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President's Message

Donna Taylor-Kolis

Dear Members,

As Al Gore said at the Academy Awards, "we have everything we need to get started with the possible exception of the will to act. That is a renewable resource. Let's renew it." Although Al was referring to global warming, his sentiment is equally applicable to our job as advocates.

Over the last several years, I have entertained numerous phone calls from despondent trial lawers looking for the light at the end of the tunnel. I have news for you: you are the light at the end of the tunnel.

I challenge each and every one of you to renew your sense of passion and indignation and become the advocates you were born to be. We cannot allow our legacy to be the dismantling of the right to trial by jury.

I recently signed up a case knowing full well that I will have to challenge Ohio Revised Code 2305.113(c) and (d). Seven years ago my client was diagnosed as having Protein C deficiency. Pregnancy in the face of this disorder can result in death. As such, my client, at the age of 21, had an irreversible tubal ligation. Last month she learned that she never had this disorder. This lovely 28 year old registered nurse will never know the personal joy of childbirth.

Should she have her day in court or should the medical community benefit because it has been more than four years since the diagnosis? The answer would seem clear.

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Announcements

Karl R. Wetzel, Esq. has joined Visual Evidence/E-Discovery, LLC as Vice President, E-Discovery Services. Wetzel, formerly with Wegman, Hessler, and Vanderburg, has over 20 years of litigation experience. He earned his law degree in 1984 from Cleveland State University's John Marshall College of Law, and is currently completing his LLM in Intellectual Property from the University of Akron. He was admitted to the US District Court, Northern District of Ohio in 1996, and the US Supreme Court in 1999. Visual Evidence/E-Discovery is the leading courtroom evidence and electronic data discovery consultancy in Northeast Ohio.

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The Fair Labor Standards Act for the Small Law Firm Practitioner

By Cathleen M. Bolek

INTRODUCTION

The Fair Labor Standards Act (FLSA), also known as the Federal Wage and Hour Law, establishes minimum wage, overtime pay, record keeping, and child labor standards for most full and part-time employees in both the public and private sector.[i] It mandates that no covered employee be paid less than $5.15 per hour, and requires that overtime pay at a rate of not less than one and one-half times the employee's regular rate be paid for all hours above 40 hours worked in any workweek.[ii] The Act provides minimum standards that may be exceeded, but cannot be waived or reduced, by collective bargaining or otherwise.[iii]

An employee who is under paid in violation of the Act may file a complaint with the Department of Labor, or institute a civil suit, within two years of the violation.[iv] Damages available include back pay for up to two years (three years in the case of a willful violation), liquidated damages in an amount equaling the compensatory award, attorney's fees, and court costs.[v] It is illegal for an employer to retaliate against an employee in any way because the employee filed a complaint under the Act or is a witness in a wage and hour case.[vi]

Anyone who routinely fields questions about workers' rights will confirm that the FLSA affords significantly fewer rights to workers than commonly believed. It does not provide for pay raises or paid meal periods, vacations, sick time or holidays. In fact, it does not require that employees over the age of sixteen be given breaks or meal periods at all. It does not require premium pay for weekend, holiday and night work, places no limit on the number of hours an adult may be required to work, and does not address severance pay. While it requires employers to keep meticulous records, it does not require that those records be available to employees.[vii]

Despite its many omissions, the Act is a labyrinth of detailed rules and exceptions, with enough pitfalls to confuse the most assiduous of practitioners and to trip up the most conscientious of employers.

Personal injury attorneys and other small firm practitioners should have at least a rudimentary understanding of the most common types of violations giving rise to liability under the Act, even if they never handle employment claims. As employers, they are faced with compliance issues when paying secretaries, bookkeepers, paralegals and other staff members. In addition, in the course of gathering wage loss information for clients, they should be able to identify clients' potential overtime claims.

The complexity of the law, industry norms, the changing legal climate, and corporate America's willingness to pinch pennies at workers' expense have combined to make this a rapidly expanding field of law. Over the past decade, wage and hour claims have increased exponentially; a simple Westlaw search reveals that while federal courts cited to the FLSA in approximately 2500 cases decided between 1986 and 1996, over the next ten years that number increased by more than one thousand.

Most individual claims involve a relatively small amount of money, but a prevailing plaintiff is entitled to recover attorney's fees without regard to the proportion of the award to the fees. Furthermore, wage and hour claims may be pursued as class and collective actions. The potential for class certification and a large fee award renders these cases economically attractive to plaintiffs' attorneys and provides an incentive for companies to settle early. For example, Sterling Jewelers of Akron recently agreed to pay $1.29 million to 16,820 current and former employees, scattered over 1,200 locations in 41 states, before suit was even commenced.[viii]

While corporate greed undoubtedly contributes to many companies' failure to comply with wage and hour requirements, many large employers have unwittingly found themselves in violation simply because of the complexity of the laws. For example, while it is generally understood that managers are exempt from wage and hour laws, clothiers Abercrombie & Fitch learned the hard way that the FLSA is not so easily summarized. Last year, the company ponied up $2 million to resolve overtime claims of store managers in California.[ix]

In many industries, common practice plays a significant role in how employees are compensated. Consequently, one worker's successful complaint often inures to the benefit of workers in an entire industry. After a successful challenge to an industry practice in the compensation of brokers, 2006 saw many of Wall Street's largest financial institutions settling claims alleging wage and

hour violations. Morgan Stanley settled with brokers in California for $42.5 million, while UBS and Smith Barney paid brokers nationwide $89 million and $98 million, respectively, to settle their wage claims.[x] Wells Fargo agreed to pay $12.8 million to settle a lawsuit accusing it of violating overtime rules.[xi] Claims on behalf of technology workers also came in waves: IBM agreed to pay $65 million to settle a class action lawsuit accusing the company of misclassifying workers as exempt from overtime,[xii] and Electronic Arts agreed to pay its software engineers $14.9 million for wage and hour violations.[xiii]

Typically, violations occur because the employer either fails to properly calculate hourly workers' "work time," treats a covered employee as exempt, or fails to maintain adequate time records.

WHAT IS "WORK TIME"?

The FLSA provides that employees must be compensated for all "work time." "Work time" includes "all the time during which an employee is necessarily required to be on the employer's premises, on duty or at a prescribed work place."[xiv] It does not include the time an employee travels to and from the parking lot.[xv]

Travel integral to an employee's job that occurs **during** the workday is "work time." "Work time" begins when the employee arrives at the first place of business, even if that involves merely retrieving instructions or tools before going to the ultimate work site.[xvi]

"Work time" does not begin until the employee commences those work-related activities that are necessary to perform the primary activities of the job; "work time" ends when he or she stops performing those activities.[xvii] With the exception of "bona fide" break periods, "work time" includes all of the time in between.

Employees are entitled to be compensated for all work they actually perform, even if the work wasn't requested by the employer, if the employer knows the work is being performed, because "(w)ork not requested but suffered or permitted is work time."[xviii] To avoid compensating employees for work not requested, employers must take affirmative steps to see that the work is not performed. An employer may not "sit back and accept the benefits" of its employees' unwanted labors.[xix]

One common error employers make is to deduct wait time, rest periods or periods of inactivity. Inactive time an employee spends waiting to work, when the wait is at the request of the employer, is "work time."[xx]

"Work time" does not include "bona fide" breaks and meal periods. "(R)est periods of short duration, running from 5 minutes to about 20 minutes" are considered working time, must be included in the employee's compensable time, and may not be offset against other working time.[xxi] Breaks and meal periods are not required by the Act, but if provided, their duration may be deducted from "work time" only if the employee was completely relieved of duty for at least thirty uninterrupted minutes. The time will be compensable if the employee is required to perform any duties during that time.[xxii]

Other potential pitfalls involve time employees spend receiving medical care, performing work for charities, and attending training during the work day. Time spent waiting for and receiving medical attention on an employer's premises, or at the employer's direction, during the employee's normal working hours is compensable.[xxiii] An employee who does work for charitable purposes (such as volunteering for the United Way) at the employer's request, must be compensated for that time.[xxiv] The time an employee spends attending lectures, meetings and training is considered work time, unless all of the following apply: (a) attendance is outside of the employee's regular working hours; (b) attendance is voluntary; (c) it is not "directly related" to the employee's job; and (d) the employee does not perform any productive work during such attendance.[xxv] To be "voluntary," the employee must understand that nonattendance will not adversely affect his employment.[xxvi]

Employers are not required to use time clocks. If they do use them, they need not compensate employees who voluntarily come in early or remain late (as long as they do not engage in any work), and may "round" time to the nearest quarter of an hour as long as the rounding is used in such a manner that it will not result, over a period of time, in failure to compensate the employees properly for all the time they have actually worked. Thus, a system that rounds up at the start of the workday and down at the end of the workday would violate the FLSA.[xxvii]

Insubstantial periods of overtime, which cannot, as a practical administrative matter, be precisely recorded, need not be compensated.[xxviii] This rule, known as the "*de minimis* rule," does not permit employers to arbitrarily fail to count time worked, no matter how small those increments might be.[xxix]

Law firms often run afoul of the Act in calculating overtime hours worked. For purposes of the FLSA, time is calculated on a strict seven day "work week" basis. There is no "carry over" into the next week or "averaging" of the hours worked, even if the employee is paid on a salaried basis. Thus, an employee who works 30 hours one week and 50 hours the next week must receive ten hours of overtime compensation. A law firm that asks a salaried secretary or paralegal to work late in one week to assist with trial preparation, while providing a paid day off in the following week to compensate, is in violation of the Act.[xxx]

WHO IS AN "EXEMPT" EMPLOYEE?

The FLSA provides a plethora of exemptions.[xxxi] To be "exempt," an employee must be salaried. An employer who makes improper deductions from salary will lose the exemption if the facts demonstrate that the employer did not intend to actually pay a salary.[xxxii]

An employee who receives a total annual compensation of at least $100,000, and who customarily and regularly performs any one or more of the exempt duties or responsibilities of an executive, administrative or professional employee, discussed below, is an exempt employee.[xxxiii]

Whether or not an employee is exempt from wage and hour laws depends upon the actual duties the employee performs and the level of authority the employee has in performing those duties. Job title does not establish exempt status.[xxxiv]

Often, an employee comes within the scope of more than one exemption. For record keeping purposes, as long as the employee is actually exempt, employers need not be concerned with identifying a specific exempt category.[xxxv]

Exempt status is granted only to employees whose primary duty includes performing office or non-manual work. Manual laborers and other "blue collar" workers who perform repetitive operations with their hands, physical skill and energy are **not** exempt employees no matter how highly paid they might be.[xxxvi] Similarly, police officers, deputy sheriffs, highway patrol officers,

inspectors, correctional officers, parole officers, fire fighters, paramedics, and similar employees, regardless of rank or pay level, who perform work such as preventing, controlling or extinguishing fires, rescuing victims, detecting crimes, interrogating and fingerprinting suspects, or other similar work, are not exempt.[xxxvii]

(A) Executive, Administrative and Professional Exemptions

Executive: Employees working in a "bona fide executive capacity" are exempt if: the employee is paid a salary of not less than **$455 per week**; the employee's **primary duty** is management of the enterprise; the employee regularly directs the work of two or more employees; and the employee has the authority to recommend or carry out the hiring and firing of other employees.[xxxviii] An employee also qualifies as a bona fide executive if the employee owns at least 20-percent equity interest in the enterprise and is actively engaged in its management. [xxxix]

Administrator: An employee is exempt as working in a "bona fide administrative capacity," if: the employee is paid a salary of not less than $455 per week; the employee's **primary duty** is the performance of office or non-manual work directly related to the management or general business operations of the employer or the employer's customers, and; the employee's **primary duty** includes the exercise of discretion and independent judgment with respect to matters of significance.[xl] **The exercise of discretion and independent judgment does not include clerical or secretarial work.**[xli] Accordingly, it is extraordinarily rare for a secretary to be an exempt employee.

Professional: "Bona fide professionals" are exempt from the wage and hour requirements. To be exempt as a professional, the employee must be paid a salary of not less than $455 per week, and his or her **primary duty** is the performance of: work requiring knowledge of an advanced type in a field of science or learning customarily acquired by a prolonged course of specialized intellectual instruction; or work requiring invention, imagination, originality or talent in a recognized field of artistic or creative endeavor.[xlii] The "field of science or learning" includes the traditional professions of law, medicine, theology, accounting, engineering, architecture, various types of physical, chemical and biological sciences, pharmacy and similar occupations. The best prima facie evidence that an employee meets this requirement is possession of the appropriate academic degree.[xliii]

Paralegals are typically not exempt employees. Although many paralegals possess general four-year advanced degrees, most specialized paralegal programs are two-year programs. The learned professional exemption is available for paralegals who possess advanced specialized degrees in other professional fields and apply that knowledge to the performance of their duties. For example, if a law firm hires an engineer as a paralegal to provide expert advice on product liability cases, that engineer would qualify for exemption.[xliv]

The "creative professional" exemption includes: actors, musicians, composers and conductors; painters who, at most, are given a subject matter to work from; cartoonists who are told only the underlying concept of a cartoon and must rely on their own creative ability to create, and; writers who choose their own subjects and prepare a finished piece. Journalists are typically not exempt if their work depends primarily on intelligence, diligence and accuracy as opposed to creativity.[xlv]

The professional exemption also applies to teachers, tutors, instructors and lecturers of an educational establishment by which the employee is employed.[xlvi]

(B) Computer Systems Analysts, Programmers and Software Engineers

Employees whose primary duty consists of: the application of systems analysis techniques and procedures to determine hardware, software or system functional specifications; the design, development, documentation, analysis, creation, testing or modification of computer systems or programs, based upon design specifications; or a combination thereof, are exempt from the requirements of the FLSA. This exemption does not include employees engaged in the manufacture or repair of computer hardware and related equipment, or whose work is highly dependent upon the use of computers and computer software programs but who are not primarily engaged in analysis, programming or other similarly skilled work.[xlvii]

WHAT RECORDS MUST BE KEPT?

The record keeping requirements of the FLSA are set forth at 29 CFR 516.2. Employers are required to maintain records containing the following information with respect to each non-exempt employee:
(1) full name, and on the same record, the employee's identifying number if used
(2) Home address
(3) Date of birth (if under 19)

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(4) Sex and occupation
(5) Time of day and day of week on which the employee's workweek begins
(6) Regular hourly rate of pay and the amount and nature of any payment excluded from the "regular rate" (commission pay, for example)
(7) Hours worked each workday and the total number of hours worked each workweek (a "workday'" is any fixed period of 24 consecutive hours and a "workweek" is any fixed and regularly recurring period of 7 consecutive workdays)
(8) Total daily or weekly straight-time earnings or wages due for hours worked during the workday or workweek, exclusive of premium overtime compensation
(9) Total premium pay for overtime hours
(10) Total additions to or deductions from wages paid each pay period
(11) Total wages paid each pay period
(12) Date of payment and the pay period covered by payment

With respect to exempt employees, employers must maintain records containing the information listed above as (1) - (9), and a description of the basis on which wages are paid in sufficient detail to permit calculation for each pay period, including fringe benefits and prerequisites. (This information may be shown as the dollar amount of earnings per pay period, with addenda such as "plus hospitalization, benefit package B, and 2 weeks paid vacation").

Payroll records must be preserved for at least 3 years. Those records include, in addition to the information listed above, all employment contracts (including collective bargaining agreements), plans, trusts, and notices. Any agreements not in writing should be summarized. For employees paid on commission, the employer must preserve sales and purchase records. [xlviii] The records must be available for inspection. If maintained off site, they must be available on 72 hour notice.[xlix]

CONCLUSION

Employers that once relied upon a general understanding of the requirements of the FLSA are becoming litigation targets. The Act provides strict liability, and has not yet been rendered toothless by those who would take away the rights of all workers. As champions of the rights of individuals, we should ensure that we comply with the wage and hour laws and that our clients' employers do so as well.

Cathleen is a partner with Cohen Rosenthal & Kramer LLP, and serves on the Board of CATA. A Founding Member of the Cleveland Employment Inns of Court, Cathleen has practiced primarily in the field of employment law for over a decade. On February 9, 2007, she participated in an employment law seminar hosted by OATL; the topic of her lecture was the FLSA.

