THE WESTERN PENNSYLVANIA TRIAL LAWYERS ASSOCIATION'S

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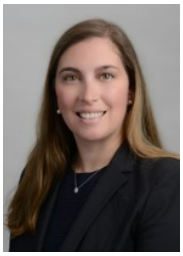
A Message from the President …



*By: Elizabeth A. Chiappetta, Esq.***

My first Message as the President of the Western Pennsylvania Trial Lawyers…this almost seems as intimidating as the first day of school!

I would be remiss if I did not thank those who came before me, and who have cultivated our organization to where it is today. Thank you, especially, to our Immediate Past President, Sandra S. Neuman. No one is a better female role model than Sandy, who somehow manages to do it all at quite a high level. She is a great mother and wife, and of course an ardent advocate for her clients. She probably holds the record for conducting the quickest WPTLA Board of Governors meetings in the history of our organization, and that, among many other things, is something I seek to emulate!

I am excited to start this WPTLA year with a new take on some of our more seasoned events. I hope to inject some new ideas into what we've already created in an effort to increase participation and attendance. By the time this is published, I hope people will have enjoyed a great evening at the Carlton with wine tasting and pairings at our Kick Off Event! We have switched the location of our Steelwheelers 5K from the North Shore to North Park. The 5K is being held on Saturday, October 21. We are hoping a new location and a better 5K course will attract more runners. Registration is now open!

Change of location for a few events may be forthcoming, and even some menu changes at some of our "go-to" locations might switch things up a bit! As with all organizations of our type and size, membership wanes with every year. The Internet age lessens people's need to seek interpersonal relationships, and our lives all seem to get busier as the years go by. However, we must remember that keeping our organization strong helps keep all of our practices strong. Meeting and talking and cocktailing with our brothers and sisters of the plaintiff's bar is always a great way to network, bounce ideas off one another and be united in our representation of the injured.

With the new WPTLA year also comes the beginning of fall. Fall always reminds us of back to school, pumpkin spice everything, the return of football…and of course, fall trial lists! As we gear up for preparing our cases for trial after summer vacations, this is always a nice time to remember why we do what we do. We all have clients who have experienced things some of us could not even imagine. It is easy to get caught up in our "to-do" lists in preparing our cases for trial, but it is nice to remember that we are truly serving others. We are called counselors at law for a reason. We are *(Continued on Page 2)*

UPCOMING EVENTS FOR WPTLA

Join us in **North Park** for a fun and relaxing morning on **Sat., Oct. 21** at our annual **5K Run/ Walk/Wheel** to benefit the Pittsburgh Steelwheelers. Bring some cash for raffle prize tickets, and don't forget to bring your team for the 5K Firm Cup Challenge. See page 15 for details.

Make your plans now to attend the annual **Comeback Award Dinner** on **Wed., Nov. 8** at the **Cambria Hotel & Suites** in Pittsburgh.

Save the date for the 3 credit **CLE & Lunch** on **Tue., Dec. 5** in the **Grant Bldg** in Pittsburgh. Brendan Lupetin will discuss *Focus Groups 102*.

President
Elizabeth A. Chiappetta

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A MESSAGE FROM THE PRESIDENT *(Continued from page 1)*

serving others who do not necessarily have a voice, or those who do not have a voice loud enough to stick up to a large corporate bully. In the hustle and bustle and stress of digging into a case, try and remember this!

No event on our WPTLA Calendar evokes more of a reminder of why we do what we do than our Comeback Award. This year's recipient is Deidre Staso, Denny and Laura Phillips' client. Deidre survived a medical error but also chronic illness and personal turmoil. She now helps others facing hard times in her work with Transitional Paths to Independent Living (TRPIL). She has selected TRPIL as the charity of choice for WPTLA's donation. This year's award recipient was selected earlier than we typically announce our selection so that we can solicit local businesses to sponsor, attend or promote our dinner in more comprehensive way. Save the date for this wonderful event: Wednesday, November 8, 2017 at the Cambria Suites near PPG Paints Arena.

Enjoy the fall, bring home some plaintiff's victories at trial, and Go Bills! (I'm from Buffalo, NY).

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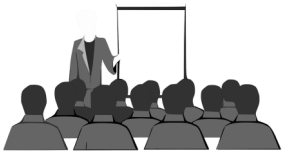
KICK OFF EVENT RECAP

*By: Jennifer L. Webster, Esq. ***

I attended the WPTLA kickoff event that was held on September 14th and 15th. Thursday evening consisted of a wine tasting and mini dinner event at the Carlton, which was a new venue for our events. It was a fun night of networking, great food, and an introduction to some unique wines.



On Friday, an open forum CLE, with breakfast, was held at the Cambria Hotel. It covered some really interesting issues in jury selection and mediation and featured seasoned trial attorneys, Larry Kelly, Paul Lagnese, and Rick Schubert. I appreciated the more relaxed atmosphere of the CLE and think it fostered some really open and frank discussions on issues that affect all of our practices. It was interactive and allowed everyone to bring up issues in their current cases, as well as discussing our own experiences with different judges and mediators.

Overall, I think the kickoff events were extremely worthwhile and fun. I look forward to attending similar WPTLA events in the future.

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INFORMED CONSENT AFTER THE SUPREME COURT DECISION IN SHINAL

*By: Veronica A. Richards, Esq.***

On June 20, 2017, the Pennsylvania Supreme Court ruled in *Shinal v. Toms* that the duty to obtain informed consent is the physician's non-delegable duty. The case involved a surgical procedure that resulted in hemorrhage, stroke, brain injury and partial blindness due to perforation of the carotid artery during the surgery. During the trial the jury was allowed to consider information that was provided to the patient by members of the surgeon's staff. The trial resulted in a defense verdict. The appeal that followed claimed it was an error of law to permit the jury to consider information that was not provided by the surgeon.

The majority's opinion was based upon its interpretation of The Medical Care Availability and Reduction of Error (MCARE) Act's definition of informed consent. Specifically, according to the Act: (a) Duty of physicians. – Except in emergencies, a physician owes a duty to a patient to obtain the informed consent of the patient or the patient's authorized representation prior to conducting the following procedures: (1) Performing surgery, including the related administration of anesthesia.

The Supreme Court ruled, "Without direct dialogue and a two-way exchange between the physician and patient, the physician cannot be confident that the patient comprehends the risks, benefits, likelihood of success and alternatives. Only by personally satisfying the duty of disclosure, may the physician ensure that consent is truly informed." The opinion further states, "Under the plain language of (MCARE) the duty to obtain a patient's informed consent for the several enumerated procedures, including surgery, belongs to the physician. Nothing in the plain language of the act suggests that conversations between the patient and others can control the informed consent analysis or can satisfy the physician's legal burden."

What practical implications does this decision raise for health care providers and medical malpractice attorneys? For health care providers this decision has significant implications. The reality of the practice of medicine is that many responsibilities are delegated to physician's assistants and nurse practitioners. In reviewing hospital policies, procedures, medical staff bylaws and privileges related to informed consent, many of the current guidelines do not comply with the law. I will be interested to learn whether the Department of Health and accreditation organizations surveying organizations for compliance will focus on informed consent issues during licensure survey or complaint investigation.

From a medical malpractice perspective, the case that is premised upon a failure to obtain informed consent should consider the physician's duty and the institutional systems in place to assure that compliance with the law is met. I am certain that we will see legislative efforts to lift what is now perceived as a burden on physicians. The Hospital Health System Association of Pennsylvania on behalf of the Pennsylvania Medical Society, Pennsylvania Society of Physician Assistants and the Pennsylvania Coalition of Nurse Practitioners has made this promise to its members. For more information on the health care provider's interpretation of the significance of this decision please go to: https://www.haponline.org/

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In This Issue

Features

News

Columns

COMMON LAW BAD FAITH: A NEGLECTED REMEDY

*By: James C. Haggerty, Esq. ***

Pennsylvania has long recognized a common law bad faith claim for the breach of the duty of good faith and fair dealing in insurance policies. As early as 1957, in Cowden v. Aetna, 134 A.2d 223 (Pa. 1957), the Supreme Court recognized that an insured (or its assignee) could sue an insurer for the breach of the duty of good faith and fair dealing to recover the amount of any verdict in excess of policy limits in the tort action. The Pennsylvania Courts have recognized this common law bad faith remedy, also, in the context of first party claims. See Birth Center v. St. Paul, 787 A.2d 376 (Pa. 2001). Practitioners have failed, however, to utilize this remedy in first party claims.

