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"Pennsylvania Supreme Court Overrules *Azzarello* in Landmark *Tincher* Decision, Only To Have Suggested Jury Instructions Seek Azzarello's Reinstatement" {Volume 1}

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The Pennsylvania Supreme Court's decision in *Azzarello v. Black Brothers Co.,* 391 A.2d 1020 (Pa. 1978) and its logically strained progeny created real problems from the day *Azzarello* was decided until its demise in late 2014. The *Azzarello* model was a vain attempt at "social engineering" that ultimately collapsed. The Court's decision in *Tincher v. Omega Flex, Inc.*, 104 A.3d 328 (Pa. 2014) revived Pennsylvania's self-description as a Restatement of Torts (Second), §402A jurisdiction.

Azzarello deleted the "unreasonably dangerous" element of §402A because that language "rings of negligence," 391 A.2d at 1025. *Azzarello* was understood to prohibit any use of negligence-like language or theories in a product liability trial in Pennsylvania: "besides holding that a product is defective when it leaves the supplier's control lacking any element necessary to make it safe for its intended use, we also concluded [in *Azzarello*], if not expressly then certainly by clear implication, that negligence concepts have no place in a case based on strict liability." *Lewis v. Coffing Hoist Div., Duff-Norton Co*., 528 A.2d 590, 593 (Pa. 1987).

The core ruling in *Azzarello,* now inoperative, was that the trial court had erred by using the phrase "unreasonably dangerous" in the jury charge. *Azzarello,* 391 A.2d at 1022. However, the Supreme Court came to realize that *Azzarello's* "no-negligence-in-strict-liability rubric resulted in material ambiguities and inconsistencies in Pennsylvania's procedure.' *Schmidt v.*

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A Pandora's Box: The EMR's Audit Trail

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It is safe to say that one of the most significant medical malpractice evidentiary developments since the widespread adoption of electronic medical records (EMRs) is the production of its "audit trail." By now, most who handle these types of claims know what the audit trail is; but for those who do not, it is a portion of the metadata (embedded computerized information about data entry) that can show the timing of chart entries and modifications done to it, if any. The audit trail can also show how long a portion of the chart was accessed and reviewed and who was reviewing the entry. Sometimes the audit trail information is provided within a hard copy of the EMR record itself, or it can be produced separate and apart from the EMR record in another document, depending on the EMR system. Since the audit trail is available and saved with nearly every patient, the question in medical malpractice cases no longer is whether one can be produced. Rather, and as further discussed below, the current audit trail questions are

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Boardman Co., 11 A.3d 924, 940 (Pa. 2011). *Tincher expressly* "overruled" *Azzarello. See Tincher,* 104 A.3d at 335. *Tincher* held that the "unsupported assumptions and conclusory statements upon which *Azzarello*'s directives are built are problematic on their face . . . :

> In a jurisdiction following the 2nd Restatement formulation of strict liability in Tort, the critical inquiry in affixing liability is whether the product is 'defective;' in the context of a [product liability claim], whether a product is defective depends upon whether that product was unreasonably dangerous [when sold as a new product].

104 A.3d at 380 (emphasis added). The Court emphasized that the "defect" and "unreasonably dangerous" aspects of products liability cannot and should never have been *"divorced*" from each other. *Id*. (emphasis added). "[T]he notion of 'defective condition unreasonably dangerous' is the normative principle of the strict liability cause of action." *Id* at 400. The *Tincher* Court clearly returned the threshold "unreasonable dangerous" product defect determination to the jury. *Id* at 406-08.[1]

Of equal importance, *Tincher* labeled the *Azzarello* "any element" standard for the jury's determination of defect as "impractical," opting instead for a "composite" standard where defect may be proven under either "risk-utility" or "consumer expectation" approaches, depending on the particulars of a given case and product. 104 A.3d at 384. A product may be proven defective by showing either that (1) "the danger is unknowable and unacceptable to the average or ordinary consumer," or that (2) "a reasonable person would conclude that the probability and seriousness of harm caused by the product outweigh the burden or costs of taking precautions. *Id.* at 387, 389.[2] However, to maintain integrity and fairness, each part of the standard of proof remains subject to limitations that must be observed as appropriate to the facts of a particular dispute. *Tincher,* 104 A.3d at 401.

Consequently, *Tincher* teaches that both "tests" may not be suitable for all cases involving product design. *Tincher,* 104 A.3d. at 388, 407 & n.29 (discussing *Soule v Gen. Motors Corp.,* 882 P.2d 298 (Cal. 1994)); *see also Pruitt v. GM Corp.,* 72 Cal. App. 4th 1480 (1999) (consumer expectations inappropriate in motor vehicle design case).[3]

While *Tincher* underscored that the core of the Restatement (2nd) of Torts §402A is the foundation of Pennsylvania products liability jurisprudence, at the same time the Court expressly approved certain principles of the 3rd Restatement. 104 A.3d at 397 (the "typical" design defect case involves foreseeable risks, akin to negligence, and thus approximates the "alternative design" approach of the Third Restatement).[4]

Of note, the *Tincher* decision deliberately left a number of related questions unanswered, since they were not specifically before the Court at the time. The Court then adopted an "incrementalist" approach, insisting that principles of "judicial modesty counsel . . . that we be content to permit the common law to develop incrementally." 104 A.3d at 406.

THE REVISED "SUGGESTED STANDARD JURY INSTRUCTIONS"

In June 2016 the Pennsylvania Bar Institute published a "Revision" to the "Suggested Pa. Standard Jury Instructions" for Product's Liability (Chapter 16). These revisions were drafted by the Civil Instructions Subcommittee of the Pennsylvania Supreme Court Committee for Proposed Standard Jury Instructions (hereafter the "subcommittee"). This Subcommittee's work product is neither adopted nor approved by the Supreme Court. Of significance, there was apparently no advance notice of these "revisions" prior to their publication – they were not circulated for comment or publicized in advance to anyone outside the Subcommittee. Apparently, none its members has been actively involved in the defense of strict liability cases. The "Note to the User" indicates that "these instructions are only suggested." This is confirmed by controlling precedent.[5]

The problems with the Suggested Standard Jury instructions ("SSJI") are numerous and wide-ranging, but can be summarized as follows:

a) they ignore the essence of *Tincher,* namely that the distinction between strict liability and negligence does not create a "bright line rule that any negligence rhetoric carries an undue risk of misleading lay juries in strict liability cases," and that the "notion of 'defective condition unreasonably dangerous' is the normative principle of the strict liability cause of action;

b) they make highly questionable predictions and assumptions relating to issues *Tincher* deliberately declined to decide, then ignore *Tincher's* directive to permit the common law to

develop incrementally in these specific areas. In doing so, they ignore the *Tincher* Court's express commitment to "judicial modesty;" and attempt to influence the development of the law by suggested one-sider answers to open questions.

c) they ignore the reasons why - *and essentially ignore the fact that* - *Tincher* expressly overruled *Azzarello*. Most tellingly, the SSJI track *Azzarello* by completely omitting mention of the 402A requirement that, to support strict liability, a product must be unreasonably dangerous, and by retaining the "any element" test for defect;

d) they include negligence concepts and terminology only when doing so leads to a potential expansion of liability (such as bystander liability and limiting use-based defenses);

e) they support exclusion of evidence relating to a plaintiff's conduct;

f) they support exclusion of compliance with industry standards, industry custom and usage – issues deliberately left open by *Tincher* but exclusions clearly based on *Azzarello's* now rejected norm;

g) they create a "presumed knowledge" standard for warnings liability, and assume that *Tincher* has no impact on warnings claims; and

h) they omit any instruction on the long-established criteria for liability in "crashworthiness" cases

The most glaring problem with the Suggested Standard Jury Instructions is evident in the critical **Section 16.10, "GENERAL RULE OF STRICT LIABILITY."** First, there is no instruction*, indeed no mention at all*, of section 402A's requirement – clearly affirmed by *Tincher* as a "jury question" - that in order to support a finding of product defect, the plaintiff must prove and the jury must conclude that the product was "unreasonably dangerous" at the time of its original sale. Such a charge was standard before *Azzarello*.[6] Astoundingly, **Section 16.10** retains the "any element" language that was the unique and never imitated benchmark of the *Azzarello* charge,[7] and was essentially repudiated by *Tincher*.[8] Thus, the most important Suggested Instruction cannot withstand appellate scrutiny if *Tincher* means anything at all.

On the other hand, the Subcommittee embraces the negligence concepts of "reasonableness" and "foreseeability" when doing so *expands* potential liability. For example, **Sections 16.10(1) (GENERAL RULE OF STRICT LIABILITY)** and **16.20 (DETERMINATION OF DESIGN DEFECT / CONSUMER EXPECTATION TEST)** allow the jury to impose liability if a product is being used in an "unintended but reasonably foreseeable way." **Section 16.100 (STRICT LIABILITY RESPONSIBILITY NON-DELEGABLE)** provides for the imposition of liability "despite the foreseeable conduct, negligent or otherwise, of others." **Section 16.120 (AFFIRMATIVE DEFENSE / SUBSTANTIAL CHANGE)** brings this affirmative defense into play only if the defendant establishes that the alteration "was so extraordinary that it was not reasonably foreseeable." Finally, **Section 16.121 (AFFIRMATIVE DEFENSE / USEOFPRODUCTINUNINTENDED WAY)** allows this affirmative defense only if the defendant establishes that the use "was so extraordinary that it was not reasonably foreseeable." Such instructions, particularly in the *absence* of the core "unreasonably dangerous" charge (and *inclusion* of the *Azzarello* "any element" charge), will likely give the plaintiff the advantage in most cases. The Pennsylvania Supreme Court had rejected this kind of one-way use of negligence concepts solely to increase liability even before *Tincher*.[9]

Ignoring *Tincher*'s call for judicial modesty, the Subcommittee proposes critical instructions not only expressly contrary to issues that *Tincher* did decide, but also effectively decides issues that *Tincher* expressly reserved for future ruling within a fully developed factual context. **Section 16.122 (DEFENSES NOT AVAILABLE IN STRICT LIABILITY CLAIMS)** preempts the treatment of a plaintiff's fault as well as the admissibility of industry customs or standards, by commenting on the excludability of such evidence. *Tincher* did not decide, but rather specifically reserved these issues for future decision, on a case-by-case basis. 104 A.3d at 409-410. In effect, the Subcommittee attempts to throw a life-preserver to many pre-*Tincher* decisions that were expressly grounded in and predicated on the now-overruled *Azzarello* quarantine of negligence principles in product liability trials.[10] Surely each of these decisions will, at the proper time, be an appropriate target for repudiation as "fruit of the poisonous Azzarello decision."

Section 16.122 makes a mockery of *Tincher*'s "not purport[ing] to either approve or disapprove prior decisional law" on such issues. *Id.* at 409-10. Its instructions "approve" what *Tincher*" deferred. As stated previously, a fundamental premise of *Tincher* is that the character of the product and the conduct of the manufacturer are "largely inseparable," 104 A.3d at 405. By blatantly ignoring this prescript, **Section 16.122** likewise cannot withstand appellate scrutiny.

Compounding the problem, **Section 16.122 (1) (KNOWLEDGE OF DEFECT)** actually creates a "presumed knowledge" standard for liability in warnings and other claims. Such standard is nowhere to be found in any Pennsylvania case law – *Tincher* was not a warnings case – and should likewise be discarded as improper.

In the Subcommittee's notes to **Section 16.30**, it assumes that *Tincher* "does not affect the law concerning this charge." However, the Subcommittee totally ignores the Superior Court's precedential opinion in *Amato v. Bell & Gossett*, 116 A.3d 607, 620 (Pa. Super. 2015), *appeal dismissed* ____ A.3d ____ (Pa. 2016), which holds that the opposite is true, and that the question whether a product was "unreasonably dangerous" at the time of original sale is likewise vital to a warnings-based claim. *Id*.