Endnotes:

i.The Act, titled the Fair Labor Standards Act of 1938, as Amended, is codified at 29 U.S.C. §201 *et seq.* There are volumes of regulations which explain the statutory requirements. This article is not intended to provide a comprehensive description of the requirements of the FLSA and its regulations. To review the statute and the interpretive regulations, visit http://www.dol.gov/esa/whd/flsa/ This website, hosted by the Department of Labor, provides compliance assistance to employers as well as information for employees.

ii.*Id.* The Ohio Minimum Fair Wage Standards Act incorporates all of the requirements of the FLSA, and generally, a violation of one constitutes a violation of the other. R.C. §4111.03(A). One notable exception is contained in the recently enacted HB 690, which amended Ohio law to provide for a minimum wage of $6.85.

iii.29 CFR 541.4.

iv.29 U.S.C.§255. For a willful violation, the statute of limitations is three years. *Id.*

v.29 U.S.C. §216, 260.

vi.29 U.S.C.§215 (a)(3). Willful violation of this section is a criminal act, punishable by up to a $10,000 fine and six months imprisonment, although an employer may not be imprisoned for a first conviction under the Act. 29 U.S.C.§216 (a).

vii.Recent changes to Ohio law require that an employer must make an employee's records available to that employee or his or her representative, upon request. HB 690.

viii.Business and Legal Reports, June 14, 2006, online at http://hr.blr.com/display.cfm/id/18591.

ix.Jan. 23, 2006, Los Angeles Business Journal, http://www.allbusiness.com/government/employment-regulations-overtime-pay/865165-1.html.

x.Nov. 29, 2006, Registered Rep, http://registeredrep.com/news/merrill-overtime-settlement/; see, also, Business and Legal Reports, Feb. 10, 2006, http://hr.blr.com/display.cfm/id/17799.

xi. Business and Legal Reports, Oct. 12, 2006, http://hr.blr.com/display.cfm/id/19236.

xii.Business and Legal Reports, Nov. 26, 2006, online at http://hr.blr.com/display.cfm/id/75005.

xiii.April 26, 2006, Industry News, online at http://www.gamasutra.com/php-bin/news_index.php?story=9051.

xiv.*Anderson v. Mt. Clemens Pottery Co.*, 328 U.S. 680 (1946), emphasis added. See, also, *Tennessee Coal, Iron & Railroad Co. v. Muscoda Local No. 123*, 321 U. S. 590 (1944).

xv.Shortly after the enactment of the FLSA, the United States Supreme Court held that workers were entitled to be compensated for all of the time they spent on their employer's premises, including their travel time to and from their work sites. *Anderson v. Mt. Clemens Pottery Co.*, 328 U.S. 680 (1946), Thereafter, the FLSA was amended by "The Portal-to-Portal Act," 29 U.S.C. 251-262; see, also 29 CFR 785.35.

xvi.*Walling v. Mid-Continent Pipe Line Co*., 143 F. 2d 308 (C. A. 10, 1944); 29 CFR 785.38.

xvii.*Steiner v. Mitchell*, 350 U.S. 247, 248, 76 S.Ct. 330, 100 L.Ed. 267 (1956). "Work time" begins when the employee starts to don specific, necessary safety gear in the employer's locker room, and includes the time the employee then spends walking between the dressing area and the production area. *IBP, Inc. v. Alvarez*, 546 U.S. 21, 126 S.Ct. 514 U.S. (2005). It also includes the time spent showering in the employer's shower room if the nature of the employee's work requires him or her to shower for health reasons. *Steiner*, 350 U.S. 247 (involving work that exposes employee to caustic and toxic chemicals which must be washed away immediately).

xviii.29 U.S.C. §203(g), 29 CFR 785.11. Even work performed for, but not requested by, the employer, at an employee's home, is compensable, if the employer **"knows or has reason to believe**" that the work is being performed. 29 CFR 785.12. See, *Handler v. Thrasher*, 191, F. 2d 120 (C.A. 10, 1951); *Republican Publishing Co. v. American Newspaper Guild*, 172 F. 2d 943 (C.A. 1, 1949); *Kappler v. Republic Pictures Corp*., 59 F. Supp. 112 (S.D. Iowa 1945), aff'd 151 F. 2d 543 (C.A. 8, 1945); 327 U.S. 757 (1946); *Hogue v. National Automotive Parts Ass'n*. 87 F. Supp. 816 (E.D. Mich. 1949); *Barker v. Georgia Power & Light Co.*, 2 W.H. Cases 486; 5 CCH Labor Cases, para. 61,095 (M.D. Ga. 1942); *Steger v. Beard & Stone Electric Co., Inc.*, 1 W.H. Cases 593; 4 Labor Cases 60,643 (N.D. Texas).

xix.29 CFR 785.13.

xx.See, *e.g., Armour & Co. v. Wantock*, 323 U.S. 126 (1944); *Skidmore v. Swift*, 323 U.S. 134 (1944); 29 CFR 785.7. Examples of compensable "wait time" include that spent by a stenographer waiting for dictation, a messenger awaiting assignments, a firefighter waiting for alarms and a factory worker waiting for machinery to be repaired. Such time is compensable even if the employee spends it reading a book, working a crossword puzzle, playing checkers, or socializing. Even if an employer permits the employee to leave the work premises during periods of inactivity, the time is compensable as long as the time periods are unpredictable, of short duration, and the employee is unable to use it effectively for his own purposes. See, for example, *Skidmore v. Swift*, 323 U.S. 134, 137 (1944); *Wright v. Carrigg*, 275 F. 2d 448, 14 W.H. Cases (C.A. 4, 1960); *Mitchell v. Wigger*, 39 Labor Cases, para. 66,278, 14 W.H. Cases 534 (D.N.M. 1960); *Mitchell v. Nicholson*, 179 F. Supp, 292,14 W.H. Cases 487 (W.D.N.C. 1959); 29 CFR 785.15.

xxi.*Mitchell v. Greinetz*, 235 F. 2d 621, 13 W.H. Cases 3 (C.A. 10, 1956); *Ballard v. Consolidated Steel Corp., Ltd.*, 61 F. Supp. 996 (S.D. Cal. 1945); 29 CFR 785.18.

xxii.29 CFR 785.19.

xxiii.29 CFR 785.43.

xxiv.29 CFR 785.44.

xxv.29 CFR 785.27.

xxvi.29 CFR 785.27.

xxvii.29 CFR 785.48.

xxviii.*Anderson v. Mt. Clemens Pottery Co.*, 328 U.S. 680 (1946).

xxix.See *Glenn L. Martin Nebraska Co. v. Culkin,* 197 F. 2d 981, 987 (C.A. 8, 1952), cert. denied, 344 U.S. 866 (1952), rehearing denied, 344 U.S. 888 (1952), holding that working time amounting to $1 of additional compensation a week is "not a trivial matter to a workingman," and was not *de minimis*; *Addison v. Huron Stevedoring Corp*., 204 F. 2d 88, 95 (C.A. 2, 1953), cert. denied 346 U.S. 877, holding that "To disregard workweeks for which less than a dollar is due will produce capricious and unfair results." *Hawkins v. E. I. du Pont de Nemours & Co.*, 12 W.H. Cases 448, 27 Labor Cases, para. 69,094 (E.D. Va., 1955), holding that 10 minutes a day is not *de minimis*. 29 CFR 785.47.

xxx.See, 29 CFR 778.104.

xxxi.Exemptions are set forth in 29 U.S.C. §213, and are further defined in the attendant regulations.

xxxii.29 CFR 541.603. An employer's practice of giving salaried employees a "bank" of sick leave from which hours are deducted, and docking the employee's pay if those hours are exceeded, may cause the employer to lose the salaried exemption. See, *e.g. Whetsel v. Network Property Services,*

LLC, 246 F.3d 897 (7th Cir. 2001). An employer does not risk losing the exemption by making deductions from the pay of an exempt employee who is absent from work for one or more full days for personal reasons, other than sickness or disability. If the employee works a partial day, however, he or she must be paid for the full day. 29 CFR 541.602.

xxxiii.The "total annual compensation" must include at least $455 paid on a weekly basis. If that amount and the employee's additional fees or commissions do not total $100,000 over the 52 week period, the employer may, within one month of the end of the 52-week period, make one payment of the difference. Total annual compensation excludes the costs of fringe benefits. 29 CFR 541.601

xxxiv.29 CFR 541.2.

xxxv. (for example, a computer programmer who manages a team of programmers and whose primary duty includes planning, scheduling, and coordinating the activities of a team working to create a business system). 29 CFR 541.402

xxxvi.29 CFR 541.3, specifically listing, as examples, non-management production-line employees, maintenance workers, carpenters, electricians, mechanics, plumbers, craftsmen, operating engineers, longshoremen, construction workers and laborers.

xxxvii.These persons are not "executive" employees because their primary duty is not management of the enterprise (even if they direct the work of other employees in the conduct of their primary job duties). They are not "administrative" employees because their primary duty is not the performance of work directly related to the management or general business operations of the employer or the employer's customers. They are not "professionals" because their primary duty is not the performance of work requiring knowledge of an advanced type in a field of science or learning customarily acquired by a prolonged course of specialized intellectual instruction or the performance of work requiring invention, imagination, originality or talent in a recognized field of artistic or creative endeavor. While they may have college degrees, a specialized academic degree is not a standard prerequisite for employment in such occupations. 29 CFR 541.3.

xxxviii.29 CFR 541.100.

xxxix.29 CFR 541.101.

xl.29 CFR 541.200-201. For examples of jobs meeting the administrative exemption requirements, see 29 CFR 541.203. They include: insurance claims adjusters, employees in the financial services industry, human resources managers, and purchasing agents.

xli.29 CFR 541.202.

xlii.29 CFR 541.300.

xliii.29 CFR 541.301.

xliv.29 CFR 541.301.

xlv.29 CFR 541.302. Journalists are exempt if their primary duty is performing on the air in radio, television or other electronic media; conducting investigative interviews; analyzing public events; writing editorials, opinion columns or other commentary; or acting as a narrator or commentator.

xlvi.29 CFR 541.303.

xlvii.29 CFR 541.400.

Binding Arbitration Agreements in the Nursing Home Context

By Christopher J. Carney

In your run-of-the-mill car accident or premises liability trial, the plaintiff has the difficult task of overcoming a societal belief that the such claims are frivolous. Not so in nursing home litigation. Most people have a family member or friend, or at least know of someone, who has had a negative experience in a nursing home. In addition, the plaintiff in such a case is generally an elderly and frail person. In our society, the elderly are given respect, which tends to translate into credibility. As a result, unlike other personal injury claims, a nursing home case is tried on a more level playing field.

How have nursing home proprietors fought to keep the field unbalanced? Simple, by attempting to revoke the resident's Constitutionally guaranteed right to trial by jury through the use of binding arbitration agreements.

These agreements are generally buried among the pages and pages of nursing home admission forms, somewhere between the *Pneumoccocal/Influenza Vaccine Status Consent Form* and the *Funeral Home Preference Form.* They generally read something like this:

"Any controversy, dispute, disagreement or claim of any kind arising between the parties after the execution of this Agreement shall be settled exclusively by binding arbitration. This arbitration clause is meant to apply to all controversies, disputes, disagreements or claims including, but not limited to, all breach of contract claims, negligence and malpractice claims, and all other tort claims."

In the midst of the whirlwind of being admitted into the dreaded nursing home, these agreements are commonly signed by unwitting, often uneducated, people who do not understand their implications or their import. Alternatively, they are signed by the spouse or child of a new resident who is dealing with the emotional baggage attached to putting a loved one into a nursing home.

It need not be stated that binding arbitration is not the ideal manner of resolving a claim against a nursing home. Not only is the resident deprived of a jury trial, the cost of arbitrating such cases can be exorbitant. Unlike traditional arbitrations, these arbitration provisions specifically identify the forum in which the dispute will be arbitrated.

These "neutral forums" generally have procedural requirements similar to the tax code in their ease of understanding and compliance. In addition, they require excessive fees along every step of the way.

In one such forum, the filing fee alone can be as high as $1,750. Additional costs are taxed upon the claimant throughout the process. The following costs are illustrative of how costs in such a forum can pile up:

Request for Subpoena: $75
Request for Extension of Time: $100
Request for Non-Dispositive Order: $250
Request for Dispositive Order: $500
Request for Discovery Order: $500
Objection to Discovery Order: $500
Request for Expedited Relief: $750

This is a sampling of the potential costs involved in the initial stages of such an arbitration. They increase when the actual arbitration is commenced. If the parties in this particular forum will settle for a non-participatory hearing (i.e. where the arbitrator makes a ruling based on documents filed), the cost can be as much as $2,500. Want to actually participate in the hearing? That can cost $5,000 (with the caveat that the arbitration forum may assess higher fees!).

As you can see, the procedural nightmare associated with these arbitration forums, coupled with the expense of pursuing a binding arbitration under these parameters, can effectively destroy a litigant's ability to pursue a claim. So, can a resident who signed such a clause avoid a binding arbitration? Maybe, but it won't be easy.

First of all, many of these clauses contain a statement that the agreement can be revoked by the resident within 30 days of entering into the agreement. As such, attorneys who take in a nursing home case which involved an incident or accident that occurred shortly after admission, should immediately revoke the arbitration agreement in writing. This should be done in all cases in which it is known that the agreement was entered into, and in all cases in which the existence of an arbitration agreement is unknown or uncertain.

Unfortunately, many cases of nursing home neglect arise after that 30 day period has expired. If that is the case,

the agreement is difficult to overcome. However, there are some avenues which can be taken to attempt to defeat an arbitration provision. They include (1) proving the provision is unconscionable, (2) attacking the power of attorney in cases in which a relative signed the provision on behalf of the resident, and (3) attacking the provision based on statutory defects.

Unconscionability

In order to succeed on the unconscionability argument, the plaintiff must prove that the agreement was both substantively and procedurally unconscionable. Substantive unconscionability refers to the commercial reasonableness of the contract terms themselves.[i]

Since "commercial reasonableness" varies based on the context of the provision, there is no generally accepted list of factors which are indicative of substantive unconscionability. However, in the nursing home context, one item which is indicative of substantive unconscionability is a "loser pays" provision.

In *Small v. HCF of Perrysburg*,[ii] the 6th District held that the binding arbitration provision was substantively unconscionable because it contained a clause which stated: "the prevailing party in the arbitration shall be entitled to have the other party pay its costs for the arbitration, including reasonable attorneys' fees and prejudgment interest."[iii] The court found this clause "troubling" because it could discourage the pursuit of claims, and for that reason deemed it "undoubtedly unconscionable."[iv]

Other arguments weighing in favor of substantive unconscionability include (1) terms that the resident must arbitrate all of his claims but the home can bring a claim for non-payment in a court of law,[v] (2) arbitration terms that are not conspicuous,[vi] and (3) an arbitration provision that does not expressly advise the resident that he is giving up his right to a jury trial.[vii]

Procedural unconscionability involves an examination of the respective bargaining positions of the parties. [viii] Arbitration provisions in nursing home admission agreements can be found procedurally unconscionable if the resident or agent is under stress at the time of the execution and if the provision is not explained to them. This was found to be the case in *Small, supra*, where the court affirmed the trial court's finding that the arbitration provision was not enforceable because, at the time of its execution, the signor, who was 69 years old, was under a great deal of stress and the agreement was not explained to her. This, according to the 6th District, amounted to procedural unconscionablility. Other considerations in regard to procedural conscionability include the "age, education, intelligence, business acumen, experience in similar transactions, whether terms were explained to the weaker party, and who drafted the contract."[ix]

However, in order for this tact to succeed, the provision must be substantively **and** procedurally unconscionable. For instance, in *Fortune v. Castle Nursing Homes,*[x] the plaintiff successfully argued that the provision was *substantively* unconscionable because it contained a "loser pays" provision. However, because the court was not convinced that there also existed *procedural* unconscionability, the case was remanded for binding arbitration.

On the other hand, in *Manley v. Personacare*,[xi] the plaintiff was able to convince the 11th Appellate District that the clause was *procedurally* unconscionable because of the age of the resident, the fact that she was under a great deal of stress during the admission process, the fact that she had no legal expertise, and the fact that she had a mild cognitive impairment. However, the court held that the clause was nonetheless enforceable because it was not *substantively* unconscionable.

Although it can be done, proving unconscionability can be a difficult row to hoe, and arbitration provisions are being updated to comply with changes in Ohio law, thus making them even more difficult to overcome.

Attacking the POA

Oftentimes, individuals admitted to nursing homes are suffering from Alzheimer's, dementia and/or other maladies and are unable to complete the paperwork necessary for admission. This often results in a family member, pursuant to a healthcare power of attorney, completing the paperwork, and entering into the binding arbitration agreement.

