

SC91867

IN THE MISSOURI SUPREME COURT

DEBORAH WATTS, as Next Friend for NAYTHON KAYNE WATTS,
Appellant/Cross-Respondent,

vs.

LESTER E. COX MEDICAL CENTERS, d/b/a FAMILY MEDICAL CARE CENTER,
LESTER E. COX MEDICAL CENTERS,
Respondent,

vs.

MELISSA R. HERMAN, M.D., MATTHEW P. CRANE, D.O.
and WILLIAM S. KELLY, M.D.,
Respondents/Cross-Appellants.

On Appeal from the Circuit Court of Greene County, Missouri
Case No. 0931-CV01172

AMICI CURIAE BRIEF OF AMERICAN CONGRESS OF OBSTETRICIANS AND
GYNECOLOGISTS; MISSOURI COLLEGE OF EMERGENCY PHYSICIANS; AND
MISSOURI ASSOCIATION OF RURAL HEALTH CLINICS IN SUPPORT OF
RESPONDENTS/CROSS-APPELLANTS MELISSA R. HERMAN, M.D., MATTHEW
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JURISDICTIONAL STATEMENT

Amici Curiae American Congress of Obstetricians and Gynecologists, Missouri College of Emergency Physicians and Missouri Association of Rural Health Clinics adopt and incorporate herein the jurisdictional statement in the Brief filed on behalf of Respondents/Cross-Appellants Melissa R. Herman, M.D., Matthew P. Green, D.O. and William S. Kelly, M.D. American Congress of Obstetricians and Gynecologists, Missouri College of Emergency Physicians and Missouri Association of Rural Health Clinics file its a brief pursuant to Rule 84.05(f)(2) with the consent of all of the parties.

STATEMENT OF FACTS

For purposes of their Brief, *Amici Curiae* American Congress of Obstetricians and Gynecologists, Missouri College of Emergency Physicians and Missouri Association of Rural Health Clinics adopt and incorporate herein the statement of facts set forth in the Brief filed on behalf of Respondents/Cross-Appellants Melissa R. Herman, M.D., Matthew P. Green, D.O. and William S. Kelly, M.D.

INTERESTS OF *AMICI CURIAE*

American Congress of Obstetricians and Gynecologists

American Congress of Obstetricians and Gynecologists (“ACOG”) is a nonprofit educational and professional organization with more than 56,000 members, including 1038 in Missouri. ACOG is the premier organization for obstetricians and gynecologists and providers of women’s health care. ACOG serves as a strong advocate for quality health care for women. In addition, ACOG works to provide the highest quality education worldwide and continuously improve health care for women through practice and research.

Medical liability reform, such as the reforms contained in House Bill 393 and § 538.210 R.S.Mo. (Cum. Supp. 2011),¹ is a top priority for ACOG. When obstetricians-gynecologists cannot find or afford medical liability insurance, they are forced to stop delivering babies, curtail surgical services, or close their doors. Across America and in Missouri, pregnant women cannot get the prenatal and delivery care they need. In addition, ACOG warns that the medical liability crisis hurts all women. With the physician shortages, there are fewer obstetricians-gynecologists available to provide gynecologic surgery and preventative care, such as screening and special procedures. Women lose care that helps protect fertility, and treat pelvic pain, and treat cancer early. Women travel longer distances to find a doctor, have longer waiting periods for appointments, and have shorter visits once they get there. The constitutionality of HB

¹ All references are to R.S.Mo. 2000 unless otherwise indicated.

393 including the amendments to § 538.210 presented by this appeal generates considerable interest to ACOG members. ACOG believes that the resolution of the issues presented in this appeal could have a dramatic and substantial impact not only on Missouri tort law, but also on the availability and affordability of health care services to women across Missouri.

ACOG believes this Court will benefit from a policy-oriented discussion of some of the broad-based issues presented in this proceeding. Therefore, the purpose of this brief is to provide the Court with analysis of some of the issues from the perspective of a nonprofit educational and professional organization composed of professionals who specialize in the health care of women.

Missouri College of Emergency Physicians

Missouri College of Emergency Physicians (“MoCEP”) is a nonprofit Missouri corporation comprised of approximately 350 emergency room physicians and 75 residents and medical students. MoCEP is the Missouri Chapter of American Congress of Emergency Physicians (ACEP). The primary purpose of MoCEP is to promote the improvement of the practice of emergency medicine. MoCEP is committed to promoting education of the general public and of patients who may require emergency medical care. MoCEP also encourages and implements training and continuing education of emergency physicians. MoCEP is committed to promoting research, which will result in improving emergency medicine.

MoCEP also promotes the coordination of community emergency care facilities and personnel. MoCEP is involved in the establishment of standards for emergency

medicine. MoCEP also promotes policies which preserve the integrity of private practice. One of the purposes of MoCEP is to study and analyze socioeconomic aspects of emergency medical care. MoCEP also promotes the establishment of full and autonomous emergency departments within all hospital and medical staff structures providing full-time emergency department coverage by emergency room physicians. MoCEP continually monitors trends in the health care environment and analyzes issues affecting emergency physicians and their patients and strives to uphold the following values: quality emergency care is an individual right and should be available to all who seek it; there is a body of knowledge unique to emergency medicine that requires continuing refinement and development; quality emergency medicine is best practiced by qualified credentialed emergency physicians in a fair, equitable and supportive environment; and the emergency physician has the responsibility to play the lead role in the definition, evaluation and improvement of quality emergency care.

