

# THE PERRY LAW FIRM

update

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## Institution Update

### *Major Changes In Two Areas Of Longstanding Controversy: Venue And Joint Several Liability*

Within the last four months, the Pennsylvania legislature has approved significant changes in the law pertaining to two controversial topics: medical malpractice venue and joint and several liability. These changes should be considered positive for the defense bar and may impact claims evaluation.

In late October, 2002, the Pennsylvania legislature amended 42 Pa. C.S. §921 to include a general rule that a “medical professional liability action may be brought against a healthcare provider for a medical professional liability claim only in the county in which the cause of action arose.” This change in the law is a result of the passage of the MCARE act in March of 2002 which created a commission to investigate the venue issues associated with medical malpractice claims. This provision will have a significant impact on the number of cases that are brought in Philadelphia County, which as many know, is one of the least desirable venues for defendants. However, this provision will also have a significant impact in the Northeastern and Central Pennsylvania region as well, preventing causes of action from being brought in more Plaintiff friendly venues.

The new venue provision will take effect in sixty (60) days from the passage of the legislation and will impact all medical

professional liability actions filed on or after the effective date of this action. Therefore, there is no retroactive application of the statute to cases that are currently pending.

The other significant piece of legislation passed within the last four months was the “Fair Share Act” which limits joint and several liability in Pennsylvania. Senate Bill 1089 amended the comparative negligence act 42 Pa. C.S. §7102 which mandates that a defendant is only liable for his or her fair share of damages, except where there is intentional fraud, an intentional tort or a defendant is found to be liable for 60% or more of the total damages awarded. More specifically, under the amended act, “a defendants’ liability should be several and not joint, and the court shall enter a separate and several judgment in favor of the plaintiff and against the defendant for the apportioned amount of that defendant’s liability.” This is a significant change in Pennsylvania Law and places Pennsylvania along with thirty-five other states to have changed this doctrine.

In its old form, the legal concept of joint and several liability held each defendant in a lawsuit was financially liable for the full amount of a damage award, even if the defendants’ legal responsibility was deemed to be minimal. An injured plaintiff could recover damages from any one or a combination of defendants. For example,

a defendant found even one percent liable in a civil lawsuit could be held 100% financially responsible. The result was that litigants would often go after the “deep pocket” defendants. The basis of this rule was to insure that a plaintiff could be fully recovered and the damages awarded even though some of the defendants were unable to pay their share. Now, under the new act, a defendant’s liability will be assessed based on their level of responsibility. As stated above, joint and several liability will still apply to any defendant found 60% or more liable for causing an injury. It will also apply in a situation where defendants negligence resulted from fraud or an intentional act.

With the passage of these two changes in the law, it has created a somewhat better environment for insureds in Pennsylvania. Medical malpractice defendants can no longer be called into plaintiff oriented venues just because they do business in that area — the negligence must occur in the county where the action is brought. Moreover, damages will be divided on a proportional share, which is a benefit to the “deep-pocket” defendants, traditionally hospitals and health care organizations.

*Mark T. Perry, Esq.*

## Offset Application

### *Offset Applies to PRE-PIGA Workers’ Compensation Injury*

Very recently, the Commonwealth Court of Pennsylvania held that a workers’ compensation lien generated as a result of a 1993 injury is subject to the offset provisions of the PIGA statute. In *Fetters v. PIGA*, 804 A. 2d 126 (Cmwlth. Ct. 2002), the plaintiff filed a medical malpractice lawsuit against doctors who treated her for 1993 work related injuries. At the time the medical malpractice lawsuit had concluded, \$95,000.00 worth of benefits were paid by the workers’ compensation carrier. PIGA asserted an off-set for \$95,000.00 from a \$200,000.00 settlement. Thereafter, the plaintiff filed a declaratory judgment action, arguing that PIGA was not entitled to offset of the Workers’ Compensation benefits because the current PIGA legislation was not in effect in 1993 and the prior legislation

did not include a provision providing for an off-set for workers’ compensation benefits. Further, plaintiff argued that her substantive rights are governed by law in effect at the time of the injury and that legislation affecting these rights can not be applied retroactively absent clear legislative intent. In addition, the workers’ compensation carrier argued that the PIGA off-set would abridge their subrogation interests which accrued at the time of the injury.

