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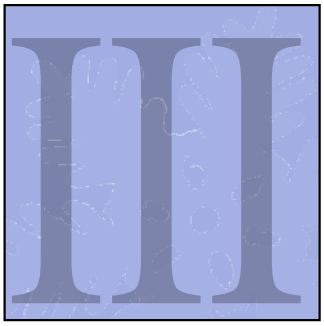

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Articles: All articles published in the *Michigan Defense Quarterly* reflect the views of the individual authors. The *Quarterly* always welcomes articles and opinions on any topic that will be of interest to MDTC members in their practices. Although MDTC is an association of lawyers who primarily practice on the defense side, the *Quarterly* always emphasizes analysis over advocacy and favors the expression of a broad range of views, so articles from a plaintiff's perspective are always welcome. Author's Guidelines are available from Michael Cook (Michael.Cook@ceflawyers.com) or Jenny Zavadil (jenny.zavadil@bowmanandbrooke.com).

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President's Corner

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A Call to Arms

We've heard it scores of times: The only constant is change. Arguably, the practice of law defied Greek-philosopher Heraclitus' observation for decades, if not longer. While to some extent that defiance continues today, the practice of law has changed dramatically in the last 20 years in at least one way: What was once heralded as a profession is now more accurately characterized as a business.

This is not a news flash. But what does it mean? Well, it can mean a lot of things. Like generating a lot of work is more important than producing quality work. Increasing cash flow is valued more than character. Self-interest prevails over integrity. And advancing one's self wins out over developing others.

On a more practical level, however, it means that law students graduating from law school need to start thinking about not only learning how to practice law – a skill historically not emphasized in law schools – but also learning how to generate business as soon as possible. The former process begins by actually obtaining experience practicing law, self-education, being trained/mentored by more senior lawyers, and participating in educational programs. The latter process begins by networking and – a need that actually hasn't changed over the years – building a great reputation.

Fortunately, both of these objectives can be met by becoming active in a bar organization like MDTC. Yet that's easier said than done. Because in conjunction with this shift in focus to the business of law, which requires new lawyers to jump into the business-development side of the practice sooner rather than later, many firms have become much more sensitive to tracking dollars and cents, much more stingy about doling out business-development funds, and much more demanding about seeing a quick return on investment.

I'm not sure how we reconcile these two competing demands. But I do know that now is not the time to pull back on providing lawyers, particularly relatively new ones, with the opportunity to become involved in organizations – if only by giving them the time to make that investment. If you care about developing attorneys and investing in the long-term success of your firm and the legal profession, you cannot ignore this. Of course, this is not a one-sided proposition. New lawyers also must be committed to investing time and money into themselves and their future.

Why is this commitment by both parties so important? Because involvement in bar organizations – any organization, really – adds value to both lawyers and their firms.

Bar organizations provide legal education to new lawyers, which is critical to their development. Bar organizations give new lawyers a place to meet their peers at other law firms or organizations, with whom they can share and compare their experiences. This gives them the chance to learn not only about the practice of law but also about the Michigan legal market. It also gives them a place to meet more experienced lawyers, from whom they can learn and with whom they can develop

What was once heralded as a profession is now more accurately characterized as a business

mentor-mentee relationships. These opportunities, in turn, allow attorneys to build one of the most important and key components to business development – relationships. The sooner they do this, the better. For as most attorneys who are successful at business development know, there's no substitute for putting in your time. Occasionally, manna falls from Heaven. More often than not, however, the more accurate idiom is no pain, no gain.

An equally important component of business development is building a strong reputation for, among other things, quality work, hard work, consistency, reliability, and integrity. This too takes time. But involvement in bar organizations can accelerate that process by providing lawyers with the chance to both develop and feature their skills via publishing, speaking, and leadership opportunities. This, of course, increases their visibility, as well as the nature and scope of their reputation, which enhances both them and their firms.

It's easy to view participation in bar organizations as yet another expense and time demand that doesn't yield immediate results. But like so many things, the analysis is more complicated than that. The business development process takes time. Lawyers – particularly those who took the bar more recently – must invest resources in their business-development efforts, while law firms must provide their attorneys with the opportunity to do so.

So, if you know any new (or experienced) lawyers who are committed to educating other attorneys, expanding their network, and building their reputation, all while meeting some great people, please contact me. I know just the place for them.

Failures in Computer Software: Software Failures are Different than Hardware Failures

By: Dr. Timothy Ward Athan, P.E. *Engineering Systems Inc.*.

Human lives and fortunes are increasingly entrusted to computer programs. Every sizeable computer program *will* contain defects, because there is *no* method for catching them all. That makes software defect liability different from hardware defect liability. Rather than debating whether the software was perfect, the debate is over due diligence in the development of the software.

Computer Intelligence Surrounds Us!

In 1946, Alan Turing presented the first reasonably complete design of a computer with program instructions stored in electronic memory.[1] Since then, computer power has become critical to almost every aspect of our lives. Computer software on a small chip can make decisions faster than a human and can consider more inputs. These chips are not expensive, so they are being added to almost everything. There may be one in your toaster, another in your dishwasher; if one fails, what could be the worst outcome?

Computer chips make continual adjustments to automobile systems as we drive, including brakes, transmission, engine, passive restraints, and, increasingly, steering. Automotive control systems are becoming much more complicated as the originally separate control systems are increasingly interacting. Computer chips handle much of the control of aircraft and ships.

Computers are in the thick of financial markets, in power generation, and in manufacturing. Software is central to modern manufacturing and to every sort of data management. Computer control in homes is expected to grow, to make our homes actively responsive to our needs. We can expect computer control to become an even bigger part of our lives.

Dr. Timothy Ward Athan specializes in control systems and safety critical software, safe code software development, design optimization, simulation, and test methods, (design of experiments, engineering statistics, and data analysis). His work experience has spanned automotive, aerospace and power generation industries, and governmental regulatory work. He can be reached at twathan@esi-mi.com.

Computer Programs have Defects

Computer defects are common; we all know this too well! Many defects are trivial; perhaps they are gone when we restart our PC. But many have serious consequences. Some defects have made big news when they resulted in dramatic catastrophes, such as rocket or aircraft failures. The Therac-25 medical device, which delivered lethal doses of radiation due to a coding-logic error, is infamous.[2] Many other defects have beset industrial sites and consumer products without much media attention. For example, not many of us are aware that a poorly implemented resource planning system led Fox Meyer Drug Company, a $5 billion wholesale drug distribution company, to plummet into bankruptcy in 1996.[3]

On average, professional coders make 100 to 150 errors in every thousand lines of code they write, according to a multiyear study of 13,000 programs.[4] It has been estimated that 5 to 15% of information-technology (IT) projects "will be abandoned before or shortly after delivery as hopelessly inadequate. Many others will arrive late and over budget, or require massive reworking."[5] When software mistakes are addressed, there is only about a 50% chance that the program will have fewer problems than it did before the correction.[6] The cost of failed software projects in the United States alone has been estimated at $75 billion a year."[7]

Every sizeable computer program will contain defects, because there is no method for catching them all.

Opportunities for litigation are obvious in dramatic cases such as a software defect that results in a plane crash. Less obvious is a case in which a database software error resulted in blood donor records to be overwritten, allowing the distribution of tainted blood, or a case in which the use of faulty structural design software resulted in a building performance failure. It has been noted that "Litigation involving computers and software has exploded recently,"[8] "costs of litigation are rising faster than any other aspect of software development," and "[l]itigation costs are … a larger component than coding."[9]

There are no formal requirements for becoming a software developer, even for "safety-critical" applications. This is also true for hardware engineers. Many argue that this should change.

Yet most hardware engineers have received formal training, in the form of at least an undergraduate degree. In contrast to this, marketable programming language skills can be quickly learned by some people simply by reading a book and watching some Internet videos. This has become a popular career path.

Governments have developed requirements for some applications. However, as has happened with other fast-changing technologies, there tends to be a lag before regulation arrives.

Technical societies have created guidelines for control code development. Most industries have published a set. The various guidelines, whether for the medical-product industry (IEC 60601), the locomotive-transportation industry (EN 50126), the stage-and-theatrical-equipment industry (SR CWA 15902-1:2009) or another industry, are in relatively close agreement. However, they are recommendations; they aren't legally binding.

Work contracts can require compliance to relevant industry guidelines for computer control. However, often computer control is being added to an existing, more traditional technology. Many times in these cases, the manufacturer of the traditional technology is not familiar with computer code development, and leaves the requirements and methods to the firm contracted for the software development.

The software development firm should be aware of the state-of-the-art methods, but isn't always. If the developers picked up computing skills on their own, they may have shortchanged their self-instruction in proper development methods. Also, software development has a culture of the "lone cowboy" programmer; someone who isn't a team player but who can rapidly write code that will do amazing things. Who wants to step up to put a saddle on such a bronco?

When software fails and blame is to be leveled, all too often the traditional manufacturer says, "It's not my fault; we don't know computing; that's why we contracted a software house to do it for us." Meanwhile, the software house's defense is "We did everything they specified in the [loosely worded] contract." Cosgrove reports a case in which "[t]he difficulty of establishing what 'adequate reliability' meant was used to delay resolution of the issues as the costs to both parties climbed into seven figures."[10]

DeMarco and Lister note:

> Buyers are particularly prone to one of the worst fallacies of contracting, the idea that risk always moves with responsibility. It does not. When you are the buyer and another organization agrees to build a system for you, signing the contract moves primary responsibility for successful implementation from you to the builder. Not all the risks involved in attempting the project move with that responsibility (no organization can completely buy its way out of risk). If the contractor fails to deliver, both parties lose. Since this is a real risk from the buyer's point of view, it is incumbent on that buyer to manage that risk.[11]

There are no formal requirements for becoming a software developer, even for "safety-critical" applications.

Why it is Hard to Prove that Software Works?

When **hardware** fails, the question is, "How could this fail? You knew what it was designed to do – didn't you test to verify that it could do that without failing?" Generally this leads to a determination that either the performance requirements were incomplete or incorrect, or the testing against the performance requirements was not properly conducted.

When **hardware** is developed, clear requirements and thorough testing can

assure expected performance. The developers prove that the hardware holds up to the requirements, and then they add a safety factor, just to be sure.

That's not how it goes with **software** development. Many computer programs are so large they cannot be completely tested! And it is recognized that anything so large and complex will have mistakes.

The constraint is the "curse of dimensionality." There are many, many possible paths through a computer program. Even though high-speed computers are utilized to explore those paths in the testing process, checking every possible combination of pathways is usually not possible.

As a quick example, let's estimate that a small program of 350 lines makes a decision every 5 lines, and so it contains 70 possible branches. That means there are 2^{70} possible paths through the software. That is about a sextillion paths, which is a rough estimate of the number of grains of sand on earth. Assuming a computer calculation takes about a picosecond, it would take a computer a billion seconds, which is about 37 years, to execute every possible path! Few programs are this small; many programs are larger than 100,000 lines. The Boeing 787 systems required 6.5 million lines of code.[12]

Because this challenge is universally acknowledged, software developers generally cannot be expected to deliver a perfect product. That means that the discovery of a defect in a program does not necessarily mean that the developer bears fault.

Courts will typically try to determine a baseline by looking at the state-of-the-art and standard due care. The typical course of legal action has been described as "software expert witnesses are hired to prepare reports and testify about industry norms for topics such as quality control, schedules costs, and the like …. The expert reports produced for lawsuits attempt to compare the specifics of the case against industry background data for topics such as defect removal efficiency levels, schedules, productivity, costs and the like."[13]

Consequently, it has been observed that "companies delivering software that exceeds the bounds of common industry practice are vulnerable to penalties."[14] In such cases, the company's defense must be based upon showing that general standards have been followed. "Evidence is mounting that public [codes of conduct] serve as standards for evaluating the performance and determining the responsibilities not only of the IEEE [Institute of Electrical and Electronics Engineers] members, but IT professionals in general….Following [codes of conduct] is one way to… insulate contracting parties from potential legal liability."[15]

Generally, legal risk is reduced if the development process for a system encompasses "all reasonable steps" and if "good engineering" principles are followed.[16] The system developer also has to document the processes and principles employed so that it can be proved that all activities in the process have been followed. Importantly, design alternatives and tradeoffs need to be documented as well.[17] Generally, "documentary evidence is persistent and not easily dismissed" whereas "total reliance on human testimony… is a very risky strategy."[18]

It has been observed that "organizations that cannot or do not measure themselves in a fairly systematic way are always at a huge disadvantage in litigation…. Metrics is one of the… major subjects on which virtually all litigations turn."[19] Also, "courts, juries, and arbitration panels are finding that failure to follow generally accepted public standards for design and testing of software are grounds for seeking damages."[20]

Ideally, for each step in the development process there should be negligence analysis as well as dedicated evidence generation, archiving, and traceability. Liability issues can be addressed by "the creation of a database where important legal constraints are linked to specific development aspects that address them."[21] Documentation that is not in sync with the software's capabilities may be a liability risk.[22]

Risk Analysis

Because it is impossible to completely test large software programs, it is important for the software developer to make a determination of the amount of verification and validation required. There is no simple answer to this; instead it depends upon the application.

Risk assessment should be an early part of this process because the more severe the consequences from a software failure, the more important is the assurance of reliable software. The Food and Drug Administration (FDA) separates medical devices into three categories (Class I, II, or III) with different development standards. The Department of Defense, in MIL-STD-882D, defines four categories of mishap severity (catastrophic, critical, marginal, and negligible) based upon the degree of human suffering, the amount of dollar loss, and the extent of damage to the environment. This standard allows the severity to be expressed in terms of potential occurrences per unit of time, events, population, items, or activity.

Risk assessment is itself a challenging undertaking in any arena, but it is ever so much more so for software. When a software program is created, it must be processed by a compiler (other software), and then it will operate within an

operating system (more software), often with an operator interface (even more software). In fact, as science writer James Gleick observes, "Software built up over years from millions of lines of code, branching and unfolding and intertwining, comes to behave more like an organism than a machine."[23]

Estimates of the number and severity of unknown defects in a computer program are murky. A program could have worked well over many years, but a slight modification could introduce an error that completely undermines its performance. For example, a software error doomed the Ariane 5 launch vehicle, even after the software had been used successfully on the Ariane 4.[24] A simple data conversion (64-bit to 16-bit) of the sideways velocity of the rocket resulted in a number too big for the variable field, causing an overflow. There should have been a software check, but the programmers believed that such a large velocity would never be reached, (it was never reached on the less powerful Ariane 4). For protection there was a redundant control system, but it ran identical software, so it failed within a few milliseconds of this failure. [25]

It could be argued that this reflects another difference between hardware design and software design. Hardware design is often incremental, building to greater and greater reliability, while software design is vulnerable every time it is altered. A single, improper key stroke can make a very big difference. In 1990, a portion of AT&T's telephone network failed, leaving 12 million subscribers without service for 9 hours, because of a single, mistyped character.[26]

What Constitutes Due Diligence?

Even the most thorough risk analysis cannot produce an exact number to quantify risk. However, an estimate of the **magnitude** of risk will place the project in a risk category, which will guide the determination of due diligence. Greater risk can be addressed with system designs that are more robust, and with more extensive verification and validation.

Improving System Design

One approach to making a system design more robust is the inclusion of redundancy. This can take various forms.[27] For example, a safety-critical operation could be controlled by three controllers, each one developed by a different team, perhaps using a different computer language and a different computer chip type. Control decisions could be made with all three controllers voting.

In many cases the system design can be created to ensure "fail safe" operation, which means that if the control system fails, the system defaults to a probably vastly simplified safe mode.

Because it is impossible to completely test large software programs, it is important for the software developer to make a determination of the amount of verification and validation required. There is no simple answer to this; instead it depends upon the application.

Validation and Verification

There are many parts to a thorough plan for validation and verification.[28, 29, 30] A Failure Mode and Effects Analysis (FMEA) is a systematic approach to addressing potential risks. A list of all conceivable failure modes is brainstormed by a diverse team, each is rated for likelihood and severity, and mitigation approaches are conceived. Another type of reliability analysis is a fault tree analysis (FTA).

