

1970

# Thomas R. Broadbent v. United States Fidelity and Guaranty Company : Appellant's Brief

Utah Supreme Court

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# IN THE SUPREME COURT OF THE STATE OF UTAH

THOMAS R. BROADBENT,  
*Plaintiff and Appellant.*

vs.

UNITED STATES FIDELITY AND  
GUARANTY COMPANY,  
*Defendant and Respondent.*

## APPELLANT'S

Appeal By Plaintiff From Judgment  
Granted By Third Judicial District  
For Salt Lake County, September 19, 1934.

REKSTAD  
HANSEN  
BRAND  
Attorneys  
Appellant  
702 Kearns  
Salt Lake City

RAY R. CHRISTENSEN  
CHRISTENSEN AND JENSEN

*Attorneys for Defendant and Respondent*  
1205 Continental Bank Building  
Salt Lake City, Utah 84101

Clerk, Salt Lake City

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# IN THE SUPREME COURT OF THE STATE OF UTAH

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THOMAS R. BROADBENT,  
*Plaintiff and Appellant.*

vs.

UNITED STATES FIDELITY AND  
GUARANTY COMPANY,  
*Defendant and Respondent.*

Case No.  
12263

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## APPELLANT'S BRIEF

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### NATURE OF THE CASE

This is an action by an insured against his professional liability insurance carrier for the recovery of the prescribed policy limits together with damages.

### DISPOSITION IN THE LOWER COURT

The District Court of Salt Lake County granted defendant's motion for Summary Judgment and entered Judgment thereon. After hearing a motion to state the grounds upon which judgment was rendered, the Court entered an amended Judgment on September 11, 1970, from which judgment this appeal has been taken.

## RELIEF SOUGHT ON APPEAL

Appellant seeks to have the Summary Judgment vacated and an order entered remanding this matter to the District Court for further proceedings, including trial.

## STATEMENT OF FACTS

On or about May 4, 1954, defendant issued to plaintiff a professional liability insurance policy wherein defendant promised to defend and pay up to \$50,000.00 on each liability claim made against plaintiff (see Exhibit "A" attached to Complaint). On or about May 10, 1954, plaintiff commenced medical treatment of one Adrienne H. Gyr which consisted of the attempted shrinkage of a tumor located in the cheek of the patient by means of the implantation of a radioactive substance known as Radon Seeds in the area of the tumor. (Broadbent Depo. pp. 10-11, hereinafter referred to only as "Depo.>"). The Radon Seeds were implanted by means of an operation which took place on or about June 30, 1954 (Depo. p. 12). Within a period of several weeks after the operation Gyr developed certain anticipated reactions to the radiation in the area of the treatment in the form of swelling, tenderness, redness and increased salivation. (Depo. p. 13). But for reasons unknown the degree of her reaction was greater than expected. These reactions manifested themselves in the form of certain bone and skin deteriorations both inside and outside of the mouth in the area where the seeds were implanted. (Depo. pp. 13, 14, 20, 22, 25). Gyr remained a patient of Dr. Broadbent and received continual treatment voicing no complaint until June 9, 1967, when

her attorney informed the plaintiff that a claim was being made against him for malpractice. (Depo. pp. 48-49). Dr. Broadbent notified defendant of the claim the next day. (Depo. p. 49). On July 28, 1967, Gyr commenced an action against plaintiff. After investigating the facts, defendant defended that action under a reservation of rights, claiming that Dr. Broadbent had failed to give timely notice of the claim as required in his policy and the company was therefore absolved from liability to pay any judgment obtained against him. In that case Dr. Broadbent effected a settlement with Gyr and then called upon defendant to contribute its policy limits toward the settlement which defendant declined to do. Thereupon this action was commenced against the defendant for the purpose of recovering (1) the policy limits to be used toward the liquidation of the settlement figure and (2) the damages plaintiff suffered by reason of defendant's refusal to pay the policy limits at the time of settlement. Defendant answered denying the existence of any such policy and asserting that if such policy existed, plaintiff had failed to give the defendant prompt notice as required in the policy thereby breaching the terms of the policy and absolving the defendant from any contractual duty toward plaintiff. On motion of the defendant, the Third Judicial District Court, in and for Salt Lake County, Stewart M. Hanson presiding, entered a Summary Judgment for defendant from which Judgment and amended order, plaintiff has appealed.

