IN THE SUPREME COURT OF THE STATE OF NEVADA

LYNN YAFCHAK, Statutory Heir and Special Administrator to the ESTATE OF JOAN YAFCHAK, Deceased, Appellants, vs. LIFE CARE CENTERS OF AMERICA, a foreign corporation d/b/a LIFE CARE CENTER OF SOUTH LAS VEGAS; and DOES 1-10, inclusive, Respondent.	Case No.: 82746

APPELLANTS' ADDENDUM TO OPENING BRIEF PURSUANT TO NRAP 28(f)

VOLUME 1 (ADD 0001–0213)

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MINUTES OF THE
SENATE COMMITTEE ON JUDICIARY

Seventy-Eighth Session
March 26, 2015

The Senate Committee on Judiciary was called to order by Chair Greg Brower at 1:05 p.m. on Thursday, March 26, 2015, in Room 2134 of the Legislative Building, Carson City, Nevada. The meeting was videoconferenced to Room 4412E of the Grant Sawyer State Office Building, 555 East Washington Avenue, Las Vegas, Nevada. Exhibit A is the Agenda. Exhibit B is the Attendance Roster. All exhibits are available and on file in the Research Library of the Legislative Counsel Bureau.

COMMITTEE MEMBERS PRESENT:

Senator Greg Brower, Chair
Senator Becky Harris, Vice Chair
Senator Michael Roberson
Senator Scott Hammond
Senator Ruben J. Kihuen
Senator Aaron D. Ford

COMMITTEE MEMBERS ABSENT:

Senator Tick Segerblom (Excused)

STAFF MEMBERS PRESENT:

Patrick Guinan, Policy Analyst
Nick Anthony, Counsel
Cassandra Grieve, Committee Secretary

OTHERS PRESENT:

Garrett Gordon, Community Associations Institute; Olympia Companies; Southern Highlands Homeowners Association
Donna Zanetti, Community Associations Institute
Angela Rock, Southern Highlands Homeowners Association; Olympia Companies
Mark Leon, Mountain's Edge Master Association
Marilyn Brainard, Wingfield Springs Community Association
Pamela Scott, The Howard Hughes Corporation

Glen Proctor
Jon Sasser, Legal Aid Center of Southern Nevada
Kathie Chism
Jonathan Friedrich, Nevada Homeowner Alliance
Barbara Holland, H&L Realty and Management Company
Keith Wand
Bruce Woodbury
J.D. Decker, Administrator, Real Estate Division, Department of Business and Industry
Jennifer Gaynor, Nevada Credit Union League; Fundamental Administrative Services, LLC
Marcus Conklin, Nevada Mortgage Lending Association
George Ross, Nevada Bankers Association
John Cotton, Keep Our Doctors In Nevada
Rudy Manthei, M.D., Keep Our Doctors In Nevada
Robert Rourke, Horizon Hospital and Rehabilitation Center
Darrin Cook, CEO, Horizon Specialty Hospitals
Margo Piscevich, Nevada Rural Hospital Partners Foundation
Kathleen Conaboy, Nevada Orthopaedic Society
Denise Selleck, Executive Director, Nevada Osteopathic Medical Association
Elizabeth MacMenamin, Retail Association of Nevada; Retail Chain Drug Council
Adam Plain, Nevada Dental Association
Stephen Osborne, Nevada Justice Association
Christian Morris, Nevada Justice Association
Lawrence Smith
John Echeverria, Nevada Justice Association

Chair Brower:
I will open the hearing of the Senate Committee on Judiciary with Senate Bill (S.B.) 260.

SENATE BILL 260: Revises provisions governing common-interest communities. (BDR 10-726)

Senator Becky Harris (Senatorial District No. 9):
During the economic collapse, long before I contemplated being a member of the Nevada Senate, I saw the necessity for S.B. 260. As an attorney who represents homeowners losing their homes to foreclosure, I know if homeowners are not making mortgage payments, they are also not making their

association payments. Delinquent association payments pose a problem for banks with regard to superpriority liens and who can lay claim to the title of a property or when foreclosure is appropriate. Senate Bill 260 provides a solution to a larger problem of when associations are able to foreclose.

Generally, the association's lien is not prior to a first security interest on a unit; however, the association's lien is prior to the first security interest on a unit to the extent of certain maintenance and abatement charges and a certain amount of assessments for common expenses. The portion of the association's lien that is prior to the first security interest on the unit is commonly referred to as the superpriority lien.

Senate Bill 260 requires lenders to establish impound accounts for the payments of common-interest community assessments. Since banks already impound for taxes and insurance, they should also impound for association fees. If banks establish impound accounts for association fees, they will have real-time knowledge of their secured interest in those properties. Under S.B. 260, banks will access their customers' accounts to determine if mortgage payments include association dues.

Including association dues with mortgage payments would be helpful for people in various situations: people burdened with writing monthly dues checks, people forgetting about their payments or people who may not want to bother with their household obligations. Under S.B. 260, homeowners will make their mortgage payments and have stability in dealing with the expenses of their properties.

The Committee will hear opposition to this bill from lending institutions. The banks will say putting association fees into impound accounts is something they cannot do and that creating and managing such accounts will be expensive and burdensome. To that argument, I say implementing S.B. 260 will not be any more expensive than having a first mortgage wiped out because of a superpriority lien by an association.

To the claim that S.B. 260 will be burdensome, I point out that banks were able to get the necessary requirements in place to work with the State's Foreclosure Mediation Program. Additionally, since January 2015, WestStar Credit Union voluntarily collects association fees as part of its mortgage payment plan.

