**TITLE 78B, CHAPTER 3, PART 4**
**UTAH HEALTH CARE MALPRACTICE ACT**

**78B-3-401. Title.**

This part shall be known and may be cited as the "Utah Health Care Malpractice Act."

**78B-3-402. Legislative findings and declarations - Purpose of act.**

(1) The legislature finds and declares that the number of suits and claims for damages and the amount of judgments and settlements arising from health care has increased greatly in recent years. Because of these increases the insurance industry has substantially increased the cost of medical malpractice insurance. The effect of increased insurance premiums and increased claims is increased health care cost, both through the health care providers passing the cost of premiums to the patient and through the provider's practicing defensive medicine because he views a patient as a potential adversary in a lawsuit. Further, certain health care providers are discouraged from continuing to provide services because of the high cost and possible unavailability of malpractice insurance.

(2) In view of these recent trends and with the intention of alleviating the adverse effects which these trends are producing in the public's health care system, it is necessary to protect the public interest by enacting measures designed to encourage private insurance companies to continue to provide health-related malpractice insurance while at the same time establishing a mechanism to ensure the availability of insurance in the event that it becomes unavailable from private companies.

(3) In enacting this act, it is the purpose of the legislature to provide a reasonable time in which actions may be commenced against health care providers while limiting that time to a specific period for which professional liability insurance premiums can be reasonably and accurately calculated; and to provide other procedural changes to expedite early evaluation and settlement of claims.

**78B-3-403. Definitions.**

As used in this part:

(1) "Audiologist" means a person licensed to practice audiology under Title 58, Chapter 41, Speech-language Pathology and Audiology Licensing Act.

(2) "Certified social worker" means a person licensed to practice as a certified social worker under Section 58-60-205.

(3) "Chiropractic physician" means a person licensed to practice chiropractic under Title 58, Chapter 73, Chiropractic Physician Practice Act.

(4) "Clinical social worker" means a person licensed to practice as a clinical social worker under Section 58-60-205.

(5) "Commissioner" means the commissioner of insurance as provided in Section 31A-2-102.

(6) "Dental hygienist" means a person licensed to engage in the practice of dental hygiene as defined in Section 58-69-102.

(7) "Dentist" means a person licensed to engage in the practice of dentistry as defined in Section 58-69-102.

(8) "Division" means the Division of Occupational and Professional Licensing created in Section 58-1-103.

(9) "Future damages" includes a judgment creditor's damages for future medical treatment, care or custody, loss of future earnings, loss of bodily function, or future pain and suffering.

(10) "Health care" means any act or treatment performed or furnished, or which should have been performed or furnished, by any health care provider for, to, or on behalf of a patient during the patient's medical care, treatment, or confinement.

(11) "Health care facility" means general acute hospitals, specialty hospitals, home health agencies, hospices, nursing care facilities, assisted living facilities, birthing centers, ambulatory surgical facilities, small health care facilities, health care facilities owned or operated by health maintenance organizations, and end stage renal disease facilities.

(12) "Health care provider" includes any person, partnership, association, corporation, or other facility or institution who causes to be rendered or who renders health care or professional services as a hospital, health care facility, physician, registered nurse, licensed practical nurse, nurse-midwife, licensed Direct-entry midwife, dentist, dental hygienist, optometrist, clinical laboratory technologist, pharmacist, physical therapist, physical therapist assistant, podiatric physician, psychologist, chiropractic physician, naturopathic physician, osteopathic physician, osteopathic physician and surgeon, audiologist, speech-language pathologist, clinical social worker, certified social worker, social service worker, marriage and family counselor, practitioner of obstetrics, licensed athletic trainer, or others rendering similar care and services relating to or arising out of the health needs of persons or groups of persons and officers, employees, or agents of any of the above acting in the course and scope of their employment.

(13) "Hospital" means a public or private institution licensed under Title 26, Chapter 21, Health Care Facility Licensure and Inspection Act.

(14) "Licensed athletic trainer" means a person licensed under Title 58, Chapter 40a, Athletic Trainer Licensing Act.

(15) "Licensed Direct-entry midwife" means a person licensed under the Direct-entry Midwife Act to engage in the practice of direct-entry midwifery as defined in Section 58-77-102.

(16) "Licensed practical nurse" means a person licensed to practice as a licensed practical nurse as provided in Section 58-31b-301.

(17) "Malpractice action against a health care provider" means any action against a health care provider, whether in contract, tort, breach of warranty, wrongful death, or otherwise, based upon alleged personal injuries relating to or arising out of health care



rendered or which should have been rendered by the health care provider.

(18) "Marriage and family therapist" means a person licensed to practice as a marriage therapist or family therapist under Sections 58-60-305 and 58-60-405.

(19) "Naturopathic physician" means a person licensed to engage in the practice of naturopathic medicine as defined in Section 58-71-102.

(20) "Nurse-midwife" means a person licensed to engage in practice as a nurse midwife under Section 58-44a-301.

(21) "Optometrist" means a person licensed to practice optometry under Title 58, Chapter 16a, Utah Optometry Practice Act.

(22) "Osteopathic physician" means a person licensed to practice osteopathy under Title 58, Chapter 68, Utah Osteopathic Medical Practice Act.

(23) "Patient" means a person who is under the care of a health care provider, under a contract, express or implied.

(24) "Periodic payments" means the payment of money or delivery of other property to a judgment creditor at intervals ordered by the court.

(25) "Pharmacist" means a person licensed to practice pharmacy as provided in Section 58-17b-301.

(26) "Physical therapist" means a person licensed to practice physical therapy under Title 58, Chapter 24b, Physical Therapy Practice Act.

(27) "Physical therapist assistant" means a person licensed to practice physical therapy, within the scope of a physical therapist assistant license, under Title 58, Chapter 24b, Physical Therapy Practice Act.

