

**STATE OF MICHIGAN**  
**COURT OF APPEALS**

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WALLACE G. PEARSON,

Plaintiff-Appellant,

v

PROVIDENT LIFE AND ACCIDENT  
INSURANCE COMPANY,

Defendant-Appellee.

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UNPUBLISHED

January 22, 1999

No. 204889

Marquette Circuit Court

LC No. 96-032667 CK

Before: Markman, P.J., and Griffin and Whitbeck, JJ.

PER CURIAM.

Plaintiff appeals as of right the trial court's grant of summary disposition in favor of defendant pursuant to MCR 2.116(C)(10). The trial court determined that a shoulder disability suffered by plaintiff did not result solely from an "accidental bodily injury" since a pre-existing degenerative shoulder condition contributed to the disability and, therefore, recovery for enhanced benefits was precluded under the disability insurance policy that defendant issued to plaintiff. We reverse and remand for further proceedings.

I. Basic Facts And Procedural History

In 1984, plaintiff, a medical doctor, began experiencing pain in his left shoulder and was diagnosed with early and mild rotator cuff (or impingement) syndrome by Dr. J. Michael Coyne. Dr. Coyne found that plaintiff's syndrome was a "degenerative mechanical process secondary to progressive wear over a period of time," in which his rotator cuff was impinged upon by a bone spur. However, at that time, plaintiff responded well to treatment, experienced few continuing problems and continued working as a gynecologist. Dr. Coyne testified that even seven years later, degenerative changes in plaintiff's shoulder were still not very significant, although they were more evident than in 1984.

In September 1991, plaintiff lifted a gas can over the gunwale of his boat. While lifting, plaintiff reported, he felt something in his shoulder snap. Subsequently, plaintiff experienced significant pain. When his shoulder did not seem to respond to nonsurgical treatment, plaintiff underwent arthroscopic

surgery, performed by Dr. Kenneth Davenport. During the procedure, Dr. Davenport discovered that plaintiff had a complete rotator cuff tear. The area was smoothed down during the surgery, but the tear was not repaired. Following surgery, plaintiff did not respond well to physical therapy and continued to experience pain. Thereafter, he was forced to discontinue his medical practice and he filed for disability insurance benefits from defendant.

Plaintiff's insurance policy with defendant provided for monthly benefits of \$1,000 for life if total disability was "the result of Injuries," but only until age sixty-five if total disability was "the result of Sickness." The policy defined injuries as "accidental bodily injuries occurring while your certificate is in force," and defined sickness as "sickness or disease which is first manifested while your policy is in force." Defendant paid benefits to plaintiff until he reached the age of sixty-five in May 1996, then discontinued payment because it considered plaintiff's disability to be due to "sickness." Plaintiff brought suit against defendant in 1996, alleging breach of contract. Subsequently, defendant moved for summary disposition. The trial court granted defendant's motion, finding that accidental bodily injury "requires accident on both ends of the equation, the cause of the injury and the resulting injury," such that "the voluntary act does not fit within the language of this policy . . . at least where there is an identifiable pre-existing process in place" that contributed to the disability.

## II. Standard Of Review

This Court reviews decisions on motions for summary disposition de novo to determine if the moving party was entitled to judgment as a matter of law. *Stehlik v Johnson (On Rehearing)*, 206 Mich App 83, 85; 520 NW2d 633 (1994).

MCR 2.116(C)(10) permits summary disposition when, except for the amount of damages, there is no genuine issue concerning any material fact and the moving party is entitled to [judgment] as a matter of law. A court reviewing such a motion must consider the pleadings, affidavits, depositions, admissions, and any other evidence in favor of the opposing party and grant the benefit of any reasonable doubt to the opposing party. [*Id.*]

## III. Accidental Bodily Injury And Voluntary Acts

As plaintiff argues, an "accidental bodily injury" can result from the unintended consequences of a voluntary act, such as lifting a gas can. In *Collins v Nationwide Life Ins Co*, 409 Mich 271; 294 NW2d 194 (1980), the Michigan Supreme Court determined that there was a distinction between accidental means and accidental death or injury:

[A]ccidental death is an unintended and undesigned result arising from acts voluntarily done, whereas death by accidental means is a result arising from acts unintentionally done or events undesignedly occurring. [*Id.* at 275, quoting 10 Couch, Insurance (2d ed), § 41:28, pp 49-50.]

