Jackson & Campbell
Attorneys and Counselors at Law

DECISIONS

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California Appellate Court Holds That The Owner Of A Skilled Nursing Facility Is Not Entitled to The MICRA Damages Cap

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Special points of interest:

- California Appeals Court places limitations on MICRA Damages Cap
- New York Court Applies "Continuous Treatment" Exception to running of statute of limitations
- Kentucky Federal Court rules that deliberate indifference claim need not be submitted to Kentucky medical review panel
- Kansas Supreme Court rules that issues of fact precluded summary judgment based on timeliness of reservation of rights letter

In a decision issued on July 12, 2018, the California Court of Appeals for the Fourth District concluded that the management company of a skilled nursing facility was not a health care provider and, thus, was not entitled to the Medical Injury Compensation Reform Act ("MICRA") cap that places a $250,000 cap on noneconomic damages in medical malpractice cases. *Cochrum v. Costa Victoria Healthcare, LLC*, 25 Cal.App.5th 1034 (Cal. App. 4th Dist. 2018). The case involved the death of a manwho was diagnosed with a treatable form of cancer who was residing at Victoria Healthcare Center (Victoria Center), a skilled nursing facility, while he underwent treatment and recovered from various injuries. After being served with dinner that did not comport with his diet one night, he was found in respiratory distress. He apparently had chocked on the food served to him. He died the following day due to complications from oxygen deprivation to his brain. His niece subsequently filed suit against the operator of the facility and asserted causes of action for elder abuse and negligence. A jury returned a verdict in favor of Plaintiff on all causes of action. It awarded $15,511.27 in economic damages, $900,000 in noneconomic damages on the elder abuse cause of action, $350,000 in noneconomic damages for wrongful death, and over $350,000 in attorney fees pursuant to the elder abuse claim. Subsequently, the court granted a motion for judgment notwithstanding the verdict (JNOV) finding insufficient evidence of recklessness to support the elder abuse cause of action. It also adjusted the remaining damages pursuant to the damages cap under California Civil Code section 3333.2.1 Plaintiff appealed from the amended judgment, contending the evidence supported the elder abuse cause of action. Two of the defendants cross-appealed, contending the court improperly applied the MICRA cap. On appeal, the Appellate Court upheld the trial court's ruling that there was not sufficient evidence of recklessness to

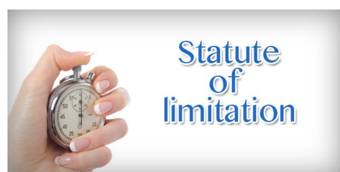
The Great Seal

support the elder abuse claim. The Appellate Court then addressed the issue as to whether the trial court properly applied the MICRA cap to the owner of the facility even though it did not actually manage or provide healthcare services at the facility. On appeal, the defendant facility owner argued that the case of *Lathrop v. Healthcare Partners Medical Group*, 114 Ca. App. 4th 1412 (Cal App. 2004), which held that an entity alleged to be *vicariously liable* for a health care provider is subject to the MICRA cap, applied to limit the damages against the facility owner. The Appellate Court rejected the argument and concluded that the facility owner may not avail itself of the MICRA cap because its liability was not purely vicarious through Costa Victoria. Instead, the jury found the facility owner was 20 percent at fault for Plaintiff's death, and that the facility owner's employee acted negligently. In so ruling, the Court distinguished the case from the *Lathrop* case. In *Lathrop*, the court premised the application of the cap on its analysis that "there was no basis for a jury finding of direct negligence by [the partnership] as an entity." Instead it "was held vicariously liable for the professional negligence of [the doctors] under the doctrine of respondeat superior." The Appellate Court in *Cochrum* noted that this was not the case before them. The facility owner in the case was vicariously liable for the acts of its owner employee, not for the acts of the operator of the facility and the employee was not a health care provider under MICRA. Accordingly, the Court concluded that the cap on noneconomic damages under MICRA did not apply to the facility owner and, thus, affirmed the ruling of the trial court. The California Supreme Court denied review of the Appellate Court's decision on October 17, 2018.

