IN THE SUPREME COURT OF THE STATE OF OREGON

SCOTT RAYMOND BUSCH, Plaintiff-Appellant, Respondent on Review, and DEANNE MARIE BUSCH, Plaintiff, v. MCINNIS WASTE SYSTEMS, INC., Defendant-Respondent, Petitioner on Review.	Multnomah County Circuit Court Case No. 15CV13496 Court of Appeals No. A164158 Supreme Court No. S066098

BRIEF OF *AMICI CURIAE* OREGON MEDICAL ASSOCIATION, AMERICAN MEDICAL ASSOCIATION, AND AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS IN SUPPORT OF MCINNIS WASTE SYSTEMS, INC.

On Review of a Decision of the Court of Appeals
on Appeal from a Judgment of the Multnomah County Circuit Court,
by the Honorable Michael A. Greenlick

Court of Appeals opinion filed: July 18, 2018
Author: Ortega, P.J.
Concurring: Garrett and Powers, J.

(Continued) October 2019

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TABLE OF CONTENTS

Page

INDEX OF AUTHORITIES

Page

Cases

Statutes

Other Authorities

Constitution

I. INTRODUCTION AND INTEREST OF *AMICI CURIAE* OMA/AMA/ACOG

This case involves significant issues, including whether the noneconomic damages limit in ORS 31.710, as applied, is a constitutional exercise of the legislature's authority and whether it violates the remedy clause in Article I, section 10, of the Oregon Constitution. Because it provides a remedy, the limit on noneconomic damages for personal injury actions is constitutional; it is an appropriate, not arbitrary, action by the legislature to further an important public interest, and it should not be disturbed by the court. The legislature must be given latitude to enact reforms to address the changing needs and circumstances of our healthcare system, including how patients injured by medical negligence are compensated. The rule of law announced will affect possibilities for continued healthcare reform, and, as evidence before the legislature just this year showed, the very availability of healthcare for those who need it most. Reaching the correct answer is imperative.

This court should not put access to healthcare for innumerable Oregonians at risk in favor of invalidating the limit on damages in a single case. Taking action to address social issues of the day, including healthcare reform, requires an agile and effective legislative body. This court should not do what the legislature refuses to do, nor should it turn back the clock on healthcare in Oregon.

The Oregon Medical Association (OMA) is a private, not-for-profit, professional association of physicians organized for the purpose of serving and supporting physicians in their efforts to improve the health of Oregonians and the safety of patients.

The American Medical Association (AMA) is the largest professional association of physicians, residents, and medical students in the United States. Additionally, through state and specialty medical societies and other physician groups seated in its House of Delegates, substantially all physicians, residents, and medical students in the United States are represented in the AMA's policy-making process. The AMA was founded in 1847 to promote the science and art 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 Oregon.

The AMA joins this brief on its own behalf and as a representative of the Litigation Center of the American Medical Association and the State Medical Societies. The Litigation Center is a coalition among the AMA and the medical societies of each state, and the District of Columbia. Its purpose is to represent the viewpoint of organized medicine in the courts.

The American College of Obstetricians and Gynecologists (ACOG) is the nation’s leading group of physicians providing health care for women. With more

than 58,000 members, representing obstetricians-gynecologists in the United States, including in the State of Oregon, ACOG advocates for quality health care for women, maintains the highest standards of clinical practice and continuing education of its members, promotes patient education, and increases awareness among its members and the public of the changing issues facing women's health care.

The defendant in this case happens to be the owner of a garbage truck; however, it could very well be another type of essential service provider such as a doctor, dentist, or day care provider. The rule of law framed in this case will affect how ORS 31.710(1) is applied in negligence actions against medical providers, and many others. There are real implications, not just in litigated claims and exposure, but in Oregonians' access to essential services, including healthcare.

The OMA/AMA/ACOG appear as *amici curiae* in support of McInnis Waste Systems, Inc.'s (McInnis) arguments that the limit in ORS 31.710(1) is constitutional as applied to plaintiff's recovery in this case. The *Amici* address the court's role in interpreting the remedy clause and argue that it should be construed in a way that, as intended, does not affect the legislature's power to innovate and improve the quality of life and services for Oregonians. Specifically, the *Amici*

address the impact the noneconomic damages limitation has on the important patient safety policy objectives of access to and the provision of medical care.

A. Challenges Facing Healthcare Access and the Medical Community.

Amici are committed to providing high quality medical care to their patients. "Unlike the market for almost any other product or service, the market for medical care is one in which all individuals inevitably participate." *Nat. Fedn. of Indep. Businesses v. Sebelius*, 567 US 519, 590-91, 132 SCt 2566, 183 LEd2d 450 (2012) (Ginsburg, J., concurring in part, concurring in the judgment in part, and dissenting in part).

Physicians provide quality health care to patients, in many cases serving patients in unideal or complex circumstances. While physicians continue to provide quality healthcare to their patients as they have done for centuries, the burdens on the profession continue to increase. No one does their best work while under duress, and physicians are no exception. For all patients to be able to receive quality health care and for our medical system to continue functioning, there must be reasonable limits on liability.

The path to becoming a physician is significantly different than it once was. It takes years of graduate education and residency, often followed by specialty fellowship training before a physician settles in to practice. This may take a decade to complete. New physicians carry an average of $200,000 in student loan

debt.[1] Physicians today face a different and changing climate with respect to the public perception of doctors, healthcare, how it is delivered, paid for, and their own personal liability risks.

Many of today's physicians expect to be sued during their careers. Anupam B. Jena, *et al*, *Malpractice Risk According to Physician Specialty*, 365 N Engl J Med 629, 629-636 (2011). This likelihood increases for certain specialities, including those that often provide lifesaving care. *Id*. The majority of lawsuits for medical malpractice are not meritorious. Anupam B. Jena, *et al*. *Outcomes of Medical Malpractice Litigation Against US Physicians*, 172:11 Arch Intern Med 892, 893 (2012). In a state like Oregon, which does not have pretrial expert discovery or a pre-filing affidavit of merit requirement, it takes significant resources to evaluate and defend malpractice claims, even those that are unfounded. The personal and professional toll that litigation has on an accused doctor cannot be understated. In turn, it has an effect on the overarching healthcare system.

