IN THE SUPREME COURT OF FLORIDA

STATE FARM FIRE AND CASUALTY COMPANY,

Petitioner,

vs.

EXECUTIVE HEALTH SERVICES, INC., and WAYNE O. MONTGOMERY, M.D.,

Respondents.

CASE NO.: 69,897

On Notice To Invoke Discretionary Jurisdiction To Review A Decision Of The Second District Court Of Appeal

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RESPONDENTS' ANSWER BRIEF ON THE MERITS

CLIFFORD J. SCHOTT, ESQUIRE
SCHOTT AND DALE, P.A.
P.O. Box 1808
Lakeland, Florida 33802
(813) 683-6551
Attorney for Respondents

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PRELIMINARY STATEMENT

In this brief, the Petitioner, STATE FARM FIRE AND CASUALTY COMPANY will be referred to as "Petitioner". The Respondents, EXECUTIVE HEALTH SERVICES, INC., and WAYNE O. MONTGOMERY, M.D., will be referred to as "Respondents" or by their respective names. The Appendix attached to this brief will be referred to as "App.", followed by the appropriate page number. The record on appeal will be referred to as "R", followed by the appropriate page number.

STATEMENT OF THE CASE AND OF THE FACTS

The Petitioner's statement of the case and of the facts provide an accurate but incomplete account of the nature of the case. Rather than restate the facts contained therein, the following paragraphs contain supplemental facts which are of relevance and importance to this case and of which the Court should be aware.

The sales agent for State Farm Fire and Casualty Company that sold the subject insurance policy to the Defendant, Executive Health Services, Inc., is a man by the name of Quince Cannon. Coincidentally, he is not only a sales representative of State Farm Fire and Casualty Company, but he was Vice President of the Defendant corporation and a member of the Board of Directors of said corporation (R-132). Another member of the Board of Directors of the Defendant corporation is also a State Farm sales agent whose name is Joel Mercer (R-133). When the subject insurance policy was purchased from State Farm by the Defendant corporation, said corporation

requested complete liability coverage other than for medical malpractice. The doctors who worked as independent contractors for the Defendant corporation were required to have medical malpractice insurance coverage with regard to any medical cases or claims that might arise as a result of the doctor's medical treatment (R-133-134). The principle business of Executive Health Services, Inc. was always the rendering of medical services (R-135). It was the understanding of Mr. French, in his executive capacity with the Defendant corporation, that the corporation had full liability coverage to protect it with regard to everything except medical malpractice (R-131). Further, Mr. Quince Cannon has verified to the corporate representatives before the incident and after the subject incident in question that the corporation had full and complete liability coverage (R-132). The incident referred to is the lawsuit filed against both Executive Health Services, Inc. and Wayne O. Montgomery, M.D. A copy of said Complaint filed by Ronald Ray was attached and incorporated by reference as Exhibit "B" to the Petition for Declaratory Decree instituted by State Farm Fire and Casualty Company (R-1-2) (R-30-34). Since the incident involving Mr. Ray occurred, Quince Cannon, the State Farm agent, as agent, assured the corporation that the corporation and all of its employees were fully covered for any liability coverage with regard to this incident. Mr. Cannon is also a member of the Executive Committee of the Defendant corporation, which conducts weekly meetings, and the subject of the lawsuit by Mr. Ray was discussed a number of times. Mr. Cannon, during

those meetings, advised the Defendant corporation that it was his opinion that the corporation was fully covered for liability and there should be no problem as far as coverage is concerned. He continued to advise the Defendant corporation even after this declaratory decree action was filed. Mr. Cannon is also the State Farm sales agent that sold the subject policy of liability insurance to the Defendant corporation (R-136-138).

Wayne O. Montgomery, M.D., Defendant herein, has been a medical doctor in the State of Florida since 1954, and was in continuous practice up until 1984 when he retired. On January 25, 1982, the date on which the Plaintiff, Ronald Ray, claims he was injured while a patient at Executive Health Services, Inc., Dr. Montgomery was a physician working for the Defendant corporation and in charge of the Emergency Room while on duty (R-80). Dr. Montgomery had been practicing medicine at the location of the Defendant corporation, 4710 South Florida Avenue, some 17 years. Dr. Montgomery was paid a salary as an independent contractor to render medical services to patients of the Defendant corporation (R-86-87).

When Dr. Montgomery was on duty, he was the sole person then in charge of any and all areas of medical treatment. He had full and complete authority and no officers or members of the Board of Directors of Executive Health Services, Inc., had any authority over his medical decisions as to employment examinations, workmen's compensation cases or walk-in patients. He felt that when he treated patients of the Defendant corporation he was acting in an executive

capacity since there was no one else who was qualified to make any medical decisions except him while he was on duty (R-98-99). (Emphasis supplied.)

Dr. Montgomery was a stockholder in the Defendant corporation from the time when Executive Health Services, Inc., purchased the building from Dr. Montgomery and his other medical partners. The building, together with all personal property, was sold to the Defendant corporation in approximately 1979. The subject examining table, which was part of the sales transaction in 1979 to the Defendant corporation, was located in the building throughout the entire 17 years when Dr. Montgomery was in practice. (Emphasis supplied).

After January 25, 1982, the day when Mr. Ronald Ray claims to have been injured on the premises of the Defendant corporation, Dr. Montgomery became an officer for the Defendant corporation. He became its Medical Director. He also was a member of the Board of Directors, as well as a stockholder of the Defendant corporation (R-90) (R-141).