The Commonwealth Court rejected all of the plaintiff’s arguments and held that the triggering date of the current PIGA legislation, which included a workers’ compensation benefit off-set, is the date of the insurers’ insolvency and subsequent liquidation, not the date when the underlying claim arose. Since the intended

physicians were PIC insured and PIC became insolvent after the effective date of the current PIGA Act, the Act and all of the limitations provided therein would apply to any claim which would have been covered by PIC absent its insolvency and liquidation. Therefore, in determining whether an off-set applies to a given case, it is important to look for the date of the carrier’s insolvency, as opposed to the date of the injury, to determine whether the off-set provision applies.

*William J. Aquilino, Esq.*

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## *Doctrine of Ostensible Agency Extended to Doctors For Their Independent Contractors*

In a case of first impression nationally, the Pennsylvania Superior Court recently expanded the doctrine of ostensible agency to include physicians, holding a doctor liable for the negligence of an independent certified registered nurse anesthetist for treatment rendered in an office-based surgical procedure.

In the matter of *Parker v. Freilich, M.D.*, 803 A. 2d 738 (Pa. Super.2002), the patient underwent a colonoscopy at Dr. Freilich's medical office, with the anesthesia being provided by an independent CRNA, Mr. Robert Shaw. After the procedure, the patient was discharged home where she discovered that a catheter placed by Mr. Shaw remained in her arm.

An action was subsequently filed, culminating in a jury trial where the court granted non-suit on the issue of ostensible agency, holding that this theory was applicable only to hospitals and HMOs and inapplicable to doctors. The trial proceeded on the remaining issues where the jury found that Mr. Shaw was negligent, but not an agent of Dr. Freilich.

In extending the ostensible agency doctrine, the Pennsylvania Superior Court found that the modern realities of medical practice

indicate that some physicians without any affiliation with a hospital or HMO maintain private offices in which they consult with patients and sometimes perform minor medical procedures. As such, these physicians hire staff including nurses on an independent contract for hire basis.

The patient does not normally visit a doctor's office seeking or expecting to be treated by a doctor's independent contractor. The patient looks to the doctor or the doctor's agents for care. As such, they held that in an office practice setting, the theory of ostensible agency is quite consistent with the rationale behind its application of this theory to hospitals and HMOs.

The court further delineated a test in determining whether or not the doctrine of ostensible agency would apply to a doctor's office. The first question the court must determine is whether the patient looks to the doctor, rather than the independent contractor for care. The second question is whether the doctor "holds out" the independent contractor as an employee. The court further provided specific instructions as to this second prong of the ostensible agency test. The court held that to separate themselves from the independent contractor, a physician

must first expressly inform the patient of their independent contractor status. Further, the doctor must also inform the patient that he will not be liable for the negligence of this independent contractor.

Applying this test to the facts in *Parker*, the court found that the patient looked to Dr. Freilich for his medical care in performing the colonoscopy. With the second prong of this test, the court held that Dr. Freilich held out Mr. Shaw as his employee, despite the fact that Mr. Shaw had his own letterhead with a separate business address on both his consent and history forms which the patient reviewed prior to the performance of the colonoscopy.

In light of the *Parker* holding, it appears that physicians have an affirmative duty to separate which of their employees are employees of their office as opposed to independent contractors and there will be a much tighter scrutinization of office practice, procedures, and staffing.

