JACKSON & CAMPBELL, P.C.

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Decisions

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Seventh Circuit Court of Appeals Upholds Ruling that Insurer's Duty to Settle within Policy Limits Never Arose

In a decision issued on April 25, 2019, the United States Court of Appeals for the Seventh Circuit ruled that an insurer did not act in bad faith by failing to settle for policy limits. *Surgery Ctr. at 900 N. Michigan Ave., LLC v. Am. Physicians Assurance Corp., Inc.*, 2019 WL 1855397 (7th Cir. Apr. 25, 2019). The underlying action involved a medical malpractice action against a surgery center ("Surgery Center") and doctor after the independent contractor doctor performed outpatient laparoscopy on an otherwise healthy 34 year old woman, which caused a perforated bowel and rendered her a quadripalegic as a result of surgical complications. Surgery Center and doctor were each defended by their respective insurers. Initially, Surgery Center's insurer rated the case "high exposure" because it believed the damages in the event of an adverse verdict could exceed the center's policy limits. After discovery and before the first of two trials on July 31, 2007, plaintiff's counsel offered to settle with the Surgery Center for the full policy limits of $1 million. The insurer rejected the $1 million settlement demand. A month later, the doctor's carrier settled for his $1 million policy limit. That same day, the Surgery Center moved for the court to reconsider its motion for summary judgment; the court granted reconsideration and dismissed the case. In December 2009, the Illinois Appellate court remanded for trial the issue of whether the Surgery Center's nursing staff breached the standard of care when discharging plaintiff and whether the breach proximately caused plaintiff's injury. Following remand, Surgery Center's insurer raised the reserve to the policy limit - $1 million. Prior to the second trial, in May 2010, plaintiff sent Surgery Center another settlement demand for $1 million, which Surgery Center again rejected. At trial, the jury returned a verdict for $5.17 million against the Surgery Center. In May 2015, Surgery Center sued its insurer, alleging state law claims of negligence, breach of fiduciary duty and concert of action because the insurer acted in bad faith by failing to settle. The insurer filed for summary judgment but the motion was denied on the grounds that a true assessment of the likelihood of a liability finding against the Surgery Center and potential damages amount in excess of the policy limit were disputed issues of material fact. The case proceeded before a jury. At the close of the case, the insurer moved for judgment as a matter of law and the district court concluded that the disputed facts that had prevented an award of summary judgment were no longer in dispute. The evidence at trial showed that the insurer believed that the case was "highly defensible." The Seventh Circuit affirmed the district court's ruling relying on *Haddick ex rel. Griffith v. Valor Ins.*, 198 Ill. 2d 409, 414 (2001), which set forth the standard for when an insurer has a duty to respond to a settlement offer. The court stated that in Illinois, an insurer has a duty to act in good faith when responding to a settlement offer. To sustain a bad faith claim against its insurer, a policy holder must establish that: (1) the duty to settle arose; (2) the insurer breached the duty; and (3) the breach caused injury to the insured. The duty to settle arises when a third party demands settlement within the policy limits, a claim has been made against the insured and there is a reasonable probability of a finding of liability against the insured. Surgery Center put forth no evidence that its liability was reasonably probable. Testimony at trial by the claims handler indicated that she believed the case was defensible and thought the case got stronger after remand because plaintiff was limited to a single claim and lacked a proper expert to testify. The attorneys handling the case similarly testified about their belief in the case's defensibility. Surgery Center's president and main witness at trial similarly believed that Surgery Center was not liable because it was not negligent and should be defended; she had repeatedly emailed defense counsel imploring them not to settle and to aggressively defend the matter. In support of its bad faith argument, Surgery Center pointed to the insurer's increased reserves and failure to inform it of the increase, claiming that the reserve increase indicated an increased liability risk. But, there was evidence to the contrary - the insurer repeatedly reminded Surgery Center of the policy limit and of its responsibility for any judgment exceeding the limit. Counsel also repeatedly reminded Surgery Center of the severity of plaintiffs' injuries and that damages could easily be in excess of $10 million. The court concluded that this evidence was insufficient to establish a reasonable probability of Surgery Center's liability. The Seventh Circuit held that judgment as a matter of law was properly granted and concluded that Surgery Center did not present any evidence that anyone involved in litigating the case believed that there was more than a mere possibility Surgery Center would be found liable. Because "a reasonable jury would not have a legally sufficient evidentiary basis to find the duty to settle arose … the district court properly granted judgment as a matter or law" for the insurer.