“The communications [in the malpractice suit] were made in the course of anticipated and actual litigation and [the parties] share the common purpose of seeking an order for [the insurer] to pay the outstanding judgment.”

New Jersey Appellate Court Prohibits Med Mal Insurer From Obtaining Insured Communications in Bad Faith Case

In an unpublished decision issued on October 26, 2018, the Superior Court of New Jersey, Appellate Division, overturned a trial court's order giving a medical malpractice insurer access to communications between counsel representing an insured doctor and a patient plaintiff who sued the insured doctor concluding that the communications were protected by the attorney-client privilege. *DiPaolo v. New Jersey Physicians United Reciprocal Exchange,* 2018 WL 5304599 (N.J. App. Div. Oct. 26, 2018). The case stems from a $5.2 million jury award against the insured physician. The insurer paid the $1 million policy limits available, leaving a $4.8 million unsatisfied judgment. The insured physician commenced a bad faith action against his insurer and alleged that the insurer failed to make a good-faith effort to settle the medical malpractice case within the policy limits. The plaintiff intervened in the bad faith action and requested that the insurer pay the entire outstanding judgment. In discovery, the malpractice insurer sought the production of communications between plaintiff's counsel and counsel for the insured physician following the verdict. The trial court judge ordered the production and the physician and patient appealed. The two-judge panel of the appellate court overturned the decision reasoning that the patient and insured physician had a common interest in recouping the $4.8 million judgment and the materials, which detailed strategy, settlement possibilities, and the scope of questioning of the defense witnesses, were protected from disclosure. The panel relied on the New Jersey Supreme Court's 2014 ruling in *O'Boyle v. Borough of Longport*, 218 N.J. 168 (2014). Under the *O'Boyle* test, attorney-client communications are privileged if the parties share a common, even if not identical, interest in the outcome of the litigation. In the instant lawsuit, the patient plaintiff intervened in the bad faith lawsuit against the insurer. In so ruling, the Court held that “[t]he communications [in the malpractice suit] were made in the course of anticipated and actual litigation and [the parties] share the common purpose of seeking an order for [the insurer] to pay the outstanding judgment. The disclosures were intended to be confidential and were not made to a third party ‘ in a way inconsistent with keeping it from an adversary.’”



New York Appellate Court Affirms Denial of Statute of Limitations Defense Based On “Continuous Treatment” Exception

In a decision issued on October 31, 2018, the Supreme Court of New York, Appellate Division, Second Department affirmed the trial court's denial of a motion to dismiss a medical malpractice complaint on the grounds that the lawsuit was not precluded by the 2 1/2 year statute of limitations. *Osborn v. DeChiara*, 2018 WL 5623919 (N.Y. App. Div. 2nd Dept. Oct. 31, 2018). The case involved a claim for damages for medical malpractice arising from a physicians' postoperative care of the plaintiff, which involved a postsurgical methicillin-resistant Staphylococcus aureus (“MRSA”) wound infection after a bilateral mastectomy and bilateral breast reconstruction surgery. The defendant moved to dismiss the complaint against her as time-barred arguing that she last treated the plaintiff on November 4, 2011 and the suit was filed more than 4 months after the 2 1/2 statute of limitations expired. The plaintiff argued that she had been a patient of the practice until October 15, 2012 and that the postoperative treatment she received from the defendant and others constituted a continuous course of treatment such that the statute of limitations did not start to run until the plaintiff stopped receiving treatment in October, 2012. The trial court denied the motion and the defendant appealed. On appeal, the Appellate Division concluded that the plaintiff had raised a triable issue of fact as to whether the continuous treatment doctrine tolled the time from which the statute of limitations started to run to the date when the plaintiff's continuous course of postoperative care and treatment at the practice ended. The Court noted that the plaintiff had submitted evidence demonstrating she was treated by other nonparty physicians who were employees of the practice until October, 2012.

