COMBATTING A DISABILITY CARRIER'S EFFORTS TO DICTATE AN INSURED'S MEDICAL CARE: WHOSE BODY IS IT ANYWAY?

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I. INTRODUCTION

Your client has made a claim under his "own occupation" disability policy, and the insurer has been paying benefits for a few months. But now, the insurer is taking the position that the treatment your client is receiving is inappropriate for his condition. Perhaps the insurer is arguing that your client has to undergo carpal tunnel surgery (instead of cortisone injections, night splints and anti-inflammatory medication), even though the policy contains no duty or requirement to undergo surgery. Or maybe the insurer is asserting that your client should have back surgery, even though conservative treatment (pain injections, physical therapy and chiropractic manipulations) is providing your client with some relief. And to make matters worse, the insurer is threatening to cut-off your client's benefits – or even sue him for declaratory relief and reimbursement of the benefits previously paid – if he doesn't undergo the surgery.

But your client doesn't want to undergo surgery. Perhaps he feels that the conservative treatment he is receiving will eventually correct the problem. Perhaps he feels that the risks of the supposed safe, simple and routine surgery outweigh the benefits. Perhaps he has peripheral neuropathy or some other condition that lessens the likelihood that the operation would be a success. Maybe his religious convictions preclude him from receiving medical treatment of any kind. Or perhaps, like many people, he is simply afraid of surgery.

What should your client do? Does the law support his right to decide whether he will undergo invasive medical treatment? What about the constitutional right to privacy? Does the insured's duty to mitigate and/or duty to act in good faith include a duty to submit to treatment dictated by his insurance company? And even if the insurer can condition benefits on whether its insured undergoes appropriate care, who determines what care is "appropriate" – is it the insured, the treating physician, the insurance company, or the jury?

This syllabus, and the presentation that accompanies it, will try to answer these and other questions surrounding this critical issue.

II. THE MAJORITY RULE IS THAT A DISABILITY INSURER CANNOT DICTATE MEDICAL CARE

Actually, it's rather remarkable that disability insurers are even arguing that policyholders have a duty to undergo surgery or other corrective treatment. That is because if your client shelled out big bucks for "special" coverage in the 70's, 80's or early 90's, his individual policy contains *no written duty to undergo any surgery of any kind in any circumstance.*

But that has not stopped disability carriers from combing their policies for other language that they hope will require an insured to undergo surgery or other curative treatment. Sometimes, insurers rely on – without success – the policy provision that requires an insured to "cooperate" with the insurer. More often, however, carriers focus on the policy's definition of "total disability." In addition to requiring that the insured be unable to perform the substantial and material duties of his occupation, that definition either requires (depending on which version the insurer is using) that the insured be in the regular care and attendance of a physician (Type 1) or that the insured be receiving care by a physician which is appropriate for the condition causing his disability (Type 2).

A. What Constitutes "Regular" Care Under A Disability Policy?

As stated in a leading insurance treatise:

> "[A]n insurer ***cannot*** take advantage of the insured's refusal to submit to a simple surgical operation, even though such an operation would be reasonable under the circumstances, unless the policy expressly provides therefor. [Citations]. In accordance with this view, where a policy insures against 'total and permanent disability' rather than against 'incurable disability,' the insured is under ***no*** duty to submit to an operation for the purpose of minimizing damages [Citations], even though the operation could have been undergone with reasonable safety, would have proved successful, and would have entailed only a reasonable cost. [Citation]."

10 Couch on Insurance (3d ed. 1998) §146:53:85 (emphasis added)[1].

And that is the *majority rule* in this country. As stated in Casson v. Nationwide Ins. Co., 455 A.2d 361, 366-77 (Del. Super. 1982), **"the majority view" is that "an insured need not attempt to minimize his disability by undergoing medical treatment**." Indeed, an insured cannot be penalized for refusing to undergo a surgery or other significant procedure even where it is usually successful (North American Acc. Ins. Co. v. Henderson, 170 So. 528, 529-30 (Miss. 1937) and the refusal to undergo the treatment was unreasonable (Jefferson Standard Life Ins. Co. v. Hurt, 72 S.W.2d 20, 23 (Ky. 1934)). As observed by Appleman, "[t]o hold otherwise [would] mean[] that the court requires the insured either to spend his own funds for the doing of a useless thing, if the operation proves unsuccessful, or to expend his own money to relieve the insurer of an obligation which it has voluntarily contracted." Appleman, Insurance Law and Practice § 656, p. 281.

Accordingly, for "regular care" (Type 1) policies, most courts have concluded that an insurer *cannot* require its insured to undergo surgery as a condition to receiving benefits.

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[1] Unless otherwise noted, all emphasis added by authors.

And this is so even where surgery is usually successful and the refusal to undergo surgery was arguably unreasonable.

The Seventh Circuit's decision in Heller v. Equitable Life Assurance Society, 833 F.2d 1253 (7th Cir. 1987), is particularly instructive. In Heller, a disability insurer refused to pay benefits to an insured physician who had carpal tunnel syndrome but refused to undergo corrective surgery. The policy required the insured to be "under the regular care and attendance of a physician," which the court found to require no more than regular monitoring of the insured by a physician to determine whether the disability condition persisted. Id. at 1257. The court held that the insured was "***not*** required to undergo surgery for treatment of his carpal tunnel syndrome condition before he receives disability income payments" (Id. at 1258) even though the insurer claimed the surgery was "common and of a minor, low-risk variety" (Id. at 1257, n. 10) and the court found it might very well relieve him of his pain and allow him to resume his practice. The court reasoned that adding a surgery requirement would constitute improper judicial activism:

> "[W]e refuse to add to and construe the policy beyond its clear and obvious language, to require the insured to submit to surgery . . . . *We refuse to indulge in judicial activism and condition coverage under the contract on the insured's undergoing surgery, when the insurer failed to provide such a conditional clause in the policy.*"

Id. at 1257.

