW RULE PROHIBITING ARBITRATION PROVISIONS IN NURSING HOME AGREEMENTS

The Centers for Medicare and Medicaid Services ("CMS"), the federal agency that controls Medicare and Medicaid funding, has issued a rule preventing nursing homes from forcing claims of elder abuse, sexual harassment and wrongful death into arbitration. The rule bars any nursing home that receives federal funding from requiring its residents to resolve disputes in arbitration instead of court. The rule is slated to affect 1.5 million residents. According to CMS, the idea behind the rule is to deliver new protections to residents, as arbitration clauses have allowed the nursing home industry to push disputes about safety and the quality of care out of public view. The current system has also reduced the nursing home industry's legal costs. The new rule was issued after officials in 16 states and the District of Columbia urged the government to cut spending to nursing homes that use arbitration clauses, claiming that arbitration allows the pattern of wrongdoing to remain hidden from prospective residents and their families.

Lawyers who work with the elderly say that residents are being admitted at a stressful point in their lives and are often desperate for a room so that the resident does not fully grasp what they are signing. The nursing home industry claims that allowing more lawsuits could drive up costs and force some homes to close. One news article published by The Times found many troubling examples where issues of abuse and potential neglect never made it into the public light because they were blocked from court. For example, in May 2014, a woman with Alzheimer's was twice sexually assaulted by residents at a nursing home in California. A subsequent investigation by the state's public health department found that the nursing home failed to protect the woman. When the woman's family tried to hold the nursing home accountable, the case was moved to arbitration based on an arbitration clause in the contract. The family ultimately gave up and settled with the nursing home. The Rule is scheduled to go into effect on November 28, 2016. The American Health Care Association and four other state and local health care groups, however, filed a lawsuit on October 17, 2016 in the United States District Court for the Northern District of Mississippi fighting the measure. In their Complaint filed against the Secretary of Health and Human Services and the Acting Administrator of CMS, the groups argue that the rule violates the Federal Arbitration Act and that "neither the Medicare Act nor the Medicaid Act says anything at all about arbitration agreements or alternative dispute resolution—let alone authorizes HHS or CMS to prohibit the use of those agreements entirely."The Plaintiffs in the lawsuit recently filed a Motion for a Preliminary Injunction to prevent the rule from going into effect. The Motion is pending.

West Virginia's Highest Court Rules That Insurer Had Right to Settle Case Without the Insured's Consent

"We agree with respondent that petitioner's insurance policy gives respondent the right to investigate and settle any claim made under it and [it] does not require respondent to obtain petitioner's consent."

In a decision issued on September 2, 2016, the Supreme Court of Appeals of West Virginia held that an insured's right to a jury trial had not been violated when his automobile insurer settled a lawsuit against him without obtaining his consent. *Gravely v. Wilson*, 2016 WL 4579073 (W.V. Sept. 2, 2016). The lawsuit stemmed from a multiple vehicle accident that took place in June, 2013. Petitioner insured was sued in an action and his automobile liability insurer defended the action. Petitioner disagreed with his insurer's decision to settle the claim against him for the limits of his policy so he discharged the attorney retained by his insurer to represent him and demanded a jury trial. The insurer, through its own attorney, settled the claim and issued a payment to the claimant. The Petitioner insured filed an objection to the settlement but the Circuit Court where the lawsuit was pending overruled his objection and found that the policy at issue gave the insurer the right to investigate and settle the claim. In this regard, the policy provided that the insurer "may investigate or settle any claim or suit for damages against anyone we protect at our expense." Plaintiff filed a separate lawsuit against his insurer for allegedly violating his right to a jury trial. The insurer filed a motion to dismiss for failure to state a claim upon which relief could be granted. The Court granted the Motion to Dismiss and the Petitioner appealed. On appeal, the Court of Appeals of West Virginia agreed with the trial court that the complaint was a baseless pleading that failed to state a viable claim. The Court of Appeals also agreed with the trial court that

the insurer's policy was clear and unambiguous and that it gave the insurer the right to investigate and settle any claim made under it and that it did not require the insurer to obtain the insured's consent. The Court of Appeals further ruled that the Petitioner's contention that the settlement violated his Constitutional right to a jury trial was not implicated in the case because the Petitioner failed to allege that the insurer was a "state actor" or that its settlement of the claims against the Petitioner constituted a state action. The Court, therefore, ruled that the trial court did not err in dismissing Petitioner's case.

