CAIIA Status Report

May 2013

Building Vacancy Conditions Applied Without Regard to Policy Effective Date; Broker Free from Duty to Subsequent Owners

Credit to Haight, Brown & Bonesteel, Los Angeles, CA

In a case of first impression in California, the Second District of the Court of Appeal, in *Travelers Property Casualty Company v. Superior Court* (no. B243650, filed 4/17/13), enforced vacancy provisions limiting coverage where a building had been vacant more than 60 days prior to loss. In affirming summary judgment for the insurer, it held the vacancy conditions applied unambiguously even though the loss occurred within 60 days of policy issuance.

The issue arose when the developer of an unfinished condominium project defaulted on its construction loan. Its builders' risk insurance had lapsed and, prior to the foreclosure, its agent obtained condominium association insurance from Travelers.

After foreclosure by the project's note holder, and less than 60 days after inception of the Travelers policy, vandals damaged the property, including removal of all appliances and fixtures.

The new owner, as the loss payee under an assignment obtained in the foreclosure, made a claim against Travelers. When Travelers denied coverage in reliance on a 60-day vacancy limitation, the owner sued for bad faith and also alleged professional negligence against its agent. The new owner argued that the vandalism exclusion should not apply since Travelers could not prove the policy had been in effect for 60 days when the loss occurred.

The property policy excluded coverage for vandalism and theft, "even if they are Covered Causes of Loss, if the building where loss or damage occurs has been 'vacant' for more than 60 consecutive days before that loss or damage occurs. . . ." Based on that language, the Court of Appeal held that the exclusion applied if the building was vacant in the sixty days before loss, regardless of whether the policy was in force that entire time.

The California Court of Appeal joined the majority of courts enforcing such wording. It distinguished the pertinent clause from wording that excludes losses when the building is vacant "beyond a period of sixty days." Citing that distinct phrasing in the policy in *Gas Kwick, Inc. v. United Pacific Ins. Co.* (11th Cir. 1995) 58 F.3d 1536, the *Travelers* court said that "the use of 'beyond' is prospective-looking and must therefore commence at or after policy issuance. However, when the policy language is defined in terms of 'days before [the] loss,' the time period is clearly backward-looking from the date of the loss, and does not implicate policy issuance.... There is no ambiguity in the instant policy; the period is backward looking from the date of the loss."

The *Travelers* court also distinguished *TRB Investments, Inc. v. Fireman's Fund* (2006) 40 Cal.4th 19, where the vacancy exclusion contained an express exception stating that buildings under construction are not considered vacant. In the absence of such an exception, Travelers was free to apply its exclusion.

Finally, the court also ruled that the agent owed no duty of care to the subsequent owner to obtain insurance that would have applied to a vacant building. Since the agent procured the policy on behalf of the developer only, it could not be liable to the subsequent owner for any professional negligence.

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Inside this issue.....

Vacancy Provisions Limiting Coverage — Pg. 1
President's Message — Pg. 2
Note & News from Members — Pg. 3
Update on Howell — Pg. 4
Exception to Horizontal Exhaustion Rule — Pg. 5
SIR Doesn't Relieve Insurer of Covered Portion — Pg. 6
Common Law Right of Privacy — Pg. 7
On the Lighter Side — Pg. 8

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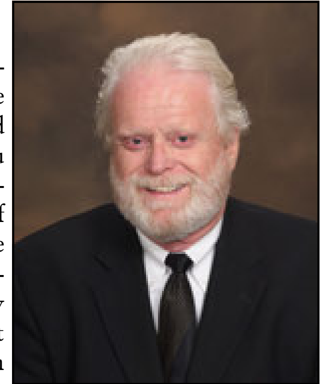
President's Message