The Seventh Circuit found that the lack of an express surgery requirement was fatal to the insurer's position:

> "In the absence of a **clear, unequivocal and specific contractual requirement that the insured is obligated to undergo surgery** to attempt to minimize his disability, we refuse to order the same. To hold otherwise and to impose such a requirement would, in effect, *enlarge the terms of the policy* beyond those clearly defined in the policy agreed to by the parties."

Id.

The Heller court flatly rejected the insurer's argument that "the 'principle of fairness and good faith, a policy of motivating persons to correct rather than accept physical disabilities,' necessitates that an insured suffering from causes that disabled him, avail himself of all reasonable means and remedies to relieve his disability, including surgery." Id. at 1259. The court found "no moral, much less legal obligation or compelling reason, to second guess an insured's . . . decision to forego surgery" and thereby avoid the "risk, trouble, expense and often trying experiences incident to medical treatment." Id.

In the end, the court reemphasized the principal basis for its decision – that the rights of the parties are governed by *the terms of the policy*:

> Although we might not choose to follow the same course of conduct and path of reasoning as Dr. Heller, there is no moral, much less legal obligation or compelling reason, to second guess an insured's, and in this case, Dr. Heller's decision to forego surgery. The insurance company seeking to condition coverage on its insureds' acquiescence to undergo surgery to minimize the extent of their disabilities, as well as the financial loss to the insurer, need only incorporate a specific requirement to that effect in the policy, and we would not hesitate to enforce the same. On the other hand, insurers who *fail to include this express surgical contractual requirement*, and who *refuse to cover an insured after accepting substantial premiums*, in circumstances such as those before us, cause problems not only for the insured, but for the insurance industry as well. Insurance companies, members of a service industry, must recognize that, like their insureds, they have corresponding duties and obligations under the policy and must conduct themselves accordingly instead of attempting to rely on the courts to correct their own deficiencies in underwriting and/or careless policy drafting."

Id. at 1259-60.

But see Provident Life and Accident Ins. Co. v. Van Gemert, 262 F. Supp. 2d 1047 (C.D. Cal. 2003), holding that a provision requiring the insured to be "under the care and attendance of a physician" should be "construed to both govern the care required, and that such care may consist of surgery where surgery represents the only course of medical care a reasonably prudent person would pursue." Id. at 1050-51. The court denied the

insurer's motion for summary judgment as there were triable issues as to whether the surgery urged by the insurer "reflected the only treatment option a reasonably prudent person would choose." Id. at 1052.

Cases following the majority rule include the following:

- Seaman v. New York Life Ins. Co., 115 P.2d 1005, 1009 (Mont. 1941) [Where life policy did not provide for operative repair or treatment and did not require insured to first have medical care or treatment in attempt at a cure before receiving disability benefits, insured who had been afflicted with recurrent double hernia for 11 years, and who had made unsuccessful efforts at rehabilitation and amelioration, and who did not lack good faith in not having another operation, was not required to submit to operation in order to recover disability payments.]

- Wagner v. Prudential Ins. Co., 14 Northumb. L. J. 389 (Pa. 1940) [Insured was not required to have an operation in order to recover disability benefits where the operation was not a simple and safe one, but one serious and attended with grave danger, and where the operation would compel plaintiff to expend a sum almost equal to one year's benefits.]

- John Hancock Mut. Life Ins. Co. v. Spurgeon, 134 S.W.2d 155, 156 (Tenn. 1939) [Insurer could not avoid liability under Group LTD policy on ground of insured's refusal to submit to an operation to remove the disability, in the absence of policy provision requiring such a submission.]

- Miller v. Mutual Life Ins. Co. of New York, 289 N.W. 399, 400-401 (Minn. 1939) [Where the express provisions of life insurance policy providing for total disability benefits did not require insured to submit to medical treatment, there was no duty on insured's part to undergo treatment as a condition precedent to recovery of benefits.]

- Stewart v. Home Life Ins. Co., 29 F. Supp. 834 (D.C. Colo. 1939) [Under Colorado law an insured cannot be required to submit to an operation as condition precedent to recovery of disability benefits.]

- Pacific Mutual Life Ins. Co. v. Matz, 81 P.2d 775-76 (Colo. 1938) [Where disability policy did not contain provision requiring insured to submit to operation to minimize disability nor provision that policy insured against only incurable disability, insured was not required to submit to operation to cure disability as a prerequisite to recovery of benefits.]

- North American Acc. Ins. Co. v. Henderson, 170 So. 528 (Miss. 1937) [Where insured who was suffering from inguinal hernia was financially unable to undergo curative operation, his failure to do so did not preclude recovery of total disability benefits under health and accident policy on ground that he was not totally disabled because an operation would result in complete cure.]

- Reinsch v. Travelers Ins. Co. of Hartford, 274 N.W. 572 (Neb. 1937) [Insured's refusal to submit to operation to repair inguinal hernia did not defeat his claim for total disability benefits under a life insurance policy.]

