THE PROBLEMS OF MEDICAL MALPRACTICE INSURANCE

Bulletin No. 77-1

LEGISLATIVE COMMISSION
OF THE
LEGISLATIVE COUNSEL BUREAU
STATE OF NEVADA

September 1976

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Senate Concurrent Resolution No. 21—Committee on Judiciary

FILE NUMBER 115

SENATE CONCURRENT RESOLUTION—Directing the legislative commission to study the problems of medical malpractice insurance.

WHEREAS, There is a nationwide problem of doctors and health care providers obtaining malpractice insurance with many of the insurance carriers getting out of malpractice coverage and others increasing premiums by several hundred percent; and

WHEREAS, A major insurer of Nevada doctors has elected to leave the malpractice field this year; and

WHEREAS, The problems related to obtaining malpractice insurance have been studied by a special committee of the 58th session and that committee has made recommendations to ameliorate some of the problems; and

WHEREAS, The malpractice problem in Nevada is presently in a state of transition with the exact dimensions of a number of the problems unclear; and

WHEREAS, The several legislative proposals concerning medical malpractice insurance should be watched closely over the next 2 years in order to gauge their adequacy and to determine what other solutions might be necessary so as to avoid another crisis situation for the legislature; now, therefore, be it

Resolved by the Senate of the State of Nevada, the Assembly concurring, That the legislative commission study the ongoing problem of medical malpractice insurance, in particular assessing the effectiveness of legislation enacted on the subject by the 58th session of the legislature and recommending other changes deemed necessary to ensure high quaiity health care in Nevada; and be it further

Resolved, That the committee appointed to make such study shall include those members of the legislature most involved in the study of malpractice during the 58th session of the legislature and the insurance commissioner of the State of Nevada as well as members of the medical, legal and insurance professions at the discretion of the commission; and be it further

Resolved, That the legislative commission report the results of such study to the 59th session of the legislature and recommend appropriate legislation.

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REPORT OF THE LEGISLATIVE COMMISSION

To the Members of the 59th Session of the Nevada Legislature

This report is submitted in compliance with Senate Concurrent Resolution No. 21 of the 58th Session of the Nevada Legislature, which directed the Legislative Commission to study the ongoing problem of medical malpractice insurance in Nevada.

The Legislative commission appointed a subcommittee to make the study and recommend appropriate legislation to the next session of the legislature. Senator Norman Ty Hilbrecht was designated chairman of the subcommittee and Assemblyman Robert E. Heaney, vice chairman. The following legislators were named as members: Senators Richard E. Blakemore and C. Clifton Young and Assemblymen Karen W. Hayes and Zelvin D. Lowman.

The subcommittee has attempted, in this report, to present its findings and recommendations briefly and concisely. A great deal of data was gathered in the course of the study. That data which bear directly upon recommendations in this report are included. The report is intended as a useful guide to busy legislators. All supporting documents, research and comprehensive minutes are on file with the Legislative Counsel Bureau and readily available to any member.

The subcommittee was assisted in its study by a number of people including several representatives from the fields of medicine, law and insurance and a great many other interested citizens. A special recognition for valuable assistance to the subcommittee is in order for Dr. Dick L. Rottman, Insurance Commissioner of the State of Nevada. His broad experience and knowledge in the field of insurance and his leadership of the National Association of Insurance Commissioners which has produced excellent data in the field of medical malpractice insurance, combined with a ready willingness to assist the subcommittee, greatly facilitated the study.

The report is transmitted to the members of the 1977 legislature for their consideration and appropriate action.

Respectfully submitted,

Legislative Commission
Legislative Counsel Bureau
State of Nevada

August 1976

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LEGISLATIVE COMMISSION

Senator Richard H. Bryan	Assemblyman Keith Ashworth
Senator Melvin D. Close, Jr.	Assemblyman Joseph E. Dini, Jr.
Senator Carl F. Dodge	Assemblyman Lawrence E. Jacobsen
Senator James I. Gibson	Assemblyman Paul W. May
Senator Lee E. Walker	Assemblyman Donald R. Mello
Senator Thomas R. C. Wilson	Assemblyman Sue Wagner

SUMMARY OF RECOMMENDATIONS

This summary represents the major conclusions reached by the subcommittee. These conclusions are based upon suggestions that came from four public hearings, written communications to the subcommittee, testimony from experts from other states, staff research and the experience of the subcommittee's members.

The subcommittee recommends that:

1. No medical malpractice claim filed be acted upon by the district court until an affidavit is filed with the clerk stating that a copy of the claim has been sent to the Insurance Commissioner. (BDR 2-9)

2. All medical malpractice claims made or closed be reported to the Insurance Commissioner by insurance companies. (BDR 54-10)

3. All medical malpractice claims made or closed be reported by the Insurance Commissioner to the Board of Medical Examiners. (BDR 54-10)

4. The membership of the Board of Medical Examiners be expanded by the addition of two lay members. (BDR 54-7) A general recommendation for which legislation is not appended is that all professional licensing boards should include lay members.

5. In all hospitals with 200 or more beds, an internal risk management program be mandatory. (BDR 40-8)

6. All closed medical malpractice claims be investigated by the Board of Medical Examiners with all results reported to the Insurance Commissioner and unfavorable reports transmitted to the Attorney General for possible licensure action. (BDR 54-10)

7. The immunity shield for any person or group having power over licensing or insurability of doctors be increased. (BDR 54-10)

8. Chapter 630 of NRS be amended to clarify which categories of medical deficiencies or conduct are subject to administrative or judicial remedies. (BDR 54-77)

9. The legislature memorialize the Joint Commission on Accreditation of Hospitals to include a risk management capability in its hospital accreditation criteria. (BDR 17)

10. The Nevada Medical Liability Insurance Association or any Joint Underwriting Association be required to offer the option to its insureds of being assessable for the association's losses for a particular year or paying a lump sum in addition to the premium up to the amount of the premium to insure that they will not be so assessed. (BDR 57-15)

11. Legal guarantees of access to patients' health care records by patients or investigatory entities be provided, such records to be maintained for 5 years and copies provided at reasonable costs. (BDR 54-12)

12. All medical malpractice settlements or awards in excess of $50,000 be subject to payment on a periodic basis with any portions unspent at time of death to revert to the insurer. (BDR 3-11)

13. All medical malpractice awards be reduced by the amount of public, nondiscretionary collateral sources to which the judgment creditor would be entitled. (BDR 3-14)

14. The composition and procedures for the medical-legal screening panels established in 1975 be amended as follows:

    a. Increase the number of doctors and attorneys from which the six-member panels are chosen.

    b. Extend the time limit for peremptory challenges of panel members from 5 days to 10 days.

    c. Require that a request for a hearing before a panel include the time of the incident and names of all the parties involved.

d. Exempt screening panel procedures from the doctor-patient privilege.

e. Exempt screening panels from the open meeting law.

(BDR 3-13)

15. The provisions under which a doctor may treat a minor without obtaining parental consent be broadened and clarified. (BDR 11-19)

16. Those legal guardians responsible for filing actions on behalf of prisoners, mental incompetents or minors be responsible only if they knew, or with reasonable diligence could have known, that the legally disabled person has a cause of action. (BDR 2-20)

17. The 59th session establish a select committee on medical malpractice insurance and that the legislative commission be directed to continue the study of this subject in the next interim. (BDR 18)

REPORT OF THE LEGISLATIVE COMMISSION FROM THE SUBCOMMITTEE ON MEDICAL MALPRACTICE INSURANCE

I. INTRODUCTION AND BACKGROUND

The 58th session of the Nevada Legislature, through Senate Concurrent Resolution No. 21, directed the Legislative Commission to "* * * study the ongoing problem of medical malpractice insurance, in particular assessing the effectiveness of legislation enacted * * * by the 58th session * * * and recommending other changes * * * to ensure high quality health care in Nevada."

The subcommittee, with an original budget of $4,250, subsequently augmented with another $400, held four public hearings, two subcommittee work sessions and paid for the publishing of this report. The budget also includes payment of expenses for witnesses from California and Florida and attendance by the chairman at a seminar on medical malpractice insurance sponsored by the National Conference of State Legislatures in Dallas, Texas. Public hearings were held in Las Vegas on July 23, 1975; in Reno on September 18, 1975; in Las Vegas on November 25, 1975; and in Reno on January 15, 1976. Work sessions were held in Carson City on April 3, 1976, and again on July 30, 1976.

The interim study of medical malpractice insurance was an outgrowth of intense and significant legislative activity by the 1975 session of the legislature. The development of a so-called malpractice crisis began in the early 1970's and, by 1975, most states were experiencing the twin problems of high cost and decreasing availability of medical malpractice insurance. The causes of this crisis will be discussed below. No state has experienced this crisis to a greater extent than California. Because Nevada is tied socially and economically to California, the impact of the malpractice crisis in Nevada was much more severe than in the other Great Basin or Rocky Mountain states.

The 1975 session of the legislature responded to the situation of increasing medical liability insurance costs and decreasing availability by first appointing a select committee to conduct hearings and prepare legislation. The 1975 session then passed a significant legislative package designed to assure availability of insurance at an affordable

price. To better appreciate the context of this report and the situation as this subcommittee began its work, it should be useful to recount the legislation of the 58th session concerning medical malpractice insurance.

S.B. 400 - Provides for the creation and operation of a joint underwriting association (JUA) to provide for essential insurance when the private insurance market is unwilling or unable to provide it. The casualty and liability insurers doing business in the state must participate in the JUA in order to continue doing business in Nevada.

S.B. 401 - Provides for technical amendments in the Insurance Code to facilitate the operation of the JUA.

S.B. 402 - Provides additional legal protections to health care providers who render assistance gratuitously in a medical emergency.

S.B. 403 - Provides for the deduction from a judgment of any payments made by a defendant in medical malpractice actions prior to the judgment.

S.B. 405 - Provides for a limitation on the res ipsa loquitur rule and provides in other cases that expert medical testimony be presented to establish medical negligence.

S.B. 406 - Provides that the tolling of the statute of limitations for persons under legal disability, such as convicted prisoners, mental incompetents or minors be eliminated. This law places the responsibility for bringing suit for such persons with legal guardians.

S.B. 408 - Provides for the necessary elements of an informed consent to a medical procedure.

S.B. 409 - Provides for medical-legal screening panels composed of three doctors and three lawyers each, with one panel for northern Nevada and another for southern Nevada. These panels screen all malpractice claims prior to their going to court. The panels attempt, where possible, to facilitate settlements without going to court.

S.B. 432 - Provides for increased powers to the Board of Medical Examiners to assure medical competency and, where necessary, to discipline doctors. It also provides for the Attorney General to apply for an injunction or a restraining order in district court to immediately limit, suspend

or revoke a doctor's license. A mechanism is also provided for any person to file a complaint against a doctor and have it investigated. The act also defines "gross malpractice," "malpractice" and "professional incompetence."

The thrust of these several bills was to assure the availability of medical malpractice insurance in the state, to refine the tort system to prevent awards for anything that was not clear negligence and to give the medical licensing body the power to assure the highest possible competency for Nevada doctors, thereby minimizing negligent acts. The legislature recognized two facts that led to this interim study. First, the medical malpractice insurance situation nationally, and in the state, was changing even as the 1975 legislation was being enacted. The legislature recognized that the 1977 session would have to face the issue also and it was a basic precaution to monitor the situation during the interim so that data and information would be available early in that session. Second, several of the 1975 acts represented new approaches, especially as regards screening panels and the new powers of the Board of Medical Examiners and the Attorney General. There was strong concern about how these measures would work.

Before going into an assessment of the effect of the 1975 legislation or further proposals for 1977, it is essential that legislators understand the nature of the medical malpractice insurance crisis, the dynamics of the crisis and developments nationally in response to the crisis. The situation in Nevada in particular will be discussed later in this report.

The medical malpractice crisis is very definitely a national one. As late as 2 years ago, the incidence of medical malpractice actions in rural states was quite low even as the incidence was dramatically rising in places like California, New York and Florida. This is no longer true. Data available in 1976 shows that in South Carolina, for instance, the ratio of claims to those insured went from 1:188 to 1:14 in a 5 year period. While this is far better than the 1:4 ratio prevalent in California, it is obvious, nevertheless, that the crisis has spread to every state.[1] The impact of the crisis in various states is still quite different. At one extreme, in California in 1975 the highest risk doctors, denominated as Class V, paid over $20,000 a year for basic

$100,000/$300,000 coverage. That same coverage in Colorado was $3,590,[2] in Florida $15,808[3] and in Nevada, just under $10,000.[4] The same coverage for a low risk, or Class I, doctor in 1975 in California was about $4,000, in Colorado $430, in Florida $1,113 and in Nevada $1,364.[5] Even though diversity still marks the dollar dimensions of the crisis, it is a crisis everywhere on a relative basis. Even in Colorado, the Class V premiums increased by 67 percent in 4 years.[6] That is certainly cause for concern although it is considerably less frightening than the 385 percent increase for the same class in just 2 years in California![7] Those states with relatively smaller problems at present realize that California is not necessarily that different from the rest of the states; it is just usually several years ahead in new trends in many areas.

References are often made in testimony and in articles about the impact of rising insurance costs on the direct costs of health care. No one claims that doctors are absorbing the increased costs. Just as any other professional businessman, the doctor, whose costs of doing business increase, increases the cost of his services. This is no different than if his rent or his employees' salaries go up. Many doctors have fixed fee patients, however, to whom increases in costs cannot be passed on and these costs are being absorbed in some cases at least until the fixed fees are increased. Very little has been produced to show what the malpractice crisis has meant to the average health care consumer. The California Auditor General did produce figures for northern California comparing the 1973 and 1975 costs of malpractice insurance in each doctor-patient contact. In 1973, the cost of an office visit to a general practitioner with $1,000,000/$3,000,000 coverage included about 7 cents for the doctor's insurance. Two years later that cost had increased to 53 cents! The same figures for an anesthesiologist went from $2.38 in 1973 to $11.54 in 1975![8] With the costs of hospital malpractice insurance going up at a rate in excess of even the highest increases for doctors, the part of the room cost per day for malpractice insurance is rapidly rising.

The Insurance Services Office (ISO), the major insurance rating group in the country, has recommended a per bed premium for Nevada hospitals of $1,069.[9] This is up from $96 in 1974, more than a 1,000 percent increase! If a bed is used 100 percent of the time, which is unlikely, almost $3 per day would have to be charged for the malpractice

insurance premium. An additional problem for hospitals is the question of uninsured doctors on the staff. The Farmers Insurance Group, which insures most Nevada hospitals, has addressed the issue in California by charging a 20 percent premium surcharge if a hospital has uninsured doctors on the staff. Almost 80 percent of malpractice claims are for injuries sustained in hospitals. Hospitals are almost always named as codefendants in the actions. If a physician-defendant is uninsured, the liability of the hospital increases. The Farmers Group has not applied this surcharge to Nevada hospitals thus far. Nationally, many large hospitals and corporations owning several hospitals are becoming self-insurers because premiums are fast approaching coverages. Just as with doctors, hospitals are passing on the costs of increased premiums to their patients, except for fixed fee patients. It should be noted that doctors or hospitals will pass on costs to those who can pay increases at a greater rate to compensate for fixed fee patients who cannot be charged more.

Just 3 years ago, when the Secretary of Health, Education and Welfare's (HEW) Committee on Medical Malpractice presented its findings, there was very little information to suggest the causes of the developing crisis in medical malpractice insurance, let alone what the solution might be. That 1973 HEW report[10] represents a watershed in understanding medical malpractice. Before that report, no meaningful, comparative data or analysis of medical malpractice insurance existed. Since 1973, data gathering and analysis of causes has undergone a virtual explosion in the private and public sectors. As a result, the causes of the crisis and the continuing dynamics of the medical malpractice insurance environment are fairly clear. It is useful to consider these causes and then to examine the major approaches that have developed for dealing with the situation.

a. Causes of the Medical Malpractice Insurance Crisis

By way of introduction, it should be noted that no data exists to identify the cause of the current crisis. The one thing that all involved, informed parties agree upon is that the issue is quite complex involving an intricate interplay of the medical, legal and insurance professions and general social attitudes. Beyond that, there is a marked difference in where the various parties place the emphasis concerning the most important causes of the crisis. This

report, because there is no reliable objective data identifying a simple cause or even the leading cause, will not attempt to place the discussion of causes in any order of importance or impact.