Creating an impound account for association fees makes common sense and is good for the consumer and associations. Associations do not want to hire collection companies to go after the homeowner for unpaid dues. Having impound accounts is good for the banks because they will have first-hand, real-time knowledge of their investments. Banks will be in control and be able to make sure association fees are paid in a timely manner, thereby ensuring associations cannot take their security away.

Senator Hammond:
I thank Senator Harris for bringing this consumer-friendly bill to the Committee.

Garrett Gordon (Community Associations Institute; Olympia Companies; Southern Highlands Community Association):
We support S.B. 260 and appreciate Senator Harris putting forward a commonsense solution to this problem. This is the fourth session I have worked on common-interest community bills, and every session deals with the question of whether there should be judicial or nonjudicial foreclosures. Every session, we attempt to sort out answers to questions such as the cost of collections and payment plans.

This Session alone has 25 common-interest community bills, many trying to do a fix for the lending industry relating to superpriority liens and the recent Nevada Supreme Court case, *SFR Investments Pool 1 v. U.S. Bank*, 130 Nev. Adv. Op. 75, 334 P.3d 408 (2014). Even the Nevada Supreme Court attempted a fix hearing that case, posing many of the same questions again: How should the superpriority lien problem be addressed? Should more notice to lenders be provided? Should the process be stretched out? If so, for how long?

Senate Bill 260 is a commonsense solution because an impound account resolves all these problems. With an impound account, there would be no more discussion about associations foreclosing, the cost of collection, how much the costs should be and how long payment plans should continue. Associations want only to be paid so the landscaper can be paid, the gate maintained, the water bill paid, etc.

We understand that an impound account would not apply to a cash buyer, so a provision is necessary to address that. We know impound accounts would not apply retroactively and only be applicable going forward with respect to new loans or the refinancing of loans.

I spoke with Senator Harris about some citation tweaks, so an amendment is needed. Senator Harris agreed to sponsor such an amendment if S.B. 260 goes to work session.

Chair Brower:
If people are in the audience here on behalf of an association that supports this bill, the Committee knows the association community supports this bill. In an effort to save time, please keep your testimonies brief.

Donna Zanetti (Community Associations Institute):
The Nevada Legislative Action Committee of the Community Associations Institute is comprised of people who work for management companies, law firms and collection agencies. We support S.B. 260 even though it may reduce the income we derive from assisting associations with collections. We support the bill because it is good for the associations, which only want to be paid so they can provide the services required of them.

Chair Brower:
As an association payer myself, I think homeowners want to pay their dues and do not want to forget, which is part of the rationale behind S.B. 260.

Angela Rock (Southern Highlands Community Association; Olympia Companies):
I have testified alongside Mr. Gordon countless times over many sessions on the multitude of problems affecting the ability of homeowners to pay their assessments. I testified last week in front of the Assembly Committee on Judiciary on issues regarding judicial or nonjudicial foreclosure and superpriority liens. I was asked how I would solve the problem, and I mentioned S.B. 260.

Put simply, impound accounts solve problems. Providing impound accounts solves the biggest problem of all—which is homeowners forgetting to pay their dues. It also solves the problem of unjust enrichment. It seems unjust that a home worth $800,000 forecloses for $5,000. While S.B. 260 forces an infrastructure shift for the banks, in the end, the bill protects them. Senator Harris outlined that expertly. We support this bill.

Mark Leon (Mountain's Edge Master Association):
I support S.B. 260 and submit my testimony (Exhibit C).

Marilyn Brainard (Wingfield Springs Community Association):
Impound accounts are the best way to solve the current situation. I hope the banks and lending companies find a way to make S.B. 260 work. Impound accounts will protect bank investments as well as the properties. I support S.B. 260.

Pamela Scott (The Howard Hughes Corporation):
I support S.B. 260 because it solves many problems the banks are having with foreclosed properties. The banks have made business decisions to slow down or even stop many foreclosures. We have been tracking bank foreclosures in Summerlin since 2010. In this time, foreclosures in Summerlin reached a high of 1,043 properties; there were 125 foreclosed properties last year. There are still numerous liens filed against properties and many years' worth of foreclosures that have not even happened yet.

If an impound account is set up under S.B. 260 and the bank continues to pay that property's association fees while waiting out its foreclosure, it makes good sense and is less expensive than losing equity on that property, paying collection costs, etc.

Glen Proctor:
I have had my home in Mountain's Edge since 2008 and my mortgage is with JPMorgan Chase. The company has an escrow account for both my Clark County Special Improvement District payment and my taxes, and I have never received a notice of late or nonpayment. The escrow system works, and S.B. 260 is a marvelous solution for every party involved.

The banks are going to say it will cost them money to implement S.B. 260, but many property assessments are due quarterly, so the banks will earn interest on the monthly payments. Banks already have a system in place to handle other types of payments, so they will not have to create a new system to manage association fees.

My association spent $375,000 in collection costs last year, not counting foreclosure notices. That is money the association would not have had to spend if impound accounts had been in place. My assessment might even go down if my association does not have to spend that kind of money yearly.

Jon Sasser (Legal Aid Center of Southern Nevada):
We represent the third group in this process, the homeowners. We think homeowners will benefit along with the banks and the associations. Senate Bill 260 takes care of the problem of remembering to pay. Additionally, only about 10 percent of nonjudicial foreclosures actually go to foreclosure sale. The vast majority of foreclosures are taken care of by homeowners before becoming final, but by that point, homeowners are paying hundreds, if not thousands of dollars, in collection costs for overdue fees.

Senate Bill 260 will help homeowners avoid getting into arrears and help the banks because those collection costs will have been avoided. This bill is a win for all involved.

