



ACOG's push for medical liability reform: What's the latest?

➔ Despite broad support, real change remains elusive. Here, a look at key proposals and the politics surrounding them.

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“miracle on the Hudson”—he’s become a national champion of medical liability reform. In a recent interview with *Politico*, Sullenberger equated the 200,000 lives estimated to be lost each year due to medical errors to “20 jetliners crashing per week,” a situation he insists would close airports and ground flights until the problem was solved. But these 200,000 deaths cause little more than a ripple of concern, he claims.¹

Among the solutions he proposes is “a whole different approach to reviewing medical errors, figuring out what’s behind them, not just blaming doctors and nurses.”¹

Captain Sullenberger is discovering the difficult reality we’ve experienced for too many years: Solutions just don’t come very fast to medical liability reform, despite widespread support for it.

At the American Congress of Obstetricians and Gynecologists (ACOG), our campaign for medical liability reform has focused, as always, on patients, using the campaign line: “Who will delivery my baby?” ACOG supports caps on noneconomic damages and other reforms, such as those contained in the California Medical Injury Compensation Reform Act (MICRA), the gold standard for medical liability reform. We will continue to push for national MICRA reform until we’ve won that important protection for all ObGyns and their patients.

Until we reach that goal, we’re working to accomplish meaningful steps to liability reform where we can, including

It’s a conundrum. There seems to be no doubt about the need for medical liability reform—in fact, there is widespread support for it. And yet...

Four years after Captain Chesley “Sully” Sullenberger saved a planeload of passengers during an emergency landing—the



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ILLUSTRATION: PAUL ZWOLAK FOR OBG MANAGEMENT



testing state alternatives. And our colleague organizations? Many of them, once insisting on federal adoption of MICRA or nothing at all, now actively support meaningful alternatives, too.

What do we want?

Proposals for tort reform, based on California's MICRA statute, include:

- mandatory periodic payments of all future damages exceeding \$100,000
- a \$250,000 ceiling on noneconomic damage awards
- a requirement that claims must be filed within 2 years of the date by which the alleged injury reasonably should have been discovered but in no event more than 4 years from the time of the alleged injury. In the case of alleged injury to children under 4 years of age, claims must be filed by the child's 8th birthday.
- limits on punitive damages, with 50% of punitive damage awards going to a state disciplinary fund
- limits on attorney contingency fees
- reductions in awards based on the amount paid from another source, such as health or disability insurance
- a requirement for "clear and convincing evidence" rather than the usual "preponderance of evidence" when a health-care professional who provided delivery services but not prenatal care is sued
- alternative systems for dispute resolution.

10 alternative reforms

Good ideas include:

1. Require a certificate of merit from the plaintiff

This proposal would require the plaintiff to file an affidavit with the court to demonstrate that the case has merit before the complaint can move forward. Certificates would necessitate the written opinion of a legally qualified health-care provider affirming that the defendant failed to meet the care standards that would be followed by a reasonably

prudent health-care provider—and that this failure caused or directly contributed to the damages claimed.

2. Facilitate early settlement offers

Under this idea, a physician or hospital would be allowed to offer economic damages to an injured party without involving the courts. This offer would not constitute an admission of liability and would be inadmissible if a lawsuit were later filed in the case. Physicians would have an incentive to make a good-faith offer as early as possible after the injury is discovered, and patients would have an incentive to accept legitimate offers of compensation. Early-offer programs would require the injured party to meet a higher burden of proof for alleged negligence if that party chooses to reject the offer and file a lawsuit.

3. Create health-care courts

Health-care courts would allow for a bench or jury trial presided over by a specially trained judge to exclusively hear medical liability cases. Such courts have the potential to correct severe deficiencies in the current medical justice system and to reduce health-system errors and improve patient safety.

4. Allow a physician to say, "I'm sorry"

This proposal would encourage physicians to directly discuss errors and injuries with patients, to apologize and outline corrective action. Such discussions would be inadmissible if a patient later files a lawsuit.

5. Establish medical review panels

Any claim against a physician would be reviewed by a panel of experts who would provide an opinion on whether the physician failed to act within the relevant standards of care.

