WALKUP, MELODIA, KELLY & ECHEVERRIA

FOCUS on torts

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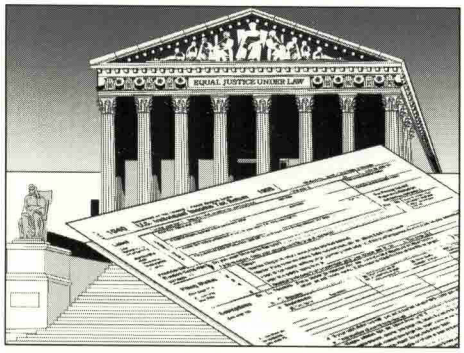
Taxability of Settlements and Judgments Follows S.B.A. Amendments

Internal Revenue Code §104(a)(2), governing the taxability of recoveries in personal injury actions, was dramatically altered when Congress, (in a rider to the Small Business Job Protection Act of 1996), made certain personal injury judgments and settlements taxable.

As amended, §104(a)(2) now provides that the following are excluded from gross income for tax purposes: "the amount of any damages (other than punitive damages) received on account of physical injuries or physical sickness."

Potential tax problems created by the amendments to §104(a)(2) spring from its definition of "physical injury or sickness" as excluding emotional distress. Employment and race discrimination claims were the principal target of the provision as Congress intended recovery for such claims to be made taxable.

The conference report generated in association with the amendments provides that if an action has its origin in a physical injury or a physical sickness, then all damages (other than punitive damages) which flow from the underlying injury are treated as payments received on account of physical injury or physical sickness, and therefore excludable from gross income.



Some emotional distress recoveries will continue to be non-taxable. For example, damages received by a person on account of a claim for loss of consortium due to the physical injury of a spose should be treated as flowing from a physical injury, and not as taxable "emotional distress" damages.[1]

The conference report also spells out that any damages received based on claims of employment discrimination or injury to reputation are intended to be taxable. Only emotional distress which flows from an actual physical injury remains non-taxable.[2] Taxable damages for "pure" emotional distress includes some physical symptoms produced by that distress (nervousness, ulcers, stomach disorders, sleeplessness, etc.).

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H. M. O. LIABILITY: THE LANDSCAPE IS CHANGING

Managed care plans now constitute the dominant form of health insurance in California. Nonetheless, many doctors and lawyers, and most patients, are not aware of how the plans work, and the effect the plans have on medical negligence liability.

Managed care is the marriage of insurance management and medicine. The common denominator among the 600 available plans is that an insurance company determines what health services a patient needs.

Historically, the aim of the medical practitioner has been to give the patient the best available care irrespective of cost, while the historic goal of insurers has been to make a profit by increasing revenues and lowering expenses.

Traditional indemnity plans, which gave the patient freedom to choose a doctor and a hospital (thereafter reimbursing providers for services ordered or performed) permitted physicians to utilize expensive medical tests and procedures. This practice inevitably fell out of favor with insurance companies because it had a negative effect on the bottom line.
To reduce expenses, managed care seeks to create a disincentive to spend money by incorporating financial penalties to

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H. M. O. Liability:

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providers who spend money on diagnostic tests and procedures.

The "staff model" HMO does this by buying medical facilities and directly employing physicians as its employees. These physicians see only members of the plan. Because the salaries and bonuses of the participating physicians are tied to the profitability of the HMO, it is within the doctor's financial incentive to minimize utilization of medical services.

A second HMO model minimizes expenses in a different way. Under the "group model" a middle man recruits groups of doctors and then contracts with various HMOs to provide these doctors' services. The HMO is able to contract for the doctors' services at a lower rate by purchasing them through the middle man. Patients are restricted to seeing only the doctors with whom the entrepreneur has contracted.

As different middle men supply different medical groups and specialists to different HMOs, the web of contracts came to be known as the "network model". In time, however, physicians realized they could reduce their administrative costs by merging into multi-specialty groups and contracting themselves out as Independent Practice Associations or IPAs. The physicians run their own offices, generating their own expenses, and can then see HMO members as well as traditional indemnity insureds.