SPECIAL POINTS OF INTEREST:

- *Seventh Circuit upholds ruling that insurer did not act in bad faith in rejecting policy limits demand*
- *Oklahoma Supreme Court Strikes Down Cap on Non-Economic Damages as Unconstitutional*
- *Birth-related injuries to mother and child constitute multiple "medical occurrences"*
- *Insurer owes coverage for judgment against doctor who fled the country after being sued for malpractice*

Oklahoma Supreme Court Holds that Cap on Noneconomic Damages Is Unconstitutional

In a decision issued on April 23, 2019, the Oklahoma Supreme Court ruled that the legislative enactment of 23 O.S. 2011 § 61.2 (B) –(F) was unconstitutional in its entirety. *Beason v. I. E. Miller Servs., Inc.*, 2019 WL 1772328 (Okla. Apr. 23, 2019). In the case at issue, the plaintiff was injured when he was hit by a boom crane that was operated by defendant's employee and underwent two amputations on his arm. Plaintiff and his wife brought an action against defendant. At trial, a jury awarded $14 million to plaintiff and $1 million to his wife. A supplemental verdict form allocated $5 million of the $14 million awarded to plaintiff as noneconomic damages and all of the wife's damages were pegged noneconomic. 23 O.S. 2011 § 61.2 (B) – (F) places a $350,000 cap on noneconomic losses in a civil action from a claimed bodily injury. However, the statute allows for limitless noneconomic damages when the trier of fact finds by clear and convincing evidence more than mere negligence, *i.e.* - reckless disregard, gross negligence, fraud, or intent. Applying 23 O.S. 2011 § 61.2(B) – (F), the district court reduced plaintiff's verdict to $9.7 million, which meant that the total award of $6 million in noneconomic damages was lowered to $700,000 total, namely $350,000 per person in accordance with the statute's cap on damages. Plaintiffs filed a motion to conform the jury's verdict and evidence and argued that the statute was unconstitutional, which was denied. Plaintiffs appealed the judgment to the Supreme Court of Oklahoma arguing that the statute is unconstitutional because it is a special law in violation of Article 5, Section 46 of Oklahoma's Constitution. Article 5, Section 46 of Oklahoma's Constitution enacts a mandatory prohibition against special laws. The Supreme Court agreed. In its decision, the Court held that the statutory cap on noneconomic damages resulting from bodily injury is a special type of law that targeted less than the entire class of similarly situated persons who sue to recover for bodily injury and treated them differently. The Court further held that the statute fails by purporting to limit recovery for pain and suffering in cases where the plaintiff survives the injury-causing event, while persons who die from injury-causing events face no such limitation. The Supreme Court reasoned that these two categories are not just similarly situated; they stand on identical footing with respect to recovery. The personal representative of a person who dies from an injury-causing event can maintain an action to the same extent as if the deceased "might have maintained an action had he or she lived." If a decedent can recover without limitation for pain and suffering during the time between the harm-causing event and his or her death, no good reason exists to treat a person who survived the harm causing event differently with respect to recovery for the very same detriment. The fact that an injured party can lift the statutory cap by showing different degrees of culpability does not save the statute from a discriminatory effect. "Pain and suffering do no vary depending upon the source of the collapse and do not care if the source of the collapse is the result of a tornado, an earthquake, a terrorist act, intentional conduct, negligent design, or strict-liability activity." Culpability has no bearing on the extent of suffering. Further evidence of the legislation's discriminatory nature was that it appeared to only remove the jury's power to decide the amount of pain and suffering for survivors' injuries, while leaving the jury power to determine the same for the dead. Because the people have vested juries with the constitutional responsibility to determine the amount of recovery for pain and suffering from injuries resulting in death, a jury would be equally competent to make the same determination in a case where the injury does not result in death. This is implied by the right to trial by jury set forth in the Oklahoma Constitution's Bill of Rights. The Supreme Court held that the statute violated Article 5, Section 46 and remanded the case with instructions to enter a judgment for the plaintiffs in the full amount of the jury's verdict.