- Volunteer State Life Ins. Co. v. Weaver, 167 So. 268, 269 (Ala. 1936) [Rule that injured person must minimize his damages by complying with treatment prescribed or suggested by physicians held inapplicable to insured suing for disability benefits under life insurance policy containing no such requirement.]

- Roderick v. Metropolitan Life Ins. Co., 98 S.W.2d 983, 986 (Mo. App. 1936) [Where employee is insured for disability, he need not submit to operation to relieve disability, since he is under no contractual obligation to submit and thereby incur expense and risk life so that insurer might be relieved of liability.]

- Prudential Ins. Co. of America v. Brasier, (Ky.1935) 84 S.W.2d 43 [Under life policy with clause insuring against total and permanent disability, insured disabled by inguinal hernia was not required to submit to operation in an attempt to remove the cause of his disability.]

- Ford v. New York Life Ins. Co., 180 S.E. 37, 41 (S.C. 1935) [Insured was not required to submit to corrective surgical or medical treatment to recover benefits for disability under life policies where policies did not require submission to surgical treatment provided for cessation of disability payments if insured should later recover.]

- Temples v. Prudential Ins. Co. of America, 79 S.W.2d 608 (Tenn. 1935) [Person insured under group disability policy was not required to undergo operation to remove hernia to recover benefits of policy.]

- Jefferson Standard Life Ins. Co. v. Hurt, 72 S.W.2d 20, 23 (Ky. 1934) [Insurer's liability on policy requiring monthly payments to insured during continuance of his total disability was not terminated if disease was aggravated, caused, or continued by insured's unreasonable refusal or neglect to submit to or follow competent surgical treatment, aid, or advice; doctrine of minimizing damages being inapplicable.]

- Tittsworth v. Ohio National Life Ins. Co., 6 Tenn. App. 206 (Tenn. 1927) [Where insurance company contended that insured could remove his disability by submitting to a simple operation and therefore the company was not liable because of insured's refusal to do so, as the requirement of an operation, though a minor one and reasonable, under any circumstances, was not contained in the policy, the insurer was not entitled to take advantage of the failure or refusal of the insured to submit to such an operation.]

The above discussion involves disability policies that require the insured to be "under the regular care and attendance of a physician." However, more and more disability policies are requiring the insured to be "receiving care by a physician which is appropriate for the condition causing the disability."

B. What Constitutes "Appropriate" Care Under A Disability Policy?

Surprisingly, there is little case law regarding "appropriate care" (Type 2) policies. Some courts have found that medical care can be "appropriate" even if it was not the ideal, perfect or best possible treatment for the disabling condition. Others have concluded that where the insured had two reasonable courses of treatment for his disability, the insurer has no right to complain that the insured chose one rather than the other. But, unfortunately, some judges have ruled otherwise.

In Sebastian v. Provident Life and Accident Insurance Co., 73 F. Supp. 2d 521 (D. Md. 1999), the insurer filed a motion seeking summary adjudication that the insured had not received "care by a physician which is appropriate for the condition causing the disability." Although the court concluded that the insured did not receive appropriate care during the first three months of his disability "because he was not under the care of *any* physician," the court otherwise *denied* the insurer's motion. Id. at 529. Significantly, the court held that "a reasonable jury could find that [the insured] received 'appropriate care' for his disabling psychiatric disorder" (Id. at 530) despite the fact that:

- The insured had been treated by his primary care physician – *not* a psychiatrist or psychologist;

- The insured's physician had waited five months before physically examining the insured and had prescribed anxiety and antidepressant medications before examining the insured;

- It was undisputed that the insured's physician had *misdiagnosed* his condition; and,

- A psychiatrist had testified that had the insured been properly diagnosed, the treatment protocol would have been different.

In so holding, the court emphasized that treatment for a disability can be "appropriate" even if "it was ***not the ideal treatment***," and that "[a]ppropriate means suitable under the circumstances . . . ***not . . . perfect care, or best possible care***." Id. at 529-30.[2]

Similarly, in Stamm v. Provident Life and Accident Insurance Co., 1998 WL 596700 (N.D. Ill. 1998), an ERISA case, the insurer argued that a chiropractor's diagnosis and treatment of a stress-related disorder was not "care by a physician which is appropriate for the condition causing the disability" because "such disorders are within the expertise of a psychiatrist or psychologist." The court flatly rejected that argument, holding that the insured's reliance on a chiropractor for diagnosis and treatment of a stress-related disorder was "appropriate" care under the policy. The court reasoned that the policy "contains no language limiting treatment of stress-related disorders to psychiatrists and psychologists." Id. at *9.

In Morinelli v. Provident Life and Accident Insurance Co., 617 N.W.2d 777 (Mich. Ct. App. 2000), the insurer presented evidence at trial regarding the poor quality of care rendered by the insured's physician along with the treatment that would have been

[2] See also 10 Couch on Insurance (3d ed 1998), § 146:3:4 ("A provision requiring treatment by a 'qualified' physician has not been interpreted so as to require treatment by a specialist in the field encompassing the insured's condition.").

successful in controlling the insured's diabetes. In his closing argument, the insurer's counsel asserted that the insured's doctor had given the insured the wrong treatment, and that the doctor should have changed his treatment and/or referred the insured out for a consultation.

