Tort Reform in Utah: Disclosure and Apology

By Lieutenant Governor Greg Bell

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In late September 2011, Governor Gary Herbert staged his first annual health summit, Utah Solutions for a Healthy Economy and Community. The Summit brought together more than 100 of Utah’s best and brightest leaders in the field. Governor Herbert also chose to pursue medical tort reform as a principal topic for the Summit. To this end, the Governor asked me to convene a group of key community stakeholders to review the tort reform landscape in Utah and improve it, if possible.

It is widely assumed that two major drivers of health care costs are related to medical malpractice claims. Costs are said to be driven up by, first, the practice of “defensive medicine,” and second, the high cost of malpractice insurance for doctors, hospitals, and other health professionals.

Our work group reviewed Utah’s tort reform history, national and state trends, current problems—both real and perceived—with current law, current legal procedures, and whether changes to the judicial system are warranted. Our objectives were:

- To assist patients in receiving the highest quality health care,
- To make sure those injured by medical errors have appropriate recourse,
- To deal fairly with medical providers whose reputations and livelihoods can be seriously impaired or lost through medical malpractice claims, and
- To take away incentives for medical providers to practice costly “defensive medicine.”

Our group asked these questions:

- How do our laws and procedures compare with other states?
- Are doctors ordering medically unnecessary tests to protect themselves from lawsuits?
- Do these costs drive up the cost of medical insurance to a significant degree?
- Are patients receiving open and honest communication from their doctors when medical errors or unanticipated outcomes occur?
- Are medical errors being reported and shared with patients?
- Are compassion, condolences, and/or apologies offered when warranted?
- Do medical providers feel free to discuss with the patient and their family follow-up care needed to address medical errors?

What are the current laws and procedures surrounding medical malpractice in Utah?

Utah has adopted most of the popular tort reform measures that have been discussed nationally over the past decades, and in this context, our state has a very conservative legal environment. The measures Utah has adopted in this area include:

- A statute of limitations that was shortened to two years (Title 78B § 3–404(1), 2008).
- Requiring medical malpractice claimants to give advance notice of a claim (Title 78 B § 3–404(5), 2008).
- Before a lawsuit can be filed, each claimant must go before a pre-litigation panel of three people: one chosen by the plaintiff, one by the defendant, and one by the other two panelists. The panel will designate the claim either meritorious or non-meritorious, although the claimant may still proceed to suit with a non-meritorious finding. Many do.
- At the pre-litigation hearing, the plaintiff must provide an affidavit from an expert stating malpractice has occurred (Title 78B § 3–416, 2008). This is a big hurdle for plaintiffs. The inability for the plaintiff to obtain an expert’s opinion at this stage of the proceedings bars proceeding further.
- A statutory ceiling of $450,000 for pain and suffering. Formerly, this cap was automatically adjusted yearly for inflation and reached $488,000, but the inflator clause was revoked a few years ago (Title 78B § 3–415, 2008).
- Specialists treating people other than their own patients in the emergency room can be held liable for malpractice based only on clear and convincing evidence, compared to the much lower standard of preponderance of the evidence, which typically applies to malpractice cases (Title 78B § 5–817, 2008).
- One-half of punitive damages, in excess of $50,000, relating to a personal injury recovery must be paid to the State (Title 78B § 8–201, 2008).
- “I’m Sorry” laws, referred to later.

Lawyers from both the plaintiff and defense bars agree that Utah has adopted most measures used around the nation to limit non-meritorious cases and “lottery” type recoveries. Our group reached the same conclusion. There seemed to be almost nothing of a legal nature that we could recommend to ameliorate illegitimate malpractice claims. Importantly, we also concluded that doctors and other providers seem to have a sense of their risk of incurring a liability claim far beyond what the evidence justifies.

National research shows that doctors are ordering medically unnecessary tests to protect themselves from lawsuits. Although we were not able to obtain Utah-specific data, it was the group’s consensus that Utah physicians sometimes order tests and procedures with at least the partial motivation of protecting themselves from claims. Moreover, there is much anecdotal evidence that patients are pushing physicians for procedures such as an MRI instead of a simple X-ray, or an angiogram instead of a much cheaper
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EKG. Combine the demands of patients with the doctor's desire to insulate himself or herself from liability and there is little doubt that defensive medicine is alive and well in Utah. Shannon Brownlee, who recently spoke in Salt Lake City, wrote in her 2007 book Overtreated that a third of every healthcare dollar goes toward procedures, tests, treatments, and surgeries of dubious medical necessity.