Finally, while the Subcommittee

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acknowledges in its notes the requisite elements of a products liability claim based on "crashworthiness" or "enhanced injury," the Suggested Standard Jury Instructions themselves are silent on this topic. This silence is unjustifiable, as the elements and the burden of proof in crashworthiness cases have been established repeatedly in binding Pennsylvania precedent.[11]

In sum, *Tincher* abolished the prohibition of negligence principles in product liability cases and trials, holding that the "broad" reading of *Azzarello* in previous decisions, "to the point of correcting that negligence concepts have no place in Pennsylvania strict liability doctrine," was error. 104 A.3d at 376.[12] Yet, that elimination is exactly what the suggested standard jury instructions and the accompanying notes purport to do in many critical areas. The Subcommittee, through its Suggested Standard Jury Instructions, proceeds as though the *Tincher* "paradigm" never took place, except when the effect is to expand potential liability.

This past July, more than 50 members of the statewide defense community as well as a group of nationwide product manufacturers and insurers wrote a letter to the chairman of the Subcommittee that drafted these controversial Suggested Standard Jury Instructions, outlining in detail how the suggested instructions "veer sharply from the course that the Court plotted in *Tincher.*" The authors of the letter urged the Subcommittee to acknowledge and address the serious concerns raised, and invited members of the Subcommittee to meet with delegates from the defense group. The Subcommittee acknowledged receipt of the letter, but ignored repeated requests for further action.

{VOLUME 2 WILL OFFER A SPECIFIC *APPROACH* TO OFFERING COUNTER-INSTRUCTIONS, ON A CASE-BY-CASE BASIS}

ENDNOTES

[1]In discussing the relative roles of the judge and jury in a product liability trial, the *Tincher* Court pointed out that "severing findings relating to the risk-utility calculus from findings relating to the condition of the product is impractical and inconsistent with the theory of strict liability." *Id.* at 406

[2]Consumer expectations and risk-utility are not substantive theories of liability. Neither "test" has elements independent of those that define the tort of strict liability. Both are more precisely understood as rubrics for methods of proof that a product was designed or manufactured in a defective condition rendering it unreasonably dangerous – i.e., proof of breach of the duty owed under Section 402A. *Tincher*, 104 A.3d at 362, 384 (discussing malfunction evidence and res ipsa loquitur); *Breidor v. Sears Roebuck and Co*., 722 F.2d 1134, 1140 fn. 14 (3d Cir 1983) (malfunction test is not a legal theory); *1836 Callowhill St. v Johnson Controls, Inc*., 819 F.Supp. 460, 463 (E.D. Pa. 1993) ("malfunction rule" and "res ispa loquitur" are rules of evidence and not distinct theories of liability); *see also Mikolajczyk v. Ford Motor Co*., 901 N.E.2d 329, 349 (Ill. 2008) (consumer expectations and risk utility are methods of proving defect in a strict liability case, not legal theories).

[3]Since *Tincher*, the consumer expectation standard has been found inapplicable to the facts of several Pennsylvania cases. *See Yazdani v. BMW of North America, LLC*, ___ F. Supp.3d ___, 2016 WL 3041869, at *3 (E.D. Pa. May 26, 2016); *Wright v. Ryobi Technologies, Inc.*, 175 F. Supp.3d 439, 452-53 (E.D. Pa. 2016); *DeJesus v. Knight Industries & Associates, Inc.*, 2016 WL 4702113, at *9 (E.D. Pa. Sept. 8, 2016); *Capece v. Hess Maschinenfabrik GmbH & Co. KG*, 2015 WL 1291798, at *3 (M.D. Pa. March 20, 2015).

[4]In fact, the primary reason for the Court's decision not to adopt the Third Restatement in toto was its unwillingness to replace one all-encompassing approach (i.e., the Azzarello approach) with another. Id. at 399 ("[O]ur reticence respecting broad approval of the Third Restatement is separately explainable by looking no further than to the aftermath of Az zarello . . .."). Pennsylvania can now be characterized as a "Restatement 2.5"state!

[5]"Suggested" instructions "exist only as a reference material available to assist the trial judge and trial counsel in preparing a proper charge." *Commonwealth v. Smith*, 694 A.2d 1086, 1094 n.11 (Pa. 1997). "[A]s their title suggests, the instructions are guides only." *Commonwealth v.Simpson*, 66 A.3d 253, 274 n.24 (Pa. 2013). *See Carpinet v. Mitchell*, 853 A.2d 366, 374 (Pa. Super. 2004) (reversing for a new trial where trial court charged with an erroneous SSJI); *Butler v. Kiwi, S.A.*, 604 A.2d 270, 273 (Pa. Super. 1992) ("the suggested standard jury instructions have not been adopted by our supreme court and therefore are not binding").

[6]*E.g.*, *Forry v. Gulf Oil Corp.*, 237 A.2d 593, 597 (Pa. 1968) ("unreasonably dangerous" part of plaintiff's burden of proof); *Greiner v. Volkswagenwerk Aktiengeselleschaft*, 540 F.2d 85, 94-95 (3d Cir. 1976) (applying Pennsylvania law).

[7]Suggested Standard Jury Instruction 16.1.0 states that a product is defective "if at the time the product left [name of defendant's] control, it lacked any element necessary to make it safe for [it's intended] use, [or use in an unintended but reasonably foreseeable way], or contained any condition that made it unsafe for [its intended] use [or use in an unintended but reasonably foreseeable way]."

[8]See *Tincher*, 104 A.3d at 384. It is noteworthy that the Subcommittee Notes to §16.10, pp. 3-5, expressly embrace the *Tincher*-repudiated "bright line" quarantine of negligence concepts.

[9]*Schmidt*, 11 A.3d 924, 940 (Pa. 2011) ("comment[ing] on the fundamental imbalance, dissymmetry, and injustice of utilizing the no-negligence-in-strict-liability rubric to stifle manufacturer defenses, while at the same time relying on negligence concepts to expand the scope of manufacturer liability"); *Pa. Dep't of General Services v. U.S. Mineral Products Co.*, 898 A.2d 590, 603 (Pa. 2006).("incongruous to constrain manufacturer resort to use-related defenses based on the logic that negligence concepts have no place in strict liability cases, while at the same time expanding the scope of manufacturer liability without fault in a generalized fashion using the negligence-based foreseeability concept").

[10]See, e.g. *Kimco Dev. Corp. v. Michael D's Carpet Outlets,* 637 A.2d 603 (Pa. 1993), *Lewis v. Coffing Hoist Div.,* 528 A.2d 590 (Pa. 1987), and *Reott v. Asia Trend, Inc.,* 55 A. 3d 1088 (Pa. 2012).

[11]*Stecher v. Ford Motor Co.*, 812 A.2d 553, 558 (Pa. 2002) (reversing Superior Court decision that would have shifted the burden of proof); *Schroeder v. Com. Dep't of Transportation*, 710 A.2d 23, 27 n.8 (Pa. 1998); *Parr v. Ford Motor Co*., 109 A.3d 682 (Pa. Super. 2014) (post-*Tincher*); *Gaudio v. Ford Motor Co.*, 976 A.2d 524, 532, 551-52 (Pa. Super. 2009); *Colville v. Crown Equipment Corp*., 809 A.2d 916, 922 (Pa. Super. 2002); *Kupetz v. Deere & Co.*, 644 A.2d 1213, 1218 (Pa. Super. 1994).

[12]"[T]hose decisions essentially led to puzzling trial directors that the bench and bar understandably have had difficulty following in practice." *Id.*

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(1) whether the audit trail should be produced; (2) if so, what parts should be produced; and, (3) how the information from the audit trail can be utilized at trial. The following will be an overview of how courts are handling these emerging audit trail issues.

No Fishing Expeditions: The Audit Trail Information Must Be for Legitimate Reasons

There is no clear precedent currently on the issue of whether a defendant health care provider must produce an audit trail as a matter of standard course as if it were the medical record itself. Courts surprisingly are deciding the issue primarily on relevance grounds, considering its broad definition. There are a number of decisions standing for the proposition that absent allegations of record alteration, "cover up" or improper health care provider access to the EMR, audit trail requests are irrelevant, overly broad and unduly burdensome to the defendant health care provider. *See, Bentley v. Highlands Hospital*, 2016 U.S. Dist. LEXIS 23539 (U.S.D.C., E. Dist. of KY)(Feb. 23, 2016) and *Vargas v. Youssef*, 2015 N.Y. Misc. LEXIS 2176, 2015 NY Slip Op. 31048 (U) (Sup. Ct. Kings Cty., June 10, 2015)("[g]eneral comments that the audit trail may provide discovery on the 'timing and substance of the plaintiff's care' are insufficient" and more needed to be shown before a defendant would have to turn over the audit trail).

In addition to medical malpractice cases where the content of the EMR is at issue, audit trails have also been ordered to be produced in instances where it was necessary to establish who received certain medical information that was important to the claims or defenses of a party. *Gilbert v. Highland Hospital*, 2016 N.Y. Misc. LEXIS 1672; 2016 NY Slip Op 26147 (March 24, 2016) ("[w]hile the *Vargas* court concerned itself with the former consideration of relevance, it is the latter consideration [the who, what and when of chart access] which was at issue here."). *See also, Moan v. Mass. General Hospital*, 2016 Mass. Super. LEXIS 28 (Mar. 31, 2016) , where the defendant hospital was ordered to produce all audit trails or other documents sufficient to identify each person who accessed the patient's EMR; the periods of time they had accessed it; what they had accessed; and, all changes or additions made to the EMR by each person at each time in both paper and electronic form.

Further, audit trail information can be used to deny a summary judgment motion. In *Prantner v. U.S.*, 2012 WL 2060632 (U.S.D.C. D. Minn. 2012), a hospital's EMR audit trail was cited as a main reason denying a defendant doctor's dispositive motion seeking dismissal from a medical malpractice case, where it was argued he had no duty to the patient. In that case, the critical issue for the defendant doctor was whether he was made aware of a critical laboratory value of a patient. The EMR was absent any specific reference or indication that the defendant physician had received, reviewed or even considered the critical lab value. During his deposition, the defendant physician specifically denied knowing if he had or had not received the lab value, because he had no memory of it, and the EMR was not clear that he had received it. He was later confronted with the audit trail during his deposition, which indicated the lab value was available to him at a time when the patient was within the hospital. When asked, the physician admitted it was possible that he was aware of the lab value based on the audit trail information. At the conclusion of discovery, the physician filed a motion for summary judgment, arguing he had no duty to the patient, because the EMR did not reflect that he was given the critical lab results, nor did he know or admit that he was given the lab results. In denying the physician's dispositive motion, the court held that in considering the record most favorably to the plaintiff, the doctor's deposition testimony and the audit trail suggested the doctor was made aware lab value which was enough to deny his dismissal at that point procedurally.

At this point Pennsylvania law is absent any guidance on these audit trail issues, so the cases stated above are suggestive. That being said, these decisions provide guidance to the defense and objections to requests for the audit trail based on relevance should be considered if there are no issues pertaining to the contents and access to the EMR. Once the question of whether the audit trail should be provided is answered, the next issue deals with its production. Again, Pennsylvania courts are silent on these issues, but other jurisdictions can provide guidance on the production of the audit trail.

Do Your Job: Counsel Should Know What the Audit Trail Entails

Those lawyers who represent hospitals and large health care facilities know that plaintiff's document requests can result in significant time and expense to comply with those requests, not only to counsel, but also to the health care provider client. Some courts have considered cost-shifting arrangements in resolving issues of audit trail production on the basis that the request is "unduly burdensome" and "not likely to lead to relevant information." The *Myers v. Riverside Hospital,* 2016 VA Cir. LEXIS 53 (Cir. Ct. Newport News 2016)(April 21, 2016) case provides well-reasoned and practical guidance on how to handle the issue of producing an audit trail, when its production would assist plaintiff in advancing the claim, but result in considerable expense to the defendant.
In *Myers*, the plaintiff requested "any audit trails, metadata, EMR, or other identifiable health information" from the defendant hospital who conceded that plaintiff was entitled to this information, but the dispute was how to provide it. The plaintiffs specifically requested that the defendant load the EMR and metadata on USB drives and provide them to counsel, because they were not willing to sacrifice the convenience of accessing discovery materials on own terms, at any time. The defendant hospital suggested that plaintiff's counsel be given access to computer terminal at one of its locations at an agreed-upon time and that the request for the loaded USB be denied because it would expose it to undue expense.