(28) "Physician" means a person licensed to practice medicine and surgery under Title 58, Chapter 67, Utah Medical Practice Act.

(29) "Podiatric physician" means a person licensed to practice podiatry under Title 58, Chapter 5a, Podiatric Physician Licensing Act.

(30) "Practitioner of obstetrics" means a person licensed to practice as a physician in this state under Title 58, Chapter 67, Utah Medical Practice Act, or under Title 58, Chapter 68, Utah Osteopathic Medical Practice Act.

(31) "Psychologist" means a person licensed under Title 58, Chapter 61, Psychologist Licensing Act, to engage in the practice of psychology as defined in Section 58-61-102.

(32) "Registered nurse" means a person licensed to practice professional nursing as provided in Section 58-31b-301.

(33) "Relative" means a patient's spouse, parent, grandparent, stepfather, stepmother, child, grandchild, brother, sister, half brother, half sister, or spouse's parents. The term includes relationships that are created as a result of adoption.

(34) "Representative" means the spouse, parent, guardian, trustee, attorney-in-fact, person designated to make decisions on behalf of a patient under a medical power of attorney, or other legal agent of the patient.

(35) "Social service worker" means a person licensed to practice as a social service worker under Section 58-60-205.

(36) "Speech-language pathologist" means a person licensed to practice speech-language pathology under Title 58, Chapter 41, Speech-language Pathology and Audiology Licensing Act.

(37) "Tort" means any legal wrong, breach of duty, or negligent or unlawful act or omission proximately causing injury or damage to another.

(38) " Unanticipated outcome" means the outcome of a medical treatment or procedure that differs from an expected result.

**78B-3-404. Statute of limitations - Exceptions - Application.**

(1) A malpractice action against a health care provider shall be commenced within two years after the plaintiff or patient discovers, or through the use of reasonable diligence should have discovered the injury, whichever first occurs, but not to exceed four years after the date of the alleged act, omission, neglect, or occurrence.

(2) Notwithstanding Subsection (1):

(a) In an action where the allegation against the health care provider is that a foreign object has been wrongfully left within a patient's body, the claim shall be barred unless commenced within one year after the plaintiff or patient discovers, or through the use of reasonable diligence should have discovered, the existence of the foreign object wrongfully left in the patient's body, whichever first occurs; or

(b) In an action where it is alleged that a patient has been prevented from discovering misconduct on the part of a health care provider because that health care provider has affirmatively acted to fraudulently conceal the alleged misconduct, the claim shall be barred unless commenced within one year after the plaintiff or patient discovers, or through the use of reasonable diligence, should have discovered the fraudulent concealment, whichever first occurs.

(3) The limitations in this section shall apply to all persons, regardless of minority or other legal disability under Section 78B-2-108 or any other provision of the law.

**78B-3-405. Amount of award reduced by amounts of collateral sources available to plaintiff - No reduction where subrogation right exists - Collateral sources defined - Procedure to preserve subrogation rights - Evidence admissible - Exceptions.**

(1) In all malpractice actions against health care providers as defined in Section 78B-3-402 in which damages are awarded to compensate the plaintiff for losses sustained, the court shall reduce the amount of the award by the total of all amounts paid to the plaintiff from all collateral sources which are available to him. No reduction may be made for collateral sources for which a subrogation right exists as provided in this section nor shall there be a reduction for any collateral payment not included in the award



of damages.

(2) Upon a finding of liability and an awarding of damages by the trier of fact, the court shall receive evidence concerning the total amounts of collateral sources which have been paid to or for the benefit of the plaintiff or are otherwise available to him. The court shall also take testimony of any amount which has been paid, contributed, or forfeited by, or on behalf of the plaintiff or members of his immediate family to secure his right to any collateral source benefit which he is receiving as a result of his injury, and shall offset any reduction in the award by those amounts. Evidence may not be received and a reduction may not made with respect to future collateral source benefits except as specified in Subsection (5).

(3) For purposes of this section "collateral source" means payments made to or for the benefit of the plaintiff for:

(a) medical expenses and disability payments payable under the United States Social Security Act, any federal, state, or local income disability act, or any other public program, except the federal programs which are required by law to seek subrogation;

(b) any health, sickness, or income disability insurance, automobile accident insurance that provides health benefits or income disability coverage, and any other similar insurance benefits, except life insurance benefits available to the plaintiff, whether purchased by the plaintiff or provided by others;

(c) any contract or agreement of any person, group, organization, partnership, or corporation to provide, pay for, or reimburse the costs of hospital, medical, dental, or other health care services, except benefits received as gifts, contributions, or assistance made gratuitously; and

(d) any contractual or voluntary wage continuation plan provided by employers or any other system intended to provide wages during a period of disability.

(4) To preserve subrogation rights for amounts paid or received prior to settlement or judgment, a provider of collateral sources shall, at least 30 days before settlement or trial of the action, serve a written notice upon each health care provider against whom the malpractice action has been asserted. The written notice shall state:

(a) the name and address of the provider of collateral sources;

(b) the amount of collateral sources paid;

(c) the names and addresses of all persons who received payment; and

(d) the items and purposes for which payment has been made.

(5) Evidence is admissible of government programs that provide payments or benefits available in the future to or for the benefit of the plaintiff to the extent available irrespective of the recipient's ability to pay. Evidence of the likelihood or unlikelihood that the programs, payments, or benefits will be available in the future is also admissible. The trier of fact may consider the evidence in determining the amount of damages awarded to a plaintiff for future expenses.

(6) No provider of collateral sources is entitled to recover any amount of benefits from a health care provider, the plaintiff, or any other person or entity as reimbursement for collateral source payments made prior to settlement or judgment, including any payments made under Title 26, Chapter 19, except to the extent that subrogation rights to amounts paid prior to settlement or judgment are preserved as provided in this section.