As an organization composed of emergency physicians, MoCEP is concerned and interested in the establishment of fair and predictable laws affecting medical litigation that will maintain the integrity of fairness of civil litigation for both plaintiffs and defendants without compromising access to quality health care. The constitutionality of HB 393 and the amendments to § 538.210 presented by this proceeding generates considerable interest by emergency physicians. MoCEP believes that the resolution of the issues presented in this proceeding could have a dramatic and substantial impact not only on Missouri tort law, but also on the availability and affordability of emergency medical care in Missouri.

MoCEP believes this Court will benefit from a policy-oriented discussion of some of the broad-based issues presented by this proceeding. Therefore, the purpose of this brief is to provide the Court with an analysis of some of the issues from the perspective of an organization composed of emergency physicians who provide care to individuals requiring emergency medical care.

Missouri Association of Rural Health Clinics

Missouri Association of Rural Health Clinics (“MARHC”) is a nonprofit corporation founded by health professionals committed to providing a forum to exchange information specific to federally-certified Rural Health Clinics. More than 330 Rural Health Clinics are members of MARHC, and together they provide primary health care to more than 500,000 low-income Missourians across rural Missouri. The specific purpose of MARHC is to study, discuss, and exchange professional knowledge, expertise, and ideas with regard to federally-certified Rural Health Clinics; to promote high standards for quality patient care; to stimulate interest in continuing education for Rural Health Clinic health care providers; to improve access to quality health care through the establishment of federally-certified Rural Health Clinics and through cooperative efforts with other professional health care organizations and individuals; and to promote and maintain communication and cooperative relations with other professional health care organizations. As an organization composed entirely of Missouri Rural Health Clinics, MARHC is concerned and interested in the establishment of fair and predictable laws affecting medical liability litigation that will maintain the integrity and fairness of civil

litigation for both plaintiffs and defendants without compromising access to quality health care.

The constitutionality of HB 393 and the amendments to § 538.210 presented by this proceeding generates considerable interest by rural clinicians in Missouri. MARHC believes that the resolution of the issues presented in this proceeding could have a dramatic and substantial impact not only on Missouri tort law, but also on the availability and affordability of primary health care services in Missouri, and particularly in rural, low-income communities.

MARHC believes this Court will benefit from a policy-oriented discussion of some of the broad-based issues presented by this proceeding. Therefore, the purpose of this brief is to provide the Court with an analysis of some of the issues from the perspective of a nonprofit corporation composed of federally-certified Rural Health Clinics that provide care to individuals in lower-income, rural communities.

ARGUMENT

THE TRIAL COURT DID NOT ERR IN FINDING THAT MISSOURI'S UPPER LIMITATION ON NONECONOMIC DAMAGE AWARDS IN MEDICAL LIABILITY CASES IS A VALID AND CONSTITUTIONAL EXERCISE OF LEGISLATIVE AUTHORITY

A. Introduction

Prior to the enactment of HB 393, Dr. Julie Wood was forced to leave her small full-service family practice in her hometown of Macon, Missouri. (See E. Katherine Underwood and Joi Preciphs, *Premium Blues: Doctors' Insurance Costs Soar*, MISSOURIAN (Sept. 28, 2003); *Medical Liability Impact of Small Business Examined by House Committee*, WOMEN'S POLICY, INC. (2005). Dr. Wood made that decision after her insurer raised her annual premium from \$19,000.00 to \$71,000.00. E. Katherine Underwood and Joi Preciphs, *Premium Blues: Doctors' Insurance Costs Soar*, MISSOURIAN (Sept. 28, 2003). Dr. Wood was forced to move her full-service family practice to an academic health center in the Kansas City, Missouri area where the hospital could pay her liability premium. *Id.*; *Medical Liability Impact of Small Business Examined by House Committee*, WOMEN'S POLICY, INC. (2005). The result was that the indigent in her home community lost obstetrical and primary care because they could not afford the two-hour drive to her new office. *Medical Liability Impact of Small Business Examined by House Committee*, WOMEN'S POLICY, INC. (2005).

Prior to the enactment of HB 393, Dr. Al Elbendary left a group practice and eliminated a rural outreach clinic because of rising liability premiums. John Nelson, M.D. MPH, RE: Impact of Medical Liability Issues on Patient Care, testimony before the

United States Senate Committee on the Judiciary (August 20, 2004). “Women with gynecologic cancers in Ste. Genevieve, Carbondale and Chester now have to drive over 100 miles to see a oncologist and receive the care they deserve,” explained Dr. Elbendary. *Id.*

Dr. Jamie Ulbrich, an obstetrician, faced a similar situation. After Dr. Ulbrich’s liability insurance carrier stopped doing business in Missouri prior to the enactment of HB 393, the best coverage he and his three colleagues at their Marshall clinic could find would have cost them double what they paid in 2003. *Id.* The four doctors decided they could not each afford the \$50,000.00 liability insurance premium so they decided to stop providing obstetric services and instead in 2004 started to work as family physicians. *Id.*

These are just a few of the countless examples of the impact of the medical liability environment prior to the enactment of HB 393. It was in response to situations such as the ones described above that the Missouri Legislature enacted the reforms contained in HB 393 to promote greater access to affordable health care for all Missourians. The Missouri Legislature decided upon a very substantial but not unlimited remedy for the distinct minority of Missourians that may claim extraordinary noneconomic loss in medical malpractice cases. The impact of this legislation is lessened by the fact that, in addition to the substantial noneconomic damages that may be awarded, all liability plaintiffs’ economic damages are uncapped and punitive damages may be available in appropriate cases. Amici urge this Court to uphold Section 538.210 R.S.Mo. (Cum. Supp. 2011).