Kathie Chism:
I live in Yellowstone, a development within Mountain's Edge, so I pay two association fees. Both of my association fees increased this year, and I believe the reason was the huge collection costs my association incurred trying to collect dues owed by people who did not pay their assessments. I support S.B. 260 because it will save me money as a homeowner. Associations will save money on collection costs, and as a result, my assessment costs may stabilize. I am a retired schoolteacher on a fixed income; I cannot afford for my assessments to go up year after year.

Jonathan Friedrich (Nevada Homeowner Alliance):
I support S.B. 260. Does the bill consider those who do not have a mortgage? Also, has there been input from the banking industry on this bill?

Chair Brower:
Your points are good. We will hear testimony from the banking industry today.

Barbara Holland (H&L Realty and Management Company):
I support S.B. 260. This Session, numerous bills in both the Assembly and the Senate use the term "judicial foreclosure." Judicial foreclosure—also discussed last week in the Assembly Committee on Judiciary hearing on Assembly Bill 240—would be disastrous to all associations. No association will be able to afford the time and money to participate in judicial foreclosure.

ASSEMBLY BILL 240: Revises provisions governing liens of a unit-owners' association. (BDR 10-821)

In 2013, the Legislature passed S.B. No. 280 of the 77th Session, which allowed lenders to impound association fees in the way lenders impound property taxes and insurance expenses under *Nevada Revised Statutes* (NRS) 116. Lenders could have taken advantage of that law to insulate themselves from losing loans in their portfolios. Senate Bill 260 changes that language, thereby forcing banks to create impound accounts. This bill solves so many different problems, especially since too many bills this Session have the word "judicial" in them.

It will be too costly for associations to pursue judicial foreclosure. It is already costly for associations to wait for banks to finally foreclose on properties in order to get the money owed. Associations are sitting on a large amount of delinquencies, and homeowners who do pay their assessments are paying increasing assessments solely because the associations do not have enough money to do the basic operations required of them.

This is a good bill, but banks may pose an obstacle by claiming not to know who manages a property. There are ways for banks to access the information needed with regard to management companies. The Real Estate Division is a resource banks can use to solve that issue. Property managers must report to the Real Estate Division yearly on who has the first deed of trust on a property. The Division must be notified every time a management company changes a portfolio or a property is lost to foreclosure. It will be easier for banks to access the necessary information through the Division than for property managers to investigate the various lenders.

This fix to the law is long overdue and will take care of many problems regarding late fees, collection costs, etc.

Keith Wand:
I am a homeowner in Henderson. I met with Senator Harris and Senator Hammond in Carson City regarding S.B. 260. I have been a financial planner in Las Vegas for 10 years and have many contacts in the banking industry. These industry contacts have told me that when association fees are impounded, they are included in the mortgage calculations made when a buyer seeks to qualify for a mortgage.

Because it is likely to be unpopular, Legislators and bankers will not say this, but there are times when people should not buy homes. Association costs should be included in a mortgage; if they were to be included, it may put that house out of reach for a buyer—a reality that needs to be reviewed. I support S.B. 260. We need to protect our communities. Not everyone may favor associations, but they exist for a reason, and we need to fund them.

Bruce Woodbury:
I am an attorney in Boulder City who represents a few associations and other interested individuals. I support S.B. 260.

J.D. Decker (Administrator, Real Estate Division, Department of Business and Industry):
We protect the common-interest community marketplace as well as regulate it and the broader real estate marketplace. It is important to the Real Estate Division that homeowners pay associations in a timely manner. It is also important that the lender protect its security interest in property. Any positive impact this bill would have on the common-interest community marketplace would extend to the broader real estate market.

Jennifer Gaynor (Nevada Credit Union League):
While we appreciate the intent of the bill, we oppose S.B. 260. I submit a written statement outlining the reasons for our opposition (Exhibit D).

Our issues with the bill revolve around the legality and feasibility of implementing S.B. 260. On top of the expected implementation expense, there are technical concerns. One concern is residents within associations may have difficulty disputing erroneous association charges paid via an escrow account. Another concern is credit unions would be required to adjust the variability of association payments out of escrow accounts to address nonregular association payments, such as capital improvements.

There may also be conflict with the Real Estate Settlement Procedures Act and other federal regulations administered and enforced by the Consumer Financial Protection Bureau. The Truth in Lending Act is also a federal regulation that creates variability on when and how escrow accounts should be established.

Another potential issue with S.B. 260 is buyers who want control over paying their property taxes, insurance and association dues. We like to allow buyers

this flexibility, assuming they meet certain credit requirements. We want S.B. 260 to have more flexibility and not be mandatory. We would like to work with Senator Harris to accomplish that.

Chair Brower:
The details you highlighted seem to be something you can work on with the bill's sponsor.

Marcus Conklin (Nevada Mortgage Lending Association):
We are opposed to S.B. 260. We oppose the bill for three reasons, the first reason is the complexity in implementing the bill, as testified by Ms. Gaynor. Property taxes are collected into escrow, and one remit is made to one county. Insurance is collected into escrow, and remits are made to a handful of entities. Association dues will need to be remitted to hundreds, if not thousands, of associations. The law also permits a group of homeowners living in a same neighborhood to create its own association. Tracking association payments will be incredibly complex, especially if current loan contracts need to be included.

The second reason we oppose S.B. 260 is the cost associated with its enactment. Instead of the normal one-time costs associated with creating a loan—the closing costs—we will have to add an impound cost for multiple months.

The bill may solve the problem of delinquent dues, but it does not address penalties or extra association assessments done by an association. Even though owners may be current in their dues structure, that does not ensure they are not carrying penalties.

If you look at the impound structure, dues collections happen up front in the transaction of the home. This lowers the amount that homeowners can actually borrow for their homes. If you take that out, the money available to purchase a home is a little bit lower. Doing this does not change the number of transactions, but it does lower the amount of the transaction, which equates to lower home values.

