JACKSON & CAMPBELL, P.C.

VOLUME 5, ISSUE 2

Decisions

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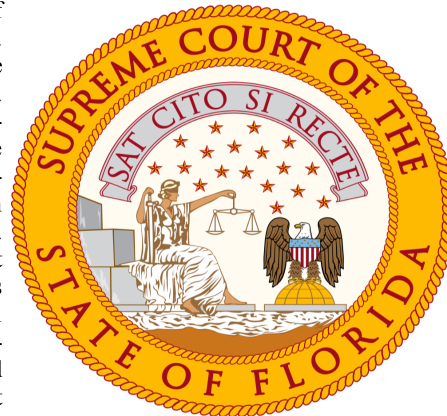
Florida Supreme Court Rules That A Plaintiff Need Only Prove a Doctor's Actions Were the Proximate Cause Of An Injury In Order to Recover in Malpractice Action

In a 4 – 3 decision issued on December 20, 2018, the Florida Supreme Court reaffirmed a relaxation of the causation standard applied to medical malpractice actions. *Ruiz, etc. v. Tenet Hialeah Healthsystem, Inc.*, *et al.* 2018 WL 6696028 (Fla. Dec. 20, 2018). In Ruiz, plaintiff's late wife noticed a mass in the back of her head and sought advice from her primary care physician ("PCP"). The PCP diagnosed her with a tumor and referred her to a neurosurgeon, who recommended that she undergo surgery to be performed by the neurosurgeon. In advance of surgery, decedent's PCP ordered a battery of lab tests to ensure she was medically fit for surgery, including an EKG and urinalysis. After the tests, her chart included EKG results that were an illegible copy of a copy. However, despite illegibility, the results indicated an abnormal readout - suggesting that her heart was enlarged and she may have suffered two myocardial infarctions. Her urinalysis results indicated the abnormal presence of a protein. Despite these abnormal results, she was cleared for neurosurgery. On the day of surgery, during preoperative evaluation, two separate anesthesiologists successively reviewed her test results and cleared her for surgery. Neither anesthesiologist alerted decedent to her abnormal EKG readings or urinalysis results. During the surgery, decedent lost a large amount of blood and suffered a drop in blood pressure; she went into cardiac arrest and could not be resuscitated. Plaintiff filed a medical malpractice action against each physician involved, including the initial anesthesiologist who cleared decedent for surgery. Plaintiff alleged that he breached the standard of care by: (1) not reviewing all the available data in decedent's chart; (2) not ordering a second EKG to reconcile the abnormal results with the first EKG; and (3) not reporting the abnormal lab results – some of which he did not review— to decedent's surgeons. The trial court granted a directed verdict in the anesthesiologist's favor, holding that even assuming he was negligent in caring for decedent, he did nothing more than place her in a position to be injured by the independent actions of third parties. The court analogized the first anesthesiologist to a "cab driver that drove decedent to the hospital." The District Court affirmed, concluding that no competent, substantial evidence in the record would allow a reasonable fact finder to conclude that this doctor was the "primary cause" of decedent's death. Plaintiff appealed the District Court's ruling. In ruling on the appeal, the Supreme Court revisited Florida's standard on proximate causation. The Court stated that "[a] harm is 'proximate' in a legal sense if prudent human foresight would lead one to expect that similar harm is likely to be substantially caused by the specific act or omission in question." Furthermore, "in the absence of a freakish and improbable chain of events" leading to injury "the question of foresee ability as it relates to proximate causation generally must be left for the fact finder to resolve." Accordingly, the Court reasoned that "the law does not require an act to be the exclusive or even the primary cause of an injury in order for it to be considered the proximate cause of the injury; rather, it need only be a substantial cause of the injury." The Court stated that Florida medical malpractice jurisprudence allows for a physician to be the proximate cause of a patient's injury even if that physician is not the primary cause of that injury. The Court had previously held a treating physician could not insulate himself from liability for negligence by presenting a subsequent treating physician who testifies that adequate care by defendant would not have altered the subsequent care. The issue of whether a treating physician acted in a reasonably prudent manner must be determined for each individual physician who is a defendant in a medical malpractice case. The Supreme Court held that the District Court erred when it upheld the directed verdict because in light of Florida precedent, defendant could not prevent plaintiff from establishing proximate cause merely by showing his actions or omissions were not the primary cause of decedent's death. Rather, to foreclose liability on the grounds of causation, defendants' actions must not have substantially contributed to decedent's death as part of a natural continuous sequence of events that brought about that result.