A Second Florida Appellate Court Rules That Medical Malpractice Cap Is Unconstitutional

In a decision issued on October 26, 2016, Florida's Second District Court of Appeal joined the state's Fourth District in finding that a state law capping noneconomic damages in medical malpractice personal injury lawsuits is unconstitutional, adopting an opinion currently under review by the Florida Supreme Court. *Port Charlotte HMC, LLC v. Suarez*, 2016 WL 6246703 (Fla. 2nd DCA Oct. 26, 2016). The medical malpractice lawsuit was brought by a mother against several healthcare providers alleging inadequate care during her pregnancy which resulted in her daughter's severe neurological impairments. After a lengthy trial, a jury found that the negligence of a medical care facility and a physician was the legal cause of the daughter's injuries and awarded $13,500,000 to the daughter, which included $1,250,000 in noneconomic damages, and $9.6 million in damages to the mother, which included $4 million in noneconomic damages. The defendants filed a motion to reduce the jury verdict after trial claiming that the noneconomic damages should be limited. The trial court, relying on a 2015 decision from the Fourth District, denied the request to apply the statutory cap for noneconomic damages. [The 2015 case was discussed in the September, 2015 edition of *Decisions*]. The three-judge panel of the Second District Court followed the 2015 decision and concluded that the caps are unconstitutional on the grounds that they violate equal protection. The Court further noted that in the absence of interdistrict conflict, the earlier decision issued by the Fourth District Court bound all Florida trial courts.

California Appellate Court Concludes that Hospital Was Not Vicariously Liable for Actions of Non-Employee Physician

In a decision issued on October 4, 2016, the Court of Appeal of the State of California, Second Appellate District Court ruled that a pain management physician was not an "ostensible agent" of a hospital and, therefore, the trial court's striking of the jury's apportionment of fault to the hospital was proper in a medical malpractice case that resulted in a verdict against the physician and the hospital. *Markow v. Rosner*, 2016 WL 5765470 (Cal. App. 2nd Oct. 4, 2016). Plaintiff and his wife filed suit against pain management physician Howard Rosner ("Dr. Rosner") and Cedars-Sinai Medical Centers ("Cedars") for professional negligence and loss of consortium after Dr. Rosner's treatment rendered Markow a quadriplegic. A jury found that both Dr. Rosner and Cedars had been negligent but that only Dr. Rosner's negligence had been a substantial factor in causing Markow's severe injuries. The jury nonetheless apportioned 40 percent of the fault to Cedars, apparently on the basis of its finding that Dr. Rosner was Cedar's ostensible agent. Both Dr. Rosner and Cedars appealed. Under California law, an agency is ostensible when the principal intentionally, or by want of ordinary care, causes a third person to believe another to be his agent who is not really employed by him. In order for the principal to be liable for the acts of the ostensible agent, the person dealing with the agent must do so with a reasonable belief in the agent's authority, such belief must be generated by some act or neglect by the principal, and the person relying on the agent's apparent authority must not be negligent in holding that belief. On appeal, Cedars contended that, as a mater of law, Dr. Rosner could not be found to be its ostensible agent because in the Conditions of Admissions forms Markow initialized and signed on 25 separate occasions Cedars unambiguously informed Markow that all physicians furnishing services to patients were independent contractors, not agents or employees of Cedars. The Court of Appeal agreed and reversed the judgment as to Cedars. In so ruling, the Court held that under the circumstances Markow knew or should have known that Dr. Rosner was not Cedar's agent. The Court further noted that Markow's belief to the contrary was not objectively reasonable and that Cedar's motion for judgment notwithstanding the verdict should have been granted.

