ORIGINAL

No. 10-0667

In the Supreme Court of Ohio

APPEAL FROM THE COURT OF APPEALS
SECOND APPELLATE DISTRICT
GREENE COUNTY, OHIO
CASE NO. 2009-CA-0006

THE MEDICAL ASSURANCE COMPANY, INC.,

Plaintiff-Appellant,

v.

ROBERT P. DILLAPLAIN, M.D., et al.,

Defendants-Appellees.

MEMORANDUM IN SUPPORT OF JURISDICTION OF APPELLANT MEDICAL ASSURANCE COMPANY, INC.

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I. Explanation of why this case involves an issue of public and great general interest.

The 2-1 decision of the Second Appellate District in this matter does to "claims made" medical malpractice insurance coverage what *Scott-Pontzer v. Liberty Mut. Fire Ins. Co.* (1999), 85 Ohio St.3d 660, did to uninsured/underinsured motorist coverage—expand the coverage provided so drastically as to threaten the continuing availability of this affordable form of insurance.

The error arises out of the majority's misunderstanding of the basic nature of a claims-made policy—a type of policy that has not been examined by this Court. The risk insured in most liability policies is an "occurrence." But often the person injured in the occurrence may not file a "claim" against the insured for months or years, well after the liability policy in effect at the time of the occurrence has expired. The risk insured in a claims-made liability policy, on the other hand, is that later-arising claim. Thus, the policy covers all "claims made" during a policy period—for example, 2002 to 2003—even though the "occurrence" giving rise to the claim may have happened in 2000 or 2001, before coverage under the claims-made policy attached.

Most claims-made policies do not provide coverage for *all* claims made in the policy period; they usually set an outermost time limit—the "retroactive date"—for the occurrence giving rise to a claim. Thus, a claims-made policy with a policy period of 2002-2003 and a retroactive date of 1983 would cover all claims (1) made in 2002-2003, that (2) arise out of occurrences in 1983-2003. The policy would not cover a claim made in 2002-2003 stemming from an occurrence in 1982.

Claims-made policies are particularly advantageous for physicians because the medical malpractice statute of limitations is tolled for minors, who may file a claim for medical malpractice many years after the "occurrence" of the alleged medical malpractice. They are also advantageous because the retroactive date of the policy allows physicians to fill any "gaps" in coverage from previous years. And claims-made policies are affordable for the physician because the insurer knows with certainty when its coverage obligations begin and end and can price the coverage accordingly. In the scenario above, for example, the insurer is only liable for claims made in 2002-2003, or for a period of time beyond 2003 if an extended reporting provision existed. The insurer can therefore price that coverage more affordably than it could for occurrence policies that cover all "occurrences" in a policy period, which would extend coverage obligations indefinitely into the future (such as asbestos claims made 25 years after the "occurrence" triggering coverage).

Here, the Second District confused the timing of *coverage* with the timing of the *risk of loss*. It misinterpreted a "previously reported" exclusion in the policy that is premised, in part, on the "first date coverage is provided under the policy." The majority held that coverage under the policy—a policy that, like the example given, has a policy period of 2002-2003 with a retroactive date of 1983—attaches *in 1983*. That is wrong. Coverage attaches no earlier than 2002, as it should be. This is so because coverage under a claims-made policy is triggered by the *reporting* of a claim in the policy period, or any extended period beyond the policy period. And because the *reporting* of a claim

cannot occur before the insurer issues the policy, the duty of coverage cannot arise before the policy period begins.

The reason for the limitation is clear—claims reported to other insurers before the claims-made policy period begins are the responsibility of the previous insurer. But not according to the Second District. The majority surmised that a claim first made to another insurer in 1995—before the policy period begins but after the retroactive date—was the responsibility of the insurer issuing a claims-made policy with a policy period of 2002-2003 and a retroactive date of 1983 because the policy protected the risk of loss all the way back to 1983.

Judge Grady, in dissent, concisely explained the majority's error as follows:

> The trial court's analysis confuses the point in time after which a risk of loss can occur for which Medical Assurance owes a duty to provide coverage on a claim made by Dr. Dillaplain, with the point in time when Medical Assurance assumed the duty of coverage it owes. Medical Assurance assumed that duty on January 1, 2002, when the policy it issued to Dr. Dillaplain became effective. The risk of losses to Dr. Dillaplain which the policy covers can arise from medical incidents that occurred as early as January 27, 1983, but no coverage was **then** provided, because no duty of coverage **then** existed. Instead, coverage "is provided" under the terms of the policy only on and after January 1, 2002, when claims by Dr. Dillaplain requiring coverage may be made. (Emphasis sic.)

See 3/5/10 Op., Appx. 17-18. Judge Grady recognized that the insurer's duty of coverage could not have existed before the beginning of the policy period regardless of the policy's retroactive date because the retroactive date—a risk-of-loss *timing* concept—is distinctly different from the policy period-imposed duty of coverage. Stated differently, the

retroactive date merely sets the *risk of loss* time period; it neither creates coverage nor imposes a duty of coverage upon the insurer.

Unfortunately, Judge Grady was the dissenting judge. The majority, unaware of the fallacy it had created, effectively converted a one-year claims-made policy into an almost 20-year "occurrence" policy. This rewriting of the parties' contract—reminiscent of the days of *Scott-Pontzer*—drastically expands coverage beyond the parties' intent and will directly impact not only the cost of claims-made liability insurance, but an insurer's decision to offer this type of insurance in the first instance. Because the continued availability of affordable claims-made medical malpractice insurance is a matter of public and great general interest to both insureds and insurers, and, indeed, all Ohio citizens, this Court should address this important matter of first impression.

II. Statement of the case and facts

A. Robert P. Dillaplain, M.D., becomes an insured under a claims-made professional liability policy issued by The Medical Assurance Company on January 1, 2002.

Defendant-appellee Robert P. Dillaplain—an obstetrician—applied for, and subsequently purchased, a claims-made professional liability policy from plaintiff-appellant The Medical Assurance Company. Effective January 1, 2002, the policy's insuring agreement provides that Medical Assurance would pay, on Dr. Dillaplain's behalf, any legally obligated damages due to any medical incident that occurred after the policy's retroactive date, as long as the claim was "first reported" during the policy period. The policy's stated policy period is from January 1, 2002 to January 1, 2003—the period of time within which the duty of coverage can be triggered. The policy's

retroactive date is January 27, 1983—the date on or after which the medical incident must have occurred when the duty of coverage is triggered. See 3/5/10 Op., Appx. 4-5.

The policy also contains an extended reporting endorsement, which amends the policy's insuring agreement and operates to extend the reporting period beyond the policy period's January 1, 2003 end date. See 3/5/10 Op., Appx. 5-6.

The policy also contains several exclusions, including exclusions for previously reported and known medical incidents. Known as Exclusion K in the policy, it excludes, among other things, coverage for medical incidents reported to another insurer before the "first date coverage is provided under the policy." Id., Appx. 5.

B. Dr. Dillaplain is sued in May 2005 for a medical incident occurring in 1993-1994, which he first reported to another insurer in 1995.

Intervening defendant-appellee Cheryl Neer became a patient of Dr. Dillaplain sometime in 1993,[1] when she was pregnant with her son Jeffrey Coleman, Jr. Dr. Dillaplain was not insured by Medical Assurance at this time, but was instead insured by since-liquidated P.I.E. Mutual Insurance Company. In March 1994, Neer presented to intervening-defendant Greene Memorial Hospital and Jeffrey Jr. was born sometime thereafter, allegedly with birth-related injuries.

In February 1995—while Dr. Dillaplain was still insured by P.I.E.—Neer and Jeffrey Coleman, Sr. (collectively the "Colemans") notified Dr. Dillaplain that they were considering bringing an action against him stemming from professional care and

[1] The trial court's decision incorrectly states that Neer's treatment and Jeffrey Jr.'s birth occurred in 1983.

treatment surrounding the labor and delivery of Jeffrey Jr. Shortly thereafter—in March 1995—Dr. Dillaplain notified P.I.E. of the claim and P.I.E. assigned counsel to defend against the claim. Id., Appx. 6.

In May 2005, Neer, as the natural guardian of Jeffrey Jr., sued Dr. Dillaplain, among others, in Greene County Common Pleas Court. Captioned *Jeffrey Coleman, et al. v. Robert P. Dillaplain, M.D., et al.* and designated case number 2005CV0381, Neer asserted several negligence-based medical claims related to the obstetrical care she received during Jeffrey Jr.'s March 1994 birth.

C. Medical Assurance seeks declaratory relief under the previously reported exclusion, but the trial court finds coverage.

Although Medical Assurance agreed to provide a defense for Dr. Dillaplain in the underlying lawsuit, it did so under a reservation of rights. Contemporaneously, it sought a declaration that it had no duty to defend or indemnify Dr. Dillaplain under the policy's previously reported exclusion. The Colemans and the hospital thereafter intervened.

The trial court ultimately resolved cross-motions for summary judgment in favor of coverage. Relying on the extended reporting endorsement alone, the trial court magistrate found that the language of the endorsement is "clear and unambiguous" and imposed a duty of coverage as of the 1983 retroactive date. The magistrate thereafter concluded that because the 1983 retroactive date is the "first date coverage is provided under the policy," the previously reported exclusion did not bar coverage because Dr. Dillaplain neither reported nor knew about the Coleman claim before the 1983 retroactive date. See 10/29/08 Mag. Dec., attached to 1/14/09 J. Entry, Appx. 38-39.

Despite Medical Assurance's argument that the trial court's interpretation renders the exclusion meaningless because the policy already excluded medical incidents taking place before the retroactive date, the magistrate found the exclusion had meaning and could apply to related medical incidents occurring both before and after the retroactive date. Id., Appx. 39-40. The magistrate reached this conclusion despite acknowledging that the policy defines a "medical incident" as "a single act or omission or a series of related acts or omissions" arising out of the professional care by the insured (id., Appx. 31), which would necessarily mean that related medical incidents occurring both before and after the retroactive date would not be covered under the policy without resort to the exclusion. The magistrate thereafter denied Medical Assurance's motion for summary judgment and granted the corresponding cross-motions. Id., Appx. 40-41.

Over Medical Assurance's objections, the trial court judge agreed, found no ambiguity in the policy, and ultimately adopted the magistrate's decision. See 1/14/09 J. Entry, Appx. 24, 27.

D. The appellate court, in a split decision, affirms.

Like the trial court before it, the majority relied on an isolated reading of the extended reporting endorsement to equate "the first date coverage is provided under the policy" with the policy's retroactive date, and affirmed.[2] See 3/5/10 Op., Appx. 1, 10-11.

Judge Grady, in dissent, understood what the majority did not—that the retroactive date is a risk-of-loss concept that sets the timing "after which a risk of loss can occur for

[2] The appellate court incorrectly states that the trial court found an ambiguity in the policy when it did not. Compare 3/5/10 Op., Appx. 11 with 1/14/09 J. Entry, Appx. 21, 26, 41.

which Medical Assurance owes a duty to provide coverage on a claim made by Dr. Dillaplain." It is not "the point in time when Medical Assurance assumed the duty of coverage it owes." Id., Appx. 17-18. Distinguishing between these two distinct concepts, Judge Grady explained:

> Medical Assurance assumed that duty [of coverage] on January 1, 2002, when the policy it issued to Dr. Dillaplain became effective. The risks of losses to Dr. Dillaplain which the policy covers can arise from medical incidents that occurred as early as January 27, 1983, but no coverage was **then** provided, because no duty of coverage **then** existed. (Emphasis sic.)

