NORMAN, HANSON & DETROY, LLC

newsletter

Current developments in Maine law
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Diagnosing chronic back pain

Are discograms an accurate, reliable test?

BY JONATHAN BROGAN

Discogenic pain, despite its name, was not invented by John Travolta. Many doctors diagnose a pain in the back which is persistent, unresponsive to non-operative therapies, and shows no surgically correctable source, as "discogenic pain."

Discogenic pain can involve cervical, thoracic and/or lumbar discs. Patients generally report it as a constant debilitating pain which is aggravated by movement in the affected areas.

Discogenic pain lacks any neurologic signs or deficits. There is no evidence of nerve root compression. CT and MRI studies appear normal, although advanced MRI scans sometimes show high intensity zones (HIZs) of possible disc damage.

When an HIZ has been identified, many doctors follow that test with a discogram. It is also called a diagnostic disc injection, or discography, because it involves injecting x-ray dye under pressure into the center internal area of the disc. If a disc is damaged or disrupted, the dye runs into the tears in the disc which may cause a subjective pain response. Because the dye is radioactive, it can be tracked "leaking" out of the annular wall of the disc.

While the disc is being injected, patients are asked to report if they have any discomfort or pain. Doctors evaluate the severity and reality of a patient's complaints by their responses. If they report that they are feeling pain and it is a familiar pain, or as medical doctors call it "concordant" pain, then some physicians believe this is evidence that the injected disc is the source of the patient's pain. However, for the test to be interpreted as "valid," another disc must be tested. In other words, some clinicians believe the only way to determine if the test performed on a patient is accurate is to test a second disc in which the patient has no complaints of pain and determine that the test indeed reveals no pain.

The reason for the disc injection testing is that many doctors believe that spinal fusion can be done to stabilize the disc area and to bring the patient relief of their back pain.

Award-winning studies led by Dr. Eugene Carragee of Stanford University have called into question the use of spinal fusion techniques to relieve back pain and the use of discograms to diagnose it. The researchers used a study technique that involved people with reported back pain and people without any back pain. Those tests demonstrated that pain intensity on discographic evaluation was similar in both the symptomatic and the asymptomatic groups, therefore the tests cannot reliably indicate where the pain is coming from.

The researchers also called into question the doctor's reliance on concordant pain. The study suggested that

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concordant pain cannot reliably discriminate between symptomatic and asymptomatic individuals, and that high intensity zones are not a reliable indicator of discogenic pain. The test data show that the prevalence of HIZs in asymptomatic people, those who are not complaining of back pain, make the test clinically useless to diagnose back pain.

The researchers found that discography was not a useful tool in discriminating between painful and non-painful back conditions. The studies showed that a positive HIZ usually leads to a positive and painful disc injection, but the complaint of pain with a disc injection appears to be independent of chronic low back pain.

Stress markers

What then are doctors left with as a real marker for chronic back complaints? Not coincidentally, the studies showed that the best predictor of back pain in discograms is the psychological and social stress that a patient is suffering from at the time of their back complaints. People with poor coping skills, or those with ongoing workers' compensation or personal litigation issues that are related to a back injury, are more likely to perceive discography as painful, and to have symptoms of low back pain during daily activities.

Virtually everyone will develop disc tears at one time or the other, although not everyone will have painful side effects. The research studies do show that not every disc tear is painful and not all low back pain results from a damaged disc.

Physicians need to be acutely aware of the emotional and psychological factors that may be affecting how patients perceive their back pain. Many believe it is vital for a patient's recovery to get to the true root of the problem, which may have both physical and emotional dimensions. It is extremely important to avoid unnecessary, invasive and expensive treatments, such as back fusions, that reinforce the patient's belief that he has a grave disease of the spine, or an injury to it.

In defending claims involving a diagnosis of discogenic pain, the very diagnosis must be questioned from the outset. Clearly there are people who suffer from painful discs. However, just as clearly doctors do not have the ability to reliably indicate the source of such pain through the tests of discography and MRI.