Too often, the statutory bad faith claim, alone, is asserted in the first party bad faith claim, e.g. UM, UIM, property damage, etc. The Legislature enacted the bad faith statute, 42 Pa.C.S.A. § 8371, in response to the decision of the Supreme Court in D'Ambrosio v. Pennsylvania National Mutual Cas. Ins. Co., 431 A.2d 966 (Pa. 1981). In D'Ambrosio, the Court refused to recognize a tort for the breach of the implied covenant of good faith and fair dealing. Section 8371 was enacted in 1990 in SubChapter G of Title 42, entitled "Special Damages". Section 8371 did not supplant or replace the claim for common law bad faith. Instead, as noted in Allstate v. Wolfe, 105 A.3d 1181, 1187 (Pa. 20014), § 8371 is a "mere supplementation of remedies" already existing at common law. In DeWalt v. Ohio Casualty, 513 F. Supp. 287 (E.D. Pa. 2007), the Court noted that bad faith by an insurer can give rise to two separate causes of action, namely: (1) a breach of contract action for violation of the implied duty of good faith; and (2) a statutory action under 42 Pa.C.S.A. § 8371. Id., at 291. This common law claim should be asserted, along with the statutory claim, in bad faith actions against insurers.

In the context of UM and UIM claims, the common law bad faith cause of action is particularly important. While the statutory bad faith claim is tried by the court, alone, the common law claim is to be heard by a jury. Where only a statutory claim is asserted, insurers will often seek to sever and stay that claim so that the bad faith discovery and trial are relegated to a time after the conclusion of the UM/UIM claims. The assertion of a common law bad faith claim may frustrate the insurer's strategy. Since the common law bad faith claim is to be tried before a jury, it is unfair and unjust to sever and stay the bad faith claims, thereby forcing the plaintiff to try the case before two different juries. When common law bad faith is asserted, the Court may likely permit discovery to proceed forward on both the UM/UIM claim and the bad faith claim with only the trial being bifurcated so that the bad faith claims are tried to the same jury immediately after the trial of the UM/UIM claim. In this situation, forcing the insurer to proceed forward with the bad faith action discovery may lead to a more prompt resolution of the entire case.

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President's Challenge 5K Run/Walk/Wheel
will be held on Saturday, Oct 21, 2017
at the North Park Boathouse, in Pittsburgh

STEELWHEELERS

Make your plans now to attend, and bring along your co-workers, family and friends. This is a relaxing and fun event for a worthy cause.

Registration is available on our website at wptla.org/event/5k-run-walk-wheel/

New this year, we are partnering with Anytime Fitness for an extra category involving running and circuit exercises. Look for more details at registration.

ANYTIME FITNESS

And don't forget about the **WPTLA 5K Firm Challenge**!

Details on page 15.

THE FACILITATOR: EFFECTIVE REPRESENTATION OF INSUREDS IN FIRST PARTY INSURANCE CLAIMS

By: Patrick J. Loughren, Esq. **

I. INTRODUCTION

> **fa·cil·i·tate:** to make easier **:** help bring about <*facilitate* economic recovery> Pronunciation: f&-'si-l&-"tAt; Function: *transitive verb*; Inflected Form(s): **-tat·ed**; **-tat·ing;** Date: 1611
>
> **fa·cil·i·ta·tor** /-"tA-t&r/ *noun* : one who helps bring about <the *facilitator* of economic recovery>

When asked to offer some commentary on the subject of the plaintiff's "case strategy" in statutory bad faith actions, the opportunity arose to share a "strategy" that was initially conceived in 1996, and which has been practiced since shortly thereafter when I was admitted to the bar. I can confidently say that the "strategy", or theory, presented herein is sound, effective and just. However, instead of discussing a strategy on how to handle statutory bad faith actions, I am instead going to talk about a "strategy" on how to handle first party insurance ***claims***.

You may be asking, "How will a discussion about handling a first party insurance claim assist me in prosecuting an insurance bad faith claim?" Well, bad faith claims arise out of first party insurance claims. And, in the majority of statutory bad faith claims that are filed, the plaintiff (i.e. the insured/underlying claimant) was represented by counsel throughout the underlying claim during which, it is alleged in the bad faith claim, the insurer acted in bad faith. Indeed, most of the time, the attorney that files the bad faith claim is the same attorney who represented the insured in the underlying first party insurance claim. This attorney frequently makes mistakes in file handling leading to predictable, yet preventable, defenses to the later bad faith claim.

The necessity to formulate an effective strategy to handling first party insurance claims arose out of the defenses being raised to subsequently filed bad faith claims. There is a laundry list of affirmative defense the carriers make to statutory bad faith claims, but the most effective defenses are those that focus on the conduct of the insured, and even more so, the insured's attorney. I speak of the so-called affirmative defense of "reverse bad faith":

a. The insured's lawyer said he would provide us with information and he never did.

b. The plaintiff's lawyer wouldn't produce his client for examination under oath, produce his client for a medical examination, return telephone calls and/or respond to letters.

c. The insured's lawyer made unreasonable demands on us to act in time periods that we couldn't possibly meet even if our entire staff were assigned to this claim.

The availability of "reverse bad faith" to an insurer in a bad faith claim means only one thing: the plaintiff's attorney did not effectively represent his client in the underlying claim for first party benefits. Indeed, even if the claimant's counsel was able to obtain a payment of first party benefits at or near the policy limits in the first party benefits claim, that fact will not vitiate, nor exonerate, counsel's conduct in concomitantly providing the insurer with a viable affirmative defense to the bad faith claim. And, where the claimant's counsel determines that the insurer acted in bad faith and subsequently files a bad faith claim on behalf of his client, there is no worse result than to have the bad faith claim dismissed on summary judgment because the court concludes that counsel's own conduct gave the carrier a reasonable basis for its alleged bad faith conduct.

Thus, the most effect "case strategy" in a bad faith claim is to effectively represent, in the first instance, the insured in the first party insurance claim. And that is an easy thing to do, although it is respectfully submitted that not enough thought is given to the manner in which counsel should proceed when representing insureds in first party claims. When counsel is retained to represent an insured in a first party insurance claim, the only objective that the claimant's counsel should focus his efforts on is effectively representing the claimant in just that - - a first party insurance claim. The goal is to secure a fair payment of benefits to the insured for his loss, and one that is paid in a timely manner. Furthermore, from the minute counsel is retained, counsel should be cognizant of the fact that a bad faith claim ***may*** arise in favor of his client, and counsel should at all times act to protect his client's interests with respect to that putative bad faith claim.

As difficult as it may be to set aside our egos, claimant's counsel should concede that if an insurer is intent on acting in bad faith toward its insured, the insurer is going to do that regardless of who the insured's counsel is, and regardless of what the insured's counsel does during the course of the first party claim. Indeed, it is often the case during the prosecution of the underlying claim that claimant's counsel realizes that nothing is going to discourage the bad faith insurer from promoting ill will upon its insured - - not the law, not the obligations set forth in the contract, and

Continued on Page 6

THE FACILITATOR … *(Continued from Page 5)*

last, but not least, not the efforts of claimant's counsel.

Because the merit of a statutory bad faith claim revolves around the manner in which both the insurer and the insured acted in the underlying claim, and because counsel are usually involved in the underlying claim from the outset, I firmly believe that the plaintiff's "case strategy" in a statutory bad faith claim begins **not** after the filing of the bad faith action, rather, the "case strategy" begins when counsel is retained to represent the claimant in the underlying claim for first party benefits. Reduced to its essence, the case strategy in a statutory bad faith claim is simple to articulate: Handle the underlying contract claim perfectly. In order to do that, you must not be the litigator. Rather, you must be the **Facilitator**.