*Cindy A. Sheridan, Esq.*

## Insurance Update

### *605/715 Coverage Update: Prejudice Must Be Shown Prior to Rejecting a Claim Based on the 180 Day Rule.*

The Commonwealth Court in the matter of *PMSLIC v. The Medical CAT Fund*, 2002WL1889548 (August, 2002), has altered the process in requesting section 605/715 coverage with the Medical CAT Fund. Specifically, claims can not be rejected as untimely due to the 180 day rule unless it can be proven that the Fund has been prejudiced by late submission of coverage.

By way of background, section 605/715 is a form of extended claim coverage provided by the CAT/Care Fund. Specifically, the CAT /Care Fund must defend claims made greater than four years from the date of the alleged malpractice. In 1996, Act 135 added the 180 day reporting requirement to section 605/715 coverage. Since 1996, the Fund would regularly reject coverage requests on the basis of the 180 day rule, forcing primary carrier's to keep claims that otherwise met the four year requirement under section 605/715.

PMSLIC challenged the 180 day rule associated with section 605/715 coverage, citing old section 702(c) of the act which had a provision explaining that the Fund could not reject coverage unless they have been prejudiced by failure of notice. Section 702(c) was not changed by the Act 135 amendments of 1996.

The Commonwealth Court held that old section 702(c) should be read in conjunction with section 605/715 and held that prejudice and an expiration of the 180 days must be found before the Fund can reject coverage on a 605/715 basis.

Therefore, the fund can no longer reject 605/715 coverage merely because of the 180 day rule has expired. Actual prejudice to the Fund must be shown before they can reject coverage.

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#### **THE PERRY LAW FIRM update**

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# ***Prior Motor Vehicle Accident Release May Preclude Subsequent Medical Malpractice Action if it was a Matter Within the Contemplation of the Plaintiff at the time of the Signed Release***

The Pennsylvania Superior Court, in Fortney v. Callenberger, 801 A 2d 594 (Pa. Super. 2002), recently confirmed that a general release signed before a medical malpractice lawsuit's initiation may preempt the subsequent action.

In Fortney, the plaintiff was involved in a motor vehicle accident on January 3, 1996 requiring emergency room treatment and surgery to his ankle. Prior to signing a motor vehicle accident settlement release, the evidence showed that the patient had complaints of pain, lack of mobility and inability to walk on the ankle that was operated on as a result of the motor vehicle accident. Further, prior to signing the release, the plaintiff had an interview with the motor vehicle insurance company adjuster in which he indicated he had a great deal of pain and problems walking as a result of his ankle injury. On May 17, 1996, the plaintiff signed the motor vehicle release for \$75,596.60 and subsequently filed a medical malpractice suit against the surgeon who operated on his ankle on January 3, 1996. The defense lawyer for the surgeon raised a prior release in their new matter and subsequently filed a motion for summary judgment.

The Superior Court reaffirmed that courts must scrutinize the ordinary meaning of the

language of a release and determine whether subsequently filed claims can fairly have been said to be within the contemplation of the parties when the release was signed. It further emphasized that releases are to be strictly construed so as to not bar the enforcement of a claim that had not accrued at the date of the execution of the release.

In the instant matter, the court held that the surgeon was covered by the motor vehicle accident release and therefore had standing to assert the claim. The court then proceeded to the more challenging issue of whether plaintiff was contemplating a medical malpractice action at the time the release was signed. After reviewing the evidence, the Superior Court found that the plaintiff was in fact contemplating the medical malpractice release and therefore affirmed the trial court's granting of the defendant's motion for summary judgment.

Plaintiff argued that he had no knowledge of the potential medical malpractice claim until after this release was signed during a second opinion by another physician in 1997. However, the court paid particular attention to the complaints made by the plaintiff during his office visits subsequent to January 3, 1996 surgery and the taped interview by the motor vehicle accident insurance claim representative.