In fighting an agreement under these circumstances, the scope of the power of attorney must be determined. According the Ninth District Court of Appeals, "a power of attorney is a written instrument that authorizes an agent to perform **specific acts** on behalf of his principal. * * * In general, a power of attorney **is to be construed strictly against any enlargement beyond the authority actually conferred**." (Emphasis added.) *Bacon v. Donnet.*[xii]

As such, the argument can be made that while a healthcare POA does provide the attorney in fact with the power to sign standard, boilerplate admission forms, signing

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away the Constitutionally guaranteed right to trial by jury exceeds the scope of the authority granted in such a POA, and the resident is not bound as a result.

Although no Ohio appellate court has specifically addressed this issue, it has been addressed by two California appellate courts. In *Goliger v. AMS Properties, Inc.,*[xiii] the court refused to compel arbitration under these circumstances, indicating that while the attorney in fact did have the power to make health care decisions, that "does not equate with being an agent empowered to waive the constitutional right of trial by jury."

Similarly, in *Pagarigan v. Libby Care Center, Inc.,*[xiv] the court refused to enforce an arbitration agreement entered into by an attorney-in- fact pursuant to a health care POA, stating "the nursing home defendants do not explain how the next of kin's authority to make medical treatment decisions for the patient...translates into authority to sign an arbitration agreement on the patient's behalf at the request of the nursing home."

(*Note*: a similar argument was advanced in Ohio's 9th District in *Broughsville v. OHECC, LLC*.[xv] However, *Broughville* is distinguishable in that the resident was competent yet gave her daughter authority to complete the admission forms on her behalf. The court rejected the argument that she exceeded the scope of her authority because the daughter had apparent authority to sign all forms, including the arbitration agreement.)

Statutory Defects in the Agreement

According to R.C. §2711.23, "t*o be valid and enforceable* any arbitration agreements pursuant to sections 2711.01 and 2711.22 of the Revised Code for controversies involving a medical, dental, chiropractic, or optometric claim that is entered into prior to a patient receiving any care, diagnosis, or treatment *shall include* or be subject to the following conditions ...." The statute then enumerates 10 conditions for enforceability, the absence of any one of which "shall" invalidate the arbitration provision.

These conditions include the right to treatment/care whether or not the agreement is signed, a mandatory 30 day revocation period, that the agreement constitutes a waiver of the right to trial by jury, and several others. While no appellate court has yet invalidated an arbitration agreement in the nursing home context because it lacked the conditions mandated by R.C. §2711.23, at least one trial court has done so.

In *Heppner v. Beverly Enterprises-Ohio, Inc.,* [xvi] the Lake County Court of Common Pleas refused to enforce an arbitration agreement because it did not specifically state that the costs of the arbitration must be divided equally between the parties, as mandated by R.C. §2711.23(E).

While these are not the only avenues of defeating binding arbitration agreements, they are among those that have met with some success. Unfortunately, these binding arbitration provisions are very difficult to overcome, and many Ohio courts have held that they are valid and enforceable.

(Note: the issue of whether an arbitration provision can be enforced on beneficiaries in a wrongful death claim outside of the nursing home arena is currently pending in the Ohio Supreme Court in *Peters v. Columbus Steel Castings Co.*, 10th App. No. 05AP-308, 2006 Ohio 382.)

Endnotes

i	*Collins v. Click Camera & Video, Inc. (1993), 86 Ohio App.3d 826, 621 N.E.2d 1294.*
ii	*159 Ohio App.3d 66, 2004-Ohio-5757.*
iii	*Id. at ¶ 17.*
iv	*Id. at ¶ 26.*
v	*Fortune v. Castle Nursing Homes, 5th App. No. 05 CA 1, 2005-Ohio-6195.*
vi	*Id.*
vii	*Id.*
viii	*Collins v. Click Camera & Video, Inc. (1993), 86 Ohio App.3d 826, 621 N.E.2d 1294.*
ix	*Featherstone v. Merrill Lynch, Pierce, Fenner & Smith, Inc., 159 Ohio App.3d 27, 2004-Ohio-5953 ¶ 13.*
x	*5th App. No. 05 CA 1, 2005-Ohio-6195.*
xi	*11th App. No. 2005-L-174, 2007-Ohio-343.*
xii	*9th App. No. 21201, 2003-Ohio-1301, ¶28.*
xiii	*(Oct. 21, 2004), CA 2nd App. No. B166686.*
xiv	*(2002), 99 Cal. App.4th 298, 302.*
iv	*9th App. No. 05CA008672, 2005-Ohio-6733.*
xvi	*Lake County Common Pleas No. 05CV002059.*

Law Updates

by Andrew Thompson

Asbestos Litigation – Summary Judgment Denied Because Exposure To Asbestos In Workplace Not Considered Inherently Dangerous

***Rettig, et al. v. General Motors Corporation, et al.*, 8th Dist. App. No. 86837, 2006-Ohio-6576, 2006 WL 3634522.**

Appellant, Lee Rettig, worked as an electrician for over 40 years. During that time, he was exposed to asbestos at sites owned by General Motors and Toledo Edison. As a result of his exposure to asbestos, Rettig suffers from malignant mesothelioma. He filed suit against GM and Toledo Edison, claiming that they breached their duty of care to provide a safe workplace by failing to warn him of the dangers of asbestos or by removing it from the premises. Both defendants filed motions for summary judgment, arguing that they did not owe a duty to Appellant because the work he was engaged in was "inherently dangerous." The trial court granted both motions for summary judgment.

Ohio Revised Code sections 4101.11 and 4101.12 require employers to provide a safe place to work for its employees and frequenters. Frequenters include employees of independent contractors hired to do work on an employer's premises. The duties imposed by the statutes include the duties to keep the premises in a reasonably safe condition and to warn others of dangers of which the owner has knowledge. An owner is relieved from these duties, however, when an independent contractor performs work on his or her premises that is "inherently dangerous." This exception was set forth in *Wellman v. East Ohio Gas Co.* (1953), 160 Ohio St. 103, as follows: "Where an independent contractor undertakes to do work for another in the very doing of which there are elements of real or potential danger and one of such contractor's employees is injured as an incident to the performance of the work, no liability for such injury ordinarily attaches to the one who engaged the services of the independent contractor." The exception does not apply when the owner of the premises actively participates in the work.

Appellant worked at a Toledo Edison facility during a two or three week period in 1948 or 1949 while installing a generator. His employer, Ohio Pipe Trades, required him to take asbestos fiber from bags and mix it with another substance in a five gallon bucket. This mixture was then applied to spark plugs on the generator. Appellant claims that Toledo Edison knew of the dangers of asbestos and failed to provide him proper warnings or instructions about using the material. The court disagreed, and held that summary judgment in favor of Toledo Edison was appropriate. Appellant was only exposed to asbestos at the Toledo Edison facility from the material provided by his employer, not from asbestos at the facility. Since there was no evidence that Toledo Edison exposed Appellant to asbestos, summary judgment was properly granted. The mere fact that he used the material while on the Toledo Edison property is insufficient to impose liability.

Appellant worked at several General Motors facilities, including at a foundry plant in Defiance, Ohio for a year and a half in 1953. He performed electrical work on GM property numerous other times from 1953 to 1990. While there, he was exposed to asbestos-covered steam lines, asbestos-insulated wires, and he used an asbestos blanket provided by GM while working in its plant. GM argues that Appellant's work was inherently dangerous, and therefore it is protected from liability by the exception stated in *Wellman*. Inherently dangerous work has been defined as "work which, although not highly dangerous, involves a risk recognizable in advance that danger inherent in the work itself, or in the ordinary or prescribed way of doing it, may cause harm to others." *Bohme, Inc. v. Sprint International Communications Corp.* (8th Dist. 1996), 115 Ohio App.3d 723, 736. The court held that GM was not entitled to summary judgment because genuine issues of fact exist as to whether Appellant's work with asbestos products was inherently dangerous. At the time the work was done, Appellant and his employer did not know the dangerous propensities of the product. Asbestos was a commonly used material, and therefore would not be considered inherently dangerous.

Asbestos Litigation – H.B. 292 Is Remedial, Not Substantive, And Therefore May Be Applied Retroactively

***Wilson v. AC&S, Inc., et al.*, 12th Dist App. No. CA2006-03-056, 2006-Ohio-6704, 2006 WL 3703350.**

Chester Wilson was employed by A.K. Steel Corporation and its predecessors from 1964 until his retirement in April 2000. On August 4, 2000, Mr. Wilson was diagnosed with lung cancer. He filed suit against a number of companies that were involved in the mining, processing, manufacturing, or sale and distribution of asbestos, asbestos-containing products and machinery. Mr. Wilson claimed that he developed lung disease as a result of his

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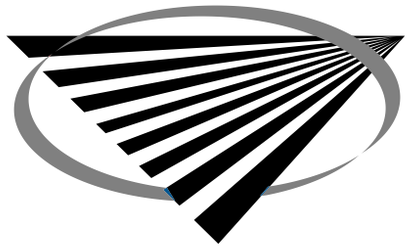

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exposure to asbestos during his employment. On April 15, 2003, Mr. Wilson died of lung cancer, and his wife was substituted as a party in interest.

On September 2, 2004, while the instant case was pending, H.B. 292 went into effect. This law required, among other things, that a person bringing an asbestos claim make a prima facie showing that he or she has a physical impairment from a medical condition and that his or her exposure to asbestos was a substantial contributing factor to causing the medical condition. In March 2005, Appellee filed a motion with the trial court to establish the prima facie case necessary under the new statute. During a hearing on the matter, Appellee acknowledged that her case did not meet the requirements necessary under H.B. 292; however, she claimed that the law should not be retroactively applied to her claim. The trial court issued an order stating that retroactive application of the statute violated Section 28, Article II of the Ohio Constitution, and that it would thereafter "adjudicate substantive issues in asbestos cases filed before September 2, 2004 according to the law as it existed prior to [H.B. 292]'s enactment, and [to] administratively dismiss, without prejudice, any claim that fails to meet the requisite evidentiary threshold."

An Ohio statute "is presumed to be constitutional, and before a court may declare it unconstitutional it must appear beyond a reasonable doubt that the legislation and constitutional provisions are clearly incompatible." *State ex rel. Dickman v. Defenbacher* (1955), 164 Ohio St. 142, paragraph one of syllabus. The test for whether a statute can be applied retroactively requires the court to determine whether the General Assembly expressly intended the statute to be so applied, and if so, whether the statute is substantive, making it unconstitutionally retroactive, or merely remedial, rendering it constitutionally retroactive. *Bielat v. Bielat* (2000), 87 Ohio St.3d 350, 352-353. The parties agreed that the General Assembly intended the asbestos litigation statute to apply retroactively. The remaining issue, therefore, is whether the subject provisions of the statute are "remedial" or "substantive."

"[A] retroactive statute is substantive – and therefore unconstitutionally retroactive – if it impairs vested rights, affects an accrued substantive right, or imposes new or additional burdens, duties, obligations, or liabilities as to a past transaction." *Bielat*, supra. at 354. Appellee argues that she has a vested right in the underlying cause of action, and therefore retroactive application of the statute would be unconstitutional. The Court of Appeals disagreed. Although the law prohibits the legislature from taking away a cause of action after it has accrued, the court held that H.B. 292 does not impede Appellee's right to continue her cause of action. The relevant provisions of the law affect only the methods and procedure by which the claim is recognized, protected and enforced. A right is not vested until it is more than an expectation of future benefits. The court found that Appellee "had nothing more than a mere expectation of future benefits founded upon an anticipated continuance of the law."

Appellee also argues that particular definitions included in the statute conflict with the Ohio Supreme Court's decision in *Horton v. Harwick Chem. Corp.* (1995), 73 Ohio St.3d 679, and therefore their retroactive application would impair the substantive rights of persons with asbestos claims. The court initially acknowledged that the General Assembly is not free to make retroactive changes to the settled meaning of a law. "When the Ohio Supreme Court interprets a key word or phrase in a statute, those interpretations define substantive rights given to persons who are affected by the statute." The court ruled, however, that Appellee's substantive rights were not violated by the retroactive application of H.B. 292 because the definitions at issue did not conflict with the Supreme Court's holding in *Horton*. The court analyzed the definitions in R.C. 2307.91(FF) and 2307.92(B)-(D), and determined that the language selected by the General Assembly was consistent with the holding in *Horton* and other common law interpretations of the terms used. The only definition that expressly contravened *Horton*, found at R.C. 2307.96, was made only prospective. In addition, the court found that *Horton* was limited to the issue of the proper standard for determining liability of a particular defendant in a multi-defendant case and the causative role of that defendant's product in producing injury to the plaintiff. H.B. 292, on the other hand, deals with the threshold, prima facie proof necessary to establish that collective exposure to asbestos in general was sufficient to cause injury. Since the definitions from these sources are applied to different issues, the court reasoned, they cannot conflict.

The court found that retroactive application of the statute also would not impose any "new or additional burdens, duties, obligations, or liabilities" on persons making asbestos claims. Any changes made by the law were deemed procedural or remedial, not substantive, so there is no violation of the Ohio Constitution. The decision of the trial court was reversed.

Civil Procedure – Physician-Patient Privilege Did Not Protect Hospital From Producing Medical Records Of Third Party Patient To Prove Notice

***Alcorn, et al. v. Franciscan Hospital Mt. Airy Campus*, 1st Dist. App. No. C-060061, 2006-Ohio-5896, 2006 WL 3231208.**

Appellee admitted herself into Franciscan Hospital during a manic episode caused by her bipolar disorder. During her admission in the psychiatric ward, Appellee was sexually assaulted by another patient. She filed suit against the hospital, claiming that the hospital was negligent in protecting her from the patient in light of the hospital's knowledge of his dangerous propensities. During discovery, Appellees sought production of the medical records of the third party patient, claiming that the records would reveal Appellant's knowledge of the danger. After an in-camera review, the trial court granted Appellees' motion to compel production.

Appellant argued on appeal that the trial court erred in ordering production of the records because they were protected by the physician-patient privilege. Appellees admit that the records do not fall within any of the statutory exceptions to the privilege, but argue in the alternative that the records are discoverable based on the common-law exception articulated in *Biddle v. Warren Gen. Hosp.* (1999), 86 Ohio St.3d 395. In *Biddle*, the court held that otherwise privileged records may be disclosed where "disclosure is necessary to protect or further a countervailing interest that outweighs the patient's interest in confidentiality."

The Court of Appeals upheld the ruling of the trial court, finding that application of the privilege in this case would have prevented Appellees from proving that Appellant was aware of the patient's dangerous proclivities and therefore prevent them from establishing a breach of the hospital's duty. In reaching this conclusion, the court relied on the reasoning of *Fair v. St. Elizabeth Med. Ctr.* (2nd Dist. 2000), 136 Ohio App.3d 522, in which the court held that a patient's right to recourse for a hospital's breach of its duty to protect mentally ill patients outweighed a patient's interest in the confidentiality of his or her records.

The court rejected Appellant's argument that this case was distinguishable from *Fair* because in this matter the identity of the third party is known, whereas in *Fair* the patient could remain anonymous. The court stated that the same interest in seeking recourse is being implicated, and a party should not be denied the opportunity to present a case simply because he or she happens to know the identity of the attacker. The trial court properly took measures to insure that the records would not be disclosed beyond what was necessary for discovery.

Other objections by Appellant to the method of disclosure of the records were overruled by the court since the management of the discovery process was within the discretion of the trial court.

Civil Procedure – Cleveland Clinic Foundation Not Entitled To Summary Judgment On Claim By Patient For Unauthorized Disclosure Of Her Medical Records To Her Employer

***Herman v. Kratche, et al.*, 8th Dist. App. No. 86697, 2006-Ohio-5938, 2006 WL 3240680.**

On March 11, 2003, Appellant Janet Herman was seen by Dr. Richard Kratche at the Cleveland Clinic's Solon Family Health Center for a physical examination. The written records of that visit were mistakenly sent to Appellant's employer, Nestle. Appellant registered a complaint with the facility, and was told that the records were sent for "workers' comp coverage." The Clinic acknowledged the error and changed the records designation to her personal family account.

Appellant returned to the Clinic on April 2, 2003 for a mammogram screening. On April 10, 2003, she underwent a diagnostic mammogram. The records from both of these visits were again marked as relating to workers' compensation and forwarded to Nestle. The Clinic's Administrator acknowledged that all the records sent to Nestle contained personal private medical information.

Appellant filed suit against the doctor and hospital for unauthorized disclosure, invasion of privacy, and intentional infliction of emotional distress. The defendants filed a joint motion for summary judgment, which was granted by the trial court. Appellant appealed the ruling against the hospital. The Clinic cross-appealed the trial court's earlier denial of its motion for judgment on the pleadings.