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As a way to resolve the issues, the trial court held that the defendant provide plaintiff with a good faith estimate of the costs associated to load a read-only EMR, including audit trails and metadata on USB drive. If plaintiff believed the estimate to be reasonable, then defendant would produce the USBs and bill plaintiff for the costs associated with its production. If plaintiff felt that the defendant overstated the costs associated with the USB production, a hearing on that issue would be held. The court reasoned "So long as plaintiff shoulders the expense of preparing the electronic materials in her preferred format, defendant does not incur any additional cost. And if plaintiff so values the ease of accessing the materials at her own convenience, plaintiff must be willing to pay for that right."

The *Myers* case represents an excellent example of expense cost-shifting for information that may be difficult, time-consuming and expensive. By shifting the costs of such an endeavor, it compels plaintiffs to seriously consider whether the potential gain of the metadata and audit trail is worth the expense in advancing their medical claim. In some instances, it just may not be worth it. Pennsylvania courts may be persuaded by such an approach in handling the expense of audit trail production.

For defendant health care providers, another issue to consider when agreeing to produce the metadata and audit trail is knowing just what you will be producing. A complete understanding of what information is "out there" is necessary. Vague or incomplete understanding of the magnitude of the response to metadata discovery which results in partial or less than complete answers can lead to considerable additional time and expense to an endeavor that if done right the first time, would not have been as intensive. The case of *Picco v. Glenn*, 2015 U.S. Dist. LEXIS 58703 (U.S. Dist. Ct. CO 2015) is an example of what can happen when a half-hearted effort is placed in providing a "complete audit trail."

In *Picco*, the defendant health care provider agreed it would provide a complete EMR audit trail as a part of a settlement agreement. Thereafter, during a hearing to enforce the terms of the settlement, the trial court held that the hospital had not complied with their agreement and was ordered to (1) produce a truly complete audit trail including all software applications, including independent systems that was excluded from the general EMR program (radiology department and EKG monitors); (2) permit entry by plaintiff's expert to conduct a forensic examination of the EMR in order to ensure that a complete audit trail was produced; (3) provide a database manager with knowledge, skills and credentials necessary to assist plaintiff's forensic examiner during the examination; (4) allow the plaintiff's forensic examiner at least 16 hours in the EMR; and, (5) bear the cost for providing a database manager to assist plaintiff's forensic expert.

Why so harsh a ruling on the defendant hospital? It appears from the case that despite agreeing to produce the "complete audit trail," the hospital failed repeatedly to do so. Instead, the hospital gave contradictory answers to audit trail responses and produced piecemeal audit trail information after repeatedly representing to the court and counsel that the audit trail was complete (in some instances limited by arbitrary date limitations). The hospital also was held to be in noncompliance with audit trail requests by not having someone available at hospital to assist with prior attempts to have plaintiff's forensic examiner review the EMR metadata. The court rationalized that the defendant hospital's production of "materials constituting 'building blocks' with which plaintiff might themselves assemble" as a complete audit trail was inconsistent with their rules of civil procedure which held that it was "the duty of the disclosing party, not the receiving party, to translate such information 'into reasonably usable form.'"

The *Picco* case is an example for hospital and health care system defense lawyers that courts may not take lightly issues of production of the complete audit trail. Defense counsel should know just what they are agreeing to produce before they agree to provide the "entire metadata" on a patient. Without knowing what is available, counsel may not know what they are agreeing to provide which may result in considerable time and expense borne by their clients.

Proper Experts Required for Introduction of Evidence of EMR Alteration

Once the audit trail is produced and counsel has had a chance to review it to the care rendered, plaintiff's counsel may seek to make an issue regarding the truthfulness of the information contained in the EMR at trial including allegations of alteration or wrongdoing. The limited precedent available indicates that prior to such attempts plaintiff's lawyers must support such factual charges with qualified expert testimony.

In *Desclos v. Southern New Hampshire Medical Center,* 2006 N.H. LEXIS 101 (July 11, 2006) the Superior Court of New Hampshire held that simple conjecture or inferences that an EMR record was altered based on a review of the audit trail is not enough, and expert testimony to support that position may be required. Absent expert testimony, a plaintiff patient was not permitted to present evidence to the jury that the EMR had been altered despite information that suggested after-the-fact changes to the record. It was specifically held that "[w]hether a medical record can be and has been altered on a computer, or on an electronic medical record system after having been transcribed is an issue requiring expert testimony." In that the plaintiff did not submit an expert to support the argument that the defendant emergency room physician altered a treatment note, the plaintiff was not permitted to present evidence to establish the claim of alteration. The court concluded that as a matter of law, no rational juror could conclude from the evidence that there was a EMR record alteration.

Similarly, a Pennsylvania trial court concluded that proper expert testimony is required to prove an EMR alteration.

The person providing testimony that a record was altered must be qualified prior to doing so. In *Green v. Pennsylvania Hospital,* 30 Pa. D & C. 5th 245 (2013), *rev'd and rem'd other grounds*, 123 A.3d 310 (Pa. 2015) , an informatics expert was precluded from offering expert testimony regarding EMR alterations because she lacked adequate qualifications and would provide testimony on a review of limited information.

In this medical malpractice case, the plaintiff sought to produce an informatics expert on EMR alterations against the defendant hospital, however after a voir dire hearing, the court determined it was appropriate to preclude the expert. During the voir dire hearing as to the proposed expert's credentials, it was learned that alterations expert had never worked with the specific EMR system either as a nurse or as an informatics consultant. Further, she had never seen the audit logs generated by this EMR system prior to this case. In precluding this expert based on her lack of qualifications, the court held that she was completely unfamiliar with the complex EMR and that "a passing entry level knowledge of the system was not enough given the seriousness of the conclusions she was alleging."

In addition, the court inquired as to the methodology of the informatics' expert's conclusions. When asked by the court as to how she reached her professional conclusion that the EMR was altered, the expert stated "I can't give you specifically what was altered, nor by whom. I can only look at what the audit trail shows as people having documented and then trying to track it back to the medical record and not being able to find entries that support that notation in the audit log." The court found the basis of the expert's opinions more troubling than her lack of experience with the EMR system and its audit trail. The court concluded that the expert came to her opinions "based merely on the fact that of a few records out of many hundreds of pages of hospital records being missing, that the record had surreptitiously been altered " was a "leap in logic [that] took it from the domain of expert testimony to pure unsupported assumption."

The *Green* trial court decision demonstrates that EMR experts whose testimony is proposed for purposes of proving an alteration must be both qualified and supported by proper methodology. From this case, it can be argued that the expert must have some prior working knowledge (either as a practitioner or expert) on the specific EMR system in use by the defendant and its specific audit trail. Further, a simple comparison of the audit trail to the EMR chart is not the proper methodology for proving a records alteration based on the complexity of the systems. For such a serious allegation to be presented to a jury for consideration, evidence of alteration or spoliation should be based on competent and qualified expert testimony.

Split Decisions: Application of Privilege to the Audit Trail

The audit trail is also problematic for hospital or health system defendants because the audit trail can reveal what information is being reviewed by those conducting a peer review and what information is being reviewed once a lawsuit is filed. The *Hall* and *Moan* decisions represents the first of what is anticipated to be several decisions regarding what portions of the audit trail should be discoverable and what should be protected by privilege.

In the first case that specifically dealt with the issue it was held that a peer review and attorney-work product privileges do not apply to an audit trail. In *Hall v. Flannery, et. al.,* 2015 U.S. Dist. LEXIS 57454 (U.S.D.C., S. Dist. of Ill.)(May 1, 2015) the audit trail containing embedded information regarding what information the peer review committee viewed during a formal review and actions by the risk management team once litigation was anticipated was ordered to be produced to the patient's lawyer.

In *Hall*, the hospital defendant allegedly produced two "different" medical charts related to plaintiff's care. Believing there may have been records alterations, plaintiff's attorney requested manuals and instructional material and information regarding the EMR system vendor and an audit trail. The audit trail in this instance displayed embedded information from the peer review committee, including the identity of those on the peer review committee and what particular area of the plaintiff's EMR that was viewed. Similarly, it showed information viewed and utilized by risk management personnel and attorneys in anticipation of litigation.

The defendants collectively argued that these portions of the audit trail not be produced on the basis of the peer review and attorney work-product privilege. Plaintiff's counsel countered these arguments on several grounds. First, it was argued that the unredacted audit trail would be the best form of evidence to prove an alteration or after-the-fact change. It was further argued that the audit trail was a part of the medical record, and the peer review privilege would not protect it from disclosure as an "original source" document. Lastly, it was argued that the audit trail information produced as a result of defense counsel's review of the record was not considered "work-product" and subject to privilege because it was not solely created in anticipation of litigation.

The *Hall* court acknowledged that no legal precedent existed on this particular issue and was a case of first impression nationally. The court held that the audit trail and metadata was not peer review protected because: (1) the data was not specifically generated by a peer review committee in order to further its discussion of the medical care at issue; (2) it did not contain any information regarding the discussions held during the peer review committee meeting; (3) there was no evidence that the peer review committee looked at the audit trail during their discussions; (4) the audit trail only showed the time and portions a person viewed the EMR rather than interviews, memoranda or peer review meeting minutes; (5) it was generated in the normal and ordinary course of business and not for the specific use or consideration of the peer review committee; and, (6) there was no

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argument that the members of the peer review committee were to be kept secret or confidential.

Significantly, and in response to the defense's argument that the unredacted audit trail information would allow a "periscoping" of the peer review committee's concerns the court held that "to the extent that Plaintiff may acquire some advantage in knowing what documents were viewed by a committee member, such an advantage is negligible because the Plaintiff has already have had years to review the medical records themselves." Further, and in response to the defense's argument that the audit trail's information regarding the activities of the risk management department after the plaintiff requested a copy of the chart would violate the work-product privilege, the court held the audit trail was not protected by the attorney work-product privilege because: (1) the audit trail was not created in anticipation of litigation; (2) it was a part of the EMR; and, (3) it did not implicate the "mental impressions, conclusions, opinions or legal theories of a party's attorney or other representative concerning the litigation." The court concluded in this regard that he audit trail is only a reflection of who, when and what a person did in relation to the EMR and any additional knowledge or advantage to be gained from such information was negligible.

At least one court has specifically disagreed with the *Hall* ruling with respect to the application of privilege to the audit trail and the more narrow issue of whether the defendant health system would need to supply the names of those from a peer review committee who would be identified by the production of an audit trail. The Massachusetts trial court held in *Moan, supra*., that this information should not be produced, which acknowledges the privilege argument to the audit trail. The hospital defendant in *Moan* was excused from providing the names of the individuals who investigated the medical care on behalf of the peer review committee and to the extent that any of the information ordered to be provided was claimed to be privileged, it would produce a privilege log.

Hall and *Moan* are the first cases discussing the issue of privilege to the audit trail and for the defense and health care providers, this will be a considerable issue moving forward. The *Hall* court's conclusion that the embedded information from the peer review committee as a part of the audit trail is of negligible advantage to the patient or their legal representatives is ripe for debate. There can be very strong arguments made that the submission of embedded audit trail information recorded during a peer review analysis or after when litigation is reasonably anticipated reveals the thought process, work-product and medico-legal analysis that is otherwise privileged and protected. The audit trail from the peer review or attorney investigation could potentially show where there are concerns, weaknesses or deviations from accepted medical standards that would not have otherwise been made available. Further, the production of a completely unredacted audit trail could create a "chilling effect" discouraging frank and vigorous reviews by health care providers immediately after the care rendered which is contrary to why the peer review privilege was created. The lack of a thorough review by health care professionals because of the fear of litigation and discovery of their audit trail could contribute to health care providers repeating the same medical errors at the expense of quality patient care. It may also discourage early attorney investigations when memories are fresh and witnesses are available. It remains to be seen how Pennsylvania courts will decide this issue, and when it eventually comes before a court for consideration, it is anticipated to raise the attention of many.