CAIIA



W.L. (BILL) McKenzie
CAIIA President

Most of you are probably aware of Kevin Quinley, who publishes in Claims Magazine. He also has a site on LinkedIn. He has taken a poll as to the following question, "If your child came to you and said, I want to be a claims adjuster, would you encourage them, discourage them, or seek out health professionals?" I have followed the remarks made by a number of adjusters and most are very positive with an occasional negative comment. One of the comments I thought was most interesting was the following, "Is this a trick question? Because nobody grows up and says they want to be an adjuster." Surprisingly, it was signed by an adjuster and the son of an adjuster. I know in the CAIIA, we have members whose parents were adjusters. They have followed in their footsteps to become adjusters, but I have never heard any comments from them that they would encourage or discourage their children from going into the field of adjusting. I never really encouraged or discouraged either one of my children and both worked for me as secretarial staff. Neither expressed any desire to become an adjuster. In fact, when my youngest daughter worked for me as a secretary over the summer between her Freshman and Sophomore years in college, she thought the job was extremely boring and definitely not something she ever wanted to do. My daughters became acquainted with the business only because I spoke about my work throughout their growing up and neither expressed any desire to enter the adjusting field.

I have to agree that sometimes the job is boring, but most often it is not. We meet many personalities, some great, some good, and some just a royal pain and difficult at best to deal with. However, that is part of our job as adjusters. We have been trained for that and, as we get older, we should have acquired certain skills that make us better people and facilitate our dealing with the more difficult insureds and/or claimants. It is relatively easy to deal with the great and good people, but it challenges us all when we are dealing with an insured or claimant that poses challenges to our patience, intellect and attitude. By the way, my daughter graduated from MIT with an Electrical Engineering Degree, an Economic Degree (which I thought was boring), and is now an attorney in the San Jose area. I cautioned her not to become a claimant's attorney in insurance-related issues. She actually does Intellectual Property Law.

Mr. Quinley also posed the question on LinkedIn, "Did you land in the claims profession by accident, or was it something you planned?" I have already laid out as to how and why I became an adjuster, but I have really enjoyed reading the comments by our colleagues who have responded to the question. Ours is a challenging job and, as I look back in the twilight of my career. for the most part I have enjoyed it,. It has been satisfying career and I have met some of the most interesting individuals that I could ever hope to meet.

Mr. Tim Waters, as Co-Chairman of the Educational Committee, has again arranged a wonderful class on Ethics, which was held at our Mid-Term Meeting in South Lake Tahoe, and presented by attorney Steve Hutching. In fact, it was one of the most enlightening ethics class I can remember. Thank you again Steve.

There was an excellent turnout at the Combined Claims Conference and Mr. Jackson made available some new Directories which were given out to participants at the Conference. I want to personally thank all of the members of the CAIIA who volunteered and assisted the organization in manning our booth and in talking to and encouraging independent adjusters to join the CAIIA. Mr. Waters and Mr. Jackson have forwarded information to the members and other adjusters about the up-coming Annual Fair Claims Settlement Practices Regulations, SIU Regulations, and the SEED Seminars. I anticipate a full house at all of these venues. It is unfortunate at times that the only time we see other independents, particularly non-members, is at these events. When I attend the San Diego California Fair Claims Settlement Practices Regulations, it has always amazed me that most of the time this was the only

(Continued on page 3)

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time I actually ran across many of our members in the San Diego area, along with non-members, and for whatever reason, it was the only time we got together to discuss business and/or our relationships. Through LinkedIn, I see more of our members and our adjusting colleagues posting comments about the adjusting business. At times, I still miss the one on one, or person to person contacts. For that reason, I enjoy attending the Combined Claims Conference and the Northern California Conference. Many of the readers of this letter will know that I am technically challenged as I don't text and I prefer to communicate in person or, if that's not possible, over the phone. I am not a good person for communicating via e-mail and have never texted over the years that has been available. I so enjoy the personal contact.

I hope to see many of you at the SEED Seminar that I will be attending and also at the CCNC, which will be held September 16-17, 2013 in Sacramento.

