IN THE SUPERIOR COURT OF THE STATE OF DELAWARE

IN AND FOR NEW CASTLE COUNTY

VICTORIA E. ROSENTHALIS,)
individually and in her capacities as)
surviving spouse of Raphael)
Rosenthalis, and as Administratix)
of the Estate of Raphael Rosenthalis,)
deceased, and as Guardian Ad Litem)
and Next Friend of her minor child,)
NATHANIEL ROSENTHALIS,)
and ABIGAIL ROSENTHALIS,)
)
Plaintiffs,)
)
v.) C.A. No. 99C-09-217-FSS
)
DOCTORS FOR EMERGENCY)
SERVICES, P.A., a corporation of the)
State of Delaware; and JERRY P.)
GLUCKMAN, M.D.,)
)
Defendants.)

Submitted: July 8, 2003
Oral Argument: December 19, 2003
Decided: March 31, 2004

CORRECTED COVER PAGE[1]

OPINION AND ORDER

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[1] Michael Sensor was omitted from the cover page as counsel for the Intervening party, DIGA..

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SILVERMAN, J.

This is an insurance coverage case of first impression in Delaware. The issue is whether the $300,000 cap[2] specified in the Delaware Insurance Guaranty Association Act[3] applies on a "per incident" or "per claimant" basis. Here, a single incident of medical negligence left four plaintiffs – a patient who died, his widow and two children – with two causes of action, a survival claim and a wrongful death claim. DIGA contends that its maximum exposure for the incident is $300,000, split among the estate and the next of kin. Plaintiffs contend that each of them is entitled to collect up to the cap, $1.2 million total, or at least until DIGA's payments exhaust the underlying insurance policy's coverage, $1 million.

I.

On September 23, 1999, Victoria E. Rosenthalis filed a complaint following the death of her husband, Raphael Rosenthalis, on August 19, 1998. Rosenthalis filed an amended complaint on July 24, 2000. The amended complaint incorporates two causes of action: a survival action on behalf of Raphael's estate, and a wrongful death action by Raphael's next of kin. Some of the originally named defendants have been dismissed, leaving only Doctors for Emergency Services, P.A. (DES) and Jerry P. Gluckman, M.D. as Defendants.

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[2] DEL. CODE ANN. tit. 18, §§ 4208(a)(1) (1999).

[3] DEL. CODE ANN. tit. 18, §§ 4201-4223 (1999).

Relying on the parties' Stipulation of Facts, Plaintiffs moved for summary judgment against Defendants and DIGA, as Intervenor, on May 14, 2003. DIGA responded to Plaintiffs' motion on June 12, 2003. Plaintiffs replied on July 8, 2003. The parties agreed that the case should be decided by summary judgment. After reviewing the parties' written submissions, the court called for oral argument, which was held on December 19, 2003.

II.

The facts are neither complicated, nor disputed. As mentioned, the parties stipulated to them. Raphael Rosenthalis died on August 19, 1998, allegedly due to medical negligence. He left a widow, Victoria, and two children, Nathaniel and Abigail. Rosenthalis's treating physician was Dr. Gluckman, who was associated with DES.

Gluckman was the named insured on a professional liability insurance policy issued by the now defunct PHICO Insurance Company. The policy provides a $1 million liability limit per incident and a $3 million liability limit in the aggregate.[4] Part PL, Section IV, states:

> Regardless of the. . .number of claims made, [PHICO's] liability is limited as follows. . .[PHICO's] total liability for all damages because of *one medical incident*. . . shall not

[4] PHICO Insurance Policy, Declarations page.

> exceed the amount stated in the Declarations as the "each incident" limit of liability.[5] (emphasis added)

The policy's effective dates were July 1, 1998 to July 1, 1999.[6] DIGA admits that PHICO should have responded. On February 1, 2002, however, the Commonwealth Court of Pennsylvania declared PHICO insolvent. Its obligations to Delawareans were then assumed by DIGA pursuant to the Act.

On October 7, 2002, the first day of trial in the underlying medical negligence case, the parties settled. DIGA agreed to pay Plaintiffs, collectively, at least $300,000. Plaintiffs received another $300,000 from DES. Plaintiffs and DIGA further agreed to put the question to the court whether DIGA must cover each Plaintiff's damages until the policy's $1 million per incident limit is reached. Finally, Plaintiffs agreed not to hold Gluckman personally liable beyond whatever DIGA pays on his behalf.

III.

Plaintiffs rely on the Act for their contention that DIGA must cover their individual losses up to the policy's $1 million limit. The Act created DIGA partly as a way to pay covered claims against insolvent insurers, without delay and "to avoid

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[5] PHICO Insurance Policy, Part PL at pg. 2.