The third reason we oppose S.B. 260 is it does not look at the diversity of situations. Currently, only homes with federally backed loans that are 80 percent/20 percent (80/20), or worse in terms of owner equity, are required

to have escrow accounts. Not all loans are 80/20, and individual lenders or portfolio lenders have differing standards. This bill promotes wrapping all loans, regardless of the amount, into an escrow account even though there is the option not to do this. I am not sure we want to take that away.

Cash buyers are not addressed in the bill, even though they can equally be delinquent in their dues. With S.B. 260, only those with impound accounts will be paying their dues for certain.

George Ross (Nevada Bankers Association):
We oppose S.B. 260. This is going to be a logistical nightmare for banks. Databases already exist to handle the impound accounts for taxes. No database matches loans with associations; one would have to be created. Banks also use vendors for tax remittances; no vendors exist for associations.

A big accounting system—a tracking system—would have to be established for associations. Setting up such a system would take time and money. This cost will show up in the expenses people pay for their mortgages, perhaps as larger escrow fees or closing costs. It may not show up in the interest rate, but it will definitely show up in cost to the consumer or homeowner.

If this bill applies to existing loans, that is an even larger problem.

Senator Ford:
Implementing S.B. 260 will be a difficult task, but banks are doing a similar task already. The banking industry knows how to set up a process like this.

Implementing the bill may also be expensive. Associations are going to have to communicate with the banks. The bill is a decent idea sufficient for our consideration. I hope you will figure out a way to assist Senator Harris by offering amendments. Senate Bill 260 represents a decent opportunity to cut down on unnecessary litigation.

Senator Harris:
I have listened to the points made by those opposed to the bill. Hearing testimony will help us fashion a better piece of legislation that will truly address this problem.

I want to clarify that some lenders in Nevada already do this task, so a model exists. There is a way to comply with S.B. 260, and I have been told the model has been successful. It has been proven that putting association fees in impound accounts can happen and can work.

I do not think we will find a perfect solution to this issue of delinquent association fees, but S.B. 260 will go a long way in addressing it. How often do collection companies, associations and legal aid come together to say a bill is a great idea? That unity should underscore how we need to move forward to pass this bill.

Chair Brower:
We will now close the hearing on S.B. 260 and open the hearing on S.B. 292.

SENATE BILL 292: Revises provisions relating to certain civil actions involving negligence. (BDR 3-954)

Senator Michael Roberson (Senatorial District No. 20):
Senate Bill 292 revises chapter 41A of *Nevada Revised Statutes* concerning medical malpractice and awards of noneconomic damages.

Keep Our Doctors In Nevada (KODIN) submitted a proposed amendment that addresses a typographical error in the bill (Exhibit E). I support this amendment and will elaborate on it later in my testimony.

Sections 1, 5, 6, 7, 8 and 10 of the bill delete the words "medical malpractice" and "dental malpractice" from statute and replace that language with the term "professional negligence" in order to broaden the chapter's applicability beyond these two narrow terms.

Section 2 revises the definition of "provider of health care" to include physician assistant, practitioner of respiratory care, occupational therapist, licensed marriage and family therapist, licensed clinical professional counselor, music therapist, athletic trainer, perfusionist, pharmacist and any clinic, surgery center or other entity that employs any such person.

The proposed amendment modifies that list, which will be addressed later.

Section 3 provides that the total noneconomic damages that can be awarded to the injured plaintiff in a civil action brought against a provider of health care claiming injury or death upon professional negligence is $350,000, regardless of the number of plaintiffs, defendants or theories upon which liability may be based.

Section 4 sets forth the means by which a court or other trier of fact must determine the percentage of liability to be assigned to all persons against whom the action is being pursued. This section also establishes the procedure by which the responsibility of a nonparty to the action may be determined in order to accurately determine the fault of named parties—and this is the key—without subjecting the nonparty to any liability.

The typographical error I spoke of earlier is in section 4, subsection 2, paragraph (c). The language in the original bill says "May be introduced as evidence of liability in any action." That statement should say, "May not be introduced as evidence of liability in any other action." The proposed amendment, Exhibit E, addresses this error.

Section 4, subsection 3 provides that, in order to establish the percentage of liability of any party or nonparty, a defendant may submit an affidavit, expert report or expert testimony pursuant to the Nevada Rules of Civil Procedure (NRCP).

Section 6 adds two items to the list of elements, the absence of which will require a district court to dismiss without prejudice an action for professional negligence. These items state that the support affidavit must: one, identify by name, or describe by conduct, each alleged provider of health care; and two, comply with any written report required under Rule 16.1 of the NRCP.

Section 9 provides that the rebuttable presumption of professional negligence described in section 9, subsection 3 does not apply in an action where the plaintiff submits an affidavit or otherwise provides for an expert witness or expert testimony to establish the claim of negligence.

John Cotton and Dr. Rudy Manthei of KODIN will further testify on S.B. 292.

Chair Brower:
The bill provides that the $350,000 cap for noneconomic damages is a per action cap. This was implemented via Question No. 3 of the Statewide Ballot Questions of 2004. Why is there a need for this new language?

John Cotton (Keep Our Doctors In Nevada):
There are judges who are choosing not to read the language in Question No. 3 as written. These judges interpret the language to read that there can be multiple defendants and multiple plaintiffs with actions for $350,000 each, even though the group is in one action for negligence.

Some cases filed have upwards of seven or eight plaintiffs and multiple doctors involved. The language in Question No. 3 used "an action." Senate Bill 292 is an effort to clarify that there is only one $350,000 cap. Senate Bill 292 will eliminate wasted legal fees and motion practice spent trying to enforce this statute. If some judges feel that Question No. 3 needs clarification, S.B. 292 provides that clarity.