Id., Appx. 18. Coverage could only be "provided" under the terms of the policy on or after January 1, 2002, when Medical Assurance issued the policy and assumed the duty of coverage for claims made after that time. And because coverage could only be provided at that time, Dr. Dillaplain's 1995 report to another insurance carrier triggered the previously reported exclusion and "relieves Medical Assurance of its duty of coverage" with respect to the Coleman lawsuit brought in 2005. Id. To conclude otherwise, as Judge Grady said, was to "render the exclusion wholly superfluous, and therefore a nullity." Id., Appx. 19. And because it is assumed that the parties would not "have agreed to a term which is meaningless" when it comes to their rights and duties under the policy, the majority's interpretation of the exclusion is flawed. Id.

The majority, however, found the exclusion had independent meaning based on both a misunderstanding of basic insurance principles and a faulty interpretation of the policy's "medical incident" definition. Id., Appx. 19-20. Under that definition, "medical incident" includes not only a single medical incident, but "a series of related acts or

omissions" arising out of an insured physician's medical care. Id., Appx. 5. For purposes of prenatal and postnatal obstetrical care, the treatment of a mother and fetus "from conception through postpartum care constitutes a single medical incident" just as a "continuing course of professional services relating to substantially the same medical condition" constitutes a single medical incident. Id., Appx. 5. Despite this definition, the appellate majority found the previously reported exclusion had independent meaning because the exclusion could operate to exclude related medical incidents "spanning a period of time both before and after the retroactive date." Id., Appx. 9.

As Judge Grady recognized, this finding is wrong. Id., Appx. 19. Related medical incidents that span before and after the retroactive date—a "continuing course of treatment"—are still a single medical incident that would be excluded without resort to the exclusion. "Therefore, being a part of a continuing course of treatment that began prior to January 27, 1983, renders acts and omissions that occurred after that date medical incidents to which the policy extends no coverage at all in relation to the risk of losses arising from them." Id., Appx. 19. Judge Grady correctly realized that the "independent meaning" the majority thought it was ascribing to the previously reported exclusion is based on faulty reasoning. But more importantly, as Judge Grady recognized, a policy exclusion cannot create coverage; it can only preclude coverage that is already provided. Id. And because the policy—without resort to the exclusion—provides no coverage for a continuing course of treatment that began before the retroactive date, the majority's conclusion "simply does not hold water." Id.

III. Argument in support of proposition of law

Proposition of Law:

> An insurer's duty of coverage under a claims-made liability policy is distinct from the timing of risk of loss set by the policy's retroactive date and can arise no earlier than the beginning of the policy period.

Claims-made liability policies are a relatively recent creature of the insurance industry. Sol Kroll, in the frequently cited article *The Professional Liability Policy "Claims Made"* (1978), 13 Forum 842, defends the emerging need for claims-made insurance not only as a product of "a more complex society," but one that provides a much needed benefit for both the insured and the insurer. He explains:

> With the development of a more complex society, it became more reasonable, particularly with respect to the activities of professionals, to insure against the making of claims, rather than the happening of occurrences, and "claims made" insurance developed to meet a need for professionals to insure against the making of a claim as the insured event, rather than having to struggle with traditional concepts and difficulties inherent in determining whether the "event" insured against was the commission of an act, error or omission or the date of discovery thereof or the date of injury caused thereby.

Id. at 843, cited with approval in *Hood v. Cotter*, 2008-0215 (La. 12/2/08); 5 So.3d 819.

Other commentators have agreed that claims-made liability policies are advantageous to both the insured and the insurer. Carolyn Frame, in *'Claims-Made' Liability Insurance: Closing the Gaps with Retroactive Coverage* (1987), 60 Temp.L.Q. 165, noted—as most in the insurance industry have—that claims-made policies are advantageous for insureds because they are generally less expensive than occurrence policies and allow the insured to better estimate the limits of liability the insured will

need in the upcoming policy period. This cost-efficient feature is especially attractive to professionals who would otherwise be unable to afford insurance. Id. at 179-80; see, also, Kroll, 13 Forum at 847-48 (claims-made insurance is attractive for the insured because the insured "can more accurately judge" the limits of liability needed based on known factors such as practice size, amount of income, the state of the economy, and the area of practice).

Claims-made policies are also advantageous for the insurer. The Eighth Appellate District, in *Mueller v. Taylor Rental Ctr.* (1995), 106 Ohio App.3d 806, traced the development of claims-made policies and noted the "obvious advantage" to the insurer because the insurer is able to "to calculate risks and premiums with greater exactitude" knowing that the insurer's exposure ordinarily begins and ends at a fixed point in time. Id. at 811, quoting *Zuckerman v. Natl. Union Fire Ins.* (1985), 100 N.J. 304, 495 A.2d 395. Indeed, the insurer can establish its reserves "'without having to consider the possibilities of inflation beyond the policy period, upward-spiraling jury awards, or later changes in the definition and application of negligence.'" *Mueller*, quoting *Hasbrouck v. St. Paul Fire & Marine Ins.* (Iowa 1993), 511 N.W.2d 364, 366; accord *Homestead Ins. Co. v. Am. Empire Surplus Lines Ins. Co.* (1996), 44 Cal.App.4th 1297, 1304, 52 Cal.Rptr.2d 268.

An important feature of most claims-made policies—like that included in the policy at issue here—is a "retroactive date" term. A protective feature for both the insured and insurer, it sets the timing of loss events—here a "medical incident"—on or after which the event must have occurred. A retroactive-date term is advantageous for

the insured because it prevents gaps in coverage when an insured switches from occurrence to claims-made coverage. Frame, 60 Temp.L.Q. at 173. It effectively provides coverage for claims made during the policy period for covered risks that occurred before the policy period, but after the retroactive date.

Although a policy's retroactive date is sometimes accompanied by terms such as "covered" or "coverage," the retroactive date—as a timing event—does not trigger coverage. In this case, for example, the extended reporting endorsement states that the insured will be "covered" for medical incidents occurring on or after the retroactive date. Indeed, both the trial court and appellate majority focused on this term when interpreting the "first date coverage is provided under the policy" phrase of the previously reported exclusion. But the retroactive date does not trigger the duty of coverage under a claims-made policy. Instead, as Judge Grady recognized, it sets "the time after which a risk of loss can occur." See 3/5/10 Op., Appx. 17. Indeed, Judge Grady realized, as the majority did not, that an insurer's duty of coverage for any such risk cannot arise before the insurer agreed to assume that risk, which can be no earlier than the beginning of the policy period. Id., Appx. 18.

This common-sense conclusion is supported by the well-established differences between claims-made and occurrence policies. Kroll explains the difference this way:

> The major distinction between the "occurrence" policy and the "claims made" policy constitutes the difference between the peril insured. In the "occurrence" policy, the peril insured is the "occurrence" itself. Once the "occurrence" takes place, coverage attaches even though the claim may not be made for some time thereafter. While in the "claims made" policy, it is the making of the claim which is the event and peril being

> insured and, subject to policy language, regardless of when the occurrence took place.

Id. at 843. The "peril" insured under a claims-made policy is the reporting of the occurrence. Id.; see, also, *Mueller*, 106 Ohio App.3d at 810 ("The very essence of a claims-made policy requires the claim to be first made during the policy period."); *Chas. T. Main, Inc. v. Fireman's Fund Ins. Co.* (1990), 406 Mass. 862, 865, 551 N.E.2d 28, 30 (the "insured event" is the claim being made during a specified period); 20 Holmes' Appleman on Insurance 2d (2002) 254 Section 130.3 (coverage is triggered in a claims-made policy when a claim is first made). The occurrence itself, however, does not trigger coverage. And because the retroactive date in a claims-made policy merely sets the date on and after which the occurrence must occur, it cannot trigger coverage because to do so would effectively transform the claims-made "reporting" policy into an "occurrence" policy.

The Eighth Appellate District recognized the operation of a retroactive date in *Mueller*. The claims-made policy at issue in that case contained a retroactive date exactly one year before the beginning of the policy period. The insured argued—similar to the appellees here—that the insurer's duty of coverage was triggered because the loss event occurred after the retroactive date even though it occurred before the policy period began. 106 Ohio App.3d at 811. The court, in a unanimous decision, was unpersuaded. Relying on *United States v. A.C. Strip* (C.A.6, 1989), 868 F.2d 181, the *Mueller* court noted the important distinctions between occurrence and claims-made policies and concluded that

an after-the-retroactive-date injury alone is insufficient to trigger coverage because no duty of coverage arose before the policy period began. Id. at 813.

The reasoning of *Mueller* is sound. It is consistent with the "purpose of claims-made insurance in general, which is to limit liability "to a fixed period of time." *A.C. Strip*, 868 F.2d at 187; see, also, *Checkrite Ltd., Inc. v. Illinois Natl. Ins. Co.* (S.D.N.Y. 2000), 95 F.Supp.2d 180, 191-92 ("The existence of a cut-off date is integral to a claims-made policy . . . [and] is a 'distinct characteristic . . . that directly relates to rate setting.'"). And it is equally consistent with the purpose of retroactive dates in particular, which is not only to prevent gaps in insurance, but bring further cost predictability to both the insured and insurer. To expand coverage outside that "fixed period of time"—like the Second District did here—effectively turns the less expensive, one-year claims-made policy into a costly, 20-year occurrence policy because it gives the insured "more coverage than he bargained for and paid for" and "requires the insurer to provide coverage for risks not assumed." *A.C. Strip*, 868 F.2d at 187.

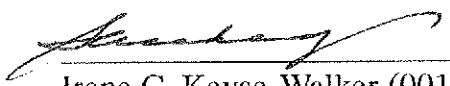
Dr. Dillaplain bargained for and paid for a claims-made liability insurance from Medical Assurance for "claims" that were "made" beginning January 1, 2002. Because Dr. Dillaplain could make no claim before that time that would trigger Medical Assurance's duty of coverage, the "first date coverage is provided under the policy" can be no earlier than January 1, 2002. Like the insureds in *Mueller*, the occurrence of a loss event after the retroactive date but before the policy was even issued cannot trigger coverage because no duty of coverage could exist before the policy began. Judge Grady understood this. The appellate majority, however, did not.

IV. Conclusion

Claims-made policies serve important protective interests for both an insured and the insurer. If courts are allowed to effectively transform claims-made policies into occurrence policies, those important interests are left unprotected and may limit the continued availability of this affordable form of insurance. This Court's guidance in establishing clear interpretive principles that will guide courts throughout Ohio when resolving issues related to claims-made insurance will ensure that this does not happen.

Appellant The Medical Assurance Company therefore respectfully requests that this Court accept jurisdiction so that this important issue of first impression may be reviewed on the merits.

Respectfully submitted,



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IN THE COURT OF APPEALS FOR GREENE COUNTY, OHIO

THE MEDICAL ASSURANCE COMPANY, INC.	:	
Plaintiff-Appellant	:	C.A. CASE NO. 2009 CA 6
v.	:	T.C. NO. 2007 CV 0725
ROBERT P. DILLAPLAIN, M.D., et al.	:	**FINAL ENTRY**
Defendants-Appellees	:	
	:	

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Pursuant to the opinion of this court rendered on the 5th day of March, 2010, the judgment of the trial court is affirmed.

