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Case Nos. 79658, 80113, 80968

IN THE SUPREME COURT OF THE STATE OF NEVADA

VALLEY HEALTH SYSTEM, LLC, A NEVADA LIMITED LIABILITY COMPANY D/B/A CENTENNIAL HILLS HOSPITAL MEDICAL CENTER,
Appellant,

vs.

DWAYNE ANTHONY MURRAY, INDIVIDUALLY, AND AS HEIR, GUARDIAN, AND NATURAL PARENT OF BROOKLYN LYSANDRA MURRAY, AND AS SPECIAL ADMINISTRATOR OF THE ESTATE OF LAQUINTA ROSETTE WHITLEY-MURRAY,
Respondents.

Appeal from the Eighth Judicial District Court
Clark County, Nevada
District Court Case Nos. A-14-699586-C & A-14-699612-C (*Consolidated*)

AMICI CURIAE BRIEF OF AMERICAN MEDICAL ASSOCIATION AND NEVADA STATE MEDICAL ASSOCIATION IN SUPPORT OF APPELLANT

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NRAP 26.1 DISCLOSURE STATEMENT

Pursuant to Rule 26.1 of the Nevada Rules of Appellate Procedure, *Amici Curiae* American Medical Association and Nevada State Medical Association submit this Disclosure Statement:

The undersigned counsel of record certifies that the following are persons and entities as described in NRAP 26.1(a) and must be disclosed. These representations are made in order that the judges of this court may evaluate possible disqualification or recusal:

1. *Amici Curiae* American Medical Association and Nevada State Medical Association have no parent corporations, and there are no publicly held companies that own 10% or more of the organization's stock.

2. Counsel for *Amici Curiae* American Medical Association and Nevada State Medical Association is Jenn O. Hatcher, Shook, Hardy & Bacon L.L.P.

3. *Amici Curiae* American Medical Association and Nevada State Medical Association are not using pseudonyms for the purpose of this brief.

DATED this 30th day of April, 2021.

SHOOK, HARDY & BACON L.L.P.

By: */s/ Jenn Odell Hatcher*
JENN ODELL HATCHER (NV Bar # 14248)
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INTEREST OF *AMICI CURIAE*

The American Medical Association ("AMA") and Nevada State Medical Association ("NSMA") and their members have a substantial interest in the proper application of the medical liability laws, including commonsense limits on noneconomic damages the Nevada Legislature and voters have enacted to maintain rational boundaries on medical malpractice litigation in the State. These statutes are critical to promoting the health and welfare of Nevada residents by making available professional liability insurance for health care providers in the state. Without these statutes, liability insurance costs would rise, once again making health care less affordable and available for Nevadans across the state.

The AMA is the largest professional association of physicians, residents and medical students in the United States. Through state and specialty medical societies and other physician groups seated in its House of Delegates, substantially all U.S. physicians, residents and medical students are represented in the AMA's policymaking process. The AMA was founded in 1847 to promote the art and science of medicine and the betterment of public health, and these remain its core purposes. AMA members practice in every medical specialty and in every state, including Nevada. The NSMA is a Nevada non-profit corporation that represents physicians of all specialties and is the State's largest physician organization.

The AMA and NSMA appear on their own behalves and as representatives of the AMA Litigation Center. The Litigation Center is a coalition of the AMA and the medical societies of every state, plus the District of Columbia. The Litigation Center is the voice of America's medical profession in legal proceedings across the country. Its mission is to represent interests of the medical profession in the courts. It brings lawsuits, files *amicus* briefs, and otherwise provides support or becomes actively involved in litigation of general importance to physicians. *Amici*'s participation on behalf of their physician memberships will help educate the Court on the potential impact of this case on the practice of medicine in Nevada.

ISSUES PRESENTED DISCUSSED IN THIS *AMICI* BRIEF

1. Did the district court err in entering judgment against Centennial on Plaintiffs' claim for intentional breach of fiduciary duty when
    a. Nevada law does not recognize a heightened fiduciary duty owed by a hospital to a patient in the administration of medical care?
    b. Plaintiffs did not plead or present substantial evidence that Centennial's Medication Administration Procedure intentionally exploited Ms. Murray for benefit or gain?
2. Under this Court's "gravamen" jurisprudence, did the district court err in concluding that Chapter 41A's limits on noneconomic damages and joint liability do not apply to a hospital where a patient alleges injuries caused by

medication prescribed by physicians and administered by medical staff according to hospital procedures?

