DePaul Journal of Health Care Law

Volume 6
Issue 2 *Spring 2003: Symposium - Medical Malpractice: Innovative Practice Applications*

Article 8

November 2015

Case Briefs

DePaul College of Law

CASE BRIEFS

AGENCY

Hospital Vicariously Liable For Physician's Malpractice Only When Patient Reasonably Looked to Hospital for Treatment or When Patient Viewed Hospital as Location For Treatment

The Court of Appeals of Michigan held there was no basis to hold hospital defendants liable merely because patient relied on their perception of their qualifications, their belief their physician was an agent of the hospital, or their belief in obtaining services from the physician.[1]

Plaintiff Virginia VanStelle took plaintiff Robert P. VanStelle to the emergency room at co-defendant Bon Secours Hospital.[2] The hospital discharge papers showed the patient was referred to co-defendant Dr. Thomas U.[3] Dr. U was an employee of co-defendant Michigan Neurological Associates, P.C., and had staff privileges at a few area hospitals – including St. John Hospital and St. John Riverview Hospital.[4] Patient went to Riverview Medical Offices to see Dr U, wherein Dr. U diagnosed patient as having had a small vessel lacunas stroke and hypertension and gave patient his card, which listed "St. John Health System" and "Riverview Medical Offices."[5] Soon after, patient suffered a stroke.[6] Patient instituted this medical malpractice suit and alleged Dr. U was "an agent, whether real or ostensible, servant and/or employee of defendants, Michigan Neurology Associates, P.C.; St. John's Hospital and Medical Center; St. John Health Systems; and St. John Health Systems Detroit Medical Campus."[7]

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[1] Vanstelle et al. v. Macaskill et al., No. 229123, 2003 Mich. App. LEXIS 43, at *23 (Jan. 14, 2003).

[2] *Id.* at *3.

[3] *Id.*

[4] *Id.*

[5] *Id.*

[6] *Vanstelle*, 2003 Mich. App. LEXIS at *4.

[7] *Id.*

The court considered whether a hospital could be held vicariously liable for treatment at a medical professional building "affiliated" with the hospital.[8] In addition, whether a hospital could be held vicariously liable for medical treatment rendered by a physician who represented himself as the hospital's physician for treatment not provided at the hospital.[9] The court identified three elements necessary to establish an allegation of ostensible agency: (1) the person dealing with the agent must do so with a reasonable belief in the agent's authority, (2) the belief must be generated by some act or neglect of the principal sought to be charged, and, (3) the person relying on the agent's authority must not be guilty of negligence.[10]

The court found the Riverview defendants made no representations that would lead patient to reasonably believe Dr. U was an agent of St. John Riverview Hospital.[11] Also, there was no evidence linking St. John Riverview Hospital or the Riverview Medical Offices with patient's selection of Dr. U because patient only went to Dr. U after his own inquiry as to whether he was a "St. John doctor."[12] The court said a critical factor was whether patient looked to the hospital for treatment or whether patient "merely viewed the hospital as the situs where the doctor would treat him," and found the hospital did not make any representations Dr. U was acting on behalf of Riverview Hospital.[13] As for the St. John defendants, the court reviewed whether patient looked to St. John for treatment and found St. John did not provide patient with Dr. U's information, in the alternative, the emergency room physician at Bon Secours Hospital provided patient with Dr. U's information.[14] Therefore, the court held no reasonable person would believe Dr. U was acting as an agent of the St. John defendants when providing services for patient; the judgment of the trial court was reversed, and the case was remanded to the trial court for entry of an order granting summary disposition to the hospitals.[15] *Vanstelle et al. v. Macaskill et al. No. 229123, 2003 Mich. App. LEXIS 43 (Jan.14 2003).*

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[8] *Id.*
[9] *Id.* at *7.
[10] *Id.* at *11.
[11] *Vanstelle*, 2003 Mich. App. LEXIS at *16.
[12] *Id.* at *17.
[13] *Id.* at *19.
[14] *Id.* at *22-23.
[15] *Id.* at *23-24.

COPYRIGHT LAW

Filing of a Patent Application Prior to Patent Expiration Is Not an Act of Infringement Unless the Application Seeks Approval to Manufacture, Use, or Sell the Drug Prior to the Expiration of a Patent.

The United States Court of Appeals for the Seventh Circuit held that the United States District Court for the Northern District of Illinois did not err in holding competitors did not infringe in seeking approval to market their drug for use as an epilepsy treatment because neither the drug or its stated use was covered by an existing patent.[16]

Appellant, Warner-Lambert, sold a drug, gabapentin under an expired patent for use in the treatment of partial seizures.[17] Appellee competitor Apotex, filed an Abbreviated New Drug Application ("ANDA"), seeking approval to market a generic form of gabapentin upon the expiration of Warner-Lambert's patent.[18] Apotex declared that its proposed manufacture, use, and sale of the drug would be limited solely to epilepsy treatment and its marketing would not conflict with Warner-Lambert's use of its patent; namely, Apotex would not include any indication for use in the treatment of neurodegenerative of neurogenerative disease.[19] Warner-Lambert commenced a patent infringement action, contending that patients would use Apotex's gabapentin for all purposes for which Warner-Lambert's product is used, and doctors would prescribe the Apotex product for such uses, including the treatment of neurodegenerative diseases.[20]

The court reviewed the district court's grant of summary judgment de novo, interpreting the language of the patent statute at issue.[21] When interpreting a statute, the court will not look merely to a particular clause in which general words may be used, but will consider the language in connection with the whole statute.[22] As a result, the court found that the statute does not make the filing of an ANDA prior to patent expiration an act of infringement unless the application sought approval to manufacture, use, or sell the drug

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[16] Warner-Lambert Co. v. Apotex Corp., 2003 U.S. App. LEXIS 594 at **48. (U.S. Jan 16, 2003).

[17] *Id.* at **4.

[18] *Id.*

[19] *Id.* at **5.

[20] *Id.* at **7.

[21] *Warner-Lambert Co.*, 2003 U.S. App. LEXIS 594 at **9.

[22] *Id.* at **13.

prior to expiration of a patent.[23] The court concluded that because Apotex had not submitted an application to sell a drug for treatment of neurodegenerative diseases, which is the only use covered by the patent involved, Apotex was entitled to summary judgment of non-infringement.[24]

The court next addressed the question of whether Warner-Lambert demonstrated the existence of a genuine issue of material fact with respect to inducement.[25] The court concluded that mere knowledge of possible infringement by others does not amount to inducement; specific intent and action to induce infringement must be proven.[26] As Warner-Lambert failed to produce any evidence Apotex possessed or would encourage doctors to infringe its patent, there has been no genuine issue of material fact raised.[27]

The court agreed with the district court's granting of summary judgment in favor of Apotex., as the statute's language indicates that Apotex did not infringe on an existing patent, and induced neither patients nor doctors into infringing acts. Therefore, the court affirmed the grant of non-infringement for Apotex.[28] *Warner-Lambert Co. v. Apotex Corp., 2003 U.S. App. LEXIS 594 (Jan. 16, 2003).*

CRIME

Individual Is Guilty of Manslaughter When He Demonstrated Reckless Behavior by Driving Contrary to Medical Orders and Driving with the Knowledge That He Is Prone to Seizures

The Court of Appeals of Texas affirmed the District Court's judgment convicting appellant of manslaughter.[29] There was sufficient evidence to show that appellant was reckless and caused the death of the victim by driving despite physician's orders not to drive because he is prone to seizures.[30]

Appellant Robertson suffered a grand mal seizure while driving in his car, causing the car to run off the highway and ultimately into the living room of a house, where a nine year old girl

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[23] *Id.* at **15.

[24] *Id.* at **36.

[25] *Id.* at **37.

[26] *Warner-Lambert Co.*, 2003 U.S. App. LEXIS 594 at **42.

[27] *Id.* at **41.

[28] *Id.* at **1.

[29] Robertson v. State of Texas, No. 08-00-00147-CR, 2003 Tex. App. LEXIS 931 at *1 (Jan. 30, 2003).

[30] *Id.* at *20-21.

was killed.[31] Robertson was subsequently convicted of manslaughter and sentenced to 15 years in prison by a jury.[32] Previously, Robertson had suffered a severe head injury from a motorcycle accident, after which he became prone to seizures.[33] He had since experienced other episodes of seizures, one of which was while driving, and subsequently required anti-seizure medication.[34] The physician prescribing the medication ordered Robertson not to drive, operate dangerous equipment, and to see a neurologist.[35] Robertson did not see a neurologist and stopped taking the anti-seizure medications, despite physicians' orders to continue the medication.[36]

The issue addressed by the court was whether there was sufficient evidence to prove Robertson had recklessly caused the girl's death by: (1) not taking anti-seizure medications as ordered, (2) driving against the orders of the physician, and (3) driving with the knowledge that he was prone to seizures.[37] With respect to the first factor, the court found that Robertson's failure to take the medication was not intentionally done in disregard of the risks associated with it, since he had seen numerous physicians, some or all of who did not strongly enforce the necessity for the medication.[38] The court held, however, that Robertson was liable in the other two factors, given his past history of automobile accidents while suffering seizures and evidence that he may have not disclosed the truth about his medical condition on his driver's license application.[39] These facts reflect evidence that Robertson was acting in conscious disregard of the danger he would pose to others.[40] His conviction was therefore affirmed.[41] *Robertson v. State of Texas, No. 08-00-00147-CR, 2003 Tex. App. LEXIS 931 (Jan. 30, 2003).*

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[31] *Id.* at *1.
[32] *Id.* at *1.
[33] *Id.* at *3.
[34] *Robertson*, 2003 Tex. App. LEXIS 931 at *4.
[35] *Id.* at *4-5.
[36] *Id.* at *5.
[37] *Id.* at *15-16.
[38] *Id.* at *16-20.
[39] *Robertson*, 2003 Tex. App. LEXIS 931 at *20-21.
[40] *Id.* at *21.
[41] *Id.* at *21.

DEFAMATION

A False Claim That a Physician Is Dying Harms a Physician by Implying That S/he Lacks a Necessary Professional Characteristic.

The Supreme Court of Massachusetts held a physician who has been falsely accused of having a terminal illness can recover damages under defamation laws, without having to prove specific economic loss.[42]

Both Ravnikar and Bogojavlensky were physicians of obstetrics and gynecology.[43] Ravnikar ("plaintiff") was diagnosed with breast cancer in 1995 and treated successfully. [44] Two years later, Bogojavlensky ("defendant") was approached by a patient who was interested in finding a new gynecologist, and mentioned hat she was also going to visit plaintiff.[45] In response, defendant said plaintiff suffered from terminal breast cancer.[46] When the patient repeated these comments, plaintiff sued, alleging defamation, intentional interference with business relations, invasion of privacy and unfair competition. [47] After the district court granted defendant's motion for summary judgment, the plaintiff appealed to the appellate division, which affirmed the lower court's decision.[48] The Supreme Court subsequently reviewed the case and concluded that summary judgment was improperly entered on both the defamation and invasion of privacy claims. [49]

The issue was whether plaintiff met the burden of proof necessary to overcome a motion for summary judgment. [50] To withstand summary judgment, plaintiff must prove four elements of defamation.[51] First, the defendant must have made a comment about the plaintiff to a third party.[52] Second, the statement could damage plaintiff's reputation and third, the defendant was at fault.[53] Lastly,

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[42] Ravnikar v. Bogojavlensky, SJC-08820, 2003 Mass. LEXIS 114 at ***3 (Dec. 3, 2003).

[43] *Id* at ***1.

[44] *Id.*

[45] *Id.*

[46] *Id.*

[47] *Ravnikar*, 2003 Mass. LEXIS 114.

[48] *Id* at ***1.

[49] *Id* at ***1-2.

[50] *Id* at ***2.

[51] *Id* at ***2.

[52] *Ravnikar*, 2003 Mass. LEXIS 114 at ***2.

[53] *Id.* at ***2.

the statement either caused plaintiff economic loss or falls within one of the exceptions of this requirement.[54] Four types of statements are actionable without proof of economic loss including libel, those that charge plaintiff with a crime, alleging plaintiff has certain diseases and those that prejudice a person's business or profession.[55]

The court held plaintiff falls within the exception that allows economic damages when statements prejudice a profession or business.[56] By falsely informing a patient that plaintiff was terminally ill, the defendant prejudiced her business or profession by implying she lacked a necessary characteristic of the profession.[57] Such a statement assumes that a physician cannot maintain a caring, long-standing relationship with patients.[58] Therefore, the court vacated and remanded the lower court's decision, concluding that defendant's action was actionable without having to prove specific economic damage.[59] *Ravnikar v. Bogojavlensky, 2003 Mass. LEXIS 114 (Dec. 3, 2003).*

DISABILITY

State Law Claims For Disability Benefits Are Preempted by ERISA When An Insurance Policy Falls within ERISA's Safe Harbor Provision and Plaintiff Is a Participant or Beneficiary of ERISA.