Malpractice

The term "malpractice" means "* * * bad, wrong, or injudicious treatment of a patient, professionally and in respect to the particular disease or injury, resulting in injury, unnecessary suffering, or death to the patient, and proceeding from ignorance, carelessness, want of proper professional skill, disregard of established rules or principles, neglect, or a malicious or criminal intent."[11] Whenever used in this report, this is the general meaning ascribed to the term. NRS 630.012 and 630.013 define "gross malpractice" and "malpractice" for legal purposes in Nevada. These definitions do not conflict with the one quoted above from Black's Law Dictionary.

With this definition in mind, it should be stated certainly that one of the causes for the malpractice crisis is malpractice. Some representatives of the trial bar choose to emphasize this fact over all others. The subcommittee heard from no doctor who would dispute this truism. By even the strictest standards, it is unquestioned that some doctors commit negligent acts constituting malpractice which injure or even kill patients. The exact extent of such acts is unknown but compared to the total number of patient-doctor contacts, the number is quite small. In California, a general practitioner experiences about 9,000 patient contacts in a year.[12] In 1975, one in four doctors was the object of a claim. A general practitioner is a low risk doctor so the claims to doctor ratio is more favorable than 1:4 for GP's. Even using the 1:4 ratio, it can be seen that in the state with the most malpractice claims, there is only one claim per some 36,000 doctor-patient contacts. Using high-risk anesthesiologists, there is one claim for every 8,000 contacts. Clearly the risk to the individual patient of sustaining an iatrogenic injury is extremely remote. This remoteness attests to the training, skill and dedication of the medical profession. As remote as such a risk is, it does exist and it is based upon the fact that doctors err. The result of a doctor's error, however, can be extremely costly and it is for this reason that doctors have malpractice insurance. It is extremely doubtful that doctors today are more careless or negligent than doctors 10 or 20 years ago. In fact,

new medicines, equipment and techniques make the modern doctor more effective than ever at curing disease, mending bodies or reducing suffering. Why, then, have the volume and size of malpractice claims gone up?

The Media

Any society with mass media is greatly influenced by the media. Probably no nation in the world has a more pervasive or influential media than is found in the United States. One of the major themes of American television over the past 15 years has been the medical show. There was Ben Casey and Dr. Kildaire in the 1960's. Currently there is Medical Center, Emergency and the wonderful Marcus Welby to name just a few shows in which modern medicine almost always triumphs over pain, disease and injury and doctors never seem to have more than one patient at a time. Patients almost never die on TV medical shows. The doctors always have a great deal of time to lavish on their patients on television. There never seem to be problems of informed consent or the amount of the patient's bill on these shows. These shows all emphasize the latest breakthroughs in medical knowledge also. In the real world, not every doctor is Marcus Welby, there are many diseases that are not curable, many injuries that cannot be mended and there are many irritants in large hospitals such as indifferent staff, tasteless food and controversy over payments, all of which contrast with the ideal medical settings portrayed on TV. The result is often a feeling of relative deprivation for the patient. He is sure that other patients in other hospitals or with other doctors are being cured and treated sensitively as individuals. He is being shortchanged. He looks for some way to compensate for his unsatisfactory treatment or results. A patient in this frame of mind becomes a potential malpractice claimant. Some observers have characterized this phenomenon as the "Marcus Welby syndrome."[13] As should be obvious, there is little that legislation can accomplish relative to this cause of the malpractice crisis but its existence is real and important in accounting for the rapid increase in frequency of claims and size of awards.

Litigiousness

Another social attitude more prevalent in the United States than in almost any other nation is the propensity to sue. This has been true for many years and is reflected in the fact that we have far more attorneys per capita than any

nation in the world and that attorneys, like doctors, are portrayed in the media as ever-successful. In many nations, the things over which we sue are considered the work of the hand of fate and simply accepted, especially in the tort area of personal injury. Americans have sought to place the responsibility for injuries on negligent parties and the result has been the establishment of a large body of tort law in this country, much of it codified, but even more is found in case law. This traditional American readiness to sue has been further encouraged in the past 15 years by a legal rights explosion. In the area of civil suits, the War on Poverty included legal aid funds that enabled poor people to file civil actions. Ralph Nader produced much publicity about product safety and product liability suits. The media gave increasing publicity to successful suits, especially in tort actions. The result was that by the early 1970's most of the populace had become aware that ordinary people could successfully sue large corporations, the government or powerful and wealthy individuals. This realization contributed to the increases in litigation frequency in the 1970's.

Contingency Fees

Just as the trial bar emphasizes doctor incompetence and negligence as the primary causes of the malpractice crisis, the medical profession emphasizes lawyer contingency fees and the flight of automobile liability attorneys into malpractice litigation as a result of no-fault auto insurance. Testimony before the subcommittee, and evidence nationally, offers some basis for understanding these causes. The contingency fee is a two edged sword. In the first instance, a contingency fee is an incentive for an attorney to accept and prosecute a suit on behalf of a plaintiff with a good case. In the second instance, however, an attorney will not take a poor case on a contingency basis since he will not receive anything if he loses. The contingency fee system is a screening device. There are definitely some problems with contingency fees. While they allow a plaintiff with a good case to find an attorney without having to pay anything, they do not help the person who was injured as a result of negligence but whose claim would be small. Generally, the subcommittee learned that the meritorious, but small claim is seldom successful because an attorney will not take the case. The criticism of the fees for cases with high awards is that the attorney benefits not necessarily from the amount

or quality of work he does on a case but from the extent of the injuries to the plaintiff. There is little that can be done to encourage attorneys to take cases with small claims. In terms of overall malpractice insurance costs, about 26 cents of every premium dollar go for defense legal costs and about 12 cents end up with plaintiffs' attorneys.[14] Naturally, increase in claims of any size is going to increase the total costs which have produced the current crisis. A number of attempts have been made to reduce the percentage contingency fees as the size of the award goes up. This was first done by the New Jersey Supreme Court by rule and has since been enacted into law in nine other states. Greatly restricting or eliminating contingency fees would undoubtedly have the effect of virtually ending malpractice litigation but it would also end the ability of the iatrogenically injured to be compensated.

Relationship to No-Fault Auto Insurance

The subcommittee heard several references to the flight of attorneys into malpractice suits when no-fault insurance curtailed auto liability suits. There is no evidence or hard data to support this accusation. Malpractice lawyers are highly specialized. Malpractice suits are the most complex and difficult to try. An attorney does not become competent in such a field without considerable experience. There may well be more attorneys specializing in malpractice suits today but it seems that this is related more to increased plaintiff demand than to an excess of attorneys from another specialty.

Stock Market Losses

Some observers have pointed out the fact that a number of malpractice insurers experienced heavy stock market losses in the early 1970's which cut their anticipated reserves and resulted in a panic to raise rates or get out of malpractice insurance altogether. All insurance companies as well as most other investors experienced stock market losses in the period in question. Insurers, along with everyone else, felt the effects of double digit inflation in the same period, thereby increasing the size of settlements and awards. These factors have affected all casualty and liability insurance lines, and premiums for these lines have all gone up. Medical malpractice insurance premiums, however, have shot up far more rapidly, leading one to conclude that other factors

were at work in this line of insurance. In fact, many other factors were at work.

Inadequate Underwriting

Most medical malpractice insurers in the past have not specialized in this line. They have carried malpractice insurance as a sideline. As a result, underwriting in this line has seldom been specialized and certainly not well developed. In short, medical malpractice insurers suddenly realized within the past 2 years that they were in deep trouble because of the increased claims rate and grossly inadequate underwriting practice that failed to discern the rapidly changing claims environment. Premiums should have been increasing steadily over the past decade but they were not. This assessment of past underwriting was conveyed to the subcommittee by Nevada's Insurance Commissioner, Dr. Dick Rottman,[15] and was also acknowledged by Mr. Thomas Uehlin, a vice president of the St. Paul Fire and Marine Insurance Company.[16] Mr. Larry Baker, President of Argonaut Insurance Company, a major carrier for Nevada doctors, also testified to such underwriting practices. The Argonaut did not employ actuaries to study its malpractice policies until it became apparent that the company's loss rate was becoming excessive.[17]

Insurers' Reactions

There have been two basic reactions by insurers. The first is to simply bail out of the market and the second is to stay in but only if astronomical rate increases are granted. Both of these reactions reflect the basically conservative approach of underwriters, especially underwriters who have been burned by a failure to anticipate rapid increases in claims. Almost every state legislature passed legislation in 1975-76 designed to improve the insurance climate and thereby hold down premium rates. There has been much frustration among legislators and doctors in particular that legislation has had no apparent impact on rates. There are rational reasons for this. First, some legislative changes in several states have represented new legal approaches. Some have been successfully challenged in the courts already and others are likely to be. Underwriters are going to ignore such changes until the courts have dealt with them. Second, although other changes may not come under legal challenges, their impact on claims cannot be assessed before they have been at work 3 or 4 years.

Underwriters deal with certainties, not probabilities, whenever possible. As a result, they are currently assuming the worst about future malpractice claims and hoping to be surprised.

Excessive Surgery

It has already been noted that a fundamental cause of the malpractice crisis is malpractice. There are other medical activities or practices that are also causes, to varying degrees, of the crisis. There is growing evidence produced by HEW, the Federal Trade Commission and Congress to indicate that more surgery is performed in the United States than is medically justified.[18] The Congressional report suggested as many as three million unnecessary operations annually. The methodology, definitions and data used in the report of the House Subcommittee on Oversight and Investigations entitled "Cost and Quality of Health Care: Unnecessary Surgery" are open to serious questions, so the figure of three million is very possibly inflated. Each operation carries a risk in itself. In addition, some operations such as hysterectomies or mastectomies can have severe emotional effects, or in the former, can prevent childbearing for a woman wanting a child. If such an operation is unnecessary, the patient has grounds for a suit.

Conflicts of Interest

A potential for unnecessary hospitalization and surgery also exists when doctors own hospitals, especially when hospital beds are in surplus. A similar tendency to prescribe tests and medicines that may not be necessary is present when doctors own laboratories or pharmacies separate from hospitals. As rare as such unethical behavior may be, it increases the likelihood of malpractice. Also, most hospitals have no requirements for second opinions as to the necessity of surgery and in many, tissue committees do not attempt to assess the necessity of surgery. Finally, doctors are attempting high risk medical procedures more often today than 15 years ago. New advances and techniques, while increasing the number of maladies that can be successfully treated, also carry with them new risks and unknowns.

Availability of Expert Testimony

A factor related to the medical community that has contributed to an increase in successful malpractice claims is a breakdown

in the so-called "conspiracy of silence." Such a breakdown is certainly not to be lamented but it has made successful claims easier. Until recent years, it was very difficult to find a doctor who would testify against another doctor in a community. As a result, the courts adopted locality rules which allowed doctors from similar communities to testify in suits. The res ipsa loquitur rule also was adopted by many courts which identified certain situations in which expert medical testimony was not required. Although many states have acted to codify narrower locality rules and res ipsa loquitur rules, these doctrines continue to exist in some states and where they do, they contribute to the malpractice crisis.

The Long Tail

Over the years, the one aspect of malpractice insurance that has been most difficult for underwriters is the "long tail" in this line of insurance. This means that the claims originating in the medical acts occurring in a particular year often are not paid or even made until several years later. The 1973 HEW study found an average of 6 1/2 years from incident to payment of malpractice claims. This contrasts with 1 1/2 years for auto liability claims.[19] The statute of limitations in most states account for this "tail." These statutes allow a claim to be filed, for instance, within 4 years of an incident or within 2 years of the discovery of an injury. If an injury is not discovered for 10 years, there would be 12 years to file a claim and it could take another year or two before a claim is paid. In 1975, 19 states modified statutes of limitation to restrict this "tail." A number of states, including Nevada, have a maximum limitations period regardless of discovery. This allows underwriters a good deal of certainty.

Informed Consent

Even if a doctor is not negligent in performing a procedure that injures his patient, he may still be sued for battery if he has failed to obtain the consent of the patient to the procedure. The courts require that the consent be informed and a body of case law has grown under the doctrine of informed consent in recent years to indicate how the doctor must inform his patient. In 1975, eight states, including Nevada, narrowed the grounds for suits based upon failure to obtain informed consent from a patient. A somewhat different communications problem arises when the doctor appears to guarantee

particular results from his treatment. Doctors have been successfully sued for breach of their oral guarantee of good results because a patient was led to believe that a procedure would cure a particular malady but it did not. Statutory provisions for informed consent, in most cases, could eliminate the problem of oral guarantees of good results. This is the case with Nevada's informed consent law. See NRS 41A.110.

Ad Damnum

Several other lesser causes of the malpractice crisis nationally should be mentioned. An ad damnum clause is the part of the initial pleading in a lawsuit that states the amount of the damages sought. The damages a plaintiff seeks can be grossly exaggerated. The media pick up such inflated figures and the public often concludes that is what the plaintiff is likely to get. The fact that the plaintiff may get nothing, or a greatly reduced award or out of court settlement is seldom given the same publicity. The result is that the public is led to believe that large, successful malpractice awards are common. The belief increases the likelihood of additional suits. Because Nevada law requires that the pleadings state only whether damages are over or under $10,000, this problem is not present in Nevada.

Good Samaritans

The American Medical Association and its state affiliates pushed strongly in 1975 for increased protection for so-called "Good Samaritan" acts. The subcommittee learned of no instances of successful suits against a doctor who provided gratuitous emergency medical care. To insure that such circumstances do not become grounds for a suit, Nevada and five other states in 1975 added to the protection from liability of Good Samaritan acts.

Awards for Bad Results

There is another purported general cause of the medical malpractice crisis. Its actual impact is difficult to assess. A jury must decide two things in determining the liability of the defendant in a medical malpractice action. First, the jury must find that the plaintiff was injured. Second, it must find that the injury was caused by a negligent act of the doctor. There is a strong suspicion, based on limited

evidence, that in cases where the injury is bad enough, some juries will make a finding of negligence only because of the severity of the injury. The most recent National Association of Insurance Commissioners malpractice claims study fails to justify this suspicion. In its second volume, covering claims closed between July 1, 1975, and February 3, 1976, the NAIC addressed the subject of jury awards given for bad medical results. They found such awards to be only 9 percent of the claims closed with payment.[20] This means that in the opinion of the insurance companies filing the closed claims reports, awards or settlements for a bad result without negligence were made in only 9 percent of the cases. This is still enough to warrant close scrutiny by the courts and very explicit jury instructions.

b. Solutions Proposed for the Malpractice Crisis

Joint Underwriting Associations

Solutions to the crisis have aimed at its basic elements, which are decreasing availability and increasing cost. The most immediate aspect of the crisis was the availability of insurance. In 1975 some private carriers were getting out of the malpractice line altogether. Others were staying only in those states with excellent claims environments. A great many states, including Nevada, were faced with the need to create some device to provide insurance to health care providers. The question of rising costs, while important, became secondary to the question of availability. Most states facing the availability problem responded with insurance pooling devices, commonly known as joint underwriting associations (JUA's). A JUA is intended as a temporary expedient to provide a particular coverage until the private market is willing to pick up that line. Under a JUA, all liability insurers are required to participate in its financing and operation. The reserves of the various companies become available to the JUA and they share the risks jointly. The advantage to the companies is that JUA's provide for recoupment of losses in any one year through retroactive assessment of its insureds. A company doing business by itself cannot do this. If it loses money, it absorbs the loss. Doctors strongly oppose the retroactive assessment feature because of the uncertainty of these possible charges. A doctor can be retired for several years but find himself faced with an assessment for a policy year prior to his retirement.

Nevertheless, in several states, including Nevada, uninterrupted availability of insurance would have been impossible without JUA's.

Reinsurance

Another problem for insurers in the malpractice line is reinsurance. Reinsurance can be viewed as insurance on insurance. A company may issue a policy with $1,000,000/$3,000,000 coverage and then pay for reinsurance with another company to cover claims over $100,000/$300,000. The ability to get reinsurance plays a large role in the decision to write malpractice insurance. States can be involved in reinsurance in one of two ways. They can create a JUA type arrangement for reinsurance or they can go into the reinsurance business themselves. The former approach does not require any state capitalization. The latter approach does. In a small state, a required reinsurance JUA may be resisted by companies and a small state has little leverage over companies. This is because a company can drop a small state without affecting its business to any great extent and will do so if the participation in a mandatory plan becomes too disagreeable.

The American Medical Association, in September 1975, approved the incorporation of a "captive" reinsurance company known as the American Medical Association Assurance Company. This company is to be entirely AMA owned and it is to provide reinsurance only to state and local captive companies. This means that doctors' reciprocals or mutuals would qualify as well as any other insurance company owned and operated solely by doctors. A JUA or a private insurer is not eligible for the AMA reinsurance.