While the risk of liability has continued to increase, there are physician shortages throughout the country, including in states like Oregon. The shortage is especially pronounced for rural areas and for underserved populations. Lack of access is a public health crisis, one that is exacerbated when needed boundaries,

[1] *See* American Association of American Medical Colleges, available at: https://store.aamc.org/downloadable/download/sample/sample_id/240/.

such as limits on noneconomic damages, are eliminated. Office of the Assistant Secretary for Planning and Evaluation, U.S. Dep't of Health and Human Servs., *Addressing the New Health Care Crisis: Reforming the Medical Litigation System to Improve the Quality of Health Care,* 11 (2003). It is no surprise that even with the strongest defense a settlement may be paid, even to policy limits, because the risk of trial becomes too great when confronted with the possibility for unlimited damages and the personal toll on providers or families. This reality creates perverse incentives and can encourage litigation of claims that are not meritorious.

It is no surprise that the Oregon legislature has enacted reforms to address these concerns, including unpredictability, and the real costs to the public of unlimited noneconomic damages awards. The legislature is not and should not be restrained in acting by the remedy clause. Nor is access to care or the public health served by a construction of the Oregon Constitution that prevents the legislature from responding to the changing needs of all Oregonians.

II. ARGUMENT

A. The Appropriate Starting Point.

The legislature's judgment in enacting the limit should not be subject to judicial reexamination. "A proper analysis begins with the understanding that ORS [31.710] is presumptively constitutional, and that [the court] cannot declare a law that the legislature has passed in the best interests of all of the citizens of

Oregon unconstitutional except when the unconstitutionality is clearly shown." *Tenold v. Weyerhaeuser Co.,* 127 Or App 511, 530, 873 P2d 413 (1994), *rev dismissed,* 321 Or 561 (1995) (Edmonds, J., concurring) (citing *Bowden v. Davis*, 205 Or 421, 289 P2d 1100 (1955); *see also, Jehovah's Witnesses v. Mullen*, 214 Or 281, 293, 330 P2d 5 (1958), *cert den*, 359 US 436, 79 S Ct 940, 3 L Ed 2d 932 (1959). In other words, without clear constitutional prohibition, the remedy clause has nothing to say about challenged legislation and the inquiry is over.

When examined in light of Oregon's unique methodology, it is evident that the remedy clause was not intended as a means to tie the hands of the legislature. *See e.g.*, pp 13-23 of OMA/AMA brief filed in *Vasquez v. DoublePress Mfg. Inc.*, S065574, on May 24, 2018. Neither the language nor the relevant history supports such a premise. *Horton v. OHSU*, 359 Or 168, 219, 376 P3d 998 (2016) ("the remedy clause does not protect only those causes of action that pre-existed 1857, nor does it preclude the legislature from altering either common-law duties or the remedies available for a breach of those duties."). A deferential approach to the legislative body tasked with advancing public health is consistent with how the other clauses of Article I, section 10 are interpreted and how the remedy clause was interpreted pre-*Smothers*, and in *Horton*, and should be interpreted here.

Whether viewed through the lens of a *quid pro quo*, or simply the policy role of the legislature, the choice to enact a limit on noneconomic damages was

intended to produce a public benefit, which is still needed. An analysis that considers *why* the legislature acted compels the conclusion that ORS 31.710(1) is constitutional.

The legislature defines the duty physicians owe to their patients. ORS 677.095. In enacting the limit on damages, the legislature did not alter that duty or eliminate a cause of action or remedy. It also did not affect economic damages, which remain unlimited. Rather, it imposed a limit on noneconomic damages for a breach of such duties as part of a comprehensive statutory scheme intended to extend benefits to some persons while adjusting benefits to others and advancing a public purpose. *Horton*, 359 Or at 223-24 (legislature recognized that damages available under the OTCA would not provide a complete remedy to everyone injured; however the increased limits provide complete recovery in many cases and expand the state's liability, and advance the purposes of sovereign immunity and ensure a solvent defendant available to pay a plaintiff's damages); *Vasquez v. DoublePress Mfg. Inc.*, 364 Or 609, 629-33, 437 P3d 1107 (2019) (recognizing that enactment of SB 323 was a part of a larger package of legislation and that one of its purposes was to "improve the justice system").

The legislature made a policy determination in light of the public benefit conferred that the recovery of $500,000 in noneconomic damages was a sufficient remedy. The $500,000 limit was designed to be sufficient for decades to come.

Michelle M. Mello, JD, PhD & Allen Kachalia, MD, JD, *Medical Liability Reform in Oregon: Possibilities, Costs, and Benefits*, A Report to the Oregon Health Authority, 11 (January 2, 2012).[2] The limit is a reflection of legislative policy; it was designed to endure well into the future, and will continue be an effective limit if upheld.

B. A Workable Test with Guidance to Lower Courts is Needed.

Case by case determination of the application of the limit undermines any purpose of providing predictability and cannot be squared with legislative intent. However, if the court is going to countenance individualized review of damages awards, there must be a workable test that lower courts can apply without need for every case to come to the appellate courts.

Amici join McInnis's arguments that where economic damages are fully recovered and noneconomic damages are available up to the legislative limit, the remedy afforded is constitutional. Although the court needs to look no further, should it do so, *amici* urge the proper application of Article I, section 10, as follows.

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[2] Available at: https://www.oregonlegislature.gov/citizen_engagement/Reports/2012_OHA_Medical%20Liability%20Reform%20in%20Oregon%20-%20Possiblities,%20Costs,%20and%20Benefits.pdf.

1. A "Substantiality" Test is rooted in Misconception and is Ill-Advised.

Recognizing the important public interests at stake, it is appropriate to revisit the basic departure from constitutional construction that initiated the court's inconsistent application and interpretation of the remedy clause. *Horton*, 359 Or at 187-88 (overruling *Smothers v. Gresham Transfer, Inc*., 332 Or 83, 23 P3d 333 (2001) and finding that the central premise of the decision finds no support in the text and history of Article I, section 10, and continues to prove problematic). Pre-*Smothers*, the court properly allowed the legislature latitude to legislate for the public good. *Horton*, 359 Or at 193-94 (cases following *Perozzi v. Ganiere,* 149 Or 330, 40 P2d 1009 (1935) interpreted it as holding that Article I, section 10, does not deny the legislature latitude to modify and sometimes eliminate common law duties where changing conditions warrant, citing *Noonan v. City of Portland*, 161 Or 213, 249, 88 P2d 808 (1939)). The early cases recognized the imperative of allowing legislative flexibility.