Chair Brower:
I am looking at the official explanation that accompanied Question No. 3. The official explanation states, "if passed, would remove the two statutory exceptions to the existing $350,000 cap, and limit the recovery of noneconomic damages to $350,000 per action." I find that direction clear, but it sounds like it is not being interpreted that clearly by some courts.

Mr. Cotton:
Yes. For a minor technical matter, this confusion is wasting time, money and effort fighting something that should not be fought.

Rudy Manthei, M.D. (Keep Our Doctors In Nevada):
I am chairman of Keep Our Doctors In Nevada. I submit my testimony in support of S.B. 292 (Exhibit F).

I submit a document from Nevada Mutual Insurance Company showing that since Question No. 3 passed in 2004, premiums have dropped from 100 percent to 51.2 percent (Exhibit G). There has been a 50 percent drop in malpractice premiums in the last 10 years.

Very simply stated, we are in a good place. KODIN did what it set out to do. We need to continue to work to stay there.

Chair Brower:
Mr. Cotton, we have heard that we are in a good place, but yet we have a bill in front of us. Please explain to the Committee why S.B. 292 is important.

Mr. Cotton:
Senate Bill 292 clarifies technical errors that have periodically arisen from the courts' misinterpretation of Question No. 3. I was asked by KODIN to devise changes lessening the instances of litigation, as well as reiterate the Legislature's intent from the 18th Special Session in 2002 and the Statewide Ballot in 2004. Hundreds of thousands of dollars are spent on unnecessary motions that do need to be filed; S.B. 292 will address this.

When doctors talk about the expense of lawsuits, they are talking about the costs they incur to get to the point of dismissal. We are hopeful S.B. 292 will cut down on that expense.

Section 2 of S.B. 292 defines the term "provider of health care." As Senator Roberson testified, the proposed amendment, Exhibit E, removes many of the names that were added to the bill.

The proposed amendment was necessary because NRS 630A already has a number of different types of caregivers included. It was not our intent to add additional providers of health care into the bill. Our goal with S.B. 292 was to reiterate and clarify KODIN's intent with Question No. 3 from 2004.

Having said that, we did add clinics, surgery centers or other entities that employ any such person because lawyers are filing actions not only against doctors but also against the clinics for which those doctors work or in which those doctors operate.

Some judges are taking the position that clinics are not subject to the $350,000 cap. These judges allow lawyers to go for an amount of money beyond the cap if only the clinic is sued and not the doctor. We took a strong position on that opinion and, in most of the cases, it was upheld that a plaintiff cannot get a liability level higher than the cap from a clinic that is responsible

for a doctor's conduct than it could get against a doctor. Senate Bill 292 will clarify this opinion and take that issue off the table.

The bill will serve the expressed intent of holding the doctor and whatever entity he or she works for to the $350,000 cap. We do not want any more rogue rulings that impact the ability to enforce the cap.

Section 4 of S.B. 292 addresses several liability. I have a case in front of the Nevada Supreme Court right now on this issue, *Piroozi v. Dist. Ct.*, No. 64946 (Nev. filed Feb. 5, 2014).

In the 18th Special Session in 2002 and again in the Statewide Ballot in 2004, the Legislature decided medical malpractice actions would only be several liability. In other words, each defendant in a case would be responsible only for the percentage of negligence allocated by a jury.

The issue with this decision is exemplified here: there are two defendants in a case. The jury holds Doctor A 90 percent responsible and Doctor B 10 percent responsible. If the plaintiff were to settle with Doctor A but fail to submit any evidence specific to Doctor A's misconduct, we believe that is a fraud on the jury. Under statute, the jury is not told all the facts of what caused the plaintiff's injury, and so it may overly act in a negative fashion against Doctor B, who, at 10 percent, may have merely committed wrongful conduct.

Statute indicates several liability. When Question No. 3 was codified, no mechanism was put in place to address several liability. Senate Bill 292 puts in a mechanism that allows the conduct of all responsible parties to be displayed in front of a jury. This change in statute will allow a jury to rule on 100 percent of the facts, not on a portion of the facts.

The changes in section 5 are technical in nature, removing language about when cases have to be filed and when cases have to go to trial. Changing the wording with regard to timing of cases clarifies legislative intent. Essentially, absent something out of the ordinary with the judge or a motion, a case has to be tried within 2 years with the intent of getting cases brought to trial even sooner, if possible.

The changes in section 6 are also technical in nature, addressing the use of "professional negligence" over "medical malpractice" or "dental malpractice."

When Question No. 3 was voted on in 2004, the term "professional negligence" was added when the term "medical malpractice" already existed in the wording. Ever since that vote, there has been confusion between the two definitions and how the cap applies. One judge ruled the cap did not apply to professional negligence and that affidavits did not need to be filed, etc. This judge ruled these requirements were only necessary for medical malpractice. A lot of nondoctor defendants covered under this bill are not being pulled into the cap. Senate Bill 292 attempts to correct that ambiguity. The Nevada Supreme Court actually affirmed confusion about the language between professional negligence and medical malpractice. Senate Bill 292 would clarify the language.

Sections 7 and 8 also exchange the term "professional negligence" for "medical malpractice."

Section 9 addresses what is called a concept of res ipsa loquitur, which means, "the thing speaks for itself," or in common law, taking the position that when negligence is self-evident, a jury does not need the assistance of an expert. An example of res ipsa loquitur would be a doctor cutting off a patient's left leg when he should have cut off the right leg.