The United States District Court for the Northern District of Illinois, Eastern Division, granted a motion to dismiss in favor of Liberty Life Assurance Company, pursuant to Fed. R. Civ. P. 12(b)(6), on all counts of emotional distress, retroactive benefits and punitive damages because plaintiff's claims are state law claims that are pre-empted by the Employee Retirement Income Security Act (ERISA).[60]

While Bernard Turnoy was employed as an independent agent on behalf of the Massachusetts Mutual Life Insurance Company, he received short and long-term disability coverage through a Liberty

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[54] *Id.* at ***2.

[55] *Id.*

[56] *Id* at ***3.

[57] *Ravnikar*, 2003 Mass. LEXIS 114 at ***3.

[58] *Id.*

[59] *Id.*

[60] Bernard Turnoy v. Liberty Life Assurance Company of Boston, No. 02 C 6066, 2003 U.S. Dist. LEXIS 1311 at *1 (N.D. Ill. Jan. 30, 2003).

group policy.[61] In December 2000, plaintiff's health began to deteriorate to such an extent that he sought disability benefits from Liberty.[62] After his petition was denied on February 5, 2002, the plaintiff unsuccessfully appealed the decision.[63] Plaintiff alleged that Liberty failed to respond to his appeal and that he was owed benefits in the amount of $4255.90/month since March 17, 2001. He also sued for tort damages of emotional distress and punitive damages for "unreasonable conduct."[64] In its motion to dismiss, Liberty asserts plaintiff's insurance policy is an ERISA "employee welfare benefit plan" thereby preempting any state claims.[65] Furthermore, his claims for emotional distress and punitive damages must also be stricken. [66]

The Seventh Circuit has construed 29 U.S.C. § 1002(1), which defines "employee welfare benefit plans," to include five elements. These are: (1) a plan, fund, or program, (2) established or maintained, (3) by an employer, and (5) top participants or their beneficiaries.[67] Moreover, ERISA's safe harbor regulation states that an employee welfare benefit plan does not include certain provisions outlined in 29 C.F.R. §2510.3-1(j). [68]

The first issue the court addresses is whether Mass Mutual's policy was "established and maintained" in such a way that it fell outside of ERISA's safe harbor provision.[69] For a plan to remain outside the provision, employer neutrality must be established.[70] In this case, Mass Mutual was not neutral because Mass Mutual was extensively involved in the establishment and maintenance of the policy.[71] For example, the policy states Mass Mutual is the "sponsor," eligible classes of insurance benefits will be published annually by the company, and all premiums are payable to Mass Mutual.[72] Therefore, Mass Mutual's policy falls outside the safe harbor policy and ERISA is implicated.[73] The second issue is whether plaintiff can properly be classified as a beneficiary covered

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[61] *Id* at *2.
[62] *Id.*
[63] *Id.*
[64] *Id.* at *2.
[65] *Turnoy*, 2003 U.S. Dist. LEXIS 1311 at *2.
[66] *Id.*
[67] *Id.*
[68] *Id* at *2-3.
[69] *Id.* *3.
[70] *Turnoy*, 2003 U.S. Dist. LEXIS 1311 at *3.
[71] *Id.*
[72] *Id.*
[73] *Id.*

by ERISA when he was an independent contractor.[74] The court held that the plaintiff was a beneficiary to whom ERISA provisions apply, even if he is not an employee of Mass Mutual and a participant of ERISA[75]. Thus, an independent contractor may be subject to ERISA's provisions.[76]

The third issue addressed by the court concerned whether ERISA preempts plaintiffs' state law claims.[77] The court concluded plaintiff's claims of breach of contract, emotional distress and unreasonable conduct relate to an ERISA plan, thus falling within its preemption clause.[78] However, plaintiff maintains his claims fall within the saving clause, 29 U.S.C. §1144(b)(2)(A), which allows persons to pursue claims under state laws notwithstanding their relation to ERISA.[79] To determine whether saving clause applied, the court had to ask whether the state law is directed to the insurance industry.[80] Next, the court determined whether the law regulates insurance by (1) transferring policy holder risk, (2) being integral to a policy relationship and (3) limiting the entities of the insurance industry.[81] The court held the saving clause does not apply so plaintiff's claim is not preempted.[82] Since each of plaintiff's claims was preempted by ERISA, the court granted defendant's motion to dismiss all counts. *Bernard Turnoy v. Liberty Life Assurance Company of Boston, No. 02 C 6066, 2003 U.S. Dist. LEXIS 1311 (N.D. Ill. Jan. 30, 2003).*

Employer Improperly Discontinued Employee's Temporary Total Disability Compensation without Evidence of Maximum Medical Improvement and without Offering Alternative Work

The Court of Appeals of Ohio, Tenth Appellate District, said a magistrate's determination was correct in holding defendants' findings that an employer improperly discontinued temporary total disability payments to respondent employee, were proper.[83] There was sufficient evidence by respondent worker's physician and the

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[74] *Id.*
[75] *Turnoy*, 2003 U.S. Dist. LEXIS 1311 at *4.
[76] *Id.*
[77] *Id* at *5.
[78] *Id.*
[79] *Id.*
[80] *Turnoy*, 2003 U.S. Dist. LEXIS 1311 at *5.
[81] *Id.*
[82] *Id* at *5.
[83] Nestle USA v. Industrial Comm'n of Ohio, No. 01AP-1214, 2003 Ohio 413, *P7-*P8.

fact employer did not provide other work to her to show that relator improperly discontinued payments.[84]

Respondent worker Karen S. Chesnick ("Chesnick") filed a claim regarding an injury sustained during employment with relator Nestle USA ("Nestle").[85] After Nestle refused to certify the claim, a district hearing officer allowed the claim and gave temporary total disability (TTD) compensation to Chesnick.[86]

The TTD compensation continued until Chesnick's physician granted her permission to return to work but with restrictions for light duty work only.[87] Nestle then sent a letter to Chesnick, acknowledging the findings by physicians that required her to perform only light work.[88] It also stated that Nestle did not have any light duty work available and therefore they must discharge Chesnick.[89] Ten days later, Nestle sent another letter that stated that Chesnick's TTD compensation will be discontinued.[90] Chesnick filed a complaint against Nestle on the grounds that Nestle improperly discharged her without a hearing and without a statement by a physician informing them of maximum medical improvement and/or permanency of injury.[91] Respondent Self-Insuring Employers Evaluation Board (SIEEB) found the complaint valid.[92] Nestle sought, among other requests, to vacate this finding and maintain discontinued TTD benefits.[93]

The main issue before the court was whether Nestle's termination of Chesnick's TTD compensation was proper.[94] The court held Nestle did not have the authority to terminate compensation since it did so in violation of the Ohio statute.[95] The statute states that a self-insured employer cannot terminate an employee's TTD compensation unless one of several exceptions exists.[96] Though Nestle claimed that one of these exceptions occurred the court found otherwise and held that Nestle misinterpreted the statute.[97] Therefore, the court ruled for a writ of

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[84] *Id.* at *P5-*P7.
[85] *Id.* at *P10.
[86] *Id.* at *P10-*P11.
[87] *Id.* at *P13-*P15.
[88] *Nestle*, 2003 Ohio 413 at *P20.
[89] *Id.* at *P21.
[90] *Id.* at *P23.
[91] *Id.* at *P24-*P25.
[92] *Id.* at *P31.
[93] *Nestle*, 2003 Ohio 413 at *P1.
[94] *Id.* at *P69.
[95] *Id.* at *P106.
[96] *Id.* at *P99.
[97] *Id.* at *P101-*P106.

mandamus ordering TTD compensation to be awarded to Chesnick based on the physician's reports.[98] *Nestle USA v. Industrial Comm'n of Ohio, No. 01AP-1214, 2003 Ohio 413 (Jan. 30, 2003).*

Administrative Law Judges Must Explain with Sufficient Specificity and Substantial Evidence Its Decision to Discount an Insurance Claimant's Treating Physician's Opinion about the Claimant's Onset of Medical Conditions

The United States District Court for the Southern District of New York held an Administrative Law Judge ("ALJ") who discounts an insurance claimant's treating physician's opinion regarding the onset of a medical condition must explain with sufficient specificity and substantial evidence the basis for discounting the opinion.[99]

Plaintiff had back surgery in 1981 to remove a herniated disc.[100] After the operation, plaintiff continued to experience pain and limited mobility.[101] She was admitted for hospital treatment two times in 1982.[102] A subsequent hospital stay in 1985 led to a diagnosis of sciatic radiculopathy and cervical radiculitus, both back conditions.[103] Plaintiff Martinez began seeing Dr. Edgar Baraya in 1988.[104] Martinez's insurance terminated in March 1997.[105] Dr. Baraya's reports consistently explained that Martinez's back conditions were after-effects of her 1981 back surgery.[106] Four additional doctors subsequently examined Martinez.[107] Two doctors to whom Martinez was referred by her treating physician found that her pain and mobility restrictions derived from her 1981 back surgery.[108] Two doctors to whom Martinez was referred by the Social Security Administration found no back condition originating from her 1981 surgery.[109]

Martinez underwent various MRI testing from 1989 to 1996 which reported some back disc deterioration and bulging, disc

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[98] *Nestle*, 2003 Ohio 413 at *P116.

[99] Martinez v. Massanari, 01 Civ. 2114, 2003 U.S. Dist. LEXIS 1002, at *9, 24 (S.D.N.Y. Jan. 24, 2003).

[100] *Id.* at *3.

[101] *Id.* at *4.

[102] *Id.*

[103] *Id.*

[104] *Martinez*, 2003 U.S. Dist. LEXIS 1002 at *4.

[105] *Id.*

[106] *Id.* at *5.

[107] *Id.* at *5-7.

[108] *Id.* at *5-6.

[109] *Martinez*, 2003 U.S. Dist. LEXIS 1002 at *5-7.

protrusion, denervation, and loss of disc signal, all adverse back conditions.[110] X-rays revealed arthritic changes and localized sclerosis.[111] Later MRIs taken between 1996 and 1998 and further X-rays revealed similar degeneration.[112] The Social Security Act requires that a person claiming insurance benefit coverage for a disability have been insured at the moment of the onset of the disability.[113]

The court addressed the standard of review which binds an ALJ in his or her determination of an insuree's claim for disability benefits.[114] The court held an ALJ must meet a "substantial evidence" standard and apply a five-step evaluation of claims.[115] The court defined "substantial evidence" as evidence a reasonable person would consider adequate to prove a claim for benefits.[116] The five-step process of evaluation of a claim includes identifying whether the claimant is capable of gainful employment, has a severe impairment, has the capacity to perform past work, and whether the claimant could perform other work.[117] The court reasoned a judge should give the treating physician's opinion substantial weight as long as it is well-supported and consistent with other evidence presented in the claimant's record.[118] Further, the ALJ should explain his or her decisions with sufficient specificity that discount the treating physician's medical opinion or make conclusions about an administrative record that contains unresolved ambiguities or inadequate clarifications.[119]

The court also addressed the weight a treating physician's opinion should have when applied to retrospective diagnoses.[120] The court held a treating physician's opinion should control unless other evidence in the record contradicts the opinion. The court reasoned the treating physician is currently treating the claimant despite the possibility that the treating physician may not have treated the claimant during the insured period.[121] Moreover, the diagnosis of a claimant's medical condition may be made after the

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[110] *Id.* at *7-8.
[111] *Id.* at *8.
[112] *Id.* at *9.
[113] *Id.* at *10.
[114] *Martinez*, 2003 U.S. Dist. LEXIS 1002 at *10.
[115] *Id.* at *9-10.
[116] *Id.*
[117] *Id.* at *11.
[118] *Id.*
[119] *Martinez*, 2003 U.S. Dist. LEXIS 1002 at *13-14.
[120] *Id.* at *16.
[121] *Id.* at *19.

actual moment of onset of the condition.[122] The court also reasoned, however, an ALJ may weigh the treating physician's opinion against factors such as the length of the physician-claimant relationship, the support of the physician's opinion by other medical sources, and whether the treating physician is a specialist.[123] Plaintiff's motion for judgment on the pleadings was denied and plaintiff's motion for remand for a new hearing was granted.[124] Defendant's motion for judgment on the pleadings was also denied.[125] *Martinez v. Massanari, 01 Civ. 2114, 2003 U.S. Dist. LEXIS 1002 (S.D.N.Y. Jan. 24, 2003).*

EMPLOYMENT PRACTICES

The Court Did Not Find Employer to Have Violated the Family Medical Leave Act (FMLA) When It Discharged Employee after Granting More than Twelve Weeks of Leave.