W.L. (Bill) McKenzie

W.L. (BILL) MCKENZIE, RPA

President – CAIIA 2012-13

Notes and News from Members

You too can now be licensed in the State of Nevada

You can now adjust claims legally in Nevada. If you have a California Independent Adjuster's License in good standing, Nevada will now award a reciprocal license upon application. If you apply through Sircon.com, all that you must do is complete an application. Sircon checks the database to confirm that you are in good standing in your home state and submits this information to Nevada. Most states department of insurance web sights have a link to sircon.com. If you go to the Sircon sight through a link from a state department of insurance, you will go straight to the forms and instructions. If you apply directly to any state DOI, you must order a letter from the California DOI declaring that you are in good standing.

Since Nevada is our closest neighboring state, this is a natural area for a growing IA in which to expand. I have just added Nevada to the list of states that I have been licensed to adjust claims in. I was not previously licensed in Nevada because historically they would only license residents of the state, or those residing within 5 miles (to accommodate Lake Tahoe adjusters on the California side). Nevada was sued in Federal Court, and lost. As the Nevada DOI website reports;

> The United States District Court for the District of Nevada concluded in *Reitz v. Kipper* that the opportunity to obtain a license to work as an insurance adjuster in the state of Nevada is a fundamental privilege protected by the Privileges and Immunities Clause of the United States Constitution.

Since the above legal finding, Nevada has joined most of the rest of the country in offering non-resident independent adjuster licenses. I have obtained reciprocal licenses in all of the following states:

Arizona Adjusting License #172913
Idaho Adjusting License IA117608
Oregon Adjusting License194640
Utah Adjusting License 221678
Washington State Adjusting License 233718
California License individual 2B56617
California License Business 2E75371
New Mexico License 148669
Nevada License #874380
Oklahoma License A 085410
Texas License #1431382
Wyoming License #159396

When I first applied for a license in Arizona, they, and many other states, did not honor reciprocal agreements with California. I had to travel out of state at that time to take a test in order to get licensed in Arizona. This has all become easier now due to the standardizing of the process by the National Association of Insurance Commissioners (NAIC). Today, very few states do not have a reciprocal arrangement with California, as well as most other states. One state that does not honor reciprocal applications is Hawaii.

I constantly hear people complain about how difficult it is to get an independent adjuster's license in Texas. Texas residence are required to take a class offered only in Texas that lasts several days, and then requires a test on the material from the class. At one time Texas had no reciprocal agreement and all applicants had to take that test. Many adjusters still believe that they have to take this test to

(continued on page 4)

(continued from page 3)

get the Texas license. I can tell you that all that I did was submit a form (the same form as every other state) to Texas, and I am now a Licensed Independent in that “Great State”.

Except for Wyoming, I have handled claims with one or more visits to each of the above states. Wyoming has only 576,412 souls, and not a whole lot in machinery and equipment. I am still hoping to get that first assignment in Wyoming.

The following states do not require a license of an independent adjuster, so you and I can legally provide service in the following states as well.

Illinois
Wisconsin
Iowa
Missouri
Colorado
South Dakota
North Dakota

The big disadvantage of having 12 state licenses is that I am now responsible for 12 renewals. Many state charge $75.00 for a nonresident renewal, but the state with the smallest population, Wyoming, charges $150.00. I have very little hope of ever recouping the money that I have spent on licenses in Wyoming.

Pete Vaughan , RPA
Vaughan and Associates, Bencia, CA

Howell Affirmed and Extended Again
Good News for California Businesses and Insurers!
Credit to Tyson & Mendes, La Jolla, CA

Tyson & Mendes was fortunate to win the multi-billion dollar *Howell v. Hamilton Meats & Provisions, Inc.* (2011) 52 Cal.4th 541 case before the California Supreme Court. *Howell* held an injured plaintiff was only entitled to recover the amount that was actually paid by health insurance, not the much greater amount that was billed. The difference between what is billed by medical providers and what is actually paid totals over $3 Billion dollars a year. The Consumer Attorneys of California have understandably been quite unhappy with our win and continue to fight the decision in lower courts. One such example happened just last week.