[6] PHICO Insurance Policy, Declarations page.

financial loss to claimants or policyholders. . . ."[7] The language at issue appears in § 4208(a)(1)(iii), which reads, in part:

> The Association shall:
>
> (1) Be obligated to pay valid covered claims. . . . Such obligation shall be satisfied by paying to the claimant . . . :
>
> (iii) an amount not exceeding $300,000 per claimant for all other covered claims.[8]

In part, the statute defines "claimant" as any person making a liability claim.[9] "Person" includes any individual.[10] "Covered claim" is:

> . . .an unpaid claim. . . submitted by a claimant, which arises out of and is within the coverage, and subject to the applicable limits, of an insurance policy to which this chapter applies, issued by. . .an insolvent insurer. . . .[11]

Just as the parties agree that PHICO should have responded here, they also agree that PHICO's insolvency triggered the Act and DIGA must respond in PHICO's place.

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[7] 18 *Del. C.* § 4202.

[8] 18 *Del. C.* § 4208(a)(1)(iii).

[9] 18 *Del. C.* § 4205(3).

[10] 18 *Del. C.* § 4205(10).

[11] 18 *Del. C.* § 4205(6)(a).

As discussed below, the parties interpret § 4208(a)(1) differently. Plaintiffs focus on the statute's mandate that DIGA must pay "$300,000 per claimant." Therefore, each of the four plaintiffs has a $300,000 potential claim. DIGA, however, focuses on the section's reference to "covered claim." DIGA argues that a covered claim is defined by the underlying insurance policy and general insurance law. According to DIGA, the four plaintiffs have but one covered claim. Therefore, they are entitled to no more than $300,000, in the aggregate, from DIGA.

IV.

As mentioned, the parties agree as to what law applies. They agree on the facts, as presented above. And they agree the case is ripe for summary judgment.[12] The court must now apply what it finds the law to be to the undisputed facts, and in that way decide the case.

DIGA starts by establishing an undisputed point: Plaintiffs are not entitled to more than the underlying policy's per incident limit, $1 million. Therefore, even if the Act might require DIGA to pay as much as $300,000 for each of the four Plaintiffs, or $1.2 million, the policy limits Plaintiffs collectively to $1 million, at

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[12] *Johnson v. Bowman*, 1997 WL 719354, at *1 (Del. Super. Ct.)(citing *Merrill v. Crothall-American, Inc.*, 606 A.2d 96, 99-100 (Del. 1992))(summary judgment is proper where there are no genuine issues of material fact, thus entitling the moving party to judgment as a matter of law).

most. Plaintiffs' position is that under the Act they each would be entitled to $300,000. And because there are four of them, they would divide $1.2 million. But everyone agrees that despite the Act's potentially higher cap, the policy's "per medical incident" limit caps DIGA's exposure at $1 million. Therefore, the way DIGA lowers Plaintiffs' potential recovery from $1.2 million to $1 million is clear.

As suggested above, the controversy concerns whether each Plaintiff is entitled to $250,000 or whether DIGA's total liability is capped at $300,000. Initially, the court agrees with DIGA that its obligations to Plaintiffs "must be viewed through the prism of the underlying PHICO policy."[13] By the same token, the court agrees that "the policy cannot be given broader interpretation after PHICO's insolvency than it would be given had PHICO remained solvent."[14] Even so, the case turns on the Act. It is controlling. It establishes DIGA and it directly speaks about DIGA's liability.

The Act commands DIGA to pay all covered claims "in an amount not exceeding $300,000 per claimant." A claimant is "any person making a liability claim." The underlying policy is implicated by the way the Act defines "covered claim." A covered claim must "arise[] out of and [be] within the coverage, and

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[13] Intervenor DIGA's brief at pg. 8.

[14] Id. at pg. 21.

subject to the applicable limits, of [the underlying policy.]" Thus, as explained above, Plaintiffs' total claims cannot exceed the underlying policy's $1 million per medical incident limit. The further questions remain, however, whether Plaintiffs are claimants making covered claims. And if they are, how many claims are they making?

The simple answer is that the complaint contains a wrongful death claim on behalf of the next of kin. DIGA is correct that under Delaware law, the wrongful death count is a single claim.[15] Here, the claim is on behalf of decedent's three beneficiaries. Therefore, they are pursuing one liability claim arising from one incident of medical negligence. Accordingly, DIGA is obligated to pay them $300,000.

The complaint also contains a survival claim on behalf of the deceased. That is a seperate claim. It is not, as DIGA suggests, merely derivative or otherwise combined with the wrongful death claim.[16] Both claims arise from the same incident. But that fact does not give rise under the Act or the policy for combining them into

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[15] *Essick v. Barksdale*, 882 F.Supp. 365, 371 (D. Del. 1995)(citing 10 *Del. C.* § 3724(e))(regardless of the number of people claiming damages, only one cause of action lies with respect to the death of a person).