SPECIAL POINTS OF INTEREST:

- *Florida Supreme Court addresses proximate causation standard in medical malpractice case.*
- *Seventh Circuit holds that apparent authority is enough to impose vicarious liability*
- *Virginia Supreme Court reaffirms respondeat superior standard in privacy case*
- *Rhode Island Supreme Court holds that insurers' duties of good faith only apply to insureds*

Seventh Circuit Appellate Court Holds That Apparent Authority Over Independent Contractor Is Enough to Impose Vicarious Liability

In a decision issued on February 27, 2019, the United States Court of Appeals for the Seventh Circuit held that a diagnostic imaging facility was liable for an independent contractor radiologist's error. *Webster v. CDI Indiana, LLC*, 2019 WL 943171 (Feb. 27, 2019). In *Webster*, plaintiff brought a medical malpractice action against a diagnostic imaging facility alleging that an independent contractor radiologist hired by the facility failed to timely diagnose her colon cancer, resulting in a reduction in her prospects for survival. After discovery, the facility and plaintiff filed cross-motions for summary judgment. The facility argued that the doctor was not its apparent agent because it did not employ or contract with him for services, rather a radiologist practice did. The Court applied *Sword's* apparent agency standard to determine apparent authority. *Sword v. NKC Hospitals, Inc.*, 714 N.E.2d 142 (Ind. 1999). The *Sword standard* focuses on the principal's manifestations and the patient's belief and reliance thereon. At trial, the practice's director testified that the imaging facility was responsible for every aspect of obtaining a patients' radiological imaging study except interpreting results. Parties jointly stipulated that the imaging facility was responsible for training, hiring, employing, supervising, disciplining, and discharging the radiation technicians and non-physician personnel. They further stipulated that there was a corporate relationship between the two – each doing business under the other's name. Plaintiff testified that she had absolutely no knowledge about this corporate relationship and no information was ever provided to that effect. The jury returned a verdict in plaintiff's favor, finding CDI vicariously liable for the doctor's negligent conduct and awarded plaintiffs $15 million in damages—well in excess of the Indiana Medical Malpractice Act cap, which caps total damages available to a patient for an act of malpractice at $1.25 million. Although the facility provided health care services – which included obtaining patients' informed consent, injecting patients with contrast, and interpreting orders from referring physicians— it did not qualify as a health care provider under the Indiana Medical Malpractice Act, thus it was deemed to have waived the protection of the statutory cap on damages. The District Court upheld the ruling, stating that the facility "could have taken simple steps to avoid liability by either providing notice to plaintiff that the radiologist who would review her CT examination was an independent contractor who was not subject to [their] control or becoming a qualified health care provider under Indiana's Medical Malpractice Act." In affirming the District Court's application of *Sword* , the Court of Appeals stated "nothing in *Sword's* holding indicates that a health care facility must have a direct employment relationship with an independent contractor physician to be held liable for the acts of its apparent agent." In upholding a contrary position, the Court of Appeals further held that "health care facilities could easily evade liability by using independent contractor professional organizations to employ physicians … a medical center cannot hold itself out to the public as offering health care services – and profit from providing those health care services – yet escape liability by creating a complex corporate arrangement of interrelated companies."