STATEMENT OF THE CASE AND FACTS

The facts are not in dispute with regard to the application of NRS § 41A to the jury's award of noneconomic damages, which is the focus of this *amici curiae* brief. As discussed in the trial court's order, Ms. Murray was diagnosed with sickle cell disease at a young age and had sickle cell crises periodically during which she would experience intense pain. She arrived by ambulance at the Centennial Hill Hospital emergency room during such an episode and was prescribed 30 mg of Toradol, an anti-inflammatory pain reliever. After being admitted to the hospital, she was prescribed 30 mg of Toradol to be administered by the nursing staff every six hours. According to the hospital's Medication Administration Procedure (MAP), Toradol was a "non-time critical" medication, meaning nurses had a one-hour grace period before or after the six hours to administer the drug.

Throughout the day, nurses provided the medication within the grace period before six hours elapsed, allowing her to receive a fifth dose within a 24-hour period. Thus, her total dosage exceeded the 120 mg daily maximum. Lab reports indicated kidney complications. She was taken off Toradol, but suffered a series of cardiac arrests and died in the hospital. Plaintiffs allege Ms. Murray died from complications related to this fifth dose of Toradol. In addition to bringing a medical malpractice

claim, Plaintiffs allege a breach of fiduciary duty, first based on staffing and then on the MAP. The jury returned a verdict for Plaintiffs, awarding $14.5 million in noneconomic damages and $32.42 million in punitive damages. Despite the fact that NRS § 41A limits noneconomic damages in medical liability claims to $350,000, the trial court allowed the full award to stand, concluding NRS § 41A does not apply to Plaintiffs' breach of fiduciary duty claim.

SUMMARY OF ARGUMENT

In an effort to ensure Nevadans have access to quality and affordable care, the Nevada has joined with the majority of states in enacting a separate statutory regime to govern medical liability claims such as the one at bar. In 2002, to maintain the integrity of medical liability claims and avert a medical liability crisis, the Nevada Legislature adopted Nev. Rev. Stat. ("NRS") § 41A.031, which provides upper limits on noneconomic damages of $350,000.[1] These limits were affirmed by Nevada voters in 2004. The Legislature also enacted NRS § 41A.071 to require a medical expert to provide an affidavit stating the belief that medical malpractice occurred and caused a plaintiff's alleged harm before filing such a claim and NRS § 41A.045 to reject joint liability medical malpractice claims. These laws, among

[1] Nevada's current medical malpractice damages cap statute, NRS § 41A.035, is a revision of NRS § 41A.031.

others, prevent excessive verdicts and enable liability insurance premiums to remain stable and affordable for physicians and, in turn, their patients.

Here, Ms. Murray's family is seeking to circumvent these laws by recasting their medical liability claims as violations of a fiduciary duty. This goal is understandable from their perspective; they were awarded $14.5 million in noneconomic damages and another $32.42 million in punitive damages. But, these are the exact types of large verdicts the Nevada Legislature and voters sought to avoid in an effort to maintain rational limits on the state's medical liability system.

There is no denying Plaintiffs' case sounds in medical malpractice. The crux of their allegations is Ms. Murray died because she was administered a prescription drug in a way that violated the applicable standard of care. Even if Plaintiffs had proved financial matters were factors as to why the standard of care was allegedly violated, invoking business operations cannot convert a claim based on medical judgment, care, or treatment into a non-medical claim. Courts around the country addressing this very issue have found that, in these situations, fiduciary duty claims are subsumed into medical malpractice claims and subject to medical liability laws.

Amici respectfully urge the Court to overturn the ruling below and uphold the express will of Nevada's Legislature and voters. As detailed below, the state's noneconomic damages limits protect Nevadans' access to affordable health care. The Court should not allow Plaintiffs to plead around this law or the other aspects

of this statutory regime. Patients, physicians, and other health care providers must be able to rely on Nevada courts to follow the law, even in difficult situations.

ARGUMENT

I. Noneconomic Damage Limits Provide a Rational Response to the Irrational Growth in Noneconomic Damages.

Nevada is one of more than thirty states across the country that have legislative limits on noneconomic damages. Some limits apply only in medical negligence actions such as the one in Nevada, and others apply to all personal injury cases. The reason states have limited noneconomic damages is because they are inherently subjective and unpredictable. There is "no standard for measuring pain and suffering damages, or even a conception of those damages or what they represent." Dan B. Dobbs, *Law of Remedies* § 8.1(4), at 383 (2d ed. 1993).[2]