The Court of Appeal held that the trial court abused its discretion in allowing the insurer's testimony and argument regarding the quality of care received by the insured. In so holding, the appellate court determined that "'appropriate care' does *not* require a qualitative evaluation of the care provided" and that "whether the level of treatment met the standard of care is *not* pertinent to a determination of whether the care was appropriate." Id. at 782. Instead, the court concluded that "[t]he insurer's review of the nature of the care" received by the insured should be limited to "whether it is 'necessary and causally related' to the alleged disability." Id. at 781. Moreover, "the [insurer's] allegation that the care received by [the insured] was inappropriate in that it did not meet the *standard of care* was not a proper contractual defense to his claim for disability benefits." Id. Thus, the court determined that: "Care 'appropriate for the condition causing the disability' is care that is ***necessary and causally related to the condition forming the basis of the disability claim***." Id. at 782.

In Kottle v. Provident Life and Accident Insurance Co., 775 So. 2d 64, 72 (La. App. 2 Cir. 2001), the insured physician became disabled due to "panic disorder" and treated with a psychiatrist, with many of the therapy sessions occurring by telephone due to the distance between the insured and his treating physician. The insurer denied the claim because, among other things, the insured had not received appropriate care for his psychological disorder. At trial, defense presented three medical experts, all of whom criticized the use of "telemedicine" and opined that the insured had not received appropriate care for his condition. Id. at 73. Following a bench trial, the court found that insured was "unable to perform the substantial and material duties of his occupation" and

was "receiving care by a physician which was appropriate for the condition causing the disability." Id. at 74.

On appeal, the insurer argued (among other things) that the trial court erred in concluding as a matter of law that the insured was receiving appropriate care when, according to the insurer, "the plaintiff not only failed but steadfastly refused to seek appropriate care as is required by the contract." Id. While the court of appeal agreed with the insurer that the purpose of the appropriate care requirement is to "insure proper treatment so as to shorten the period of disability," it agreed with the trial court that the medical treatment received by the insured was "sufficient and appropriate." Id. at 77. The court of appeal acknowledged that there was "considerable disagreement regarding [the treating physician's] current treatment and whether additional treatment would have allowed [the insured] to return to his occupation. Id. The court reasoned, however, that "although we consider the opposing views raised by [the insurer's] experts to be significant, we nevertheless do not find that the trial court was clearly wrong in its acceptance of [the treating physician's] testimony, and its conclusion that appropriate care has been given." Id.

The appellate court disagreed with the insurer's contention that all of the evidence was directly contrary to the trial court's conclusion that the insured had received appropriate care, noting that the trial court had made the following finding: "While having expressed their respective opinions as to what each believes to be the optimum regime or treatment for [the insured's] disorder, which recommendations differ from the course of treatment utilized by [the treating physician]," none of the insurer's medical experts "suggested that the course of treatment was "either inappropriate or ineffective." Id. at 77-78. Thus, even though the insurer's experts disagreed with the course of treatment provided by the treating physician, the insured was still receiving "appropriate care."

More recently, in Reznick v. Provident life and Accident Ins. Co., 364 F. Supp. 2d 635 (E. D. Mich. 2005), the court held that the "receiving appropriate care" language imposed an affirmative duty on the insured, and the insured could not satisfy both the "unable to perform" and appropriate-care prongs of the "total disability" definition, since his psychiatric treatment was indicative of a mild disorder only.

In Reznick, an insured physician with bipolar disorder sued Provident Life and Accident Insurance Company, seeking benefits for total disability. After a bench trial, the district court entered judgment for Provident. Under the policy, total disability required that Reznick be unable "to perform the material and substantial duties of his occupation" and must be "receiving care by a Physician which is appropriate for the condition causing the disability." Id. at 637.

Relying on both Provident Life and Accident Insurance Co. v. Henry, 106 F. Supp. 2d 1002 (C.D. Cal. 2000), and Provident Life and Accident Ins. Co. v. Van Gemert, 262, F. Supp. 2d 1047 (C.D. Cal. 2003), the court interpreted "appropriate care" requirement as "imposing on the insured a duty to seek and accept appropriate care." Id. at 638. According to the court, "appropriate care requires a relationship between the severity of the symptoms and the level of care that is received." Id. at 640.

Even though Reznick's psychiatrist opined that Reznick was totally disabled, the psychiatrist had prescribed a dosage of antidepressant indicative of a mild disorder only. Further, Reznick had informed his psychiatrist that he did not need intensive therapy. The court reasoned that *if* Reznick's symptoms were so severe as to preclude him from performing his occupation, then based on the combination of the infrequency of his therapy sessions, his noncompliance with his medication, and the dosage of medication prescribed, Reznick was not receiving appropriate care for his disabling condition. Id. at 640. In the alternative, the court reasoned that *if* the care Reznick was receiving was

appropriate, he did not have a psychiatric condition that prevented him from performing his occupation. Id.

Even if the court believes that your client has a duty to undergo "appropriate" care, it is clear that the issue of what constitutes "appropriate" care is a *factual* question that must be determined by the jury – *not* by a judge via summary adjudication.

This principle is exemplified by the district court's decision in Provident Life and Accident Ins. Co. v. Henry, 106 F. Supp. 2d 1002 (C.D. Cal. 2000). In Henry, the court held that "the policy's appropriate-care provision . . . create[s] a duty to submit to appropriate medical treatment, which, *in some circumstances, may* include a surgical procedure." Id. at 1004. In so holding, the court acknowledged that "there is substantial ground for difference of opinion" regarding whether a disability insurer can condition benefits on the insured's acceptance of appropriate treatment, and even authorized the insured to take "an immediate appeal from this order." Id. at 1005, n.2. The case settled while an appeal was being prepared.

