Jackson &Campbell
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DECISIONS

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FLORIDA SUPREME COURT STRIKES DOWN CAP ON NONECONOMIC DAMAGES IN MEDICAL MALPRACTICE ACTIONS AS UNCONSTITUTIONAL

In 2014, the Florida Supreme Court in *McCall v. United States,* 134 So. 3d 894 (Fla. 2014) held that the legislative caps imposed on non-economic damages in wrongful death cases, imposed by section 766.118 of the Florida Statutes, violated the Equal Protection Clause of the Florida Constitution. In a decision issued on July 1, 2015, the Fourth District Court of Appeal in *North Broward Hospital District v. Susan Kalitan,* 174 So.3d 403 (Fla. 4th DCA 2015) extended the ruling from the *McCall* case and concluded that the non-economic damages caps in medical malpractice cases involving non-death personal injury cases likewise violated the Equal Protection Clause of the Florida Constitution. The Supreme Court of Florida subsequently granted review of the case. On June 8, 2017, the Supreme Court of Florida issued a decision upholding the decision of the Fourth District Court of Appeal. *North Broward Hospital District v. Kalitan*, 2017 WL 2481225, - So.3d - (Fla. 2017). The case involves a patient (Susan Kalitan) who had outpatient surgery to treat carpel tunnel syndrome. The surgery required general anesthesia, and during intubation, her esophagus was perforated. A jury awarded $4.7 million, including $2 million in noneconomic damages for pain and suffering and $2 million for future pain and suffering. The trial judge reduced the noneconomic damages by close to $2 million because of the statutory cap and cut the damages by another $1.3 million, as the hospital's share of liability was capped at $100,000 because of its status as a sovereign entity. The Fourth District declared

the statute unconstitutional, applying the test utilized by the Florida Supreme Court in *McCall,* where the court concluded that the cap on noneconomic damages for medical malpractice cases does not pass the rational basis test because it arbitrarily reduces medical malpractice claimants' rights to full compensation when there are multiple claimants. The State and reform groups claimed that the appeals court misinterpreted the *McCall* decision and expanded it to such an extent that other caps could be struck down. On appeal, the plaintiff argued: (1) that the cap should only apply to multiple claimants; and (2) that the caps are unconstitutional because they limit access to the courts and the right to trial by jury, as caps applied to a verdict deprives the plaintiff of the damages awarded by the jury. The four-member majority of the Supreme Court found that the caps on "non-economic" damages violated equal-protection rights. In so ruling, the Court rejected the notion that a malpractice insurance "crisis" existed — a justification that lawmakers used in approving the limits. "We conclude that the caps on noneconomic damages … arbitrarily reduce damage awards for plaintiffs who suffer the most drastic injuries," said the majority opinion shared by Chief Justice Jorge Labarga and justices Barbara Pariente, R. Fred Lewis and Peggy Quince. "We further conclude that because there is no evidence of a continuing medical malpractice insurance crisis justifying the arbitrary and invidious discrimination between medical malpractice victims, there is no rational relationship between the personal injury noneconomic damage caps … and alleviating this purported crisis. Therefore, we hold that the caps on personal injury noneconomic damages … violate the Equal Protection Clause of the Florida Constitution." In the dissent, three justices argued that the Court overstepped its role, noting that it is the Legislature's role to decide if a malpractice crisis exists.

Iowa Supreme Court Recognizes "Wrongful Birth" Claims

"The compensable injury in a wrongful birth claim is the parents' loss of the opportunity to make an informed decision ..."