Horton allows for the principle the remedy clause only requires a remedy that is not "paltry" or worthless. A careful reading of *Horton* supports the conclusion that if a claim for injury to person, property, or reputation exists, there must be some remedy afforded the injured party. Precedent does not require the court to weigh, balance or determine what it means in a particular case that a

plaintiff have a "substantial" remedy because all that is required is that the remedy not be paltry.

Indeed, separation of powers forbids such a judicial exercise. *Horton* foretells that "substantiality" is not required in order for a remedy afforded by the legislature to be constitutional, although the concept infiltrated remedy clause jurisprudence over the years and became tainted by *Smothers*. *Horton* took care to say that "the substantiality of the legislative remedy *can* matter in determining whether the remedy is consistent with the remedy clause." 359 Or at 221 (emphasis added). It did not state that it *must* be the measure, and for good reason.

The "substantiality" test, articulated as such for the first time in 1995 in *Greist v. Phillips*, has suffered the fate and realized the flaws cautioned by Justices Unis and Fadeley. 322 Or 281, 906 P2d 789 (1995). Justice Unis took the majority to task, telegraphing the problems now evident as the courts struggle to apply substantiality as a marker of constitutionality: "In my view, the 'substantial' test adopted by the court in this case is an unclear, imprecise, and flawed basis for applying the Oregon constitutional remedy guarantee clause." *Id.* at 311 (Unis, J., concurring). Justice Unis noted that the test "calls for the comparison of immeasurables," that it is vague and provides no guidance to legislators, litigants, or citizens about how the court will apply it and further will

lead to "haphazard" results. *Id.* at 311-14. Indeed, in seeking to flesh the remedy clause out or provide factors or circumstances that inform the analysis here, the court would be engaging in judicial legislation of a statute designed for broad application.

Justice Unis disagreed that the majority's reliance on "substantial" flowed from the passage it was based on in *Hale v. Port of Portland*, 308 Or 508, 523, 783 P2d 506 (1989), and otherwise found the decision problematic:

> "In this case, the court's interpretation of Article I, section 10, of the Oregon Constitution (the "remedy guarantee clause") does not, in my view, meet those criteria [for appropriate constitutional interpretation]; it is another individually tenable but inconsistent opinion about the remedy guarantee clause."

Id. at 303 (footnote omitted).

Justice Fadeley warned that the "discussion of whether a statutory remedy is 'substantial'—a discussion engaged in to support the argument that less than a full remedy may be substituted for a full one by act of the legislature—is unnecessary and wide of the mark." *Id.* at 301.

Those shortcomings are manifest in how trial courts reacted after *Horton*. They were asked to apply ORS 31.710(1), the lack of appellate guidance with respect to how trial courts were to make substantiality determinations in individual cases was consistently cited as a problem. The problems are no less when this Court is asked to engage in a similar analysis. The framers would not

have understood that the analysis of constitutionality would be reduced to "case by case" valuations.

Even more problematic is the reality that

> "[a] determination that a particular remedy is 'substantial' necessarily is a policy decision. Asking this court to decide whether a particular remedy is 'substantial' places this court in one of two untenable positions: either this court defers to the legislative judgment that a particular remedy is 'substantial,' thus negating any meaningful judicial review, or this court substitutes its own judgment as to whether it believes that the remedy afforded by the legislature is adequate, leading to, in effect, judicial legislation."

Greist, 322 Or at 312 (Unis, J., concurring). Substantiality is not a requirement articulated in the Constitution. The requirement's origin in Oregon jurisprudence can be traced to *dicta* in *Hale.*

It was rejected and disappeared from analysis during the reign of *Smothers*, and appears again in *Horton*. The reintroduction of substantiality in *Horton* is by no measure secure and gives way entirely with the weight of principles of constitutional interpretation. Article I, section 10 does not contain a modifier indicating the character or type of the remedy afforded, only that there is one. Whether the modifier is "substantial" or "paltry" or "adequate" – all stray from the text and none are needed.

Greist held the plaintiff was not left without a remedy, and in fact, acknowledged the remedy afforded was "substantial," without any real discussion or analysis indicating that substantiality is required, though it existed in the

application of ORS 31.710(1). 322 Or at 291. *Horton* tiptoed around "substantiality." This court should continue the work begun in *Horton* and heed Justice Unis's call to reexamine whether substantiality has *any* bearing on the legislature's plenary authority to shape remedies. *Id.* at 312 ("I believe that this court should reconsider any analysis based on an evaluation of whether a remedy is 'substantial.'").[3]

2. Deference is a Better Test.

All that is required by the Oregon Constitution is that there be a remedy. Here, plaintiff recovered all of the economic damages proven and noneconomic damages up to the statutory limit. The law recognizes a remedy, plain and simple. It need not be substantial or paltry; it must simply be something for the loss that was caused by the defendant. Paltry means that the remedy is so small as to be no remedy at all. An unlimited award of economic damages or a noneconomic damages award of $500,000 cannot be considered paltry, whether alone or combined. Either actually affords the injured party a remedy, which is all that is

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[3] Justice Unis also took on the problem in how to measure substantiality:

> "Is it measured in reference to a plaintiff's actual injuries, or is it measured by an abstract conclusion that a particular remedy is "substantial" as to a particular class of injuries? Is the "substantiality" of a remedy to be measured by reference to economic damages or by both economic and noneconomic damages? How do you determine substantiality in relation to the history of the remedy for the particular legally cognizable injury?"

322 Or at 311-12.

required by Article I, section 10. Whether the remedy is "substantial" is not a proper consideration to a true reading of the clause. A principled approach that is faithful to the remedy clause is one that allows the legislature to act in its role and the court to consistently apply its methodology. That approach results in deference to the legislative decision that does not run afoul of the Oregon Constitution.