Thus, the Court held that since the policy at issue there required only that the insured sustain “accidental bodily injury,” and since injury and death were in fact unforeseen by the decedent, his death after voluntarily drinking liquor at one sitting until he died would qualify as accidental

bodily injury, unless the decedent “intended or expected it to have fatal consequences.” *Id.* at 277-278. Although defendant claims that *Collins* is not controlling here because of the decisions of subsequent cases, it seems to have misread these cases. Defendant cites *Coffer v American Income Life Ins Co*, 168 Mich App 144, 145; 423 NW2d 587 (1988), but that case is not applicable here. The policy at issue in *Coffer* required a disability “due to accident” rather than an accidental bodily injury, as here, and this Court found that the definitions of these terms were not interchangeable. Similarly, in *Rynerson v Nat’l Casualty Co*, 203 Mich App 562, 563; 513 NW2d 436 (1994), the accidental bodily injury had to be “the direct result of an accident.” Thus, there is no conflict among these cases, since an accident cannot be voluntary. However, an accidental injury can be the result of a voluntary act according to *Collins, supra*.

Indeed, the Supreme Court in *Nehra v Provident Life & Accident Ins Co*, 454 Mich 110; 559 NW2d 48 (1997)—a case involving identical contract language to that used by defendant in this matter—approved the analysis in *Collins, supra*. However, the facts in *Nehra* were distinguishable from those in *Collins* because the plaintiff in *Nehra* was unable to show that his injury was caused by a single, discrete event and instead tried to recharacterize his carpal tunnel syndrome as an injury. Specifically, we find the following language enlightening:

Cases like *Collins* (where an insured drank himself to a blood-alcohol level of 0.37 percent on November 29, 1973, and died of acute alcohol intoxication) present the issue whether foreseeable but unintended injuries suffered as the result of an intentional act (like Mr. Collins' drinking) can be deemed "accidental." [*Collins, supra* at 273] The present case is distinguishable because Dr. Nehra suffered no discrete injury. His own expert has ably explained that carpal tunnel syndrome is the product of prolonged repetition of hand movements. No single event caused the disability.

\* \* \*

It is true that, in unusual cases, the word "accident" can be ambiguous in the sense explained in *Collins* -- the distinction between an accidental (unanticipated) cause and an accidental (unintended) outcome. However, the word is not ambiguous insofar as its ordinary meaning includes the temporal and spatial elements discussed in the no-fault cases. Thus, if Mr. Collins had drunk himself to death over many years, gradually eroding his vital organs, instead of poisoning himself on a single occasion, there would have been no "accident" in either of the senses discussed in *Collins*. Without the temporal/spatial component, the word "accidental" adds almost nothing to the phrase "accidental bodily injuries." [*Nehra, supra* at 116-117.]

Thus, in our judgment, where the language of a policy requires only an accidental injury, it would be incongruous to enable an insurance company to refuse payment simply because a plaintiff's injuries were caused by a plaintiff's voluntary act. Instead, consistent with the decisions of *Collins* and *Nehra*, we conclude that the distinction between accidental and non-accidental injuries lies between injuries that are caused by a discrete event and that are not intended or expected—whether they are the result of a

voluntary triggering action or not—and injuries that either (1) are intended or expected or (2) are the result of a relatively gradual and prolonged process.

#### IV. Accidental Bodily Injury As The Sole Cause Of The Disability

Plaintiff argues that the existence of a pre-existing condition that contributed to some extent to the disability that he suffered does not preclude recovery under his policy for “accidental bodily injury,” since the policy does not require injury to be the sole cause of the disability.

An insurance policy is a contract and should be interpreted according to its plain meaning. The court is mindful of the rule of law that where the provisions of an insurance policy are uncertain or ambiguous, or the meaning is not clear, that those terms should be given such interpretation or construction as is most favorable to the insured. This rule does not mean, however, that the plain meaning of plain words should be perverted, or that a word or phrase, the meaning of which is specific and well-recognized, should be given some alien construction merely for the purpose of benefiting the insured. [*Coffer, supra* at 148-9, quoting *Wozniak v John Hancock Mutual Life Ins Co*, 288 Mich 612, 615; 286 NW 99 (1939).]