Final Thoughts

For defense counsel, there are several considerations that need to be made with respect to the production of a health care client's audit trail. First, will the information advance the plaintiff's case in some manner, or is it a fishing expedition? A review of the plaintiff's complaint will provide guidance in this regard, and if there is no relevance for such a request, consideration should be made to object on these grounds. Second, know what the audit trail is and what its' production entails before producing it. Determine how labor intensive and expensive compliance with the request will be to the client and the professional liability carrier. If the time and effort are expansive, consider requesting a cost-shifting arrangement that bears costs upon the plaintiff. If the decision is made to produce the audit trail, make sure it is complete so as to avoid further criticism, scrutiny and cost to your client if it turns out that what was produced was incomplete. Third, demand that alteration evidence be precluded in the absence of qualified expert testimony. If it turns out the expert has no prior first-hand experience with the EMR system at issue or if they are simply comparing the audit trail to the record in coming to their conclusion, seek the preclusion of the evidence. Lastly, consider raising the appropriate privileges to audit trail entries by risk management (once litigation is anticipated) or if a peer review is conducted. By contemplating these issues, defense counsel will narrow the EMR's audit trail liabilities and keep the Pandora's Box shut.

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The Supreme Court of Pennsylvania Grants Several Petitions for Appeal in Important Pennsylvania Workers' Compensation Matters

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Between 2012 to 2015, the Supreme Court of Pennsylvania granted only two petitions for appeal out of the 182 filed in Pennsylvania workers' compensation matters. But in 2016, the Court granted four petitions out of 21 filed, although one has since been dismissed. This would seem to be a clear indication that the Supreme Court is demonstrating increased receptivity to, and perceived need for, appellate review of workers' compensation matters. A close examination of the pending cases shows their importance, and the somewhat novel and complex issues the Court will be addressing as it continues to provide judicial guidance and direction.

To address an issue related to Impairment Rating Evaluations (IREs), the Court granted the petition for allowance of appeal filed on behalf of the claimant in the case of *Duffey v. Workers' Comp. Appeal Bd. (Trola-Dyne, Inc.)*, 131 A.3d 480 (Pa., Feb. 3, 2016). The Court framed the issue it has agreed to hear as follows:

> **Did the Commonwealth Court err in concluding that an Impairment Rating Evaluation (IRE), which is designed to rate the percentage of disability two years out from a work injury, was valid where the IRE only considered the injuries listed on the notice of compensation payable issued at the time of injury, and did not consider additional injuries that subsequently arose and were known at the time of the IRE but not yet formally added to the description of injury?**

Id.

The fact pattern of this case is representative of the reality that following the issuance of the Notice of Compensation Payable (NCP), it is not at all unusual for significant changes to occur with the passage of time in terms of the full nature and scope of the work related injuries sustained by the Claimant and extent of disability. Let us now turn to the somewhat complex fact pattern of this case and the Court's analysis.

On March 6, 2009, Claimant sustained work-related injuries to both hands. Employer issued a NCP describing his injuries as "bilateral hands, electrical burn, stripping some electric wire." On March 6, 2011, Claimant reached 104 weeks of receiving total disability compensation.

Employer requested an IRE pursuant to Section 306(a.2)(1) of the Workers' Compensation Act (Act). The designated IRE physician found that Claimant had a 6% Impairment Rating. Employer proceeded to issue a Notice of Change of Workers' Compensation Disability Status Form on June 28, 2011, informing Claimant of his impairment rating and changing his disability status from total to partial.

Subsequently, Claimant was able to establish by Review Petition that he had sustained injuries additional to those set forth in the NCP, specifically in the form of an adjustment disorder, depressed mood, and PTSD. The workers' compensation judge (WCJ) added these additional injuries to the Claimant's NCP. Claimant asserted that the scope of the IRE had not included these additional injuries and, therefore, was invalid.

The Court disagreed and ruled that the IRE was valid. The Court pointed out that Claimant had been diagnosed with these additional conditions almost one year before the IRE, but had failed to file a review petition to add them to the NCP. The Court also stressed that the NCP establishes the description of injury, and Section 306 (a)(2) of the Act directs the IRE physician to base his impairment rating on the injury described in the NCP. And, it explained that the special IRE procedure was part of the General Assembly's 1996 reform measures intended to reduce rising workers' compensation costs and restore efficiency to the workers' compensation system.

The Court reasoned that to hold the IRE invalid would encourage claimants to wait to add additional diagnoses to their work related injuries until after an IRE is performed as a way to automatically render the IRE invalid. This, the Court explained, would effectively strip the employer of its only opportunity to obtain a self-executing change in disability status by adding injuries to the NCP after the IRE is performed and having the IRE declared invalid. The cost of obtaining an IRE under such circumstances would be wasted.

IREs, enabling a shift from total disability to partial disability without the employer assuming the burden of demonstrating earning power, are proving to be rather controversial.

Our Supreme Court has also granted, in part, two petitions for allowance of appeal in the case of *Protz v. Workers' Comp. Appeal Bd. (Derry Area Sch. Dist.),* Nos. 412 and 416 WAL 2015. *See* 133 A.3d 733 (Pa., Mar. 22, 2016). The Court framed the issues for appeal as follows:

> **Whether the Commonwealth Court - after properly determining that Section 306(a.2) of the Workers' Compensation Act was unconstitutional -erred in remanding the case to the Workers' Compensation Judge with instructions to apply the Fourth Edition of the American Medical Association's *Guides to the Evaluation of Permanent***

> ***Impairment*** **when neither Section 306(a.2) nor any other section of the Act ever references the Fourth Edition and its usage was not sanctioned by the Pennsylvania Legislature.**

And:

> **Does Section 306(a.2) of the Pennsylvania Workers' Compensation Act unconstitutionally delegate the State Legislature's law making authority in violation of Article II, Section 1 of the Pennsylvania Constitution by incorporating the most recent edition of the AMA *Guides to the Evaluation of Permanent Impairment*?**

Id.

Here is the factual context of this case and how the Commonwealth Court approached the issues raised in its opinion at *Protz v. Workers' Comp. Appeal Bd. (Derry Area Sch. Dist.),* 124 A.3d 406 (Pa. Cmwlth. 2015):

In April 2007, Claimant sustained a compensable work injury to her right knee when she fell while working for Employer. Benefits were suspended when Claimant returned to work, but she subsequently suffered a recurrence and her benefits were reinstated. Claimant underwent an IRE and, using the "most recent" Sixth Edition of the American Medical Association (AMA) Guides to the Evaluation of Permanent Impairment (Guides), the IRE physician provided a 10% impairment rating.

Employer filed a modification petition, seeking to convert Claimant's total disability benefits to partial disability, and limiting Claimant's ongoing temporary partial disability (TPD) to 500 weeks. The impairment rating was determined pursuant to Section 306(a.2) of the Act requiring the use of "the most recent edition of the American Medical Association 'Guides to the Evaluation of Permanent Impairment.'"

When Section 306(a.2) of Act was enacted in 1996, the Fourth Edition of the AMA Guides was in effect. However, at the time of Claimant's examination, the then "most current version" (the Sixth Edition) was being used. Each edition has the potential to change the impairment rating for the same injury.

The WCJ determined that, as of January 16, 2012, Claimant's impairment rating was less than fifty percent under the Sixth Edition of the Guides and, accordingly, held Claimant was entitled only to partial disability benefits. The Workers' Compensation Appeal Board (Board) affirmed. Claimant appealed to the Commonwealth Court challenging Section 306(a.2) of the Act, 77 P.S. §511.2, (Act 57) as an unconstitutional delegation of legislative authority pursuant to Article II, Section 1 of the Pennsylvania Constitution.

Specifically, Claimant argued that this provision gave the AMA, rather than the General Assembly, the authority to establish the criteria under which a claimant is adjudicated to be partially or totally disabled. Claimant asserted that the AMA Guides have undergone two revisions since 1996, and that the current (Sixth) Edition provides substantially different standards than those set forth in the Fourth Edition, thereby causing some claimants who would have been considered more than fifty percent impaired under the Fourth Edition to be less than fifty percent impaired under the Sixth Edition.

The decision of the Commonwealth Court in favor of the Claimant was predicated on the application of Article II, Section 1 of the Pennsylvania Constitution. Article II vests legislative power in the General Assembly, "embodying the fundamental concept that only the General Assembly may make laws, and cannot constitutionally delegate the power to make laws to any other branch of government, or to any other body or authority," citing *Association of Settlement Companies v. Department of Banking,* 977 A.2d 1257, 1265 (Pa. Cmwlth. 2009) (en banc).

> The Court closely examined the content of Section 306(a.2) of the Act and found it to be:
>
> …wholly devoid of any articulations of public policy governing the AMA in this regard and of adequate standards to guide and restrain the AMA's exercise of this delegated determination by which physicians and WCJs are bound. Indeed, Section 306(a.2) merely requires that the most recent version of the AMA Guides be used to determine a claimant's impairment rating. Accordingly, under this basis alone, we find Section 306(a.2) of the Act unconstitutional.

124 A.3d at 415.

The Court also noted that Section 306(a.2) of the Act lacks a mechanism requiring governmental review of the Guides through promulgation of regulations. Further, the Court found that the General Assembly had not reviewed and re-adopted the methodology contained in subsequent editions of the Guides thereby leaving unchecked discretion completely in the hands of a private entity. The Court opined that the legislature provided a private party—the AMA—with *carte blanche* authority to implement its own policies and standards, proactively adopting those standards, sight unseen.

The Court did acknowledge that the General Assembly may delegate authority in connection with the execution and administration of a law to an independent agency or an executive branch agency but only where the General Assembly first establishes primary standards and imposes upon others the duty to carry out the declared legislative policy in accordance with the general provisions of the enabling legislation. However, it reasoned that the AMA is a "private party" and, therefore, the presumption that governmental agencies will act disinterestedly and only for the public good does not apply when it comes to private entities such as the AMA. The Commonwealth Court vacated the Board's decision with respect to Employer's modification petition and remanded this matter to the Board with instructions to remand to the WCJ to apply the Fourth Edition of the AMA Guides in adjudicating this matter.

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Judge Robert Simpson issued a dissenting opinion (joined by Judges Leadbetter and Covey), stressing that the General Assembly delegated initial determinations of impairment ratings to impartial, Pennsylvania-licensed, board-certified, clinically active physicians; the AMA does not participate in impairment ratings under the Act. Judge Simpson maintained that the General Assembly provided numerous standards to guide impairment rating decisions made by physicians. He pointed out that legislative policy decisions are clearly set forth in the various provisions of Section 306(a.2) of the Act. Given the numerous requirements to qualify as an IRE physician and the many policy decisions reflected in Section 306(a.2) of the Act, he did not believe that legislative deference to the AMA's professional expertise in periodically updating the complex medical standards in the Guides amounted to an unconstitutional delegation of legislative power.

Judge Covey also issued a dissenting opinion, arguing that the mandated use of the AMA Guides constitutes the permissible involvement of a private organization in the rule-making process, and thus, Section 306(a.2)(1) is not unconstitutional. In support of her argument, she cited the case of *Gima v. Hudson Coal Co.,* 165 A. 850 (Pa. 1933), where the Pennsylvania Supreme Court affirmed the constitutionality of Rule 29 of the Anthracite Mine Law (Law) which provided that the use of high explosives, other than gunpowder, shall be in accordance with special rules as furnished by the manufacturers of the same. In approving this legislative approach, the Court reasoned:

> We have had much legislation which does not delegate the power of the General Assembly to make laws, but does delegate to some person or body the power to determine some fact or state of things upon which the law makes, or intends to make, its own action depend. . . .

Judge Covey also cited the case of *Johnson v. Pa. Hous. Fin. Agency,* 309 A.2d 528 (Pa. 1973), as lending support to her position. There the Supreme Court stated:

> …it is not objectionable that 'many things upon which wise and useful legislation must depend which cannot be known to the law-making power, must, therefore, be a subject of inquiry and determination outside of the halls of legislation.

Judge Covey maintained that the General Assembly cannot be expected to enact laws which shall in themselves keep abreast of every advance of science and invention, and it is unreasonable to impose upon the General Assembly the burden of frequently revisiting legislation to reflect evolving, broadly-accepted changes in the medical field that are beyond the expertise of the legislative body.