The court also emphasized that the insurer "does *not* have [the] power" to force the insured to "obey every doctor's recommendation" or "defer to [the insurer's] judgment about the appropriate care for his condition." Id. at. 1004. And most importantly, the court *denied* the insurer's motion for summary judgment on the issue of whether the insured's treatment for carpal tunnel syndrome (which did *not* include surgery) was "care . . . which is appropriate for the condition causing the disability" – and it did so even though carpal tunnel surgery is (at least according to the insurer) "a common, low-risk procedure with the potential to cure the insured's disability and enable him to return to his practice." Id. at 1003. The court concluded that the question of "whether [the insured] has fulfilled his duty under the appropriate-care policy provision" was "a genuine issue of material fact" for the jury to resolve. Id. at 1005.

Similarly, in Provident Life and Accident Ins. Co. v. Van Gemert, 262 F. Supp. 2d 1047 (C.D. Cal. 2003), an insured was disabled from performing his occupation as an oral surgeon due to the loss of vision in one eye. The insurer brought a declaratory relief action that it was not required to pay benefits during the period of time in which the insured refused to undergo curative surgery, and claiming that it was entitled to restitution for benefits it paid. The court adopted as its own the reasoning set forth in Henry and held there "remains a triable issue of fact whether the surgery urged by the insurer represents 'appropriate care,' i.e., whether such care 'would be determined objectively as the treatment a patient would make a reasonable decision to accept after duly considering the opinions of medical professionals.'" Id. at 1050, quoting Provident Life and Accident Ins. Co. v. Henry, 106 F. Supp. 2d 1002, 1004 (C.D. Cal. 2000).

III. GROUNDS FOR CONTESTING INSURERS' EFFORTS TO DICTATE CARE

It is our fervent belief that a disability insurer *cannot* utilize the "appropriate care" provision to force an insured to undergo invasive medical treatment. Following are some grounds for contesting insurers' efforts to dictate medical care.

A. The Express Language of the Policy is Controlling

Insurance contracts are generally recognized as contracts of adhesion. AIU Ins. Co. v. Superior Court, 51 Cal. 3d 807, 822, 274 Cal. Rptr. 820, 831 (1990). As a result, an insurance contract will be interpreted to mean that which a reasonable person would expect it to mean. Gray v. Zurich Ins. Co., 65 Cal. 2d 263, 271, 54 Cal .Rptr. 104, 109 (1966). Ambiguities in the contract must be interpreted in favor of the insured. Smith v. Westland Life Ins. Co., 15 Cal. 3d 111, 120, 123 Cal. Rptr. 649, 656 (1975). Exceptions to coverage which would not ordinarily be expected by the policyholder must be called to his attention, clearly and plainly, *by the language of the policy*. Logan v. John Hancock Mut. Life Ins. Co., 41 Cal. App. 3d 988, 995, 116 Cal. Rptr. 528, 532 (1974).

Moreover, "[c]larity, indeed *explicitness*, of the language of coverage" is required. National Auto & Cas. Ins. Co. v. Contreras, 193 Cal. App. 3d 831, 836, 238 Cal. Rptr. 627, 629 (1987). Significantly, *"[e]xceptions to coverage cannot be implied.* If an insurer wishes to limit coverage, it must do so in *express* policy language that is 'conspicuous, plain and clear.'" DiMugno and Glad, California Insurance Law Handbook (2001) § 61.05(4), p. 1221, quoting Crane v. State Farm Fire & Cas. Co., 5 Cal. 3d 112, 115, 95 Cal .Rptr.513, 514 (1971).

Accordingly, in Commercial Union Assurance Companies v. Safeway Stores, Inc., 26 Cal. 3d 912, 164 Cal. Rptr. 709 (1980), the California Supreme Court rejected the argument that the insured "impliedly promise[d] that it would take all reasonable steps" concerning settlement. Id. at 920. The Court refused to "read into the policy obligations which are neither sought after nor contemplated by the parties," concluding that if an insurer wants to impose conditions upon the insured "it may do so by appropriate *language in the policy*." Id. at 921.

The requirement that coverage conditions be express has been imposed throughout the country. For example, in Volunteer State Life Insurance Co. v. Weaver, 167 So. 268, 269 (Ala. 1936), the court held that the insured need not undergo doctor-recommended treatment in order to recover disability benefits because "the *language of the policy*" contained no such requirement. Similarly, in Heller v. Equitable Life Assurance Society, 833 F.2d 1253, 1258 (7th Cir. 1987), the court held that "[i]n the absence of an *express provision* obligating the insured to undergo surgery, *we refuse to place such a requirement upon the insured*." See also Miller v. Mutual Life Ins. Co. of New York, 289 N.W. 399, 400 (Minn. 1939) ["If [the insurer] desired to incorporate into its policies the obligation to submit to reasonable curative measures, it could very easily have done so."].

Thus, if the carrier had wanted to insure the policyholder only against "incurable" disability, it could have done so via express policy language. Its failure to do so was at its peril. Indeed, that was the reasoning of the court in Prudential Insurance. Co. of America v. Brasier, 84 S.W.2d 43 (Ky.1935), wherein the insurer argued that the insured was not entitled to benefits because his condition could have been cured by an operation. The court rejected the insurer's argument:

> "The policy before us does not insure against 'incurable disability,' but insures against total and permanent disability. **We can see no reason for reading the word 'incurable' into the policy when the insurance company has not seen fit to put it there.**"

Id. at 44.