Where policy language is ambiguous, the policy should be construed in favor of coverage:

Insurance policies drafted by the insurer must also be construed in favor of the insured to uphold coverage. . . . To be given full effect, an insurer has a duty to clearly express the limitations in its policy. . . . A technical construction of policy language which would defeat a reasonable expectation of coverage is not favored. [*Herring v Golden State Mutual Life Ins Co*, 114 Mich App 148, 155; 318 NW2d 641 (1982), quoting *Crowell v Federal Life & Casualty Co*, 397 Mich 614, 623; 247 NW2d 503 (1976).]

See also *State Farm Mutual Automobile Ins Co v Enterprise Leasing Co*, 452 Mich 25, 38-39; 549 NW2d 345 (1996) (any ambiguity in insurance contract drafted by insurer should be construed in favor of coverage and against its drafter).

Accordingly, in an effort to analyze this case consistently with existing insurance contract law, we must begin by looking to the words of the insurance contract to determine their meaning. In our judgment, there is some ambiguity in the interplay of the provisions for disability “as the result of injuries” and disability “as the result of sickness.” Viewed together, these provisions neither clearly include nor exclude enhanced coverage in the event that disability is the result of a combination of injury and sickness. The trial court based its decision to grant summary disposition to defendant, in part, on the fact that plaintiff’s degenerative condition contributed in *some way* to the disability; thus interpreting the contract to require that disability result *solely* from injuries in order to grant the enhanced injury benefits.

First, it seems clear that in order to recover enhanced benefits for disability resulting from an accidental bodily injury, a claimant must suffer his disability, at least in part, as a result of a “single event.” *Nehra, supra* at 117. The Supreme Court held that the term “accidental bodily injury” includes temporal and spatial elements, such that benefits are not recoverable where the disability results only from a gradual series of events. *Id.*, at 117-18. Thus, the plaintiff in *Nehra* could not reclassify his carpal tunnel syndrome disability as resulting from accidental bodily injury because he could allege only a degenerating condition over a number of years, but no discrete event as the cause. *Id.* In the case at hand, plaintiff did claim that a discrete injury, the sudden tearing of his rotator cuff when he picked up a gas can, directly resulted in his injury. We must next examine the insurance policy and applicable law to determine if the discrete injury must be the sole cause of the disability.

Accordingly, we turn to this second factor and note that defendant did not include any words of limitation in the policy to restrict the enhanced coverage to disability *solely* caused by injury and without any other contributing factors. Indeed, the policy does not even mandate that injury must be the main cause or a substantial cause of the disability. The policy is wholly silent on this issue. In this case, we must look to the phrase “the result of injuries” to determine whether the parties meant “*solely* the result of injuries.” Webster’s Ninth New Collegiate Dictionary (1989) defines “result” to mean “beneficial or tangible effect” or “derived from.” Nothing in the definition of result requires a necessary implication that there can be only one cause of the disability. *Cf., Hagerman v Gencorp Automotive*, 457 Mich 720, 732; 579 NW2d 347 (1998) (an injury may have more than one proximate cause). Thus, we refuse to read the limitation “*solely*” into the phrase “the result.” If the insurer had wanted to limit enhanced benefits to disabilities which were solely the result of injuries, it could, and should, have explicitly written this into the policy so that the limitation could be understood clearly by all parties.

#### V. Causation in Fact - The Substantial Factor Test

While we have found that there is some ambiguity in the interplay of the provisions for disability “as the result of injuries” and disability “as the result of sickness” in the policy at issue, we do not intend to overemphasize this point. A court cannot simply end its inquiry at the point at which it finds an ambiguity in an insurance contract and summarily adopt whatever interpretation would benefit the insured to the greatest degree. Rather, an insurance contract, as with any other contract, must still be viewed as a whole, its provisions read to give meaning to each, and conflicts between provisions reasonably harmonized. *Fresard v Michigan Millers Mut Ins Co*, 414 Mich 686, 694; 327 NW2d 286 (1982). “An interpretation of the contract which would render it unreasonable should be avoided.” *Id.* In addition, the rule of reasonable expectation mandates that courts examine whether a policyholder, upon reading the contract, was lead to a reasonable expectation of coverage. *Vanguard Ins Co v Clarke*, 438 Mich 463, 472; 475 NW2d 48 (1991). If there was a reasonable expectation of coverage, such coverage will generally be afforded. *Id.* While this rule is often invoked to grant greater coverage to the insured than the insurer would like to provide, it is a rule that also reminds us of our fundamental obligation to interpret insurance contracts in a reasonable manner as a whole. Where the parties to a contract could not reasonably have expected a certain coverage, it would be unfair to force the parties to abide by a construction in favor of such coverage.