Nonphysical factors, including secondary gain issues, need to be explored with any doctor diagnosing discogenic pain. Discography is rife with false positive results. Most people over the age of 50 will likely have internally disruptive discs, and many asymptomatic people will have high intensity zones on MRIs and positive discograms when injected. Discograms should not be the only basis for expensive and ultimately unsuccessful fusion surgery on people reporting chronic pain. These issues must be explored in deposing any doctor, and refuting claims that trauma associated with an accident led to a disc disruption that eventually led to chronic back pain. □

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newsletter
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Prevailing party may recover expert witness deposition costs

If the party who prevails in a lawsuit must depose an expert witness because that witness is unable to appear at trial, the fees for the expert's appearance at the deposition, and all costs in connection with preparing, editing and presenting the transcript and videotape may now be included in trial costs. The fees and costs are at the discretion of the court.

The Maine Supreme Judicial Court recently amended the Maine Rules of Civil Procedure to allow compensation for expert witnesses who appear at trial by deposition, as well as those who testify at trial in person. Prior to this amendment, an expert witness fee and the costs for videotaping the deposition, were not allowed as taxable costs if the witness did not appear live at trial. The Court determined that the costs of videotaping, other recording and editing related to presentation at trial may now be recovered by the party that prevails.

MORE LIMITS ON HOMEOWNERS COVERAGE

Maine is among the 34 states and District of Columbia that have signed on to the mold limitation in homeowners policies approved by the Insurance Service Office. It allows insurers to exclude coverage for loss because of mold and wet or dry rot, unless the loss results from a covered peril of water damage such as a windstorm, or accidental overflow of water or steam. A policy may include an option of a $10,000 limit for loss caused by fungi, wet or dry rot, and include the cost of mold removal that would necessitate replacing any part of the property.

Taking the offensive in third-party mold claims

By Tom Marjerison

The major verdicts awarded in first-party mold cases have attracted major media attention. This growth in mold litigation has extended to third-party claims, and many of the same coverage issues apply to both types of claims. Nevertheless, the similarities end there.

Third-party claims present a variety of unusual defenses that insurers may employ to avoid liability before coverage issues are even raised. For instance, the economic loss doctrine may provide statute of limitation defenses in many mold claims. It is important that adjusters consider the economic loss doctrine, and other unique liability defenses, when evaluating these cases.

Claims against homeowners

In most cases involving active, indoor exposure to mold, the HO-3 resident relative exclusion will bar coverage. Usually, any person routinely exposed to indoor mold will be an insured or a relative of an insured. The one exception to this rule involves the sale of an insured home.

Insurers throughout Maine have experienced an increase in "bad home" cases arising from incomplete or inaccurate disclosures in private home sales. Insurers can expect to see an increase in claims centered on a failure to disclose the existence of mold or prior property damage.

Insurers can also anticipate claims centering on negligence and intentional misrepresentation and fraud. The insured's knowledge of water damage or mold prior the sale will be of considerable importance in defending these cases, and in seeking summary judgment once suit is filed. At the outset of any mold claim, it is imperative that insurers conduct a thorough investigation to establish that the insured did not have knowledge or reason to know that mold was present in a house they sold.

Claims against commercial landlords

Claims against commercial insureds will be more complex and more dangerous. Landlords frequently will face a variety of claims from tenants exposed to mold. Although there is a tenuous connection between indoor mold exposure and personal injuries in healthy individuals, the business interruption and property damage components on these claims will have significant value.

For instance, mold infestation of a restaurant may result in significant damages for business interruption during remediation efforts, and additional business interruption from public knowledge of the presence of mold—i.e. residual stigma damages. These damages can be significant without a personal injury claim.

Claims against construction professionals

The inherent conflict between designing an energy efficient home and the need for proper ventilation often results in a good environment for mold growth. As insurers have discovered, many water intrusion claims actually result from improper ventilation. Insurers should anticipate that many of these "moisture problems" will result in future mold claims against construction professionals. Of course, these claims also present complex coverage issues under exclusions j-m of standard CGL policies.

TOM MARJERISON

The economic loss doctrine

The economic loss doctrine is one of the more difficult legal concepts to grasp, and presents difficulties for adjusters who are accustomed to analyzing economic loss and property damage issues in the context of CGL policies. However, it can be a "silver-bullet" defense in construction defect mold claims.

Part of the confusion surrounding the doctrine arises from its underlying rationale. The economic loss doctrine marks the fundamental boundaries between the law of contracts, which is designed to enforce expectations created by agreement, and, the law of torts, which is designed to protect citizens and their property by imposing a duty of reasonable care on others. See ***Fireman's Fund Ins. Co. v. Childs,*** *52 F.Supp.2d 139, 142 (D.Me. 1999),* citing Sidney R. Barrett, Jr., *Recovery of Economic Loss in Tort for Construction Defects: A Critical Analysis, 40 S.C.L.Rev. 891, 894-95 (1989).* In other words, the economic loss doctrine provides the dividing line between contractual causes of action and tort causes of action.