An HMO controls its costs through an IPA in many ways. First, it can utilize a capitated rate, meaning that the physician is paid a certain amount of money per patient per month, regardless of the service rendered to the patient. If the physician agrees to see patients at an $8 per month capitated rate, and the patient has a chronic or difficult medical condition which generates $10 or $12 a month in actual medical costs, the independent physician's office must then pay the $2-$4 in extra expenses out of its own pocket. In addition, most HMOs designate specific primary care physicians as "gatekeepers". The gatekeepers then have a direct economic interest in the amount of services provided to the patient. If a gatekeeper orders too many lab tests, or too many expensive specialist consultations, the plan can lower the physician's capitated rate, deduct money from that amount of the gatekeeper's income which is held in an escrow account, send capitation plan patients to other primary care physicians, or even withhold bonuses. Because the gatekeeper personally feels the economic impact associated with the amount and scope of medical care which she or he orders, the physician's incentive is to reduce expenditures to maximize income.

These cost control mechanisms have created a previously unknown conflict of interest in the doctor/patient relationship. Before the growth of HMOs, the financial interests of both doctor and patient were traditionally allied. It was always in the doctor's best interest to fully explore the patient's complaints. It was always in the patient's health interest to have the physician do so.

Now, with managed care, it is in the gatekeeper's best interest not to order diagnostic tests, not to order specialty referrals, not to prescribe ancillary services and not to diagnose or treat the patient's symptoms, complaints or disease early.

These powerful financial disincentives towards providing care have led to generally lower standards and an increased incidence of medical malpractice claims. Although claims have traditionally been focused against providers, there is rising anger in the patient community about the managed care industry. Unfortunately, to date, most managed care plans have avoided exposure for medical negligence.

Perhaps the largest obstacle to suing any managed care plan arises from claims of ERISA preemption. ERISA preempts state law tort claims related to employee benefit plans. Because most patients receive health benefits through their employment, ERISA has been raised as a bar to state actions alleging medical malpractice or bad faith. Pilot Life v. Dedeaux, 481 U.S. 41 (1987). Recently, however, there have been some indications that the bar of ERISA preemption may not be absolute. The 10th Circuit has now held that ERISA does not preempt a medical malpractice claim against an HMO premised on vicarious liability. Oklahoma v. Burrage, 59 F.3d 151 (1995).

A second roadblock faced by patients in their attempts to prosecute court actions is that most plans contain mandatory arbitration clauses. Generally, th patient's rights to jury trial have been waived by the employer who purchased the plan. Routing claims into arbitration has prevented pro-patient precedent from being set in courts of competent jurisdiction. Actions where patients have struck at the heart of managed care by alleging that cost-control systems interfere with the quality of medical care have settled quickly, out of court, under confidentiality orders. See, for example, Bush v. Dake, No. 86-25767-NM (Michigan Circuit Court, Saginaw County).

Claims against plans alleging vicarious liability or ostensible agency on the part of plan physicians too often have been unsuccessful. One exception is Wickline v. California, 231 Cal.Rptr.560 (1987). There, a surgeon felt that eight days of hospital observation was required to monitor a patient's recovery following complex surgery for treatment of a large blood clot. The patient was a Medi-Cal recipient (California's Medicaid provider). The Medi-Cal gatekeeper authorized only a four day hospitalization. On the fourth day, the doctor discharged the patient who then proceeded to reform the clot with resultant amputation of her leg. The patient claimed that the gatekeeper's actions were the result of limitations imposed by Medi-Cal.

The court held that only the doctor was liable because he failed to challenge and appeal Medi-Cal's decision, implying that the doctor should have been the gatekeeper for the gatekeeper. The court also set forth, in dicta, language indicating that a third party payor like Medi-Cal may be held liable for medically inappropriate decisions resulting from negligently designed or administered cost containment programs.

This dicta spawned the 1996 enactment of Business & Professions Code §2056, which protects physicians who advocate for medically appropriate health care from managed care plan retaliation. It also supplies the basis for the reversal of a defendant insurer's summary judgment in Wilson v. Blue Cross, 271 Cal.Rptr.876 (1990). In Wilson, Blue Cross had denied a four week in-hospital stay for suicide prevention observation. It agreed to pay only for a two week stay. The patient was discharged early and promptly killed himself. The appellate court held that the physician's testimony that the denial of benefits was a substantial factor in the patient's suicide justified reversal and remand.

Governor Wilson recently signed the Friedman/Knowles Experimental Treatment Act. (Health & Safety Code §1370.4; Insurance Code §10145.3) Under the act, when an HMO denies coverage to a patient who is likely to die within two years, the patient may have the decision reviewed by third party experts. The review process established by the act becomes available on July 1, 1998.