On January 25, 1982, Mr. Ronald Ray came to the Emergency Room of the Defendant, Executive Health Services, Inc., Dr. Montgomery was on duty at that time. Mr. Ray came in for medical treatment because of an injury he suffered on the job, which was covered under his company's workmen's compensation policy. He had a splinter in his thigh. When he came into the Emergency Room, a nurse had seen him and written some information down concerning his injury. He had been seated on an examination table before Dr. Montgomery came into the room. (Emphasis supplied.)

When Dr. Montgomery came into the room, he asked Mr. Ray what his problem was. Mr. Ronald Ray told Dr. Montgomery what had happened in that he had brushed against some timber and ran a splinter into his thigh. At that point, Dr. Montgomery having read the notes written by the nurse, asked the patient to lie down so that he could get a better look at the splinter in the thigh. Ronald Ray proceeded to do that and he fell back rather heavily upon the examination table causing it to up-end and Ronald Ray fell of on his right shoulder.

Dr. Montgomery assisted the patient up and he again sat on the examination table after it had been righted. Dr. Montgomery then examined the patient with regard to the splinter in the thigh and advised Mr. Ronald Ray that Dr. Montgomery was doubtful that he could remove the splinter since it was rather deep and therefore, he referred him to Dr. Barrios, a surgeon in the Lakeland area for treatment. Dr. Montgomery did not see the patient or treat him thereafter (R-82-84). (Emphasis supplied).

In January of 1984, Ronald Ray filed his Complaint alleging negligence against the Defendants herein. He alleged among other things that the Defendant corporation owed a duty to the Plaintiff to provide safe facilities and equipment to those persons being examined or treated on its facilities; that the examining table was unreasonably dangerous and not safe for its intended use, and that the defective and unsafe condition of the examining table was caused by the negligence of the Defendant corporation in installing or maintaining said equipment. Further, that the Defendant

corporation knew or should have known of the table's defective and dangerous condition.

Mr. Ray alleged that Dr. Montgomery owed a duty to the Plaintiff to ensure that the facilities and equipment used by him in examining patients were safe and adequate before attempting to perform an examination; that Dr. Montgomery knew or should have known of the table's defective and unsafe condition, and it was not prudent for the doctor to have the Plaintiff ascend the table as the table was unreasonably dangerous and unsafe or inadequate for the purpose for which Dr. Montgomery attempted to use said examining table (R-32-34).

In February of 1985, the Plaintiff, State Farm Fire and Casualty Company, filed its Petition for Declaratory Decree reciting the facts of the lawsuit brought by Ronald Ray and requesting the trial Court to rule on whether or not the exclusion under the comprehensive general liability insurance policy (R-18) would preclude liability insurance coverage with regard to both of the Defendants herein. It was the position of the Plaintiff, State Farm Fire and Casualty Company, that the Defendants were excluded from coverage because the injuries which Ronald Ray allegedly incurred resulted from the rendering or failure to render a service or treatment conducive to health of a professional nature. It is the Defendant's position that the alleged injury to Ronald Ray was caused by an occurrence arising out of the ownership, maintenance or use of the insured premises, together with operations necessary or incidental to the business of the named insured and the exclusion did not apply as

Dr. Montgomery had not yet started to render any medical service when the examining table collapsed and the Plaintiff was allegedly injured.

This Court is hereby advised that the jury trial was held in the case of Ronald Ray v. Executive Health Services and Wayne O. Montogmery, M.D., on the 2nd, 3rd, and 4th day of April, 1986. That the jury in that case rendered a verdict in which they found no negligence against the Defendant, Dr. Wayne O. Montgomery. That perhaps makes the question of insurance coverage moot with regard to Dr. Montgomery. However, the jury did render a verdict in favor of the Plaintiff and against Executive Health Services, Inc., finding it was responsible for the Plaintiff's injuries without any contributory negligence on the part of the Plaintiff and in an amount of $85,000.00.

SUMMARY OF ARGUMENT

I. SECOND DISTRICT ERRED IN RULING THAT THERE WAS NO MATERIAL ISSUE OF FACT FOR THE JURY TO CONSIDER ON THE ISSUE OF WHETHER THE EXCLUSIONARY PROVISION OF THE SUBJECT COMPREHENSIVE LIABILITY POLICY APPLIED.

The general and observable facts which gave rise to the Plaintiff's injuries in this case are not disputed. Stated quite simply and directly, Plaintiff fell back heavily on an examining table, the table up-ended and Plaintiff fell on his right shoulder (R-82-84). Plaintiff sued Executive Health Services, Inc., and Dr. Montgomery, Defendants, for damages.

Executive Health Services was covered by a comprehensive insurance policy. The insurance policy language which is most pertinent to this review is as follows:

> "The company will pay on behalf of the insured all sums which the insured shall become legally obligated to pay as damages because of bodily injury or property damage to which this insurance applies, caused by an occurrence and arising out of the ownership, maintenance or use of the insured premises and all operations necessary or incidental to the business of the named insured conducted at or from the insured premises . . ."
>
> "Each of the following is an insured under this insurance to the extent set forth below:
>
> > if the named insured is designated in the Declarations as other than an individual, partnership or joint venture, the organization so designated and any executive officer, member of the board of trustees, directors or governors or stockholder thereof while acting within the scope of his duties as such;"

The insurance company seeks to avoid its responsibility fr coverage to the Defendants by asserting that the Plaintiff's bodily injury was not caused by an occurrence arising out of the ownership, maintenance or use of the insured premises or any operations necessary and incidental to the business of the named insured (rendering medical services) conducted at or from the insured premises.

However, the facts of this case unequivocally show that the Plaintiff's claim arises out of the ownership, maintenance, and use of a table which was owned by the Defendant corporation and was necessary and incidental to the business of the corporation (rendering medical services) and was maintained and used by the insured corporation on the insured premises. Therefore, the conclusion that the insurance company is under a duty to provide coverage to the insureds is inescapable.