The economic loss doctrine prevents recovery in tort for damages for inadequate value, cost of repair and replacement of defective product, or consequent loss of profits—without any claim of personal injury or damage to other property. See ***Oceanside at Pine Point Condo. Ass'n v. Peachtree Doors, Inc.,*** *659 A.2d 267, 270 n.4 (Me. 1995).* Parties are limited to contractual causes of action, rather than tort theories of recovery.

Statute of limitation defenses

The most significant difference between contract claims and tort claims involves the accrual of a cause of action. In contract, a cause of action accrues at the time of the breach—i.e. the date of the poor workmanship or incomplete work.

In tort, a cause of action accrues at the time of the damage.

In many construction defect cases, the damage—i.e. mold infestation—does not occur or is not discovered for many years. For instance, if poor workmanship or incomplete construction occurring in 1995 resulted in mold infestation discovered in 2003, contractual causes of action would be barred by the statute of limitations. See ***Dunelawn Owners' Association, et al. v. Gendreau,*** *750 A.2d 591 (Me. 2000).* In other words, since the complaint was filed more than six years from the date of the breach—i.e. poor or incomplete workmanship—the statute of limitations has run.

On the other hand, tort causes of action would not be barred by the statute of limitations since the cause of action does not accrue until the date of the damage—i.e. the mold infestation in 2003. However, since the economic loss doctrine bars tort claims for damages for inadequate value, cost of repair and replacement of defective product, or consequent loss of profits, the plaintiff's claims are time-barred. This is the "silver-bullet" defense afforded by the economic loss doctrine.

The "integrated product" rule under the economic loss doctrine

The economic loss doctrine also engenders confusion due to different meanings of the terms "product" and "economic loss" in liability and coverage analyses. The meaning of these terms in the context of the economic loss doctrine is very different than the meaning of the same terms in standard CGL policies.

Under the economic loss doctrine, the "product" is defined by what the plaintiff is buying rather than a specific product sold by a defendant. In other words, a homeowner purchases a completed home from a general contractor, and not component parts of a building-i.e. windows, insulation, roof shingles, etc. Even if defective windows caused water and mold damage to insulation and wallboard, the economic loss doctrine treats the defective windows as an integrated part of the whole product, that is the completed building. See *Oceanside at Pine Point Condo. Ass'n v. Peachtree Doors, Inc.*. (Condominium owners were precluded under economic loss doctrine from recovering under tort theories since damages alleged were to finished condominium units purchased by owners).

Conclusion

Third-party mold claims do not present the same pitfalls posed by first-party claims. Because of the unique liability issues raised in mold litigation, insurers often have the opportunity to use unique defenses to short-circuit claims. Although the economic loss doctrine is confusing, insurers need to quickly flag those cases where the doctrine may be applicable. If insurers and the defense bar take the offensive on these claims, defense verdicts will be the norm rather than the exception. □

Briefs/Kudos

A daring credit union rescue: As a young mother drove up to the teller's window to make a deposit at EVERGREEN CREDIT UNION in Windham, a sharp gust of wind snatched her paycheck, and she tried to retrieve it, leaving the transmission in drive. The van rolled into traffic with her 4-year-old child inside, but quick-thinking teller Jamie Smith charged across the busy roadway and leapt into the driver's seat. Nobody was hurt, though Smith said she had sore legs. "I was wearing 4-inch heels, and I'm very out of shape."

STEVE MORIARTY spoke on the topic of Smallpox Immunization and Workers' Compensation at a program sponsored by Synernet at the Augusta Civic Center in February.

Attorney **LANCE WALKER** tells us that, in addition to his liability practice, he will now be working closely on insurance coverage matters with JIM POLIQUIN. He has moved to our expanded offices on the sixth floor.

DAN CUMMINGS and **ROD ROVZAR** accompanied a delegation of Maine Credit Union leaders to CUNA's annual Governmental Affairs Conference in Washington in late February. Trip highlights included breakfast meetings with Senators Olympia Snowe and Susan Collins, and freshman Representative Michael Michaud.

In early March, Rod addressed the Alex Ferguson Chapter of Maine Credit Unions on the Patriot Act.