The findings of the neutral expert panel are binding on any insurer. If a majority of the experts recommend a proposed therapy, the recommendation is binding on the insurer. If the panel is evenly divided, the decision is to be deemed in favor of coverage. If less than a majority recommends therapy, the insurer is not required to offer therapy; however, the decision is not binding on the patient in a subsequent legal action.

Although that act is silent regarding its intent to affect available legal procedures, its provisions reflect the growing concern HMOs should not be able to shield themselves from fault or liability for important medical decisions.

WALKUPDATES

Pictured below are Rich Schoenberger and Cynthia Newton, who have recently been elected to the Board of Directors of the San Francisco Trial Lawyers Association. SFTLA's governing board oversees affairs for its 700+ members, sponsors C.L.E. programs, engages in community outreach and volunteer work, involves itself on behalf of tort victims at the legislative and appellate court levels, and promotes social interaction between its membership and other specialty bars.

Rich and Cynthia join a long list of firm members who have served the SFTLA in the past. In fact, our firm has produced more SFTLA presidents (four) than any other. Most recently, Dan Kelly (in 1982) and Mike Kelly (in 1996) have served as the Association's top officer.

Rich, a partner in the firm, has practiced with us since 1987, developing particular expertise in premises liability claims, highlighted by his 2.5 million dollar verdict in the notorious "911" wrongful death case of a San Francisco tourist killed while waiting for emergency personnel to respond.

Rich makes his home in San Francisco with his wife, Monica, and their two children. He regularly lectures for a number of CLE providers and has served as an instructor for the National Institute of Trial Advocacy.

Cynthia, who joined our firm three years after Rich, has tried or co-tried multiple cases since 1990 involving medical negligence, premises liability and government liability. She also has special expertise in employment, gender harassment and sexual discrimination claims. Prior to her appointment as a member of the SFTLA board, she worked extensively with the organization's community outreach committee. She is also a member of the State Bar Litigation Section and the Edward McFetridge Inn of Court.

Cynthia resides in Alameda with her husband Mark, a recently ordained minister. She is active in youth programs in his church and particularly enjoys working with underprivileged children.

We congratulate both Rich and Cynthia on their election as SFTLA Board members....One of the SFTLA Board spots being vacated, to make room for Cynthia and Rich, has belonged for the last seven years to Ron Wecht. As a Board member this fall, Ron chaired a C.L.E. panel discussion focused on preparation and trial of medical malpractice cases... Dr. Ken Facter was selected Best Program Speaker for his presentation at the American College of Surgeons 82nd Clinical Congress held in San Francisco. The topic of Ken's address was "The Surgeon on Trial: The Physician's Rights and Responsibilities." Earlier this year Ken spoke on the topic of managed care to the American Association of Clinical Endocrinologists in Keystone, Colorado...In November, John Echeverria participated as a panelist on programs in San Francisco and Los Angeles given for the benefit of the California Brain Injury Foundation. The focus of the seminar dealt with evaluating economic damage in brain injury cases. John spoke on how the use of a life care planner assists the patient in proving future medical costs...In December, Mike Kelly spoke on the practical applications of Proposition 213 at a San Francisco Trial Lawyers/Bancroft Whitney CLE program. In November, Mike served as a faculty member for the National Institute of Trial Advocacy's four day Western Deposition Program...Jeff Holl has been elected to membership in the San Francisco Lawyers Club American Inn of Court. Jeff will also be serving as a panelist for CEB on a spring program dealing with advanced tort issues.

PROPOSITION 213 APPROVAL ELIMINATES RIGHTS OF FAULTLESS MOTORISTS

On November 5, 1996, California voters overwhelmingly approved Proposition 213, the so-called "Quackenbush Initiative."

Drafted and qualified for the ballot by Insurance Commissioner Chuck Quackenbush, the initiative (which adds Civil Code §§3333.3 and 3333.4) eliminates all general damages for uninsured motorists, whether or not they are at fault, in vehicle collisions. Its application is made retroactive to injuries occurring before the date of the election.

Advertised as a measure to prevent felons and drunk drivers from recovering damages in cases where their illegal activity proximately caused their own injuries, 213 also included provisions to punish blameless drivers who are uninsured. The more widespread effect of the proposition deals with these faultless victims who have not purchased, cannot afford, or cannot obtain auto insurance.

Newly enacted Civil Code §3333.4 provides that where an injured person is the owner of a vehicle which was not insured as required by the Vehicle Code, who cannot establish financial responsibility as required by the Vehicle Code, he/she may not recover non-economic losses to compensate for pain, suffering, inconvenience, disfigurement, etc.