> *"A medical center cannot hold itself out to the public as offering health care services … yet escape liability by creating a complex corporate arrangement of interrelated companies."*

Massachusetts' Highest Court to Decide Whether Wrongful Death Claim is Subject to Arbitration Under Agreement Executed by Resident's Representative

In a ruling issued on February 26, 2019, the United States Court of Appeals for the First Circuit held that the Massachusetts Supreme Court ("SJC") should decide whether a nursing home resident's mandatory arbitration agreement applies to her daughter's wrongful death claim. *GGNSC Administrative Services, LLC et al. v. Schrader*, 2019 WL 926091 (Feb. 26, 2019). The *Schrader* case centered around the execution of admission documents by the patient's personal representative, rather than the patient, upon her admission to a nursing home facility. One of the agreements contained a mandatory arbitration provision requiring that any disputes arising out of her stay must proceed to arbitration. After her death, her daughter filed a wrongful death action against the nursing home's operator as personal representative of decedent's estate and on the heirs' behalf. Plaintiff alleged decedent's injuries were "injuries for which she would have been entitled to bring an action had she survived, and the right to bring the action survives her." The nursing home brought a federal action under the FAA to compel plaintiff to arbitrate the dispute. The District Court granted the motion, finding a valid agreement to arbitrate that was not unconscionable under state law. Both parties argued about whether plaintiff's claims for wrongful death were derivative – subjecting them to arbitration – or independent – such that the claims did not fall within the scope of the Agreement. Because there was no state precedent on the issue, the District Court made an "informed prediction" that the SJC would hold that a wrongful death claim is derivative claim and decedent's representatives would be bound by decedent's agreement to arbitrate. The Circuit Court of Appeals, on its own motion, certified the question to the SJC. The Court reasoned that state contract law controls who is bound by an arbitration agreement, thus Massachusetts law would guide the court in determining whether plaintiff was bound by decedent's agreement to arbitrate her wrongful death claims. The Court noted that there was no clear Massachusetts precedent on whether a wrongful death claim is derivative or independent, and acknowledged that "it may be that the SJC will conclude that wrongful death claims have both independent and derivative aspects." Under Massachusetts General Laws, "claims under the first clause of the wrongful death statute require a personal representative to show negligence against the decedent resulting in death." On the other hand, the SJC has noted that "in a very real sense, a wrongful death claim is the beneficiary's cause of action." The matter remains pending before the SJC.

New York Appellate Court Reverses Dismissal of Medical Malpractice Case On Grounds That Hospital Had Actual Knowledge of Birth Injury Claim

In a decision issued on February 20, 2019, the New York Supreme Court, Appellate Division reversed a lower court's dismissal of a medical malpractice case against a hospital on the grounds that a notice of claim was not timely filed J.*H., etc. v. New York City Health and Hospitals Corp.*, 2019 WL 693462 (N.Y. App. Div 2019). In the case, Plaintiff sought to recover for negligence during prenatal care provided in November, 2010 that resulted in brain damage to the infant from a loss of oxygen before birth. Plaintiff's mother visited the hospital two days prior to the infant's birth, complaining about pain, diminished fetal activity, and vaginal leakage, but was discharged later that day. She returned two days later and gave birth via C-section after complications. New York law, required that Plaintiff serve a notice of claim within 90 days after the claim accrued. Plaintiff served the hospital with a notice of claim in August, 2013 and then filed suit in March 2014. Plaintiff later moved to deem the notice of claim served in August, 2013 timely served and the hospital filed a motion to dismiss on the grounds that Plaintiff failed to provide timely notice of the claim. Plaintiff argued that the hospital had knowledge of the essential facts upon which a claim was based within the statutory 90-day period or a reasonable time thereafter because it had hospital records demonstrating its apparent malpractice, because it had this knowledge, the hospital was not prejudiced by delay, and there was a reasonable excuse for the delay. The trial court denied Plaintiff's motion and granted the hospital's motion to dismiss. On appeal, the Court applied a three part test to determine whether to exercise its discretion to allow a late notice of claim. The Court considered whether the hospital acquired actual knowledge of the essential facts constituting the claim within 90 days of its accrual or a reasonable time thereafter; whether the delay substantially prejudiced the hospital in maintaining its defense on the merits; and whether the claimant had demonstrated a reasonable excuse for the delay. "Actual knowledge of the essential facts constituting the claim, in particular, is an important factor in determining whether to grant an extension and should be accorded great weight." Plaintiff put forth medical records showing that the hospital failed to admit Plaintiff's mother when she initially presented to the emergency room, notwithstanding an emergency room record ordering that the mother "was to be admitted secondary to non-reassuring fetal heart tracing." The Court concluded that the hospital had actual knowledge of the essential facts because medical records showed that the Plaintiff's mother was not admitted to the hospital on initial arrival, despite a physician's order, and two days later, Plaintiff was delivered an hour after arrival and only after a fetal heart monitor alarm sounded four times. The Court further held that the hospital was not prejudiced by the late notice because the hospital had timely actual knowledge of the essential facts of the claim. Because of the hospital's actual knowledge and an absence of prejudice, the lack of a reasonable excuse did not bar granting leave for late service of the notice of claim.

