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DISCOVERY OF ONE'S "SOCIAL NETWORKS"

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An old French proverb tells us that the more things change, the more they stay the same. This can hold true in the law as elsewhere. Just as several decades ago courts were wrestling with new questions raised by the growth of computers in society, today they are faced with new issues created by the Internet.

A question asked frequently in recent years: "Can I get access to a plaintiff's Facebook page to look for evidence that he might be exaggerating his claim?" can be answered by looking to a pre-Internet era source: the rules of discovery.

So far, courts in Pennsylvania and other jurisdictions have applied traditional theories of discovery in allowing parties to obtain information found on a person's social network page. Put another way, "Discovery of [social networking sites] requires the application of basic discovery principles in a novel context." *E.E.O.C. v. Simply Storage Management, LLC*, 270 F.R.D. 430, 434 (S.D. Ind., 2010), cited in *Offenback v. L.M. Bowman, Inc*., *Slip Copy*, 2011 WL 2491371 at *3 (M.D. Pa., 2011).

In usually concluding that liberal discovery rules require relevant materials on a social network site be discoverable, courts, including those in Pennsylvania, have generally analyzed the issue from the perspective of privacy and privilege.

What is a social network?

Court decisions considering "social network" discovery issues have generally referred to efforts to obtain material on Facebook or MySpace pages, and to a lesser extent on Meetup.com, a website that facilitates forming groups of people with similar interests. But other "social networking" sites could include Linked-in, a business-related site, special interest locations which may have public and "members only" pages and dating websites such as Match.com.

For a discussion of the definition and history of social networking sites, *See* Boyd, D. M., and Ellison, N. B., "Social Network Sites: Definition, History, and Scholarship." *2007Journal of Computer-Mediated Communication*, *13*(1), article 11, http://jcmc.indiana.edu/vol13/issue1/-boyd.ellison.html

Pennsylvania decisions

There appear to be only two written opinions regarding discovery of a person's social networking pages in Pennsylvania, both at the trial court level. Each recognized the state's liberal discovery policy and each granted the motion to compel discovery of private website pages. A third decision rejected a motion for discovery without an opinion.

In *McMillen v. Hummingbird Speedway, Inc*. Jefferson Co., No 113-2010-CD (9/9/10), 2010 Pa.D&C LEXIS 270; 2010 WL 4403285, Judge Foradora considered defendant's motion to compel plaintiff to provide his user ID and password to Facebook and MySpace. Plaintiff McMillen claimed substantial and possibly permanent injuries when

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IS IT FINALLY TIME TO CHALLENGE *KACZKOWSKI*?

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Overview

A dissenting opinion to the Pennsylvania Supreme court's ruling in *Helpin v. Trustees of the University of Penn-sylvania*, 981 A. 2d 1280, 603 Pa. 60 (Dec. 2010), could signal that the court would welcome a challenge to *Kaczkowski v. Bolubasz*, 491 Pa. 561, 421 A.2d 1027 (Pa., 1980), the opinion that effectively eliminates the need to reduce personal-injury awards for lost future income to present value.

Kaczkowski held that lost future earnings in personal injury matters must be calculated using the "total offset" method. This methodology favors plaintiffs in almost all cases. The question in *Helpin* was whether *Kaczkowski* could be used to calculate damages in a breach of contract claim involving the future profits of a dental practice.

The dissent in *Helpin,* written by Justice

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Discovery

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he was rear-ended during a cool down lap after a stock car race at Hummingbird Speedway in Reynoldsville in July 2007. During discovery McMillen said he belonged to the social network sites Facebook and MySpace but declined to provide his user ID or passwords, claiming they were confidential. A review of the public portion of plaintiff's Facebook site showed comments about a fishing trip and attendance at the Daytona 500 in Florida. Defendants moved to compel production of the passwords and user IDs so they could "determine whether or not plaintiff has made any other comments which impeach and contradict his disability and damages claims." Plaintiff asked the court to recognize the information as confidential and protected against disclosure.

The court reasoned that because Pa.R.C.P. 4003.1 makes only privileged materials non-discoverable, plaintiff was asking the court to recognize a "social network privilege." But Judge Foradora said no such privilege has been adopted by Pennsylvania courts. He added that generally the law disapproves of privileges, *see*, *Joe v. Prison Health Services*., 782 A.2d 24, 31 (Pa. Cmwlth. 2001), and privileges are to be narrowly construed. *Joyner v. S.E. Penna. Transport. Auth.*, 736 A.2d 35, 38 (Pa. Cmwlth. 1999). To establish a new privilege, the claimant must establish: "1) that communications originated in confidence that they would not be disclosed; 2) that the element of confidentiality is essential to fully and satisfactorily maintain the relationship between the parties; 3) that community agreement that the relationship must be "sedulously" fostered; and 4) that the potential injury to the relationship because of the disclosure outweighs the benefits of correctly disposing of the litigation. *Matter of Adoption of Embick*, 351 Pa. Super. 491, 502, 506 A.2d 455, 461 (Pa. Super. 1986), *citing* 8 *J. Wigmore on Evidence* §2285 (McNaughton's Rev. Ed. 1961)", *McMillen, Slip Op.* at p. 3.

The court noted that websites such as Facebook are on-line places "people utilize to connect with friends and meet new people. That is, in fact, their purpose and they do not bill themselves as anything else. Thus, while it is conceivable that a person could use them as forums to divulge and seek advice on personal and private matters, *it would be unrealistic to expect that such disclosures would be considered confidential*." *Id.* at p. 3 (emphasis supplied.) Further, a detailed review of the terms of use on both Facebook and MySpace shows the access of the operators of those sites and defeats plaintiff's argument that his communications were confidential. *Id.* at p. 5.

Looking at privilege from Professor Wigmore's perspective leads to the same conclusion, the court said. Applying the factors found in *Matter of Adoption of Embick, supra,* no one using Facebook or MySpace could reasonably expect their communications were confidential. And this type of privilege is not one the community seeks to foster because, unlike professional relationships where confidentiality must be assured, history has shown that friendships flourish without the guarantee of confidentiality. *Id.* at p. 6.

Therefore, the court concluded that where there is "an indication that a person's social network sites contain information relevant to the prosecution or defense of a lawsuit . . . access to those sites should be freely granted." *Id.* at p. 7.

Nine months after *McMillen*, the Court of Common Pleas of Northumberland County reached the same conclusion in *Zimmerman v. Weis Markets, Inc.*, Northumberland County, No. C-09-1535, 5/19/11. In addition to approving the rationale in *McMillen*, Judge Charles H. Saylor adopted the "sound, logical approach" of a comprehensive New York decision, *Romano v. Steelcase, Inc.*, 30 Misc. 3d 426, 907 N.Y.S. 2d 650 (Suffolk Co. 2010). In so doing, he recognized Pennsylvania's policy that "liberal discovery is generally allowable and the pursuit of truth as to alleged claims is a paramount ideal." *Zimmerman, supra, slip op.* at p. 3.

In *Zimmerman*, the plaintiff was injured while operating a forklift at defendant's warehouse in Milton while employed by a subcontractor of defendant. He claimed pain and suffering, wage loss and permanent injury to his health in general and a "permanent diminution in the ability to enjoy life and life's pleasures." *Zimmerman*, *slip op.*, at p. 2.

Weis reviewed the public portion of plaintiff's Facebook page and learned that his interests included "ridin'" and bike stunts, while his MySpace page contained photographs showing him with a black eye and his motorcycle before and after an accident. There were also photographs of him wearing shorts in which a scar from the accident was clearly visible. At his deposition Zimmerman had testified that he never wore shorts because he was embarrassed by the scar. Weis filed a motion to compel disclosure of plaintiff's passwords and user IDs and to preserve the information on the sites.

Judge Saylor, noting that *McMillen, supra,* appeared to be the only published opinion in Pennsylvania relating to discovery of information on social networking sites, adopted the rationale of that decision, but also approved and relied upon the privacy analysis set forth in *Romano*, *supra*. He said that "All the authorities recognize that Facebook and MySpace do not guarantee complete privacy," and added that ". . . Facebook's privacy policy and its revisions have been the subject of criticism and controversy that may be never ending." *Zimmerman, slip op., supra*, at p.5, and n. 5.

In its opinion, the court recognized that just two weeks earlier the Court of Common Pleas of Bucks County had denied a defendant's motion to compel plaintiff to provide access to photos posted on her Facebook page. *Piccolo v. Paterson*, Bucks Co. No. 2009-04979. *See*, "Facebook Postings Barred From Discovery In Accident Case," *The Legal Intelligencer*, 5/17/11. Although defendant cited *McMillen* in support of her motion, plaintiff's counsel argued that numerous photographs pre and post accident had been provided and that there was no claim that postings on plaintiff's Facebook page would lead to the discovery of material evidence.

The decision in *Zimmerman* granting defendant's motion to compel concluded, "With the initiation of litigation to seek a monetary award based upon limitations or harm to one's person, and relevant, non-privileged information about one's life that is shared with others and can be gleaned by defendants from the Internet, is fair game in today's society." *Zimmerman, slip op., supra*, at p.6.

Other jurisdictions

In *Romano*, *supra*, relied upon in *Zimmerman, supra,* the defendant sought to compel access to plaintiff's Facebook and MySpace pages, including deleted pages, on the grounds that they were believed to be inconsistent with her clai ms made in the case concerning the nature and extent of her injuries and those for loss of enjoyment of life. Steelcase claimed that the public portion of plaintiff's Facebook and MySpace pages showed an active lifestyle, including travel to Florida and Pennsylvania during a time she said her injuries prohibited such activity.

The court recognized New York's "strong public policy in favor of open disclosure," 30 Misc. 3d at 428, 907 N.Y.S. 2d at 652, but recognized that there were no New York decisions addressing this issue. It cited *Ledbetter v. Wal-Mart Stores, Inc.*, 2009 WL 1067018 (D. Colo. 2009) in which the court denied a motion for a protective order regarding subpoenas to Facebook, MySpace and Meetup on the grounds that plaintiffs had waived their claims of physician-patient and marital privilege, and several cases which rejected privacy claims.

In addressing the privacy issue, the court began by saying any such concerns were outweighed by defendant's need for the information. However, the court said that in determining whether a privacy right exists within a Fourth Amendment context, a reasonableness standard is applied, as set forth in *Katz v. United States*, 389 U.S. 347, 88 S.Ct. 507, 19 L.Ed.2d 576 (1967) (Harlan, J, concurring). This opinion holds that 1) there must be an actual subjective expectation of privacy; and 2) society is prepared to recognize that expectation as reasonable. The Second Circuit has held that there is no reasonable expectation of privacy in Internet postings or e-mails that reach their intended recipient. *See United States. v. Lifshitz*, 369 F.3d 173 (2d Cir.2004) *citing Guest v. Leis*, 255 F.3d 325 (6th Cir.2001). 30 Misc. 3d at 432, 907 N.Y.S. 2d at 652 at 656.

In *Beye v. Horizon Blue Cross Blue Shield of New Jersey*, 2007 WL 7393489 (D.N.J. 2007), also cited in *Romano*, the court granted defendant's request that certain web page entries be produced and said that the "privacy concerns are far less where the beneficiary herself chose to disclose the information." 2007 WL 7393489, at *2. The *Romano* Court also referred to *Moreno v. Hanford Sentinel Inc.*, 172 Cal. App. 4th 1125, 91 Cal. Rptr. 3d 858 (Ct. App. 5 Dist.2009) (no person would have reasonable expectation of privacy where person took affirmative act of posting own writing on MySpace, making it available to anyone with a computer and opening it up to public eye); and *Dexter v. Dexter*, 2007 WL 1532084, (Ohio Ct. App., Portage Co. 2007) (no reasonable expectation of privacy regarding MySpace writings open to public view).

Because neither Facebook nor MySpace guarantee complete privacy, a plaintiff has no legitimate expectation of privacy, the court concluded. 30 Misc. 3d at 434, 907 N.Y.S. 2d at 656.

Also cited in both *Romano* and *Zimmerman*, was *Leduc v. Roman*, 2009 Carswell Ont. 843 (2/20/09) in which the appellate court reversed the decision of the trial court denying a defense request for an order compelling all materials on plaintiff's Facebook pages. The Superior Court of Justice of Ontario said that to permit a party claiming substantial damages "to hide behind self-set privacy controls on a website, the primary purpose of which is to share information about how they lead their social lives, risks depriving the opposite party of access to material that may be relevant to ensuring a fair trial"[1] *Cited in Ledbetter,* 30 Misc. at 431, 907 N.Y.S.2d at 654.

Future direction

It seems clear that courts are willing to allow discovery of on-line materials assuming the opposing party can make the showing required under existing scope of discovery standards that the information sought is relevant and if not admissible, then reasonably calculated to lead to the discovery of admissible evidence. Pa.R.C.P. 4003.1 (a), (b). As with other discovery, any concerns of over-reaching can be met with a stipulation of confidentiality or motion for protective order limiting the scope of the discovery. *See, e.g., Ledbetter, supra*, 2009 WL 10067018 at *2, ¶10

Presumably this willingness to allow such discovery will extend beyond the so-called social networking sites of Facebook, MySpace and the like. For example, if a personal injury plaintiff participated in an organization such as a ski club that provided a "members only" page, it is difficult to think a court would not grant a defendant access to that page to discover whether a plaintiff might have posted photos or notes which could contradict claims of the detrimental effects of a subject accident.