Nevertheless, the insurance company seeks to escape its legal obligation by taking the position that the coverage is excluded under the following provision of the policy:

PARAMEDIC & PRE-EMPLOYMENT EXAMS

> It is agreed that with respect to any operations described above or designated in the policy as subject to this endorsement, the insurance does not apply to bodily injury or property damage due to:
>
> 1. the rendering of or failure to render
>
> (a) medical, surgical, dental, x-ray or nursing service or treatment,

or the furnishing of food or beverages in connection therewith;

(b) any service or treatment conducive to health or of a professional nature; (Emphasis added)

The facts of this case clearly show that the Plaintiff's injuries were not due to the rendering of medical service or treatment. The Plaintiff's injury was caused by the up-ending of a general examining table. The injury was not due to anything Dr. Montgomery did or failed to do in the rendering of his medical service or treatment and the jury in the trial Court so found as a matter of fact that this was the case. Furthermore, there is absolutely no evidence that the doctor was conducting a paramedic or pre-employment exam. Thus, the aforementioned policy exclusion is inapplicable.

The result should be the same if the floor upon which the table was located had given way causing injury to the Plaintiff, or; the door to the emergency room fell on the patient, or; the ceiling to the examining room collapsed, or; the Plaintiff was seated on a chair in the emergency room and the chair collpased causing his injury, or; the chair was in the waiting room when it collapsed. It would be inconsistent to conclude the coverage should be allowed under the examples given above and denied in the instant case. Yet, the logic of the circumstances is the same.

The controlling question is not whether the patient was receiving or about to receive treatment at the time of injury, but rather, as stated in the policy, whether the injury was due to the rendering or failure to render

a medical service or treatment. Each case should turn on its own facts. A factual determination to be made by a jury.

II. SECOND DISTRICT CORRECTLY RULED THAT THERE WAS A MATERIAL ISSUE OF FACT FOR THE JURY TO CONSIDER ON THE ISSUE OF WHETHER THE INSURER IS BARRED AND ESTOPPED FROM DENYING COVERAGE.

It is clear from the terms of the policy in question that coverage should be provided to the Defendants in this case. However, assume arguendo, that the Court finds that the policy is unclear or ambiguous as to whether or not coverage is provided under the facts of this case. Any ambiguity which may exist in the terms and conditions of said policy of insurance should be construed against the insurance company as the party who wrote the subject liability insurance policy. Therefore, the issue as to coverage should be resolved in favor of the insured.

Furthermore, the representatives of the insurer verified to the insured, prior to purchase, subsequent to purchase, before the accident and after the subject accident, that the insured had full and complete coverage under the terms of the policy in regard to the facts of this case. Therefore, the insurer should be barred or estopped from denying coverage.

The insurance company in this case knew at all times it was insuring a business in which the sole activity was rendering medical treatment and services. To allow the insurer to escape liability by a malpractice and professional services exclusion without a finding that the injury was

due to the rendering of medical treatment or service as opposed to being "connected with" the rendering of medical treatment or service would in effect exclude any and all coverage for the insured. The policy would be worthless because all business conducted by the insured is "connected with" the rendering of medical treatment or service.

ARGUMENT

I. SECOND DISTRICT ERRED IN RULING THAT THERE WAS NO MATERIAL ISSUE OF FACT FOR THE JURY TO CONSIDER ON THE ISSUE OF WHETHER THE EXCLUSIONARY PROVISION OF THE SUBJECT COMPREHENSIVE LIABILITY POLICY APPLIED.

The decision of whether or not there is a genuine material issue of fact for a jury's consideration has often been subject to interpretation from one Court to another. Indeed, our District Courts of Appeal have often rendered conflicting decisions on similar facts as to whether or not a Summary Judgment had properly been granted where there was a claim by one of the parties that a genuine material issue of fact was in dispute, and thus it was a question for the jury's consideration. Our Florida Supreme Court in Holl v. Talcot, 191 So.2d 40 (1966) took jurisdiction where it was apparent that there was a conflict among various District Courts as to when Summary Judgment might be granted. That case involved a MALPRACTICE ACTION against surgeons, anesthesiologists, and a hospital brought by a patient of the doctors who was hospitalized. The Supreme Court in the Holl case (supra) gave guidelines with reference to principles of law which are still applicable and should be applied herein. The Supreme Court stated at page 43:

> ". . . As this Court and other Appellate Courts have repeatedly held, the burden of proving the absence of a genuine issue of material fact is upon the moving party. Until it is determined that the movant has successfullly met this burden, the opposing party is under no obligation to show that issues do remain to be tried . . . It must first be determined that the movant has successfully met his

> burden of proving a negative, i.e., the non-existence of a genuine issue of material fact. Matarese v. Lessburg Elks Club (supra). He must prove this negative conclusively. The proof must be such as to overcome all reasonable inferences which may be drawn in favor of the opposing party. Harvey Building, Inc. v. Haley (supra).
>
> The proper Rule on this subject was well applied in the Matarese case. There the District Court of Appeal, Second District, reversed a Summary Final Judgment entered against the Plaintiff, not because it found the movant-Defendant's Affidavits were successfully met by the opposing party Plaintiff, but because the movant's Affidavits and other evidence did not establish the absence of genuine triable issue of material fact."

These principles of law with regard to Summary Judgment were recently repeated and the Supreme Court language in the Holl case (supra) was again used as authority in the recent case of Carrousel Concessions, Inc., Dania Jai-Alai Palace, Inc., and Saturday Corporation v. Florida Insurance Guaranty Association and Public Services Mutual Insurance Company, 483 So.2d 513 (Fla. App. 3 Dist. 1986).