If res ipsa loquitur is present, plaintiffs are allowed to go to the jury without having to incur the expense of hiring experts. In a res ipsa loquitur situation, the jury is instructed that if one element is proven, the plaintiff is allowed a rebuttable presumption that there was a negligent breach of the standard of care. The jury would not necessarily have to rule against the defendant, but the plaintiff would not need the expert under those circumstances.

Unfortunately, in a myriad of cases, the presumption of negligence is alleged. The plaintiff provides affidavits from experts regarding the presumed negligent act. The matter goes to trial and the plaintiff calls an expert witness. The jury is given both the negligence instruction and the presumption of negligence instruction. This is double-dipping in a tried lawsuit.

We want to clarify the language and have the law comport with law around the Country. Common law holds that if the plaintiff is claiming a presumption of negligence—a standard of care violation—the jury is so instructed to adhere to the statute. If a plaintiff brings in an expert to testify, then the jury does not get the presumed negligence instruction. To bring an expert in to testify when the

plaintiff is claiming the action itself speaks to negligence flies in the face of the law.

This situation is a misstatement of what has been the law for years—even going back to England. Senate Bill 292 clarifies that if plaintiffs want to bring in an expert to testify, they get the negligence instruction and then go to the jury. To have those two elements, an expert and affidavits, is a double-dip on the standard of care issue; this is harmful to doctors.

Senator Ford:
I have already expressed to the witnesses and Senator Roberson my issues with caps. I do not like the notion of capping the division of grief. If a father and a mother lose a son, they do not have to split their grief between themselves and get half of $350,000 each.

I was here in 2003 and 2004 when we discussed this issue, but I left before the vote came. I cannot fathom that we thought back then that the term "action" did not mean legal action.

I have a hard time determining why we would want to require grief splitting in a situation when the word "action" is to indicate legal action. I reviewed Question No. 3, and I understand "action" to be a legal action—versus an event of malpractice. I wonder what kind of conversation was going on during that time period.

This ambiguity has existed since 2004, yet over the course of the last 14 years, premiums have dropped 50 percent. I do not understand the need to clarify that $350,000 must be per action, per event, when the word "action" means a legal action.

Dr. Manthei:
Based on how the initiative was drafted, the interpretation has always been per event. I am a doctor, not an attorney, so I did not participate in drafting it, but I was part of the group. There has been no misunderstanding that it has been anything more or less than that—an event. Question No. 3 was based on a California law that was at least 10 years old before our law took effect—and that California law is per event.

If you get away from "per event," you get away from any kind of predictability. If there is one part of Question No. 3 that is mainly responsible for the controlling and reduction of liability premiums, it is the ability to be predictable about that one issue—per event.

I agree there is no fair way to legislate for these issues. No amount of money will make somebody whole after an event, but the reality is Nevada has health care issues. The State has a responsibility to provide health care to all its citizens.

The State already has limits on damages, which have affected even me. I was rear-ended by a school bus. Is it fair that I lost my ability to practice medicine because of that event and the only recourse was $50,000 from the State? No, it was not fair, but the reality is government services such as health care and education have to be provided to all, and sometimes that is not fair to the few.

Senator Ford:
You are making part of my point that there should not be arbitrary caps placed on damages. Cannot the same jury who determines whether a criminal lives or dies in a criminal case be able to determine how much damage a victim has incurred when rear-ended by a school bus?

You are telling me that "action" means "event." I do not see how "action" and "event" are equivalent, especially when "action" is used in the statute and "action" is used in Question No. 3.

You testified that over the last 14 years, premiums have dropped. How many court cases have interpreted "action" to mean legal action versus "action" as an "event?"

Mr. Cotton:
The majority of judges rule that there is an action against somebody for injuries caused. Let me illustrate the problem we are running into: there is one family with seven children. The family files one action for the group's injuries; it should be viewed by the court as one action, not seven actions; however, not all judges adhere to this view.

The sad part is this: if Nevada does not have any doctors, the State has a major problem. If an unquantifiable number of cases can be brought to court,

premiums cannot be actuarially set. If premiums cannot be actuarially set, they will not continue to drop. If premiums do not continue to drop, the State will not be able to attract doctors. Doctors will not come to Nevada because insurance will not be affordable.

Senator Ford:
As I said earlier, there has to be a better way. I have a lawsuit consortium action, so does my wife, her brother and her brother's wife. Is it correct that those constitute four different actions?

Mr. Cotton:
Those four actions are different rights of recovery or theories of recovery. They are not an action in themselves and that is the problem with these cases. You can have multiple people who can have theories of recovery, but the bottom line is that you still only have one action that you can file. Then you move forward under that one action.

Senator Ford:
Do I have to file them all together? Can I file my own?

Mr. Cotton:
They would be consolidated in an action for negligence and the event that took place.

Senator Ford:
Unless one case ends and I come in later.

Mr. Cotton:
No, you still have the same event and the same action even if you chose to file 2 months after someone else. They are consolidated because the seminal facts are the same: it is the same incident. In medical malpractice, it is whether the doctor's conduct caused somebody to die, lose his or her leg, etc. This issue has been debated all over the Country.

Is this situation fair? This sounds terrible, but for those fighting a specific lawsuit, the issue here today is not about fairness for them. It is about fairness for the entirety of Nevada and that there be fair, reasonably priced access to medical care. That has to trump personal fairness. I do not like that situation, but that is the reality.

From 2002 to 2004, a number of my clients left Nevada—and even before that, they were leaving. Doctors will continue to leave if their premiums climb back up again. If the 50 percent reduction goes back up again, the State will lose more doctors and not be able to attract new ones. At the same time, Nevada is trying to establish a medical school specifically to keep doctors in the State. All these elements are in play with this situation, so when we talk about fairness, we cannot isolate the one aspect of personal fairness.