C. The Need for Limits on Noneconomic Damages Remains.

1. The Scope of Physician Liability Has Expanded.

Recent Oregon decisions have expanded the professional liability of physicians, more broadly than ever before. Just within the last few years, courts in Oregon have recognized new theories of liability against physicians. *See, e.g*., *Smith v. Providence Health & Services—Oregon*, 361 Or 456, 393 P3d 1106 (2017) (recognizing a cause of action based on the loss of an opportunity for a better outcome); *Tomlinson v. Metropolitan Pediatrics, LLC*, 362 Or 431, 412 P3d 133 (2018) (permitting a claim against medical providers for failure to diagnose in favor of non-patients. Cases like *Philibert v. Kluser*, 360 Or 698, 385 P3d 1038 (2016), are urged as support for claims for emotional distress brought by family members involved or present for a patient's medical care, leading to dramatically increased prayers for noneconomic damages.

Court decisions such as these increase claims against medical providers. Physicians are already sued at high rates, and many claims lack merit. Claims continue to be increasingly costly to defend. Jose Guardado, *Medical Professional Liability Insurance Premiums: An Overview of the Market 2009-2018*, AMA Policy Research Perspectives 1, 5 (2018).[4] This climate does not allow medical liability premium rates to decrease. Jose Guardado, *Medical Professional Liability Insurance Indemnity Payments, Expenses and Claim Disposition 2006-2015*, AMA Policy Research Perspectives, 1, 5 (2019).[5] Whereas in 2009 nearly thirty six percent of premiums rates decreased, in 2018 only five percent decreased. *Id.* Conversely, the number of rates that increased in 2018 was double the number that increased in 2009. *Id*. Exposing healthcare providers to more litigation for unlimited amounts undermines the resolution of meritorious claims and exacerbates such problems and undermines the access and availability of services.

[4] Available at: https://www.ama-assn.org/practice-management/sustainability/medical-liability-market-research.

[5] Available at: https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/government/advocacy/policy-research-perspective-liability-insurance-claim.pdf.

2. Despite Ample Opportunity and Frequent Consideration, the Legislature has not Altered the Limit on Noneconomic Damages.

The legislative function continues in real time. ORS 31.710 was first enacted in 1987; it has remained on the books since that time for over thirty years, despite the court's lunges and retreats. Although this Court invalidated it as applied to certain cases in 1999 and 2000, the legislature has never rescinded or even amended it. Instead, over the years, the legislature has actively continued to hear proposals and evidence about why it is or is not needed. This important legislative function and activity should not go unnoticed or be disregarded.

Most recently, during the 2019 session, bills were considered that would increase the limit, repeal it altogether, or limit its application to certain types of cases. None of the proposed changes were enacted. The arguments made in the 2019 legislative session as to why the limit on damages is necessary gave the policy-making branch the opportunity to hear once again why the limit on damages is needed to avoid further public health crises in Oregon.[6]

Evidence was submitted from myriad medical providers about the need to retain the limit to enable access to quality healthcare. The American College of Obstetricians and Gynecologists (ACOG) and its 530 practicing Oregon members told the legislature the grave affects repeal of the limit would have, stating it

[6] The testimony and exhibits presented on HB 2014 are available at: https://olis.leg.state.or.us/liz/2019R1/Measures/Overview/HB2014.

"would turn back the clock on women's health care in our state."[7] ACOG stated that Oregon has made investments in prenatal, obstetric, post-partum, and well-woman healthcare services which serve as an investment in Oregon's present and future. Repealing the limit threatens that investment. *Id*.

Medical liability costs contribute to the difficulty in maintaining the financial viability of women's healthcare practices and to recruitment and retention of practitioners. ACOG stated that the proposed bill would lead to: less prenatal care, shorter visits and longer waits, decreased availability of gynecological surgery, less preventative health, less care for the underserved, and less training for women's health. *Id.* The Oregon chapter of the American College of Emergency Physicians as well as other practitioners, medical students, and the OMA, joined those views, asking the legislature not to unwind the gains that have been made. Testimony, House Committee on Judiciary, HB 2014, March 5, 2019 Exhibit 5 (statement of Bryan Boehringer)[8]; Exhibit 6 (statement of

[7] Testimony, House Committee on Judiciary, HB 2014, March 5, 2019, Exhibit 7 (testimony of Dr. Carrie Miles), available at: https://olis.leg.state.or.us/liz/2019R1/Downloads/CommitteeMeetingDocument/168306.

[8] Available at: https://olis.leg.state.or.us/liz/2019R1/Downloads/CommitteeMeetingDocument/168284

Kevin Reavis)[9]; Exhibit 17 (statement of Katy King)[10]; Exhibit 15 (statement of Drew Hagedorn).[11]).[12]

Also, a physician testified about the enormous burden of being the target of a malpractice action.[13] The physician testified about their personal experience as a defendant in a nearly $47 million lawsuit which arose from a 20-minute visit with the plaintiff's mother. Even though the jury found for the defense, the stress on the doctor, their partners, patients, and family was "terrifying" and they considered leaving Oregon and the practice. *Id*. This is but one example of the

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[9] Available at: https://olis.leg.state.or.us/liz/2019R1/Downloads/CommitteeMeetingDocument/168282

[10] Available at: https://olis.leg.state.or.us/liz/2019R1/Downloads/CommitteeMeetingDocument/167256

[11] Available at: https://olis.leg.state.or.us/liz/2019R1/Downloads/CommitteeMeetingDocument/167589

[12] Also instructive was testimony from an actuary about effects of the cap on insurance premiums and damages amounts. The actuary testified about the impact repealing the cap would have on professional liability insurance and provided evidence of the spike in premiums that occurred following *Lakin*. Audio Video Recording, Senate Committee on Judiciary, HB 2014, May 6, 2019, at 1:15:56, (Comments of Susan Foray), available at: http://oregon.granicus.com/MediaPlayer.php?clip_id=9217836f-5a0d-454a-af45-12ed7e0ed8b7&meta_id=5cf23ebe-4438-4d24-b3ac-ee81b0345a54 (accessed Oct 15, 2019).