Historically, the availability of noneconomic damages did not raise serious concern because "personal injury lawsuits were not very numerous and verdicts were not large." Philip L. Merkel, *Pain and Suffering Damages at Mid-Twentieth Century: A Retrospective Review of the Problem and the Legal Academy's First Responses*, 34 Cap. U. L. Rev. 545, 560 (2006). Further, prior to the 20th century,

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[2] *See* Restatement (Second) of Torts § 903 cmt. a (1965) ("There is no scale by which . . . suffering can be measured and hence there can only be only a very rough correspondence between the amount awarded as damages and the extent of the suffering.").

courts often reversed large noneconomic awards. *See* Ronald J. Allen & Alexia Brunet Marks, *The Judicial Treatment of Noneconomic Compensatory Damages in the Nineteenth Century*, 4. J. Empirical Legal Stud. 365, 379-87 (2007) (finding no such awards exceeding $450,000 in present dollars prior to the 20th century).

The average size of pain and suffering awards took its first leap after World War II, as personal injury lawyers became adept at finding ways to enlarge awards. *See generally* Melvin M. Belli, *The Adequate Award*, 39 Cal. L. Rev. 1 (1951); *see also* Merkel, 34 Cap. U. L. Rev. at 560-65 (examining post-war expansion of pain and suffering awards). In a nine-month period in 1957, for example, there were fifty-three verdicts of $100,000 or more. *See* Merkel, 34 Cap. U. L. Rev. at 568. Scholars began to question the proper role and measurements for pain and suffering. *See, e.g.*, Charles A. Wright, *Damages for Personal Injuries*, 19 Ohio St. L.J. 155 (1958); Marcus L. Plant, *Damages for Pain and Suffering*, 19 Ohio St. L.J. 200, 210 (1958) (proposing "a fair maximum limit" as a viable solution).

In the 1960s, plaintiffs' lawyers began the controversial (now ubiquitous) practice of summation "anchoring," suggesting to juries an extraordinary monetary value for a plaintiff's pain and suffering. *See* Joseph H. King, Jr., *Counting Angels and Weighing Anchors: Per Diem Arguments for Noneconomic Personal Injury Tort Damages*, 71 Tenn. L. Rev. 1, 13 (2003). The anchor establishes an arbitrary but powerful baseline for jurors to accept or negotiate upward or downward. *See id.* at

37-40. Empirical evidence confirms that anchoring "dramatically increases" noneconomic damage awards. John Campbell et al., *Time is Money: An Empirical Assessment of Non-Economic Damages Arguments*, 95 Wash. U. L. Rev. 1, 28 (2017). "[T]he more you ask for, the more you get." Gretchen B. Chapman & Brian H. Bornstein, *The More You Ask for, the More You Get: Anchoring in Personal Injury Verdicts*, 10 Applied Cognitive Psychol. 519, 526 (1996). By the 1970s, pain and suffering in personal injury cases became "the largest single item of recovery, exceeding by far the out-of-pocket 'specials' of medical expenses and loss of wages." *Nelson v. Keefer*, 451 F.2d 289, 294 (3d Cir. 1971).[3]

This upward trend has continued and worsened over the past few decades. Studies have shown that juries clearly struggle when attempting to assign a monetary value on pain and suffering:

> Some roughly split the difference between the defendant's and the plaintiff's suggested figures. One juror doubled what the defendant said was fair, and another said it should be three times medical[s] . . . A number of jurors assessed pain and suffering on a per month basis. . . . Other jurors indicated that they just came up with a figure that they thought was fair.

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[3] Scholars attribute this rise to the (1) availability of future pain and suffering damages; (2) rise in automobile ownership and personal injuries resulting from automobile accidents; (3) greater availability of insurance and willingness of plaintiffs' attorneys to take on lower-value cases; (4) rise in affluence of the public and a change in public attitude that "someone should pay"; and (5) better organization by the plaintiffs' bar. *See* Merkel, 34 Cap. U. L. Rev. at 553-66.

Neil Vidmar, *Empirical Evidence on the Deep Pockets Hypothesis: Jury Awards for Pain and Suffering in Medical Malpractice Cases*, 43 Duke L.J. 217, 253-54 (1993). Some juries may be influenced by whether they relate to or have sympathy for a plaintiff, rather than the plaintiff's level of the harm. *See generally* Dobbs, Law of Remedies, § 8.1(4), at 398 ("[V]erdicts vary enormously . . . invit[ing] the administration of biases for or against individual parties."). They also may award higher amounts when they have a bias against a deep-pocket defendant or desire to punish the defendant rather than compensate the plaintiff—which appear to be factors here. Over the years, plaintiffs' lawyers have become highly skilled at leveraging these dynamics to generate large awards.