Supreme Court of Kansas Reverses Summary Judgment Finding Issues of Fact Existed on Timlieness of Reservation of Rights Letter

In a decision issued on October 26, 2018, the Supreme Court of Kansas held that genuine issues of material fact existed regarding whether an insurer's issuance of a reservation of rights letter was untimely, thus precluding summary judgment on the issue of estoppel. *Becker v. Bar Plan Mutual Ins. Co.*, 2018 WL 5304671 (Kan. Oct. 26, 2018). The underlying case involved a legal malpractice action brought against an attorney stemming from alleged negligence in providing legal advice for a commercial loan transaction. The plaintiff client sent a letter to the attorney prior to suit noting her alleged "monumental" legal errors and asking her to contact her insurance carrier. The attorney subsequently renewed her malpractice policy but failed to disclose the letter. A lawsuit was subsequently filed and a policy limits demand was made. The attorney placed her insurer on notice and the insurer assigned an attorney several days later. The insurer sent a reservation of rights letter to the insured two months after counsel was assigned. After concluding the claim was not covered due to late notice, the insurer denied coverage three weeks later. The attorney insured then confessed judgment and assigned all of her rights to sue her insurer to the plaintiff in consideration for an agreement not to enforce or collect on the judgment. The plaintiff filed a bad faith action and both parties moved for summary judgment. The trial court granted summary judgment in favor of the insurer and the decision was upheld on appeal. On appeal to the Supreme Court, the plaintiff argued that the insurer assumed the defense without a timely reservation of rights and that the insurer should have been estopped from asserting any coverage defenses. The Court, noted that the reservation of rights rule allows an insurer to assume a defense of an insured without waiving noncoverage defenses by issuing a timely notice to that person, reserving the right to question coverage and assert policy defenses. However, an insurer that fails to timely or effectively reserve rights will be estopped from asserting coverage defense because the insured must make an informed decision about "whether to consent to the assumption of his defense and the control of his lawsuit by the carrier, or to take another course." Here, the Supreme Court concluded that issues of fact existed as to whether the reservation of rights letter was sent timely and, thus, reversed the summary judgment ruling.

"The insured must make an informed decision about 'whether to consent to the assumption of his defense and the control of his lawsuit by the carrier, or to take another course.'"

Kentucky Federal Court Rules that Deliberate Indifference Claim Need Not Be Reviewed By Medical Panel Prior To Suit

In a decision issued on October 10, 2018, the United States District Court for the Eastern District of Kentucky concluded that a prisoner's claim that state officials were deliberately indifferent to his medical needs in violation of the Eight Amendment should not be dismissed for his failure to comply with a recently-enacted Kentucky law requiring medical malpractice claims to seek review of their medical malpractice claims by a medical review panel before filing suit. *Hacker v. Madison County,* 2018 WL 4926303 (E.D. Ken. Oct. 10. 2018). The case stems from civil rights violations claims and a claim for negligence and gross negligence brought by a prisoner in the Madison County Detention Center against the County and the jail's medical provider. The jail filed a motion to dismiss the complaint on the grounds that the plaintiff had not complied with KRS 216C.020(1), that provides that all malpractice and malpractice-related claims against a health care provider must be reviewed by a medical review panel and an opinion given by the panel prior to commencing litigation in court. The jail argued that the claims were "malpractice-related" bringing them within the scope of the statute. The Court disagreed with respect to the two § 1983 claims while noting that the issue raised by the motion was "a new question for Kentucky's federal courts." The Court, in denying the motion, relied on the Supremacy Clause of the US Constitution, which provides that states lack authority to nullify a federal right or cause of action. The Court further held that Kentucky's interest does not validly extend to regulating or limited federal courts hearing or adjudicating federal causes of action. The Court, however, held that the state law claims for negligence and gross negligence fell directly within the statute and, thus, should be dismissed.