The Court of Appeals of Colorado reviewed a trial court's decision to grant summary judgment de novo.[126] Summary judgment is appropriate only if the pleadings and documents illustrate no genuine issue of material fact.[127] Here, the court affirmed the lower court's summary judgment stating that the employer did not violate the Family Medical Leave Act (FMLA) when it discharged employee after granting more than twelve weeks of leave. [128]

Plaintiff Krauss was a long-term employee of Catholic Health Initiatives Mountain Region. She first took leave under FMLA in 1999 and then again in 2000 because of serious health problems.[129] When her twelve-week entitlement was used, her employer gave her an extension, but terminated her employment when she failed to request personal leave or return to work.[130] Consequently, plaintiff sued for denial or interference with her FMLA rights, constructive discharge and public policy wrongful discharge.[131]

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[122] *Id.* at *17.
[123] *Id.* *12.
[124] *Martinez*, 2003 U.S. Dist. LEXIS 1002 at *25.
[125] *Id.* at *25.
[126] Krauss v. Catholic Health Initiatives Mountain Region, 02 CA 0108, 2003 Colo. App. LEXIS 124.
[127] *Id* at *1.
[128] *Id.*
[129] *Id.*
[130] *Id.*
[131] *Id.*

Krauss maintained that disputed facts remain concerning employer's violation of the FMLA.[132] The FMLA guarantees employees twelve weeks leave each year and the reinstatement of the employee to her former position once she has returned.[133] Under 29 U.S.C. §2614(a) (1), employees may sue for entitlement, interference, retaliation or discrimination.[134] The court held the employer did not deprive plaintiff of FMLA rights by discharging her while she was on leave.[135] To satisfy an entitlement claim, plaintiff must prove employer interfered with, restrained or denied her rights, and this denial resulted in prejudice.[136] In this case, employee received written notice that her additional leave would expire soon.[137] The letter specified that employee must return to work or request personal leave.[138] This letter was followed by a phone call and another letter but plaintiff never responded.[139] Since employer discharged her after she had received more then twelve weeks, the trial court did not err in finding the discharge lawful.[140] Second, employer did not interfere with FMLA rights when a supervisor verbally reprimanded plaintiff for absences.[141] With respect to this and other allegations, employee did not show prejudice since she received more than twelve weeks of FMLA leave regardless.[142] Third, plaintiff did not establish a prima facie case of retaliation.[143]

To establish such a case, an employee must show assertion of FMLA right, followed by an adverse employment action and their causal connection.[144] Adverse employment action means a final decision regarding hiring, firing, compensation, benefits or the failure to promote or grant leave.[145] The court did not find plaintiff's denial of Christmas vacation time or her termination to be adverse employment action.[146] Fourth, employer did not violate the

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[132] *Krauss*, 2003 Colo. App. LEXIS 124 at *1.
[133] *Id.*
[134] *Id.* at *2.
[135] *Id.*
[136] *Id.* at *2.
[137] *Krauss*, 2003 Colo. App. LEXIS 124 at *2.
[138] *Id.* at *2.
[139] *Id.*at *2.
[140] *Id.* at *2.
[141] *Id.*
[142] *Krauss*, 2003 Colo. App. LEXIS 124 at *3.
[143] *Id.*
[144] *Id.*
[145] *Id.*
[146] *Id.* at *3-4.

FMLA by constructively discharging her.[147] To establish constructive discharge, employee must present enough evidence to show employer deliberately made working conditions so intolerable that a reasonable person would be forced to resign.[148] Here, since plaintiff was an at-will employee, subject to discharge at any time, she must combine her constructive discharge claim with a right to continued employment.[149] Lastly, the court does not find a public policy wrongful discharge.[150] Therefore, the trial court did not err in granting summary judgment on employee's FMLA claims.[151] *Krauss v. Catholic Health Initiatives Mountain Region, No. 02CA0108, 2003 Colo. App. LEXIS 124 (Jan. 30, 2003).*

Terminating an Employee While the Employee Is Awaiting Disability and Employee Benefits Does Not Constitute Conspiracy or Breach of Contract Unless the Employer Acted Overtly and Purposely in Terminating the Employee While Benefits Were Pending

The United States District Court for the Southern District of New York held an employer may terminate an employee while the employee is awaiting disability and employee benefits as long as the employer is not overtly acting to prevent the receipt of benefits and the loss of benefits is a "mere consequence" of the termination.[152]

Plaintiff Enrique Caraveo began employment as a recruiter with Nielson Media Research, Inc. in December 1988.[153] In July 1998 and March 1999, Caraveo suffered a stroke and the onset of legal blindness in his left eye.[154] Due to these conditions, Caraveo was unable to fully perform the duties of his position, which entailed travelling cross-country and computer data processing.[155] Caraveo notified his employer of his vision problems and requested reassignment to a position that did not require continuous driving.[156] Nielsen removed Caraveo from its payroll and Caraveo applied for and began receiving disability benefits from Metropolitan Life

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[147] *Krauss*, 2003 Colo. App. LEXIS 124 at *4.
[148] *Id.* at *4.
[149] *Id.* at *4.
[150] *Id.* at *5.
[151] *Id.* at *5.
[152] Caraveo v. Nielsen Media Research, Inc., 01 Civ. 9609, 2003 U.S. Dist. LEXIS 941, at *12-13, 17 (S.D.N.Y. Jan. 22, 2003).
[153] *Id.* at *3.
[154] *Id.*
[155] *Id.*
[156] *Id.* at *4.

Insurance, Inc. ("MetLife").[157] Nielsen granted Caraveo short-term disability benefits upon Caraveo's request, while he sought a different job more compatible with his medical restrictions.[158] MetLife ended Caraveo's disability coverage on April 19, 2000.[159]

Caraveo's renewed request for a transfer to a different position with Nielsen was finally granted on May 5, 2000.[160] Caraveo relocated to New Jersey to begin work on May 27, 2000.[161] However, thereafter Nielsen terminated Caraveo's employment.[162] Subsequently, Caraveo filed a complaint against Nielsen with the Equal Employment Opportunity Commission ("EEOC").[163] Caraveo made several attempts to obtain documents from Nielsen relevant to his complaint, but was repeatedly unsuccessful.[164] Although Caraveo explained to the EEOC that his requests for documents from Nielsen were being denied, the EEOC dismissed Caraveo's claims on July 20, 2001.[165] Caraveo then filed suit in federal court against Nielsen alleging civil conspiracy and that his employer violated the Employee Retirement Security Income Act ("ERISA") by terminating his employment with the intention of interfering with his pending claims for benefits.[166]

The first issue before the court was whether Nielsen conspired against Caraveo to violate state human rights laws and to deny Caraveo employment and benefits because of his disability.[167] The court held that an employer could only have civilly conspired against an employee if it had overtly and intentionally acted in furtherance of a corrupt agreement which caused damage to the employee.[168] The court reasoned civil conspiracy required a meeting of the minds of the parties and evidence of overt acts of conspiracy to deny an employee employment and disability benefits.[169]

The second issue the court considered was whether an ERISA action exists when (a) an employee is fired contemporaneously with

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[157] *Caraveo*, 2003 U.S. Dist. LEXIS 941 at *4.
[158] *Id.*
[159] *Id.*
[160] *Id.*
[161] *Id.* at *5.
[162] *Caraveo*, 2003 U.S. Dist. LEXIS 941 at *5.
[163] *Id.*
[164] *Id.* at *5-6.
[165] *Id* at *6.
[166] *Id.*
[167] *Caraveo*, 2003 U.S. Dist. LEXIS 941 at *12-13.
[168] *Id.* at *10.
[169] *Id.* at *12-13.

pending appeals for benefits and (b) the employer refuses employee requests for documents.[170] The court held an employer does not violate ERISA when an employee's loss of pension benefits is a "mere consequence" of the end of his/her employment.[171] In relation to beneficiary documents, the court held an employer cannot be held liable for refusing to supply beneficiary documents to an employee when the employee displays knowledge that another entity was its benefit plan administrator.[172] The court also reasoned the American Disabilities Association ("ADA") regulations did not apply to employers who offer employees insurance through a third-party company.[173] The court further reasoned that, in order for a valid claim for a violation against the EEOC to exist, the employee must have requested documents from the EEOC in compliance with its document request policies.[174] Plaintiff's claims were dismissed except for Count 18, which alleged that respondent employer did not obtain plaintiff's written consent prior to disclosing plaintiff employee's information to a third party.[175] Defendant's motion to dismiss was otherwise granted.[176] *Caraveo v. Nielsen Media Research, Inc., 01 Civ. 9609, 2003 U.S. Dist. LEXIS 941 (S.D.N.Y. Jan. 22, 2003).*

The United States Government Can Invoke an Independent Contractor Exception to Preserve Sovereign Immunity Against Legal Claims If It Does Not Explicitly Control or Supervise the Performance of Its Contractors

The United States District Court for the Eastern District of Pennsylvania held the independent contractor exception to tort claims against the United States may be invoked if the government does not explicitly supervise the daily operations and activities of its contractors.[177]

Thomas Threadgill resided and worked at Potomac Job Corps Center in Washington, D.C.[178] The United States Department of Labor runs The Job Corps program which provides training for at-

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[170] *Id.* at *17-18.
[171] *Id.* at *17.
[172] *Caraveo*, 2003 U.S. Dist. LEXIS 941 at *19.
[173] *Id.* at *26.
[174] *Id.* at *37.
[175] *Id.* at *38.
[176] *Id.*
[177] Young v. United States, No. 01-5484 and 02-3611, 2003 U.S. Dist. LEXIS 1341 at *18-19 (E.D. Pa. Jan. 7, 2003).
[178] *Id.* at *1.

risk young adults aged 16-24 years of age.[179] Threadgill died following an altercation with another Job Corps resident on the Center grounds.[180] Threadgill's father (plaintiff) initiated lawsuits against the United States government and Management and Training Corporation ("MTC"), the contractor that runs the Potomac Center.[181] Plaintiff alleged that neglect to provide adequate security, supervision, and proper maintenance of common areas in a federal facility proximately caused his son's death.[182] Plaintiff also argued the government should be estopped from claiming an independent contractor exception as the Job Corps program is government-sponsored.[183]

The federal government may not be sued under the doctrine of sovereign immunity.[184] The Federal Tort Claims Act ("FTCA") waives the United States from claiming liability against certain tort claims.[185] However, the FTCA waiver does not include torts by employees of contractors hired by the government, deemed the "independent contractor" exception.[186]

The court addressed whether the United States government was responsible for actions of its independent contractors in maintaining common areas, security, and supervision for programs sponsored by the United States.[187] The court held the government may assert an independent contractor exception and establish immunity to legal claims unless the government directly supervises the daily operations and actions of its contractors.[188] The court reasoned government responsibility for negligence of contractors is explicitly and purposely limited by the contract, such as the government delineating its duties separately from those of the contractor.[189]

The court continued by holding contracts in which the government specifically reserves for itself a daily role in the activities of the contractor would not allow the government to invoke the independent contractor exception. However, the absence of specific language prohibiting the government from exercising

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[179] *Id.*
[180] *Id.*
[181] *Id.* at *2.
[182] *Young*, 2003 U.S. Dist. LEXIS 1341 at *3.
[183] *Id.* at *6.
[184] *Id.* at *5.
[185] *Id.*
[186] *Id.*
[187] *Young*, 2003 U.S. Dist. LEXIS 1341 at *5.
[188] *Id.* at *10.
[189] *Id.* at *18.

supervision over the contractor's activities does not automatically exclude the government from invoking the independent contractor exception.[190] Plaintiff's complaints against the United States were dismissed.[191] The United States' motion to dismiss was granted.[192] Plaintiff's separate action against MTC is not affected by the dismissal of Plaintiff's complaint against the United States.[193] The United States' motion for a stay was denied.[194] *Young v. United States, No. 01-5484 and 02-3611, 2003 U.S. Dist. LEXIS 134 (E.D. Pa. Jan. 7, 2003).*

EVIDENCE

Enzyme Analysis Used to Test Blood Alcohol Level Meets *Frye* Test as a Matter of Law

The Supreme Court of Kansas reversed a finding by the district court that an enzyme analysis testing procedure did not meet the requirements of the *Frye* test, and remanded the case to the lower court with the finding that the results of the enzyme analysis test were admissible.[195]

Wayne Graham ("Graham") was found guilty of driving under the influence of alcohol, and in his appeal to the district court, he filed a motion to suppress results of the blood alcohol test administered to him the night of his arrest.[196] The state's expert testified that the enzyme analysis used in the blood test was commonly used in hospitals and labs, and that the test results produced by the machine were generally accepted both by the hospital laboratory community and by physicians in treating patients.[197] Graham's expert, however, testified that he did not agree that the enzyme analysis test was "generally accepted in courts of law for the purposes of ascertaining blood alcohol content" in criminal cases, and that the high percent of error rate rendered it unreliable.[198]

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[190] *Id.* at *21.
[191] *Id.* at *23.
[192] *Young*, 2003 U.S. Dist. LEXIS 1341 at *22.
[193] *Id.* at *23.
[194] *Id.* at *19.
[195] Kansas v. Graham, No. 88,881 2003 Kan. LEXIS 13 at *20 (Jan. 24, 2003).
[196] *Id.* at *3-4.
[197] *Id.* at *6.
[198] *Id.* at *7-8.