Patient Compensation Funds

There is another form of state run reinsurance adopted by eight states in 1975, known as patient compensation funds (PCF's). A PCF is funded by initial state capital and then financed by surcharges on the policies of all participating insureds. PCF's then pay the portions of claims in excess of some figure, usually $100,000. The insurer then has a limited liability with the state being the excess coverage carrier. In the event of a PCF deficit that would reduce the capital, the surcharge in subsequent years would be increased. The Indiana PCF was initially funded with $1,500,000 in state money and financed with a 10 percent

surcharge. In Louisiana, the surcharge was placed at a more conservative 20 percent. PCF surcharges simply increase a doctor's premium but they do have the advantage of keeping private insurers in the market. Also, if a PCF runs a surplus, the insureds can get a refund.

The State as Insurer

Another device, thus far used only in Indiana and Louisiana, is a state residual malpractice insurance. Under this device, the state actually goes into the insurance business. In the two states using it, a doctor must have been refused insurance by two insurers before he is eligible for the state insurance. With such a plan, the state assumes all the risks of a normal insurance company and would have to have the staff expertise in underwriting and claims management that is available to a normal company. Indiana has contracted for these services rather than building a state bureaucracy but the costs are still there.

Reciprocal Insurance

Two other insurance devices are also available as alternatives to the private insurance market. The devices are very similar but do have distinctions worth noting. The first is a reciprocal exchange which is an unincorporated group or association of persons known as subscribers who, through an attorney-in-fact, cooperate to furnish to themselves and each other assurance against designated risks. In the malpractice context, the subscribers would be physicians or other health care providers. The attorney-in-fact functions to issue insurance contracts to the subscribers on their behalf and to comply with state insurance laws and regulations. Funding for a reciprocal is through premiums and through special assessments to establish a capital surplus. There is at least one doctors' reciprocal now in operation in northern California. The insurance codes of most states, including Nevada, currently allow the establishment of reciprocals.

Physicians' Mutuals

The other insurance device in use for medical malpractice insurance is the physicians' mutual. This is an incorporated insurer organized without capital stock or shares which is owned by its physician policyholders. A capital surplus may

be established by an initial special assessment or by a loan from the state. Physicians' mutual companies currently exist in Maryland, California, New York and North Carolina with the Maryland operation, the Medical Mutual Liability Society of Maryland, the largest. It has about 2,000 policyholders.[21] The insurance codes of most states, including Nevada, provide for mutual insurance companies.

The discussion of solutions thus far has centered on various alternatives for providing insurance coverage for health care providers as the willingness of the private market to provide such insurance has diminished. It is appropriate now to turn to solutions proposed for those problems which have caused the flight of private insurers out of the medical malpractice line. The first such area is tort reform.

Tort Law

A tort is "A private or civil wrong or injury. A wrong independent of contract * * *. A violation of a duty imposed by general law or otherwise upon all persons occupying the relation to each other which is involved in a given transaction * * *. There must always be a violation of some duty owing to plaintiff, and generally such duty must arise by operation of law and not by mere agreement of the parties."[22] There are three elements of every tort action: existence of a legal duty from defendant to plaintiff, breach of duty and damage as a proximate result.[23]

In medical malpractice, the doctor owes a legal duty to a patient. Through some fault of the doctor, there is a breach of that duty and, as a result, the patient suffers damage. The tort system of law has developed as a method to compensate for damages thus incurred. Under tort law, that compensation comes from the party at fault. Tort reforms, in theory, can be directed at any of the three elements of a tort action. There can be redefinitions of what constitutes a legal duty between a doctor and his patient, redefinitions of what constitutes a breach of that duty and a modification of the damages that can be obtained. Suggestions have been made from throughout the country concerning each of these elements.

Legal Duty

One way to limit the incidences of a legal duty existing is to exempt emergency, gratuitous medical assistance from

liability. This has been done by Nevada and most other states. A statute of limitations is, in a sense, another example of limiting the legal duty. While such limitations do not apply to the legal duty at the time of a medical procedure, they do act to limit the period for which a doctor is liable for the legal duty to the patient. Most states have acted to restrict their statutes of limitation.

Breach of Legal Duty

The definition of the breach of duty element of a tort action can also be modified. Several concepts are involved at this stage. Before a breach of duty can be established, there must be a standard against which the doctor's performance can be measured. This is known as the standard of care. The quality of medical care in a large city hospital is certainly higher than it is in a rural clinic. Doctors in the two settings cannot be held to the same standard of care. Legislatures can codify locality rules that make it clear that doctors in a smaller community cannot be charged with a breach of duty to a patient if they do not know all the techniques or cannot perform all the procedures done in university teaching hospitals. The breach of duty element may also be modified by requiring expert medical testimony except for a very few, obvious situations where such testimony is not required. This is a limitation on the res ipsa loquitur rule discussed earlier.

Most of the witnesses before the subcommittee and most of the data being accumulated nationally attest to the limited impact of reform of the first two elements of a tort action. The exception to this is the statute of limitations. The limitations that almost all states have placed on their statutes of limitation should have an impact at least on underwriting practices within a few years. The third element of a tort action, the damages, has the most direct impact on the shape and extent of the malpractice crisis. There are several modifications of this element which have been suggested.

Damages

Awards or settlements can be divided into economic loss and noneconomic damages. Economic losses for a victim of malpractice are the medical expenses necessary to repair the results of the negligent act or to care for the person whether or not the physical damage can be repaired. These

costs can involve treatment, surgery, hospitalization, therapy and nursing care at home. The other part of economic loss is the loss of income if the injured party cannot work at the job he had before the injury. There can be economic loss for an unsalaried person such as a homemaker, if others must be hired to perform duties she can no longer carry out.

Noneconomic damages are of two types. The first is pain and suffering. The second is punitive damage. Noneconomic damages are most often the target of those seeking to limit damages. California has limited damages for pain and suffering to $250,000. The argument for such limitations is that all such damages are arbitrary anyway. There is no way to quantify pain and convert it to dollars. Whether it is arbitrary or not, the concept of pain and suffering as a compensable element in a personal injury suit is well established. There has not yet been a court test of California's limitation. Punitive damages are awarded only when a defendant is obviously derelict and irresponsible in his breach of duty to the plaintiff. Punitive damages are not awarded for negligence alone, but for blatantly unprofessional conduct as contributory to the negligence. Punitive damages are rare. There is no data currently available which reflects the percentage of claims with punitive damages. The fact that the NAIC closed claims study lists 39 associated issues contributing to awards but does not list punitive damages reflects its rarity.[24]

Limitation of Awards

The most obvious approach to limiting awards for damages is to enact an absolute dollar limitation for a malpractice award. This has been tried in several states with a mixed and unsure result to date. Indiana, Illinois and Louisiana adopted $500,000 limitations on awards in 1975. Idaho enacted a $150,000 limitation. A lower court in Idaho has held the limitation unconstitutional. The Illinois Supreme Court held that the limit was unconstitutionally arbitrary. The limitations in Indiana and Louisiana have not been tested in court. The Louisiana attorney general has issued an opinion that that state's limitation is constitutional.[25] Legal research by the Legislative Counsel Bureau, based on Nevada cases in other types of insurance, has concluded that a similar limitation on recovery could be held constitutional in Nevada but the subcommittee was unconvinced of any expectation of certainty.

Structured Awards

In addition to the amount of damages, the method of payment of damages is susceptible to modification. A frequent criticism of settlements and awards paid in lump sums is that when the injured party dies shortly thereafter, the heirs are left with a windfall. There is such an example in Nevada in 1974. Another aspect of the lump sum payment is the possibility that some or all of the money can be squandered by those responsible for the injured person, leaving no money for necessary medical care. Such a person then becomes a burden to the taxpayer. A possible solution to both of these eventualities and one that would assist insurers in underwriting would be to structure large awards and settlements. This solution is also referred to as periodic payments. At the time of a judgment or settlement in excess of a certain amount, such as $50,000, a plaintiff is given an amount to cover damages up to that point. In addition, the attorney's fee is paid at that time based on the total settlement. All other payments are then made on a periodic basis with the amount based on actuarial projections for the injured. There are two ways to implement periodic payments. Some witnesses before the subcommittee have suggested that such payments be determined on a monthly basis with the total amount uncertain. If the injured outlives the actuarial projection, the insurer pays more than anticipated. If he dies before anticipated, the insurer pays less money than planned. The other way is to determine a total maximum figure for the award or settlement and then actuarily prorate it. When the total is reached, there are no further payments. Either of these methods can include an adjustment mechanism but the effect of adjustments would be different for each method. The only way to adjust monthly payments under the fixed sum approach would be to accelerate the payments, making them larger over a shorter period. With the open end approach the payments could be adjusted upward, resulting in a greater total payout.

With either approach, portions of an award or settlement unspent at the time the injured dies, and not obligated to the dependents of the deceased, revert to the insurer. Also, with either approach, some form of security for future payments must be provided by the insurer. The open ended periodic payment approach would protect the injured person's future care and would prevent so-called windfalls but it would do nothing to improve underwriting certainty for insurers. The fixed sum approach would have the same advantages plus the added feature of increased underwriting certainty.

Collateral Sources

There is yet another aspect to the figuring of damages. Many of the costs that can be a part of an award may be covered by other, collateral sources. In some states, evidence of collateral sources is not admissible in a medical malpractice trial. This is known as the collateral source rule. This rule can take various forms. California allows introduction of collateral sources into evidence but the plaintiff can introduce evidence of premiums paid to obtain benefits from those sources.

Pennsylvania requires the reduction of an award by the amount of public collateral sources but not private insurance. The question of equity on the subject of collateral sources is far from clear. In general, it seems unfair for a malpractice insurer to pay for lost wages if all or part of those wages were paid by unemployment compensation plans. On the other hand, it seems unfair for a person who has had the foresight to have a generous health insurance plan to have such benefits deducted from a malpractice award. Seven states modified their collateral sources rules to some extent in 1975.

Prior Payments

A final proposed solution related to the payment of damages pertains to any payments made by a defendant or his insurer prior to an award. There are two factors involved. First, there is the question of whether such payments constitute an admission of negligence and, if so, if they should be admitted as evidence of such negligence. Second, there is the question of whether any prior payments made should be deducted from the final award. Most states, including Nevada, prevent the introduction of prior payments into evidence as an admission of liability. In addition, Nevada and several other states provide for the deduction of prior payments from awards.

Whether malpractice victims are compensated through the tort system, arbitration or a no-fault compensation scheme, a primary goal of the entire health delivery system should be to minimize the incidence of malpractice, not just the incidence of malpractice claims. The realization of this goal centers on the health professions and their education, training and standards. There are several proposed solutions which are designed to improve the quality of health care and thereby reduce medical misadventures.

Risk Management

Almost 80 percent of malpractice claims result from incidents in hospitals. In virtually all of these, hospitals become malpractice defendants. In spite of this fact, the concept of risk management is new and seldom used in hospitals. Risk management has been used very successfully in industry for a number of years. It is a vital factor in ratings. Florida has required all hospitals with 300 beds or more to institute risk management programs. An official from the office of the Florida Insurance Commissioner reported that the programs seemed effective and that Florida's malpractice study committee recommended including more hospitals in the requirement.[27] The risk management concept is a possible solution for doctors operating medical centers, health maintenance organizations or even individual offices. The concept is of definite applicability to hospitals and could be made a part of accreditation procedures.

Staff Privileges

Hospitals, in their administration and standards, can have a considerable impact upon the quality of medical care. A hospital's strongest lever in encouraging high standards is the power over staff privileges. A doctor without hospital staff privileges is quite limited in his practice. A full denial of privileges means that a doctor cannot even admit a patient to a hospital, let alone operate. The power to revoke or limit privileges is meaningless without established standards and procedures for assessing doctor performance against those standards. There is little that can be done by law in areas such as these. The requirement for risk management could result in tighter hospital review of surgery to include second opinions on the necessity of surgery and then a regular review by tissue committees of the results of surgery. Related to these increased oversight and peer review functions is an increase in the legal protections for those involved in investigations and action to limit or revoke privileges. To maximize the effectiveness of such review, doctors charged with oversight responsibility must know they are legally protected from liability.

Licensing Boards

The licensing and regulatory boards for health care providers are extremely important to the maintenance of high quality health care. There have been numerous criticisms expressed

of the Nevada Board of Medical Examiners in particular and such boards in general. The criticism involves two elements. First, until very recently, the boards in most states had little power to require anything of a doctor once he was licensed. If he was adjudged incompetent, his license could be revoked. This is an extreme act, denying a doctor his livelihood. Because it is extreme, boards have been very reluctant to use it and, even when they have used it, such actions are often successfully appealed to a court. Second, there is a reluctance to limit a doctor, to revoke his license or to embarrass him publicly. This reluctance is, in part, because of the very limited success of such actions in the past. There is also the possibility, present in all professional licensing bodies, that concern for the public welfare is secondary to professional concerns.

Whatever the reasons for the limited effectiveness in the past of boards of medical examiners, two things can be done by law to increase future effectiveness. The first is to make the powers of such boards flexible, giving them a range of remedies for a range of professional shortcomings. Possible remedies short of license revocation are required education, limits on procedures, limits on size of practice, suspension of license for a set period or reexamination. The second is to broaden the membership of such boards to include people with no vested interests in the regulated profession.

Immunity Shields

Just as with hospital peer review, professional licensing boards also need the broadest possible legal protection for the actions they take against individual practitioners. Protection is also necessary for any group or individual presenting charges or complaints to a licensing body. In 1975, 21 states acted to increase the ability of health care licensing agencies to maintain high health care standards. Nevada was one of those.

Expense of Litigation and Alternatives to Litigation

It is well established from testimony before the subcommittee and from the comprehensive data gathered by the NAIC that any claims that find their way into courts will be expensive to insurers regardless of the outcome. For this reason, only 8 percent of all claims ever go to trial. Only 6 of that 8 percent go all the way to verdict.[28] Of those, only 17 percent were in favor of plaintiffs. The average expense to defend a case that goes to trial is over $5,500, win or lose. For

those settled out of court, with or without payment to the claimant, the average defense cost is about $1,100.[29] There are no data available on specific plaintiff legal costs of cases that go to trial as opposed to those that did not, but there is every reason to expect a cost ratio similar to the one for defense costs. In most cases, all parties are interested in resolving claims without going to court. There are suggestions for ways in which laws can assist in minimizing the use of the courts in malpractice claims.

Screening Panels

The most popular device for resolving malpractice claims without going to trial is the screening or mediation panel. In many states, such panels are informally provided by the medical and legal professions. In 13 states, including Nevada, such panels have been institutionalized by law. The composition of these panels varies widely. Admissibility of findings into subsequent trials also varies. Seven states allow it, four states do not, one does under certain circumstances and the other has arbitration panels. The success rate for plaintiffs is only slightly better with screening panels than it is in going to trial. About 19 percent of claimants are successful with screening panels as opposed to the 17 percent of plaintiffs successful in trials. Defense costs, when panels resolved claims, were only 30 percent of defense costs for a trial. The average awards to claimants by screening panels were 95 percent of the average awards by judges or juries.[30] Clearly the overall costs to the health care system are lower when panels can resolve claims. The data available on review panels are still very limited.

Arbitration

The next step beyond screening and mediation of claims is arbitration. Many states, including Nevada, have adopted the Uniform Arbitration Act which is available to any doctor or hospital and patient who mutually agree to use it. Two states, Michigan and Pennsylvania, have enacted specific arbitration procedures for medical malpractice claims. These states have provided for a particular panel composition appropriate to malpractice issues. The major difference between Michigan and Pennsylvania is that in the former state, a court appeal from an arbitration decision cannot be made on the basis of the facts. In Pennsylvania, an appeal results in a trial de novo. Pennsylvania requires that all claims go to

arbitration panels. Michigan requires that all health care providers offer an arbitration agreement to a patient. The patient does not have to accept it and cannot be denied care on that basis. Neither state has been using arbitration long enough to know how it will affect total costs. There is the suspicion that arbitration results in most claims getting something. If this were the case, the total costs of an arbitration system would be greater than for the tort system. The limited NAIC data does show that more claimants were sucessful in arbitration than in either trials or mediation panel decisions; 41 percent versus 17 and 19 percent respectively. Defense costs in arbitration are only 22 percent of those for trials and the average award in arbitration is only 25 percent of the average trial award.[31] These data do not reflect any experience with mandatory arbitration and it seems likely that persons with smaller claims are more likely to choose arbitration. In fact, some suggestions would have claims under a certain size subject to mandatory arbitration as is the case now for motor vehicle damages under $3,000. Arbitration systems, whether voluntary or mandatory, whether applicable to all claims or only those in a size class, do not change the role of malpractice insurance. Individual doctors and hospitals would continue to need insurance and the costs for such insurance would continue to be high until and unless experience proves that the costs to insurers of arbitration are less than for the tort system. It should also be noted that an arbitration panel would be guided by the same elements of a tortious act as a court. They would have to find a relationship imposing a legal duty, a breach of that duty and an injury. The time and cost of arriving at arbitration findings should be less than for a court and all parties should benefit. The experience of two states will soon be available to assess this proposition.