As drafted, the act purports to apply to any and all injuries occurring after the date of the election (11/5/96) and to any previously filed cases not tried before January 1, 1997.

Challenges to the retroactivity provisions of the statute have been filed by individuals who could not get their cases to trial, despite due diligence, prior to January 1, 1997, and who relied on prior law in prosecuting their actions prior to the election. No appellate decision regarding retroactivity have been handed down as this issue of Focus goes to press.

Under the terms of the new law, fault is irrelevant. The owner of an uninsured vehicle, whether driving or riding as a passenger, is denied recovery of non-economic damages because of her/his status.

The statute does not require that an operator know she is driving an uninsured vehicle. For example, assume that at a party, a Samaritan observes that another party-goer is intoxicated. Holding a valid license, but not owning a vehicle (and therefore not having auto insurance) the Good Samaritan offers to drive the drunk home. The drunk's car is uninsured.

On the way home, while legally stopped at a red light, the Samaritan and her passenger are broad-sided. Even though neither is at fault, because the vehicle is uninsured, and the driver does not have insurance because she does not own a car, neither passenger is entitled to recover any non-economic damages. This is true even if both are paralyzed, permanently disfigured or disabled. The driver, who thought she was doing the right thing, is denied non-economic damages even though she was unaware that the vehicle was not insured.

TIPS FOR HANDLING U.M. AND U.I.M. CLAIMS

1. Read Insurance Code §11580.2. It provides the ground rules for uninsured motorist and underinsured motorist claims.
2. There is a one year statute of limitations for uninsured motorist claims. The statute can be protected in 1 of 3 ways: settlement of the claim, filing of a Superior Court lawsuit against all appropriate defendants, and/or, formally demanding arbitration. The best and safest way to make sure the statute is tolled is to file a lawsuit against all defendants. This preserves any U.I.M. as well as the U.M. claim.
3. If a hit and run accident is involved, the accident must be reported to police within 24 hours, and the carrier put on notice within 30 days.
4. If the claimant was injured while at work, Insurance Code §11580.2(f) requires that the demand for arbitration include a declaration regarding the pendency of any worker's compensation claim.
5. If the plaintiff has received med pay benefits, the policy may provide that an insurer can deduct from U.M. claims the amount it has previously paid under med pay coverage (§11580.2(e)). This does not mean that the credit is against the policy limits. The set-off should come from the total damages payable.
6. U.M. coverage tends to be broad. Don't forget that named insured and relatives of named insureds are covered, whether or not they are permanently residing in the insured's household. Pedestrians are also covered. (Lopez v. State Farm Fire and Casualty (1967) 250 Cal.App.2d 210)
7. An uninsured motorist (and an underinsured motorist claim) is a first party claim. The carrier is required to act consistent with traditional obligations of fairness and good faith with its own insured.
8. Although there is no way to "take the lid off" a U.M. policy by obtaining an arbitration award larger than the limits, there is the potential for a derivative bad faith action where the U.M./U.I.M. carrier has acted unreasonably. (Neal v. Farmers Ins. Exch. (1978) 21 Cal.3d 910)

Many California citizens who hold driver's licenses rely on public transportation and do not own an automobile. On occasion, they may have a need to borrow the car of another, to run errands, etc., and may in good faith assume that the vehicle they are driving is insured. Even if they are hit by a reckless driver, their uninsured status prevents them from being made whole.

Most troubling is the fact that the reckless driver who causes injury and damage is not accountable for his conduct. By fortuitously striking someone who is uninsured, the reckless driver (unless he or she is drunk), is off the hook.

After the election, a rush of motions to advance for trial per CCP §36(e) met with mixed results. In some counties, the motions were granted. In other counties, the motions were denied on the basis of impossibility. Writs have been taken in at least two such cases seeking a judicial declaration that the retroactive provisions of the statute are unconstitutional as applied because they deny procedural due process and equal protection of the laws.

The measure's retroactivity provision arbitrarily differentiates between plaintiffs whose cases can be brought to trial before January 1, 1997, and those whose cases cannot. Application of the January 1, 1997 cutoff date is artificial and unrelated to any legitimate state purpose. In most counties the ability to bring an action to trial is entirely outside of the plaintiff's control because it rests on factors such as the availability of courtrooms, the number of criminal cases on docket, the county's attitude on "three strikes," and the recency of the filing. Where counsel is faced with a trial date after January 1, 1997, they should make sure to preserve the issue of the act's unconstitutional nature by way of a motion in limine and by specifically requesting instructions regarding non-economic damages.