Similarly, in Roderick v. Metropolitan Life Insurance. Co., 98 S.W.2d 983 (Mo. App. 1936), the disability carrier contended that "as a fundamental principle of right and justice [the insured] should be compelled, as a condition precedent to his right to recover, to show that he had done everything which a reasonably prudent man would have done under the same or similar circumstances towards curing his ailment." Id. at 985. In rejecting that contention, the Court reasoned that:

> "Had [the insurer] at the time of the issuance of its policy desired to limit its liability to incurable disability only, it would have had the right to have done so; but it did not do so, and we can only conclude therefore that the duty to submit to an operation was not within the contemplation of the parties when the contact was entered into."

Id. at 985.

In the typical disability insurance policy, there is absolutely no language which indicates that payments can be suspended or benefits can be subject to reimbursement if the insured refuses a risky surgery or other major procedure. As a result, the policy must be interpreted in a fashion consistent with the insured's reasonable expectations. Gray v. Zurich Ins. Co., supra, 65 Cal. 2d at 271. An insurer can hardly argue that it is reasonable for its policyholders to assume that they will be forced to either undergo surgery

demanded by the carrier or run the risk of the insurer suing them for declaratory relief and reimbursement of benefits. If the insurance company truly intended to make such a provision a part of its contract, it had a duty to do so clearly, plainly and *expressly.* Logan v. John Hancock Mut. Life Ins. Co., supra, 41 Cal. App. 3d at 995. Having failed to limit coverage "in *express* policy language" when it issued the policy, the insurer certainly cannot do so *after* a claim is submitted. DiMugno and Glad, California Insurance Law Handbook (2001) § 61.05(4), p. 1221.

Moreover, as indicated above, the policy itself typically states that "[t]his policy, including the endorsements and the attached papers, if any, constitutes the entire contract of insurance." Enlarging the contract to include a provision that was not contemplated by the parties at the time of execution is counter to the very terms of the policy. Therefore, according to the terms of the insurance contract, the insurer has absolutely no right to force its insured to submit to a surgery or other risk-laden procedure against his wishes.

B. An Insured Has the Right to Make Decisions About His Medical Treatment

Faced with an insured who does not want to undergo surgery, a disability insurer often argues that the insured is abdicating personal responsibility for his own health. In truth, however, the exact *opposite* is usually true. An insured who declines to undergo invasive surgery (or other medical treatment championed by the insurer) is typically a staunch *advocate* of personal responsibility – specifically, personal responsibility and autonomy over his own body, the treatment he undergoes, and the risks he is willing to take in connection with that treatment. That insured firmly believes that it is his right – *and no one else's* – to decide about the medical care he undergoes, and that he has sole responsibility and control over the treatment inflicted on his body.

Not surprisingly, such an insured is far from alone in this view. For example, numerous courts concur that an individual has the right to decide what medical treatment to

undertake (and what treatment *not* to undertake), and that the individual has the *final say* with respect to *all* decisions concerning that treatment.

For example, in Pettus v. Cole, 49 Cal. App. 4th 402, 57 Cal. Rptr. 2d 46 (1996), an employee alleged that his employer violated his right to privacy when it forced him, under threat of termination, to enroll in an alcohol rehabilitation program and thereafter terminated his employment when he refused to waive his rights. The Court of Appeal held that the employee had "***an 'autonomy privacy' interest in making intimate personal decisions about an appropriate course of medical treatment for his disabling stress condition***, without undue intrusion or interference from his employer." Id. at 458, 57 Cal. Rptr. 2d at 84.

Significantly, the court felt that the employee had the right to choose the treatment for his disability even though his employer was paying for his disability benefits:

> "It is reasonable for the employee to believe that, notwithstanding the fact the employer is paying for the examination and will pay benefits upon adequate proof of disability, he or she will remain **free to control . . . the medical decision-making about a disabling medical condition**."

Id. at 459, 57 Cal. Rptr. 2d at 84-85.

The court added that "it would be *unprecedented* for this court to hold that an employer may *dictate to an employee the course or medical treatment he or she must follow*," and that it is "eminently reasonable for employees to expect that their employers will *respect – i.e., not attempt to coerce or otherwise interfere with – their decisions about their own health care*." Id. at 459, 57 Cal. Rptr. 2d at 85. And the court concluded as such "notwithstanding the fact that the employee had placed his mental condition in issue" by making the claim for benefits. Id. at 458, 57 Cal. Rptr. 2d at p. 84.

Similarly, in Riese v. St. Mary's Hospital and Medical Center, 209 Cal. App. 3d 1303, 271 Cal. Rptr. 199 (1987), an involuntary psychiatric patient sought a determination that

he could not be forced to take antipsychotic drugs against his will. The court held that as long as the patient had the capacity to make an informed decision regarding the drugs, he "may not be required to undergo the treatment." Id. at 1323, 271 Cal. Rptr. at 212. The court pointed to "the great value our society places on the autonomy of the individual" (Id. at 324, 271 Cal. Rptr. at 212), and insisted that it is essential that individuals have the right to choose their own medical treatment without interference:

> "***[I]t is the individual who must have the final say in respect to decisions regarding his medical treatment*** in order to insure that the greatest possible protection is accorded his autonomy and *freedom from unwanted interference* with the furtherance of his own desires."

Id.