As many of you know, **STEVE HESSERT** was seriously injured while training with his sled dog team in New Hampshire on February 15, 2003. Toward dusk, a speeding snowmobiler struck Steve and his dog sled from behind, and fled the scene. Fortunately, Steve was found and rescued by other snowmobilers, and was ultimately airlifted to the Maine Medical Center in Portland. While not yet back to work, Steve is progressing well and the long-term prognosis is good. A suspect has been arrested, and is facing criminal charges in New Hampshire.

TOM MARJERISON conducted a well-attended seminar on the Economic Loss Doctrine in March, particularly its value in defense of claims of mold in buildings.

In our uncertain economic times, it comes as a pleasant surprise that members of the EAST MILLINOCKET FEDERAL CREDIT UNION received rebates from the CU's earnings at the end of 2002. A total of $79,927.17 was returned to many of its 4,481 members as share dividend and loan interest rebates. □

Workers' compensation – Law Court decisions

By Stephen W. Moriarty

Extension of benefits

In 1999 and 2000, the Workers' Compensation Board acted pursuant to §213(4) to extend the period of entitlement to benefits for partial incapacity by 52 weeks in each instance. As a result, in the spring of 2001 the duration of entitlement stood at 364 weeks. In early 2001 the Board proposed a rule extending the period by an additional 52 weeks, but in April a motion to adopt the rule and extend benefits failed on a 4-0-3 vote. As the result, the benefit period was not extended.

The Maine AFL-CIO and several individuals plaintiffs filed a complaint in the Kennebec County Superior Court challenging the Board's implicit factual finding that the frequency of Maine cases paying benefits for total or partial incapacity was greater than the national average. The Superior Court dismissed the action on the grounds that it was brought in an untimely fashion, and the Law Court affirmed on appeal.

The Court's decision turns largely upon the intricacies of the Maine Administrative Procedure Act, 5 M.R.S.A. §8001 et seq. The Court initially held that the Board was not required by law to actually adopt a rule, and that therefore there could be no judicial review of the alleged refusal or failure to adopt. As the Court reasoned, the Board did not need to adopt a rule in order to maintain the existing 364 week entitlement.

The plaintiffs also sought to challenge the Board's final agency action and its implicit finding regarding the comparison of Maine cases to the national average. By statute, such an appeal must be filed within 40 days, but the plaintiffs' appeal was filed after the period expired. As a result, the Law Court determined that the Superior Court had appropriately dismissed the claim as untimely, and did not reach the issue of whether the plaintiffs could have appealed from the Board's implied factual findings.

Section 201(6) entitlement

Six years ago the Law Court held in *Ray v. Carland Construction, Inc., 1997 ME 206, 703 A.2d 648*, that in multi-injury cases, the entitlement to benefits is governed exclusively by Title 39-A. In 1998 the Legislature acted to reverse the Court's decision and adopted §201(6), which provides that if disability is partly attributable to an injury occurring before January 1, 1993, all rights and benefits are determined by the law in effect at the time of the earlier injury. In a recent decision, the Law Court applied 201(6) in an unusual and unexpected fashion.

In ***Dunson v. South Portland Housing Authority,*** *2003 ME 16 (February 7, 2003)* the employee had been found to be totally disabled due to the combined effects of three separate occupational injuries with three different employers, the first of which occurred in 1991. The presiding Hearing Officer found that the 1991 injury was only 25% responsible for the overall disability. The law in effect at the time of that injury mandated annual inflation adjustments for total incapacity commencing on the third anniversary date of the injury, although no adjustments were to be made for partial incapacity. Initially, the Hearing Officer ruled that the employee was entitled to inflation adjustments for that portion of the disability attributable to the 1991 injury, but reversed the determination in findings of fact on the grounds that the employee was only 25% partially disabled as a result of the 1991 injury.

On appeal, the Law Court vacated the decision of the Hearing Officer and remanded the matter for further proceedings. The Court reasoned that where two or more occupational injuries combine to produce total incapacity, an employee is entitled to benefits for total "even though each injury considered separately would have caused partial incapacity only." The Court ruled that §201(6) requires a Hearing Officer to consider the entire disability that flows from all causally related injuries. Therefore, because Ms. Dunson's resulting level of disability was total, she was entitled to an annual inflation adjustment for the 25% portion of the disability that was attributable to the 1991 injury.