HOLDING

On April 8, 2013 the California Court of Appeal held in *Luttrell v. Island Pacific Supermarkets, Inc.* (2013) --- Cal.Rptr.3d ----, WL 1400850, that the *Howell* rule applies not only to medical care paid for by a private insurer, but also to treatment covered by Medicare. Secondly, this Northern California Appellate Court held that medical expenses must first be reduced to the amount paid (the *Howell* cap) and then be reduced by any comparative fault of the plaintiff. Both of these rulings are extremely favorable for defendants in California.

FACTS

The facts in *Luttrell* were that plaintiff James Luttrell suffered a fractured hip when struck by an automated door at the Island Pacific Supermarket. After undergoing hip replacement surgery, James Luttrell was readmitted to the hospital three months later with an ulcer on his posterior.

Luttrell contended Island Pacific Supermarket was liable not only for his broken hip, but also for the ulcer on his posterior resulting from his limited movement while recovering from surgery. During trial Luttrell submitted two medical bills: one totaling $179,443.72 for the hip surgery and the other totaling $511,105.21 for the treatment of the ulcer. All medical treatment was covered by Medicare.

The jury found Island Pacific primarily negligent (95%) and Luttrell contributorily negligent (5%). They awarded Luttrell the full $179,443.72 (100% of the billed amount) for the hip surgery and $76,665.78 (only 15% of the billed amount) for the ulcer, on the basis that Luttrell’s ulcer was a pre-existing condition. They also awarded Luttrell a total of $156,664.50 for future medical expenses, pain and suffering and future noneconomic loss. The total award of $412,774.00 was reduced to $392,135.30 due to Luttrell’s 5% contributory liability.

Subsequent to the jury verdict, Island Pacific moved to reduce the medical expenses to the amount actually paid, citing *Hanif v. Housing Authority 200 Cal.App.3d635.* (Tyson & Mendes was still arguing *Howell* in the California Supreme Court.) Luttrell conversely moved for a new trial on the grounds the 15% awarded for the ulcer was grossly under what he deserved. The Court of Appeals ruled Luttrell was 50% responsible for his ulcer (compared to the trial courts’ finding of 85% responsibility) in that his failure to equitably attempt to care for himself added to the severity of his ulcer.

ANALYSIS

The published portion of the *Luttrell* opinion addressed two main issues:

1. Does *Howell* Apply to Medicare?
2. Should The Mitigation Reduction or Comparative Fault Be Applied to Amounts Billed or Paid?

On the first issue, Luttrell simply argued *Howell* did not involve Medicare, and only applied to private insurance. Appellant failed to articulate a reason why *Howell* should not apply to Medicare, given the similarities of both Medicare and private insurance. The Appellate Court was fortunately not persuaded to limit *Howell* to only private insurance. The second issue addressed whether the 50 percent reduction (due to Luttrell’s contributory negligence with regard to the ulcer) should be applied to the full medical bill from the provider or the reduced amount paid by the insurer (be it private or government). The court found Luttrell was only entitled to apply the 50 percent mitigation to the “Howell cap”, or amount paid, not the full amount of the medical bills. The court explained the amount paid is the *most* a plaintiff can hope to recover and the plaintiff should not get a windfall by using the amount billed. This holding resulted in Luttrell receiving much less in damages than if the court had used the amount billed.

This case represents another significant win for California businesses and insurers.

Appeals Court Renews Finding of Exception to Horizontal Exhaustion Rule
Credit to Haight, Brown & Bonesteel, Los Angeles, CA

In *Kaiser Cement & Gypsum Corp. v. Insurance Co. of State of Pennsylvania* (No. B222310, filed 4/8/13), a California Court of Appeal again carved out an exception to the rule of horizontal exhaustion holding that, given the right policy language, an insurer issuing successive policies that span a continuous loss is only obligated for a single year's limit per occurrence.

