Jackson & Campbell
Attorneys and Counselors at Law

DECISIONS

July, 2018

Volume 4, Issue 4

WISCONSIN SUPREME COURT UPHOLDs MED-MAL NONECONOMIC DAMAGES CAP

INSIDE THIS ISSUE:

Damages Cap—WI	1
Informed Consent —IA	2
Inadmissible Testimony—OH	2
Overbilling Defense—CO	3
Negligent Hiring—CA	4
Healthcare Privacy—AK	4
Jury Verdicts	5
Defense Verdicts	5

Special points of interest:

- Wisconsin Supreme Court upholds medical malpractice noneconomic damages cap, ruling the cap is constitutional.
- Supreme Court of Iowa revives informed consent claims in Plaintiff's negligence case.
- Ohio Court of Appeals holds that doctor's testimony regarding three previously successful deliveries is inadmissible.
- Tenth Circuit Court of Appeals rules that under Colorado law, an insurer has no duty to defend an insured against claims of overbilling.
- California Supreme Court holds that employers are entitled to coverage on negligent hiring claims.
- Alaska Supreme Court rules medical malpractice defense attorneys are not entitled to ex-parte discussions with plaintiffs' treating physicians.

In *Mayo v. Wisconsin Injured Patient and Families Compensation Fund*, 2018 WL 3132486 (Wis. June 27, 2018), the Wisconsin Supreme Court ("the Court") reversed an appellate court's ruling that declared unconstitutional a state law that places a $750,000 cap on noneconomic damages in medical malpractice suits, stating that the Wisconsin legislature put much thought into the limit and the trade-off is a guarantee of unlimited awards for all other damages. The Court's finding addresses the cap as it applies to all medical malpractice cases, and its constitutionality as it applies specifically to Plaintiffs Ascaris Mayo ("Ms. Mayo") and her husband, Antonio Mayo (collectively "Plaintiffs"). Plaintiffs' action arose after Ms. Mayo made two trips to two emergency rooms in May, 2011. On the first occasion, she visited the emergency room at Columbia St. Mary's Hospital in Milwaukee, Wisconsin after experiencing abdominal pain and a high fever. She was seen by a physician and a physician's assistant and was advised to follow up with her gynecologist because she had a history of uterine fibroids. The following day, Ms. Mayo went to a different emergency room where she was diagnosed with sepsis caused by an untreated infection. As a result of the sepsis, many of her organs failed and all four of her limbs developed gangrene, necessitating amputations. Subsequently, a jury awarded Plaintiffs $25.3 million total in damages, with $16.5 million of the damages qualifying as economic damages. The trial court held that reducing Plaintiffs' award to $750,000 based on the noneconomic damages cap would be unconstitutional, because it unfairly put a burden on those sustaining the most devastating of injuries by reducing damages awarded beyond the state-imposed cap. The court of appeals, in a published opinion, affirmed the jury's noneconomic damage award, but on a different basis. The court of appeals "concluded that the statutory cap on noneconomic damages is unconstitutional on its face because . . . [it imposes] an unfair and illogical burden only on catastrophically injured patients, thus denying them the equal protection of the laws." Ultimately, the Court reversed the appellate court's decision, noting that the legislature's objective of the cap was to "ensure affordable and

accessible health care for all of the citizens of Wisconsin while providing adequate compensation to the victims of medical malpractice." According to the legislature, "[a]chieving this objective requires a balancing of many interests. Based upon documentary evidence, testimony received at legislative hearings, and other relevant information . . . a limitation on the amount of noneconomic damages recoverable by a claimant or plaintiff for acts or omissions of a health care provider, together with mandatory liability coverage for health care providers and mandatory participation in the injured patients and families compensation fund by health care providers, while compensating victims of medical malpractice in appropriate circumstances by the availability of unlimited economic damages, ensures that these objectives are achieved. Establishing a limitation on noneconomic damage awards accomplishes the objective[.]" The Court also acknowledged that Plaintiffs were "treated the same under the cap as any other persons from whom the jury has awarded noneconomic damages in excess of $750,000" Specifically, the Court said, "[Plaintiffs] argue that the cap does not apply equally to all members of the class whose noneconomic damages exceed $750,000 because the greater the award given, the smaller the percentage of that award that is recovered. However, contrary to [Plaintiffs'] argument, the cap on noneconomic damages remains at $750,000 regardless of whether an individual is awarded $750,000 or $15 million. Therefore each person for whom the cap is a factor in recovery is treated exactly the same. Their noneconomic damages will be capped at $750,000." The Court further stated, "[b]y enacting the cap, the legislature made a legitimate policy choice, knowing that there could be some harsh results for those who suffered medical malpractice and would not be able to recover the full amount of their noneconomic damages. However, any cap, by its very nature, will limit the amount that some people will be able to recover. If the cap did not do so, it would have no economic effect. It must also be noted, however, that while there is a cap on noneconomic damages, there also is a guarantee of payment for all other categories of damages that a victim of medical malpractice may be awarded. No other tort has a guarantee of unlimited payment for a jury's award of economic damages."