The Court held further that all benefits were payable based on the average weekly wage at the time of the last injury. The third employer argued that it should receive the benefit of the inflation adjustment for the first injury, so that its payments to the employee would correspond more closely with its proportionate share of responsibility. The Court disagreed, and held that the employee was entitled to receive the benefit of the inflation adjustment for the earlier injury. The mechanism of reimbursement among the three employers is unclear from the opinion, and may be resolved upon remand to the Board.

Terminating capped benefits

Individuals injured between November 19, 1997 and October 16, 1991 are entitled to receive 400 weeks of benefits for partial incapacity from the date of maximum medical improvement. Those injured between October 17, 1991 and December 31, 1992 are entitled to receive 520 weeks of benefits for partial from the date of injury, and weeks in which benefits for total incapacity have been paid apply against the cap. Two years ago, the Court held in *Russell v. Russell's Appliance Service, 2001 ME 32, 766 A.2d 67* that an employer paying benefits for par-

tial pursuant to a compensation payment scheme must file a Petition for Review before ceasing payment of compensation at the expiration of the cap. In a decision of major importance to the system, the Court has now held that an employer may obtain a prospective order from the Board that authorizes termination of benefits as soon as the 400 week period expires.

In ***Young v. Central Maine Power Company,*** *2003 ME 10 (January 23, 2003)*, the employee was injured on November 10, 1989 and the date of MMI had been established by decree. The employee had returned to work for the pre-injury employer, and continued to receive partial benefits. The parties stipulated to the date on which the 400 week period would expire, but a Hearing Officer refused to issue an advance order allowing the employer to stop payments as soon as the expiration date was reached. The Hearing Officer ruled that because the employee's medical or economic circumstances could change prior to expiration of the cap, it would be inappropriate to approve a prospective termination.

The Court vacated the Board's decision, and observed that waiting until the 400 week period expires would inevitably produce an overpayment. Finding that such a result would violate legislative intent in capping benefits, the Court held that the Board has full authority to authorize termination of compensation payments in advance of the expiration period. The Court noted that an employee could file a petition for restoration if circumstances changed before the cap expired.

Although *Young* dealt with the 400 week cap, the rationale of the decision applies equally well to entitlement governed by the 520 week cap. For injuries occurring on or after January 1, 1993, Chapter 2, §5(1) of the WCB Rules provides that an employer must give at least 21 days written notice of the expiration of entitlement to partial, and must provide information to the employee concerning the right to seek a hardship extension of benefits. However, if partial benefits are being paid under a compensation payment scheme, a Petition for Review must be filed in accordance with §205(9)(B)(2). □

U. S. District Court addresses firing of an employee reporting harassment

A recent U.S. District Court decision provides guidance to employers investigating conflicting allegations of harassment by co-workers. In ***Andrews v. American Red Cross Blood Services, New England Region,*** *No. 02-113-B-S (D. Me. Feb. 4, 2003)*, the plaintiff alleged that he was a victim of sexual harassment, and that his employment was terminated in retaliation for reporting the harassment.

The plaintiff had engaged in a brief consensual relationship with a coworker. After the plaintiff cut off the relationship, the coworker allegedly continued to harass him in an effort to maintain the relationship. The plaintiff alleged that, despite numerous complaints to supervisors, nothing was done to end the harassment; instead, the situation worsened as other coworkers circulated rumors regarding plaintiff. Matters culminated in a confrontation between plaintiff and another coworker regarding the rumors, and plaintiff struck this coworker in the chest.

The employer investigated this incident, and discharged plaintiff for violation of the employer's Work Place Violence Guidelines. Subsequently, the plaintiff was convicted of assault.

The conflict between the plaintiff and this co-worker placed the employer in a difficult position. On the one hand, the employer had an obligation under Title VII and the Maine Human Rights Act to investigate the plaintiff's allegations of harassment, and take appropriate corrective action. On the other hand, the employer's policies mandated investigation of the allegations of work place violence. Could the employer's Work Place Violence Guidelines trump the protection afforded to any employee who reports sexual harassment?

The Court analyzed the employer's competing obligations under Title VII and the Maine Human Rights Act, and its own Work Place Violence Guidelines. The Court compared plaintiff's allegations of sexual harassment to plaintiff's conduct toward his coworker. The allegations of sexual harassment involved unwelcome sexual advances toward the plaintiff, sexual behavior directed at the plaintiff, and messages relayed from the alleged harasser to the plaintiff via another employee. The violation of the Work Place Violence Guidelines involved an assault that led to a criminal conviction. Weighing the gravity of the conduct giving rise to the sexual harassment complaint against the plaintiff's own conduct, the Court determined that the plaintiff's conduct justified discharge under the Work Place Violence Guidelines.