These discovery principles will most likely also be applied in litigation beyond the personal injury sphere such as matrimonial litigation (for example where a party makes on-line comments about a lifestyle contradicting a claim for need of alimony); business and bankruptcy litigation (for example a statement on Facebook about closing a big deal being contrary to testimony about the financial health of a company) and even real estate (for example, an on-line post referring to a fire that could adversely affect the value of property).

Undoubtedly there will be efforts to resist such discovery requests but the prediction is that if the requests meet the tests of Pa.R.C.P. 4003.1 or Rule 26(b), Fed. R. Civ. P., and any other discovery rules and relevant case law, the discovery will be allowed.

ENDNOTE

[1]Canadian law requires each party to disclose every document relating to any matter in the action of which he has possession or control, absent a claim of privilege.

The Supreme Court

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Thomas G. Saylor, notes many of the problems inherent in the *Kaczkowski* methodology, flatly stating that *Kaczkowski* is "overly compensatory." The dissent's succinct listing of these problems certainly would serve as a good basis for a challenge to *Kaczkowski*. Saylor may be indicating that the court might, finally, be favorably disposed to such a challenge.

However, the 4-3 majority in *Helpin* held that lost future income derived from business profits should be calculated based on the methodology mandated for injury and death torts by *Kaczkowski*, apparently extending the *Kaczkowski* methodology to breach-of-contract matters as well as personal injury torts.

This should be disturbing to the defense bar – the implicit assumption is that future profits are not subject to risk and thus there is no need to consider business risk factors when assessing future business loss.

The Helpin Case

Helpin, a dentist, entered into an employment contract with the University of Pennsylvania in 1996. Under the contract he received a salary and 50 percent of the profits of a dental clinic. He resigned in 2004 after a transfer to a suburban clinic, alleging constructive discharge, and brought an action for tortious interference with a prospective economic relationship and breach of contract. The trial court granted the defendant's motion for nonsuit regarding the tort claim, but the contract claim was upheld. The jury awarded $4.04 million.

On appeal, the Supreme Court majority held that the *Kaczkowski* methodology should be applied to the award, even though it was to compensate for lost business profits under a breach of contract theory, and not a personal injury claim.

The *Helpin* majority reasoned, oddly, that not applying *Kaczkowski* would deny the plaintiff compensation for the effects of future inflation. This makes little sense in a claim for future business loss.

Competing Economic Analyses for Future Losses

The accepted methodology for business loss analysis takes into consideration a discount for risk factors inherent in business. Abandoning adjustments for risk provides plaintiffs in business loss claims an even greater advantage than *Kaczkowski* offers in the personal injury context.

Kaczkowski, a wrongful death and survival action, was brought by the family and estate of a 20-year-old student of computer science. The *Kaczkowski* court adopted an innovative approach to the calculation of the decedent's lost future income. Earnings tend to grow due to adjustments for inflation, and also due to productivity — the increasing value of an individual worker's experience and skill, and increases in national productivity overall.

In almost all jurisdictions, awards for lost future earnings take these increases into consideration – claims for future loss are grown to account for productivity gains. The awards are then discounted to present value – the amount the plaintiff can invest now to cover future losses.

The total-offset method mandated by *Kaczkowski* is based on the theory that, over time, inflationary growth in wages roughly equals, and thus offsets, the interest rate. Under the total-offset method, the present value of lost future wages is current earnings times the number of years the earnings will be received, adjusted upward to account for both individual and national productivity increases. (Prior to *Kaczkowski*, Pennsylvania injury and death awards for future damages were discounted uniformly at 6 percent.)

The generally accepted discounting methodology is outlined in the 1983 U.S. Supreme Court decision J*ones & Laughlin Steel Corp. v. Pfeifer*, 462 US 523 (1983), which reduced future lost-earnings damages to present value using the "real" rate of return — the rate of return on a safe investment minus the estimated rate of inflation and productivity.

The difference between the *Jones & Laughlin* calculations and the total-offset method are significant. For example, under *Kaczkowski*, a $50,000 per year loss for ten years yields $500,000. Under *Jones & Laughlin*, discounting by the "real" rate of 1.5 percent (a return of 4.5 percent minus an inflation rate of 3 percent), the present value of the loss is $461,109. That's an 8 percent difference between the two calculations.

If a productivity growth factor is warranted, *Kaczkowski* simply adds the enhancement to the bottom line. Under *Jones & Laughlin*, productivity increases are reduced to present value using the real rate of return.

The rate of inflation and interest rates rarely, if ever, offset each other in any given period. Thus, *Kaczkowski* defies economic logic. In fact, the Pennsylvania legislature implicitly rejected *Kaczkowski* in the 2002 Medical Care Availability and Reduction of Error Fund, under which lost future earnings in medical malpractice matters are discounted to present value.

While there may be some vague justification for the use of total-offset methodology in personal injury matters (the *Kaczkowski* court cited its simplicity and the court's preference to err on the side of the plaintiff if precision cannot be achieved), the use of total-offset methodology in assessing business loss makes little or no sense.

In *Helpin*, the court makes no distinction between lost future profits and lost future wages. From an economic standpoint, these are not the same.

It is well established that future business income is subject to such risk factors as the nature of the industry in question and the history and relative stability of the particular business. When estimating future profits for the purpose of business valuation or to determine loss in a breach of contract or tort matter, estimated future profits are routinely discounted to reflect these risks. Risk-adjusted discount rates typically range from 15 to 25 percent. As noted, under *Kaczkowski* a $50,000 annual loss for 10 years would be $500,000, but, adjusted for risk at 20 percent rate, the loss would be $209,624.

Thus, *Helpin* is a strong incentive for the defense bar to challenge *Kaczkowski* and the use of the total-offset method of calculating future loss in either a business loss or personal injury matter.

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LET'S BE CLEAR ABOUT THIS: THERE IS NO NEED TO PRESENT RESTORATION OF EARNING POWER EVIDENCE FOR AN EMPLOYER TO PREVAIL IN SEEKING A FOREFEITURE OF BENEFITS WHERE AN INJURED WORKER REFUSES REASONABLE MEDICAL SERVICES

By Thomas R. Bond, Esquire, Of Counsel, Timoney Knox, LLP, Fort Washington, PA

As medical science progresses, a greater array of medical and surgical treatments are available to address disabling medical conditions, including those of a work-related nature. Undoubtedly, with increasing frequency, situations will arise where a wider array of medical treatment options will be presented to injured workers with the goal of increasing their physical capacity to engage in some form of gainful employment. What remedies are available to the employer when the injured worker rejects a treatment program or procedure without good cause? Judicial guidance in answering this question can be found through a close examination of the recent case of *Bereznicki v. WCAB (Eat 'N Park Hospitality Group)*, No. 1047 C.D. 2009; 2009 Pa. Commw. LEXIS 1720. This important case will be viewed within the wider context of Pennsylvania appellate law providing strong support for the proposition that there is no need to present evidence of restoration of earning power when a petition for forfeiture of benefits is filed under Section 306(f) of the Pennsylvania Workers' Compensation Act.

Section 306 (f) of the Act provides, in part, that:

> If the employee shall refuse reasonable medical services of a duly licensed practitioner of the healing arts, surgical, medical and hospital services, treatment, medicines and supplies, *he shall forfeit all rights to compensation for any injury or any increase in his incapacity shown to have resulted from such a refusal*. (Emphasis supplied.)

The claimant in *Bereznicki* sustained a work-related low back strain in 1996 from which she was unable to recover due to underlying congenital defects in her lumbar spine.

Leading up to the employer's filing of a petition under Section 306(f) for forfeiture of benefits, a workers' compensation judge, in adjudicating a utilization review petition before him, found that the prescribed medications that the claimant was taking were not reasonable and necessary. Further, the judge found that the claimant was in need of a detox program to help wean her off of most of the medications being prescribed.

A detox program was offered to the claimant by the employer, and the claimant refused to avail herself of this proposed treatment. It is significant, and at least in the mind of this author quite astounding, that the medications being taken by the claimant included Methadone, Oxycodone, Neurontin, Alprazolam, Zanaflex, Effexor, Wellbutrin, Depakote and Etodolac.

After considering the evidence presented, the judge found that the claimant had, in fact, refused reasonable medical services which, in the words of the employer's medical expert, would improve the claimant's ability to "love, work and play." The decision issued by the judge reflected that he realized that this program would not guarantee that the claimant could return to her pre-injury job, but believed that improvement of functioning would make it possible for her to return to work of some nature.

As has proven to be typical in cases litigated under this statutory provision, the judge suspended the claimant's benefits. The claimant, on appeal, challenged this holding on the basis that the employer's medical expert did not clearly testify that a detox program would increase the claimant's capacity to work.

The Commonwealth Court affirmed. In doing so, the court found ample evidentiary support for the finding of the judge that this treatment program would be of benefit to the claimant; that her functionality and prospects to engage in some form of employment would be enhanced. It is of interest to note that the court identified the claimant's drug dependency as part of the compensable injury in that it developed from treatment of the work-related back injury. Further, noted the court, although such a program would not return the claimant to her pre-injury job, her refusal of treatment certainly increased her incapacity. Significantly, the suspension of benefits was affirmed despite the fact that the employer presented no work availability or restoration of earning power evidence.

In an article entitled "Commonwealth Court Decision May Make Muse Burden Lighter," appearing in the January 14, 2010, issue of *The Legal Intelligencer*, Christian Petrucci expresses concerns about the outcome reached in *Bereznicki*, finding the suspension of benefits to be "inexplicable because, while the employer may have proven that the claimant refused reasonable medical treatment, nothing else was established." He then states, "The third aspect of the *Muse* burden requires proof that the 'reasonable medical treatment' would have resulted in decreased disability or restored earning power." The reference to "the *Muse* burden" relates to the case of *Muse v. WCAB (Western Electric Co.)*, 574 Pa. 1, 522 A.2d 533 (1987), a forfeiture case we will be examining shortly. A "*Muse* petition" is a shorthand way of referring to a petition for forfeiture filed under Section 306(f) of the Act.

He then goes on to state:

> It would seem impossible to effectively establish the reasonableness of any given medical treatment, without first determining the injured's projected earning capacity following the successful treatment in question. Perhaps, the only way to prove a projected earning capacity is through vocational evidence.

Let us bring the case of *Muse v. WCAB (Western Electric Co.),* 514 Pa. 1, 522 A.2d 533 (1987), into focus. The claimant in this leading case had undergone an unsuccessful surgical procedure to correct a work-related bilateral hernia. His attending surgeon recommended a second surgery which, if successful, would leave him relatively asymptomatic with no limitations in his ability to lift objects or perform any kind of work. The Supreme Court of Pennsylvania stressed that there was substantial and competent

evidence supporting the legal conclusion that the claimant had refused reasonable medical services in that the proposed surgery involved minimal risk and offered a high probability of success. The Court upheld the judge's ruling that the claimant's benefits should, accordingly, be suspended.

Significantly, the Court rejected the argument that, even if the claimant's refusal had been unreasonable, the employer still had the burden of proving that the refusal led to further injury or to an increase in his incapacity. Again, we see relief provided to the employer under Section 306(f) without the court requiring that the employer proffer evidence relating to earning power.

Our appellate courts have been very clear about when work availability or earning power evidence is required to support a petition and when it is not. For example, in the case of *Commonwealth of Pennsylvania, Department of Labor & Industry, Bureau of Workers' Compensation v. WCAB (Exel Logistics)*, the court differentiated between the burden of proof assumed by an employer in filing a petition for suspension, as opposed to that upon filing a petition for relief under Section 306(f) of the Act. The court, citing language found in *Piper v. Ametek-Thermox Instruments Div.*, 526 Pa. 25, 584 A.2d 301, 304-05 (Pa. 1990), noted that:

> A suspension of benefits is supported by a finding that the earning power of the claimant is no longer affected by his disability, whether it arises from his employer offering suitable replacement employment, or from the ability of the claimant to secure other suitable employment that provides equal or greater compensation. *Forfeiture is based on the claimant's own unwillingness to receive treatment, rather than a change in status*. With forfeiture, there is no requirement of a change which alters a claimant's right to benefits, as exists with a suspension of benefits . . . "(Emphasis supplied.)

An examination of the holding reached by the Commonwealth Court of Pennsylvania in the case of *Litak v. WCAB (Comcast Cablevision)*, 155 Pa. Commw. 147, 624 A.2d 773 (1993), provides further guidance. The claimant sustained a back injury while performing his duties as a line technician for Comcast Cablevision. He was diagnosed as suffering from spondylolisthesis, and surgery was recommended. The claimant refused to undergo surgical intervention.

Medical testimony presented by the employer established that there was at least an 80% chance that the surgery would be successful and that the claimant "should certainly be much improved physically." The risk of surgery was identified in the range of 4% - 5%. The physician testifying on behalf of the employer acknowledged that the surgery would probably not enable the claimant to return to his pre-injury position, but stated, "Shooting for medium work would be a reasonable goal." Based upon this testimony and the claimant's refusal to avail himself of the recommended surgery, the workers' compensation judge suspended the claimant's benefits.