It is admitted and there is not dispute that the named insured in the contract of insurance is Executive Health Services, Inc. There is no question that the incident which is the subject of Mr. Ray's lawsuit alleging negligence against these Defendants arose out of the use of an examining table which was on the insured's premises and that said table was incidental tc the business of the named insured (Executive Health Services, Inc.), which was conducted at or from the insured's premises.

The obvious intent of the comprehensive liability insurance coverage was to offer insurance coverage to its insureds

under these conditions. That is what the Plaintiff company said under "Coverage C - Bodily Injury and Property Damage Liability" wherein it stated:

> "The company will pay on behalf of the insured all sums which the insured shall become legally obligated to pay as damage because of bodily injury or property damage to which this insurance applies, caused by an occurrence and arising out of the ownership, maintenance or use of the insured premises and all operations necessary or incidental to the business of the named insured conducted at or from the insured premises . . ." (R-13).

However, State Farm Fire and Casualty Company then turns around and goes to its exclusion and argues that under the terms of the exclusion, this insurance does not apply to bodily injury due to: the rendering of or failure to render medical service . . . State Farm Fire and Casualty Company then goes on to argue in its Motion for Summary Judgment that Dr. Montgomery had commenced the rendering of medical services and the bodily injury to Mr. Ray arose because of the fact that he was rendering medical services. (Emphasis supplied.)

Overlooking for the moment that the jury in the actual case of Ray v. Dr. Montgomery found that the alleged bodily injury suffered by Mr. Ray was not caused by any action on the part of Dr. Montgomery, we should turn then to the testimony of Dr. Montgomery to see if, despite the contention of the insurance company, whether there was indeed a genuine issue of material fact.

Dr. Montgomery testified under oath in his deposition that back on January 25, 1982, the day of Mr. Ray's incident,

that he was on duty as the treating doctor at the clinic owned by Executive Health Services, Inc. That Mr. Ray came in because of an injury under his workmen's compensation coverage where he had gotten a splinter in his thigh while at work. That when the doctor first came into the room, Mr. Ray was already seated on the examining table. The doctor merely asked him what the problem was and the doctor read some notes that had been written down by the nurse prior to the doctor coming into the room.

The patient then explained what had happened was that he had brushed against some timber and ran a splinter into his thigh. The doctor then asked the patient (Mr. Ray) to lie down so that he can get a better look at it, which Mr. Ray proceeded to do and he fell back rather heavily on the table, causing it to up-end and Mr. Ray fell off on his right shoulder. (Emphasis supplied.)

Thereafter, when the table was righted, Mr. Ray again sat on the examining table and then for the first time, the doctor looked at the splinter and told Mr. Ray that the doctor did not think he could remove it as it was rather deeply embedded and therefore, Dr. Montgomery referred him to a surgeon, Dr. Barrios, for treatment (R-82-84). (Emphasis supplied).

Clearly, there would be a genuine issue of material fact for the jury to consider under the exclusionary provision of the subject liability insurance policy. Did the bodily injury to Mr. Ray occur by the rendering or failure to render of any medical services by Dr. Montgomery? Did Dr. Montgomery

start to render any medical service to Mr. Ray?

The uncontroverted evidence is that Dr. Montgomery had only asked a question of the patient, looked at the nurse's notes, and then asked the patient to lie down in order to have a look at the splinter in the thigh when the examining table collapsed. What medical service had he rendered to that point? What medical service had he failed to render to that point? Was not the actual injury to the Plaintiff caused by an occurrence arising out of the ownership, maintenance or use of the insured premises and all operations necessary or incidental to the business of the named insured conducted at or from the insured premises? Was the bodily injury in question incurred under the language of the exclusion which indicates the description of the operations to which this exclusion applies as a paramedic and pre-employment exam? Does the exclusion apply to a workmen's compensation injury where that language is not part of the exclusion? If the bodily injury to Mr. Ray occurred as a result of a defectively designed or manufactured table or the examining table having a latent defect collapsed throwing the Plaintiff, Mr. Ray, to the floor, are these material questions of fact for the jury to consider?

It is the Defendant's position that under the facts of the case, the doctor had merely walked into the Emergency Room, looked at the nurse's notes, asked the patient what had occurred, and then requested the patient to lie down in order that the doctor could examine the wound. He had not yet begun to render medical services.

A jury could reasonably have concluded that the rendering of medical services began when Dr. Montgomery examined the wound and made a determination that the splinter was too deep and then referred him to a surgeon. That would have the commencement of the rendering of medical services after the table had collapsed and after the Plaintiff, Ronald Ray, was allegedly injured as a result of the fall from the collapsing table.

In looking at various cases around the country that have focused on the rendering of professional or medical services as it relates to insurance coverage, we find there were decisions going in many directions. Sometimes on the same set of facts, two different Courts in two different States have found two different answers.

A case illustrating the divergence of opinion among various Courts on similar fact situations is the case of Ratliff v. the Employers Liability Assurance Corporation, Ltd., Ky., 515 S.W.2d 225 (Court of Appeals of Kentucky, 1974). A review of that decision gives us an insight into some of the problems that have been considered in insurance liability policies having an exclusion similar to the one under review herein. The Court of Appeals at page 228 stated:

> "Both parties have submitted excellent Briefs containing a comprehensive citation of cases. The apparently simple task of determining whether Ratliff's injuries fall within the malpractice and professional services exclusion immediatley becomes complex when one considers the cases which have reached exactly opposite results upon similar factual situations . . . In D'Antoni v. Sara Mayo Hospital, La., 144 So2d 642, . . . After administering oxygen to the patient, a nurse failed to raise a bed rail on one side of the bed. The Plaintiff was injured when she fell from the bed. The