B. Rational Basis Test

The preservation of public health and the maintenance of generally affordable health care costs are reasonable legislative objectives. . . *Adams v. Children's Mercy Hospital*, 832 S.W.2d 898, 904 (Mo. banc 1992). The primary goal of the General Assembly in passing HB 393—in particular, the limitation on one category of damages, noneconomic damage awards—was to confront a medical liability crisis that threatened to adversely affect health care in Missouri. The General Assembly was responding to a situation in Missouri where insurers were leaving the state and physicians were leaving “high risk” areas of practice, potentially leaving many Missourians, particularly those in rural areas, without access to affordable health care. HB 393, including the amendments to § 538.210, is rationally related to a legitimate state interest in confronting this situation.

It is the province of the legislature to determine socially and economically desirable policy and to determine whether a medical liability crisis exists. *Adams*, 832 S.W.2d at 904. After conducting extensive hearings, the Legislature rationally believed that the limitation on noneconomic damages would work to reduce in the aggregate the amount of damage awards for medical liability and, thereby reduce medical liability insurance premiums paid by health care providers and increase the number of insurers writing coverage in Missouri. In turn, the Legislature could reason that physicians would be willing to continue “high risk” medical practices in Missouri providing quality medical services at a less expensive level statewide.

Legislation that touches only upon economic interests carries with it a presumption of rationality that can only be overcome by a clear showing of arbitrariness and irrationality. *In re Marriage of Kohring*, 999 S.W.2d 228, 233 (Mo. 1999). Under the rational-relationship test, a statute will be upheld, if any set of facts reasonably may be conceived to justify it. *Doe v. Phillips*, 194 S.W.3d 833, 845 (Mo. 2006). When undertaking rationality review, it is not the province of the court to question the wisdom, social desirability or economic policy underlying a statute, as these are matters for the Legislature's determination. *Id.* If a question of the legislative judgment remains at least debatable, the issue settles on the side of the validity. *Linton v. Missouri Veterinary Medical Board*, 988 S.W.2d 513, 516-17 (Mo. 1999). Under a rational basis test, a court does not have to determine whether the Legislature "should have" done something different or whether there is a better means to accomplish the same goal, and certainly not whether the chosen means is the best method. *Id.* at 516. Thus, even if it is argued that the Legislature's choices are socially undesirable, unwise, or even unfair is of little consequence, if, as here, the Legislature's classification advances the Legislature's legitimate policy. *Adams*, 832 S.W.2d at 903-04. Furthermore, a law will be upheld, if it is justified by any set of facts. *Committee for Educational Equality v. State of Missouri*, 294 S.W.3d 477, 491 (Mo. 2009).

Ensuring that physicians are able to practice in Missouri, and provide health care to Missouri residents, is clearly a legitimate end. *See Adams*, 832 S.W.2d at 904. The enactment of HB 393, which contains a \$350,000.00 upper-limit on one category of damages, noneconomic damage awards in medical liability actions, is not irrational. No

provision of the Missouri Constitution forbids this upper-limit on noneconomic damage awards in medical liability cases, and no mandate requires that noneconomic damages in every type of personal injury case be equal. *See Thompson v. Committee on Legislative Research*, 932 S.W.2d 392, 394 (Mo. banc 1996) (the Legislature has plenary power and may act unless denied power to do so in the Constitution.)

C. Prior Tort Reform Has Survived Constitutional Challenges in this Court

In *Adams*, this Court was faced with constitutional challenges to tort reform enacted in 1986, which contained a provision that limited noneconomic damages for the first time in medical liability cases. In *Adams*, plaintiffs contended that the provisions of § 538.210 limiting noneconomic damages, of § 538.220 permitting payment of future damages in periodic or installment payments, and of § 538.230.2 modifying joint and several liability violated a host of provisions in the Missouri Constitution: the open courts provision, right to trial by jury, equal rights and opportunities, due process, special law, privileges and immunities, one subject requirement, separation of powers, and constitutional directives for amending statutes. This Court determined that because neither a denial of a fundamental right nor a suspect class was present, the challenged statutory provisions must be examined for purposes of the equal protection challenge under the rational basis test. *Id.* at 903.

This Court noted in *Adams* that the provisions of Chapter 538 were enacted in 1986 in an effort to address a perceived liability crisis in the health care industry, which in turn threatened the availability and affordability of health care services. According to

amicus briefs filed in *Adams*, the Legislature considered information that the number of medical liability claims in Missouri increased 249 percent between 1981 and 1986; that aggregate and individual damage awards had accelerated to the extent that the State risked losing insurers; and that many physicians were believed to be considering leaving high-risk areas of practice, such as neurosurgery, obstetrics and urgent care, potentially leaving many Missourians, particularly those in rural areas, without adequate medical protection. Thus, the statute was enacted in an effort to reduce rising medical liability insurance premiums and in turn prevent physicians and others from discontinuing high-risk practices and procedures.