Retrospective application of a statute is unconstitutional where it deprives a person of a substantive right without due process of law. In re: Marriage of Bouquet (1976) 16 Cal.3d 583. Prior to the enactment of this statute, all Californians had the right to be fully compensated for damages caused by negligence. The right to be free from tortiously caused injury has been codified since Civil Code §3333 was enacted in 1872. Further, the right to be compensated for injuries negligently caused by another is a fundamental cornerstone of American tort law.

Financially, the initiative creates a great windfall for insurers who will be relieved of paying claims for which they charged premiums and had previously set reserves. There is no requirement in the statute that there by any corresponding decrease in insurance premiums.

If our associate counsel are involved in cases where the injured plaintiff is a person who falls within any of the prohibited status categories of newly enacted Civil Code §3333.4, we can be of assistance in providing arguments and authorities relating to the constitutional challenge.

Proposition 213 does not in any way affect the handling of traditional uninsured motorist or underinsured motorist claims where the injured party is insured, but is injured by the conduct of an uninsured motorist. In such circumstances, the injured party makes a claim against his or her uninsured motorist (UM) or underinsured motorist (UIM) coverage. These cases are handled in the manner specified in Insurance Code §11580.2, generally outside of the judicial system, by way of mandatory binding arbitration. In an accompanying article, we provide eight helpful tips for handling UM and UIM claims. Counsel having questions relating to vehicle accidents involving any uninsured motorist scenario should feel free to call Michael Kelly, Kevin Domecus or Daniel Dell'Osso of our firm.

Taxability of Settlements and Judgments

Continued from front page

Because of the significance of the origin of the emotional distress (i.e. does it arise independently or does it flow from a compensable physical injury), it is important to keep the causal link between injury and distress in mind when drafting complaints and settlement agreements in cases where emotional distress damages are sought or recovered.

When possible, any complaint seeking emotional distress damages should allege that the harm flows from a physical injury. Further, in drafting and reviewing settlement agreements, counsel should be careful to make certain that the language of any agreement or release does not inadvertently make taxable some or all of a recovery which should otherwise be excludable from gross income.

In some cases, it may be difficult to apportion some or all of the recovery to claims that are non-taxable. In such circumstances, counsel should anticipate that the IRS will carefully scrutinize or challenge any allocation which is made. Counsel should attempt to fashion an allocation which is fair and mirrors the relative strengths of the theories in the complaint; takes into account prior similar verdicts and settlements for like kinds of injuries; identifies the methodology undertaken to apportion between taxable and non-taxable claims; and, whenever possible, seeks judicial approval of the apportionment method, as, for example in connection with a motion for good faith settlement and/or compromise for minors.

Finally, to avoid misunderstandings down the road, at the time of resolution, counsel who handle employment discrimination, race or gender discrimination, fair housing discrimination, libel, slander, or negligent infliction of emotional distress claims, should advise their clients, as part of any settlement accounting, that the recovery being received is subject to taxation.

[1]Conference report on Small Business Job Protection Act of 1996 at 142, 143.

[2]Id. at 143.

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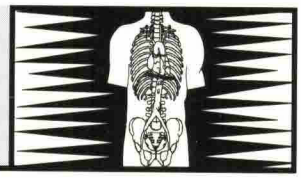
MEDICAL NEGLIGENCE



Decedent v. Internal Medicine Group

In Decedent v. Internal Medicine Group (Confidential Settlement) Daniel J. Kelly negotiated a $588,000 settlement on behalf of the surviving wife and three adult sons of a 61-year-old man who died of undiagnosed prostate cancer.

The deceased initially saw his doctor for a routine examination in June of 1992. As part of that exam the doctor ordered a P.S.A. (prostatic specific antigen) test to screen for prostate cancer. The lab result was abnormal. Plaintiff claimed this information was never relayed to him. The physician's office claimed that the information was relayed to the plaintiff's wife.

Approximately 18 months later, in January of 1994, the plaintiff returned to the defendant's office for another routine exam. The defendant again ordered a P.S.A. test (the prior abnormal test was never discussed with the patient) and the second test was again elevated, by a factor of more than 6 times normal. The defendant once more failed to inform plaintiff of the significance of this abnormal test, and took no steps to work the patient up.