[13] Audio Video Recording, Senate Committee on Judiciary, HB 2014, May 6, 2019, at 1:26:35 (comments of Dr. Carrie Miles), available at: http://oregon.granicus.com/MediaPlayer.php?clip_id=9217836f-5a0d-454a-af45-12ed7e0ed8b7&meta_id=5cf23ebe-4438-4d24-b3ac-ee81b0345a54 (accessed Oct 15, 2019).

many physicians who are sued every year in Oregon with similar experiences. The toll this process takes and the uncertainty it thrusts upon the professionals we all rely on is oppressive and unyielding and contributes to shortages in those who wish to enter the these professions.

D. The Damages Limitation is Beneficial to Healthcare in Oregon.

The legislature has a legitimate interest in guaranteeing access to quality health care for all Oregonians. Asked to upend the limit in the 2019 legislative session, the legislature refused, in part based on the evidence about the effect on Oregon healthcare. Limits on noneconomic damages have a positive impact, for example, improved access to care, improved physician supply, improved delivery of healthcare in rural areas, and the elimination of waste in the system. The legislature is permitted to achieve a balance in providing adequate and ongoing benefits to the public and also compensating those unintentionally injured.

1. <u>Improving Physician Supply for Patients</u>.

There are two parts to this issue. The first is simply having enough medical providers to meet the needs to ensure an appropriate level of access to care for all. The second is attracting the best and brightest to practice in Oregon, including in its rural areas. All Oregonians have a vested interest in ensuring a steady flow of knowledgeable and skilled physicians are available and willing to provide care. The omnipresent cloud of potential liability impacts where physicians decide to

practice, their chosen specialty, what procedures they will perform and in certain cases even *if* they will practice at all. Brenda E. Sirovich, MD, MS, Steven Woloshin, MD, MS, & Lisa M. Schwartz, MD, MS, *Too Little? Too Much? Primary Care Physicians' Views on US Health Care*, 171:17 Archive of Internal Medicine 1582 (2011); *see also Massachusetts Medical Society's 2013 Physician Workforce Study Shows Physician Shortages, Difficulty in Recruiting*, Massachusetts Medical Society (2013).[14]

Like the rest of the country, Oregon is experiencing a shortage of providers in many areas and specialities. *See Oregon Areas of Unmet Health Care Need Report*, Oregon Office of Rural Health (2019).[15] As an example, obstetrics, a field that experiences extremely high liability exposure, continues to be an under-filled speciality in Oregon. This adversely affects neonatal and maternal health, infant mortality, and complications during delivery. Ariel K. Smits, et al, *Change in Oregon Maternity Care Workforce after Malpractice Premium Subsidy Implementation*, 44:4 Health Services Research, 1254 (August 2009).

Oregon is not alone; there are nationwide shortages that adversely affect the delivery and quality of care. *See* William F. Rayburn, MD, MBA, FACOG, *The*

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[14] Available at: http://www.massmed.org/News-and-Publications/MMS-News-Releases/Massachusetts-Medical-Society-s-2013-Physician-Workforce-Study-Shows-Physician-Shortages,-Difficulty-in-Recruiting/#.Xa94uehKiUk

[15] Available at: https://www.ohsu.edu/sites/default/files/2019-08/2019%20Areas%20of%20Unmet%20Health%20Care%20Needs%20Report.pdf.

Obstetrician-Gynecologist Workforce in the United States: Facts, Figures, and Implications, 2017, ACOG, 4 (2017) (half of the counties in the United States already do not have any obstetrician-gynecologists). Shortages often occur in areas and ways that affect the most vulnerable populations. For example, the shortage of OBGYNs and family practice physicians greatly affects access to healthcare for women and underserved communities. Shortages increase with increased risk for liability. Eric Helland & Mark H. Showalter, *The Impact of Liability on the Physician Labor Market*, 52:4 Journal of Law and Economics 635, 655 (2009).

2. Access and Delivery of Healthcare.

Access to care is an evolving problem in Oregon, as elsewhere.[16] It does not only affect rural areas as explained below, but also occurs more generally with

[16] For example, there is grave concern that changed national policy and rulemaking will have serious and deleterious effects on the access and availability of healthcare, particularly for women and children and those in underserved areas. This Court should not assist the regression of the gains achieved that are now threatened by the Administration.

One example of regression is the drastic regulatory changes by HHS on Title X. Title X is an extremely successful, nearly 50 year-old program that supports vital reproductive health services for millions of low-income individuals. A Final Rule issued by HHS earlier this year, however, threatens to undo progress and decimate the program. Because of this, the AMA joined by the OMA, Oregon's Attorney General, together with AGs from 20 states and DC, Planned Parenthood, and others, filed suit to prevent the Final Rule from taking effect because of the irreparable harm it would cause. *State of Oregon v. Azar, et al*, US Ct of Appeals for Ninth Cir. No. 19-35386. The central issues for the medical practitioners and organizations involved include: access to care, the effect of

respect to certain specialties. As an example, Oregon is sorely lacking in the substantial number of mental health practitioners needed to care for our population. *See e.g.*, American Psychiatric Nurses Association, *Expanding Mental Health Care Services In America*, An Information Report Prepared by the American Psychiatric Nurses Association (2019);[17] *Oregon Areas of Unmet Health Care Need Report*, Oregon Office of Rural Health (2019). As the stigma of mental health is lessening and more people seek the care they need, the delivery system must adapt and the legislature must also be able to keep up. *See e.g.*, ORS 426.005 to 426.390 (statutory scheme providing civil and criminal immunity for medical providers and others involved in mental health assessments, holds, and commitments).

Oregon is a rural state, with the majority of its land area designated rural under federal and state standards. Smits, *et al*, Health Services Research at 1254. According to the Office of Rural Health, patients residing in rural areas make up a large percentage (34.9 percent) of Oregonians. Rural residents are most effected

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physician shortages on women's healthcare, and interference in the physician-patient relationship. Although raised in a different context, the concerns are present here.

Three district courts, including the District of Oregon, granted the plaintiffs' motion for a preliminary injunction, making detailed findings about the harms that would occur if the Final Rule takes effect. *See* Opinion and Order, US Dist Ct of Oregon, No. 6:19-cv-00318-MC, ECF #61, McShane, J., April 29, 2019.

[17] Available at: https://www.apna.org/files/public/Resources/Workforce_Development_Report_Final_Draft_6_25.pdf (accessed October 18, 2019).

by and have historically experienced shortages in physician supply and decreased access to care.