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Ohio Supreme Court Rules That Medical Malpractice Cases Must Be Filed Within Four Years of Claimed Injury

In a decision issued by the Supreme Court of Ohio on October 25, 2016, the Court ruled on Ohio's medical malpractice statute of repose, which limits the period in which malpractice actions may be commenced. *Antoon v. Cleveland Clinic Foundation*, 2016 WL 6275504 (Ohio Oct. 25, 2016). In the case, the Plaintiffs attempted to bring a medical malpractice case more than five years after the care and treatment at issue. The trial court dismissed the lawsuit as untimely but the case was reinstated on appeal by the Court of Appeals. Specifically, the Court of Appeals held that once a lawsuit vests (when a plaintiff knows of his or her cause of action) the statute of repose does not apply because the statute of repose can never extinguish a vested claim. The Supreme Court of Ohio rejected this argument and held that the medical malpractice statute of repose applies to both vested and unvested claims. In so ruling, the Court clarified a prior ruling issued in 2012 involving the application of the statute of repose to a non-vested claim. The Court further held that medical providers should not be forced to defend against claims that occurred five, ten, twenty, or fifty years prior to the filing of the lawsuit and that the statute of repose is the only way to enforce this critical public policy decision enacted by the General Assembly. The Court also rejected the Plaintiffs' contention that they had triggered Ohio's savings statute when they filed a vaguely related but much different action in federal court within one year of the voluntary dismissal of their original suit. The Supreme Court noted that in order to utilize the savings statute, the first filed and the refilled lawsuits must be "substantially similar."

Ohio Supreme Court Rules that Four Year Statute of Repose Applies to Medical Malpractice Claims

Florida Supreme Court Clarifies Duty of Physician in Case Alleging Liability for Patient's Suicide

"A doctor may owe a legal duty of care but not be liable because proximate cause cannot be proven."

On August 25, 2016, the Florida Supreme Court clarified that the foreseeability of a patient's suicide is not relevant to determine the duty owed by a doctor to the patient. *Chirillo v.* Granicz, 199 So.3d 246 (Fla. 2016). This decision clears up an issue that Florida courts had grappled with for years – whether a doctor has a duty to act when it appears likely a patient will take his or her life. In *Chirillo v. Granicz,* the patient had a history of depression and her primary care doctor prescribed her an antidepressant. A month later, the patient telephoned the doctor to inform him that she had stopped taking the medication due to side effects. The doctor prescribed a new medication and referred her to a gastroenterologist. The next day, the patient's husband discovered she had killed herself. The husband sued the doctor for medical malpractice. The doctor filed a motion for summary judgment and argued that he owed no duty to prevent the decedent from committing an unforeseeable suicide while she was not in his control. The trial court granted the doctor's motion finding that he did not have a duty to prevent the suicide of an outpatient, even if it was forseseeable. The appellate court reversed, stating that the doctor had a general duty to use ordinary skill in caring for a patient. The appeals court stated that the pretrial judgment was granted improperly, because a question remained as to whether the doctor's failure to see her was a contributing factor in her suicide. The Florida Supreme Court addressed the case in light of a split in appellate authority as to a physician's duty to a patient who commits suicide. The Supreme Court held that because there is no duty to prevent a noncustodial patient's suicide, the doctor's ability to predict that the patient would kill herself was not relevant to determine the duty he owed to her. The Could held that the foreseeability of a patient's suicide is relevant to the analysis of whether the doctor's conduct was a contributing cause, not the determination of duty. According to the court, it is possible for a defendant to owe a legal duty of care to a specific plaintiff yet not be liable to that plaintiff because proximate causation cannot be proven. In reviewing the underlying record, the Supreme Court concluded that the appellate court was correct in finding that there was a genuine issue of material fact remaining as to proximate cause and, therefore, summary judgment should not have been granted. The Court reversed and remanded the case with instructions to the trial court to proceed to trial.