The result has been substantially distorted litigation outcomes. According to the Bureau of Justice Statistics, the median damage award in medical liability jury trials in state courts, adjusted for inflation, was 2.5 times higher in 2005 ($682,000)—around the time Nevada enacted its limits on noneconomic damages—than in 1992 ($280,000). *See* Lynn Langton & Thomas H. Cohen, *Civil Bench and Jury Trials in State Courts, 2005*, at 10 tbl. 11 (Bur. of Justice Stats., Apr. 9, 2009). Medical negligence awards saw the most significant hikes in noneconomic damage awards, increasing by 44% from 2001 to 2005. *See id.* at 10; *see also* Thomas H. Cohen, *Medical Malpractice Trials and Verdicts in Large Counties, 2001*, at 1 (2004) (median award in medical malpractice cases was sixteen times greater than

the overall median award in all tort trials). Overall, pain and suffering awards in the United States are often more than ten times those in the most generous of other nations. Stephen D. Sugarman, *A Comparative Look at Pain and Suffering Awards*, 55 DePaul L. Rev. 399, 399 (2006).

Many states, including Nevada, responded to these dramatic rises in noneconomic damage awards by adopting commonsense statutory ceilings on them. Today, many states limit noneconomic damages, particularly in medical negligence cases,[4] with a few states limiting *total* damages in medical negligence cases.[5] Nevada's noneconomic damages limits are well within the mainstream. Some states have lower limits. *See, e.g.*, Cal. Civ. Code § 3333.2(b) ($250,000 limit in medical liability cases). Other states have noneconomic damage limits in the same range as Nevada.[6] In each state, the limits provide a rational response to a sustained distortion

[4] *See, e.g.*, Alaska Stat. § 09.55.549; Cal. Civ. Code § 3333.2; Colo. Rev. Stat. § 13-64-302; Iowa Code § 147.136A; Md. Cts. & Jud. Proc. Code § 3-2A-09; Mass. Gen. Laws ch. 231 § 60H; Mich. Comp. Laws § 600.1483; Mont. Code Ann. § 25-9-411; Nev. Rev. Stat. § 41A.035; N.C. Gen. Stat. § 90-21.19; N.D. Cent. Code § 32-42-02; Ohio Rev. Code Ann. § 2323.43; S.C. Code Ann. § 15-32-220; S.D. Codified Laws § 21-3-11; Tex. Civ. Prac. & Rem. Code § 74.301; Utah Code § 78B-3-410; W. Va. Code Ann. § 55-7B-8; Wis. Stat. § 893.55.

[5] *See, e.g.*, Ind. Code Ann. § 34-18-14-3; La. Rev. Stat. § 40:1299.42; Neb. Rev. Stat. § 44-2825; Va. Code Ann. § 8.01-581.15.

[6] *See, e.g.*, Idaho Code § 6-1603 ($250,000 limit in personal injury cases adjusted for inflation to $372,865 in 2019); Haw. Stat. § 663-8.7 ($375,000 limit in personal injury cases, subject to exceptions); Tex. Civ. Prac. & Rem. Code Ann. § 74.301 ($250,000 limit against single health care provider; $500,000 limit against multiple

of liability law by recognizing the broader public good is served when medical liability remains reasonable and predictable.

II. Nevada Enacted Noneconomic Damage Limits to Address a Health Care Crisis in Nevada Caused by Excessive Liability.

In the early 2000s, Nevada's Legislature and voters enacted limits on noneconomic damages for medical liability claims because the lack of such limits created an unsustainable economic environment for the practice of medicine. An uptick in the number of claims filed and a dramatic increase in noneconomic awards per claim led to a medical malpractice insurance crisis that "helped urge policy makers toward reform." Justin Shiroff, *Shielding Hippocrates: Nevada's Expanded Pleading Standard for Medical Malpractice Actions and the Need for Legislative Reform*, 12 Nev. L.J. 231, 236 (2011). The large awards creating this crisis were $6 million, $5.4 million and $4.6 million—much less than the $14.5 million in noneconomic and $32.42 million in punitive damages here. *See id.*

Medical liability insurance companies servicing Nevada significantly increased premiums or refused to write policies in Nevada altogether. *See Zohar v. Zbiegien*, 334 P.3d 402, 405 (Nev. 2014) (noting medical malpractice insurers "were quoting premium increases of 300 to 500 percent"). Faced with "skyrocketing