Kaiser had tendered thousands of asbestos claims involving continuing bodily injury to its primary insurer, Truck Insurance Exchange (Truck). Truck insured Kaiser for several years, and Kaiser selected 1974 as the policy year to respond for injuries occurring, in part, during that year. Certain of the claims exceeded Truck's $500,000 per occurrence limit and Truck had argued that because its successive primary policies all specified that "The limit of liability stated in this policy as applicable per occurrence is the limit of the company's liability for each occurrence," Truck's liability was limited to $500,000 per occurrence, not $500,000 per occurrence-per year.

In a prior opinion the Court of Appeal had agreed, announcing an exception to the rule of horizontal exhaustion, holding that any primary insurer issuing successive policies is only obligated for a single year's per occurrence limit before excess insurance is triggered. Thus, an insurer that renewed for 10 years would only owe one year's primary coverage for a continuing loss. (*Kaiser Cement v. Ins. Co. of Pa.* (2011) 196 Cal.App.4th 140, review granted Aug. 24, 2011, S194724.)

The broader principal of horizontal exhaustion was then confirmed by the California Supreme Court in *State of California v. Continental Insurance Co.* (2012) 55 Cal.4th 186, which held that continuing losses were not broken down into discrete policy years but instead, all policies in effect during any part of a continuous loss were obligated for "all sums," and could be "stacked," resulting in one big pool of "uber insurance" for the policyholder.

The Supreme Court vacated the earlier *Kaiser Cement* opinion, and ordered the Court of Appeal to reconsider its decision in light of the *State of California* case. But, having done so, the Court of Appeal again found that, under the language of Truck's 1974 primary policy, Truck was responsible to pay policy limits only once per occurrence, not once per occurrence per year or once per occurrence per policy.

To get there, the Court of Appeal acknowledged the holding in *State of California*, but noted that the Supreme Court had specifically left the door open with a caveat that insurers could contract around the "all sums with stacking" rule by use of express policy language. The appeals court noted that the Truck primary policies stated that "[t]he limit of liability stated in this policy as applicable 'per occurrence' is the limit of the company's liability for each occurrence" and "[t]here is no limit to the number of occurrences for which claims may be made hereunder, however, the limit of the Company's liability as respects any occurrence involving one or any combination of the hazards or perils insured against shall not exceed the per occurrence limit designated in the Declarations."

Further, the policy specifically provided that, "[t]he limit of liability stated in this policy as applicable 'per occurrence' is the limit of the company's liability for each occurrence" and "the limit of the Company's liability as respects any occurrence . . . shall not exceed the per occurrence limit designated in the Declarations."

According to the *Kaiser Cement* court, this is "anti-stacking" wording as contemplated by the Supreme Court in the *State of California* case: "Notably, the policy does not say that the per occurrence limit is the limit of the company’s annual liability for any occurrence, or that the per occurrence limit is the limit of the company’s liability under the policy. Rather, it says that the per occurrence limit is the limit of the company’s liability. We presume, as we must, that the parties intended this language to mean what it plainly says—that for any single occurrence, Truck is liable up to the per occurrence limit, and no more. We thus conclude that the trial court correctly determined that Kaiser may not 'stack' the liability limits of Truck’s primary policies, but rather may recover only up to the 'per occurrence' limit of one policy."

Having essentially reached the same decision it was ordered to reconsider by the Supreme Court in the wake of the *State of California* case, it is not clear that this opinion will remain citable as precedent. The decision once again ignores the fact that each policy renewal constitutes a separate contract for which a separate premium is paid, and would appear to limit the coverage available to policyholders that renew, which could be seen as inconsistent with the "all sums with stacking" rule announced by the Supreme Court.

Don’t forget!
Mother’s Day
is May 12th.