Andrews v. American Red Cross affirms the right of employers to impose discipline for serious misconduct. An employee's allegation of discrimination will not insulate him from the consequences of his own work place misconduct. The Court's analysis suggests that employers in the difficult position of choosing between competing policies should base disciplinary action on the severity of the misconduct. □

Anne M. Carney

Insuring acts of terrorism

By Lance E. Walker

The damage caused by the terrorist attacks of September 11, 2001, represents the greatest loss in the history of the U.S. insurance industry: $40 billion. Before September 11, insurance companies covered terrorism free as part of most commercial policies. In response to the attacks, most insurers attempted to exclude terrorism risk coverage from their policies altogether. As a result, owners of stadiums, skyscrapers, and hospitals in urban areas encountered difficulty in finding coverage.

In response to intense lobbying by trade groups, Congress passed the Terrorism Risk Insurance Act last November. The bill that President Bush signed into law on November 26, 2002 brings much needed capacity back to the market at a critical time. Without such a measure, insurers faced incalculable risks.

The Act applies to commercial property and casualty insurers that are licensed or admitted in any state. The Act does not apply to personal lines, health insurance, certain federally backed insurance programs, medical malpractice insurance and reinsurance.

What does the Act do?

• Insurers will be required to make coverage available for losses resulting from "acts of terrorism" as defined by the Act. The coverage must not differ materially from the terms, amounts and other limitations applicable to losses arising from events other than "acts of terrorism."

• Insurers also are required to provide policyholders with disclosures regarding the premiums for terrorism coverage and the federal share of terrorism losses by February 24, 2003. After this deadline, insurers will provide these disclosures as part of their policies.

• Each insurance company will be responsible for paying out a deductible before Federal assistance is available. The deductible is based on a percentage of direct earned premiums from calendar year 2002, and is graduated through 2005. For losses above a company's deductible, the Federal government will cover 90%, while the company contributes 10%.

What constitutes an "Act of Terrorism?"

An "act of terrorism" is any act that is certified by the Secretary of the Treasury, together with the U.S. Secretary of State and the U.S. Attorney General, that satisfies these criteria:

• A violent act or an act that is dangerous to human life, property or infrastructure;

• The act must have resulted in damage within the United States, or outside the United States in the case of an air carrier, U.S. flag vessel or on the premises of a U.S. mission; and to have been committed by an individual or individuals acting on behalf of any foreign person or foreign interest as part of an effort to coerce the civilian population of the United States, or to influence the policy or affect the conduct of the U.S. Government by coercion.

• No act shall be certified as an "act of terrorism" if the act is committed as part of the course of a war declared by Congress, except this clause shall not apply with respect to any coverage for workers compensation.

• No act shall be certified as an "act of terrorism" if property and casualty insurance losses resulting from the act, in the aggregate, do not exceed $5,000,000. If this requirement is not met, the federal law does not apply, and the federal government will not cover any portion of a claim. Presumably, insurers are free to offer coverage for claims less than $5M. To the extent insurers are inclined to provide such coverage, it likely will be expensive and an unattractive option to most commercial insureds.

How is coverage provided?

All terrorism exclusions currently in effect on commercial and casualty policies of participating insurers (i.e., most ISO and AAIS currently in place), are rendered void to the extent that they eliminate coverage for certified acts of terrorism as covered by the Act. Exclusions that deal with terrorist activities outside the scope of the Act, such as domestic terrorism or losses that do not amount to $5 million, remain enforceable.

Terrorism exclusions may be reinstated if the insured decides not to purchase the new terrorism coverage. Before the exclusions can be reinstated, the insurer must obtain a written statement by the insured authorizing reinstatement of the exclusion. Terrorism exclusions also can be reinstated if the insured fails to pay the terrorism premium within 30 days after the insurer provides notice as required by the Act.

Early developments and outlook

Many firms are rejecting terrorism coverage. Industry professionals cite as the reason uncertainty among insureds as to what the Federally backed coverage means. Many banks are beginning to offer loan covenants requiring companies that borrow from them to obtain terrorism coverage.