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providers); W. Va. Code Ann. § 55-7B-8 ($250,000 limit in medical liability cases rising to $500,000 in cases of catastrophic injury, which adjust for inflation but to no more than 150% of the statutory amounts).

insurance premiums or an absence of coverage altogether," many Nevada physicians closed their practices. Shiroff, *supra*, at 236. They were "forced to leave the state, retire early or limit their services because they [could not] find medical malpractice insurance or afford the rates for the insurance in Nevada." Patrick C. McDonnell, *Nevada's Medical Malpractice Damages Cap: One for All Heirs or One for Each?*, 13 Nev. L.J. 983, 992 (2013) (internal quotations omitted). Nevada lacked qualified doctors, particularly in needed specialties and sparsely populated areas of the state. The crisis reached a tipping point when the University Medical Center (UMC), southern Nevada's Level I Trauma Center, closed its doors to patients after a critical mass of doctors resigned because they were unable to secure malpractice insurance. Shiroff, *supra*, at 236.

The Nevada Legislature convened a special session to address this crisis. *See Zohar*, 334 P.3d at 405. Legislators explained that providing commonsense limits on noneconomic damages was "of extraordinary importance to all Nevadans" because there was "a crisis in the availability and affordability of medical liability insurance that threatens to impact access to health care." S. Journal, 18th Special Sess. (Nev. July 29, 2002) (remarks of Senator Raggio). Then-Governor Guinn, in his testimony to the Senate, said the legislation "balances the needs of injured parties, patients who seek the best medical care available and the doctors who must purchase and carry insurance to protect themselves and their patients." Hearing on S.B. 2

Before the Senate Comm. of the Whole, 18th Special Sess. (Nev. July 29, 2002). This enacted reform package included NRS § 41A.031, which limited non-economic damages for medical malpractice cases to $350,000.

However, the 2002 legislation to limit noneconomic damages proved insufficient; there were several exceptions to the limits, namely, if "exceptional circumstances" were established by clear and convincing evidence or if the physician's conduct constituted "gross malpractice." 2002 Nev. Stat., ch. 3, at 3 (18th. Special Sess.). Creative lawyers took advantage of these good faith exceptions and artfully pled around the $350,000 limits with regularity.

In response, voters adopted a ballot initiative to prevent lawyers from pleading around the noneconomic damages limits. The initiative imposed a "hard cap limiting potential noneconomic damages arising from an incident of malpractice" at $350,000 "to provide greater predictability and reduce costs for health-care insurers and, consequently, providers and patients." *Tam v. Eighth Jud. Dist. Ct.*, 358 P.3d 234, 239 (Nev. 2015). During the general election in November 2004, about 59 percent of voters approved this ballot initiative. *See* McDonnell, *supra*, at 993. Thus, limits on noneconomic damages and joint liability represent the will of the Legislature, Executive Branch, and voters throughout the state.

In 2015, the Legislature amended the noneconomic damages statute to clarify that the recovery for noneconomic damages is limited to $350,000, "regardless of

the number of plaintiffs, defendants or theories upon which liability may be based." 2015 Nev. Stat., ch. 439 § 3, at 2526. They were concerned, as here, that creative lawyers would continue searching for ways to circumvent these limits. The ruling below, therefore, violates this statement of public policy. This Court has recognized NRS § 41A.035 as constitutional. *Tam*, 358 P.3d at 242.

Since these enactments, "the medical professional liability insurance market in Nevada appears to be relatively healthy." Nev. Div. of Ins., Report on the Nevada Insurance Market, at 56 (February 2009). The number of insurance carriers in the Nevada market has increased and insurance rates have decreased. *See id.*; *see also* Nev. Div. of Ins., 2019 Insurance Market Report, at 14 (2009) ("The number of companies offering medical professional liability insurance in Nevada has been generally increasing over time."). From 2007 to 2008, four major insurance carriers in Nevada decreased insurance rates by 12%, 16.3%, 17%, and 25.8%, respectively. *See* Nev. Div. of Ins., Report on the Nevada Insurance Market, at 56. The number of medical liability cases and the amount of the awards had returned to rational bounds and allowed Nevada's health care industry to function properly.

Nevada's noneconomic damage limit of $350,000 has worked. It has balanced the "needs of injured parties, patients who seek the best medical care available and the doctors who must purchase and carry insurance to protect themselves and their

patients." *Zohar*, 334 P.3d at 405. Without it, Nevada residents face losing dependable access to quality and affordable health care.