Although Insured's Insolvency Renders It Unable to Pay Self-Insured Retention, That Does Not Relieve Insurer of Duty to Pay Covered Portion of Judgment
Credit to Smith, Smith & Feeley, Irvine, CA

Although an insured's insolvency rendered it unable to pay a self-insured retention, that did not relieve the insurer of a duty to pay the covered portion of a judgment against the insured. (*Phillips v. Noetic Specialty Insurance Company* (S.D. Cal. 2013) --- F.Supp.2d ----, 2013 WL 244536)

Facts

Electric Mobility Corporation (EMC) sold a motorized scooter to Claud Phillips (Mr. Phillips). Sometime later, Mr. Phillips was traveling on the scooter when it toppled over, injuring him. As a result, Mr. Phillips filed a personal injury lawsuit against EMC in California state court.

EMC tendered the defense of the lawsuit to its products liability insurer, Noetic Specialty Insurance Company (Noetic). The Noetic policy provided EMC with liability limits of $2 million in excess of a $500,000 self-insured retention (SIR). Noetic assigned one of its panel defense attorneys to represent EMC in the personal injury lawsuit.

While the personal injury lawsuit was pending, EMC became insolvent. At that point, Noetic's panel defense attorney successfully moved to withdraw from representing EMC in the personal injury action. After the defense attorney withdrew, the court struck EMC's answer and entered a default judgment against EMC for slightly over $1 million.

Mr. Phillips then demanded that EMC's liability insurer, Noetic, pay the judgment pursuant to the terms of the policy. Noetic denied coverage for the judgment, asserting that the policy had a $500,000 SIR and that Noetic's liability under the policy was "not triggered until ... [EMC] pays the judgment."

Mr. Phillips died, and his judgment against EMC thus became an asset of his estate. Mr. Phillips' wife, Billie Phillips (Mrs. Phillips), as executor of Mr. Phillips' estate, demanded that Noetic pay the judgment "less the unsatisfied amount of EMC's SIR." Noetic again denied coverage for the judgment, claiming that coverage was no longer possible because EMC had gone out of business.

Mrs. Phillips as executor of Mr. Phillips' estate then sued Noetic in federal court based on Noetic's refusal to pay the portion of the judgment that exceeded EMC's SIR. Mrs. Phillips included claims for breach of third-party beneficiary contract and breach of the implied covenant of good faith and fair dealing. Noetic moved to dismiss Mrs. Phillips' complaint, arguing in part that EMC's payment of the $500,000 SIR was a "condition precedent" to coverage under the Noetic policy.

Holding

The United States District Court, applying California law, denied Noetic's motion to dismiss. The court rejected Noetic's argument that EMC's payment of the $500,000 SIR was a "condition precedent" to Mrs. Phillips' right to collect any portion of the judgment under the Noetic policy. The Noetic policy's insuring clause provided that Noetic would pay "*those sums, in excess of the 'self-insured retention,' that the insured becomes legally obligated to pay as 'damages'* because of 'bodily injury' ... to which this insurance applies." The policy's conditions section provided that the insured's "bankruptcy, insolvency or inability to pay the 'self-insured retention' will not increase our obligations under this policy," but also provided that *"[b]ankruptcy or insolvency of the insured or of the insured's estate will not relieve us of our obligations under this policy*." The district court observed that the policy Noetic had issued to EMC "does not state that payment of the SIR is a condition precedent to coverage," and indeed "expressly states that the insolvency of the insured will not relieve the insurer of [its] obligations under the policy." Thus, EMC's payment of the SIR was not a condition precedent to coverage under the terms of the Noetic policy. Mrs. Phillips could thus proceed with her lawsuit alleging that Noetic was required to pay that portion of the judgment that exceeded the SIR.

Comment

The court observed that an insurer can include terms making the insured's payment of an SIR a condition precedent to coverage. Here, however, the insurer had failed to include such terms in its policy. Because the policy did not make payment of the SIR a condition precedent to coverage, the court would not read such a requirement into the policy.