(7) All policies of insurance providing benefits affected by this section are construed in accordance with this section.

**78B-3-406. Failure to obtain informed consent - Proof required of patient - Defenses - Consent to health care.**

(1) When a person submits to health care rendered by a health care provider, it is presumed that actions taken by the health care provider are either expressly or impliedly authorized to be done. For a patient to recover damages from a health care provider in an action based upon the provider's failure to obtain informed consent, the patient must prove the following:

(a) that a provider-patient relationship existed between the patient and health care provider;

(b) the health care provider rendered health care to the patient;

(c) the patient suffered personal injuries arising out of the health care rendered;

(d) the health care rendered carried with it a substantial and significant risk of causing the patient serious harm;

(e) the patient was not informed of the substantial and significant risk;

(f) a reasonable, prudent person in the patient's position would not have consented to the health care rendered after having been fully informed as to all facts relevant to the decision to give consent; and

(g) the unauthorized part of the health care rendered was the proximate cause of personal injuries suffered by the patient.

(2) In determining what a reasonable, prudent person in the patient's position would do under the circumstances, the finder of fact shall use the viewpoint of the patient before health care was provided and before the occurrence of any personal injuries alleged to have arisen from said health care.

(3) It shall be a defense to any malpractice action against a health care provider based upon alleged failure to obtain informed consent if:

(a) the risk of the serious harm which the patient actually suffered was relatively minor;

(b) the risk of serious harm to the patient from the health care provider was commonly known to the public;

(c) the patient stated, prior to receiving the health care complained of, that he would accept the health care involved regardless of the risk; or that he did not want to be informed of the matters to which he would be entitled to be informed;

(d) the health care provider, after considering all of the attendant facts and circumstances, used reasonable discretion as to the manner and extent to which risks were disclosed, if the health care provider reasonably believed that additional disclosures could be



expected to have a substantial and adverse effect on the patient's condition; or

(e) the patient or his representative executed a written consent which sets forth the nature and purpose of the intended health care and which contains a declaration that the patient accepts the risk of substantial and serious harm, if any, in hopes of obtaining desired beneficial results of health care and which acknowledges that health care providers involved have explained his condition and the proposed health care in a satisfactory manner and that all questions asked about the health care and its attendant risks have been answered in a manner satisfactory to the patient or his representative.

(4) The written consent shall be a defense to an action against a health care provider based upon failure to obtain informed consent unless the patient proves that the person giving the consent lacked capacity to consent or shows by clear and convincing evidence that the execution of the written consent was induced by the defendant's affirmative acts of fraudulent misrepresentation or fraudulent omission to state material facts.

(5) This act may not be construed to prevent any person 18 years of age or over from refusing to consent to health care for his own person upon personal or religious grounds.

(6) The following persons are authorized and empowered to consent to any health care not prohibited by law:

(a) any parent, whether an adult or a minor, for his minor child;

(b) any married person, for a spouse;

(c) any person temporarily standing in loco parentis, whether formally serving or not, for the minor under his care and any guardian for his ward;

(d) any person 18 years of age or over for his or her parent who is unable by reason of age, physical or mental condition, to provide such consent;

(e) any patient 18 years of age or over;

(f) any female regardless of age or marital status, when given in connection with her pregnancy or childbirth;

(g) in the absence of a parent, any adult for his minor brother or sister; and

(h) in the absence of a parent, any grandparent for his minor grandchild.

(7) A person who in good faith consents or authorizes health care treatment or procedures for another as provided by this act may not be subject to civil liability.

**78B-3-407. Limitation on actions against health care providers when parent or guardian refuses to consent to health care of child.**

(1) A malpractice action against a health care provider may not be brought on the basis of the consequences resulting from the refusal of a child's parent or guardian to consent to the child's health care, if:

(a) the health care is recommended by the health care provider;

(b) the parent or guardian is provided with sufficient information to make an informed decision regarding the recommendation of the health care provider; and

(c) the consent of the parent or guardian is required by law before the health care may be administered.

(2) The sole purpose of this section is to prohibit a malpractice action against a health care provider under the circumstances set forth by this section. This section may not be construed to:

(a) created a new cause of action;

(b) expand an existing cause of action;

(c) impose a new duty on a health care provider; or

(d) expand an existing duty of a health care provider.

**78B-3-408. Writing required as basis for liability for breach of guarantee, warranty, contract or assurance of result.**

Liability may not be imposed upon any health care provider on the basis of an alleged breach of guarantee, warranty, contract or assurance of result to be obtained from any health care rendered unless the guarantee, warranty, contract or assurance is set forth in writing and signed by the health care provider or an authorized agent of the provider.

**78B-3-409. Ad damnum clause prohibited in complaint.**

A dollar amount may not be specified in the prayer of a complaint filed in a malpractice action against a health care provider. The complaint shall merely pray for such damages as are reasonable in the circumstances.

**78B-3-410. Limitation of award of noneconomic damages in malpractice actions.**

(1) In a malpractice action against a health care provider, an injured plaintiff may recover noneconomic losses to compensate for pain, suffering, and inconvenience. The amount of damages awarded for noneconomic loss may not exceed:

(a) for a cause of action arising before July 1, 2001, $250,000;

(b) for a cause of action arising on or after July 1, 2001 and before July 1, 2002, the limitation is adjusted for inflation to $400,000;

(c) for a cause of action arising on or after July 1, 2002, and before May 15, 2010 the $400,000 limitation described in Subsection (1)(b) shall be adjusted for inflation as provided in Subsection (2); and

(d) for a cause of action arising on or before May 15, 2010, $450,000.

(2) (a) Beginning July 1, 2002 and each July 1 thereafter until July 1, 2009, the limit for damages under Subsection (1)(c) shall be adjusted for inflation by the state treasurer.

