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SUPREME COURT, STATE OF COLORADO 2 East 14th Avenue, 4th Floor Denver, Colorado 80203	
On Petition for Writ of Certiorari to the Colorado Court of Appeals Case No. 2019CA0987 Opinion by Judge Berger Judge Jones, concurring Judge Vogt, concurring in part and dissenting in part Appeal from Arapahoe County District Court Honorable Elizabeth Beebe Volz, Judge Case No. 2017CV030368	▲ **COURT USE ONLY** ▲
Petitioners: MARECA PALLISTER, M.D., and CATHOLIC HEALTH INITIATIVES COLORADO, d/b/a CENTURA HEALTH-MERCY REGIONAL MEDICAL CENTER OF DURANGO, **v.** **Respondent:** ABIGAIL DEAN, a minor, by and through her parent and next friend, ORIEL KAMINKY.	Case No. 2021SC000040
Attorneys for Amicus Curiae, American College of Obstetricians and Gynecologists: Name: Theresa Wardon Benz (#41510) Meghan Frei Berglind (#35574) Joseph A. Farchione (#44446) Brian S. Osterman (#50489) Wheeler Trigg O'Donnell LLP Address: 370 Seventeenth Street Suite 4500 Denver, CO 80202-5647 Telephone: 303.244.1800 Facsimile: 303.244.1879 Email: benz@wtotrial.com berglind@wtotrial.com	

BRIEF OF AMICUS CURIAE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS IN SUPPORT OF PETITION FOR WRIT OF CERTIORARI

CERTIFICATE OF COMPLIANCE

I hereby certify that this brief complies with C.A.R. 29 and C.A.R. 32, including all formatting requirements set forth in these rules. Specifically, the undersigned certifies that

The amicus brief complies with the applicable word limit set forth in C.A.R. 53(g).

☑ It contains **3,089** words (does not exceed 3,150 words).

The amicus brief complies with the content and form requirements set for in C.A.R. 29(c).

I acknowledge my brief may be stricken if it fails to comply with any of the requirements of C.A.R. 29 and C.A.R. 32,

Dated: February 24, 2021

s/ Meghan Frei Berglind
Meghan Frei Berglind
WHEELER TRIGG O'DONNELL LLP

Attorneys for *Amicus Curiae* American College of Obstetricians and Gynecologists

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IDENTITY AND ISSUE OF AMICUS CURIAE

The American College of Obstetricians and Gynecologists ("ACOG") is a non-profit membership organization composed of women's healthcare physicians. With more than 60,000 members, ACOG is the nation's leading professional association of physicians providing health care for women. ACOG's objectives are to foster and stimulate improvements in all aspects of health care of women; to establish and maintain the highest possible standards for education; to foster the highest standards of practice in its relationship to public welfare; to promote high ethical standards in practice; and to promote publications and encourage contributions to medical and scientific literature. ACOG's core values include access for all women to high quality safe health care, professionalism of its membership, and scholarship in medical science. ACOG works to provide evidence-based knowledge in women's health to its membership and the women they serve and to promote quality, safety, efficiency and stability for the delivery of women's health care services.

The issues presented in this case are of great importance to ACOG, its physician members, and the patients for whom they care. The quality of evidence proffered and admitted as "medical science" in professional liability litigation can significantly influence ACOG's members' medical practices and the cost and availability of medical services. The issues presented by this case will therefore have an immediate and lasting effect on women's medical care in the State of Colorado.

INTRODUCTION

Courtroom science should follow mainstream science. It should not endorse theories that are unproven, and it especially should not accept theories that the scientific community has rejected. But here, the Court of Appeals has done just that.

Cranial compressive ischemic encephalopathy ("CCIE") is a causation theory that tries to place blame for newborns' tragic brain injuries on medical care birth teams when no accepted medical science supports this. CCIE is not supported by the authorities its proponents rely on and is unheard of in clinical obstetrics. It is no surprise, then, that its proponents' attempts to legitimize CCIE have been rejected during peer review or that an industry-wide, comprehensive look at neonatal brain injury failed to recognize CCIE as an injury cause. In fact, the only peer-reviewed article to address CCIE roundly rejected it, finding it had no support in the scientific literature.

The trial court had all of this in front of it and, after a two-day hearing, correctly excluded evidence of CCIE because it lacked the reliability required by *People v. Shreck*, 22 P.3d 68 (Colo. 2001). A Division of the Court of Appeals reversed, holding that, even though CCIE is not scientifically accepted, because some of its component parts are reliable, it must be reliable too.

