Settlement Demand: $425,000 was the lowest settlement demand from the general contractor.

Settlement Offer: $100,000 was the highest offer to the general contractor.

Trial Type: Jury/Judge

Trial Length: 12 weeks

Verdict: Defense

THE BOTTOM LINE:

Case Title: Donald Pitchers as Personal Representative and Successor in interest to Patricia Pitchers (deceased); Donald Pitchers, an individual v. Mary C. Murphy, M.D.; Alan C. Wittgrove, M.D., an individual; and Alvarado Surgical Associates, A Medical Group, Inc., a California Corporation doing business as Wittgrove Bariatric Center; and does 1-25

Case Number: 37-2008-00077589-CU-MM-CTL

Judge: Hon. David B. Oberholtzer

Plaintiff's Counsel: Gordon R. Levinson of Levinson Law Group and Sean Simpson of Simpson-Moore LLP

Defendant's Counsel: Sheila S. Trexler of Neil, Dymott, Frank, Mcfall & Trexler APLC

Type of Incident/Causes of Action: Husband of Decedent, a 48-year old woman brought a wrongful death and survival action alleging negligence against Defendant physician. Plaintiff contacted Defendant physician who was covering for her surgeon for complaints of nausea, dry heaves and a sensation of fullness. Defendant physician recommended plaintiff drink hot teat, lie down and call within an hour or two. She did not and Defendant physician followed up. Reportedly, she was feeling better and sleeping. The husband was instructed to contact her if she had any further symptoms or problems. She never heard from the couple again. The Decedent was driven by her husband to the hospital early the next morning, instead of calling the paramedics. She had astrangulated bowel and lactic acidosis which led to full cardiac arrest. She was taken off life support after three days as she was brain dead as a result of the cardiac arrest although the surgery was successful in removing the necrotic bowel. Plaintiff expert testified the doctor should have sent the patient to the emergency department as she had a "developing" bowel obstruction in the early evening, many hours before her arrest. Defendant's expert opined the standard of care did not require the physician to send her to the emergency department and most likely suffered an acute bowel obstruction that could not have been predicted. Further, the couple never advised Defendant physician that she had previously suffered a small bowel obstruction which was not previously repaired. Defendant's expert testified that the previous bowel obstruction could have contributed to the development of the acute condition.

Insurance Update
Challenge to the Pleadings

By James M. Roth
The Roth Law Firm

The common thread among each of the cases discussed below is that all have been reviewed following a challenge to the pleadings, rather than final adjudication.

Although the Made-Whole Rule Applies in the Med-Pay Insurance Context, and the Insured must Be Made Whole as to All Damages Proximately Caused by the Injury, Liability for Attorney Fees Is Not Included under the Made-Whole Rule; Rather, Those Fees Instead Are Subject to a Separate Equitable Apportionment Rule (Or Pro Rata Sharing) That Is Analogous to the Common Fund Doctrine.

In 21st Century Insurance Company v. Superior Court (2009) 47 Cal.4th 511, 98 Cal.Rptr.3d 516 (August 24, 2009), the Supreme Court of California held that although the made-whole rule applies in the med-pay insurance context, and the insured must be made whole as to all damages proximately caused by the injury, liability for attorney fees is not included under the made-whole rule; rather, those fees instead are subject to a separate equitable apportionment rule (or pro rata sharing) that is analogous to the common fund doctrine.