(b) By July 15 of each year until July 1, 2009, the state treasurer shall:

(i) certify the inflation-adjusted limit calculated under this Subsection (2); and

(ii) inform the Administrative Office of the Courts of the certified limit.

(c) The amount resulting from Subsection (2)(a) shall:

(i) be rounded to the nearest $10,000; and

(ii) apply to a cause of action arising on or after the date the annual adjustment is made.

(3) As used in this section, "inflation" means the seasonally adjusted consumer price index for all urban consumers as published by the Bureau of Labor Statistics of the United States Department of Labor.

(4) The limit under Subsection (1) does not apply to awards of punitive damages.

**78B-3-411. Limitation on attorney's contingency fee in malpractice action.**

(1) In any malpractice action against a health care provider as defined in Section 78B-3-402, an attorney may not collect a contingent fee for representing a client seeking damages in connection with or arising out of personal injury or wrongful death caused by the negligence of another which exceeds 331/3% of the amount recovered.

(2) This limitation applies regardless of whether the recovery is by settlement, arbitration, judgment, or whether appeal is involved.

**78B-3-412. Notice of intent to commence action.**

(1) A malpractice action against a health care provider may not be initiated unless and until the plaintiff:

(a) gives the prospective defendant or his executor or successor, at least 90 days' prior notice of intent to commence an action; and

(b) except for an action against a dentist, the plaintiff receives a certificate of compliance from the division in accordance with Section 78B-3-418.

(2) The notice shall include:

(a) a general statement of the nature of the claim;

(b) the persons involved;

(c) the date, time, and place of the occurrence;

(d) the circumstances surrounding the claim;

(e) specific allegations of misconduct on the part of the prospective defendant; and

(f) the nature of the alleged injuries and other damages sustained.

(3) Notice may be in letter or affidavit form executed by the plaintiff or his attorney. Service shall be accomplished by persons authorized and in the manner prescribed by the Utah Rules of Civil Procedure for the service of the summons and complaint in a civil action or by certified mail, return receipt requested, in which case notice shall be considered served on the date of mailing.

(4) Notice shall be served within the time allowed for commencing a malpractice action against a health care provider. If the notice is served less than ninety days prior to the expiration of the applicable time period, the time for commencing the malpractice action against the health care provider shall be extended to 120 days from the date of service of notice.

(5) This section shall, for purposes of determining its retroactivity, not be construed as relating to the limitation on the time for commencing any action, and shall apply only to causes of action arising on or after April 1, 1976. This section shall not apply to third party actions, counterclaims or crossclaims against a health care provider.

**78B-3-413. Professional liability insurance coverage for providers - Insurance commissioner may require joint underwriting authority.**

(1) The commissioner may, after a public hearing, find that professional liability insurance coverage for health care providers is not readily available in the voluntary market in a specific part of this state, and that the public interest requires the action be taken.

(2) The commissioner may promulgate rules and implement plans to provide insurance coverage through all insurers issuing professional liability policies and individual and group accident and sickness policies providing medical, surgical or hospital expense coverage on either a prepaid or an expense incurred basis, including personal injury protection and medical expense coverage issued incidental to liability insurance policies.

**78B-3-414. Periodic payment of future damages in malpractice actions.**

(1) In any malpractice action against a health care provider, as defined in Section 78B-3-402, the court shall, at the request of any party, order that future damages which equal or exceed $100,000, less amounts payable for attorney fees and other costs which are due at the time of judgment, shall be paid by periodic payments rather than by a lump sum payment.

(2) In rendering a judgment which orders the payment of future damages by periodic payments, the court shall order periodic payments to provide a fair correlation between the sustaining of losses and the payment of damages.

(a) Lost future earnings shall be paid over the judgment creditor's work life expectancy.

(b) The court shall also order, when appropriate, that periodic payments increase at a fixed rate, equal to the rate of inflation which the finder of fact used to determine the amount of future damages, or as measured by the most recent Consumer Price Index applicable to Utah for all goods and services.

(c) The present cash value of all periodic payments shall equal the fact finder's award of future damages, less any amount paid for attorney fees and costs.

(d) The present cash value of periodic payments shall be determined by discounting the total amount of periodic payments projected over the judgment creditor's life expectancy, by the rate of interest which the finder of fact used to reduce the amount of future damages to present value, or the rate of interest available at the time of trial on one year U.S. Government Treasury Bills.

(3) Before periodic payments of future damages may be ordered, the court shall require a judgment debtor to post security which assures full payment of those damages. Security for payment of a judgment of periodic payments may be in one or more of the following forms:

(a) a bond executed by a qualified insurer;

(b) an annuity contract executed by a qualified insurer;

(c) evidence of applicable and collectable liability insurance with one or more qualified insurers;

(d) an agreement by one or more qualified insurers to guarantee payment of the judgment; or

(e) any other form of security approved by the court.

(4) Security which complies with this section may also serve as a supersedeas bond, where one is required.

(5) A judgment which orders payment of future damages by periodic payments shall specify the recipient or recipients of the payments, the dollar amount of the payments, the interval between payments, and the number of payments or the period of time over which payments shall be made. Those payments may only be modified in the event of the death of the judgment creditor.

(6) If the court finds that the judgment debtor, or the assignee of his obligation to make periodic payments, has failed to make periodic payments as ordered by the court, it shall, in addition to the required periodic payments, order the judgment debtor or his assignee to pay the judgment creditor all damages caused by the failure to make payments, including court costs and attorney fees.

(7) The obligation to make periodic payments for all future damages, other than damages for loss of future earnings, shall cease upon the death of the judgment creditor. Damages awarded for loss of future earnings may not be reduced or payments terminated by reason of the death of the judgment creditor, but shall be paid to persons to whom the judgment creditor owed a duty of support, as provided by law, immediately prior to his death. In that case the court which rendered the original judgment may, upon petition of any party in interest, modify the judgment to award and apportion the unpaid future damages in accordance with this section.