III. These Noneconomic Damage Limits Have Proven Effective in Safeguarding Available and Affordable Health Care.

As the Nevada experience has shown, limits on noneconomic damages are effective. They lead to lower medical liability insurance premiums, higher physician supply, improved patient access to care, lower defensive medicine and health care costs, and lower claim severity and frequency. *See, e.g.*, Am. Med. Ass'n, *Medical Liability Reform NOW!*, at 11-13 (2018 ed.); Patricia Born et al., *The Effects of Tort Reform on Medical Malpractice Insurers' Ultimate Losses*, 76 J. Risk & Ins. 197 (2009); W. Kip Viscusi & Patricia Born, *Damages Caps, Insurability, and the Performance of Medical Malpractice Insurance*, 72 J. Risk & Ins. 23 (2005). Maintaining reasonable limits on subjective awards is critical for ensuring that adequate, affordable health care is available to the public, particularly in states such as Nevada that have regions where healthcare can be scarce.

First, limits on noneconomic damages increase physician supply and access to medical care. *See* AMA, *Medical Liability Reform NOW!*, at 3-4 (discussing studies). "Many studies demonstrate that professional liability exposure has an important effect on recruitment of medical students to the field and retention of physicians within the field and within a particular state." Robert Barbieri, *Professional Liability Payments in Obstetrics and Gynecology*, 107 Obstetrics &

Gynecology 578, 578 (Mar. 2006). States that limit noneconomic damages experience increases in physician supply per capita compared to states without them. *See* William Encinosa & Fred Hellinger, *Have State Caps on Malpractice Awards Increased the Supply of Physicians?*, 24 Health Aff. 250 (2005); Ronald Stewart et al., *Tort Reform is Associated with Significant Increases in Texas Physicians Relative to the Texas Population*, 17 J. Gastrointest. Surg. 168 (2013). If Nevada's medical liability climate is not stable, doctors will practice elsewhere. *See* Chiu-Fang Chou & Anthony Lo Sasso, *Practice Location Choice by New Physicians: The Importance of Malpractice Premiums, Damage Caps, and Health Professional Shortage Area Designation*, 44 Health Serv. Res. 1271 (2009).

Second, noneconomic damages limits reduce the pressure to engage in defensive medicine.[7] "[T]he fear of being sued . . . leads to an increase in the quantity of care rather than an increase in the efficiency or quality of care." Scott Spear, *Some*

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[7] *See* AMA, *Medical Liability Reform NOW!*, at 5-7 (discussing studies); Timothy Smith et al., *Defensive Medicine in Neurosurgery: Does State-Level Liability Risk Matter?*, 76 Neurosurgery 105 (Feb. 2015) (neurosurgeons are 50% more likely to practice defensive medicine in high-risk states); Manish K. Sethi et al., *Incidence and Costs of Defensive Medicine Among Orthopedic Surgeons in the United States: A National Survey Study*, 41 Am. J. Orthop. 69 (2012) (96% of orthopedic surgeons surveyed reported having practiced defensive medicine to avoid liability); Mass. Med. Soc'y, *Investigation of Defensive Medicine in Massachusetts*, at 3-5 (Nov. 2008) (finding 83% of physicians reported practicing defensive medicine and that 28% of all CT scans, 27% of MRI studies, and 24% of ultrasound studies were ordered for defensive reasons).

Thoughts on Medical Tort Reform, 112 Plastic & Reconstructive Surgery 1159 (Sept. 2003). Doctors may order costly tests to ward off potential liability, not for medical reasons. Others may eliminate high-risk procedures and turn away high-risk patients. *See* Brian Nahed et al., *Malpractice Liability and Defensive Medicine: A National Survey of Neurosurgeons*, PLoS ONE, vol. 7, no. 6, at 6 (June 2012) ("Reductions in offering 'high-risk' cranial procedures have decreased access to care for potentially life-saving neurological procedures."); Mass. Med. Soc'y, *Investigation of Defensive Medicine in Massachusetts*, at 3-5 (Nov. 2008) (finding 38% of physicians in the sample reduced the number of high-risk services or procedures they performed; 28% reduced the number of high-risk patients they saw). Overall, noneconomic damage limits and other legal reforms have led to "reductions of 5 to 9 percent in hospital expenditures without substantial effects on mortality or medical complications." Donald Palmisano, *Health Care in Crisis: The Need for Medical Liability Reform*, 5 Yale J. Health Pol'y, L. & Ethics 371, 377 (2005) (citing Daniel Kessler & Mark McClellan, *Do Doctors Practice Defensive Medicine?*, 111 Q. J. of Econ. 353 (1996)).