## STATEMENT OF POINTS

### POINT I

THE THIRD JUDICIAL DISTRICT COURT IN AND FOR SALT LAKE COUNTY, ERRED IN ENTERING SUMMARY JUDGMENT FOR DEFENDANT AND RESPONDENT UNITED STATES FIDELITY AND GUARANTY COMPANY.

## ARGUMENT

### POINT I

#### A. PLAINTIFF GAVE PROPER NOTICE ACCORDING TO THE PROVISIONS OF HIS POLICY.

The critical question in this case is whether plaintiff, Dr. Broadbent, rendered timely notice to the defendant of the injury to Mrs. Gyr. Before that question can be answered, however, one must first ascertain when the duty to report arose. In this regard the terms of the coverage and notice clauses in the policy are informative. With respect to coverage, defendant agrees in its policy:

To pay on behalf of the Insured all sums which the Insured shall become legally obligated to pay as damages because of injury arising out of *malpractice, error or mistake* in rendering or failing to render professional services in the practice of the Insured's profession described in the declarations, committed during the policy period by the Insured or by any person for whose acts or omissions the Insured is legally responsible except as a member of a partnership. (See Exhibit "A" attached to complaint; emphasis added).

The pertinent portion of the foregoing provision as far as this case is concerned is that coverage applies only to

"injuries" caused by "malpractice," "errors," or "mistakes."

With respect to notice, plaintiff's policy contained the following provisions:

Upon the Insured becoming aware of any alleged injury covered hereby, written notice shall be given by or on behalf of the Insured to the Company or any of its authorized agents as soon as practicable, together with the fullest information obtainable. . . .

. . . .

No action shall lie against the Company unless, as a condition precedent thereto, the Insured, shall have fully complied with all the terms of this policy. . . .

The notice provisions set forth above are fairly standardized and are found in virtually all liability contracts. The primary purpose of such provision is to allow the company to make a timely investigation of the facts:

The purpose of a policy provision requiring the insured to give the company prompt notice of an accident or claim, is to give the insurer an opportunity to make a timely and adequate investigation of all the circumstances. An adequate investigation often cannot be made where notice is long delayed, because of the possible removal or lapse of memory on the part of witnesses, the loss of opportunity for examination of the physical surroundings and making photographs thereof for use at trial and the possible operation of fraud, collusion, or cupidity. Such a requirement tends to protect the insurer against fraudulent claims, and also against invalid claims made in good faith. And further, if the insurer is thus given the opportu-

ity for a timely investigation, reasonable compromises and settlements may be made, thereby avoiding prolonged and unnecessary litigation. 8 Appleman, *Insurance Law and Practice*, §4731 at 2-3 (1962).

See also *Leach vs. Farmer's Auto Interins. Exch.*, 70 Idaho 156, 213 P.2d 920, 923 (1950). The notice provisions referred to above require the insured to give notice as soon as practicable after becoming aware of an injury. Such policy provisions usually require only that notice be given with reasonable dispatch in view of all the facts and circumstances of a particular case; notice need not be given instantaneously. See *Hartford Acc. & Indem. Co. vs. Day*, 359 F.2d 484, 486 (10th Cir. 1964); *Johnson Ready-Mix Concrete Co. vs. United Pac. Ins. Co.*, 11 U.2d 279, 358 P.2d 337, 338 (1961); 8 Appleman, *supra*. §4734, at 22.