(8) If security is posted in accordance with Subsection (3), and approved by a final judgment entered under this section, the judgment is considered to be satisfied, and the judgment debtor on whose behalf the security is posted shall be discharged.

**78B-3-415. Actions under Utah Governmental Immunity Act.**

The provisions of this part shall apply to malpractice actions against health care providers which are brought under the Utah Governmental Immunity Act if applicable. This part may not affect the requirements for filing notices of claims, times for commencing actions and limitations on amounts recoverable under the Utah Governmental Immunity Act.

**78B-3-416. Division to provide panel - Exemption - Procedures - Statute of limitations tolled - Composition of panel - Expenses - Division authorized to set license fees.**

(1) (a) The division shall provide a hearing panel in alleged medical liability cases against health care providers as defined in Section 78B-3-402, except dentists.

(b) (i) The division shall establish procedures for prelitigation consideration of medical liability claims for damages arising out of the provision of or alleged failure to provide health care.

(ii) The division may establish rules necessary to administer the process and procedures related to prelitigation hearings and the conduct of prelitigation hearings in accordance with Sections 78B-3-416 through 78B-3-420.

(c) The proceedings are informal, nonbinding, and are not subject to Title 63G, Chapter 4, Administrative Procedures Act, but are compulsory as a condition precedent to commencing litigation.

(d) Proceedings conducted under authority of this section are confidential, privileged, and immune from civil process.

(2) (a) The party initiating a medical liability action shall file a request for prelitigation panel review with the division within 60 days after the filing of a statutory notice of intent to commence action under Section 78B-3-412.

(b) The request shall include a copy of the notice of intent to commence action. The request shall be mailed to all health care providers named in the notice and request.

(3) (a) The filing of a request for prelitigation panel review under this section tolls the applicable statute of limitations until the later of:

(i) 60 days following the division's issuance of:

(A) an opinion by the prelitigation panel; or

(B) a certificate of compliance under Section 78B-3-418; or

(ii)_the expiration of the time for holding a hearing under Subsection (3)(b)(ii).



(b) The division shall:

(i) send any opinion issued by the panel to all parties by regular mail; and

(ii) complete a prelitigation hearing under this section within:

(A) 180 days after the filing of the request for prelitigation panel review; or

(B) any longer period as agreed upon in writing by all parties to the review.

(c) If the prelitigation hearing has not been completed within the time limits established in Subsection (3)(b)(ii), the claimant shall:

(i) file an affidavit of merit under the provisions of Section 78B-3-423; or

(ii) file an affidavit with the division within 180 days of the request for pre-litigation review, in accordance with Subsection (30(d), alleging that the respondent has failed to reasonably cooperate in scheduling the hearing.

(d) If the claimant files an affidavit under Subsection (3)(c)(ii):

(i) within 15 days of the filing of the affidavit under Subsection (3)(c)(ii), the division shall determine whether either the respondent or the claimant failed to reasonably cooperate in the scheduling of a pre-litigation hearing; and

(ii)(A) if the determination is that the respondent failed to reasonably cooperate in the scheduling of a hearing, and the claimant did not fail to reasonably cooperate, the division shall, issue a certificate of compliance for the claimant in accordance with Section 78B-3-418; or

(B) if the division makes a determination other than the determination in Subsection (3)(d)(ii)(A), the claimant shall file an affidavit of merit in accordance with Section 78B-3-423, within 30 days of the determination of the division under this Subsection (3).

(e) (i) The claimant and any respondent may agree by written stipulation that no useful purpose would be served by convening a prelitigation panel under this section.

(ii) When the stipulation is filed with the division, the division shall within ten days after receipt issue a certificate of compliance under Section 78B-3-418, as it concerns the stipulating respondent, and stating that the claimant has complied with all conditions precedent to the commencement of litigation regarding the claim.

(4) The division shall provide for and appoint an appropriate panel or panels to hear complaints of medical liability and damages, made by or on behalf of any patient who is an alleged victim of medical liability. The panels are composed of:

(a) one member who is a resident lawyer currently licensed and in good standing to practice law in this state and who shall serve as chairman of the panel, who is appointed by the division from among qualified individuals who have registered with the division indicating a willingness to serve as panel members, and a willingness to comply with the rules of professional conduct governing lawyers in the state of Utah, and who has completed division training regarding conduct of panel hearings;

(b) (i) one member who is a licensed health care provider listed under Section 78B-3-403, who is practicing and knowledgeable in the same specialty as the proposed defendant, and who is appointed by the division in accordance with Subsection (5); or

(ii) in claims against only hospitals or their employees, one member who is an individual currently serving in a hospital administration position directly related to hospital operations or conduct that includes responsibility for the area of practice that is the subject of the liability claim, and who is appointed by the division; and

(c) a lay panelist who is not a lawyer, doctor, hospital employee, or other health care provider, and who is a responsible citizen of the state, selected and appointed by the division from among individuals who have completed division training with respect to panel hearings.

(5) (a) Each person listed as a health care provider in Section 78B-3-403 and practicing under a license issued by the state, is obligated as a condition of holding that license to participate as a member of a medical liability prelitigation panel at reasonable times, places, and intervals, upon issuance, with advance notice given in a reasonable time frame, by the division of an Order to Participate as a Medical Liability Prelitigation Panel Member.

(b) A licensee may be excused from appearance and participation as a panel member upon the division finding participation by the licensee will create an unreasonable burden or hardship upon the licensee.

(c) A licensee whom the division finds failed to appear and participate as a panel member when so ordered, without adequate explanation or justification and without being excused for cause by the division, may be assessed an administrative fine not to exceed $5,000.