These are the patients who would be disproportionately affected by a ruling curbing the legislature's authority. States with limits on noneconomic damages enjoy a positive impact among surgical and support specialists locating in rural counties. David A. Matsa, *Does Malpractice Liability Keep the Doctor Away? Evidence from Tort Reform Damage Caps*, 36:2 J Legal Stud 143-182 (2007) (for surgical and support specialties, rural counties in states with limits had about 10 percent more physicians per capita than rural counties in states without limits).

In the years immediately following this Court's decision in *Lakin v. Senco Products, Inc.*, Oregon's rural physician workforce decreased as liability premiums rose and instability in the malpractice market increased. 329 Or 62, 987 P2d 463, *modified*, 329 Or 369, 987 P2d 476 (1999) (holding application of *former* ORS 18.560(1) to common law claims existing in 1857, violated Article I, section 17's provision for trial by jury) *overruled by Horton,* 359 Or 168; *see* note 13.[18] This adversely affects delivery of care to patients in need. For example, specialists such as neurosurgeons, orthopedic surgeons, and obstetricians-gynecologists reported facing decisions between practicing in a difficult liability

[18] OHSU Center for Rural Health, in 2004 the Portland Area had 302 physicians for every 100,000 residents, while rural Oregon residents had only 104 physicians per 100,000 residents.

environment and providing care in high need communities.[19] Two rural cities closed their only obstetrical practices due to the rapidly rising costs of medical liability insurance, which meant that patients in Roseburg had to drive sixty to ninety miles for obstetrical services. Valerie Hedrick, *The Medical Malpractice Crisis: Bandaging Oregon's Wounded and Protecting Physicians*, 43:3 Willamette L R 363, 384 (2007). The fallout from *Lakin* resulted in the AMA classifying Oregon as one of twelve states "experiencing a medical malpractice liability crisis." *Id*.

In contrast to the Oregon experience following *Lakin*, Texas has had a different evolution. In 2003, Texas enacted legislation limiting liability for noneconomic damages in medical liability cases to $250,000. Texas Medical Association, *Proposition 12 Produces Healthy Benefits* (2016).[20] In the years that followed, Texas's physician workforce outpaced its population. Access to care improved, including for obstetricians and other specialities in rural areas and areas not previously served. *Id*.

After *Lakin*, the Oregon legislature was able to respond, in part, and created the Oregon Rural Medical Practitioners Subsidy Program to incentivize rural practice and attempt to mitigate the physician shortage. ORS 315.613. The

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[19] *See, e.g. Physician Workforce Data Sources* Oregon Medical Association Memorandum, HB 4136, Feb 4, 2016.

[20] Available at: https://www.texmed.org/tortreform/.

legislation sought to ease an immediate burden; nevertheless, the recruitment and retention of rural physicians and midlevel providers such as nurse practitioners remains difficult when the risk is often too great to serve. *See* Smits, *et al*, Health Services Research at 1254 (indicating that in Oregon rural physicians were stopping maternity care at a significantly higher rate than urban physicians). However, the situation will likely become dire and unstable again if the limit on damages is invalidated.

The result of another "*Lakin*" would be to further destabilize the medical care available to a large portion of Oregon's residents. Damages limits have a significant impact on physician supply, and even more so in rural areas, as the findings discussed above show. Mello and Kachalia, Report to OHA at 17; *see also*, Allen Kachalia, MD, JD & Michelle M. Mello, JD, PhD, *New Directions in Medical Liability Reform*, 364 N Engl J Med 1564, 1566 (2011) (studies of limits on noneconomic damages have nearly uniformly found limits are an effective means of reducing the size of indemnity payments). [21] Liability exposure is a substantial disincentive to the skilled surgeons, obstetricians, and other specialists so desperately needed in rural areas that would otherwise be willing to accept lower salaries, even in the face of mounting student debt, in order to serve the greater public need.

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[21] Available at: https://www.nejm.org/doi/pdf/10.1056/NEJMhpr1012821 (accessed May 13, 2018).

Of course, upholding the limit is not only constitutionally mandated, it will have a positive effect on the provision of health care in Oregon. Indeed, in the short time between when *Horton* was decided in May 2016 and the contrary court of appeals opinion in this case, there was an immediate effect on trial court judgments and the valuation of claims. *See* Matsa, 36:2 J Legal Stud at 143-182 (research shows that it may take at least six to ten years for the full effect of limits on physician supply to be felt and that this long term effect is twice that of the short-term effect). *Horton*, of course, expressly declined to pass on ORS 31.710, limiting its holding to the OTCA. Since *Horton*, the majority of physicians in Oregon who are not employed by public bodies have not been able to experience a positive impact from that decision.

3. Improving Patient Care.

Rather than focus on the provider side of healthcare, liability reforms are rightly more patient-centered than ever before. Focusing on patient safety and efficiency of care are objectives of the healthcare system. How injured patients are compensated when negligence occurs must be viewed in that context. Improving transparency and communication between patients and providers is a goal of clinical practice and safety measures. Legislatively-imposed boundaries to liability such as noneconomic damages limits, the OTCA, statutes of limitation and repose, comparative fault, limits on attorney's fees, providing immunity for

certain services, and collateral source reforms, allow strides toward patient safety goals to continue as the system adjusts toward greater reform. Those boundaries must be allowed to remain in place while allowing the legislature freedom to implement new approaches to improving healthcare.

With respect to medical malpractice claims in particular, the legislature has legitimate concerns about the availability and cost of liability insurance for healthcare providers, and thus the cost and continued availability of quality healthcare for Oregonians. *Jones v. Salem Hosp.*, 93 Or App 252, 258-59, 762 P2d 303 (1988), *rev den*, 307 Or 514 (1989) ORS 12.110(4) was "enacted in response to the so-called 'medical malpractice crisis'" and that treating minors and adults identically for malpractice claims had a rational basis despite the fact that minors and others with disabilities were given more time under ORS 12.160 for other claims; *Fields v. Legacy Health Sys*., 413 F3d 943, 955 (9th Cir 2005) ("Here, the classifications made in the Oregon statutes of limitations and repose are rationally related to the legitimate legislative ends of avoiding stale claims and limiting the costs of litigation and medical care;" court upheld the ORS 12.110 **Error! Bookmark not defined.**(4) five-year period of repose for medical malpractice claims against Article I, section 10 challenges as well as equal protection and due process challenges under the U.S. Constitution). Medical providers and insurers must be able to depend on legislation in order to

appropriately value cases and resolve meritorious claims. Encouraging reasonable settlement serves all participants in the process.

