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Case Study

UIM Coverage: Determining Whether There Were One or Two Accidents

By Jeffrey D. Eberhard

Claims Pointer: When claiming two accidents occurred instead of one, the plaintiff must prove that the collisions were separated in space and time and that each collision arose from distinct causation. If the evidence is insufficient to prove two accidents occurred, only one accident occurred and a single UIM policy limit applies.

It is not uncommon for a collision involving one vehicle hitting another to result in subsequent collisions with other vehicles. Whether the multiple collisions are close enough in time and space to be legally considered arising from the same cause is crucial in determining if one or more accidents occurred as defined by an insurance policy. The answer to this question — whether one or more accidents occurred — is important because it determines the applicable insurance policy limits. In Wright v. Turner, et al., in the Court of Appeals of the State of Oregon, A144126, --- P3d ---- (October 24, 2012), the court determined whether there were one or two accidents and how to apply UIM policy limits.

Martha Wright driven by her friend Lorenz was travelling northbound on Interstate 5 in the Siskiyou Pass when John Turner suddenly lost control of the sedan he was driving and collided with the front-end of Wright's truck. The two vehicles separated and collided again before both vehicles slowed to a stop against a center barrier on the highway median. Lorenz pulled herself out of the truck through the driver's window since the door was pinned shut against the barrier and walked to Turner's sedan to check on its occupants. She noticed they needed medical attention so she returned to Wright's truck to get her cell phone and call 911. While standing outside the truck, Lorenz leaned into the truck and saw her purse on the floorboard. She asked Wright to reach over and grab her purse. Wright unbuckled her seatbelt and proceeded to lean over to retrieve the purse when a sports utility vehicle driven by Sherri Oliver struck the back-end of Wright's truck. The impact pushed Wright's truck into Turner's sedan. The collision drug Lorenz forward and knocked Wright about the truck's cab. Both impacts caused Wright personal injuries.

Wright filed a lawsuit against Turner and Oliver seeking recovery for her injuries. Wright also sought UIM benefits to the extent the other drivers were underinsured. Wright settled with Turner and Oliver for a total of \$175,000. However, Wright and the insurer providing UIM coverage disputed the amount of her damages and the extent of defendant's coverage.

The insurer requested a jury trial to determine the monetary value of Wright's claims. Wright claimed there were two accidents and sought the full policy limits of \$500,000 per accident. During trial, the number of accidents became an issue when determining the policy limits — were the defendant's liability policy limits \$500,000 because there was only one accident or \$1 million because there were two accidents. The insurer contended that the number of accidents needed to be established to determine: (1) whether Turner was underinsured and if so, by how much, and (2) whether Wright intended to split those and make two \$500,000 claims. The insurer requested the court submit a verdict form to the jury that would apportion damages among the alleged two accidents. The trial court rejected the insurer's request deferring the issue of one versus two accidents for post-verdict determination. The jury determined Wright's total damages were \$979,540. The insurer objected to Wright's proposed general judgment in that amount minus the \$175,000 offset from Turner and Oliver. The insurer claimed the verdict was insufficient to determine the insurer's total liability because there was no determination whether there were one or two accidents or whether two policy limits were available. Over the insurer's objection, the trial court entered the general judgment and the insurer appealed.

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On appeal, the insurer argued that the trial court erred because Wright failed to prove more than one accident occurred; therefore, only one \$500,000 policy limit applied. Wright continued to argue that two accidents occurred and two policy limits were available. The Court of Appeals referred to the language of the insurance policy and determined that qualifying language stating that \$500,000 is the most the insurer would pay per accident regardless of the number of vehicles involved in the accident made clear that multiple vehicles with potentially tortious impacts could be involved in one accident. The Court concluded Wright failed to prove two accidents occurred that were separated in space and time and that the two collisions arose from distinct causation. The first collision was not a proximate cause of the second collision; thus, there was only one accident. Since evidence was insufficient to prove two accidents occurred, only one accident occurred and a single policy limit of \$500,000 in UIM coverage applied. ❖

— View the full case opinion at: <http://www.publications.ojd.state.or.us/docs/A144126.pdf>

— If you would like to be notified of these new cases, please send an email to caseupdate@smithfreed.com.

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Medical Notes

Labral Tears: Quandary in 2012

By Vincent Santoro, MD

Tears of the glenoid labrum are one of the most controversial topics in orthopedics today. Major league pitchers are susceptible to these tears and often end up on the disabled list, costing owners millions. Laborers injured on the job lose extended time from work, giving their employers strife. Labral tears in general are rare, accounting for less than 3% of all patients with shoulder problems. **However, a disturbing trend toward increased operative repairs has been seen over the last decade.** Operative treatment has increased to 12% of all operative shoulder cases, despite the relatively rare nature of the tear. Treatment of labral tears remains controversial, due to the fact that they are often difficult to clinically diagnose, have a high false positive rate by diagnostic imaging, are often overtreated surgically, and may have a high complication rate.

So, what defines a labral tear?

The labrum is the fibrocartilage disc which surrounds the glenoid or shoulder socket. It helps to deepen the dish and aids in stabilizing the glenohumeral joint. It acts as an anchor point for the shoulder capsule, i.e. ligaments and the biceps tendon. Due to its position in the shoulder, the labrum is susceptible to injury from a variety of mechanisms.

In general, tears of the labrum occur either superiorly, anteriorly, or posteriorly. Superior tears are often referred to as “SLAP” tears. This stands for superior labrum anterior posterior and defines the location of the tear relative to the biceps tendon. Mechanisms producing SLAP tears include repetitive overuse phenomenon, such as repetitive overhead sports, or as a result of a traumatic fall. Tears occurring in either the anterior or posterior portions of the shoulder occur in the inferior margin and are generally related to anterior or posterior dislocations. Degenerative changes may be seen superiorly or inferiorly. Traumatic tears of the anterior-inferior or posterior-inferior labrum are also often referred to as Bankart lesions.