After noting that both sides in *Adams* offered evidence that both supported and refuted the existence of a medical liability crisis, this Court concluded “it is a debatable proposition that such a crisis does in fact exist.” *Adams*, 832 S.W.2d at 904. Thus, this Court found as follows:

Under equal protection rational review, this doubt must be resolved in favor of the General Assembly. While some clearly disagree with its conclusions, it is the province of the Legislature to determine socially and economically desirable policy and to determine whether a medical malpractice crisis exists.

Here, the preservation of public health and the maintenance of generally affordable health care costs are reasonably-conceived legislative objectives that can be achieved, if only inefficiently, by the statutory provision under attack here.

The Legislature could rationally believe that the cap on noneconomic damages would work to reduce in the aggregate the amount of damage awards for medical malpractice and, thereby, reduce malpractice insurance premiums paid by health care providers. Were this to result, the Legislature could reason, physicians would be willing to continue “high risk” medical practices in Missouri and provide quality medical services at a less expensive level than what otherwise would be the case.

Id. at 904.

Thus, this Court determined that the limitation on noneconomic damages was a rational response to the legitimate legislative purpose of maintaining the integrity of health care for all Missourians.

D. Medical Liability Crisis

There is a plethora of empirical data to show that there has been a real medical liability crisis, both on a national and a state level.

1. National Crisis

In 2002, the Department of Health and Human Services declared that “the litigation system is threatening health care quality for all Americans as well as raising the cost of health care for all Americans.” *See* David H. Sohn, J.D., M.D.; Javad Parvizi, M.D., F.R.C.S.; and Charles S. Day, M.D., M.B.A., *The Need for Tort Reform in the Current Healthcare Debate*, AAOS NOW (September 2009). In 2003, the National Association of Insurance Commissioners reported that medical liability insurance

premiums had increased by 920 percent during the past three decades. *Id.* A 2004 Congressional Budget Office study concluded that average premiums for all physicians nationwide rose by 15 percent between 2000 and 2002, almost twice as fast as total health care spending per person during the same period due in large part to the payment of medical liability awards. Congressional Budget Office, *Limiting Tort Liability for Medical Malpractice*, Economic and Budget Issue Brief (January 8, 2004). The increases during that period were even more dramatic for certain specialties—22 percent for obstetricians/gynecologists and 33 percent for internists and general surgeons. *Id.* Insurance premiums for emergency physicians grew on average by more than 50 percent from 2002 to 2003 to \$53,500.00, with some paying more than \$100,000.00 annually. *Medical Liability Crisis Fact Sheet*, ACEP. High medical liability insurance rates and the fear of lawsuits, particularly in the higher-risk environment of emergency departments, may lead to reductions on the number of specialists willing to offer on-call services to emergency departments. *The National Report Card on the State of Emergency Medicine: Evaluating the Emergency Care Environment State by State*, AM. COLLEGE OF EMERG. PHYSICIANS, (2002 Edition).

High insurance costs also discourage medical students from going into high-risk specialties, such as emergency medicine, surgery, neurosurgery, orthopedics and obstetrics. *Id.* Another study that compared the number of obstetricians in each state to the number of births per state between 1995 and 2002 found that junior fellows, described as residents or recent graduates of an approved OB-GYN program, had a 28.5 percent increase in births per junior fellow in the ten states having the highest insurance

premiums, compared to just a five percent increase in births per junior fellow in the ten states with the lowest premiums. In other words, there were more young obstetricians available to deliver babies in the states with lower medical malpractice premiums. The study concluded that high malpractice premiums may have influenced junior fellows' decisions to practice in the low-premium states. *Id.* Moreover, high premiums have an adverse effect on the availability of qualified ob-gyn doctors, even in communities with increasing populations and an apparent need for more OB-GYNs. *Id.*

A national survey of OB-GYN residents found that more than a third of respondents chose fellowships solely in gynecology because of malpractice concerns. Xiao Xu et al., *The Effects of Medical Liability on Obstetric Care Supply in Michigan*, 198 Am. J. Obstetrics & Gynecology 205e.1, 205.e6 (2008) (citing J.L. Becker, M.P. Milad, & S.C. Klock, *Burnout, Depression, and Career Satisfaction: Cross-Sectional Study of Obstetrics and Gynecology Residents*, 195 Am. J. Obstetrics & Gynecology 1444 (2006)).