There are two reasons why this Court should grant the petition. First, by reversing the trial court's well-reasoned decision, the Division has endorsed CCIE as a

valid theory of causation. Allowing this unscientific and medically invalid theory into Colorado courts will hold physicians and health care teams liable for injuries that medical science absolves them of. Second, the Division's decision will have negative repercussions on both legal doctrine and medical care. It all but ensures the influx of unreliable scientific evidence into many other areas of the law. And with respect to medical care, this type of precedent is especially dangerous because it creates disincentives for the provision of obstetrical care. This Court should thus grant the writ and reverse the Court of Appeals on the merits.

REASONS FOR GRANTING THE PETITION

The Court should grant certiorari because the Division's decision places Colorado jurisprudence out of step with the scientific consensus and subjects physicians to one standard in the courtroom and another in the delivery room. When paired with the published, similar decision in *Trujillo ex rel. Chaparro-Levya v. Vail Clinic, Inc.*, 2020 COA 126, the Division's decision enshrines CCIE—a theory rejected by the medical and scientific community—into legal doctrine in Colorado.

I. The Court of Appeals' Decision Endorses a Scientifically Rejected Theory of Causation.

Scientific evidence is not admissible if it is not "reasonably reliable." *Shreck*, 22 P.3d at 77. By permitting the introduction of CCIE evidence here and in *Trujillo*, the Division did not just allow—it endorsed—an unreliable theory.

Nearly all births involve at least a trial of labor. Under the CCIE theory proposed by Plaintiffs and endorsed by the Division, labor itself causes birth injuries. The theory posits this: When pressure is applied to the baby's head through normal uterine contractions, that pressure transmits to the inside of the baby's skull and raises intracranial pressure. That increased intracranial pressure, CCIE proponents claim, cuts off blood flow to the baby's brain.[1] When the mother experiences "excessive uterine activity"— hard and fast contractions —these proponents contend that the contractions themselves cause encephalopathy (brain injury) by cutting off blood flow to the brain without accompanying damage to the baby's other organs. CF, p. 789; TR (10/24/18) 364:11–365:10. There is no scientific evidence to support this theory, and CCIE describes a mechanism of injury that is unheard of in clinical obstetrics.

Over the last several years, this theory has been used to make claims against delivering doctors or midwives for injuries that accepted medical science would not attribute to the mother's treatment during labor. Under this unscientific theory, claims are made against clinicians for inducing or augmenting labor or waiting to perform a cesarean section even though the medical evidence would otherwise point away from those decisions being the cause of fetal injury. With the Division's decisions here and

[1] In fact, medical science recognizes that contractions cut off blood flow to the placenta, not the fetal brain. TR (10/24/18), p. 365:11–13.

in *Trujillo*, this damaging, unscientific theory has entered Colorado's jurisprudential mainstream.

A. Physicians Must Rely on Sound Medical Science to Treat Patients.

In medicine, every medical or surgical intervention is accompanied by its own set of risks and benefits. With a clear understanding of both risk and benefit, physicians decide how to proceed in any given clinical situation. In obstetrics, for example, physicians generally do not intervene in labor by giving medication to slow or stop contractions or proceed to surgical delivery without having good cause to do so. Each intervention carries its own risks that the physician must evaluate in light of the clinical situation and the medical science supporting the intervention. To make these decisions, a physician relies on her own clinical experience, her education and field training, and evidence of good quality as reported in the medical literature. When weighing a theory that is not taught in medical schools or residency programs, like CCIE, the quantity and quality of research evidence supporting that theory becomes even more important.

To weigh that research evidence, many practitioner and scientific organizations use a method developed by the U.S. Preventative Services Task Force ("USPTF"). That method grades medical research studies for quality, with the highest quality evidence given the greatest weight in practice. According to USPTF, the highest quality evidence is from randomized, controlled interventional trials receives the

highest ranking and provides the highest quality evidence. *See* UPSTF Procedure Manual § 4, Evidence Review Development, available at https://www.uspreventiveservicestaskforce.org/uspstf/procedure-manual/procedure-manual-section-4-evidence-review-development (last visited Feb. 18, 2021). Lowest ranked are individual case reports (detailed published reports documenting the clinical course of a single patient), which are generally not considered high-quality evidence.[2]

ACOG is guided by these principles when it develops evidence-based clinical practice guidelines to assist its members in treating patients. ACOG derives those guidelines from the best available evidence of clinical efficacy and designs them for use by physicians and other health care providers to standardize care and improve the quality of health care. To do this, ACOG considers the quality and quantity of the evidence and directly links its clinical practice guidelines to that evidence. Only those studies determined to provide overall evidence of "good quality" are considered in the development of ACOG's guidelines. Those guidelines are also extensively peer reviewed by subject-matter experts before issuance.

[2] These principles are mirrored by the Federal Judicial Center's recognition the "hierarchical" nature of medical evidence, which it recognizes as a "fundamental principle of evidence-based medicine." Federal Judicial Center, Reference Manual on Scientific Evidence 723 (3d ed. 2011).