6. Require a claim to be screened and mediated

A plaintiff's claim would have to be evaluated by a screening panel before it could proceed to litigation. The panel would identify claims



Among leading proposals for tort reform are limits on punitive damages, with 50% of punitive damage awards going to a state disciplinary fund



How medical liability affects the ObGyn specialty

ACOG's 2012 Survey on Professional Liability, our 11th survey since 1983, assessed the effects of professional liability litigation and insurance issues on the practice of obstetrics and gynecology.⁶ The survey, conducted under the direction of ACOG's Vice President for Fellowship and Deputy Executive Vice President Albert Strunk, MD, JD, included segments on demographics, patient care, liability claims experience, and practice changes associated with the cost of liability insurance and the fear of litigation. The survey went to 32,238 Fellows and Junior Fellows. Of these, 9,006 completed the questionnaire. Here are major findings.

Provider profiles

A total of 72.5% of respondents provided both obstetric and gynecologic care, slightly lower than the percentage identified in the 2009 survey, which was 74.3%. Fewer than 7% of respondents provided obstetric care only; 19.8% provided gynecologic care only. Of those restricting their services to gynecology, 88.9% had previously offered obstetric care. The average age at which these physicians stopped practicing obstetrics was 49 years.

that merit compensation and encourage early resolution of those claims. It also would encourage withdrawal or dismissal of non-meritorious claims.

7. Protect physicians who follow evidence-based guidelines

Health-care providers who follow guidelines based on solid evidence, and those who have legitimate justifications for departing from guidelines, would be protected from liability claims.

8. Allow the voluntary resolution of disputes

This proposal would motivate states to encourage the creation of other innovative systems to compensate individuals who are injured in the course of receiving health-care services.

Cost of liability insurance

ObGyns spent an average of 12.4% of their gross income on liability insurance premiums in 2012, down from 18% in 2009.

How liability issues affected practice

Since the previous survey in 2009, 57.9% of respondents made one or more changes to their practice to mitigate the risk or fear of professional liability claims or litigation.

Obstetric practice. Among respondents who made changes to their obstetric practice, 27.4% decreased the number of high-risk patients they see, 23.8% increased the number of cesarean deliveries they perform, 18.9% stopped offering and performing vaginal birth after cesarean (VBAC), 11.5% reduced the total number of deliveries, and 6.2% stopped practicing obstetrics altogether.

Gynecologic practice. Respondents who changed their gynecologic practice cut back on surgical procedures (18.9%), stopped performing major gynecologic surgery (6.7%), and stopped performing all surgery (1.8%).

Other changes. Medical liability issues contributed to the decisions of 12.3% of respondents to choose salaried employment with a hospital, government, or other institution.

9. Require expert witnesses to meet certain standards

This alternative would limit expert-witness standing to individuals who:

- are licensed and trained in the same specialty as the defendant
- have particular expertise in the disease process or procedure performed in the case
- have been in active medical practice in the same specialty as the defendant within 5 years of the claim or who have been taught at an accredited medical school on the care and type of treatment at issue.

10. Create catastrophic injury systems

These systems would establish a fund for individuals who have experienced bad outcomes. Birth injury funds are an example of this model.



57.9% of respondents to an ACOG survey said they have made one or more changes to their practice since 2009 to mitigate the risk or fear of litigation

Claims experience

Obstetric claims were likely to involve a neurologically impaired infant (28.8%) as the primary allegation, followed by stillbirth or neonatal death (14.4%).

Other variables involved in obstetric claims included electronic fetal monitoring (20.9%), shoulder dystocia and/or brachial plexus injury (15.5%), and actions of ObGyn residents (11.4%).

Gynecologic claims. Survey respondents reported a total of 1,496 gynecologic claims. Major injury to the patient was the primary allegation of 29.1% of these claims. A delay in diagnosis or failure to diagnose was the second most common primary allegation (22.1%), followed by minor injury to the patient (20.7%).

Of the claims involving a delayed or missed diagnosis, 41.8% involved cancer. Of these, breast cancer was the most frequent type of cancer (39.1%), followed by uterine cancer (20.3%), ovarian cancer (14.5%), and cervical cancer (10.9%).

Many gynecologic claims (44.4%) involved surgical complications arising from hysterectomy (28.7%) and laparoscopic procedures (14.6%).

Claims outcomes. A total of 43.9% of claims

were dropped or settled without any payment on behalf of the ObGyn. Of these, 29.0% were dropped by the plaintiff, 11.2% were dismissed by the court, and 3.7% were settled without payment on behalf of the ObGyn.