What follows hereinafter is what I call "The Facilitator" approach, or theory, to representing insureds in first party insurance claims. The approach is applicable, with limited exception, to all claims for first party insurance benefits: uninsured/underinsured motorists benefits, first party medical benefits, first party income loss benefits, homeowner's benefits, fire insurance benefits, business interruption, private income disability benefits, life insurance, credit life and credit disability. In the discussion that follows, I will present the fundamentals of the theory using a typical claim for underinsured motorist benefits - - a first party insurance coverage offered under most automobile policies of insurance. I will present a hypothetical set of facts which give rise to the UIM claim. I will then discuss how the ***Facilitator*** approaches his role as the claimant's attorney in such a claim, and compare and contrast that to how many attorneys currently prosecute such claims on behalf of the insureds. Finally, to the extent that it is not apparent, I will comment on how the ***Facilitator*** approach to handling first party insurance claims protects the insured's right to seek redress for statutory bad faith by eliminating from the insurer's arsenal of defenses the so-called defense of reverse bad faith.

II. THE EXAMPLE

Since the rest of this paper is based upon the following example, it is important that you read it carefully. In the example, you are retained to represent Mr. Injured who was injured in a motor vehicle accident. Mr. Injured was operating his own vehicle, which he insured under a policy of auto insurance which provides for $100,000.00 of underinsured motorists benefits, $5,000 in first party medical benefits, and full tort. The policy does not provide income loss coverage. At the time you are retained, you do not know if the tortfeasor is insured, or, if he is in fact insured, the amount of his liability limits. You enter into a contingent fee agreement with the client that sets forth the contingency as well as the fact that you will front the costs of pursuing your client's rights, however, the fee agreement provides that the costs expended will be reimbursed to you upon settlement, verdict and/or arbitration award.

The client reports that the tortfeasor, who was intoxicated, ran a red light and crashed into the driver's door of the vehicle that the client was operating. You quickly determine that liability is reasonably clear. The client also reports that he sustained a comminuted fracture of his left lower extremity requiring internal fixation; a concussion, cuts, abrasions, bruising and other soft tissue injuries. He was emergently admitted to the hospital whereupon he underwent open reduction, internal fixation of his fracture. The client is unmarried. He is employed and has lost wages in the amount of $7,000.00. His medical expenses incurred to date amount to $25,000.00 well over the first party limit of $5,000. His employee health plan is a self-funded ERISA plan. He is currently in physical therapy, future medical care once therapy ends is expected to consist of routine six-month check-ups and yearly radiographic studies of the leg. He has been advised that he will never walk correctly again, and he is at an increased risk of arthritis.

For $15.00, you obtain the police report which identifies the tortfeasor's liability carrier. You contact that carrier and are advised that the tortfeasor has liability limits of $15,000. After providing that carrier with some of the medical bills that have been sent to your client which sufficiently support your recitation of the client's injuries, the adjuster indicates that the limits are being tendered which is confirmed in a writing to you.

You are then a prepared to pursue the underinsured motorist claim. Reduced to its essence, you've got a clear liability claim with $32,000 in specials where $15,000 has been offered and $100,000 in additional UIM benefits are available. What do you do?

III. THE CRITICAL POINT IN TIME

In the example, the tortfeasor has minimal liability limits that obviously fail to compensate the client for his injuries and damages and you are prepared to present a claim for UIM benefits. This is what I refer to as the ***critical point in time***, because at this time the duties under the UIM policy are activated. The insured must seek a waiver of subrogation, and cannot prejudice the UIM insurer's rights. And the UIM insurer must perform its obligations under the contract once the claim is submitted.

There is a ***critical point in time*** in every claim for first party benefits, and counsel for the insured is required to appreciate that and see to it that the insured performs his contractual obligations that are conditions precedent to obtaining coverage. In the context of underinsured motorist benefit claims, the ***critical point in time*** is the moment that claimant's counsel becomes aware of the tortfeasor's liability limits. For it is at this moment that you can determine whether the tortfeasor is, in your opinion, underinsured, and you can thereafter advise the UIM insurer of the amount of the limits and submit the UIM claim. In a claim where it is determined that the tortfeasor is ***uninsured***, the moment that you learn that fact is the ***critical point in time*** with respect to presenting a claim for uninsured motorist benefits. In a hit and run or phantom

Continued on Page 7

THE FACILITATOR … *(Continued from Page 6)*

vehicle claim, the ***critical point in time*** is more urgent, as most policies require the police to be notified of the happening of the accident in 30 days. Disability income, fire, homeowners and most other policies have notice provisions that must be satisfied which are usually determinative of when the insurer's duty to fairly and promptly evaluate the loss begin.

Returning to the UIM first party claim, it is, of course, not necessary for the claimant to exhaust the tortfeasor's liability limits prior to making a UIM claim. The courts long ago rejected the carrier's argument that the insured must "exhaust" the liability limits of the tortfeasor prior to receiving UIM benefits. To the extent that the claimant does not exhaust the liability limits of the tortfeasor, the UIM carrier is entitled to a credit of the full limits of liability maintained by the tortfeasor. Furthermore, recent case-law holds that the UIM claim can be arbitrated prior to the claimant receiving ***any*** payment from the tortfeasor's liability insurer. Thus, where the liability carrier for the tortfeasor unreasonably refuses to offer any money, the UIM insured can proceed to arbitrate the UIM claim. However, claimant's counsel must nevertheless learn the tortfeasor's liability limits prior to making a claim for UIM benefits because, if the tortfeasor has $5,000,000 in coverage, and the value of the loss does not exceed that amount, there is no sense in wasting the client's money by arbitrating a UIM claim that is destined to fail because the tortfeasor is not underinsured. Therefore, the ***critical point in time*** with respect to UIM claims is that point in time that you can reasonably conclude that the tortfeasor is, in fact, underinsured for the injuries and damages sustained by your client.

Once you determine that the tortfeasor is underinsured, and the insurer is put on notice of a UIM claim, it is at this point in time that both parties' contractual obligations to one another are triggered. It is at this point in time you must become the ***Facilitator***.

IV. THE CONTRACT

Before we proceed further, it is important to review the typical policy language governing the relationship between the insurer and the insured. The following UIM provision is representative of that which appears in auto policies on practically a nationwide scale:

INSURED PERSONS' DUTIES

1. The **insured** must:

   a) submit written proof of the claim to us. It must be under oath, if required. It must include:

      (1) the nature and extent of injuries;

      (2) treatment; and

      (3) any other details which could affect the amount of payment.

   b) provide all facts of the accident and the name of all witnesses.

   c) answer questions under oath as often as we require with good reason.

   d) be examined by doctors chosen by us as often as we require with good reason. At our request, the injured person must promptly authorize us to:

      (1) speak with any doctor who has treated him;

      (2) read all medical history and reports of the injury;

      (3) obtain copies of wage and medical re ports and records; and

      (4) obtain copies of all medical bills as they are incurred.

2. After notice of claim, we require the insured to take legal action against any liable party.

3. An insured may bring legal action against the other party for bodily injury. A copy of any paper served in this action must be sent to us at once.

4. The insured must:

   a) obtain our written consent to:

      (1) settle any legal action brought against any liable party; or

      (2) release any liable party.

   b) preserve and protect our right to subrogate against any liable party.

Notice, there are many duties articulated in the insuring agreement that the insured has promised to perform. Sworn examination under oath, medical examinations, providing access to documents, providing information about the accident, etc., etc. As counsel for the insured, you are expected to know what the your client's obligations are, and see to it that he performs

Continued on Page 8

THE FACILITATOR … *(Continued from Page 7)*

them. You client has a duty to cooperate under the policy, and the failure to do so will not only delay the resolution of the claim, but it may, in extreme cases, compel the carrier to deny any obligation to provide benefits.

V. THE WRONG WAY TO MAKE A UIM CLAIM

Returning to our example, we left off at the point in time where the tortfeasor's liability carrier has offered the liability limits of $15,000. Counsel for the claimant is ready to contact the client's UIM carrier. Counsel is aware that the insurer is obligated to investigate the claim in a timely manner and pay a fair amount of UIM benefits, and counsel also knows that receiving a fair amount of benefits, in a timely manner, is exactly what the client wants to have happen after the claim is submitted. The question is, what is the most effective way to achieve this result on behalf of the client?