> Louisiana Court held that the malpractice and professional services exclusion did not apply . . . "

Then at page 229 of the Ratliff decision:

> ". . . In New Amsterdam Casualty Company vs. Knowles, Fla., 95 So2d 413, the Plaintiff was a mental and physical incompetent who was also a paralytic. While receiving nursing care in a convalescent home, the Plaintiff was injured when he fell from his bed. The side rails on the bed had been left down. The Florida Court held that the general liability policy issued to the convalescent home covered the accident. The Court held that the insurance company knew it was insuring a convalescent home and could not escape liability by a malpractice and professional services exclusion. This case cannot be reconciled with cases from other jurisdictions involving similar facts.
>
> In contrast to the Knowles opinion, is the opinion of the New York Supreme Court, Appellate Division, in Brockbank v. Travelers Insurance Company, 207 N.Y.S. 2nd 723, 12 A.D.2nd 691 (1960). In summary fashion, the New York Court held that injuries sustained by a patient in a covalescent home as a result of the failure to place side rails on the patient's bed came within the malpractice and professional services exclusion. A more detailed discussion of the problem was made by the Court in Demandre v. Liberty Mutual Insurance Company, 264 F.2d 70 (5th Circuit 1969). In that case, the Plaintiff asserted that she was injured when the hospital had negligently failed to place side rails on her hospital bed while she was under extensive sedation. After holding that the case could not be disposed of by Summary Judgment on the basis of the Complaint alone, The Court pointed out that the facts could determine whether the case fell within the malpractice and professional services exclusion."

Perhaps at this point we should ask the question that might have been considered material by a jury. Can it be said that because as medical doctor is a professional man, that anything that he says or does constitutes the rendering of professional service? Perhaps the trial Judge felt that when Dr.Montgomery instructed the patient to lie down, that

was the rendering of professional service. Perhaps the mere statement by Dr. Montgomery asking the patient what is wrong was construed by the trial Judge as the rendering of professional service or the reading of the nurse's notes.

It is the Defendant's position that all of those questions are questions pertaining to material facts and should have been presented to the jury. A guideline to assist us on this matter is found in the case of Hirst v. St. Paul Fire and Marine Insurance Company, 683 P.2d 440 (Court of Appeals of Idaho, 1984). At page 444 of that decision, the Appellate Court stated:

> "The scope of "professional services" does not include all forms of doctor's conduct simply because he is a doctor. As noted by the Supreme Court of Nebraska: The insurer's liability is thus limited to the performing or rendering of "professional" acts or services. Something more than an act flowing from mere employment or vocation is essential . . . In determining whether a particular act is of a professional nature or a "professional service" we must look not for the title or character of the party performing the act, but to the act itself."

It would appear that there is no Florida cases that specifically addresses the question of whether a claim for injury arising from defective medical equipment is a claim for professional negligence from an insurance standpoint. Undoubtedly, counsel for the Plaintiff, State Farm Fire and Casualty Company, will be able to cite cases to this Court where other States have determined a different set of facts and decided that a liability policy exclusionary provision did apply, and therefore there was no coverage.

It is respectfully submitted by the Defendants that there were material issues of fact for the jury's consideration

which precluded the granting of a Summary Judgment and requires the reversal of that judgment.

The Petitioner's Initial Brief to this court on this issue states at page 27:

> "The Second District's decision ruling that Mr. Ray's accident clearly came within the professional liability exclusion is in line with the decisions in Florida and other states which have considered the issue . . ."

Respondents respectfully submit that in light of the previously stated argument and cases cited therein that Petitioner's statement is simply incorrect.

Petitioner cites Florida cases presumably in support of this statement at pages 29 thourgh 32 of its brief. Only one case deals with the issue of coverage regarding policy exclusion similar to the one in the case at bar. See New Amsterdam Casualty Company v. Knowles, 95 So.2d 413 (Fla. 1957) which is previously cited in this brief as authority for the respondent.

As previously stated herein, New Amsterdam provides a factual situation similar to the instant case and sets forth logic and public policy reasons for the position that Mr. Ray's accident does not come within the policy exclusion.

The other Florida cases cited by Petitioner at pages 20 through 32 of its brief deal with either: (1) whether or not a "claim" was first referred to mediation under the Florida Medical Malpractice Reform Act, Section 768.133 Florida Statutes (1975) prior to suit being filed, or; (2) what statute of limitations applies in a given "claim". These cases in no manner deal with the issue of whether

or not, as a matter of fact or law a certain injury was due to the rendering of or the failure to render medical service or treatment. Other than New Amsterdam, the cases cited by Petitioner address only the issue of whether or not a "factual claim" falls within the provisions of a particular statute. Neither the statutes nor the anaylsis are on point with the case on review and cases themselves provide little or no meaningful guidance.

It should be noted, however, that in one of the cases dealing with the mediation issue the facts of the case are very close to the instant case and the Court stated:

> "The Plaintiff-Appellant was allegedly injured because of the mechanical failure of a special table called a Phillips Unit to which he was strapped during the taking of a myelogram at the defendant hospital. I do not believe that his action for damages against the hospital, based essentially upon a claim of improper maintenance of its equipment is one for "malpractice", Norton v. South Miami Hospital Foundation, Inc. 375 So.2d 42 (Fla. 3d DCA 1979).

To be certain, in the case at bar, the jury found no malpractice against Dr. Montgomery.

It stretches logic and imagination to find that Mr. Ray's injury was "due to" the rendering of a medical service or treatment rather than, if at all, defective or improperly maintained equipment of the insured. Therefore, coverage for the insured should exist.

With regard to the "out of state" cases cited by Petitioner on the issue of coverage, the case before this court is distinguishable.