One of the issues presented to the court for resolution was whether, as maintained by the claimant, the employer was required to show work availability in support of its case. The court squarely held that the employer did not have this burden in that, from a procedural standpoint, the employer was not seeking a modification of the claimant's benefits but, rather, a forfeiture of benefits under Section 306(f). The court further opined that entitlement to forfeiture in no way depends upon the employer first producing evidence of work availability within the claimant's *predicted post-surgery capabilities* (emphasis added). The court goes on to emphasize that:

> Moreover, such an obligation would require that an employer hypothecate regarding an employee's predicted job limitations. The language of Section 306(f)(4) simply does not lend support this proposition.

Let us now turn to the interesting case of *Byrd v. WCAB (Temco Services Industries, et al.)*, 81 Pa. Commw. 325, 473 A.2d 723 (1984), which clearly underscores the obligation that injured workers have to avail themselves of reasonable medical services. It also stands for the proposition that further injury caused by a refusal of reasonable medical treatment will not be the responsibility of the employer under the Pennsylvania Workers' Compensation Act. The initial injury sustained by the claimant consisted of a knee strain. His attending physician prescribed a physical therapy program designed to strengthen and restore stability to his knee. The claimant without good cause cancelled eight of the twelve therapy sessions scheduled for him. This prompted the employer to file for relief under Section 306(f) of the Act.

Shortly, after the filing of this petition, the claimant's injured knee "buckled" while he was walking, and he fractured his kneecap. The employer denied liability for this subsequent injury.

The workers' compensation judge found that the claimant had missed the scheduled therapy sessions for no legitimate reason, and based on the testimony of his treating physician, would have realized a 100% recovery had he followed the prescribed course of therapy.

The court upheld the judge's suspension of the claimant's benefits and his finding that he would not have experienced buckling of his knee, with the resultant fracture and additional disability, if he had fully participated in the physical therapy program.

Employers, as well as claims professionals, should also be aware that there is case law reflecting relief in the form of a *partial suspension* of the claimant's benefits when he or she refuses reasonable medical services. This form of relief was provided to the employer in the case of *Mills v. WCAB (Super City Manufacturing, Inc.)*, 138 Pa. Commw. 691, 588 A.2d 1350 (1991). The claimant sustained a work-related injury in the form of a fractured wrist. He refused to submit to the recommended fusion surgery. The surgery, according to the several physicians who testified on behalf of the employer, carried with it an anticipated outcome of improving the function of the claimant's right wrist by at least 50%. The court upheld the partial suspension of benefits amounting to 50% of the claimant's compensation benefits.

A similar outcome occurred in the case of *Menges v. WCAB (Carnation Company)*, 93 Pa. Commw. 395, 501 A.2d 347 (1985), where the claimant had sustained a work-related compound fracture and dislocation of his left ankle. He subsequently underwent two operations on his ankle. His treating physician recommended that he undergo further surgery, with an anticipated

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Let's Be Clear

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surgical outcome of relieving him of pain and restoration of function to his ankle, which would reduce his disability from 100% to 50%. The claimant was examined by a second orthopedic surgeon, who recommended that he undergo this surgery. There was medical testimony in the case that the surgical procedure carried with it about an 80% - 85% chance of success of the bones fusing. The court upheld the partial suspension of the claimant's benefits to a level of 50%.

There is another dimension in the field of Pennsylvania workers' compensation law where the need to ensure that the injured worker avails himself or herself of reasonable medical treatment comes into play. The Workers' Compensation Act now provides employers with the right to have the claimant undergo medical examinations to determine the *degree of impairment* attributable to a compensable injury. The applicable statutory sections provide that:

> When an employee has received total disability compensation for a period of 104 weeks, the employee shall be required to submit to a medical examination to determine the degree of impairment due to the compensable injury, if any. If a determination of the degree of the employee's impairment results in an impairment rating that is equal to or greater than 50%, under the most recent edition of the American Medical Association's Guides to the Evaluation of Permanent Impairment ("Guidelines"), the employee shall be presumed to be totally disabled and shall continue to receive total disability compensation.

Section 306(a)(2) of the Act, 77 P.S. §§511(2).

> If the determination results in an impairment rating of less than 50% impairment, under the most recent guidelines, the employee shall then receive partial disability benefits; provided that no reduction shall be made until the employee is given sixty (60) days notice of the modification. Unless otherwise adjudicated or agreed to, based upon a determination of earning power, the amount of compensation shall not be affected as a result of the change in disability status and shall remain the same.

Section 306(a)(2)(3) of the Act, 77 P.S. §511.2(3).

Conceivably, refusal by the claimant to receive reasonable medical treatment would limit his recovery and sharply depress his impairment ratings to the point where the employer simply cannot demonstrate entitlement to a partial disability status rating. A partial disability rating caps the employer's liability at 500 weeks of compensation. Total disability status, on the other hand, barring some change in status, is lifetime in nature. Accordingly, when a petition for forfeiture is brought under Section 306(f), the necessity of securing fair and accurate impairment ratings should be part of the employer's argument in support of a suspension of benefits.

It is very clear under Section 306(f) of the Act that injured workers have an obligation to avail themselves of reasonable medical treatment. As reflected in this article, there are a number of judicial decisions where relief in the form of a suspension, or at the least a partial suspension, has been granted to employers. Employers are entitled to these forms of relief without the necessity of showing work availability. Refusal of reasonable medical services could very well have a significant impact on impairment ratings, and accordingly, the need for a fair and accurate impairment rating constitutes yet another basis upon which to seek relief under this statutory section.

THE CONTINUED EXPANSION OF THE ADA: THE EQUAL EMPLOYMENT OPPORTUNITY COMMISSION'S UPDATED REGULATIONS IN LIGHT OF THE AMERICANS WITH DISABILITIES ACT AMENDMENTS ACT

By Lee C. Durivage, Esquire, Marshall, Dennehey, Warner, Coleman & Goggin, Philadelphia, PA

On March 25, 2011, the Equal Employment Opportunity Commission unveiled the long-awaited final regulations to the Americans with Disabilities Act Amendments Act ("ADAAA"), eighteen months after the EEOC's Notice of Proposed Rulemaking and following its receipt of more than 600 comments. The final regulations largely confirmed what the legal and business community had anticipated when the ADAAA was first signed into law in September 2008—namely, that millions of additional Americans are now able to establish a "disability" within the meaning of the ADA than previously and that employers (and their attorneys) will be far less successful in challenging whether an employee has a "disability" than they were in the past.

Background Concerning the ADAAA

When Congress initially passed the ADAAA, it primarily sought to "provide a clear and comprehensive national mandate for the elimination of discrimination against individuals with disabilities and provide broad coverage" for those individuals that it believed had not been provided for by the courts. In particular, Congress specifically rejected the Supreme Court's holdings in *Sutton v. United Air Lines, Inc.*, *527 U.S. 471 (1999)* and its progeny, which it believed "narrowed the broad scope of protection intended to be afforded by the ADA" by requiring that the analysis as to "whether an impairment substantially limits a major life activity is to be determined with reference to the ameliorative effects of mitigating measures." Congress also expressly determined that the Supreme Court's decision in *Toyota Motor Manufacturing, Kentucky, Inc. v. Williams, 534 U.S. 184 (2002)*, likewise, improperly "narrowed the broad scope of protection intended to be afforded by the ADA" and, as a result, "lower courts have incorrectly found in individual cases that people with a range of substantially limiting impairments are not people with disabilities."

In fact, Representative Steny H. Hoyer, who was one of the original lead sponsors of the ADA in 1990, testified in 2008 that "we could not have fathomed that people with diabetes, epilepsy, heart conditions, cancer, mental illnesses and

other disabilities would have their ADA claims denied because they would be considered too functional to meet the definition of disability." As a result, the regulations promulgated by the EEOC have expressly endorsed the language referenced by Congress, specifically noting that "[t]he primary object of attention in cases brought under the ADA should be whether covered entities have complied with their obligations and whether discrimination has occurred, not whether the individual meets the definition of 'disability'…[and] [t]he question of whether an individual meets the definition of disability…should not demand extensive analysis."

The Regulation's Interpretation of Disability

While the ADAAA did not alter the basic definition of "disability," which remains defined as: "(a) a physical or mental impairment that substantially limits one or more major life activities of such individual; (b) a record of such an impairment; or (c) being regarded as having such an impairment," it did permit the EEOC and its regulations to broadly interpret the scope of the term, "disability." Significantly, the regulations have expressly determined that "major life activities" include "caring for oneself, performing manual tasks, seeing, hearing, eating, sleeping, walking, standing, reaching, lifting, bending, speaking, breathing, learning, reading, concentrating, thinking, communicating, interacting with others, and working." In addition, as a new addition, "major life activities" also include the operation of a major bodily function, "including functions of the immune system, special sense organs and skin; normal cell growth; and digestive, genitourinary, bowel, bladder, neurological, brain, respiratory, circulatory, cardiovascular, endocrine, hemic, lymphatic, musculoskeletal, and reproductive functions." These major bodily functions were not, prior to the ADAAA, otherwise identified as "major life activities."

The EEOC's new regulations further provide specific rules of construction "when determining whether an impairment substantially limits an individual in a major life activity." These rules specifically state that:

(1) "substantially limits" is not a demanding standard;
(2) an impairment is a disability if it substantially limits the ability of an individual to perform a major life activity when compared to most people in the general population;
(3) the object of attention in ADA cases is whether entities have complied with their obligations and whether discrimination occurred;
(4) the determination of whether an impairment substantially limits a major life activity is an individualized assessment;
(5) the comparison of an individual's performance of a major life activity to the performance of the same major life activity by most people in the general population will not usually require scientific, medical or statistical analysis;
(6) the determination of whether an impairment substantially limits a major life activity must be made without regard to the effects of mitigating measures;
(7) impairments that are episodic or in remission are disabilities if they would substantially limit a major life activity when active;
(8) impairments that substantially limit one major life activity need not substantially limit other major life activities in order to be considered substantially limiting; and
(9) the six month "transitory" portion of the "regarded as" definition of disability does not apply to other definition of disabilities as the effects of an impairment lasting or expected to last fewer than six months can be substantially limiting.

This interpretation of the definition of "disability" demonstrates the broad scope of the ADAAA and will ultimately preclude most employers from challenging whether an employee is "disabled" under the ADA.

Certain Impairments Will Likely Always be Deemed Disabilities

The EEOC's regulations also expanded the number of individuals who would qualify as having an "actual disability" or a "record of a disability" under the ADA by expressly noting that there were many types of impairments that "should easily be included" as substantially limiting a major life activity. Among the specific impairments that "should easily be included" as substantially limiting a major life activity are cancer, autism, cerebral palsy, diabetes, epilepsy, Human Immunodeficiency Virus (HIV), multiple sclerosis, muscular dystrophy, major depressive disorder, bipolar disorder and post-traumatic stress disorder.

The revised appendix to the EEOC's regulations, which provides interpretative guidance regarding the regulations, expressly notes that courts had previously determined that individuals with some of the above impairments were not "disabled" pursuant to the ADA. For instance, an individual who was terminated because of clinical depression was not protected because the condition was successfully managed with medication for 15 years. Similarly, another court determined that an individual was not disabled because medication reduced the frequency and intensity of a plaintiff's seizures. In addition, an individual with a hearing impairment was not protected under the ADA because a hearing aid helped correct that impairment. These challenges, however, would not be successful in light of the new regulations.

Moreover, while the ADAAA and its regulations have determined that the "ameliorative effects of ordinary eyeglasses or contact lenses shall be considered when determining whether an impairment substantially limits a major life activity" (which, ironically, was the mitigating measure at issue in *Sutton*), all other mitigating measures—no matter how well they control an individual's impairment—cannot be considered when determining whether the person is disabled under the law. The regulations, likewise, note that impairments that are "episodic or in remission" meet the definition of disability if they would substantially limit a major life activity when active. As noted in the EEOC's question and answer series, "[e]xamples of impairments that may be episodic include epilepsy, hypertension, asthma, diabetes, major depressive disorder, bipolar disorder, and schizophrenia." In addition, "[a]n impairment such as cancer that is in remission but that may possibly return in a substantially limiting form will also be a disability under the ADAAA and the regulations."

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The Continued Expansion

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These changes in the law are especially significant, as the EEOC's findings when it promulgated the regulations demonstrate that this opens protection under the ADA to several million additional members of labor force. Indeed, the EEOC noted that there are approximately 1.5 million individuals in the United States that are affected by autism, 400,000 individuals that have multiple sclerosis and 250,000 individuals that have muscular dystrophy. In addition, the EEOC noted that there were 11,714,000 individuals living with cancer in the United States during 2007, 18.8 million adults that have diabetes, 3 million individuals that have epilepsy and between 1.5 million and 2 million individuals who have cerebral palsy. The EEOC finally noted that more than 1.1 million individuals in the United States are estimated to be living with HIV and there are approximately 21 million individuals (or 1 in 17 Americans) who have a serious mental illness. Based upon these figures, there could be at least 60 million individuals whose coverage "has been clarified" with the enactment of the ADAAA and the EEOC's regulations, depending on how many of these individuals are active in the work force.