Kentucky Federal Court Concludes that Prisoner Did Not Need to Seek Review of Deliberate Indifference Claim Prior to Commencing Litigation

West Virginia's Highest Court Reverses Summary Judgment in Favor of Physician In Insurance Misrepresentation Case

"[The evidence presented at summary judgment demonstrated that [the insured] was far less than candid during the application process for his medical professional liability insurance."

In a decision issued on June 6, 2018, the West Virginia Supreme Court of Appeals overturned a summary judgment ruling in favor of a physician insured in a suit brought by his malpractice insurer seeking a declaration that it did not have an obligation to defend him in two medical malpractice lawsuits because he had failed to disclose his involvement in multiple opioid drug overdose deaths in his insurance application. *Admiral Ins. Co. v. Fisher*, 2018 WL 2688182 (W.Va. Jun. 5, 2018). The coverage dispute arose over coverage for two lawsuits filed against a physician insured for malpractice/wrongful death. Two months prior the lawsuits, the insured physician completed a policy application in which he failed to disclose that the US DEA was investigating how 14 people died of drug overdoses at least partially involving controlled substances he had prescribed. In the application, he also downplayed administrative proceeding initiated by the West Virginia Board of Osteopathic Medicine in connection with patient deaths and sexual misconduct with patients. The insurer argued that it was entitled to rescind the policy pursuant to West Virginia Code § 33–6–7 (2011). The circuit court entered summary judgment for the insured physician on the rescission issue and the insurer appealed. The West Virginia Supreme Court of Appeals reversed the entry of summary judgment and held that the alleged misrepresentations or omissions made during the application process plausibly impacted the insurer's business judgment during the insurance policy application process. "The evidence presented at summary judgment demonstrated that [the insured] was far less than candid during the application process for his medical professional liability insurance." The insurance application stated that he was not aware of any acts that may lead to a malpractice suit, and he explained that the state medical board proceedings were in connection with his treating former girlfriends and using pre-signed prescription pads. The Court concluded that because he had been judicially determined to have committed the acts that the Board attributed to him, a reasonable finder of fact could conclude that he was aware this investigation dealt with much more serious matters than "treating former girlfriends with pre-signed prescription pads" and his actions could result in a medical malpractice lawsuit. The Court also noted that it was aware of the "disturbing findings" of the state medical board because it affirmed his license revocation in 2016 and found that he breached the standard of care and contributed to/directly caused the deaths of seven patients.

Massachusetts Trial Court Rules That Insurer Is Not Obligated To Reimburse Insured for Defense Costs When Insured Rejected Defense Without Reservation

In a decision issued on October 31, 2018, the Suffolk County Superior Court concluded that two insurers were not obligated to reimburse an insured for defense costs incurred in defense of underlying asbestos liability lawsuits when the insured rejected the insurers' agreement to provide a defense without reservation. *Crosby Valve, LLC v. OneBeacon American Ins. Co.*, Case No. SUCV2012-02705-BLS2 (Suffolk Sup. Ct. Oct. 31, 2018). The coverage action stems from a dispute between the insured and a number of its insurers over the reimbursement of defense costs and indemnity expenses incurred in connection with thousands of asbestos bodily injury claims filed against the insured. Beginning in 2015, the two insurers offered to defend certain of the alleged-insured entities in connection with certain underlying lawsuits without a reservation of rights and to pay any indemnity arising out of those lawsuits "subject only to policy limits." The purported insureds rejected the offers and, in particular, the counsel the insurers had designated. The two insurers filed a summary judgment motion seeking a ruling that they have a right to control the defense having offered to defend without a reservation of rights and that, as a result, the insureds have no right to be indemnified for its defense costs going forward. The trial court, relying on *OneBeacon America Ins. Co. v. Celenese Corp.*, 92 Mass. App. Ct. 382 (2017) *rev. den'd* 479 Mass. 1107 (2018), agreed and held that the insurer's right to control the defense of its insured is necessarily inferred from the concomitant duty to defend and when an insurer offers to defend without a reservation of rights then, pursuant to the policy language, it has the right to control the defense (unless there is a conflict of interest). Because the insured in the case had not demonstrated such a conflict, the court held that the insured's refusal to allow the insurer to assume control meant that it could not be reimbursed for the costs of defending against the underlying claims.