Eleven months later, in November of 1994, plaintiff consulted another physician because the defendant had retired from practice. On examination, the new physician immediately identified a mass in plaintiff's prostate. A repeat P.S.A. showed a P.S.A. elevation of over 50 times the upper limit of normal.

Plaintiff was diagnosed as having inoperable prostate cancer. Despite aggressive treatment, he died on July 14, 1996. Defendant claimed that plaintiff's cancer was most likely incurable as early as the first abnormal P.S.A. and that it was only speculative whether treatment, timely undertaken, would have prolonged his life. Plaintiff's experts disagreed, testifying that in June of 1992, when the diagnosis was first missed, the cancer was more likely than not curable with surgery.

Patient v. Northern California Medical Center

In Patient v. Northern California Medical Center, Kevin L. Domecus negotiated an annuity and cash settlement having a present value of $725,000 on behalf of the surviving spouse and two adult children of a 50-year-old Bay Area attorney who died of salivary gland cancer.

The deceased initially presented to the defendant Medical Center in June of 1992 complaining of a small lump beneath his jaw. His physicians examined the lump and performed a fine needle aspiration. Pathological examination reported that the biopsy was negative. The defendants therefore then decided to simply observe the lump. Roughly one year later the deceased developed jaw pain and associated dental problems. He was eventually diagnosed with a widely metastasized salivary gland carcinoma from which he died in September of 1994.

Plaintiffs contended that the defendant physicians should have immediately removed the lump at the time it was first identified rather than rely on a negative fine needle aspiration. The defendant Medical Center contended that its physicians met the appropriate standard of care, that excisional biopsy was not required under the circumstances, and, that the cancer was so virulent that an earlier diagnosis would not have altered the eventual outcome.

Patient v. Anonymous Medical Providers (Confidential Settlement)

Ronald H. Wecht recovered $850,000 on behalf of a 45-year-old female patient whose neurosurgeon failed to diagnose and correct a post-operative subdural hematoma.

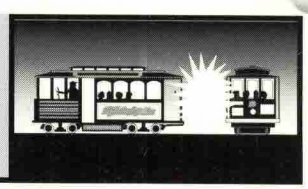
The plaintiff, who suffered from chronic pain secondary to two earlier unsuccessful cervical fusions, began to experience weakness in one of her arms. The defendant neurosurgeon suggested a takedown of the earlier fusions and the placement of titanium plates in association with a new multi-level fusion.

Shortly after surgery plaintiff reported that she was unable to move her feet. The defendant surgeon evaluated the problem, confirmed its existence, but then took no steps to correct it. After waiting several hours, a consult with a physiatrist resulted in re-operation with identification and removal of a hematoma.

Obstruction of blood flow caused by the hematoma, and resulting nerve damage, left the plaintiff wheelchair bound and unable to care for herself.

The defendant claimed that earlier intervention would have made no difference in the plaintiff's outcome, and further, that it was appropriate to delay surgical re-exploration. Plaintiff's experts testified that prompt surgery after symptoms manifested themselves would have left her with little to no physical residual. Because of unrelated respiratory difficulties, the plaintiff's life expectancy was shortened, thereby markedly reducing the cost of future care. Non-economic damages were limited to $250,000. The hospital where the surgery was performed also contributed to the settlement based upon its inability to provide an adequate staff and timely operating room for the re-operation.

GOVERNMENT LIABILITY



Jones v. City and County of San Francisco

In Jones v. City and County of San Francisco (S.F.Sup.Ct. No. 974206), Kevin L. Domecus obtained a $3,200,000 settlement for a 20-year-old Canadian visitor whose left leg was amputated in a cable car accident on August 17, 1995.

The plaintiff, a student at the University of British Columbia, was spending a holiday weekend in San Francisco prior to the beginning of the fall school term. While riding with his girlfriend on the cable car, a second, unattended car rolled out of the car barn and broadsided them. The runaway car crushed and pinned the plaintiff's legs. He remained trapped between the two cars for over one and one-half hours. The force of the impact fractured his right foot and nearly severed the left leg. By the time

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he was freed and presented for medical attention, doctors were unable to reestablish adequate circulation in his left foot. It was necessary to amputate the left leg below the knee the following day.

The plaintiff, now 22-years-old, is completing his studies at the University of British Columbia. Formerly an avid skier, golfer and hockey player, he will require multiple prosthetic devices for the rest of his life.

Although Muni representatives initially claimed that the accident was the product of a mechanical failure, subsequent investigation reflected that it was caused by employee negligence.