Formal reviews of software code are an established approach to improving software quality. Software developers should keep careful logs of defects. These logs can provide insight into progress towards greater reliability. But while some industries share defect logs, they often are considered proprietary secrets. FMEA, code reviews, and defect logs are examples of "static testing." In "dynamic testing" the program is executed in a controlled fashion.

Software **unit testing** is a computer-automated process for rigorously testing a software program. A "test harness" is used, which may sound like hardware, but it is actually a computer program that **stimulates** (the industry term) the new computer program by inputting many combinations of values, while checking to ensure that the outputs are reasonable. As mentioned above, there are too many potential paths to test them all, but a testing coverage percentage can be estimated.

Computer simulation can be used to bring realism to testing. A simulation program predicts how a system or subsystem will behave. A common controller development progression is to have a simulation of a system connected to a simulation of a controller. If the simulation of the system is precise, it will enable optimization of the controller strategy. Once the controller strategy has been optimized, a real electronic controller can be built as design optimized, and it can be connected to the system simulation. This allows the testing of the controller under realistic conditions, without real-world risks. Also, it makes around-the-clock and extreme condition testing possible.

Incident Resolution

Assessing whether software was properly developed sounds like a detail-intensive, somewhat nebulous job, and **it is** at this time. Perhaps someday there will be legal requirements that will simplify the assessment.

Each of the details matter, and taken together they influence the resolution of a software dispute. For example, in the terrible 1995 Cali aircraft crash, a jury found that one of the navigation software companies bore 17% of the fault, another software company bore 8%, while the airline was assigned 75%.[31]

In another example, DeMarco reports a case involving a software developer contracted to provide a reservation system for a hotel chain. "Since the contract was weak, the case finally turned on a single incident: [the software developer] had fired a succession of managers who tried to tell the big boss that the date was unworkable. [The Hotel Company] found out, brought in the fired managers as witnesses, then pointed triumphantly to one clearly written contract provision that said [the developer] was obliged to inform its partner if it had credible reason to believe the delivery would be late. That cost [the developer] $100 million."[32]

Cybersecurity Claims

Computer programs operate in a world of cyber attacks. In 2005 it was estimated that there were over 50,000 viruses on the Internet, and they caused $55 billion in damages.[33]

The Organization of Internet Safety (OIS) defines security vulnerability as "a flaw within a software system that can cause it to work contrary to its documented design and could be exploited to cause the system to violate its documented security policy."[34] Software vulnerabilities have widespread impact and can potentially cause enormous costs to software users in downtime and disruptions.

Software vendors have attempted to insulate themselves from security-vulnerability damages by using End User License Agreements (EULAs) that restrict their liability. These agreements normally take effect as a condition of installing software, and they ordinarily require customers to waive the right to sue over alleged vulnerabilities. The justification is that as long as the software creator isn't grossly negligent, it is the cyber criminals who should be held accountable for damaging intrusions.

A set of laws named the Uniform Computer Information Transaction Act (UCITA) would have extended this protection. State legislatures have largely abandoned this legislation in response to concern that hardware products controlled with software, i.e. automobiles, aircraft, and medical instruments, could try to redefine themselves as software to gain liability exemptions. Recent incidents of large scale hacking disruptions have reduced the popularity of such liability protection. It has been argued that a software creator bears some fault if the software has a vulnerability that a hacker has exploited. As such, Cyber-insurance products have become popular.[35]

Even if software vendors can avoid being sued for vulnerabilities, they can still be impacted by them. One study estimated that "On average, a vendor loses around 0.6% value in stock price when a vulnerability is reported. This is equivalent to a loss in market capitalization values of $0.86 billion per vulnerability announcement."[36]

In Conclusion

Software incident cases are rarely simple and quick. They are increasingly common, and they often carry enormous liabilities. Resolution of these cases depends upon an assessment of all of the pieces of a software project.

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MEMBER NEWS

Work, Life, and All that Matters

Allison Reuter has joined Amway as Corporate Counsel-Legal Division Human Resources. Ms. Reuter previously served as General Counsel for Hope Network.

Member News *is a member-to-member exchange of news of* ***work*** *(a good verdict, a promotion, or a move to a new firm),* ***life*** *(a new member of the family, an engagement, or a death) and* ***all that matters*** *(a ski trip to Colorado, a hole in one, or excellent food at a local restaurant). Send your member news item to Michael Cook (Michael.Cook@ceflawyers.com) or Jenny Zavadil (jenny.zavadil@bowmanandbrooke.com).*

Is It Time to Get a Defense Life Care Planner?[1]

By: Dawn L. Cook, *Dawn Cook Consulting LLC*

If you are an attorney involved with defense in a personal-injury or medical-malpractice case, you often have the opportunity to evaluate a life care plan written by an expert for the plaintiff. Do you ever wonder if you should go to the expense of retaining a life care planner to create a rebuttal? This question can be tricky, as there are a lot of considerations, but this question is important to you.

What is a plaintiff's life care plan?

A plaintiff's life care plan is developed as a personalized projection of the injured person's present and future medical expenses as a result of the injury or the defendant's negligence. A certified nurse life care planner usually prepares the report, although others may also engage in life care planning. The plan is normally supplemented by an economist's report that identifies the "present day value" of the life care plan. Future medical expenses, including home care, are one of the largest categories of damages claimed by a disabled or injured plaintiff and they can significantly affect the damage award as well.

Considerations for when a defense life care plan is appropriate:

1. Does the defense wish to address damages, at all? You may be wondering if you want to discuss damages, when your main strategy could be defending the case based only on **liability**. If you call for a damage witness, like a life care planner, the jury may wonder if you have somehow conceded on liability, even if this was not your intention. Conversely, there could be other issues at stake.

2. Is a defense life care plan even warranted? If the case you are representing has a plaintiff with catastrophic or serious and permanent injures, then it is probable that the plaintiff will need significant future medical care. A plaintiff life care plan that is reasonably thought out with usual and reasonable costs might only need a cross-examination by you that could confirm that there are no unnecessary or frivolous costs built into the plan.

3. Is the plaintiff's life care plan unreasonable? A more likely scenario is that the plaintiff's life care plan is excessive, including treatment for other conditions. If, for example, there is excessive home care nursing and the costs are inappropriate for the care described, then you may want to retain a life care planning expert of your own. A reasonable life care plan from the defense's expert may sway the jury for your "more reasonable" life care plan.

4. What if the plaintiff has *not* retained a life care planner? A plaintiff's attorney

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might decide to not retain a life care planner and therefore allow the expert physician to describe the care that the plaintiff may need. In this case, the plaintiff may need several "physician witnesses" to establish the evidence in this fashion. Perhaps, in this way, your life care plan may be more understandable to the jury. Likewise, the research and evidence of accurate prices should be better documented in your report, carrying more weight than physicians mentioning the costs only at their facility. Presenting the evidence through just one person, the defense life care planner could make it easier for the jury to understand. The life care plan prepared by the defense can provide the information in a more comprehensive form.

A more likely scenario is that the plaintiff's life care plan is excessive, including treatment for other conditions. If, for example, there is excessive home care nursing and the costs are inappropriate for the care described, then you may want to retain a life care planning expert of your own.

5. Is the defense life care plan or the rebuttal report credible? Be sure that the defense life care plan or rebuttal report is credible. If the plaintiff has substantial injuries, the evidence must lead to credible and realistic planning. Don't let this backfire at trial by presenting an unreasonable or miserly plan. Ultimately, credibility should win your case, and if the injuries are significant, then the damages are significant. Lack of credibility can even affect the jury's belief in your causation argument, especially if your other witnesses lack credibility.

6. What can a defense life care planner do for your case? A rebuttal life care plan will assist you, the defense attorney, in identifying the specific shortcomings of the plaintiff's life care plan**.** You may separate the actual issues of the personal-injury or medical-malpractice case from pre-existing conditions and subsequent illnesses or injuries. You can help the trier of fact understand the impact (or lack thereof) of the injury on the plaintiff's personal and professional life and you can help give a reasonable estimate of the cost of all of the future health and medical care related to the injury or injuries. If you need to challenge the validity and cost of future medical damages in the plaintiff's life care plan, a capable rebuttal plan should satisfy your needs.

Considerations for obtaining a defense life care plan:

1. How do you choose a defense life care planner?

How can you be sure that the life care planner you have retained can provide the best representation of the actual future needs of the plaintiff? The usual defense is to attack life care plans by arguing that the life care plan has no basis in the evidence and that the costs are purely speculative. A jury is then free to consider the plan like it does any other type of evidence, that is, by interpreting the validity of the report as each juror sees fit.

2. Issues when choosing a defense life care planner:

We will discuss issues to be considered when considering a rebuttal life care plan, including the qualifications of the life care planner, methodology used, foundation and costing techniques. Each of these factors is important in determining the validity of plaintiff's life care plan and in fact, the success of your defense.

3. What is a Life Care Plan and how can you evaluate it?

In terms of litigation, a life care plan is an expert report that can be created by the plaintiff's counsel or by defense counsel. The goal is to have a well-supported list of all the required care and costs related to the injury directly or indirectly (for the rest of the person's life.) Without a plan, everyone may be just guessing.

4. Role of a life care planner:

The American Association of Nurse Life Care Planners (AANLCP) defines nurse life care planning this way: "The specialty practice in which the nurse life care planner utilizes the nursing process for the collection and analysis of comprehensive client-specific data in the preparation of a dynamic document. This document provides an organized, concise plan that estimates for the reasonable and necessary (and reasonably certain to be necessary) current and future health-care needs with the associated costs and frequencies of goods and services." (AANCLP, 2014)

5. Elements of a life care plan and a rebuttal life care plan:

The steps to develop a life care plan include reviewing the medical records, interviewing the injured party, communicating with care providers, developing a list of required or beneficial services, treatment, and equipment, and researching the costs.

The steps to review or rebut a life care plan include reviewing the medical records, reviewing the documentation of the plaintiff's interview, care provider input, and the methodology of researching costs.

6. Common errors and *what to watch for*:

a. Qualifications and the CV:

The qualifications of the plaintiff's life care planner may be justification enough for having the life care plan report disqualified. Life care planners must meet the Federal Rules of Evidence 702:

A witness who is qualified as an expert by knowledge, skill, experience, training, or education may testify in the form of an opinion or otherwise if:

a. the expert's scientific, technical, or other specialized knowledge will help the trier of fact to understand the evidence or to determine a fact in issue;
b. the testimony is based on sufficient facts or data;
c. the testimony is the product of reliable principles and methods;
d. the expert has reliably applied the principles and methods to the facts of the case.

Examine the life care planner's CV for education, training, certification, and participation in ongoing education in life care planning.

b. Education:

Persons professionally involved in health care, including nurses, physicians, physical therapists, rehabilitation specialists, and other allied health care workers could prepare life care plans. Generally, most persons qualified to write a life care plan have significant experience in health care. Licensing for most health care professionals can be verified with their professional licensing body.

There are currently three certifications in life care planning—none that have been challenged as to their validity. Registered Nurses are qualified to be certified as a Nurse Life Care Planner (CNLCP) or as a Lifetime Nurse Care Planner (LNCP-C) as well as a Certified Life Care Planner (CLCP).

c. Training:

There are several courses in life care planning. The length is generally 120 hours for the course, including the development of a student "hypothetical" life care plan.

d. Certification:

There are currently three certifications in life care planning—none that have been challenged as to their validity. Registered Nurses are qualified to be certified as a Nurse Life Care Planner (CNLCP) or as a Lifetime Nurse Care Planner (LNCP-C) as well as a Certified Life Care Planner (CLCP). Certifications can be verified at http://cnlcp.org/verification/ and at http://lncp-c.weebly.com/certification.html. Many nurses and non-nurses are certified from the International Commission for Health Care Certifications (ICHCC) as a CLCP. Those certifications can be verified at http://www.ichcc.org/clcp.html.

e. Associations and ongoing life care planning education:

There are three associations of life care planners and they all conduct annual conferences. Some have webinars on a regular basis and mentorship programs to foster new professionals to the field. American Association of Nurse Life Care Planners, http://aanlcp.siteym.com; Lifetime Nurse Care Planners, http://lncp-c.weebly.com/index.html; International Academy of Life Care Planners, http://www.rehabpro.org/sections/ialcp.

***Watch for:* lack of qualifications, lack of certification, lack of experience in hands-on health care, lack of on-going education in life care planning.**

f. Methodology of the life care planner:

Did the life care planner use a standard methodology? Is he or she able to explain the usual methodology of life care planners? Can they knowledgably describe all of the activities they engaged in when developing their life care plan? Is there enough detail in their report so that your rebuttal life care planner can replicate the details and decisions made during the plan's development? Does the plan explain why standard methodology was not used? For example, if the plaintiff was in a coma and there are no family members, perhaps it is justified that an interview was omitted.

***Watch for:* disorganized report, lack of methodology, unclear how information**

was obtained, dates of receiving materials, meeting with the plaintiff, and descriptions of meeting with physicians or other care providers is missing.

g. Is the plan comprehensive?
Perhaps the plaintiff decided to use a treating or Independent Medical Exam (IME) physician as a life care planner. It could be that they have taken a course in life care planning, but it is unlikely that the plan is comprehensive enough. Often, the plan will only include medical care and it won't include home care, equipment, or supplies needed for the injured condition. This is like having only half of a life care plan. Frequently the physician life care plan does not have detailed costing and this again opens the plan up to challenges as to their validity.

Watch for: **the life care plan does not include all needs and the costs may be too high or too low.**

h. Are the medical records up to date and include pre-existing conditions?
The plaintiff's attorney is usually the one who supplies medical records to the life care planner. If medical records do not cover the time before the incident, pre-existing conditions may be wrongly included in the life care plan.

Watch for: **the life care plan does not include any mention of pre-existing conditions.**

i. Interviews of plaintiff
The usual methodology that is used by a life care planner is to interview the plaintiff either via telephone or in their home. The ideal interview is in their home along with their family and any care providers. This is especially true for plaintiffs who need specialized equipment such as wheelchairs or who have cognitive issues. A face-to-face interview can reveal future needs and home care issues that may be missed by a telephone interview. If the client is brought to the life care planner and interviewed away from their home, it is difficult to evaluate the home for accessibility for equipment and supplies. The record should document the date, times, and location of the interview as well as the names of who was present. If equipment is used, descriptions of the shortcoming of the home are vital for developing a plan for home modifications.

Watch for: **no mention of the date, time, and location of the plaintiff's interview and who was present. No mention of equipment used. No photos of the plaintiff or equipment or the home, if appropriate.**

There must be a documented reason or justification for every item listed in the tables or charts of future medical and non-medical needs.

j. Foundation for opinions
There must be a documented reason or justification for every item listed in the tables or charts of future medical and non-medical needs. For physician care, there must be medical records, letters, expert reports, and notes of an interview or other evidence that an appropriate physician or health care provider is recommending the future medical care. Likewise, the plan must indicate support for every item in the plan. For example, an explanation of the difficulties getting on and off of the toilet would accompany the recommendation for a bathroom grab bar. Nursing care in the home must have a detailed explanation of the methodology used to determine the levels and hours of care.

Watch for: **unsupported recommendations in the report, lack of qualification of life care planner to make the recommendation, no evidence of collaboration with qualified providers, lack of a letter or notes of physician input, lack of input from the plaintiff and his family.**

k. Costing evidence
Each and every item in the tables or charts must indicate the item or service, the frequency, and the cost. There should be evidence of how costs were obtained, for example, by using old bills, calling for two to three quotes, or using standard national published databases. If calling offices or when comparing prices on the Internet, the source of the cost and the date that the cost was quoted must be indicated. It is best to have two or three quotes written in the report and then the average cost should be used. When using national databases, the source should be clearly indicated and evidence that the cost was adjusted for the geographic area in which the plaintiff will receive care.

Watch for: **lack of description of the item or service, lack of the frequency of the item, and lack of good research into the cost for the particular item.**

Finally:

These are some of the most basic and important aspects to a life care plan. If the plaintiff has a qualified life care planner who interviews the plaintiff, reviews medical records from before the incident and close to the present time, collaborates with physicians and providers, and who plans, justifies, and researches the cost for every item on the life care plan, then they may have a good report. If there is evidence that the plaintiff's life care plan is inadequate, you may benefit by retaining a life care planner experienced in rebuttal life care plan reports.