"Actual knowledge of the essential facts constituting the claim, in particular, is an important factor in determining whether to grant an extension ..."

California Federal Court Holds That Timely Notice is Critical To Trigger Coverage Under Claims Made and Reported Insurance Policy

In a decision issued on February 12, 2019, the United States District Court for the Central District of California held that an insurer was not obligated to cover a Los Angeles hospital's $42 million settlement of a False Claims Act lawsuit or the costs to respond to a related DOJ investigation because the hospital insured failed to provide timely notice to its insurer of the lawsuit or the investigation. *PAMC, Ltd. v. National Union Fire Ins. Co. of Pittsburgh, PA*, 2019 WL 666726 (C.D. Cal. Feb. 12, 2019). The coverage dispute arose from a False Claims Act ("FCA") lawsuit filed against the insured by a whistleblower alleging that the hospital violated the FCA by paying above-market rates to rent space in physician's offices and provided undue benefit to physician's practices via sham marketing agreements and patient referrals. The *qui tam* action was filed in June, 2013 and unsealed in December, 2015. In 2015, the DOJ issued a subpoena to the insured pertaining to a related criminal investigation. In March, 2017, the insured reached a $42 million settlement to resolve the FCA action. The criminal investigation was dismissed with no charges filed. During the time of the lawsuit, the insured was insured under a D&O policy that provided coverage for any claim made against the insured and reported in writing during the policy period. The insured did not provide the insurer with notice of the lawsuit or DOJ investigation until more than two years after the lawsuit was unsealed and more than 4 months after the investigation concluded. The insurer denied coverage on the grounds that the claim was not first made and reported during the policy period of the 2015-2016 policy period. The insured commenced a declaratory judgment action alleging breach of contract. The insurer moved to dismiss the lawsuit. In granting the motion to dismiss, the Court held that the policy at issue was a "claims made and reported policy" that only provides coverage for claims first made and reported to the insurer in the policy period. The Court noted that, instead of reporting the *qui tam* lawsuit or subpoena to the insurer, the insured "chose to wait over four months" after receiving word from the DOJ that its investigation had concluded to provide notice. The notice, at that point, was untimely. In so ruling, the Court rejected the insured's arguments that renewal policies should be treated as one contiguous policy. The Court also rejected the insured's attempt to apply the "notice-prejudice rule" because it noted that the rule applies only to occurrence-based policies, not to claims-made or claims-made and reported policies.