Under the terms of the notice provision, plaintiff is to notify the company when he becomes "aware of any alleged injury covered hereby . . . ." The word "alleged" has been defined as being synonymous with the word "claimed." See *Williams vs. Hyman-Michaels Co.*, 277 S.W. 593, 595 (Mo. Ct. App. 1925). It has further been defined to mean "stated," "recited," "asserted," "charged," or "declared." See *State vs. Hostetter*, 222 S.W. 750, 754 (Mo. Sup. Ct. 1920); *Lynn vs. Nichols*, 122 Misc. Rep. 170, 202 N.Y.S. 401, 406 (1923). Taken within the context of the instant case, the word clearly implies some affirmative action on the part of a third party to verbally communicate a claim of injury to the insured.

The word "injured" has been defined to mean "damaged," "harmed," "impaired," or "hurt." See *Phelps Dodge Corp. vs. DeWitt*, 63 Ariz. 379, 162 P.2d 605, 607 (1945). This definition is of little value when applied to the medical profession because of the peculiarities of the profession. Physicians are daily involved in intentionally inflicting some kind of injury as a means of cure. Furthermore, aggravated reactions to normal corrective procedures are not uncommon. Such reactions are often completely unforeseeable, unanticipated, and result regardless of the use of proper medical procedures. It would appear that some distinction must be made between the injuries which are intentionally inflicted as a part of treatment and those injuries resulting from alleged negligence. The policy must refer to the latter since coverage extended only to "malpractice," "errors," and "mistakes" but, unfortunately, no specific definition of "injury" applicable to the medical profession is found in the policy. Based on the foregoing definitions and analysis of the terms of the notice and coverage clauses, it would appear Dr. Broadbent had the duty to render notice after his patient had made a claim to him for an injury which originated in some malpractice, mistake or error on his part. Only then was he under an obligation to give notice to his insurance carrier. The test as to when "an alleged injury covered hereby" is subjective; when should Dr. Broadbent as a reasonable physician under the circumstances, have known that "malpractice," "error" and "mistake" had occurred which would result in a claim.

Under the facts of this case, plaintiff met the duty which the policy imposed on him. Dr. Broadbent treated Mrs. Gyr for a period of thirteen years. During this time she made no complaints as to the treatment she was receiving. Mrs. Gyr experienced reactions greater in degree than was expected, but not different in nature. By no objective standard were the reactions occasioned by malpractice, error or mistake on the part of Dr. Broadbent. He first became aware of a complaint on June 9, 1967, when he was notified by Miss Gyr's attorney. Dr. Broadbent then gave notice to defendant the next day. Clearly, under the terms of the policy, plaintiff rendered proper notice as soon as practicable after learning of an alleged injury growing out of alleged malpractice, error or mistake. Plaintiff has, therefore, met the demands of his policy and rendered timely notice.

#### B. PLAINTIFF GAVE TIMELY NOTICE ACCORDING TO CASE LAW.

Not only do the terms of the policy sustain the timeliness of plaintiff's notice, but case law also establishes the propriety of plaintiff's action. The following cases indicate one need only give the insurer notice when the insured himself knows of a claim. As stated in *Williams vs. Cass-Crow Wing Co-op Assoc.*, 224 Minn. 275, 28 N.W. 2d 646, 650 (1947) the Minnesota Supreme Court stated as follows:

Obviously, rumor cannot be the basis of liability as a claim. There must be a claimant, and that person must either directly or through adequate agencies make such claim upon the one whom he thinks

or knows to be at fault. Obviously, it would have to be in the nature of a presentation for relief or compensation before it could be said to amount to a demand or claim.

Supporting the above view, the Arkansas Supreme Court stated as follows in *American Fid. & Cas. Co. vs. Northeast Ark. Bus Lines*, 201 Ark. 622, 146 S.W.2d 165, 166 (1941): "The general rule is that the insured is not required to give notice to the insurer until the insured, itself, has notice of a claim for damages." The most significant case in this area holding that notice need not be given to the insurer until actual notice is received by the insured is *Minnesota Farm Bureau Service Co. vs. American Cas. Co.*, 167 F. Supp. 315 (D. Minn. 1958), *rev'd on other grounds*, 270 F.2d 686 (8th Cir. 1959). In that case the residents surrounding plaintiff's plant made a complaint to plaintiff in the spring of 1954 with respect to fumes, vibrations and dust causing personal and property damage. On June 3, 1954, an attorney for those residents directed a letter to plaintiff requesting plaintiff to abate the alleged nuisances. On July 8, 1954, the residents commenced an action against plaintiff for damages and injunctive relief. On January 21, 1955, plaintiff's attorney tendered the defense of the case to defendant but defendant refused since it claimed notice had not been given to the company as soon as practicable as required by the policy. The residents prevailed in their action, plaintiff paid the judgment and brought this action against his insurance carrier for reimbursement. Under the facts of that case, the court held the notice timely. In reaching its decision it stated as follows:

The defendant contends that notice of claims required by the provisions of the policies and the notice given to it by the plaintiff were not timely. Under the terms of the policies of insurance, plaintiff was obligated to notify the defendant as soon as practicable after the accident or occurrence happened. *It was not under a duty to give notice until it was aware of the fact that some act or omission was the basis of a claim for relief against it.* With respect to this contention, it is necessary to determine first when the plaintiff became obligated to give notice. Until this is established, determination cannot be made as to whether notice was timely. The evidence shows that complaints were made by some of the residents in the area of plaintiff's plant in the early spring of 1954, but that it was not until June of 1954 that any claim was actually made by anyone against the plaintiff. *Plaintiff was not, therefore, under a duty to give notice to the defendant that claims had been made until June 1954, when it was first notified of the claims made in the state court. Minnesota Farm Bureau Service Co. vs. American Cas. Co., supra. at 318 (emphasis added).*

The reasoning of these cases is also found in *Sohm vs. United States Fid. & Guar. Co.*, 352 F.2d 65 (6th Cir. 1965) involving a malpractice action. Under the facts of that case, Sohms, a physician, performed a hernia operation on a patient on August 10, 1962. Immediately after the operation the patient complained of pain in her leg and after consulting another physician, a separate exploratory operation was performed on October 1, 1962, which Dr. Sohms observed. During the exploratory operation Dr. Sohms acknowledged having made an improper suture into a nerve. Sohms made no claim upon his insurance

carrier until a claim was made on him for malpractice on March 9, 1963. Sohm then notified his company on March 11, 1963, whereupon defendant alleged breach of the policy and declined to defend the action. The language in Dr. Sohm's liability policy was identical to that found in the instant case and the question before the court was whether proper notice had been given. The court held that the duty to render notice arose when Dr. Sohm acknowledged his negligence by observing the improper suture on October 1, 1962. Until the error became clear, there was no reasonable basis to believe that the patient would register a claim. The holding in *Sohm* clearly stands for the proposition that once a physician is aware of an error which has caused injury, he then must file notice with his insurance carrier. The case also stands for the proposition that a doctor need not report an untoward consequence of a normal surgical procedure until that doctor has reason to believe the consequence was caused by some negligence on his part. At that time the doctor must file notice with his insurer regardless of whether the patient has made a claim.

The reasoning of the above cases is rooted in sound public policy, particularly with respect to physician's liability policies. Because of the unusual nature of a physician's business, where injuries are intentionally inflicted and untoward physical consequences occasionally arise caused by no negligence of the treating physician, the only reasonable test as to when notice must be given is when the doctor himself is notified of an injury arising out of alleged negligence. If such were not the standard, physi-

time when the injured party discovered that insurance existed and knew the identity of the insurer; what prejudice to the insurance company's defense has been caused by the delay; the good faith of the insured and injured parties; the existence of any special circumstances, especially those indicating fraud or collusion. *Jackson vs. State Farm Mut. Auto Ins. Co.*, *supra.* at 179.

For additional cases, see *Century Indem. Co. vs. Serafine*, 311 F.2d 676 (7th Cir. 1963); *Phoenix Indem. Co. vs. Anderson's Groves, Inc.*, 176 F.2d 246 (5th Cir. 1949); *Cooper vs. Government Employees Ins. Co.*, 51 N.J. 86, 237 A.2d 870 (1968); *Annot.* 18 A.L.R.2d 443, 472-74 (1951).