Factually, Silvia Quintana ("Quintana") was injured in an automobile accident with a third party. She maintained an auto insurance policy with 21st Century Insurance Company ("21st Century") that included first party, no-fault medical payment ("med-pay") insurance coverage in case of an accident. 21st Century paid Quintana $1,000 under her insurance policy's med-pay provision. Quintana then separately pursued a damages claim against the third party and settled the action for $6,000, which sum represented her total damages. In obtaining the settlement, she incurred approximately $2,000 in attorney fees and costs (collectively "attorney fees"). Under its interpretation of the insurance policy's reimbursement provision, 21st Century requested that Quintana repay the $1,000 it had paid her. Quintana paid 21st Century $600, an amount arrived at by taking the $1,000 med-pay benefits disbursed to her by 21st Century and subtracting attorney fees of $400 (approximately one-sixth of Quintana's total attorney fees of $2,106.50, one-sixth being the relationship between the $1,000 she received from 21st Century and her $6,000 settlement). 21st Century eventually agreed that amount fully satisfied its reimbursement claim, because it accounted for 21st Century's pro rata share of the attorney fees Quintana expended in collecting the damages from the third party tortfeasor. Quintana subsequently filed a class action lawsuit against 21st Century, alleging that 21st Century could not lawfully require any reimbursement under its policy terms because she had not been made whole by the third party damages settlement ($6,000) and medical payments received from the insurer ($1,000) when her attorney fees of $2,106.50 were included as part of her made whole recovery.

The narrow issue before the court was whether the made-whole rule includes liability for all the attorney fees insureds must pay in order to obtain medical payment compensation from a third party tortfeasor.

The court began its analysis noting that med-pay insurers must seek recovery for personal injury claims through contractual reimbursement rights against their insureds, because they are not allowed to assert subrogation claims directly against third party tortfeasors. This is so because insurance policies typically have, and her policy did have, a provision requiring her to reimburse her insurer for monies she recovered from a third person that duplicated her recovery under her policy. Underlying these provisions is the basic idea that insureds should not recover the same amount twice, once from their insurance company and again from a third party. In sum, insureds are entitled to be "made whole"

from the insurance proceeds and tort recovery, but they are not entitled to a double recovery. Although the made-whole rule applies in the context of first party, no-fault medical payment coverage in an automobile insurance policy, and the insured must be made whole as to all damages proximately caused by the injury before the insurer may recover reimbursement from the insured's recovery from the tortfeasor, liability for attorney fees is not included under the made-whole rule.

Noting that this was a case of first impression, the court limited its analysis to auto insurance med-pay cases because automobile insurance coverage may differ in scope from coverage under other liability policies or homeowner's property insurance that may or may not have reimbursement provisions, insurer participation requirements, or definitions that apply only to the particular insurance policy terms.

After an Automobile Insurer Allegedly Destroyed a Tire Intended for Use as Evidence in the Insured's Products Liability Action Against the Tire Manufacturer, the Insured Could Add His Insurer as a Defendant in the Products Liability Suit, Alleging "Breach of Implied Covenant of Good Faith and Fair Dealing" and "Negligent Destruction of Evidence."

In Cooper v. State Farm Mutual Automobile Insurance Company (2009) 177 Cal.App.4th 876, 99 Cal.Rptr.3d 870 (September 17, 2009), the Court of Appeal, Fourth District, Division 2, held that after an automobile insurer allegedly destroyed a tire intended for use as evidence in the insured's products liability action against the tire manufacturer, the insured could add his insurer as a defendant in the products liability suit, alleging "breach of implied covenant of good faith and fair dealing" and "negligent destruction of evidence."

Factually, Bryan Cooper ("Cooper") was an insured of State Farm. He was involved in a single car accident allegedly caused by a tread separation of the right rear tire. As part of the collision damage settlement with Cooper, State Farm acquired possession of the vehicle, including the right rear tire. State Farm had the tire examined by an expert, who opined that it was defectively manufactured. State Farm notified Cooper of its expert's opinion. Cooper thereafter sued the tire manufacturer, Continental Tire North America, Inc. ("Continental Tire"). After Cooper's counsel notified State Farm of the importance of the tire to Cooper's case against Continental Tire, and after State Farm informed Cooper that it would retain the tire, State Farm disposed of the car and the allegedly defective tire. Cooper then sued State Farm for damages allegedly caused by State Farm's destruction of the tire, contending that as a result of State Farm's conduct, he was unable to prove his product defect case against Continental Tire.

The issue before the appellate court was whether an insured may legally recover damages against his automobile insurer for injuries sustained in the underlying automobile accident when the insurer allegedly destroyed a tire intended for use as evidence in the insured's products liability action against the tire manufacturer, or whether said recovery is, by its very nature, too speculative.