"Dr. Cuenoud's anticipated testimony that the presurgery condition of [Plaintiff's] heart increased the risk of death to twenty-five percent was the only expert testimony quantifying the increased risk. Our case law requires the patient to 'present expert testimony relating to the nature of the risk and the likelihood of its occurrence' whenever the undisclosed information involves a risk."

Iowa High Court Revives Heart Surgery Consent Claims

In *Andersen v. Khanna,* 2018 WL 2999519 (Iowa June 15, 2018), the Supreme Court of Iowa ("the Court") revived informed consent claims in the negligence case of Alan Andersen ("Plaintiff"). On January 2, 2004, Plaintiff underwent a Bentall heart procedure performed by Dr. Sohit Khanna, ("Dr. Khanna"), an employee of the Iowa Heart Center, P.C. (collectively "Defendants") at the Mercy Hospital Medical Center in Des Moines, Iowa. At the time, Dr. Khanna did not have any experience or training in performing the Bentall procedure used on Plaintiff. There were several complications with the procedure that resulted in Plaintiff experiencing a coma, undergoing a second heart surgery, and having a heart transplant. In September 2005, Plaintiff, along with his wife and children, filed a lawsuit against Defendants. In addition to alleging negligence against Defendants, Plaintiff alleged Dr. Khanna failed to obtain informed consent from Plaintiff. The two bases for Plaintiff's informed consent allegations were that: (1) Defendants failed to properly advise Plaintiff of the risks and dangers of the procedure; and (2) Defendants failed to advise Plaintiff that Dr. Khanna had limited experience in performing a Bentall procedure. The trial court dismissed the two informed consent claims, holding that neither issue was legally required to be disclosed to the patient. Ultimately, the Court found that the lower court abused its discretion in preventing Plaintiff from cross-examining defense expert witness Dr. Henri Cuenoud to support the informed consent claim that Dr. Khanna should have told him he had a twenty-five percent risk of dying because his heart was in poor shape. The Court stated, "Dr. Cenuoud's anticipated testimony that the presurgery condition of [Plaintiff's] heart increased the risk of death to twenty-five percent was the only expert testimony quantifying the increased risk. Our caselaw requires the patient 'to present expert testimony relating to the nature of the risk and the likelihood of its occurrence' whenever the undisclosed information involves a risk." The Court also held that Plaintiff's claim that he should have been told how inexperienced Dr. Khanna was at the Bentall procedure was wrongly dismissed, holding "[a]s for the informed-consent claim based on [Dr.] Khanna's lack of experience, Plaintiff should have the opportunity to develop his theory of injury and damages before we summarily dismiss those claims."

Ohio Court Rules Doctor's Testimony of Past Deliveries Is Inadmissible

In *Robinson v. Pettaway*, 2018 WL 2383202 (Ohio Ct. App. May 25, 2018), the Court of Appeals of Ohio, Sixth District, Lucas County ("the Court") vacated a jury verdict in favor of a doctor sued for allegedly causing a newborn's shoulder nerve damage, ruling that the trial judge erred by allowing the physician to testify about three prior instances where he safely delivered a baby after encountering similar complications. The Court ordered a new trial in a suit brought by Ishonda Pettaway ("Plaintiff") accusing Dr. Alphonsus Obayuwana ("Defendant") of negligently pulling on the baby's head and neck when attempting to dislodge his shoulder that had become stuck in the mother's birth canal, a complication known as shoulder dystocia, which caused shoulder nerve damage known as a brachial plexus injury and resulted in the permanent inability for the child to use his right arm. The Court said the trial judge should not have allowed Defendant to give trial testimony about three instances where he safely delivered babies after encountering shoulder dystocia, and testify that no babies he delivered ever suffered a brachial plexus injury. While Defendant's counsel successfully argued at trial that the testimony was necessary to rebut Plaintiff's claim that Defendant panicked during Plaintiff's delivery of her child, the Court stated testimony from a resident physician observing the delivery, the attending nurse and Defendant himself would have been suitable to counter the claim that Defendant panicked. The Court stated, "[Defendant] was not free to rebut [Plaintiff's] assertions with unverifiable information about unrelated deliveries involving different facts and circumstances. Simply put, [Defendant's] testimony regarding all of his successful deliveries involving shoulder dystocia was not probative of the relevant issue: [Defendant's] demeanor in [Plaintiff's] delivery room when presented with unique circumstances at issue in this case."