The average for all paid claims was \$510,473. The average payment for claims involving a neurologically impaired infant was \$982,051. Other average payments for obstetric claims include \$364,794 for “other infant injury–major” and \$271,149 for stillbirth or neonatal death.

Average payments for gynecologic claims include \$407,500 for a failure to diagnose breast cancer and \$315,633 for “patient injury–major.”

Most challenging locales. It will come as no surprise to many readers that average medical liability payouts are especially high in six states:

- New York - \$677,866,050
- Pennsylvania - \$319,710,250
- Illinois - \$242,108,800
- New Jersey - \$221,170,750
- Florida - \$218,123,050
- California - \$215,519,200.

Fifty-eight percent of payouts nationwide were for female patients.⁷



58% of payouts nationwide were for female patients

Who's on our side?

Congressional policy wonks give liability reform a thumbs up

In early 2010, the **Medicare Payment Advisory Commission** (MedPAC), a nonpartisan advisory counsel to the US Congress, identified three important ways that our current malpractice system harms the Medicare program and Medicare beneficiaries, the aged, and disabled:

- Medicare payments to providers include some liability costs (folded into hospital diagnosis-related group [DRG] payments; factored into physician fee schedule calculation)
- Defensive medicine drives up costs for Medicare
- Malpractice impairs the quality and safety of care to beneficiaries. That is, the current system does not improve patient safety.

MedPAC staff recommended that the commissioners urge Congress to pass government-subsidized malpractice reinsurance for providers who meet certain safety criteria or create a federal administrative adjudication process. The commissioners expressed an interest in alternatives to address the costs of medical malpractice, including ways to encourage states and providers to address medical malpractice in a manner most appropriate for them. However, when MedPAC returned to this topic at its next meeting later the same year, the commissioners mentioned medical liability only to dismiss it as an incidental issue in opening remarks.

The **Congressional Budget Office** (CBO) estimates that medical malpractice costs our health-care system \$35 billion in direct costs, with billions more as a result of defensive medicine.

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CBO has scored these medical liability reform proposals as providing significant savings to our federal budget:

- a \$250,000 cap on subjective, noneconomic damages (with no limit on economic damages)
- collateral source rule allowing evidence of outside payments to be submitted in court
- a ban on subrogation by certain collateral sources
- caps on attorney contingency fees
- periodic payments of future damages
- a reasonable statute of limitations.

In addition, in 2011, CBO scored comprehensive medical liability reform as saving the federal government \$62.4 billion over 10 years. As longtime Illinois Senator Everett Dirksen was known to say, “A billion here, a billion there, and pretty soon you’re talking real money.”

Many Republican congressional leaders “walk the walk”

Republicans have long claimed medical liability reform as their issue. And they walk the walk.

Representative Phil Gingrey, MD, of Georgia, an ACOG Fellow, has led the medical liability reform fight on Capitol Hill for a number of years. His bill, the Protecting Access to Healthcare Act (HR 5), which would have brought MICRA to the national level, was repeatedly passed by the Republican majority of the House of Representatives, only to be ignored by the Democrats controlling the Senate.

Again this year, Dr. Gingrey introduced legislation to protect physicians from unexpected liability. His Standard of Care Protection Act (HR 1473) would ensure that provisions of the Affordable Care Act (ACA) cannot be used to create new causes of action against medical professionals. HR 1473 would ensure that Medicare, Medicaid, and other federal programs that establish *government* standards and guidelines for health-care providers cannot be used to create new causes of action.

Federal health-care programs are changing to ensure that payment reflects quality of

care. As a result, new payment rules, guidelines, and standards are being written into federal laws and regulations. HR 1473 would make clear that these cannot be used to define the applicable standard of care or duty of care in a medical liability lawsuit.

ACOG supports Dr. Gingrey’s bill, as well as a second, companion approach that would ensure that ObGyns who follow guidelines and standards of care developed by their medical society are protected from liability, with sensible exceptions for egregious harm and negligence.

Representative Charlie Dent, Republican of Pennsylvania, also has introduced ACOG-supported medical liability legislation. The Health Care Safety Net Enhancement Act (HR 36) would provide federal liability protection for physicians providing care under the Emergency Medical Treatment and Active Labor Act (EMTALA). HR 36 is commonly referred to as Good Samaritan legislation, intended to protect doctors who rush to the aid of a sick individual.