Then there is the case of *Pipeline Sys. v. Workers' Comp. Appeal Bd. (Pounds),* 133 A.3d 291 (Pa. Mar. 8, 2016), where the Supreme Court framed the issue it will be addressing as follows:

> **[Did t]he Commonwealth Court err[] because [§ 601(a)(10), 77 P.S. § 1031] unambiguously provides that the employee must be within the course and scope of his employment at the time he provides aid and is injured, not merely be in the course and scope of his employment at the time of the emergency arose as the Commonwealth Court held[?]**

Id.

Here is the tragic fact pattern and how the Commonwealth Court ruled:

Claimant was an employee of Pipelines Systems, Inc. (Employer). His duties included installing new pipeline at different job sites. Claimant was performing his work duties on the premises of the Sewickley Borough Sanitation Department Plant (Borough Plant) on July 29, 2010, when he heard a call for help emanating from a pit on the construction site located about thirty feet from where he was working.

Claimant, along with several co-workers, rushed to the pit to aid an employee of the Borough Plant who had fallen into the pit. Claimant descended into the pit and discovered that this person had died. On his way out of the pit, he lost consciousness due to the inhalation of methane gas and fell with resulting injuries to his left leg, knee, foot, ribs, back, head and lungs. In deciding this case, the Commonwealth Court analyzed the fact pattern to see if Section 601(a)(10)(i)-(ii) of the Act applied. This statutory provision was added to the Act in 2003 in order to provide workers' compensation benefits, for:

> An employee who, while in the course and scope of his employment, goes to the aid of a person and suffers injury or death as a direct result of any of the following: rendering emergency care, first aid, or rescue at the scene of an emergency.

The Court opined that Subsection 601(a)(10) serves to protect employees who render aid from being removed from the definition of "employee," chiefly because rendering aid is not part of the services they regularly perform for their employer. Employer argued that the General Assembly could not have intended to provide coverage for employees who render aid who are not members of a professional or specially trained class of emergency personnel.

The Court rejected Employer's argument, stating that it was clear that the General Assembly chose not to limit the scope of this protection to members of a narrowly defined class with specialized training. Instead, the legislative body utilized the term "employee," which denotes no special training.

The Court stressed that there was no dispute that Claimant was within the course and scope of his employment at the time the tragedy occurred. He was only thirty feet away from the pit, installing pipelines in accordance with the Employer's contract with the Borough Plant.

Conclusion

For the Supreme Court of Pennsylvania to grant the above petitions for allowance of appeal within such a relatively short span of time is rather extraordinary, perhaps signaling and increased receptivity of the Court to appeals emanating from this field of law. Practitioners in this field are keenly aware of the fact that the appellate courts have played a very active and important role in giving definition to, and guidelines for, implementation of the applicable statutory and regulatory law. It will prove to be very interesting to see how the Court rules on the issues it has agreed to hear. Without question, they are rather novel and important issues to be addressed.

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Application of Frye Standards to Qualify as an Expert Witness in Workers' Compensation Cases. Never Before, Until Now!

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Quite recently, the Commonwealth Court of Pennsylvania handed down a series of decisions that are remarkable for several reasons. The injuries alleged by the claimants are strikingly different from the type of injuries usually encountered in workers' compensation litigation. These alleged injuries include such diseases as prostate cancer, malignant melanoma, and gastric cancer.

These cases also strongly support an interpretive conclusion that there are certain cases where the Workers Compensation Judge (WCJ) can and, indeed, should require those professing to be experts to meet the standards to qualify as an expert set forth in *Frye v. United States,* 293 F. 1013 (D.C. Cir. 1923), as embodied in Pa. R.E. 702.

Rule 702 provides that a witness who is qualified as an expert by knowledge, skill, experience, training, or education may testify in the form of an opinion, or otherwise if:

(a) The expert's scientific, technical, or other specialized knowledge is beyond that possessed by the average layperson;

(b) The expert's scientific, technical, or other specialized knowledge will help the trier of fact to understand the evidence or to determine a fact in issue; and

(c) The expert's methodology is generally accepted in the relevant field.

This line of judicial thinking stands in stark contrast to workers' compensation case law holding that generally a physician is competent to testify in specialized areas of medicine even though the physician is not a specialist in or certified in those fields. *Marriott Corp. v. Workers' Comp. Appeal Bd. (Knechtel)*, 837 A.2d 623 (Pa. Cmwlth. 2003).

The cases we are about to examine involve very complex, multi-factorial causation questions prompting the Court to require expert opinions from highly trained and experienced medical and scientific experts. I would urge readers to think of other workers' compensation case scenarios where arguing for application of the *Frye* standard would be in order.

Let us first examine the interesting case of *City of Philadelphia Fire Department v. Workers' Compensation Appeal Board (Sladek)*, 144 A.3d 1011 (Pa. Cmwlth. 2016).

In June 2012, Claimant, a fireman, filed a claim petition alleging that he had developed malignant melanoma as a result of his workplace exposure to carcinogens categorized by the International Agency for Research on Cancer (IARC) as Group 1 carcinogens. The City of Philadelphia ("Employer") hired the Claimant as a firefighter in 1994. The Claimant's malignant melanoma was diagnosed in 2006.

The Claimant presented the deposition testimony of Barry L. Singer, M.D., an oncologist board certified in internal medicine and hematology. He stated that he had been diagnosing and treating cancer for 40 years, with a focus on breast, colon, and lung cancers. Dr. Singer stated that he was not an epidemiologist or toxicologist, did not specialize in the etiology of cancer, and had no training in meta-analysis, i.e. the methodology used to analyze independent, but similar, studies to test the pooled data for statistical significance. He testified that the Claimant's exposure to Group 1 carcinogens while working for Employer was "a substantial contributing factor" to the development of his malignant melanoma skin cancer.

In support of this opinion, Dr. Singer

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stated that the soot to which the Claimant was exposed in his work as a firefighter contained arsenic, recognized as a Group 1 carcinogen by the International Agency for Research on Cancer. He testified that there is support in the scientific literature that arsenic can cause skin cancer. From this scientific finding, he reasoned and opined that the Claimant's malignant melanoma was caused by his exposure to the arsenic contained in the soot in that malignant melanoma is a type of skin cancer. Dr. Singer, however, was unable to point to any study relating arsenic exposure to malignant melanoma itself. He further acknowledged that, in forming his causation opinion, he had not considered the methodologies used by public health experts to determine what exposures cause cancer.

Employer submitted the deposition testimony of Tee I. Guidotti, M.D., M.P.H., D.A.B.T., board certified in internal medicine, pulmonary medicine, and occupational medicine, along with a degree in toxicology. Additionally, he testified that he was also trained in epidemiology, which he described as the "science of the patterns of diseases and populations."

Dr. Guidotti stated that specific carcinogens cause specific cancers and that the IARC Group 1 carcinogens do not cause all types of cancers in all organs. He testified that malignant melanoma has not been associated with exposure to arsenic. He further stated that melanoma is not an occupational disease of firefighters. Dr. Guidotti opined that the cause of malignant melanoma is exposure to ultraviolet radiation. He testified that Dr. Singer's approach to causation did not match the generally accepted standard practice in the field, and it did not conform to generally accepted scientific principles. He stated that Dr. Singer was not familiar with mainstream epidemiology methodology.

The Workers' Compensation Judge (WCJ) found in favor of the Claimant, noting that the Claimant had been exposed to arsenic, an IARC Group 1 carcinogen, in performing his duties as a firefighter for Employer. The WCJ found that the Claimant's exposure to this agent constituted a significant contributing factor to the development of his malignant melanoma. The statutory basis upon which the WCJ's adjudication rested was Section 108 (r) read in conjunction with Section 301 (e) of the Act.

Section 108 (r) provides for the compensability of:

> Cancer suffered by a firefighter which is *caused by* exposure to a known carcinogen which is recognized as a Group 1 carcinogen by the International Agency for Research on Cancer.(*Emphasis supplied*)

Section 301 (e) establishes a "presumption regarding occupational disease" that applies to any occupational disease. It states:

> If it be shown that the employee, at or immediately before the date of disability, was *employed in any occupation or industry in which the occupational disease is a hazard*, it shall be presumed that the employee's occupational disease arose out of and in the course of employment, but this presumption shall not be conclusive. (*Emphasis supplied)*

In affirming the decision of the WCJ, the Workers' Compensation Appeal Board (WCAB) reasoned that because the Claimant was exposed to an IARC Group 1 carcinogen at work, his malignant melanoma met the definition of an occupational disease as set forth in Section 108 (r) of the Act. The Board held that the Claimant did not need to show that the carcinogens to which he was exposed caused his particular cancer, and the Employer had failed to overcome the presumption of causality in Section 108 (r) by demonstrating that Claimant's cancer was not caused by exposures to chemical agents in performance of his firefighting duties.

The Commonwealth Court accorded considerable emphasis to the words in Section (r) "caused by" between "cancer suffered by a firefighter" and "exposure to a known [Group 1] carcinogen." In interpreting this language, the Court concluded that it was incumbent upon Claimant to prove that his malignant melanoma is a type of cancer caused by Group 1 carcinogens to which he was exposed in the workplace in order to establish an occupational disease.

Concluding that the WCAB had erred in its construction of Section 108 (r) of the Act, the Court remanded the case to the WCAB for the purposes of determining whether the Act requires a medical expert to satisfy Pennsylvania Rule of Evidence 702, *supra*, listing the requirements to be considered a qualified expert, whether it be a medical witness or other type of expert, and, if so, whether the opinion evidence given by Dr. Singer satisfied that standard. Also the Court stated that on remand the WCJ, in his role as the factfinder, must decide whether to accept the causation testimony of Dr. Singer, or that of Dr. Guidotti.

In the recent case of *Hutz v. Workers' Compensation Appeal Board (City of Philadelphia)*, 147 A.3d 35 (Pa. Cmwlth. 2016), the WCJ was very explicit as to why he rejected the medical expert proffered by the Claimant. The reasoning of the WCJ can serve as a set of guideposts for workers' compensation practitioners where the expertise of an expert is in question. The Claimant endeavored to show that he developed prostate cancer as a result of direct exposure to carcinogens while working as a firefighter for the City of Philadelphia ("Employer"). Once again, we are confronted with a very complex causation question given the number of potentially contributing risk factors.

The Claimant's medical expert was board-certified in internal medicine, hematology and medical oncology. Breast, colon, and lung cancer patients made up 90% of his practice. Further, this witness stated that he was not a toxicologist or epidemiologist, and had not designed a study protocol, or published anything on the etiology (causes or causation) of cancer. He

also stated that he never performed any research on the etiology of prostate cancer.

The Claimant's medical expert testified that firefighters are exposed to carcinogens in the course of their work. While conceding that there were many non-work-related risk factors for prostate cancer, including age, family history, and other environmental exposures to carcinogens, he opined that the Claimant's exposure to carcinogens during his employment as a firefighter was a contributing factor to the early development of his prostate cancer. This medical expert also testified, within a reasonable degree of medical certainty, that the Claimant's exposure to carcinogens while working for the City of Philadelphia as a firefighter constituted a substantial contributing factor in the development of his prostate cancer.

The WCJ, however, found the testimony of the Employer's medical expert more credible and persuasive. The Employer's medical expert was board certified in internal medicine, pulmonary medicine and occupational medicine. He also was trained in epidemiology, which is the science of methodology addressing how risk factors match up with disease patterns. Based on the testimony of this medical expert, the WCJ found that the Claimant had not met the burden of showing causation in that Claimant's medical expert:

(1) Had never designed a study protocol, and he never published on the etiology of cancer or on firefighters specifically;

(2) Never performed any research on the etiology of prostate cancer;

(3) Did not know the methodologies that various groups, including the EPA, the AMA, and the federal courts, used in attempting to link a given exposure to a given cancer;

(4) Was not an epidemiologist and could not assess reliability based on study design;

(5) Failed to address the biostatistical methods and analytic techniques used in the studies he reviewed;

(6) His expert opinions did not conform to the usual epidemiologic standards for the formation of general causation opinions.

The Commonwealth Court held that the Claimant failed to establish that his prostate cancer had been caused by the chemical exposures he experienced in carrying out his duties as a firefighter. With this being the case, the Court opined there was no need for the Employer's medical expert to testify as to the cause of Claimant's prostate cancer. This expert testified to a number of possible causes, but did not form an opinion as to which of the various risk factors at play had, in fact, caused Claimant's prostate cancer. The Court also held that, given that Claimant had failed to link his prostate cancer to his work as a fireman, he was not entitled to the presumption of causation available under Section 301 (f) of the Act.