> *"The fact that an injured party can lift the statutory cap by showing different degrees of culpability does not save the statute from a discriminatory effect."*

Insured's Late Notice Bars Coverage for Default Judgment

In decision issued on April 3, 2019, the Second Department of the New York Supreme Court, Appellate Division, ruled in favor of an insurer, finding that an underlying plaintiff and insureds failed to provide the insurer with requisite notice of a suit. *Lipnitsky v. Am. Transit Ins. Co.*, 2019 WL 1461956 (N.Y. App. Div. Apr. 3, 2019). In May 2011, plaintiff's vehicle was in an accident with the insureds' vehicle. Plaintiff commenced an action in July 2011 against the insureds to recover damages for personal injuries. A default judgment was entered in favor of the plaintiff on February 5, 2015 in the amount of $101,455. The next day, plaintiff sent a letter to the defendant's insurer notifying it of the default judgment. Twenty days later, defendant insurer notified insureds of the judgment and informed insureds and the plaintiff that it was disclaiming coverage based on a failure to provide timely notice of commencement of the action, as required by the policy. Plaintiff commenced an action against the insurer pursuant to New York Insurance Law § 3420(a)(2) to recover the amount of the unsatisfied judgment. The insurer moved for summary judgment, arguing that it timely and properly disclaimed coverage because it lacked timely notice of litigation. Plaintiff cross-moved contending that his counsel had sent notice of the accident on June 6, 2011 and notice of the commencement of litigation on November 30, 2011. The court granted the insurer's motion, finding that the notice of commencement was not sent to an address sufficient to reach the insurer. The Appellate Court agreed - reasoning that the receipt of a notice of commencement of litigation is a condition precedent to an insurer's liability under the policy. The Court concluded that the insurer established its entitlement to summary judgment by demonstrating that it had no notice of the action until it received the February 6, 2015 letter—after entry of the default judgment.

Illinois Appellate Court Upholds Doctor's Trial Victory and Concludes that the Doctor Properly Adopted and Disclosed Expert Witness of Co-Defendant