4. Physician Health Promotes Patient Safety.

Improving patient care includes retaining and recruiting a healthy physician population. Conversely, the personal toll on physicians named in litigation – even unfounded litigation – is dramatic. Litigation affects their personal well-being, their families, their practices, and their willingness and ability to continue seeing patients. *See, e.g.,* Michelle M. Mello, *et al.*, *National Costs of the Medical Liability System,* 29:9 Health Affairs 1569, 1574 (2010) (discussing the reputational and emotional toll on clinicians); *Medical Liability Reform NOW!*, AMA 1(2019 ed).[22] Pending litigation can mean the defendant physician cannot move to accept a new position or they may be unable to expand their practices in areas where additional services are critically needed because they face personal exposure in the amount alleged by the plaintiff. It can prevent physicians from being able to buy or sell their homes, or undertake the financing necessary to pay for a child's tuition or take care of an aging parent.

There is no assurance a physician can insure against unlimited losses; and, without a limit on noneconomic damages there is no way to predict what that

[22]Available at: https://www.ama-assn.org/practice-management/sustainability/state-medical-liability-reform (last accessed 10/10/19).

exposure might be. When noneconomic damages prayers eclipse policy limits, physicians are put in untenably acute circumstances: defend the claim and risk unlimited personal liability or consent to settle and suffer the professional and personal consequences that flow from settling a claim in which they believe, and have experts to support, that they met the standard of care.[23]

Access is crucial, as demonstrated by the Emergency Medical Treatment and Active Labor Act (EMTALA). EMTALA requires medical specialists to respond when called to the emergency department to care for a patient with an emergency medical condition, including treating a patient in active labor. 42 USC § 1395dd (1986). Unlike other markets for services, "the inability to pay for care does not mean that an uninsured individual will receive no care. Federal and state law, as well as professional obligations and embedded social norms, require hospitals and physicians to provide care when it is most needed, regardless of the patient's ability to pay." *NFIB v. Sebelius*, 567 US at 592-93 (J. Ginsburg, concurring in part, concurring in the judgment in part, and dissenting in part)

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[23] For example, one consequence of settlement is that it triggers a mandatory report to the National Practitioner Data Bank (NPDB). The NPDB is a national clearinghouse created by Congress that must be queried by every health care oversight body and credentialing committee nationwide. For more information *see generally*, www.npdb.hrsa.gov. The NPDB is an important patient safety measure; however, there can be unintended effects on practitioners. A malpractice settlement, whether in a case in which it is justified or not, will follow that physician for the rest of their career and can result in further investigations even after a lawsuit is resolved.

(citing, among others, American Medical Association, Council on Ethical and Judicial Affairs, Code of Medical Ethics, Current Opinions: Opinion 8.11—Neglect of Patient, p 70 (1998-1999 ed).

The patient seeking emergency care is often a stranger to the physician and may be in poor health and a poor historian, and in precarious condition when first encountered. Physicians have legal and ethical obligations to care for patients and they fulfill this duty throughout their daily work. It is certainly within the legislature's purview to protect physicians who must provide treatment despite the liability risks presented.

E. The Remedy Clause Should Not Limit Innovation.

The legislature must have flexibility to encourage and prescribe innovation in healthcare and other areas.[24] Unlike Congress, states have plenary power to adopt laws for the good of their citizens. US Const, Amend. X ("The powers not delegated to the United States by the Constitution, nor prohibited by it to the States, are reserved to the States respectively, or to the people."). The state legislature is where that lawmaking power resides. Or Const, Art III, § 2. State legislatures fulfill an important function as "laboratories of democracy." *New*

[24] The power of the legislature to encourage certain conduct to achieve public health policy objectives by granting civil immunity is well-understood. ORS 41.675 (peer review); ORS 41.685 (emergency medical services); ORS 676.175 (trauma system immunities), ORS 419.025 (child abuse reporting immunity), ORS 441.820 (physician reporting), ORS 30.800 (Good Samaritan laws), ORS 426.335 (mental health hold and civil commitment immunities).

State Ice Co. v. Liebmann, 285 US 262, 310, 52 SCt 371, 76 L Ed 747 (1932) (Brandeis, J., dissenting) ("There must be power in the states and the nation to remould, through experimentation, our economic practices and institutions to meet changing social and economic needs.").

In the area of healthcare, Oregon has pioneered ways of improving and providing near-universal healthcare for children and adults. Oregon's innovations, for example, in creating Coordinated Care Organizations (CCOs) served as a model for the underpinnings of the federal ACA.[25] ORS 414.620, *et seq* (2017). CCOs are now in the "CCO 2.0 phase" moving forward to provide greater access to care. Oregon Health Authority Health Policy & Analytics Division, CCO 2.0 Recommendations of the Oregon Health Policy Board, OR. 2018 October. [26] Oregon continues to address ways for improving patient safety, the delivery of medical care, and the system for compensating for medical negligence. Progress must continue.

Innovative reforms are being developed to complement traditional reforms such as limits on noneconomic damages. New programs to tackle the inequities in the current tort system and optimize patient safety include innovations such as

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[25] *See e.g.*, https://news.ohsu.edu/2017/03/07/oregons-cco-approach-is-a-model-for-reduced-health-care-spending-study-finds (last accessed May 10, 2018).

[26] Available at: https://www.oregon.gov/oha/OHPB/CCODocuments/2018-OHA-CCO-2.0-Report-Executive-Summary.PDF (last accessed October 18, 2019).

communication and resolution programs (CRPs), health courts or administrative compensation systems, and strengthening state apology laws.

For example, in 2012, the Oregon legislature commissioned an independent study to look in detail at key design features and likely effects of liability reform options, including: caps on noneconomic damages, medical panels, extending the applicability of the OTCA, modifying the joint and several liability statutes, and an administrative compensation system. *See generally*, Mello & Kachalia, Report to the OHA.