The likelihood of any of these bills getting enacted into law is slim. Even some conservative Republicans oppose federal liability reform as an intrusion into states’ rights.

Some Democrats have said good things

In his proposed budget for fiscal year 2012, **President Barack Obama** asked Congress for funding to address medical liability issues.

He proposed “to restrain health-care costs” through “a more aggressive effort to reform our medical malpractice system to reduce defensive medicine, promote patient safety, and improve patient outcomes.” He encouraged Republicans to work constructively with him on medical malpractice as part of an overall effort to restrain health-care costs.²

The President asked Congress for “\$250 million in grants to states to reform the way they resolve medical malpractice disputes,” including health courts, safe harbors, early disclosure and offer, and other legal reforms such as joint and several liability and collateral source rules.²



In 2011, the Congressional Budget Office scored comprehensive medical liability reform as having the potential to save the federal government \$62.4 billion over 10 years



Congress never funded the President's request.

President Obama repeated his request in his fiscal year 2013 budget proposal. Congress didn't fund it then, either.

Earlier, in March 2009, in remarks to the Business Roundtable, President Obama noted that "the cost issue is the thing that we actually think is the big driver in this whole debate...things like comparative effectiveness, health IT, prevention, figuring out how our reimbursement structures are designed under Medicare and Medicaid. Medical liability issues—I think all those things have to be on the table."³

In an interview the same month, **Senator Ron Wyden**, Democrat of Oregon, said, "I think [medical liability reform is] an essential piece for there to be enduring reform, reform that will stick and will get a significant bipartisan vote in the United States Senate."⁴

Senator Wyden's Healthy Americans Act (S391) included incentives to get states to enact malpractice reforms as a key to overhauling the health-care system.

Also in March 2009, **Representative Rob Andrews**, Democrat of New Jersey, Chairman of the House Education and Labor, Health Subcommittee, pointed to the need for medical liability reform.

"It's hard for me to imagine a [health-care reform] result that gets to the president's desk that doesn't deal with the medical malpractice issue in some way."⁴

And **Senator Max Baucus**, Democrat of Montana, Chairman of the Senate Finance Committee, proposed providing states grant money to develop alternative litigation models, such as encouraging disclosure and compensation in the case of error, and establishing health courts whose judges have health-care expertise.

As early as May 2006, President Obama (then a Senator from Illinois) and **Senator Hillary Rodham Clinton**, Democrat of New York, urged a focus on patient safety.

"Instead of focusing on the few areas of intense disagreement," they wrote in the *New England Journal of Medicine*, "such as the possibility of mandating caps on the financial

damages awarded to patients, we believe that the discussion should center on a more fundamental issue: the need to improve patient safety...."

"To improve both patient safety and the medical liability climate, the tort system must achieve four goals: reduce the rates of preventable patient injuries, promote open communication between physicians and patients, ensure patients access to fair compensation for legitimate medical injuries, and reduce liability insurance premiums for health-care providers. Addressing just one of these issues is not sufficient."⁵

And then there are the trial lawyers

Readers of OBG MANAGEMENT know all too well that the role of trial lawyers in medical liability reform has been to block meaningful reforms from passing and to repeal reforms currently in place. The Association of Trial Lawyers of America, now known as the American Association for Justice, tries to portray itself as defending vulnerable patients against a few bad apples. Its Web site (www.justice.org) points to recent National Practitioner Data Bank (NPDB) figures indicating that "just 6% of doctors are responsible for 58% of all negligence incidents. The civil justice system seeks to weed out those few doctors whose actions have such devastating impact on patients."

The Web site includes these bullet points:

- 6% of doctors have been responsible for 58% of all malpractice payments since 1991
- 2% of doctors having three or more malpractice payments were responsible for 33% of all payments
- 1% of doctors having four or more malpractice payments were responsible for 20% of all payments
- 82% of doctors have never had a medical malpractice payment.

Tell that to ObGyns, who, in 2012, paid an average of 12.4% of their gross income for liability insurance premiums in 2012, and nearly 60% of whom changed their practices based on the risk or fear of professional liability claims or litigation. And this despite the fact that 43.9% of claims were dropped or

FAST TRACK

Recent figures from the National Practitioner Data Bank indicate that 6% of doctors are responsible for 58% of all negligence incidents

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settled without any payment on behalf of the ObGyn.