Notably, there are possible long-term effects of excess medical liability costs, fueled in part by extreme noneconomic damages, which have not yet been fully explored. Michelle M. Mello, The Synthesis Project, *Medical Malpractice: Impact of the Crisis and Effect of State Tort Reforms* 5 (2006). For example, college students may be dissuaded from entering medical school, medical students may be dissuaded from entering certain specialties, and young physicians may choose not to set up practice in states with high malpractice premiums. *Id.*

Further aggravating the situation is evidence that the lack of access to on-call specialists contributes to adverse patient outcomes because of delayed treatment or the need to transfer patients long distances to obtain the care they need. Ann S. O'Malley, Debra A. Draper, Laurie E. Felland, *Hospital Emergency On-Call Coverage: Is There a Doctor in the House?* Center for Studying Health Systems Change, Issue Brief No. 115 (November 2007). In fact, two-thirds of emergency department directors in Level I and II trauma centers surveyed by American Congress of Emergency Physicians in 2006 reported that more than half of the patient transfers that they received were referred there because of a lack of timely access to specialty physicians in the emergency department of origin. *On Call Specialist Coverage in US Emergency Departments*, AM. COLLEGE OF EMERG, PHYSICIANS (April 2006). The unfortunate result of this situation is that pressures from a medical liability environment in crisis may result in a greater risk of adverse outcomes for patients.

Moreover, a number of major insurance companies started to restrict coverage based on geographic location, specialty, and provider's claims history and some discontinued the line of business altogether. Lan Zhao, *The Impact of Medical Malpractice Reforms on Access to Hospital-Based Obstetric Services* (2005) (unpublished Ph.D. dissertation, University of Maryland (College Park)). On the other hand, between 1997 and 2002, median jury awards for prevailing plaintiffs in medical liability lawsuits rose from \$157,000.00 to \$300,000.00. *Id.* Moreover, the Physicians Insurers Association of America (PIAA) reported that almost eight percent of all medical

liability awards exceeded \$1 million in 2003, doubling the percentage of million-dollar awards in 1998. *Id.*

In February 2003, TimeLine Recruiting, a retainer-based medical and allied-health professional recruiting firm, conducted a nationwide survey of rural health care providers. *Survey Identifies Major Challenges to Staffing in Rural Health Care; Medical Recruiting Firm Reveals Top 5 Specialties in Critical Need*, BUSINESS WIRE (March 17, 2003). The survey identified primary obstacles in recruiting quality medical professionals to America's rural health care facilities, where, according to the Rural Information Center Health Service (RICHS) and the American Medical Association (AMA), only 10 percent of the Nation's doctors practice in service to 20 percent of the Nation's population. *Id.* Forty-six percent of rural medical executives cited issues such as oppressive medical liability insurance premiums, inadequate Medicaid and Medicare reimbursement, and aging medical technology as reasons why they believe it is more difficult to recruit physicians into rural health care facilities than it was three years before the survey. *Id.*

A large percentage of family physicians work in small or medium sized practices of four physicians or fewer and operate with very tight financial margins. *Medical Liability Impact on Small Businesses Examined by House Committee*, WOMEN'S POLICY INC. (2005). However, those margins disappear with rising medical liability insurance premiums. *Id.* Furthermore, in rural areas, physicians are less likely to have access to advanced medical facilities such as neonatal intensive care units or to have colleagues who can help share the workload. Thomas D. Rowley, *High Insurance Premiums*

Jeopardize Rural OBs, RURAL HEALTH NEWS 9:1 (Spring-Summer 2002). Rural doctors also typically see a high percentage of Medicare and Medicaid patients, so they often get lower reimbursement levels than their urban counterparts. *Id.* Many physicians also practice defensive medicine described as “avoidance behavior,” that is, avoiding certain patients or procedures because of the risk of liability. David M. Studdert, L.L.B., Sc.D., M.P.H., et al., *Defensive Medicine Among High-Risk Specialist Physicians in a Volatile Malpractice Environment*, JAMA 293: 2609 (2005) For example, 51 of 122 OB- GYNs surveyed had stopped or were likely within two years to stop practicing obstetrics altogether, and 47 of 122 had stopped or planned within two years to stop performing specific procedures they felt were high risk, such as delivering infants, gynecologic surgery, and vaginal birth after cesarean. Studdert, et al. at 2615. These factors magnify the medical liability insurance crisis in rural areas. *Id.*

2. Missouri Crisis

In Missouri, the Missouri State Medical Association reported that more than 30 insurance companies were licensed to write medical liability insurance in 2001, but two years later in 2003, only three were willing or able to write new business. Lan Zhao, *The Impact of Medical Malpractice Reforms on Access to Hospital-Based Obstetric Services* (2005) (unpublished Ph.D. dissertation, University of Maryland (College Park)). Of those three, in 2003, one insurer raised its rates 44 percent in Missouri, while not raising rates since the mid-1990s in Kansas. M. Steele Brown and David Twiddy, *Rates Rise as Insurers Try to Catch Up with Costs*, K.C. BUS. J. (May 30, 2003). According to an

executive with the insurer, “That’s because the tort environment in Kansas is much better.” *Id.*

Of 582 physicians in the Missouri State Medical Association, the average medical liability premium increased 21 percent from 2000-2001 and an additional 61 percent from 2001-2002. Erol Amon & Hung N. Winn, *Review of the Professional Medical Liability Insurance Crisis: Lessons from Missouri*, 190 Am. J. Obstetrics & Gynecology 1534, 1535 (2004). Sixteen percent of physicians had their primary liability insurance terminated and/or application for new insurance denied; of those individuals, eighty percent were unable to find primary coverage. *Id.* As a result of increased liability premiums in 2004, Missouri obstetricians decreased high-risk obstetric care (19 percent) or stopped delivering infants altogether (12 percent). *Id.*

The U.S. Department of Justice reviewed medical malpractice insurance claims from Missouri, and found that the median insurance payouts for medical malpractice claims grew from \$33,000 in 1990 to \$150,000 in 2004, an increase of more than 350 percent. Thomas H. Cogen & Kristen A. Hughes, U.S. Department of Justice, *Medical Malpractice Insurance Claims in Seven States, 2000-2004*, Bureau of Justice Statistics Special Report, March 2007, at 8.