The Supreme Court was faced with the issue of whether the enzyme analysis test met the standards of the *Frye* test.[199] Because the standard of review for a trial court's application of the *Frye* standard is *de novo*, the court rejected Graham's argument that the court should be reluctant to take judicial notice of a scientific test under *Frye* where the district court has excluded the evidence.[200] The court held the enzyme analysis satisfied *Frye*, reasoning that a number of other states have accepted such evidence, it was not a novel method for determining blood alcohol concentration, and both experts testified that the test was commonly used in hospitals.[201] Therefore, the court reversed and remanded to include the evidence.[202] *Kansas v. Graham, No. 88,881 2003 Kan. LEXIS 13 (Jan. 24, 2003).*

Trial Court Did Not Commit Reversible Error When It Allowed Defendant, Negligent Driver, to Tell Jury He Was Unemployed Due to His Multiple Sclerosis.

The Court of Appeals of Maryland held that the trial court did not commit reversible error when it allowed defendant to tell the jury that the reason for his unemployment was due to multiple sclerosis, since it was evident to both the trial court and the jury that defendant suffered from this serious ailment.[203] This was a hearing to determine fair compensation for the plaintiff due to the admitted negligence of defendant in a car accident.[204]

An automobile driven by defendant, Babel, pulled in front of a car driven by plaintiff, Hodge, causing the two cars to collide.[205] Hodge suffered a cut and other injuries, but was released from the hospital the night of the accident.[206] Ms. Hodge brought a negligence action against Babel in which Babel conceded his negligence had caused the accident.[207] Consequently, the issue of damages was submitted to the jury in the following form: "What damages would fairly compensate Ms. Hodge for the injuries that

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[199] *Id.* at *9.

[200] *Kansas*, 2003 Kan. LEXIS 13, at *12.

[201] *Id.* at *19-20.

[202] *Id.* at *1.

[203] Hodge v. Babel, No. 1930, 2003 Md. App. LEXIS 6 at *19 (Jan. 30, 2003).

[204] *Id.*

[205] *Id.* at *1.

[206] *Id.*

[207] *Id.*

she sustained in the . . . accident?"[208] Babel testified on his behalf that he was unemployed because he suffered from "progressive multiple sclerosis."[209] Plaintiffs objected to this question on the ground that the information was irrelevant and it would otherwise disorient the jury.[210] However, the judge overruled the objection and gave a special instruction for the jury not to consider "sympathy for any party."[211] The jury returned a verdict in favor of the plaintiff in the amount of $2,600 even though plaintiff had introduced evidenced showing damages in the amount of $15,167.44.[212] Subsequently, plaintiff appealed.[213]

The sole issue in this case is whether the trial court committed reversible error where it allowed defendant to tell the jury that he was unemployed due to his condition of multiple sclerosis.[214] The court held the trial court did not commit error because testimony stating that defendant was not employed was not prejudicial.[215] Consequently, the court found that testimony regarding defendant's cause of unemployment was not prejudicial because it was undisputed that the defendant walked with an unsteady gait and had trouble rising from the counsel table.[216] Furthermore, it is not an abuse of discretion for the trial judge to allow the witness, in this case defendant, to give a brief explanation as to the cause of his physical problem where if no explanation is given, the jury may conclude that the disability caused the plaintiff's injury in question.[217] *Hodge v. Babel, No. 1930, 2003 Md. App. LEXIS 6 (Jan. 30, 2003).*

The Term "Community" is not an Entire State for Purposes of Establishing the Standard of Care in a Negligence Action.

The Court of Appeals of Tennessee at Nashville upheld summary judgment in favor of defendant physician in a negligence case

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[208] *Hodge*, 2003 Md. App. LEXIS 6 at *1.
[209] *Id.* at*2.
[210] *Id.* at *19.
[211] *Id.* at *21.
[212] *Id.* at 2.
[213] *Hodge*, 2003 Md. App. LEXIS 6 at 3.
[214] *Id.*
[215] *Id.* at *20.
[216] *Id.* at *18.
[217] *Id.*

dealing with the standard of care of the community in which the physician practices or in a similar community.[218]

The plaintiffs were husband and wife; the wife, Laura, sought treatment by Dr. Thompson at his office in Nolensville, Tennessee for pain in her upper back.[219] While injecting steroid and pain medication into the area of pain, Dr. Thompson inadvertently pierced Laura's lung with a needle, causing a partially collapsed lung.[220] Dr. Thompson informed her of the puncture and immediately admitted her to Williamson County Medical Center for observation and further x-rays.[221] After a re-expansion procedure, Laura was discharged from the hospital, and after a follow-up visit to Dr. Thompson it appeared that the injury had been resolved.[222] Plaintiffs filed suit one year later, alleging that Dr. Thompson was negligent and did not conform to the standard of care of the community in which he practiced or in a similar community as required by the Tennessee "Locality Rule."[223] The affidavit submitted by plaintiff's expert claimed that the standard of care in Nolensville, Tennessee at the time Laura was injured was the same standard of care in the state of Georgia, where the expert practiced.[224]

The appellate court did not accept this argument, reasoning that entire states are not be qualified as "communities," and because the expert's testimony did not allege the factual background it needed to establish what made the state of Georgia similar to the community of Nolensville, Tennessee.[225] The court affirmed the trial court decision that the plaintiffs' medical expert failed to establish the requisite familiarity with the standard of care in the community in which Dr. Thompson practices, or in a similar community.[226] *Totty v. Thompson, No. M2001-02539-COA-R3-CV, 2003 Tenn. App. LEXIS 11 (Jan. 8, 2003).*

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[218] Totty v. Thompson, No. M2001-02539-COA-R3-CV, 2003 Tenn. App. LEXIS 11 at *1(Jan. 8, 2003).

[219] *Id.* at *2.

[220] *Id.*

[221] *Id.*

[222] *Id.*

[223] *Totty*, 2003 Tenn. App. LEXIS 11, at *4-5.

[224] *Id.* at *6.

[225] *Id.* at *14-15.

[226] *Id.* at *1.

FDA AUTHORITY

The FDA Has Limited Authority to Create Regulations Unrelated To Those Specifically Provided by the FDC Act.

The United States Court of Appeals for the Second Circuit held the district court erred in dismissing plaintiff's complaint, which challenged the Food and Drug Administration's ("FDA") mandate regulating packaging of certain dietary supplements.[227] The issue on appeal was whether the FDA is delegated authority by Congress to regulate the packaging of dietary supplements.[228]

Plaintiffs, Nutritional Heath Alliance ("NHA"), filed a complaint seeking a declaration that the packaging restrictions were invalid and also sought a permanent injunction preventing the FDA from enforcing the regulation.[229] Plaintiff argues that Congress transferred jurisdiction from the FDA to enforce such regulations, and that the Consumer Product Safety Commission (CPSC) retained such authority under the Consumer Product Safety Act.[230] The FDA argued that they share concurrent authority with the CPSC to develop and enforce poison prevention packaging.[231] The district court agreed with the FDA, and found that the NHA did not provide sufficient evidence that by forming the CPSC, Congress intended to eliminate the FDA's ability to regulate product packaging.[232]

The FDA issued the regulation in response to "acute iron poisonings" in children under the age of six, where accidental overdoses of iron-containing supplements were the apparent cause.[233] After petitions made to the FDA, they issued a final rule, whereby "unit-dose packaging" must be used for drugs and dietary supplements that contain thirty milligrams or more of iron per dosage unit.[234] The FDA believed this packaging would limit the number of pills a child could consume, and therefore reduce the acute poisonings.[235] In its regulation, the FDA also mentioned that

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[227] Nutritional Health Alliance v. Food and Drug Administration, et. al, No. 01-6011, 2003 U.S. App. LEXIS 921 (2d Cir. Jan. 21, 2003).

[228] *Id.* at *2.

[229] *Id.*

[230] *Id.* at *4.

[231] *Id.*

[232] *Nutritional Health Alliance,* 2003 U.S. App. LEXIS 921at *5.

[233] *Id.* at *7.

[234] *Id.* at *8.

[235] *Id.* at *9.

these drugs and supplements must also comply with the CPSC child-resistant packaging regulations, as well.[236]

The primary issue before the court was whether the FDA was acting under a Congress appointed authority by issuing the packaging regulation.[237] When an administrative agency asserts jurisdiction to regulate a subject matter, the court must employ the *Chevron* analysis.[238] This analysis begins with asking if Congress has directly spoken to the precise question in issue; if so, the inquiry ends, and Congress' intent is upheld.[239] When Congress has not addressed the question, the court must respect the agency's construction of the statute, if it is permissible.[240]

The court looked to the FDC Act, wherein, the FDA is granted broad authority to regulate food, drug, and dietary supplements to guarantee consumer safety.[241] Thus, the general construction of the Act could give the appearance that the regulation falls under Congress appointed powers.[242] However, the court turned to the specific construction of the Act, and found that the FDA's interpretation of authority to regulate "adulterated" products was incorrect.[243] The Act deems adulterated products as "a product packed under unsanitary conditions whereby it may have become contaminated or may be rendered injurious to health."[244] The FDA's regulation does not deal with contaminated products; in fact, these products are not banned by the FDA as unsafe.[245] The court found that the Act unambiguously fails to address the FDA's authority, and that the FDA failed to meet the two prongs of the *Chevron* Test.[246] Accordingly, the court reversed and remanded the case to the district court, to provide for the proper remedy.[247] *Nutritional Health Alliance v. Food and Drug Administration, et. al, No. 01-6011, 2003 U.S. App. LEXIS 921 (2d Cir. Jan. 21, 2003).*

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[236] *Id.* at *10.
[237] *Nutritional Health Alliance,* 2003 U.S. App. LEXIS 921at *11.
[238] *Id.*
[239] *Id* at *12.
[240] *Id.*
[241] *Id.* at *13.
[242] *Nutritional Health Alliance,* 2003 U.S. App. LEXIS 921at *16.
[243] *Id.*
[244] *Id* at *21.
[245] *Id.*
[246] *Id* at 33.
[247] *Nutritional Health Alliance,* 2003 U.S. App. LEXIS 921at *33.

IMMUNITY

Purchase of Professional Liability Insurance Does Not Waive State Employee's Immunity, and Failure to Raise Issue at Trial Bars Raising It on Appeal.

The Supreme Court of Mississippi upheld a grant of summary judgment in favor of a defendant physician involving a claim of wrongful death arising out of allegedly substandard care received at a state university hospital.[248]

Inda Lewis ("Lewis") was admitted to the University of Mississippi Medical Center ("UMMC") for treatment of pain related to sickle cell anemia and died the following day.[249] Dr. Skelton was the attending physician at the time Lewis was admitted to UMMC.[250] An autopsy revealed elevated levels of Demerol and Meperdine Metabolite in Lewis's blood.[251] Corey, the plaintiff and administrator of Lewis's estate, filed an action for wrongful death against Dr. Skelton, alleging Dr. Skelton was not an employee of UMMC, Lewis's death was a result of substandard care received from Dr. Skelton, and UMMC was vicariously liable for all negligent acts of its employees.[252] Dr. Skelton filed a motion for summary judgment based on his immunity as a state employee, and that motion was granted.[253]

On appeal, the court was faced with three issues: (1) whether the trial court erred in finding that Dr. Skelton was an employee of UMMC and was acting within the scope of his employment, (2) whether the trial court erred in finding that Lewis's estate was not entitled to compensation from Dr. Skelton's medical malpractice policy, and (3) whether it was unconstitutional to deny Lewis's estate compensation from Dr. Skelton's medical malpractice insurance.[254] The court held Dr. Skelton was an employee of UMMC and therefore immune from all liability, he did not waive that immunity by purchasing professional liability insurance, and the constitutionality claim was procedurally barred.[255]

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[248] Corey v. Skelton, No. 00730, 2003 Miss. LEXIS 6, at *1 (Jan. 9, 2003).
[249] *Id.* at *2.
[250] *Id.*
[251] *Id.*
[252] *Id.*
[253] *Corey*, 2003 Miss. LEXIS 6, at *3.
[254] *Id.* at *4.
[255] *Id.* at *13.

With regard to the first issue, the court applied a five-part test outlined in an earlier case[256] to determine whether state-employed physicians should be granted immunity.[257] Because Dr. Skelton's functions were supervisory, the state has a compelling interest in maintaining an educational environment in training residents and interns, UMMC maintains great control over its employees, and Dr. Skelton did not receive direct payment from Lewis since she was a Medicaid patient, the court affirmed on the issue of Dr. Skelton being an employee of UMMC and thus immune from liability.[258] For the second issue, the court stated that the fact that physicians have personally acquired professional liability insurance is irrelevant to the inquiry as to whether a state employee enjoys immunity.[259] Regarding the third issue, the court reiterated the well-established rule that in order to raise an issue on appeal, it must have been raised at trial.[260] Therefore, the court affirmed the trial court's ruling that Dr. Skelton was immune from liability, he did not waive immunity, and the constitutionality claim was barred.[261] *Corey v. Skelton, No. 00730, 2003 Miss. LEXIS 6, at *1 (Jan. 9, 2003)*

INSURANCE

Where Plaintiff Fails to Establish Accidental Death There is No Cause of Action for Breach of Contract and Fair Dealing Against an Insurance Company

The United States District Court for the Northern District of California granted summary judgment to defendant insurance company.[262] Plaintiff's cause of action for breach of the insurance contract and breach of the covenant of good faith and fair dealing, where the plaintiff failed to prove that her husband's death was an accident, was denied.[263]

Plaintiff's husband, Mr. Robert Shar, purchased an Accidental Death and Dismemberment Certificate of Insurance from the

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[256] *Corey, citing* Miller v. Meeks, 762 So.2d 302 (Miss. 2000).