Appellant's first cause of action was for unauthorized disclosure, a tort separate and distinct from invasion of privacy. This claim was first recognized in *Biddle v. Warren Gen. Hosp.* (1999), 86 Ohio St.3d 395. The only way to avoid liability for the unauthorized disclosure of confidential medical information is to obtain the patient's consent. *Id.* An unauthorized disclosure by a physician or

hospital constitutes a breach of their fiduciary duty to the patient. The elements of a claim for breach of fiduciary duty include showing the existence of a duty, a breach of that duty, and damage resulting from the breach. There is no dispute in this case that the Clinic had a duty to keep Appellant's medical information confidential, and that the Clinic breached that duty. The issue was whether the Clinic's actions caused her damage.

The Clinic first argued that it was not the proximate cause of any damage to Appellant because her employer also had a duty of confidentiality, and therefore it was not an unauthorized "third party." Since Nestle had to keep the records confidential, the Clinic argued that they were never disclosed to a third party. The Court of Appeals rejected this argument. The breach of Appellee's fiduciary duty occurs the moment the records are disclosed, and it does not matter what, if any, duties the third party may have toward the patient. As soon as Nestle opened Appellant's medical records, the Clinic became the proximate cause of harm to Appellant.

The court further rejected the Clinic's attempt to rely on the duties imposed by HIPPA to Appellant's employer, claiming that Nestle was in the same "circle of confidentiality" as the hospital and therefore it did not make an unauthorized disclosure. The phrase "circle of confidentiality" was used in *Biddle* to refer to a "closed loop" of persons who had the same duty of confidentiality. In its motion for summary judgment, the Clinic argued that "an employer receiving an employee's medical records is part of the same circle of confidentiality that encompasses the medical provider responsible for sending the records in the first place." The court noted, however, that HIPPA does not mention a circle of confidentiality. Also, Nestle is not covered by HIPPA since it is not a "health plan," "healthcare clearinghouse," or "healthcare provider," so it could not possibly be a part of the same circle of confidentiality with Appellees.

The Clinic's final argument against liability for unauthorized disclosure was that Appellant consented to the disclosure of her records. A consent form signed by Appellant acknowledged that the records would be disclosed to other parties "for purposes of processing payment." The court again rejected the Clinic's reasoning, holding that Appellant did not authorize the release of her medical information to the wrong party for payment, whether it was done accidentally or not. The parties agree that the bills for treatment should have been sent to Appellant's insurance provider, not her employer.

The court also found that Appellee was not entitled to summary judgment on Appellant's claim for invasion of privacy. The Clinic argued that Appellant did not present evidence of the type of damage necessary to establish this cause of action. The court found that genuine issues of fact exist. As a result of the disclosure of her personal medical information, Appellant claimed she felt embarrassment, anger, emotional distress, and ongoing anxiety. This damage was not sufficient, however, to maintain a claim for intentional infliction of emotional distress. To establish such a claim, a plaintiff "must present some guarantee of genuineness in support of his or her claim, such as expert evidence, to prevent summary judgment in favor of the defendant." Appellant failed to meet this standard in this case.

Appellee cross-appealed the trial court's denial of its motion for judgment on the pleadings, which was based on Appellant's alleged failure to comply with the statute of limitations. The Clinic argued that a claim for unauthorized disclosure is a "medical claim" and was covered by a one-year limitations period under R.C. 2305.11. The court rejected this argument, relying on *Allinder v. Mt. Carmel Health* (1994), Franklin App. No. 93AP-156, and held that since the disclosure of confidential information does not relate to medical diagnosis, treatment, or care, it does not have a one-year statute of limitations.

Civil Procedure – Rule 41(A) Dismissal Dissolves All Interlocutory Orders, Including Summary Judgment, And Such Orders Have No Res Judicata Effect

***Hutchinson, et al. v. Beazer East, Inc., et al.*, 8th Dist. App. Nos. 86635, 87897, 2006-Ohio-6761, 2006 WL 3743078.**

Appellants filed an asbestos claim against numerous defendants, including Tasco Insulation, Inc., in 2001. After Tasco moved for summary judgment, Appellants filed a motion to amend their complaint to add a claim for spoliation of evidence. Tasco moved to strike the amendment as untimely. Following a hearing, the trial court denied Appellants' motion to amend their complaint and granted summary judgment to Tasco. The case proceeded to trial against the remaining defendants. On the day of trial, prior to empaneling the jury, Appellants orally dismissed their case without prejudice pursuant to Civil Rule 41(A).

On April 15, 2003, Appellants re-filed their complaint against all defendants, including Tasco, and included a claim for spoliation of evidence. Tasco moved to dismiss the action pursuant to Civil Rule 12(B)(6), arguing that the doctrine of res judicata barred the claims because they were fully adjudicated when the trial court granted summary judgment. The trial court granted the motion.

When a case involves more than one claim or multiple parties, an order of the court is final and appealable only if the requirements of R.C. §2505.02 and Civil Rule 54(B) are met. If an order does not dispose of all claims, and does not contain language that there is no just reason for delay, the order is interlocutory. In this case, the court's order granting summary judgment to Tasco is interlocutory because it did not dispose of the remaining claims against other defendants and did not include Rule 54(B) language. An interlocutory order may be revised up until the time when it may be appealed, or when the case has been resolved as to all parties.

A dismissal pursuant to Civil Rule 41(A) "renders the parties as if no suit had ever been filed against only the dismissed parties." The determinative issue in this case, therefore, was whether Appellants' oral dismissal without prejudice was a dismissal of all parties or whether it was only a dismissal of the defendants at trial. Tasco argues that the dismissal was limited, as evidenced by a Pretrial Statement filed by Appellants in which they stated, "[o]n April 7, 2003 Plaintiffs voluntarily dismissed the Hutchinson case against Beazer East pursuant to Civ.R. 41(A)." Tasco claims that this statement shows Appellants' intention to only dismiss the remaining defendant at trial.

The Court of Appeals disagreed with Tasco's assertion. The court's journal entry only stated that the "case" was dismissed without prejudice, and there is no evidence in the transcript showing that Appellants' oral motion was limited. An unambiguous journal entry cannot be modified by a statement made by one of the parties in a subsequent pleading. The court noted that Tasco did not ask the trial court under Civil Rule 60(A) to correct the journal entry to reflect only a dismissal to the other defendants, nor did Tasco ever request that the trial court amend its original order granting summary judgment to include Rule 54(B) language. Since Appellants' dismissal applied to the entire case, all interlocutory orders, including the summary judgment order in favor of Tasco, were dissolved and have no res judicata effect. The ruling of the trial court was reversed.

Employment Law – Jury Verdict Of $272,500, Including Punitive Damages, Upheld On Appeal In Disability Discrimination Action

***Sicklesmith v. Chester Hoist, et al.*, 7th Dist. App. No. 05-CO-20, 2006-Ohio-6137, 2006 WL 3361444.**

Appellee worked for Chester Hoist and its predecessor since 1979, most recently as an inspector. His job required him to inspect and measure parts in the plant and be on his feet about seven hours per day. In June 1996, Appellee's foot was crushed when a forklift ran over it. He underwent multiple surgical procedures and a work hardening program. In November 2001, Appellee notified his supervisor that he was medically cleared to return to his job as an inspector, with an accommodation allowing him to occasionally rest his foot and loosen his boot. Chester Hoist reviewed Appellee's medical records and reports and determined he could not return to his job. Appellee was terminated on April 8, 2002.

Appellee filed a complaint alleging disability discrimination, retaliatory discharge, and wrongful discharge in violation of public policy. Appellants filed a motion for summary judgment. The trial court granted the motion as to all claims except the cause of action for disability discrimination. The matter went to trial and the jury found in favor of Appellee, awarding him $172,500 in compensatory damages, back pay, and front pay, and $100,000 in punitive damages. Appellants appealed the verdict and raised several assignments of error.

Appellants' primary argument on appeal was that the jury verdict was against the manifest weight of the evidence. To prove a case of disability discrimination, a plaintiff must show that (1) he is disabled; (2) a negative employment action was taken (at least in part) because of the disability; (3) even though disabled, he can safely perform the essential functions of the job with or without reasonable accommodations. The first two issues were not genuinely disputed. Appellee's foot injury significantly affected his everyday life activities, qualifying him as disabled, and Appellants admit that Appellee was terminated because his disability allegedly precluded him from performing the job of an inspector. The determinative issue in the case was whether Appellee could perform the essential functions of the job with a reasonable accommodation.

The Court of Appeals found that the evidence supported the jury's verdict. The testimony established that the essential functions of the job of inspector included inspecting and measuring equipment. Other exertional requirements, such as walking and lifting, were distinguishable from the essential functions and could be accommodated. The evidence was sufficient to allow the jury to find that Appellee could perform the essential functions of the job with accommodations, including leaning, bringing parts to his desk to measure and check, using a stool occasionally, and consistently changing positions, all without interfering with the inspections. Although the medical evidence was conflicting, the jury was entitled to believe the testimony of those witnesses who stated that Appellee could perform the job of an inspector with appropriate accommodations.

The court also upheld the jury's award of punitive damages. In order to properly award punitive damages, the jury must find that a defendant acted with actual malice. Actual malice is defined as "(1) that state of mind under which a person's conduct is characterized by hatred, ill will or a spirit of revenge, or (2) a conscious disregard for the rights and safety of other persons that has a great probability of causing substantial harm." *Preston v. Murty* (1987), 32 Ohio St.3d 334, syllabus. The court found in this case that the testimony and actions of Appellant Burkey, the general manager at Chester Hoist, showed a conscious disregard for Appellee's rights. Throughout

Appellee's attempts to return to work, Burkey focused on the amount of money Appellee cost the company in workers' compensation premiums. Burkey ignored Appellee's requests for an accommodation, and seemed predisposed to terminate him. At trial, Burkey gave conflicting testimony that raised substantial questions as to his motivations and credibility. All of this evidence supported the jury's finding of malice.

Appellants' other assignments of error were also overruled. The court rejected Appellants' argument that the trial court erred in failing to issue an instruction to the jury that they were to draw no negative inferences from Appellant Burkey's invocation of the attorney-client privilege during his testimony. During cross-examination, Burkey refused to answer questions about conversations he had with the company's attorney about Appellee's accommodation request. The court held that the charge to the jury, which included the admonition that sustained objections be treated as if the jury did not hear them, was sufficient.

The Court of Appeals also upheld the trial court's decision to preclude from evidence the finding of an arbitrator upholding Appellee's termination under the collective bargaining agreement. Appellants argued that the decision was necessary to show that it acted in good faith in terminating Appellee since they had just cause under the contract. The court rejected this argument, holding that allowing evidence of the arbitration decision would confuse the jury about the determinative issue in the case. The jury was not deciding whether Appellants had just cause to terminate Appellee, but whether the decision was in violation of disability discrimination laws.

Finally, the court considered whether an award of back pay and front pay was warranted. Appellants argued that there was inadequate proof at trial of the amount of wage loss suffered to allow the jury to consider these elements of damage. The court overruled this assignment of error. Appellee presented evidence of the wages earned by another employee who took his place as the inspector at Chester Hoist, including his hourly wage, the amount of overtime he typically worked, and his annual earnings in 2004. In addition, Appellee submitted as evidence his application for workers' compensation benefits, which listed his hourly wage at the time of his termination and his weekly wages for an entire year. The court found that this evidence was enough for the jury to estimate Appellee's damages for front pay and back pay.

Evidence – Medical Expert Testimony Met Threshold Of Reliability To Be Admissible In Workers' Compensation Case

***Hyden v. Kroger Company, et al.*, 10th Dist. App. No. 06AP-446, 2006-Ohio-6430, 2006 WL 3518007.**

Apellee, Scott Hyden, worked for Kroger Company as an Order Selector. His job duties required him to lift and sort about 200 boxes an hour, most of which weighed up to 97 pounds. In May 2003, Hyden was diagnosed by his family doctor with a lumbar strain and a herniated disc. Since the doctor attributed the injuries to his work at Kroger, Hyden filed a workers' compensation claim. A hearing officer at the BWC denied Hyden's claim because he failed to establish proximate cause, and the decision was upheld by the Industrial Commission. Hyden filed an action in Franklin County Common Pleas Court, and a jury found that he was permitted to participate in the workers' compensation fund. Kroger filed the instant appeal challenging the jury's verdict.

Kroger primarily objected to the testimony of Appellee's treating physician. First, Kroger argued that it was entitled to judgment as a matter of law because the doctor did not state his causation opinion to a reasonable degree of medical certainty. Kroger cited to statements in the doctor's testimony where he said Appellee's job "could have," "within reason to believe," and "very well could have" caused the injury to Hyden's back. Kroger suggests that these statements are insufficient to meet the threshold of reliability necessary for an expert opinion to be admissible.

The Court of Appeals upheld the jury verdict, noting that the doctor also testified that "it's very likely and it's my opinion that [Hyden's employment duties] caused the problem he is having with his back." The court concluded that this statement satisfied the reasonable certainty standard because the opinion was stated to a likelihood greater than 50 percent. Although the testimony quoted by Appellant fell short of this standard, those statements do not render the fourth comment inadmissible as a matter of law. Any conflict in the testimony of the doctor would go to the weight of his opinions, not their admissibility.

Kroger next argued that the opinion was inadmissible because it was based on facts not in evidence. The doctor testified that Hyden was required to lift approximately 2,000 boxes per day over a four year period. These precise figures were not admitted into evidence. The court held that any discrepancies in the facts recited by the

doctor did not render his opinion inadmissible. Evidence Rule 703 requires that an expert base his opinions on either facts within his personal knowledge or otherwise admitted into evidence. The court stated that Hyden had numerous conversations with the doctor during his treatment, including discussions of his job duties. Hyden testified that he lifted between 200 and 225 boxes an hour. Based on this evidence, the court concluded that the doctor's opinion was sufficiently based on his personal knowledge to be admitted. Further, even though Hyden's employment records show he worked less than two years in this job, not the four years assumed by the doctor, this difference went to the weight and credibility of the doctor's testimony, not its admissibility.

The doctor's testimony was also challenged because he referenced the report of another physician who did not testify. The doctor stated that "I believe that Dr. Mullin shares my opinion that, you know, his work was affecting his back." The court acknowledged that the reference to Dr. Mullin's report is inadmissible hearsay, however Appellants' argument was rejected. The first reference to Dr. Mullin's report was made by Appellants during the doctor's cross-examination in an attempt to highlight alleged conflicting histories given by Hyden to the two physicians. The above statement was thereafter elicited during redirect examination. The court held that having "introduced the hearsay from Dr. Mullin's report into evidence, Kroger cannot invoke the hearsay prohibition in an effort to keep out additional hearsay from the same report that is not as favorable to Kroger's trial strategy." The court also noted that the hearsay statement did not prejudice Appellants because it was insufficient to establish causation, and therefore did not serve to corroborate the doctor's own causation opinion.

Appellants' final argument was that Appellee's counsel made inappropriate remarks during his closing argument about Appellants' expert witness. Counsel noted how many times the expert testified in court for Appellants, how much money he made from testifying, and twice referred to him as a "hired gun." The court held that these statements were permissible because the expert testified that he earned $600 an hour for his testimony, he provides about 40 depositions per year, and almost 90% of his examinations are performed for defense attorneys. In addition, Appellants did not object to the arguments at the time, and the use of the term "hired gun" was not so gross or abusive that it required the court to intervene sua sponte.

Evidence – Collateral Source Rule Does Not Bar Admissibility Of The Amount Accepted By Medical Provider As Payment From An Insured For Medical Care

***Robinson v. Bates,* 112 Ohio St.3d 17, 2006-Ohio-6362.**

Appellee, Carolyn Robinson, broke a bone in her foot when she stepped into an uneven slab of cement in the driveway of the property she rented. She filed suit against Appellant, the owner of the property. At trial, Appellee sought to admit as evidence medical bills totaling $1,919.00. The trial court refused to admit the bills, and instead limited her proof to $1,350.43, the negotiated amount paid by her insurance company. At the end of Robinson's case, the trial court entered a directed verdict for Appellant, holding that the condition of the driveway was open and obvious.

The First District Court of Appeals reversed the judgment, holding that reasonable minds could find that Appellant violated her duty as a landlord under R.C. §5321.04(A)(2) to repair leased premises. The Court of Appeals also relied on the collateral source rule to find that Appellee should not be limited to the amount paid by her insurer as evidence of the cost of her medical care, and her actual medical bills were admissible as evidence.