Costs to be paid as stated in App.R. 24.

Mike Fain
MIKE FAIN, Judge

THOMAS J. GRADY, Judge

JEFFREY E. FROELICH, Judge

10-03-1230

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IN THE COURT OF APPEALS FOR GREENE COUNTY, OHIO

THE MEDICAL ASSURANCE COMPANY, INC.	:	
Plaintiff-Appellant	:	C.A. CASE NO. 2009 CA 6
v.	:	T.C. NO. 2007 CV 0725
ROBERT P. DILLAPLAIN, M.D., et al.	:	(Civil appeal from Common Pleas Court)
Defendants-Appellees	:	
	:	

. . . . . .

OPINION

Rendered on the 5th day of March, 2010.

. . . . . .

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. . . . . .

FROELICH, J.

Appellee, Robert P. Dillaplain, M.D., was sued in 2005 for malpractice by Jeffrey T. Coleman, Jr., and others, in the Greene County Common Pleas Court. Greene C.P. No. 2005 CV 381. The alleged malpractice arose, generally, from obstetrical care occurring in 1993 and 1994. Appellant, The Medical Assurance Company, Inc., proceeded to defend Dr. Dillaplain under a reservation of rights and in August 2007 filed a declaratory judgment action seeking a declaration because of a "previous reported" exclusion in the policy that the insurance company was not required to defend and indemnify him. The issue was submitted on cross-motions for summary judgment and the trial court adopted the magistrate's decision finding that Medical Assurance has a duty to defend and indemnify Dr. Dillaplain on the malpractice claim. Medical Assurance also filed a Motion to Amend its Declaratory Judgment Complaint which the court denied. We will affirm.

Medical Assurance issued a liability policy covering Dr. Dillaplain with a policy period from January 1, 2002 to January 1, 2003, and with a retroactive date of January 27, 1983. The policy states that: "We agree to pay on behalf of each insured all sums which such insured shall become legally obligated to pay as damages because of any medical incident which occurs after the retroactive date applicable to such insured and which is first

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reported during the policy period. . . ."

If the analysis were to stop at this point, the doctor was covered since the alleged malpractice occurred after the retroactive date. However, the policy also contains an exclusion (at paragraph III, K) which states: "We will not pay damages because of any of the following, and we will not provide a defense for any suit alleging. . .any medical incident which has been reported to another insurance carrier prior to the first date coverage is provided under this policy; any medical incident which occurred prior to the first date coverage is provided under this policy, if on such date, the insured knew or believed, or had reason to know or believe, that such medical incident had occurred; or any other medical incident that occurred during a period in which the insured was not covered under a policy of professional liability insurance. . . ."

In the definition section, "medical incident" is defined, as relevant here, to mean: "A single act or omission or a series of related acts or omissions arising out of the rendering of or failure to render professional services to any one person by any insured or any person for whose acts or omissions an insured is legally responsible which results or is likely to result in damages. . .for purposes of this definition, treatment of mother and fetus (or fetuses) from conception through postpartum care constitutes a single medical incident, and a continuing course of professional services relating to substantially the same medical condition constitutes a single medical incident."

Additionally, there is a reporting endorsement, with an effective date of January 1, 2003, a termination date of January 1, 2003, and a retroactive date of January 27, 1983, which states: "This endorsement amends the Professional Liability Coverage Part of the policy[.] In consideration of an additional premium of $0.00 the insured physician(s) named

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below shall be covered, under the terms and conditions of the policy, for any medical incident which occurred on or after the retroactive date applicable to each insured physician, as stated below, and prior to the above-stated Termination Date, but which is first reported after such Termination Date. . . ."

In 1995, Dr. Dillaplain was given notice, by way of a 180-day letter, that the individuals who later became the plaintiffs in Greene County Common Pleas No. 2005 CV 381, were considering bringing an action against him for his professional care and treatment. Dr. Dillaplain was insured with the P.I.E. Mutual Insurance Company at that time, and he reported this letter to P.I.E. no later than March 17, 1995.

Medical Assurance argues coverage is excluded since the medical incident had been reported to another insurance company in 1995, which was "prior to the first date coverage is provided" of January 1, 2002. Medical Assurance further argues that the reporting endorsement does not extend coverage since it only extends coverage "under the terms and conditions of the policy" and that, under the terms of the policy, coverage is excluded. Dr. Dillaplain argues that the "first date coverage is provided" is January 27, 1983, and that, therefore, any exclusion is not applicable.

I.

"FIRST ASSIGNMENT OF ERROR:

"THE TRIAL COURT ERRED WHEN IT GRANTED THE INTERVENING DEFENDANTS' CROSS MOTIONS FOR SUMMARY JUDGMENT, DENIED PLAINTIFF MEDICAL ASSURANCE'S MOTION FOR SUMMARY JUDGMENT, AND DECLARED THAT MEDICAL ASSURANCE OWES DR. DILLAPLAIN A DUTY TO DEFEND AND INDEMNIFY THE UNDERLYING COLEMAN LAWSUIT."

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When reviewing the trial court's decision on a motion for summary judgment, an appellate court's review is de novo. *Grafton v. Ohio Edison Co.*, 77 Ohio St.3d 102, 105, 1996-Ohio-336. "De novo review means that this court uses the same standard that the trial court should have used, and we examine the evidence to determine whether as a matter of law no genuine issue exists for trial." *Brewer v. Cleveland City Schools Board of Education* (1997), 122 Ohio App.3d 378, 383, citing *Dupler v. Mansfield Journal Co.* (1980), 64 Ohio St.2d 116, 119-20. Therefore, the trial court's decision is not granted any deference by the reviewing appellate court with respect to issues of law presented in the appeal. *Brown v. Scioto City Board of Commissioners* (1993), 87 Ohio App.3d 704, 711.

A policy of liability insurance imposes a duty on the insurer to defend and indemnify the insured against claims of persons arising out of an occurrence of an insured risk that creates potential legal liability in the insured. That duty is generally described as a duty of "coverage." An exclusion is an "insurance policy provision that excepts certain events or conditions from coverage." Blacks Law Dictionary (7th Edition revised 1999), 585-586. Therefore, an exclusion applies only to an insured risk the policy otherwise covers. The risk insured by the Medical Assurance policy is Dr. Dillaplain's potential legal liability arising from a "medical incident" which occurred on or after January 27, 1983.

In construing the terms of exclusions in an insurance policy, courts are guided by certain rules of construction and the insurer has the burden of proving that any policy exclusions deny coverage under the policy. *Continental Ins. Co. v. Louis Marx Co., Inc.* (1980), 64 Ohio St.2d 399, 401. "Where a policy of insurance prepared by an insurance company provides generally for certain coverage, exclusions from such coverage must be expressly provided for or must arise by necessary implication from the words used on the

policy." *Butche v. Ohio Cas. Ins. Co.* (1962), 174 Ohio St.144, syllabus. "It is well-settled law in Ohio that '[w]here provisions of a contract of insurance are reasonably susceptible of more than one interpretation, they will be construed strictly against the insurer and liberally in favor of the insured.' *King v. Nationwide Ins. Co.* (1988), 35 Ohio St.3d 208...; see, also, *Buckeye Union Ins. Co. v. Price* (1974), 39 Ohio St.2d 95. It is axiomatic that this rule cannot be employed to create ambiguity where there is none. It is only when a provision in a policy is susceptible of more than one reasonable interpretation that an ambiguity exists in which the provision must be resolved in favor of the insured." *Hacker v. Dickman*, 75 Ohio St.3d 118, 119-20, 1996-Ohio-98.

The "fundamental goal in insurance policy interpretation is to ascertain the intent of the parties from a reading of the contract in its entirety and to settle upon a reasonable interpretation of any disputed terms in a manner calculated to give the agreement its intended effect." *Burris v. Grange Mut. Co.* (1989), 46 Ohio St.3d 84, 89.

"The Ohio Supreme Court also has stressed that while policy exclusions 'will be interpreted as applying only to that which is clearly intended to be excluded. . .[,] the rule of strict construction does not permit a court to change the obvious intent of a provision just to impose coverage.' *Hybud Equip. Corp. v. Sphere Drake Insurance Co. Ltd.* (1992), 64 Ohio St.3d 657, 665. . . ." *Colter v. Spanky's Doll House*, Montgomery App. No. 21111, 2006-Ohio-408, at ¶ 29.

Medical Assurance argues that the phrase "the first date coverage is provided" refers to January 1, 2002, since that is the "policy period" listed on the coverage summary, whereas Dr. Dillaplain argues that "the first date coverage is provided" is January 27, 1983, since that is the retroactive date of the policy. Medical Assurance argues (e.g. in its brief

at page 14) that the retroactive date in the policy "specifies the earliest occurrence to be covered," but that such retroactive date is not the "first date coverage is provided." Medical Assurance quotes *Gomolka v. State Auto Insurance Co.* (1982), 70 Ohio St.2d 166, 172, that "one may not regard only the right hand which giveth, if the left hand also taketh away." However, this is true only so long as it is unambiguously taken away. Even if the exclusion were reasonably susceptible to both alternative interpretations, then such ambiguity "must be resolved in favor of the insured." *Hacker*, supra.

Medical Assurance argues that such construction renders the exclusion meaningless. It argues that since the policy does not cover any medical incident occurring prior to January 27, 1983, an exclusion which simply excludes medical incidents prior to January 27, 1983, is, at most, redundant.

The trial court found that the "exclusion has meaning and would have applicability to a medical incident as defined in the policy as a single act or omission or a series of related acts or omissions. If an act or omission or a series of related acts or omissions first occurred before January 27, 1983, notwithstanding that other related acts or omissions occurred after January 27, 1983," the exclusion would prevent such "medical incident" from coverage.

We find nothing in the policy that requires a "medical incident" in order to be covered to have <u>begun</u> after the retroactive date. To the contrary, the coverage provision includes any medical incident that "occurred on or after the retroactive date." A medical incident that includes a continuing course of professional services relating to substantially the same medical condition is a single medical incident. Therefore, a single medical incident spanning a period of time both before and after the retroactive date would trigger the

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coverage provision, since it occurred on or after the retroactive date, but also the exclusion, since it also occurred prior to the first date coverage is provided under this policy. Such medical incidents (and conception through birth is, by physiological and the policy's definition, one of them) would be covered by the policy, but then arguably excluded since it also occurred prior to the retroactive coverage date.

Additionally, while it is true that an exclusion can "taketh away" what the policy "giveth,"[1] an endorsement can "giveth it back." An endorsement must be read as if its terms were printed directly in the body of the general policy. *Jay Huddle Storage, Inc. v. Midwestern Indemnity Co.*, (Jan. 13, 1986), Henry App. No. 7-84-13. However, in interpreting the effect of endorsements in relation to the general policy provisions, an endorsement must be read as a modification of a policy if a clear inconsistency appears. *Workman, et al. v. Republic Mutual Ins. Co.* (1944), 144 Ohio St 37.

The endorsement by its specific, unambiguous language provides coverage for a medical incident which occurred after January 27, 1983, and prior to January 1, 2003, but which is first reported after January 27, 2003. Coverage is thus provided for the alleged malpractice which occurred in 1993, since that was after 1983, and was first reported to Medical Assurance in 2005 when the suit was filed. Medical Assurance argues that the reporting endorsement is only applicable to claims covered "under the terms and conditions of the policy" and this claim is excluded under III, K. First, we have found that it is not so excluded. Further, such interpretation of the reporting endorsement renders the endorsement "meaningless and redundant."