The rebuttal should examine each phase of the life care plan. Were all of the medical records available actually evaluated by the plaintiff's life care planner? Were pre-existing conditions excluded as future costs? Was the interview well documented and does it support the recommendations for home care, housekeeping services, home modifications, and equipment? Did physician and other health care providers or research support the medical items? Were costs obtained in a manner that can be reproduced?

Your rebuttal life care plan should also include summaries of any depositions and expert reports that have been put forth. Expect that a good plaintiff's life care planner may provide a rebuttal to your rebuttal life care plan. It's all about examining the evidence and providing expert opinions!

Endnotes

1 A portion of this article was previously published in The Arizona Association of Defense Counsel's *Common Defense* (Summer 2015).

Study Suggests Some Employers May Disfavor Job Seekers Who Disclose a Disability

By: Deborah Brouwer and Kellen Myers, *Nemeth Law, P.C.*

A joint study conducted by Rutgers and Syracuse University recently made headlines with its conclusion that some employers may express less interest in candidates who openly disclose a disability in a cover letter responding to a job opening.[1] The researchers sent out over 6,000 fake resumes and cover letters responding to job openings across the country, and found that employers were 26% less likely to contact candidates who disclosed a disability. According to the researchers, the only variation in the study was the cover letter sent by the fictitious applicant which either openly disclosed a disability or did not.

Some commenting on the study argue that it confirms national concerns regarding a gap in the employment of disabled individuals—according to the New York Times, around 66% of working age individuals with disabilities are unemployed, compared to only 26% of non-disabled individuals.[2] Companies and their attorneys may wish to take note of this study, and use it as an opportunity to ensure their hiring processes are compliant with state and federal disability non-discrimination laws.

Laws Governing Employers

Under the Americans with Disabilities Act (ADA), employers with 15 or more employees are prohibited from discriminating against disabled employees or job applicants.[3] In addition, Michigan's Persons with Disabilities Civil Rights Act (PWDCRA) applies to all Michigan employers regardless of size.[4] This is important because the study found that it was largely small employers with less than 15 employees who did not respond to job candidates who openly disclosed a disability. Thus, even if the ADA may not apply to those employers, in states like Michigan they could still face liability. Most employers know that state and federal laws generally prohibit disability-related inquiries during the hiring process, and so they rarely encounter interview situations where a disability is openly disclosed by a job applicant. However, the results of the study show that many employers simply may not know how to proceed when a job applicant discloses a disability in his or her cover letter, so they may shy away from even contacting a disabled candidate—an act that could also violate state and federal law.

Three Phases of the Employment Process

Under the ADA, there are three phases of the employment process, with varying restrictions as to what questions may be asked regarding employee medical or health related issues.[5] During the pre-employment phase (prior to a conditional offer of

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employment), employers generally cannot ask any disability-related questions.[6] At most, an employer may ask whether the applicant is able to perform the essential functions of the job with or without accommodation. Importantly, the applicant must be informed of the essential job functions for this to apply, usually through a written job posting or description.

During this first stage, an employer may ask an applicant to describe or demonstrate how he or she will perform an essential job function or if an accommodation is needed to perform a specific, essential job function.[7] However, this applies only if the applicant has an obvious disability (for example, if the applicant uses a wheelchair) or if the applicant has voluntarily disclosed that he or she has a disability—such as the fake study applicants did here—and the employer reasonably believes the applicant will not be able to perform an essential job function due to this disability. In such a case, the employer also may need to engage in the interactive process with the applicant to determine if there is a reasonable accommodation that allows the disabled applicant to perform the essential functions of the job.

In some instances, an employer may have an obligation to reasonably accommodate a disabled job applicant with respect to certain aspects of the application process.[8] For example, an employer may have to adjust an interview location for an applicant with a mobility impairment or provide application materials in accessible formats, such as large print or Braille, in order to provide the disabled applicant with an equal opportunity to participate in the job application process. This is true even if the employer believes that it will be unable to provide the job applicant with a reasonable accommodation to perform the essential functions of the job. Thus, even if an individual needs a reasonable accommodation for the application process itself, the employer may not have to provide the same accommodation upon hire, if it is not reasonable.

The other two phases of the employment process, post-offer and employment, offer varying levels of inquiry. In the post-offer phase (after an applicant is given a conditional job offer, but before he or she starts working) an employer can make disability related inquiries and conduct medical examinations of employees, but only if it does so for all employees who start work in the same job category.[9] This is generally the area where employers have the most leeway in these inquiries. However, if the employer withdraws the offer based on the now-discovered disability, it still must show that the individual is unable to perform the essential functions of the job. As such, the ADA still prohibits disability discrimination despite allowing employers to make medical inquiries at this stage.

A joint study conducted by Rutgers and Syracuse University recently made headlines with its conclusion that some employers may express less interest in candidates who openly disclose a disability in a cover letter responding to a job opening.

In the employment phase, an employer can make disability-related inquiries or require medical examinations only if they are job-related and consistent with business necessity.[10] Generally, this means that an employer learns or knows of a particular employee's medical condition, has observed performance problems, and can reasonably attribute the problems to the medical condition. Again, the focus of the inquiry is whether the employee can perform the essential functions of the particular job.

Although Michigan's PWDCRA is often interpreted and applied based on ADA standards, it does not distinguish between pre and post-offer employment or applicant testing. That being said, like the ADA, the PWDCRA precludes an employer from taking a discriminatory employment action based on a pre-employment physical or mental examination that is not directly related to the requirements of a specific job.[11]

In addition, an employer cannot limit, segregate, or classify an employee or applicant in any way that would deprive him or her of an employment opportunity due to a disability unrelated to the individual's ability to perform the duties of a particular job.[12] Thus, refusal to even consider an applicant because of a disability disclosed in a resume or a cover letter could well violate the PWDCRA as well as the ADA.

It therefore is crucial for Michigan employers to assess the essential functions of the position to determine whether a disabled employee can perform those functions with or without reasonable accommodation. To be safe, employers may be wise to follow the ADA guidelines that offer much more specific guidance in addressing these situations.

Conclusion

Disability non-discrimination laws are designed to put disabled workers on a level playing field with non-disabled applicants or employees. If a disabled

person can perform all essential job functions, with or without a reasonable accommodation, he or she should be treated equally. And while a private employer generally does not have to give preference to an openly disabled job candidate, it also cannot presumptively disqualify one. The results of the Rutgers/Syracuse study show, in part, that some employers may not be aware of what the law requires. Undoubtedly, now that the results of this study are public, state and federal agencies (as well as plaintiffs' attorneys) may turn their attention to this potential hiring issue. Employers and their counsel should do so as well.

Endnotes

1 Mason Ameri et al., *The Disability Employment Puzzle: A Field Experiment on Employer Hiring Behavior*, NBER Working Paper No. 21560 (September 2015), available at http://www.nber.org/papers/w21560 (last visited January 16, 2016).

2 Noam Scheiber, *Fake Cover Letters Expose Discrimination Against Disabled*, The New York Times, available at http://www.nytimes.com/2015/11/02/upshot/fake-cover-letters-expose-discrimination-against-disabled.html (last visited January 16, 2016).

3 42 USC 12111.

4 MCL 37.1201.

5 See e.g. U.S. Equal Employment Opportunity Commission, Enforcement Guidance: Disability-Related Inquiries and Medical Examinations of Employees under the Americans with Disabilities Act, No. 915.002 (7/27/2000), available at http://www.eeoc.gov/policy/docs/guidance-inquiries.html#N_6_ (last visited January 16, 2016).

6 42 USC 12112(d)(2); 29 CFR 1630.13.

7 29 CFR 1630.14(a).

8 29 CFR 1630.2(o)(1).

9 42 USC 12112(d)(3); 29 CFR 1630.14.

10 42 USC 12112(d)(4)(A); 29 CFR 1630.14.

11 MCL 37.1202.

12 *Id*.

Be Ready: Arbitration, A Tool Whose Time Has Come of Age[1]

By: Martin C. Weisman

In recent years alternative-dispute-resolution processes have been increasingly used both privately and by the courts. In the past, many advocates turned away from arbitration because of their belief that the arbitration process was neither cost nor time efficient. Many thought that arbitrators "cut the baby" when rendering decisions and did not make decisions based upon the proofs and law presented. However, with the increased focus on ADR by the courts, specifically the business courts, and the recognition by ADR providers that the arbitration process needed to be cost effective as well as efficient, the landscape of arbitration and its arbitrators have materially changed. You now need to be ready to take advantage of it by fashioning an effective arbitration clause in your contracts.

The American Arbitration Association amended its commercial rules in October 2013, providing the arbitrator with an array of powers to manage the process. The Michigan Legislature adopted the Revised Uniform Arbitration Act (MCLA 691.1681 et seq.), which also increased the efficiency of arbitration and preserved much of the cost effectiveness of arbitration by empowering arbitrators to manage the process without fear of reversal. With this occurrence, it became even more important for contract drafters to incorporate an effective arbitration provision as part of their agreements in order to take full advantage of this newly improved process.

Arbitration awards are final, binding, and enforceable. Court intervention in the arbitral process has generally been limited by state and federal laws and, by doing so, arbitrators have the power, by default, to resolve disputes speedily and with cost savings. The arbitration process also allows the parties to control the selection of their arbitrator to get a decision maker who has the background and expertise relevant to their specific dispute(s). During arbitration, court room rules of evidence are not strictly enforced, discovery is limited, and the rules by which the arbitration is to be conducted are flexible.

As a result, attention should be given to drafting and including arbitration clauses in most contracts. Some of the typical arbitration provisions to be considered include identifying the number of arbitrators, the method of selection, the arbitrators' qualifications, whether or not or to what extent discovery will be permitted, the duration of the arbitral proceedings, what remedies can be utilized by the arbitrator including assessment of fees, costs, and expenses, and the type of award that will be required. The following is a discussion of some of these clauses for consideration.

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Number, Method, and Quality of Arbitrators

Typically, disputes are heard by a single arbitrator unless the dispute is significant or involves large sums of money, in which case three arbitrators are often used. The parties sometime feel more comfortable with three arbitrators because it provides a greater comfort level regarding the decision-making process. However, appointing three arbitrators significantly increases the cost of arbitration as well as the time it takes to conduct an arbitration. It is my recommendation that a sole arbitrator be appointed even for disputes which currently would be heard by three arbitrators. However, with one arbitrator more care should be taken in terms of the qualifications and the method of selecting that arbitrator.

Discovery is one of the most expensive and time consuming attributes of any litigation process and it is desirable in an arbitration to control the amount and the scope of discovery.

Arbitrators are also often selected through a party appointed process in which each side designates an arbitrator and those arbitrators then select the third arbitrator to act as the chair or the neutral. You can modify this selection process by having the two appointed arbitrators select the neutral, and then, have this neutral act as the sole arbitrator. The parties can also designate selection of an arbitrator from an ADR provider like PREMi. PREMi can provide a list of qualified arbitrators from which the selection can be made.

It is important that any arbitration clause provide the parties with the ability to also require a certain type of experience. For example, it can be said that the arbitrator must have topic-specific expertise in whatever business or type of business is involved. You might want to state that the arbitrator must be an attorney or a CPA with at least ten or more years of experience, or you can describe the background that appears best suited for that particular dispute. However, be mindful of the fact that if you provide very specific qualifications in the arbitration clause, it may decrease the number of arbitrators that are available from which you can chose. However, minimum qualifications of a general nature are always helpful.

In summary, you should draft an arbitration clause that provides guidelines for the number, method of selection, and qualifications of your arbitrator(s).

Arbitration Procedures

Arbitration clauses can also devise a discovery regiment. Discovery is one of the most expensive and time consuming attributes of any litigation process and it is desirable in an arbitration to control the amount and the scope of discovery.

The arbitration clause in a contract can provide that structure. Certainly the parties and arbitrator can, by agreement, structure the process. However, it is better to spell the procedure out in the contract leading up to the dispute. Under the Revised Uniform Arbitration Act and the American Arbitration Association rules, the arbitrator has the power to limit or allow discovery.

Arbitration clauses can also limit or provide the number of depositions and type of discovery allowed or not allowed. Disputes less than a certain dollar amount may only require document exchanges and the arbitration clause may even waive an oral hearing with the matter determined based upon written submissions only. Some of these tools are typically used in smaller dollar value cases. Additionally, the arbitration clause can provide that there be no direct testimony and that testimony can be submitted by way of affidavit with the witness provided for cross-examination and rebuttal. This process significantly decreases the time involved and costs of the arbitration process.

Because arbitration is designed to provide a speedy method of dispute resolution, some contracts specify a time period within which the arbitration must be concluded. It is not unrealistic to place a 90, 120, or 180 day deadline for the completion of an arbitration in your contract. However, a shorter timeline might be aggressive for a factually intensive multi-million dollar dispute. A clause which indicates that time is of the essence and that the hearing shall take place within 120 days of filing, with a decision rendered within 180 days is a common provision dealing with these types of issues.

Remedies

It is important to include in an arbitration clause the remedies an arbitrator may grant. Normally, we see language similar to "any remedy or relief that the arbitrator deems just and equitable." However, contracting parties may want to expand or exclude certain remedies such as awarding consequential or punitive damages, equitable relief, or injunctions. An arbitrator who has been granted direction in the arbitration clause will result in a decision that is less likely to be challenged.

Similarly, fee-shifting provisions should be built into any standard arbitration clause. This will allow the arbitrator to award reasonable fees and costs to the prevailing party or to make an award if it was reasonable and just under the circumstances of the case.

There are also several types of awards that arbitrators are called upon to make. They include a standard award, a reasoned award, or findings of fact and conclusions of law. Each of those has pluses and minuses.

A standard award is merely the statement of the result by the arbitrator with no explanation. Such an award is very difficult to reverse, since the arbitrator has great discretion and there is no statement as to how or why the arbitrator reached that decision. From an arbitrator's standpoint, that is the most favored approach.

A reasoned award or opinion is one in which the arbitrator explains how he or she arrived at the award. A reasoned award can add cost to the arbitration process and may require additional time to complete.

Findings of fact and conclusions of law is the most detailed award, requiring the arbitrator to spend a significant amount of time in reciting the facts the arbitrator relied on and the legal conclusions these facts resulted in. This clearly adds costs and delay and, in many cases, provides grounds to challenge the confirmation of the award. As a result, it is the least favored approach of arbitrators.

However, each type of award has different value to the parties in an arbitration. A standard award does not give any guidance as to how the decision was reached. While it may give comfort that there will be no appeal, it may also be disturbing that there is no ability to appeal if you believe an arbitrator has "run amok." A reasoned award increases the possibility of a challenge on confirmation and some additional costs and delay, but it may provide a little more comfort to those involved as to the whys and wherefores of the decision. Findings of fact and conclusions of law is the type of award which, unless the case has an extremely large dollar value and/or is very complicated, is not preferred and can lead to the continuation of the dispute beyond the arbitration in the courts.

General Provisions

Sometimes the parties may fight over where an arbitration should take place and, therefore, to the extent possible, the arbitration clause should clearly identify the city, county, and state where the arbitration is to take place. The clause should also provide what state's laws will govern the arbitration. The contract provision should also reaffirm the fact that neither a party nor an arbitrator may disclose the existence, content, or result of any arbitration without the prior written consent of all parties. This reinforces what is built into the Revised Uniform Arbitration Act, the Michigan Court Rules, and the American Arbitration Rules.

Miscellaneous Items

Sometimes a party may fail to pay its required share of an arbitrator's compensation or administrative charges. In that case, what happens? One suggestion would be that the arbitration clause provide that failure to pay would constitute a waiver to present evidence or cross-examine witnesses at the arbitration hearing. Under the current American Arbitration Association rules, the non-paying party's share may be paid by the opposing party and included as part of the ultimate award. It may not, however, be appropriate to include that type of language in the arbitration clause because it would only give incentive to one or the other not to pay.

Finally, the American Arbitration Association has developed optional appellant arbitration rules. These rules provide that an award can be appealed to an optional review panel through a special procedure that the American Arbitration Association has developed. Such an appeal is not available to the parties unless there is language in the agreement that permits such a process.

Some of the typical arbitration provisions to be considered include identifying the number of arbitrators, the method of selection, the arbitrators' qualifications, whether or not or to what extent discovery will be permitted, the duration of the arbitral proceedings, what remedies can be utilized by the arbitrator including assessment of fees, costs, and expenses, and the type of award that will be required.