The Supreme Court accepted the case on a discretionary appeal and held that the collateral source rule does not apply to bar evidence of the negotiated amount paid by an insurer to a medical care provider as full payment. The Court concluded that both the amount originally billed by the provider and the amount paid by the insurer are admissible to prove the reasonable value of the medical care. In *Wagner v. McDaniels* (1984), 9 Ohio St.3d 184, at paragraph one of the syllabus, the Court previously found that "[p]roof of the amount paid or the amount of the bill rendered and of the nature of the services performed constitutes prima facie evidence of the necessity and reasonableness of the charge for medical and hospital services." Either the bill itself or the amount actually paid is therefore admissible to prove the value of medical services.

The collateral source rule was first stated in *Pryor v. Webber* (1970), 23 Ohio St.2d 104, wherein the Court held that a plaintiff's receipt of benefits from sources other than the tortfeasor is deemed irrelevant and immaterial on the issue of damages. The rule was intended to keep the

jury from learning of such benefits so that the defendant was not given an advantage from third-party payments to the plaintiff. Applying this rule to the issue of medical expenses, the Court held that the written-off amounts of a medical bill are expenses that are not actually paid, and therefore it differs from compensation actually received by a plaintiff. The collateral source rule only excludes "evidence of benefits *paid* by a collateral source." Since no one actually pays the negotiated reduction, admitting this evidence to a jury does not violate the purpose of the rule.

The Court declined to adopt a bright-line rule, though, noting that to do so would create separate categories of plaintiffs based on individual insurance coverage. The "fairest approach," the Court reasoned, is to make a defendant liable for the reasonable value of medical services. Depending on the circumstances of each case, that amount could be the amount originally billed, the amount the medical provider accepted as payment, or some amount in between. The jury is charged with making this determination.

The Court also noted in dicta that it "may well be that the collateral-source rule itself is out of synch with today's economic realities of managed care and insurance reimbursement for medical expenses. However, whether plaintiffs should be allowed to seek recovery for medical expenses as they are originally billed or only for the amount negotiated and paid by insurance is for the General Assembly to determine."

Finally, the Court upheld the Court of Appeals' determination that whether the landlord breached his statutory duty to repair the premises was a question for the jury. The open and obvious doctrine does not absolve the landlord from this duty, and will not protect him from liability. Therefore, it was improper for the trial court to grant a directed verdict.

Insurance Law – Insurer Is Not Entitled To Set Off A Medical Malpractice Settlement From Its UM/UIM Coverage Limits Under R.C. 3937.18(A)(2)

***Gray, et al. v. Grange Mutual Casualty Co., et al.*, 10th Dist. App. No. 05AP-1199, 2006-Ohio-6370, 2006 WL 3491861.**

Lamar Gray was involved in a motor vehicle collision on September 8, 1999 with Craig Jackson. Gray was transported to Selby General Hospital from the accident scene and treated by Dr. John S. Barton, III. He was thereafter transferred to a trauma center in Columbus, Ohio where he died on September 18, 1999. Gray's parents and sister filed a lawsuit against Jackson for his negligence in causing the collision, and against Dr. Barton and Selby for medical negligence relating to his treatment following the accident. The complaint also sought a declaration of rights under the UM/UIM provisions of two automobile policies issued by Grange Mutual Casualty Co. to Gray's parents and sister.

The claim against Jackson was eventually settled for $12,500, the limits of his insurance policy. The medical malpractice claims against the doctor and hospital were settled for $510,000 out of the $1,000,000 in available coverage for professional liability. These parties were dismissed from the lawsuit, leaving only the claims against Grange for UM/UIM coverage. Grange filed a motion for summary judgment, arguing that the policies at issue did not apply because of the "other owned vehicle" exclusion. Grange also asserted that it was entitled to set off $1,012,500 in available coverage from the policies of the other defendants, or in the alternative the $522,500 in settlements. Plaintiffs filed a motion for summary judgment claiming that the "other owned vehicle" exclusion did not apply, and that Grange was not entitled to set off the amount available in coverage for the medical malpractice claim. The trial court found genuine issues of fact exist regarding the proper owner of the subject vehicle; however, it granted Grange's motion for summary judgment because the court found Grange was entitled to the full set off, resulting in no UM/UIM coverage.

On appeal, the court was asked to consider whether Grange was entitled to set off the amount available to Appellants from the medical malpractice defendants' insurance pursuant to R.C. 3937.18(A)(2). The version of that statute applicable to this case provides in part as follows: "…Underinsured motorist coverage is not and shall not be excess insurance to other applicable liability coverages, and shall be provided only to afford the insured an amount of protection not greater than that which would be available under the insured's uninsured motorist coverage if the person or persons liable were uninsured at the time of the accident. The policy limits of the underinsured motorist coverage shall be reduced by those amounts available for payment under all applicable bodily injury liability bonds and insurance policies covering persons liable to the insured." Appellants argue that this clause limits set off to "amounts available for payment" only from automobile liability policies. They also contend that the medical malpractice defendants are not "persons liable to the insured," because Jackson is solely liable for

the accident and all of the damages resulting therefrom, including the subsequent malpractice. Grange counters that "amounts available for payment under all applicable liability bonds and insurance policies" includes any such policy, including professional liability insurance, and that "persons liable to the insured" includes any party who makes payment to the insured. Since the doctor and hospital paid a settlement to Appellants, Grange argues that they are "persons liable to the insured."

The court initially concluded that none of the case law cited by either party was directly on point, and its independent research failed to reveal any cases in Ohio that resolved the issue. However, using the decisions as guidance, the court found that R.C. 3937.18(A)(2) should be construed to apply only to automobile liability policies. In *Clark v. Scarpelli* (2001), 91 Ohio St.3d 271, the Ohio Supreme Court used language that supports the court's interpretation. It stated that an insurance carrier could set off payments made on behalf of "an uninsured motorist," and that the statute was not intended to be excess coverage to the tortfeasor's "applicable automobile liability insurance." Nowhere does the Court's language suggest that the set off provision applies to policies other than automobile policies. In the instant case, Grange would be permitted to a set off only of the $12,500 paid from Jackson's insurance policy.

The court also accepted Appellants' construction of the "persons liable to the insured" language. In *Bedner v. Carr* (2nd Dist. 1987), 40 Ohio App.3d 149, 154, a case in which a person injured in an automobile accident was further injured through medical malpractice, the court instructed the jury that "[t]he negligence of a tortfeasor in causing the original injury is the proximate cause of damages flowing from the subsequent negligence of unskilled treatment thereof by a physician and the original wrongdoer is liable therefore." Applying this reasoning, the court found in this case that Jackson was the sole tortfeasor liable to the insured for which R.C. 3937.18(A)(2) provides a set off.

The court found that public policy lends support to its interpretation of the statute. The goal of UM/UIM coverage is to allow sufficient insurance coverage to people involved in automobile accidents. If Grange's arguments were accepted, it would receive a windfall simply because the injured party was subjected to medical malpractice following the incident.

Finally, the court considered the language in the Grange policies and held that it evidences an intent to limit coverage to automobile accidents involving uninsured or underinsured vehicles. The contractual right to set off in the policy is stated as follows: "The limit of liability shown in the declarations under Uninsured Motorists Coverage for 'each person' is our maximum limit for all damages, including damages for care, loss of services or death, arising out of bodily injury sustained by any one person in any one *auto accident*…The limit of liability shall be reduced by all sums paid because of bodily injury by or on behalf of persons or organizations who may be legally responsible. This includes all sums paid under Part A." (Emphasis added). This language does not permit Grange to set off the amount received from the medical malpractice defendants against its UIM coverage limits.

Even if not entitled to a set off, Grange argues that the "other owned vehicle" exception in its policy precludes coverage. The policy states that UIM coverage will not be provided for injury to any person while "occupying or when struck by, any motor vehicle owned by you or any family member which is not insured for this coverage under this policy." Grange supports its argument by noting that the certificate of title to the vehicle is in Lamar Gray's name. His mother, however, claimed in her deposition that she purchased the vehicle, and had not gifted it to Lamar, so she was the rightful owner. The court found that there remained issues of fact over who owned the vehicle, so summary judgment was inappropriate.

Medical Malpractice – Jury Verdict Of $6,803,460, Including Punitive Damages And Attorneys' Fees, Upheld On Appeal

***Barnes, et al. v. University Hospitals of Cleveland, et al.*, 8th Dist. App. Nos. 87247, 87285, 87710, 87903, 87946, 2006-Ohio-6266, 2006 WL 3446244.**

This case involved Natalie Barnes, a 24 year-old woman who suffered from mental retardation and epilepsy. Natalie developed kidney disease in 2000 and underwent regular hemodialysis treatments at University Hospital. She had a "perma cath" surgically implanted in her chest. A perma cath is a device made up of a flexible tube that runs through the skin into the subclavian vein into the heart, and has two openings in the chest that are utilized during dialysis. It is important that during dialysis a secure connection is maintained in the perma cath opening, because if the catheter is removed from the port, an air embolism can occur. Since Natalie was known to have a tendency to pull on the catheter during her treatments, her parents requested that a medical aide sit with her at all times. MedLink of Ohio was contacted to provide this service for Natalie.

The first medical aide provided by MedLink was informed of the importance of sitting with Natalie at all times to prevent her from pulling her catheter out during treatments. This aide provided adequate service for several of Natalie's treatments. However, she was later replaced by Endia Hill. Hill was hired by MedLink despite not meeting the minimum requirements for employment. She did not have a high school diploma and had previously been convicted of a felony. Hill revealed these facts to MedLink on her job application and did not attempt to conceal the information. As with the first medical aide, Hill was informed of the importance of remaining at Natalie's side during her dialysis treatment.

On October 19, 2000, during one of Natalie's treatments, Hill left the dialysis unit, went to the hospital cafeteria and then walked around the hospital for several hours. Natalie was left with a hospital technician who was unaware of Natalie's special needs and had four other patients to care for. At one point, while the technician looked away from Natalie for several seconds, she pulled the catheter out of her chest. She suffered an air embolism and went into cardiac arrest. The incident left Natalie without the ability to eat or breathe and in need of life support. After Natalie did not improve for several months, her parents terminated life support.

Natalie's mother filed a medical malpractice/wrongful death action against MedLink and University Hospitals. Following a trial before a retired judge, a jury found MedLink ninety percent liable and UH ten percent liable for Natalie's death. Barnes was awarded $100,000 on her survivorship claim and $3,000,000 on her wrongful death claim. The jury also found that MedLink acted with actual malice and awarded $3,000,000 in punitive damages. After a hearing, Barnes was further awarded $1,013,460 in attorneys' fees and expenses. The parties appealed, asserting numerous assignments of error in several consolidated appeals. The Court of Appeals overruled each argument asserted by the parties and upheld the judgment of the trial court in its entirety.

MedLink argued on appeal that the jury's verdict was against the weight of the evidence and the result of passion and prejudice. A damage award will only be set aside if it is so excessive that it appears to be the result of passion and prejudice. The court rejected this argument, noting that the "reality of the facts involved in this case, no matter how they were relayed to the jury, would insight passion," and therefore the "jury's three million dollar verdict was in no way shocking."

The court also rejected MedLink's objection to the award of punitive damages, finding that MedLink acted with conscious disregard for the rights and safety of others by hiring an employee who failed to meet the company's minimum educational requirements and had a felony record. This constituted actual malice and supported a finding of punitive damages. It was also within the trial court's discretion not to bifurcate the issues of compensatory and punitive damages. The facts relating to each element were "closely intertwined," and bifurcation would require two lengthy proceedings with duplicative testimony.

Both parties challenged the trial court's findings relating to attorneys' fees. MedLink argued that the contingency fee arrangement between Barnes and her attorneys should have limited the overall award. Barnes argued that the trial court committed error in basing the award on an hourly rate and lodestar multiplier instead of allowing it as a full percentage of the award. The Court of Appeals held that the trial court properly considered evidence at a hearing of the difficulty of the case, the cost of representation, and the time and diligence exerted by Barnes' attorneys. Based on these factors, the award of fees was fair and appropriate.

MedLink's insurer, Lexington Insurance Company, appealed the trial court's denial of its motion to intervene. Lexington asserts that it met all of the requirements of Civil Rule 24(A) allowing an intervention of right. Rule 24(A)(2) allows intervention "upon timely application…when the applicant claims an interest relating to the property or transaction that is the subject of the action and the appellant is so situated that the disposition of the action may as a practical matter impair or impede the applicant's ability to protect that interest." The court initially found that Lexington was not entitled to intervene because its motion was not timely. Lexington's motion was not made until one day prior to the prejudgment interest hearing, after much of the litigation was concluded. Allowing intervention at that stage of the case would have caused significant disruption to the proceedings. In addition, the court held that MedLink and Lexington's interests in the case were closely aligned, and therefore intervention was unnecessary because Lexington was adequately represented.

MedLink further appeals the subject matter jurisdiction of the retired judge who presided over the case, since during his original tenure he was appointed and not elected. The court found that R.C. §2701.10, which allows retired judges to preside over civil matters, "is

completely void of any language mandating that in order to serve as a retired judge you must have been elected rather than appointed." In addition, the parties signed an agreement consenting to the judge's jurisdiction before the case, and expressly waived the argument MedLink asserts. The court stated that MedLink "cannot now seek to question the presiding judge's authority because they did not receive their desired outcome."

The final arguments of the parties relate to the award of prejudgment interest. Barnes argued that prejudgment interest should be calculated from the date the cause of action accrued. The court found that the trial court was correct in only awarding interest from the date the complaint was filed. R.C. §1343.03(C)(1)(c)(ii) provides that interest will be awarded "[f]rom the date on which the party to whom the money is to be paid filed the pleading on which the judgment…was based to the date on which the judgment…was rendered." This version of the statute was in effect at the time of the trial court's award of prejudgment interest. The court further rejected the argument that attorneys' fees should be included in the calculation of prejudgment interest. Attorneys' fees were held to be future damages, and thus excluded from an award of interest. "Future damages" are defined as "any damages that result from an injury to a person that is a subject of a tort action and that will accrue after the verdict or determination of liability by the trier of fact is rendered in that tort action."

MedLink unsuccessfully argued that prejudgment interest was inappropriate because it made a good faith effort to settle the case. During the trial, MedLink offered Barnes $400,000 to settle. The court found that "[w]hen evaluating the nature of this case and the truly devastating circumstances surrounding Natalie's death, MedLink's offer of $400,000 did not constitute a good faith effort to settle."

Medical Malpractice – Supreme Court Clarifies Test For Determining Personal Immunity For State-Employed Medical Professionals

***Theobald, et al. v. University of Cincinnati*, 111 Ohio St.3d 541, 2006-Ohio-6208.**

Appellant, Keith Theobald, was seriously injured in a car accident and taken to University Hospital in Cincinnati. He was required to undergo ten hours of surgery, after which he could not see, lost the use of his right arm, and had little mobility in his left arm. Theobald and his family filed an action for medical malpractice against four of his treating doctors, among others, in Hamilton County Court of Common Pleas. The four defendant doctors asserted personal immunity based on R.C. 9.86, which provides immunity to employees of the state. Pursuant to R.C. 2743.02(F), Appellants filed an action in the Court of Claims against the University of Cincinnati to resolve the immunity issue. The court found that the doctors were not entitled to immunity. Although two of the doctors were held to be employees of the state, the court ruled they were acting outside the scope of their employment while treating Theobald because their private-practice plans received payment for the medical services. The other two doctors were not considered state employees since they were paid by private corporations and merely contracted with the state. The University of Cincinnati appealed.

The Court of Appeals found that all four doctors were state employees, and remanded the case for determination of whether they were acting within the scope of their employment at the time of Theobald's treatment. The court suggested that the state's interest is promoted when a doctor furthers the education of students and residents during his treatment of patients, and the Court of Claims should therefore determine if the doctors were educating students during the time of the incident. Appellants appealed the matter to the Supreme Court.

The Supreme Court upheld the decision of the Court of Appeals. To determine whether a medical practitioner is immune from liability, the first issue is whether that person is a state employee. The court should examine express contract language, financial or corporate documents, W-2 forms, invoices or other billing information. If the person is not an employee, he or she is not entitled to immunity under R.C. 9.86. If state employment is established, the court must next determine if the person was acting on behalf of the state, or in the course of their employment, at the time of the alleged incident. The Court found that a medical practitioner is acting within the scope of employment for purposes of determining immunity if evidence shows they were educating a student or resident when the alleged negligent act occurred. Since the Appellants did not appeal the issue of whether the doctors were employed by the state, the matter was remanded to the Court of Claims to determine whether the defendant doctors were acting within the scope of their employment at the time of Appellant's treatment.