No-Fault Compensation Systems

There have been a number of proposals in many states to eliminate both the tort system and the traditional professional liability insurance system as they apply to health care in general and medical malpractice in particular. These proposals are generally referred to as "workmen's compensation" approaches to malpractice. This term is used because of the analogy to some aspects of state operated workers' compensation systems. The idea is that doctors and other health care providers would pay into a state compensation system much as employers pay into the Nevada Industrial Commission. When a patient is injured

in a medical procedure, as when an employee is injured on a job, a claim is filed. An arbitration board working for the state would hear the claim and determine if the injury were related to medical treatment. If it was, the board would make an award according to a fixed schedule and, in addition, pay all medical costs related to the injury. Such a system would have at least two advantages. It would provide compensation for small claims which are presently uncompensated. It would also probably lower the overall costs of malpractice compensation. The second assertion is qualified because there would undoubtedly be a lot more claims under such a system and it is unknown whether the number of claims would more than offset the lower individual awards. Inherent in the workmen's compensation approach is the "no-fault" concept. When individual workers lost their ability to sue, they were given the advantage of not having to prove that their own negligence contributed to their injury; neither must an employer's negligence be proven. Similarly, a patient would lose his right to sue under such a system of compensation but would also not have to prove negligence by the doctor or hospital. In addition to the loss of the right to sue, patients would lose the right to receive damages for noneconomic losses. Economic losses would be paid according to a standard schedule.

Resistance to the workmen's compensation approach is based on at least three problem areas. First, it is impossible to calculate whether the overall costs of such a system would be any less than the present one. Second, the "no-fault" aspect of the approach is not conducive to maintaining high standards of health care. Third, while there are some problems with the tort system as applied to medical malpractice, it is a body of law built up over several centuries and should not be rejected except for the most compelling reasons.

II. THE EFFECT OF LAWS PASSED BY THE 58TH SESSION AND THE CURRENT MEDICAL MALPRACTICE INSURANCE ENVIRONMENT IN NEVADA

It was explained in the foregoing section that many of the laws passed in 1975 and 1976, especially in the area of tort reform, have been in effect for too short a time to have measurable effects. This is no less true in Nevada. The Nevada legislation passed in 1975 concerning gratuitous emergency care (S.B. 402), prior payments (S.B. 403), res ipsa loquitur (S.B. 405), tolling of the statute of limitations (S.B. 406)

and informed consent (S.B. 408) may have long-term beneficial effects on malpractice claims in the state. At this time, there is no evidence of the effect of any of these changes in the law.

The effects of the other legislation passed in 1975 directed at the malpractice crisis can at least be discussed, if not precisely measured. S.B. 400 has had a significant impact on the availability of medical malpractice insurance. In the space of a year, the joint underwriting association authorized in S.B. 400 has become the largest medical malpractice insurance carrier in Nevada. It insures over 200 of Nevada's 700 doctors and that number of insureds is growing regularly. With the expected loss of Signal Imperial as a malpractice insurer in Nevada, the number of doctors insured by the JUA will probably exceed 300 by the end of 1976. The other major carrier, the Argonaut, continues to carry Nevada doctors but their future participation is extremely uncertain. Without doubt, in the absence of a JUA, there would be a far larger percentage of doctors in Nevada without malpractice insurance. The best estimate of Nevada doctors without malpractice insurance is about 20 percent.[32] National news coverage in the Wall Street Journal and on CBS's "60 Minutes" have used higher estimates but gave no reliable sources. The price range for JUA coverage is from $1,364 to $9,840. These are higher rates than doctors were paying 18 months ago but far lower than the rates for comparable coverage in California. While Nevada doctors are not pleased with the rates offered by the JUA, their more serious misgiving about the organization deals with the assessability feature. This feature was discussed in the earlier explanation of how JUA's operate. Nevada doctors want to have an option of paying a premium or a premium plus a special assessment that would protect them from future unknown assessments.

S.B. 401 made technical changes in the insurance code to harmonize it with the provisions of S.B. 400 which authorized the JUA. There were no discernible effects anticipated from this legislation.

S.B. 409 is a significant piece of legislation and the subcommittee was quite interested in the effectiveness of the medical-legal screening panels provided therein. The subcommittee heard directly from representatives of the northern Nevada panel and indirectly about the operation of the southern Nevada panel. In general, the panels have functioned

as intended by the legislature. There have been some problems in complying with the law, some problems concerning the smooth functioning of the panels. These problems are discussed in greater detail under suggested legislation below. The subcommittee found little evidence of the impact of the screening panels on the extent or size of claims but this was as expected. It will take several years to assess this effect. Based upon his experience with the former informal screening panel and the statutory one, Dr. Robert P. Schultz told the subcommittee that he was convinced that the panels served a useful purpose. He felt that the panels did weed out meritless claims and that their judgments were most often confirmed by subsequent actions to settle, make awards or dismiss.[33] The subcommittee heard no evidence to suggest that the screening panels were either superfluous or ineffective.

Perhaps the most unique bill passed on the subject of medical malpractice in Nevada in 1975 was S.B. 432. Many states sought to increase the power and flexibility of medical licensing boards as a response to charges that regulation of the medical profession was not all that it might be. Nevada did this as well, giving the Board of Medical Examiners new powers of discipline and new legal protections for its official actions. Access for complaints to the board was clearly opened to any citizen with legal protections for such persons. The unique feature of the Nevada law was the role mandated to the Attorney General designed with two purposes in mind. First, the 58th session was concerned that a strong investigative capability be available to the board. It gave the Attorney General this responsibility. Second, it was concerned that the board not be its own investigator, prosecutor and judge. Under S.B. 432, the Attorney General investigates complaints referred by the board and where the grounds are adequate, recommends that the board take action. The board then has three options. It can dismiss the case, proceed administratively or direct the Attorney General to go into district court for a judicial order to suspend, revoke or modify a license. The latter option is what is unique to Nevada. The 1975 legislature wanted to avoid situations where the board would move to revoke a license but the doctor would immediately appeal to a court and ask for a stay order pending the appeal. In most cases, a stay is granted. If the appeal takes a while and the court has a backlog, the doctor could practice under the stay order for a couple of years. If the doctor is, in fact, incompetent or dangerous, such a procedure endangers the public. Dr. Kenneth F. Maclean, representing the Board of Medical Examiners, reported to the subcommittee on the use of its new powers. In general,

there have been only a handful of cases before the board since July 1975. Two cases were resolved and the others are still in progress.[34] Dr. Maclean and Deputy Attorney General William Isaeff discussed some difficulties in using the new powers of the board, but in general they reported effective usage of the new law.

The actions of the 58th session demonstrated the legislature's appreciation of the gravity of the malpractice crisis and its willingness to respond to that crisis. In that respect, those actions had a beneficial effect on the medical malpractice insurance climate in Nevada. This state, however, and most others were faced with the situation discussed in the introduction above. No matter what any state did, perhaps short of abolishing the tort system, no insurance underwriters were going to downgrade their pessimism until firm evidence of a changed insurance claims climate was produced. In that sense, the present environment in Nevada is unstable and not encouraging. Availability, except through the JUA, will be difficult if not impossible to obtain. Cost will continue to be high. The 59th session must decide if further legislative action to improve the long range insurance environment is warranted and, if so, what that action should be.

III. CONTINUING PROBLEMS CONCERNING MEDICAL MALPRACTICE INSURANCE IN NEVADA AND SUGGESTED SOLUTIONS

The subcommittee heard suggestions on every problem or difficulty mentioned in this report. The subcommittee members considered every suggestion made by anyone appearing at any of the hearings and several others produced by the members themselves or the staff. For each suggestion, the members asked if there was any evidence of a causal relationship between a suggested solution and a malpractice problem. They then asked about the costs of each suggestion to the state directly or its residents. Finally, they considered the fairness of each suggestion in terms of who would bear the costs of the various ideas proposed.

The following legislative proposals all meet the several tests mentioned. Each bears a demonstrable relationship to a malpractice problem, none would cause a fiscal drain on the state treasury and, in the view of the subcommittee members, the burdens or obligations imposed on any person or group are equitable and justified by the evidence heard by the subcommittee.

a. Information and Data Development

It has been pointed out that the information and data available concerning medical malpractice have dramatically improved in just 2 years. The availability of data in Nevada, however, is still not as complete as it might be. For this reason, and to insure that the Insurance Commissioner and the JUA have the most up-to-date claims data and that the data is effectively used, the subcommittee makes several recommendations.

(1) The subcommittee was informed by members of the legal community that research on any civil action is severely hampered by the fact that filings in Nevada courts contain no notation about the type of case such as medical malpractice, product liability, personal injury, auto liability or the like. It was pointed out that in federal court such distinctions are easily noted on a filing. The subcommittee felt that the Nevada Supreme Court should direct a system of classification of legal filings by rule. In the meantime, to insure the availability of data on malpractice filings, the subcommittee decided that evidence of a filing of a medical malpractice action should be sent to the Insurance Commissioner.

Therefore, the subcommittee recommends that:

No medical malpractice claim filed be acted upon by the district court until an affidavit is filed with the clerk stating that a copy of the claim has been sent to the Insurance Commissioner. (BDR 2-9)

(2) The subcommittee decided that information about claims made and claims closed against health care providers had value in two respects. Obviously such data have historical and statistical value providing a better idea of how a current condition has developed. In addition, such data can be a management tool for the Insurance Commissioner and for the Board of Medical Examiners. The commissioner can better judge rate requests for malpractice insurers if he is informed about the claims experience of all malpractice carriers in the most timely manner possible. Additionally, it is perfectly consistent with increased powers for the Board of Medical Examiners that the board have the capability to continually review doctors' claims experience. Even if meritless claims

are filed against a doctor, those claims can very well indicate problems that a doctor is having in relations with his patients. Problems other than professional negligence should also be of concern to the board.

Therefore, the subcommittee recommends that:

All claims closed should be reported by insurers to the Insurance Commissioner and that he shall in turn report to the Board of Medical Examiners. (BDR 54-10)

The subcommittee further recommends that:

All claims made should be reported by insurers to the Insurance Commissioner and that he shall in turn report to the Board of Medical Examiners. (BDR 54-10)

b. Increased Quality of Medical Care

If medical malpractice is a leading cause of the malpractice crisis, and it seems certain that this is the case, then a long-term solution to the crisis is to assure the highest possible quality of medical care. There are several elements in the quality of medical care including initial training, licensing, regulation, continuing education and peer review. There is little that can be done about initial medical training in a state such as Nevada that does not have a medical degree granting institution. The subcommittee did consider suggestions in other areas.

(1) All states have numerous professional regulatory boards. The purpose of these boards is to protect the public from incompetent or unscrupulous practitioners. There is no professional regulation more critical to the public welfare than the regulation of the medical profession. Traditionally, professional regulation has been placed in the hands of the professions regulated. The average person would be ill-equipped to pass on the competence of doctors, or lawyers, or architects or many other professionals. A valid question can also be raised about the complete control of a profession by a board controlled by that profession. There is the suspicion that professional regulators at times place professional welfare above public welfare. Some states, including California, have added lay members to many professional licensing boards so that public or consumer interests

are represented. The subcommittee felt that such an approach would be consistent with the desire to strengthen the powers of the Board of Medical Examiners and to have that board assume a more activist role in assuring high quality medical care. As a general proposition, the subcommittee felt that the public welfare would be enhanced by adding lay membership to all professional and occupational regulatory boards.

Therefore, the subcommittee recommends that:

The Board of Medical Examiners be expanded from five to seven members, with two of the seven lay persons. (BDR 54-7)

The subcommittee further recommends that:

Lay members be added to all professional and occupational regulatory boards. (No bill appended.)

(2) The subcommittee was surprised to learn that the concept of risk management, much used in industry, is new and little used in the field of health care. It was reported to the subcommittee that the risk management programs mandated in Florida in 1975 were quite successful and were being extended to small hospitals. The subcommittee determined that there were obvious benefits to hospital risk management programs and that the benefits would directly and favorably affect the malpractice claims environment.

Therefore, the subcommittee recommends that:

All hospitals in Nevada with 200 or more beds be required to institute risk management programs. (BDR 40-8)

The subcommittee further recommends that:

The Joint Commission on Accreditation of Hospitals be memorialized to establish risk management as a criterion of accreditation. (BDR 17)

(3) An earlier recommendation reflected the subcommittee's desire that the Board of Medical Examiners be informed of all claims made or closed against doctors. It was felt that once a claim was closed, the board should

look into the specific facts to determine if any board action is warranted. If all closed claims must be investigated, the board is not placed in the position of choosing which cases to investigate. Removal of this discretion should protect the board against charges of favoritism or harassment.

Therefore, the subcommittee recommends that:

All closed medical malpractice claims be investigated by the Board of Medical Examiners with all results reported to the Insurance Commissioner and unfavorable reports transmitted to the Attorney General for possible licensure action. (BDR 54-10)

(4) One aspect of increasing the responsibilities and activities of the Board of Medical Examiners in 1975 was to facilitate the filing of complaints by any person or group. To insure that the bodies normally involved in peer review, the Board of Medical Examiners and hospital staff committees, are unconstrained and uninhibited in their reviews and investigations, the subcommittee wanted to provide the maximum legal protection to them.

Therefore, the subcommittee recommends that:

An immunity shield be provided for all parties involved in any entity having investigatory or licensing powers over physicians. (BDR 54-10)

(5) The subcommittee requested that the staff review the regulations adopted by the Board of Medical Examiners pursuant to the expanded authority granted to the board in S.B. 432 of 1975. This review brought to light several problems in chapter 630 of NRS. Essentially, S.B. 432 added a new option for the board which is to direct the Attorney General to go directly into district court and request a licensure action against a doctor. The law is clear that such an action can be directed by the board for cases of gross malpractice, repeated malpractice or professional incompetence. It is not clear that the board does not have to use the judicial remedy in these instances but can choose instead an administrative remedy. The subcommittee felt that for all four "triggers" for possible licensure action; gross malpractice, repeated malpractice, professional incompetence

and unprofessional conduct, the board should be able to proceed administratively. For all but the last, unprofessional conduct, the board may also proceed with a judicial remedy. The review of chapter 630 also produced several other ambiguities and inconsistencies that the subcommittee felt should definitely be remedied.

Therefore, the subcommittee recommends that:

Chapter 630 of NRS be amended to make it clear that administrative remedies can be applied to gross malpractice, repeated malpractice and professional incompetence as well as to unprofessional conduct while judicial remedies are available for all but the last of the four. Further, other sections of the chapter should be revised to increase clarity and eliminate confusion. (BDR 54-77)

c. Guaranteed Availability of Insurance

The subcommittee considered all the various devices suggested to facilitate the availability of medical malpractice insurance. The subcommittee noted that the insurance code presently allows for doctors' reciprocals and doctors' mutuals. The Insurance Commissioner has existing authority to institute a reinsurance vehicle on the lines of a JUA. A patients' compensation fund would have to be infused with general fund money, at least as a loan, in the amount of $1 million or more. A state operated insurance company would require even more state money, plus the costs of operation. When the subcommittee considered the options available under current law and the detriments involved under other concepts, it was decided that new approaches in insurance were not warranted. The most serious complaint about the JUA is the retroactive accessability feature discussed above. The subcommittee concluded that the JUA was adequate to assure availability of insurance and that the objectionable aspects of the JUA could be corrected.

Therefore, the subcommittee recommends that:

The JUA be mandated to offer the policy options of a premium with the possibility of assessment or a premium plus a surcharge not to exceed the premium which would prevent a future assessment. (BDR 57-15)

d. Improvement of Claims Resolution

The recommendations in this category are rather diverse. They center on the elements of the tort system and devices to smooth claims resolution.