Conclusion

A well drafted and constructed arbitration clause can provide clear protections for the parties and a roadmap for the arbitrator for the conduct of the arbitration. Such a clause will also result in the process being much more economical, efficient, final, and binding, and result in an effective dispute-resolution tool.

Endnotes

1 Previously published in the *Detroit Legal News*, June 27, 2014.

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The Widow Wave by Jay W. Jacobs[1]

Reviewed by: Benjamin C. Heinz, *Ball, Ball, Matthews & Novak, PA*.

As a first year law-student at the University of Alabama in 1998, my section read *A Civil Action* by Jonathan Harr as required reading for our Civil Procedure class and, I assume, for a somewhat real-world view of the ins and outs of civil procedure and litigation. While I can remember the basics of the story fairly well today, the one point that has always stuck out in my mind about the book was how the author painted a not-so-flattering picture of the civil defense lawyers. A little more than sixteen years after reading *A Civil Action*, I cannot recall coming across anything written about a civil defense lawyer's actions that was flattering outside of articles in the *Alabama Defense Lawyers Association Journal* or in a DRI publication. Then again, I doubt many of us on the defense side chose our side of the bar because we expected large amounts of public praise, catchy commercials, or our faces blown-up on highway billboards. So while a large amount of public anonymity is definitely the norm for most of us, there is certainly something admirable in doing your job, following the rules, and defending your clients' interests in a professional and ethical manner. There is even the possibility of a good story coming out of the daily grind we share.

Ben Heinz is an AV-rated trial attorney in Ball, Ball, Matthews & Novak's office in Mobile, Alabama. His primary areas of practice are the defense of personal-injury actions, insurance disputes, and construction-defect claims. Ben is a member of the Defense Research Institute and the Alabama Defense Lawyers Association. He is licensed to practice law in Alabama and Mississippi, and he received his law degree from The University of Alabama School of Law in 2001 after graduating with double majors in Economics and Public Policy in 1998 from Duke University.

On that note, Jay W. Jacobs, a long-time California civil litigator, has put "pen-to-paper" to detail one of these good stories about a civil defense litigator's professional and ethical handling of an interesting piece of litigation in *The Widow Wave*. Much like *A Civil Action*, *The Widow Wave* is a non-fiction account of a lawsuit from beginning to end. Unlike *A Civil Action*, *The Widow Wave* comes directly from a real participant in the lawsuit—Jacobs himself—and focuses primarily on his handling of the defense of the case as opposed to the plaintiffs' side of the lawsuit.

Arising out of a recreational fishing tragedy off the California coast near San Francisco and following along through the related lawsuit, *The Widow Wave* offers an entertaining and insightful account of a defense lawyer's handling of the wide-ranging representation of his client's interests. Although autobiographical in nature, Jacobs does not tell the story as an infallible actor and decision-maker. Instead, Jacobs repeatedly lays open his thoughts and impliedly invites the reader to go through the key decision points along with him before he reveals the various choices he makes, the legal strategies he follows, and the tactics he uses. Throughout, Jacobs provides a vivid reminder of the often bumpy ride of litigation both from a factual standpoint and in his own confidence in his case and legal strategy. In addition, the underlying story of how the fishing tragedy occurred provides a dramatic background to the progress of the lawsuit.

While *The Widow Wave* is clearly written for the enjoyment of readers regardless of their legal acumen, for defense lawyers it has an additional layer of usefulness. From handling clients to locating witnesses to confrontations with opposing counsel, *The Widow Wave* contains numerous mini-CLE opportunities on the civil litigation process. Experienced defense lawyers with an open mind to continuously honing their craft and skill should be able to glean some refresher points for their practice throughout the book all while trying to figure out what happened out at sea. Yet *The Widow Wave* is likely even more valuable for new lawyers. Most defense firms would serve themselves well by having a copy of *The Widow Wave* available for newer associates to read as an introduction to the minutiae of the world of civil litigation that law school did not teach them. *The Widow Wave* does not necessarily have all of the answers for new lawyers, but it certainly will help open their eyes to the variety of issues they will face in their chosen profession. On top of it all, given its relatively brief length of 263 pages, reading *The Widow Wave* will likely be a less daunting but much more fulfilling (though non-billable) task for most new lawyers than slogging through a plaintiff's 70-page summary judgment response.

The Widow Wave shines a positive light on our relatively anonymous side of civil litigation and proves that there are in fact good and entertaining stories to be pulled from the daily grind of doing your job, following the rules, and defending your client's interests in a professional and ethical manner.

Endnotes

1 This book review was originally published in the *Alabama Defense Lawyers Association Journal*, vol 31, issue 1 (Spring 2015).

MDTC Legislative Section

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MDTC Legislative Report

As I finish this report on January 5th, things are quiet at the Capitol for a time. The state Christmas tree is being taken down and hauled away and the nativity scenes and competing displays have been removed, leaving only the newly refurbished, rifled cannon to decorate the snow-covered lawn. But the time for quiet reflection upon last year's accomplishments will not last long; our legislators will be back soon to take up where they left off in December.

There was a flurry of legislative activity in the last weeks of 2015, but the final sessions did not have the urgency of a lame duck session, and thus, completion of a number of initiatives was deferred until this year. The Legislature addressed a few issues which could not be put off any longer, including, most notably, the painful compromise which has finally promised some additional funding for the desperately needed repair of Michigan's roads and bridges. That legislation will begin to provide additional funding for that purpose during the 2016-17 fiscal year, with new revenue derived from increased vehicle registration fees and motor-vehicle-fuel taxes, and diversion of General Fund / General Purpose revenue. Regrettably, the roads will not be fixed this year but, if all goes as planned, the full 1.2 billion dollars currently needed will become available for use in fiscal year 2020-21. Some have suggested that this will be too little, too late, but all must agree that it will be better than nothing.

2015 Public Acts

As of this writing, there are 267 Public Acts of 2015. The new Public Acts of interest to civil-defense practitioners include:

2015 PA 209 – Senate Bill 427 (Hansen – R) has amended the "Good Samaritan Act," MCL 691.1501 and 691.1502, to include licensed EMS providers within the class of health-care providers who are granted limited immunity from civil liability for providing emergency care without compensation at the scene of an emergency, or to individuals injured as a result of participation in competitive sports. This amendatory act will take effect on February 28, 2016.

2015 PA Nos. 230-235 – Senate Bills 531 (Jones – R), 532 (Proos – R) and 533 (Schuitmaker – R), and House Bills 5028 (Kesto – R), 5029 (Heise – R) and 5030 (Price – R). This package of legislation, divided into six new acts for partial sharing of the credit, has amended the Revised Judicature Act to add a new section, MCL 600.176, and a new chapter, 19A, which will create a new Judicial Electronic Filing Fund in the Department of Treasury; provide for the administration of the fund by the State Court Administrative Office to support the implementation, operation, and maintenance of a statewide-electronic-filing system and supporting technology; and provide for the funding of the project by the collection of new fees, in addition to the previously established filing fees, to be paid once upon initiation of a civil action or review in the state trial or appellate courts. This legislation was proposed by the Supreme Court to facilitate the creation of the statewide e-filing system, which has been widely discussed for some time, and to provide the necessary statutory authorization for the collection of the new filing fees that will be used to fund the creation and implementation of that system.

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The legislation states that the new provisions shall not be construed to require a person to file documents electronically "except as directed by the Supreme Court."

The collection of the additional filing fees will begin on March 1, 2016. For civil actions filed in the Supreme Court, Court of Appeals, circuit court, probate court, or Court of Claims, the additional "Electronic Filing System Fee" will be $25.00. For actions filed in the district courts, the additional filing fee will be $20.00 in cases where a claim for money damages is joined with a claim for other relief and $10.00 for all other cases, except actions in the small-claims division, for which a $5.00 fee will be collected. An additional "Automated Payment Service Fee" of not more than 3% of the automated payment may be charged if a bank or other electronic commerce business charges the court or court funding unit a merchant transaction fee for an automated payment, and courts that are already collecting fees for electronic filing will be allowed to continue collecting specified fees for filing and service ($2.50 for filing or service and $5.00 for filing and service) in addition to the new Electronic Filing System Fee, until December 31, 2016. The new statutory authorization for collection of the additional filing fees will expire on January 1, 2021, unless extended by further legislative action.

Governmental entities will not be required to pay an Electronic Filing System Fee, and although the new fees will be paid by anyone initiating a civil action, the fee may be waived if the regular filing fee is waived for indigence of the filing party. The legislation states that the new provisions shall not be construed to require a person to file documents electronically "except as directed by the Supreme Court." Thus, the legislation will pave the way for mandatory e-filing in the future if required by the Supreme Court.

2015 PA 257 – House Bill 4658 (McCready – R) has amended the Revised Judicature Act to create a new section, MCL 600.6096, which will establish new provisions requiring collection of amounts owed for tax liabilities and other known liabilities to the state, support payments, restitution, garnishments directed to the state, IRS levies, and repayment of benefits received under the Michigan Employment Security Act, from payments made in satisfaction of judgments against the state or its departments. These new provisions will take effect on March 30, 2016.

2015 PA 267 – Senate Bill 493 (Brandenburg – R) will amend the Workers Disability Compensation Act, 1969 PA 217, to add a new section, MCL 418.120, which will clarify the employment status of employees of franchisees. The new section will provide that an employee of a franchisee is not an employee of the franchisor for purposes of the act unless both of the following circumstances apply: 1) "The franchisor and franchisee share in the determination of or codetermine the matters governing the essential terms and conditions of the employee's employment"; and 2) "The franchisee and franchisor both directly and immediately control matters relating to the employment relationship, such as hiring, firing, discipline, supervision, and direction." In related legislation, **2015 PA 266 – Senate Bill 492 (Brandenburg – R)** will amend the Franchise Investment Law, 1974 PA 269, to add a new section, MCL 445.1504b, which will provide that "To the extent allocation of employer responsibilities between the franchisor and franchisee is permitted by law, the franchisee shall be considered the sole employer of workers for whom it provides a benefit plan or pays wages except as otherwise specifically provided in the franchise agreement." These amendatory acts will take effect on March 22, 2016.

Old Business and New Initiatives

All of the bills and joint resolutions that were not passed before the end of 2015 are carried over to 2016. The pending bills of interest include:

Senate Bill 632 (Schuitmaker – R) would amend the provisions of the Revised Judicature Act defining the jurisdiction of the Court of Appeals and the probate courts to provide the necessary statutory authorization for previously proposed court rule changes that would transfer jurisdiction over all appeals from final orders and judgments of the probate courts to the Court of Appeals. This bill was introduced on December 2, 2015, and referred to the Senate Judiciary Committee.

Senate Bill 611 (Warren – D) would repeal the Self-Defense Act, 2006 PA 309, and related provisions of the Revised Judicature Act and Code of Criminal Procedure, which would currently approve and provide limited immunity from civil liability for the use of deadly force in self-defense without having to retreat in specified circumstances. This bill was introduced on November 11, 2015, and referred to the Senate Judiciary Committee.

[A new act] will amend the Workers Disability Compensation Act, 1969 PA 217, to add a new section, MCL 418.120, which will clarify the employment status of employees of franchisees.

House Bill 4686 (Santana – D) would amend the Governmental Liability Act, 1964 PA 170, to amend MCL 691.1402a, regarding municipal liability for maintenance of sidewalks, to insert a new subsection (5). The new provision would clarify that a municipal corporation having a duty to maintain a sidewalk under subsection (1) may assert, in addition to other available defenses, "any defense available under the common law with respect to a premises liability claim, including, but not limited to, a defense that the condition was open and obvious." This bill was passed by the House on December 10, 2015, and now awaits consideration by the Senate Committee on Government Operations.

Senate Bill 672 (Hansen – R) would amend the Estates and Protected Individuals Code, MCL 700.5109, which allows parents and guardians of minors to release sponsors and organizers of recreational activities, and paid or volunteer coaches conducting such activities, from liability for injuries sustained by the minor in the course of those activities. The proposed amendment would expand the statute's definition of "recreational activity" to include "camping activities" in addition to "active participation in athletic or recreational sport." This bill was introduced on December 15, 2015, and referred to the Senate Committee on Outdoor Recreation and Tourism.

What Do You Think?

Our members are again reminded that the MDTC Board regularly discusses pending legislation and positions to be taken on bills and resolutions of interest. Your comments and suggestions are appreciated, and may be submitted to the Board through any officer, board member, regional chairperson or committee chair.

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Appellate Practice Report

Seeking Supreme Court Review of Court of Appeals Decisions That Remand for Further Proceedings

As a general rule, a party wishing to seek Supreme Court review of a decision from the Michigan Court of Appeals in a civil case must file an application for leave to appeal within 42 days of the Court of Appeals' decision (or from a decision denying a timely motion for reconsideration). See MCR 7.305(C)(2). But when a Court of Appeals decision remands for further proceedings, there is an additional option. MCR 7.305(C)(5)(c) provides that "[i]f the decision of the Court of Appeals remands the case to a lower court for further proceedings," then an application for leave to appeal may also be filed after the date of "the Court of Appeals order or opinion disposing of the case following the remand procedure ...." In addition to raising issues "related to the remand proceedings," such an application may also be made "on all issues raised initially in the Court of Appeals …." *Id.*

The Supreme Court's order in *MS Development, Inc v Auto Plaza of Woodhaven*, 456 Mich 935; 575 NW2d 551 (1998), provides a good illustration of the rule's operation. In *MS Development*, the plaintiff filed a breach of contract action against the defendants relating to their alleged breach of certain lease agreements. The defendants filed a counterclaim. The trial court granted summary disposition to the plaintiff and denied the defendants' request to amend their counterclaim. See *MS Development, Inc v Auto Plaza of Woodhaven*, 220 Mich App 540, 543; 560 NW2d 62 (1996). In response, the defendants filed a new lawsuit alleging essentially the same claims that they alleged in their unsuccessful counterclaim. *Id.* at 544. The trial court granted summary disposition to the plaintiff pursuant to MCR 2.116(C)(8), and the defendants appealed the trial court's decisions in both cases. *Id.*

On appeal, the Court of Appeals reversed the trial court's denial of the defendants' request to amend their counterclaim on the ground that the court did not provide particularized reasons for its decision, and remanded the case for further proceedings. *Id.* However, the Court of Appeals affirmed the trial court's dismissal of the defendants' newly-filed complaint under MCR 2.116(C)(8). *Id.*

On remand, the defendants filed an amended counterclaim that was nearly identical to their prior counterclaim and to the complaint that had previously been dismissed. The trial court, once again, granted summary disposition to the plaintiff, this time concluding that the law of the case doctrine barred the defendants' claims in light of "the trial court's previous dismissal of the same claims and [the Court of Appeals'] affirmance of that dismissal." *Id.* at 545.

When the case returned to the Court of Appeals again, the second panel explained that although it believed the previous panel erred in affirming the trial court's dismissal of the defendants' claims, it had no choice but to affirm "because the claims raised were almost identical to those already rejected by this Court." *Id.* at 548. The Court noted, however, that the defendants were free to seek review from the Supreme Court and assert "all issues raised in this Court, including those relating to the remand question." *Id.* at 549, citing MCR 7.302(C)(4)(b) (currently numbered MCR 7.305(C)(5)(c)).

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In the face of an adverse Court of Appeals' decision remanding for further proceedings, a party wanting to "play it safe" might well decide to seek immediate review from the Supreme Court. But as *MS Development* confirms, the party is also free to await the conclusion of proceedings on remand and then file a Supreme Court application raising any and all issues that were raised initially in the Court of Appeals.

The defendants did just that, and the Supreme Court reversed *both* of the Court of Appeals' decisions in a peremptory order. *MS Development*, 456 Mich 935. The Supreme Court observed that although "[t]he law of the case doctrine barred the present panel of the Court of Appeals from correcting the error of the panel of that court which decided the previous appeal of this case," there was "no such bar to [the Supreme] Court's reviewing powers." *Id*. Because the Supreme Court believed that "[the defendants'] counterclaim to the original complaint stated a claim upon which relief can be granted," it concluded that the trial court erred in granting summary disposition to the plaintiff. *Id*.