I have informally interviewed probably 70 to 100 attorneys in the past several years regarding the manner in which they would prosecute the hypothetical UIM claim. Ninety percent of the attorneys who were interviewed told me generally the same story. Once the tortfeasor tenders his liability limits, they would write to the UIM carrier and *demand* that the UIM carrier waive subrogation in 30 days or tender its check for the amount of the offer. They would briefly describe the client's injuries which description would be followed with a *demand* for UIM policy limits ($100,000). Furthermore, they would mention that if the policy limits were not paid within 30 days, arbitration would be *demanded*.

Unfortunately, and even in the hypothetical where I believe that the damages that have been described most likely warrant the payment of the full UIM policy limit, **this is all improper**. You see that at the very same moment the insurer has been advised of the existence of a UIM claim, the insurer has been told to pay its entire policy limit in 30 days or risk being sued for bad faith. The carrier has no medical records, no police report, no liability evaluation - - it has nothing. Just how meritorious would the threatened bad faith claim be? As will soon be quite apparent, it is my impression that 90% of the attorneys I spoke to ineffectively pursue UIM claims on behalf of their clients. Indeed, if my informal survey is representative of the claimant's bar, my conclusion is that the typical manner in which UIM claims are presented is contrary to the express terms of the UIM policy, contrary to the insured's obligation to act in good faith under the policy, and contrary to the insured's interests in protecting his right to file a bad faith claim should the UIM carrier elect to act in bad faith in handling the UIM claim. In fact, presenting such claims in such a manner will most likely economically harm the client since it necessarily either increases the costs expended to recover UIM benefits, or unnecessarily delays the ultimate payment of benefits, or both.

VI. THE FACILITATOR IN ACTION

> **Discourage litigation. Persuade your neighbors to compromise whenever you can. Point out to them how the nominal winner is often the real loser -- in fees, expenses, and waste of time. As a peacemaker, the lawyer has a superior opportunity of being a good man. There will always be enough business.**[2]

The ***Facilitator*** theory in action is quite simple and can be demonstrated through a sample correspondence. In fact, the whole theory, in essence, **is** a single correspondence - - what I call ***The Initial Correspondence***. Indeed, by means of ***The Initial Correspondence*** delivered to the UIM carrier at the ***critical point in time*** wherein the tortfeasor has offered policy limits (or a lesser amount that is nevertheless acceptable), counsel for the claimant will be doing what the typical claimant's attorney utterly fails to do. He will be (1) assuring that his client satisfies all of his obligations under the UIM policy necessary for the insured to receive UIM benefits; (2) assuring that he has taken every contractually required step to effectuate a prompt and thorough evaluation of his client's claim by the carrier and (3) assuring that if the UIM insurer is intent upon handling the UIM claim in bad faith, the subsequently filed bad faith claim will be exceptional as many of the defenses raised in opposition to bad faith claims will not be available to the insurer. Thus, returning to our example, here is ***The Initial Correspondence*** that I would send out:

Dear Sir/Madam:

Please be advised that I represent your insured, Mr. Injured, with respect to the injuries and damages he suffered in the above-captioned accident. The operator of the motor vehicle responsible for this accident is Icant Drive who resides at 456 Negligence Way, Pittsburgh, PA 15219.

I am pleased to advise you at this time that Mr. Drive's liability carrier, Super Risk Ins. Co., has tendered its policy limits of $15,000.00. I have enclosed a copy of Super Risk's 10/10/96 correspondence indicating the offer. I have also enclosed a copy of Mr. Drive's declarations page as well as the proposed General Release of all claims.

At this time, I am requesting that you initiate an investigation as to whether you will waive your right of subrogation against Mr. Drive and authorize me to accept on behalf of Mr. Injured the tendered limits in exchange for an executed general release of all claims my client may have against Mr. Drive. Please advise in a reasonable time whether you will be willing to waive subrogation. If you are not willing to waive subrogation, please forward your check made payable to "Mr. Injured and Loughren, Loughren & Loughren, P.C., his attorneys".

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[2] *Abraham Lincoln. Lincoln Talks — An Oral Biography, P. 52 (Emanuel Hertz ed. 1939).*

Continued on Page 9

THE FACILITATOR … *(Continued from Page 8)*

I am also advising you that due to the woefully low limits of liability insurance maintained by the tortfeasor, my client has not been fully compensated for the injuries and damages sustained in the aforementioned accident. Therefore, my client is hereby submitting a claim for underinsured motorists benefits. In that regard, and in order to facilitate your investigation and evaluation of this claim, I have enclosed for you the following:

1. **A copy of the City of Pittsburgh Police Accident Report relative to the above referenced accident which sets forth the facts giving rise to the accident and the names of all known witnesses;**

2. **Eleven (11) medical records authorization release forms addressed to the eleven (11) health care providers and/or facilities who and/or at which my client received care and treatment for the injuries sustained in the above-captioned accident which authorizations permit you to collect and review my client's medical records;**

3. **One (1) employment records authorization permitting you to obtain any and all records from my client's employer, Work-Like-A-Dog, Inc;**

4. **One (1) authorization permitting you to obtain copies of my client's federal and state tax returns for the past 5 years;**

5. **One (1) authorization permitting you to obtain and review my client's first party benefits file; and**

6. **Color copies of my client which depict the scars, contusions and abrasion he sustained as a result of his injuries, as well as photographs which depict the property damage to his vehicle.**

As your first party file surely reveals, your insured sustained a very serious comminuted fracture of the left tibia requiring internal fixation with a metal rod and screws. He was hospitalized for nine (9) days at General Hospital and underwent five months of physical therapy subsequent to his operation. He has scars on both sides of his left leg which are permanent. He also suffered serious bruises and contusions in the accident which are clearly set forth in the enclosed photographs. Due to his injuries, your insured was off work for such a time period that he lost $17,000 in wages. The medical expenses incurred to date are $30,000, $5,000 of which have been paid by your company.

Your insured is ready and willing to submit to Examination Under Oath whereupon he will answer any questions you may have with respect to the happening of the accident, and the manner in which the injuries he sustained have affected his life. If you would like to meet your insured and examine his scars, please let me know and I will immediately make him available.

Your insured is also ready and willing to submit to a Medical Examination by a physician that you chose and pay if you reasonably believe that you require such an examination be performed. If you believe that such an examination is necessary, please advise me of the reasons why and if I agree that your request is reasonable my client will be immediately available for the examination.

Kindly notify me in writing, within a reasonable time, of course, whether or not you will waive subrogation and authorize my client to accept the $15,000 limits of the tortfeasor in exchange for an executed release.

Please utilize the enclosed authorization to collect whatever information you believe you require to promptly and fairly evaluate my client's claim. Please note that the authorizations that have been provided are effective for ninety (90) days.

Once your investigation is complete, please advise as to what amount of UIM benefits, if any, you believe will fairly and adequately compensate my client for his injuries and damages.

Please be advised that Mr. Injured is ready, willing, and able to assist you in any manner you require with respect to your evaluation of this claim. Should you require any additional information, please let me know.

I look forward to hearing from you.

Very truly yours,

PATRICK J. LOUGHREN, ESQUIRE

PJL:bp
Encl.

VII. THE BENEFITS OF BEING THE FACILITATOR

That one single correspondence is the entire ***Facilitator*** theory in practice. The ***Facilitator*** does not have to write any more correspondence to the insurer. The insurer, not the claimant's attorney, is responsible for evaluating the claim and making an offer of benefits. Upon receipt of the ***initial correspondence*** there is nothing that the insured is obligated by policy to make

Continued on Page 10

THE FACILITATOR *... (Continued from Page 9)*

available that the insured has not made available. What about the date, location, witnesses to and manner in which the accident happened? See police report. How about the nature and extent of injuries? See medical records, first party benefits file, or ask for an IME or EUO. Employment information and lost earnings? See employment authorization already addressed to the employer. Past earnings history? See tax authorizations. Any disfigurement? See photographs. The insured's compliance with the policy is precise, complete, and apparent.

What most lawyers fail to appreciate is that the insured's obligation to ***cooperate*** with the insurer's investigation does not mean that the insured has to ***perform*** the insurer's investigation. How this injures the client will be discussed in more detail hereinafter. But the distinction between cooperation with an investigation, and performing an investigation, must be emphasized. Reviewing the ***initial correspondence*** it is quite clear that performing the investigation into the ***Facilitator's*** client's claim should be quite easy for the insurer, since the ***Facilitator*** has provided the insurer with access to everything that the insurer needs. And what the insured cannot provide (IME and EUO), he has offered to make himself for, assuming that the insurer asks him to submit to EUO (examination under oath) and. I.M.E. (***insurance*** medical examination).