(1) At several points in the path that can lead from a medical incident to a medical liability trial, the question of access to medical records is relevant. Some in the medical community claim that a patient's medical records are the property of the doctor, not the patient. The subcommittee concluded that the question of ownership was not the important one but that it was important that any person be allowed complete access to his records. This right of access goes beyond the issues of medical malpractice. It simply seems right that any patient should be able to see the records and documents about his own health. For this reason and for purposes of possible medical liability actions, the subcommittee also felt that health care providers should be required to maintain health records for a minimum period. The subcommittee also heard of difficulties encountered in obtaining access to a patient's records by proper investigatory agencies such as the Attorney General. In order to maintain a strong investigatory capability, the subcommittee felt that an investigation of a doctor should not be impeded by failure to gain access to patient records.

Therefore, the subcommittee recommends that:

Patients be guaranteed access to their medical records and that copies of such records be provided when requested at the patient's expense. Further, access to patients' records should be guaranteed to any investigatory agency charged by law with the responsibility of investigating physicians. Records are to be maintained for a minimum of 5 years. (BDR 54-12)

(2) The subcommittee discovered no instant remedy to the problems of medical malpractice. It is hoped that a number of the changes in laws in Nevada and elsewhere will eventually restrain the increases in premium rates. In the meantime, there are few steps, short of replacing the tort system, that will result in any immediate changes in the medical malpractice insurance environment. The subcommittee felt that one such change would be in the way awards are paid. The problems that can arise when a large

award is paid in a lump sum are discussed above along with the fact that insurers can anticipate costs much better if they do not pay awards in lump. The subcommittee felt that the arguments in favor of structured awards and settlements were compelling.

Therefore, the subcommittee recommends that:

All medical malpractice awards and settlements in excess of $50,000 be subject to payment on a periodic basis with losses incurred to date paid in a lump sum. Either party may petition the court for such an arrangement and the court shall require a guarantee of future payments. (BDR 3-11)

(3) Another area promising some immediate, if limited, improvement in the settlement of medical malpractice claims is that of the collateral source. The subcommittee agreed that an injured party should not be compensated by a medical malpractice insurer for anything also compensated by any system of general public welfare, medical care or other system of compensation for which the injured party did not pay direct discretionary costs. The subcommittee felt that any such compensation paid up to the time of the award should be deducted from any award.

Therefore, the subcommittee recommends that:

All medical malpractice awards be reduced by the amount of public nondiscretionary collateral sources to which the judgment creditor would be entitled. (BDR 3-14)

(4) A major concern of the subcommittee's inquiry was to assess the effectiveness of laws passed in 1975. The medical-legal screening panels were of particular concern and the subcommittee learned of several problems in their operation. Each recommendation is discussed separately.

(a) The 1975 law established a northern Nevada panel and a southern Nevada panel. Each panel has a list of nine doctors and nine lawyers. Three of each are selected for any particular case. Parties to an action may use peremptory challenges to remove

names from the lists. If there is one plaintiff and one defendant, the lists are adequate. If, as is more often the case, there is more than one defendant, the lists can be exhausted through peremptory challenges before a six-member panel is selected.

Therefore, the subcommittee recommends that:

The number of doctors and attorneys comprising the lists from which medical-legal screening panels are selected be increased from nine to 15. (BDR 3-13)

(b) The subcommittee also learned that the provision allowing 5 days for a peremptory challenge of panel members is inadequate. Those experienced with the panels felt this period should be extended.

Therefore, the subcommittee recommends that:

The time limit for peremptory challenges of panel members be increased from 5 days to 10 days. (BDR 3-13)

(c) The present law does not require the filing of any details of an incident at the time a hearing is requested before a screening panel. Panels are called which know nothing about the facts until the hearing begins. The main problem arises from ignorance of who the defendants will be so the panels cannot notify all parties prior to the hearing. This results in delay. The subcommittee did not feel that this was the most efficient way to operate the panels.

Therefore, the subcommittee recommends that:

A request for a hearing by a screening panel include the time and place of the incident complained of and the names of all parties involved. (BDR 3-13)

(d) The panels have experienced some difficulties with the doctor-patient privilege. Some parties have interpreted the privilege to mean that a doctor before a screening panel cannot reveal material in a patient's records without the patient's consent. The subcommittee agrees that the panels could not function as intended under this interpretation of the privilege.

Therefore, the subcommittee recommends that:

Screening panel procedures be exempted from the doctor-patient privilege. (BDR 3-13)

(e) The informal screening panels that preceded those established by law in 1975 commonly met in private so as to maximize free and open discussion without concern for either press reports or the fear of using statements made in a subsequent trial. The subcommittee agreed that the intent of the screening panels would be enhanced if they could meet in private. They also felt that the issues discussed before the panels were not of general public interest.

Therefore, the subcommittee recommends that:

The medical-legal screening panels be exempted from the open meeting law. (BDR 3-13)

(f) The 1975 law establishing medical-legal screening panels required that reports of complaints filed and results of hearings be reported to the Board of Medical Examiners, county medical societies and the Attorney General. The subcommittee felt that the Insurance Commissioner should also receive such reports.

Therefore, the subcommittee recommends that:

Reports of complaints filed with screening panels and results of hearings should be forwarded to the Insurance Commissioner. (BDR 3-13)

(5) There was some concern expressed to the subcommittee about the protection of a doctor from liability in the treatment of a minor when parental consent cannot be obtained because parents cannot be located. A.B. 100 of the 1975 session dealt with this situation specifically. The language in S.B. 408 of 1975 is clearer in this regard.

Therefore, the subcommittee recommends that:

NRS 129.030 be amended to parallel the language on the treatment of a minor found in S.B. 408 of the 1975 session. (BDR 11-19)

(6) S.B. 406 of 1975 eliminated tolling of the statute of limitations for mental incompetents in the state hospital, for convicts in the state prison and for minor children, and made legal gardians responsible for bringing actions during the period of legal disability. That bill did not make it clear if, or under what circumstances, a person would have a cause of action for the failure of a legal guardian to bring an action. The subcommittee felt that such a provision was required but that the responsibility should be narrowly drawn.

Therefore, the subcommittee recommends that:

> The legal guardians responsible for filing medical malpractice actions on behalf of prisoners, mental incompentents or minors be responsible only if they knew, or with reasonable diligence could have known, that the legally disabled person had a cause of action. (BDR 2-20)

e. Other

The subcommittee can see no likelihood of the malpractice crisis being resolved in the foreseeable future. The shape and dimensions of the situation have undergone a series of changes in less than 2 years. The subcommittee feels that it is a necessity for the legislature to continue close surveillance of the several aspects of the malpractice situation in the next interim period. The subcommittee also feels that the complexities of medical malpractice and the various proposals dealing with it are such that there should be a select committee during the 59th session specializing in medical malpractice bills. Such a select committee should logically use the expertise and knowledge built up over the course of the interim study.

Therefore, the subcommittee recommends that:

> A select committee on the problems of medical malpractice insurance be created to operate during the 59th session, such committee to consist of members most knowledgeable and informed on the various aspects of the problem, and such committee to continue as a subcommittee of the legislative commission subsequent to the 59th session. (BDR 18)

IV. FOOTNOTES

1 Keene, Barry, Assemblyman; "Medical Malpractice: A Plague on All Our Houses" in State Legislatures, March/April 1976, p. 10.

2 Colorado Legislative Council; "Report to the Colorado General Assembly, Vol. II," Research Publ. No. 212, December 1975, p. 5.

3 Ibid.

4 Robert Byrd; Nevada Medical Liability Insurance Association; testimony before the subcommittee, January 15, 1976. Minutes, p. 13.

5 Colorado Legislative Council, Op. Cit., Byrd, Op. Cit. and Auditor General of California; "Doctors' Malpractice Insurance," Report 265.2; December 1975.

6 Colorado Legislative Council, Op. Cit.

7 Auditor General of California, Op. Cit.

8 Ibid., p. 11.

9 Fred Hillerby, Nevada Hospital Association, testimony before the subcommittee, November 25, 1975. Minutes, p. 8.

10 Department of Health, Education and Welfare; Medical Malpractice: Report of the Secretary's Committee on Medical Malpractice, DHEW Publication No. (OS) 73-88. Washington, D.C., January 1973.

11 Black's Law Dictionary, Revised Fourth Edition; West Publishing Co. (St. Paul, Minnesota, 1968) p. 1111.

12 Auditor General of California, Op. Cit., p. 11.

13 Barry Keene, Op. Cit., p. 10.

14 Senator Norman Ty Hilbrecht, citing DHEW, Op. Cit., November 25, 1975. Minutes, p. 14. Also, Exhibit C, July 23, 1975, Minutes.

15 Dr. Dick L. Rottman, Insurance Commissioner of Nevada; testimony before the subcommittee, July 23, 1975. Minutes, p. 2.

16 Thomas Uehlin, St. Paul Fire and Marine Insurance Company; remarks as a panel participant, NCSL Seminar on Medical Malpractice Crisis, February 26-28, 1976, Dallas, Texas.

17 Larry Baker, Argonaut Insurance Company; testimony before the subcommittee, September 18, 1975. Minutes, p. 2.

18 Barry Keene, Op. Cit., p. 10.

19 Office of Research, Legislative Counsel Bureau; Background Paper No. 12, 1975, p. 3.

20 National Association of Insurance Commissioners, NAIC Malpractice Claims, Vol. 1, No. 2, April 1976.

21 Arizona Legislative Council, Research Division, "Program Alternatives for Medical Malpractice Insurance" (R-75-100), October 22, 1975, p. 11.

22 Black's Law Dictionary, Op. Cit., p. 1660.

23 Ibid.

24 National Association of Insurance Commissioners, Op. Cit., p. 64.

25 Guste, William J., Jr., Attorney General, State of Louisiana, Opinion No: 75-1318, February 3, 1976.

26 Lopez, Gerald A., Memorandum of Law, Legislative Counsel Bureau WP-76-2, April 3, 1976.

27 William G. McCue; Director, Division of Insurance Company Regulation, Florida Insurance Department; testimony before the subcommittee, January 15, 1976. Minutes, pp. 3 and 4 of Exhibit C.

28 National Association of Insurance Commissioners, Op. Cit., p. 65.

29 Ibid.

30 Ibid.

31 Ibid.

32 Dr. Dick L. Rottman, Nevada Commissioner of Insurance; testimony before the subcommittee, January 15, 1976. Minutes, p. 8.

33 Dr. Robert P. Schultz, M.D., Northern Nevada Medical-Legal Screening Panel; testimony before the subcommittee, January 15, 1976. Minutes, p. 6.

34 Dr. Kenneth F. Maclean, M.D., Secretary-Treasurer, Nevada Board of Medical Examiners; testimony before the subcommittee, January 15, 1976. Minutes, p. 6.

V. CREDITS

The following is a listing of the names of persons who signed the guest register at public hearings of the subcommittee. The list reflects those who attended the hearings, as well as those who presented testimony before the subcommittee.

Presented Testimony

TOM R. ANDERSON, Reno, Nevada

LARRY C. BAKER, President, Argonaut Insurance Company, Menlo Park, California

ROBERT A. BYRD, Nevada Medical Liability Insurance Association, Reno, Nevada

KIRK CAMMACK, M.D., State Board of Medical Examiners, Las Vegas, Nevada

ROBERT F. CATHCART, M.D., Incline Village, Nevada

*IRVIN CLAMPITT, Chief Deputy Insurance Commissioner of Indiana, Department of Insurance, Indianapolis, Indiana

BONNIE DUNN COHEN, Las Vegas, Nevada

JOHN W. DENSER, M.D., Nevada State Medical Association, Hawthorne, Nevada

JACKI DIETRICK, Las Vegas, Nevada

NEIL G. GALATZ, Attorney at Law, Las Vegas, Nevada

WESLEY W. HALL, M.D., Former President, American Medical Association, Reno, Nevada

*Submitted written testimony in lieu of oral presentation before the subcommittee.

*RICHARD L. HAMILTON, D.D.S., Reno, Nevada

FRED J. HEISTAND, Consultant, Assembly Select Committee on Medical Malpractice, California Legislature, Sacramento, California

GEORGE MEAD HEMMETER, M.D., Las Vegas, Nevada

FRED HILLERBY, Nevada Hospital Association, Reno, Nevada

WILLIAM E. ISAEFF, Deputy Attorney General, Carson City, Nevada

JAMES J. JONES, SR., Reno, Nevada

MINOR KELSO, Chief, Medical Care Services, Department of Human Resources, Carson City, Nevada

RODNEY KLINE, Attorney at Law, Sacramento, California

LOUIS A. LEVY, M.D., Reno, Nevada

KENNETH F. MACLEAN, Secretary-Treasurer, State Board of Medical Examiners, Reno, Nevada

VASIL M. MARKOFF, Las Vegas, Nevada

VICTOR B. MARTIN, Reno, Nevada

NANCY MASER, Reno, Nevada

WILLIAM G. (BUDDY) MCCUE, Director, Division of Insurance Company Regulations, Florida Insurance Department, Tallahassee, Florida

BOB MILLER, Las Vegas, Nevada

JAMES J. MILLS, Nevada Medical Association, Inc., Reno, Nevada

WAYNE L. MORTIMER, Member, Northern Nevada Medical-Legal Screening Panel, Reno, Nevada

RICHARD W. MYERS, Attorney at Law, Las Vegas, Nevada

PETER CHASE NEUMANN, Acting President, Nevada Trial Lawyers' Association, Reno, Nevada

RICHARD G. PUGH, Nevada State Medical Association, Reno, Nevada

ELIZABETH REYMEULS, Reno, Nevada

BRYCE RHODES, Attorney, State Board of Medical Examiners, Reno, Nevada

DAVID L. ROBERTS, M.D., Washoe County Medical Society, Reno, Nevada

JAMES E. ROGERS, Attorney at Law, Las Vegas, Nevada

JANNESSA ROGERS, Las Vegas, Nevada

DR. DICK L. ROTTMAN, Insurance Commissioner, Department of Commerce, Carson City, Nevada

ROBERT P. SCHULTZ, M.D., Member, Northern Nevada Medical-Legal Screening Panel, Reno, Nevada

MRS. PEGGY SOWDER, Reno, Nevada

WILLIAM K. STEPHAN, M.D., President, Nevada State Medical Association; Member, American Board of Anesthesiology, Las Vegas, Nevada

PAT VAN BETTEN, Health Chairman, Consumers' League of Nevada, Las Vegas, Nevada

SID WOLFENDEN, Las Vegas, Nevada

MS. VIRGINIA WOLFENDEN, Las Vegas, Nevada

BERTHA J. ZUMWALT, Wadsworth, Nevada

Others in Attendance

G. LANT BARNEY, JR., Las Vegas, Nevada

MRS. RICHARD BLAKEMORE, Tonopah, Nevada

FRED BUSH, Henderson, Nevada

ROBERT C. CLIFT, Reno, Nevada

FRANCES DENSER, Hawthorne, Nevada

WEBB DOMINGUEZ, Florida Department of Insurance, Tallahassee, Florida

ARLO K. FUNK, Hawthorne, Nevada

JOSEPH GEORGE, M.D., Las Vegas, Nevada

DOUGLAS HACKETT, Clark County Medical Society, Las Vegas, Nevada

CHARLES B. KNAUS, Nevada Insurance Division, Department of Commerce, Carson City, Nevada

CARLA J. LAUER, Comprehensive Health Planning, Carson City, Nevada

SUSAN D. LEVY, Reno, Nevada

MILDRED G. MARTIN, Reno, Nevada

PENNY MCCARTY, Reno, Nevada

JEAN MYLES, Reno, Nevada

RICHARD PINKHAM, Las Vegas, Nevada

NUNCI RIO PRICE, Las Vegas, Nevada

BEVERLY ROWLEY, Reno, Nevada

JOHN P. SANDE, M.D., Nevada State Medical Association, Las Vegas, Nevada

RUTH STEMOCK, Las Vegas, Nevada

RICHARD VANAKEN, Las Vegas, Nevada

TERRY S. VITEZ, M.D., Las Vegas, Nevada

JERRY WILSON, American Insurance Association, San Francisco, California

SUGGESTED LEGISLATION

SUMMARY--Provides for collection of statistical data concerning certain civil actions. (BDR 2-9)
Fiscal Note: Local Government Impact: Yes.
State or Industrial Insurance Impact: No.

AN ACT relating to civil actions; providing for a cover sheet to accompany claims filed in certain civil actions; providing filing requirements; and providing other matters properly relating thereto.

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. Chapter 15 of NRS is hereby amended by adding thereto a new section which shall read as follows:

1. Every pleading in a civil action filed in a district court which sets forth a claim for relief, whether an original claim, counterclaim, cross-claim or third-party claim, shall be accompanied by a cover sheet which shall be completed by the person who files the pleading. The form, contents and manner of filing the cover sheet shall be prescribed by the state court administrator. The cover sheet shall include without limitation:

(a) Categories classifying civil actions, one of which shall be actions based upon a breach of duty toward a patient by a physician, hospital or other person who provides or employs another to provide health care; and

(b) The date of filing, the case number and any other information required for retrieval of the case file.