To be sure, MCR 7.305(C)(5)(c) is not for the faint of heart. In the face of an adverse Court of Appeals' decision remanding for further proceedings, a party wanting to "play it safe" might well decide to seek immediate review from the Supreme Court. But as *MS Development* confirms, the party is also free to await the conclusion of proceedings on remand and then file a Supreme Court application raising any and all issues that were raised initially in the Court of Appeals.

Scope of Cross-Appeals

In the Michigan Court of Appeals, when a party files an appeal as of right (or the Court of Appeals grants leave to appeal), the appellee is entitled to file a cross-appeal. MCR 7.207(A)(1) ("When an appeal of right is filed or the court grants leave to appeal any appellee may file a cross appeal."). But what is the proper scope of a cross-appeal? Is it limited to the judgment or order being appealed? Can a cross-appeal raise issues involving parties that were unaffected by the original claim of appeal?

In *Costa v Community Emergency Medical Services, Inc*, 263 Mich App 572; 699 NW2d 712 (2004), aff'd 475 Mich 403 (2006), the Court of Appeals confirmed that "[t]he language of MCR 7.207 does not restrict a cross-appellant from challenging whatever legal rulings or other perceived improprieties occurred during the trial court proceedings." *Id*. at 583-584. In *Costa*, the defendants appealed as of right from the trial court's order denying their motion for summary disposition based on governmental immunity. The plaintiffs cross-appealed from the same order, which had also denied the plaintiffs' own motion for summary disposition. The defendants argued that the Court of Appeals did not have jurisdiction to consider the plaintiffs' cross-appeal because the portion of the order denying the plaintiffs' motion for summary disposition was not appealable as of right (whereas the denial of governmental immunity was appealable as of right under MCR 7.202(6)).

In rejecting the defendants' argument, the Court in *Costa* acknowledged that the defendants' initial appeal was limited to the governmental immunity issue in accordance with MCR 7.203(A)(1), which "explicitly prescribes the scope of an appellant's appeal as of right from a final order under MCR 7.202(6)(a)(iii)-(v), such as an order denying summary disposition on the issue of governmental immunity, and limits an appellant's right to appeal under these circumstances 'to the portion of the order with respect to which there is an appeal as of right.'" *Id*. at 583. The Court observed, however, that MCR 7.207(A)(1) did not similarly restrict the scope of cross-appeals:

> [T]he court rule governing cross-appeals to this Court, MCR 7.207, does not contain any language of limitation. Instead, the clear and unambiguous terms of MCR 7.207(A)(1) authorize any appellee to file a cross-appeal whenever an appellant has either filed an appeal as of right, or when this Court has granted an appellant's application for leave to appeal. The language of MCR 7.207 does not restrict a cross-appellant from challenging whatever legal rulings or other perceived improprieties occurred during the trial court proceedings. Indeed, MCR 7.207(D) states that even "[i]f the appellant abandons the initial appeal or the court dismisses it, the cross appeal may nevertheless be prosecuted to its conclusion." See *In re MCI*, 255 Mich App 361, 364-365; 661 NW2d 611 (2003). [*Costa*, 263 Mich App at 583-584].

Although *Costa* happened to involve a cross-appeal filed in response to a claim of appeal as of right, the decision confirms that MCR 7.207(A) also applies to cross-appeals filed in connection with discretionary appeals in which the Court of Appeals has granted leave. See also *Bancorp Group, Inc v Meister*, 459 Mich 944; 590 NW2d 65 (1999) (holding that there was "no basis" for limiting a cross-appeal to issues related to the specific order appealed by the appellant on leave granted).

Finally, it does not matter whether the cross-appeal involves parties that were not affected by the original claim of appeal. MCR 7.207(A)(2) provides that "[i]f there is more than 1 party

MCR 7.207(A)(2) provides that "[i]f there is more than 1 party plaintiff or defendant in a civil action and 1 party appeals, any other party, whether on the same or opposite side as the party first appealing, may file a cross appeal against all or any of the other parties to the case."

plaintiff or defendant in a civil action and 1 party appeals, any other party, whether on the same or opposite side as the party first appealing, may file a cross appeal against all or any of the other parties to the case." As explained in Shannon & Gerville-Reache, Michigan Appellate Handbook, § 4.45 (ICLE 3d ed, 2013), this gives rise to important strategic considerations when deciding whether to file an appeal in the first instance:

> The filing of a cross-appeal entitles the filing appellee (who becomes a cross-appellant) to seek relief against not only the appellant, but also any other appellee, including one who was unaffected by the original claim of appeal. MCR 7.207(A)(2). There is no requirement that a cross-appeal be limited in scope as a result of, or that it address the same issues as, the direct appeal …. This is an important strategic nuance that every party must consider when analyzing the pros and cons of claiming an appeal (or filing an application for leave to appeal): the appeal automatically entitles all other parties in the case to file a cross-appeal. Even a defendant who has deliberately forgone an appeal of right can reconsider that decision, and change its mind, if the plaintiff claims an appeal.

Amendments of MCR 7.209 and MCR 2.614 – Stays and Bonds

On October 21, 2015, the Michigan Supreme Court amended MCR 7.209 and MCR 2.614, which are the rules governing stay bonds. The amendments are effective January 1, 2016, and were adopted with significant input from the SBM Appellate Practice Section.

The amendments of MCR 7.209 and MCR 2.614 are significant:

- They clarify that execution may not issue on interlocutory judgments. MCR 2.614 now provides that "execution may not issue on a judgment and proceedings may not be taken for its enforcement until 21 days after a **final** judgment (as defined in MCR 7.202[6]) is entered in the case." MCR 2.614(A)(1) (emphasis added). See also MCR 7.209(E)(1) ("Unless otherwise provided by rule, statute, or court order, an execution may not issue and proceedings may not be taken to enforce an order or judgment until expiration of the time for taking an appeal of right."). Under former practice, interlocutory judgments were arguably enforceable notwithstanding the unavailability of an appeal as of right.
- For appeals from money judgments, the party seeking a stay must file a bond in an amount not less than 110% of the judgment. MCR 7.209(E)(2)(a). The former rule did not specify the presumptive amount for an appeal bond.
- The trial court has discretion to stay a money judgment without a bond, or with a reduced bond. MCR 7.209(E)(2)(b).
- MCR 7.209 also recognizes a party's ability to obtain a stay of a money judgment by demonstrating the existence of insurance coverage. MCR 7.209(E)(2)(b), citing MCL 500.3036.
- The trial court has discretion to allow other forms of security in lieu of an appeal bond, such as an irrevocable letter of credit. MCR 7.209(E)(2)(c).
- Amended MCR 7.209 clarifies that when a bond or other security is filed, the judgment is automatically stayed pending review and entry of a final stay order. MCR 7.209(E)(3). The former rule was ambiguous as to whether an order was required before a stay would take effect.
- The process for reviewing the adequacy of a bond or other security is streamlined. The party seeking the stay must serve a copy of the bond along with a proposed stay order. The opposing party then has 7 days to file and serve objections. If no timely objections are filed, the court will enter the proposed stay order. See MCR 7.209(G)(1).
- The amended rule authorizes the court to hold any hearings by telephone. MCR 7.209(G)(1)(e).

Preparing for Oral Argument: A Checklist[1]

When preparing for an appellate oral argument, one of your primary goals is to be ready for anything. It's usually hard to predict with any certainty what kind of questions you'll face—or, for that matter, whether you'll get any questions at all. And although one can make educated guesses about what kinds of per-

On October 21, 2015, the Michigan Supreme Court amended MCR 7.209 and MCR 2.614, which are the rules governing stay bonds.

spectives judges may bring to a case, it's often difficult to predict how those viewpoints will play out.

Taking a few key steps before an argument, however, can help make sure you're ready for whatever a panel throws at you.

1. Re-read the entire record. Sure, you've probably read it all before. But when you read it again after briefing, you may find new issues and new perspectives. More importantly, you'll make sure that the record is fresh in your mind so you'll be ready for questions from the bench.
2. While you're at it, make a timeline of key events. The exercise will help you recall events quickly at oral argument, and it will give you a handy reference for argument.
3. Re-read and be familiar with all of the authorities cited in the briefs, both yours and your opponent's. You've probably read the cases before but re-reading them after briefing is done will give you a fresh perspective and help with recall at argument.
4. Make a cheat sheet of the key authorities in case you need to refresh your memory during oral argument. For example:

Case	Facts	Holding	Relevance	Other Notes
American Axle v National Union (unpublished 2007)	Def. failed to turn over key file, continued to object after being told to answer, gave incomplete and unresponsive answers.	Affirmed $7.5 million default judgment entered as a discovery sanction	COA affirmed because Def's failure to answer discovery was willful and flagrant	
Bass v Combs (COA - published - 1999)	The plaintiff didn't follow orders, court gave warnings that the case could be dismissed	Affirmed dismissal as a discovery sanction even though plaintiff provided partial answers. COA held that continued disobedience over 15-month period showed willful/wanton behavior	Factually similar. No express consideration of Dean v Thomas factors. No "trail of lesser sanctions."	Later overruled on venue issue.
		COA held that continued disobedience over 15-month period showed willful/wanton behavior	"trail of lesser sanctions."	

The best practices for supplemental authority, like many other questions of advocacy, are to disclose early, disclose fully, and to keep your arguments as concise as possible.

5. If your argument concerns a particular statue, court rule, or the like, make sure you have a copy of that text for reference at oral argument.
6. Update the authorities cited in your brief and your opponent's brief. Most of the time, briefs are filed several months to a year before oral argument. It's crucial to update your authorities to make sure the briefs—both yours and your opponent's—rely on good law.
7. When updating case law, you may find new cases that advance your cause (or cases that undermine it, and that you'll need to be prepared to deal with). You may also find cases that you should have addressed earlier but missed for one reason or another. See the accompanying article, *How to Raise Supplemental Authority*, for tips on how to deal with new cases and statutes.
8. Research your panel. You might learn something that will shape your presentation, such as judicial philosophy or earlier decisions on relevant legal issues.
9. Think about questions the Court may ask, especially as they relate to weaknesses in your case, and prepare answers. Before he started delivering the tough questions himself, Chief Justice John Roberts used to jot potential questions on notecards with answers on the back, and repeatedly work through his deck of questions. Advocacy guru Bryan Garner recommends keeping a notebook from the moment you start working on a case where you note weaknesses, potential questions, and difficult issues.
10. Consider how the Court should craft an opinion or order. Some judges may ask you to state the rule you'd like the Court to adopt. This is a frequent question at the Michigan Supreme Court. You should have a ready answer.
11. Consider rehearsing your argument before your colleagues—or, at the very least, record your argument with your iPhone's voice-memo application. Practicing before an audience, real or virtual, will help strengthen your advocacy muscles for the real thing.
12. Consider observing your panel in action. If you're not the first item on the docket, show up early to take the panel's temperature. If the panel is especially hot, or especially disengaged, or especially exhausted, you may want to call an audible and adjust your presentation.

No amount of preparation will prevent surprises. But these steps will help make sure you're ready to put your best foot forward, rather than in your mouth.

How to Raise Supplemental Authority

An appellate oral argument takes place months after briefing is done. It would be nice if the legal landscape remained static between briefing and argument. But as Taylor Swift might say, judges gonna judge and legislators gonna legislate. Courts keep writing new opinions. And that means legal analysis that was up-to-date when it was briefed might be out-of-date when argument rolls around.

One of the critical steps in preparing for an argument, therefore, is to re-research the governing law to determine whether there are any new opinions or statutes to account for. If you find something relevant, you'll need to figure out how to address it.

The Michigan Court Rules provide procedures for raising supplemental authority in the Michigan Court of Appeals. Rule 7.212(F) states:

> (F) Supplemental Authority. Without leave of court, a party may file an original and four copies of a one-page communication, titled "supplemental authority," to call the court's attention to new authority released after the party filed its brief. Such a communication,
> (1) may not raise new issues;
> (2) may only discuss how the new authority applies to the case, and may not repeat arguments or authorities contained in the party's brief;
> (3) may not cite unpublished opinions.

According to Rule 7.312(I), the same rules apply in the Michigan Supreme Court.

In federal appellate courts, citation of supplemental authorities is governed by Federal Rule of Appellate Procedure 28(j), which is substantively similar to the Michigan Court Rules:

If pertinent and significant authorities come to a party's attention after the party's brief has been filed–or after oral argument but before decision–a party may promptly advise the circuit clerk by letter, with a copy to all other parties, setting forth the citations. The letter

One of the critical steps in preparing for an argument, therefore, is to re-research the governing law to determine whether there are any new opinions or statutes to account for. If you find something relevant, you'll need to figure out how to address it.

must state the reasons for the supplemental citations, referring either to the page of the brief or to a point argued orally. The body of the letter must not exceed 350 words. Any response must be made promptly and must be similarly limited.

Both sets of rules contemplate a short filing focused on the supplemental authority and its impact on the case. Beware the impulse to rehash arguments you've already made.

If you need to address supplemental authority that goes beyond the narrow filing contemplated by the state and federal rules (or if your supplemental authority doesn't fit the narrow bounds of Rule 7.212(F)), you have two basic options.

First, you could file a motion that asks the court to accept a supplemental brief, along with a copy of the brief you'd like the court to consider. If you're in the Michigan Court of Appeals, you'll need to file this brief by the motion cutoff date listed on the Notice of Oral Argument to make sure the court considers your supplemental brief before oral argument. If you go this route, of course, you have to be prepared for the court to deny your motion.

Second, you can plan on saying whatever you'd like to say about supplemental authority at oral argument. As a matter of courtesy, you should let opposing counsel know beforehand and forward a copy of the case or statute you plan on raising. Appellate advocacy isn't guerilla warfare, after all. And if you tell the panel that you're raising a new case or statute (as you should, given duties of candor to the court), you'll want to be able to add that you let opposing counsel know beforehand. As with filing a motion, though, you'll need to be prepared for the court to politely, or not-so-politely, decline to consider new legal authorities.

The best practices for supplemental authority, like many other questions of advocacy, are to disclose early, disclose fully, and to keep your arguments as concise as possible.

Endnotes

1. This article is a revised version of an article from the December 2011 Appellate Practice Report.

By: Michael J. Sullivan and David C. Anderson, *Collins Einhorn Farrell P.C.*
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Legal Malpractice Update

Defining the scope of representation in an engagement letter can protect against the use of subsequent representation to extend the accrual date for a legal-malpractice claim.

Rhodes v Attorney Defendants, unpublished opinion per curiam of the Court of Appeals, issued November 12, 2015 (Docket No. 324102).

Facts: Plaintiff and her now ex-husband signed an antenuptial agreement prior to their marriage in 2002. Approximately four years later, Plaintiff hired Attorney-Defendant GLO to assist in renegotiating the terms of that agreement. Despite GLO's advice that Plaintiff should be cautious about signing anything related to her husband, Plaintiff signed an agreement in late 2006, wherein she agreed to indemnify Safeco Insurance Company of America ("Safeco"), a construction bonding company, against certain losses sustained by her husband's construction company.

Plaintiff subsequently decided to divorce her husband and, in January 2007, she retained GLO, as well as Attorney-Defendant JFS, for that very purpose. Memorializing the parties' agreement, GLO sent a confirming letter to Plaintiff, which set forth the scope of representation. The letter also confirmed the fees for the representation, namely, a $40,000 minimum engagement fee for the services provided and a results-oriented fee "which [could] only be assessed at the conclusion of the matter and which . . . [would] not exceed ten percent (10%)" of the total recovered, irrespective of the time expended by Attorney-Defendants during the course of representation.

Attorney-Defendants initiated a divorce action on behalf of Plaintiff on January 18, 2007 and, according to them, Plaintiff failed to disclose the existence of the Safeco indemnity agreement during the course of those proceedings. Moreover, during written discovery the husband denied having any "unsecured personal debts, debts secured by collateral, credit cards, open charges or any other obligation, including those as guarantor or surety." A judgement of divorce was entered on May 23, 2008, which included the following provision: "[T]hat upon entry of [the] Judgement of Divorce the attorneys of record are released from further obligations in connection with any appeals or post-judgment proceedings unless specifically re-retained to act on behalf of their former clients."