PREMISES LIABILITY

In Hartman v. S & C Ford

In Hartman v. S & C Ford (S.F. Sup.Ct. No. 980091) Jeffrey Holl negotiated a $132,500 settlement on behalf of a 74-year-old woman who was seriously injured when she slipped and fell in the showroom of defendant's auto dealership.

The plaintiff, who was helping her sister shop for a new car, slipped on a piece of laminated paper that had been peeled from the back of a sales sticker and left on the showroom floor. Plaintiff fractured her left hip and wrist. She required two weeks of inpatient hospitalization and extensive surgery.

Defendant claimed that plaintiff was guilty of significant comparative fault for failing to see and identify the hazard. Plaintiff alleged that the laminated paper was essentially transparent.

Residual complaints include pain in both plaintiff's hip and wrist which limit her independence and her ability to be self-sufficient at home.

talley v. Stalley

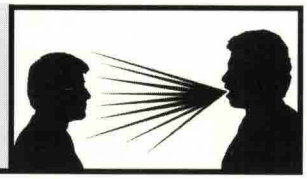
In Stalley v. Stalley (San Mateo Sup.Ct. No. 396630) Ron Wecht negotiated a combination annuity and cash settlement having a present cash value of $500,000 on behalf of a 48-year-old construction foreman who suffered crushing injury to his right (major) hand.

The injury occurred while plaintiff and his brother were cutting down a large pine tree in the plaintiff's front yard. While his brother was making a final cut through the trunk of the tree, plaintiff walked up behind him to see how the job was progressing. At that moment, the upper portion of the trunk fell and crushed plaintiff's hand. The brother claimed not to know that the plaintiff was standing behind him.

Plaintiff's partially severed limb was reattached, and, after multiple microsurgeries, some function was restored. However, the limb will never have normal, or near normal, function. Defendant claimed that he was not negligent, and that plaintiff was 100% at fault for approaching from behind while the chain saw was in operation.

Economic damages included roughly $70,000 per year in lost earnings plus in excess of $100,000 in medical bills. As part of the settlement, plaintiff's H.M.O. reduced its subrogated lien claim by 70%.

EMPLOYMENT LITIGATION



Highway Worker v. State of California

Cynthia Newton has concluded two complex and novel employment cases. In Highway Worker v. State of California (Ala.Co.Sup.Ct.) she represented a 30-year-old CalTrans employee who was repeatedly harassed by his male co-workers. The co-workers taunted the plaintiff and threatened him with profane and sexually suggestive language.

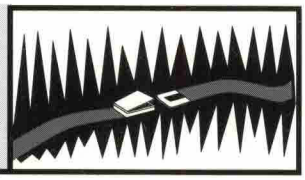
The ongoing taunting resulted in plaintiff suffering an emotional breakdown and involuntary psychiatric commitment pursuant to Welfare & Institutions Code §5150. Thereafter, plaintiff remained disabled for months.

The State of California argued that because neither the harassers nor the plaintiff were homosexual, this same-sex behavior did not constitute sexual harassment under Mogeliefsky v. Superior Court (1993) 20 Cal.App.4th 1409. On the eve of trial, the State changed its position and settled for a confidential sum.

In Female Employee v. National Corporation (Sonoma Co.Sup.Ct.) Cynthia obtained a second confidential settlement on behalf of a female Native American who worked as a machinist in a multi-national corporation. Over time, the plaintiff was regularly referred to by her co-workers as "a fat, sweaty Indian" and, on occasion, as "being on the warpath." Plaintiff claimed that her supervisor sabotaged her work and otherwise purposely engaged in efforts to make her upset and cause her to perform poorly at work.

The terms of the settlement were negotiated on the specific condition that the matter remain confidential, and further, that plaintiff resign and seek employment elsewhere.

PRODUCT LIABILITY



Adolescent v. Big Three Auto Maker

In Adolescent v. Big Three Auto Maker (confidential settlement) Michael A. Kelly and Daniel Dell'Osso negotiated a combination of cash and annuity settlement with a present value of $2,000,000 (and ultimate payment in excess of $6,400,000) on behalf of a 19-year-old North Coast high school student who sustained abdominal trauma, a fractured spine, and a closed head injury when riding as a lap-belted passenger in the rear of a full size American sedan involved in a 35 mile an hour head-on collision.