According to the American Medical Association crises maps for the early 2000s, approximately two-fifths of this Nation’s states were experiencing medical liability crises. *See* American Medical Association Crises Maps for July 2003, June 2004 and May 2005. From 2003 through 2005, Missouri was identified as a state in which tort reforms implemented to date have not been halting the crisis. *Id.* Although there have

been two comparable periods of instability in the last 30 years, these predecessor crises differ from the one facing the Legislature in 2005 in important ways. Niteesh K. Choudhry, David M. Studdert, and Allen Kachalia, *Physician Responses to the Malpractice Crisis: From Defense to Offense*, J. LAW MED. ETHICS (Fall 2005). First, while physicians mainly experienced dwindling options for obtaining coverage in the mid-1970s (i.e., availability) and exorbitant prices in the mid-1980s (i.e., affordability), the 2005 crisis had elements of both availability and affordability. *Id.* Because reimbursement rates for professional services tend to be tightly controlled through fee schedules or capitation arrangements, a physician's ability to raise charges to accommodate spikes in liability premiums are hampered in today's environment. *Id.* In addition, even if physicians are able to afford coverage in the current environment, some may not find any offerings. *Id.*

A 2003 survey conducted by ACOG, prior to the enactment of HB 393, revealed that 21.9 percent of its fellows in Missouri decreased the number of high-risk patients they treated as a result of the risk of professional liability claims or litigation. *2003 ACOG Survey on Professional Liability – Missouri as compared to National ACOG Statistics*, ACOG (2004). The survey also revealed that 28.1 percent of ACOG's Missouri fellows decreased the amount of high-risk obstetric care they provided because of professional liability insurance and affordability and availability issues. *Id.*

E. Effect of Tort Reform

In determining whether a statute is constitutional, this Court must look only to the constitutionality of the legislation and not to its propriety, justice, wisdom, necessity,

expediency, or policy. *State v. Day-Brite Lighting, Inc.*, 240 S.W.2d 886, 893 (Mo. 1951). Under a rational basis test, this Court does not have to determine whether the legislature should have done something different or whether there is a better means to accomplish the same goal, and certainly not whether the chosen means is the best method. *Linton v. Missouri Veterinary Medical Board*, 988 S.W.2d 513, 516 (Mo. 1999). If the question of the legislative judgment remains at least debatable, the issue settles on the side of validity. *Id.* at 816-17. Although not necessary under the rational basis test to uphold the legislation, it is of interest to note that tort reform, and in particular limitations on noneconomic damages, is not only achieving its goals, but it is having unexpected positive effects.

1. *Tort Reform Increases Resources for Necessary Health Care Services*

A 2005 study by the American Medical Association examined the effect of tort reforms that either directly affect the amount of malpractice awards, such as damage caps, and reforms that indirectly affect the amount of malpractice awards, such as caps on contingency fees or statute of limitations reform. Daniel P. Kessler, William M. Sage & David J. Becker, *Impact of Malpractice Reforms on the Supply of Physician Services*, 293 J. Am. Med. Ass'n. 2618 (2005). The study found that physician supply grew by 2.4 percent more in states that adopted reforms directly limiting liability than in states that had not adopted tort reform. *Id.* at 2623. These effects are more noticeable three or more years after the adoption of tort reform than in the first two years after adoption. *Id.*

Physicians in high-risk specialties such as neurological and thoracic surgery and obstetrics and gynecology are especially likely to move based on tort reforms. Jonathan Klick & Thomas Stratmann, *Medical Malpractice Reform and Physicians in High-Risk Specialties*, 36 J. Legal Stud. S121 (2007). Noneconomic damage caps increased the supply of doctors in the five specialties with the highest risk for medical malpractice litigation by 6.6 percent. *Id.* at S129. This positive effect diminishes to 3.9 percent when the top ten most high-risk specialties are considered. *Id.* at S131. No other reform was found to have as significant an effect as noneconomic damage caps alone. *Id.* at S131-32.

In addition, the study found that direct tort reforms such as damage caps had an even greater effect on retirement and entries to the profession than on the propensity of physicians to move between states. Kessler, Sage & Becker at 2624; *see also* Michelle M. Mello & Carly N. Kelly, *Effects of a Professional Liability Crisis on Residents' Practice Decisions*, 105 *Obstetrics & Gynecology* 1287, 1289 (2005).