SLAP Tear Types

SLAP tears were originally described by Steven Snyder who classified them into four types:

Type 1 is a degenerative tear, which is generally stable.

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Type 2 tears represent an avulsion or peel back lesion of the labrum.

Type 3 tears are a complex tear of the labrum, referred to as a bucket handle tear.

Type 4 tears are bucket handle type tears which include the biceps root.

Type 1 tears are the most common tears and are generally seen in combination with other shoulder pathologies and usually are not primary pain generators. Types 2, 3, and 4 occur as a result of an acute macrotrauma or repetitive microtrauma, generally rendering the labrum unstable.

Throwing athletes have a high propensity to type 2 tears. This is a result of repetitive microtrauma due to the rotation and high shear forces created in the shoulder during the throwing phases.

Falls on an outstretched arm can tear the labrum and often lead to true dislocations. Repetitive injuries to the shoulder may produce the high grade type 3 and 4 tears.

Motor Vehicular Trauma and Labral Tears

One controversial area of discussion is the role of motor vehicular trauma (MVA) in the production of labral tears. Some feel labral tears cannot occur as a result of an MVA. However, if the arm is braced against a steering wheel or dashboard and an impact causes the body to lurch forward, a sheering lesion to the joint can put the labrum at risk, producing a labral tear.

The primary complaints associated with labral tears include pain, clicking, popping, weakness, and occasionally a dead arm. Significant overlap with rotator cuff pathology exists and combined rotator cuff and labral tears may occur in the same shoulder.

The primary findings associated with labral tears on examination include a painful arc of motion, especially with rotation in overhead or cross body positioning. A click or clunk may be produced during the maneuvering of the shoulder during provocative testing. Apprehension may be induced leading one to the diagnosis of a labral tear. Many names are associated with the provocative tests, and include the O'Brien test, Kibler test, clunk test, Kim test, and several others. **Patients with labral tears may also exhibit findings that are often seen with rotator cuff pathology, such as impingement and severe weakness.**

Imaging of the shoulder should always include radiographs. Often negative, however, loose bodies or glenoid changes may be visualized on an x-ray. The MRI remains the gold standard for diagnostic imaging for shoulder problems. However, noncontrast MRI studies may lead to false representation of labral pathology and there is a high false positive and false negative with MRI alone. Therefore, the best modality to identify a labral tear is with an MRI arthrogram. Accuracy is dramatically enhanced using this modality.

One confounding issue in the identification of labral tears is that there are several labral variants which may appear to be labral tears, when indeed it is simply normal findings for that patient.

Treatment

The treatment of labral tears is straight forward. Acute injuries should be evaluated immediately with MRI arthrogram, to delineate the underlying pathology. A trial of physical therapy is warranted, even if a labral tear is seen. Rest, anti-inflammatories, and modified activities may improve symptoms, but truly unstable labral tears often require arthroscopic treatment.

Chronic complaints should get a longer trial of physical therapy. Often secondary adaptive changes become the primary pain generators and therapy may be beneficial in alleviating these symptoms. If symptoms re-

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main after 8 weeks of physical therapy, then MRI arthrogram is indicated for further evaluation. Failure to respond to conservative measures with a positive MRI arthrogram requires operative stabilization.

One must be cognisant of secondary gain and pain seeking behavior. L&I, MVA, and litigation often lead to enhanced subjective complaints, often with limited objective findings. Certainly, an annalistic approach is not warranted, but judicious treatment is needed.

If surgery is indicated, arthroscopy is the definitive treatment. A complete evaluation of both the glenohumeral and subacromial spaces at the time of surgery is warranted. Any unstable pathology should be repaired anatomically in an attempt to return normal shoulder function. Many patients undergoing surgery will have significant stiffness preoperatively. It has been shown that preoperative stiffness often leads to poor outcomes.

The techniques utilized to repair the labrum include the use of bioabsorbable anchors and suture repair. As long as the labral tissue is capable of repair, primary repair should be done. In some circumstances, the labral tissues are dramatically damaged or the tear may extend up into the biceps, rendering it incompetent. In these scenarios, a biceps tenodesis is often the best treatment modality. In certain older or less demanding patients, a simple biceps tenotomy may dramatically improve pain.

Postsurgical management should follow a standardized protocol with early sling immobilization during the first week, followed by a physical therapy program, which attempts to return full range of motion during the first three months. Strength training may be initiated once full range of motion has been achieved. Return to work is contingent upon the type of work that preceded the injury. Sedentary occupations may allow early return to desktop activities. More demanding occupations, such as construction workers or overhead athletes may take a minimum of 3 to 6 months before safe return is possible.

Prognosis is excellent for most patients with repair of the glenoid labrum; 75-90% of injured athletes and workers will return back to their premorbid status. Overhead throwers have a less favorable prognosis.

Complications associated with labral repairs include nonhealing of the labrum, persistent pain, instability, weakness, and stiffness. In some, though rare, a full frozen shoulder may occur. Chronic pain is unusual for labral repair patients. Again, those with secondary gain may have subjective complaints that far outweigh objective findings.

In summary, though rare, labral tears remain controversial in orthopedics. Clinical diagnosis may be difficult due to overlap with rotator cuff symptoms. MRI arthrogram remains the diagnostic imaging study of choice. All labral tears should be initially treated with physical therapy in an attempt to improve stiffness and function. Some patients will recover nicely with therapy alone. For those who do not, surgical evaluation and treatment done arthroscopically remains the treatment of choice. ❖