In Petitioner's "out of state" cases the alleged defective or improperly maintained or used instrumentality which caused injury was a principal and specialized instrument being used during a specialized professional treatment when the injury occurred. (i.e., a specially designed table, chair, heat lamp, hair dryer). The actual provider of the treatment knew or should have known of the danger which caused the injury.

In the case before this court the table in question was not a principal and specialized instrument used during a specialized professional treatment to Mr. Ray. No treatment had begun and the jury in the trial court found as a matter of fact that the injury was not "due to" any danger Dr. Montgomery knew or should have known in the rendering of his professional services.

II. SECOND DISTRICT CORRECTLY RULED THAT THERE WAS A MATERIAL ISSUE OF FACT FOR THE JURY TO CONSIDER ON THE ISSUE OF WHETHER THE INSURER IS BARRED AND ESTOPPED FROM DENYING COVERAGE.

There are several good legal and equitable reasons why this Court should not allow the Plaintiff, State Farm Fire and Casualty Company, the right to deny coverage under the facts and circumstances of this case. Specifically, the Court should consider the following:

A. The policy language appears to have been designed by the Plaintiff corporation itself to permit the insurance company grounds for denial of coverage under most circumstances related to the business of its insured.

B. The exclusive sales agent for the Plaintiff insurance company (Quince Cannon) was requested by Defendant corporation to obtain full coverage for all potential liability exposure to Executive Health Services, Inc. in the operation of its business. That agent sold the subject comprehensive liability insurance policy to the Defendant corporation and advised it that it had obtained full and complete protection for personal injury arising out of ownership, maintenance or use of the insured premises and all operations necessary or incidental to the business of the named insured conducted at or from the insured premises. Mr. Cannon represented there was full coverage both before and after the filing of a lawsuit by Mr. Ronald Ray. However, another division of the same Plaintiff insurance company took legal steps to deny coverage on the same comprehensive liability insurance

contract. The Plaintiff company was bound by the acts and representations of its exclusive agent.

Let us look then at the language of the insurance contract itself. On the face of the policy, the insured is Executive Health Services, Inc. (R-5). It is obvious that the business of the insured was that of the rendering of health services. With that in mind, we turn to what State Farm Fire and Casualty Company apparently offered upon the payment of a sufficient premium in the way of bodily injury and property damage liability protection (R-13).

The company said it would pay on behalf of the insured all sums which the insured shall become legally obligated to pay as damages because of bodily injury or property damage to which this insurance applies, caused by an occurrence and arising out of the ownership, maintenance or use of the insured premises and all operations necessary or incidental to the business of the named insured conducted at or from the insured premises . . .

Under the definition of named insured (R-13-14), it would appear that if the named insured in the Declaration is other than an individual, partnership or joint venture, the organization (i.e., this corporation) so designated and any executive officer, member of the board of trustees, director or governors or stockholders thereof while acting within the scope of his duties are covered under the policy provision.

We find however, when we turn to the exclusion (R-18), that apparently what the insurance company gives with one

hand, it takes away with the other hand. We all know that the business of the Defendant insured was that of the rendering of health services. The exclusion however, goes on to say that the insurance does not apply to bodily injury or property damage due to the rendering of or failure to render medical, surgical services or treatment. It then goes one step further under sub-paragraph 1 (b) and says that this insurance does not apply to bodily injury due to any service or treatment conducive to health or of a professional nature. What protection against liability does the insured obtain for the premium it pays in rendering health services to patients who come to the clinic?

If an examining table is necessary or incidental to the business of the insured and if it was used on the insured premises and an occurrence did arise out of the use of that table where it tilted and a patient was hurt, is that not the subject of the "Coverage C" section of the policy under bodily injury and property damage covered? If that occurrence is not covered under the policy, does it offer any liability protection to the insured?

It would be a valid observation to note that upon reading of the several sections of the policy, there appears to be some ambiguity on the intent of the contract language itself as to what events or occurrences (if any) were ever to be covered. It is a well known principle of contract law that any ambiguity in the policy must be construed against the party who wrote the language.

In this case, there is no question that the insurance policy was written by the Plaintiff, State Farm Fire and Casualty Company. Therefore, if it did intend to give coverage on the one hand while taking it away on the other hand, then the ambiguity which seems clear and apparent should be construed against it and the attempt at exclusions denied, thereby offering liability insurance coverage to the Plaintiff's own insured.

The language of the policy itself offers no guidelines as to the apparent conflict in what was intended to be covered under the "Coverage C" section of the policy and no further definition of what was defined or considered with regard to the rendering of medical services, when medical services commenced or was rendered, and no further definition as to the lack of coverage regarding any service or treatment conducive to health or of a professional nature.

Some helpful guidelines with reference to the Florida law interpreting insurance contract provisions is found in National Merchandise Co., Inc. v. United Service Automobile Association, 400 So.2d 526 (1st DCA 1981). In that case, the trial Judge entered Summary Judgment in favor of the insurance company, which was reversed by the First District Court of Appeal. Policy coverage was the issue involved. The Appellate Court at page 530 stated the following:

> " U.S.A.A. argues that a common sense reading of its "plain language" policy, which provides coverage for "auto accidents", does not cover situations such as occurred in this case. On the other hand, the appellants advocate the view that the term "auto accident" in the simplified insurance policy is ambiguous.