In a decision issued by the Iowa Supreme Court on June 2, 2017, the Court joined the majority of states that recognize "wrongful birth" claims. *Plowman v. Fort Madison Community Hospital*, 2017 WL 2390664 (Iowa June 2, 2017). In *Plowman*, parents of a severely disabled child brought a medical negligence action against a hospital and several physicians. In the lawsuit, they alleged that the defendants negligently failed to accurately interpret, diagnose, monitor, respond to, and communicate fetal abnormalities evidenced by prenatal ultrasound. Plaintiffs alleged that, as the result of negligent care, the mother gave birth to a child with severe brain abnormalities, and that if parents had been informed of abnormalities prior to the child's birth, they would have terminated the pregnancy. The defendants filed a motion for summary judgment and argued that the plaintiffs failed to state a claim recognized in Iowa. The District Court granted the motion and declined to recognize a new cause of action for wrongful birth, stating a decision to do so was more properly left "to the legislature or the Supreme Court." Plaintiffs appealed. On appeal, the defendants argued that the claim is a new cause of action unsupported by Iowa law. Plaintiffs, on the other hand, alleged that the case falls within the traditional elements of medical negligence and note a clear majority of other jurisdictions allow parents to sue under these facts. In a 6-1 ruling in a case of first impression, the state's highest court overturned the dismissal of the lawsuit. In so ruling, the Court concluded that wrongful birth fits within common law tort principles governing medical negligence claims, and no public policy or statute precludes the cause of action. The Court further noted that the compensable injury in a wrongful birth claim is the parents' loss of the opportunity to make an informed decision to terminate the pregnancy. This is analogous to a claim for medical negligence based on lack of informed consent. Both types of claims arise out of "the unquestioned principle that absent extenuating circumstances a patient has the right to exercise control over his or her body by making an informed decision." In support of its ruling, the Court held that "[d]eclining to recognize a claim for wrongful birth would "immunize those in the medical field from liability for their performance in one particular area of medical malpractice," namely, prenatal care and genetic counseling.

CMS Withdraws Ban on Nursing Home Arbitrations

The Centers for Medicare and Medicaid Services ("CMS") issued a rule in 2016 that prevented nursing homes from requiring claims of elder abuse, sexual harassment and wrongful death into arbitration. CMS is the federal agency that controls Medicare and Medicaid funding. The rule, which was initially scheduled to go into effect on November 28, 2016, barred nursing homes that receive federal funding from requiring its residents to resolve disputes in arbitration instead of in court. The rule was slated to affect at least 1.5 million residents. The American Health Care Association ("AHCA") and four other state and local health care groups filed a lawsuit in federal court in Mississippi in October, 2016 seeking to prevent implementation of the rule on the grounds that it violated the Federal Arbitration Act ("FAA"). *American Health Care Ass'n v. Burwell*, 3:16-cv-00233 (N.D. Miss.) The Court granted a preliminary injunction on November 7, 2016 temporarily preventing the rule from going into effect. CMS appealed the ruling to the United States Court of Appeals for the Fifth Circuit. On June 2, 2017, CMS filed an Unopposed Motion to Dismiss the Appeal. On June 5, 2017, CMS issued a proposed rule that would reverse the proposed ban. In reversing course on the ban, CMS concluded that the ban imposed "unnecessary and excessive" litigation costs on health care providers. The move was expected since the November presidential election gave Republicans control of the executive branch. The new proposal would require all agreements for binding arbitration to be in plain language, and a resident would have to acknowledge that he or she understands the agreement. Other proposed changes include making facilities post a notice regarding its use of binding arbitration in an area that is visible to both residents and visitors, and if a facility resolves a dispute with a resident through arbitration, it must maintain a copy of the signed agreement and the arbitrator's final decision so that it can be inspected by CMS.