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[1]Or as said by Tom Waits in "Step Right Up" (copyright 1976, 5th Floor Music, Inc. ASCAP), "what the large print giveth, the small print taketh away."

Medical Assurance argues this "leads to an absurd result" and that the parties never intended to provide coverage for a medical incident prior to the 2002 date of the policy when such potential claim had already been reported to another insurance company; again, we are constrained to interpret, pursuant to rules of construction, the actual language of the policy and endorsement.

Our holding that there is an ambiguity is more than a finding that the policy could have been worded more clearly or that certain words and phrases, even when read together with all the other words and phrases in the policy and endorsement, are confusing or capable of different or multiple meanings. Nor is the fact that attorneys, magistrates, trial judges, and appellate judges do not agree on a "reasonable interpretation," per se proof of legal ambiguity. However, reading an insurance policy or any contract should not be a hermeneutic exercise engaged in after the fact when each party's analytical objectivity and pre-contract intent have merged with hindsight bias. With the trial court's and our finding that the language is ambiguous, the law requires that the policy be interpreted strictly against the drafter and liberally in favor of the insured, which is exactly what the trial court did. Moreover, the reporting endorsement provides coverage with the facts before the trial court.

The first assignment of error is overruled.

II.

"SECOND ASSIGNMENT OF ERROR:

"THE TRIAL COURT ERRED WHEN IT DENIED MEDICAL ASSURANCE'S MOTION FOR LEAVE TO AMEND ITS COMPLAINT TO REQUEST A DECLARATION THAT IT HAD NO DUTY TO DEFEND OR INDEMNIFY UNDER THE POLICY'S

FRAUD/MISREPRESENTATION CONDITION."

Civ.R. 15(A) provides in pertinent part that "leave of court [to amend a pleading] shall be freely given when justice so requires." The trial court found that "justice will not be served by the court's granting the motion for leave to amend the complaint."

The complaint for malpractice was filed on May 9, 2005; the declaratory judgment action was filed on August 9, 2007. On November 12, 2008, Medical Assurance suggested for the first time that Dillaplain failed to disclose, at the time when he initially applied for the policy, the incident which is the subject of the pending malpractice lawsuit.

Medical Assurance did not raise the defense of fraud, which is a subject of General Condition XII, in its reservation of rights letter to Dillaplain or in its declaratory judgment action; Medical Assurance did not raise the Condition in its answer to the counterclaims against it; Medical Assurance did not raise it in response to specific interrogatories concerning policy defenses; Medical Assurance did not raise it in its motion for summary judgment, in response to the defendants' cross motions for summary judgment, or in any other pleadings or filings; Medical Assurance stipulated on the record before the magistrate that the only reason it contested coverage was Exclusion K (Medical Assurance argues it made no explicit stipulation regarding any fraud-related claim, but the record is clear that it never suggested such a claim in the discussion with opposing counsel or the magistrate preceeding the submission of the declaratory judgment summary judgment motions to the magistrate).

Medical Assurance raised the General Condition XII issue for the first time in November 2008 in its objections to the magistrate's decision which found that the insurance company had a duty to defend and indemnify; and when it "contemporaneously

moved" to amend its declaratory judgment action. At no time did Medical Assurance allege that the reason it did not raise the issue earlier was that it did not become aware, despite reasonable diligence, of the suspected fraud until shortly before it filed its motion to amend.

"The grant or denial of leave to amend a pleading is discretionary and will not be reversed absent an abuse of discretion. . . ." *Englewood v. Turner*, 178 Ohio App.3d 179, 2008-Ohio-4637, ¶ 49. An abuse of discretion implies an arbitrary, unreasonable, unconciousable attitude on the part of the trial court. *State v. Adams* (1980), 62 Ohio St.2d 151. Where the issue on review has been confided to the discretion of the trial court, the mere fact that the reviewing court would have reached a different result is not enough, without more, to find error. *EnQuip Technologies Group, Inc. v. Tycon Technoglass S.R.L.*, Greene App. No. 2009-CA-42, 2010-Ohio-28, ¶ 131, Fain, J., concurring. The issues had been framed and extensive discovery had taken place when the magistrate rendered his decision. Only then did Medical Assurance seek to add a claim of violation of the policy based on fraud or misrepresentation on the application for the policy. We review the court's decision, based on the record, as of the time it was made. The court did not abuse its discretion in denying the Motion to Amend to add such a claim.

The second assignment of error is overruled.

III.

The assignments of error are overruled and the judgment of the trial court is affirmed.

. . . . . .

FAIN, J., concurs.

GRADY, J., dissenting:

10-03-1223

I respectfully dissent from the decision of the majority. I would instead hold that The Medical Assurance Company, Inc. ("Medical Assurance") owes no duty to provide coverage to Dr. Robert P. Dillaplain on the claim for coverage he made with respect to the medical malpractice action commenced against him in 2005.

A policy of liability insurance is a contract in which, in consideration of the insured's payment of an agreed premium, the insurer promises that during the term of the policy the insurer will defend and indemnify the insured against risks of loss from legal liability that arise out of the occurrence of a defined event. That promise is generally referred to as the insurer's duty of coverage.

The policy that Medical Assurance issued to Dr. Dillaplain became effective on January 1, 2002, and states that its term or "policy period" is from January 1, 2002 to January 1, 2003. The policy period was subsequently extended by agreement of the parties to and including the year 2005.

The coverage Medical Assurance promised to provide Dr. Dillaplain is set out at page 4 of the policy. It states, in relevant part: "We agree to pay on behalf of each insured all sums which such insured shall become legally obligated to pay as **damages** because of any **medical incident** which occurs after the **retroactive date** applicable to such insured and which is first **reported** during the **policy period**." At page 2, the policy provides: "**Retroactive date** means the **retroactive date** applicable to each **insured** as specified in the **Coverage Summary**." That date is specified in the Coverage Summary as "1/27/1983."

The Definitions provision of the policy states:

"**Medical Incident** means:

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"A. A single act or omission or a series of related acts or omissions arising out of the rendering of, or failure to render, **professional services** to any one person by an **Insured** or any person for whose acts or omissions an **insured** is legally responsible, which results, or is likely to result, in **damages**;"

* * *

"For purposes of this definition, treatment of mother and fetus (or fetuses) from conception through postpartum care constitutes a single **medical incident**, and a continuing course of **professional services** relating to substantially the same medical condition constitutes a single **medical incident**."

The exclusion from coverage in issue appears at page 5 of the Medical Assurance policy. It provides:

"III. EXCLUSIONS

"We will not pay **damages** because of any of the following, and we will not provide a defense for any suit alleging any of the following:

* * *

"K. Any **medical incident** which has been **reported** to another insurance carrier prior to the first date coverage is provided under the **policy**; any **medical incident** which occurred prior to the first date coverage is provided under the **policy**, if on such **date**, the insured knew or believed, or had reason to know or believe, that such **medical incident** had occurred; or any **medical incident** that occurred during a period in which the **Insured** was not covered under a policy of professional liability insurance."

A medical malpractice action was commenced against Dr. Dillaplain in 2005. He presented Medical Assurance with his claim for coverage in the action. It is undisputed

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that the medical incident or incidents on which the claims for relief in the 2005 action are founded occurred in 1993 and 1994. It is also undisputed that Dr. Dillaplain had reported those same medical incidents to another insurance carrier in 1995.

Medical Assurance asked the common pleas court to construe its policy and determine what duty of coverage, if any, it owes Dr. Dillaplain with respect to the 2005 action. Medical Assurance argues that, by reason of Dr. Dillaplain's 1995 report of the same medical incident to another carrier, Medical Assurance is relieved of its duty of coverage by the exclusion in Section III.K. of its policy. The trial court rejected that argument and found that Medical Assurance owes Dr. Dillaplain a duty of the coverage he claimed. That judgment is now before us for review. Our standard of review is de novo.

In construing the terms of the exclusions section of the insurance policy, we are guided by the rules of contract interpretation. First, "[i]t is well-settled law in Ohio that '[w]here provisions of a contract of insurance are *reasonably* susceptible of more than one interpretation, they will be construed strictly against the insurer and liberally in favor of the insured.' (Emphasis added.) *King v. Nationwide Ins. Co.* (1988), 35 Ohio St.3d 208, 519 N.E.2d 1380, syllabus; see, also, *Buckeye Union Ins. Co. v. Price* (1974), 39 Ohio St.2d 95, 68 O.O.2d 56, 313 N.E.2d 844. It is axiomatic that this rule cannot be employed to create ambiguity where there is none. It is only when a provision in a policy is susceptible of more than one reasonable interpretation that an ambiguity exists in which the provision must be resolved in favor of the insured." *Hacker v. Dickman*, 75 Ohio St.3d 118, 119-20, 1996- Ohio-98.

Also, "[t]he fundamental goal in insurance policy interpretation is to ascertain the intent of the parties from a reading of the contract in its entirety and to settle upon a

reasonable interpretation of any disputed terms in a manner calculated to give the agreement its intended effect." 57 Ohio Jurisprudence 3d (2005) 394, Insurance, Section 315. "Thus, whenever two constructions can be placed on a written contract of insurance, one of which will give force to all of its provisions, that one must be adopted." 57 Ohio Jurisprudence 3d (2005) 402, Insurance, Section 320.

"The Ohio Supreme Court also has stressed that while policy exclusions 'will be interpreted as applying only to that which is clearly intended to be excluded * * *[,] the rule of strict construction does not permit a court to change the obvious intent of a provision just to impose coverage.' *Hybud Equip. Corp. v. Sphere Drake Ins. Co., Ltd.* (1992), 64 Ohio St.3d 657, 665, 597 N.E.2d 1096." *Colter v. Spanky's Doll House*, Montgomery App. No. 21111, 2006-Ohio-408, at ¶29.

The trial court adopted the decision of its magistrate, who found that the exclusion does not apply to the 2005 claim. The magistrate reasoned that the operative clause in the exclusion, "reported to another carrier prior to the first date coverage is provided under the policy," is ambiguous, in that it may refer either to a report to another carrier that was made prior to January 1, 2002, or to a report to another carrier that was made prior to January 27, 1983. The latter alternative would exclude Dr. Dillaplain's 1995 report to another carrier from application of the exception, because the exception could then apply only to reports of medical incidents which occurred before January 27, 1983. Because an ambiguity must be construed in favor of the alternative that provides coverage, the trial court found that the exclusion therefore refers to January 27, 1983.

The trial court's analysis confuses the point in time after which a risk of loss can occur for which Medical Assurance owes a duty to provide coverage on a claim made by

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Dr. Dillaplain, with the point in time when Medical Assurance assumed the duty of coverage it owes. Medical Assurance assumed that duty on January 1, 2002, when the policy it issued to Dr. Dillaplain became effective. The risks of losses to Dr. Dillaplain which the policy covers can arise from medical incidents that occurred as early as January 27, 1983, but no coverage was **then** provided, because no duty of coverage **then** existed. Instead, coverage "is provided" under the terms of the policy only on and after January 1, 2002, when claims by Dr. Dillaplain requiring coverage may be made. Therefore, Dr. Dillaplain's report to another carrier in 1995 of the same medical incident on which the 2005 action against him is founded, triggers the exclusion and relieves Medical Assurance of its duty of coverage with respect to Dr. Dillaplain's claim for coverage in connection with the medical malpractice action that was commenced against him in 2005.