Plaintiff appealed, and on remand, the judgment of divorce was amended on December 17, 2010. Based upon a verbal agreement with Plaintiff, Attorney-Defendants were compensated at an hourly rate for their post-judgment representation, having already been paid the engagement fee of $40,000 throughout the divorce proceedings at the trial level. After the appeal, Attorney-Defendants requested that Plaintiff pay a $50,000 bonus, which represented the "results-oriented fee." The parties ultimately agreed upon a $25,000 fee.

On July 26, 2011, Safeco sent Plaintiff a letter demanding payment of more than $18 million for "losses under the indemnity agreement." Thereafter, Safeco sued Plaintiff, in addition to several other parties, to recover those losses. Attorney-Defendants in turn filed a motion in the underlying divorce case, demanding the

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Providing clients with a written engagement letter at the inception of the representation that outlines the scope of professional services to be rendered, and sending the client a closing letter when those services have been completed, may later prove useful in defending against an action for professional malpractice.

ex-husband indemnify, defend, and hold harmless Plaintiff with respect to the Safeco indemnity agreement. Plaintiff and the ex-husband eventually entered into an indemnification agreement, wherein the ex-husband pledged to hold Plaintiff harmless with respect to the losses she sustained in connection with the Safeco indemnity agreement. The ex-husband, however, failed to honor that agreement, which caused Attorney-Defendants to again file a motion in the underlying divorce case on December 3, 2012. Notably, Plaintiff paid Attorney-Defendants at their hourly rates for the legal services rendered in connection with these post-judgment motions.

On July 29, 2013, Plaintiff initiated an action against Attorney-Defendants, alleging legal malpractice, breach of contract, and breach of fiduciary duty. Attorney-Defendants filed various motions for summary disposition, arguing that Plaintiff failed to inform them of the indemnity agreement and that the malpractice claim was barred by the two-year limitation period as the last date of representation was December 17, 2010—the date that the amended judgment of divorce was entered. Attorney-Defendants further argued that the results-oriented fee did not constitute an impermissible contingency fee agreement under MRPC 1.5(d). Plaintiff opposed these motions, asserting that she provided Attorney-Defendants a copy of the Safeco indemnity agreement; that JFS's last date of service was February 24, 2013; that GLO's last date of service was October 20, 2012; and that Attorney-Defendants "violated their fiduciary duty of loyalty because the fee agreement included a contingent fee, which was unethical and void as against public policy."

The trial court concluded that the two-year limitations period had expired since Attorney-Defendants "stopped serving plaintiff with regard to the matter from which the malpractice claim arose on May 23, 2008." In reaching that conclusion, the court reasoned that Plaintiff should have known of her malpractice claim at the time the judgment of divorce was signed given her existing knowledge as to the Safeco indemnity agreement. Accordingly, Plaintiff's malpractice claim was time-barred and therefore not actionable. The court further held that Plaintiff's remaining claims were nothing more than "malpractice claims in disguise," and thus found that summary disposition was similarly appropriate. Plaintiff then appealed.

Ruling: The Court of Appeals affirmed the trial court's decision on the basis that Plaintiff's malpractice claim accrued on December 17, 2010—the date the amended judgment of divorce was entered—because the legal services rendered thereafter did not involve the divorce proceedings for which Attorney-Defendants were initially retained. The Court further held that Plaintiff's breach of fiduciary duty claim was a disguised legal-malpractice claim, and even assuming it was actionable, the results-oriented fee was neither improper nor unreasonable.

The Court first held that because Plaintiff failed to initiate suit within two years of when the malpractice claim first accrued, or within six months after she discovered or should have discovered the claim, the suit was untimely. A legal-malpractice claim accrues on the last day the attorney renders professional services for the client. But, notably, there is an "important distinction between an ongoing attorney-client relationship and a remedial effort concerning past representation." In this case, Plaintiff hired Attorney-Defendants for the specific legal service of representing her with respect to her divorce proceedings, as evidenced by the letter GLO sent to Plaintiff detailing the scope of representation and setting forth when that representation would conclude—the triggering date being the entry of the ultimate judgment of divorce. And because the amended judgment of divorce, entered on December 17, 2010, ultimately concluded the matter, Plaintiff's claim accrued on that date. While it was true that Attorney-Defendants provided legal services to Plaintiff after that date in connection with the Safeco indemnity agreement, that representation did not involve the divorce proceedings. Rather, those efforts "were more akin to remedial efforts concerning past representation." Attorney-Defendants therefore did not continue to serve Plaintiff "with regard to the matters out of which the claim for malpractice arose" because discontinuation occurred upon entry of the amended judgment of divorce on December 17, 2010. So that date controlled for purposes of determining when Plaintiff's malpractice claim accrued and, consequently, Plaintiff's claim was time-barred.

The Court further rejected Plaintiff's argument that "the last treatment rule," as espoused in *Levy v Martin*, 463 Mich 478; 620 NW2d 292 (2001), controlled. "The Michigan Supreme Court clarified in *Levy* that when a plaintiff receives professional services with regard to the

The Court further held that Plaintiff's breach of fiduciary duty claim was a disguised legal-malpractice claim, and even assuming it was actionable, the results-oriented fee was neither improper nor unreasonable.

specific event out of which the injury arises, as well as continuing services that are related to the specific event, the claim accrues when the continuing services end." Under Plaintiff's application of *Levy*, her malpractice claim would have been timely because the last services would have been rendered in 2012. Plaintiff's case, however, was distinguishable from *Levy* in that she hired Attorney-Defendants for the limited purpose of representing her in the divorce proceedings, and once those proceedings concluded, she re-hired Attorney-Defendants to represent her in a separate action—one specifically aimed at seeking indemnity from her ex-husband. As a result, Plaintiff could not invoke the last treatment rule to advance the accrual date and salvage her legal-malpractice claim.

Citing to the well-established principle "that the gravamen of an action is determined by reading the complaint as a whole, and by looking beyond mere procedural labels to determine the exact nature of [a] claim," the Court of Appeals further held that Plaintiff's claim for breach of fiduciary duty "was essentially a disguised legal malpractice claim since the gravamen of [the] claim was more akin to a breach of the standard of care." While a legal-malpractice claim allows a plaintiff to recover for negligence arising out of the attorney-client relationship, a breach of fiduciary duty requires a more culpable state of mind. That is, damages are recoverable for such a breach when "a position of influence has been acquired and abused, or when confidence has been reposed and betrayed." Because Plaintiff failed to allege in her complaint that Attorney-Defendants abused their position of influence or betrayed her confidence in connection with the preparation and signing of the fee agreement, her claim for breach of fiduciary duty was not properly pled. Accordingly, the trial court did not err in dismissing that claim alongside the claim for legal malpractice.

The Court of Appeals went on to hold that even assuming the breach of fiduciary duty claim was not a disguised malpractice claim, Plaintiff still failed to properly allege a claim for breach of fiduciary duty. First, the allegation that the fee arrangement violated MRPC 1.5(d) was of no consequence, since the Michigan Rules of Professional Conduct cannot give rise to a private cause of action. And second, the fee arrangement was not void as against public policy for the reason that it was not directly contingent on the outcome achieved. While the results-oriented provision allowed for an additional fee that was capped at 10% of the total amount recovered, the final fee was not actually contingent on the amount of recovery, but rather, on various other factors, such as the time and labor required and achievement of certain objectives and goals—all of which were outlined in the confirming letter that GLO sent to Plaintiff and none of which incentivized Attorney-Defendants "to induce or advise the dissolution of marriage ties." Moreover, the results-oriented fee, which was similar to a value enhancement clause often used in "high end" divorce actions, was not otherwise unreasonable for the reason that "significant assets and income" were at stake. Accordingly, the trial court did not err in refusing to consider the breach of fiduciary duty claim.

Practice Note: Providing clients with a written engagement letter at the inception of the representation that outlines the scope of professional services to be rendered, and sending the client a closing letter when those services have been completed, may later prove useful in defending against an action for professional malpractice.

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No-Fault Report

Recent Published Court of Appeals' Decision Potentially Exposes No-Fault Insurer to "Double Jeopardy" Regarding Payment of Medical Expenses![1]

On October 22, 2015, the Michigan Court of Appeals released an opinion which will almost certainly disrupt and complicate settlements of first-party no-fault insurance claims. In *Covenant Medical Center v State Farm Mut Auto Ins Co*, __ Mich App __; __ NW2d __; 2015 WL 6394188 (October 22, 2015) (Docket No. 322108), the Court of Appeals held, in a published (and therefore binding) opinion, that a no-fault insurer must pay almost $44,000.00 to a medical provider, even though the particular medical expenses were clearly contemplated in the settlement negotiations that led up to the $59,000.00 settlement agreement between State Farm and the injured claimant. As a result, the insurer is now obligated to pay over $100,000.00 in no-fault benefits even though it thought its exposure was limited to the $59,000.00 settlement with the claimant and his attorney. To understand why the Court's reasoning in this case is questionable, it is necessary to examine earlier published precedent from the Court of Appeals which, unfortunately was not discussed by the panel in *Covenant Medical Center*.

In 2002, the Court of Appeals recognized that medical providers had an independent cause of action against a no-fault insurer for payment of its medical expenses. See *Lakeland Neurocare Ctrs v State Farm*, 250 Mich App 35; 645 NW2d 59 (2002); *Regents of the Univ of Mich v State Farm*, 250 Mich App 719; 650 NW2d 129 (2002). This right to bring an independent cause of action was recently reaffirmed by the Michigan Court of Appeals in *Wyoming Chiropractic Health Clinic v Auto-Owners Ins Co*, 308 Mich App 389; 864 NW2d 598 (2014). However, the issue still remained whether the medical provider's right to recover benefits was somehow dependent upon the injured claimant's ability to recover no-fault benefits or was entirely independent of the claimant's right to recover benefits. The issue was believed to have been resolved in 2013, in the seminal case of *Michigan Head and Spine Inst v State Farm*, 299 Mich App 442; 830 NW2d 781 (2013). In *Michigan Head and Spine Institute*, the injured claimant had settled her claim for no-fault benefits with her insurer, State Farm. As part of the settlement, she agreed to waive any claims for payment of future medical expenses or other allowable expenses. Six months after signing the release, she commenced treatment at Michigan Head and Spine Institute. When State Farm refused to pay the medical expenses, Michigan Head and Spine Institute filed a complaint in the 46th District Court in the City of Southfield. State Farm moved for summary disposition, claiming that the release executed by the injured claimant barred Michigan Head and Spine Institute's cause of action. The District Court denied State Farm's motion for summary disposition and, instead, granted summary disposition in favor of Michigan Head and Spine Institute, ruling that the release executed by the injured claimant did not waive the provider's separate cause of action. The Circuit Court affirmed the District Court's ruling on appeal. State Farm then filed an application for leave to appeal with the Michigan Court of Appeals.

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To understand why the Court's reasoning in this case is questionable, it is necessary to examine earlier published precedent from the Court of Appeals which, unfortunately was not discussed by the panel in *Covenant Medical Center*.

On appeal, the Court of Appeals reversed the decision of both lower courts and essentially ruled that the provider's right to recover benefits was derivative of the injured claimant's right to recover benefits. Because the release provided that State Farm would be discharged from liability for any medical expenses "which may be incurred at any time in the future by or on behalf of" the injured claimant, the Court of Appeals indicated that it would not interfere with State Farm's expectation that, by settling with the injured claimant, it would no longer be exposed to future liability for payment of medical expenses.

In an important passage, the Court of Appeals noted that the provider was not without a remedy. **It could file suit directly against its patient for payment of the medical expenses.** In a final cautionary note, the Court of Appeals observed what would happen if it had allowed the provider to pursue the independent claim for medical expenses against the insurer, even though the insurer had settled those claims with the claimant directly:

> Moreover, upholding the lower court's decisions would have a chilling effect on settlements of claims involving future no-fault benefits because the decisions effectively nullify Biba and defendant's settlement. The parties did not intend that result considering the clear language of the release. [*Michigan Head and Spine,* 304 Mich App 440-441.]

Thus, this case seemed to establish the proposition that even though a provider had a right to file suit, its ability to recover was wholly derivative of the injured Claimant's ability to recover benefits. If the injured Claimant could not recover benefits, neither could the provider.

The demarcation line between a provider's right to file suit, and the provider's ability to recover damages based on that suit, was reaffirmed in *Moody v Home-Owners Ins Co*, 304 Mich App 415, 849 NW2d 31 (2014). As noted by the *Moody* Court:

> **While the providers may bring an independent cause of action against a no-fault insurer, the providers' claims against Home-Owners are completely derivative of and dependent on Moody's having a valid claim of no-fault benefits against Home-Owners.** Specifically, the providers' claims are dependent on establishing Moody's claim that he suffered 'accidental bodily injury arising out of the . . . use of a motor vehicle,' MCL 500.3105(1), that they provided 'reasonably necessary products, services and accommodations for [Moody's] care, recovery or rehabilitation,' MCL 500.3107(1)(a) and that at the time of the accident, Moody was 'domiciled in the same household' as his father who was insured by Home Owners, MCL 500.3114(1). The providers' and Moody's claims with respect to the requisites of Home-Owners' liability are therefore identical. [*Moody,* 304 Mich App 440-441 (emphasis added).]

As if to drive the point home further, the Court of Appeals went on to reaffirm an earlier decision from 2006, in which it held that the right to bring an action for no-fault benefits belongs to the injured party:

> Indeed, it is Moody's claim against Home Owners that providers are allowed to assert because the no-fault act states that 'benefits are payable to or for the benefit of an injured person,' MCL 500.3112. [Citation omitted]. But the providers' claims actually belong to Moody because 'the right to bring an action for personal protection insurance [PIP] benefits, including claims for attendant care services, belongs to the injured party.' *Hatcher v State Farm Mut Auto Ins Co*, 269 Mich App 596, 600, 712 NW2d 744 (2006). Thus, the injured party may waive by agreement his or her claim against an insurer for no-fault benefits, and a service provider is bound by the waiver. See *Mich Head & Spine Institute PC v State Farm Mut Auto Ins Co*, 299 Mich App 442, 447-449, 830 NW2d 781 (2013). If an injured party waives a PIP claim, a service provider's remedy is to seek payment from the injured person. [*Moody*, 304 Mich App at 442-443.]

It should be noted that the Michigan Supreme Court granted leave to appeal in the companion case, *Hodge v State Farm*, but this writer anticipates that the Supreme Court is more interested in the jurisdictional issues, as opposed to the independent cause of action/derivative right to recover issue referenced in the *Moody* decision. See *Hodge v State Farm Mut Auto Ins Co*, 497 Mich 957; 858 NW2d 462 (2015).

Building on these precedents was another published opinion from the Michigan Court of Appeals released earlier this year, *Clark v Progressive Ins Co*, 309 Mich App 387; __ NW2d __

As far as claims are concerned, the *Covenant Medical Center* decision effectively forecloses any settlements that may be negotiated by the insurer directly with the injured claimant or his or her counsel, so long as there is at least one unpaid medical expense lurking somewhere in the claims file.

(2015). In *Clark*, Plaintiff had sued her no-fault insurer, Progressive, seeking to recover no-fault benefits incurred as a result of a motor vehicle accident. Plaintiff eventually agreed to resolve the claim for $78,000.00. There was an email exchange between Progressive's adjuster and Plaintiff's counsel, which indicated that the $78,000.00 payment "would be for all benefits to date." The insurer knew that Plaintiff had incurred medical expenses totaling $28,942.00 as a result of her shoulder surgery some six months earlier, but Plaintiff's counsel was unaware of that bill. Plaintiff's counsel argued that if he had been made aware of the bill, he would not have settled the suit for $78,000.00. After briefing and oral argument, the Washtenaw County Circuit Court ruled that the $28,942.00 facility bill was not part of the $78,000.00 settlement agreement, and could be pursued through separate litigation, apparently adopting Plaintiff's argument that (1) Plaintiff had no knowledge of the bill prior to the settlement agreement; and (2) Progressive, which was aware of the charges, provided her with no notice of them.