> When the terms used are ambiguous, we are required to construe the policy against U.S.A.A., because it drafted the policy. Excelsior Insurance Company v. Pomona Park Bar and Package Store, 369 So.2d 938, 942 (Fla. 1979); Travelers Insurance Company v. Smith, 328 So.2d 870, 872 (Fla. 3rd DCA 1976). Insurance policies are contracts, and it is well established that contracts are construed against the drafter in the face of any ambiguities. Planck v. Traders Diversified, Inc. 387 So.2d 440,441 (Fla. 4th DCA 1980); Hurt v. Leatherby Insurance Company, 380 So.2d 432, 434 (Fla. 1980). "This rule is especially true when the drafter stands in a position of trust, or greater professional or business knowledge . . . " Plank, supra, at 442. If the insurer wishes to condition its contractual liability upon the insured's conformance with certain conduct, it must do so in clear, unambiguous language. Holz Rubber Compnay, Inc. vs. American Star Insurance Company, 14 Cal.3d 45, 120 Cal.Rptr. 415, 423, 533 P.2d 1055, 1063 (1975)."
>
> "The insurer cannot, by failing to define the terms "auto accident" or to include any additional qualifying or exclusionary language, insist upon a narrow, restrictive interpretation of the coverage provided."

Should the Plaintiff, State Farm Fire and Casualty Company, be barred and estopped under the circumstances in this case from denying coverage? Fortunately for this Defendant, our Supreme Court of Florida has looked at similar language in an insurance policy where the insurance company was attempting not to offer coverage and asked the question as to what the insurance company really did intend to cover; if anything.

The case is New Amsterdam Casualty Company v. Knowles, 95 So.2d 413 (1957). This was a suit for declaratory decree to establish the right of the Plaintiffs to have the insurer provide a defense in an action under a liability policy

brought by a patient for injuries sustained while upon the premises of the convalescent home. The trial Court held the insurer was obligated to defend and the Florida Supreme Court affirmed.

In an insurance contract similar to the one under review herein was a provision that no responsibility was assumed by the insurer for claims resulting from the rendering of any professional services or omission thereof. The Court in the Knowles case found that when the policy was issued to Oak Grove Nursing Home, the insurer should have become aware of the nature of the enterprise in which the appellees were engaged. The Supreme Court went on to note on page 414:

> "It seems to us it would be more logical to expect that in the action against the appellees it might be shown that the injury was one that could happen in a nursing home without any connection with professional services. And if the insurer can under such a policy decide for itself that such an injury be as described in the complaint filed against appellees sprang from professional services, we cannot resist the rhetorical questions: "What did the appellant intend to insure when it issued the policy to a nursing home" and "What sort of protection were the appellees to receive for the premium paid?" In other words, if the appellant considered a nursing homea place in which professional services only were furnished, what did it propose to insure?"

And further on page 415 the Court stated:

> "When we undertake to reason that an insurance company may issue a policy to the operator of a "convalescent home", stipulated to be a sanitarium or health institution and not a hospital, and insure for a price, against the loss from hazards incident to the operation, and then arrogate to itself the right of deciding that, after all, an injury with which no one except an attendant seems tohave had any connection, resulted from professional services, hence responsibility to defend did not arise, we come full cycle in our thinking. And when we

> compare the allegations of the complaint filed against the appellees with the terms of the insurance policy, we discover no basis for the presumption that injury arose only from services of professional character. Moreover, the policy must be construed favorably to the holder. Poole v. Travelers Insurance Company, 130 Fla. 806, 179 So. 138."
>
> ". . . We agree with the circuit judge that the appellant should be required to keep its bargain and defend the suit brought against the appellees."

We turn our attention now under the Affirmative Defense of Bar and Estoppel to the matter of one Department of State Farm Fire and Casualty Company selling the policy to the insured and advising the insured that it indeed did have full coverage as it requested and then another Department of State Farm Fire and Casualty Company raising the question of insurance policy exclusions and no coverage to their own insured. The Affirmative Defense was raised in the Answer and Affirmative Defenses of Executive Health Services, Inc. (R-71-73).

In the Motion for Summary Judgment of the Defendant corporation (R-144-147),mention was made in paragraph 7 of that Motion of the fact that State Farm Fire and Casualty Company's agent, Quince Cannon, in his deposition, recited the fact that he was the exclusive agent for State Farm Fire and Casualty Company and that the liability section of the subject policy would offer full and complete coverage up to the policy limits.

These representations of coverage by State Farm Fire and Casualty Company's agent were made both before and after the subject incident and lawsuit brought about by Mr. Ronald Ray (R-132). Further, Mr. Cannon, during meetings of the

Defendant corporation, as agent of State Farm Fire and Casualty Company, has continued to advise this Defendant corporation even after this declaratory decree action was filed that the Defendant corporation was covered (R-136-138).

This Honorable Court addressed similar issues as are contained in this cause in the case of Russell v. Eckert, Fla., 195 So.2d 617 (2nd DCA 1967). This court enunciated several principles of law which are equally applicable here. At page 621 of its opinion in Eckert (supra), this Court stated:

> "Acts of insurance agent within scope of his real or apparent authority are binding upon his principal and members of general public may rely thereon and do not need to inquire as to special powers of agent, unless circumstances are affirmatively such as to put them upon inquiry."

Thereafter, on pages 622 and 623, this Court went on to say:

> "Another principle of law influencing the instant case is the doctrine of estoppel. Where an insurance company makes its local agent its medium through which it receives all benefits from the insured, the company is estopped to deny the agent's authority when benefits to the insured are involved. Southern States Fire Insurance Company v. Vann, 1913, 69 Fla. 549, 68 So. 647, L.R.A. 1916B, 1189. Facts within the knowledge of an insurance agent are deemed facts within the knowledge of the insurance company. Poole v. Travelers Insurance Company, 1938, 130 Fla. 806, 179 So. 138. A general agent of an insurance company, or an agent who, although called local agent because restricted to a particular locality, has general powers, may bind the company by waiver or estoppel so as to preclude the company from relying on irregularities or even on provisions contained in the contract of insurance with respect to conditions on which it shall have inception . . ." (Emphasis supplied.)