Virginia Supreme Court Revives Privacy Suit against Health Clinic and Employees

In a decision issued on November 1, 2018, the Supreme Court of Virginia partially reversed a Circuit Court's ruling dismissing a patient's claims against a clinic and its parent company for direct liability and *respondeat superior* arising out of clinic employees' disclosure of a patient's confidential medical information. *Parker v. Carilion* Clinic, 819 S.E.2d 809 (Va. 2018). In the lawsuit, Plaintiff claimed that seven months after she was diagnosed with a medical condition at the clinic owed by the defendant, she was awaiting treatment when she struck up a conversation with a male acquaintance. A clinic employee, who also knew the man, witnessed the conversation, pulled up Plaintiff's medical records, saw the diagnosis, and called another employee, who also knew the man. The second employee reviewed Plaintiff's file and the two discussed Plaintiff's diagnosis and the fact that Plaintiff was conversing with the man— whom they all knew. The second employee later told the man about Plaintiff's diagnosis and he, in turn, told Plaintiff about what he heard. Plaintiff subsequently filed a complaint against the employees, the clinic and the clinic's parent company alleging that the employees disclosed her confidential health information to others and that the employees were acting within the scope of their employment when the disclosure occurred. The clinic asserted that the vicarious liability and direct liability claims against it were untenable because the employees were acting outside the scope of their employment when the disclosure took place. The trial court agreed, granted the dismissal but allowed Plaintiff to amend her Complaint. Instead, she appealed the ruling. On appeal, the Supreme Court reversed the dismissal. In so ruling, the Court noted that Virginia's principle of vicarious liability under *respondeat superior* is that vicarious liability may be imposed on an employer when the service itself, in which the tortuous act was done, was within the ordinary course of the employer's business, i.e, "when the employee committed the tort while performing a normal function associated with his job." Virginia precedent showed that the tortious act or transaction occurred while the employee was in fact performing a specific job-related service for the employer, and but for the employee's wrongdoing, the service would otherwise have been within the authorized scope of his employment. The tortious act had to rise out of the very transaction. "in short, our established test limits respondeat superior liability to tortious acts performed within the scope of duties of the employment and in the execution of the service for which the employee was engaged." An employee's personal motives also weigh as a factor and play a role in determining whether a tort was committed in the scope of employment. The Court held that Plaintiff's complaint sufficiently alleged facts that established a rebuttable presumption that facts exist that would satisfy the established test for vicarious liability. Accordingly, the Court reversed the ruling of the trial court granting the dismissal of the *respondeat superior* claim.

> *"[O]ur established test limits respondeat superior liability to tortious acts performed within the scope of duties of the employment and in the execution of the service for which the employee was engaged."*

Rhode Island Supreme Court Rules That Insurers Do Not Owe a Duty to Proactively Make Settlement Offers to Third Parties

In a decision issued on January 15, 2019, the Rhode Island Supreme Court ruled that an automobile liability insurer did not owe a duty to a plaintiff pedestrian and his parents to act in a reasonable and good faith manner in settling a claim. *Summit Insurance Company v. Stricklett, et al.*, 199 A.3d 523 (R.I. 2019). The matter involved an insured who was operating a car and struck an eleven year old boy. The boy suffered a fractured tibia and fibula and underwent three surgeries. At the time of the accident, the insurer provided coverage under a policy with a $25,000 per person, $50,000 per accident coverage limit. The insurer investigated the claim, which included reviewing the police report, and concluded that it insured was not at fault for claimant's injuries. The insurer further responded that it would "not make any offers on this case." The claimant's attorney responded that he disagreed and that he intended to pursue the claim. On February 16, 2011, claimant's new attorney informed the insurer by letter that it intended to proceed with a lawsuit against its insured. The new attorney indicated that he disagreed with the insurer's denial of the claim and began negotiating with the insurer, seeking information about the policy, and eventually issued a demand for $300,000 to the insurer, stating that the insurer was liable for the policy limit, and because the insurer had previously failed to offer its policy limits, "the insurer would undoubtedly be held liable for all interest over and above the policy limit." The insurer filed a complaint for a declaratory judgment, naming its insured and the claimants as defendants, seeking a declaration that it had no obligation to pay any sums beyond its policy limits in connection with the underlying lawsuit. Claimants contended that the insurer owed a duty of good faith and fair dealing to third-party claimants and that the insurer had a duty to proactively engage in settlement discussions. The trial judge concluded that the insurer did owe a duty to claimants to act in a reasonable manner and in good faith in settling the claim against its insured but that the insurer had fulfilled its duty and had acted appropriately under the circumstances. On appeal, the Rhode Island Supreme Court agreed with the trial court's ruling but disagreed as to its reasons. The Court found that insurers owe no duty of good faith and fair dealing to third-party claimants. First, the Court noted that it had not previously recognized such a duty. "The relationship between an insurer and a third-party is adversarial, giving rise to no fiduciary obligation on the part of such insurance carrier to the claimant." Accordingly, "there is no duty on the part of an insurance carrier for a third party to settle promptly with a claimant." Precedent dictates that any obligation to deal with settlement offers in good faith runs only to the insured or to a party to whom the insureds have assigned their rights.