*Are patients receiving open and honest communication from their doctors when a medical error occurs? Are medical errors being reported and shared with patients? Are compassion, condolences, and/or apologies offered when warranted? Do medical providers feel free to discuss with the patient and their family follow-up care needed to address medical errors?*

Utah adopted "I'm Sorry" legislation in the last decade. Moreover, in 2010 and 2011, the Legislature also changed Rule 409 of the Utah Rules of Evidence to reflect the statutory intent "to encourage expressions of apology, empathy, and condole and the disclosure of facts and circumstances related to unanticipated outcomes in the provision of health care in an effort to facilitate the timely and satisfactory resolution of patient concerns arising from unanticipated outcomes in the provision of health care" (Joint Resolution to Amend, 2011). Even the fact that a provider had paid or offered to pay a plaintiff's medical expenses was made inadmissible under Rule 409. It was our group's consensus, however, that this legislation and rule change had not really changed the culture of how Utah physicians and hospitals address medical liability claims.

As we reviewed data on the small number of tort claims filed in the state of Utah (which were far less than 1% of all cases filed in Utah courts in recent years), and having a general knowledge of medical liability payouts during the last few years, our group concluded that Utah has relatively few claims, suits, and payouts, and that payouts seem to be reasonable. We do not suffer from the "runaway jury" syndrome present in some states. Nevertheless, we found that doctors' perception of their risk of incurring a malpractice claim is much higher than is the reality.

**BREAKTHROUGH**

Even though the actual number of suits and settlements in Utah is small and the payouts are not out-sized, mere notice of a claim is a very serious and stressful matter for medical practitioners.

The breakthrough moment for the group came when Michelle McOmber, Executive Vice President & CEO of the Utah Medical Association, clearly communicated to the attorneys in the room that doctors incur much, if not most, of the stress and trauma associated with a malpractice claim from the mere receipt of notice of a claim. Such a claim brings a doctor great stress about his or her status in the profession and worries about the ongoing ability to practice, to hold his or her head up in professional circles, and to make a living. Once the doctor has received a claim, he must report that claim on every credentialing application and renewal and on every application for and renewal of malpractice insurance, even though the claim may ultimately be dismissed as non-meritorious. Usually, a claim will cause the physician's malpractice insurance premiums to increase. It is like a scarlet letter that will not fade.

Insurance companies and self-insured medical institutions have traditionally responded to malpractice claims with a "deny, delay, and defend" strategy. Accordingly, the attorneys in our group who practice in this area explained that a plaintiff's counsel must name every medical professional whom they can determine had any role in the matter, be it ever so minor or tangential. Until a suit is filed and counsel can subpoena all the medical records, the plaintiff's counsel does not know what actions various doctors and nurses took. Thus, they name everyone they are aware of in the case as a possible defendant. Consequently, many claims are later dismissed against practitioners who had nothing to do with the claimed injury or damage, but the onus of the claim persists.

Out of this "Ah ha!" moment, the plaintiff and defense counsel from our group began meeting to explore ways of avoiding the negative impact of a mere claim. In light of our group's recommendation that counsel be given early access to medical records, as explained below, their ingenious solution was to develop a proposed rule of civil procedure that would require that before trial, each party must name all persons the party intends to name in the lawsuit. The rule is incorporated in 1SHB135, which unanimously passed both the House and Senate in the 2013 General Session of the Utah Legislature. Thus, hospitals that intend to claim against a physician must name that physician at the commencement of the suit, instead of relying on plaintiffs' counsel to do that for them. Hospitals have a hard time claiming against doctors who practice with them. Because of the incentives reflected in the new rule, it is hoped only parties who were involved in the claimed malpractice will be party to the litigation.

**University of Michigan Early Resolution and Disclosure System (EDR)**

We became aware of a program the University of Michigan Health System (UMHS) had developed and employed for many years. Called "Early Disclosure and Resolution" (EDR), it was developed by Richard C. Boothman, their Chief Risk Officer. Boothman had defended malpractice claims in private practice before joining the in-house legal staff at UMHS. As he worked more closely with patients and health professionals on malpractice claims, he realized that a patient who has suffered an unanticipated adverse surgical or medical outcome has never had greater need of communication with their doctor. Unfortunately, he found that the first casualty in a malpractice case is the physician-patient relationship. Under the deny, delay, and defend mentality, risk managers would now be interposed between patient and doctor. The risk managers thereafter deal with the patient and his representatives. When the focus should have been on addressing the patient's medical, psychological, financial, and other needs, liability concerns shoved patient care and welfare aside.

With the consent of hospital management, Boothman tried a new approach, which became EDR, by openly disclosing the adverse event and its related facts to the patient and his or her representatives, then seeking early resolution to the patient's concerns and interests. Under EDR, the hospital trained its doctors and caregivers to approach patients and their families in a manner that addresses the patients' needs above all else and keeps legal issues in the background. When a medically adverse event occurs, the doctor(s) and a hospital representative disclose to the patient and the family what they know about the event, how it occurred, what treatments or surgeries will be required to address it, and whether they have established if there was a hospital or doctor error or if the adverse outcome is simply an unfortunate but unpreventable condition. The hospital offers the patient and his or her representatives, including lawyers, complete and immediate access to all medical records and other relevant information. As appropriate, they discuss the patient's immediate financial needs that may have arisen from the adverse event. UMHS uses each event as a quality improvement opportunity by gathering everyone involved to candidly assess any errors or patient frustrations and to improve the hospital's systems to avoid or lessen the risk of such errors in the future. Under EDR, the hospital and the doctors do not seek a waiver of liability or legal settlement as pre-conditions to discuss the error and to give access to records or the terms of any settlement. It is an "open book" experience. Significantly, the doctor
and hospital continue to focus on helping the patient get well and on maintaining a cooperative rather than an adversarial attitude.