In reaching its decision, the Court rejected Appellants' suggestion that a bright-line test be used to determine scope of employment based on the billing practices of the medical provider. Appellants argued that if they paid a

private practice, and not the state, for the medical services rendered, the doctor should be considered as acting outside the scope of his state employment at the time of the treatment. The Court held that although financial factors may have relevance to whether a doctor is a state employee, it has little importance to establishing the scope of employment. Most state medical schools affiliate with private corporations staffed by clinical faculty members, allowing them to attract and compensate highly qualified instructors. The billing practices that result from this arrangement have little to do with the job duties of the medical practitioner at the time of treatment. The Court held that its approach correctly focuses on the purpose of the employment relationship, not on the financial arrangement between the doctors and the state.

Justice Pfeifer filed a dissenting opinion in which he criticized the new test, which he suggests would immunize "a doctor from negligence whenever negligence occurs in the presence of a student. This test is imbued with the fiction that teaching doctors are always teaching…Teaching by osmosis is not the same as talking a resident through an operation. The mere presence of a student does not establish that instruction is taking place." By adopting this test, Justice Pfeifer argues that the Court is encouraging doctors to "make sure a student is available every time they operate. After all, would there be any better way to avoid personal liability for negligence?" In addition, Justice Pfeifer notes that the majority decision will result in shifting the cost of the negligence of the doctors from the insurance companies to the state. He argues that this kind of policy change should be left to the General Assembly. Finally, he points out that by making it easier to establish personal immunity of doctors, plaintiffs will be forced to bring their cases in the Court of Claims where no jury trials are allowed. Justice Pfeifer suggests that the former rule, which allowed consideration for financial factors, struck a better balance between the competing interests involved in these cases.

Medical Malpractice – Expert Witness May Testify Regarding Standard Of Care Even Though He Practices A Different Medical Specialty Than Defendant

***Trevena, et al. v. Primehealth, et al.*, 11th Dist. App. No. 2005-L-163, 2006-Ohio-6535, 2006 WL 3575012.**

On June 2, 2002, Edwin Trevena became sick and left work. Three days later he saw his family physician, Dr. Robert Mulcahy, and complained of dizziness, blurred vision, vomiting, blocked ears, and room spinning. Dr. Mulcahy diagnosed him with vertigo/viral syndrome and prescribed medication. Two days later, Trevena called Dr. Mulcahy's office and reported that the symptoms were getting worse. He was referred to an ear, nose, and throat doctor to determine if he had an inner ear infection. On June 11, 2002, Trevena called the doctor's office again and was told to go to the emergency room. He decided to wait and see the ear, nose and throat doctor the next day. On his way to the doctor's office, Trevena collapsed and was rushed to the emergency room. Over the next several months, Trevena suffered seven strokes, which left him totally and permanently disabled. He is confined to a care facility and needs assistance with washing, dressing, and personal hygiene.

Trevena and his wife filed suit for medical malpractice against Dr. Mulcahy, his partner, and his practice, alleging that the doctor fell below the standard of care in treating Trevena. Appellants allege that Trevena suffered an evolving stroke beginning on June 2, 2002, and had the doctors performed adequate testing and found the stroke earlier, Trevena would have suffered only mild, residual disabilities instead of the catastrophic loss he endured instead. At the conclusion of Appellants' case at trial, the court denied a motion for directed verdict on the qualifications of Appellants' expert witness, but granted a directed verdict for Appellees on the issue of damages. Both parties appealed.

The Court of Appeals first considered whether Appellants' expert medical witness was qualified to testify under Evid. R. 702. Appellees argued that because the witness did not practice in the same specialty as Dr. Mulcahy, he was not qualified to testify regarding the standard of care that applied to him. The court disagreed. In *Schutte v. Mooney* (2nd Dist.), 165 Ohio App.3d 56, 2006-Ohio-44, at ¶24, the court held that "a witness may qualify as an expert even though he does not practice the same specialty as defendant. The witness must demonstrate, however, that he is familiar with the standard of care applicable to the defendant's school or specialty and that his familiarity is sufficient to enable him to give an expert opinion as to the conformity of the defendant's conduct to those particular standards and not to the standards of the witness' school and, or, specialty if it differs from that of the defendant," quoting *Alexander v Mt. Carmel Medical Center* (1978), 56 Ohio St.2d 155, 158. Appellants' expert witness was board-certified in psychiatry and neurology, had consulted in the area of strokes and brain injury since 1995, and testified that he was familiar with the standard of care expected of an internal medicine specialist presented with the symptoms Trevena had on the date at issue. The court upheld the trial court's denial of Appellees' motion for directed

verdict, finding that the witness met the above-described standard and his testimony was admissible.

The next issue considered by the court was whether the trial court properly granted a directed verdict on this issue of damages. Appellees argued that, even if it were assumed that Dr. Mulcahy was negligent, Appellants' expert witness failed to state with any certainty to what extent Trevena would have been better off if a diagnosis was made sooner. The trial court granted the motion, finding that the evidence only suggested that Trevena's condition would have been to a "lesser magnitude," thereby requiring the jury to speculate as to the actual damages.

The Court of Appeals found that the motion for directed verdict was improperly granted and the issue of damages should have been submitted to the jury. The court compared the instant case to those cases in which courts have applied the "loss of chance" theory, "which compensates an injured plaintiff for his or her diminished chance of recovery or survival, [and] provides an exception to the traditionally strict standard of proving causation in a medical malpractice action. Instead of being required to prove with reasonable probability that defendant's tortious conduct proximately caused injury or death, the plaintiff, who was already suffering from some disease or disorder at the time the malpractice occurred can recover for his or her 'lost chance' even though the possibility of survival or recovery is less than probable." *Roberts v. Ohio Permanente Med. Group, Inc.* (1996), 76 Ohio St.3d 483, 485. The court found that the theory was appropriate in this case because Appellants' had established a prima facie case of malpractice, and that Trevena had a reduced chance of recovery because of Dr. Mulcahy's negligence. The jury should have the chance to decide the extent to which this negligence caused Appellants' damage.

Motor Vehicle Accident – Issues Of Fact Regarding Whether A Utility Pole "Incommodes" The Public's Use Of A Road Or Constitutes A Nuisance Precludes Summary Judgment

***Turner, et al. v. Ohio Bell Telephone Company, et al.*, 8th Dist. App. No. 87541, 2006-Ohio-6168, 2006 WL 3378474.**

On September 10, 2003, Robert Turner was a passenger in a car heading southbound on Route 188 in Pleasant Township. As a result of heavy fog and poor visibility, the vehicle went off the road while going around a curve and hit a utility pole. Turner died from the injuries caused by the accident. The utility pole was located three feet, nine inches away from the edge of the highway and two feet, five inches from the berm of the road. Appellants filed a complaint alleging that Appellees were negligent in placing and maintaining a utility pole in such close proximity to the traveled portion of the road, and that the pole constitutes an absolute and/or qualified nuisance. Appellants also claimed that Appellees were negligent *per se* for their violation of R.C. §4931.01. The trial court dismissed all claims on summary judgment, finding that "the record demonstrates that the pole was neither placed on the traveled and improved portion of the road nor in such close proximity as to constitute an obstruction dangerous to anyone properly using the highway."

When a utility company places a pole near a traveled roadway, it "must not unnecessarily or unreasonably interfere with or obstruct the public in the reasonable and ordinary use of the road for the purpose of public travel." *Curry v. The Ohio Power Co.* (5th Dist.), 1980 WL 354093. The Ohio Supreme Court stated that a "highway is primarily constructed for purposes of travel, and not as a site for monuments, billboards, telephone or telegraph poles, or any other device that may create an obstruction within the limits of the right of way…The last clause [of the applicable law], 'but shall not incommode the public in the use thereof,' is a danger signal to public utilities using the highways for their own private purposes. They are placed upon notice, to the effect that if they erect 'posts, piers, and/or abutments' within the right of way of the highway, they must not prejudice the superior rights of the traveling public in so doing." *Cambridge Home Telephone Co. v. Harrington* (1933), 127 Ohio St. 1, 5. A utility company may be liable for placing a pole "in the traveled portion of the highway or in such close proximity thereto as to constitute an obstruction dangerous to anyone properly using the highway." *Id.*

The court held that there exist genuine issues of fact regarding whether the location of the subject utility pole was such that it created an unreasonable risk of harm. Contrary to Appellees' argument, a pole does not need to be placed in the traveled or improved portion of the road before liability exists. The court cited to several cases from other jurisdictions that found liability where the placement of a pole created a foreseeable and unreasonable risk of harm. In making this determination, courts should consider "the narrowness and general contours of the road, the presence of sharp curves in the road, the illumination of the pole, any warning signs of the placement of the pole, the presence or absence of reflective markers, the proximity of the pole to the highway,

whether the utility company had notice of previous accidents at the location of the pole and the availability of less dangerous locations. The court found that a jury should be entitled to consider the factors present in this case to determine liability.

For the same reasons, summary judgment should not have been granted on Appellants' claim for qualified nuisance. "A qualified nuisance is essentially a tort of negligent maintenance of a condition that creates an unreasonable risk of harm, ultimately resulting in injury." *State ex rel. R.T.G., Inc. v. State* (2002), 98 Ohio St.3d. 1, 13. Issues of fact were identified regarding whether maintaining the subject pole in its location constituted a qualified nuisance.

The court found that summary judgment was also not appropriate on the issue of causation. Appellees argued that even if they were negligent, the sole proximate cause of Turner's death was the negligent driver. The court disagreed and found that a reasonable jury could find that, but for the negligent placement of the pole by Appellees, the accident and resulting death could have been avoided.

The court upheld summary judgment on the absolute nuisance and negligence *per se* claims, however. The Ohio Supreme Court stated that "[a]n absolute nuisance is based on either intentional conduct or an abnormally dangerous condition that cannot be maintained without injury to property, no matter what care is taken." *Id.* at 13. The court found no evidence that placement of utility poles near a roadway is so abnormally dangerous that it would meet this standard. Appellants' claim that Appellees were negligent *per se* was based on R.C. §4931.01, a statute that was repealed in 1999. The statute imposed a duty on utility companies constructing posts along a public road to do so in a manner "not to incommode the public in the use of the roads or highways." Since the duty stated is general, the court held that negligence *per se* is inapplicable, and the common law elements of negligence must be shown.

Political Subdivision Liability – Statutory Immunity – Department Of Children And Family Services And Its Employees Not Immune From Liability For Reckless Failure To Investigate And Report Child Abuse

***O'Toole, et al. v. Denihan, et al.*, 8th Dist. App. No. 87476, 2006-Ohio-6022, 2006 WL 3317797.**

Appellants brought a wrongful death and survival action on behalf of the estate of Sydney Sawyer against the Department of Children and Family Services ("DCFS"), its executive director and other supervisors and social workers. The decedent was a 4 year-old girl who was physically abused. On April 28, 2000, she was pronounced dead at Rainbow Babies and Children's Hospital from blunt trauma to her body that caused a perforation of her small intestine and acute peritonitis. DCFS is the agency within the Cuyahoga County Department of Human Services charged with investigating allegations of child abuse, and is responsible for providing care, protection and support to abused children. Appellants alleged in their complaint that Appellees failed to report abuse of decedent to law enforcement, recklessly created a substantial risk of harm to her, negligently performed their job duties, breached their statutory duty of care, and recklessly implemented a risk assessment protocol used for investigation of abuse cases.

Appellees filed motions for summary judgment, asserting statutory immunity from liability under R.C. 2744.02 and 2744.03, which provide immunity to political subdivisions from actions for injury, death or loss caused by an action or omission of an employee in connection with a governmental or proprietary function. The trial court granted Appellees' motions, finding "that plaintiff has failed to present genuine issues of material fact for trial affirmatively refuting the binding case law of *Marshall v. Montgomery County Children Services Board*, 92 Ohio St.3d 348, 2001-Ohio-209."

The Court of Appeals overruled the award of summary judgment, finding that genuine issues of material fact exist in the case. There was a dispute regarding whether Appellees ever notified the Cleveland Police Department of the abuse of decedent prior to her death, as required by R.C. 2151.421(C). Factual issues also remained concerning whether the DCFS was reckless in assigning an inexperienced worker to decedent's case, whether the social worker was provided adequate supervision, whether workers possessed the skills and clinical judgment to implement a safety and risk assessment model, whether supervisors demonstrated proper skills and knowledge to remain in their positions, whether independent medical examiners should have been provided, and whether the department instituted proper mechanisms to determine if its risk assessment program was properly implemented. Finally, the court noted that there was an issue of fact regarding whether Appellees acted recklessly, since the child was returned to her mother despite evidence that the girl had bruising on her face, whip marks on her back, and burn marks on her palm.

The Court of Appeals also found that the trial court erred in its application of the *Marshall* case, in which the Ohio Supreme Court found that R.C. 2151.421 provided statutory immunity from liability for negligent failure to investigate. The instant case was distinguishable because Appellants' claims include allegations of reckless behavior, whereas the *Marshall* decision was limited to negligence. In addition, the *Marshall* decision does not apply to Appellants' claim for violation of the statutory duty to report the matter to the police, which falls under an exception to Appellees' claimed immunity.

Premises Liability – Slip And Fall – Genuine Issue Of Fact Regarding Whether Accumulation Of Ice Was Natural Or Man-Made Precluded Summary Judgment

***Sherwood, et al. v. Mentor Corners Limited Partnership, et al.*, 11th Dist. App. No. 2006-L-020, 2006-Ohio-6865, 2006 WL 3772220.**

On December 28, 2001, Earl Sherwood and his wife had breakfast at the Manhattan Deli with friends. The deli is located in Mentor Corners shopping mall. As Mr. Sherwood was leaving the premises, he slipped and fell on an access ramp leading from the storefront sidewalks to the parking lot, causing him to shatter his pelvis. A steady snow fell throughout the morning, and Mr. Sherwood claimed that the access ramp was slippery and covered with snow.

The Sherwoods filed suit against Mentor Corners Limited Partnership, the property manager, and R. J. Snow Services. The defendants moved for summary judgment, arguing that they were not liable because Mr. Sherwood's injuries were caused by a natural accumulation of snow, and they did not have notice of an unusually hazardous condition. The trial court granted defendants' motion.

In *Lawrence v. Jiffy Print, Inc.*, (11th Dist.), 2005-Ohio-4043, ¶9, the court held that the occupier of premises is not liable for a slip and fall that results from the natural accumulation of ice and snow because such condition is deemed an open and obvious hazard. The court noted two exceptions to this general rule. Liability may attach if the accumulation of ice and snow is "unnatural," or caused by factors other than weather patterns, such as when man-made factors cause the ice and snow to gather in an unexpected place or way. An occupier of premises may also be liable if it has notice, express or implied, that a natural accumulation of ice and snow creates conditions that are substantially more hazardous than a person would anticipate.

Appellants argue in this case that Mr. Sherwood's fall was caused by an unnatural accumulation of ice, hidden beneath the snow, that resulted from a covering built over the sidewalks outside the mall. Photographs taken after the incident show that icicles formed in a valley between a gable in the roof and the edge of the roof, directly over the access ramp. Appellants argue that this evidence shows that the design of the covering allowed water to flow off the roof and on the access ramp below, creating an unnatural accumulation of ice. Appellants submitted a report from an expert witness that states that the "discharge of water onto the ramp from the valley results in a greater accumulation of water and/or ice than normal and creates a greater maintenance concern than if the curb ramp were located at another location." The court held that this evidence was sufficient to create an issue of fact that should be decided by a jury. Although Mr. Sherwood was unable to state with certainty whether ice accumulated on the ramp, he was able to testify that it was snow covered and slippery. A reasonable jury could conclude that this testimony, coupled with the opinion of Appellants' expert, is sufficient to impose liability on Appellees for a man-made accumulation.

The court also held that summary judgment was inappropriate because an issue of fact remained as to whether Appellees were on notice that the access ramp became unusually slippery during the winter. An employee of an adjacent store submitted an affidavit that she had previously seen other people fall on the access ramp, and that employees of the stores in the mall regularly shoveled and salted the ramp because of its "obviously slippery and hazardous condition." The court found it important that this employee did not state that any other portion of the sidewalk or parking lot was regularly maintained, thereby indicating that the ramp was a particular hazard. The trial court's order granting Appellees' motion for summary judgment was overruled.

Workers' Compensation – Statute Limiting Amount Of Benefits To Work-Relief Employees Violates Equal Protection Clauses Of The Ohio And United States Constitutions

***State ex rel. Beck, et al. v. Industrial Commission of Ohio,* 10th Dist. App. No. 04AP-1094, 2006-Ohio-2630, 2006 WL 3719413.**

Relators sought a writ of mandamus ordering the Industrial Commission of Ohio to vacate its order because the Commission failed to properly calculate relators' benefits. Relators also sought certification of a class action. A magistrate granted the request for a writ of mandamus, and further recommended that the matter be certified as a class. The Commission filed objections to the decision to the Court of Appeals.