Once the ***initial correspondence*** leaves his office, at all times **via certified mail**, the ***Facilitator*** feels good about himself. He has made sure that his client has totally complied with his obligations under the contract, and he has made it very easy for the insurer to investigate, evaluate and pay his client's claim. He knows that the responsibility to act is now on the insurer. The ***Facilitator*** does not have to do anything more. Indeed, since the ***Initial Correspondence*** is always sent via certified mail, the ***Facilitator*** doesn't even have to write to ask if the insurer received it. All he has to do is wait. Will they ask for an IME? Will they ask for an EUO? Will they make an offer of benefits? Or, will they do nothing? Time will tell. But if the insurer does nothing, the ***Facilitator*** knows, with certainty, that the insurer has no reasonable basis for doing nothing, and if the failure to act gives rise to a statutory bad faith claim, the ***Facilitator*** knows that the insurer will not have available the defense of reverse bad faith.

And how much of the client's money has the ***Facilitator*** spent? The police report costs about fifteen ($15) to obtain, and it was necessary for the third party claim anyway. The only other costs incurred were the nominal costs for color copies of pictures, copying and postage. The total costs do not exceed $25.

VIII. THE FACILIATOR VS. THE LITIGATOR

It is important to scrutinize the difference between the typical attorney (i.e. the **litigator**) and the ***Facilitator*** in order to see if the proposed approach to representing insureds in first party

Continued on Page 11

MEMBER PICTURES & PROFILES

Name: Gianni Floro

Firm: Gianni Floro, P.C.

Law School: Duquesne University

Year Graduated: 2000

Special area of practice/interest, if any: Civil Rights

Tell us something about your practice that we might not know: My federal practice includes the Middle District of Pennsylvania.

Most memorable court moment: The Court's tipstaff had fainted and everyone just froze for what seemed like a minute, and then Defendant Doctor came off the stand to render assistance.

Most embarrassing (but printable) court moment: Forgetting my suit coat at home, and appearing (at the mercy of the Court) without a suit coat.

Most memorable WPTLA moment: Good dialogue at recent focus group CLE.

Happiest/Proudest moment as a lawyer: Getting sworn into the United States District Court for the Western District of Pennsylvania with my wife.

Best Virtue: Tenacity.

Secret Vice: Mortadella.

People might be surprised to know that: I enjoy hunting in Canada.

Favorite movie: Raiders of the Lost Ark

Last book read for pleasure, not as research for a brief or opening/closing: Team of Rivals

My refrigerator always contains: Oranges

My favorite beverage is: Water

My favorite restaurant is: Tessaro's

If I wasn't a lawyer, I'd be: Carpenter

THE FACILITATOR … *(Continued from Page 10)*

claims is actually more effective than the typical manner in which such claims are prosecuted. there are two questions to ask.

The litigator, as has been discussed, writes to the carrier, demands a waiver of subrogation and demands a payment of UIM policy limits. He provides the insurer with no other information, nor with the ability to obtain any other information. Will he be able to put his file in the cabinet and wait for the offer of benefits? Most likely that will not be the case. The insurer who receives the litigator's initial correspondence will necessarily be compelled to ask for medical records, the identity of the tortfeasor, the police report, etc., etc. Furthermore, in light of the threatened arbitration, and the impossibility of evaluating the claim in 30 days even if policy limits will ultimately be offered, the claim representative will either assign the file immediately to counsel. If the file is assigned to counsel, that will result in interrogatories and requests for production being issued. Even an issue as simple as providing authorizations has become an exercise for the litigator. Since authorizations were not provided at the outset of the claim, the carrier has a reasonable time to send them to the litigator, who must send them to his client, who must send them back to the litigator, who must then forward them to the insurer, after which the insurer will wait for the answers to interrogatories in order to know who to send the authorizations to. **Time**, ***time***, ***time***, is wasted. In the end, the litigator gets just what he doesn't want, litigation.

While the ***Facilitator*** sits back and watches the carrier do (or not do) what it is contractually obligated to do, the ***litigator*** is swamped with paperwork and finds himself basically performing the carrier's investigation himself. While the ***Facilitator*** properly places the responsibility and cost of investigation upon the insurer, the litigator and his client will be answering interrogatories, collecting medical records, or providing authorizations. Indeed, by approaching the claim as an aggressor, stirring up litigation, the litigator has achieved nothing but misery.

And what about the costs? We've seen how the ***Facilitator*** spent less than $25 to present his client's claim. The ***litigator***, on the other hand, impulsively undertakes to collect what he believes the carrier requires in order to evaluate the claim. He collects all available medical records (**$$**); he solicits narrative reports from treating physicians (**$$**); he retains an economist in order to obtain a lost earnings narrative (**$$**); he photocopies all of the records (**$$**); he tabulates and summarizing the contents of the medical records and narratives into a "package" (**$$**). It is simply outrageous that attorneys spend their client's money to spoon feed an insurer with information that the insurer is obligated to obtain pursuant to its good faith obligation to investigate the insured's claim. Furthermore, where the UIM benefits are insufficient to compensate the insured in the first place, as in the example, such conduct is particularly egregious. The hundreds, or perhaps thousands of dollars spent by the litigator does nothing more than further economically injure his client.

Reviewing the duties of the insured as set forth hereinabove in the sample contract language, it is clear that **nowhere** in the policy is it set forth that the insured and/or his counsel is responsible for making a determination as to what the carrier requires to evaluate and pay the claim. **Nowhere** in the policy is it set forth that the insured and/or his counsel is required to collect such documentation and provide it to the carrier. **Nowhere** in the policy does it say that the insured has the right to make a **demand** upon the insurer for "policy limits" or, for that matter, any amount of benefits.

Some attorneys may say, "Hey, that's the way these claims have been handled for years." To the extent that the above contractual analysis does not clearly demonstrate that "the way its been done for years" is improper, the intelligent response is to educate by example. People used to think cigarettes were good for you, Pintos were great cars, and insurers kept their insured's best interests in mind when they evaluated claims. "That's the way it's always been done," is not a sound reason to economically, and improperly, injure your client, and it is not a cognizable defense to a claim for legal malpractice. Doing the insurer's job, to the economic detriment of the client because "that's the way it's always been done," is the manifestation of herd mentality that upon proper reflection should be seen as such.

In fact, the ***litigator's*** decision to undertake the responsibilities contractually imposed upon the carrier often results in a delayed resolution of the claim. If I were a claim representative who received a letter from a ***litigator*** that said, "I am advising you that we're demanding the payment of policy limits. In that regard, I will be providing you with my client's complete medical chart, lost wage summary and all other documentation substantiating this clear claim for policy limits," I'd know that I didn't have to do anything on the claim until the attorney did what he promised to do. I can set the claim file aside until the attorney gets around to submitting the documentation, and I can mark my file to indicate that I will not have to spend one single penny on the investigation of the claim. Furthermore, I know that **any delay** in the ultimate reso-

Continued on Page 12

THE FACILITATOR … *(Continued from Page 11)*

lution of the claim can most likely be attributed to the attorney's decision to undertake to investigate the claim for me. In fact, I now have a reasonable basis for not investigating the claim, to wit, the attorney agreed to do the investigation for me. Finally, as is often the case that once counsel does submit those documents he believes are necessary for the carrier's evaluation, I know I'll be able to write to him to ask for the information that he did not submit, but I'll only be able to do that, of course, once I've taken a month or two to read what he has submitted. All of this delay and expenditure of money is absolutely unnecessary, it economically injures the client, and it could well extinguish any putative claim against the carrier for bad faith failure to investigate and pay the claim in a timely manner.

IX. THE INSURER'S RESPONSE TO THE FACILTATOR'S INITIAL CORRESPONDENCE

How does the insurer respond to the ***Facilitator's*** initial correspondence? Well, I can tell you that I have never had an adjuster write the following letter:

> Dear Mr. Loughren:
>
> I received your initial correspondence. Thank you for making my job so easy. I'm evaluating the request that we waive subrogation. I've sent out the authorizations, and when I receive the records, I'm going to promptly evaluate them. However, while I'm waiting for the records to arrive, I like to take you up on your offer to have the EUO and IME performed as I want to learn as much as I can about this loss. Would you please provide me with dates upon which you and your client are available?