The Utah Supreme Court has endorsed by implication the foregoing rule in the case of *Johnson Ready-Mix Concrete Co. vs. United Pac. Ins. Co.*, 11 U.2d 279, 358 P.2d 337 (1961). In that case an employee of plaintiff was slightly injured in the back and made an oral report to his superior. His superior made no report of the accident until the injured employee filed a lawsuit against the plaintiff some three years late. Defendant refused to defend as liability carrier for plaintiff since the insured had not given notice of the accident as soon as practicable as required by the policy. This case was brought to recover the amount paid on the judgment recovered by the employee. The court held that the delay in notice was excusable stating that "[c]ommon sense dictates that it is quite impracticable to report every trivial occurrence . . . which might be described as an accident." *Johnson Ready-Mix Concrete Co. vs. United Pac. Ins. Co.*, *supra.* at 338. The

court also stated that the insured is "not obligated to give a notice until and unless it learned of an accident which would indicate to a reasonable and prudent person that it had resulted in some injury for which a claim might arise," *Johnson Ready-Mix vs. United Pac. Ins. Co., supra.*

With respect to the law set forth above relating to excused notice, the facts of the case at hand come within this recognized exception. If a reportable injury took place during the thirteen years of treatment, no claim thereof was made by the patient. The complications which ensued from the Radon Seed treatment presented possible extreme reactions to the treatment, but not injuries separate and distinct from what could have been expected. A different result might have been obtained had the Radon Seeds been placed in a portion of the patient's body other than where the tumor was located or if complications had arisen in an area not under treatment. Under those circumstances notice would likely not be excused. But under the facts of this case, Dr. Broadbent was treating an extreme reaction to a normal corrective operation for the tumor and had no information either professional or from his patient which would indicate he had done anything which would give rise to a claim for damages. To verify his treatment, plaintiff conferred with three other specialists to ascertain if additional corrective measures could be taken. (Depo. pp. 25-26, 39-40). Plaintiff also inquired of the company which manufactured the Radon Seeds and verified the proper dosage. (Depo. p. 58). Based on these facts plaintiff had no information which would lead a

reasonably prudent person to believe the aggravation would result in a possible claim; therefore, any delay in rendering notice is excused.

**D. LATE NOTICE, IF ANY, IS EXCUSED BECAUSE DEFENDANT WAS NOT PREJUDICED THEREBY.**

If plaintiff had a responsibility for giving notice prior to the time actual notice was given such failure is nevertheless excused since defendant has not been prejudiced. As noted previously, the purpose of the notice clause is to afford the insurer adequate opportunity to investigate the facts of the case to prepare a defense. There is a substantial line of authority which holds that lack of notice will not preclude recovery under the policy unless the insurer has been prejudiced by the delay in notice, even though the insured knew that a reportable injury had taken place. This position has been specifically adopted by the highest appellate courts in our sister states of California, Idaho, and Arizona. For example, in *Campbell vs. Allstate Ins. Co.*, 60 Cal.2d, 303, 384 P.2d 155 (1963) plaintiff obtained a default judgment against defendant's insured and then brought an action against defendant to collect on the judgment. Defendant defended on the basis (1) that its insured had breached the cooperation clause of the policy by not forwarding suit papers and other documents to the defendant as required by the policy, and (2) defendant had thereby been prejudiced by the delay. On appeal the court held that even though defendant's insured breached the cooperation clause defendant was nevertheless not absolved from liability because of lack of prejudice. With respect to prejudice resulting from the breach of the co-

operation and notice clauses in the insurance contract, the court stated:

An insurer may assert defenses based upon a breach by the insured of a condition of the policy such as a cooperation clause, but the breach cannot be a valid defense unless the insurer was substantially prejudiced thereby. [Citations omitted.] Similarly, it has been held that prejudice must be shown with respect to breach of a notice clause. [Citations omitted]. We are satisfied that the requirement of prejudice set forth by these decisions is proper. *Campbell vs. Allstate Ins. Co., supra.* at 156.