Potential Costs to Employers

The EEOC's findings set forth in connection with the new regulations also provide annual "estimates of the likely incremental cost of providing reasonable accommodations attributable to the Amendments Act and the final rule, using a $150 mean annual cost of accommodation." Significantly, while the EEOC recognizes that there is a "high level of uncertainty" between the number of individuals who may request an accommodation in light of the ADAAA, it nonetheless projects a minimum of 400,000 new accommodations annually. From this "lower-bound estimate," the EEOC projects a cost of $60 million to employers annually to provide new, reasonable accommodations in light of the ADAAA. In addition, the EEOC's "higher-bound estimate" predicts costs of $183 million annually to employers to provide reasonable accommodations to its employees. While these numbers are staggering, these numbers are lower than some of the estimates the EEOC received during the public comment period, which included one employer association that asserted that the cost "will be at least $305.7 million for the first year, with administrative costs likely to exceed $101.9 million per year on a recurring basis."

The EEOC's findings also indicate that employers will spend approximately $70 million in one-time administrative costs in order to comply with the ADAAA. These costs include revisions to employee policies and training sessions for its employees and managers. Moreover, while the EEOC expressly acknowledges that it "anticipate[s] that plaintiffs' lawyers…will now be more inclined to file lawsuits in cases where the lawyers believe that discrimination on the basis of disability—broadly defined—has occurred," and "there may be additional legal fees and litigation costs associated with bringing and defending these claims," the EEOC provides no estimate of these costs. These litigation costs will be significant, however, as the ADAAA largely precludes an employer's challenge to the legal determination of whether an employee is "disabled" under the ADA and will result in more plaintiffs avoiding summary judgment and proceeding to trial. Indeed, no matter what cost estimate ultimately comes to fruition, it is evident that employers will ultimately be the group that will bear the cost burden to provide these accommodations to employees and potential employees.

The Process for Providing Reasonable Accommodations and the Defense of Undue Hardship Have Not Been Altered by the ADAAA and the EEOC's Regulations

While the ADAAA and its regulations have broadly expanded the coverage under the ADA to, potentially, 60 million more individuals in the labor force, it did not change the process for requesting accommodations for disabilities. The regulations, likewise, did not alter the definition of undue hardship and, as a result, it is clear that the focus for the courts, the EEOC and employers will gravitate towards the interactive process and, ultimately, determining whether an employee's requested accommodation constitutes an "undue hardship" on the employer. In particular, the EEOC's questions and answers for small businesses published following the enactment of the regulations specifically note that "[g]enerally, a person with a disability still has to make a request for an accommodation, and an interactive process between the person with a disability and the employer may still be necessary to determine an appropriate accommodation." However, while the employer may ask for documentation showing a disability and the need for a potential accommodation, "documentation may focus less on whether the person has a disability and more on the need for an accommodation."

In addition, the courts and the EEOC will likely look to a number of different factors to determine whether a requested accommodation could be deemed to be an undue hardship, including evaluating the nature and size of an employer's business to determine whether the expense is "significant or difficult." "Undue hardship" means "significant difficulty or expense in, or resulting from, the provision of the accommodation" and "refers to any accommodation that would be unduly costly, extensive, substantial, or disruptive, or that would fundamentally alter the nature or operation of the business." While smaller companies will have a better opportunity to argue that an expense is "significant or difficult," many mid-sized and large companies will be expected to make accommodations that would require greater expenses or efforts.

Unfortunately, there is little case law or guidance from the courts as to what potential accommodations could be deemed an undue hardship or could be deemed unreasonable—as the large number of cases analyzing the ADA determined the threshold issue of whether the individual had a disability under the law. The cases that have addressed this issue have found that an accommodation was unreasonable or an undue hardship (1) where the proposed accommodations would effectively eliminate one or more essential functions of the employee's job, (2) where the proposed accommodations would require the employee to have "no contact" with co-workers, (3) where the proposed accommodation would require the creation of an entirely new position and/or (4) where the proposed accommodations would eliminate the essential functions of the position. Again, these requests for accommodations must be considered on a case-by-case basis and employers must be open to utilizing the interactive process to make sure that an employee's disability is reasonably accommodated. Failure to address these

issues could have a substantial and detrimental impact on an employer and may expose an employer to liability under the ADA.

Conclusion

As can be seen from the foregoing, the EEOC's updated regulations have marked the continued the expansion of the ADA. Over the next several years, employers must prepare themselves to immediately address an employee's request for an accommodation due to an impairment and must immediately engage in the interactive process in order to comply with the ADAAA. Otherwise, it is evidence that these employees (and their attorneys) will file claims with the EEOC and lawsuits in federal court that may have otherwise been prevented.

MEDICAL MALPRACTICE UPDATE
SEPTEMBER 2011

By Howard M. Levinson, Esquire, Thomas J. Campenni, Esquire and Paul G. Batyko, III, Esquire, Rosenn, Jenkins & Greenwald, Wilkes-Barre, PA

SUMMARY OF CASES

A. Res Ipsa Loquitor
   a. Facts Give Rise To Application Of Doctrine
   b. Causation Established If Alleged Negligence More Likely Than Not As Cause of Injury

B. MCARE Requires Reduction To Present Worth On Future Impairment Of Earning Capacity

C. Defense Waived Right To Argue On JNOV Issue With Respect To Cause Of Harm By Failing To Request A Special Interrogatory

In *Asbury v. Mercy Fitzgerald Hospital*, 13 Pa.D. & C. 5th 225 (2010 Ct. Common Pleas Delaware County) the court reviewed in detail the principles of res ipsa loquitor and the facts which are necessary in order to give rise to a claim such that the Judge can charge the verdict based on this legal doctrine.

In *Asbury*, plaintiffs contended that the defendants were medically negligent in removing subcutaneously implanted Norplant contraceptive rods from the left upper arm of plaintiff Dana Asbury in February 2003. Plaintiff contended that her median nerve had been injured due to defendants' negligence and she developed reflex sympathetic dystrophy (RSD) and complex regional pain syndrome (CRPS) on the left side of her body as a result.

The removal of the Norplant rods was a minor surgical procedure. Dr. Lebed, an experienced gynecological surgeon, was inexperienced in this particular procedure, having performed the removal procedure only three times prior. In addition, he received instruction on how to perform the procedure from a sales representative and booklet using a plastic arm model. Lebed took 20 to 25 minutes to position plaintiff on the table to properly visualize the area of removal. He made an incision that was far larger than standard and gave repeated anesthetic injections because of plaintiff's significant pain. Lebed could not remove any of the rods and notified Dr. Wilson, who succeeded in removing the rods. Five days later, plaintiff presented to her primary care physician with left arm pain, which over time became a pain syndrome on the left side of her body.

The court, at trial, instructed the jury on the res ipsa loquitur doctrine, which allowed the jury to infer causation from the circumstances surrounding the injury. On appeal, defendants contended that the court erred in giving this instruction and that the jury's verdict was against the weight of the evidence.

The court disagreed with both defendants' contentions. The court presented an extensive review of the res ipsa loquitur doctrine. There is a three-pronged test that must be met before a res ipsa loquitur instruction can be given allowing the jury to infer negligence; (1) the event does not normally occur in the absence of negligence; (2) other responsible causes are sufficiently eliminated; and (3) the negligence is within the scope of defendant's duty to plaintiff. The court stated that expert testimony is required in a res ipsa loquitur case to establish that the result does not ordinarily occur in the absence of negligence.

Here, plaintiff's expert testified that he could find no other case of median nerve damage arising form a Norplant removal procedure. Further, he was uncertain whether the RSD was caused by direct trauma to the median nerve or excess manipulation of the surrounding tissues. Plaintiff's expert also testified as to the requisite standard of care and that it was breached by Lebed. Lebed persisted in futilely proceeding for 15 to 20 minutes, while knowing plaintiff was experiencing significant pain during what should have been a relatively painless procedure. Lebed should have stopped altogether and sent plaintiff home for at least four weeks. The court concluded that the res ipsa loquitur instruction was proper and permitted the jury to resolve the issue of whether direct or indirect damage to plaintiff's median nerve had been sustained more likely than not from Lebed's negligence. Plaintiff's evidence showed that defendant owed plaintiff a duty to prevent injury, that defendant breached this duty by failing to stop the procedure and that plaintiff was injured thereby. Plaintiff produced evidence to establish that the nerve injury could not have occurred in the absence of negligence and that the injury was sustained while she was alone in the treatment room with defendant who had exclusive control of the operative site.

It was sufficient under the law for the plaintiffs to show that the alleged negligence by Dr. Lebed was more likely than not the probable explanation for her injury in order to warrant a res ipsa loquitur instruction to the jury.

The defendant's argued that the plaintiffs Norplant removal expert never said that Dr. Lebed's technique of using a scalpel to make the incision and a hemostat to remove the Norplant rods was faulty, thus entitling defendants to judgment n.o.v. because the inference of negligence could not arise merely from an unfortunate result. The court rejected this argument.

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Defendant also argued that the plaintiff's actuarial accounting economics expert doctor, Andrew Verzilli, did not reduce his $1,094,805 calculation of plaintiff's life-time earning capacity to present value as required under Section 510 of the MCARE Act. 40 PS. § 1303.510. The court held that this argument was not timely raised and was deemed waived. Further, the court, following an examination of the testimony of Dr. Verzilli, concluded that his calculation on earning capacity was reduced to present value.

Further, the defendants took issue with the court's denial of their request for a special interrogatory which they claimed should have required that the jury decide if the type of RSD which plaintiff claimed she had was caused as a result of the Norplant surgery. Defendants argue that there was no reasonable scientific evidence to establish that Type II RSD can be triggered by damage to the left median nerve. Because no such request is made to the court prior to submission of the case to the jury, this contention was deemed to be waived.

Preliminary Objections Seeking To Compel Arbitration Are Overruled Because The Defendants Did Not Provide Sufficient Evidence That Deceased's Wife Had Authority To Bind Her Husband To Arbitration

In *Carr v. Immaculate Mary Nursing Home*, 15 Pa. D. & C.5th 415 (Philadephia Cty. 2010), the plaintiff, John Carr, Jr., the executor of the estate of John Carr, Sr. ("Carr") commenced an action for negligence and wrongful death against defendants Immaculate Mary Nursing Home ("Immaculate"), Catholic HealthCare Services of Philadelphia ("CHS"), and the Archdiocese of Philadelphia ("Archdiocese").

In January of 2009, Carr was admitted to the dementia program at Immaculate where residents were to be housed on a secure dementia floor. Carr's wife executed an Immaculate admission agreement containing a binding, mandatory arbitration clause. Carr's wife did not have power of attorney and had not been appointed legal guardian. In May of 2009, Carr left his room on the dementia floor, climbed into the laundry chute and fell three stories into the basement. Carr sustained serious injuries and died in November of 2009. Plaintiff commenced suit thereafter.

The defendants filed preliminary objections to compel arbitration. The plaintiff responded that the arbitration clause was invalid because Carr's wife did not have authority to waive his right to a jury trial. The defendants argued that the agreement was valid because Carr's wife had apparent authority to act on his behalf. The court overruled the preliminary objections and suggested the issue be raised later as a motion for summary judgment once discovery was complete. In reaching its decision, the court stated:

> In the instant case, there was no evidence of a writing expressly granting Carr's wife actual authority. There is no authority by estoppel because defendants offered no evidence Carr was negligent. Defendants offered no evidence showing Carr knew of the arbitration clause, authorized his wife to sign the agreement, or otherwise agreed to arbitrate. Defendants knew of Carr's diminished mental capacity, having admitted him to an area specifically designated for dementia patients. In fact, defendants offered no evidence of Carr's conduct when the agreement was executed.

The Court Held That Genuine Issues Of Material Fact Existed As To: (1) Whether Doctor Was An "Ostensible Agent" Of Hospital As The Decedent Met The Doctor At The Hospital's Emergency Room, Was Treated By Him At The Hospital, And Was Billed By The Hospital For The Treatment She Received While Under His Care, As A Jury Could Infer, Under The "Reasonably Prudent Person" Standard, That She Believed She Was Under The Care Of The Hospital And/Or That The Doctor Was Its Agent; And (2) Plaintiff's Expert Reports Opining That The Doctor Was Negligent In Failing To Order A CT Scan And In Not Having The Decedent Undergo Surgery Merited Sending The Case To A Jury

As set forth in *Dubranski v. Relan*, 2010 Pa. Dist. & Cnty. Dec. LEXIS 431 (Lackawanna County, 2010), plaintiff, Kevin Dubranski, Administrator of the Estate of Roselyn Dubranski, instituted a medical malpractice action against the defendants, Manish Relan, M.D. and Mercy Hospital. Plaintiff alleged that decedent was admitted to Mercy Hospital on March 15, 2004. Despite confirmation of a hernia and a small bowel obstruction, these conditions were not addressed and she was discharged on March 18 without further treatment. On April 10, 2004, decedent presented to and was admitted to Community Medical Center with a large ventral hernia with incarcerated bowel. At this time she was not stable enough to undergo surgery, and she died on April 11 from necrotic ischemic incarcerated bowel in the hernia.