Third, these reforms reduce medical liability premiums, claim severity, and claim frequency. *See* AMA, *Medical Liability Reform NOW!*, at 11-13. One study found internal medicine premiums were 17.3% lower in states with limits on noneconomic damages than in states without such limits. *See* Meredith L. Kilgore,

Michael A. Morrisey & Leonard J. Nelson, *Tort Law and Medical Malpractice Insurance Premiums*, 43 Inquiry 255, 265 (2006). Surgeons and OB-GYNs experienced 20.7% and 25.5% lower insurance premiums, respectively, in states with damage limits compared to those without them. *Id.* at 268. "[T]here is a substantial difference in the level of medical malpractice premiums in states with meaningful caps . . . and states without meaningful caps." U.S. Dep't of Health & Human Servs., *Confronting the New Health Care Crisis: Improving Health Care Quality and Lowering Costs by Fixing Our Medical Liability System* 15 (2002).

Finally, noneconomic damage limits facilitate the ability of parties to reach fair settlement. *See, e.g.*, Ronen Avraham, *An Empirical Study of the Impact of Tort Reforms on Medical Malpractice Settlement Payments*, 36 J. Legal Stud. S183, S221 (June 2007) (A study of 100,000 settled cases showed noneconomic damage limits "do in fact have an impact on settlement payments."). The courts should not undermine these benefits, which represent successful public policies enacted by the Legislature and furthered by voters through a ballot initiative.

IV. The Court Should Not Allow Plaintiffs To Plead Around Nevada Medical Liability Laws and Undermine Their Benefits.

This attempt to plead medical liability claims as fiduciary duty claims is a clear effort to circumvent the mandate of the Nevada Legislature and voters. All of Plaintiffs' claims relate to the medical treatment Ms. Murray received. In fact, all of the fiduciary duty claims cited by the trial court refer to the faith, confidence and

trust Ms. Murray put in Defendants "to care and treat her." As this Court has explained, whenever allegations involve "medical judgment, diagnosis, or treatment," the claims sound in medical negligence. *Estate of Curtis v. South Las Vegas Medical Investors, LLC*, 466 P.3d 1263 (Nev. 2020) (citing *Szymborski v. Spring Mtn. Treatment Ctr.*, 133 Nev. 638, 642 (2017)). Therefore, Plaintiffs' claims must be determined based on the applicable medical standards of care and are subject to Nevada's statutory regime for medical liability claims, regardless of how the claims are artfully packaged or pled.

Courts in Nevada and other states have consistently found that in order for a patient to assert a breach of fiduciary duty claim separately from an underlying medical claim, the fiduciary duty claim must be entirely distinct from medical care or treatment. For example, in *Hoopes v. Hammargren*, the plaintiff alleged claims related to medical care and treatment, as well as for an improper sexual relationship. *See* 102 Nev. 425 (1986). The Court properly applied standards of medical care to the claims for misdiagnosis and mistreatment, and referenced fiduciary duties only in the claim for sexual advantage. *Id.* at 430-32.

The U.S. Supreme Court adhered to the same line in an ERISA case, where plaintiffs made fiduciary allegations against a health maintenance organization related to treatment decisions. *See Pegram v. Herdrich*, 530 U.S. 211 (2000) (holding plaintiffs cannot assert a separate fiduciary claim when it is tied to

allegations of improper medical treatment). The Court noted that many medical decisions involve both health care and financial considerations: "physicians' conclusions about when to use diagnostic tests; about seeking consultations and making referrals to physicians and facilities . . . about proper standards of care, the experimental character of a proposed course of treatment, the reasonableness of a certain treatment, and the emergency character of a medical condition." *Id.* at 229-230. When financial and treatment considerations are both present, regardless of how much, the fiduciary standard of care is the "malpractice standard traditionally applied" against health care providers. *Id.* at 235. Medical negligence laws govern.

The Supreme Court of Illinois echoed this ruling in *Neade v. Portes*, which involved claims that improper financial incentives led to substandard medical care. 739 N.E.2d 496 (Ill. 2000). Citing *Pegram* and other cases, the Illinois court explained that breach of fiduciary duty claims must be dismissed when mixed with medical negligence claims, calling them "duplicative." *Id.* at 506; *see also Spoor v. Serota*, 852 P.2d 1292, 1294-95 (Colo. Ct. App. 1992) ("[A]ssertion of a claim for breach of fiduciary duty against Serota would have been duplicative because the same issue was before the jury in the context of plaintiffs' negligence claims."); *Hales v. Pittman*, 576 P.2d 493, 497 (Ariz. 1978) ("We do not believe that the law in Arizona should be extended to recognize a new cause of action based on breach of trust when an adequate remedy for this case already exists.").