In a decision issued on March 28, 2019, an Illinois Appellate Court held that the language of a doctor's Rule 213 answer was sufficient disclosure of his intention to use a co-defendant's retained expert witness. *Wilson v.* Moon, 2019 WL 1429329 (Ill. App. Mar. 29, 2019). The lawsuit involved a 23 year old decedent who died from a saddle pulmonary embolism (blood clot that blocked the large pulmonary artery straddling his lungs). After his death, his mother sued the emergency room physician and hospital alleging that the physician negligently failed to diagnose and treat her son's condition and that the hospital was liable because of its principal agency relationship with the doctor. The doctor denied negligence and the hospital sought summary judgment on the grounds that the doctor was an independent contractor. Prior to trial, the hospital settled with the plaintiff. At trial, the doctor called the hospital's retained expert on pulmonary medicine, who testified that decedent's signs and symptoms did not suggest a pulmonary embolism and that what subsequently occurred was sudden and unsurvivable regardless of the doctor's efforts. The doctor had also retained an expert in emergency medicine who testified that the doctor complied with the standard of care for emergency medicine. The jury rejected the malpractice claim. Plaintiff appealed. On appeal, the Illinois Appellate Court considered whether the doctor's witness disclosure adequately warned the plaintiff that the doctor would call the hospital's expert witness at trial after the hospital was no longer in the case. The pretrial witness disclosure at issue stated: "defendant adopts herein and reserves the right to call any Rule 213(f)(1), 213(f)(2) or 213(f)(3) witness disclosed by any party." In arguing that this disclosure was improper, plaintiff contended that if the doctor intended to call the settling hospital's witness, he should have expressly supplemented his witness list. Plaintiff argued that this non-disclosure was prejudicial because until the expert testified at trial, plaintiff did not know whether his opinions had changed; she claimed that she was unprepared for cross examination about the expert's compensation because she had not issued discovery inquiring about how much he was paid, the number of hours spent reviewing the case, and when and by whom the expert was retained. Applying the standard from *Sullivan v. Edward Hospital*, 209 Ill. 2d 100 (2004), the Appellate Court looked to the following factors to determine whether exclusion of an expert witness is a proper sanction for nondisclosure: the surprise to the adverse party; (2) the prejudicial effect of the testimony; (3) the nature of the testimony; (4) the diligence of the adverse party; (5) the timely objection to the testimony; and (6) the good faith of the party calling the witness. Applying the *Sullivan* factors, the Court rejected plaintiff's argument. The expert testimony did not surprise plaintiff as his identity and opinions were disclosed to all parties eight months before trial when the hospital issued its initial Rule 213 answers. Also, one of the documents produced in response to plaintiff's requests for the production of documents included a letter confirming that the expert was being retained for the purpose of defending the doctor and the hospital. Furthermore, plaintiff's alleged prejudice due to a lack of financial information was belied by the fact that her attorney posed only one financial question at the expert's depositions and plaintiff had the expert's financial information before the expert took the stand. As far as the nature of testimony, the expert testified specifically on the decedent's ailment and helped the jury identify and understand the ailment. The Court viewed plaintiff's diligence and objection to testimony as untimely in light of the fact that defendant's Rule 213 answers, which expressly adopted the other parties' witnesses and opinions were filed months before the trial. Once the expert was on the stand, his testimony was apparently limited to the opinions and bases that had been previously disclosed either during his deposition or in Rule 213 answers because plaintiff made no specific Rule 213 objections while he was testifying. Because the expert was set to testify on the hospital's behalf by virtue of the principal-agency relationship between hospital and doctor, his testimony was limited to what the doctor did or did not do correctly, which was no different from the opinion that he was originally prepared to offer. Lastly, the Court noted that no case law supported the proposition that a defendant would have to supplement his disclosures after a codefendant settled in order to include specific mention of a co-defendant's expert witness. Rather, the Court concluded that the timely adoption of another party's expert is all that is necessary under Rule 213.

"Plaintiff's alleged prejudice due to a lack of financial information was belied by the fact that her attorney posed only one financial question at the expert's depositions and plaintiff had the expert's financial information before the expert took the stand."

New York and New Jersey Extend Statute of Limitations in Sex Abuse Cases

New York—On February 14, 2019, New York's Governor signed Senate Bill 2440/ Assembly Bill 2653 into the law. The legislation changes various statutes of limitations regarding claims involving sexual abuse of minors. Specifically, Section 2 of the law changed the civil statute of limitations for child sexual abuse offenses so that the child-victim may bring suit against any responsible defendant any time before reaching age 55. Section 3 creates a reviver period in which any victim with a time-barred claim, or with a claim previously dismissed as time -barred, may file a new suit against any responsible defendant without facing a statute of limitations or res judicata bar. Such a suit must be filed not earlier than *six months* after the Child Victim's Act ("CVA") went into effect and not more than eighteen months after the CVA went into effect.

New Jersey—On May 13, 2019, New Jersey's Governor enacted legislation similar to New York's CVA. Under the newly enacted law, child victims will be able to make claims until they turn 55, or seven years from the moment they discover an injury was caused by past abuse, whichever is later. In addition, the New Jersey law gives victims two years, starting on December 1, 2019, to bring civil actions regardless of when the alleged abuse occurred. Under the previous law, victims of sexual abuse had only two years from the time they realized the abused caused them harm to file suit. New Jersey is the eleventh state to enact a statute extending the SOL for abuse claims.

Missouri Appellate Court Holds That Suit Over Birth-Related Injury Constitutes Multiple Medical Occurrences Under Medical Malpractice Policy