Two recent reports have yielded additional evidence that tort reform reduces the use of health care services. Letter to Sen. Orrin G. Hatch from the Congressional Budget Office (CBO) Dir. Douglas Elmendorf, Oct. 9, 2009. Based in part on these reports, the latest analysis from the nonpartisan CBO estimates that government health care programs could save \$41 billion over 10 years if nationwide limits on jury awards for pain and suffering and other similar curbs were enacted. *Id.* These savings would be nearly ten times greater than the CBO estimated just last year. *Id.* Previously, the CBO had ruled that any savings would be limited to lower medical liability insurance premiums for doctors, saying there was no clear evidence that physicians would also change their

approach to treatment, but recent research has provided additional evidence that lowering the costs of medical liability tends to reduce the use of health care services. *Id.* Thus, the CBO essentially acknowledged what doctors have been arguing for years: Fear of being sued leads them to practice defensive medicine. *Id.* Ricardo Alonso-Zaldivar, *Report: Limiting Medical Lawsuits Could Save \$41B*, ASSOCIATED PRESS (October 9, 2009). As Senator Charles Grassley of Iowa, the ranking Republican on the Finance Committee, stated: “The more federal health care programs spent on unnecessary tests, the less money is available for necessary patient care.” *Id.*

In 2005, a study was published in the *Journal of the American Medical Association* that reported results of a survey of six high-risk specialties in Pennsylvania in May 2003. See David-M. Studdert, L.L.B., Sc.D., M.P.H., et al., *Defensive Medicine Among High-Risk Specialist Physicians in a Volatile Malpractice Environment*, JAMA 293: 2609-17 (2005). The specific questions studied were how often physicians changed their clinical behavior as a result of the threat of medical liability. *Id.* Ninety-three percent of the physicians who responded to the survey reported practicing defensive medicine, including ordering unnecessary imaging tests, referring patients unnecessarily to other specialties, and recommending unnecessary invasive tests. *Id.*

According to ACOG’s 2009 survey on professional liability, 62.9 percent of OB/GYNs report making changes in their practice due to the risks or fear of liability claims of litigation, and 60 percent made changes to their practice because insurance is either unavailable or unaffordable. *ACOG Releases 2009 Medical Liability Survey: Results Paint Dismal Reality for OB-GYNs and Their Patients*, ACOG (September 11,

2009). Of those reporting changes to their obstetric practices as a result of the risks or fear of professional liability claims or litigation, 30 percent decreased the number of high-risk obstetric patients that they accepted, 29 percent reported performing more cesarean deliveries, and 25.9 percent stopped offering or performing vaginal birth after cesareans (VBACs) *Id.* An additional 13.9 percent decreased the number of total deliveries. Of those OB/GYNs who reported making changes to their gynecologic practices as a result of the risks or fear of professional liability claims or litigation, 15 percent decreased gynecological surgical procedures, 5 percent ceased to perform major gynecologic surgery, and 2 percent stopped performing all surgery. *Id.* Nearly 91 percent of OB/GYNs indicated they had experienced at least one liability claim filed against them during their professional careers, for an average of 2.69 claims per physician. *Id.* Of the total reported claims for the survey period, 62 percent were for obstetric care, and 38 percent were for gynecologic care. *Id.*

2. *Physician Supply is Higher in States with Limitation on Noneconomic Damage Awards*

National data indicates that physician supply is 12 percent higher in states that impose limits on noneconomic damages compared to states that do not. F.J. Hellinger and W.E. Encinosa, *The Impact of State Laws Limiting Malpractice Awards on the Geographic Distribution of Physicians*, U.S. Department of Health and Human Services (July 3, 2003). Rural counties have appeared to have benefited the most from limitations on damages, as physician supply per capita in rural counties in states with limitations on damages is about 4 percent larger than in similar counties in states without limitations on

damages. Carol K. Kane, Ph.D., and David W. Emmons, Ph.D., *Policy Research Perspectives: The Impact of Liability Pressure and Caps on Damages on the Healthcare Market: An Update of Recent Literature*, AMA (2007). Other studies have even higher increases. For example, another study found that damage caps increased the supply of rural physicians by about 10 percent. David A. Matsa, *Does Malpractice Liability Keep the Doctor Away? Evidence from Tort Reform Damage Caps*, 36 J. Legal Stud. S143 (2007).

In addition, the number of physicians in high-risk areas of medicine per capita in states with limitations on damages is between 4 and 7 percent larger than in states without such limitations. *Id.*

In Missouri, our citizens lost the services of 225 physicians in the three years leading up to tort reform, according to figures from the Board of Healing Arts. Terry Ganey, *Doctor's Malpractice Insurance Rates Drop with Fewer Negligence Claims*, COLUMBIA DAILY TRIB. (October 4, 2009). And, despite national reports indicating that it usually take six to 10 years for the full effects of the limitation to be felt on increasing physician supply, see Carol K. Kane, Ph.D., and David W. Emmons, Ph.D., *Policy Research Perspectives: The Impact of Liability Pressure and Caps on Damages on the Healthcare Market: An Update of Recent Literature*, AMA (2007), Missouri citizens started to experience benefits after the first full year the new law was in place, when the services of 486 more doctors were added. *Id.*

Moreover, with respect to the key healthcare services for women in Missouri provided by members of ACOG, in the four years prior to the effective date of HB 393

the number remained flat at around 850 ACOG members per year. *See* ACOG Total Members from Missouri 2001 – 2008. However, with the passage of HB 393 early in 2005, ACOG membership in Missouri quickly climbed to 910 (an immediate 7 percent increase). And, by 2011, that figure climbed by another 11 percent, reaching 1007 ACOG members providing health care services to women in Missouri. *Id.*

3. *Limitations on Noneconomic Damage Awards Has Meaningful Effect on Reducing Growth of Medical Liability Insurance Premiums*