The Legislature has to decide how to balance these elements. The balance has worked since 2004. We lowered premiums and we are attracting more doctors to the State. The only way we will continue to attract doctors is if we have quantifiable amounts of damage—not acting out of emotion—within a range of fairness. A range of fairness is all that should be promised.

Chair Brower:
I call upon others to testify in support of S.B. 292.

Jennifer Gaynor (Fundamental Administrative Services, LLC):
We support S.B. 292 because it creates clarity and avoids unnecessary and expensive litigation. We have submitted a proposed amendment to add further clarity to the bill by enhancing the language of section 2 to ensure that skilled nursing facilities, as defined in NRS 449.0151, are included in the entities listed in S.B. 292 (Exhibit H).

Our proposed amendment would also make clear that a plaintiff cannot circumvent the limitations of NRS 41A by bringing in an additional claim under NRS 41.1395. Physicians may not encounter this situation very often, but Nevada's skilled nursing facilities do. Skilled nursing facilities spend money on needless litigation defending themselves over this confusion.

Nevada's skilled nursing facilities have not had a rate increase in almost 20 years and, in fact, have had their rates cut. Most skilled nursing facilities operate at a 1.5 percent margin, which is very tight. Hundreds of thousands of dollars are spent on lawsuits litigating these technicalities, and it is draining for these businesses.

Chair Brower:
We will consider your proposed amendment.

Robert Rourke (Horizon Hospital and Rehabilitation Center):
I represent many skilled nursing facilities in the Las Vegas area and litigate quite often with Mr. Cotton. His explanation as to why we need to rectify and clarify some of the issues in this statute was spot on. I echo Mr. Cotton's testimony with regard to the cost to the clinic being potentially higher than the cost to the doctors that the clinics employ. What is happening to clinics is also happening to skilled nursing facilities.

While nurses and therapists are covered under statute, almost every single lawsuit we encounter makes the claim that skilled nursing facilities are not covered by NRS 41A. With a few exceptions, these cases are dismissed, but not before the facility incurs an exorbitant cost. As was testified by Ms. Gaynor, the margins, the costs and the availability of insurance for these types of facilities makes staying in business tough. These issues are magnified when money has to be allocated to defend a case that will most likely be dismissed.

While we welcome the elimination of the confusion surrounding medical malpractice and professional negligence claims, our priority is that the definition of provider of health care include skilled nursing facilities. Naming skilled nursing facilities in the definition will ensure we will not have to litigate every single case with the same issues at a huge cost.

When I say at a huge cost, I am not only referring to my clients' costs but costs to the system. Judges have crowded dockets already and are hearing these types of motions and arguments repetitively. The associated costs are attributable not only to filing a motion but doing the discovery in advance to prepare the fact pattern for that motion. Adding skilled nursing facilities to S.B. 292 is important and will be consistent with Question No. 3.

The second change in our proposed amendment, Exhibit H, relates to NRS 41.1395. Not all doctors have experienced this issue yet; but some are seeing it more recently …

Chair Brower:
Please remind the Committee what NRS 41.1395 states.

Mr. Rourke:
The elder abuse statute, or NRS 41.1395, provides an avenue for damages for injury or loss suffered by an older or vulnerable person from abuse, neglect or exploitation. In both skilled nursing facilities and hospitals, we see plaintiffs post tort reform. Plaintiffs file lawsuits containing causes of action for NRS 41.1395 as a way to get around the caps of NRS 41A. These lawsuits focus on the neglect portion of NRS 41.1395, which states,

> "Neglect" means the failure of a person who has assumed legal responsibility or a contractual obligation for caring for an older person or a vulnerable person, or who has voluntarily assumed responsibility for such a person's care, to provide food, shelter, clothing or services within the scope of the person's responsibility or obligation, which are necessary to maintain the physical or mental health of the older person or vulnerable person. For the purposes of this paragraph, a person voluntarily assumes responsibility to provide care for an older or vulnerable person only to the extent that the person has expressly acknowledged the person's responsibility to provide such care.

The key language in this paragraph is "which are necessary to maintain the physical or mental health of the older or vulnerable person."

Plaintiffs are blending negligence under NRS 41A—professional negligence—with neglect under NRS 41.1395. It is extraordinarily expensive to defend this cause of action.

In the end, most judges accept that NRS 41A and NRS 41.1395 cannot be read in harmony while giving meaning to the caps in 41A and still providing for double damages, attorney's fees, unlimited damages and costs under essentially the same fact pattern with one motion proceeding under neglect and one motion proceeding under negligence. To address this issue in statute, we propose language be added to NRS 41.1395 stating that when an action is due to professional negligence, it will be governed by NRS 41A, and if that occurs, then NRS 41.1395 is no longer an available remedy.

We ask that if the definition of provider of health care is expanded to include skilled nursing facilities, changes be made throughout the NRS to maintain consistency. That is, if changes to the definition of provider of health care are

made to NRS 41A, then the same changes must be made to NRS 629.031 and NRS 42.021. Making changes to the language across the NRS will preclude us from having to face arguments like we have been in which the provider of health care is defined under NRS 41A one way and then defined under NRS 629 another way.

Darrin Cook (CEO, Horizon Specialty Hospitals):
I support S.B. 292 and the proposed amendment, Exhibit H. I submitted my written testimony for the record (Exhibit I).

Margo Piscevich (Nevada Rural Hospital Partners Foundation):
I have practiced law 43 years with 25 to 30 of those years practicing professional malpractice. This means I have worked continually with lawyers, doctors and hospitals.

I support S.B. 292 and concur with the proposed amendment, Exhibit E. I agree that caps on damages is a public policy issue. Question No. 3 worked fine for the first few years it was implemented and then some judges decided to interpret it to be a cap per person, not per action—about 25 percent of judges do this.