The front seat occupants of the vehicle were both lap and shoulder belted. Each sustained only modest leg injuries. All three rear seat occupants of the car (plaintiff and two friends) were restrained only by the lap belts provided

RECENT CASES

by the manufacturer. At impact, the lap belt rode up onto plaintiff's abdomen. As he flexed forward, his head struck the rear of the driver's seat. The belt exerted knifelike pressure on his abdominal organs, causing a ruptured bowel and mesentery lacerations. Plaintiff was rendered comatose for 11 days. An L2-3 fracture required stabilization with Harrington rods.

Plaintiff claimed that the vehicle was defective by reason of its failure to incorporate a shoulder harness for outboard rear seat passengers. By the time the vehicle was manufactured in 1985, all domestic vehicles were equipped with anchor points for shoulder harnesses which were sold as after market options. Plaintiff claimed the harness should have been installed as standard equipment. Defendant claimed that the accident was so severe that plaintiff's injuries would have occurred notwithstanding the presence of a shoulder belt. The defendant further claimed that all fault rested with the driver who caused the accident.

Claimed economic damages included an inability to engage in the competitive work force as a result of residual brain damage, and, the need for a supervised living situation.

The case represents the sixth passenger restraint product defect claim, concluded by our firm in the last three years.

McGarva v. Hyster International

In McGarva v. Hyster International (Washoe Co., Nevada, No. CV95-00596) John Echeverria negotiated a pretrial settlement in the amount of $4,250,000 on behalf of a 20-year-old man who lost his left leg at the hip joint.

The plaintiff was employed by a construction company building a leach field for Santa Fe Pacific Gold. After roughly 30 minutes of orientation on how to drive a compactor, he was assigned to operate one. The compactor, manufactured by defendant Hyster, was not equipped with rollover protection, though it was available as an option.

While compacting near the edge of the leach field, plaintiff lost control and the vehicle rolled down an embankment, severely injuring his right leg.

Medical bills were roughly $700,000, paid by worker's compensation. Past and future lost earnings were estimated to be in the range of $500,000.

Plaintiff alleged that the defendant manufacturer should have equipped the 30 ton compactor with rollover protection. Plaintiff also claimed that the project owner (defendant Santa Fe Pacific Gold) failed to adequately supervise the job site. Defendants claimed liability rested primarily with plaintiff's employer who failed to adequately train him. (Under Nevada State law, the employer is immune from liability.)

Plaintiff also claimed that the mine operator (defendant of Santa Fe Pacific Gold) breached obligations it owed under the Federal Mine Safety and Health Act to ensure that equipment utilized on the job complie[d] with the Act's safety requirements. The Mine Safety & Health Act requires rollover protection systems on all equipment manufactured after 1969 and utilized in mining operations.

The case settled roughly one month prior to trial after 18 months of intensive discovery. The case was handled in association with Thomas Brennan of Reno's Durney & Brennan, Ltd.

We are available for association and/or referral in all types of personal injury matters. Fees are shared with referring counsel in accord with Rule of Professional Conduct 2-200. Additionally. if there is a particular subject you would like to see discussed in future issues of ***Focus on Torts*** please contact Michael Kelly or Lisa LaRue.

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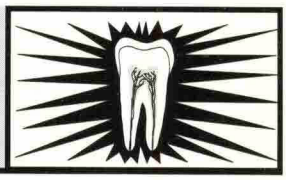

Phillips v. USA

In Phillips v. USA (U.S.D.C. No.Dist. No. C95 2833 SBA) Jeffrey Holl[...] concluded a dental malpractice case against the Veteran's Administratio[n] on behalf of a 36-year-old veteran who underwent extraction of four impacted wisdom teeth at the San Francisco V.A. Hospital with catastrophic residual consequences.

The plaintiff underwent oral surgery expecting the procedure to be relatively benign. Prior symptoms from the impacted teeth had been minimal. Informed consent for the procedure was highly disputed.

The procedure, performed by an incompletely trained U.C.S.F. resident, resulted in severe damage to both the left and right inferior alveolar nerves, with post-traumatic neuromas developing bilaterally.

Post-operatively, when Mr. Phillips complained of numbness and pain in his jaw, the V.A. physicians undertook four additional surgeries over the next six months. The attempted repairs included vein grafts and nerve grafts, cryalysis of the IAN nerves, removal of scar tissue, and unsuccessful neuroma removal at the initial operative site. None of the surgeries was effective in relieving the plaintiff's pain.

Because of constant pain, plaintiff has been unable to work and continues to undergo treatment through the UCSF Pain Clinic. The settlement, consisting of both a cash payment and a guaranteed annuity, has a present value of $700,000.