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

Richmond County, SC—September, 2018. A Richmond County jury awarded $10 million to the estate of a woman who died after a 5 year delay in diagnosing renal cell carcinoma. The patient, who was 70 years old, died from the carcinoma and her estate subsequently sued her urologist for failing to diagnose the cancer. During trial, the estate presented expert evidence that she had a 90% chance of a cure had she been diagnosed earlier.

Oklahoma County, OK—August, 2018. An Oklahoma County jury awarded the estate of a deceased $3.75 million in a case involving alleged nursing home negligence. The decedent suffered a fall while rehabilitating from knee replacement surgery at a skilled nursing facility. The Plaintiff alleged that the facility failed to implement an adequate fall prevention plan for the 89-year old patient.

Broward County, FL—August, 2018. The estate of a decedent was awarded $9.5 million in damages in a case involving a 54-year old woman who died from complications of a blood disorder. The decedent's husband alleged that the primary care physician negligently failed to examine the decedent after she experienced a reaction to contrast material used to perform a CT scan. The plaintiff maintained that the physician misdiagnosed the patient with suffering a UTI rather than acute hemolytic anemia brought on by the contrast material. The defendant denied any negligence. The jury returned a verdict in favor of the plaintiff after a 12 day trial.

Dallas County, TX—August, 2018. After 2 1/2 week trial, a Dallas County jury awarded $19.5 million to the estate of a 33-year old female patient in a case in which plaintiff alleged that the defendant surgeon negligently failed to remedy an air leak which resulted from performing two tracheotomies on the same day. Plaintiff alleged the negligence caused the tube to become dislodged, resulting in hypoxia, permanent brain damage and death.

Cook County, IL—October, 2018. A Cook County jury awarded $50.3 million to a boy who suffered a severe brain injury after hospital physicians failed to diagnose and treat his oxygen deprivation during birth. The boy, now 9 years old, developed cerebral palsy and cannot care for himself.

Notable Defense Verdicts

Brevard County, FL—August, 2018. A Brevard County jury found in favor of a neurologist and his practice group in a case in which plaintiff alleged that the defendant doctor fell below the standard of care for failing to timely diagnose cervical cord compression, resulting in permanent paralysis to the plaintiff. The defendants argued that the paralysis was not caused by any act or omission of the defendants relating to his work-up of the patient prior to diagnosis.

Palm Beach County, FL—August, 2018. A Palm Beach County jury found in favor of a hospital in a lawsuit in which a 42-year old man alleged that the hospital's nursing staff were negligent in failing to timely diagnose and treat plaintiff's compartment syndrome. Plaintiff alleged that the failure resulted in permanent lower limb nerve damage. The defendant claimed that the nurses followed appropriate protocol by contacting two vascular surgeons

Missouri Court of Appeals, Western District—October, 2018. A Missouri appeals court upheld the dismissal of a lawsuit involving allegations that a hospital and doctor negligently gave a maternity patient an excessive dose of morphine, which caused various injuries. In upholding the dismissal, the court held that the injuries could have come from two or more possible causes and that she failed to offer medical expert testimony to support her allegations on causation.

Illinois Appellate Court, First District—June, 2018. An Illinois Appellate Court upheld the dismissal of a malpractice case involving a woman who suffered a stroke. The Court held that the doctor preparing to treat the woman had no responsibility to order a special procedure be performed on the patient while she awaited transfer from another hospital.

Alabama Supreme Court—September, 2018. The Alabama Supreme Court vacated a jury's $20 punitive damage award in a suit accusing a rehab hospital of negligently caring for an elderly patient and causing her death. The Court found that certain instructions given to the jury were misleading and erroneous.