B. CCIE Is Not Based in Sound Medical Science.

The Division suggests that CCIE theory is the subject of legitimate scientific debate. *See id.* ¶¶ 29–31. Not true. This is not a case of "evidence with strong support within the community but that may fall short of general acceptance." *Shreck*, 22 P.3d at 75. Instead, the scientific community has **considered and rejected** CIEE multiple times. In fact, Plaintiffs' expert Dr. Stewart Ater, one of the originators of the CCIE theory, admitted that **each time** he submitted the theory for peer review in journals, it was rejected. TR (10/23/18), pp. 197:1–4, 198:12–200:11.

Dr. Ater's theory had failed to gain acceptance in other ways too. He submitted the theory for evaluation by ACOG and the American Academy of Pediatrics joint task force on neonatal encephalopathy. *Id.*, pp. 200:12–201:1. That Task Force followed ACOG's evidence-based guideline development process. It consisted of 16 physicians with specialties in obstetrics, perinatal medicine, pediatrics, neurology, and maternal-fetal medicine. Liaison members included representatives from the American Academy of Pediatrics, the Council on Resident Education in Obstetrics and Gynecology, the Royal College of Obstetricians and Gynaecologists, the Eunice Kennedy Shriver National Institute of Child Health and Human Development, the Society for Maternal-Fetal Medicine, the Society of Obstetricians and Gynaecologists of Canada, and a scientist-liaison from the Centers for Disease Control and Prevention National Center on Birth Defects and Developmental Disabilities.

Its work led to a 236-page report that was reaffirmed in 2019. *Neonatal Encepholopathy and Neurological Outcome* (2d ed. 2019), available at https://www.acog.org/-/media/project/acog/acogorg/clinical/ files/task-force-report/articles/2014/neonatal-encephalopathy-and-neurologic-outcome.pdf (last accessed Feb. 20, 2021). The report presents "the current state of scientific and clinical knowledge relating to neonatal encephalopathy and neurologic outcomes." and was endorsed by organizations of obstetricians and gynecologists from the United States, Great Britain, Canada, Australia, Japan and New Zealand. *Id.* at xv, xvii. Despite Dr. Ater's submission, nowhere does the Task Force's report describe CCIE or any mechanism resembling it. *Id. passim.*

In fact, CCIE is **unheard of in clinical obstetrics**. TR (10/24/18), pp. 366:13–367:12, 375:25–376:18, 394:6–10. **No article** proving or even supporting the theory **has ever been published in any peer-reviewed publications**. *Id.*, p. 391:6–9. It is not part of any education or training program for medical students or obstetrics residents. *Id.*, pp. 391:19–392:2. It is not in any obstetrics textbook.[3] *Id.*, p.

[3] Dr. Ater asserted at the *Shreck* hearing that a book by Joseph Volpe titled *Neurology of the Newborn* supported his CCIE theory. TR (10/23/18), pp. 213:10–217:20. But Dr. Volpe has disclaimed reliance on his book by CCIE proponents. Dr. Volpe does not "believe that there is sufficient evidence to conclude that uterine hyperstimulation can create sufficient intracranial pressure to cause hypoxic-ischemic injury." CF, pp. 496–99.

392:11; TR (10/23/18), pp. 213:11–20. It is not mentioned in any bulletins or literature reviewed by practicing obstetricians. TR (10/24/18), pp. 392:12–393:4. In fact, **there is no evidence that any practicing clinical obstetrician endorses this theory in their own practice—proponents of the theory included**. TR (10/24/18), pp. 366:13–367:12, 375:25–376:18.

What is more, the only peer-reviewed published study considering CCIE theory roundly rejected it. In 2017, Dr. Heyborne performed a "systematic[] review [of] what is known about fetal head compression and its effects on fetal intracranial pressure, oxygenation, blood flow and cerebral function, and the plausibility that it might cause fetal brain injury." Kent D. Heyborne, *A Systematic Review of Intrapartum Fetal Head Compression: What Is the Impact on the Fetal Brain?*, AJP Reports (Apr. 2017), available at https://www.thieme-connect.com/products/ ejournals/html/10.1055/s-0037-1602658 (last visited Feb. 20, 2021). He concluded that "fetal intracranial pressure is well protected from extracranial forces" and that the "data do[es] not support intrapartum fetal extracranial pressure as a cause of fetal brain injury." *Id.*

Dr. Heyborne testified at the *Shreck* hearing and explained that he reviewed all the articles and literature relied on by CCIE proponents—other than some reports from the 1700s and 1800s he could not locate—and searched for other relevant articles and studies. TR (10/24/18), pp. 369:24–372:4, 374: 9–20. After this review, he

concluded "that the published scientific literature does not support the hypothesis that's being put forth by the plaintiffs." *Id.*, p. 375:6–11. In short, the scientific consensus is that CCIE does not exist.