The issue before the Court was the application of *State ex rel. Patterson v. Industrial Commission* (1996), 77 Ohio St.3d 201, in which the Supreme Court held that R.C. 4127.04 violates the Equal Protection Clause because it provides a different benefit to dependents of work-relief employees than to dependents of other employees whose death is caused by a work-related injury or disease. Relators argue that the decision also extends to the actual work-relief employees, not just their dependents. The Commission, on the other hand, maintains that the *Patterson* decision was limited to benefits awarded only to dependents.

The Court of Appeals upheld the magistrate's decision. The court noted that the *Patterson* decision included language that clearly encompassed both employees and their dependents. For example, the decision states that R.C. 4127.04 "does not treat similarly situated persons – all employees and their dependents – in a similar manner;" that there is no justification for disparate treatment of "work relief employees and non-work relief employees," and; that R.C. 4127.04 is "inherently unfair and contrary to the purpose of compensating employees and dependents." This language supported the magistrate's finding that the Ohio Supreme Court did not intend to limit its analysis to only dependents of work-relief employees. The court rejected the Commission's arguments to the extent they challenged the reasoning behind *Patterson*, concluding that the issue of constitutionality was already decided and the court was bound to apply the holding of *Patterson*.

The court sustained the Commission's objections to the magistrate's decision to certify a class action, however. The court found that in an action challenging the implementation of a statute, class litigation was unnecessary, and therefore not the superior method with which to determine the claims of members of the proposed class. The decision in the instant case will require the bureau to apply the standards to all of its participants, and further litigation would only be necessary if the bureau refused to comply. Class litigation would serve only to complicate the matter, not simplify it.

Workers' Compensation – Termination For Misconduct Considered Voluntary Abandonment Of Employment And Precludes Recovery Of Temporary Total Disability Benefits

***State ex rel. Gross v. Industrial Commission of Ohio*, 112 Ohio St.3d 65, 2006-Ohio-6500.**

David Gross, a 16 year-old high school student, began working for Food, Folks & Fun, Inc. ("FFF"), d.b.a. KFC, on September 27, 2003. On November 26, 2003, Gross put water into a pressure cooker in order to clean it. This method of cleaning the cooker was a violation of KFC's employee handbook, was contrary to written warnings on the cooker, and was something Gross had previously been reprimanded for by his supervisor. As Gross removed the lid of the cooker, against the instructions of a co-worker, the extreme pressure from the boiling water caused him and two other employees to be severely burned.

Gross filed a claim for workers' compensation benefits following the incident. He was awarded and received temporary total disability benefits. On February 13, 2004, FFF informed Gross that his employment was terminated following investigation. FFF stated that it "cannot and will not tolerate employees who pose a danger to themselves and others based upon their refusal or failure to follow instructions and recognized safety procedures." FFF asked the Industrial Commission to terminate Gross's TTD benefits as of the date of his termination. It argued that the discharge constitutes a voluntary abandonment of his employment. The Commission agreed and stopped his benefits. On appeal, the Court of Appeals reinstated Gross's benefits, holding that a termination resulting from an incident that causes the subject injury is an involuntary separation and does not bar the receipt of TTD benefits.

The Supreme Court reversed the Court of Appeals, holding that Gross' willful violation of work rules justifying his termination constitutes a voluntary abandonment of his employment. Gross argued that he did not abandon his employment, because "a claimant can abandon a former position or remove himself or herself from the work force only if he or she has the physical capacity for that employment at the time of the abandonment or removal." *State ex rel. Brown v. Indus. Comm.* (1993), 68 Ohio St.3d 45, 48. Gross notes that his doctor certified his disability on November 26th, and he wasn't terminated until February 13th. Based on the above rule, he claims he could not voluntarily abandon his employment. The Court rejected this argument, and found that "Gross's disability and the misconduct that precipitated a finding of voluntary abandonment occurred simultaneously, not sequentially." The Court suggested that Gross's misconduct was such that his immediate termination was likely warranted, and the only reason he was not discharged until a later date was the time necessary for FFF to complete its investigation.

Gross alternatively argues that a job loss caused by an industrial injury is involuntary, and an involuntary separation does not prevent a claimant from recovering TTD benefits. He cites *State ex rel. Pretty Prods, Inc.*, (1996), 77 Ohio St.3d 5, in which an employee was terminated following an on-the-job injury as a result of unexcused absences. The Court noted in that case that if the discharge was for absences precipitated by the workplace injury, a finding of involuntary separation was sustainable. The Court held that the *Pretty Prods.* decision is distinguishable from Gross's case because Gross was not terminated because of absenteeism. "He was fired because he directly and deliberately disobeyed repeated written and verbal instructions not to boil water in the pressurized deep fryer and injuries followed."

The Court finally disregarded Gross's position that barring his recovery of benefits in this case would result in the inappropriate insertion of negligence into the workers' compensation system. Gross argued that fault, by either the employer or the employee, should not be considered. The Court responded by noting that he "offers a thought-provoking argument, but we do not find that these particular facts are conducive to further discussion of that proposition. Gross *willfully* ignored *repeated* warnings not to engage in the proscribed conduct, yet still wishes to ascribe his behavior to simple negligence or inadvertence. To address his argument further is to validate that categorization – something we decline to do."

In a dissenting opinion joined by Justice Pfeiffer, Justice Lundberg Stratton concluded that although KFC may have been justified in terminating Gross, his firing should not bar the availability of TTD benefits. Since Gross's termination was causally related to his industrial injury, it is not voluntary and does not preclude his eligibility for benefits. Justice Lundberg Stratton argued that the

majority's holding presents great potential for abuse in allowing an employer to allege misconduct of an employee simply to preclude his TTD compensation. She also cited concern that the majority is injecting the element of fault into the workers' compensation system, allowing contributory negligence to act as a defense. She stated that the majority's holding "will place us on a slippery slope toward assessing fault in industrial accidents. The employer will examine the employee's conduct following an industrial accident and use any infraction discovered to terminate the employee. When this occurs, where do we draw the line?"

Verdicts & Settlements

(For members and educational purposes only)

The Official Committee of Unsecured Creditors of PHD, Inc., on Behalf of the Estate of PHD, Inc., et al. v. Bank One, N.A., et al.

Type of case: Chapter 11 Bankruptcy Adversary Proceeding (Claims included Equitable Subordination, Avoidance of Preferential Transfers, Improvement in Position, Declaratory Judgment, Breach of Fiduciary Duty, Fraud and Negligent Misrepresentation)
Settlement: $1,000,000 Cash Settlement; $3,106,540 Waiver/Subordination Settlement
Plaintiff's Counsel: Dennis R. Landsdowne, Esq. and Nicholas A. DiCello, Esq. of Spangenberg, Shibley & Liber LLP; Larry Oscar, Esq. and Rocco Debitetto, Esq. of Hahn Loeser + Parks LLP
Defendant's Counsel: Isaac Schulz, Esq. and Christopher Fisher, Esq. for Defendant Bank One, N.A. (nka JP Morgan Chase Bank N.A.); Harry Wright, Esq. for Defendant Banc One Capital Partners LLP ("BOCP")
Court: United States Bankruptcy Court for the Northern District of Ohio/Judge Morgenstern-Clarren/Adversary Proceeding No. 03-01332
Date: August 30, 2005 – Settlement with BOCP; April 7, 2006 – Settlement with JP Morgan
Insurance Company: N/A
Damages: Funds paid into Bankrupt Estate and/or unencumbered for distribution to unsecured creditors

Summary: On behalf of unsecured creditors and the Bankrupt Estate, the Committee of Unsecured Creditors sought recovery from Bank One, N.A. (nka JP Morgan Chase Bank, N.A.), Debtors' senior secured lender, and Banc One Capital Partners, LLC, Debtors' subordinate lender, and various of Debtors' former Officers and Directors. Specifically, the Committee sought to equitably subordinate Bank One's secured claims to those held by unsecured creditors under the Bankruptcy Code based upon allegedly false and misleading statements made by Bank One representatives to the community of Debtors' vendors (unsecured creditors) regarding Debtors' financial condition and creditworthiness prior to and leading up to the Bankruptcy. Common law fraud and misrepresentation claims were premised upon the same alleged misrepresentations. The Committee sought to equitably subordinate BOCP's secured claims based upon its relationship with a former Director of Debtors, against whom the Committee asserted a claim for breach of fiduciary duty. The Committee asserted claims for breach of fiduciary duty against certain former Officers and Directors of Debtor entities. Plaintiff asserted claims against Bank One and BOCP for Improvement in Position under the Bankruptcy Code and sought to recover, on behalf of the Debtors' Estates, amounts by which the lenders allegedly reduced unsecured debt within the applicable period defined by the Bankruptcy Code. The Committee sought a declaratory judgment that the assets of one of the Debtors were not subject to either lender's security interests because said Debtor was allegedly not a signatory to any applicable security agreement or, alternatively, the allegedly effective financing statement filed by Bank One constituted an avoidable preference under the Bankruptcy Code. The Committee also sought to recover various transfers by and between Debtors and BOCP as preferential under the Bankruptcy Code.

Plaintiff's Experts: Michael Pappas, CPA
Defendant's Experts: Robert M. Brlas, CPA

Joseph LaManna v. United States of America

Type of case: Federal Tort Claims Act
Settlement: $650,000.00
Plaintiff's Counsel: Ellen McCarthy, Esq. of Nurenberg, Paris, Heller & McCarthy
Defendant's Counsel: William Kopp, U.S. Attorney's Office
Court: United States District Court, Northern District of Ohio; Judge Donald C. Nugent
Date: October, 2006
Insurance Company: N/A
Damages: Removal of ascending colon, several hernia surgeries.

Summary: Plaintiff entered the VA for a screening colonoscopy which identified a polyp in the transverse colon. The surgeon removed the ascending colon and learned there was no polyp. The surgeon then removed the transverse colon. The incision dehisced, resulting in a several month confinement and multiple surgeries.

Plaintiff's Experts: Joseph A. Scoma, M.D. and John F.

Burke, Ph.D.
Defendant's Experts: None

(Case Caption Withheld)
Type of case: Breach of contract, bad faith
Settlement: $1,650,000.00
Plaintiff's Counsel: Peter H. Weinberger, Esq. and Nicholas A. DiCello, Esq. of Spangenberg, Shibley & Liber LLP
Defendant's Counsel: Michael Eagen, Brett Bacon
Court: Cuyahoga County Court of Common Pleas
Date: July, 2006
Insurance Company: Withheld
Damages: Cancellation of health insurance

Summary: Defendant health insurance terminated Plaintiff's health insurance, claiming she had understated her weight on her application. The termination occurred after Plaintiff was diagnosed with a cerebral aneurysm and was going to require surgery.

Plaintiff's Experts: Steven Prater (insurance practice); Bruce Carson (actuary)
Defendant's Experts: None

(Case Caption Withheld)
Type of case: Medical Malpractice
Settlement: $1,300,000.00
Plaintiff's Counsel: Peter H. Weinberger of Spangenberg, Shibley & Liber LLP
Defendant's Counsel: Withheld
Court: Lucas County Court of Common Pleas
Date: March, 2006
Insurance Company: Withheld
Damages: Inability to completely remove pituitary tumor, causing acromegaly symptoms

Summary: Plaintiff was referred for an MRI due to headaches. A radiologist misread his MRI as normal when in fact he had a pituitary adenoma. Three years later when Plaintiff noticed signs of enlarged facial features (acromegaly), the tumor was diagnosed by repeat MRI. However, the tumor could not be completely removed and Plaintiff requires monthly injections of sandastatin, which has significant side effects.

Plaintiff's Experts: Lennard Nadalo, M.D. (neuroradiologist); Ariel Barkam, M.D. (endocrinologist)
Defendant's Experts: Stuart Point, M.D. (neuroradiologist); Michael Potchen, M.D. (neuroradiologist)

(Case Caption Withheld)
Type of case: Medical Malpractice
Verdict: $900,000.00
Plaintiff's Counsel: Peter H. Weinberger, Esq. of Spangenberg, Shibley & Liber LLP
Defendant's Counsel: John Polito
Court: Withheld
Date: April, 2006
Insurance Company: Withheld
Damages: Requires chemotherapy, surgery, and has a reduced life expectancy.

Summary: 71 year old lady has colonoscopy for rectal bleeding. Four polyps are found, three are removed and one is biopsied. The biopsied polyp tissue is benign but two of the other four are adenomatous (potentially cancerous). The gastroenterologist fails to remove the biopsied polyp. 18 months later, Plaintiff is diagnosed with colorectal cancer, Stage IV. She requires chemotherapy and surgery, and has a reduced life expectancy.

Plaintiff's Experts: Todd Eisner, M.D. (gastroenterology); Robert Sklaroff, M.D. (oncology); Douglass Ackermann, M.D. (pathology)
Defendant's Experts: None

Jankovsky v. Auto Owners Insurance
Type of case: Underinsured Motorist Claim based on rear-end collision
Verdict: $950,000.00 (Plaintiff's demand in closing argument was $1.5 million; Defendant's suggestion in closing argument was $200,000.00).
Plaintiff's Counsel: Dennis P. Mulvihill, Esq. of Lowe Eklund Wakefield & Mulvihill Co., LPA
Defendant's Counsel: David Cheney, Esq.
Court: Allen County/Judge Jeffrey L. Reed
Date: November, 2006
Insurance Company: Auto Owners Insurance

Damages: Post-traumatic fibromyalgia (chronic myofascial pain syndrome)

Summary: Plaintiff, a 55 year old nurse, was in near perfect health when she was rear-ended. She suffered soft tissue injuries which led to a diagnosis of post-traumatic fibromyalgia (chronic myofascial syndrome). She worked on and off over the next three years before her doctors said she was totally disabled from the pain. Defense argued that the injuries were all subjective, with all radiological tests being normal. Plaintiff had $20,000.00 in medical expenses, $355,000.00 in wage loss, and $730,000.00 in diminished earning capacity.

Plaintiff's Experts: Lynn Thompson, M.D. (family practice); Frank M. Baldauf, M.D. (family practice)
Defendant's Experts: Maris Young, M.D. (rehab medicine); Raymond Spriggs (orthopaedic surgery).

John Doe, et al. v. ABC Hospital, et al.
Type of case: Medical Malpractice
Settlement: $12,500,000.00
Plaintiff's Counsel: Christopher M. Mellino, Esq. of Mellino Law Firm, LLC
Defendant's Counsel: Withheld
Court: Withheld
Date: Withheld
Insurance Company: Withheld
Damages: Anoxic brain injury in 51 year old male

Summary: In July 2004, John Doe was admitted to Defendant ABC Hospital for evaluation of intermittent chest pain. After testing was performed by the cardiologist, it was determined that Mr. Doe should undergo cardiac bypass surgery. Although John and his wife inquired as to being transferred to another hospital for the surgery, they were told John had a "widow maker" and would not survive transfer. They were given no choice in their surgeon but instead were assigned Defendant Dr. #1 who, unknown to them, had an extensive history of medical malpractice. At the end of surgery, diffuse oozing was noted by Dr. #1 but he did not communicate this to anyone in the Surgical Intensive Care Unit (SICU) who would be caring for John postoperatively. Despite John being hemodynamically unstable and having excessive bleeding from his chest tube, Dr. #1 left the hospital early that evening. After continued instability, Defendant Dr. #2, the intensivist in the SICU overseeing John's care, confirmed by chest x-ray that John was suffering from cardiac tamponade which required immediate re-opening of the chest to remove clots and stop the bleeding. But this wasn't done until almost three hours later after John had arrested and suffered severe anoxic brain damage. Notwithstanding John's immediate postoperative instability, the Nurse and the respiratory therapists continued to wean the ventilatory support John was receiving in violation of the hospital's weaning protocol. Even following the diagnosis of cardiac tamponade, they voluntarily removed John's breathing tube without a physician's order or presence at the bedside. Soon after and still unstable, John was left unattended. He then arrested and suffered an anoxic brain injury, leaving him in a persistent vegetative state. John was 51 years old at the time of the malpractice. He and his wife have five minor children and John has three adult children from a previous marriage. Before the surgery, John worked full-time as a computer systems builder while Jane worked as a nurse.