In the event this Court should agree that it is difficult

under the exclusionary clause to see what coverage, if any, was offered by this policy and there is apparent conflict in the intent of the parties and ambiguity as to coverage, then another decisions of this Honorable Court indicates that the interpretation or construction of the general agent of the insurer may well bind the insurer. See E.J. Evans Company v. The Ohio State Life Insurance Company, Fla., 144 So.2d 833 (2nd DCA 1962), where at page 835, this Court indicated:

> ". . .Where the terms of the insurance policy are ambiguous, a contruction placed upon them by a general agent may bind the insurer, Kendrick v. Mutual Ben-Life Insurance Company, 124 N.C. 315, 32 S.E. 728 (N.C.): Wilson v. Hawkeye Casualty Company, 67 Wyo. 141, 215 P.2d 867 (Wyo.) . . ."

Clearly, in the interest of equity and justice, it would be total unjust to permit the Plaintiff insurance company to sell a policy of comprehensive liability insurance to a health care provider where said policy appears to offer full coverage and then after a claim is brought under the policy, to use our Florida Courts to enforce an exclusionary provision of said policy and deny coverage to its own insured. The terms of an insurance policy must be construed to promote a reasonable, practical, and sensible interpretation consistent with the intent of the parties. United States Fire Insurance Company v. Pruess, Fla., 394 So.2d 468 (4th DCA 1981).

The several statements by the agent for State Farm Fire and Casualty Company that Defendant corporation had full and complete coverage (except for malpractice) was unequivocable and under existing Florida law, should bind

the Plaintiff insurance company and bar it from disclaiming coverage. It is respectfully submitted that the Affirmative Defenses raised by the Defendant corporation when viewed under the facts and circumstances of this cause, should require a Summary Judgment in favor of Executive Health Services, Inc.

Petitioner advocates in its brief that this Court resolve the case before it on the basis of broad statements of law which do not take into account the mixed questions of law and fact presented.

As a general statement of law, Petitioner is correct in asserting that an agent's representations as to coverage cannot operate by way of estoppel to create coverage where the terms of the policy are unambiguous.

However, the situation before the Court cannot be resolved on the basis of broad statements of law which do not take into account mixed questions of law and fact presented by the instant case. Burns vs. Consolidated American Insurance Company, 359 So.2d 1203 (Fla. 3d DCA 1978).

Every case cited by Petitioner which stands for the proposition that an agent's representations as to coverage cannot operate by way of estoppel to create coverage where the terms of the policy are unambiguous is distinguishable on law and facts from the case at bar.

First, in each of Petitioner's cases the terms of the policy are clearly stated and the intent to provide or exclude coverage in the given factual situation is easily discernable. Therefore, each of the cases cited by Petitioner meet the

caveat of the general rule of law that coverage cannot be created where the terms of the policy are unambiguous. The unambiguous requirement must be met for the general rule to apply.

In the case at bar the unambiguous requirement is not met. Therefore,the general rule does not apply in the case before the Court. As stated in the argument previously made herein, the terms of the policy are irreconcilable and the intent to provide coverage or exclude coverage in the given factual situation is not easily discernable. Therefore, the Court should adopt the contruction which provides the most coverage and the general rule does not apply. Coleman v. Valley Forge Insurance Company, 432 So.2d 1368 (Fla. 2d DCA 1983).

Second, in the instant case, in addition to the terms of the policy being irreconcilable and the intent to provide coverage or exclude coverage in the given factual situation, not being easily discernable, the insured relied on the insurer's agent at the time of purchase of the policy, after purchase, before the incident in questions to verify that coverage in the given factual situation did in fact exist.

Such reliance under these facts, is not the situation in those cases cited by Petitioner and distinguishes this case as falling within an exception to the general rule as was correctly and justly decided by the Second District in citing Peninsular Life Insurance Co. v. McBride, 472 So.2d 870 (Fla 4th DCA 1985); Kramer v. United Services Automobile Association, 436 So.2d 935 (Fla. 4th DCA 1983).

CONCLUSION

The Summary Judgment entered by the trial Court should be reversed and the decision of the Second District affirmed. The Record, including the depositions and pleadings together with existing coverage to this insured under the cited facts and circumstances. It would send the wrong message to the buying public in these troubled days of high premium insurance coverage or the inability to purchase liability coverage by many individuals and corporations.

In this case, the Plaintiff insurance company should not obtain judicial sanction for its actions in selling insurance to a health care provider for which it is paid a premium and then when a claim is made against the insured, and not withstanding the statements made by the exclusive agent of the insurer, that there is full and complete coverage for liability claims, the insurer is permitted to ultimately escape all responsibility and leave its insured unprotected.

It is respectfully submitted that the Defendant corporation was entitled to a Summary Judgment as a matter of law and that the Affirmative Defenses of Bar and Estoppel would preclude the Plaintiff corporation from denying coverage. That in the alternative; in the event this Court finds that there was indeed material issues of fact which should have been considered by the jury, then this Court is requested to reverse the Summary Judgment entered by the trial Judge affirming the decision of the Second District and send the case back to the lower Court with instructions to permit trial by jury on all issues which are the subject of this review.

Respectfully submitted,

CLIFFORD J. SCHOTT, ESQUIRE

CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true copy of this brief and the attached appendix has been furnished by U.S. Mail this 24th day of June, 1987, to TERRENCE E. KEHOE, ESQUIRE, Post Office Box 2593, Orlando, Florida 32802-2593.

SCHOTT & DALE, P.A.
ATTORNEYS AT LAW

Clifford J. Schott
Post Office Box 1808
Lakeland, Florida 33802
(813) 683-6551
Attorney for Respondents