The courts have explained that allowing fiduciary duty claims to "constitute an impermissible recasting of a medical negligence claim" would undermine important legal protections for the health care system. *Neade*, 739 N.E.2d at 501. As here, they would vitiate statutory regimes that balance the rights of plaintiffs with the viability of a state's health care system. "To hold otherwise would permit avoidance of every statute defining the physician/patient relationship." *D.A.B. v. Brown*, 570 N.W.2d 168, 171 (Minn. Ct. App. 1997). "Indeed, it is difficult to imagine any medical malpractice claim that would not be pleaded as a breach of fiduciary duty claim in order to bypass legislative procedures" restricting medical liability claims. *Id.* As indicated, NRS § 41A was enacted to protect Nevada's health care system; it represents proper legislative balancing.

Further, allowing the claims at bar would undermine the ability of health care providers to be judged based on the applicable standards of medical care for their medical judgment, diagnosis, or treatment decisions. The result would be an expansion of medical liability untethered from whether medical negligence actually occurred. Commentators have appreciated that one of the most difficult tasks for jurors is to "differentiate between adverse events and medical errors." David Sohn, *Negligence, Genuine Error, and Litigation*, 6 Int'l J. Gen. Med. 49, 50 (2013). According to a Harvard Public Health Study, only about 27 percent of adverse events are caused by negligence. *See* T. A. Brennan et al., *Incidence of Adverse Events and*

Negligence in Hospitalized Patients, 13 Qual. Saf. Health Care 145, 146 (2004). Without proper medical standards, a jury sitting in hindsight would be more likely to determine that when a patient experiences a poor outcome, it is the result of "incompetence, folly, or worse." Michael A. Haskel, *A Proposal for Addressing the Effects of Hindsight and Positive Outcome Biases in Medical Malpractice Cases*, 42 Tort & Ins. Prac. L.J. 895, 906 (2007).

Allowing medical judgment, care or treatment claims to be decided on fiduciary, rather than medical liability laws and standards of care, would make liability against health care providers medically rudderless. The gains achieved through Nevada's medical liability statutes, which include limits on noneconomic damages and a certificate of merit requirement, would be in jeopardy. The Court should not open the door to more meritless and excessive lawsuits against health care providers and unnecessarily costly litigation that will thwart the intent of the Legislature and voters in establishing the State's medical liability regime.

CONCLUSION

For these reasons, *amici curiae* respectfully urge the Court to reverse the ruling below and hold that NRS § 41A applies to all claims involving the delivery of medical care or treatment, or the exercise of medical judgment.

DATED this 30th day of April, 2021.

SHOOK, HARDY & BACON L.L.P.

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CERTIFICATE OF COMPLIANCE

Pursuant to Rule 28.2 of the Nevada Rules of Appellate Procedures, I, Jenn O. Hatcher, certify that this brief complies with the formatting requirements of NRAP 32(a)(4), the typeface requirements of NRAP 32(a)(5) and the type style requirements of NRAP 32(a)(6) because it has been prepared in a proportionally spaced typeface using Microsoft Word 2016 in 14-point Times New Roman.

I further certify that this brief complies with the page- or type-volume limitations of NRAP 32(a)(7) because, excluding the parts of the brief exempted by NRAP 32(a)(7)(C), it is proportionally spaced, has a typeface of 14 points, and contains 5,362 words.

I hereby certify that I have read this *amici* brief, and to the best of my knowledge, information, and belief, it is not frivolous or interposed for any improper purpose. I further certify that this brief complies with all applicable Nevada Rules of Appellate Procedure. I understand that I may be subject to sanctions in the event that the accompanying brief is not in conformity with the requirements of the Nevada Rules of Appellate Procedure.

DATED this 30th day of April, 2021.

SHOOK, HARDY & BACON L.L.P.

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CERTIFICATE OF SERVICE

Pursuant to NRAP 25(c), I hereby certify that on the 30th day of April, 2021, I electronically filed the foregoing ***AMICI CURIAE* BRIEF OF AMERICAN MEDICAL ASSOCIATION AND NEVADA STATE MEDICAL ASSOCIATION IN SUPPORT OF APPELALNT** with the Clerk of the Court by using the CM/CMF system which will send a notice of electronic filing and service upon the Court's Service List for the above-referenced case.

/s/ Jenn Odell Hatcher
JENN ODELL HATCHER