On appeal, the Court of Appeals issued a rather scathing published (and therefore binding) opinion, chastising Plaintiff's counsel for attempting to impose a duty on an adversary to the proceedings which did not exist under law. After citing numerous cases about releases being a contract, "governed by the legal rules applicable to the construction and interpretation of other contracts" and decisions concerning the finality of settlement agreements, including the fact that "settlements are favored by the law, and therefore will not be set aside, except for fraud, mutual mistake, or duress," the Court of Appeals then discussed the roles of adversaries in civil litigation:

> In essence, plaintiff's attempt to invalidate the settlement agreement is a misguided effort to force Progressive or its counsel to perform a duty that should have been performed by her trial attorney. Before a plaintiff settles a case for all charges incurred to date, it is incumbent upon the plaintiff's attorney to ensure that he and his client consider all possible claims, so that the client makes an informed settlement. It is the lawyer's professional duty to ensure that his client is fully advised and aware of all the ramifications of such a settlement. And here, this means that plaintiff's trial attorney should have advised her that the settlement at issue wiped the slate clean prior to November 5, 2013.
>
> This professional obligation is the core duty of the plaintiff's lawyer – not the opposing party or its counsel. If the plaintiff's lawyer fails to fulfill this obligation – and does not ensure that he and his client consider all possible claims before signing a settlement agreement – the lawyer cannot shift this responsibility to the opposing party or opposing counsel. To do so would ignore the nature of contested litigation and the adversarial process, as well as the obligations of opposing counsel, which entail zealous representation of **his** client, not consideration of whether the plaintiff has thought of all the possible implications of a settlement agreement. ...
>
> Here, plaintiff seeks to engage in exactly this sort of obligation shifting: because her trial attorney did not consider that she might face additional (and perhaps unknown) charges for PIP benefits incurred before November 5, 2013 – i.e., the $28,942.00 Synergy billing – she argues that Progressive had a duty to inform her of this billing during the settlement negotiations. Of course, Progressive has no such duty. Progressive, as a defendant in litigation, is in an adversarial position with plaintiff and, as such, has every right to protect its interests and to expect that Court will uphold a settlement freely entered into by the parties. Progressive paid to buy its peace, not to advise plaintiff and her lawyer on how to settle a case. Were we to accept the proposition advanced by plaintiff, we would undermine the finality of settlements, and, perhaps, place opposing counsel in the untenable and conflicted position of advising two parties: his client on how to best settle a claim, and his opponent on what claims to include in a settlement. This we cannot and will not do.

Thus, because Plaintiff had agreed to release all claims for no-fault benefits incurred through a specific date, the medical provider, which undoubtedly had submitted its medical expenses to the insurer prior to the settlement, had no alternative but to seek payment of those expenses from the injured Claimant – not her no-fault insurer. Against this backdrop, let us examine what transpired in *Covenant Medical*

[I]t should be noted that Covenant Medical Center did nothing more than submit its medical records and medical bills to State Farm, as countless medical providers do on claims for no-fault insurance benefits.

Center v State Farm.

In *Covenant Medical Center*, State Farm's insured, Jack Stockford, was injured in a motor vehicle accident in 2011. In 2012, Stockford sought treatment at Covenant Medical Center and incurred medical expenses totaling $43,484.80. In November 2012, State Farm denied payment of those medical expenses on the basis that the need for the medical treatment did not arise out of the 2011 motor vehicle accident. Because Stockford was already involved in litigation with State Farm, State Farm and Stockford eventually agreed to resolve all claims for no-fault benefits incurred through January 10, 2013, for the sum of $59,000.00. **The settlement specifically contemplated the Covenant Medical Center bills** because the release contained a provision that Stockford would "indemnify, defend and hold harmless [State Farm] from any liens or demands made by any provider . . . including . . . Covenant Medical . . . for payments made or services rendered…in connection with any injuries resulting" from the accident. Based upon the aforementioned case law, State Farm reasonably believed that the $59,000.00 settlement would include the nearly $44,000.00 in medical expenses incurred by Stockford at Covenant Medical Center in 2012.

At this point, it should be noted that **Covenant Medical Center did nothing more than submit its medical records and medical bills to State Farm**, as countless medical providers do on claims for no-fault insurance benefits. There was no separate letter from Covenant Medical Center or its counsel demanding that payment be submitted only to Covenant Medical Center and to no one else – including the injured Claimant or his attorney.

Covenant Medical Center then filed suit against State Farm, seeking to collect the nearly $44,000.00 in medical expenses incurred by Stockford in 2012. State Farm moved for summary disposition, arguing that Covenant's claims were barred by the release that was executed between Stockford and State Farm, discharging State Farm from any and all liability for claims incurred through January 10, 2013. The trial court ruled in favor of State Farm and Covenant appealed.

On appeal, Covenant argued that because it provided "written notice" to State Farm, it was entitled to pursue payment of the nearly $44,000.00 in medical expenses from State Farm. In doing so, Covenant relied upon the provisions of MCL 500.3112, which states:

> Personal protection insurance benefits are payable to or for the benefit of an injured person or, in case of his death, to or for the benefit of his dependents. **Payment by an insurer in good faith of personal protection insurance benefits, to or for the benefit of a person who it believes is entitled to the benefits, discharges the insurer's liability to the extent of the payments unless the insurer has been notified in writing of the claim of some other person.** If there is doubt about the proper person to receive the benefits or the proper apportionment among the persons entitled thereto, the insurer, the claimant or any other interested person may apply to the circuit court for an appropriate order. The court may designate the payees and make an equitable apportionment, taking into account the relationship of the payees to the injured person and other factors as the court considers appropriate. [MCL 500.3112 (emphasis added).]

The Court of Appeals **agreed** with Covenant Medical Center's argument and noted:

> MCL 500.3112 provides that if the insurer does not have notice in writing of any other claims to payment for a particular covered service, then a good faith payment to its insured is a discharge of its liability for that service. However, the plain text of the statute provides that if the insurer has notice in writing of a third party's claim, then the insurer cannot discharge its liability to the third party simply by settling with its insured. Such a payment is not in good faith because the insurer is aware of a third party's right and seeks to extinguish it without providing notice to the affected third party. Instead, the statute requires that the insurer apply to the circuit court for an appropriate order directing how the no-fault benefits should be allocated. This was not done in this case. Accordingly, pursuant to the plain language of the statute, because State Farm had notice in writing of Covenant Medical's claim, State Farm's payment to Stockford did not discharge its liability to Covenant Medical. [*Covenant Med Ctr*, slip op at pp 2-3.]

The Court of Appeals went on to distinguish its earlier decision in *Michigan Head and Spine Institute* on the

[T]he Court of Appeals conflated the medical provider's ability to file an independent cause of action with the provider's derivative right to recover benefits, based upon what the claimant could or could not recover from the insurer, given the terms of the settlement.

basis that the medical treatment in that case occurred **after** the release had been signed. In *Covenant Medical Center*, the services were rendered **before** the settlement occurred. The Court of Appeals also failed to reference the key holdings in *Moody* and *Hatcher*. Finally, the Court of Appeals conflated the medical provider's ability to file an independent cause of action with the provider's derivative right to recover benefits, based upon what the claimant could or could not recover from the insurer, given the terms of the settlement and release.

Here are, in my opinion, the weaknesses of the Court's analysis:

- The Court failed to reference its earlier decision in *Hatcher v State Farm*, 269 Mich App 596, 600; 712 NW2d 7404 (2006), which unequivocally held that "the right to bring an action for personal protection insurance [PIP] benefits, including claims for attendant care services, belongs to the injured party" – not necessarily the medical provider;
- The Court of Appeals' attempt to distinguish its earlier holding in *Michigan Head and Spine Institute PC*, is unavailing – a release is a release, no matter when it is executed and no matter what information the plaintiff may have had at the time of signing the release;
- The Court of Appeals fails to mention the *Clark* decision anywhere in its opinion regarding the finality of settlements – again, in *Clark*, the insurer was well aware of the $28,942.00 charges that remained unpaid, yet the Court of Appeals, in a published decision, held that the settlement was final. Under *Covenant Medical Center*, there would be nothing (except the one-year-back rule) to prevent the provider in *Clark* from filing a separate cause of action and getting paid by the insurer, even though it was definitely not the intent of the parties, in *Clark*, to expose the insurer to such additional liability;
- It fails to recognize the practical realities of settlement in first-party no-fault PIP litigation;
- Finally, if one examines the language of MCL 500.3112 in context, one discovers that it is designed to cover claims for survivor's loss benefits – not claims between injured claimants and their medical providers. The last part of the first sentence in MCL 500.3112 discusses survivor's loss benefits being paid "to or for the benefits of his dependents." The last sentence of this section specifies the individuals to whom survivor's loss payments are to be made, in the absence of a court order. In this regard, the Court of Appeals erred by focusing in on one isolated sentence, instead of understanding the context within which the sentence that was relied upon by the Court of Appeals appears.

As far as claims are concerned, the *Covenant Medical Center* decision effectively forecloses any settlements that may be negotiated by the insurer directly with the injured claimant or his or her counsel, so long as there is at least one unpaid medical expense lurking somewhere in the claims file. This is because even if money is paid directly to the injured claimant and his attorney, and even if a release is signed, the medical provider still has the ability to seek payment of its expenses, above and beyond that paid to the claimant and his or her attorney. This is true even though the release may specify that all claims for medical expenses are being resolved by the release. Instead, the insurer may need to retain counsel to file an action in the Circuit Court and to provide notice to all providers with unpaid medical bills that their interests are about to be extinguished by virtue of the proposed settlement and release.

Unless modified on appeal by the Michigan Supreme Court,[2] or challenged in a subsequent decision by the Michigan Court of Appeals, the Court of Appeals' decision in *Covenant Medical Center* will most certainly complicate settlements of PIP claims, and could very well end up clogging the dockets of the circuit courts throughout this state, as a motion to approve settlement and to determine proper payees will need to be filed on practically every PIP claim currently in litigation.

Endnotes

1. This report is an edited version of the author's analysis of the *Covenant Medical Center v State Farm* decision, which appeared in the firm's newsletter. The opinions expressed herein are solely those of the author.
2. State Farm filed an application for leave to appeal in the Michigan Supreme Court on December 3, 2015.

Supreme Court

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Supreme Court Update

Governmental Employees May Be Entitled to Immunity Under the Fireman's Rule Even When They Were Grossly Negligent

On January 4, 2016, the Michigan Supreme Court held that a governmental employee may still be entitled to tort immunity for injuring a police officer or firefighter, despite the employee's gross negligence. *Lego v Liss,* __ Mich __; __ NW2d __; 2016 WL 39629 (2016) (Supreme Court Nos. 149246 & 149247).

Facts:A police officer was shot and injured by another police officer while attempting to apprehend an armed-robbery suspect. The injured officer and his wife filed a lawsuit against the other officer, alleging that he was grossly negligent in shooting the injured officer.

The defendant moved for summary disposition under MCL 600.2966 (the "Governmental Fireman's Rule") which provides that governmental employees are "immune from tort liability for an injury to a firefighter or police officer that arises from the normal, inherent, and foreseeable risks of the firefighter's or police officer's profession." The trial court denied the defendant's motion.

The Court of Appeals affirmed in an unpublished opinion per curiam, finding that the applicability of the Governmental Fireman's Rule could not be determined as a matter of law under the facts which could support a finding of gross negligence. The Court of Appeals reasoned that, if the defendant did engage in the grossly negligent conduct alleged, he would not be entitled to immunity under the Governmental Fireman's Rule because the injury would not have arisen out of the "normal, inherent, and foreseeable risks" of the profession. The Court of Appeals relied on *Rought v Porter*, 965 F Supp 989 (WD Mich, 1996), in which the court denied a defendant summary disposition under the Governmental Fireman's Rule in an analogous case. *Rought* reasoned that when an officer fails to follow department policies, resultant injuries to another officer might not be a normal risk of the profession.

Ruling: The Michigan Supreme Court reversed the Court of Appeals. The Court disapproved of the Court of Appeals' reliance on *Rought v Porter*, finding it to be non-binding and unpersuasive. The Court explained that the Court of Appeals' interpretation of the Governmental Fireman's Rule conflicted with MCL 600.2967, which provides that a police officer or firefighter may recover damages from a non-governmental employee for injury "arising from the normal, inherent, and foreseeable risks of his or her profession" only if the injuring party was, among other mental states, grossly negligent. The Court noted that the Governmental Fireman's Rule possessed no such exception for gross negligence. As such, the Court found that to consider the degree of recklessness in determining whether immunity under the Governmental Fireman's Rule is applicable would undermine the statutory language and the clear purpose of the statute to provide immunity to governmental defendants. The Court therefore held that the defendant officer was entitled to summary disposition under the Governmental Fireman's Rule as a matter of law, despite the possibility that he was grossly negligent.

Practice Note: This opinion clarifies the status of the Governmental Fireman's Rule, which had become unclear after the *Rought v Porter* decision and the Court of Appeals' decision underlying the present opinion.

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MDTC Schedule of Events

2016

May 12-14	Annual Meeting – The Atheneum, Greek Town
September 21-23	SBM Annual Meeting – Grand Rapids
September 21	Respected Advocate Award Presentation – Grand Rapids
October 6	MDTC Meet the Judges – Sheraton, Novi
October 19-23	DRI Annual Meeting – Boston
November 10	MDTC Board Meeting – Sheraton, Novi
November 10	Past Presidents Dinner – Sheraton, Novi
November 11	Winter Meeting – Sheraton, Novi

2017

June 22-24	Annual Meeting – Shanty Creek, Bellaire
Sept 27-29	SBM – Annual Meeting – Cobo Hall, Detroit

2018

May 10-11	Annual Meeting & Conference – Soaring Eagle, Mt. Pleasant

2019

June 20-22	Annual Meeting – Shanty Creek, Bellaire

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Medical Malpractice Report

Helping Your Client Navigate a Licensing Investigation

Societal trends breed practice trends. One of the hottest issues in modern healthcare is the management of chronic pain. Treatment is being monitored and evaluated by state licensing agencies against a backdrop of epidemic proportions of prescription drug addiction and overdose.[1] The severity of the epidemic is such that even the Oval Office[2] has entered the dialogue, which has resulted in increased enforcement of physician licensing obligations with respect to prescribing narcotic pain medications. Physicians providing long-term pain management, particularly to large segments of their patients, put themselves at risk of significant scrutiny. Healthcare attorneys are frequently involved in defending clients in licensing actions involving chronic pain management.

The goal of this article is to provide healthcare defense counsel with the tools necessary to defend a physician in a licensing action based on the prescription of narcotics for the treatment of chronic pain.

Licensing Actions

In the course of representing physicians, it is likely that you will be asked to assist a client in a state licensing action. These actions have distinct procedural aspects. It is important to become familiar with how a licensing action proceeds from investigation to final resolution.[3] A licensing action can have serious short and long-term consequences for a physician. These range from mere inconvenience and potential harm to one's reputation arising from the investigation alone,[4] to significant fines, license revocation, and mandatory reporting to patients, privileging facilities, and the National Practitioner Data Bank.

Physicians, who prescribe narcotic pain medication to a large patient population, have a markedly increased likelihood of becoming the subject of a state investigation. In the case of fatal overdose, a state investigation is inevitable. Of some irony is the fact that the same automated prescription service that allows physicians to monitor what prescriptions a patient is taking, can be used by the state medical board to monitor the prescriptions physicians are writing. In the event of an overdose death, the police or medical examiner investigation may trigger state action.

Not all state licensing investigations result in discipline. It is best to involve legal counsel early on. A strong defense at the investigation stage can help prevent a disciplinary record. The worst response to a state investigation is no response at all. Unfortunately, some physicians ignore an initial request for information, or believe an investigation will "go away" if they do not acknowledge it.

In the case of actions involving pain management practices, some specific ground rules apply: understand the basic principles of chronic pain management; get to know your client; understand the client's approach to the treatment; understand the medical records; consider the input of an independent expert; and, always follow your instincts.

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Healthcare attorneys are frequently involved in defending clients in licensing actions involving chronic pain management.

Basic Principles of Chronic Pain Management

One key skill that effective and defensible pain management physicians have is the ability to recognize certain patient behaviors that send up red flags. Watch for these behaviors reflected in the medical records or mentioned in the investigation documents:

- Requesting specific drugs by name and/or in specific dosages;
- Requesting increased dosages of medication;
- Losing prescriptions or medications;
- Claiming prescriptions or medications were stolen;
- Requesting early refills;
- Offering subjective complaints inconsistent with objective observations; and
- Going to multiple physicians.