Given this lack of support, it is no surprise then that every other published appellate decision to address CCIE has approached it with skepticism. *See Yerks v. Trest*, 246 So.3d 956, 957 (Miss. Ct. App. 2018); *Smith v. Braswell*, 804 S.E.2d 709, 710–12 (Ga. Ct App. 2017); *Schmidt v. Bellevue Med. Ctr.*, No. 8:13CV143, 2015 WL 3407826, at *4–6 (D. Neb. 2015).[4]

Here, the trial courts correctly excluded evidence of CCIE. After a two-day *Shreck* hearing, the Special Master and then the trial judge determined the theory was neither relevant nor reliable. CF, pp. 2262–66, 2912–27. By reversing the trial court's decision, the Division ended up endorsing this untested and unreliable theory. This Court should therefore grant review.

[4] The decisions cited by the Court of Appeals permitting CCIE evidence predated Dr. Heyborne's analysis of the literature that found no support for CCIE. *See Dean v. Catholic Health Initiatives Colorado, et al.* No.19CA0987 at ¶¶ 35–36 & n.3 (Colo. App. Nov. 19, 2020).

II. Allowing Evidence of CCIE Undermines this Courts' Precedents and Disincentivizes the Provision of Medical Care.

The Division's endorsement of CCIE has negative implications for both the treatment of scientific evidence in Colorado courts and the provision of medical care to Colorado patients.

A. The Court of Appeals' Decision Contradicts this Court's Jurisprudence on Scientific Evidence.

This issues raised by birth injury cases are "confessedly foreign . . . to the jury's own" experience. *Kumho Tire Co. v. Carmichael*, 526 U.S. 137, 149 (1999). The trial court must, therefore, make an "effort to assure that the specialized testimony is reliable and relevant" to "help the jury to evaluate that foreign experience." *Id.*

By excluding CCIE evidence, the trial court "ke[pt] unreliable and irrelevant information from of the jury because of its inability to assist in factual determinations, its potential to create confusion, and its lack of probative value." *Allison v. McGhan Med. Corp.*, 184 F.3d 1300, 1311–12 (11th Cir. 1999). But with *Trujillo* and now this case, the Division has usurped that gatekeeping role. It expects a jury of lay people to review technical scientific evidence that the experts have already said lacks scientific support. *See Dean*, 19CA0987, ¶ 21. Permitting a lay jury to consider a theory that the medical-scientific community has rejected creates a dual standard of care—one for the delivery room and one for litigation. Moreover, this approach eviscerates the trial

court's "broad discretion" to "determine the admissibility of expert testimony." *Estate of Ford v. Eicher*, 250 P.3d 262, 266 (Colo. 2011).

The Division's reasoning has damaging implications for another reason. Here, it held that CCIE evidence was admissible because "the scientific principles *underlying* the CCIE theory are themselves widely accepted."[5] *Dean*, 19CA0987, ¶29. This invites a Frankenstein-like approach to scientific evidence. As long as the scientific theory's building blocks have general acceptance, and the witness espousing it has strong credentials, *see id.* ¶¶ 32–34, scientific evidence would be admitted regardless of its reliability.

This approach is contrary to this Court's jurisprudence. It does not guarantee that scientific evidence is "grounded in the methods and procedures of science rather than subjective belief or unsupported speculation." *People v. Ramirez*, 155 P.3d 371, 378 (Colo. 2007) (internal quotation omitted). Instead, it invites the admission of junk science as long as a party can find a qualified witness willing to tie together disparate

[5] Even if this reasoning were valid, the Court of Appeals was wrong to find that the scientific principles underlying CCIE are widely accepted. Indeed, "the most critical part" of the theory—that pressure outside the skull causes pressure inside the skull to increase and reduce blood flow—"just plain does not seem to be true." TR (10/24/18) p. 375:12–24. If anything, the literature shows the opposite: during a contraction, blood flow to the brain increases. *Id.*, p. 379:14–380:5.

scientific threads to reach a preordained conclusion. Such an approach does not guarantee that scientific evidence is reliable.

B. The Court Of Appeals' Decision Discourages the Provision of Health Care.

By creating a different standard of care for the courtroom, the Division also disincentivizes physicians from providing maternal health care to Colorado patients. This is a particular concern for ACOG because adequate access to obstetrical services remains a significant problem nationwide, particularly in rural areas. As Colorado's population continues to grow, demand for women's services will only increase.