Supreme Court of Arizona Clarifies Elder Abuse Standard Governing Nursing Home Abuse Lawsuits

On June 20, 2017, the Supreme Court of Arizona ruled that a standard governing nursing home abuse lawsuits was too restrictive and runs contrary to the aims of state law. Delgado v. Manor Care of Tucson, AZ, LLC, 2017 WL 2655326 (Ariz. June 20, 2017). The lawsuit, brought on behalf of a resident, alleged abuse and neglect of a vulnerable adult under Arizona's Adult Protective Services Act ("APSA"). In the case, the plaintiff alleged that the facility failed to treat a septic infection in 2012 and, as a result, the resident died. In the lawsuit alleging abuse and neglect under the APSA, the trial court granted a motion for summary judgment filed on behalf of the facility and a doctor ruling that the claims failed a four-part test derived from a 2002 decision issued by the Supreme Court of Arizona in *Estate of McGill v. Albrecht,* 203 Ariz. 525 (2002). Under the *McGill* test, in order for a claim to be brought under the APSA the claim has to arise from a caregiver-recipient relationship, be closely connected to the relationship, be connected to service given "because of the recipient's incapacity," and be related to the problems causing the incapacity. The trial court ruled that the resident's death from sepsis was not related to the conditions that caused her incapacity. The Court of Appeals reversed the ruling, holding that a triable issue existed as to whether the alleged abuse "was related to the problems that caused [the resident's] incapacity." The Supreme Court of Arizona vacated the Court of Appeals' opinion, reversed the trial court's grant of summary judgment, and remanded the case to the trial court for further proceedings. In so ruling, the Court held that the *McGill* test was especially troublesome to apply in cases like the one at issue, where patients had multiple medical conditions going into their nursing home stay. The Court noted that "courts navigating their way through the *McGill* test have made fine distinctions which, at times, seem to be at odds with the broad protective provisions of the APSA." Instead, the Court looked back to the law itself, noting that it provides four elements: the individual is a vulnerable adult, who has suffered an injury caused by abuse from a caregiver. As such, the court concluded that the *McGill* test should be abandoned in favor of using the four elements in the APSA it identified. Under that re-evaluation, the court ruled that the plaintiff's suit on behalf of the resident was valid.

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Indiana Appellate Court Allows Insurer to Rescind Physician's Liability Policy

In an unpublished decision issued on May 11, 2017, the Court of Appeals of Indiana upheld the rescission of an orthopedic surgeon's medical malpractice liability insurance policy issued by Lancet Indemnity Risk Retention Group, Inc. on the grounds that important facts were misrepresented on the policy application. *Svabek v. Lancet Indemnity Risk Retention Group, Inc.*, 2017 WL 1955048 (Ind. App. May 11, 2017). At issue in the case was a "tail" policy the surgeon purchased which covered the period of December 7, 2010 to December 7, 2012 and which required him to report claims by December 7, 2013. In the policy application, he confirmed that he was free of any "known potential or anticipated losses and that no prior carrier had declined or refused coverage for a medical incident." The appellate court noted that the surgeon had knowledge of three legal matters before the policy incepted. Despite the knowledge, the surgeon failed to disclose any of them in the policy application. One of the lawsuits, which was the focus of the appellate court's decision, had been filed with the Indiana Department of Insurance in August, 2012. The surgeon had forwarded that complaint to his former insurance carrier in November, 2012 but the insurer denied the claim three days before Lancet Indemnity issued the tail policy because the policy had expired. On appeal, the surgeon argued that genuine issues of material fact exists as to whether he was aware of one or more of the three medical malpractice incidents and that the carrier had not timely moved to rescind the policy. The appellate court rejected these argument. In upholding the trial court's grant of summary judgment rescinding the policy, the three-judge panel of the appellate court held that "[f]alse representations warrant rescission 'regardless of whether the misrepresentation was innocently made or made with fraudulent design' because innocent misrepresentations are 'just as injurious as intentional fraud.'"

Indiana Appellate Court upholds lower court's decision to rescind malpractice policy based on misrepresentations in policy application

Oregon Supreme Court Recognizes "Loss Of Chance" Injury in Malpractice Cases

"In the context of Oregon common-law medical malpractice claims, loss of chance of a better medical outcome is itself a type of injury."