The appellate court began its analysis noting that a volunteer who, having no initial duty to do so, undertakes to come to the aid of another is under a duty to exercise due care in performance and is liable if the harm is suffered because of the other's reliance upon the undertaking. While there may be no general tort duty to preserve evidence, this does not preclude the existence of a duty based on contract, created by mutual agreement or promissory estoppel. Thus, when an insurer enters upon an affirmative course of conduct affecting the interests of another, it is regarded as assuming a duty to act, and will thereafter be liable for negligent acts or omissions. The insured's damages for his automobile insurer's destruction of a tire that the insured intended to use as evidence in a products liability action against tire manufacturer, on a theory of promissory estoppel based on the insurer's promise not to destroy tire, would be the damages the insured would have been entitled to recover in the underlying products liability action against tire manufacturer if the tire had been available as evidence, less the amount that the insured actually received in settlement from the tire manufacturer. Because the insurer was aware of the value of the tire and the value range of personal injury actions, the damages were ascertainable in both their nature and origin.

When the Trial Court Finds That the Factual Issues to Be Resolved in a Declaratory Relief Action Brought by a Liability Insurer Regarding its Duty to Defend Overlap with Issues to Be Resolved in the Underlying Litigation, the Trial Court must Stay the Insurer's Declaratory Relief Action.

In Great American Insurance Company v. Superior Court (2009) 178 Cal.App.4th 221, 100 Cal.Rptr.3d 258 (October 0, 2009), the Court of Appeal, Second District, Division 3, held that when the trial court finds that the factual issues to be resolved in a declaratory relief action brought by a liability insurer regarding its duty to defend overlap with issues to be resolved in the underlying litigation, the trial court must stay the insurer's declaratory relief action.

Factually, Great American Insurance Company ("GAIC") insured Angeles Chemical Company ("Angeles") and its officers and directors. Angeles and a neighboring property owner, McKesson Corporation ("McKesson"), sued each other for cleanup costs relating to environmental contamination of the groundwater beneath both sites. The complaints also named officers and directors of each company. Various cross-complaints were filed; the subsequent owner of the Angeles site sued some, but not all, of the Angeles owners and directors; those owners and directors sued Angeles. GAIC settled the lawsuits filed against its insureds by McKesson and McKesson-related individuals, leaving actions among the Angeles-related parties still pending. GAIC then brought a declaratory relief action, seeking a declaration that those settlements had exhausted its policy limits and that it was therefore no longer obligated to defend its insureds in the then still-pending litigation. The insureds sought a stay of the declaratory relief action, on the basis that resolution of the issues raised in the declaratory relief action would prejudice it in the still pending underlying litigation.

The issue before the appellate court was under what circumstances must the trial court grant a stay requested by an insured to a declaratory relief action filed by an insured which believes there is no longer a potential for coverage and, therefore, it is no longer required to defend.

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The appellate court began its analysis noting well-settled law that in determining whether a duty to defend exists under a liability policy, courts compare the allegations of the underlying complaint with the terms of the policy, and facts extrinsic to the complaint may also be considered. If a potential for coverage exists under a liability policy, there is a duty to defend. Normally, a liability insurer with a duty to defend must defend until the underlying action is resolved by settlement or judgment. A liability insurer that withdraws a defense does so at its own risk. Thus, an insurer may protect itself from "bad faith" exposure by engaging a declaratory relief action to obtain a judicial declaration that it need no longer do so. To prevail in a declaratory relief action, where the issue cannot be resolved as a matter of law, the insured must prove the existence of a potential for coverage, while the liability insurer must establish the absence of any such potential. When the declaratory relief action depends on coverage issues, and the resolution of those issues might prejudice the insured in the underlying litigation, the proper course of action is to stay the declaratory relief action until resolution of the underlying action. However, when the declaratory relief action can be resolved without prejudice to the insured in the underlying action – by means of undisputed facts, issues of law, or factual issues unrelated to the issues in the underlying action – the declaratory relief action need not be stayed pending resolution of the underlying action. If the factual issues to be resolved in a declaratory relief action regarding a liability insurer's duty to defend overlap with issues to be resolved in the underlying litigation, the trial court must stay the declaratory relief action. Any prejudice to the insured, noted the court, in being compelled to fight a two-front war, doing battle with the plaintiffs in the third party litigation while at the same time devoting its money and its human resources to litigating coverage issues with its carriers, does not depend on the existence of factual overlap with the underlying action, and will be an issue for the trial court to consider every time an insured seeks to stay a declaratory relief action while the underlying action is still pending. In considering an insured's motion to stay the declaratory relief action, the court must consider possible prejudice to the insurer which may be caused by staying the declaratory relief action.