A reasonably busy obstetrician is likely to encounter multiple cases involving a neurologically-impaired infant during the course of her career. The detrimental effects of obstetrical litigation, including these cases, means that obstetricians pay among the highest malpractice premiums of all medical specialties, averaging 10.6% of gross revenues. The last time ACOG surveyed its members on this topic, almost half reported having made changes to their practices as a result of malpractice liability fears, including decreasing the number of high-risk, decreasing the number of deliveries, increasing the number of Cesarean deliveries, or halting the practice of obstetrics altogether. Nearly 40 percent reported making similar changes because of the cost or unavailability of adequate malpractice insurance coverage. *See* Andrea M.

Carpentieri et al., *Overview of the 2015 American Congress of Obstetricians and Gynecologists' Survey on Professional Liability* (attached as Ex. 1).

This underscores the need to prevent unwarranted expansion of obstetrical liability theories. CCIE is especially worrisome because of its potential applicability to any birth with a trial of vaginal delivery. All vaginal deliveries featured some cranial compression as the fetus descends through the birth canal. And because there is no science behind the theory, there is no accepted method to measure or defend against it.

Unscientific courtroom determinations complicate the already difficult decision-making processes of physicians and their patients. Those risk-benefit calculations will only be further clouded if they must contend with unproven theories legitimized by the courts. Given the current challenges in ensuring adequate access to obstetrical care and the deterrent effect of malpractice litigation, the introduction of CCIE into Colorado jurisprudence will harm Colorado patients and physicians.

CONCLUSION

For these reasons, this Court should issue a writ of certiorari.

Dated: February 24, 2021.

Respectfully submitted,

s/ Meghan Frei Berglind

Theresa Wardon Benz
Meghan Frei Berglind
Joseph A. Farchione
Brian S. Osterman
Wheeler Trigg O'Donnell LLP
Attorneys for Amicus Curiae American College of Obstetricians and Gynecologists

CERTIFICATE OF SERVICE

I certify that on February 24, 2021, a true and correct copy of **BRIEF OF AMICUS CURIAE AMERICAN COLLEGE OF OBSTETRICIANS AND GYNECOLOGISTS IN SUPPORT OF PETITION FOR WRIT OF CERTIORARI** was filed with the Court via Colorado Courts E-Filing System, with e-service to the following:

John M. Palmeri John R. Mann Gordon & Rees LLP 555 17th Street, Suite 3400 Denver, Colorado 80202 Telephone: 303.534.5160 Email: jpalmeri@grsm.com jmann@grsm.com *Attorneys for Petitioner Mareca Pallister, M.D.*	( ) First Class Mail ( ) Hand Delivery ( ) Facsimile ( ) Overnight Delivery (X) Colorado Courts E-Filing ( ) E-Mail
Thomas M. Evans Rendigs, Fry, Kiely & Dennis, LLP 1434 Spruce Street, Suite 100 Boulder, Colorado 80302 Telephone: 720.354.3948 Email: tevans@rendigs.com *Attorneys for Petitioner Catholic Health Initiatives Colorado, d/b/a Centura Health-Mercy Regional Medical Center of Durango*	( ) First Class Mail ( ) Hand Delivery ( ) Facsimile ( ) Overnight Delivery (X) Colorado Courts E-Filing ( ) E-Mail
Robert T. Fishman Ridley, McGreevy & Winocur, PC 303 16th Street, Suite 200 Denver, CO 80202 Telephone: 303.629.9700 Email: fishman@ridleylaw.com *Attorneys for Respondent Abigail Dean, A Minor, By And Through Her Parent And Next Friend, Oriel Kaminky*	( ) First Class Mail ( ) Hand Delivery ( ) Facsimile ( ) Overnight Delivery (X) Colorado Courts E-Filing ( ) E-Mail

Scott J. Eldredge Charles R. Mendez Marc C. Johnson Angela McGraw Burg Simpson Eldredge Hersh & Jardine, P.C. 40 Inverness Dr. East Englewood, CO 80112 Telephone: 303.792.5595 *Attorneys for Respondent Abigail Dean, A Minor, By And Through Her Parent And Next Friend, Oriel Kaminky*	( ) First Class Mail ( ) Hand Delivery ( ) Facsimile ( ) Overnight Delivery (X) Colorado Courts E-Filing ( ) E-Mail
Thomas J. Kresl Karman J. Reed Kresl & Singer, PC 130 Rampart Way, Suite 200 Denver, CO 80230 Telephone: 303.336.2100 Facsimile: 303.388.1749 Email: tkresl@kreslsinger.com kreed@kreslsinger.com *Attorneys for Partial Suppressed Party*	( ) First Class Mail ( ) Hand Delivery ( ) Facsimile ( ) Overnight Delivery (X) Colorado Courts E-Filing ( ) E-Mail

s/ Ben Marquez

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EXHIBIT 1

Overview of the 2015 American Congress of Obstetricians and Gynecologists' Survey on Professional Liability

Andrea M. Carpentieri, MA; James J. Lumalcuri, MSW; Jennie Shaw, MPH; and Gerald F. Joseph Jr, MD

The 2015 Survey on Professional Liability is the twelfth survey conducted since 1983 to assess the effects of professional liability litigation and related liability insurance issues on the practice of obstetrics and gynecology. The entire population of the American College of Obstetricians and Gynecologists (ACOG) Fellows and Junior Fellows in practice in the 50 states, the District of Columbia, and Puerto Rico were surveyed and, as was the case in 2012, the questionnaire was available exclusively online. Junior Fellows still in residency and fellowship (subspecialty) training, Founding Fellows, Life Fellows, members of the Armed Forces District, and members living outside the 50 states, the District of Columbia, and Puerto Rico were excluded from the survey.