[257] *Corey*, 2003 Miss. LEXIS 6, at *6.

[258] *Id.* at *7-9.

[259] *Id.* at *10.

[260] *Id.* at *11.

[261] *Id.* at *13.

[262] Schar v. Hartford Life Insurance Co., No. C 02-1073 JL, 2003 U.S. Dist. LEXIS 1022 at *31 (N.D. Cal. January 23, 2003).

[263] *Id.* at *31.

defendant, Hartford, and designated his wife as the beneficiary.[264] The policy excluded from coverage "a loss resulting from sickness or disease" or a "loss resulting from . . . medical or surgical treatment of a sickness or disease."[265] The parties dispute the cause of death of Mr. Shar.[266] Mr. Shar's wife contends it was from an embolism resulting from surgery and Hartford believes it was from either atrial fibrillation or an embolism caused from surgery for Mr. Shar's arthritis.[267] Mr. Shar's doctor, indicated that the primary cause of death was presumed cardiac arrest and the secondary or contributory cause was pulmonary embolism with atrial fibrillation as a possible contributing factor.[268] Defendant filed a Motion for Summary Judgment that Plaintiff opposed on the ground that there were genuine issues of material fact as to the cause of Mr. Shar's death, whether it was an accident, and whether it was covered under the insurance policy.[269]

The first issue addressed by the court was whether Mr. Shar's death was the result of a sickness or disease or what could arguably be an accident.[270] Both parties accepted the Supreme Court of California's working definition for the term accident as "a casualty -- something out of the unusual course of events and which happens suddenly and unexpectedly and without design of the person injured."[271] The court held that if an embolism caused Mr. Shar's death it was not an accident, nor an unforeseen external event, but a sickness or disease not covered under his accidental death policy.[272] The court further held "nearly all deaths are unintended by the insured, whether they are 'expected' is impractical to ascertain and so is whether they happened outside the usual course of events."[273]

The second issue was whether Hartford, defendant, intentionally and explicitly waived its defense that it properly denied coverage and Mr. Shar's death was not an accident.[274] The court held that defendant's reliance on the sickness and disease exclusion does not constitute the express waiver the law requires.[275]

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[264] *Id.* at *2.
[265] *Id.*
[266] *Id.* at *3.
[267] *Schar*, 2003 U.S. Dist. LEXIS 1022 at *3.
[268] *Id.* at *9.
[269] *Id.* at *11.
[270] *Id.* at *14.
[271] *Id.* at *15-16.
[272] *Schar*, 2003 U.S. Dist. LEXIS 1022 at *25.
[273] *Id.* at *24.
[274] *Id.* at *26.
[275] *Id.* at *30.

The final issue was whether the court should grant defendant's Motion for Summary Judgment.[276] The court held that there was no coverage under the policy for Mr. Shar's death, defendant's denial of coverage was proper and not a breach of the insurance contract, and defendant did not waive its entitlement to claim that Mr. Shar's death was not caused by an accident under California law.[277] Consequently, the court granted summary judgment to defendant on plaintiff's cause of action for breach of the insurance contract. *Schar v. Hartford Life Insurance Co., No. C 02-1073 JL, 2003 U.S. Dist. LEXIS 1022 at *31 (N.D. Cal. January 23, 2003).*

The Opinion of Treating Physicians Should Be Given Deference When ERISA Sponsored Insurance Companies Determine Long Term Disability Benefits

The United States Court of Appeals for the Sixth Circuit reversed the district court decision granting summary judgment in favor of defendant insurance company, where the plaintiff sued defendant alleging violations of the Employee Retirement Income Security Act of 1974 (ERISA), with regard to the denial of continued long term-disability (LTD) benefits.[278]

Plaintiff brought the lawsuit as a result of the defendant insurance company's denial of continued LTD benefits.[279] Plaintiff claimed that he was permanently disabled due to a degenerative disc disease and osteoarthritis in his back.[280] From October 1996 through August 1998, defendant paid plaintiff monthly disability benefits.[281] However, the payments ceased because plaintiff's policy included a "special conditions" provision limiting the LTD benefits (related to conditions other than arthritis) for 24 months. [282] Defendant eventually agreed with plaintiff that the special conditions provision did not apply to him, they justified their further refusal to continue benefits based on the plaintiff's failure to satisfy the "Occupation Test".[283] The "Occupation Test" is defined as a

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[276] *Id.* at *12-15.

[277] *Schar*, 2003 U.S. Dist. LEXIS 1022 at *31.

[278] Darland v. Fortis Benefits Insurance, No. 01-5387, 2003 U.S. App. LEXIS 937 (6th Cir. Jan. 22, 2003).

[279] *Id.* at *3.

[280] *Id.*

[281] *Id.*

[282] *Id* at 4.

[283] *Darland*, 2003 U.S. App. LEXIS 937 at *4.

disability that prevents the beneficiary from performing the material duties of his regular occupation.[284]

Before analyzing the case on the merits, the court recognized that the district court failed to acknowledge a conflict of interest.[285] Defendant's final disability determination was based upon "peer review" panels which were selected by a group defendant contacted to assess plaintiff's claim.[286] Since defendant was plaintiff's plan administrator, they had an incentive to contract with a peer review company whose medical experts were motivated to deny plaintiff's claim to benefits.[287] Thus, when analyzing if defendant abused its discretion, this conflict of interest must be taken into account.[288]

The court reviewed the evidence and in light of this conflict of interest found the defendant's denial of benefits to plaintiff was arbitrary and capricious.[289] The court believed defendant ignored the findings of plaintiff's attending physicians, and deferred their decision to their own peer review committees.[290] Defendants argued that plaintiff was capable of performing his material tasks at work, because he spent his days "reading, walking at home, and watching t.v."[291] The court identified the relevant issue as whether plaintiff's treating physicians' opinion should be entitled to greater weight than defendant's peer review panel.[292] This "treating physicians rule" applying to ERISA had not been adopted in the Sixth Circuit, so the court looked to other Circuits for guidance.[293] The court ultimately decided that the treating physician rule should apply to ERISA cases because it will increase the accuracy of disability determinations because decisions not to grant benefits must have substantial evidence on the record.[294]

Finally, the court recognized that while defendant was rejecting plaintiff's request for benefits, they asked him to apply for benefits through the Social Security Administration (SSA).[295] The SSA determined plaintiff was permanently disabled, and granted

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[284] *Id.* at 10.
[285] *Id.* at 21.
[286] *Id.*
[287] *Id.*
[288] *Darland,* 2003 U.S. App. LEXIS 937 at *22.
[289] *Id.*
[290] *Id.* at *27.
[291] *Id.*
[292] *Id.*
[293] *Darland,* 2003 U.S. App. LEXIS 937 at *27.
[294] *Id.* at *29.
[295] *Id.* at *24.

him monthly disability checks.[296] Since the SSA's standard for granting disability benefits is more stringent than defendant's, the court found defendant's repeated denial of LTD benefits in error.[297] Thus, the court reversed the district court decision. *Darland v. Fortis Benefits Insurance, No. 01-5387, 2003 U.S. App. LEXIS 937 (6th Cir. Jan. 22, 2003).*

A Health Insurance Benefits Plan Does Not Discriminate on the Basis of Sex When Male and Female Employees Afflicted By Infertility Are Equally Disadvantaged by the Exclusion of Surgical Impregnation Procedures.

The United States Court of Appeals for the Second Circuit affirmed the district court's grant of summary judgment in favor of the employer with respect to the employee's Title VII and Pregnancy Discrimination Act ("PDA") claims.[298] The Court of Appeals reversed and remanded in part for a determination of whether the employer sufficiently pleaded the federal preemption under the Employee Retirement Income Security Act ("ERISA").[299]

Rochelle Saks was a member of her employer Franklin Covey's health benefits plan, which provided coverage to full-time employees.[300] Under the plan, an employee was entitled to benefits for "medically necessary" procedures, which were defined as "any service...required for the diagnosis or treatment of an active illness or injury that is rendered by or under the direct supervision of the attending physician."[301] Under the plan, employees could claim benefits for infertility products and procedures, including oral fertility drugs and surgical infertility treatments.[302] Saks, unable to conceive, sought reimbursement for all the costs associated with her infertility treatments, but was refused for the majority of the costs, including the costs for intrauterine inseminations and injectable fertility drugs.[303]

Saks alleged that Franklin Covey breached its contractual obligations and that the plan's exclusion for surgical impregnation procedures violated her civil rights under Title VII of the Civil

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[296] *Id* at *25.

[297] *Id.*

[298] Saks v. Franklin Covey Co., No. 00-9598, 2003 U.S. App. LEXIS 549 at *3 (2d Cir. Jan. 15, 2003).

[299] *Id.*

[300] *Id.* at *3.

[301] *Id.*

[302] *Id.* at* 4.

[303] *Saks*, 2003 U.S. App. LEXIS 549 at*6.

Rights Act of 1964, the Pregnancy Discrimination Act, the Americans with Disabilities Act, and the New York Human Rights Law.[304] The district court held that the lack of coverage for the contested infertility procedures did not violate the federal statutes and that Saks's state law claims were preempted by ERISA.[305]
The court reviewed the district court's grant of summary judgment de novo.[306] Although the court found that the district court applied incorrect standards in analyzing both the PDA and Title VII sex-discrimination claim, the court affirmed the district court's summary judgment decision because the plan's exclusion of surgical impregnation procedures does not fall within the purview of the PDA, and because the plan is gender-neutral.[307]
The court determined that the district court erred in applying the equal access standard to the employee's Title VII claim.[308] Citing *Gilbert*, the court confirmed that the proper inquiry in reviewing a sex discrimination challenge to a health benefits plan is whether exclusion of benefits for those conditions results in a plan that provides inferior coverage to one sex.[309] As for the PDA, the court concluded that because the exclusion of surgical impregnation procedures disadvantages infertile male and female employees equally, the PDA does not cover Saks's claim.[310] The court remanded Saks's ERISA question to the district court to determine whether Franklin Covey's motion for summary judgment should be construed as a motion to amend the answer.[311] *Saks v. Franklin Covey Co., No. 00-9598, 2003 U.S. App. LEXIS 549 (2nd Cir. Jan. 15, 2003).*

MEDICAL MALPRACTICE

Medical Standard of Care Requires Experts Have Personal Knowledge of Relevant Medical Community Because of Variance of Practice Between States.

The United States Court of Appeals for the Sixth Circuit held a physician was barred from offering expert testimony because he did not have knowledge of "the recognized standard of acceptable

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[304] *Id.* at *2.
[305] *Id.*
[306] *Id.* at *8.
[307] *Id.* at *10.
[308] *Saks*, 2003 U.S. App. LEXIS 549 at *12.
[309] *Id.* at *13.
[310] *Id.* at *20.
[311] *Id.* at *34.

professional practice in the profession and the specialty thereof" that defendant practiced in the community at the time of the alleged injury.[312]

In 1996, patient traveled from Carbondale, Illinois to Nashville, Tennessee to see co-defendant, Dr. G. William Davis.[313] Defendant performed surgery on patient's back in a Nashville hospital and returned to the same hospital to have another physician remove a stabilizing device.[314] Patient's condition worsened soon after leaving the Nashville hospital.[315] During the subsequent negligence lawsuit, patient made it known Dr. Gornet would not be a retained expert because he was a treating physician.[316] Defendant successfully moved to exclude Dr. Gornet from testifying at trial under Federal Rule of Evidence 104 unless patient made him reasonably available for deposition.[317] However, patient attempted to admit Dr. Gornet's testimony regardless of his lack of production for deposition.[318]

The issue was whether Dr. Gornet was competent enough to offer opinion evidence in this case with regard to the applicable standard of care.[319] The court found based on the importance of proving breach of a particular standard of care to prevail in a Tennessee medical malpractice claim, the district court did not err in determining Dr. Gornet had no personal knowledge of the standard of care in Nashville nor in a similar community.[320] The court found the medical standard of care varied between states, the law to be applied is the law of that state, and Dr. Gornet admitted he did not "know any of the characteristics of the Nashville medical community."[321] Thus, the court held the district court did not abuse its discretion in entering judgment against patient because patient could not prove his claims against defendant without proper medical opinion testimony.[322] *Sommer v. Davis et al., No. 01-5761, 2003 U.S. App. LEXIS 1457 (6th Cir. Jan. 30, 2003).*

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[312] Sommer v. Davis et al., No. 01-5761, 2003 U.S. App. LEXIS 1457, at *14 (6th Cir. Jan. 30, 2003).

[313] *Id.* at *2.

[314] *Id.* at *2-3.

[315] *Id.* at *3.

[316] *Id.* at *4-5.

[317] *Sommer*, 2003 U.S. App. LEXIS at *6.

[318] *Id.*

[319] *Id.* at *10-11.

[320] *Id.* at *15-16.

[321] *Id.* at *20-21.

[322] *Sommer*, 2003 U.S. App. LEXIS at *22-24.