If your client appears to have failed at recognizing these behaviors, it is important to understand why. That means sitting down with the client, the medical records and the investigation documents, and going through the process of analyzing what occurred. If you conclude that your client lacks experience, education or training, there are numerous resources available to enhance your client's knowledge.[5]

Physicians want to ease the suffering of patients. A compassionate but naïve physician can be easily seduced into enabling a long-time patient to sustain an addiction. If your client becomes defensive in the course of your attempts to understand his or her decisions, this should be a red flag for **you**.

Exemplar best practices in long-term pain management, which will significantly help in defending your client, include the following:

- Clear documentation of the reason for prescribing the medication;
- The patient has signed a pain-management contract;
- Frequent urine and/or blood screens;
- Frequent automated prescription service reports;
- The results of the screens and reports are recorded and acted upon;
- The patient is regularly counseled about drug dependence and it is documented;
- Patients are referred for psychiatric/psychological counseling when appropriate;
- The physician communicates and documents concerns of suspected misuse/abuse; and
- Noncompliant patients are referred to a pain-management specialist or rehab.

Be on the lookout for the following "worst" practices, reflected either in the medical records or in the course of discussing the records with your client:

- Reliance on electronic medical record (EMR) systems to explain actions;
- Reliance on (or blaming of) EMR to explain a lack of documentation of the reasons for providing care and/or concerns about the care;
- A physician who considers only the medication a patient reports;
- Not discussing or recommending pain-treatment modalities other than medication; and
- Allowing repeated episodes of non-compliance by the patient.

A good physician consistently uses a fresh set of eyes and ears, as well as objective information, to evaluate long-term pain-management patients, no matter how long the relationship, or how well they think they know them. Some patients need a multidisciplinary center where they can have the expertise of a pain management specialist **and** treatment for dependency. When your client understands this, even in retrospect, it may go a long way towards easier representation in a licensing action.

Defending a licensing action that involves a fatal overdose poses some additional unique challenges. This is a devastating outcome in the management of chronic pain for the physician and the patient's family members. Your client's culpability, if any, for an overdose will depend on several factors. Since a licensing action is typically instigated months or more following the death, you are likely to have had little say in the following:

- Medical examiner's investigation;
- Autopsy results;
- Toxicology screenings; and
- Characterization of the overdose as accidental or intentional.

The medical examiner is charged with investigating reportedly suspicious deaths. This investigation can set the scene for how other information is interpreted. The medical examiner will

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order an autopsy in every case they determine to be suspicious. In a suspected overdose, toxicology screens are the only scientifically reliable evidence to support or refute the role of prescribed substances, if any, in the patient's death. If no toxicology screens were performed, look carefully at the circumstances surrounding the death that might refute an overdose.

A fatal overdose is usually categorized as "accidental" or "intentional" based on the medical examiner's investigation. While civil culpability typically does not attach to an intentional overdose,[6] the state medical board may investigate an overdose death, regardless of the determination of accident or intent, to determine the physician's competence with reference to the treatment provided.

In an overdose death or other adverse outcome, your client may be tempted to "supplement" the medical record with information that, in retrospect, they wish was there. Manual alterations of paper records are easy to identify and are a crime in Michigan.[7] In limited situations when it is absolutely necessary to amend a medical record, an appropriate late entry can be made. A late entry should be dated and noted as to why it is late. Your client should be able to clearly explain any late entry in the event of a licensing investigation. Electronic records create an "audit trail" of any attempt to change or amend information in the records, making it impossible to alter an EMR without leaving an electronic footprint.

Under some limited circumstances, a summary of the patient's care can be included in the medical records. Such a summary can provide the explanation for certain actions when the record is deficient.[8] If your client insists on preparing such a summary, they must resist the temptation to over-explain their actions, express regret, or make other emotional appeals. Make sure they understand that they are supplementing a medical record, not explaining an unexpected outcome. Explanations and emotional entreaties are best kept within the auspices of attorney-client (or some other recognized) privilege.[9]

One aspect of a licensing action that sets it apart from defending a civil suit for malpractice is the importance of retrospect. Retrospect can be the bane of defending a malpractice case.[10] In a difficult licensing action, a bit of reflection and remediation often bring about a better outcome. Encourage your client to honestly assess their actions and potential for improvement. Encourage your client to seek out ways to improve practices as early as possible. If your client's actions are difficult to defend, the defense is easier when the client acknowledges this and wants to do something about it. Demonstrating the desire to enhance competency can have impressive effects.

As healthcare defense attorneys, we remind our clients of the worst experiences of their lives. It is truly a love/hate relationship in many respects. If your client resists your inquiries and counsel, it may simply be the stress and anxiety they are feeling due to the circumstances. It is important to root out the cause of a client's defensive behavior. Ultimately, if the client doesn't understand the obligation to explain treatment decisions, it is the good advocate's responsibility to explain the consequences of that position.

Know Your Client

Physicians come in all shapes, sizes, and temperaments. Law is, at best, foreign territory for most healthcare providers. Get to know your client's disposition, especially their ability to listen and accept constructive advice. Determine how well your client knows "thyself." If the client's actions and words are not in accord, the good advocate cannot run for cover. You must zealously represent the client, which means pitching the tough questions their way and holding their feet to the fire.

Ideally, you have a great rapport with a forthright client who is objectively defensible. At the other end of the spectrum, you may find yourself trying hard to like an arrogant client who sees the entire proceeding as a radical, unfounded blindsiding. Most of the time, your client will fall some place between these extremes. If the client seems competent but anxious, try to help the client deal with their anxiety. If the client seems reluctant to admit to anxiety, you can recommend enlisting the support of a spouse or family member.

When your client feels responsible for an adverse outcome, or questions his or her own competence, it is essential to recognize this. Help your client by offering resources such as psychological counseling or continuing educational opportunities. Your experience as counsel, concern for the client, and demonstrated confidence in the process, are important.

Medical and Other Records

You may find yourself defending a multi-patient disciplinary action or a

In a difficult licensing action, a bit of reflection and remediation often bring about a better outcome. Encourage your client to honestly assess their actions and potential for improvement.

case in which the medical records are voluminous. It may be a service to your client to have a skilled paralegal review and summarize the records. The records always provide the essential information necessary to plan a defense. Make sure they are reviewed in great detail. Have the client clarify any missing or undecipherable information. It is essential that you and the client know the records "cold" to properly defend the case.

In a licensing action related to prescribing practices, it is important to review the medical records and the state's file materials against the backdrop of the "Michigan Guidelines For The Use Of Controlled Substances For The Treatment Of Pain." The guidelines will be cited – but may not be quoted – in the state's investigative and/or disciplinary documents. The actual guidelines are found on the Michigan Department of Community Health website.[11] If you retain an expert, make sure that the expert also has a copy of the guidelines and compares your client's care to what those guidelines instruct.

You and your client are entitled to see the state's investigation file, including any medical records procured by the state investigator. Any information provided by the state must be compared to the medical information provided by the client. All parties should have the same, complete information. Be sure to review the state investigator's comments in detail. You may find positive comments that enhance your defense. You may also find contradictory comments that indirectly help your defense. Certainly, you will get a flavor for the most salient issues and allegations.

Expert Opinions

Consider getting an expert opinion to shore up your defense. The input of an expert is strongly recommended when you and your client believe the care is defensible and the records can support that conclusion. An expert can get involved as early as the investigation stage. Sometimes a qualified expert can provide information that dissuades the state from pursuing further disciplinary action. When you are confident about your defense, it is practical to share your intent to retain an expert with the state. Typically, the proceedings will be held in abeyance pending the expert review.

Select your expert with care. You want someone who can address the specific issues in your case.[12] If your client is an internist with a large population of chronic pain patients, you want to find a similarly practicing internist. Any relationship between your expert and your client will be very important to the state. It is important to select someone that is neither an indirect colleague, nor a competitor.

You may want an expert opinion because you are not sure how defensible your case really is. Retain the expert and get their input as early on as possible. The plan of defense can be designed based on the expert's findings and conclusions. If your first expert review is negative but equivocal, investing in a second expert may be well worth the time and expense. Always involve your client in these decisions.

Instincts

Good instincts are important. When you are charged with handling an important matter that may affect your client's life and livelihood, it is imperative to follow your instincts. Your instincts about the client will guide what you do and what you recommend. Your instincts about the treatment your client provided can help guide how vigorously the care is defended. Do not confuse instincts with assumptions. Instincts are reactions you feel in your gut. Assumptions are conclusions based on "logic."

If you get to know your client, and get to know the records related to your client's case, you should be prepared for even the toughest conversations and case handling. Understand the case thoroughly so that you can give your best advice based on all of the information, as well as what your gut tells you. With your experienced, knowledgeable assessment and assistance, the client can be sure that going forward they are getting the best defense possible.

Conclusion

There are several schools of thought about the current trend of increasing investigations of physicians who prescribe narcotic pain medication. Some physicians feel the government is on a "witch hunt," or that ultimately the patients who need medication are the real losers in the political debate. Other physicians are pleased that the government is uncovering prescription-drug fraud and calling out "script doctors" through these efforts. Certainly, there is a large population of primary care providers who do not believe these issues pertain to them. In reality, they are the most likely to be the subject of an investigation. An understanding of the issues, the process, the practical work,

In a licensing action related to prescribing practices, it is important to review the medical records and the state's file materials against the backdrop of the "Michigan Guidelines For The Use Of Controlled Substances For The Treatment Of Pain."

the mutual expectations, and "public opinion" on this topic is intended to instill confidence in the attorney handling such a matter.

Endnotes

1 According to the National Institute on Drug Abuse 2011 statistics, *National Institute on Drug Abuse, Popping Pills: Prescription Drug Abuse In America*, www.drugabuse.gov in 2010, enough painkillers were prescribed in the United States to medicate every American adult every four hours for one month. Painkillers exceeded tranquilizers 2:1 as the most abused prescription drugs.

Megan Brooks reported in her June 17, 2015 article on www.medscape.com that prescription-drug overdoses were reported to be the leading cause of deaths from injury in the U.S.

According to a report in Sports Illustrated, there are epidemic levels of opioid addiction among high school athletes prescribed opioid pain medication to treat an acute injury. Many high school athletes become addicted, get cut off from their pain prescriptions, and turn to heroin. Wercheim, L. Jon and Rodriguez, Ken; *Smack Epidemic: How Painkillers are Turning Young Athletes into Heroin Addicts*, Sports Illustrated (June 22, 2015).

2 Lowes, Robert, *Obama Plan for Opioid Abuse Stresses Prescriber Training*, www.medscape.com, October 22, 2015.

Gray, Kathleen, *Increase in Drug Abuse, Death Prompts State Action Plan*, Detroit Free Press (October 26, 2015).

3 Fortunately, Kelly Elizondo, a Michigan Assistant Attorney General with the Healthcare Division, wrote an excellent article describing the procedural aspects of state licensing investigations and disciplinary actions. Elizondo, *Cracking the Case: How to Decipher the Unique Procedural Twists in a Health Professional Licensing Action, 94* Mich B J 52 (July 2015).

4 State licensing investigations are confidential, but the process can be very intrusive. Investigations typically cause a level of upheaval within the intra-office framework of the medical practice. The residual of this upheaval can permeate the clinical practice and the community.

5 There are many educational resources and programs available to enhance a physician's knowledge of prescribing for chronic pain, including:

- CO*RE, the Collaborative on REMS Education, based on the FDA's approved Risk Evaluation and Mitigation Strategy for Extended Release and Long Acting Opioid medications. CO*RE hosts educational programs on a national level, including through many state medical societies/associations.
- Medical professional organizations, including the American Academy of Pain Management, offer courses related to controlled substance and pain management. http://www.aapainmanage.org.
- Read Rita Volchayev, PhD's course outline for "Pain Management 101" conducted by the National Institutes of Health, then take the course: www.clinicalcenter.nih.gov/ccc/nurse_practitioners/pdf/pain_management_slid.pdf.

6 If an overdose was intentional, similar to other acts of suicide, civil culpability will typically not attach. Most jurisdictions subscribe to the principle that suicide is an unpredictable and unpreventable event. See, e.g., *Teal v Prasad*, 283 Mich App 384, 392; 772 NW2d 57 (2009).

7 MCL 750.492a provides

(1) Except as otherwise provided in subsection (3), a health care provider or other person, knowing that the information is misleading or inaccurate, shall not intentionally, willfully, or recklessly place or direct another to place in a patient's medical record or chart misleading or inaccurate information regarding the diagnosis, treatment, or cause of a patient's condition. A violation of this subsection is punishable as follows:

(a) A health care provider who intentionally or willfully violates this subsection is guilty of a felony.

(b) A health care provider who recklessly violates this subsection is guilty of a misdemeanor, punishable by imprisonment for not more than 1 year, or a fine of not more than $1,000.00, or both.

8 In a civil malpractice case, "failure to document" in the medical record is ***not*** a recognized theory of recovery, on the basis that writing something in the medical record – or not – could never cause or prevent an injury. See, e.g., *Boyd v Wyandotte*, 402 Mich 98; 260 NW2d 439 (1977). The sufficiency of medical record-keeping is important in a state licensing investigation.

9 Such as spousal, priest-penitent, or therapist-client.

10 In malpractice actions, defense attorneys often lament that the plaintiff's case is built on hindsight based upon a bad outcome, and argue that physicians practice prospectively, and are not held to a standard of omniscience.

11 www.mich.gov/document/mdch_MI_guidelines_91795_7.pdf.

12 In another example, don't hire your "favorite" vascular surgeon if the real issue is the appropriateness of performing certain procedures at an outpatient surgical center and not a hospital. Make sure your expert practices at an outpatient surgical center. Otherwise, that individual will lack the specific background to speak with weight and credibility on the issues.

Meet the MDTC Leaders

A key component of MDTC's mission is facilitating the exchange of views, knowledge, and insight that our members have obtained through their experiences. That doesn't happen without interaction. And interaction doesn't typically happen until you've been introduced. So, in this section, we invite you to meet the new (and, possibly, some not-so-new) MDTC leaders who have volunteered their time to advance MDTC's mission.

MEET: Vanessa McCamant

Vanessa is a partner at Aardema Whitelaw PLLC in Grand Rapids. Her concentration is on the defense of medical malpractice claims. She graduated from DePaul University College of Law in Chicago in 2004.

More about Vanessa

Q: *What's the most unusual thing in your desk drawer?*
A: Soy sauce.

Q: *How old were you when you had your worst haircut and what style was it?*
A: In high school, I essentially had a buzz cut.

Q: *If you weren't doing what you do today, what other job would you have?*
A: Deep-sea charter fisherwoman in the Caribbean.

Q: *What "lesson from mom" do you still live by today?*
A: If you don't have fun, it's your own fault.

Q: *If you could be any animal what would it be and why?*
A: I would be a seagull because they get to spend every day at the beach.

How to contact Vanessa

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MEET: Stephanie L. Arndt

Stephanie L. Arndt joined the defense bar in 2015 after several years of litigating on behalf of personal-injury plaintiffs. Throughout her career, Stephanie has litigated a variety of matters in both state and federal court. While her practice has largely focused on nursing-home negligence and medical-malpractice cases, Stephanie also has a growing real-estate practice and has defended developers in a variety of actions.

Stephanie is committed to improving the legal profession. Currently, she is a member of the Oakland County Bar Association, MDTC, and DRI. She also serves on the Oakland County Bar Association's Case Evaluation Committee.

At MDTC, Stephanie is the current chair of the Annual Meeting, co-chair of the Trial Section, and assists with the Social Media Committee.

More about Stephanie

Q: *What's the most unusual thing in your desk drawer?*
A: A collection of stress balls from various seminars.

Q: *How old were you when you had your worst haircut and what style was it?*
A: I don't remember how old I was. It was traumatic and looked like a reverse mullet.

Q: *If you weren't doing what you do today, what other job would you have?*
A: I would work for a charity. I love volunteering.

Q: *What "lesson from mom" do you still live by today?*
A: My grandpa's motto was "never dishonor your family."

Q: *If you could be any animal what would it be and why?*
A: I have no idea. Probably a dog. They seem to have a very relaxed life.

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