The survey questionnaire was developed and tested with select ACOG Fellows and staff members. The questionnaire included segments on demographics, patient care, liability claims experience, and practice changes associated with the cost of liability insurance and the fear of litigation. In total, 32,425 Fellows and Junior Fellows in practice were surveyed. The final 4,294 completed surveys were coded and analyzed using Statistical Package for Social Sciences. Data analysis yielded frequency distributions and percentages for each of the survey questions. The final data represent only those 4,294 obstetrician-gynecologists (ob-gyns) who responded to the survey.

Similar to the 11 previous ACOG national surveys[1], this survey addresses the impact of professional liability on the practice of obstetrics and gynecology. It provides continuing trend data about ob-gyns' professional liability experiences and changes in their practice patterns. For all purposes, except analysis of claims, the survey interval is January 1, 2012 through December 31, 2014. Claims themselves may have a duration which extends beyond the survey interval. Similar to the previous surveys, the 2015 survey includes data on professional liability claims in both obstetrics and gynecology, although these claims have been limited to those opened or closed or both between January 1, 2012 and December 31, 2014.

Physicians' Demographics

A majority of the survey respondents were female (56.1%). The average age of survey respondents was 51.4 years. The average male age was higher than the average female age (56.8 years versus 47.1 years).

Practice Setting

The 2015 Survey respondents were asked to identify their practice type. Most of respondents identified their practice as group practice (42.7%), followed by hospital employee (17.8%), solo practice (15.7%), and academic faculty (14.5%).

Patient Care

Physicians were asked a series of questions about the type of patient care they currently provide. A total of 71.8% of respondents indicated that they are providing both obstetric and gynecologic care, which is slightly lower than the 2012 survey result of 72.5%. Gynecologic care only is provided by 19.5% of physicians and obstetric care only is provided by 7.9% of physicians. Of the 19.5% providing gynecologic

[1] 1983, 1985, 1987, 1990, 1992, 1996, 1999, 2003, 2006, 2009, and 2012

care only, 83.5% had previously offered obstetric care. The average age at which these physicians stopped practicing obstetrics was 48 years, slightly younger than that of the 2012 survey (49 years).
Physicians were asked to identify the number of procedures, if any, they performed during an average month. The average number of vaginal deliveries reported was 8.3; cesarean deliveries, 3.5; surgical assists, 2.3; hysterectomies, 2.2; and vaginal births after cesarean deliveries (VBACs), 0.8. The average number of total procedures performed was 25.7, a decrease from the 34.7 reported in 2012.

Professional Liability Insurance

Of all ob-gyns surveyed, 96.6% reported being covered by professional liability insurance, similar to the 2012 result of 96.5%. Of these insured physicians, 58.8% had claims-made coverage, 32.0% had occurrence coverage, and 9.2% had another unidentified type of insurance or were self-insured.

Of those respondents who reported not being covered by professional liability insurance, 38.8% were covered by a bond, escrow account, or other pledge of personal assets to cover defense costs of medical liability claims and adverse judgments. Physicians reported spending an average of 10.6% of their gross income on liability insurance premiums each year. This is a small decrease from the 12.4% reported in 2012.

Changes in Practice as a Result of the Affordability or Availability of Professional Liability Insurance

The 2015 ACOG Survey on Professional Liability asked whether ob-gyns had made any practice changes since January 2012 because of the affordability or availability of professional liability insurance. Of the 4,294 responses to this question, 39.8% reported having made one or more changes to their practice. This is a considerable decrease from the 2012 survey which reported 51.1% of ob-gyns making changes. Compared with national data, more ob-gyns in District II (52.4%) and District XII (53.1%) and fewer ob-gyns in Districts VIII (34.2%) and XI (31.6%) reported such changes.

Obstetric Practice Changes

Of the survey respondents who reported making changes to their obstetric practice because of insurance affordability or availability, 9.6% reported increasing the number of cesarean deliveries. Additionally, 13.6% reported decreasing the number of high-risk obstetric patients, 6.4% decreased the number of total deliveries, 8.4% stopped offering or performing VBACs, and 3.9% stopped practicing obstetrics altogether.