Fraudulent Conduct by an Insurer, Which Is Connected with Conduct That Would Violate Insurance Code Section 790.03 *et Seq*. – Sometimes Referred to as the "Unfair Insurance Practices Act" – Could Also Give Rise to a Private Civil Cause of Action under the Unfair Competition Law, Business and Professions Code Section 17200 *et Seq.*

In Zhang v. Superior Court (2009)__Cal.App.4th__, 100 Cal. Rptr.3d 803, the Court of Appeal, Fourth District, Division 2, held that the alleged acts by California Capital Insurance Company of making fraudulent misrepresentations and promulgating misleading advertising with respect to its intention to pay proper coverage in the event the insured suffered a covered loss, while it allegedly had a policy or regular practice of "lowballing," delaying, or taking unfair advantage, were a proper basis for insured's civil cause of action under the Unfair Competition Law ("UCL").

Factually, Yanting Zhang ("Zhang") sued her insurer, California Capital Insurance Company, over a dispute following a fire at Zhang's commercial premises. In the complaint's "Factual Background" and first two causes of action – based on the legal theories of breach of contract and breach of the covenant of good faith – Zhang set out a litany of misconduct relating generally to California Capital's handling of her loss claim and its refusal to authorize adequate payment under the policy for the repair and restoration of the premises. In the third cause of action, based on the UCL, Zhang alleged that California Capital "engaged in unfair, deceptive, untrue, and/or misleading advertising.... [California Capital] promises its insureds that it will timely pay proper coverage in the event the insured suffers a covered loss.... However ... [California Capital] in fact has no intention of properly paying the true value of its insureds' covered claims. [¶] ... [California Capital] had and has no intention of honoring such advertised promises." California Capital demurred to that third cause of action on the basis that the conduct alleged in the third cause of action was prohibited by the Unfair Insurance Practices Act (i.e., Insurance Code section 790.03 *et seq.*), and it was therefore impermissible for Zhang to plead a private cause of action thereto.

The issue before the appellate was whether fraudulent conduct by an insurer, which is connected with conduct that would violate Insurance Code section 790.03 *et seq.* – sometimes referred to as the "Unfair Insurance Practices Act" – could also give rise to a private civil cause of action under the UCL, Business and Professions Code section 17200 *et seq.*

Because this was a pleadings appeal, the appellate court was not concerned with plaintiff's ability to prove the allegations, but only with the allegations' adequacy to state a cause of action. Noting that a violation of Unfair Insurance Practices Act does not create a private right of action under the statute in either the first- or third-party context against insurers who commit the unfair practices enumerated in that provision," a claim under the UCL is not based upon the Unfair Insurance Practices Act. The UCL, which on its face applies to all "businesses" and does not expressly except or exempt insurers, does authorize any injured person to sue for the violation of its requirements and/or prohibitions-that is, for "unfair competition." (Bus. & Prof. Code, § 17204.) "Unfair competition" is defined in Business and Professions Code section 17200 to "include any unlawful, unfair or fraudulent business act or practice and unfair, deceptive, untrue, or misleading advertising...." "Undoubtedly," concluded the appellate court, an insurer is subject to suit under the UCL because there is no reason to treat insurers differently from other businesses when it comes to actions under the UCL except that insurers cannot be sued under the Unfair Insurance Practices Act.