Studies show that UMHS’s EDR system has reduced the size of payouts and has made them more rational. Generally, the prevailing tort litigation system results in most injured patients not making any claim, losing their claims, or getting paltry payouts, while a few fortunate plaintiffs get lottery-size settlements or judgments. There is no way to reconcile such payouts when they are granted one at a time by hundreds of different courts and juries. UMHS’s rationalized payout system considers many factors, including the extent of discomfort, suffering and disability, the seriousness of the medical error, the need for extended care, the patient’s age, career, and earning capacity, and any limitations on the patient returning to full employment. Every claimant is treated fairly and equitably. This one outcome of the EDR program alone justifies the program.

In my personal conversation with Mr. Boothman, he indicated the UMHS and its related doctors are very pleased with the system. Plaintiffs’ counsels have embraced the program, in part, because it is simpler for them to reach settlement for their clients. They have early and complete access to relevant records and evidence. The hospital and doctors want to reach an accord that fairly addresses the patient’s needs. In such a system, a wise lawyer will become part of a team that focuses on the patient’s immediate and long-term medical, psychological, and financial needs.

Another distinct advantage of EDR is that it preserves the paramount doctor-patient relationship, rather than letting the adversarial risk management mentality set the tone of doctor and hospital interaction with the patient. Because the system is voluntary for all participants, everyone works toward resolution rather than either protecting themselves from risk or seeking legal recovery. The process seeks a human solution to what are, at their core, human problems, rather than legal problems. The legal issues are still attended to, but in a more collaborative manner.

Research has also shown that under the traditional delay, deny, and defend philosophy, many patients sue simply out of frustration at one or more factors: being barred from obtaining medical information about the medical error, being denied a chance to discuss the events with their doctors, and failing to receive appropriate information about what went wrong and whether human error caused it. Moreover, it has been shown that a patient who feels his or her doctor has shown compassion and perhaps even apologized is far less likely to sue for an adverse outcome. EDR takes much of the angst and frustration out of the equation, and the patient is therefore much more likely to reach a reasonable settlement with the medical providers, or perhaps not seek one at all. Patients are also gratified when they learn the adverse outcome in their case will be studied and used as a learning experience to address flaws in hospital systems and procedures for the benefit of future patients. We also learned of the work of Dr. Thomas Gallagher of the University of Washington Medical School, who has been developing an EDR system throughout the State of Washington. Dr. Gallagher spoke to the Governor’s Health Summit in 2012, and indicated that although getting all the stakeholders to the table in Washington had been very difficult, they were on the cusp of rolling out a state-wide EDR system.

**Treasure in Our Own Backyard**

Through pure serendipity, we stumbled on treasure in our own backyard. Dr. Elizabeth Guenther, a wonderful doctor, was a practicing emergency room pediatrician at Primary Children’s Medical Center (PCMC) and researcher at the University of Utah. She has worked extensively with her colleagues in Utah and in other states in researching and promoting a system of early disclosure and resolution of medical errors. Dr. Guenther joined our group and has become an important contributor. She did much of her research under a now-expired grant through the U.S. Department of Health:

Agency for Healthcare and Research Quality (AHRQ). We applied for and received a grant from AHRQ for $1 million to expedite finding innovations in Utah’s health care systems, which Dr. Guenther will use to continue her research on early disclosure and resolution.

In addition to bringing the benefit of her own research and expertise in this area to our group, Dr. Guenther also made us aware of the early disclosure and resolution system at PCMC in Salt Lake City, Utah. Over the past decade, Dr. Edward Clark, Chief Medical Officer at PCMC and Chair of the Department of Pediatrics at the University of Utah, has instituted an ECR program at PCMC similar to the Boothman model. At PCMC, they have found it to be well received by patients and professionals and economically advantageous to the hospital as well. We have presented this model to other local hospital systems and are hopeful they will embrace it, too. Early signs are most encouraging.

**CONCLUSION**

A system of early disclosure, apology, and resolution of medical injuries exemplifies what I think will be a major trend. This system elevates human relationships, specifically that of doctor-patient, above legal and institutional considerations and the complexity they bring. EDR is an organic, collaborative process looking for positive outcomes for all participants, but especially for the patient. An additional important outcome is that medical professionals who work in an EDR environment are able to practice with confidence that human errors will not likely be met with threats, legal claims, or the potential loss of reputation, professional standing, and their livelihood.

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**REFERENCES**


Joint Resolution To Amend Rule Of Evidence, H.R. 38, 59th, General Session (Utah 2011).


“We never conquer other minds until we conquer our own.

We never conquer fear until we are masters of ourselves.”

-Robert H. Hinckley