At this early stage, it appears that the Act is doing what it was intended to do. Insurers are pleased that they can quantify the potential risks to their commercial insureds, upon which they can base their premiums. Insureds are relieved by the certainty that the federal backstop provides, should they suffer a devastating loss like those of September 11. □

Immunization and workers' compensation — A brief summary

By Stephen W. Moriarty

It was announced recently that a limited number of health care workers in Maine have voluntarily chosen to be vaccinated against the remote possibility of an outbreak of smallpox. Immunization is an established and effective means of protection against a broad variety of diseases, and for the vast majority of people there are no further complications beyond the minor inconvenience of the injection itself. However, with many vaccines the possibility of an adverse reaction exists, and in the event of disability the question of workers' compensation coverage may arise.

A serum or vaccine may carry an inherent risk of disease, but in other cases the development of a reaction may be idiopathic and unpredictable. In either event, it is clear that in Maine, the mere exposure to a potentially harmful substance does not constitute a compensable personal injury. For example, in *Carroll v. Celsius Contractors, 637 A.2d 111 (Me. 1994)* the Law Court held that simple exposure to a radioactive "pill" in the work place was not a compensable event in the absence of symptoms or other manifestations of actual injury. Similarly, in *Manzo v. Great Northern Paper Company, 615 A.2d 605 (Me. 1992)* the Court held that the protection of the Act was not available for non-disabling and asymptomatic asbestosis. Accordingly, the mere receiving of a vaccine, even though potentially harmful, cannot be considered a compensable personal injury.

There do not appear to be any Maine cases addressing the compensability of disabling reactions to immunization, but there are a number of reported decisions from other jurisdictions. For a good summary, see Arthur Larson and Lex K. Larson, 2 Larson's Workers' Compensation Law, §27.03[2] (2002). As Professor Larson explains, the possible compensability of an inoculation is directly related to the degree of employer involvement in the process. The easier cases are those in which an employer has compelled its employees to become inoculated. For example, in *Texas Employer's Insurance Association v. Mitchell, 27 S.W. 2nd 600 (Tex. Ct. App. 1930),* benefits were awarded to an employee who experienced a disabling reaction to a smallpox vaccination where the employer had directed all employees to be vaccinated. The same result was reached in *Neudeck v. Ford Motor Company, 229 N.W. 438 (Mich. 1930),* when an employee died from an infection which developed following a smallpox vaccination mandated by the employer. Actual employer compulsion is undoubtedly much less common today, with the exception of medical precautions for unusual circumstances or overseas assignments.

However, even in the absence of employer insistence, a disability following immunization may be compensable.

In cases in which an employer has encouraged or advised its employees to receive immunizations, benefits have been awarded for adverse reactions to a smallpox vaccination *(Saintsing v. Steinbach Company, 64 A.2d 99 (N.J. 1949)),* a flu shot *(Monette v. Manatee Memorial Hospital, 579 So.2d 195 (Fla. App. 1st Dist. 1991)),* a typhoid shot *(Suniland Toys & Juvenile Furniture, Inc. v. Karns, 149 So.2d 523 (Fla. 1963)),* and a swine flu shot *(City of Austin v. Smith, 579 S.W.2d 84 (Tex. Ct. App. 1979)).* In some of these cases, the shots were provided by the employers free of charge and were administered on premises. However, the primary common feature of these and similar decisions is the existence of employer urging, coupled with the mutually beneficial result of protection from disease, plus decreased absenteeism and maintenance of productivity. The Supreme Court of Missouri concisely summarized the conditions under which disability following immunization may be compensable as follows:

> ...when the inoculation is occasioned by the particular conditions of employment, or where the employer requires the inoculation, or where there is a combination of strong urging by the employer and mutual benefit, then an injury resulting from inoculation arises out of and in the course of employment.

Lampkin v. Harzfeld's, 407 S.W.2d 894, 898 (Mo. 1966). Accordingly, compensability may be established upon the combination of employer encouragement and mutual benefit.

The connection between employment and disability becomes more tenuous when an employer has neither encouraged nor promoted the inoculation, and where the inoculation is received off premises, on personal time, and at personal expense. It would be difficult to argue, for example, that an injury arises out of and in the course of employment where an individual makes a purely personal decision to obtain a flu shot. Nevertheless, the greater the degree of employer involvement in the process, the greater the likelihood that a disability following immunization will be found to be compensable. □

Two recent Law Court decisions

By David P. Very

A government's liability for negligent operation of a public building

What constitutes negligent operation of a public building? The Law Court answered that question in the recent case of ***Lightfoot v. SAD #35,*** *2003 ME 24 (February 28, 2003).*

Cody Lightfoot, a student of Marshwood High School and a member of the school's varsity wrestling team, was injured while performing a running drill in the hallways of the high school during wrestling practice. The wrestling team would routinely conduct timed relay races in the empty hallways to practice and train. As Cody was nearing a fire door, a teammate bumped him causing Cody to put his left arm through the glass window of the open fire door. Cody's mother filed a lawsuit against School Administration District No. 35 alleging that it was negligent in permitting the wrestling team to competitively race through the high school's corridors.