Of course, an insurer intent upon acting in good faith and performing its contractual duties to fairly and promptly investigate, evaluate and pay an insured's claim would put the authorizations to use, evaluate the information obtained and make an offer of benefits. Does this ever happen? Not too often, in fact, it rarely happens. In fact, in my experience, the response to the ***Facilitator's Initial Correspondence*** is a call from a very confused UIM claim representative who asks me what I intend by the ***initial correspondence***. I never really have understood this inquiry. Anyone who reads the initial correspondence should clearly be able to understand that what I would like the carrier to do is investigate the claim and make and offer of benefits that will fairly and adequately compensate my client. That response is usually not well received, although I have yet to this day to figure out why. The claim representative then usually asks me what "my" demand is on the claim, usually couched in questions like "What's this case all about?" "What's your client want?" "What's it going to take to shut this claim down."

When I'm asked those questions, I advise the adjuster that I am the facilitator of my client's claim to the insurer. My job is not to collect medical records, and I have not done that. My job is to not evaluate the claim, and I have not done that. My job is not to investigate the claim, and I have not done that. My job is simply to ensure and assure that the insured performs his contractual obligations, which he has done, and that the insurer performs its contractual obligations, which is to fairly and promptly investigate, evaluate and pay the claim. That response is also usually not too well received.

In the end, most adjusters say something along the lines of "I'm not going to do anything until you make a demand," or "Once you provide the documentation to support the claim, I'll be in a position to make an offer." **If they in fact proceed in that manner, they are acting in bad faith.** I always ask them to put that advice in writing. Other times, the adjuster will make an offer of $5,000, despite the fact that absolutely no investigation has been done, and despite the fact that that amount is woefully inadequate to compensate the insured for his losses (such as in the hypothetical example). I always request that all offers of benefits be confirmed in writing, and I always confirm in writing to the adjuster offers that are made orally. Usually, the adjuster will confirm the oral offer in writing.

But, while the ***Facilitator*** would like to see the insurer perform its contractual obligations in a timely manner, the ***Facilitator*** is not one to beg the insurer to do its job, nor should he be. The insurer who fails to perform its contractual duty, does so at its own peril. And the facilitator, cognizant of the statutory remedy for bad faith, will begin to document the carrier's failure to fairly and promptly evaluate the UIM claim.

Sometimes, the UIM carrier pays value on the claim in a very short time and when that occurs I feel quite confident that I have ably served my client. However, most times, the end result of the ***facilitator's*** efforts is that while the insurer usually waives subrogation in a timely manner, the insurer does not use the authorizations in the 90 period that the authorizations were effective and, in fact, the insurer does nothing to investigate the claim. At around the three month anniversary of the ***initial correspondence***, the adjuster receives a short note wherein inquiry is made as to the status of the claim evaluation. The adjuster is reminded that the insured remains ready, willing and able to sit for IME or EUO. The adjuster is asked to call if any additional information is needed. No call is received, and at this time, the ***Facilitator*** starts to undergo a metamorphosis into the litigator. Thirty days later, and now a full blown ***litigator***, counsel writes to the insurer and states as follows:

Continued on Page 13

THE FACILITATOR … *(Continued from Page 12)*

> This claim was submitted four months ago. To date, there have been no offers of benefits extended by you to my client. The policy's arbitration clause states that where "you and we" disagree as to the amount of benefits due and owing under the policy, either side may demand arbitration. Please be advised that your insured is hereby demanding arbitration under the policy. John Stoof, Esquire is the claimant's arbitrator. Please appoint your arbitrator within a reasonable time. Thank you.

The next response you will get is an appearance by counsel. This will be followed up with interrogatories and a request for production, included with which will be authorizations. Confirm that the initial authorizations were never used. Decide whether or not to answer the interrogatories. There is nothing in the policy which suggests that the insured has to answer interrogatories. Furthermore, the carrier has not yet requested an EUO. Document that fact as well.

What happens after the insurer retains counsel is so routine that it would be environmentally destructive to waste paper writing anything more than to mention that the EUO will take place, perhaps an IME, the arbitration panel established, calendars will be shuffled back and forth, and the claim paid on or near the date of the arbitration hearing. The only additional comment necessary with respect to the ***faclitator/litigator's*** duties that he is to remain **steadfast** in his efforts to cooperate with the insurer. He is also to remain steadfast in his resolve to receive the carrier's written evaluation of the client's claim without first placing his own value on the claim and "demanding" that amount as a "settlement". Remember, the lawyer is facilitating a contractual relationship in which the carrier promised to evaluate and pay covered claims. The carrier did not promise to only pay claims in which the insured retains counsel who makes demands upon the carrier. An effective advocate should have the arbitration within four months. If the insurer does not appoint its arbitrator, counsel files a petition to appoint the arbitrator. Some attorneys, like me, file a petition to appoint the neutral if the insurer does not appoint its arbitrator in a timely manner. Indeed, if the insurer does not want to voluntarily select its arbitrator, there is nothing wrong with that. However, the insurer's decision to not exercise its right to select an arbitrator should not prejudice the insured's right to establish an arbitration panel. The policy, of course, states that the insurer's selected arbitrator and the claimant's selected arbitrator will agree on the third arbitrator. However, if the insurer never appoints an arbitrator, this exercise cannot take place. Implied in the policy is the fact that both sides will appoint their arbitrator's in a reasonable period of time. Thus, where the insurer refuses to appoint its arbitrator, a petition to appoint the neutral is certainly appropriate. If the court does not grant that petition, the court will either appoint the carrier's arbitrator and/or order the carrier to appoint its arbitrator immediately. If the panel is not established within 30 days of the carrier appointing its arbitrator, return to court and have the third arbitrator appointed by the court. Then, make sure that you expeditiously have the arbitration date established. The UIM claim (such as the one in the example) will settle for policy limits prior to you opening your mouth at arbitration.

Lastly, the comment must be made, **under no circumstance**, **ever**, should a general release be signed in any first party insurance claim, unless your client is receiving consideration for the release of those putative claims that exist beyond the contract claim.

X. BAD FAITH

Some may say that the facilitator approach is a failure, as demonstrated in the hypothetical which resulted in the insured having to litigate his claim through discovery and preparation for the arbitration hearing. But those individuals are mistaken. While they view the litigator's conduct in spending his client's money and performing the insurer's job as laudable because the litigator may get the claim paid in a shorter period of time, they fail to appreciate that the payment made on the claim is the only recovery the client will receive. We earlier agreed that the $100,000 UIM limits are insufficient to compensate the insured for his losses. Thus, when the $100,000 is reduced by the litigator's fee and his costs the client goes home woefully uncompensated.

On the other hand, the facilitator's client has a claim for statutory bad faith arising out of the insurer's failure to investigate and pay the claim. The remedy in the bad faith action includes, of course, the fee taken by the ***facilitator*** out of the $100,000 UIM payment, interest on the $100,000 from the date the claim should have been paid and the date it ultimately was paid at the prime rate plus 3%, and punitive damages. The question is, does the bad faith claim have merit?

The facts that the facilitator will be able to prove at trial are that the insured complied with the policy in all respects. The carrier did not utilize authorizations for 90 days and, in fact, the carrier did nothing for ninety days. The carrier failed to request an IME for three months. The insurer failed to request an EUO for three months, and probably longer. The insurer's attorney served interrogatories that asked for information that had been available to the insurer since the day the claim was made. The same is true for request for production of documents. All of the information the carrier ultimately received, pursuant to which the carrier decided to pay the claim, had been available to the carrier for many, many months. Further, the result of the carrier's

Continued on Page 14

THE FACILIATATOR … *(Continued from Page 13)*

failure to investigate the claim and make an offer of benefits was that the insured had to institute legal proceedings (arbitration) in order to obtain benefits under the policy. Perhaps the insurer failed to appoint its arbitrator; dragged its feet in agreeing on a neutral arbitrator; dragged its feet in agreeing on an arbitration date. The bad faith claim has merit.