The trial court erred when it found an ambiguity, because the terms of the exclusion are not reasonably susceptible to more than one interpretation. Reasoning that its reference to when coverage "is provided" means January 27, 1983, creates an ambiguity when there is none. The policy creates coverage which "is provided" beginning on January 1, 2002, and only then. Furthermore, reading the contract in its entirety and in a manner calculated to give the agreement its intended effect, and to give force to all of its provisions, it is clear that the disputed provision cannot refer to the alternative date the trial court settled on.

An exclusion is "[a]n insurance-policy provision that excepts certain events or conditions from coverage." Black's Law Dictionary (7th Ed., Rev. 1999), 585-86. Therefore, an exclusion can only apply to a claim for coverage of losses arising from an insured risk which the policy otherwise covers. Under no interpretation of its terms does the policy

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provide coverage for claims made by Dr. Dillaplain for a risk of losses arising out of medical incidents that occurred prior to January 27, 1983. By selecting that date as "the first date coverage is provided under the policy," the trial court confined application of the exclusion to claims by Dr. Dillaplain concerning medical incidents for which no risk of loss is covered by the policy. That interpretation renders the exclusion wholly superfluous, and therefore a nullity. Parties to a contract cannot be assumed to have agreed to a term which is meaningless in relation to the rights and duties the contract creates. The interpretation is therefore unreasonable, preventing its application even were there an ambiguity.

Appellees argue that the construction given the exclusion by the trial court would not render the exclusion meaningless. They contend that, in that application, the exclusion could nevertheless apply to acts or omissions that occurred after January 27, 1983, but which were part of a continuing course of treatment that began prior to that date, though they were part of a single "medical incident." The majority embraces that argument and adopts it as a finding, but it simply does not hold water.

In defining the term "medical incident," the policy provides: "For purposes of this definition, treatment of mother and fetus (or fetuses) from conception through postpartum care **constitutes a single medical incident**, and a continuing course of professional services relating to substantially the same medical condition **constitutes a single medical incident**." (Emphasis supplied.) Therefore, being a part of a continuing course of treatment that began prior to January 27, 1983, renders acts and omissions that occurred after that date medical incidents to which the policy extends no coverage at all in relation to the risk of losses arising from them. An exclusion cannot create coverage; it can only preclude coverage which is otherwise provided.

I would sustain the second assignment of error on a finding that the trial court erred when it granted the motion for summary judgment filed by the Appellees, and would remand the case to the trial court for further proceedings consistent with the views I have stated.

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10-03-1229

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COMMON PLEAS COURT
GREENE COUNTY, OHIO

IN THE COMMON PLEAS COURT OF GREENE COUNTY, OHIO
GENERAL DIVISION (CIVIL)

THE MEDICAL ASSURANCE COMPANY, INC.,

Plaintiff,

v.

ROBERT P. DILLAPLAIN, M.D., et al.,

Defendants.

CASE NO: 2007 CV 0725

JUDGE WOLAVER
MAGISTRATE REYNOLDS

JUDGMENT ENTRY ADOPTING MAGISTRATE'S DECISION ON PLAINTIFF'S MOTION FOR SUMMARY JUDGMENT, AND ON INTERVENING DEFENDANTS' CROSS-MOTIONS FOR SUMMARY JUDGMENT; AND STRIKING AFFIDAVIT OF KEVIN BRENNAN

FINAL APPEALABLE ORDER

09-01-1967

This matter is before the Court on the Plaintiff's Objections filed November 12, 2008 to the Magistrate's Decision filed on October 29, 2008.

In the Magistrate's Decision, the Magistrate:

-DECIDED that the Medical Professional Liability Policy that Plaintiff issued to Robert P. Dillaplain, (Exhibit A to Complaint) unambiguously and by its plain meaning, and without resort to any extrinsic documents, clearly and unambiguously provides coverage to Robert P. Dillaplain under the terms of the policy for the medical incident that is the subject of Case No. 2005 CV 0381 pending in this Court.

-DENIED Plaintiff's, The Medical Assurance Company, Inc.'s, Motion for Summary Judgment for Declaratory Judgment against Defendant Robert P.

Dillaplain, that Plaintiff has no obligation to defend the Defendant Dillaplain in the related medical malpractice law suit involving Intervening Defendants Jeffrey T. Coleman, Jr., a minor, Jeffrey Coleman, Senior, and Cheryl Neer (Case No. 2005 CV 0381), and DENIED Plaintiff's Motion for Summary Judgment for Declaratory Judgment that Plaintiff has no obligation under the terms of its Medical Professional Liability Policy ("Policy") to indemnify Defendant Dillaplain against any Judgment entered against Dilliplain in the related medical malpractice law suit involving Intervening Defendants Jeffrey T. Coleman, Jr., a minor, Jeffrey Coleman, Senior, and Cheryl Neer (Case No. 2005 CV 0381 in this Court).

-GRANTED the Cross-Motion for Summary Judgment for Declaratory Judgment, of the Intervening Defendants Jeffrey T. Coleman, Jr., a minor, Jeffrey Coleman, Senior, and Cheryl Neer, and GRANTED the Cross-Motion for Summary Judgment for Declaratory Judgment, of Intervening Defendant Greene Memorial Hospital that under the Policy, Plaintiff has an obligation to defend Dillaplain in the related medical malpractice suit involving the Colemans and Cheryl Neer, and has an obligation to indemnify Dillaplain to the limits of the Policy for any judgment entered against Dillaplain in Case No. 2005 CV 0381 in this Court.

-Assigned Court costs to the Plaintiff.

09-01-1968

I. Objection and Response

On November 12, 2008, Plaintiff, The Medical Assurance Company, Inc. filed its Objections to the Magistrate's decision filed on October 29, 2008. On November 26, 2008, Plaintiff filed its Supplement to its Objections.

On November 21, 2008, November 24, 2008 and November 24, 2008, respectively, Defendant Dillaplain, Intervening Defendants Colemans and Neer, and Intervening Defendant Greene Memorial Hospital filed their responses to Plaintiffs' objections.

II. Court's Review of Objections to a Magistrate's Decision:

1. Procedure

The procedure for a trial court to review a Magistrate's Decision is set forth

in Civ.R. 53(D)(4)(a) through (e):

(4) *Action of court on magistrate's decision and on any objections to magistrate's decision; entry of judgment or interim order by court.* (a) *Action of court required.* A magistrate's decision is not effective unless adopted by the court. (b) *Action on magistrate's decision.* Whether or not objections are timely filed, a court may adopt or reject a magistrate's decision in whole or in part, with or without modification. A court may hear a previously-referred matter, take additional evidence, or return a matter to a magistrate. (c) *If no objections are filed.* If no timely objections are filed, the court may adopt a magistrate's decision, unless it determines that there is an error of law or other defect evident on the face of the magistrate's decision. (d) *Action on objections.* If one or more objections to a magistrate's decision are timely filed, the court shall rule on those objections. In ruling on objections, the court shall undertake an independent review as to the objected matters to ascertain that the magistrate has properly determined the factual issues and appropriately applied the law. Before so ruling, the court may hear additional evidence but may refuse to do so unless the objecting party demonstrates that the party could not, with reasonable diligence, have produced that evidence for consideration by the magistrate. (e) *Entry of judgment or interim order by court.* A court that adopts, rejects, or modifies a magistrate's decision shall also enter a judgment or interim order.

2. Ohio Court of Appeals, Second Appellate District's Opinions on the Trial Court's Review of Objections to a Magistrate's Decision:

a. The trial Court must conduct an independent review:

"In reviewing the magistrate's decision, however, the trial court must conduct an independent, de novo, review of the magistrate's factual and legal conclusions:

A magistrate functions as an arm of the trial court, which is in no way bound to follow or accept the findings or recommendations of its magistrate. *Seagraves v. Seagraves* (August 25, 1995), Montgomery App. Nos. 15047 and 15069, unreported. In accordance with Civ.R. 53, the trial court must conduct an independent de novo review of the facts and conclusions contained in the

09-10-1969

magistrate's report and recommendations and enter its own judgment. *Dayton v. Whiting* (March 29, 1996), Montgomery App. No. 15432, unreported. The trial court may adopt the magistrate's findings, conclusions, and recommendations, but the court's discretion in that regard is not limited. Therefore, the court cannot abuse its discretion by rejecting some or all of its magistrate's findings." *Seagraves*, supra.

"The roles of a magistrate and the trial court are different. The function of a magistrate is to aid the court in the expedition of the court's business, not to act as a separate or substitute judicial officer. *Whiting, supra.*"

Breece v. Breece, 1999 WL 999759, (Ohio App. 2 Dist.,1999)

b. Sufficiency of review:

"We conclude that an order is sufficient for the purposes of Civ.R. 53(E)(4) if it announces that, upon independent review, the trial court has decided to adopt the magistrate's decision."[1]

III. Court's review

The Court has independently reviewed the Magistrate's Decision filed on October 29, 2008, and each of the objected matters. The Court OVERRULES every objection of Plaintiff Medical Assurance Company as to the Magistrate's Decision.

The objections, save one, are directed to the interpretation of the Policy concerning the date of coverage and the possible exclusion of coverage under Paragraph III. K. of the Professional Liability Coverage Part of the Policy. Having read the Policy, the Court concludes that the Policy provided coverage to Dr. Dillaplain from a retroactive date for coverage of January 27, 1983 and the coverage is not excluded by Paragraph III.K. The Court also concludes that it is not against public policy, and as a matter of law, it is the Court's obligation to interpret the coverage and exclusion provisions of the insurance contract in accordance with their clear and unambiguous terms.

09-01-1970

[1] *Dayton Area School E.F.C.U. v. Nath*, 1998 WL 906397, (Ohio App. 2 Dist.,1998)

The other objection of Plaintiff is an issue or defense to coverage raised for the first time in the Plaintiff's objections filed on November 12, 2008. That objection concerns General Condition XII of the Policy, **FRAUD AND MISREPRESENTATIONS.** The subject matter of that one objection was not addressed in the Magistrate's Decision, with good reason. Plaintiff raised the issue or defense related to General Condition XII for the first time in the Plaintiff's November 12, 2008 Objections to the Magistrate's Decision.

Plaintiff did not allege any issue or defense related to General Condition XII of the Policy:

-in the Complaint for Declaratory Judgment filed on August 9, 2007, or

-in the Plaintiff's "Answer" to Intervening Defendant's, Greene Memorial Hospital's Counterclaim, filed on October 19, 2007, or

-in the Plaintiff's "Answer" to the Counterclaim of Intervening Defendants Coleman, Coleman and Neer, filed on November 28, 2007, or

-in the Plaintiff's Motion for Summary filed on March 25, 2008, or

-in the Plaintiff's Opposition filed on June 24, 2008 to Intervening Defendants', Coleman, Coleman, and Neer's Motion for Summary Judgment on their Counterclaim for Declaratory Judgment, or

-in the Plaintiff's Opposition filed on June 24, 2008, to Intervening Defendant's, Greene Memorial Hospital's, Motion for Summary Judgment on their Counterclaim for Declaratory Judgment.