Overall, in relation to national averages, more respondents in Districts II and XII and fewer respondents in Districts I, VIII and XI reported adverse obstetric practice changes (See Table 1).

Gynecologic Practice Changes

Of all ob-gyns who reported making changes in their gynecologic practice due to the affordability or availability of professional liability insurance, 12.0% decreased gynecologic surgical procedures. An additional 4.9% stopped performing major gynecologic surgery, and 1.4% stopped performing all surgery.

Compared to national averages, more respondents in Districts II and XII and fewer respondents in District XI reported negative changes in gynecologic practice (see Table 1).

Changes in Practice Economics

Relative to changes in practice economics, 13.1% of all ob-gyn respondents reported they had reduced their salary by greater than 10%; 2.6% of respondents reported relocating their practice to another state

or to another jurisdiction within the same state; and 0.4% ceased carrying liability insurance coverage completely. Many more respondents in District XII (Florida) reported dropping all liability insurance coverage (6.7%).

Changes in Practice as a Result of the Risk or Fear of Professional Liability Claims or Litigation

The 2015 ACOG Survey on Professional Liability asked whether ob-gyns had made any practice changes since January 2012 as a result of the risk or fear of professional liability claims or litigation. Of the 4,294 responses, 49.7% reported having made one or more changes to their practice. More ob-gyns in District XII (65.2%) and fewer ob-gyns in District VIII (42.3%) reported any changes relative to the national average.

Obstetric Practice Changes

Of the survey respondents who reported making changes to their obstetric practice as a result of the risk or fear of professional liability claims or litigation, 23.8% decreased the number of high-risk obstetric patients, 17.0% reported increasing the number of cesarean deliveries, and 13.4% stopped offering and performing VBACs. An additional 9.3% decreased the number of total deliveries, and 5.1% stopped practicing obstetrics altogether.

More respondents in Districts II and XII and fewer respondents in Districts I and VIII reported adverse practice changes (See Table 2).

Gynecologic Practice Changes

Of all ob-gyns who reported making changes in their gynecologic practice as a result of the risk or fear of professional liability claims or litigation, 19.7% decreased gynecologic surgical procedures, 7.7% stopped performing major gynecologic surgery, and 2.0% stopped performing all surgery.

Relative to national averages, more respondents in Districts II and XII and fewer respondents in District XI reported negative changes in gynecologic practice (see Table 2).

Changes in Practice Type and Location

In relation to practice type and practice location, 10.7% of all ob-gyn respondents became an employee of a hospital, the government, or other institution and 3.6% relocated their practice to another state or to another jurisdiction within the same state.

Professional Liability Claims Experience

At least one professional liability claim was filed against 73.6% of respondents during their professional careers, with an average of 2.59 claims per ob-gyn. Of these, 41.1% reported they experienced at least one professional liability claim filed against them as a result of care rendered during their residency training. The average age at which an ob-gyn experienced his or her first claim was 36.6 years old.

Respondents to the 2015 survey were asked a series of questions on claims opened and/or closed during the interval of January 1, 2012 through December 31, 2014. Of the 4,294 ob-gyn respondents, 40.5% reported one or more such claims: 28.0% had one claim, 9.3% had two claims, 2.4% had three claims, and 0.8% had four or more claims. Of these claims, 63.5% involved obstetric care, and 36.5% were related to gynecologic care.

Obstetric Claims

The survey respondents reported on a total of 1,117 obstetric claims. Neurologically impaired infant claims were more likely to be the primary allegation of an obstetric claim (27.4%) than any other primary

allegation. Stillbirth or neonatal death was the second most frequent primary obstetric allegation (15.0%). Of the neurologically impaired infant claims, 55.2% were delivered by cesarean, 40.5% were delivered vaginally, and 2.0% were delivered by VBAC.

Other Factors

Respondents were asked to identify other primary factors that applied to their obstetric claims. Among the associated primary factors, 22.1% involved electronic fetal monitoring, 14.2% of cases involved shoulder dystocia/brachial plexus injury, 10.6% involved actions of ob-gyn residents, and 10.5% involved lack of communication among health care providers.

Gynecologic Claims

Survey respondents reported on a total of 641 gynecologic claims. “Patient injury-major” claims were more likely to be the primary allegation of gynecologic claims (27.9%) than any other allegation. “Patient injury-minor” was the second most frequent primary allegation (23.4%) followed by "delay in or failure to diagnose" (21.5%). Of the claims involving “delay in or failure to diagnose,” 59.4% involved a failure to diagnose cancer. Of these, breast cancer (39.0%) was the most frequent type of cancer; cervical, uterine, and other cancers were second at a frequency of 15.9% each; followed by ovarian and fallopian tube cancer, 12.2% and 1.2%, respectively.