But, more importantly, what is the insured culpable of? Nothing. What is his counsel culpable of? Nothing. The facilitator wrote no nasty letters, he made no outrageous demands, he provided the carrier with everything necessary for the carrier to evaluate the claim, and his efforts at facilitating the insurer – insured relationship were rebuffed for no good reason. What, indeed, is the defense to the bad faith claim? The defense that the insurer must proffer is that it was negligent. While the court has the opportunity to determine, in the first instance on a motion for summary judgment, whether the insurer acted negligently, or with reckless disregard to the rights of the insured, where the insured did nothing wrong, and the insurer did absolutely nothing, the court will most likely let the jury (federal court) resolve the issue.

In the end, the facilitator has obtained the contract benefits for his underinsured client, and his conduct, coupled with the insurer's decision to act in bad faith, has created an opportunity for the facilitator to ensure that his client is fully compensated, and the insurer appropriately penalized. Is this not what the Legislature intended in enacting the Bad Faith Statute? Of course it is!

Good Luck.

*** Pat is a WPTLA Member with the firm of Loughren Loughren & Loughren P.C. Email: patrick@loughren.com*

LOCAL VERDICTS

In an effort to combat the common refrain that local juries never give money to plaintiffs, we want to publish your verdicts within the western district of PA. If you have had a recent verdict - within the past year - please forward that information to our Executive Director (laurie@wptla.org) for publication in the next issue.

Congratulations to our
2017 Comeback Awardee
Deidre Staso

Deidre is a client of Laura Phillips, of Phillips Phillips & Smith-Delach, of Washington County.

Deidre's chosen charity is TRPIL, of Washington, PA.

Mark your calendar to join us on
Wednesday, Nov 8, 2017,
as we honor Deidre and her accomplishments, as well as recognize the wonderful work of TRPIL, at the annual Comeback Award Dinner.

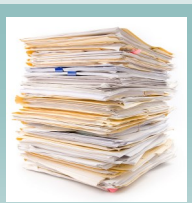
THE ADVOCATE

ARTICLE DEADLINES and PUBLICATION DATES

VOLUME 30
2017-2018

	DEADLINE	PUB DATE
Vol 30, No 2	Dec 1, 2017	Dec 15, 2017
Vol 30, No 3	Mar 3, 2018	Mar 23, 2018
Vol 30, No 4	Jun 19, 2018	Jun 15, 2018

We Need Article Submissions!!



This publication can only be as good as the articles that are published, and those articles come from our members. Please contact our Editor, Erin Rudert with any ideas you have, or briefs that could be turned into articles. Erin can be reached at 412-338-9030 or er@ainsmanlevine.com

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WPTLA 5K Firm Challenge

Prize: Trophy, presented to the winning team. Trophy will be in possession of the winning team for one year. It must be returned to WPTLA prior to next year's event. Includes bragging rights!

Rules:

- Four-person teams must consist of at least 1 current WPTLA member. All other team members must be either employees of the WPTLA member's firm, or immediate family members of the employees.
- Names of team members must be submitted to our Executive Director prior to race start.
- Fastest combined times of team will win trophy.
- Trophy will be in the possession of the winning firm for the duration of the year, after it has been updated, until the next 5K event, at which time it must be returned to WPTLA.
- WPTLA will pay the $1,000 prize to the winning team's charity of choice.

Register now at
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TRIVIA CONTEST

Enter for a Chance to Win a $100 Visa Gift Card

Trivia Question #12

In 1987, which American fast food restaurant opened its first Chinese location with its slogan inaccurately translated to read "eat your fingers off"?

Please submit all responses to Laurie at laurie@wptla.org with "Trivia Question" in the subject line. Responses must be received by Friday, Dec 8, 2017. Prize for this contest is a $100 Visa gift card. Winner will be drawn the week of Dec 11, 2017. The correct answer to Trivia Question #12 will be published in the next edition of The Advocate.

Rules:

- Members only!
- One entry per member, per contest
- Members must be current on their dues for the entry to count
- E-mail responses must be submitted to laurie@wptla.org and be received by the date specified in the issue (each issue will include a deadline)
- Winner will be randomly drawn from all entries and winner will be notified by e-mail regarding delivery of prize
- Prize may change, at the discretion of the Executive Board and will be announced in each issue
- All entries will be considered if submitting member's dues are current (i.e., you don't have to get the question correct to win - e-mail a response even if you aren't sure of your answer or have no clue!)
- There is no limit to the number of time you can win. Keep entering!

The correct answer to each trivia question will be published in the subsequent issue of The Advocate along with the name of the winner of the contest. If you have any questions about the contest, please contact Erin Rudert - er@ainsmanlevine.com.

Answer to the Trivia Question #11 - **In what country were sausages considered legal tender until 1990?**
Answer: East Germany.

Congratulations to Question #11 winner Bryan Neiderhiser, of Marcus & Mack, P.C.

BY THE RULES

*By: Mark E. Milsop, Esq. ***

VARIATIONS IN THE RULE TO SHOW CAUSE

The Superior Court recently offered its view on the difference between rules to show cause under as a matter of discretion pursuant to Pa. R.C.P. No. 206.5[1] and as of course pursuant to Pa.R.C.P. No 206.6.[2] That decision is reported as U.S. Spaces, Inc. v. Berkshire Hathaway Home Services, 2017 Pa.Super 174.

There, the issue was whether or not a Court in a county choosing the as of course rule can refuse a Rule to Show Cause. The Court concluded that where Rule 206.6 is employed, the court may deny a rule where "The allegations in the petition taken as true, do not provide for a legal remedy."

In the opinion of the undersigned, the U.S. Spaces, court misapprehended the rules since the standard it employed, while stated differently is analytically the same as Rule 206.5's requirement that the court shall enter an order issuing a rule if the petition is " properly pleaded and states prima facie grounds for relief.". As a result, the U.S. Spaces Court has eliminated any distinction between 206.5 and 206.6.

This leads to a more troubling problem. The U.S. Spaces Court while stating that the issue of the amount of proof that must be appended to a Petition under Rule 205.5 was not before the court created an apparent requirement of appending proof to a petition. Rule 205.5 creates not no such requirement of appending proof. Rather, a properly pleaded petition under rule 205.5 requires nothing other than the statement of a prima facie case. The ensuing hearing is the proper time and place to present such evidence. As such, the Court in U.S. Spaces has created confusion concerning rules where there previously was none. Now the question is whether or not wary practitioners will attach unnecessary evidence or whether courts will erroneously weigh evidence before granting a petition.

The apparent problem seems to be that by essentially interpreting Rule 206.6 to function exactly the same as Rule 206.5 the Court needed to explain why the two rules remained different. Hence, the erroneous dicta suggesting the need to append evidence to a Petition.

[1] Rule 206.5(c) provides:

> (c) If the petition is within the scope of Rule 201.1(a), is properly pleaded, and states prima facie grounds for relief, the court shall enter an order issuing a rule to show cause and may grant a stay of proceedings.

[2] Rule 206.6(a) provides in pertinent part:

> (a) A rule to show cause shall be issued as of course upon the filing of the petition.

SUMMARY JUDGMENT INVOLVING CONSTRUCTIVE NOTICE

A recent trial court decision reminds us that summary judgment should almost never be granted in a case involving constructive notice. In Brown v. Stroud Mall, 7599 CV 2013 (Monroe County), Judge Jennifer Harlacher Sibum provided an encyclopedic discussion of constructive notice in fall down cases. There, the plaintiff had suffered injuries when she tripped on a wire in a hallway in a mall. Although the plaintiff could not establish how long the wire was present, the evidence did establish that a mall guard was last present in that hallway ten to sixty minutes before the fall. The plaintiff also pointed to a persistent problem of children creating mischief at the mall. The court found that evidence sufficient to create an issue of material fact as to constructive notice. In doing so, the court quoted Commonwealth of Pennsylvania Department of Transportation v. Patton, 546 Pa. 562, 568, 686 A.2d 1302 (1997) for the proposition that:

> The question whether a landowner had constructive notice of a dangerous condition and thus should have known of the defect, i.e., the defect was apparent upon reasonable inspection, is a question of fact. As such, it is a question for the jury, and may be decided by the court only when reasonable minds could not differ as to the conclusion.