[16] *Emmons v. Hartford Underwriters Insurance Company*, 697 A.2d 742, 743 (Del. 1997)("A wrongful death action is separate and distinct from a survival action. . . .").

a single claim. Therefore, the survival action is a second claim and DIGA is obligated to decedant on that claim, too.

As this case involves statutory interpretation, it is important to remember that the "plain meaning" of words controls when a statute is unambiguous.[17] "Statutes must be read as a whole and all the words must be given effect."[18] The DIGA Act should be liberally construed,[19] and as a remedial statute, should be interpreted to counteract the loss suffered by an insolvent insurer's claimants.[20] By writing § 4208(a)(1) as it did, the General Assembly did not intend to limit an insolvent insurer's claimants to an absolute $300,000 recovery. If that is what the legislature intended, it would have written the law differently. The legislature did not write the statute in a way that limits DIGA to one $300,000 payout, or less, no matter what.

The court's allowing both of Plaintiffs' claims is consistent with other courts' treatment of insurance guaranty acts.[21] The Superior Court of Pennsylvania,

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[17] *Ingram v. Thorpe*, 747 A.2d 545, 547 (Del. 2000).

[18] *Industrial Rentals, Inc. v. New Castle County Board of Adjustment*, 776 A.2d 528, 530 (Del. 2001).

[19] 18 *Del. C.* § 4204.

[20] *Process Industries, Inc. v. Delaware Insurance Guaranty Association*, 1994 WL 680122, at *2 (Del. Super. 1994)(citing *J.D.P. v. F.J.H.*, 399 A.2d 207, 210 (Del. 1979)).

[21] Compare *Ramage v. Alabama Insurance Guaranty Association*, 919 F.2d 1010, 1012 (5th Cir. 1990)(personal injury and wrongful death

in *Keystone Aerial Surveys, Inc. v. Pennsylvania Property & Casualty Insurance Guaranty Association,*[22] stated that a claimant is a person with enforceable rights against the insured, or someone with a covered claim.[23] The court further opined that the Pennsylvania guaranty act is "designed to protect claimants and policyholders, not to limit recovery."[24] In our case, both the survival and wrongful death actions are allowable because Mr. Rosenthalis's estate and family, respectively, have enforceable rights against Dr. Gluckman. There are two "covered claims." Therefore, both claimants should be protected rather than having their recovery limited.

V.

The theory by which DIGA reduces Plaintiffs' total, potential recovery to $300,000 is an *ipse dixit*: "The Guaranty Act simply serves to preserve the rights and obligations of the parties under the policy and then reduce DIGA's total obligation from $1 million to $300,000." It begs the question. Moreover, under that theory, the policy's limit does not matter unless it is less than $300,000. Nor does it

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claims arising from one occurrence "separate and distinct actions"), with *Vickodil v. Pennsylvania Insurance Guaranty Association*, 514 A.2d 635, 638 (Pa. Super. Ct. 1986)(separate claims allowed unless policy liability limitation language unites them).

[22] 777 A.2d 84 (Pa. Super. Ct. 2001).

[23] *Id.* at 90.

[24] *Id.* at 94.

matter how many claimants there are. DIGA contends, in effect, that the Act notwithstanding, one incident of medical negligence can result in no more that a single, $300,000 claim, at most.

DIGA also offers a more sophisticated argument based on the underlying policy. DIGA, however, conflates the policy's "per medical incident" limit with the Act's reference to "covered claims." DIGA attempts to establish that Plaintiffs are pursuing only one covered claim. And that is so because their claim stems from a single medical incident involving a single wrongful death. According to DIGA, one medical incident gives rise to only one covered claim, regardless of how many causes of action or claimants the incident spawns.

DIGA supports its position with assorted cases from other states. But they are neither controlling nor persuasive in light of the dissimilarity between the policies, claims and insurance guaranty laws here and in the out-of-state authorities. For instance, the difference between the Delaware and Maryland insurance guaranty laws cuts against DIGA. Under Maryland's law its guaranty corporation's "obligation 'shall include only the amount of each covered claim that . . .is . . . less than $300,000. . . .'"[25] DIGA, in contrast, is obligated to pay "an amount not

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[25] *Igwilo v. Property & Casualty Insurance Guaranty Corporation*, 750 A.2d 646, 650 (Md. Ct. Spec. App. 2000)(quoting MD. CODE ANN., INS § 9-306 (2004)).

exceeding $300,000 *per claimant* for all. . .covered claims."[26] The difference between the two insurance guaranty laws is unmistakable.

VII.

For the foregoing reasons, as a matter of law and without further fact-finding, Plaintiff's motion for summary judgment is ***GRANTED*** in the amount of $600,000, as explained above.

IT IS SO ORDERED.

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Judge

oc: Prothonotary (Civil Division)
pc: John A. Elzufon, Esquire
Mason E. Turner, Jr., Esquire

[26] 18 *Del. C.* § 4208(a)(1)(emphasis added).