Plaintiff did not raise the issue or defense of General Condition XII until the Plaintiff filed objections to the Magistrate's decision on November 12, 2008, fifteen months after Plaintiff filed its Declaratory Judgment action. Consequently, all discovery and motions proceeded in the Case with no issue pleaded or related to General Condition XII.

By not pleading the Civ.R. 8(C) affirmative defense of fraud in response to the Intervening Defendants' Cross Motions for Declaratory Judgment, Plaintiff waived the defense. *Jim's Steak House, Inc. v. City of Cleveland,* 81 Ohio St.3d 18, 20, 688 N.E.2d 506, 508 (Ohio,1998).

Similarly Plaintiff could waive its contractual right to rely upon or to enforce General Condition XII of the Policy.

09-01-1971

"The most frequently employed definition of waiver is that it is the voluntary relinquishment of a known right. As a general rule, the doctrine of waiver is applicable to all personal rights and privileges, whether secured by contract, conferred by statute, or guaranted by the Constitution, provided that the waiver does not violate public policy."

State ex rel. Hess v. City of Akron, 132 Ohio St. 305, 307, 7 N.E.2d 411, 413 (1937)

In addition to not raising the issue in its pleadings or in any filing prior to November 12, 2008, Plaintiff effectively waived General Condition XII as a defense to providing coverage, by stipulation at the oral hearing, on the record, before the Magistrate on October 8, 2008, on the Plaintiff's Motion for Summary Judgment and the two Cross-Motions for Summary Judgment filed by Intervening Defendants. Counsel for the Parties, Ms. Lydon, Mr. Blatt, Mr. Rudloff, and Mr. Haviland all stipulated on the record that: but for the exclusion at Paragraph III. K. of the Professional Liability Coverage Part, Plaintiff Medical Assurance Company would provide coverage to Dr. Dillaplain under the Medical Professional Liability Policy [policy number: MP36469].

As a result, the Court concludes that Plaintiff has waived or relinquished by stipulation, the affirmative defense of fraud or misrepresentation, and any potential effect of the contract provision related to General Condition XII. Therefore, the Court OVERRULES Plaintiff's objection related to General Condition XII.

08-10-1972

IV. Order of Adoption and Judgment Entry

The Court concludes that the Medical Professional Liability Policy that Plaintiff issued to Robert P. Dillaplain, (Exhibit A to Complaint) unambiguously and by its plain meaning, without resort to any extrinsic documents, clearly and unambiguously provides coverage to Robert P. Dillaplain under the terms of the policy for the medical incident that is the subject of Case No. 2005 CV 0381

pending in this Court, and that coverage is not excluded by Paragraph III. K. of the Professional Liability Coverage Part of the Policy.

Accordingly, the Court, ADOPTS as the Order of the Court the Magistrate's Decision filed on October 29, 2008 (Copy Attached).

The Court DENIES the Motion for Summary Judgment of Plaintiff, The Medical Assurance Company, requesting that the Court declare that Plaintiff has no obligation to defend the Defendant Robert P. Dillaplain in the Coleman underlying law suit, or to indemnify Defendant against any Judgment entered against him in the related Coleman medical malpractice law suit.

The Court GRANTS the Cross-Motions for Summary Judgment of Intervening Defendants Coleman Jr., a minor, Coleman Sr., and Cheryl Neer, and the separate Motion for Summary Judgment of Greene Memorial Hospital for a declaratory judgment that Plaintiff has an obligation to defend Defendant and to indemnify Defendant.

The Court GRANTS Summary Judgment in favor of the Intervening Defendants, the Colemans and Ms. Neer, and Greene Memorial Hospital and similarly grants a Declaratory Judgment that Plaintiff is obligated under the terms of the Medical Professional Liability Policy that it issued to Robert P. Dillaplain to defend Robert P. Dillaplain in the Coleman law suit and to indemnify Defendant Dillaplain against any Judgment entered against him in the Coleman law suit, Case No. 2005 CV 0381 in this Court.

The Court also GRANTS Greene Memorial Hospital's Motion to Strike the Affidavit of Kevin Brennan that was attached to Plaintiff's Objections to the Magistrate's Decision. The other Defendants joined in the Motion. The Court concludes that the affidavit was not directed to any issue, finding of fact or conclusion of law of the Magistrate's Decision. The Court does not require that the Affidavit of Mr. Brennan be removed from the file, but in ordering that it is stricken, the Courts ORDERS that the Affidavit be of no effect in this Adoption Order or with respect to any other motion in the Case.

09-01-1973

The Court assigns Court costs to Plaintiff The Medical Assurance Company, Inc.

This is a Final Appealable Order. There is no just cause for delay.

IT IS SO ORDERED

JUDGE STEPHEN A. WOLAVER 9/14/9

CERTIFICATE OF SERVICE: A copy hereof was faxed to:
John F. Haviland, Esq., 400 National City Center, 6 North Main Street, Dayton, Ohio 45402 via facsimile (937) 223-6339
Matthew P. Moriarty, Esq., and Ed E. Duncan, Esq., 1150 Huntington Bldg., 925 Euclid Avenue, Cleveland, OH 44115-1414 via facsimile (216) 592-5009
Drew Rudloff, Esq., the Greene Town Center, 50 Chestnut Street, Suite 230, Dayton, Ohio 45440 via facsimile (937) 427-8816
Shawn M. Blatt, Esq., One Dayton Centre, 1 South Main Street, Suite 1800, Dayton, Ohio 45402 via facsimile (937) 222-5369
Deborah R. Lydon, Esq., 255 East Fifth Street, Suite 1900, Cincinnati, Ohio 45202 via facsimile (513) 977-8141
on the date of the filing.

Gayle Manker
Gayle Manker, Assignment Commissioner

01-1974

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FILED

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TERRI A. MAZUR, CLERK
COMMON PLEAS COURT
GREENE COUNTY, OHIO

IN THE COMMON PLEAS COURT OF GREENE COUNTY, OHIO
GENERAL DIVISION (CIVIL)

THE MEDICAL ASSURANCE COMPANY, INC.,	CASE NO: 2007 CV 0725
Plaintiff,	JUDGE WOLAVER MAGISTRATE REYNOLDS
v.	
ROBERT P. DILLAPLAIN, M.D., et al.,	MAGISTRATE'S DECISION ON PLAINTIFF'S MOTION FOR SUMMARY JUDGMENT, AND ON INTERVENING DEFENDANTS' CROSS-MOTIONS FOR SUMMARY JUDGMENT
Defendants.	

This matter came before the Magistrate upon referral by the Court for hearing and decision on three pending Motions for Summary Judgment. The Court's Notice of Hearing and Order of Referral was filed on September 29, 2008. The Notice scheduled the hearing before the Magistrate on October 8, 2008 at 1:00 p.m.

On October 8, 2008 at 1:00 p.m., in Courtroom No. 3, Lower Level, Greene County Court of Common Pleas, 45 North Detroit Street, Xenia, Ohio 45385, the Magistrate held the hearing on the pending Motions for Summary Judgment. John F. Haviland, Esq., appeared on behalf of Plaintiff, The Medical Assurance Company, Inc. Drew Rudloff, Esq., appeared on behalf of Defendant Robert P. Dillaplain, M.D. Deborah R. Lydon, Esq., appeared on behalf of Intervening Defendants Jeffrey T. Coleman, Jr., a minor, Cheryl Neer, and Jeffrey Coleman, Sr. Shawn M. Blatt, Esq., appeared on behalf of Defendant Greene Memorial Hospital.

09-01-1975

Conclusions of Fact:

Defendant Robert P. Dillaplain is a medical doctor licensed to practice medicine in the State of Ohio. Doctor Dillaplain is a Party Defendant in another pending law suit in this Court; *Jeffrey T. Coleman, Jr., a minor, et al.*, v. *Robert P. Dillaplain, et al.*, Case Number 2005 CV 0381.

Plaintiff, the Medical Assurance Company, Inc. ("Medical Assurance") issued a medical professional liability policy to policy holder R. P. Dillaplain, M.D., Inc., policy number MP36469. (Complaint Exhibit A) Medical Assurance's underwriting supervisor Debra D. Parr certified that the Medical Professional Liability Policy attached to her memorandum at Exhibit A to the Complaint, Reporting Endorsement, is a true accurate copy of the Reporting Endorsement from policy number MP36469 issued effective 01/01/2003 with a retroactive date of 01/27/1983 to the insured physician Robert. P. Dillaplain, M.D. (Complaint Exhibit A)

The Professional Liability Coverage Part of the Policy at paragraph I. Insuring Agreement states:

> "We agree to pay on behalf of each **insured** all sums which such **insured** shall become legally obligated to pay as **damages** because of any **medical incident** which occurs after the **retroactive date** applicable to such **Insured** and which is first **reported** during the **policy period**; provided, however, that **insured paramedical employees** and **other covered employees** are covered only for **medical incidents** which occur while such persons are employed by an **insured organization** or **insured physician** and acting within the scope of such employment and while engaged in the performance of **professional services** which such persons hold any required license to perform. This insurance applies only to **medical incidents** arising out of **professional services** or peer **review services** rendered, or which should have been rendered, within the United States of America."

Professional Liability Coverage Part of the Policy at paragraph III. Exclusions states:

> "We will not pay **damages** because of any of the following, and we will not provide a defense for any suit alleging any of the following:
> *
> *
> *
> K. Any **medical incident** which has been **reported** to another insurance carrier prior to the first date coverage is provided under the **policy**; any **medical incident** which occurred prior to the first date coverage is provided under the **policy**, if on such date, the **insured** knew or believed, or had reason to know or believe, that such **medical incident**

had occurred; or any **medical incident** that occurred during a period in which the **insured** was not covered under a policy of professional liability insurance; or
L. Liability arising out of any claim or investigation instituted by a patient of any **insured** alleging errors or omissions by the **insured** in billing statements for **professional services** rendered to such patient."

Medical Professional Liability Policy Definitions section states:

"As used in the **policy**, the following terms shall have the following meanings:
*
*
*

Insured means any **insured organization**, any **insured physician**, any **insured paramedical employee**, and any **other covered employee**.
*
*
*

Medical Incident means:

A. a single act or omission or a series of related acts or omissions arising out of the rendering of, or failure to render, **professional services** to any one person by any **insured** or any person for who acts or omissions an **insured** is legally responsible, which results, or is likely to result in **damages**; or
B. a single act or omission or a series of related acts or omissions by an **insured physician** during the performance of **peer review services** which results, or is likely to result, in **damages**.

*
*
*

Policy means the **Cover Page**, the forms listed thereon, and any endorsements issued from time to time. The **policy** terms in effect at the time a **medical incident** is first **reported** shall apply to that **medical incident**.

Policyholder means the person or entity designated as such in the **Coverage Summary**.

Policy Period means the period specified as such in the **Coverage Summary**.

Professional services means the provision of medical services, including medical treatment, making medical diagnoses and rendering medical opinions or medical advice.

Report, reported, and reporting means when used with respect to a **medical incident**, the giving by an **insured** or his representative of notice of such **medical incident** either in writing or by telephone to **our** Claims Department specifying (1) the date, time, and place of the **medical incident**, (2) a description of the **medical incident**, (3) the name, address, and age of the patient or claimant, (4) the names of witnesses, including other treating physicians, and (5) the circumstances resulting in the **medical incident**.