In a decision issued on April 23, 2019, a Missouri Appeals Court ruled that injuries to a mother and a child during an emergency C-section constituted multiple medical occurrences under a medical malpractice liability policy and, as such, the insurer was responsible for paying $2 million under its policy. *John Patty, D.O., LLC v. Missouri Professionals Mut. Physicians Prof'l Indem. Ass'n*, 2019 WL 1771507 (Mo. Ct. App. Apr. 23, 2019). The underlying suit accused the doctor of ignoring certain red flags and failing to timely order an emergency delivery, which caused the mother and child permanent disability and brain damage. The doctor involved in the care specialized in obstetrics, including prenatal care, delivery, post-delivery care, and complications associated with pregnancy and delivery ("Doctor"). The mother was under Doctor's care while she was pregnant with child ("Mother"). During the third trimester, the Mother began having preterm contractions and abdominal pain and Doctor admitted mother to the hospital where he treated her and monitored the child's health. After four days, Doctor discharged the Mother despite her continuing and ongoing symptoms and problems. Four days after her follow-up to discharge, the Mother returned for treatment with the Doctor because her symptoms worsened. The Doctor tried to check her blood pressure, but could not detect it. The Doctor also monitored the child, who was not moving and had a low and failing heart rate. Concluding that the child was in fetal distress, the Doctor performed an emergency cesarean section in his office, with no access to medication, anesthesia, equipment or typical personnel. The child was born minimally responsive with depressed respiratory and heart function. The Mother and child filed a lawsuit against the Doctor seeking to recover for the injuries they sustained. The Doctor's medical malpractice insurer settled all claims for the maximum limit of professional liability coverage. However, the settlement agreement failed to resolve whether the maximum limit applicable to the Mother and child's claims implicated one liability limit or two. In coverage litigation brought by the Dcotor, the trial judge ruled that the maximum policy limit of $1 million applied because a single course of medical treatment can be considered a single "medical occurrence" for the purposes of the policy. The policy at issue defined the term "medical occurrence" as any act or omission in the furnishing of professional medical services and that "any such act or omission, together with all related acts or omissions in the furnishing of such services to any one person shall be considered one medical incident or occurrence." The Appellate Court disagreed with the trial court's ruling that the claims constituted a single medical occurrence and held that the Doctor's negligent treatment of the Mother was a separate "medical occurrence" from his treatment of her newborn baby. In examining the "to any one person" language, the Court held that the definition of 'medical occurrence' could "not reasonably be interpreted to include all acts and omissions in providing medical services to multiple individuals."

> *"The definition of 'medical occurrence' could not reasonably be interpreted to include all acts and omissions in providing medical services to multiple individuals."*

Fourth Circuit Court of Appeals Holds That Malpractice Insurer Owes Coverage for Default Judgment for Doctor Who Fled the Country After Being Sued

In a decision issued on May 7, 2019, the United States Court of Appeals for the Fourth Circuit, applying Maryland law, ruled that an insurer should have appeared in the underlying lawsuit and mounted a defense in a malpractice lawsuit filed against its insured physician even though the physician fled the country after being sued. *Mora v. Lancet Indem. Risk. Ret. Group, Inc.*, 2019 WL 2004205 (4th Cir. May 7, 2019). The underlying lawsuit involved the death of a patient from cardiac arrest after being treated by the insured physician in January, 2015 for complaints by the patient of chest pains and shortness of breath. The patient's family sued the physician 2016 in federal court in Maryland alleging that the physician and others failed to refer the patient to a cardiologist leaving his condition undiagnosed and untreated, resulting in his death. On the day the plaintiffs filed suit, they mailed a copy of the complaint to the physician's medical malpractice insurer. The insurer retained defense counsel and informed the insured that it needed his assistance in defending the lawsuit. The physician never responded to defense counsel's efforts to contact him and the insurer ultimately learned that the physician had moved to Pakistan with no plans to return. Defense counsel advised the insurer that he could not ethically defend the physician because he did not obtain his consent to represent him. The insurer elected not to participate in the defense of the malpractice action and it sent a disclaimer letter to the physician denying coverage based on his failure to cooperate in the defense. The plaintiffs obtained a $2.56 million default judgment, which it sought to collect from the insurer. After a two-day bench trial, the District Court held that the insurer was not prejudiced by the physician's absence and refusal to cooperate. The District Court also held that neither the ethical rules nor Maryland law prevented counsel from defending the malpractice action. The Appellate Court affirmed. The Court found that coverage was owed based on the policy's "advanced" consent provision, which the Court noted required the insured to permit the insurer's lawyer to defend claims insured under the policy. Accordingly, the Court held that counsel could have entered an appearance without the consent of the physician to represent both the physician and the insurer's interest. The Court further held that, based upon expert testimony, it would have been possible to mount a defense based upon the available medical records and, as such, the insurer was not prejudiced by the physician's lack of cooperation in defending the lawsuit.