Other Factors

Respondents were asked to identify other primary factors that applied to their gynecologic claims. Among the associated primary factors, 42.0% cited “surgical complications” as a general category. Two specifically identified areas within this category were claims arising from hysterectomies (27.0%) and laparoscopic procedures (20.3%).

Claim Outcomes

Of the 1,085 respondents who indicated how their claims were closed, 47.8% were reported dropped or settled without any payment on behalf of the ob-gyn. Outcomes included those dropped by the plaintiff (33.5%), dismissed by the court (10.4%), and settled without payment on behalf of the ob-gyn (3.9%). A total of 35.9% of respondents reported a settlement that involved payment on behalf of the ob-gyn. The remaining claims were resolved through either jury or court verdict (11.2%) or arbitration/another form of alternative dispute resolution (5.0%). Of those, 33.5% resulted in an indemnity payment on behalf of the ob-gyn.

The average for all paid claims was $486,066. The average payment for claims involving a neurologically impaired infant was $1,030,151. Other average payments for obstetric claims include “other infant injury-major,” $493,691, and “stillbirth/neonatal death,” $308,107. Average payments for gynecologic claims include “failure to diagnose breast cancer," $420,667, and “patient injury-major,” $424,838.

Conclusion

More than one-third (39.8%) of ob-gyn survey respondents have made one or more changes to their practice as a result of the affordability or availability or both of professional liability insurance, and almost one half (49.7%) have made one or more changes to their practice as a result of the risk or fear of professional liability claims or litigation. In both instances, ob-gyns significantly decreased the number of high-risk obstetric patients (13.6% and 23.8% respectively) and stopped performing or offering VBACs (8.4% and 13.4% respectively). In both instances, approximately 4% and 5% of respondents stopped practicing obstetrics altogether. The average age at which physicians stopped practicing obstetrics was 48 years, at one time the near midpoint of an ob-gyn’s professional career. In sum, the current medical-legal

environment continues to deprive women of all ages, especially pregnant women, of their most educated and experienced women's health care physicians. Quality health care for women is negatively affected through a diminution of obstetric services, a reduction in gynecologic surgery, and the widespread practice of defensive medicine**.**

Table 1. Obstetric and Gynecologic Practice Changes as a Result of the Affordability or Availability of Professional Liability Insurance

Practice Changes	National Rate (%)	Greater than National Rate		Less than National Rate	
		District*	Rate (%)	District*	Rate (%)
Decreased number of high-risk obstetric patients	13.6	XII II	23.2 22.5	I, VIII XI	8.5 9.2
Increased number of cesarean deliveries	9.6	II XII	16.5 14.7	VIII XI	4.5 6.1
Stopped offering and performing VBAC	8.4	XII	18.3	VIII I	3.4 4.1
Decreased number of total deliveries	6.4	II	11.4	VIII XI	4.0 4.8
Stopped practicing obstetrics	3.9	XII	9.4	VIII	2.0
Decreased gynecologic surgical procedures	12.0	II XII	21.9 18.3	XI	3.7
Stopped performing major gynecologic surgery	4.9	II	11.4	XI VII	2.4 2.5
Stopped performing all surgery	1.4	I XII	3.7 3.6	VI	0.5

Table 2. Obstetric and Gynecologic Practice Changes as a Result of the Risk or Fear of Professional Liability Claims or Litigation

Practice Changes	National Rate (%)	Greater than National Rate		Less than National Rate	
		District*	Rate (%)	District*	Rate (%)
Decreased number of high-risk obstetric patients	23.8	II XII	33.8 32.1	VIII I	16.3 17.3
Increased number of cesarean deliveries	17.0	II XII	23.7 21.0	VIII	9.8
Stopped offering and performing VBAC	13.4	XII	29.0	I VIII	6.4 6.7
Decreased number of total deliveries	9.3	II VI	12.6 12.3	IV, VIII	6.5
Stopped practicing obstetrics	5.1	XII	10.7	VII, VIII	3.4
Decreased gynecologic surgical procedures	19.7	XII II	28.6 27.2	XI	9.9
Stopped performing major gynecologic surgery	7.7	II	17.1	VII	4.1
Stopped performing all surgery	2.0	I XII	4.1 4.0	XI	0.7

***ACOG Districts:**
District I: CT, ME, MA, NH, RI, and VT
District II: NY
District III: DE, NJ, and PA
District IV: DC, GA, MD, NC, PR, SC, VA, and WV
District V: IN, KY, MI, and OH
District VI: IL, IA, MN, NE, ND, SD, and WI
District VII: AL, AR, KS, LA, MS, MO, OK, and TN
District VIII: AK, AZ, CO, HI, ID, MT, NV, NM, OR, UT, WA, and WY
District IX: CA
District XI: TX
District XII: FL

Exhibit 1