Truman v. Thomas, 27 Cal. 3d 285, 165 Cal .Rptr. 308 (1980), was a medical malpractice action against a physician for wrongful death. In holding that the doctor had a duty to advise his patient of the material risks of not consenting to a recommended treatment, the California Supreme Court emphasized that patients must be able to "meaningfully exercise their ***right to make decisions about their own bodies***." Id. at 292, 165 Cal. Rptr. at 312. The Court added that "*it is the patient who must ultimately decide which medical procedures to undergo*." Id. at 296, 165 Cal. Rptr. at 314.

And in Bartling v. Superior Court, 163 Cal. App. 3d 186, 209 Cal. Rptr. 220 (1984), the court held that a competent adult patient with serious illnesses which are probably incurable but have not been diagnosed as terminal has the right – over the objection of his physicians and hospital – to have life-support equipment disconnected even though it likely will hasten his death. The court emphasized the ***"clearly recognized legal right to control one's own medical treatment"*** and "exercise control over his own body," and that a competent adult therefore has ***"the legal right to refuse unwanted medical treatment***." Id. at 193-94, 209 Cal. Rptr. at 224.

These cases, and others like them, make it clear that a disability insured has the right to decide on the medical treatment he feels is appropriate for his disabling condition, and that a disability insurer *cannot* impose a duty to undergo surgery or otherwise control the insured's decision.

C. A Court Cannot Rewrite the Parties' Contract

Disability insurance policies typically contain no express obligation to undergo surgery or other curative procedures. Thus, in order to impose a surgery requirement against the insured, a Court would have to rewrite that policy.

But it is well settled that "[n]either abstract justice nor the rule of liberal interpretation justifies the creation of a contract for the parties which they did not make themselves," and that *"[t]he courts cannot rewrite a contract to avoid difficulty or hardship."* Jacobsohn v. Simmons Real Estate, 23 Cal. App. 4th 1285, 1294, 28 Cal. Rptr. 2d 699, 704 (1994). Moreover, *"courts are not at liberty to revise an agreement or create a contract not made by the parties* under the guise of liberal construction." Diaz v. United Calif. Bank, 71 Cal. App. 3d 161, 172, 139 Cal. Rptr. 314, 321 (1977). That is because a court ***"has no power to make a new contract for the parties***." American Home Ins. Co. v. Travelers Indemnity Co., 122 Cal. App. 3d 951, 963, 175 Cal. Rptr. 826, 832 (1981). And if an insurer becomes disenchanted with a policy it drafted, the California Supreme Court confirms that a "***court cannot assume the obligation of rescuing carriers from their own failure to write policies with precision.***" Bareno v. Employers Life Ins. Co., 7 Cal. 3d 875, 888, 103 Cal. Rptr. 865, 873 (1972).

Accordingly, the disability insurer is "stuck" with the policy it issued to the insured – a policy which includes an "Entire Contract" clause and **no** duty to undergo surgery. Its failure to secure more favorable provisions was at its peril.

D. The Duty to Mitigate Does Not Include a Duty to Undergo Treatment Advocated by the Insurer

Couch on Insurance rejects the concept that an insured's refusal to undergo surgery somehow constitutes a failure to mitigate damages, even if that refusal could be considered unreasonable:

> "Where a policy provides for both partial and total disability, and does not in terms require the insured to minimize damages, his or her neglect or refusal to submit to or follow competent surgical treatment, aid, or advice, even though unreasonable, does not change the insurer's liability from payment of total disability benefits to payment of partial benefits".

10 Couch on Insurance (3d ed. 1998), § 146:51:83. See also Prudential Ins. Co. of America v. Brasier, supra, 84 S.W.2d at 44 ["[W]e have never gone so far as to apply the doctrine of minimizing damages . . . to a policy of insurance."].

And even if the insured had a duty to mitigate, *any* reasonable choice – not just the choice the insurer claims is reasonable – will satisfy that duty. It is well settled that "[i]f a choice of two reasonable courses presents itself, the person whose wrong forced the choice cannot complain that one rather than the other is chosen." Green v. Smith, 261 Cal. App. 2d 392, 397, 67 Cal. Rptr. 796, 800 (1968) (citing McCormick on Damages, p. 134).

Further, even if a disability insured had a duty to mitigate (which, again, he does ***not***), he would not breach that duty just because he opted for conservative treatment despite the fact that certain doctors may have felt that surgery was the best treatment. A refusal to undergo an operation "may be found not unreasonable even though such operation be advised by a competent physician." Dodds v. Stellar, 77 Cal. App. 2d 411, 423, 175 P.2d 607, 614 (1946).

And mitigation of damages is particularly unnecessary where it would require the claimant to give up significant rights. "The rule of mitigation of damages has no

application where its effect would be to require the innocent party to sacrifice and surrender important and valuable rights." Seaboard Music Co. v. Germano, 24 Cal. App. 3d 618, 623, 101 Cal. Rptr. 255, 258 (1972). Here, as discussed above, the courts have recognized that an individual has:

- "[A] clearly recognized legal right to *control one's own medical treatment"* and *"exercise control over his own body*" (Bartling v. Superior Court, supra, 163 Cal. App. 3d at 194, 209 Cal. Rptr. at 224);

- "[T]he right . . . to *refuse unwanted medical treatment"* (Id. at 193, 209 Cal. Rptr. at 224);

- "[A]n 'autonomy privacy' interest in *making intimate personal decisions about an appropriate course of medical treatment for [a] disabling . . . condition*, without undue intrusion or interference" (Pettus v. Cole, supra, 49 Cal. App. 4th at 458, 57 Cal. Rptr. 2d at 84); and,

- The "right to *make decisions about their own bodies*" (Truman v. Thomas, supra, 27 Cal. 3d at 292, 165 Cal. Rptr. at 312).