10th Circuit Rules Insurer Has No Duty To Defend Firm Against Overbilling Claims

In *Evanston Insurance Company v. Law Office of Michael P. Medved, P.C.*, 890 F.3d 1195 (10th Cir. 2018), the United States Court of Appeals for the Tenth Circuit ("the Court"), applying Colorado law, affirmed that an insurer has no duty to defend a law firm against allegations of overbilling. In this matter, the insured law office ("the insured") was confronted with overbilling. The insured processed foreclosures for lenders and investors. The insured's fees were often passed on to either the debtors or the purchasers of the foreclosed properties. In 2012, the Colorado Attorney General began investigating the insured, questioning whether it had overbilled. When the investigation became public, a group of property owners brought a class action lawsuit against the insured for overbilling. Evanston Insurance Company ("the insurer") defended the law firm under a reservation of rights but ultimately concluded that the allegations of overbilling fell outside of the insured's coverage for professional services. The policy at issue covered damages "as a result of a 'Claim' . . . by reason of a 'Wrongful Act' in the performance of or failure to perform 'Professional Services[.]'" The policy defined "Professional Services" as "'those services performed by the 'Insured' for others . . . as a lawyer . . . .'" The Court found that "[t]he policy did not create a duty to defend because the allegations had arisen from billing practices, not professional services." The Court cited its previous ruling in *Zurich American Insurance Company v. O'Hara Regional Center for Rehabilitation*, 529 F.3d 916 (10th Cir. 2008) as the basis for their finding, which held that a medical provider's billing practices did not fall within an insurance policy's coverage for professional services. The Court rejected the insured's argument that, because its bills were passed on by its clients, its billing practices came within the ambit of professional services. The insured further argued that the phrase "by reason of" in the insuring agreement was the functional equivalent of "arising out of," which would lead to coverage so long as there was at least a causal relationship between the overbilling and the claims. The Court ruled that the "by reason of" language pertained only to the relationship between the claim and the wrongful act, and the wrongful act still had to be "in the performance of or failure to perform Professional Services." The Court further noted that, even if the claims only had to "arise out of" professional services to be covered, Colorado law suggested they did not.

"The policy did not create a duty to defend because the allegations had arisen from billing practices, not professional services."

Massachusetts Court Holds No Coverage For Medical Provider's Alleged Billing Fraud

In *Barron v. NCMIC Insurance Company*, 2018 L 2089357 (D. Mass. May 18, 2018), the United States District Court for the District of Massachusetts ("the Court") considered whether billing practices qualify as a professional service insured under a medical malpractice insurance policy. In the matter, NCMIC Insurance Company ("the insurer") insured a chiropractic group ("the insured") under a professional liability policy affording coverage for "damages because of an injury" subject to the requirement that injury be caused by an accident arising from the negligent omission, act, or error in the provision of professional services. The policy defined "professional services" as "services which are within the scope of practice of a chiropractor in the state or states in which the chiropractor is licensed." The insured sought coverage for an underlying lawsuit brought against it by GEICO ("the GEICO Lawsuit"). GEICO alleged that the insured engaged in various fraudulent schemes in an effort to obtain higher payments from GEICO. The Court ultimately held that the GEICO lawsuit did not come within the policy's grant of coverage, and in doing so, rejected the insured's argument that the GEICO lawsuit alleged a "mix of both negligence claims and fraudulent billing." While the GEICO lawsuit made reference to patients having been mistreated as a result of the insured's negligent care, the Court concluded that it did not allege that this mistreatment caused injury to any particular individual, nor was any relief sought by GEICO for such injuries. The Court further observed that the policy did not broadly cover all suits arising out of the insured's rendering of professional services, but only suits seeking damages for injuries resulting from such services. The Court concluded, "[t]he [GEICO lawsuit] targets alleged fraudulent billing practices that caused GEICO to pay or settle false or inflated medical insurance claims, not professional malpractice that caused patient injuries."