The court not only sustained the requirement of showing prejudice but placed the burden therefore on the insurance company. *Campbell vs. Allstate Ins. Co., supra.* at 157.

A similar result obtained in the Idaho case of *Leach vs. Farmer's Auto. Interins. Exch.*, 70 Idaho 156, 213 P.2d 920, (1950), where the Idaho Supreme Court held at page 923 that

Violations of conditions by the assured will not release the insurer unless it is prejudiced by the violations. . . .

Both the fact of the violation of the conditions of the policy, and that prejudice resulted therefrom are matters of affirmative defense, which must be pleaded and proved by the insurer.

In a similar vein, the Supreme Court of Arizona held in *Lindus vs. Northern Ins. Co.*, 103 Ariz. 160, 438 P.2d 311 (1968), that even though the insured had failed to give notice to the two defendant insurance companies until seventeen months and twenty-four months respectively after the accident occurred, the failure to give timely

notice did not absolve the companies from defending because no actual prejudice had been shown. The significant point in *Lindus* is that *actual prejudice must be shown*; the mere fact that a delay took place does not give rise to a presumption of prejudice. See *Lindus vs. Northern Ins. Co., supra.*, at 315.

The decision in the above listed jurisdictions are merely illustrative of the judicial trend throughout the country. For example, the New Jersey Supreme Court in *Cooper vs. Government Employees Ins. Co.*, 51 N.J. 86, 237 A.2d 870 (1968), stated at page 874 that the carrier may not forfeit the bargained-for protection unless there are both a breach of the notice provision and a likelihood of appreciable prejudice. The burden of persuasion is the carrier's. For other cases with similar holdings see *Young vs. Traveler's Ins. Co.*, 119 F.2d 877 (5th Cir. 1941); *Jackson vs. State Farm Mut. Auto. Ins. Co.*, 211 La. 19, 29 So. 2d 177 (1946); *Fox vs. National Savings Ins. Co.*, 424 P.2d 19 (Okla. 1967); *Annot.* 18 A.L.R.2d 443, 482 (1951).

With this general legal background, the question then arises as to whether any prejudice has occurred in this particular case. If plaintiff had reported an injury to defendant at a time prior to when actual notice was received, little if anything could have been done by the defendant to investigate. Defendant possibly could have reviewed all records of treatment to ascertain the nature of the alleged injury but would not have learned any more than it now knows. Certainly defendant would not have contacted the patient for fear of precipitating an actual

claim. If an active investigation were undertaken on the part of the defendant, suspicions would have been aroused which would have occasioned doubts in the patient's mind as to the caliber of treatment she was receiving thereby likely occasioning an actual claim for negligence. In that event it would not be Dr. Broadbent who would have necessarily precipitated the claim but, at least in part, his insurer.

Plaintiff conferred repeatedly with other specialists and confirmed the dosage with the supplier of the radioactive material. He treated his patient consistently for a period of several years. Had the defendant company been contacted earlier, it likely would not have recommended Dr. Broadbent do more than he did on his own initiative. The full and complete records of the case are available; witnesses are still present to testify and no element of collusion is extant. Defendant has lost no opportunity to examine or assemble facts and is at no disadvantage because of the alleged time lapse. The opportunity to defend was at least as good when the notice actually was given at any other previous time; no prejudice has resulted.

**E. PLAINTIFF'S REASONABLE EXPECTATIONS AS  
LAY PURCHASER OF LIABILITY INSURANCE  
SHOULD BE REWARDED.**

In interpreting insurance contracts it is elementary that all ambiguities are resolved against the company as drafter of the contract. See *Handley vs. Mutual Life Ins. Co.*, 106 Utah 184, 147 P.2d 319 (1944); *Continental Cas. Co. vs. Phoenix Construction*, 46 Cal.2d 423, 296 P.2d