In a decision issued by the Oregon Supreme Court on May 11, 2017, the Court overturned the dismissal of a medical malpractice lawsuit brought against a hospital and several physicians wherein the plaintiff alleged that the defendants deprived him of a chance of a full recovery from a stroke, saying such "loss of chance" theories are fair game in medical negligence cases. *Smith v. Providence Health & Services—Oregon*, 393 P.3d 1106 (Or. 2017). In the case, the plaintiff alleged that the hospital and physician defendants failed to properly follow up on his complaints of stroke symptoms which robbed him of a one-third chance at a full recovery in cases like his, had he received timely and proper treatment. The trial court dismissed the action and the appellate court affirmed the decision. On appeal, the plaintiff argued that the loss of chance is not an aspect of causation, but rather is a distinct type of injury or harm, and one that numerous jurisdictions have recognized in common law medical malpractice cases. The Oregon Supreme Court agreed and stated that in the context of Oregon common law medical malpractice claims, loss of chance of a better medical outcome is itself a type of injury, rejecting the defendants' arguments that such a ruling would be an improper relaxation of standards regarding causation. While many states bar loss-of-chance theories and instead take an "all-or-nothing" approach which requires a medical malpractice plaintiff to prove the patient would have had a better than 50 percent chance of survival or favorable outcome, the Court said this approach is problematic because it insulates health care providers from claims made by patients whose odds of recovery are 50 percent or less, and runs counter to the purpose of tort law. In addition, the Court noted that the physician-patient relationship is a special one in which the patient with an ailment or injury seeks to optimize the chance of recovery and the physician undertakes a duty of care, skill, and diligence to the patient. And when the physician's negligence—conduct below the standard of care—deprives a patient of the one chance that the patient had at recovery, even when that chance was not greater than a fifty-fifty proposition, considerations of fairness weigh in favor of compensation for the destruction of that chance. In so ruling, the Court noted that when the lost chance is the injury in a medical malpractice action, the plaintiff still bears the burden to prove that, more likely than not, the defendant's negligence caused the plaintiff to lose the chance of a favorable medical outcome.

United States Supreme Court Rules that FAA Preempts Kentucky Arbitration Rule

The United States Supreme Court issued a decision on May 15, 2017 and ruled that the Kentucky Supreme Court's refusal to send a wrongful death lawsuit against a nursing home to arbitration violated the Federal Arbitration Act ("FAA"). *Kindred Nursing Centers, LP v. Clark*, 137 S.Ct. 1421 (U.S. 2017). In a 7-1 decision, the justices sided with the nursing center in a wrongful death case in which Kentucky's high court had ruled that a state-law contract rule required individuals with powers of attorney to explicitly authorize such arbitration agreements. In the case, two designees of nursing home residents with powers of attorney signed separate agreements on admission stipulating that any disputes arising out of the residents' stay would be resolved in arbitration. After the residents died due to alleged negligent care, their designees filed suit against the nursing home facility. The trial court dismissed the actions pursuant to the arbitration clauses but the Kentucky Supreme Court reversed the ruling finding that the power of attorney did not extend to the signing of optional health care agreements. The U.S. Supreme Court reversed the ruling. The Court held that "[p]lacing arbitration agreements within [a class of contracts like freedom of worship and forcing someone into servitude] reveals the kind of 'hostility to arbitration' that led Congress to enact the FAA… And doing so only makes clear the arbitration-specific character of the rule, much as if it were made applicable to arbitration agreements and black swans." The Court noted that "[a]dopting the respondents' view would make it trivially easy for States to undermine the Act … Their reasoning would allow States to pronounce any attorney-in-fact incapable of signing an arbitration agreement — even if a power of attorney specifically authorized her to do so …" "If the respondents were right, States could just as easily declare everyone incompetent to sign arbitration agreements."