In Order to Add Another Physician as Joint Tortfeasor, Defendant Must Prove Fault By Establishing the Other Physician Acted Below Medical Standard of Care.

The Court of Appeal of California, Fourth Appellate District, Division Two, held the trial court did not err in denying defendant's motion to include Dr. Metros as a joint tortfeasor in a medical malpractice judgment.[323]

Plaintiff was treated by defendant for bunions on her feet.[324] In July 1998, defendant performed a bunionectomy on plaintiffs' right foot which caused plaintiff a lot of pain.[325] In September 1998, defendant performed a second corrective surgery which was unsuccessful.[326] After plaintiff suffered pain and an infection, defendant performed a third surgery. [327] Following this surgery, plaintiff was admitted into the hospital for osteomyelitis, an infection of the bone and soft tissue.[328] After the fourth surgery, the toe was deformed, shorter and nonfunctional.[329]

Plaintiff next went to Dr. Metros, who performed three more unsuccessful surgeries on her foot.[330] While Dr. Metros' efforts weren't entirely successful, they did succeed in improving the toe.[331] Plaintiff subsequently filed a medical malpractice claim against defendant.[332] Defendant appeals a medical malpractice judgment against her, claiming that Dr. Metros should be brought in as a joint tortfeasor, thus reducing her liability for non-economic damages.[333] This court is asked to review whether proof of medical malpractice was needed to add Dr. Metros to the special verdict as an additional tortfeasor.[334]

In order to add Dr. Metros as a joint tortfeasor, defendant must establish fault within the meaning of Civil Code Section 1431.2.[335] When determining a defendant's share of fault, the court may consider the other joint tortfeasors' degree of fault and therefore

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[323] Deborah Wilson v. Sharlene M. Ritto, No. 030818, 2003 Cal. App. LEXIS 43 (Jan. 14, 2003) at ***1.

[324] *Id.*

[325] *Id.*

[326] *Id.*

[327] *Id.*

[328] *Wilson*, 2003 Cal. App. LEXIS 43 at ***2.

[329] *Id.*

[330] *Id.*

[331] *Id.*

[332] *Id.*

[333] *Wilson*, 2003 Cal. App. LEXIS 43 at ***2.

[334] *Id.*

[335] *Id.* at ***3.

minimize the defendant's portion.[336] However, there can be no apportionment of fault unless there is substantial evidence that an individual is at fault, which is lacking in this case.[337] Although defendant argues that all that is needed to establish fault is a showing of contribution, the court disagrees.[338] Fault implies wrongdoing or blameworthiness which is measured by the standard of care in the medical community. [339]So in order to prove fault, defendant must show the doctor violated medical standard of care under California Civil Code § 1431.2.[340] This was not proven here. Fault or wrongdoing in the context of medical malpractice is measured by the standard of care in the medical community.[341] Mere error of judgment is not enough to establish a doctor's fault according to the medical standard of care. [342]

Applying the medical malpractice burden of proof, the court held defendant did not establish Dr. Metros was a joint tortfeasor.[343] defendant's expert witness only testified Dr. Metros did not use spacers to stretch the tissue, but there is no proof that this practice falls below standard medical care.[344] Therefore, the trial court was correct in denying defendant's motion to add Dr. Metros as a joint tortfeasor, and the judgment was affirmed.[345] *Deborah Wilson v. Sharlene M. Ritto, No. E030818, 2003 Cal. App. LEXIS 43 (Jan. 14, 2003).*

MEDICARE/MEDICAID

Non-Parent Caregivers are Entitled to Receive Similar Medicaid Benefits as Parent Caregivers

The United States Court of Appeals for the Sixth Circuit found that the Michigan Medicaid plan's methodology for calculating benefits for parents and non-parents of dependent children violates federal Medicaid law and regulations.[346] The Sixth Circuit affirmed the

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[336] *Id.*
[337] *Id.* at ***1.
[338] *Wilson* 2003 Cal. App. LEXIS 43 at ***4.
[339] *Id.* ***4.
[340] *Id.* at ***4.
[341] *Id.* at ***1.
[342] *Id.* at ***1.
[343] *Wilson* 2003 Cal. App. LEXIS 43 at ***5.
[344] *Id.*
[345] *Id.*
[346] Richard Markva, et al v. James K. Haveman, Jr., et al, No. 012509, 2003 U.S. App. LEXIS 1225 at **1 (6th Cir. Jan. 27, 2003).

District Court's ruling permanently enjoining the defendant's from using the distinguishing methodology.[347]

The plaintiffs are grandparents who are raising one or more of their grandchildren because their grandchildren's parents are unable to care for them.[348] These grandparents are considered medically needy, which means that their incomes are too high for welfare programs, yet they qualify for Medicaid because their incomes do not cover their medical needs.[349] Thus, if the applicant's income exceeds the minimum, Medicaid benefits are not awarded unless certain out of pocket expenses for medical care exist.[350] This "spend down" is the difference between the applicant's countable income and the minimum protected income.[351] It is here where the statute makes a distinction between a "caretaker relative" and a parent caretaker and other family members.[352] If a parent caretaker applies for "caretaker relative" Medicaid, Michigan reduces the parent's income by the amount needed to care for the children.[353] This proration does not apply to the relatives who are not biological or adoptive parents of the children. [354] Thus, the "caretaker relative" parent is entitled to the greater benefits than otherwise similarly situated relatives who are not biologically related to the children.[355] The district court agreed with plaintiffs that the distinction violated the federal Medicaid law.[356]

The Court of Appeals reviewed the case de novo to see if the district court erred in granting plaintiffs' motion for summary judgment that no material fact existed as to whether the Medicaid law was violated.[357] In examining the statute, the court looked to the methodology used in determining eligibility for assistance under the Aid to Families with Dependent Children program ("AFDC").[358] Before this program was superceded by the Social Security Act, the AFDC program's methodology for granting benefits to the caretaker treated parents and non-parents equally.[359]

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[347] *Id* at *4.
[348] *Id.*
[349] *Id.* at **5.
[350] *Id.* at **6.
[351] *Markva*, 2003 U.S. App. LEXIS 1225 at **7.
[352] *Id.*
[353] *Id.*
[354] *Id.*
[355] *Id.* at **8.
[356] *Markva*, 2003 U.S. App. LEXIS 1225 at **9.
[357] *Id.* at **7.
[358] *Id.* at **13.
[359] *Id.* at **14.

The court found no relevant basis to justify this distinction in the medically needy "caretaker relative" group.[360] Thus, the court agreed with the district court that the current methodology used by the Michigan statute was more restrictive than the AFDC methodology.[361]

The court also rejects the "anti-deeming" argument, where Michigan argues that the "anti-deeming" statute precludes them from treating parents and non-parents equally.[362] The anti-deeming rule means that when a state calculates a dependent child's eligibility for Medicaid, the state is not allowed to take into consideration non-parent caretaker's responsibility for children.[363] The state argues that since the state is not allowed to assume non-parent caretaker contribution for determining a child's benefits, the state is also precluded from using this criteria when calculating the non-parent's eligibility for Medicaid.[364] The court agreed with the district court that although this methodology could be seen as reasonable, it still did not comply with Congress' requirements.[365] Finally, the court concluded that the district court was correct in determining that Michigan's policy violated the regulation which provides that similarly situated caretaker relatives should get equal "amounts, duration, and scope" of Medicaid coverage.[366] Also, the court rejected the state's argument that the plaintiffs lacked standing.[367] *Richard Markva, et al v. James K. Haveman, Jr., et al, No. 012509, 2003 U.S. App. LEXIS 1225 (6th Cir. Jan. 27, 2003).*

The Term "Medicare Eligible Expenses" Is Not Ambiguous For Purposes of Determining Terms of Insurance Contract in Breach of Contract / Promissory Estoppel Claim

The United States Court of Appeals for the Sixth Circuit held the district court was correct in granting summary judgment to defendant insurance company on a claim of breach of contract and promissory estoppel by plaintiff health care facility.[368] Plaintiff alleged that defendant breached its contract when it made only

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[360] *Id.* at **17.
[361] *Markva*, 2003 U.S. App. LEXIS 1225 at **17.
[362] *Id.* at **18.
[363] *Id.* at **20.
[364] *Id.* at **21.
[365] *Id.* at **25.
[366] *Markva*, 2003 U.S. App. LEXIS 1225 at **26.
[367] *Id.* at **29.
[368] Vencor v. Standard Life and Accident Ins. Co., No. 015435, 2003 U.S. App. LEXIS 835, **3 (6th Cir. Jan 21, 2003).

partial payment on a bill based on Medicare's per diem rates, not its standard rates, which it alleged was the correct rate of calculating costs.[369] When interpreting the contract for the term "Medicare eligible expenses," the court held the term was not ambiguous and it clearly referred to Medicare per diem rates.[370]

Vencor, a long-term health facility, submitted a bill to Standard Life and Accident Insurance Company ("Standard Life") for services rendered to two patients.[371] However, Standard Life only made partial payments of the bills, basing their calculation of the cost on the per diem rate set by Medicare.[372] Vencor claimed the rate should be based on their standard rates, citing the language in the insurance policy and interpreting the meaning of the term "Medicare eligible expenses" as all reasonable and necessary care provided.[373]

The issue before the court was whether the language in the insurance policy was ambiguous regarding payment based on the rate set by Medicare.[374] This involved interpretation of the term "Medicare eligible expenses" as described in the insurance policy.[375] The court, looking at the contract as a whole, examining each word separately, and citing numerous cases that support their holding, held the term was not ambiguous and clearly referred to the Medicare per diem rate.[376] The court also held Vencor did not have a claim under promissory estoppel, finding no promise that Standard Life would pay the alleged expenses and no detrimental reliance, since reliance by Vencor on the Outline of Coverage, and not the actual insurance contract, was misguided.[377] The court affirmed the district court's finding of summary judgment for the defendant.[378] *Vencor v. Standard Life and Accident Ins. Co., No. 015435, 2003 U.S. App. LEXIS 835 (6th Cir. Jan 21, 2003).*

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[369] *Id.* at **2.
[370] *Id.* at **31.
[371] *Id.* at **9.
[372] *Id.* at **9.
[373] *Standard Life*, 2003 U.S. App. LEXIS 835 at **10-16.
[374] *Id.* at **11.
[375] *Id.* at **15-16.
[376] *Id.* at *16-*31.
[377] *Id.* at **31-36.
[378] *Standard Life*, 2003 U.S. App. LEXIS 835 at **37.

The Secretary of Health Services Cannot Routinely or Arbitrarily Deny a Skilled Nursing Facility's (SNF's) Request For an Upward Adjustment From the Routine Cost Limit Applicable to Hospital–Based SNF's.

The United States Court of Appeals for the Eighth Circuit held the district court was correct in granting summary in favor of plaintiff concerning reimbursements for the "reasonable costs" of covered services that they provide to Medicare beneficiaries.[379]

Plaintiff St. Luke's Hospital requested an upward adjustment from the routine cost limit applicable to hospital-based skilled nursing facilities ("SNFs").[380] By statute, the federal government reimburses SNFs for the "reasonable cost" of covered services that they provide to Medicare beneficiaries.[381] In 1984, Congress changed the formula for calculating the "reasonable cost limit" ("RCL") for free-standing SNFs.[382] It provides that the Secretary "may make adjustments" in the cost limits for any SNF to the extent that the Secretary "deems appropriate, based upon case mix or circumstances" beyond the facility's control.[383]

St. Luke's sought reimbursement under which the Secretary may grant an upward adjustment for "atypical services."[384] Any upward adjustment may be made "only to the extent the costs are reasonable, attributable to the circumstances specified, separately identified by the provider, and verified by the intermediary.[385] The court found that the Secretary, in his attempt to justify the particular section of the Medicare Provider Reimbursement Manual, confused two distinct concerns: reimbursement of SNFs for their typical costs and reimbursement of an individual SNF for providing services atypical of similarly classified providers.[386] The court concluded that the section was likely to discourage efficient hospital-based SNFs with typical costs below the routine cost limit from providing atypical services to those who needed them because the SNFs would not be reimbursed for those services.[387]

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[379] St. Luke's Methodist Hospital v. Thompson, No. 01-3995, 2003 U.S. App. LEXIS 427 (U.S. Jan 13, 2003).

[380] *Id.* at **4.

[381] *Id.* at **2.

[382] *Id.* at **3.

[383] *Id.*

[384] *Thompson*, 2003 U.S. App. LEXIS 427 at**4.

[385] *Id.*

[386] *Id.* at **11.

[387] *Id.* at **13.