Turning next to the case of *City of Williamsport v. Workers' Compensation Appeal Board (Cole) (Deceased),* 145 A.3d 806 (Pa. Cmwlth. 2016), we see once again the strict causation analysis the Commonwealth Court brings to this line of cases.

The Decedent, a firefighter with Employer, died from gastric cancer, which allegedly resulted from direct exposure to known carcinogens during the course of his work. Decedent's widow (Claimant) was pursuing benefits under Section 108 (r) and Section 301(f) of the Act, which mandates that there be a showing of direct exposure to a known carcinogen. Claimant testified that on approximately 15 occasions, when decedent did not have the opportunity to shower at work, she observed that "he smelled smoky and appeared to be someone who came out of ashes."

This testimony constituted the only evidence of record as to workplace exposures experienced by the Decedent while executing his firefighting duties. The Court observed that, while this testimony was sufficient to show that the Decedent was exposed to smoke and ash while working for Employer, it was insufficient to show exposure to asbestos or any other known carcinogen within the smoke. The court further commented that the medical expert who testified on behalf of the Claimant had *assumed* that the Decedent was exposed to heat, smoke, fumes, gases, asbestos and other carcinogens based solely on his general knowledge of the firefighting profession and the general exposure of firefighters to carcinogens.

Turning away from firefighter cases, there can be found additional signs of increasing judicial scrutiny of the credentials of medical experts. In the case of *IA Construction Corporation* v. *Workers' Compensation Appeal Board (Rhodes)*, 139 A.3d 154 (Pa. 2016), the Pennsylvania Supreme Court stressed the importance of basing impairment rating decisions on the opinions of medical experts best qualified to evaluate the particular type of work injury involved.

In 2005, the Claimant suffered injuries in a vehicular accident while in the course of his employment with the Employer. In 2007, a WCJ granted the claim petition filed by Claimant finding that he had sustained a number of injuries as a result of the vehicular accident entitling him to total disability benefits. These injuries included traumatic brain injury with organic affective changes, persistent cognitive problems, memory impairment, posttraumatic headaches, posttraumatic vertigo or impaired balance, and musculoskeletal or myofascial neck and back injuries.

At the request of Employer, Claimant underwent an impairment rating evaluation (IRE) several years after he started receiving temporary total disability benefits. The IRE physician, M. Bud Lateef, M.D., designated by the Bureau of Workers' Compensation (the "Bureau"), maintained board certifications in physical, rehabilitation, and pain medicine. Dr. Lateef conducted an IRE examination and assigned a permanent impairment rating of 34% to Claimant. On the basis of this impairment rating, Employer proceeded to file a modification petition.

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The WCJ denied Employer's modification petition finding that Dr. Lateef's assessment of Claimant's cognition was unduly limited, since he performed only a cursory examination, and otherwise relied upon only a limited range of medical records. The WCJ also pointed out that Dr. Lateef specialized in physical medicine and pain management, not neurology.

The WCAB affirmed the decision of the WCJ. However, the Commonwealth Court of Pennsylvania reversed the decision of the WCJ pointing out that Claimant had failed to produce any evidence as to the insufficiency of the IRE. Further, the Commonwealth Court noted that the WCJ did not make reference to any provisions of the AMA Guides, or other evidence, in support of her rejection of the impairment rating arrived at by Dr. Lateef.

The Pennsylvania Supreme Court squarely held that Pennsylvania, in contrast to certain other states, does not have what it termed an "uncontradicted medical evidence rule," which precludes workers' compensation factfinders from rejecting uncontradicted medical evidence. The Court, citing its decision in *Diehl v. Workers' Compensation Appeal Board (I.A. Constr.),* 5 A.3d 230 (Pa. 2010), pointed out that an IRE under Section 306 (a.2) (6) "is entitled to no more or less weight than the results of any other examination." *IA Construction Corp.,* 139 A.3d at 161.

The evidentiary record in *IA Construction Corp.* revealed to the Court that the examination performed by Dr. Lateef relative to the Claimant's brain injury appears to have centered on Claimant's ability to say his name, describe his present location, supply the correct date, spell a word backwards, and identify the President of the United States. *IA Construction Corp.,* 139 A.3d at 163. The Court noted that the AMA Guides specify that an examination for neurological impairment "should be based on a detailed mental status examination, often in concert with neuropsychological assessment and testing." *Id.* Like the WCJ, the Court could find little in Dr. Lateef's deposition or report to suggest that such a detailed mental status examination had been undertaken.

The Court ruled that the WCJ had not erred in expressing concerns about the fact that Dr. Lateef was not a neurologist. The Court held that a workers' compensation judge may validly accord lesser weight to an underdeveloped, out-of-specialty opinion regarding the degree of impairment associated with traumatic brain injury. The Court ordered that the Commonwealth Court's decision be reversed and the matter remanded for reinstatement of the WCJ's adjudication.

Conclusion:

The cases discussed in this article would seem to strongly suggest that, while workers' compensation law is administrative in nature and the rules of evidence in this field are more relaxed, the Courts are evidencing increasing judicial scrutiny of the credentials of alleged experts. This closer examination of expert credentials can be seen both in occupational disease situations, as well as IRE litigation. These recent developments underscore the need for workers' compensation practitioners to use considerable care in the selection of experts, medical or otherwise. Additionally, practitioners should be sure, where appropriate, to vigorously challenge the credentials of proffered experts.

The Role of the Rule: Parol Evidence & Coverage Case

By C. Scott Rybny, Esquire, and Matthew B. Malamud, Esquire, Timoney Knox, LLP, Fort Washington, PA

Most insurance coverage disputes involve the interpretation of policy language. In the thirty years since the Pennsylvania Supreme Court issued the seminal decision in *Standard Venetian Blind Co. v. American Empire Ins. Co.*, 469 A.2d 563 (Pa. 1983), there have been numerous opinions from Pennsylvania's courts on the topic. Regardless of the policy type or coverage at issue, the disputes begin with the consideration of the words in the contract. One approach to policy interpretation, cloaked as an evidentiary standard, is the consideration of extrinsic evidence to determine the parties' intent when the policy was written and/or issued. In this article, we will review Pennsylvania's application of the "parol evidence rule" to insurance matters.

The Parol Evidence Rule

In *Standard Venetian Blind*, Pennsylvania's Supreme Court instructed courts to give effect to policy language as written where that language is clear and unambiguous. 469 A.2d 563, 566 (Pa. 1983). Over the three decades since this decision, Pennsylvania courts have not traveled the same road to this destination. Some courts focused exclusively on policy language, while others considered -- for various reasons -- the reasonable expectations of the insured. Another approach, again depending on the facts of the dispute and the willingness of the court, involved the consideration of extrinsic evidence. In sum, the wake of *Standard Venetian Blind* revealed an often-asked, but infrequently answered, question: when, if ever, may a court properly resolve a coverage dispute by looking beyond the terms of an insurance policy? The answer to this question is in the parol evidence rule.

The parol evidence rule provides, "[w]here the parties, without any fraud or mistake, have deliberately put their engagements in writing, the law declares the writing to be not only the best, but the only, evidence of their agreement." *Yocca v. Pittsburgh Steelers Sports, Inc.*, 854 A.2d 425, 436 (Pa. 2004). A court may not consider extrinsic evidence to explain or vary the terms of the written agreement. *Id.*, at 436-37. Like most rules, the parol evidence rule is not without its exceptions.

Exceptions to the Parol Evidence Rule

The first exception may also be the most logical. Parol evidence may be considered where a party argues that the written contract does not represent the parties' true agreement. This arises where one party alleges fraud in the execution of the policy. *Toy v. Metro. Life Ins. Co.*, 928 A.2d 189, 205 (Pa. 2007). Parol evidence may also be considered where an insurer issues a policy that differs from that for which the insured applied. *Tonkovic v. State Farm Mut. Auto. Ins. Co.*, 521 A.2d 920 (Pa. 1987). This also applies where the insurer or its agent misrepresented the terms of coverage and the insured justifiably relied on the misrepresentation. *Rempel v. Nationwide Life Ins. Co.*, 370 A.2d 366 (Pa. 1977), or to resolve an ambiguity in the written agreement. *Yocca*, 854 A.2d at 437. While the first three exceptions track the historical application of the parol evidence rule, the fourth, ambiguity, warrants additional discussion.

Ambiguous Policy Language

When faced with an ambiguity in the policy language, Pennsylvania courts typically apply the doctrine of *contra proferentem* and construe ambiguous language against the insurance company. *Madison Constr. Co. v. Harleysville Mut. Ins. Co.*, 735 A.2d 100 (Pa. 1999). While the *contra proferentem* doctrine appears to eliminate consideration of an entire class of parol evidence, this may not always be the case. *Compare Yocca*, 854 A.2d at 437 (permitting parol evidence to resolve an ambiguity).

Policy language is only ambiguous where it is "subject to more than one reasonable interpretation when applied to a particular set of facts." *Madison Constr. Co.,* 735 A.2d at 106. Whether or not a particular policy provision is ambiguous should not be resolved in a vacuum; instead the proffered interpretation must be a reasonable one. *Id*. Reasonableness is an objective standard requiring consideration of the specific facts of the case at issue. *Id.* To determine whether policy language is ambiguous (i.e. subject to more than one reasonable interpretation), and, therefore, whether the doctrine of *contra proferentem* may be applied, Pennsylvania courts will often look to extrinsic evidence beyond the four corners of the written insurance policy. *See Yocca*, 854 A.2d at 437.

The parol evidence rule also permits use of extrinsic evidence to resolve an ambiguity created by "collateral circumstances." In the insurance context, a "collateral circumstance" exists where the policy contains a latent ambiguity. Latent ambiguity is where the policy language is unambiguous, but extraneous or collateral facts render its application uncertain. *Burke v. Independence Blue Cross,* 103 A.3d 1267, 1274 (2014). Insurance practitioners should tread cautiously under this scenario, given the Pennsylvania Supreme Court's directive to the trial courts against distorting "the meaning of the language or resort to a strained contrivance in order to find an ambiguity." *Madison Constr. Co.,* 735 A.2d at 106.

Sunbeam Corp. v. Liberty Mut. Ins. Co., 781 A.2d 1189 (Pa. 2001), is a special case that steps beyond the enumerated exceptions to the parol evidence rule. In *Sunbeam*, the Pennsylvania Supreme Court held that, regardless of ambiguity, "[w]here terms are used in a contract which are known and understood by a particular class of persons in a certain special or peculiar sense, evidence to that effect is admissible for the purpose of applying the instrument to its proper subject matter." *Sunbeam*, 781 A.2d at 1193. In so holding, the Pennsylvania Supreme Court effectively removed evidence of trade usage and custom from the proscription against parol evidence. Rather, once a particular custom or usage has been established, it becomes an unwritten part of the contract. *Id*.

Conclusion

Pennsylvania case law concerning insurance policy interpretation can sometimes appear inconsistent. Close consideration of *Standard Venetian Blind* and its progeny do reveal a common thread running through the decisions: the parol evidence rule. Many of these cases never mention the rule, but its influence is undeniable. The relevance of extrinsic evidence during discovery -- and at trial -- is based on these cases, and the potential topic of a future article.

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Assault on the Citadel of Privilege: Bad Facts Make Really Bad Law*

By Dennis M. Wade, Esquire and Colleen E. Hayes, Esquire, Wade Clark & Mulcahy

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When a new matter lands on an insurance professional's desk, the first question the insurance professional asks is this: Is this matter covered under the contract of insurance? Sometimes the answer is obvious. But often, the insurance professional will seek the guidance of coverage counsel before making that critical decision, with the insurance professional assuming that counsel's advice and the insurance professional's communications with counsel will be shielded by privilege.

A fine line has always existed between an insurance professional's work in assessing coverage and the analysis undertaken by coverage counsel. Until very recently, that line, though admittedly fine, has been generally respected by courts across the country. But a decision by New York's First Department has called into question time-honored assumptions about privilege and may well signal a new assault on what was long perceived to be the citadel of attorney-client privilege in coverage investigations.