Plaintiff's experts opined that as of decedent's admission to Mercy Hospital on March 15, 2004, she was a surgical candidate and would have tolerated surgery to repair the small bowel obstruction. However, Dr. Relan allegedly failed to obtain the necessary studies to determine the cause of the small bowel obstruction and failed to obtain a surgical follow-up. Without surgery and proper treatment, the incarcerated bowel became necrotic, caused pain, suffering and ultimately death.

Defendants filed motions for summary judgment and the court addressed two primary issues: (1) whether a triable issue of fact existed as to whether Dr. Relan was an "ostensible agent" of Mercy Hospital; (2) whether a triable issue of fact existed as to whether Dr. Relan's alleged deviation from the standard of care was the proximate or factual cause of decedent's harm.

In resolution of the first issue, the court began by citing the Medical Care Availability and Reduction of Error Act ("MCARE"), 40 P.S. §1303.101 *et seq*., specifically §§ 1303.516(a)(1)(2) and (b), which codified the law of ostensible agency as follows:

> (a) Vicarious liability – A hospital may be held vicariously liable for the acts of another health care provider through principles of ostensible agency only if the evidence shows that:
>
> (1) a reasonably prudent person in the patient's position would be justified in the belief that the care in question was being rendered by the hospital or its agents; or
>
> (2) the care in question was advertised or otherwise represented to the patient as care being rendered by the hospital or its agents

(b) Staff privileges – Evidence that a physician holds staff privileges at a hospital shall be insufficient to establish vicarious liability through principles of ostensible agency unless the claimant meets the requirements of subsection (a)(1) or (2).

Noting that the facts of record revealed that decedent met with Dr. Relan at Mercy Hospital after presenting for care, that decedent was treated by Dr. Relan from March 15 to March 18, and that decedent was billed by Mercy Hospital for treatment rendered under the care of Dr. Relan, the court found that the issue of whether decedent reasonable believed she was under the care of Mercy Hospital and/or that Dr. Relan was an agent of the hospital was for the jury to decide, and denied defendants' motion for summary judgment on this ground.

In resolution of the second issue, the court noted that plaintiff presented two expert reports which merited sending the case to the jury. One of plaintiff's experts, Dr. Feingold opined, *inter alia*, that decedent's presentation to Dr. Relan at Mercy Hospital with signs, symptoms, and radiological findings of a small bowel obstruction required further evaluation with an abdominal CT scan and a surgical consultation to determine the underlying cause of her condition. Dr. Feingold further noted that Dr. Relan failed to order a work-up for the underlying cause of decedent's small bowel obstruction and the same was never addressed.

Plaintiff's other expert, Dr. Leitman, opined, *inter alia*, that decedent should have undergone surgery while under Dr. Relan's care and would have been a reasonable surgical candidate by March 18, 2004, but by the time she presented to Community Medical Center on April 10, 2004, her condition had deteriorated to such a degree that she not longer could tolerate surgical intervention.

Based on plaintiff's experts, the court concluded that genuine issues of material fact existed as to whether Dr. Relan's alleged deviation from the standard of care was the proximate or factual cause of decedent's harm, and, as such, denied defendants' motion for summary judgment on this ground.

The Court Granted Defendants' Motion For A New Trial Based On Plaintiff's Counsel's Reference To The Defendant Doctor Allegedly Being Addicted To A Drug, In Violation Of The Court's ***In Limine*** Ruling, And Found That The Use Of The Word Addict Was Prejudicial And Beyond Mere Harmless Error

As set forth in *Golden v. Smolko*, 2010 Pa. Dist. & Cnty. Dec. LEXIS 267 (Lackawanna County, 2010), plaintiff's decedent, Terrence Golden, contracted and died from bladder cancer. Decedent began treating with defendant, urologist Dr. Smolko, for urinary difficulties beginning in September 2002. Decedent continued to present to Dr. Smolko from September 2002 to March 2004, when decedent saw a different urologist, Dr. Cassone, who found that Mr. Golden had invasive high-grade transitional cell carcinoma. In August of 2004 Mr. Golden underwent bladder removal surgery, and thereafter had several more surgeries and chemotherapy. In January 2008, decedent died.

Plaintiff commenced an action alleging medical malpractice against the defendants, Milan Smolko, M.D. and Milan Smolko, M.D., P.C., for failure to properly diagnose and treat decedent's bladder cancer. Defendants presented a motion *in limine* to preclude the presentation of evidence on the subject of Dr. Smolko's OxyContin use. The court specifically allowed testimony on Dr. Smolko's use of prescribed OxyContin to be introduced at trial. However, the court's *in limine* ruling barred plaintiff's counsel from mentioning or referring to Dr. Smolko as an addict or addicted to OxyContin. A jury returned a verdict in May 2009, and defendants filed timely post-trial motions requesting a new trial. The primary issue was whether the court should have granted a mistrial upon plaintiff's reference to Dr. Smolko's alleged addiction to OxyContin.

Defendants maintained that they were entitled to a new trial because plaintiff's counsel intentionally violated the court's *in limine* ruling which barred plaintiff's counsel from mentioning or referring to Dr. Smolko as an addict or addicted to the narcotic OxyContin. Defendants relied, *inter alia*, on the Superior Court's ruling *Poust v. Hylton*, 940 A.2d 380 (Pa. Super. 2007). Conversely, plaintiff contended that because Dr. Smolko was misleading the jury during questioning, they had a right to question him about being addicted to OxyContin.

During the plaintiff's case in chief Dr. Smolko was called to testify. Plaintiffs' counsel inquired into Dr. Smolko's use of OxyContin and then asked whether OxyContin was an addictive drug and whether Dr. Smolko was addicted to OxyContin. As soon as plaintiff's counsel asked Dr. Smolko if he was addicted to OxyContin, defense counsel objected and this court sustained the objection. Plaintiff's counsel then finished the examination of Dr. Smolko and the jury was dismissed for lunch. Immediately following the jury's dismissal defense counsel moved for a mistrial and the court denied the request, but offered to give a curative instruction, to which defense counsel declined.

In deciding to grant defendants' motion for a mistrial on the ground that the use of the word "addict" was prejudicial and beyond harmless error, the court relied on *Poust*, wherein the Superior Court held that the trial court's denial of plaintiffs' request for a mistrial was an abuse of discretion when defense counsel used the word cocaine, in violation of a court order, during cross-examination of a witness. In *Poust*, the plaintiffs had filed a motion *in limine* to preclude defense counsel from using the word cocaine, with reference to plaintiffs' decedent. During cross examination of plaintiffs' witness, defense counsel specifically asked the witness a question referencing cocaine in the decedent's system. Plaintiffs' counsel objected and the trial court sustained the objection. A side bar was held were plaintiffs' counsel requested a mistrial. At some point later in that same day of trial, the court denied plaintiffs' request for a mistrial and decided a curative instruction would not be given.

The Superior Court in *Poust* stated, "The grant of a motion *in limine* is a court order that must be observed. To allow appellee's counsel to violate such a court order, without the declaration of a mistrial, as was immediately sought by appellant's counsel here, would defeat the intended purpose of such orders." 940 A.2d at 385. The Superior Court went on to state, "The trial court clearly abused its discretion in failing to grant the requested relief of a mistrial, which should have been granted to Appellant immediately at the time that the court order was violated by defense counsel." Id. Further, the court stated, "Under Pennsylvania law, Appellant was entitled

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to the declaration of a mistrial, ipso facto, immediately upon Appellee's counsel's flagrant and intentional use of this obviously prejudicial word 'cocaine', in violation of the prior pre-trial preclusion order of the trial court." *Id*.

An At-Will Employee Cannot Raise A Claim for Intentional Interference With An Existing Employment Relationship

In *Haun v. Community Health Systems, Inc.,* 14 A.3d 120 (Pa. Super. 2011), the plaintiff, a former chief financial officer of the defendant hospital, who was terminated after he filed a medical malpractice action his employer, commenced suit against his employer alleging violation of Pennsylvania public policy, the specific intent exception to the at-will doctrine, and alternatively, tortious interference with contract. After the defendants filed preliminary objections, the trial court issued an order which dismissed the plaintiff's claim for specific intent wrongful termination and overruled all remaining preliminary objections.

The defendants appealed and the Superior Court addressed the following three issues: (1) Whether the plaintiff failed to state a claim for public policy wrongful discharge where he alleged that his employment was terminated for filing a medical malpractice claim against his employer for alleged malpractice committed on his newborn son; (2) Whether the plaintiff failed to state a claim for public policy wrongful discharge where he failed to identify a clear mandate of Pennsylvania public policy violated by his discharge; and (3) Whether the plaintiff failed to state a claim for tortious interference with contractual relations where the contract in question was an existing contract for at-will employment?

In its opinion, the Superior Court summarily affirmed the first two issues, stating that "the trial court's opinion accurately concludes that '[Appellants'] right to a demurrer, at this stage of the proceedings, is not clear and free from doubt. A good faith argument has alleged that [Appellee's] dismissal violated public policy.' " (Brackets in original.)

However, as to the final issue, the Superior Court reversed the trial court's overruling of the defendants' preliminary objections on the plaintiff's tortious interference claim, holding:

> In the present case, our review of the record reflects that [plaintiff] does not allege any interference with a prospective employment relationship, nor does he establish that he was not an at-will employee. As we previously stated, "an action for intentional interference with performance of a contract in the employment context applies only to interference with a prospective employment relationship whether at-will or not, not a presently existing at-will employment relationship." Accordingly, [defendants'] claim has merit and we are constrained to reverse the order of the trial court in this regard and to sustain the preliminary objections in the form of a demurrer as to the third cause of action specified in [plaintiff's] amended complaint.

Order That Purportedly Granted New Trial On Issue Of Causation Following The Declaration Of A Mistrial Due To A Deadlocked Jury Was Not Appealable As A Matter Of Right Under Pa. R.A.P. 311(a)(6) Because Mistrial Already Required A New Trial

In *Kronstain v. Miller*, 19 A.3d 1119 (Pa. Sup. 2011), the executrix of the estate of Bert Dares ("Dares") and the plaintiff's widow filed an action against the deceased's physician, Dr. Thomas Miller ("Dr. Miller") and the physician's practice group, Hatboro Medical Associates ("Hatboro") alleging that the Dares' stroke was caused by the negligent medical and treatment he received. After trial of the matter, the jury found that the Dr. Miller was not negligent in treating Dares, but concluded that Hatboro was negligent in the care that it provided to Dares. The jury, nevertheless, was unable to reach a decision as to whether Hatboro's negligence caused Dares' injury. Consequently, the trial court declared a mistrial as to the questions of causation and damages, and discharged the jury without a final verdict.

Following the mistrial, the plaintiffs filed motions for post-trial relief. The plaintiffs requested that the trial court not disturb the jury's finding of negligence as to Hatboro and the jury's finding in favor of Dr. Miller be vacated. The plaintiffs further requested that the new trial, necessitated by the mistrial, be limited to the issues of causation and damages. In contrast, the defendants requested that the trial court vacate the jury's finding of negligence and, rather, conduct the new trial on all issues *de novo*. On December 16, 2009, the trial court granted the plaintiffs' motion for post-trial relief as to Hatboro, ordering a "new trial on causation only." In the same order, the trial court denied the plaintiffs' motion as to Dr. Miller, asserting that "the finding of no negligence as to Dr. Miller stands."

Following an appeal by the defendants, the Superior Court quashed the appeal. In reaching its decision, the court stated:

> In the case sub judice, . . ., the trial court declared a mistrial before issuing the December 16, 2009 order. In attempting to answer the questions presented in the special interrogatories, the jury in this case found Hatboro was negligent but was unable to reach a decision as to whether Hatboro's negligence caused Dares' injury. We note that "[a] mistrial is granted in a case in which the jury is discharged without a verdict[.]" Here, the trial court dismissed the jury without a final decision as to liability and damages because it had become deadlocked on the issue of causation. . . . Consequently, although it did not render a decision regarding Hatboro's negligence, the jury in this case "[was] discharged without a verdict[.]" Hence, the trial court issued its December 16, 2009 order granting a new trial after it had properly declared a mistrial. Thus, . . ., the December 16, 2009 order is not an order awarding a new trial. (Brackets and emphasis in original; internal citations omitted.)
>
> Accordingly, because it is not an order awarding a new trial, we conclude that the December 16, 2009 order is outside the scope of Pa. R.A.P. 311(a)(6) and, consequently, is not an appealable order as of right. Because a mistrial had occurred in this case, a new trial would have followed as a matter of course. As such, the litigants were entitled to a new trial regardless of the December 16, 2009 order. Thus, despite its language, the trial court's order could not grant a new trial as it purported to do. Rather than award a new trial, the court's order simply limited the scope of the retrial to causation and, perhaps, damages.