Obviously, were an insured forced to undergo surgery against his wishes, he would be sacrificing highly significant, valuable rights. He ***cannot*** be required to do so.

E. The Insured's Duty of Good Faith and Fair Dealing Does Not Encompass a Duty to Submit to Invasive Procedures

As discussed above, if an insurer wants to impose obligations upon the insured, "it may do so by appropriate *language in the policy*". Commercial Union Assurance Companies v. Safeway Stores, Inc., supra, 26 Cal. 3d at 921, 164 Cal. Rptr. at 714. But "such a duty ***cannot*** be predicated upon an insured's implied covenant of good faith and fair dealing". Id. "[W]hat [the insured's] duty [of good faith and fair dealing] embraces is ***dependent upon the nature of the bargain struck between the insurer and insured".*** Id. at 918, 164 Cal. Rptr. at 712. The extent of the insured's implied covenant of good faith and fair dealing "must be determined in the light of ***what the parties bargained for***." Id. at 920, 164 Cal. Rptr. at 713. See also Agricultural Insurance Co. v. Superior Court, 70 Cal.

App. 4th 385, 389-90, 82 Cal. Rptr .2d 594, 595 (1999) [An insured's "breach of the covenant of good faith and fair dealing . . . is, at base, a breach of *contract*."].

The typical disability policy does not condition benefits on the insured undergoing surgery or other invasive treatment. Since the insured's implied covenant of good faith and fair dealing "must be determined in the light of *what the parties bargained for*" and "is *dependent upon the nature of the bargain struck between the insurer and insured*", an insured's refusal to undergo a surgery or other major procedure does ***not*** breach that duty. Commercial Union Assurance Companies v. Safeway, supra, 26 Cal. 3d at 918, 920, 164 Cal. Rptr. at 712-713.

Moreover, "[a]n . . . insurer [that] acts adversely to its insured's interests cannot claim that the insured acted in bad faith" toward the insurer. DiMugno and Glad, California Insurance Law Handbook (2001) § 11.06(2)(k), p. 341. Thus, where "the insurer . . . took specific action which could well be described as a violation of its own obligation of good faith and fair dealing to its insureds," the insurer "is in no position to urge that, nevertheless, the [insureds] remained under an obligation to protect [the insurer]" Safeco Ins. Co. v. Tholen, 117 Cal. App. 3d 685, 701-02, 173 Cal. Rptr. 23, 33 (1981). Accordingly, if the insurance company violated its own duty of good faith and fair dealing toward the insured, it is in no position to argue that the insured still owed it a duty of good faith and fair dealing (nor, of course, that he somehow breached that duty).

Finally, even if the insured had a duty to undergo surgery (which he did *not*) and his failure to undergo that surgery was unreasonable, he still would be entitled to receive and retain all disability benefits. As set forth in California Insurance Code § 533, "[a]n insurer . . . is **not** exonerated by the negligence of the insured."

Hopefully, the above arguments will help you convince the court that your client has no duty to undergo surgery or other care deemed "appropriate" by the insurer. But even if

the court believes that your client in fact *has* a duty to undergo "appropriate" care, there are things your client can do to address such concerns.

IV. WHAT CAN CLAIMANTS DO?

If the disability insurer is questioning your prospective client's choice of medical treatment (or you suspect its going to do so), you should consider the following:

- Review the advertising and marketing materials that led the insured to purchase his policy (newspaper or magazine ads, trade journals, flyers, brochures, etc.). these will show whether the insurer warned the insured that the decision regarding medical care for a disabling condition might not be his own.

- Make sure that all significant communications with the insurer are in writing. If the insured had a telephone conversation with a claim adjuster or other insurer representative, be sure he confirms it in writing. And if the adjuster sends the insured a confirming letter that misstates the substance of their discussion, be sure the insured sends a letter that corrects the misstatements.

- Have the insured instruct his treating physicians to state in their Attending Physician's Statements and other communications with the insurer that they recommend the treatment the insured is receiving and that it is appropriate for the condition. For example, if the insured is choosing conservative treatment over surgery, have his physicians explain the reasons why that is an appropriate choice (e.g., risks of surgery outweigh the benefits, surgery has a relatively low likelihood of success in this particular case, etc.).

- Ask whether the insurer will accept responsibility for nay complications, injuries or damages that might flow from the surgery it is advocating.

V. CONCLUSION

An insurer that tries to condition disability benefits on the insured undergoing surgery typically goes to great lengths to paint the operation as a benign, risk-free enterprise. However, that argument is nothing more than an elaborate red herring. The legal issue is not whether the risks of surgery outweigh the benefits. The only issue before the court is whether or not an insurance company can force its policyholder to undergo surgery against his wishes.

And if an insured has to undergo carpal tunnel syndrome surgery just because his disability insurer says so, where will it stop? Can a disability insurer require an insured with back problems to undergo back surgery, even where conservative treatment (pain injections, physical therapy, chiropractic maneuvers) is providing some relief? Can an insurer force an insured to undergo open heart surgery? How about brain surgery? Can the insurer condition a Christian Scientist's entitlement to benefits on some surgery or other curative medical treatment? What about a Jehovah's Witness who refuses to accept a blood transfusion?

Obviously, the only way to avoid this slippery slope is to stop it before it starts. Only if the decision regarding medical care is left in the hands of the person who receives it – the insured – will insurance companies be prevented from practicing medicine without a license, and insureds be able to control their own bodies without interference.