The court agreed that the Secretary had discretion, but not to the extent that was claimed.[388] Furthermore, the court explained that it had seen no evidence to support the conclusion that section 2534.5 promoted efficiency or helped Medicare recipients receive the care they need.[389] The court was convinced that the Secretary's determination of denying hospital-based SNFs all costs expended was therefore unreasonable and arbitrary.[390] Therefore, the court affirmed the district court grant of summary judgment to the hospital.[391] *St. Luke's Methodist Hospital v. Thompson, No. 01-3995, 2003 U.S. App. LEXIS 427 (U.S. Jan 13, 2003).*

MENTAL HEALTH

Judicial Finding of a Psychiatric Patient's Capacity to Make Decisions About Future Care and Treatment May Not Be Constitutionally Required Prior to Temporary Detainment If Private Interests, Governmental Interests, and Probability of Error Do Not Mandate a Hearing

The Appellate Division of the Supreme Court of New York, Queens County, held a psychiatric patient may be temporarily detained for evaluation for 72 hours and was not constitutionally entitled to a judicial hearing to determine his or her capacity to make further decisions about treatment if, by clear and convincing evidence, private and governmental interests do not mandate a hearing.[392]

Dr. Martin, a hospital director of the Department of Psychiatry, requested a court order to authorize a non-compliant psychiatric patient be temporarily detained for a psychiatric evaluation to determine whether the patient needed to receive assisted outpatient treatment ("AOT").[393] Plaintiff patient argued that participation in AOT against her will violated constitutional rights of Due Process, Equal Protection, and personal liberty.[394]

The court addressed whether it violates personal rights guaranteed by the Constitution for a doctor to temporarily retain a non-compliant psychiatric patient for 72 hours for evaluation without mandating a judicial hearing to determine the patient's

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[388] *Id.* at **10.

[389] *Thompson*, 2003 U.S. App. LEXIS 427 at **13.

[390] *Id.* at **14.

[391] *Id.* at **1.

[392] In re Kwang L. (Anonymous), No. 2001-02263, 2003 N.Y. App. Div. LEXIS 758, at *5, 6 (Feb. 23, 2003).

[393] *Id.* at *2-3.

[394] *Id.* at *4.

capacity to make his or her own treatment decision.[395] The court held a judicial finding of incapacity is not mandated if the court determines a judicial hearing will not significantly reduce the possibility of an incorrect removal decision and if party interests do not require a hearing.[396] The court must weigh three factors to determine whether a judicial hearing is mandated prior to detainment: the private interest of the patient, the government's interest and additional burdens of a mandated hearing, and the probability that the patient will be wrongly deprived of his or her interests by not mandating a pre-removal judicial hearing.[397]

The court reasoned that requiring a judicial hearing may burden the government, who has a strong interest in avoiding lengthy hearings.[398] Also, mental health professionals should not be required to divert their resources to defend their well-considered decisions of retention of psychiatric patients in judicial hearings.[399] Moreover, patients have notice and hearing provisions available to them for any involuntary detention beyond 72 hours which meet due process standards.[400] The court also reasoned, by requiring a clear and convincing standard of proof that a patient requires AOT, a separate judicial finding of capacity is unnecessary.[401]

Plaintiff's appeal to reverse the court's order granting respondent's petition to authorize AOT of plaintiff patient without a pre-removal judicial hearing was denied. *In re Kwang L. (Anonymous), No. 2001-02263, 2003 N.Y. App. Div. LEXIS 758 (Feb. 3, 2003).*

Fast Food Restaurant Has No Duty to Warn Consumers of Unhealthy Attributes of Its Food Products If Reasonable Consumers Know Or Should Know the Food Contains Unhealthy Products.

The United States District Court for the Southern District of New York held a retail food outlet has a duty to warn consumers of dangerous or unhealthy contents of its food products only if a reasonable consumer would be unaware of these dangerous or unhealthy characteristics of the food based on the ordinary

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[395] *Id.* at *6.
[396] *Id.* at *7.
[397] *In re Kwang L. (Anonymous)*, 2003 N.Y. App. Div. LEXIS 758 at *6.
[398] *Id.* at *7.
[399] *Id.*
[400] *Id.*
[401] *Id.* at *6.

knowledge of the community.[402] Also, the duty to warn extends to latent dangers in the products which would result from foreseeable uses of the products.[403] A food retailer may be held liable for negligence if the retailer failed to fulfill its duty to warn and if the consumer can adequately prove that the dangerous characteristic of the food sold by the specific retailer proximately caused unhealthy damage, or addiction, or allergic sensitivity to the consumer.[404]

Plaintiff minors consumed food at two McDonald's retail outlets.[405] Thereafter, plaintiffs developed a number of adverse medical conditions – obesity, diabetes, coronary heart disease, high blood pressure, and other detrimental health conditions.[406] Plaintiffs' parents filed a class action lawsuit against the two individual McDonald's retail outlets, McDonald's of New York who does business with McDonald's retail outlets in the state, and McDonald's Corporation who does business with McDonald's outlets worldwide.[407] All activities, including advertising, product ingredients, and promotions of individual McDonald's retail outlets are authorized by McDonald's Corporation and McDonald's of New York.[408] McDonald's Corporation ensures the quality and substance of products sold at individual outlets are "substantially identical."[409] McDonald's Corporation has an exemption, as a restaurant, from the Federal Nutritional Labeling and Education Act, which requires that specific nutritional qualities of retailed food be marked on all packages.[410]

Medical studies show that obesity is associated with a higher risk of developing preventable diseases, such as diabetes and coronary heart disease.[411] McDonald's food products generally contain high amounts of cholesterol, fat, salt, and sugar.[412] Excessive consumption of foods high in cholesterol, fat, salt, and sugar may lead to obesity and adverse health conditions.[413]

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[402] Pelman v. McDonald's Corp., No. 02-7821, 2003 U.S. Dist. LEXIS 707, at **48-49 (S.D.N.Y. Jan. 22, 2003).

[403] *Id.* at **73-74.

[404] *Id.* at **72-73.

[405] *Id.* at **10-11.

[406] *Id.* at **11.

[407] *Pelman*, 2003 U.S. Dist. LEXIS 707 at **11, 14.

[408] *Id.* at **12.

[409] *Id.*

[410] *Id.* at **30.

[411] *Id.* at **13-14.

[412] *Pelman*, 2003 U.S. Dist. LEXIS 707 at **52.

[413] *Id.* at **53.

The first issue the court addressed was whether McDonald's acted negligently by failing to warn consumers of dangerous and unhealthy ingredients of its products, selling dangerous products to consumers, and advertising and promoting products but failing to warn of dangerous or unhealthy characteristics of the products.[414] The court held McDonald's duty to warn consumers only exists if the danger of the product is outside the knowledge and expectations of a reasonable consumer.[415] The court reasoned that the nutritional information of McDonald's food products was available online to consumers and upon consumer request.[416] The court additionally held advertising is only negligent where advertisements or promotions explicitly assert misleading product information.[417]

Moreover, the court reasoned fast food, including McDonald's food products, is well-known to consumers to possess high amounts of cholesterol, fat, salt, and sugar which are generally unhealthy characteristics of food.[418] Food products which would require a warning include food composed of genetically modified ingredients or food which is additionally processed so that its danger to consumer health would not be realized by a reasonable consumer.[419] Also, recovery for damages resulting from adverse medical conditions require that the consumer show, with "sufficient specificity," the food product proximately caused the damage.[420] Defendants' motion to dismiss all complaints was granted.[421] Plaintiffs' motion to remand complaints to state court was denied, while plaintiffs' motion for leave to amend the complaints was granted.[422] *Pelman v. McDonald's Corp., No. 02- 7821, 2003 U.S. Dist. LEXIS 707 (S.D.N.Y. Jan. 22, 2003).*

Physician Was Negligent Where No Blood Tests Were Not Ordered in a Timely Fashion and Patient Suffered from Hypertension.

The Court of Appeal of Louisiana held that trial court did not clearly commit error where it held that defendant, physician, was

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[414] *Id.* at **15.
[415] *Id.* at **51.
[416] *Pelman*, 2003 U.S. Dist. LEXIS 707 at **45.
[417] *Id.* at **37.
[418] *Id.* at **52.
[419] *Id.* at **61.
[420] *Id.* at **73.
[421] *Pelman*, 2003 U.S. Dist. LEXIS 707 at **82.
[422] *Id.* at **25, 82.

negligent in treating plaintiff, Costa, in not ordering baseline blood tests when the patient had a history of hypertension.[423]

Defendant first treated the plaintiff, Costa, on June 15, 1993.[424] On this date, defendant took plaintiff's history and performed a physical examination.[425] Plaintiff informed defendant that she suffered from hypertension and took medicine to treat it.[426] Defendant did not order any lab work at this time.[427] Over the next 15 months, plaintiff visited defendant sixteen times for symptoms such as: headaches, stomach cramps, knee pains, high blood pressure, congestion in the lungs, coughing, a pain between her shoulders, nausea, vomiting, shakiness, swollen face, matting eyes, weight loss, and fatigue.[428] On November 21, 1994, defendant ordered a lab work-up on plaintiff.[429] The next day, defendant informed plaintiff that she needed to go to the hospital.[430] Due to a lack of insurance and at the advice of defendant, plaintiff went to LSU Medical Center.[431] At LSU Medical Center, plaintiff was diagnosed with chronic renal failure and it was discovered that her kidneys had shrunken to one-half their normal size.[432] Plaintiff remained on dialysis until she died on April 1, 1999.[433] Plaintiff petitioned to impanel a Medical Review Panel alleging that she had suffered acute renal failure due to defendant's negligence.[434] The Medical Review Panel opined that defendant failed to meet the applicable standard of care, but this failure was not a contributing factor in the eventual outcome of this case.[435] Subsequently, plaintiff filed suit against defendant.[436] Defendant pled plaintiff's own fault in failing to comply with treatment because she did not want him to order lab tests due to her financial condition and lack of insurance.[437] The trial court held that defendant failed to meet the standard of care and the evidence established that even though

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[423] Costa v. Boyd, No. 36-584-CA, 2003 La. App. LEXIS *141, 1 (LA App. Jan. 31, 2003).

[424] *Id.*

[425] *Id.*

[426] *Id.*

[427] *Id.* at *2.

[428] *Costa*, 2003 La. App. LEXIS 141 at *6.

[429] *Id.* at *5.

[430] *Id.* at *6.

[431] *Id.*

[432] *Id.*

[433] *Costa*, 2003 La. App. LEXIS 141, at *7.

[434] *Id.*

[435] *Id.* at *7-8.

[436] *Id.* at *8.

[437] *Id.* at *8, 13.

plaintiff may have suffered renal failure sooner or later, her condition worsened faster due to defendant's negligence.[438] The trial court awarded $30,000 in general damages and $6,150 in special damages representing the medical expenses incurred during her stay at LSU Medical Center.[439] Defendant appealed the trial court's judgment.[440]

The first issue addressed by the court was whether the trial court was clearly wrong in finding that defendant breached the applicable standard of care. The court held that defendant clearly breached the applicable standard of care.[441] Furthermore, the court held that if defendant believed plaintiff could only afford incomplete treatment, then he should have refused treatment when she first voiced concerns about spending money on lab work.[442]

The second issue is whether the trial court erred in finding that defendant's conduct caused damages to plaintiff.[443] The court held that the trial court was not clearly wrong in assessing damages against defendant in this matter.[444] The court also held that it is gross speculation to suggest that if plaintiff had started dialysis earlier, then the aforementioned pain and suffering would have simply been displaced by the discomfort of dialysis.[445]

The third issue was whether the trial court erred in awarding $6,150 in medical expenses incurred by plaintiff at LSU Medical Center.[446] The court held that only $1,665 was incurred due to defendant's negligence.[447] Therefore, the trial court abused its discretion in awarding any additional medical expenses.[448] Consequently, the award of special damages was reduced to $1,665 and affirmed.[449]

The final issue was whether the trial court erred in not reducing defendant's fault due to the noncompliance of plaintiff and the negligence of the first physician to treat her hypertension.[450] The court held that because plaintiff's first physician last examined

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[438] *Costa*, 2003 La. App. LEXIS 141 at *9.
[439] *Id.* at *9-10.
[440] *Id.* at *10.
[441] *Id.* at *15.
[442] *Id.*
[443] *Costa*, 2003 La. App. LEXIS 141 at *15.
[444] *Id.* at *25.
[445] *Id.*
[446] *Id.*
[447] *Id.* at *28-29.
[448] *Costa*, 2003 La. App. LEXIS 141 at 29.
[449] *Id.*
[450] *Id.*

plaintiff nearly two years before she suffered damages, his failure to order lab tests was too attenuated from plaintiff's damages to find causation.[451] The court also held that the trial court was not clearly wrong in assessing defendant with 100% of the fault for pain, suffering and mental anguish experienced by plaintiff due to defendant's failure to order baseline blood tests.[452] The decision of the trial court was affirmed.[453] *Costa v. Boyd, No. 36-584-CA, 2003 La. App. LEXIS *141, 1 (LA App. Jan. 31, 2003)*

PROVING MALICE

Plaintiffs Must Meet Three Requirements for Malice When Suing a Hospital for Malicious Credentialing of Physicians.