Common Law Right of Privacy – No Requirement of Written "Publication"
Ignat v. Yum! Brands, Inc.
Court of Appeal, Fourth District
(March 18, 2013)
Credit to Low, Ball & Lynch, San Francisco, CA

Traditionally, a common law right of privacy based on the disclosure of private facts required that there be a written "publication" of such facts. This case considered and eliminated the written publication requirement in the context of an employer's oral statements sharing private facts to other employees.

Melissa Ignat worked for Yum! Brands, Inc., assisting paralegals in the real estate department in obtaining title to properties for some of Yum!'s franchises, including Taco Bell, KFC, and Pizza Hut. Ms. Ignat suffered from bipolar disorder, and claimed that she missed work on occasion as a result of the side effects of medication she took for the disease. Ms. Ignat claimed that during her absence, her supervisor told co-workers that Ms. Ignat suffered from bipolar disorder, causing her co-workers to "shun" her upon her return to the company. A fellow co-worker even stated that Ms. Ignat could "go postal," referring to Ms. Ignat's disorder. A few months later, Ms. Ignat's employment was terminated.

Ms. Ignat filed suit against her employer, Yum! Brands, and her immediate supervisor, alleging one cause of action for invasion of privacy by public disclosure of private facts. The Trial Court granted summary judgment in favor of the employer since the alleged publication of Ms. Ignat's ailment was not made in writing.

The Court of Appeal reversed, discarding the "writing" requirement and holding that verbal disclosures would suffice. In support of its shift from prior case law, the Court of Appeal looked at the historic background of the right of privacy cause of action, which had its roots in the late 1890's, when there was concern that "advances in photography and the proliferation of newspapers" left individuals exposed to invasions of their privacy not covered by "established legal protections." Over the years, the cause of action for invasion of privacy and the public disclosure of private facts had evolved with a requirement that the disclosure be in writing because otherwise, the disclosure would not reach the level of "special damages" to one's reputation that required protection.

The Court of Appeal found that in the modern era, there is no justification for distinguishing between an oral or written publication of such private facts. The Court stated that "limiting liability for public disclosure of private facts to those recorded in a writing is contrary to the tort's purpose, which has been since its inception to allow a person to control the kind of information about himself made available to the public." The Court further noted that while this restriction may have made sense in the 1890's- when no one dreamed of talk radio or confessional television-it certainly makes no sense now. The Court noted that nowadays, private facts can be just as widely disclosed – if not more so – through oral media as through written ones.

COMMENT

It is important for employers to ensure safekeeping of employees' records and to train managers regarding the privacy of employees, particularly of medical information. Managers should be trained on what information must be kept confidential, and they should only disclose information to other managers who have a legitimate, business-related need for that information.

On the Lighter Side...

Actual writings from hospital charts

1 . The patient refused autopsy.

2. The patient has no previous history of suicides.

3. Patient has left white blood cells at another hospital.

4. Patient has chest pain if she lies on her left side for over a year.

5. On the second day the knee was better and on the third day it disappeared.

6. The patient is tearful and crying constantly. She also appears to be depressed.

7. The patient has been depressed since she began seeing me in 1993.

8. Discharge status: Alive but without permission.

9. Healthy appearing decrepit 69-year old male, mentally alert but forgetful..

10. Patient had waffles for breakfast and anorexia for lunch.

11. She is numb from her toes down.

12. While in ER, she was examined, x-rated and sent home.

13. The skin was moist and dry.

14. Occasional, constant infrequent headaches.

15. Patient was alert and unresponsive.

16. Rectal examination revealed a normal size thyroid.
(OMG! that is some examination)

17. She stated that she had been constipated for most of her life, until she got a divorce.

18. I saw your patient today, who is still under our car for physical therapy.

19. The lab test indicated abnormal lover function.

20. Skin: somewhat pale but present.

21. Patient has two teenage children, but no other abnormalities.