In other words, the main goal in interpreting a contract, including an insurance contract, is to achieve a reasonable construction according to the intent of the parties. See *Auto-Owners Ins Co v Churchman*, 440 Mich 560, 566; 489 NW2d 431 (1992). The myriad rules of construction that have been adopted by this Court—including the resolution of ambiguities in an insurance contract in favor of the insured—are at best tools to aid in reaching the goal of reasonable construction; they are not ends in themselves. Rather, we must give consideration to the impact of such rules of construction upon the contract as a whole and the overall reasonableness of its interpretation.<sup>1</sup> While these rules properly act to protect insureds from being unfairly disadvantaged by insurers, they should not act either to transform altogether the substance of an insurance contract or to accord windfall coverage to insureds fortunate enough to contract with insurers who have drafted their policies with insufficient precision.

Looking to the language of the insurance policy at issue, it is not immediately certain what the proper coverage is for a disability that is the result of both injury and sickness. Neither the provision for sickness coverage nor the provision for injury coverage explicitly states that it either applies or does not apply to disabilities that are the result of a combination of injury and sickness. As we have noted above, the trial court improperly required that plaintiff's disability be "solely" the result of injuries.

This Court must interpret the policy as a whole on the basis of logical analysis and, using the rules of construction as tools, must determine the standard to apply to plaintiff's disability. The enhanced injury benefit clause cannot be read in isolation. The first clause offers benefits for disability as the result of injuries, while the second clause offers benefits for disability as the result of sickness. The two clauses appear to be mutually exclusive and of apparently equal significance; they are the only two subdivisions of the section pertaining to "total disability," and cover alternative causes of disability, either "sickness or disease" or "accidental bodily injuries." This dichotomy of provisions suggests a continuum of coverage between sickness and injury, in which benefits are paid for an injury disability from the point where an insured suffers solely from an injury until the point where the marginal effect of the injury is outweighed by the marginal effect of sickness, and vice versa as to sickness benefits. Absent any alternative textual guidance, the logical point at which sickness benefits would be transformed into injury benefits is where the injury was a *substantial* factor in causing plaintiff's disability. See *Brisboy v Fibreboard Corp*, 429 Mich 540, 547-548; 418 NW2d 650 (1988) citing *Glinski v Szylling*, 358 Mich 182, 203; 99 NW2d 637 (1959); *McLean v Rogers*, 100 Mich App 734, 737; 300 NW2d 389 (1980); 2 Restatement Torts, 2d, § 431, p 428. In this case, therefore, one must look to the facts of plaintiff's disability to see whether his torn rotator cuff resulted from a discrete injury that was a *substantial* factor in bringing about the disability.

## VI. Conclusion

We therefore conclude that the language and structure of the insurance policy here indicates that enhanced injury benefits should be paid only where the insured can show that his injury was a substantial factor in causing his disability. Even accepting that the language at issue is ambiguous, this Court must nevertheless read the entirety of the policy in light of the insured's (and the insurer's) reasonable expectations. *Raska v Farm Bureau Ins*, 412 Mich 355, 362; 314 NW2d 440 (1982) (opinion of J. Kavanagh). Because the trial court misapplied the law regarding voluntary acts resulting in accidental bodily injury, and also applied the wrong standard in determining the policy coverage for a disability

resulting from injuries by requiring the disability to result solely from injuries, we reverse the trial court's grant of summary disposition. We remand to the trial court for application of the correct law consistent with this opinion and for a determination as to whether plaintiff suffered a discrete injury that was a *substantial* factor in causing his disability. We do not retain jurisdiction.

/s/ Richard Allen Griffin

/s/ William C. Whitbeck

<sup>1</sup> This is especially true where the rule of construction in question—here the resolution of ambiguities in an insurance contract—appears designed less to achieve a more perfect interpretation of the words of a contract than to achieve an understandably equitable result as between the insured and the insurer. The rule, perhaps, is better described as a rule of resolution than as a rule of construction.