The Fourteenth Circuit Court of Appeals of Texas found evidence was legally and factually insufficient to justify a jury finding of malice against a hospital. [454] Thus, the court reversed the jury decision and reversed the awarding of damages because they were based on this finding of malice.[455]

Plaintiff Ricardo Romero suffered severe neurological injuries following a back surgery performed by Dr. Baker.[456] This procedure was performed at the Columbia Kingwood Medical Center ("Hospital").[457] During the surgery, Mr. Romero suffered extreme blood loss, went into cardiac arrest, but was resuscitated.[458] Stemming from this event, Mr. Romero suffered brain damage that left him disabled. [459] In order for Dr. Baker to use the Hospital's facilities, he had to go through the credentialing process. [460] This consists of completing a questionnaire and providing peer recommendations. Once the doctor provides this information, the Hospital verifies the information, reviews licenses, and contacts the state and federal agencies.[461] Then, the chairman of the surgery

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[451] *Id.* at *36.

[452] *Id.* at *38-39.

[453] *Costa*, 2003 La. App. LEXIS 141 at 29.

[454] KPH Consolidation, Inc. d/b/a Columbia Kingwood Medical Center v. Dolores Romero, et al, No. 14-00-01177-CV, 2003 Tex. App. LEXIS 128 at *6 (Tex. App. January 9, 2003).

[455] *Id.*

[456] *Id.* at *1.

[457] *Id.* at *4.

[458] *Id.* at *3.

[459] *KPH Consolidation*, 2003 Tex. App. LEXIS 128 at *3.

[460] *Id.* at *4.

[461] *Id.*

department reviews the collected information and then gives his recommendation to the Medical Executive Committee.[462] After the Medical Executive Committee reviews the doctor's credentials, the Board of Trustees has the final say in granting the credentials.[463] Following this process, the Hospital granted Dr. Baker provisional status access to the Hospital, which eventually was upgraded to active staff privileges.[464] After Mr. Romero's botched procedure, Dr. Baker's privileges were suspended, and he did not reapply for privileges the following year. [465] Plaintiffs sued the Hospital where the surgery was performed because they claimed the Hospital acted maliciously in granting Dr. Baker credentials.[466] They asserted the Hospital was aware that Dr. Baker abused prescription drugs and was also an incompetent surgeon.[467]

To establish their malicious credentialing claim, plaintiffs must show proof of malice.[468] The definition of malice contains two parts, objective and subjective.[469] To satisfy the objective test, the defendant's conduct must involve an extreme risk of harm, which is considerably higher than the objective test for negligence.[470] Then, subjectively, the defendant must have actual awareness of the risk created by the conduct.[471] After establishing this framework, the court analyzed the evidence presented by plaintiffs. Due to the Hospital's right to invoke privacy privilege in regards to credentialing process, plaintiffs were not able to examine what the Hospital actually knew about Dr. Baker. [472] They were left to present circumstantial evidence of risk, that by inference, the Hospital had to know about. [473]

To satisfy the objective test of "extreme risk of harm," the plaintiffs relied on evidence of Dr. Baker's drug abuse and professional incompetence, and peer evaluations of Dr. Baker.[474] The court believed plaintiffs' evidence of drug abuse was legally and factually sufficient to satisfy the objective test.[475] Plaintiffs'

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[462] *Id.*
[463] *Id.*
[464] *KPH Consolidation*, 2003 Tex. App. LEXIS 128 at *5.
[465] *Id.* at *6.
[466] *Id.* at *2.
[467] *Id.* at *2.
[468] *Id.* at *7.
[469] *KPH Consolidation*, 2003 Tex. App. LEXIS 128 at *8.
[470] *Id.* at *9.
[471] *Id.*
[472] *Id.* at *16.
[473] *Id.* at *18.
[474] *KPH Consolidation*, 2003 Tex. App. LEXIS 128 at *20.
[475] *Id.* at *30.

called an expert witness to testify to the potential threat of a physician who abuses drugs.[476] They also called Dr. Baker's ex-wife who testified to his behavior prior to Mr. Romero's surgery.[477] She believed his erratic behavior was due to his abuse of Vicotin.[478] The court saw this evidence as sufficient to justify a jury finding of an extreme risk of harm.[479] However, plaintiffs' evidence of professional incompetence and peer evaluations was not sufficient.[480] Nevertheless, plaintiffs' evidence of drug abuse was enough to satisfy the first prong of the malice test.[481]

To prove subjective awareness, the plaintiffs employed the same evidence presented for satisfying the objective test.[482] They argue that the Hospital became aware of Dr. Baker's drug abuse during the credentialing process.[483] This argument was supported by the testimony of Dr. Baker's ex-wife, who testified the Hospital was aware of Dr. Baker's drug abuse.[484] Also, Dr. Baker was investigated by the State Board of Medical Examiners for drug abuse and excessive lawsuits. [485] The Hospital was aware of this investigation, and postponed its credentialing process of Dr. Baker until the investigation was over.[486] The court found that this evidence proved the Hospital had actual, subjective awareness that Dr. Baker's drug use posed an extreme risk to patients.[487] Next, the court examined the final requirement, conscious indifference. [488] Plaintiffs' evidence of conscious indifference included the following: the Hospital's decision to credential Dr. Baker, despite its awareness of his drug abuse, the Hospital's allowance for Dr. Baker to continue performing surgery following Mr. Romero, and expert testimony.[489] After reviewing this evidence, the court found that plaintiffs did not prove conscious indifference.[490] Although there was evidence to find the Hospital was subjectively aware of the extreme risk, as the Hospital invoked its confidentiality

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[476] *Id.* at *20.
[477] *Id.* at *21.
[478] *Id.* at *22.
[479] *KPH Consolidation*, 2003 Tex. App. LEXIS 128 at *32.
[480] *Id.* at *18.
[481] *Id.* at *32.
[482] *Id.* at *34.
[483] *Id.* at *35.
[484] *KPH Consolidation*, 2003 Tex. App. LEXIS 128 at *36.
[485] *Id.*
[486] *Id.* at *37.
[487] *Id* at *38.
[488] *Id.*
[489] *KPH Consolidation*, 2003 Tex. App. LEXIS 128 at *38.
[490] *Id.* at *39.

privilege, the court could not determine what the Hospital did in response to the information it had regarding the surgeon's drug abuse. [491] Thus, there was no evidence that the Hospital acted with conscience indifference in not suspending the surgeon prior to the patient's surgery.[492] Thus, plaintiffs failed to meet their burden and the court reversed the jury verdict and damages against the Hospital. *KPH Consolidation, Inc. d/b/a Columbia Kingwood Medical Center v. Dolores Romero, et al, No. 14-00-01177-CV, 2003 Tex. App. LEXIS 128 (Tex. App. January 9, 2003).*

RIGHT TO TREATMENT

A Jury May Weigh the Absence of Adverse Medical Effects In Assessing the Objective Sufficiency of Prisoner's Eighth Amendment Claim

The United States Court of Appeals for the Second Circuit held the United States District Court for the Northern District of New York was correct in denying prisoner's motion for a new trial on his Eighth Amendment denial of medical care claim after a jury found that the prisoner had not established that he suffered from a "serious medical need."[493] The court held that evidence regarding the absence of actual medical injury may be considered as a relevant factor in assessing whether an alleged denial of medical care is sufficiently serious to establish a claim under the Eighth Amendment.[494]

Prisoner Willie Smith contended that defendant prison officials acted with deliberate indifference to his serious medical needs because the prison officials failed to provide him with his daily HIV medication on two occasions while he was incarcerated at Camp Pharsalia.[495] The prisoner maintained that the first episode occurred due to a delay in refilling Smith's prescriptions after his existing medication ran out, resulting in seven days of scheduled doses.[496] The prisoner missed another five days of scheduled doses due to a random search of his living quarters.[497]

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[491] *Id.* at *39.

[492] *Id.*

[493] Smith v. Nurse Carpenter et al., No. 01-0294, 2003 U.S. App. LEXIS 503 (2d Cir. Jan. 14, 2003).

[494] *Id.* at **2.

[495] *Id.* at **3.

[496] *Id.* at **4.

[497] *Id.*

The prisoner explained to the district court the importance of maintaining strict compliance with his drug regimen in order to prevent the deterioration of his immune system and the proliferation of his HIV infection.[498] Although defendant prison officials recognized the importance for HIV patients to follow a regular drug regimen, they contended that the alleged episodes of missed medication did not subject the prisoner to a serious risk of harm.[499] To buttress the argument, the prison officials presented a medical expert who testified that the prisoner's reported symptoms of itching and headaches were likely side effects of the medications themselves and would not have been caused by the lack of medication.[500]

The court reviewed the district court's decision to deny the prisoner's motion for new trial for abuse of discretion.[501] "In order to establish an Eighth Amendment claim arising out of inadequate medical care, a prisoner must prove 'deliberate indifference to his serious medical needs.'"[502] The prisoner argued that HIV was a serious medical need, and the district court improperly allowed the jury to consider evidence regarding the absence of actual medical injury in determining that the prisoner had no serious medical need.[503] The court, however, concluded that the prisoner's claim was based solely on short-term interruptions in his otherwise adequate HIV treatment, and the district court correctly focused on the risks attributable to the missed medication.[504] Consequently, the court affirmed in holding that the jury was entitled to consider the prisoner's lack of any adverse medical effects from the missed medication in finding that the prisoner's medical need lacked the severity necessary to constitute a constitutional violation.[505] *Smith v. Nurse Carpenter et al., No. 01-0294, 2003 U.S. App. LEXIS 503 (2d Cir. Jan. 14, 2003).*

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[498] *Smith*, 2003 U.S. App. LEXIS 503 at **5.

[499] *Id.* at **6.

[500] *Id.*

[501] *Id.* at **10.

[502] *Id.* at** 11 (citing Chance v. Armstrong, 143 F.3d 698, 702 (2d Cir. 1998)).

[503] *Smith*, 2003 U.S. App. LEXIS 503 at **16.

[504] *Id.* at **19-21.

[505] *Id.* at **22.

STATUTE OF LIMITATIONS

Despite Evidence of Concealment, Patient Did Not Timely Bring the Action Because She Experienced, Almost Immediately After the Surgery, Symptoms That Should Have Led to the Discovery of the Removal of the Skin Tags

The Court of Appeals of Indiana for the Third District held the circuit court was incorrect in denying the physician's motion for summary judgment on the ground that there was an issue of fact as to whether the physician had fraudulently concealed a certain surgery he performed on plaintiff.[506] The court held the circuit court was correct in granting the physician's motion for summary judgment as to the patient's allegation of negligence.[507]

GYN-OB Consultants, L.L.C., and Stephen E. Coats, M.D., performed a hysterectomy on patient, Lynn C. Schopp.[508] Two months before the hysterectomy was performed, the patient told the physician that she had noticed some skin tags on her vagina and that they itched.[509] Dismissing the tags as a health risk, the physician advised that the skin tags appeared normal, and that he could remove them that day in the office.[510] The patient declined.[511] During the surgery, the physician removed the skin tags from her vaginal area, without her consent.[512] One month later, the patient scheduled an appointment with the physician because the appearance of her clitoris had changed.[513] Subsequently, she complained to the physician that she was experiencing swelling and discomfort in her vagina.[514] There, the physician told her that he had removed the skin tags at the time of the hysterectomy; however, he told her there was no connection to between their removal and her symptoms, and that he had not operated near her clitoris.[515] Two years later, after requesting a surgical report, she learned the physician had performed surgery near her clitoris.[516]

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[506] GYN-OB Consultants, L.L.C. v. Schopp, 780, 15 N.E.2d 1206 (2003).
[507] *Id.* at 16.
[508] *Id.* at 2.
[509] *Id.*
[510] *Id.* at 3.
[511] *Schopp*, 780 N.E.2d. at 3.
[512] *Id.*
[513] *Id.* at 4.
[514] *Id.*
[515] *Id.* at 4.
[516] *Schopp*, 780 N.E.2d. at 4.

The court reviewed the facts of the case to determine whether the lower court was correct in denying the physician's motion for summary judgment based on the assertion that the patient's claim of active and constructive concealment is barred by the statute of limitations, and whether the lower court was correct in granting the physician summary judgment on the issue of the physician's negligence in the manner of performing the surgery.[517] A medical malpractice claim must generally be brought within two years of the alleged act, omission, or neglect.[518] The court concluded that despite evidence of concealment, the patient did not timely bring the action because she discovered, less than two months after the surgery, that the skin tags had been removed without her consent, and later, that she had symptoms relating to the problem area.[519] The court concluded that the action was barred by the statute of limitations because the medical malpractice statute of limitations is tolled until the patient experiences symptoms that would cause a person of reasonable diligence to take action that would lead to the discovery of the malpractice.[520] As for the patient's negligence claim, the court concluded that the patient failed to offer evidence to rebut the physician's proof that he exercised the requisite standard of care in performing the removal of the skin tags near the patient's clitoris.[521] The patient offered a deposition of a physician of the medical review panel, but the court concluded that the deposition addressed only the issue of the patient's consent, not the physician's alleged negligence.[522] Thus, the physician's grant of summary judgment by the trial court was affirmed. *GYN-OB Consultants, L.L.C. v. Schopp*, 780 N.E.2d 1206 (2003).

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[517] *Id.* at 6.
[518] *Id.* at 7.
[519] *Id.*
[520] *Id.* at 13.
[521] *Schopp*, 780 N.E.2d. at 13.
[522] *Id.* at 15.