Florida Supreme Court Rules That Policyholders Can Recover Attorneys' Fees From Insurer Even Without a Finding of Bad Faith

On September 29, 2016, the Florida Supreme Court reaffirmed Florida's protection for policyholders regarding recovery of attorneys' fees. In *Johnson v. Omega Insurance Company*, 2016 WL 5477795 (Fla. Sept. 29, 2016), the Florida Supreme Court denied an insurer's attempt to require malice before a policyholder is entitled to attorneys' fees and costs under Florida Statute 627.428. According to the court, once an insurer has incorrectly denied benefits and the policyholder files an action to dispute the denial of coverage, the insurer cannot then abandon its position without repercussion. To allow the insurer to backtrack after the legal action has been filed without consequences, according to the court, would essentially eliminate the insurer's burden of investigating a claim. The court noted that the need for fee and cost reimbursement is deeply rooted in public policy. The Florida Legislature recognized that it was essential to "level the playing field" between the economically-advantaged and sophisticated insurance companies and the individual citizen. Without the funds necessary to compete with an insurance carrier, a policyholder's only means to take protective action is to hire that expertise in the form of legal counsel. The court made clear that no malice or bad faith conduct on behalf of the insurer is required – if an insurer fails to pay what it is owed, intentional or innocent, a policyholder is entitled to attorneys' fees and costs.

Seventh Circuit Rules That Trial Court Erred In Refusing to Allow Insurer To Obtain Discovery on "Insured" Issue

In a decision issued by the United States Court of Appeals for the Seventh Circuit on September 22, 2016, the Court ruled that the United States District Court for the Northern Illinois erred in refusing to permit a professional liability insurer to undertake discovery to establish that the claimant was not an insured under its professional liability policy. *Landmark American Ins. Co. v. Hilger*, 2016 WL 5239833 (7th Cir. Sept. 22, 2016). The lawsuit stems from a declaratory judgment action filed by the insurer seeking a declaration that it had no duty to defend or indemnify an insurance broker under a professional liability policy for an underlying fraud action. The district court entered judgment on the pleadings for the claimant, rejected the argument that discovery was required to determine the claimants' relationship with the insured, and that any consideration of evidence outside the underlying complaints was inappropriate absent strong evidence that the claimant was not an insured under the policy. Notwithstanding Illinois' general adherence to the "four corners" rule, the Seventh Circuit reversed and declared that insurers were only restricted to the allegations in the complaint when they refuse to defend or fail to bring a declaratory judgment action. The Court concluded that it was appropriate to allow the insurer to present evidence beyond the underlying complaint in a declaratory judgment action so long as it does not tend to determine an ultimate issue in the underlying proceeding.

Indiana Legislature Increases Cap on Medical Malpractice Awards

On March 8, 2016, the Indiana State Senate approved Senate Enrolled Act 28, which had been previously passed by the House of Representatives five days earlier. The act was subsequently signed into law by Governor Pence. Since 1999, the state's Medical Malpractice Act ("MMA") which is embodied by I.C. § 34-18-14-3, has capped medical malpractice awards against "Qualified Healthcare Providers" at $1.25 million. The new cap will be increased twice. The first increase, to be effective on July 1, 2017, will raise the cap to $1.65 million, with the first $400,000 of any award to be paid by the healthcare provider. The cap would be further raised in 2019 to $1.8 million, and require that the first $500,000 come from the healthcare provider. In addition to this increase in the recovery cap, the act also increases the percentage of maximum compensation for plaintiff attorneys from 15 percent to 32 percent of the amount recovered. The act also requires timelier payments from the Indiana Patient's Compensation Fund. The caps in Indiana had not been raised in nearly two decades. The effort was a compromise by a variety of interest groups - both for and against raising the caps.

Supreme Court Of Illinois Rules That a Six Person Jury Is Unconstitutional

On September 22, 2016, the Supreme Court of Illinois ruled that a six-person jury is unconstitutional. *Kakos v. Butler*, 2016 IL 120377 (Ill. Sept. 22, 2016). The lawsuit involved causes of action for medical malpractice and loss of consortium filed by the Plaintiffs against several physicians and their employers. The Defendants filed a motion requesting a 12-person jury and seeking a declaration that Public Act 98-1132 (effective June 1, 2015) is unconstitutional. Public Act 98-1132 limits the size of a civil jury to 6 persons. The Circuit Court found the Act unconstitutional and the Plaintiffs appealed to the Supreme Court as a matter of right. On appeal, the Defendants argued that the Act violates the right of a trial by jury as protected by the Illinois Constitution. The Court began its analysis by noting that it construed the right of a trial by jury protected by the Illinois Constitution differently than the rights protected by the federal constitution. In this regard, the Illinois Constitution preserved the right of a trial by jury as it existed under common law. After analyzing the law at the time of the enactment of the Constitution in 1970, the Court concluded that "because the size of the jury—12 people—was an essential element of the right of a trial by jury enjoyed at the time the 1970 Constitution was drafted, we conclude jury size is an element of the right that has been preserved and protected in the constitution."