Action at the state level

We need a federal solution, but since that isn't within reach, we're looking to the states for action. And there's a lot of action in some states, including Connecticut, Florida, Georgia, Hawaii, Illinois, Iowa, Missouri, Oregon, Rhode Island, Tennessee, and Utah.

Advocates in these states are trying a number of different approaches, hoping that some type of meaningful reform will be signed into law. Here's a sampling of what's under way.

Connecticut

HB 6687, amend certificates of merit in medical liability actions. **Status:** April 1, 2013: Joint Committee on Judiciary hearing. The bill would eliminate the need for a detailed basis for the formation of an opinion and replace it with a lower threshold stating the appearance of one or more specific breaches of the prevailing professional standard of care.

In addition, HB 6687 would allow any expert who may testify in court to satisfy the certificate of merit requirement, but at trial the "expert," in order to testify, needs to have the court determine him or her to be qualified to testify based on discovery and evidentiary issues that are decided at trial. This expert then could sign a certificate of merit but have the court determine that he or she is indeed not an expert for that case. HB 6687 delays the challenging of qualifications of an expert only after the completion of discovery, adding substantial time and cost to defending meritless suits. Finally, the bill allows for a second bite of the apple for cases that did not meet this watered down standard for certificate of merit and would eliminate the automatic dismissal of cases filed with inadequate certificates that did not meet the rules of the court.

SB 1154, amend Connecticut's failure of suit statute to allow a plaintiff whose lawsuit was dismissed due to a failure to file a certificate

of good faith as required by statute, to commence a new action.

HB 5229, limit noneconomic damages in medical liability cases to \$250,000 for each health-care provider and institution per event, and \$750,000 overall for each event.

HB 5270, establish peer-review panels in medical liability actions. The panels would consist of physicians, medical professionals, and individuals outside the medical profession who would review claims of alleged negligence and determine whether there is probable cause that the medical liability claims have been made in good faith prior to the action being referred to mandatory mediation.

SB 97, extend the statute of limitations in medical liability cases, allowing for an action to be brought no more than 10 years from the date of the act or omission that serves as the basis for the claim.

Florida

The Birth-Related Neurological Injury Compensation Association (NICA). NICA is a statutory organization that manages the compensation plan used to pay for the care of infants born with certain neurological injuries. This plan is available to eligible families statewide without litigation. By eliminating costly legal proceedings, and through professional management of its disbursements, NICA ensures that birth-injured infants receive the care they need while reducing the financial burden on medical providers and families. Defensive work continues on the NICA Board and trial bar.

HB 7015, expert witness. **Status:** March 28, 2013, the House Justice Appropriations Subcommittee reported favorably. This bill would adopt the Daubert standard for expert witness testimony. It provides that a witness qualified as an expert by knowledge, skill, experience, training, or education may testify in the form of an opinion as to the facts at issue in a case.

Georgia

HB 499, Provider Shield Act. Georgia is the first state to introduce legislation based on the



In Connecticut, HB 5229 would limit noneconomic damages in medical liability cases to \$250,000 for each health-care provider and institution per event, and \$750,000 overall for each event



American Medical Association's model bill, "The Provider Shield Act," which clarifies language in the Affordable Care Act by providing that a physician's failure to comply with, or a breach of, any federal statute, regulation, program, guideline, or other provision shall not: **(1)** be admissible; **(2)** be used to determine the standard of care; or **(3)** be the legal basis for a presumption of negligence.

Status: Enacted May 6, 2013. The law prohibits the use of payer guidelines and quality criteria outlined in federal law as a legal basis for negligence or standard of care in determining medical liability. Physicians are concerned that without such protections, the medical profession could be exposed to charges of negligence that aren't based on clinical standards or the patient's unique medical needs. Implementation of any guideline by any public or private payor, or the establishment of any payment standard or reimbursement criteria under any federal laws or regulations related to health care, **shall not be construed, without competent expert testimony establishing the appropriate standard of care, to establish a legal basis for negligence or the standard of care or duty of care owed by a health-care provider to a patient in any civil action for medical malpractice or product liability.**

This first-of-its-kind legislation reinforces the concept that medical decisions should be based on a patient's unique medical needs. HB 499 makes it clear that federal standards or guidelines designed to enhance access to high-quality health care cannot be used to invent new legal actions against physicians.

Hawaii

SB 1308, health-care provider benevolent gesture legislation.