801 (1956). The courts have gone beyond the rule set forth above, however, and have adopted an even more strict method of construction when faced with contracts such as the one at hand which are largely standard in form, given to the buyer on a take-it-or-leave-it basis and drafted in legal terms not readily understandable to the layman. Such contracts have been denominated "adhesion contracts" since the "adherer" cannot obtain the desired service without acquiescence in the form agreement. Because of the inequities in such contracts, the courts tend to look behind the terms and give consideration to the reasonable expectations of the lay purchaser. The most striking case illustrating the above approach is *Gray vs. Zurich Ins. Co.*, 54 Cal. Rptr. 104, 419 P.2d 168 (1966). In that case the California Supreme Court made the following observations with respect to insurance contracts as adhesion contracts:

In interpreting an insurance policy we apply the general principle that doubts as to meaning must be resolved against the insurer and that any exceptions to the performance of the basic underlying obligation must be so stated as clearly to apprise the insured of its effect.

These principles of interpretation of insurance contracts have found new and vivid restatement in the doctrine of the adhesion contract. As this court has held, a contract entered into between two parties of unequal bargaining strength, expressed in the language of a standardized contract, written by the more powerful bargainer to meet its own needs, and offered to the weaker party on a "take it or leave it basis" carries some consequences that extend beyond orthodox implications. Obligations

arising from such a contract inure not alone from the consensual transaction but from the relationship of the parties.

Although courts have long followed the basic precept that they would look to the words of the contract to find the meaning which the parties expected from them, they have also applied the doctrine of the adhesion contract to insurance policies, holding that in view of the disparate bargaining status of the parties we must ascertain that meaning of the contract which the insured would reasonably expect. Thus as Kessler stated in his classic article on adhesion contracts: "In dealing with standardized contracts courts have to determine what the weaker contracting party could legitimately expect by way of services according to the enterprises's 'calling' and to what extent the stronger party disappointed reasonable expectations based on the typical life situation." (Kessler, *Contracts of Adhesion* (1943) 43 *Colum.L.Rev.* 629, 637).

Professor Patterson, in describing one characteristic consequence of "the conception of adhesion, whether the term is used or not." writes: "The court interprets the form contract to mean what a reasonable buyer would expect it to mean, and thus protects the weaker party's expectation at the expense of the stronger's. This process of interpretation was used many years ago in interpreting (or construing) insurance contracts. . . ." (Fn. omitted; Patterson, *The Interpretation and Construction of Contracts* (1964) 64 *Colum.L.Rev.* 833, 858).

*Gray v. Zurich Ins. Co., supra.* at 171-72

The strong interpretive stance taken regarding insurance contracts is not only explained on the basis of the layman's lack of knowledge of the contract, but also on the basis of a desire on the part of the courts to protect innocent third parties for whom the insurance contract is partially purchased and designed. In this regard, liability insurance contracts serve a distinct social function. The interest which the courts have in protecting innocent victims is set forth in a statement by the New Jersey Supreme Court in *Cooper vs. Government Employee's Ins. Co.*, 51 N.J. 86, 237 A.2d 870, 873-74 (1968):

But since then we have recognized that the terms of an insurance policy are not talked out or bargained for as in the case of contracts generally, that the insured is chargeable with its terms because of a business utility rather than because he read or understood them, and hence an insurance contract should be read in accordance *with the reasonable expectations of the purchaser so far as its language will permit*. [Citations omitted]. And although the policy may speak of the notice provisions in terms of "conditions precedent" . . . nonetheless what is involved is a forfeiture, for the carrier seeks, on account of a breach of that provision, to deny the insured the very thing paid for. This is not to belittle the need for notice of an accident, but rather to put the subject in perspective. Thus viewed, it becomes unreasonable to read the provisions unrealistically or to find that the carrier may forfeit the coverage even though there is no likelihood that it was prejudiced by the breach. To do so would be unfair to insureds. *It would also disserve the public interest, for insurance is an instrument of social policy that the victims of negligence be compensated. To that end the companies are franchised to sell coverage. We should therefore*

*be mindful also of the victims of accidental events in deciding whether a forfeiture should be upheld.*  
[Emphasis added.]