(d) A licensee whom the division finds intentionally or repeatedly failed to appear and participate as a panel member when so ordered, without adequate explanation or justification and without being excused for cause by the division, may be assessed an administrative fine not to exceed $5,000, and is guilty of unprofessional conduct.

(e) All fines collected under Subsections (5)(c) and (d) shall be deposited in the Physicians Education Fund created in Section 58-67a-1.

(6) Each person selected as a panel member shall certify, under oath, that he has no bias or conflict of interest with respect to any matter under consideration.

(7) Members of the prelitigation hearing panels shall receive per diem compensation and travel expenses for attending panel hearings as established by rules of the division.

(8) (a) In addition to the actual cost of administering the licensure of health care providers, the division may set license fees of health care providers within the limits established by law equal to their proportionate costs of administering prelitigation panels.

(b) The claimant bears none of the costs of administering the prelitigation panel except under Section 78B-3-420.



**78B-3-417. Proceedings - Authority of panel - Rights of parties to proceedings.**

(1) No record of the proceedings is required and all evidence, documents, and exhibits are returned to the parties or witnesses who provided the evidence, documents, and exhibits at the end of the proceedings upon the request of the parties or witnesses who provided the evidence.

(2) The division may issue subpoenas for medical records directly related to the claim of medical liability in accordance with division rule and in compliance with the following:

(a) the subpoena shall be prepared by the requesting party in proper form for issuance by the division; and

(b) the subpoena shall be accompanied by:

(i) an affidavit prepared by the person requesting the subpoena attesting to the fact the medical record subject to subpoena is believed to be directly related to the medical liability claim to which the subpoena is related; or

(ii) by a written release for the medical records to be provided to the person requesting the subpoena, signed by the individual who is the subject of the medical record or by that individual's guardian or conservator.

(3) Per diem reimbursement to panel members and expenses incurred by the panel in the conduct of prelitigation panel hearings shall be paid by the division. Expenses related to subpoenas are paid by the requesting party, including witness fees and mileage.

(4) The proceedings are informal and formal rules of evidence are not applicable. There is no discovery or perpetuation of testimony in the proceedings, except upon special order of the panel, and for good cause shown demonstrating extraordinary circumstances.

(5) (a) A party is entitled to attend, personally or with counsel, and participate in the proceedings, except upon special order of the panel and unanimous agreement of the parties. The proceedings are confidential and closed to the public.

(b) No party has the right to cross-examine, rebut, or demand that customary formalities of civil trials and court proceedings be followed. The panel may, however, request special or supplemental participation of some or all parties in particular respects.

(c) Communications between the panel and the parties, except the testimony of the parties on the merits of the dispute, are disclosed to all other parties.

(6) The division shall appoint a panel to consider the claim and set the matter for panel review as soon as practicable after receipt of a request.

(7) Parties may be represented by counsel in proceedings before a panel.

**78B-3-418. Decision and recommendations of panel - No judicial or other review.**

(1)(a) The panel shall issue an opinion and the division shall issue a certificate of compliance with the pre-litigation hearing requirements of this part in accordance with this section.

(b) A certificate of compliance issued in accordance with this section is proof that the claimant has complied with all conditions precedent under this part prior to the commencement of litigation as required in Subsection 78B-3-412(1).

(c)(i) Notwithstanding any other provision of this part, any party in a medical malpractice action or arbitration hearing may request a prelitigation panel review as t a health care provider and obtain a certificate of compliance for that specific, individual health care provider for the purpose of allocating fault to that health care provider. A party in a medical malpractice action or arbitration hearing may not attempt to allocate fault to any health care provider unless a certificate of compliance has been issued in accordance with this section for that specific, individual health care provider. A health care provider exempted from the requirement of a prelitigation hearing by statute or an arbitration agreement, may nevertheless be joined in a prelitigation hearing to satisfy the requirements of this section. Participation in a prelitigation hearing may not waive any right to enforce an arbitration agreement.

(ii) The party making the claim against, or seeking to allocate fault to, a health are provider is required to seek and obtain the certificate of compliance required by this Subsection (1)(c).

(2)(a) The panel shall render its opinion in writing not later than 30 days after the end of the proceedings, and determine on the basis of the evidence whether:

(i) each claim against each health care provider has merit or has no merit; and

(ii) if a claim is meritorious, whether the conduct complained of resulted in harm to the claimant.

(b) There is no judicial or other review or appeal of the panel's decision or recommendations.

(3) The division shall issue a certificate of compliance to the claimant, for each respondent named in the intent to file a claim under this part, if:

(a) for a name respondent, the panel issues an opinion of merit under Subsections (2)(a)(i) and (ii);

(b) for a named respondent, the claimant files an affidavit of merit in accordance with Section 78B-3-423 if the opinion under Subsection (1)(a) is non-meritorious under either Subsection (2)(a)(i) or (ii);

(c) the claimant has complied with the provisions of Subsections 78B-3-416(3)(c) and (d); or

(d) the parties submitted a stipulation under Subsection 78B-3-416(3)(e).

**78B-3-419. Evidence of proceedings not admissible in subsequent action - Panelist may not be compelled to testify - Immunity of panelist from civil liability - Information regarding professional conduct.**

(1) Evidence of the proceedings conducted by the medical review panel and its results, opinions, findings, and determinations are not admissible as evidence in any civil action or arbitration proceeding subsequently brought by the claimant against any respondent



and are not reportable to any health care facility or health care insurance carrier as a part of any credentialing process.

(2) No panelist may be compelled to testify in a civil action subsequently filed with regard to the subject matter of the panel's review. A panelist has immunity from civil liability arising from participation as a panelist and for all communications, findings, opinions, and conclusions made in the course and scope of duties prescribed by this section.

(3) Nothing in this chapter may be interpreted to prohibit the division from considering any information contained in a statutory notice of intent to commence action, request for prelitigation panel review, or written findings of a panel with respect to the division's determining whether a licensee engaged in unprofessional or unlawful conduct.