Eighth Circuit Finds That Notice Within Policy Period Still Violated Notice Provision in a Claims-Made Policy

On May 25, 2017, the United States Court of Appeals for the Eighth Circuit issued a ruling affirming a District Court's grant of summary judgment in favor of an insurer in a coverage action involving the timely notice of a claim. *Food Market Merchandising Inc. v. Scottsdale Indemnity Co.*, 857 F.3d 783 (8th Cir. 2017). In the case, the insured was sued in January 2014 by a salesperson for more than $250,000 in allegedly unpaid commissions. The insured sought coverage for the lawsuit under a Business and Management Indemnity Policy issued by the defendant insurer. The indemnity policy was a "claims made" policy that provides coverage for claims first made against the insured during the policy period and reported in accordance with the notice provisions of the policy. The notice provisions of the policy required the insured to provide notice of claims "as soon as practicable." The insured provided notice of the lawsuit to its insurer in August 2014, within the policy period but seven months after the lawsuit was filed. The insurer denied coverage on the grounds that notice was untimely. The insured filed litigation against the insurer in a Minnesota federal court. The insurer filed a motion for summary judgment in the action on the late notice issue. The District Court granted summary judgment in favor of the insurer finding that notice was a condition precedent of coverage and that notice was not timely provided to the insurer. The insured appealed. On appeal, the insured argued that its notice was timely because it was given during the "claims-made" period of the policy and, in any event, genuine issues of material fact existed as to whether the notice was given "as soon as practicable." The three-member panel of the Eighth Circuit rejected the insured's argument. The Court held that the insured's provision of notice within the policy period did not save coverage, explaining: "Here, the policy did not require notice to be given during the policy period, but instead only required that notice be given as soon as practicable, but in no event later than sixty (60) days after the end of the policy period." The court continued: "[the insured] presented no evidence that providing notice over seven months after being sued was as soon as practicable." In so concluding, the decision places Minnesota alongside courts in Pennsylvania, New Jersey, and Connecticut that likewise have allowed insurers to deny claims on the basis of "untimely notice" even when the notice was given within the policy period of a claims-made policy.

Untimely Notice of Claim During Claims-Made Policy

Maryland Appellate Court Allows Case To Proceed Against Clinic After Patient Dismisses Claims Against Physician

On May 31, 2017, the Maryland Court of Special Appeals, in a matter of apparent first impression, held that a patient's voluntary pretrial dismissal with prejudice of a claim against a physician did not operate as adjudication of the claim on its merits and, thus, did not bar prosecution of the same claim against the physician's employer based on vicarious liability. *Women First Ob/Gyn Associates, LLC v. Harris*, 2017 WL 2351498 (Md. App. May 31, 2017). In the case, the plaintiff brought a medical negligence action against a hospital, based solely on vicarious liability, alleging that a physician negligently performed a laparoscopic hysterectomy and caused injury to patient's left ureter. Following a jury trial, the Circuit Court entered judgment in favor of the patient. The hospital appealed, arguing that the voluntary dismissal with prejudice of the claim against the physician employee for no consideration and in the absence of a release barred the prosecution of the same claim against the employer based solely on vicarious liability. The appellate court rejected the argument. In so ruling, the Court noted that under Maryland law, plaintiffs may sue an employer in tort based on the wrongful conduct of the employee, under *respondeat superior,* without suing the employee. The Court further noted that in a suit against an employer, the plaintiff need only prove that an employee committed the tort and did so while acting within the scope of his employment to establish the employer's liability. The Court noted that Maryland has recognized only two situations in which resolution of the tort claim against an employee would preclude *respondeat superior* liability against the employer: exoneration of the employee or release of the employee. In the case, there was no exoneration of the physician and there was no release or consideration given for the dismissal. The Court also rejected the argument that the dismissal of a claim is an adjudication on the merits equal to an exoneration.