Adopting reforms or further development of the ideas from the 2012 report would likely require the legislature to define the boundaries and the compensation allowed for claims, perhaps altering or eliminating certain types of damages or even the way in which "damages" are conceived. There are a myriad of changes and innovations that the legislature could entertain; however, it must be free to do so. Kachalia & Mello, 364 N Engl J Med at 1564-1570.

As a step toward reform, in 2014, the legislature passed Oregon's Early Discussion and Resolution (EDR) law. Or Laws 2013, ch 5, §§ 20, 21; OAR Ch 325. The goals of the EDR program include creating a system that will expedite the resolution of meritorious claims and provide more consistent damage awards.[27] Other states and groups, including in Massachusetts and Iowa, have

[27] *See e.g.*, https://oregonpatientsafety.org/edr/about-edr/.

adopted similar programs. *See e.g.*, the Massachusetts Alliance for Communication and Resolution following Medical Injury (MACRMI).[28] Proponents of CRPs are optimistic that such programs will lower the number of lawsuits brought against medical providers, reduce meritless claims, expedite settlement, provide consistency to the compensation paid to injured patients and reduce transactional expenses such as attorney fees.[29] Such improvements further the goals of providing compensation to patients harmed by medical negligence in a less adversarial climate than the tort system and without a large percentage of a damages award going to lawyers and experts, rather than the injured person. *See e.g.*, Medical Injury Compensation Reform Act, Cal Civ Code, § 3333.2, *et seq*

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[28] Available at: http://www.macrmi.info/#sthash.UyfIe63V.dpbs.

[29] *See e.g.*, Michelle M. Mello and Allen Kachalia, *et al*, *Outcomes in Two Massachusetts Hospitals Give Reasons For Optimism*, 36:10 Health Affairs 1795, 1800-1802 (2017) available at: https://www.healthaffairs.org/doi/abs/10.1377/hlthaff.2017.0320; Florence R. LeCraw, *et al*, *Changes in Liability Claims, Costs, and Resolution Times Following the Introduction of a Communication-and-Resolution Program in Tennessee*, 23:1 Journal of Patient Safety and Risk Management 14, 16 (2018), available at: http://journals.sagepub.com/doi/abs/10.1177/1356262217751808?journalCode=cric; William M. Sage, *et al*, *How Policy Makers can Smooth the Way for Communication-and-Resolution Programs*, 33:1 Health Affairs 11, 12, 15 (2014), available at: https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2013.0930; Michelle M. Mello, *et al*, *Communication-and-Resolution Programs: The Challenges and Lessons Learned from Six Early Adopters*, 33:1 Health Affairs 20, 24, 26, 28 (2014) ("Interviewees at two programs indicated that their state's cap on noneconomic damages probably helped their CRP succeed, especially in terms of assessing the value of serious injury"), available at: https://www.healthaffairs.org/doi/pdf/10.1377/hlthaff.2013.0828.

(limiting noneconomic damages to $250,000 and creating a sliding scale with limits on the percentage a contingent fee lawyer can earn that decreases as the size of the plaintiff's award increases).

CRPs are thought to encourage transparency, strengthen the patient-provider relationship, and provide resolution for adverse outcomes without the costs associated with the traditional tort system with a strong focus on improving the quality of healthcare. Mello & Kachalia, 36:10 Health Affairs at 1797-99, 1801; LeCraw, 23:1 Journal of Patient Safety and Risk Management at 14, 16; Jennifer Moore, LLB, MA, PhD, Marie Bismark, LLB, MPH, MD, & Michelle M. Mello, JD, PhD, MPhil, *Patients' Experiences with Communication-and-Resolution Programs after Medical Injury*, 177:11 JAMA Intern Med 1595, 1596-1600 (2017);[30] Sage, 33:1 Health Affairs at 11, 18; Mello, 33:1 Health Affairs at 22-28.[31]

The construction of Article I, section 10, repeatedly urged by plaintiffs has the potential to chill innovation. The more favorable approach is to allow the legislature to act. The legislature is the branch of government with the opportunity and resources to conduct research, commission studies and task forces, and view available options or develop new ones to increase patient safety

[30] Available at: https://jamanetwork.com/journals/jamainternalmedicine/article-abstract/2656885?redirect=true.

[31] S*ee generally*, http://communicationandresolution.org/.

and access to health care. *See e.g.*, ORS 734.770, *et seq* (creating the Oregon Life & Health Insurance Guaranty Association in 1975 to protect policyholders, up to certain limits, when their insurers become insolvent). Indeed, it did as much with respect to ORS 31.710 in the 2019 session. The legislature cannot fulfill its functions effectively if it is limited by a dated interpretation of the remedy clause. Holding that a damages award in a single case must be individually assessed for constitutionality against the legislature's policy choice undermines the ability of the legislature to reform the system and place reasonable boundaries on liability in order to promote the public interest.

Necessity is forcing progress at an increased pace. The remedy clause should not stand as a roadblock to further advancement of a system that is indisputably in need of repair. The court should not exchange access to care for those who need it most for an arbitrary noneconomic damages award in an individual case.

III. CONCLUSION

Amici urge the court to carefully consider how and why the court is subjecting the legislature's action in ORS 31.710 to strict scrutiny. The Oregon legislature has reevaluated the damages limit, as recently as the 2019 session, and it has not altered it. This limit is essential to ensure continued access to healthcare in Oregon. Invalidating the limit would result in further instability for an essential

service needed by all Oregonians. In the exercise of principled interpretation, the court should uphold the constitutionality of ORS 31.710(1).

DATED this 24th day of October, 2019.

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CERTFICATE OF COMPLIANCE

I certify that this memorandum complies with the word count limitation for briefs pursuant to ORAP 5.05(2)(b); the word count is 8,221words. I further certify that this brief is produced in a type font not smaller than 14 point in both text and footnotes pursuant to ORAP 5.05(2)(d)(ii).

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CERTIFICATE OF FILING AND MAILING

I certify that I electronically filed the attached with the State Court Administrator, using the Oregon Appellate eFiling system, on October 24, 2019.

I further certify that on the same date, through the use of the electronic service function of the appellate eFiling system, I served the foregoing **Brief on *Amici Curae* Oregon Medical Association, American Medical Association, and American College of Obstetricians and Gynecologists on Behalf of Petitioner on Review** on the following parties:

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