The United States District Court for the District of Massachusetts holds that an insured medical provider is not entitled to coverage for purported billing fraud.

California Supreme Court Rules Negligent Hiring Claims Are Entitled to Coverage

"[The insured's] allegedly negligent hiring, retention, and supervision were independently tortious acts, which form the basis of its claim against [the insurer] for defense and indemnity."

In *Liberty Surplus Insurance Corporation v. Ledesma & Meyer Construction Company, Inc.,* 418 P.3d 400 (Cal. 2018), the California Supreme Court held that Liberty Surplus Insurance Corporation and Liberty Insurance Underwriters, Inc. ("the insurer") must cover the costs of Ledesma & Meyer Construction Company, Inc. ("the insured") to defend against claims it negligently hired and failed to supervise a former employee who sexually assaulted a middle school student. Specifically, in 2003, the insured hired employee Darold Hecht ("Mr. Hecht") as an assistant superintendent and assigned him to the project. In 2010, a thirteen year old student at the school sued in state court alleging that Mr. Hecht had sexually abused her. The student's claims included a cause of action against the insured for negligently hiring, retaining, and supervising Mr. Hecht. The commercial general liability policy at issue provided coverage for "'bodily injury'" "caused by an 'occurrence.'" The policy defined "occurrence" as "an accident." The Court noted that "the meaning of the term 'accident' in a liability insurance policy is settled in California." The Court stated that "[a]n accident is 'an unexpected, unforeseen, or undersigned happening or consequence from either a known or an unknown cause.'" The Court accepted the insured's position that the insured's allegedly negligent failure to properly monitor Mr. Hecht was an accident because the insured did not anticipate that Mr. Hecht would commit the crime when hiring him. The Court relied on a previous case, *Minkler v. Safeco Insurance Company of America*, 232 P.3d 612 (Cal. 2010) for its decision. In *Minkler*, the Court determined that an intentional act of molestation is distinct from negligent supervision. In that case, the plaintiff had sued his Little League coach for sexual abuse and sued the coach's mother for purportedly failing to prevent incidents of molestation that occurred in her home. The Court said that while the *Minkler* ruling did not consider whether a negligent supervision claim is an accident for insurance coverage purposes, the high court's reasoning in that case "establishes that [the insured] may be covered even though [Mr.] Hecht's intentional acts were beyond the scope of its policy." The Court stated, "[the insured's] allegedly negligent hiring, retention, and supervision were independently tortious acts, which form the basis of its claim against [the insurer] for defense and indemnity." The Court held, "[w]e . . . acknowledge that insurance does not generally cover intentionally inflicted injuries. But as noted in *Minkler*, "the public policy against insurance for one's own intentional sexual misconduct does not bar liability coverage for others whose mere negligence contributed in some way to the acts of abuse. In such cases . . . there is not overriding policy reason why a person injured by sexual abuse should be denied compensation for the harm from insurance coverage purchased by the negligent facilitator."

Alaska Supreme Court Prioritizes Privacy in Medical Malpractice Case

In *Harrold-Jones v. Drury*, 2018 WL 3078869 (Alaska June 22, 2018), Tarri Harrold-Jones ("Plaintiff") sued Dr. Tucker Drury, Dr. William Pace, and Denali Orthopedic Surgery ("Defendants") for medical malpractice after they performed surgery on her to repair a broken clavicle. Defendants sought Plaintiff's permission to speak to her subsequent treating physicians, but Plaintiff declined to grant permission. Accordingly, the Alaska Supreme Court ("the Court") had to determine whether medical malpractice defense attorneys were allowed to speak with plaintiffs' treating physicians without their consent. The Court found that, while privacy requirements in the federal Health Insurance Portability and Accountability Act do not preempt the state's case law allowing ex-parte contacts, changing attitudes toward medical privacy dictated that prior Alaska case law decisions allowing such contacts had to be overturned. The Court held that defense attorneys may not speak with plaintiffs' health-care providers without the plaintiffs' agreement, unless authorized by a court order, which "should be available only under extraordinary circumstances." *Harold-Jones* is an example of federal privacy frameworks persuading courts to revisit their decisions, even where they must overturn existing precedent. The Court approved ex parte contact as part of informal discovery in a series of cases in the 1970s and 1980s. The cases held that a medical malpractice plaintiff waived the physician-patient privilege as to information relevant to matters at issue in the litigation. In reaching its decision in *Harrold-Jones*, the Court found that HIPAA did not preempt Alaska law on ex parte contact because under HIPAA, information may be disclosed pursuant to authorization by the patient or as ordered in litigation. Nevertheless, the court found that "HIPAA embodies a cultural shift in how medical privacy is viewed and has created a new procedural framework for sharing information in litigation."