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Jury Verdicts/Settlements

Broward County, FL — April, 2019. A jury in Broward County awarded $24.5 million to the family of a mother of four who died hours after giving birth to her fourth child. The family alleged that the negligence of four physicians and their practice in delaying a C-section caused the mother to bled to death. The jury deliberated for only two hours in the damages-only trial before reaching its decision.

Lake County, IL — April, 2019. An Illinois hospital and its emergency room physicians agreed to pay $14.98 million to resolve a lawsuit accusing the providers of causing a woman's permanent blindness with their negligent treatment in failing to diagnose and properly treat a blood clot in her brain.

Middlesex County, MA— April, 2019. A Middlesex County jury awarded a man $9.4 million in a lawsuit accusing a surgeon of failing to properly treat a patient's post-surgery complications, which caused a severe infection and permanent injuries. Specifically, the patient alleged the physician failed to properly recognize and appreciate the signs of an anastomotic leak and advanced sepsis and failed to inform him of his post-surgical condition. The patient required several additional surgeries and 18 hospitalizations.

San Francisco, CA — April, 2019. A Santa Rosa, California hospital agreed to pay $3.8 million to settle a medical malpractice lawsuit filed by the family of a woman after she went into cardiac arrest in an emergency room waiting area after being discharged. The family alleged that the hospital staff ignored signs that the 33 year-old woman was suffering heart failure. The woman has been in a coma since the incident happened in 2015.

Cook County, IL — Feb., 2019. A hospital system and several physicians agreed to pay $20.6 million to settle a medical malpractice claim brought by a 64 year-old patient who claimed he is permanently disabled because the physicians failed to diagnose and treat his ruptured aneurysm. As a result, the patient became paralyzed, had to have several toes removed, and required bilateral fasciotomies of both lower extremities. The man requires round the clock care due to his injuries.

Notable Defense Verdicts

Baltimore County, MD — Feb., 2019. After a six day trial, a Baltimore County jury concluded that a hospitalist did not commit malpractice when he discharged a 68 year-old woman who went into cardiac arrest after an eight day hospitalization. The woman's estate alleged that the hospitalist had negligently discharged the woman because the source of her gastrointestinal bleeding had not been identified and was actively bleeding at discharge.

Monmouth County, NJ — Feb, 2019. The Appellate Division of the Superior Court affirmed a defense verdict in a lawsuit alleging a doctor failed to obtain a patient's informed consent before removing his appendix and a portion of his colon. On appeal, the plaintiff alleged that the jury interrogatory should have been separated for each surgery. The Court disagreed.

Los Angeles County, CA — Nov., 2018. The Court of Appeals, Second District, affirmed a verdict that a doctor was not liable for allegedly concealing the failure of a spinal disc surgery, concluding that the trial court was within its discretion to exclude evidence that four of the doctor's other patients had experienced the same thing. The trial court had held that the other patients were not properly designated as witnesses before trial and were excluded on that basis.

Lafayette Parish, LA—Feb., 2019. A Louisiana appellate court affirmed the dismissal of a lawsuit accusing a pediatrician of failing to diagnose a toddler's brain tumor that caused injuries, holding that the doctor properly established that he did not breach the standard of care and there was no evidence to establish that his treatment caused damage.

Bexar County, TX — Feb., 2019. A Texas appellate court held that a Bexar County trial court should have granted an anesthesiologist and spinal clinic's motion to dismiss a medical malpractice lawsuit when the medical expert's report failed to sufficiently explain how the physician's acts and/or omissions in providing a steroid injection were a substantial factor in bringing about the harm allegedly suffered by the patient

Montgomery County, PA — Dec., 2018. A Montgomery County jury held that an orthopedist was not negligent in a lawsuit in which the patient alleged the physician was negligent in disregarding repeated complaints of pain in his hip after a hip injection. Plaintiff alleged he had to undergo hip replacement surgery as a result. The jury found no negligence on the part of the physician.