This line of cases dealing with the insurance contracts as adhesion contracts is particularly relevant to the instant case. Dr. Broadbent purchased a liability insurance policy as a layman reasonably expecting that coverage extended to his negligent acts which resulted in claims made against him or which he knew may be made against him. If no complaint had been made to him, and if he in good faith believed no malpractice had been involved in the treatment of any given patient, he would reasonably feel no compulsion to render notice of a nonexistent claim. He would reasonably expect the insurance coverage to exist and not to require notice in cases such as the case at hand where anticipated effects from proper surgical procedures became aggravated by means unknown to the doctor. His insurance contract covered only injuries arising from malpractice, mistake or error. By no reasonable objective standard was Dr. Broadbent aware of such an injury so caused; he could not be reasonably expected to render notice. Dr. Broadbent's reasonable expectations as well as those similarly situated should be rewarded in view of the inherent inequities of the contract and its ambiguities.

Not only should the expectations of the physicians be rewarded, but legitimate interest of innocent third parties should be protected who are the recipients of insurance coverage. In this regard the public interest is of considerable importance. In this day and age when the risk of

substantial monetary recoveries is great, both doctor and patient should be accorded the protection which both reasonably expect is present in any given case. To allow insurance companies to defeat coverage in a substantial case because of a highly technical and unprejudicial defect would not accord with public policy in view of the nature of the contract, its vague terms and its manner of execution.

#### F. THIS CASE IS NOT RIPE FOR SUMMARY JUDGMENT.

Under Rule 56, Utah Rules of Civil Procedure, summary judgment may only be entered when there is no genuine issue as to any material fact and the moving party is entitled to a judgment as a matter of law. Crucial factual determinations remain in this case which are incapable of being resolved as a matter of law. First, there is the distinct factual question which is disputed as to whether plaintiff gave timely notice under the policy. Second, there is the crucial question as to whether notice would be excused under the circumstances of this case, if it be determined that the duty to give notice arose at a prior date. Third, there is the vital question as to whether defendant has been prejudiced by any delay in notice. The facts set forth in this brief amply establish that a genuine issue of material fact arises under each one of the issues set forth above and that a determination thereof cannot be made as a matter of law.

As might be expected the courts when confronted with problems similar to those in this particular case have

been reluctant to decide such issues as a matter of law and have held such matters to be factual questions for the jury. As stated in *Hoffman vs. Employer's Liab. Ass. Corp.*, 146 Ore. 66, 29 P.2d 557, 563 (1934):

What is a reasonable time depends upon the circumstances of each particular case and, ordinarily, the question whether required notice has been given within a reasonable time is a question of fact for the jury, having due regard to the nature and circumstances of the case.

See also *Yanago vs. Aetna Liab. Ins. Co.*, 164 Va. 258, 178 S.E. 904, 906 (1935) wherein the court held that the time within which notice must be given and the necessity for prompt action within fair limits are jury questions. For an extensive listing of cases where such issues was held to be issues for the jury, see *Annot.* 76 A.L.R. 23, 61, 64-65 (1932). Based on these cases and upon the facts as set forth in this brief, plaintiff submits genuine issues of material fact remain which must be submitted to the jury.

## CONCLUSION

By way of summation and conclusion, it is respectfully submitted that plaintiff gave reasonable notice as required under the terms of the policy upon receipt of a claim from his patient; that he could not have been reasonably aware of any circumstance prior to that time which would have indicated to any reasonable and prudent doctor that a claim would be made for damages. If it should be ascertained that the duty to render notice arose at a prior time, such notice was excused since no reasonable claim was apparent to plaintiff. Furthermore, defend-

ant has not been prejudiced by the alleged failure to render notice, should such late notice be found, and therefore defendant is not discharged on its liability. The contract in question should be strictly construed against the insurer as drafter of the document, and should be further construed to reward the reasonable expectations of both the doctor and the public. Finally, plaintiff submits that the issues raised by this case are incapable of being settled at this time as a matter of law and, therefore, requests the court to vacate the Summary Judgment entered by the lower court and remand this matter for further proceedings including trial.

Respectfully submitted,

HANSON, BALDWIN,  
BRANDT & WADSWORTH

By  
REX J. HANSON