2. Compliance with any rule of the supreme court or direction of the court administrator for the classification of civil actions in the district courts shall be deemed to constitute compliance with the requirements of subsection 1.

3. If the pleading sets forth a claim based upon a breach of duty toward a patient by a physician, hospital or other person who provides or employs another to provide health care:

(a) The person who files the pleading shall deliver or mail by registered or certified mail a copy of the pleading, bearing a notation by the clerk of the court that it has been filed, to the commissioner of insurance, and file with the clerk of the court an affidavit of such delivery or mailing which shall become part of the case record.

(b) The court shall not hear the claim or entertain any application by the claimant until the requirements of this subsection are satisfied.

Sec. 2. Section 1 of this act applies to civil actions filed on or after July 1, 1977.

SUMMARY--Provides for reporting and investigation of certain medical malpractice claims. (BDR 54-10)
Fiscal Note: Local Government Impact: No.
State or Industrial Insurance Impact: Yes.

AN ACT relating to medical malpractice; providing immunity from liability and suit in certain investigations and proceedings; providing reporting requirements; providing for the investigation of certain claims; and providing other matters properly relating thereto.

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. Chapter 630 of NRS is hereby amended by adding thereto a new section which shall read as follows:

Any person who or organization which, without malicious intent, initiates or assists in any lawful investigation or proceeding concerning the licensure of a physician or his insurability against liability for malpractice is immune from any civil action for such initiation or assistance or any consequential damages.

Sec. 2. NRS 630.341 is hereby amended to read as follows:

630.341 1. Any medical review panel of a hospital, medical-legal screening panel or other medical society which becomes aware of gross or repeated malpractice or of professional incompetence on the part of a physician shall, and any other person who is so aware may, file a written allegation of the relevant facts with

the board or, if the physician has his office in a county of this state whose population if 100,000 or more, as determined by the last preceding national census of the Bureau of the Census of the United States Department of Commerce, the county medical society. A claim for breach of duty by a physician toward a patient with respect to which the commissioner of insurance has reported to the board that a settlement or award was made or judgment rendered shall be deemed equivalent to a written allegation filed with the board pursuant to this subsection.

2. [A person who, acting individually or as a member of any panel or organization, and a panel or organization which files any allegation for the purposes of this section, except with malicious intent, are immune from any civil action for such filing or any consequential damages.

3.] All proceedings subsequent to the filing of an allegation are confidential until a determination is made by the board following investigation and recommendation by the attorney general. If the board dismisses the allegation, the proceedings shall remain confidential. If the board proceeds administratively under this chapter or directs the attorney general to proceed judicially, confidentiality concerning the proceedings is no longer required.

Sec. 3. Chapter 690B of NRS is hereby amended by adding thereto a new section which shall read as follows:

1. Each insurer which issues a policy of insurance covering the liability of a physician licensed under chapter 630 of NRS for a breach of his professional duty toward a patient shall report to the commissioner within 30 days:

(a) Each claim made under the policy, giving the name and address of the claimant and physician, and the date and circumstances of each alleged breach so far as known.

(b) Each settlement or award made or judgment rendered by reason of a claim, identifying the claim as previously reported.

2. The commissioner shall report to the board of medical examiners of the State of Nevada, within 30 days after receiving the report of the insurer, each claim made and each settlement, award or judgment.

SUMMARY--Adds lay members to board of medical examiners. (BDR 54-7)
Fiscal Note: Local Government Impact: No.
State or Industrial Insurance Impact: No.

AN ACT relating to the board of medical examiners of the State of Nevada; increasing the number of members of the board; providing for the qualifications and terms of the additional members; and providing other matters properly relating thereto.

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. NRS 630.050 is hereby amended to read as follows:

630.050 The board of medical examiners of the State of Nevada [consisting of five] consists of seven members appointed by the governor . [is hereby created.]

Sec. 2. NRS 630.060 is hereby amended to read as follows:

630.060 1. [Each member] Five members of the board shall be persons licensed to practice medicine in the State of Nevada [, shall] who have been engaged in the practice of medicine in the State of Nevada for a period of more than 5 years preceding [his appointment and shall be] their respective appointments and are actually engaged in the practice of medicine in the State of Nevada.

2. The remaining members shall be residents of the State of Nevada:

(a) Not licensed in any state to practice any healing art; and

(b) Not actively engaged in the administration of any health and care facility.

3. The members of the board shall be selected without regard to their individual political beliefs.

4. As used in this section:

(a) "Health and care facility" has the meaning attributed to it in NRS 449.007.

(b) "Healing art" means any system, treatment, operation, diagnosis, prescription or practice for the ascertainment, cure, relief, palliation, adjustment or correction of any human disease, ailment, deformity, injury, or unhealthy or abnormal physical or mental condition for the practice of which long periods of specialized education and training and a degree of specialized knowledge of an intellectual as well as physical nature are required.

Sec. 3. NRS 630.070 is hereby amended to read as follows:

630.070 1. Upon the expiration of the terms of those members serving on the board on July 1, 1973, the governor shall appoint two members for 2-year terms, one member for a 3-year term and two members for 4-year terms. On July 1, 1977, the governor shall appoint two additional members, one for a 1-year term, the other for a 3-year term. Thereafter, each member shall be appointed for a term of 4 years.

2. Upon expiration of his term of office, a member shall continue to serve until his successor is appointed and qualifies. No term of office shall extend more than 4 years beyond the expiration of the preceding term of office.

3. If a vacancy occurs in the board, a member is absent from the state for a period of 6 months without permission from the board, a member fails to attend meetings of the board or a member fails to attend to the business of the board, as determined necessary in the discretion of the board, the board shall so notify the governor, and the governor shall appoint a person duly qualified under this chapter to replace the member for the reminder of the unexpired term.

Sec. 4. NRS 630.080 is hereby amended to read as follows:

630.080 Before entering upon the duties of his office, each member of the board shall take:

1. The constitutional oath of office; and

2. An oath that he is [licensed to practice medicine in this state and is actually engaged in the practice of medicine in this state.] <u>legally qualified to serve on the board.</u>

SUMMARY--Requires certain hospitals to establish internal risk management programs. (BDR 40-8)
Fiscal Note: Local Government Impact: No.
State or Industrial Insurance Impact: No.

AN ACT relating to hospitals; requiring the establishment of internal risk management programs; requiring reports; providing a privilege; and providing other matters properly relating thereto.

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. Chapter 449 of NRS is hereby amended by adding thereto a new section which shall read as follows:

1. Every hospital licensed pursuant to the provisions of NRS 449.001 to 449.240, inclusive, which has more than 200 beds shall establish an internal risk management program which includes at least the following components:

(a) The investigation and analysis of the frequency and causes of general categories and specific types of adverse incidents causing injury to patients;

(b) The development of appropriate measures to minimize the risk of injuries and adverse incidents to patients through the cooperative efforts of all personnel; and

(c) The analysis of patient grievances which relate to patient care and the quality of medical services.

2. The risk management program shall be carried out through a person on the administrative staff of a hospital as part of his administrative duties, by a committee of the hospital board of trustees or directors or by the medical staff in a manner which they deem appropriate.

3. The person, committee or staff responsible for carrying out the program shall prepare and file with the insurance division of the department of commerce and the health division of the department of human resources a plan which describes the hospital's current risk management program in the manner prescribed by the commissioner of insurance.

4. Every hospital whose plan is filed as provided in subsection 3 has a privilege to refuse to disclose and to prevent any other person or organization from disclosing the plan or any writing which relates to any corrective action taken under the plan.

SUMMARY--Revises provisions relating to discipline of physicians.
(BDR 54-77)
Fiscal Note: Local Government Impact: No.
State or Industrial Insurance Impact: No.

AN ACT relating to the practice of medicine; revising provisions of chapter 630 of NRS respecting disciplinary proceedings initiated by complaint and by allegation; and providing other matters properly relating thereto.

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. NRS 630.300 is hereby amended to read as follows:

630.300 1. [The board may revoke, either permanently or temporarily for a period to be determined by the board, the license to practice medicine of any person:

(a) Who is guilty of unprofessional conduct;

(b) Who is convicted of violating any federal or state law regulating the possession, distribution or use of a controlled substance as defined in chapter 453 of NRS;

(c) Who is convicted of a felony or of any offense involving moral turpitude; or

(d) Whose license to practice medicine has been suspended or revoked by any other state for acts similar to those constituting unprofessional conduct convictions as described in paragraphs (b) and (c),

and the board may suspend that person from the practice of medicine within this state for a period to be determined by the board.] The grounds for initiating a disciplinary proceeding before the board by complaint are:

(a) Unprofessional conduct;

(b) Conviction of:

(1) A violation of any federal or state law regulating the possession, distribution or use of any controlled substance as defined in chapter 453 of NRS;

(2) A felony; or

(3) Any offense involving moral turpitude; or

(c) Suspension or revocation of the license to practice medicine by any other state for acts similar to those described in paragraph (b).

2. A certified copy of the record of a court or a licensing agency showing any such conviction, revocation or suspension is conclusive evidence of its occurrence.

Sec. 2. NRS 630.310 is hereby amended to read as follows:

630.310 [Every] Any person, including the board or any [member thereof,] of its members, may file a complaint with the secretary of the board against any holder of a license provided for in this chapter charging [unprofessional conduct.] any one or combination of the grounds stated in NRS 630.300. The complaint shall be in

writing and verified by the person making it, except when filed by the board as a body. When a complaint has been [duly] filed with the secretary, proceedings shall then be had as provided in [this chapter.] NRS 630.320 to 630.340, inclusive.

Sec. 3. NRS 630.320 is hereby amended to read as follows:

630.320 1. When [charges as stated in NRS 630.310 have been duly filed with the secretary of the board, the same] a complaint has been filed as provided in NRS 630.310, it shall be considered by the president [and] or the secretary of the board. If the complaint is considered to be frivolous, it shall be held in abeyance and discussed at the next meeting of the board.

2. If from the [sworn statement] complaint or from [such] other official records it [is made to appear that such charge or charges may be well founded in fact, then the president and] appears that the complaint is not frivolous, or, with respect to an allegation reported by the attorney general under NRS 630.343, the board has determined to proceed with administrative action, the secretary shall fix a time and place for a hearing [,] and [the secretary shall] cause [written notice of such charges, together with] a copy of the complaint [,] or the allegation to be served on the person charged at least 20 days before the date fixed for the hearing.

[2. If the charges are not deemed by the president and the secretary to be of sufficient import or sufficiently well founded to merit bringing proceedings against the person charged, then they shall be held in abeyance and discussed at the next meeting of the board.]

Sec. 4. NRS 630.330 is hereby amended to read as follows:

630.330 1. The person charged shall be given a full and fair trial by the board, with the right to be heard and to appear in person and by counsel, to cross-examine witnesses who appear against him and to present witnesses. The failure of the person charged to attend his hearing or his failure to defend himself shall not serve to delay or [make] void the proceedings. The board may, for good cause shown, continue any hearing from time to time.

2. The secretary or the president of the board [shall have power to] may issue subpenas for the attendance of witnesses or for the production of documents or tangible evidence. A subpena may be served by the sheriff, his deputy or any other person who is not a party and is not less than 18 years of age. If any person refuses to obey [any] the subpena [so issued] or refuses to testify or produce any tangible evidence designated therein, the board may petition the district court of the county where the person is served or where he resides to secure the attendance of that person and the production of any tangible evidence. Upon receiving the petition

the court shall issue an order requiring that person to obey the subpena or to show cause why he failed to obey the subpena. The failure of any person, without adequate excuse, to obey a subpena [shall be] is contempt of the court.

3. [If after hearing the charges it appears to the satisfaction of the board that the person is guilty as charged, the board may revoke the license of such person either permanently or temporarily, and by its order suspend the person from the practice of medicine within this state either permanently or temporarily in the discretion of the board. The board may likewise after finding the person guilty as charged place him on probation for such period and subject to such terms as may be determined by the board or administer to him a public or private reprimand. The order of the board may also contain such other terms, provisions or conditions, including terms and conditions for reinstatement of license, as the board may deem proper.] If the board finds the person is guilty as charged in the complaint or the allegation, it may by order:

(a) Place the person on probation for a specified period or until further order of the board.

(b) Administer to the person a public or private reprimand.

(c) Limit the practice of the person to, or by the exclusion of, one or more specified branches of medicine.

(d) Suspend the license of the person to practice medicine for a specified period or until further order of the board.

(e) Revoke the license of the person to practice medicine.

The order of the board may contain such other terms, provisions or conditions as the board deems proper and which are not inconsistent with law.

4. In all cases of revocation of license, the secretary of the board shall file a certified copy of the order of the board with the county recorder of the county in which the person's certificate has been recorded.

5. In all cases where a license is revoked or suspended or a person placed on probation a transcript of the proceedings before the board, and the findings and order of the board, shall be filed within 30 days with the clerk of the district court of the county in which the license has been recorded.

Sec. 5. NRS 630.343 is hereby amended to read as follows:

630.343 1. When an allegation has been filed:

(a) With the board, it shall be reviewed by the board.

(b) With a county medical society, the society may choose to review it or may refer it to the board for review. Whether or not the society chooses to conduct the review itself, it shall forward a copy of the allegation to the board and advise the board of its decision to review or refer. Whenever an allegation is referred by

the county medical society to the board for review, it shall be reviewed by the board.

Upon completion of the review, the board or the county medical society conducting the review shall determine whether the allegation is frivolous, and if it is not, [determine whether, in the judgment of the board or the society, the case warrants further investigation. If it finds that further investigation is warranted,] the board or society shall transmit the original allegation, along with further facts or information derived from its own review, to the attorney general.

2. The attorney general shall conduct an investigation of each allegation transmitted to him to determine whether such allegation warrants proceedings for suspension, revocation or modification of licensure. If he determines that such further proceedings are warranted, he shall report the results of his investigation together with his recommendation to the board [.] <u>in a manner which does not violate the physician's right to due process in any later hearing before the board.</u>

3. The board shall promptly make a determination with respect to each allegation reported to it by the attorney general as to what action shall be pursued. The board shall:

(a) Dismiss the allegation;

(b) Proceed with appropriate administrative action under this chapter; or

(c) Direct the attorney general to file a petition in the district court on behalf of the board for a judicial suspension, revocation or modification.

4. The filing and review of an allegation, its dismissal without further action or its transmittal to the attorney general, and any subsequent disposition by the board, the attorney general or any court do not preclude any measure by a hospital or other institution or medical society to limit or terminate the privileges of a physician according to its rules or the custom of the profession. No civil liability attaches to any such action taken without malice even if the ultimate disposition of the allegation is in favor of the physician.

5. A county medical society may act for the purposes of this section through its governing board or through a committee appointed for this purpose.

Sec. 6. NRS 630.350 is hereby amended to read as follows:

630.350 1. [Any person whose license has been revoked for unprofessional conduct for a specified period may apply at the end of the period of revocation for reinstatement of his license. If such an application is made, the board may take such evidence and require such proof of good moral and professional character as it shall deem proper. If the evidence fails to establish to the satisfaction of the board that the person is then of good moral and professional character or establishes that the person has practiced

medicine in this state during the period of revocation, the board may deny the application for reinstatement of license.

2. Any person whose license has been revoked for professional incompetency on the ground of practicing medicine after having been found to be mentally ill by a court of competent jurisdiction may apply to the board for a reinstatement of his license upon restoration to or declaration of sanity. Prior to the hearing the board may require the person to submit to a mental examination by physicians designated by it and to submit such other proof of fitness as may be deemed proper by the board.] Any person:

(a) Whose practice of medicine has been limited; or

(b) Whose license to practice medicine has been:

(1) Suspended until further order; or

(2) Revoked,

by an order of the board or the court may apply after a reasonable period for removal of the limitation or restoration of his license to the authority which issued the order.

2. The authority hearing the application:

(a) May require the person to submit to a mental or physical examination by physicians whom it designates and submit such other evidence of changed conditions and of fitness as it deems proper;

(b) Shall determine whether under all the circumstances the time of the application is reasonable; and

(c) May deny the application or modify or rescind its order as it deems the evidence and the public safety warrants.

Sec. 7. Chapter 630 of NRS is hereby amended by adding thereto a new section which shall read as follows:

1. When the board has determined to proceed with administrative action on an allegation reported to it by the attorney general, the board may require the person charged in the allegation to submit to a mental or physical examination by physicians designated by the board.