Patton, 686 A.2d at 1305

The Brown Court further identified the factors that should be considered in determining whether or not constructive notice has been established. Those factors include:

> the time elapsing between the origin of the defect and the accident, the size and physical condition of the premises, the nature of the business conducted thereon, the number of persons using the premises and the frequency of such use, the nature of the defect and its location on the premises, its probable cause and the opportunity which defendant, as a reasonably prudent person, had to remedy it.

Brown, at 9 citing Bremer v. W. W. Smith, Inc., 126 Pa. Super. 408, 411-12, 191 A. 395, 397 (1937).

Continued on Page 18

COMP CORNER

*By: Thomas C. Baumann, Esq.***

First Post Protz IRE Decision is Helpful

The Commonwealth Court had offered its first interpretation of *Protz v. WCAB (Derry Area School District), 161 A.3d 827 (Pa. 2017) (Protz II)* in *Thompson v. WCAB (Exelon Corporation) No. 1227 C.D. 2016*. This decision is helpful to individuals representing claimants.

Debra Thompson underwent an Impairment Rating Evaluation in October of 2005. The examining physician found an impairment rating of 23%. Thompson then received a Notice of Change of Workers' Compensation Disability Status changing her compensation from total disability to partial.

Litigation commenced between the parties in 2010 with the filing of a Modification and Suspension Petition by Employer. In 2011, the Claimant filed a Review Petition seeking to review the IRE determination because she had not reached maximum medical improvement. The Judge consolidated the petitions and found that the employer was entitled to modify the Claimant's benefits from total disability to partial disability. However, the Judge changed the effective date of the Modification Petition to a later date than that noted in the Notice of Change of Status.

Both sides appealed to the Workers' Compensation Appeal Board. The Appeal Board addressed only the issue of whether the claimant was time-barred from challenging her disability status. The board felt that she was as she did not file her appeal within the 60 day period following receipt of the Notice of Change of Status. Claimant appealed to the Commonwealth Court, but did not raise any of the constitutional issues associated with the *Protz* decision. Instead, one of the main issues was whether or not the Claimant was deprived of due process through the use of the Notice of Change of Status. In *Thompson I*, the court held that the Claimant was deprived of her due process right due to the inadequacy of the language of the Notice of Change of Status. The Commonwealth Court remanded to the Appeal Board at that point. In a decision dated July 18, 2016, the Appeal Board determined that an automatic modification of the Claimant's benefits under Section 306 (a.2) of the Workers' Compensation Act was appropriate and ordered the benefits to be modified from total to partial disability, effective August 30, 2005. The Claimant had received severance benefits after the cessation of employment in lieu of workers' compensation benefits. The appeal board determined that this period of benefits did not count toward the receipt of total disability. Therefore, the employer's requests for an Impairment Rating Examination was timely.

The Claimant then appealed to the Commonwealth Court. She raised for the first time whether the Workers' Compensation Judge committed error in modifying the claimant's benefits based on that IRE performed under the Fifth Edition of the AMA Guides to the Evaluation of Permanent Impairment. At the time of filing the appeal to the Commonwealth Court in *Thompson II*, *Protz I* had been decided by the Commonwealth Court. The Employer did not argue that the use of the Fifth Edition of the guides was not unconstitutional. It argued that Thompson failed to ***timely*** raise the constitutional issue. In other words, this is the waiver issue put forth by the defense bar. Footnote Four of the decision is confusing, yet instructive. It notes there, "Because this matter began before *Protz I* and *Protz II* were decided and this appeal implicates the validity of Section 306 (a.2)(1) of the Act, Claimant raised this issue at the first opportunity do so. *See* Pa. R.A.P. 1551(a). Thus, Claimant is not precluded from raising the issue of the improper use of the Fifth Edition of the AMA guides on appeal."

This decision potentially represents a mortal blow to the waiver issues being raised and/or contemplated by the defense bar. While the reasoning of the court is not especially developed in the above-mentioned language, this is a case all practitioners must use in dealing with the Protz case and waiver issues.

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BY THE RULES *... Continued from Page 17*

Westmoreland County Electronic Filing

Westmoreland County has adopted Local Rule 205.4 which permits electronic filing. There are some exceptions as to what can be filed. The most noteworthy of the exceptions are appeals from an arbitration award or to an appellate court and a precipe to reinstate or reissue a complaint or writ. Users of the system are deemed to have consented to accepting electronic notices from the Court. The full rule can be found here: http://www.co.westmoreland.pa.us/DocumentCenter/View/6040.

HOT OFF THE WIRE

*By: James Tallman, Esq.***

Kote v. Bank of NY Mellon, 2017 Pa. Super 277 (Pa. Super. Aug. 25, 2017) – Property owner not liable to delivery person shot on premises.

In Kote, the appellant/plaintiff ("plaintiff") made a delivery of Chinese food to a foreclosed and vacant property owned by Defendant Bank of NY Mellon ("Mellon") in a Philadelphia neighborhood. Upon entering the building, the plaintiff was shot multiple times in the chest. The plaintiff alleged in his amended complaint that Mellon knew the property was in an area of known criminal activity, but failed to comply with the local property maintenance code and violated Section 322 of the Restatement (second) of Torts. Plaintiff also sued two companies that Mellon had hired to sale the property and secure and inspect the property. The trial court granted judgment on pleading for Mellon and preliminary objections for the other defendants.

On appeal the Superior Court affirmed the trial court's ruling that the plaintiff was not a business invitee as he was lured to the property by a criminal for a purpose unrelated to Mellon's business. The court also found that the defendants hired to maintain and secure the property did not owe plaintiff a duty. Further, the court held that that any failure by the defendants was not the proximate cause of the plaintiff's injury, as he was shot by an unknown criminal assailant and trespasser.

Cassel v. Mechanicsburg Club 66,, 66 Cumb. 115 (April 13, 2017) – Punitive damages claim supported by alleged facts in Dram Shop claim.

In Cassel, the plaintiff sued a bar for serving him alcohol while he was visibly intoxicated and included a claim for punitive. The plaintiff alleged that the bar employees knew continued to serve him because they found his drunken behavior to be entertaining. The court found that a punitive damages claim based on such allegations was proper and overruled preliminary objections. In Cassel, the court also held that the Dram Shop act precludes common law negligence claims.

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Any changes/updates that need to be made to your record, please contact the Association office at 412-487-7644 or laurie@wptla.org.

2017-2018 CALENDAR OF EVENTS

Saturday, Oct 21, 2017	**WPTLA's President's Challenge 5K Run/Walk/Wheel Event** Boat House in North Park, Pittsburgh, PA Registration 9:00 a.m. -- Race Start 10:00 a.m.
Wednesday, Nov 8, 2017	**WPTLA Board Meeting / Comeback Award Dinner** Cambria Hotel & Suites, Pittsburgh, PA 4:30 p.m. Board Meeting -- 5:30 p.m. Cocktails -- 6:15 p.m. Dinner
Tuesday, Dec 5, 2017	**3 Credit CLE / Lunch** Gulf Tower, Pittsburgh, PA 8:30 Registration Opens; 9:00-12:30 CLE, 12:30 Lunch
January, 2018	**WPTLA Board Meeting / Past Presidents Dinner** Pittsburgh, PA
February, 2018	**Junior Member Event** Escape Room, Pittsburgh, PA
March, 2018	**WPTLA Board Meeting / Dinner**
April, 2018	**WPTLA Board Meeting / Dinner / Elections** Carmody's Grille, Pittsburgh, PA
Friday, May 4, 2018	**Annual Judiciary Dinner** Heinz Field, UPMC Club, Pittsburgh, PA 5:30 p.m. Cocktails -- 7:00 p.m. Dinner
June, 2018	**Ethics Seminar/Golf Outing**

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...Through the Grapevine

Member **John Carlson** has a new email address: jbcarlsonesq@gmail.com.

Member **Art Schwarzwaelder** has moved his law office to One Gateway Center, 410 Fort Duquesne Blvd, Suite 882, Pittsburgh 15222. Phone and email remain the same.

A speedy recover to Past President **Larry Kelly**, who is recovering from surgery, due to breaking his arm while sliding into second base!

Congratulations to President **Liz Chiappetta**, Member **David Houck**, Board of Governors Member **Katie Killion**, and Board of Governors Member **Jason Schiffman** on their election to the Academy of Trial Lawyers of Allegheny County.