The Superior Court granted summary judgment to the District on the grounds that it was entitled to absolute governmental immunity.

Lightfoot appealed the judgment to the Law Court, arguing that the District was liable pursuant to the public buildings exception to absolute immunity. The exception states, "A governmental entity is liable for its negligent acts or omissions in the construction, operation or maintenance of any public building or the appurtenances to any public building." 14 M.R.S.A. § 8104(A)(2). Lightfoot contended that permitting relay races in the high school hallways constituted the operation of a public building.

The Law Court stated that the public building exception applies only to the governmental entity's acts in the care or operation of its buildings and property, not to the governmental entity's care or supervision of people in its charge. The Court noted that it was not the operation of the building that was the focus of Cody's complaint, rather, it was the manner in which the wrestling team was

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permitted to run through the school hallways during their after-school practices. Cody's argument faulted the high school's failure to enact a rule or regulation to prohibit the use of hallways and corridors for indoor running.

The Law Court held that the operation of a public building exception to immunity must implicate the physical structure of the public building and involve more than passive conditions. Lightfoot did not argue that the hallways, the fire door openings, or the fire doors were physically operated in an unsafe manner, or improperly maintained. The Court ruled that Lightfoot's assertion focused on the supervision of the students, and not on the District's actual maintenance or operation of the building. Therefore, the Court held that the Superior Court correctly concluded that the District's failure to prohibit the wrestling team from using the school hallways for practices is not the "operation" of a public building.

What constitutes "total disability?"

Richard Giustra, an orthopedic surgeon, filed a claim under his disability insurance policy stating that he was suffering from severe depression and was totally disabled. The insurer denied the claim, and Dr. Giustra filed a complaint for the wrongful denial of total disability benefits. The Superior Court granted summary judgment to the disability insurer finding that the undisputed facts demonstrated that Dr. Giustra was not totally disabled within the definitions of the policy.

On appeal, in ***Giustra v. UNUM Life Insurance Co. of America,*** *2003 ME 8 (January 22, 2003),* the Law Court noted that the undisputed facts from the parties' Statement of Material Facts demonstrate that Dr. Giustra is an orthopedic surgeon who suffered from depression. He stopped handling emergency room duty, and his psychiatrist determined that while Dr. Giustra could do patient exams and minor surgery, he should not perform major surgery. Dr. Giustra acknowledged that evaluating patients in the office and performing minor surgeries were "important duties" in his orthopedic practice, but they were not duties that financially sustained his practice.

The disability policy in question defined "total disability" to mean that the insured was "completely unable to perform the important duties of [the insured's] regular occupation." "Partial disability" was defined as either an inability to perform the regular daily duties of the insured's occupation at least one-half of the time usually required, or an inability to perform one or more important regular duties of the insured's occupation.

The Law Court noted that there was no dispute that Dr. Giustra was suffering

from depression and was under the care of a physician. The only dispute was whether his inability to perform major surgery rendered him totally disabled under the policy definition even though he could perform minor surgery and patient evaluations. Dr. Giustra argued that because he was unable to do major surgery, which is what sustained his practice financially, he was unable to perform "the important duties" of his occupation.

The Law Court stated that the policy definition of "total disability," must be read in the context of the entire policy. "Because the policy provides for lesser benefits for partial disability, which is defined as being unable to do one or more of the important regular duties, total disability refers to something more debilitating," the Court said. The Law Court held that "the important duties" of an orthopedic surgeon must, therefore, be interpreted as meaning "all of the important duties." The Court noted that if the phrase "the important duties" was construed to mean "one of the important duties," it would mean the same as "partial disability," and such interpretation would be unreasonable. The Court held that as long as Dr. Giustra was able to do one or more of the important duties of an orthopedic surgeon, such as evaluate patients in the office and perform minor surgeries, he was not totally disabled under the policy. □

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