2. For the purposes of this section:

(a) Every physician licensed under this chapter who accepts the privilege of practicing medicine in this state is deemed to have given his consent to submit to a mental or physical examination when directed to do so in writing by the board.

(b) The testimony or examination reports of the examining physicians are not privileged communications.

3. Except in extraordinary circumstances, as determined by the board, the failure of a physician licensed under this chapter to submit to an examination when directed as provided in this section constitutes an admission of the charges against him.

Sec. 8. NRS 630.315 is hereby repealed.

SUMMARY--Memorializes Joint Commission on Accreditation of Hospitals to require risk management as prerequisite to accreditation. (BDR 17)

SENATE CONCURRENT RESOLUTION--Memorializing the Joint Commission on Accreditation of Hospitals to require establishment of risk management program as prerequisite to accreditation.

WHEREAS, A 1975 study by the National Association of Insurance Commissioners showed that 79 percent of all malpractice claims filed were for injuries occurring in hospitals; and

WHEREAS, That study indicated that 86 percent of indemnities paid on such claims were for injuries sustained in hospitals; and

WHEREAS, Malpractice claims against doctors for procedures performed in hospitals almost always include claims against the hospitals; and

WHEREAS, Malpractice insurance costs are rising for hospitals at an even greater rate than for doctors; and

WHEREAS, The usefulness and effectiveness of internal risk management programs in business and industry are well established; and

WHEREAS, Comparatively few hospitals in Nevada and across the country have established internal risk management programs; and

WHEREAS, Internal risk management programs encompass procedures and practices related to the overall level of health care and hospital effectiveness; now, therefore, be it

RESOLVED BY THE SENATE OF THE STATE OF NEVADA, THE ASSEMBLY CONCURRING, That the 59th session of the Nevada legislature hereby memorializes the Joint Commission on Accreditation of Hospitals to require the establishment of an effective internal risk management program as a prerequisite to accreditation by the Commission; and be it further

RESOLVED, That a copy of this resolution be prepared and transmitted forthwith by the legislative counsel to the director of the Joint Commission on Accreditation of Hospitals, John D. Porterfield, M. D.

SUMMARY--Provides for option to essential insurance policyholders to pay annual charge in lieu of assessments. (BDR 57-15)
Fiscal Note: Local Government Impact: No.
State or Industrial Insurance Impact: No.

AN ACT relating to insurance; providing for an option to essential insurance policyholders to pay an annual charge in lieu of assessments for certain deficits; and providing other matters properly relating thereto.

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. NRS 686B.180 is hereby amended to read as follows:

686B.180 1. If the commissioner finds after a hearing that in any part of this state any essential insurance coverage is not readily available in the voluntary market, and that the public interest requires such availability, he may by regulation [either] promulgate plans to provide such insurance coverages for any risks in this state which are equitably entitled to but otherwise unable to obtain such coverage, or may call upon the industry to prepare plans for his approval. Such plans may also include any kind of reinsurance that is unavailable and that would facilitate making essential insurance coverage available where it would otherwise not be available.

2. The plan promulgated or prepared under subsection 1 shall:

(a) Give consideration to the need for adequate and readily accessible coverage, to alternative methods of improving the market affected, to the preferences of the insurers and agents, to the inherent limitations of the insurance mechanism, to the need for reasonable underwriting standards, and to the requirement of reasonable loss-prevention measures;

(b) Establish procedures that will create minimum interference with the voluntary market;

(c) Spread the burden imposed by the facility equitably and efficiently within the industry; and

(d) Establish procedures for applicants and participants to have grievances reviewed by an impartial body.

3. Each plan shall require participation by all insurers doing any business in this state of the kinds covered by the specific plan and all agents licensed to represent such insurers in this state for the specified kinds of business, except that the commissioner may exclude kinds of insurance, classes of insurers or classes of persons for administrative convenience or because it is not equitable or practicable to require them to participate in the plan.

4. The plan may provide for optional participation by insurers not required to participate under subsection 3.

5. Each plan shall provide for the method of underwriting and classifying risks, making and filing rates, adjusting and processing claims and any other insurance or investment function that is necessary for the purpose of providing essential insurance coverage.

6. In providing for the recoupment of deficits which may be incurred in the plan, an option shall be offered to an insured each policy year to pay a capital stabilization charge which shall not exceed 100 percent of the premium charged to the insured in that year. The commissioner shall determine the amount of the charge from appropriate factors of loss experience and risk associated with the plan and the insured. An insured who pays the stabilization charge shall not be required to pay any assessment to recoup a deficit in the plan incurred in any policy year for which the charge is paid. The plan shall provide for the return to the insured of so much of his payment as remains after all actual or potential liabilities under the policy have been discharged.

7. The plan shall specify the basis of participation and assessment of insurers as necessary and shall provide for the participation of agents and the conditions under which risks must be accepted.

[7.] 8. Every participating insurer and agent shall provide to any person seeking coverages of kinds available in the plans the services prescribed in the plans, including full information on the

requirements and procedures for obtaining coverage under the plans whenever the business is not placed in the voluntary market.

[8.] 9. The plan shall specify what commission rates shall be paid for business placed in the plans.

[9.] 10. If the commissioner finds that the lack of cooperating insurers or agents in an area makes the functioning of the plan difficult, he may order that the plan set up a branch service office or take other appropriate steps to insure that service is available.

[10.] 11. The existing assigned risk plan set up under former NRS 694.390 shall continue unless changed in accordance with this chapter.

Sec. 2. NRS 686B.230 is hereby amended to read as follows:

686B.230 1. The Nevada Essential Insurance Association [shall,] has, for purposes of this section and to the extent approved by the commissioner, [have] the general powers and authority granted under the laws of this state to carriers licensed to transact the kinds of insurance defined in NRS 681A.020 to 681A.080, inclusive.

2. The association may take any necessary action to make available necessary insurance, including but not limited to the following:

(a) Assess participating insurers amounts necessary to pay the obligations of the association, administration expenses, the cost of examinations conducted pursuant to NRS 687A.110 and other expenses

authorized by this chapter. The assessment of each member insurer for the kind or kinds of insurance designated in the plan shall be in the proportion that the net direct written premiums of the member insurer for the preceding calendar year bear to the net direct written premiums of all member insurers for the preceding calendar year. A member insurer may not be assessed in any year an amount greater than 5 percent of his net direct written premiums for the preceding calendar year. Each member insurer shall be allowed a premium tax credit at the rate of 20 percent per year for 5 successive years following termination of the association.

(b) Enter into such contracts as are necessary or proper to carry out the provisions and purposes of this section.

(c) Sue or be sued, including taking any legal action necessary to recover any assessments for, on behalf of or against participating carriers.

(d) Investigate claims brought against the fund and adjust, compromise, settle and pay covered claims to the extent of the association's obligation and deny all other claims. Process claims through its employees or through one or more member insurers or other persons designated as servicing facilities. Designation of a service facility is subject to the approval of the commissioner but such designation may be declined by a member insurer.

(e) Classify risks as may be applicable and equitable.

(f) Establish appropriate rates, rate classifications and rating adjustments and file such rates with the commissioner in accordance with this chapter.

(g) Administer any type of reinsurance program for or on behalf of the association or any participating carriers.

(h) Pool risks among participating carriers.

(i) Issue and market, through agents, policies of insurance providing the coverage required by this section in its own name or on behalf of participating carriers.

(j) Administer separate pools, separate accounts or other plans as may be deemed appropriate for separate carriers or groups of carriers.

(k) Invest, reinvest and administer all funds and moneys held by the association.

(l) Borrow funds needed by the association to effect the purposes of this section.

(m) Develop, effectuate and promulgate any loss-prevention programs aimed at the best interests of the association and the insuring public.

(n) Operate and administer any combination of plans, pools, reinsurance arrangements or other mechanisms as deemed appropriate to best accomplish the fair and equitable operation of the association for the purposes of making available essential insurance coverage.

3. In providing for the recoupment of a deficit of the association, an option shall be offered to an insured each policy year to pay a capital stabilization charge which shall not exceed 100 percent of the premium charged to the insured in that year. The board of directors shall determine the amount of the charge from appropriate factors of loss experience and risk associated with the association and the insured. An insured who pays the stabilization charge shall not be required to pay any assessment to recoup a deficit of the association incurred in any policy year for which the charge is paid. The association's plan of operation shall provide for the return to the insured of so much of his payment as remains after all actual or potential liabilities under the policy have been discharged.

SUMMARY--Provides for retention of and access to certain medical records. (BDR 54-12)
Fiscal Note: Local Government Impact: No.
State or Industrial Insurance Impact: No.

AN ACT relating to the healing arts; requiring certain providers of health care to retain patients' records for a specified period and make them available for physical inspection and copying under certain circumstances; providing immunity from liability; providing an exception to the doctor-patient privilege; and providing other matters properly relating thereto.

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. Chapter 629 of NRS is hereby amended by adding thereto the provisions set forth as sections 2 to 6, inclusive, of this act.

Sec. 2. As used in this chapter, unless the context otherwise requires, words and terms defined in sections 3 and 4 of this act have the meanings ascribed to them in those sections.

Sec. 3. "Provider of health care" means a physician licensed under chapter 630 or 633 of NRS, dentist, registered nurse, dispensing optician, optometrist, registered physical therapist, podiatrist, licensed psychologist, chiropractor, doctor of traditional Oriental medicine in any form, medical laboratory director or technician, or a licensed hospital as the employer of any such person.

Sec. 4. "Health care records" means any written reports, notes, orders, photographs, X-rays or other written record received or produced by a provider of health care, or any person employed by him, which contains information relating to the medical history, examination, diagnosis or treatment of the patient.

Sec. 5. Each provider of health care shall retain the health care records of his patients as part of his regularly maintained records for 5 years after their receipt or production. Health care records may be retained by microfilm or any other recognized form of size reduction which does not adversely affect their use for the purposes of section 6 of this act.

Sec. 6. 1. Each provider of health care shall make the health care records of a patient available for physical inspection by the:

(a) Patient or his designated representative; or

(b) Any authorized representative or investigator of the board of medical examiners of the State of Nevada or the attorney general in the course of any investigation conducted pursuant to NRS 630.-330 or 630.343,

upon the request of any of them. The records shall be made available at a place convenient for physical inspection and inspection shall be permitted at all reasonable office hours and for a reasonable length of time. The provider of health care shall also furnish

a copy of the records to each of such persons who requests it and pays the costs of making the copy.

2. A provider of health care, his agents and employees are immune from any civil action for any disclosures made in accordance with the provisions of this section or any consequential damages.

Sec. 7. NRS 49.025 is hereby amended to read as follows:

49.025 1. A person making a return or report required by law to be made has a privilege to refuse to disclose and to prevent any other person from disclosing the return or report, if the law requiring it to be made so provides.

2. A public officer or agency to whom a return or report is required by law to be made has a privilege to refuse to disclose the return or report if the law requiring it to be made so provides.

3. No privilege exists under this section in actions involving false statements or fraud in the return or report [.] or when the report is contained in health care records furnished in accordance with the provisions of section 6 of this act.

Sec. 8. NRS 49.245 is hereby amended to read as follows:

49.245 [1.] There is no privilege under NRS 49.225 or 49.235 : [for]

1. For communications relevant to an issue in proceedings to hospitalize the patient for mental illness, if the doctor in the course of diagnosis or treatment has determined that the patient is in need of hospitalization.

2. [If the judge orders an examination of the condition of the patient,] As to communications made in the course [thereof are not privileged under NRS 49.225 or 49.235] of a court-ordered examination of the condition of a patient with respect to the particular purpose [for which] of the examination [is ordered] unless the [judge] court orders otherwise.

3. [There is no privilege under NRS 49.225 or 49.235 as] As to communications relevant to an issue of the condition of the patient in any proceeding in which the condition is an element of a claim or defense.

4. [There is no privilege under NRS 49.225 or 49.235:

(a)] In a prosecution or mandamus proceeding under chapter 441 of NRS.

[(b)] 5. As to any information communicated to a physician in an effort unlawfully to procure a narcotic, dangerous or hallucinogenic drug, or unlawfully to procure the administration of any such drug.

6. As to any communication placed in health care records which are furnished in accordance with the provisions of section 6 of this act.

Sec. 9. NRS 49.265 is hereby amended to read as follows:

49.265 1. Except as provided in subsection 2:

(a) The proceedings and records of organized committees of hospital medical staffs having the responsibility of evaluation

and improvement of the quality of care rendered in such hospital and medical review committees of medical societies are not subject to discovery proceedings.

(b) No person who attends a meeting of any such committee may be required to testify concerning the proceedings at such meetings.

2. The provisions of subsection 1 do not apply to:

(a) Any statement made by a person in attendance at such meeting who is a party to an action or proceeding the subject of which is reviewed at such meeting.

(b) Any statement made by a person who is requesting hospital staff privileges.

(c) The proceedings of any meeting considering an action against an insurance carrier alleging bad faith by the carrier in refusing to accept a settlement offer within the policy limits.

(d) Any matter relating to the proceedings or records of such committees which is contained in health care records furnished in accordance with section 6 of this act.

SUMMARY--Provides for periodic payment of certain damages recovered in malpractice claims against health care providers. (BDR 3-11)
Fiscal Note: Local Government Impact: No.
State or Industrial Insurance Impact: No.

AN ACT relating to damages; providing for the periodic payment of future damages recovered in malpractice claims against certain providers of health care; and providing other matters properly relating thereto.

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. Chapter 42 of NRS is hereby amended by adding thereto the provisions set forth as sections 2 to 8, inclusive, of this act.

Sec. 2. As used in sections 3 to 8, inclusive, of this act:

1. "Future damages" means damages for:

(a) Medical treatment; and

(b) Care or custody,

to be received or incurred by the judgment creditor after judgment is rendered.

2. "Judgment debtor" includes the judgment debtor's successors in interest and an insurer obligated under a policy of insurance to cover the liability of the judgment debtor for future damages for breach of his professional duty towards a patient.

3. "Provider of health care" means a physician licensed under chapter 630 or 633 of NRS, dentist, registered nurse, dispensing

optician, optometrist, registered physical therapist, podiatrist, licensed psychologist, chiropractor, doctor of traditional Oriental medicine in any form, medical laboratory director or technician, or a licensed hospital as the employer of any such person.

Sec. 3. 1. In any action for damages for personal injury against a provider of health care which is based upon a breach of his professional duty toward a patient, where the award for future damages is $50,000 or more, the district court shall, at the request of either party, include in its judgment an order that monetary compensation for future damages be made in periodic payments. If the defendant is insured against liability for such future damages, the order shall not be entered until his insurer is made a party to the action.

2. In the judgment, the court shall make a specific finding of the total dollar amount of periodic payments which will compensate the judgment creditor for such future damages. The judgment shall also specify each recipient of the payments, the dollar amount of each payment, the interval between payments and the number of payments which shall be made.

Sec. 4. 1. As a condition to authorizing periodic payments of future damages, the court shall require a judgment debtor who is not adequately insured to provide security adequate to assure full payment of the future damages awarded by the judgment. At

any time before payments are terminated, the court, upon petition of any party in interest and a showing that the ability of the judgment debtor to satisfy the obligations of the judgment is impaired, or is about to become impaired, may order the judgment debtor to provide such further security or make such other financial arrangements as the court deems appropriate.

2. Upon the termination of periodic payments of future damages, the court shall order the termination of such arrangements and the return of any security deposited, or so much as remains, to the judgment debtor.

Sec. 5. 1. Except as provided in subsection 2, the court may, for good cause shown, modify a judgment for periodic payment of future damages with respect to the amount of each payment, the number of payments or the interval between payments. The court shall award costs and attorneys' fees to the prevailing party where the motion for modification is contested.

2. A judgment which provides for periodic payment of future damages is not subject to modification as to accrued payments. Payments which have not accrued at the time a motion for modification is filed may be modified as provided in this section whether or not the court has expressly retained jurisdiction for such modification. The total amount of future damages awarded by a periodic payments judgment shall not be increased.

Sec. 6. Payments of future damages under a periodic payments judgment terminate upon the satisfaction or expiration of all obligations specified in the judgment. All obligations with respect to payments then unaccrued expire upon the death of the judgment creditor.

Sec. 7. 1. Each periodic payment of future damages upon becoming due under the terms of a periodic payments judgment constitutes a separate judgment upon which execution may issue.

2. If the court finds that the judgment debtor has repeatedly failed without good cause to make the payments specified in the judgment, the court shall find the judgment debtor in contempt of court and, in addition to the required periodic payments, shall order the judgment debtor to pay the judgment creditor all damages caused by the failure to make the periodic payments, including court costs and attorneys' fees.