Supreme Court Reverses Decisions Below Holding That The Pertinent Settlement Agreement, Which Stated

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Medical Malpractice Update *continued from page 14*

That The "Total Consideration" To Be Received Was $6.3 Million, And Provided For Certain Lump Sum Payments Followed By Monthly Payments Of $20,000 Until Decedent's Death, As Well As An Option To Purchase An Annuity To Assign The Duty To Make Payment Pursuant To The Agreement To An Insurer, Unambiguously Reflected The Parties' Intentions That Payments Would Cease At The Death Of Decedent

As set forth in *Lesko v. Frankford Hospital-Bucks County*, 11 A.3d 917 (Pa. 2011), Kathleen Bernath ("Bernath") brought a medical malpractice claim against Frankford Hospital-Bucks County, *et al*. ("Frankford") for injuries sustained following surgery. In 2005, Bernath entered into a written settlement agreement with Frankford. The agreement provided that the "total consideration" was $6,300,000. Frankford was to pay Bernath lump sums of $400,000 and $4,239,890. Of particular importance, the agreement provided that Frankford agreed to make monthly payments of $20,000 which were to continue for the life of Bernath. The agreement further provided that no payments were due on or after the date of Bernath's death. Bernath agreed these periodic payments could not be accelerated, deferred, increased, or decreased. Frankford reserved the right to fund the periodic payment liability via the purchase of an annuity policy from New York Life, which would then take full responsibility for the payment obligations to Bernath. Bernath specifically agreed to this assignment.

Pursuant to the agreement, Frankford issued a $4,239,890 check to Bernath. It also issued a $1,660,100 check to New York Life for the annuity purchase, but some two weeks after the check was sent to New York Life, Bernath died. Though Frankford had sent the check to New York Life, at the time of Bernath's death, the annuity contract had not yet been executed. Frankford asked New York Life to refund the $1.6 million check, claiming the annuity obligation was premised on Bernath being alive at the time the payments commenced. Plaintiff, Jeanne Lesko, as Executrix of Bernath's estate, challenged the claim and requested the $1.6 million be paid to Bernath's estate.

The trial court ordered Frankford to pay Bernath's estate $1,660,110. The trial court found the settlement agreement unambiguously revealed the parties' intent that the total consideration to be paid was $6.3 million, and Frankford's portion of that amount was $5.9 million – the $4.24 million lump sum and the $1.6 million paid to New York Life to fund the annuity. It held the obligation to pay the annuity arose when the parties entered into the agreement; thus, as Bernath's death made the annuity purchase impossible, the $1.6 million should be paid to her estate.

Frankford appealed, and the Superior Court affirmed, finding the duty to pay the $1.6 million to obtain an annuity arose when the contract was executed. The Superior Court concluded that changed circumstances, which made it impossible for Frankford to purchase the annuity, failed to release them from their promise to pay Bernath's estate the entire amount specified in the settlement agreement; instead, only the form of the obligation changed following her death, and the estate was owed $1.6 million to satisfy the $6.3 million "total consideration" mentioned in the contract.

Frankford contended that the court rewrote the agreement as it clearly stated that no payments were due after Bernath's death. Frankford disputed the trial court's reliance on the "total consideration" clause claiming it was an isolated sentence in the agreement and was clearly qualified by the specific sections pertaining to payment. Frankford also argued that there was no obligation in the agreement requiring it to purchase an annuity, only the option to do so. Frankford contended that even if there were such an obligation, performance was made impossible by Bernath's death; as her survival was a basic premise of the contract, performance was impossible, and Frankford's duty was discharged.

Conversely, plaintiff maintained that Frankford owed $1,660,110 to Bernath's estate because the agreement was drafted to release the medical malpractice claims in exchange for the unconditional sum of $6.3 million as "total consideration" pursuant to the agreement. Plaintiff argued that Frankford was obligated to pay $5.9 million to settle the claims, via a $4.24 million direct payment and a $1.6 million annuity purchase. Plaintiff believed that the language stating no monthly payments would be due on or after Bernath's death referred only to the payments under the annuity contract, not Frankford's threshold obligation to pay $5.9 million. Plaintiff argued that Frankford had to fulfill their commitment to pay $5.9 million, even if the method of payment has changed due to a changed circumstance; otherwise, Bernath would be denied the benefit of the bargain.

In reversing the decisions below, the Supreme Court reviewed the plain language of the agreement and concluded that it was never the parties' intention that Bernath receive a total payment of $6.3 million, and, as such, Frankford was not obligated to pay $1,660,110 to Bernath's estate. The court noted that while the agreement indicated that Frankford planned to purchase the annuity, and had Bernath's approval to exercise such an option, the language only reserved Frankford's right to purchase the annuity. The agreement never obligated Frankford to do so. The court found to be of great significance the fact that if Frankford had chosen not to exercise their right to purchase the annuity, but opted instead to pay out of their own pocket, Bernath's estate would have no claim to the $1.6 million because the language of the contract clearly states the periodic payments cease upon Bernath's death. Bernath had no right to the payments after death, regardless of who was funding the payments.

With respect to the "total consideration" clause, the court agreed with Frankford that the specific provisions of the contract would be disregarded and rendered meaningless if one general sentence referring to "total consideration" governed the outcome of the entire settlement agreement, especially given the fact that the same sentence naming the general amount owed under the contract was clearly qualified by specific contractual provisions.

The Supreme Court held that Frankford had no threshold obligation to pay $5.9 million to Bernath, but to directly pay her $4,239,890 and $20,000 per month, with the option to assign that duty to New York Life by buying an annuity for $1.6 million. The unambiguous language of the settlement agreement terminated the periodic payments upon Bernath's death. As Bernath did not agree to receive a $1.6 million lump sum, but rather $20,000 periodic payments to end upon

her death, Frankford was not obligated to provide Bernath's estate with what Bernath herself did not bargain for.

1. Statute of limitations applicable to a wrongful death claim and a survival claim.

2. An Obstetrician, who allegedly treated a mother during the course of a second pregnancy, may be liable for harm caused to the mother's child which was born following her sixth pregnancy, even though the obstetrician did not treat or care for the mother during the sixth pregnancy.

3. Assumption of Risk Doctrine not applicable to newborn.

In *Matharu v. Muir*, 211 Pa. Super. 134 (2011), the court addressed a number of issues in the context of a medial malpractice action. These issues are as follows:

1. The statute of limitations applicable to a wrongful death claim and a survival claim.

2. Whether an obstetrician, who allegedly treated a mother during the course of a second pregnancy, is liable for harm caused to the mother's child which was born following her sixth pregnancy, when the obstetrician did not treat or care for the mother during the sixth pregnancy.

3. Application of the assumption of risk doctrine, and whether the mother's knowing failure to take precautions which arguably gave rise to harm and ultimately death to her child can be imputed to the child.

Facts

Blood work during the mother's first pregnancy in 1997 indicated she was Rh-negative, and the father was determined at that time to be Rh-positive. With this combination, there is a risk that the mother can become iso-immunized. This can be prevented by an injection of RhoGAM. Following her first pregnancy, the mother was administered RhoGAM. However, in 1998 during the second pregnancy, the mother was again found to be Rh-negative, but the treating obstetrician failed to administer the RhoGAM. The discharge summary reflected that the obstetrician advised the mother and father of the ramifications of Rh sensitization, including the potential adverse health effects on an unborn. It further indicated that the mother and father stated they desired no more children.

Subsequently, the mother became pregnant a third time and had an abortion. She gave birth to a fourth child (who was apparently healthy), and her fifth pregnancy terminated with a miscarriage.

In 2005, the mother became pregnant for a sixth time. The mother knew she was iso-immunized and there were certain risks associated with the pregnancy. She knew of these concerns following the birth of her second child. On November 10, 2005, a child was born who died two days later, i.e., on November 12, 2005.

The parties agreed that the alleged negligence which formed the basis for the lawsuit, occurred in 1998 when Dr. Muir failed to administer RhoGAM during the mother's pregnancy.

Statute of Limitations

Defendants filed a motion for summary judgment on the basis of the statute of limitation applicable to wrongful death and survival actions.

In addressing the statute of limitations issue, the court noted that in 2002 the General Assembly passed the MCARE Act, which included a specific statute of repose for medical professional liability claims. The statute provides that, with certain exceptions, "…no cause of action asserting a medical professional liability claim may be commenced after seven years from the date of the alleged tort or breach of contract." Further, the statute provides that if a death action is brought, "the action must be commenced within two years after the death."

40 P.S. § 1303.513(d).

The court also addressed the accrual of a survival cause of action and noted that it is different from that for a wrongful death action.

For a survival action, the statue of limitations, as a general rule, begins to run on the date of injury, as though the decedent were bringing his or her own lawsuit.

By contrast, a cause of action for wrongful death is not the deceased's cause of action. Rather, a wrongful death action is designed only to deal with the economic effect of the decedent's death upon specified family members.

In the context of a summary judgment motion, and viewing the evidence in a light most favorable to the plaintiffs as the non-moving parties, the record reflected that the child suffered an injury either at his birth on November 10, 2005, or upon his death two days later. Plaintiffs commenced their survival cause of action on April 25, 2007, well within the two years of child's injury.

As to the cause of action for wrongful death, there was no evidence that the plaintiffs suffered a pecuniary loss, caused by the child's death, until at least November 12, 2005, the date of death. Applying the two year period of limitation afforded no relief to defendants.

Duty of Obstetrician

Defendants further argued that the trial court improperly denied their motion for summary judgment where plaintiffs had failed to establish a duty owed to them by defendants. According to defendants, they provided no care to mother during her 2005 pregnancy, and no doctor-patient relationship was formed or existed during mother's pregnancy with child. Absent the doctor-patient relationship, defendants argued that there could be no duty owed by them to plaintiffs.

The court noted that a physician may be liable to a third party who is injured because of the physician's negligent treatment of a patient.

In determining whether or not a cause of action existed, the court applied the factual allegations in the complaint to the principles of law set forth in the *Restatement (Second) of Torts* § 324A.

In rejecting defendants' motion for summary judgment, the court, in viewing the evidence in a light most favorable to plaintiffs, noted that the child was in a class of persons whose health/life was likely to be threatened by defendants' failure to administer RhoGAM to mother in 1998. Further, it was reasonably foreseeable that defendants' failure to administer RhoGAM to mother in 1998 could injure future unborn children.

Medical Malpractice Update *continued from page 17*

Finally, the purpose for administering RhoGAM was to protect the future unborn children of mother and father. All these factors weighed in favor of finding a duty owed by the defendants to child.

While the court noted that recognizing the consequences of imposing a duty upon physicians under these circumstances could subject physicians to liability years and possibly even decades later, the court also considered, as a consequence of imposing such a duty, the prevention of injury or death resulting from Rh-sensitization.

In the final analysis, the court held that recognition of a duty advanced the public policies of the Commonwealth.

Assumption of Risk

With respect to application of the assumption of risk doctrine, the court noted that the continuing vitality of the document remained in doubt. Defendants argued that the mother knew full well the risk to her unborn, yet continued to become pregnant. Nevertheless, in quoting with approval the reasoning of the trial court, the Superior Court rejected the motion for summary judgment on the basis of assumption of risk:

> "We do not know whether plaintiffs (mother and father) fully understood the risk. Nor can we agree with Defendants that Plaintiffs' assumption of risk should somehow be imputed to [Child]. How can [the court] say that [Child] "assumed the risk" by being conceived? [The court] is compelled, therefore, to deny the Motion for Summary Judgment based on the assumption of the risk."

Trial Court Rejects Plaintiff's Claim For A Mistrial On The Ground That Defendants' Expert Testified Outside Scope Of Expert Report And Identified One Of The Plaintiff's Experts As A Defendant In Another Case

In *Nika v. Schelkun*, 14 Pa. D. & C.5th 208 (Montgomery Cty. 2010), the plaintiff appealed from the court's order denying plaintiff's motion for post-trial relief which requested that the court vacate judgment in favor of the defendants and grant the plaintiff a new trial.

The plaintiff's claims arose from the alleged negligence stemming from oral surgery performed on the plaintiff and her subsequent post-operative treatment. The defendants, Dr. Michael Schelkun and Dr. Michael Dachowski, performed the plaintiff's initial surgery followed by a second surgery by Dr. Schelkun. Dr. Schelkun also oversaw most of the plaintiff's post-operative care.

During the course of the trial, the court heard approximately five hours of expert testimony from Dr. Schelkun's expert, Dr. Raymond Fonseca. While he was testifying, Dr. Fonseca discussed two issues which plaintiff's counsel argued at trial constituted grounds for a mistrial. According to the plaintiff, the first basis for mistrial concerned Dr. Fonseca's allegedly deliberate violation of the court's order prohibiting the doctor from criticizing the plaintiff's expert, and blaming the expert's subsequent treatment for the plaintiff's post-surgical and present complications. The plaintiff's second ground for mistrial arose when Dr. Fonseca gratuitously offered that he had previously testified in a case against the plaintiff's other expert witness. The court denied the plaintiff's oral motion at trial concluding that neither supported the request for a mistrial. The jury then returned a verdict in favor of the defendants.

The plaintiff appealed and, in response, to trial court's Pa. R.A.P. 1925(b) request, the plaintiff presented two issues for appellate review: (1) whether the trial court erred in denying the motion for mistrial for Dr. Fonseca's violation of the court's instruction precluding him from testifying outside the scope of his expert report; and (2) Dr. Fonseca's testimony that he had previously testified against one of the plaintiff's experts. The court rejected the plaintiff's claims and recommended its orders be affirmed.