09-01-1977

Reporting Endorsement means an endorsement issued with respect to an **insured** under Section VI, VII or VIII of the Professional Liability Coverage Part to provide coverage for **medical incidents first reported** after the insurance provided by the **policy** terminates as to such **insured**.

Retroactive date means the **retroactive date** applicable to each **insured** as specified in the **Coverage Summary**.

We, our and **us** refer to the company issuing the **policy**, which is designated as "THE COMPANY" on the **Cover Page**."

The Medical Professional Liability Policy Reporting Endorsement-Insured Physician(s) at Exhibit A to the Complaint, attached to a certification by Debra D. Farr, Underwriting Supervisor for The Medical Assurance Company, Inc. states that the policyholder is R.P. Dillaplain, M.D., Inc., that the endorsement effective date is January 1, 2003, the policy number is MP36469, the Termination Date is January 1, 2003, and the Retroactive Date is January 27, 1983. The endorsement states:

"This endorsement amends the Professional Liability Coverage Part of the **policy**.
In consideration of an additional premium of **$ 0.00**, the **insured physician(s)** named below shall be covered, under the terms and conditions of the **policy**, for any **medical incident** which occurred on or after the **retroactive date** applicable to each **insured physician**, as stated below, and prior to the above-stated Termination Date, but which is first **reported** after such Termination Date.
Our limits of liability resulting from **medical incidents** first **reported** after such Termination Date shall be as stated below. The limit of liability stated for each **insured physician** as "Each Medical Incident" is the total of **our** liability to such **insured physician** resulting from any one **medical incident** which is first **reported** after the Termination Date. The limit of liability stated for each **insured physician** as "Aggregate" is the total of **our** liability to such **insured physician** resulting from all **medical incidents** which are first **reported** after the Termination Date.
If Additional Limits of Liability are shown below, such Additional Limits of Liability shall apply only (1) to **medical incidents** which occur after the Additional Coverage Retroactive Date shown below for each **insured physician** and (2) after exhaustion of the Primary Limits of Liability applicable to such **insured physician**.
[Except for nonpayment of premium and acts by an **insured** which render the **policy** terminable by **us** or void, the **policy** may not be cancelled by **us**.]

09-01-1978

INSURED PHYSICIANS

Primary Limits of Liability

Name	Retroactive Date	Each Professional Incident	Aggregate
Dillaplain, Robert P.	1/27/1983	$1,000,000.00	$3,000,000.00"

At the hearing on Plaintiff's, Medical Assurance's, Motion for Summary Judgment and on the two Cross-Motions for Summary Judgment by Intervening Defendants Jeffrey Coleman, Jr, a minor, Cheryl Neer, and Jeffrey Coleman, Sr., and by Intervening Defendant Greene Memorial Hospital, respectively, Counsel for the Plaintiff, John F. Haviland, Esq., and Counsel for the Intervening Defendants Debrorah R. Lydon, Esq. (for the Colemans and Ms. Neer) and Shawn M. Blatt, Esq. (for Greene Memorial Hospital), and Drew Rudloff, Esq. for Defendant Robert P. Dillaplain, stipulated on the record:

(1) Defendant Dillaplain was given written notice in 1995 that the Plaintiffs in the case, *Jeffrey T. Coleman, a minor, et al.* v. *Robert P. Dillaplain, M.D., et al.*, Case Number 2005 CV 0381 in the Court of Common Pleas of Greene County Ohio, in a 180 day letter, were considering bringing an action against Dr. Dillaplain for his professional care and treatment of certain of the individuals who later became the Plaintiffs in that law suit, case No. 2005 CV 0381. (Complaint, Para 8.) The allegation was denied by Greene Memorial Hospital in Answer to Complaint and denied by Intervening Defendants Coleman and Neer in Answer to Complaint. Plaintiff's answer to Interrogatory 5 from Greene Memorial Hospital stated: "without waiving this objection, this malpractice claim was made known to Dr. Dillaplain on or about February 7, 1995. The malpractice claim was reported to the P.I.E. Mutual Insurance Company no later than March 17, 1995. Dr. Dillaplain had been insured with the P.I.E. Mutual Insurance Company in February 1995."

(2) At the hearing on the Motion for Summary Judgment, Counsel for the Parties, Drew Rudloff, Esq., Deborah R. Lydon, Esq., Shawn M. Blatt, Esq., and John F. Haviland, Esq. also stipulated on the record that: the first time Medical Assurance Company became aware of a medical incident involving Defendant Robert P. Dillaplain, M.D., and Jeffrey Coleman, Jr., was on or about the time when the medical malpractice action, Case No. 2005 CV 0381, was filed in

09-01-1979

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this Court against Dr. Dillaplain. The Court takes judicial notice of the Court's Docket for that case and finds that the Complaint in that medical malpractice action was filed on May 9, 2005.

(3) At the hearing on October 8, 2008 on the Plaintiff's Motion for Summary Judgment and on the two Cross-Motions for Summary Judgment filed by Intervening Defendants, Counsel for the Parties, Ms. Lydon, Mr. Blatt, Mr. Rudloff, and Mr. Haviland all stipulated on the record: But for the exclusion at Paragraph III. K. of the Professional Liability Coverage Part, Plaintiff Medical Assurance Company would provide coverage to Dr. Dillaplain under the Medical Professional Liability Policy [policy number: MP36469].

Conclusions of Law:

1. An insurance policy is a contract:

"An insurance policy is a contract whose interpretation is a matter of law... when confronted with an issue of contractual interpretation, the role of a court is to give effect to the intent of the parties to the agreement...we examine the insurance contract as a whole and presume that the intent of the parties is reflected in the language used in the policy... We look to the plain and ordinary meaning of the language used in the policy unless another meaning is clearly apparent from the contents of the policy...When the language of a written contract is clear, a court may look no further than the writing itself to find the intent of the parties...As a matter of law, a contract is unambiguous if it can be given a definite legal meaning." *Cincinnati Ins. Co. v. C.P.S. Holdings, Inc.* (2007), 115 Ohio St. 3d 306, 875 N.E. 2d 31, 2007-Ohio-4917 (other citations, page 307, omitted).

In the case of *Felton v. Nationwide Mutual Fire Insurance Company* (2005), 163 Ohio App.3d 436, 839 N.E. 2d 34 (Ohio App. 9 Dist., 2005) the Court cites three guiding principles from decisions of the Supreme Court of Ohio applicable to the interpretation of an insurance contract:

"The interpretation of an insurance contract is a matter of law. *Nationwide Mut. Fire Ins. Co. v. Guman Bros. Farm* (1995), 73 Ohio St. 3d 107, 108, 652 N.E. 2d 684. When interpreting an insurance contract, it is incumbent upon this court to 'look to the plain and ordinary meaning of the language used in the policy unless another meaning is clearly apparent from the contents of the policy.' *Westfield Inc. Co. v. Galatis*, 100 Ohio St. 3d 216, 2003-Ohio-5849, 797 N.E. 2d 1256, at paragraph 11. As *Felton* points out, it is axiomatic that a policy will be construed

liberally in favor of the insured and strictly against the insurer where the provisions at issue are reasonably susceptible of more than one interpretation. *King v. Nationwide Ins. Co.* (1988), 35 Ohio St. 3d. 208, 211, 519 N.E.2d 1380."

2. Summary Judgment:

A. Civ. R. 56

B. Summary judgment is proper when (1) no genuine issue as to any material fact remains to be litigated, (2) the moving party is entitled to judgment as a matter of law, and (3) it appears from the evidence that reasonable minds can come to but one conclusion, and viewing such evidence most strongly in favor of the party against whom the motion is made, that conclusion is adverse to that party. *Harless* v. *Willis Day Warehousing Co.*, Inc. (1978), 54 Ohio St.2d 64, 65-66, 375 N.E.2d 46.

"[A] party seeking summary judgment, on the ground that the nonmoving party cannot prove its case, bears the initial burden of informing the trial court of the basis for the motion, and identifying those portions of the record that demonstrate the absence of a genuine issue of material fact on the essential element(s) of the nonmoving party's claims." *Dresher* v. *Burt* (1976), 75 Ohio St.3d 280, 293, 662 N.E.2d 264.

If the moving party has satisfied this initial burden, the nonmoving party has a reciprocal burden under Civ.R. 56(E) to set forth facts showing there is a genuine issue for trial. *Id.* at 293, 662 N.E.2d 264.

The nonmoving party is entitled to have the evidence construed most strongly in his favor. *Zivich* v. *Mentor Soccer Club, Inc.*, (1998), 82 Ohio St. 3d 367, 369-370, 696 N.E.2d 201.

The burden of establishing that the material facts are not in dispute and that no genuine issue of facts exists is on the party moving for summary judgment. *Hamlin* v. *McAlpin Co.* (1964), 175 Ohio St. 517, 519-520, 196 N.E.2d 781.

When a properly supported motion for summary judgment is made, an adverse party may not rest on mere allegations or denials in the pleading, but must respond with specific facts showing that there is a genuine issue of material fact. Civ.R. 56(E). A material fact is one which would affect the outcome of the suit under the applicable substantive law. *Needham* v. *Provident Bank* (1996), 110 Ohio App.3d 817, 826, 675 N.E.2d 514, citing *Anderson* v. *Liberty Lobby, Inc.* (1986), 477 U.S. 242, 248, 91 L. Ed. 2d 202, 106 S. Ct. 2505.

Discussion:

The issue raised by the three Motions for Summary Judgment in this Case is whether the Medical Professional Liability Policy ("Policy") provided by Plaintiff Medical Assurance Company to Dr. Dillaplain excluded coverage of Dr. Dillaplain in the related medical malpractice case (Case No. 2005 CV 0381) presently stayed in this Court awaiting the Court's determination in this Case of Plaintiff's Complaint for Declaratory Judgment.

Coverage:

Before considering whether coverage is excluded for any reason under the Policy, the Magistrate must first determine whether the Policy provides coverage to Dr. Dillaplain for the medical incident that is the basis for Case No. 2005 CV 0381. Coverage under the Policy depends upon when a medical incident occurred and when it is first reported.

Provisions applicable to coverage appear in pertinent part in "The Professional Liability Coverage Part of the Policy at paragraph I. Insuring Agreement" ("Insuring Agreement") and in "The Medical Professional Liability Policy Reporting Endorsement-Insured Physician(s)" ("Reporting Endorsement").

The Insuring Agreement and the Reporting Endorsement provide "payment" (Insuring Agreement) or cover[age] (Reporting Endorsement) in pertinent part as follows: "any **medical incident** which occurs after the **retroactive date** applicable to such **Insured physician**" (Insuring Agreement) or "for any **medical incident** which occurred on or after the **retroactive date** applicable to each **Insured physician**" (Reporting Endorsement).

As to the reporting date for purposes of coverage, the language of "The Professional Liability Coverage Part of the Policy at paragraph I. Insuring Agreement" at Exhibit A differs from the language of "The Medical Professional Liability Policy Reporting Endorsement-Insured Physician(s)" at Exhibit A to the Complaint.