Six Person Jury Ruled Unconstitutional by Illinois Supreme Court

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Recent Notable Verdicts and Settlements

Notable Verdicts/Settlements

Lackawanna County, PA — September 2016. A Pennsylvania federal jury reached an $11.9 million verdict against PrimeCare Medical, Inc. and various medical staff members over the wrongful death of a man who killed himself while being held at a Monroe County jail. The jury found in favor of the Plaintiffs on the causes of action for medical negligence, Section 1983 deliberate indifference, wrongful death, and punitive damages.

Los Angeles, CA—February, 2016. Defendants in a medical malpractice case reached a $4.3 million settlement with a man in his late 20's after he suffered cardiac arrest when his heart was inappropriately shocked by an implantable cardioverter defibrillator (ICD). The shock caused the man to suffer a brain injury due to lack of oxygen leaving him unable to care for himself. Defendants allegedly failed to take into account the man's heart vessels' transposition when reprogramming the device.

Baltimore County, MD—April, 2016. After an eight day trial, a Baltimore County jury awarded $1.2 million to a 71 year old retiree who sustained permanent motor, speech and memory deficits after sustaining a stroke as a result of an alleged unnecessary angiogram. Patient argued that the angiogram was not needed as all the information necessary for planning surgical intervention was already available on a CT scan performed weeks earlier.

New York City, NY—September, 2016. The City of New York agreed to pay $5.75 million to the mother of a mentally ill man who died in his cell at Rikers Island. Plaintiff alleged that the man's death was caused by sepsis which developed after he mutilated himself and failed to receive necessary medical care at the facility.

Lancaster County, PA—August, 2016. A Lancaster County jury issued a $8.5 million verdict in a medical malpractice case for an 8 year old boy who developed severe neurological defects after an incident at a pediatric care facility. The boy, who had been at a pediatric nursing home for treatment of mild neurological injuries suffered at birth, was found unconscious and in cardiac arrest when his tracheotomy tube was displaced.

Notable Defense Verdicts

Eastern District, PA — September, 2016. The United States District Court for the Eastern District of Pennsylvania entered summary judgment in favor of a hospital in a case brought by senior researcher who alleged the hospital failed to protect him against the effects of radiation, which he contended caused him to contract a rare form of cancer. In its ruling issued on September 8, 2016, the Court noted that Plaintiff failed to offer expert evidence to connect his cancer to his exposure to radiation.

Nassau County, NY—May 2016. A Nassau County jury found that a defendant general surgeon was not negligent in a case in which plaintiff contended that the surgeon negligently exceeded the recommended number of rotations when placing a cardiac pacemaker which resulted in the perforation of the right atrium The surgeon argued that the perforation was caused by the anatomical structure of the atrium and occurred despite the compliance with the standard of

Oklahoma County, OK—May, 2016. An Oklahoma County jury found in favor of an Emergency Medical Services defendant in a wrongful death case involving the mother of a 16-year old decedent. Plaintiff alleged that the defendant failed to timely respond to a call for help and when they did, they provided inadequate lifesaving care to her son—who had sustained a deep laceration to his arm after punching a window at his girlfriend's home. The defendant denied all allegations of negligence and the jury agreed.

Washington, DC—July, 2016. A District of Columbia jury concluded that an orthopedic surgeon was not negligent in a lawsuit in which the patient alleged that the surgeon failed to perform a complete release of the transverse carpal ligament during a carpal tunnel release surgery. The surgeon denied the negligence claim and contended that the patient's symptoms were unrelated to the treatment the surgeon provided. The Patient had demanded $750,000 prior to trial.