Jackson & Campbell
ATTORNEYS AND COUNSELORS AT LAW

1120 20th Street NW
Washington, DC
20036

Phone: 202-457-1600
Fax: 202-457-1678
www.jackscamp.com

Recent Notable Verdicts and Settlements

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

Sathima H. Jones
(202) 457-1656
sjones@jackscamp.com

Jury Verdicts/Settlements

Tazewell County, IL — Nov., 2018. A Tazewell County jury awarded $5 million to a 36 year-old female patient in a lawsuit filed against a hospital and an ob/gyn alleging medical malpractice in the performance of a hysterectomy. Plaintiff alleged that the surgeon caused internal bleeding that went undiagnosed for several hours until the patient went into cardiac arrest.

Cook County, IL — Dec., 2018. A Cook County jury awarded a 34 year-old female and her husband $11 million in a case in which she alleged the defendant ob/gyn negligently failed to order a C-section and negligently failed to diagnose a fourth degree tear which occurred during delivery from the alleged use of metal forceps.

Westchester County, NY — Feb., 2019. After a three-week trial, a Westchester County jury rendered a $7.6 million gross award against a pediatric neurologist, otolaryngologist and neurosurgeon in a case in which a 13 month-old infant plaintiff alleged the defendants were negligent in failing to review MRI films showing a structural lesion in her temporal lobe. Plaintiff alleged that, as a result, a malignant tumor was not diagnosed for more than one year, during which time it tripled in size and caused a left-side facial palsy and a partial left-sided hearing loss.

Providence County, RI — Sep., 2018. After an eight day trial, a Providence County jury awarded $40 million in damages to a 55 year-old man in a lawsuit in which he alleged two physicians and a hospital were negligent in taking him off his blood thinners when he presented to the ER complaining of back pain and exhaustion. Plaintiff alleged he developed blot clots and gangrene, which required the amputation of his left leg.

Multnomah County, OR — Feb., 2019. A Multnomah County jury awarded $3.7 million to a 38 year-old female plaintiff in a lawsuit in which she alleged that an emergency medicine physician and a radiologist negligently failed to diagnose her with a stroke. She alleged that the delay in diagnosis and treatment resulted in permanent neurological injuries. Defendants alleged they rightfully believed she suffered a psychiatric stress response.

Notable Defense Verdicts

Montgomery County, PA — Nov., 2018. A Montgomery County jury concluded that an anesthesiologist was not negligent in a lawsuit brought by a 52 year-old female patient who allegedly suffered nerve injury after the defendant physician performed knee replacement surgery. The anesthesiologist maintained that the femoral nerve block procedure was properly performed and that the complications were known and accepted complications.

Philadelphia County, PA — Dec., 2018. A Philadelphia County jury held that a defendant hospital was negligent in its failure to protect a female patient's pressures sores from worsening but that the negligence was not a factual cause of bringing harm to the patient. Defendant argued that the patient's death was caused by her underlying medical conditions.

Baltimore County, MD — Oct., 2018. After a five day trial, a Baltimore County jury returned a defense verdict in favor of a physician and her practice in a lawsuit in which a 42 year-old woman suffered a urethral injury as a result of a surgery to treat stress urinary incontinence. The patient sued alleging medical malpractice and lack of informed consent. The defense contended that injury to the urethra was a known complication that does and can occur in the absence of negligence.

Kentucky Supreme Court — Dec., 2018. The Kentucky Supreme Court reinstated a jury's finding that a hospital was not negligent for a patient's death from an infection. The court held that, although the trial court erred by granting a directed verdict against an "empty chair" defendant who settled, the error was harmless.

Washington, DC — Oct., 2018. After an eight day trial, a Washington, DC jury returned a verdict in favor of two internists in a lawsuit in which the 60 year-old female patient alleged that they failed to properly inform her of the risks associated with the use of a blood thinner. Plaintiff suffered a stroke and alleged that the stroke was caused by the failure to tell her about the risk of bleeding and the failure to monitor and treat her.

Pennsylvania Superior Court — June, 2018. .A Pennsylvania appeals panel has upheld a verdict in favor of a hospital in a malpractice action in which the estate of a woman with fall injuries and intestinal issues alleged more should have been done to save her life. On appeal, the Court held that the trial court properly excluded testimony from an expert witness designated late.