They felt that those complaints were sufficient to prove that the plaintiff was contemplating a medical malpractice action. The Superior Court further reconciled this holding with their decision in Vaughn v. Didizain, 648 A. 2d 38 (Pa. Super. 1994) where they found the medical malpractice cause of action did not accrue prior to the signing of the release. In Vaughn, the motor vehicle accident release was signed in November of 1983 and the treatment in question was rendered in August of 1984. Because the 1984 surgery was not contemplated in 1983, the Court in Vaughn held that a medical malpractice action was not a matter within the contemplation of the plaintiff at the time the release was signed.

Unlike Vaughn, the treatment at issue occurred prior to the release and plaintiff had documented problems with the ankle prior to the signing of the release. Because the plaintiff knew that he had potential problems resulting from the January 3, 1996 surgery, the medical malpractice claim had accrued and was contemplated by the time the plaintiff signed the release.

*John R. Hill, Esq.*

## Expert Testimony

# ***Expert Testimony Not Required to Prove Plaintiff's Emotional Damages***

The Pennsylvania Supreme Court recently held that expert testimony would not be required by the plaintiff to prove emotional injuries related to personal injury actions. In Montgomery v. Bazaz-Sehgal, M.D., 798 A. 2d 742 (Pa. 2002), the plaintiff was treating with the defendant urologist who specialized in impotence. The defendant doctor's initial diagnosis was that plaintiff suffered from venous insufficiency and attempted to treat this condition conservatively. After a number of weeks utilizing conservative treatment, the parties agreed they should proceed surgically. In a surgery performed in March of 1990, the defendant doctor removed the venous structures at issue and implanted an inflatable pump prosthesis in the plaintiff's penis.

At this point, the parties' stories diverge. The defendant doctor claimed that he informed the patient that they would be considering this procedure. Plaintiff, however, denied that he was ever informed that he would have an inflatable

pump placed in his body. He stated the first time he ever knew it was in his body was when he woke up and the nurse handed him a warranty card for his prosthesis. Plaintiff immediately demanded that the prosthesis be removed; but, defendant doctor stated that he could not because there was nothing left within the structure.

The plaintiff subsequently filed a medical malpractice suit including informed consent/battery claims. One of the issues at trial was whether the plaintiff was required to produce expert testimony to prove his emotional injuries. The Supreme Court held that plaintiff must present expert testimony to confirm his physical injuries because, to the ordinary lay person, it would be difficult to determine whether the plaintiff's diminished sensation was the result of the prosthesis or a result of the natural progression of the pre-existing condition.

However, the Court held that expert testimony was not required to prove emotional injuries as a result of the prosthesis. The unwanted penile prosthesis was cumbersome, embarrassing and felt like a machine because it had to be pumped before intercourse.

The Court reasoned that the above complaints were obviously and clearly connected to the prosthesis and it was within the range of comprehension of the jurors whether the emotional injuries might reasonably be attributable to the prosthesis. Therefore, an expert was not required to explain the connection between the unwanted implant and emotional injuries associated with it. It was clear that the subject matter was within the expertise and comprehension of the lay jurors.

*Frank J. Brier, Esq.*

# Question

*Are hospitals vicariously liable for a doctor's failure to obtain a patient's informed consent?*

# Answer

*No. A medical facility lacks control over the manner in which a physician performs his duty to obtain informed consent. Valles v. AEMC 2002 WL 1980149 (Pa. Super. 2002)*

The Pennsylvania Superior Court was recently presented with the question of whether vicarious liability for the conduct of a defendant physician could

be imposed on the hospital with regard to plaintiff's claim that the physician did not obtain her informed consent for the performance of a procedure. The Superior Court held that the hospital cannot be found vicariously liable in an informed consent claim because the battery which results from a lack of informed consent is not the type of action that occurs within the scope of employment. A medical facility cannot maintain control over this aspect of the physician-patient relationship and therefore the duty to obtain informed consent belongs solely to the physician. The area of informed consent

flows from the discussions each patient has with their physician based on the facts and circumstances that each case presents. The Superior Court explicitly stated that they "decline to interject an element of a hospitals' control into the highly individualized and dynamic relationship." This would be both "improvident and unworkable" for the physician in their duties.

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