Plaintiff's Experts: Brian deGuzman, M.D. (Cardiothoracic Surgeon, Phoenix, AZ); James Herson, M.D. (SICU Medical Director, San Francisco, CA); Michelle McGonigal, R.N. (SICU Nurse Manager, Pittsburgh, PA); John F. Burke (Economist, Cleveland); Marianne Boeing, R.N. (Life Care Planner, Cleveland)
Defendant's Experts: Mark Botham, M.D. (Cardiothoracic Surgery, Cleveland); Norman Silverman, M.D. (Cardiothoracic Surgery, Detroit, MI); Joseph Craver, M.D. (Cardiothoracic Surgery, Atlanta, GA); Christopher Bonnet, M.D. (Intensive Care, Pittsburgh, PA); Thomas Donnelly, M.D. (Intensive Care, Dayton, OH); Mary Carson, R.N. (Charlottesville, VA); Michael Spitrey, R.N. (Hudson, FL); John E. Scarbrough, Ph.D. (Economist, Ridgefield, CT); Jonathan Fellus, M.D. (Neurology, East Orange, NJ); Ronald E. Cranford, M.D. (Neurology, Minneapolis, MN); Norman Schneiderman, M.D. (Credentialing Expert, Columbus, OH)

John Doe, M.D., et al. v. XYZ LASIK Eye Center
Type of case: Breach of Contract, Fraud
Settlement: $648,000.00
Plaintiff's Counsel: Phillip A. Ciano, Esq. and Andrew S. Goldwasser, Esq. of Ciano & Goldwasser, LLP

Defendant's Counsel: Stacy Wood, Esq. (North Carolina)
Court: American Arbitration Association (commercial arbitration), Charlotte, North Carolina
Date: January 13, 2006
Insurance Company: Cincinnati Insurance Company (employment practices liability)
Damages: Loss of incentive-based professional fees

Summary: Plaintiffs, two eye surgeons, entered into incentive-based Employment Agreements with a LASIK Eye Center. When the Eye Center shifted from a mechanical to an "all-laser" LASIK procedure, Plaintiffs were designated to perform Step 1 of the procedure (incision of the cornea), while other physicians at the Eye Center were designated to perform Step 2 (vision correction). Under their incentive-based Employment Agreements, Plaintiffs were to receive a percentage of any professional fees collected from all "surgical procedures" Plaintiffs performed at the Eye Center. Plaintiffs performed thousands of Step 1 procedures, fully expecting a percentage of the fee collections from Step 1 of the "surgical procedure." Upon completing the first year of the surgical procedures at issue, the Eye Center refused to compensate Plaintiffs for the procedures at issue, claiming that the Plaintiffs did not perform a "surgical procedure" as that term was contemplated in the Agreements. Due to a contractual clause in Plaintiffs' Employment Agreements, the claims were arbitrated under AAA commercial arbitration in Charlotte, North Carolina. After completing discovery, the parties engaged in Mediation, and the case settled for $648,000.00, plus the Mediator's fees and costs.

Plaintiff's Experts: N/A
Defendant's Experts: N/A

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(by specialty)

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Briccio Celerio, MD
Timothy C. Lyons, MD */Cardiothoracic*
Amir Dawoud, MD
John B. Downs, MD
Charles J. Hearn, MD
Leonard Lind, MD
Alan Lisbon, MD */Cardiac*
Michael S. Loboda, MD
Mary McHugh, MD */Resident*
Stephen W. Minore, MD
Howard Nearman, MD
David S. Rapkin, MD
John Schweiger, MD /*Critical Care*
Michael Smith, MD
Kenneth E. Smithson, MD
Jeffrey S. Vender, MD
Jean-Pierre Jarned, MD

Cardiology

Krzyslof Balaban, MD
Mandeep Bhargava, MD/*Card. Elec. Physio.*
Mark T. Botham, MD
Robert E. Botti, MD
Delos Cosgrove, MD
Reginald P. Dickerson, MD
Barry Allan Effron, MD
Barry George, MD
Wayne Gross, MD
Patricia Gum, MD */Interventional Cardio.*
Steven C. Hirsch, MD
Todd L. Johnson, MD
Alan Kamen, MD
Alfred Kitchen, MD
Allan Klein, MD
Alan Kravitz, MD
John MacGregor, MD /*Interventional*
Raymond Magorien, MD
Steven Meister, MD
Michael Oddi, MD */Cardiothoracic Med*
Geoffrey Rosenthal, MD
Patricia Rubin, MD
George Q. Seese, MD
Bruce S. Stambler, MD
Sabino Velloze, MD
Thomas Vrobel, MD */Intern/Pulm*
Richard Watts, MD
Bruce L. Wilkoff, MD/*Electro Physiology*
Steven Yakubov, MD
Kenneth G. Zahka, MD */Pediatrics*
Christine M. Zirafi, MD
Benjamin Felia Zolta, MD

Cytopathology

William Tench, MD */Chief of Cytopathology*

Dentistry/Oral Surgery

Mitchell Barney, DDS
John Distefano, DDS
Michael Hauser, DDS
Don Shumaker, DDS
Pankaj Rai Goyal, MD */Oral Surgery*
John F. Zak, MD */Oral Maxillofacial Surg.*

ER Medicine/Physicians

Mikhail Abourjeily, MD
Thomas J. Abramo, MD
David Abramson, MD
Joseph Cooper, MD
Rita K. Cydulka, MD
Phyllis T. Doerger, MD
David Effron, MD
Mark Eisenberg, MD
Charles Emerman, MD
Cory Franklin, MD
Richard Frires, MD */Family Medicine*
Gayle Galen, MD
Howard Gershman, MD
Thomas Graber, MD
Hannah Grausz, MD
Ginger A. Hamrick, MD
Mark Hatcher, MD
Dominic Haynesworth, MD
Bruce Janiak, MD
Allen James Jones, MD
Nour Juralti, MD */Intern*
Gerald Geromin, MD
Allen Jones, MD
Samuel Kiehl, MD
Frederick Luchette, MD
Jeffrey Pennington, MD
Pradyumna Padival, MD
Norman Schneiderman, MD
Albert Weihl, MD
Robert C. Woskobnick, MD

ENT

Alicia Barbary, MD /*ENT Surgery*
Steven Houser, MD
Yunn W.Park, MD
Seth J. Silberman, MD
Barry Wenig, MD

Epileptology

Stephen Collins, MD
Barbara Swartz, MD

Family Medicine

Arthur M. Amdur, MD
Robert T. Blankfield, MD
Douglas L. Burchett, MD
David M. Cola, MD

Mary Corrigan, MD
Julia Ann Heng, MD
Theodor F. Herwig, MD
John E. Hollin, MD
Joseph J. Kessler, Jr., MD
Jeffrey R. Kontak, MD
Kelly Oh, MD
Dean P. Rich, MD
Elisabeth Righter, MD
Michael Rowane, MD
John E. Sutherland, MD

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Aaron Brzezinski, MD
Subhash Mahajan, MD
Eric J. De Maria, MD */Gastric Surgeon*
Todd D. Eisner, MD
R. Kirk Elliott, MD
Kevin Olden, MD
Anthony B. Post, MD

General Internal Medicine

Thomas Abraham, MD */Pulmonology*
Bruce L. Auerbach, MD
Sharon Lynn Balanson, MD
Stephen Baum, MD
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Alok Saxena, MD
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Patrick Whelan, MD */Pulmonology*
Leonard S. Williams, MD
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David Yana, MD

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Manuel C. Abellera, MD
Samual Adornato, MD
Henry Bohlman, MD */Spinal*
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Raphael S. Chung, MD
Stanley Dobrowski, MD
David Fallang, MD
William F. Fallon, Jr., MD
Daniel Goldberg, MD
Thomas H. Gouge, MD
Theodor F. Herwig, MD
Micheal Hickey, MD */Trauma*
Mark Hoeksema, MD
Moises Jacobs, MD
Frederick Luchette, MD */Trauma*
Donald Malone, MD */Psycosurgery*
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Dilip Narichania, MD
Abdel Nimeri, MD */Resident*
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Doug Reintgen, MD/*Oncologist*
William Schirmer, MD
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Elizabeth E. O'Toole, MD
Neal Wayne Persky, MD

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Vinodkumar Sutaria, MD
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Ronald A. Sacher, MD */Pathology*
Roy Silverstein, MD

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Robin Avery, MD
Michael Bergman, MD
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George J. Gianakopoulos, MD
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David Longworth, MD
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Martin Raff, MD
Susan Rehm, MD
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Neonatology

Richard E. McClead, MD

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Nancy Bass, MD */Pediatrics*
Bennett Blumenkopf, MD
Jonathan A. Borden, MD
Elias Chalub, MD */Pediatrics*
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Dennis Landis, MD
Charles Lanzieri, MD
Alan Lerner, MD
Hans Luders, MD
Donald Mann, MD
Sheldon Margulies, MD
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David C. Preston, MD
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Tarvez Tucker, MD

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Bruce Ammerman, MD
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Daniel Cain, MD
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Ricardo Loret deMola, MD
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Method Duchon, MD
Stuart Edelberg, MD
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Gath Essig, MD
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David Klein, MD
Steven Klein, MD
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Baha Sibai, MD
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Josephine Wang, MD
Louis Weinstein, MD
Jean Pierre Yared, MD
David Zbaraz, MD

Occupational Therapy

Ellen Flowers
Rod W. Durgin

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Nathan Levitan, MD
Michael T. Lotze, MD */Surgical Oncology*

Howard Muntz, MD */GYN Oncologist*
Howard Ozer, MD
David Stepnick, MD

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Thomas R. Hedges, MD
Gregory Kosmorsky, MD
Andrew G. Lee, MD */Neuro-Ophthalmologist*
Andreas Marcotty, MD
Peter J. Savino, MD
Robert Tomsak, MD */Neuro-Ophthalmologist*

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William Bohl, MD
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Robert Corn, MD
Ahmed Elghazawi, MD
Robert Erickson, MD
Richard Friedman, MD
Robert Fumich, MD
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Keith Owen Yeates, MD */Neuropsychology*

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David Shaffer, MD */Pediatrics*
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Cheryl D. Wills, MD

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Mark Janis, PhD
Jim Mushkat /*Psychotherapist*

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Robert DeMarco. MD
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William Murphy, MD
David Spriggs, MD

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Karl A. Schwarze, MD
Thomas M. Zizic, MD

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Leo J. Brooks, MD
Steven Feinsilver, MD
Thomas Hobbins, MD */Pulmonology*

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Barry Mickey */Professor/Teacher*
Diane Mirabito

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Mehmet C. Oz, MD */Cardiothoracic*
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Nicholas Smedira, MD
V.C. Smith, MD */Cardiac Surgeon*

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Frederick Levine, MD

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John J. Alexander, MD
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Richard Paul Cambria, MD

General/Misc.

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Mack A. Anderson */Counselor*
Lisa Ann Atkinson, MD */Staff Physician*
Stanley P. Ballou, MD */Unknown*
Elizabeth Barker */CT Technologist*
Sandy Brightwell, *Registered Technologist*
Amardeep S. Chauhan*/Osteopath- Physical Medicine & Rehab*
Tracey Cherry */Residential Case Worker*
Charles E. DuVall */Chiropractor*
Ahmed Elghazawi */Independent Med Exam*
Nancy Holmes */Cert. Physicians Assistant*
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Albert I. King */Bio-Mech Engineering*
Paul M. Matus */Coroner*
Donald Mayes */Dental Consultant*
George W. Nadolski, *Cert. Surgical Assist.*
Ronald Nichols */Microbiologist*
Norman B. Ratliff, MD */Staff Physician*
Jesse Smith, *Postal Worker*
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Caroline Wolfe */M.EdLCP (Rehab Counselor)*
Karen Wolffe */Professional Counselor*
Gary M. Yarkony */Physical Medicine; Rehab*
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Debbie Bazzo, RN */Obstetrics*
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Yelena Beregovskaya, RN */Nurse Midwife*
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Linda Bullock, RN
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Phyllis Hayes, RN
Deborah Heusser, RN
Laura Hoover, RN
Denise Hrobat, RN
Lori A. Huber, RN
Mary Hulvalchick, RN */Obstetrics*
Dawn Hutchins, RN
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Donna Joseph, RN
Geraldine Kern, RN
Jodi Lasher, RN
Linda Law, RN
Judith Wright Lott, RN */Neonatal N.P.*
Mary Lucy, RN
Patricia J. Lupe, RN */Nurse Midwife*
Debra MacDowell, RN
Migdalia Mason, RN
Susan Massoorli, RN
Darlene McCullough, RN
Rosiland McKeon, RN
Kathleen McKillip, RN
Kristina Milavec, RN
Tracy Miller, LPN
Cassandra Minocchi, RN
Robbin Moore, RN
Susan Morgan, RN */Midwife*
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Madeleine Murphy, CNP
Lekita Nance, LPN
Karen Nye, CRNA
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Jeanne O'Toole, RN
Francoise Payen-Healy, BSN/*Cardiovascular*
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Patricia Russo, RN
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All Saylor, RN
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Debra Seaborn, RN
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Penny Sonters, RN
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Suzanne Smith, RN */Midwife*
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Laurel Thill, RN
Ginger Varca, RN
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JulieWarner, LPN
Helenmarie Waters, RN */Obstetrics*
Marsha Weigel, RN
Jacqueline Whittington, RN
Angelique Young, RN
Colleen Zelonis, LPN
Joanne Zelton, RN, *Legal Nurse Consultant*
Catherine Zilka, RN

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Edward B. Bell */Economist*
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Thomas Hilbert /*Consultant*
Gary Himmel, Esq. */Attorney*
Albert I. King */Biomechanical Engineer*
Susan Kirkland */Mgr, Safety Programs-*
Ohio Rail Commission
Terri Lefever, *Claims Adjuster*
Toni Madden, *Medical Secretary*
Clark Millikan */Dir.of Academic Affairs*
Donald Plunkett */Architect*
Sue Sanford */Dir. Obstetrical Services*
Richard W. Schule */Mgr, Surg. Process Dept.*
David Silvaaggio */Dept. Admin. - Fam. Pract.*
Stephen L. Spearing */Admin. Dir. Radiology*
Kelly Sted */Manager of Enrollment*
Kelly Trease */Office Manager, Dr.Cola*

CATA VERDICTS AND SETTLEMENTS

Case Caption:_____

Type of Case:_____

Verdict:_____ **Settlement:**_____

Counsel for Plaintiff(s):_____
Address:_____
Telephone:_____

Counsel for Defendant(s):_____

Court/Judge/Case No:_____

Date of Settlement/Verdict:_____

Insurance Company:_____

Damages:_____

Brief Summary of the Case:_____

_____

_____

_____

_____

Experts for Plaintiff(s):_____

_____

_____

Experts for Defendant(s):_____

_____

_____

RETURN FORM TO:

Andrew Thompson, Esq.
Stege & Michelson Co., LPA
200 Public Square, suite 3220
Cleveland, Ohio 44114
FAX: 216.348.0803

Alison Ramsey, Esq.
The Brunn Law Firm
700 West St.Clair Ave., Suite 208
Cleveland, Ohio 44113
FAX: 216.623.7330

The Cleveland Academy of Trial Attorneys
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Cleveland Academy of Trial Attorneys
Sixth Floor, Standard Building
1370 Ontario Street
Cleveland, Ohio 44113
216-621-0070
216-687-4231

Application for Membership

I hereby apply for membership in The Cleveland Academy of Trial Attorneys, pursuant to the invitation extended to me by the member of the Academy whose signature appears below. I understand that my application must be seconded by a member of the Academy and approved by the President. If admitted to the Academy, I agree to abide by its Constitution and By-Laws and *participate fully in the program of the Academy*. I certify that I possess the following qualifications for membership prescribed by the Constitution:

1. ***Skill, interest and ability in trial and appellate practice.***
2. ***Service rendered or a willingness to serve in promoting the best interests of the legal profession and the standards and techniques of trial practice.***
3. ***Excellent character and integrity of the highest order.***

In addition, I certify that no more that 25% of my practice and that of my firm's practice if I am not a sole practitioner, is devoted to personal injury litigation defense.

Name_____Age:_____

Firm Name:_____

Office Address:_____Phone no:_____

Home Address:_____Phone no:_____

Spouse's Name:_____No. of Children:_____

Schools Attended and Degrees (Give Dates):_____

_____

Professional Honors or Articles Written:_____

_____

Date of Admission to Ohio Bar:_____Date of Commenced Practice:_____

Percentage of Cases Representing Claimants:_____

Do You Do 25% or More Personal Injury Defense:_____

Names of Partners, Associates and/or Office Associates (State Which):_____

_____

Membership in Legal Associations (Bar, Fraternity, Etc.):_____

_____

Date:_____ Applicant:_____

Invited:_____Seconded By:_____

President's Approval:_____Date:_____

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