Recent studies show that medical liability premiums are lower in states with limits on noneconomic damages. Carol K. Kane, Ph.D., and David W. Emmons, *Policy Research Perspectives: The Impact of Liability Pressure and Caps on Damages on the Healthcare Market: An Update of Recent Literature*, AMA (2007). Researchers at the Lister Hill Center for Health Policy at the University of Alabama at Birmingham examined state medical liability reform legislation from 1975 to 2004 to evaluate the effects of medical liability reforms on physician liability insurance premiums, general economic conditions on liability insurance premiums, and medical liability reforms on employer-sponsored health insurance premiums. The researchers found that in states that introduced limitations on noneconomic damages, medical liability insurance premiums decreased for internal medicine by 17.3 percent, general surgery by 20.7 percent, and obstetrics/gynecology by 25.5 percent. *See* Robert Wood Johnson Foundation, *Insurance Premiums Decline in States Capping Malpractice Payouts, Alabama University Study Finds*, December 29, 2007.

The study also found that if a limitation of \$250,000.00 on noneconomic damages was introduced in all states that did not have a cap as of 2005, and was reduced to \$250,000.00 in states that have higher limits, there could be annual savings of \$1.4 billion, or 8 percent of total malpractice premium costs. *Id.* In addition, the study found that of the many types of medical liability reforms, only limitations on noneconomic damages have had a meaningful effect on reducing the growth of medical liability insurance premiums. *Id.*

4. Texas as Example of the Efficacy of Tort Reform

Texas is a good example about both the immediate and the expected long-term efficacy of tort reform. The Texas reforms implemented in 2003 provided for a limitation on noneconomic damages, product liability reform and changes to punitive damage and strict liability loss. Leary D. Weiss, M.D., J.D., F.A.A.E.M, *AAEM President's Message: Tort Reform: Our Permanent Issue*, AM. ACAD. OF EMERG. MED. (August 2008). At least five insurance companies significantly decreased the cost of premiums in Texas within the first two years after the enactment of Texas reforms. *See id.* In addition, in four years, the number of insurers offering medical liability coverage rose from 4 to 33. Eric Torbenson and Jason Roberson, *TORT REFORM: Debate Still Thrives Over Limit on Damages in Texas Malpractice Suits*, DALLAS MORNING NEWS (June 17, 2007).

By 2005, the volume of medical liability suits in Harris County (Houston) dropped to 50 percent of the 2001-2002 level. *Id.* This resulted in a net gain of 689 physicians, or 8.4 percent, in Harris County during that period of time. *Id.* In 2009, it was reported that

more than 3,000 physicians had returned to the State since the passage of Proposition 12. See David H. Sohn, J.D., M.D.; Javad Parvizi, M.D., FRCS; and Charles S. Day, M.D., M.B.A., *The Need for Tort Reform in the Current Healthcare Debate*, AAOS NOW (September 2009). According to the Texas Alliance for Patient Access, since the passage of Proposition 12, 82 Texas counties have seen a net gain in emergency medicine physicians, including 43 medically underserved counties, 29 counties that are partially medically underserved, and 33 rural Texas counties, including 24 counties that previously had none; 26 rural Texas counties have added at least one obstetrician, including 10 counties that previously had none; and 12 rural Texas counties have added at least one orthopedic surgeon, including 7 counties that previously had none. See *Eighty-Two Texas Counties See Gains in ER Docs*, TAPA (2009); *Twenty-Six Rural Texas Counties Add Obstetricians*, TAPA (2009); *Thirty-Three Rural Texas Counties See Gains in ER Docs*, TAPA (2008); *Gains in Rural Orthopedic Surgeons*, TAPA (2008); and *Twelve Texas Counties Add Obstetrician*, TAPA (2008).

In a 2008 survey of over 1,000 physicians practicing in Texas, the Texas Medical Association reported that the reduced threat of unlimited verdicts in lawsuits have made doctors more willing to accept high-risk patients and have helped bring more doctors into Texas. See Vic Kolenc, *Doctors Laud 5 Years of Malpractice Relief: Tort Reform: Keeping Physicians in Texas*, EL PASO TIMES (September 14, 2008). In addition, a survey conducted by the Texas Hospital Association in July 2008 found that 85 percent of hospitals were finding it easier to recruit medical specialists and subspecialists, and 69

percent of responding hospitals maintained or expanded services because of declining hospital liability costs. *Id.*

CONCLUSION

Based on the foregoing, *Amici Curiae* American Congress of Obstetricians and Gynecologists, Missouri College of Emergency Physicians and Missouri Association of Rural Health Clinics respectfully suggests that statutory limit on noneconomic damage awards in medical liability actions is a necessary and constitutional enactment to ensure the availability of affordable health care to Missourians.

Respectfully Submitted,

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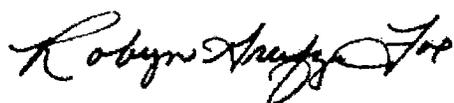
CERTIFICATE OF COMPLIANCE WITH RULE 84.06(B)

I certify that:

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2. The brief complies with the limitations contained in Rule 84.06(b);

and

3. According to the word count function of counsel's word processing software (Microsoft® Word 2007), the brief contains 7,026 words.



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CERTIFICATE OF SERVICE

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