Illinois

On March 22, 2013, several pieces of tort-reform legislation were re-referred to the House Committee on Rules, effectively killing the bills for the session. The House Speaker would have to choose to "release" any of the bills in order for them to move again; this is highly unlikely.

HB 138 would have deleted existing-venue language providing that an action may commence in any county if all defendants are nonresidents of the state, and replaced it with language providing that, if no defendants that are joined in good faith and with probable cause for the purpose of obtaining a judgment against them are residents of the state, an action may be commenced only in the county in which the transaction or some part thereof occurred out of which the cause of action arose.

HB 2220 and **HB 2222** provided that, with respect to certain types of actions, for any defendant whose fault is less than 25% of the total fault attributable to the plaintiff, the defendants sued by the plaintiff, and any third-party defendant who could have been sued by the plaintiff (instead of any third-party defendant except the plaintiff's employer), shall be severally liable for all other damages. In addition, these bills provided that, for any defendant whose fault is 25% or greater of the total fault attributable to the plaintiff, the defendants sued by the plaintiff, and any third-party defendants who could have been sued by the plaintiff (instead of any third-party defendants except the plaintiff's employer), shall be jointly and severally liable for all other damages.

HB 2221 created requirements regarding qualifications, testimony, disclosure and compensation of expert testimony and standards for reviewing courts to follow in ruling on the admissibility of expert testimony.

Iowa

SSB 1054 and **HSB 36**, expert's certificate of merit affidavit and noneconomic cap. These bills provide that in any medical liability action, the plaintiff is required, within 180 days of the defendant's answer, to serve the defendant with an expert's certificate of merit affidavit for each expert scheduled to testify. They also would limit noneconomic damage awards in medical liability cases to \$1 million.

Missouri

HJR 6 proposes a constitutional amendment



In Georgia, new legislation reinforces the concept that medical decisions should be based on a patient's unique medical needs, not on payer guidelines and quality criteria outlined in federal law

allowing the legislature to cap noneconomic damages in medical liability cases.

SJR 1 grants the legislature the power to limit, by statute, jury awards for noneconomic damages.

SB 64 changes the evidentiary standard in medical liability cases to “clear and convincing” for noneconomic damages.

Oregon

SB 483, early discussion and resolution.

Status: Passed by the legislature. This bill establishes an early discussion and resolution (EDC) process within the Oregon Patient Safety Commission. This voluntary process is intended to facilitate open communication about all outcomes of care, including serious events, between the provider, health-care facility, and the patient. When an adverse health-care incident occurs, the patient, health-care provider or health-care facility where the incident occurred may file a notice of adverse health-care incident with the Commission. This notice triggers discussion of the health-care incident and, if appropriate, an offer of compensation. If discussion does not result in the resolution of the claim, the bill gives the parties the option of participating in Commission-facilitated mediation. The entire process is voluntary.

SJR 30, proposed amendment to constitution, \$1 million limit on noneconomic awards in medical liability cases. Slated for next general election.

Rhode Island

HB 5380, apology bill. **Status:** Heard in House Judiciary Committee on March 27, 2013; no action was taken. This bill provides that statements by a health-care provider to a patient or to the patient’s family regarding the outcome of such patient’s medical care and treatment, such as an **apology or expression of sympathy, shall be inadmissible** as evidence or an admission of liability in any claim or action against the provider.

Tennessee

Joint and several liability. Status: On March 26, 2013, the House Civil Justice

Subcommittee reported favorably. This bill would codify current state law by providing that if multiple defendants are found liable in a civil action governed by comparative fault, a defendant shall only be severally liable for the percentage of damages for which fault is attributed to such defendant by the trier of fact, and no defendant shall be held jointly liable for any damages.

SB 274, medical liability expert witness reform.

Utah

HB 135, rules, arbitration. **Status:** March 21, 2013, sent to Governor Gary Herbert for his approval. HB 135 provides that a party in a medical liability action or arbitration may not attempt to allocate fault to any health-care provider unless a certificate of compliance has been issued. HB 135 also requires that evidence from a medical review panel remain unreportable to a health-care facility or health insurance plan.

Summing up

Medical liability reform—the obvious need for it, the good reasons to do it, and the fact that it remains beyond reach—is a constant source of frustration among many ObGyns. Maybe Captain Sully can save the day. 🍷

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In Oregon, a proposed amendment to the state constitution would place a \$1 million limit on noneconomic awards in medical liability cases