"The Professional Liability Coverage Part of the Policy at paragraph I. Insuring Agreement" states in pertinent part:

> "We agree to pay on behalf of each **insured** all sums which such **insured** shall become legally obligated to pay as **damages** because of any **medical incident** which occurs after

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the retroactive date applicable to such Insured *and which is first reported during the policy period....* (Italicized emphasis added)

The "Reporting Endorsement" states in pertinent part:

"This endorsement amends the Professional Liability Coverage Part of the policy. In consideration of an additional premium of $ 0.00, the insured physician(s) named below shall be covered, under the terms and conditions of the policy, for any medical incident which occurred on or after the retroactive date applicable to each insured physician, as stated below, and prior to the above-stated Termination Date, *but which is first reported after such Termination Date.* (Italicized emphasis added)

The apparent conflict between the reporting date in the Insuring Agreement and the reporting date in the Reporting Endorsement is readily resolved by the plain language of the Reporting Endorsement that expressly states, "This endorsement amends the Professional Liability Coverage Part of the policy." Hence, the Magistrate concludes that for the insured physician, Dr. Dillaplain, to be covered for a medical incident, the medical incident must have occurred after the retroactive date applicable to Dr. Dillaplain, i.e., January 27, 1983, but prior to the Termination date, i.e., January 1, 2003, and, must have been first reported after such Termination Date, i.e., after January 1, 2003. The medical incident occurred September 16, 1983, after the Policy's retroactive date for coverage, January 27, 1983, but prior to the Termination Date of the policy, January 1, 2003. Unless coverage is excluded, Dr. Dillaplain is covered by Plaintiff's Policy for the medical incident that is the subject of Case No. 2005 CV 0381.

Exclusions:

Plaintiff argues that Subparagraph III. K. excludes coverage in this Case because the insured Dr. Dillaplain knew of a "medical incident" involving Jeffrey T. Coleman, a minor, in 1995 and because Dr. Dillaplain reported the medical incident to another insurance carrier, P.I.E. Mutual Insurance Company, in 1995. The specific wording of the exclusion is that any medical incident which has been reported to another insurance carrier prior to the first date coverage is provided under the Policy is excluded from coverage. In addition, any medical incident which occurred prior to the first date coverage is provided under the Policy is excluded, if on such date

(the first date coverage is provided under the policy), the insured knew or believed, or had reason to know or believe, that such medical incident had occurred.

"First date coverage is provided under the policy."

The question of whether an exclusion applies, and the determination of the Motions for Summary Judgment, depend upon the date that is "the first date coverage is provided under the policy." Plaintiff and Defendants disagree on what that date is.

Plaintiff argues that the first date that coverage is provided under the policy is the first date of the policy period, January 1, 2002, as stated on the coverage summary page of the policy attached to the Complaint. Intervening Defendants argue that the first date coverage is provided under the policy is the policy's retroactive coverage date, January 27, 1983. Counsel for Intervening Defendants Colemans and Cheryl Neer correctly points out that, when drafting the Policy, Medical Assurance Company could have used the term "policy period" in the exclusion instead of the term "first date coverage is provided" if Medical Assurance intended exclusion III. K. to exclude from coverage medical incidents reported or known prior to the first date of the policy period, January 1, 2002.

The "retroactive date" "as stated below" on the Reporting Endorsement is January 27, 1983. The medical incident in Case No. 2005 CV 0381, *Jeffrey T. Coleman, a minor, et al.* v. *Robert P. Dillaplain, M.D., et al.* occurred after the retroactive date of January 27, 1983. The medical incident "ar[ose] from care and treatment provided by the Defendant [Robert P. Dillaplain] commencing on or about September 16, 1983 and continuing thereafter." (Complaint for Declaratory Judgment by Medical Assurance Company Inc., para 6.) The medical incident was first reported to the Medical Assurance Company in 2005, after the Termination Date of the Policy, January 1, 2003.

The Magistrate concludes that "the first date coverage is provided under the policy" is January 27, 1983 the "Retroactive Date" for coverage. That date is the first date that coverage is provided to Dr. Dillaplain by the Policy as amended by the Reporting Endorsement. The clear and unambiguous language of the Reporting Endorsement attached to the Complaint states that the "insured physician named below shall be covered, under the terms and conditions of the policy, for any medical incident which occurred on or after the retroactive date applicable to each

insured physician, as stated below [January 27, 1983], and prior to the above-stated Termination Date [1/1/2003], but which is first reported after such Termination Date."

Reported to another insurance carrier and Insured's knowledge or belief

Hence, unless coverage is otherwise excluded under Para. III. K. pursuant to terms applicable to reporting of the medical incident to "another insurance carrier" or because of the knowledge or belief of Dr. Dillaplain on January 27, 1983, the Medical Professional Liability Policy including the Reporting Endorsement covered the insured physician, Robert P. Dillaplain for the medical incident that occurred on September 16, 1983 involving the Colemans and Cheryl Neer.

The Magistrate concludes that coverage is not excluded by Policy Subparagraph III. K that excludes coverage for any medical incident which has been reported to another insurance carrier prior to the first date coverage is provided under the Policy, i.e., prior to January 27, 1983. Dr. Dillaplain first reported the medical incident that later became the basis for the medical malpractice Case No. 2005 CV 0381, to P.I.E. Medical Insurance Company on or about March 17, 1995, after Dr. Dillaplain was notified of the medical incident by 180 day letter, on or about February 7, 1995.

In addition, coverage is not excluded by the next sentence of Para. III. K. that excludes any medical incident which occurred prior to the first date coverage is provided under the Policy, if on such date, the insured knew or believed, or had reason to know or believe, that such medical incident had occurred. Dr. Dillaplain could not have known on January 27, 1983 of the medical incident that occurred on and following September 16, 1983.

In support of its argument that January 1, 2002 is the first date that coverage is provided to Dr. Dillaplain under the policy, the Medical Assurance Company also argues that the exclusion at paragraph III.K. of the Professional Liability Coverage Part of the policy is meaningless and superfluous if "the first date coverage is provided" is January 27, 1983. Medical Assurance argues that the exclusion at subparagraph K is meaningless if the first date of coverage is January 27, 1983, because "any incident that occurred prior to January 27, 1983 is necessarily not covered under the terms of the policy."

The Magistrate does not agree with Plaintiff's argument. The exclusion has meaning and would have applicability to a medical incident as defined in the policy as a single act or omission

or a series of related acts or omissions. If an act or omission or series of related acts or omissions first occurred before January 27, 1983, notwithstanding that other related acts or omissions occurred after January 27, 1983, Subparagraph III. K. would exclude the "medical incident" from coverage. In this Case, the exclusion does not apply because the medical incident first occurred on September 16, 1983.

The Magistrate concludes that the Plaintiff's Medical Professional Liability Policy issued to Robert P. Dillaplain provides coverage for the medical incident that is the subject of Case No. 2005 CV 0381 pending in this Court, and that coverage for the medical incident is not excluded by the Policy.

Decision:

Plaintiff The Medical Assurance Company requested that the Court declare that Plaintiff has no obligation to defend the Defendant Robert P. Dillaplain in the related Coleman/Neer medical malpractice law suit, or indemnify Defendant Dr. Dillaplain against any Judgment entered against him in the related Coleman medical malpractice law suit. In its Motion, Plaintiff sought such Declaratory Judgment by Summary Judgment. Intervening Defendants the Colemans, Cheryl Neer and Greene Memorial Hospital opposed the Plaintiff's Motion for Summary Judgment and filed their own Cross Motions for Summary Judgment. Defendant Dr. Dillaplain, in his Memorandum in Opposition filed on June 10, 2008, incorporated in his memorandum, the arguments of Intervening Defendants in their oppositions to Plaintiff's Motion for Summary Judgment. The Magistrate DENIES the Plaintiff's, Medical Assurance Company's Motion for Summary Judgment and request for Declaratory Judgment.

By Cross-Motions for Summary Judgment, Intervening Defendants Coleman Jr., a minor, Coleman Sr., and Cheryl Neer, and by separate Motion, Greene Memorial Hospital seek a declaratory judgment that Plaintiff has an obligation to defend Defendant Dr. Dillaplain and to indemnify Defendant Dr. Dillaplain in the related medical malpractice law suit, Case No. 2005 CV 0381. There is no genuine issue of material fact and Intervening Defendants are entitled to Judgment as a matter of law.

Pursuant to Civ. R. 56, the Magistrate GRANTS the two Cross-Motions for Summary Judgment filed by the Colemans and Ms. Neer, and by Greene Memorial Hospital respectively. The Magistrate GRANTS Intervening Defendants' requests for declaratory judgment and

concludes that Plaintiff has an obligation to defend and to indemnify Dr. Dillaplain within the terms, including the limits, of the Policy.

Accordingly, it is the Magistrate's Decision that the Medical Professional Liability Policy that Plaintiff issued to Robert P. Dillaplain, (Exhibit A to Complaint) unambiguously and by its plain meaning, provides coverage to Robert P. Dillaplain under the terms of the policy for the medical incident that is the subject of Case No. 2005 CV 0381 pending in this Court, and such coverage is not excluded under the Policy.

The Magistrate GRANTS Summary Judgment in favor of the Intervening Defendants, the Colemans and Ms. Neer, and Greene Memorial Hospital against Plaintiff Medical Assurance Company, and grants a Declaratory Judgment that Plaintiff is obligated under and in accordance with the terms and limits of the Medical Professional Liability Policy that it issued to Robert P. Dillaplain to defend Robert P. Dillaplain in the Coleman law suit and to indemnify Defendant Dillaplain against any Judgment entered against him in the Coleman law suit, Case No. 2005 CV 0381 in this Court, under the terms, including the limits, of the Policy.

The Magistrate assigns Court costs to Plaintiff The Medical Assurance Company, Inc.

MAGISTRATE GEORGE B. REYNOLDS

09-01-1987

PARTIES AND COUNSEL ARE REFERRED TO CIV. R. 53 FOR FILING OBJECTIONS TO A MAGISTRATE'S DECISION. THIS MAGISTRATE'S DECSION WILL NOT TAKE EFFECT UNLESS AND UNTIL ADOPTED AS THE ORDER OF THE COURT.

PARTIES AND COUNSEL ARE WARNED THAT CIV.R.53 (D)(3)(b)(iv) PROVIDES THAT A PARTY SHALL NOT ASSIGN AS ERROR ON APPEAL, A COURT'S ADOPTION OF ANY FACTUAL FINDING OR LEGAL CONCLUSION OF A MAGISTRATE, WHETHER OR NOT SPECIFICALLY DESIGNATED AS A FINDING OF FACT OR CONCLUSION OF LAW UNDER CIV.R.53(D)(3)(a)(ii), UNLESS THAT PARTY HAS OBJECTED TO THAT FINDING OR CONCLUSION AS REQUIRED BY CIV. R. 53 (D)(3)(b).

CERTIFICATE OF SERVICE: A copy hereof was faxed to:
John F. Haviland, Esq., 400 National City Center, 6 North Main Street, Dayton, Ohio 45402 via facsimile (937) 223-6339

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Drew Rudloff, Esq., the Greene Town Center, 50 Chestnut Street, Suite 230, Dayton, Ohio 45440 via facsimile (937) 427-8816
Shawn M. Blatt, Esq., One Dayton Centre, 1 South Main Street, Suite 1800, Dayton, Ohio 45402 via facsimile (937) 222-5369
Deborah R. Lydon, Esq., 255 East Fifth Street, Suite 1900, Cincinnati, Ohio 45202 via facsimile (513) 977-8141
on the date of the filing.

Sarah E. Thompson
Assignment Commissioner

8861-10-60