With respect to the first issue, the court found that Dr. Fonseca's testimony about the treatment by the plaintiff's expert would not prejudice the jury. Although the court found Dr. Fonseca's conduct to be "brazen" and "entirely uncalled for in this thinly disguised attempt to assign blame," it determined that he had not offered any direct criticism of the expert's treatment of the plaintiff. The court believed that any fleeting references to the causes of the plaintiff's complications did not render the jury incapable of reaching a fair and objective verdict.

With regard to the second issue, the court examined the context within which the alleged offending comments arose regarding Dr. Fonseca's criticism of defendant's expert. The court found that any prejudice or harm done by Dr. Fonseca's critical assessment of the plaintiff's expert was minimal and of no consequence, especially since it occurred so late in the trial, the comments were made in response to a question posed by the plaintiff's counsel, and the exchange was short and included an admonishment to defense counsel.

Court Holds That MCARE Liability On First Dollar Indemnity Extended Claims Is $1,000,000 And Is Not Subject To Any Deduction For Exhaustion Of Aggregate Limits

In *West Penn Allegheny Health System v. Medical Care Availability and Reduction of Error Fund,* 11 A.3d 598 (Pa. Commonwealth Ct. 2010) the Court was called upon to decide whether the MCARE Fund's obligation to defend and pay "extended claims" up to $1,000,000 per occurrence on a breach of contract or tort claim was subject to MCARE Fund's annual aggregate liability limit, which would reduce the available coverage to $394,917.

In June 2008, Tamara Blanchard, the parent and guardian of Kiana Townes, filed a medical malpractice action against Allegheny General on behalf of Townes in the Court of Common Pleas of Allegheny County. Blanchard alleged that Townes was born on March 29, 1998 at Allegheny General by an emergency C-section and that Townes experienced seizures at birth and was diagnosed with birth asphyxia and multi-organ dysfunction as a result of the negligent care of Allegheny General and its nursing staff on the day of her birth. In July 2008, Gateway Risk Services, Inc., which provides claims services for Allegheny General's professional liability insurance carrier, sent the MCARE Fund notice of a potential extended claim under Section 715 of the MCARE Act and asked the MCARE Fund to defend and indemnify Allegheny General for Townes' claim.

In a letter dated September 25, 2008, the MCARE Fund's chief counsel informed Allegheny General that the MCARE

Fund had accepted Townes' action as an "extended claim" under §715 of the MCARE Act. The chief counsel further stated that the MCARE Fund was required to provide Allegheny General with a legal defense and indemnity coverage up to $1,000,000 for each occurrence, but that "any exhaustion of aggregate limits may affect available coverage." The trial court scheduled a jury trial on Townes' action for March 16, 2010. Before the case reached a jury verdict, the parties settled the action for $1,100,000 on March 26, 2010, which settlement was approved by the trial court.

Before the settlement, Allegheny General filed a petition for review in the nature of a declaratory judgment against the MCARE Fund and Townes pursuant to the Commonwealth Court's original jurisdiction. Allegheny General sought a declaration that the MCARE Fund's $1,000,000 per occurrence liability limit under §715(b) of the MCARE Act was not subject to MCARE Fund's annual aggregate liability limit. The MCARE Fund alleged that its annual aggregate liability limit for 1998 when Townes' cause of action was accrued, was $2,700,000 under §701(d)(1) of the MCARE Act, and that Allegheny General had eroded the MCARE Fund's 1998 annual aggregate liability limit, and this had only $394,917 available to cover Townes' extended claim. The MCARE Fund averred that it agreed to pay Blanchard $394,917.

The court undertook a detailed analysis of the "extended claims" provision of MCARE, specifically §715. This section provides that if a medical malpractice liability claim against a healthcare provider is made more than four years after the breach of contract or tort occurred, and if the claim is filed within the applicable statute of limitations, the claim shall be defended by the Insurance Department as long as appropriate notice is given. Under such circumstances, the obligation of MCARE under §715 is to defend and fully indemnify healthcare providers for claims against them based on what is commonly referred to as "first dollar" indemnity. The limit for first dollar indemnity is $1,000,000.

The court's opinion contains a detailed analysis of the history of the CAT Fund, the MCARE Fund and the statutory framework with respect to "extended claims". The court focused on the fact that there was no aggregate limit in §715. The court held that when a primary carrier is obliged to defend a medical malpractice claim, based on the statutory scheme, the aggregate liability limit applies, but there is no such provision in the statute with respect to "extended claims" and thus, the aggregate liability limit does not apply. *Expressio unius est exclusion alterius,* the express mention of a specific matter in a statute implies the exclusion of others not mentioned.

Ultimately, the court's holding was the MCARE Fund's liability limit with respect to "extended claims" was $1,000,000.

Pennsylvania Employment Law Update

By Lee C. Durivage, Esquire, Marshall, Dennehey, Warner, Coleman & Goggin, Philadelphia, PA

The Supreme Court Holds That the Fair Labor Standard Act's Anti-Retaliation Provision Includes Oral as Well as Written Complaints.
Kasten v. Saint-Gobain Perf. Plastics Corp., 131 S. Ct. 1325 (Mar. 22, 2011)

The plaintiff alleged that his employment was terminated after he made several oral complaints to his supervisors and his employer's representatives concerning potential violations of the Fair Labor Standards Act. The trial court and the Court of Appeals determined that the plaintiff's retaliation claim failed as a matter of law, holding that the Fair Labor Standards Act did not protect oral complaints.

The Supreme Court, however, reversed the lower courts' decisions, holding that "an oral complaint violation of the Fair Labor Standards Act is protected conduct under the [Act's] anti-retaliation provision." In so holding, the Supreme Court initially examined the anti-retaliation provision itself, which forbids employers from "discharge[ing] or in any other manner discriminat[ing] against any employee because such employee has filed any complaint."

Although the Supreme Court conceded that the phrase "filed any complaint" was ambiguous and did not, by itself, provide any rationale for whether the provision may or may not encompass oral complaints, it reasoned that several functional considerations indicate that Congress intended the anti-retaliation provision to cover oral as well as written complaints. Specifically, the Court noted that limiting the provision to only written complaints would undermine the Act's basic objectives to prohibit "labor conditions detrimental to the maintenance of the minimum standard of living necessary for health, efficiency, and general well-being of workers" and would prevent the government agencies from using hotlines, interviews and other oral methods for receiving complaints.

Although the Supreme Court unequivocally determined that the provision covers oral complaints, it did not decide (because the employer did not seek *certiorari* on the issue) whether the anti-retaliation provision covers complaints made to private employers, as opposed to the government. From this, it is anticipated that the plaintiffs (and their attorneys) will be filing more claims for purported retaliation under the Fair Labor Standards Act that are premised on their internal complaints to their supervisors.

The Third Circuit Holds That Plaintiff's Admitted Violation of His Employer's Zero Tolerance Policy Regarding Workplace Threats Mandates Dismissal of His Discrimination Claims.
Venter v. Potter, 2011 U.S. App. LEXIS 10948 (3d. Cir. May 27, 2011)

The Third Circuit upheld summary judgment in favor of an employer who terminated the plaintiff's employment for violating its zero tolerance policy. The plaintiff had previously filed three claims of discrimination against the employer

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Pennsylvania Employment Law Update

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for various employment issues, and each of the three claims were dismissed by an administrative law judge. Subsequently, the plaintiff's working hours were changed, and he approached his union steward to lodge a grievance on his behalf. The union steward informed the plaintiff that a grievance was not warranted. The plaintiff later approached the steward and, again, reiterated his request to file a grievance on his behalf. The union steward sought the assistance of an operations supervisor, who spoke with the plaintiff and informed him that his behavior was unacceptable.

As a result of this discussion, the plaintiff became upset and sought treatment from the employer's occupational health office. While being treated, the plaintiff informed one of the nurses that he wanted to "punch" or "kill" the union steward. The plaintiff was sent home for the day, and an investigation was initiated into the plaintiff's statements regarding the union steward. While the plaintiff admitted to making the statements in question, he denied any actual intent to harm the union steward. However, as a result of the plaintiff's admitted statements, the employer found that the plaintiff violated its zero tolerance policy and terminated his employment.

Following his termination, the plaintiff filed a lawsuit against his former employer, alleging age discrimination, disability discrimination and retaliation for filing prior discrimination claims. In rejecting the plaintiff's claims and upholding summary judgment in favor of the employer, the court held that the employer plainly had a legitimate reason for terminating the plaintiff's employment and, notably, the plaintiff admitted he made the threatening statements and that he understood the importance of the zero tolerance policy. Moreover, the court reasoned that the plaintiff provided no evidence that would either cast doubt on the veracity of the employer's reason for his termination or suggest that the reason was not in fact the motivating cause for his termination.

District Court Holds That the Public Policy Exemption to At-Will Employment Does Not Extend to Wage Payment-Related Retaliatory Discharge Claims.
Donaldson v. Informatica Corp., 2011 U.S. Dist. LEXIS 57943 (W.D. Pa. May 31, 2011)

The plaintiff filed a wrongful discharge claim against his former employer, alleging his employment was terminated in retaliation for filing a prior lawsuit against his employer, which alleged violations of the Pennsylvania Wage Payment and Collection Law. In rejecting the plaintiff's claim, the court held that the plaintiff's theory does not support a wrongful discharge claim under Pennsylvania law.

In so holding, the court first noted that "[t]he presumption of at-will employment is strong, and an employee may bring a cause of action for a termination of that employment only in the most limited circumstances, where the termination implicates a clear mandate of public policy." With that background in mind, the court noted that the Pennsylvania Supreme Court directly found a public policy exception to at-will employment in two circumstances, both of which involved workers' compensation claims. In predicting that the Pennsylvania Supreme Court would not permit a wrongful discharge claim premised on the prior filing of a lawsuit pursuant to the Pennsylvania Wage Payment and Collection Law, the court reasoned that while the Workers' Compensation Act "creates a substantive duty in the employer to compensate employees for work-related injuries" and "is the exclusive means for obtaining compensation for [work-related] injuries," these characteristics are not shared in the Pennsylvania Wage Payment and Collection Law.

Specifically, the court determined that "the [Wage Payment and Collection Law] does not create a substantive right to compensation, but rather provides a statutory remedy when an employer breaches a contractual obligation to pay earned wages" and "[t]he [Wage Payment and Collection Law] also is not an employee's exclusive remedy for obtaining wages allegedly due." As a result, the court rejected the plaintiff's wrongful discharge claim and found that "the public policy exception to at-will employment does not extend to wage payment-related retaliatory discharge claim" under Pennsylvania law.

The Pennsylvania Superior Court Upholds a $187 Million Judgment in Favor of Employees Who Were Allegedly Forced To Work Off the Clock and Skip Breaks.
Braun v. Wal-Mart Stores, Inc., 2011 Pa. Super 121 (Pa. Super. Ct. June 10, 2011)

The Pennsylvania Superior Court upheld a jury verdict and award in favor of a class of Wal-Mart employees who were allegedly forced to work through their break periods in violation of the company's policy. Specifically, the class of plaintiffs alleged, *inter alia*, that the company violated the Pennsylvania Wage Payment and Collection Law because it failed to compensate them for rest breaks and off-the-clock work as mandated in its policies. Specifically, the policies required it to pay "for non-working time on rest breaks" and that "[i]t is against Wal-Mart policy for any Associate to perform work without being paid." Following a 32- day jury trial, the jury found in favor of the class of employees and judgment was entered in their favor.

On appeal, the employer argued, among other things, that the "rest periods are not 'wages, wage supplements, or fringe benefits' within the meaning of the Pennsylvania Wage Payment and Collection Law." In upholding the judgment, the court initially noted that it was undisputed that the policies were disseminated to employees and employees received handbooks at orientation which contained the promise of certain benefits, including benefits relating to rest breaks. As a result, and based upon the plaintiffs' testimony that they relied on the representations contained in the handbook to continue working, the court noted that the provisions concerning getting paid for rest breaks could constitute a "unilateral contract" that the employees accepted by continuing to work there. In addition, the court noted that to present a wage-payment claim, "the employee must aver a contractual entitlement 'to compensation from wages' and a failure to pay that compensation." As a result, the court held that "monetary payments for rest breaks pursuant to an agreement between an employer and employee are 'fringe benefits,' and thus 'wages'" pursuant to the Wage Payment and Collection Law.

In so holding, the court reasoned that "the payment associated with a paid, agreed-

upon rest break is both 'guaranteed' and pursuant to an agreement and is, therefore, similar to severance pay." The court further rejected the employer's argument that "the employees were not denied any payment for missed rest breaks because they were paid regardless of whether they took a break or not." In rejecting this argument, the court noted that "[e] ssentially, [the employer] promised to pay a full-time hourly employee[s] for a forty-hour workweek in exchange for thirty-seven-and-a-half hours of labor (including meal periods) and two-and-a-half hours of rest," and because of the unequivocal language of their policies, their failure to provide these paid rest breaks can constitute liability under the Wage Payment and Collection Law. Accordingly, the court upheld the jury verdict in favor of the class of employees who were not compensated for missing their rest breaks or cutting their breaks early.

While it is likely that the employer will seek an appeal to the Pennsylvania Supreme Court, the opinion as it stands now creates a need for employers to examine their own policies regarding rest breaks and modify them as necessary. Indeed, in light of the fact that the court determined that the employee handbook could constitute a "unilateral contract" that could subject an employer to liability under the wage laws, it is highly likely that plaintiffs and their attorneys will continue to litigate "missed break" cases and seek compensation when an employee (or a group of employees) miss their paid rest breaks or cut their rest breaks short.