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

Alyssa Lechmanik
(202) 457-1629
alechmanik@jackscamp.com

Recent Notable Verdicts and Settlements

NOTABLE VERDICTS/SETTLEMENTS

Wayne County, MI – July, 2018. After a two-week trial, a Wayne County jury awarded $135 million to a 17 year old girl and her family in a lawsuit accusing Children's Hospital of Michigan at Detroit Medical Center of botching her spinal surgery causing severe and permanent injuries. The girl was 10 years old at the time of the surgery and now suffers from permanent loss of bowel and bladder control and other problems. The hospital alleged that her health was affected by a blood clot.

Sioux County, IA — June, 2018. A Sioux County jury awarded $29.5 million to a 40 year old woman who died after she had an allergic reaction to the contrast dye for a CT scan. The jury concluded that the local hospital and physician were negligent in causing her death.

Lancaster, PA — May, 2018. A Lancaster County jury awarded $4 million to the mother who blamed her daughter's doctors for failing to diagnose the baby's whooping cough leading to her death in 2010 at 32 days old. In the lawsuit, the mother alleged that Lancaster Pediatric Associates should have diagnosed and treated it earlier because the baby's mother described having symptoms of the disease herself and asked that the baby be treated.

King's County, NY — April. 2018. A King's County jury found that an attending ob/gyn negligently applied excessive pressure when shoulder dystocia was encountered during a vaginal delivery and awarded the family of the child $3.5 million in damages. The family alleged that as a result of the defendant's negligence, the child suffered a brachial plexus injury causing permanent Erb's Palsy on her left side. Defendant denied the allegation and alleged the injuries were the result of either an in-utero event or the natural forces of labor.

Cook County, IL — May, 2018. A Cook County jury awarded $11 million to a woman who contended that her ob/gyn and hospital staff negligently determined that a vaginal delivery was proper despite undergoing a C-section due to dilation problems with a prior delivery. The woman sustained a fourth degree tear extending into the rectal area and the misdiagnosis of the tear prevented a timely surgical repair.

NOTABLE DEFENSE VERDICTS

Monterey County, CA — June, 2018. The Court of Appeal for the Sixth District affirmed a Monterey County jury's verdict that a doctor's negligence did not contribute to the development of brain damage in a baby he helped deliver in 2008. In the unpublished decision, the three-judge panel rejected the plaintiff's argument that the trial court erred when it permitted defendant's expert to testify about an MRI in 2012 and when it prohibited plaintiff from posing a hypothetical question to his expert neuroradiologist.

Madison County, KY — June, 2018. The Court of Appeals of Kentucky upheld the Madison County Circuit Court's grant of a new trial to a nursing home after the jury awarded $18 million in damages to the daughter of a deceased resident. The Appeals Court agreed that the resident's claims did not survive the death of the resident and the erroneous jury instruction created a material prejudice warranting a new trial.

Walker County, AL — May, 2018. The Supreme Court of Alabama vacated a $10 million Walker County jury award in a lawsuit accusing a hospital of causing a baby's blindness, deafness and seizure disorder due to a meningitis misdiagnosis. In its ruling, the Court held that the introduction of 10 previous cases of alleged medical malpractice was improperly admitted after the provider allegedly "opened the door" to such information.

District of Columbia — May, 2018. After an eight day trial, a District of Columbia jury found in favor of a physician holding that she did not breach the standard of care in her treatment of an 84 year man who died several days after hip replacement surgery. Plaintiff's estate contended that complications from the anesthesia that was administered by the defendant physician caused his death. The defense did not dispute that the patient suffered post-operative complications but it denied liability for his death.