Jackson & Campbell
Attorneys and Counselors at Law

Jackson & Campbell, P.C.
1120 20th Street, NW
Washington, DC 20036
www.jackscamp.com

Timothy Dingilian
(202) 457-1664
tdingilian@jackscamp.com

Christopher Ferragamo
(202) 457-5458
cferragamo@jackscamp.com

Marie VanDam
(202) 457-1622
mvandam@jackscamp.com

Elderidge A. Nichols, Jr.
(202) 457-1696
enichols@jackscamp.com

Recent Notable Verdicts and Settlements

Notable Verdicts/Settlements

Montgomery County, PA—April, 2017. The estate of a deceased 36 year old woman reached a $6 million settlement with the defendant ob/gyn, attending doctors and staff and a hospital in a lawsuit alleging wrongful death arising from the alleged failure to properly recognize and treat the decedent's life-threatening postpartum hemorrhage following the delivery of the decedent's child via C-section. The settlement was allocated 80% to wrongful death and 20% to the survival action.

Huntingdon County, PA—June, 2017. After a three day trial, a Huntingdon County jury awarded a man $870,000 in a medical malpractice action accusing a physician of removing the wrong testicle during surgery. The jury also concluded that the physician's conduct constituted "reckless indifference" warranting the imposition of punitive dam-

Southern District of Illinois—June, 2017. An Illinois federal judge increased a $29.7 million bench award by $1.5 million to a man who claimed that egregious treatment at a federally funded health clinic led to his kidney failure. The judge ruled in March that the failure of a nurse practitioner employed at the East St. Louis clinic to take adequate measures to control plaintiff's hypertension resulted in severe kidney damage that ultimately required a transplant. The increase in the award was to account for the present value of future medical expenses.

Cook County, Illinois—May, 2017. A Cook County Circuit Court Judge has awarded more than $23.1 million to the family of a 5-year-old girl who suffers ongoing health problems due to complications at birth. The girl, whose numerous health problems include cerebral palsy and epilepsy, suffered massive blood loss and was not fully transfused for some three hours after her birth. The neonatologist involved in the child's care was found negligent but the hospital was not.

Union County, AR—March, 2017. A Union County jury awarded $46.5 million to the family of an infant who suffered brain damage after concluding that doctors at the hospital were negligent by failing to undertake procedures to prevent the child's skin condition from worsening. The parents alleged that the defendants' failure to treat the baby's jaundice led to brain damage in the child.

Notable Defense Verdicts

New Castle County, DE—September, 2016. A New Castle County jury found no negligence on the part of the defendant hospital emergency room in a medical malpractice action brought by a 19 year-old woman who alleged that she suffered brain damage as a result of the hospital's failure to properly address issues relating to a severe asthma attack. The defendant denied the allegations and maintained that the patient was treated in accordance with the standard of care.

Newport News, Virginia—November, 2016. After a 7-day trial, a City of Newport News jury found in favor of two physicians and their practice in a case brought by a patient who alleged he suffered a stroke and leg paralysis during or after hip surgery. Plaintiff alleged that the physicians failed to properly monitor his blood pressure during and after surgery, which resulted in a stroke. The defendants contended that the injuries were caused by pre-existing spinal stenosis.

Charlottesville, VA - June, 2017. A Charlottesville federal jury found that a University of Virginia Hospital anesthesiologist was not responsible for the death of a West Virginia resident who died during aortic valve replacement surgery. Plaintiff alleged that the physician was negligent in causing the woman's death by failing to properly insert a breathing tube during surgery or in monitoring her breathing during surgery.

Western District, PA — May 2017. A Pennsylvania federal jury found that a medical clinic and several of its staff were not responsible for the death of a 42-year old woman who underwent surgery for appendicitis after allegedly being sent away from the clinic twice without treatment by an employee who allegedly was not properly supervised.

New York, NY - May, 2017. A jury in New York federal court sided with three obstetricians and the U.S. Government in a $35 million lawsuit that sought to hold them liable for the death of a pregnant Hasidic patient who hemorrhaged at home while delivering her fourth child. Plaintiff alleged that the physicians failed to diagnose her with Noonan syndrome, which can cause excessive bleeding problems.