Sec. 8. The court may order periodic payment of future damages agreed upon in a settlement or awarded in arbitration of a claim for breach of duty toward a patient by a provider of health care in the manner provided in sections 2 to 7, inclusive, of this act, where the parties to the settlement or arbitration cannot agree on such periodic payment and either party petitions the court for the order.

SUMMARY--Requires reduction of damages awarded in medical malpractice actions by amounts from certain collateral sources. (BDR 3-14)
Fiscal Note: Local Government Impact: No.
State or Industrial Insurance Impact: No.

AN ACT relating to medical malpractice actions; requiring reduction of damages by amounts of compensation or benefits accrued from public collateral sources; and providing other matters properly relating thereto.

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. NRS 42.020 is hereby amended to read as follows:

42.020 In any action for damages for personal injury against any provider of medical care or services [,] which is based upon breach of a professional duty toward a patient, the amount of damages, if any, awarded in such action shall be reduced by : [the]

1. The amount of any prior payment made by or on behalf of the provider of medical care or service to the injured person or to the claimant to meet reasonable expenses of medical care, other essential goods or services or reasonable living expenses [.] ; and

2. The amount of each of the following payments which has accrued to the injured person or claimant, was not bargained for individually or collectively by the injured person or claimant with his employer, and arose out of the specific injury for which the damages are awarded:

(a) Medical payments under any title of the Social Security Act (42 U.S.C. §§ 301 et seq.);

(b) Payments under any unemployment compensation system;

(c) Medical payments by reason of former service in any branch of the Armed Forces of the United States;

(d) Payments provided under any national health insurance program which may become available; and

(e) Payments from any public welfare program.

SUMMARY--Amends various provisions of law relating to medical-legal screening panels. (BDR 3-13)
Fiscal Note: Local Government Impact: No.
State or Industrial Insurance Impact: No.

AN ACT relating to medical-legal screening panels; expanding the membership of tentative panels; extending the time for peremptory challenges; providing for a request for a hearing; exempting certain communications and meetings from the doctor-patient privilege and the provisions of chapter 241 of NRS respectively; and providing other matters properly relating thereto.

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. NRS 41A.010 is hereby amended to read as follows:

41A.010 As used in NRS 41A.020 to 41A.090, inclusive, and section 6 of this act, unless the context otherwise requires:

1. "Administrator" means a screening panel administrator designated by the board of governors of the State Bar of Nevada or the executive committee of the Nevada State Medical Association.

2. "Medical malpractice" means neglect or negligence that imports a want of such attention to the natural or probable consequences of an act or omission of an act or standard of care as would reasonably be expected of an ordinarily prudent physician.

3. "Physician" means a person who is a graduate of an academic program approved by the board of medical examiners of the State of Nevada and has been issued a license by the board of medical examiners of the State of Nevada pursuant to chapter 630 of NRS.

4. "Screening panel" means a joint medical-legal screening panel composed of attorneys and physicians selected from a tentative screening panel to hear a particular medical malpractice claim.

5. "Tentative screening panel" means a joint medical-legal panel of persons proposed by the board of governors of the State Bar of Nevada and the executive committee of the Nevada State Medical Association for service on screening panels.

Sec. 2. NRS 41A.030 is hereby amended to read as follows:

41A.030 1. The board of governors of the State Bar of Nevada shall designate [nine] 15 of its members to serve on the northern tentative screening panel and [nine] 15 to serve on the southern tentative screening panel. Each person so designated shall serve for a term of 1 year. The executive secretary of the State Bar of Nevada, or such other person as may be designated by the board of governors, shall serve as the attorneys' screening panel administrator.

2. The executive committee of the Nevada State Medical Association shall designate [nine] 15 of its members to serve on the northern tentative screening panel and [nine] 15 to serve on the southern tentative screening panel. Each person so designated shall serve for a term of 1 year. The executive director of the Nevada State Medical Association, or such other person as the executive committee may designate, shall serve as the physicians' screening panel administrator.

3. At least 10 days in advance of a scheduled malpractice hearing the respective administrators shall provide to both parties lists of the names of attorneys and physicians serving on the tentative screening panel for the geographic area involved. Each party may strike up to three peremptory challenges from the list of attorneys and three from the list of physicians and shall return the lists, with challenges, to the administrators within [5] 10 days.

4. The administrator for each profession shall select three persons from among those not challenged from the list of persons serving from the profession he represents. The six persons so selected shall constitute the screening panel for the particular medical malpractice claim to be heard, and the administrators shall immediately notify the parties and each of the members selected.

5. The screening panel shall designate one of its members as chairman.

Sec. 3. NRS 41A.040 is hereby amended to read as follows:

41A.040 Subject to applicable requirements and procedures of chapter 233B of NRS, the screening panel administrators shall adopt uniform procedural rules for the submission and consideration of cases relating to medical malpractice against physicians. All medical malpractice claims against any physician, his associates, servants, agents or employees shall be submitted and heard by the

appropriate screening panel pursuant to the uniform procedural rules adopted by the administrators.

Sec. 4. NRS 41A.050 is hereby amended to read as follows:

41A.050 [All medical malpractice claims against any physician, his associates, servants, agents or employees shall be submitted and heard by the appropriate screening panel pursuant to the uniform procedural rules adopted by the administrators.]

1. A claim is properly presented to a screening panel by delivery of a request for hearing to any screening panel administrator in person or by registered or certified mail.

2. The request for hearing shall contain a clear and concise statement of the facts of the case, showing the persons involved and the dates and circumstances, so far as they are known, of the alleged medical malpractice.

Sec. 5. NRS 41A.090 is hereby amended to read as follows:

41A.090 1. In any case where a screening panel determines, by a majority vote of the members present who have sat on all hearings pertaining to the case, that the acts complained of were or reasonably might constitute professional negligence, and the claimant was or may have been injured thereby, or if there is an equal division of opinion of a panel on either or both of these issues, the panel, its members, and the Nevada State Medical Association shall provide a suitable witness who shall be a physician qualified in the field of medicine involved who shall, upon payment of a reasonable fee, consult and testify on behalf of the claimant to

the same effect as if the physician had been employed originally by the claimant. If no suitable witness is available in the area in which the trial is held, the Nevada State Medical Association shall cooperate in providing a suitable witness from elsewhere.

2. Copies of the original complaint and of the findings of each screening panel with regard to each matter considered by the panel shall be forwarded to:

(a) The board of medical examiners of the State of Nevada;

(b) The county medical society of the county in which the alleged malpractice occurred; [and]

(c) The attorney general of the State of Nevada [.] ; and

(d) The commissioner of insurance.

Sec. 6. Chapter 41A of NRS is hereby amended by adding thereto a new section which shall read as follows:

The provisions of chapter 241 of NRS do not apply to any meeting of a screening panel.

Sec. 7. NRS 49.245 is hereby amended to read as follows:

49.245 [1.] There is no privilege under NRS 49.225 or 49.235 : [for]

1. For communications relevant to an issue in proceedings to hospitalize the patient for mental illness, if the doctor in the course of diagnosis or treatment has determined that the patient is in need of hospitalization.

2. [If the judge orders an examination of the condition of the patient,] As to communications made in the course [thereof are not privileged under NRS 49.225 or 49.235] of a court-ordered examination of the condition of a patient with respect to the particular purpose [for which] of the examination [is ordered] unless the [judge] court orders otherwise.

3. [There is no privilege under NRS 49.225 or 49.235 as] As to communications relevant to an issue of the condition of the patient in any proceeding in which the condition is an element of a claim or defense.

4. [There is no privilege under NRS 49.225 or 49.235:

(a)] In a prosecution or mandamus proceeding under chapter 441 of NRS.

[(b)] 5. As to any information communicated to a physician in an effort unlawfully to procure a narcotic, dangerous or hallucinogenic drug, or unlawfully to procure the administration of any such drug.

6. In a hearing before a screening panel under chapter 41A of NRS.

Sec. 8. NRS 241.020 is hereby amended to read as follows:

241.020 Except as otherwise provided in NRS 241.030 [,] and any other statute which provides a specific exemption, all meetings of public agencies, commissions, bureaus, departments, public corporations, municipal corporations and quasi-municipal corporations and political subdivisions shall be open and public, and all persons shall be permitted to attend any meeting of these bodies.

SUMMARY--Clarifies circumstances which excuse efforts to obtain minor's consent to notify parents before administering medical treatment. (BDR 11-19)
Fiscal Note: Local Government Impact: No.
State or Industrial Insurance Impact: No.

AN ACT relating to health care services; clarifying the circumstances under which efforts to obtain a minor's consent to notify his parents before administering medical treatment may be omitted; and providing other matters properly relating thereto.

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. NRS 129.030 is hereby amended to read as follows:

129.030 1. [A] Except as otherwise provided in subsection 3 and in NRS 442.250, a minor may give consent for the [health care services provided in subsection 2 for herself or] provision of any health care service to himself or [for her or] his child, if such minor is:

(a) Living separate and apart from [her or] his parent, parents or legal guardian, with or without the consent of such parent, parents or legal guardian, for a period of at least four months;

(b) Married or has been married;

(c) A mother, or has borne a child; or

(d) In a physician's judgment, in danger of suffering a serious health hazard if health care services are not provided.

The consent of the minor given pursuant to this subsection is not subject to disaffirmance because of minority.

2. Except as otherwise provided in NRS 442.250, the consent of the parent or parents or the legal guardian of a minor is not necessary for a local or state health officer, board of health, licensed physician or public or private hospital to examine or provide treatment for any minor, [included within the provisions of] empowered to consent by subsection 1, who understands the nature and purpose of the proposed examination or treatment and its probable outcome, and voluntarily requests it. [The consent of the minor to examinatic or treatment pursuant to this subsection is not subject to disaffirmance because of minority.]

3. A person who treats a minor pursuant to [subsection 2] this section shall, prior to initiating treatment, make prudent and reasonable efforts to obtain the minor's consent to contact the parent, parents or legal guardian of [such] the minor, and shall make a note of such efforts in the minor's health care record. If such person believes that [such efforts would jeopardize treatment necessary to such minor's life or necessary to avoid a serious and immediate threat to such minor's health, such] any delay in providing the proposed treatment could reasonably be expected to result in death, disfigurement, impairment of faculties, or serious bodily harm, the

person may omit such efforts and note the reasons for [such] the omission in the minor's health care record.

4. [Notwithstanding the provisions of subsection 2, a] A minor may not consent to [her or] his own sterilization.

5. In the absence of negligence, no person providing health care services pursuant to [subsection 2 shall be] this section is subject to civil or criminal liability for providing such services.

6. The parent, parents or legal guardian of a minor who receives health care services pursuant to [subsection 2 shall not be] this section is not liable for the payment for such health care services unless such parent, parents or legal guardian has consented to such health care services. The provisions of this subsection [shall] do not relieve a parent, parents or legal guardian from liability for payment for emergency health care services provided to a minor pursuant to NRS 129.040.

SUMMARY--Specifies conditions under which persons under disability may recover damages for parents' or guardians' failure to bring medical malpractice action. (BDR 2-20)
Fiscal Note: Local Government Impact: No.
State or Industrial Insurance Impact: Yes.

AN ACT relating to medical malpractice actions; specifying the conditions under which persons under legal disability may recover damages for failure of parents or certain guardians to bring such actions; and providing other matters properly relating thereto.

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT AS FOLLOWS:

Section 1. NRS 11.400 is hereby amended to read as follows:

11.400 1. Except as provided in subsection 2, an action for injury or death against a [health care provider as defined in subsection 5] provider of health care shall not be commenced more than 4 years after the date of injury or 2 years after the plaintiff discovers or through the use of reasonable diligence should have discovered the injury, whichever occurs first, for:

(a) Injury to or wrongful death of a person, based upon [such health care provider's] alleged professional negligence [; or] of the provider of health care;

(b) Injury to or wrongful death of a person [for rendering] from professional services rendered without consent; or

(c) Injury to or wrongful death of a person [for] from error or omission in [such health care provider's] practice [.] by the provider of health care.

2. This time limitation is tolled for any period during which [such health care provider] the provider of health care has concealed any act, error or omission upon which such action is based and which is known or through the use of reasonable diligence should have been known to [such health care provider.] him.

3. For purposes of this section, the warden of the Nevada state prison and the administrator of the mental hygiene and mental retardation division of the department of human resources shall be deemed the guardian of every person subject to their respective control who is under a legal disability and are responsible for exercising reasonable judgment in determining whether to [initiate] prosecute any cause of action [arising under this section which any such legally disabled person may have against any health care provider under] limited by subsection 1. If the warden or administrator fails to [take] commence an action on behalf of such legally disabled person within the prescribed period of limitation, the legally disabled person shall not be permitted to bring an action based on the same injury against any [health care] provider [under subsection 1] of health care upon the removal of his legal disability.

4. For purposes of this section, the parent, guardian or legal custodian of any minor child is responsible for exercising reasonable judgment in determining whether to [initiate] prosecute any cause of action [which such minor child may have against any health care provider under] limited by subsection 1. If the parent, guardian or custodian fails to [take any] commence an action on behalf of such child within the prescribed period of limitations, such child shall not be permitted to bring an action based on the same alleged injury against any [health care] provider [under subsection 1] of health care upon the removal of his disability, except that in the case of brain damage or birth defect the period of limitation is extended until the child attains 10 years of age.

5. If the warden or administrator with respect to a legally disabled person under his control, or a parent, guardian or legal custodian with respect to his minor child:

(a) Has actual or constructive knowledge that the legally disabled person or minor child may have a cause of action under this section against any provider of health care;

(b) Fails to exercise reasonable judgment in determining whether to prosecute the cause of action; and

(c) Fails to bring the action on behalf of the legally disabled person or minor child within the prescribed period of limitations, he is personally liable to the legally disabled person or minor child for damages sustained because of such failure.

6. As used in this section, ["health care provider"] "provider of health care" means a physician [or surgeon,] licensed under chapter 630 or 633 of NRS, dentist, registered nurse, dispensing optician, optometrist, registered physical therapist, podiatrist, licensed psychologist, [osteopath,] chiropractor, [clinical laboratory bioanalyst, clinical laboratory technologist, veterinarian] doctor of traditional Oriental medicine in any form, medical laboratory director or technician, or a licensed hospital as the employer of any such person.

SUMMARY--Directs appointment of legislative committee to study present medical liability insurance problem and submit recommendations to the 59th legislative session and study by legislative commission of ongoing problems of medical malpractice insurance. (BDR 18)

SENATE CONCURRENT RESOLUTION--Directing that a legislative committee be appointed to study the present medical liability insurance problem in Nevada and submit recommendations to the 59th session of the legislature and that the legislative commission study the ongoing problems of medical malpractice insurance.

WHEREAS, The 58th session of the Nevada legislature responded to the medical malpractice insurance crisis by enacting a package of legislation which has since been acclaimed as one of the most far reaching and effective in the nation; and

WHEREAS, Those legislative proposals were produced by a select committee of legislators appointed to study the medical liability insurance problem during the session; and

WHEREAS, The knowledge and understanding developed by the members of the select committee was used to great advantage in the membership of the interim subcommittee on medical malpractice insurance; and

WHEREAS, Reliable and extensive testimony before the interim subcommittee indicates that despite the work of the last legislative session complex malpractice insurance problems persist and require further legislative action to protect the health and

welfare of Nevadans and avoid a health care crisis in this state; now, therefore, be it

RESOLVED BY THE SENATE OF THE STATE OF NEVADA, THE ASSEMBLY CONCURRING, That a committee composed of three members of the Senate to be appointed by the President of the Senate, two from the majority political party and one from the minority political party, and three members of the Assembly to be appointed by the Speaker, two from the majority political party and one from the minority political party, is hereby directed to study all aspects of the medical liability insurance problem in Nevada and submit recommendations and any appropriate legislation to the 59th session of the Nevada legislature prior to March 21, 1977; and be it further

RESOLVED, That the legislative commission study the ongoing problem of medical malpractice insurance, in particular assessing the effectiveness of legislation enacted on the subject by the 59th session of the legislature and recommending any other changes deemed necessary to ensure high quality health care in Nevada; and be it further

RESOLVED, That the committee appointed by the legislative commission to make such study shall include those members of the legislature most involved in the study of malpractice during the 59th session of the legislature and the commissioner of insurance,

as well as members of the medical and legal professions and persons engaged in the business of insurance, at the discretion of the commission; and be it further

RESOLVED, That the legislative commission report the results of such study to the 60th session of the legislature together with its recommendations and any appropriate legislation.