**78B-3-420. Proceedings considered a binding arbitration hearing upon written agreement of parties - Compensation to members of panel.**

Upon written agreement by all parties, the proceeding may be considered a binding arbitration hearing and proceed under Title 78B, Chapter 11, Utah Uniform Arbitration Act, except for the selection of the panel, which is done as set forth in Subsection 78B-3-416(4). If the proceeding is considered an arbitration proceeding, the parties are equally responsible for compensation to the members of the panel for services rendered.

**78B-3-421. Arbitration agreements.**

(1) After May 2, 1999, for a binding arbitration agreement between a patient and a health care provider to be validly executed or, if the requirements of this Subsection (1) have not been previously met on at least one occasion, renewed:

(a) the patient shall be given, in writing, the following information on:

(i) the requirement that the patient must arbitrate a claim instead of having the claim heard by a judge or jury;

(ii) the role of an arbitrator and the manner in which arbitrators are selected under the agreement;

(iii) the patient's responsibility, if any for arbitration-related costs under the agreement;

(iv) the right of the patient to decline to enter into the agreement and still receive health care if Subsection (3) applies;

(v) the automatic renewal of the agreement each year unless the agreement is canceled in writing before the renewal date;

(vi) the right of the patient to have questions about the arbitration agreement answered;

(vii) the right of the patient to rescind the agreement within ten days of signing the agreement; and

(viii) the right of the patient to require mediation of the dispute prior to the arbitration of the dispute;

(b) the agreement shall require that:

(i) except as provided in Subsection (1)(b)(ii), a panel of three arbitrators shall be selected as follows:

(A) one arbitrator collectively selected by all persons claiming damages

(B) one arbitrator selected by the health care provider; and

(C) a third arbitrator be:

(I) jointly selected by all persons claiming damages and the health care provider; or

(II) if both parties cannot agree on the selection of the third arbitrator, the other two arbitrators shall appoint the third arbitrator from a list of individuals approved as arbitrators by the state or federal courts of Utah; or

(ii) if both parties agree, a single arbitrator may be selected;

(iii) all parties waive the requirement of Section 78B-3-416 to appear before a hearing panel in a malpractice action against a health care provider;

(iv) the patient be given the right to rescind the agreement within 30 days of signing the agreement;

(v) the term of the agreement be for one year and that the agreement be automatically renewed each year unless the agreement is canceled in writing by the patient or health care provider before the renewal date;

(vi) the patient has the right to retain legal counsel;

(vii) the agreement only apply to:

(A) an error or omission that occurred after the agreement was signed, provided that the agreement may allow a person who would be a proper party in court to participate in an arbitration proceeding;

(B) the claim of:

(I) a person who signed the agreement;

(II) a person on whose behalf the agreement was signed under Subsection (6); and

(III) the unborn child of the person described in this Subsection (1)(b)(vii)(B), for 12 months from the date the agreement is signed; and

(C) the claim of a person who is not a party to the contract if the sole basis for the claim is an injury sustained by a person described in Subsection (1)(b)(vii)(B); and

(c) the patient shall be verbally encouraged to:

(i) read the written information required by Subsection (1)(a) and the arbitration agreement; and

(ii) ask any questions.

(2) When a medical malpractice action is arbitrated, the action shall:

(a) be subject to Chapter 31a, Utah Uniform Arbitration Act; and



(b) include any one or more of the following when requested by the patient before an arbitration hearing is commenced:

(i) mandatory mediation;

(ii) retention of the jointly selected arbitrator for both the liability and damages stages of an arbitration proceeding if the arbitration is bifurcated; and

(iii) the filing of the panel's award of damages as a judgement against the provider in the appropriate district court.

(3) Notwithstanding Subsection (1), a patient may not be denied health care on the sole basis that the patient or a person described in Subsection (6) refused to enter into a binding arbitration agreement with a health care provider.

(4) A written acknowledgment of having received a written explanation of a binding arbitration agreement signed by or on behalf of the patient shall be a defense to a claim that the patient did not receive a written explanation of the agreement as required by Subsection (1) unless the patient;

(a) proves that the person who signed the agreement lacked the capacity to do so; or

(b) shows by clear and convincing evidence that the execution of the agreement was induced by the health care provider's affirmative acts of fraudulent misrepresentation or fraudulent omission to state material facts.

(5) The requirements of Subsection (1) do not apply to a claim governed by a binding arbitration agreement that was executed or renewed before May 3, 1999.

(6) A legal guardian or a person described in Subsection 78B-3-406(6), except a person temporarily standing in loco parentis, may execute or rescind a binding arbitration agreement on behalf of a patient.

(7) This section does not apply to any arbitration agreement that is subject to the Federal Arbitration Act, 9 U.S.C. Sec. 1 et seq.

**78B-3-422. Evidence of disclosures - Civil proceedings - Unanticipated outcomes - Medical care.**

(1) As used in this section:

(a) "Defendant" means the defendant in a malpractice action against a health care provider.

(b) "Health care provider" includes an agent of a health care provider.

(c) "Patient" includes any person associated with the patient.

(2) In any civil action or arbitration proceeding relating to an unanticipated outcome of medical care, any unsworn statement, affirmation, gesture, or conduct made to the patient by the defendant shall be inadmissible as evidence of an admission against interest or of liability if it:

(a) expresses:

(i) apology, sympathy, commiseration, condolence, or compassion; or

(ii) a general sense of benevolence; or

(b) describes:

(i) the sequence of events relating to the unanticipated outcome of medical care;

(ii) the significance of events; or

(iii) both.

(3) Except as provided in Subsection (2), this section does not alter any other law or rule that applies to the admissibility of evidence in a medical malpractice action.