WORKERS' COMPENSATION UPDATE

By Francis X. Wickersham, Esquire, Marshall, Dennehey, Warner, Coleman & Goggin, King of Prussia, PA
and G. Jay Habas, Esquire, Marshall, Dennehey, Warner, Coleman & Goggin, Erie, PA

Inconsistencies in the Testimony of the Employer's Medical Expert Render the Expert's Opinion Equivocal With Respect to the Issues of the Claimant's Full Recovery and Ability to Return to Work. The Employer's Issuance of a Notice of Compensation Denial Did Not Constitute an Illegal Supersedeas.
John Potere v. W.C.A.B. (KEMCORP); 1349 C.D. 2010; filed May 20, 2011; by Judge McCullough

The claimant was a tractor-trailer driver and sustained injuries in an accident that occurred on January 22, 2005. The employer issued a notice of temporary compensation payable (TNCP) in February 2005. In March 2005, the claimant was seen for an IME, and the IME physician described the examination as normal. The employer then contacted the claimant, requesting a return to his pre-injury job in April 2005. The claimant advised that he was not capable of doing so. The employer issued a notice stopping temporary compensation and a notice of denial (NCD). The claimant then filed a claim petition.

The WCJ granted the claim petition but found that the claimant had fully recovered as of the date of the IME. The judge also found the claimant had not sustained his burden of proving ongoing disability beyond April 20, 2005, the date he was asked to return to his pre-injury job. The claimant appealed, and the Appeal Board reversed the decision and remanded the case to the judge. On remand, the judge again granted the claim petition but concluded the claimant was capable of returning to his pre-injury job without restrictions as of the IME date. The judge also suspended the claimant's benefits as of April 13, 2005, based on the full-duty job offer made to the claimant, which he refused. The claimant appealed to the Appeal Board again, and this time, the Appeal Board affirmed.

The Commonwealth Court, however, partially granted the claimant's appeal, concluding the testimony given by the employer's medical expert was equivocal regarding the claimant's ability to return to his time-of-injury job as of the date of the IME. For example, although the employer's expert testified he thought the claimant was fully recovered, he also said the claimant was able to work in a light to moderate setting that would transition to a full-duty return to work in about four weeks after the claimant completed a physical therapy program. The court, therefore, remanded the case to the judge.

However, the court did reject an argument made by the claimant that the employer's issuance of the NCD constituted an illegal supersedeas. The court held that the issuance of the NCD by the employer was in compliance with the Act and was not an illegal suspension of the claimant's benefits.

In Calculating a Claimant's Average Weekly Wage, §309 (d) Applies When the Claimant Is a Long-Term Employee. The WCJ Properly Subtracted Depreciation From Com-mission Earnings in Calculating the Claimant's Average Weekly Wage.
Gregory Pike v. W.C.A.B. (Veseley Brothers Moving); 1227 C.D. 2010; filed May 23, 2011; by Judge Cohn Jubelirer

In this case, a WCJ issued a decision concerning the calculation of the claimant's average weekly wage (AWW). In calculating the AWW, the judge included substantially lower earnings from periods prior to the time the claimant received a promotion to a much higher paying position and subtracted expenses the claimant listed on a federal income tax return, such as depreciation and home office business use deductions, rather than only those expenses actually paid. The deduction taken by the judge in calculating the claimant's average weekly wage represented the total amount claimed as business expenses on the claimant's income tax return. The judge also rejected the claimant's contention that the business expenses he declared for deductions should actually be added back onto his income for purposes of calculating the pre-injury AWW.

The Appeal Board affirmed the calculation of the AWW, and the claimant appealed to the Commonwealth Court. On appeal, the claimant argued that his AWW should have been calculated based on §309 (d.1), since his fourth quarter was most reflective of his new economic reality in light of his promotion. The claimant also argued

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that the judge improperly subtracted tax return deductions, which artificially lowered his earnings.

The Commonwealth Court rejected these arguments and affirmed the decision of the judge. According to the court, §309 (d.1) did not apply because the claimant was a long-term employee for whom a look-back period was appropriate. The court also held that there was no evidence that the claimant's earnings in the fourth quarter were indicative of what he would earn in commissions in the future. Finally, the court held that the judge properly subtracted depreciation from commission earnings in calculating the claimant's AWW and rejected the claimant's argument that depreciation deductions should be added to the total AWW calculation.

The Employer Meets Its Burden of Proof To Take an Offset for Its Contribution to Defined Benefit Pension Plan Through Actuarial Testimony of the Extent to Which It Funded the Plan and the Basis for the Calculation of the Offset.
Horner v. W.C.A.B. (Liquor Control Board), 2155 C.D. 2010 (Pa. Cmwlth. June 14, 2011), Judge McCullough

The Commonwealth Court confirmed several recent court decisions holding that an employer may meet its burden of proof of the amount of its contribution to a defined benefit pension plan in order to obtain a § 204(a) offset through the presentation of evidence from an actuary of the amount of the employer's contribution to fund the plan. The court reaffirmed that the employer need not establish the actual dollar amounts of its contributions to the pension plan, but it may utilize actuarial testimony that calculates the contribution based on factors such as employee contributions, investment income, rates of return and interest rates. In upholding the decisions of the WCJ and the Appeal Board, the Commonwealth Court accepted the determination that the actuarial evidence was credible and based upon sufficient information and explanation calculating the offset.

An Employer's Job Offer Letter Inviting a Return to Work to a Previous Job With Modifications Based on Current Medical Restrictions, But Without Detailing the Duties of the Work, Is Sufficient To Support a Modification of Benefits.
Vaughn v. W.C.A.B. (Carrara Steel Erectors), 1790 C.D. 2010 (Pa. Cmwlth. March 11, 2011), Judge Butler

Following an IME identifying that the claimant could return to work in a modified, medium-duty capacity, the employer notified the claimant simply that his work activities would be modified to accommodate the IME's work restrictions. When the claimant failed to report to work, the employer filed a modification/suspension petition, which was granted by the WCJ and upheld by the Appeal Board.

On appeal, the claimant argued that the employer failed to provide sufficient notice of an available job under § 306(b)(2) of the Act and *Kachinski v. W.C.A.B. (Vepco Construction Co.)*. In finding that the job offer letter provided sufficient notice, the court stated that the job referral must be reviewed in a common sense manner, particularly where the offer relates to the employee's pre-injury position. The employer's offer letter clearly intended, according to the court, for the claimant to return to his pre-injury job with restrictions rather than an alternative position, and the testimony established that it would make further accommodations as necessary. The court found this was sufficient for the employer to meet its burden of proof.

The Supreme Court Holds That An Insurer Is Entitled To Supersedeas Fund Reimbursement For Payment Of A Medical Bill Made After A Request For Supersedeas Was Denied, Even Though The Bill Was For Medical Treatment Received Before The Supersedeas Request Was Made.
Department of Labor and Industry, Bureau of Workers' Compensation v. WCAB (Crawford & Company); 102 MAP 2009; decided July 19, 2011; by Mr. Justice Eakin

In this case, the claimant, who was receiving benefits for a July 1995 work injury, was seen for an IME on March 16, 2004. On June 1st of that year, surgery was performed on the claimant, which the claimant maintained was related to his work injury. On July 19, 2004, the employer filed a petition to terminate the claimant's benefits, based on the results of the March 2004 IME. The employer also requested supersedeas in connection with the termination petition. The request for supersedeas was denied.

In October 2004, the bill for the June 2004 surgery was submitted to the insurer. The insured made payment in January 2005. In June 2005, the employer's Termination Petition was granted by the WCJ. The Workers' Compensation Appeal Board (WCAB) affirmed.

The insurer then requested reimbursement from the Supersedeas Fund for the surgery bill, which was over $35,000. However, the Bureau challenged the request. The Bureau took the position that because the claimant's surgery occurred before the Supersedeas Request was made, the insurer was not entitled to a supersedeas fund reimbursement. The WCJ, however, awarded reimbursement, and the WCAB affirmed, as did the Commonwealth Court.

The Supreme Court affirmed the decisions below, holding that the insurer was entitled to reimbursement from the supersedeas fund for the bill for surgery performed prior to the Supersedeas Request being made, but submitted after the request was denied. According to the court, the insurer had the obligation to cover the bill pending the final determination and that obligation was the direct and singular result of the denial of supersedeas. In the court's view, to make reimbursement dependent on the date of the event giving rise to the bill would serve to insert an additional element into the Act. The court also noted that the insurer was not asking for payments made before the supersedeas filing date, much less the date of granting supersedeas. The insurer was seeking reimbursement for payment made after a supersedeas denial, "an obligation incurred when the insurer was denied permission to suspend compensation payments."

A Claimant's Burden of Proof on a Reinstatement Petition Was Not Met Where the Claimant's Evidence Failed To Show That the Reason for a Suspension of Benefits No Longer Existed.
Upper Darby Township v. WCAB (Nicastro); 1285 C.D. 2010; filed March 17, 2011; by Judge Leavitt

The claimant sustained a work-related injury to his low back in April of 2002. Approximately two years later,

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he returned to his regular job with no restrictions, and his benefits were suspended pursuant to a notification of suspension. In June of 2004, the claimant again hurt his low back and filed a claim petition. During litigation, the parties resolved the claim petition by stipulation. The parties agreed to the work injury and that there was a limited period of disability from June 8, 2004, through October 7, 2004. It was also agreed that the claimant returned to his regular job without restrictions on October 8, 2004, and that the claimant stopped working for the employer in December of 2004 because of injuries unrelated to his back. The WCJ issued a decision adopting the stipulation in May of 2006.

Later, in January 2008, the claimant filed a reinstatement petition, alleging that his condition worsened and his work injury caused him to suffer a loss of earning power as of January 24, 2008. In actuality, the claimant was requesting a reinstatement of as of December 5, 2004, when he stopped working for the employer. During litigation of the reinstatement petition, the claimant testified that he was terminated by the employer in December of 2004 for taking too many sick days. He also acknowledged that no specific incident prompted him to seek a reinstatement and said that since December of 2004, he has been capable of performing his pre-injury job without restrictions. The claimant's medical expert testified that the claimant would not have been able to perform his regular job at any time between December of 2004 and November of 2006, when he began treating the claimant.

The WCJ granted the reinstatement petition, and the WCAB affirmed. The Commonwealth Court, however, reversed. They agreed with the employer that the claimant failed to meet his burden of proof for the reinstatement petition, since he failed to show that the reasons for the suspension no longer existed. The court pointed out that the claimant had previously stipulated that he stopped working for the employer in December 2004 for reasons unrelated to the work injury. The court also noted that the claimant acknowledged he could perform his regular job as of December 2004 and February 2008. The court viewed this testimony as contrary to the theory that the claimant's work injury once again negatively impacted his earning power.

Pennsylvania Supreme Court Addresses What Is Sufficient Notice of a Work Injury.
Gentex Corporation v. W.C.A.B. (Morack); No. 33 MAP 2010; filed July 20, 2011; Madame Justice Todd

The claimant in this case, a 45-year employee who worked as an Air Force helmet inspector, left work complaining about intolerable pain in her hands but did not report her condition as work-related. She submitted an application for short-term disability benefits, indicating that she did not believe that her condition was work-related, and attributed it to pre-existing fibromyalgia and high blood pressure. Two months after leaving work, the claimant was diagnosed with work-related tendonitis, bilateral carpal tunnel syndrome and a cartilage tear. She then left voice messages with the human resource manager, at least one of which was that she had unspecified "work-related problems." No medical documentation was submitted to the employer identifying the conditions as work-related.

The WCJ found that the claimant gave timely notice of her injury under section 311 of the Act and sufficiently described it pursuant to section 312, and the WCAB agreed. The Commonwealth Court reversed as to the sufficiency of the description of the notice under section 312, finding that the short-term disability application and voice message did not adequately describe a work-related injury.

The Supreme Court, in holding that the claimant provided sufficient notice of a work injury, held that a precise description of the work injury is not necessary and that the notice requirement under section 312 is met when it is conveyed in ordinary language, takes into consideration the context and setting of the injury, and may be provided over a period of time or a series of communications if the exact nature of the injury and its work-relatedness is not immediately known by the claimant. While the Court acknowledged that the claimant's notice in this case was not "letter perfect," it nonetheless stressed that the humanitarian purpose of the Act directs that "a meritorious claim ought not, if possible, be defeated for technical reasons and technicalities." The Court stated that what constitutes sufficient notice is a fact-intensive inquiry taking into consideration the totality of the circumstances.

The *Gentex* decision is disconcerting to employers and insurers as it can be viewed as promoting a low threshold for claimants to satisfy the notice requirement of section 312, as well as seemingly shifting the burden to the employer to identify the occurrence of a work injury where an employee does not specify or offer medical evidence that a medical condition or injury is work-related, and, indeed, provides information to the contrary that the problem is due to a pre-existing condition. Of concern is the Court's suggestion that the mere mention of a "work-related problem" is sufficient to trigger an employer's duty to investigate the circumstances to determine if compensation is due, or face sanctions.

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