The First Department sent shockwaves through the insurance industry when it required a group of insurers in a declaratory judgment action to disclose a coverage opinion prepared by outside counsel. In *National Union Fire Ins. Co. of Pittsburgh* v. *TransCanada Energy USA, Inc.,* 981 N.Y.S.2d 68 (1st Dep't Feb. 25, 2014), the court held that a coverage opinion was discoverable because it was "an opinion as to whether the insurance companies should pay or deny the claims" and because "documents prepared in the ordinary course of an insurer's investigation of whether to pay or deny a claim are not privileged, and do not become so merely because the investigation was conducted by an attorney." *Id.* Although the February 25, 2014 decision was recalled and seemingly modified in *National Union Fire Ins. Co. of Pittsburgh v. TransCanada Energy USA, Inc*., 119 A.D.3d 492 (1st Dep't July 31, 2014), the First Department, ultimately stood by its prior decision based in part on its conclusion that "counsel were primarily engaged in claims handling – an ordinary business activity for an insurance company." *Id.* Further, the New York Court of Appeals dismissed the insurance companies' motion for leave to appeal the First Department's order – implicitly affirming the lower court's decision.

On its face, *National Union* is an alarming ruling that seemingly holds that insurance companies are not entitled to the protections afforded by attorney-client privilege; the common interest exception to the waiver of attorney-client privilege; and, the doctrines of work product and materials prepared in anticipation of litigation – if coverage counsel is hired before denying coverage. But to grasp the potential import and long-term impact of the court's ruling, it is worthwhile to delve into the procedural history of how the First Department ultimately arrived at its July 31, 2014 decision.

Procedural History of National Union

National Union arises out of an incident that occurred on September 12, 2008 – that resulted in a disclaimer of coverage to the insureds for the ensuing loss. Specifically, the insureds were owners of a power generating facility in Long Island who had obtained insurance from five different companies on the same day they acquired the facility. Three days after taking ownership and obtaining the insurance policies, the insureds noticed excessive vibration emanating from one of the facility's generators. The generator was ultimately shut down when a crack was discovered in the rotor.

Shortly after the incident, the insureds notified their insurance companies of the loss, making claims for repair costs as well as business interruption losses. Following their investigations, the insurance companies disclaimed coverage for the loss and brought a declaratory judgment action.

During the course of litigation, the insureds sought discovery from their insurance companies, specifically, discovery from Factory Mutual Ins. Co. ("FMIC"), Chartis, ACE INA Insurance, and Arch Insurance Company (collectively referred to as "Market Insurers," FMIC and Market Insurers referred to as the "Insurance Companies"). In response to the demand, the Insurance Companies claimed several documents at issue were protected work product and attorney-client privileged communications, and thus, not discoverable. Following the Insurance Companies' refusal to produce these documents, the insureds filed a motion to compel (the impetus leading to the First Department's February 25, 2014 and July 31, 2014 decisions). The Insurance Companies subsequently crossed-moved for a protective order. To address the dispute, the matter was referred to a special referee, who, following an *in camera* review of a sampling of the documents[1] concluded any documents that pre-dated the date of the Insurance Companies' rejection of the insureds' claim were not subject to privilege; and, thus, needed to be produced.

The referee's decision was subsequently appealed to the Supreme Court, New York County by all parties. *See National Union Fire Insurance Company of Pittsburgh, Pennsylvania, et al. v. TransCanada Energy USA, Inc., et al*., 2013 WL 4446917 (Sup. Ct., N.Y. County August 15, 2013). In their motion to the court, the insureds contended that the referee's recommendation should be confirmed as the referee had properly

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determined that documents created prior to an insurer's denial of coverage could never constitute protected attorney-client communications or work product; and, since all documents at issue were created pre-denial, they needed to be produced. But the Insurance Companies argued that the recommendation should be rejected because the referee had applied the wrong legal standard and failed to review all documents at issue. Yet the insurers asked the recommendation be confirmed to the extent the referee had recommended billing records need not be produced. The trial court ruled for the insureds.

In its analysis, the trial court cited three categories of protected materials under the New York Civil Code: Attorney-client communications; attorney work product; and trial preparation materials. The court then discussed the requirements needed to trigger these potential protections.

Turning first to documents protected by work product and/or as trial preparation materials, the trial court held, in order to be protected by these doctrines, the documents needed to be prepared for, or in anticipation of, litigation; and, in the insurance context, an insurer could not claim documents were prepared in anticipation of litigation until a firm decision to deny coverage had been made.[2] Furthermore, the burden was on the insurer to establish the date of denial.

Next as to documents protected by attorney-client privilege, the trial court, first noted, attorney-client privilege was not tied to the contemplation of litigation (thus, distinguishing this protection from documents purported to be protected as work product or trial preparation materials). Thus, in order to claim this privilege, the court concluded, the party attempting to withhold a document must show it was a confidential communication between an attorney and a client made in the context of legal advice or services. But the court cautioned documents prepared in the ordinary course of business were not protected by attorney-client privilege, even if drafted by an attorney.

In applying this rule in the context of insurance claims, the court pointed out that the business of insurers is to investigate claims and decide whether to accept or deny coverage. As such, courts have consistently held that using an attorney to conduct claim investigations would not cloak the documents in privilege; and thus, these documents could not be withheld as privileged.[3] Despite this stark holding, the court clarified that documents could still constitute privileged attorney client communications (even if these documents were created pre-denial) if they were primarily of a legal nature, and not related to an insurer's ordinary business activities.[4] While the court drew this important distinction, it offered no guidance on the criteria used to ascertain the line between "claim activity" and legal advice regarding coverage.

Finally, the trial court briefly touched on the common interest privilege, holding it was not a separate privilege, but an exception to the usual rule that disclosure to a third party waives privilege. According to the court, to avoid waiver, and fall within the exception, the parties needed to have a common interest that was primarily legal rather than commercial, and disclosure needed to occur either during the course of litigation or at least in the anticipation of litigation. The court, again, noted, in the claim context, an insurance company could not aver that it anticipated litigation until a firm decision regarding coverage had been made.

With these legal standards in mind, the trial court reviewed the challenged documents to determine if any of them fell within the embrace of recognized privilege. First, the court applied the above principles to documents withheld by FMIC. The court determined these documents were improperly withheld because they were prepared by the insurers' attorneys working chiefly as claim handlers. Several key facts prompted the court to reach this conclusion. First, the document review showed that the insurers' attorneys were supervising, coordinating, and directing the investigation into the claimed loss, including collecting documents and hiring investigators. Also, the documents revealed the attorneys were preparing reports, summarizing the results of these investigations. The court took the view that these documents were not privileged because the attorneys were working primarily to determine whether to deny coverage. Yet, even with this blanket pronouncement, the court still found that some of the documents were privileged because they contained communications between an attorney and client for the purpose of obtaining legal advice. Also, draft denial letters were deemed privileged because they were created after FMIC had decided to deny coverage.

Next, the court turned to documents withheld by the Market Insurers. With little to no discussion, the court determined the Market Insurers had failed to show the documents were privileged, finding the insurers conflated their decision to file a declaratory judgment action with their decision to deny coverage; noting the same attorneys had been hired to handle both the investigation of the claim and to assist with the coverage determination. Oddly, the bulk of the court's analysis focused on the fact the Market Insurers's counsel had freely communicated with each other, reasoning that, if attorney-client privilege did exist for any of the documents, it was waived because no common interest existed among these independent insurers.

The trial court's order was then appealed to the First Department, Appellate Division. With no real analysis, the First Department affirmed the lower court's holding. *See National Union*, 981 N.Y.S.2d. 68. In brief, the First Department reasoned that the trial court had properly determined that the majority of the documents the Insurance Companies had sought to withhold were not protected by attorney-client privilege, the work product doctrine, or as materials prepared in anticipation of litigation. The First Department made a general pronouncement saying the record revealed that the Insurance Companies

had retained counsel to provide "an opinion as to whether the insurance companies should pay or deny claims". *Id*. at 595-96. Because an insurer's investigation of whether to pay or deny a claim constituted an insurer's ordinary course of business, documents created in that context did not become privileged merely because the investigation was conducted by an attorney. *Id*. at 596. The court also briefly addressed the common interest exception, noting the exception was not applicable as, at the time of disclosure, there was no pending or reasonably anticipated litigation, a necessary element for the exception to apply. *Id.*

Then, with no explanation, the First Department recalled and vacated its February 25, 2014 decision and issued a new decision, dated July 13, 2014.[5] *See National Union Fire*, 119 A.D.3d 492. Despite recalling and vacating its previous decision, the First Department stood by its previous decision, and again affirmed the trial court's decision. In its terse analysis, the First Department ruled the trial court had properly determined certain documents were privileged because they contained pure legal advice. But, of significance, the First Department sided with the trial court, finding that, for the most part, the Insurance Companies had failed to carry their burden establishing the privileged nature of the documents. The court, with virtually no analysis, found the Insurance Companies' counsel were primarily engaged in claims handling and were retained to provide a coverage opinion as to whether the companies should pay or deny the claims.

In fact, the only seeming change on recall in the First Department's new decision was a refusal by the court to reach a decision regarding the common interest exception because of a determination that the documents were not privileged in the first instance.

And that is the end of the road because the Court of Appeals denied the Insurance Companies' leave to appeal because the order below did not finally determine the action.

Impact of National Union

Looking deep into the record of *National Union*, the First Department's ruling may not be as foreboding as its sweeping wording suggests.

The briefs filed by the parties to the litigation, although full of oblique references to caches of sealed documents, tell the story of coverage attorneys who were more involved in their clients' investigative and decision-making process with respect to denying the claim than attorneys merely offering a legal opinion on how a court would interpret policy provisions in light of facts that were already known.

The submissions show that the First Department did not simply carpet bomb the insurance industry's right to the protections of attorney-client privilege. What the First Department (and the trial court) fail to mention in their written decisions is that there were at least two coverage opinions at issue in *National Union.* One insurer did not rely on the coverage counsel retained by the other four insurers, but rather, hired a different firm to provide it with legal advice in respect of coverage issues. Further, the First Department and the trial court decisions do not reveal that one of the documents the courts held protected by the attorney-client privilege was a coverage opinion written by coverage counsel, hired independently by one of the insurers, before the insurer denied the claim.

Yet *National Union* is an assault on the citadel of privilege and definitely a cause for concern. As detailed above, the First Department's holdings – that a coverage opinion is discoverable – are bereft of legal analysis and virtually silent on the facts giving rise to such bold pronouncements.[6] As such, the decisions may easily be misinterpreted as a blanket ruling that anything an insurer receives from coverage counsel before denying coverage is fair game in discovery. But a close review of the decisions suggests that the court still recognizes that, under the right circumstances, insurers are entitled to the protection of attorney-client privilege and other privileges in coverage investigations.

As discussed, the court actually shielded one of the pre-denial coverage opinions from disclosure and was plainly more concerned with curtailing the practice of shielding key facts from disclosure by tasking coverage counsel with an investigative role and making decisions that ought to have been made by insurers. However, the brevity of the decision is troubling as it seemingly masks its true import. *National Union* aptly illustrates the old adage that bad facts make really bad law. The real problem, as we develop here, is the bad facts are nowhere developed in the opinion itself.

Thus, given the stark nature of *National Union's* holdings, in an attempt to flesh out the potential ramifications of these rulings, including the effect they ultimately may have on the citadel of privilege, an overview of the cases citing *National Union* may offer some insight into how courts, insurers and policyholders view the impact of the *National Union* decisions.

One of the first times *National Union* was cited was in December 2013 in *34-06 73, LLC, et al, v. Seneca Insurance Company, Inc*.[7] *Seneca* arose out of a first-party property damage claim brought by the plaintiff-insureds seeking coverage for property damage. *See 34-06 73, LLC, et al, v. Seneca Insurance Company, Inc*., 2013 WL 6328672 (Sup. Ct., N.Y. County December 5, 2013). In *Seneca*, the insureds moved to compel the production of certain records that the defendant-insurer had generated before the rejection of the insureds' claim. The insurer opposed the motion on the basis that the documents were protected by attorney-client privilege and work product. The documents were later submitted for an *in camera* review before the court.