**78B-3-423. Affidavit of merit.**

(1)(a) Before a claimant may receive a certificate of compliance under Sections 78B-3-416 and 78B-3-418, a claimant shall file an affidavit of merit under this section:

(i) within 60 days of the date of the panel's opinion, if the claimant receives a finding from the pre-litigation panel in accordance with Section 78B-3-418 of non-meritorious for either:

(A) the claim of breach of applicable standard of care; or

(B) that the breach of care was the proximate cause of injury;

(ii) within 60 days of the expiration of the time limit in Subsection 78B-3-416(3)(b)(ii), if a prelitigation hearing is not held within the time limits under Section 78B-3-416(3)(b)(ii) or

(iii) within 30 days of the division's determination under Subsection 78B-3-416(3)(d)(ii)(B), if the division makes a determination under Section 78B-3-416(3)(d)(ii)(B).

(b) A claimant who is required to file an affidavit of merit under Subsection (1)(a) shall:

(i) file the affidavit of merit with the division; and

(ii) serve each defendant with the affidavit of merit in accordance with Subsection 78B-3-412(3).

(2) The affidavit of merit shall:

(a) be executed by the claimant's attorney or the claimant if the claimant is proceeding pro se, stating that the affiant has consulted with and reviewed the facts of the case with a health care provider who has determined after a review of the medical record and other relevant material involved in the particular action that there is a reasonable and meritorious cause for the filing of a medical liability action; and

(b) include an affidavit signed by a health care provider who meets the requirements of Subsection (3), which states that in the



health care provider's opinion:

(i) there are reasonable grounds to believe that the applicable standard of care was breached;

(ii) the breach was a proximate cause of the injury claimed in the notice of intent to commence action; and

(iii) the reasons for the health care provider's opinion.

(c) The statement required in Subsection (2)(b)(i) shall be waived if the claimant received an opinion that there was a breach of the applicable standard of care under Subsection 78B-3-418(2)(a)(i).

(3) A health care provider who signs the affidavit of merit under Subsection (2) shall:

(a) if none of the respondents is a physician licensed under Title 58, Chapter 67, Utah Medical Practice Act, or an osteopathic physician licensed under Title 58, Chapter 68, Utah Osteopathic Medical Practice Act, hold a current unrestricted license issued by the appropriate licensing authority of Utah or another state in the same specialty or of the same class of license as the respondents; or

(b) if at least one of the respondents is a physician licensed under Title 58, Chapter 67, Utah Medical Practice Act, or an osteopathic physician licensed under Title 58, Chapter 68, Utah Osteopathic Medical Practice Act, hold a current unrestricted license issued by the appropriate licensing authority of Utah or another state to practice medicine in all its branches.

(4) A claimant's attorney or claimant may obtain up to a 60-day extension to file the affidavit of merit if:

(a) the claimant or the claimant's attorney submits a signed affidavit for extension with notice to the division attesting to the fact that the claimant is unable to submit an affidavit of merit as required by this section because:

(i) a statute of limitations would impair the action; and

(ii) the affidavit of merit could not be obtained before the expiration of the statute of limitations; and

(b) the claimant or claimant's attorney submits the affidavit for extension to each named respondent in accordance with Subsection 78B-3-412(3) no later than 60 days after the date specified in Subsection (1)(a)(i).

(5) (a) A claimant or claimant's attorney who submits allegations in an affidavit of merit that are found to be without reasonable cause and untrue, based on information available to the plaintiff at the time the affidavit was submitted to the division, is liable to the defendant for the payment of reasonable expenses and reasonable attorney fees actually incurred by the1 defendant or the defendant's insurer.

(b) An affidavit of merit is not admissible, and cannot be used for any purpose, in a subsequent lawsuit based on the claim that is the subject of the affidavit, except for the purpose of establishing the right to recovery under Subsection (5)(c).

(c) A court, or arbitrator under Section 78B-3-421, may award costs and attorney fees under Subsection (5)(a) if the defendant files a motion for costs and attorney fees within 60 days of the judgment or dismissal of the action in favor of the defendant. The person making a motion for attorney fees and costs may depose and examine the health care provider who prepared the affidavit of merit.

(6) If a claimant or the claimant's attorney does not file an affidavit of merit as required by this section, the division may not issue a certificate of compliance for the claimant and the malpractice action shall be dismissed by the court.

(7) This section applies to a cause of action that arises on or after July 1, 2010.

**78B-3-424. Limitation of liability for ostensible agent.**

(1) For purposes of this section:

(a) "Agent" means a person who is an "employee," "worker," or "operative" as defined in Section 34A-2-104, of a health care provider.

(b) "Ostensible agent" means a person:

(i) who is not an agent of the health care provider; and

(ii) who the plaintiff reasonably believes is an agent of the health care provider because the health care provider intentionally, or as a result of a lack of ordinary care, caused the plaintiff to believe that the person was an agent of the health care provider.

(2) A health care provider named as a defendant in a medical malpractice action is not liable for the acts or omissions of an ostensible agent if:

(a) the ostensible agent has privileges with the health care provider, but is not an agent of the healthcare provider;

(b) the health care provider has by policy or practice, ensured that a person providing professional services has insurance of a type and amount required, if any is required, by the rules or regulations as established in:

(i) medical staff by-laws for a health care facility; or

(ii) other health care facility contracts, indemnification agreements, rules or regulations;

(c) the insurance required in Subsection (2)(b) is in effect at the time of the alleged act or omission of the ostensible agent; and

(d) there is a claim of agency or ostensible agency in a plaintiff's notice of intent to commence an action, the healthcare provider, within 60 days of the service of the notice of intent to commence an action, lists each person identified by the plaintiff who the provider claims is not an agent or ostensible agent of the provider.

(3) This section applies to a cause of action that arises on or after July 1, 2010.

# UTAH HEALTH CARE MALPRACTICE ACT

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