In determining whether the insurer was entitled to withhold the documents because they constituted either work product or trial preparation materials, the court cited *National Union's* August 15, 2013 decision, holding that an insurance company could not claim documents were prepared in anticipation of litigation until a firm coverage decision had been

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made. Applying *National Union's* holding, the court determined that since all of the documents at issue were created before the denial of coverage, they would not be protected as work product or trial preparation materials, and thus were discoverable.

But *Seneca's* analysis as to whether documents were protected by attorney-client privilege illustrates why *National Union's* holdings may not be as caustic as they first appear. In its analysis, despite referring to *National Union's* broad holding, the court held that documents (even documents produced pre-denial) could still be protected by attorney-client privilege so long as they were primarily of a legal, as opposed to investigatory, character and not related to an insurance company's routine protocol in reaching a claim decision.

Applying this standard, the court proceeded to analyze some of the documents at issue finding that a case note report, authored by a property adjuster, which detailed legal strategy and information about reserves was protected; email communications between the insurer's attorney and the insurer's vice president of claims, which detailed steps taken in the investigation of the claim, which also included discussions regarding legal strategy were protected; documents regarding reserve information were protected; and invoices and billing information were also protected. Thus, *Seneca* shows that a close read of *National Union* still allows, under the right circumstances, for the attorney-client privilege and other privileges to remain in full-force during coverage investigations and, if carefully applied, may not cause a total shift in jurisprudence in the coverage context.

In August 2015, the New York County Supreme Court again cited *National Union* – once more offering hope that courts subsequently applying *National Union* would apply it in such a way as not to completely strip the attorney-client privilege of all protection in the coverage context. *See New Hampshire Ins. Co., et al. v. MF Global Finance USA Inc.,* 2015 WL 5049915 (Sup. Ct., N.Y. County August 25, 2015). Specifically, in *MF Global*, the plaintiff-insurers were seeking a declaration that their insured, MF Global Finance USA Inc. ("MF Global") was not entitled to recover under bonds issued by the plaintiff. During the course of discovery, MF Global moved to compel the production of documents prepared primarily during the period preceding the insurers' coverage determination, to which the insurers asserted attorney-client privilege.

The court referred the motion to a special referee, who conducted an *in camera* review of the documents at issue – ultimately determining, that before the decision to deny coverage, the insurers' counsel were acting as claims investigators and not attorneys. As such, the referee recommended that the insurers be compelled to produce all documents predating the coverage decision, reasoning that such documents revealed neither legal advice nor legal recommendations. MF Global subsequently moved to confirm the referee's report, and the insurers moved to reject the report.

In its analysis as to whether the documents were protected by attorney-client privilege, the court stated the critical inquiry in determining whether a communication was privileged was whether, viewing the lawyer's communication in full content and context, it was made in order to render legal advice or services to the client. Further, the court noted that in the insurance context, the First Department had previously compelled the disclosure of opinions "as to whether the insurance company should pay or deny claims" prepared by an insurer's counsel, where the review of the record showed that counsel were primarily engaged in claims handling – an ordinary business activity for an insurance company, citing *National Union's* July 13, 2014 decision. But the court caveated this rule, again, citing *National Union*, holding that even in cases where an insurer's counsel were primarily carrying out claims handling activities, certain documents, which contained legal advice may be privileged nonetheless.

Against that criteria, the court rejected the referee's conclusion that privilege did not apply to any document prepared before a coverage denial because no such *per se* rule existed. In its analysis, the court found that the referee had acknowledged that the documents at issue included attorney memoranda containing summaries of legal research, case law, discussions of the applicable law, and application of the law to the facts at issue. Yet the plaintiff-insurers failed, on the record, to support their claim that their services were legal and not investigatory in nature. Specifically, plaintiff-insurers submitted no supporting evidence of the performance of in-house claims investigations; rather the documents reflected that the insurers' counsel had investigated the claim themselves. Thus, although the insurers' counsel had provided legal advice and legal services, they also had acted as the claims investigators prior to the coverage decision. The fact that lawyers had conducted the investigation did not serve to cloak the pre-denial documents with attorney-client privilege; the documents needed to be of a legal character for privilege to apply. Thus, the court concluded, to the extent that the documents reflected the pure legal advice or legal services, including: case or choice of law analysis; contained legal strategy; or other indicia of true legal services, those portions of the documents need not be produced.

To provide guidance, the court went through a sample of the documents, noting what should and should not be redacted. For example, the court noted that the analysis of a policy term may not be protected by privilege because the analysis of relevant policy terms is the type of analysis a claims adjuster would perform in making a coverage determination. But to the extent that such analysis involved the express delivery of legal advice, including the discussion of case law or prediction of litigation outcomes, such content could be redacted. Further, if a document

were primarily legal in nature, or if the legal advice was inextricably interwoven with other content and redaction was therefore impracticable, such document, or relevant part, would also be immune from disclosure. As with *Seneca*, *MF Global* shows that the application of *National Union* still allows for the attorney-client privilege to provide protection throughout coverage investigations.

Yet, by contrast, a July 2014 ruling by the New York County Supreme Court illustrates how the brevity of *National Union's* pronouncements may result in blanket rulings, allowing for a continued assault on the attorney-client privilege. *See e.g., Belfer v. Travelers Ins. Co. et al*., 2014 WL 3728495 (Sup. Ct., N.Y. County July 25, 2014).

In *Belfer*, the plaintiff-insured, Shira Belfer ("Belfer") moved to compel defendants to produce, among other things, any records of communications that Belfer's insurer, Travelers Insurance Company, a named defendant, had with the other defendants regarding the insured's claim. The defendants claimed, among other things, that the communications the defendants had with the plaintiff's insurer were protected by attorney-client privilege, as they arose out of communications between an insured and its insurer. In reaching a determination whether the documents were protected, the court first determined that there was no confidential relationship between the defendants and the insurer, and thus, this was not a basis to withhold documents. Moreover, citing *National Union's* February 25, 2014 decision, the court noted that, if the documents at issue involved the insurer's investigation into the insured's claim, and whether to deny or pay the claim, these documents were not privileged, and, needed to be produced. *Belfer's* ruling seemingly broadens *National Union's* impact as the court failed to caveat its ruling by conceding certain documents may still constitute privileged attorney-client communications provided they were of legal character, a holding implicit but unfortunately buried in *National Union.*

While *National Union* and its progeny may not be the all-out assault they appear to be, the decision underscores the need for insurance professionals to take ownership of their decisions to deny coverage. As coverage attorneys, we like to think that we serve an important role in identifying issues; marshaling relevant facts; researching applicable law; and, giving our opinion on the probable outcome of the coverage contest. But coverage counsel is frequently involved from the very outset of a problematic claim, assisting in a variety of ways: Drafting Reservations of Rights; suggesting necessary field investigation; and, generally, helping to assemble the information base upon which a decision may be reached. Will such a role invite a *National Union* attack? That question, we suggest, will trigger discovery battles across New York and will likely reach the Court of Appeals forcing it to address the issue as *National Union* literally begs for explication.

But the supreme irony of the role of coverage counsel is this: While we may give counsel, insurance professionals must make the decision, articulate the facts supporting the decision, and do whatever else is necessary to prevail. An insurer's "ownership" of the coverage position is the best chance of surviving a *National Union* attack.

As general matter, when in the witness chair, the insurance professional may never rely upon coverage counsel's work product – whether the Reservation of Rights, a Disclaimer Letter, or a rationale for a coverage decision.[8] In fact, as a practice pointer, we insist that our clients read the transcripts of all examinations under oath and study the accompanying exhibits. Put simply, the insurance professional must take ownership of all facts and the rationale and wording of the published coverage position letter.

This is not to say, of course, that insurance professionals may never refer to coverage counsel's role. The real point is that an insurance professional may not defer responsibility to coverage counsel, making counsel, in effect, a witness in the proceeding.

So, what are the takeaways from *National Union?*

- The decision to pay or deny coverage rests with the insurer. The insurer must "own" its decision.
- The factual investigation must be conducted and directed by the insurance company, not the attorney.
- Insurers can seek the guidance of coverage counsel for legal advice on how courts will interpret policy provisions in light of the facts the insurer has developed.

Conclusion

In discovery, whether first or third party, truth is a precious commodity. And, insurance professionals are the guardians. Insurance professionals must be vigilant. No good comes from delegating authority in coverage matters or from hiding or masking bad facts.

ENDNOTES

[1] In their submissions to the First Department, both sides acknowledged that the court did not review all of the documents submitted for an *in camera* review. While the insureds emphasized the fact that the court relied on a sample selected by the insurers, one of the insurers claimed that the trial court limited its review to ten sample documents because the referee said: "I'm not going to look at a thousand documents."

[2] The case cited for this proposition, *Millen Industries, Inc. v. American Mut. Liability Ins. Co*., 37 A.D.2d 817 (App. Div. 1st Dep't 1971), offers little to no analysis before reaching its holding.

[3] The case cited for this proposition is *Brooklyn Union Gas Co. v. American Home Assur. Co*., 803 N.Y.S.2d 532 (App. Div. 1st Dep't 2005); however, this case seems to suggest that if the documents contained legal advice, legal recommendations or attorney thought processes, that these documents may be privileged, regardless if they were not prepared in anticipation of litigation.

[4] The case cited for this proposition is *All Waste Systems, Inc. v. Gulf Ins. Co*., 743 N.Y.S.2d 535 (App. Div. 2nd Dep't 2002). In this case, Gulf Insurance Co. had asserted a claim of privilege in denying disclosure of coverage opinion reports and a draft disclaimer letter, which outside legal counsel had prepared. All Waste attempted to compel these documents arguing they were prepared in the regular course of business. The court denied the request holding that the documents sought were primarily and predominately legal in nature and, in their full content and context, were made to render legal advice or services.

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Assault of the Citadel of Privilege

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[5] We note that *National Union* was cited by *AMBAC v. Assurance Corporation, et al. v. Countrywide Home Loans, Inc*., *et al*., 124 A.D.3d 129 (App. Div. 1st Dep't December 4, 2014). Specifically, in *AMBAC*, the First Department recognized that there had been inconsistency in its prior rulings regarding the elements needed for the common interest exception to apply. Ultimately, the court determined that pending or reasonably anticipated ligation was not a necessary element of the common interest exception – a ruling that is inapposite to the First Department's February 25, 2014 ruling, possibly offering a reason for why the February 25, 2014 opinion was vacated and recalled by the court with the updated opinion opting not to address the common interest exception. We, however, note on June 9, 2016, the New York Court of Appeals reversed its holding in *AMBAC* and, in respect of the common interest exception held, in order to fall within this exception, any communication must relate to litigation, either pending or anticipated. *See AMBAC Assur. Corp. v. Countryside Home Loans, Inc*., 27 N.Y.3d 616 (N.Y. June 9, 2016). The Court of Appeals did not reference *National Union* in its opinion.

[6] The only way we were able to glimpse the case's factual background was by retrieving copies of the briefs from the First Department.

[7] As mentioned above, *National Union* was also cited in connection with the common interest exception. *See e.g.*, *AMBAC Assurance Corporation, et al. v. Countrywide Home Loans, Inc., et al.,* 124 A.D.3d 129 (App. Div. 1st Dep't December 4, 2014), *overruled by AMBAC Assurance Corporation, et al. v. Countrywide Home Loans, Inc.*, 27 N.Y.3d 616 (N.Y. June 9, 2016); and *Levy v. Arbor Commercial Funding, LLC,* 2015 WL 5049915 (Sup. Ct., N.Y. County August 25, 2015), *aff'd as modified by Levy v. Arbor Commercial Funding, LLC*, 138 A.D.3d 561 (App. Div. 1st Dep't April 21, 2016). The First Department in neither *AMBAC* nor *Levy* referenced *National Union* in its opinion overruling / modifying the lower court's ruling in either of these cases.

[8] The major exception to this general rule occurs when the insurer seeks to defend against claims of "bad faith" or "unfair claim practices" by asserting that the action taken was "upon the advice of coverage counsel". This potential defense is necessarily beyond the scope of this article.

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