I agree with the addition of section 4, subsection 2, paragraph (c) to the law.

Regarding the definition of professional malpractice, the term includes numerous entities from lawyers to engineers to licensed professionals. My preference would be to use professional malpractice and maybe include medical malpractice or dental malpractice. Professional malpractice applies to all licensed practitioners whether you are an architect or an engineer.

Regarding the bill's statement of bringing a trial within 2 years, I have never seen this happen. Generally, parties stipulate that the case can be brought later because the parties will receive preferential settings. We also have to contend with a conflict between the way Clark County and Washoe County, the State's two largest counties, set trials. Washoe County gives a firm setting of 18 months out, 24 months out, 30 months out, etc. Clark County has a calendar call and the case may go on that first calendar call, but it is not certain.

In my experience, it takes at least 3 years to get cases to trial because of various conflicting situations, including the fixed setting date used in Washoe County and the stacked calendar used in Clark County.

Regarding section 6, I agree on the necessity that an affidavit identify the physicians or nurses, etc., or that it at least identify the practitioners' actions. For the past 5 years, complaints have been coming in that say, "The conduct in this hospitalization was below the standard of care." The affidavit will say the testifier is an expert witness who agrees with the allegations of the complaint. That is literally the allegation of the affidavit. We do not know the identity of the person or that person's alleged misconduct.

I have one case where seven nurses from two different shifts are named. I understand the plaintiffs may not know the contents of what is going to be said, but it can definitely be said what misconduct was done: a misdiagnosis, a wrong injection, the wrong amount—the plaintiff can at least state the nature of the misconduct. It is costly to defend these cases.

Regarding the res ipsa loquitur, yes, there are simple solutions for when the wrong leg is amputated. It is a given, and an expert witness is not needed for determination; however, an expert witness is needed on causation. There can be many different issues in a medical setting that are bad, but those issues may not have caused anything.

If there is going to be expert testimony, then res ipsa loquitur is sort of "inside baseball." If res ipsa loquitur is used and there is causation, then it is important not to give both jury instructions because it becomes confusing.

Kathleen Conaboy (Nevada Orthopaedic Society):
We support S.B. 292 and KODIN's proposed amendment, Exhibit E. I want to address Senator Ford's concerns about fairness. We see this as a policy tension between a physician providing good care and a physician being available to provide good care. Clarity and predictability in the law is crucial so doctors can run effective business models.

Senator Ford:
I appreciate your perspective, but the patient needs to be in that calculus as well. My concern is that with the $350,000 cap, we are being asked to decide that grief be divided among those who have been aggrieved by a physician's

malpractice. That important policy consideration weighs heavily on me. My vote is not needed to pass this S.B. 292, but if you want me to vote for this bill, we need to have a conversation about finding an alternative.

Ms. Conaboy:
The physicians we represent do see the patient as paramount, and that is why there is tension for them. Doctors need predictability.

Denise Selleck (Executive Director, Nevada Osteopathic Medical Association):
I support S.B. 292. The Nevada State Medical Association asked me to relay its support for the bill as well as support for the proposed amendment, Exhibit E.

Elizabeth MacMenamin (Retail Association of Nevada; Retail Chain Drug Council)
We support S.B. 292. I am opposed to the proposed amendment, Exhibit E. We were excited to see pharmacists included in the original bill, but the proposed amendment strikes pharmacists from the list of providers. I would like the Committee to consider including pharmacists and will speak with the bill's sponsor.

Adam Plain (Nevada Dental Association):
We support S.B. 292.

Stephen Osborne (Nevada Justice Association):
It was testified that Nevada is in a good place and that rates have stabilized. Senate Bill 292 attempts to expand the scope of the $350,000 cap on damages. This further expansion violates the Seventh Amendment of the U.S. Constitution, which is a right to trial by jury. In fact, the Nevada Constitution provides that the right to jury trial be secured to all and remain inviolate forever.

This bill does not fairly compensate victims and limits the meritorious cases—not the frivolous cases, but the cases that have merit and value. It does not limit the health costs for consumers and does not ensure quality of care.

In 2002, it was agreed and voted upon that $350,000 would be for each plaintiff and each defendant. A bill presented in 2003 did not pass, so by law, it went to the voters. In that initiative, Question No. 3 was presented, but not fairly. In *Jones v. Heller*, No. 43940 (Nev. Sep. 18, 2004) (order granting in part petition for writ of mandamus), seven Nevada Supreme Court Justices held

that the initiative removed two statutory exceptions to the cap: one, gross negligence, and two, exceptional circumstances. Despite this issue, the intent of Question No. 3 is still per plaintiff, per defendant.

The Nevada Supreme Court ruled that the condensation and explanation of Question No. 3 misinformed the voters—that it was deficient and could not stand. Despite that ruling, the explanation remained and was distributed to voters. *Nevada Revised Statute* 41A.035 clearly states the singular: "a" provider of health care based upon professional negligence and "the" injured plaintiff. Singular. In fact, the term "professional negligence" is defined in NRS 41A.015 as "a" negligent act or omission to act. Again, singular.

The term "action" was testified to be clear, but seven Nevada Supreme Court Justices did not interpret it that way. Seven Supreme Court Justices ordered those two statutory exemptions to the cap to be removed.

Chair Brower:
What is the year of the case you are citing?

Mr. Osborne:
September 18, 2004.

Chair Brower:
Is that the unpublished *Jones v. Heller* decision?

Mr. Osborne:
I do not know.

Chair Brower:
Legislative Counsel informs me it was an unpublished order. In the time since that Nevada Supreme Court order, have a majority of district court judges decided the other way?

Mr. Osborne:
Some judges have ruled that way, many judges have not.

Chair Brower:
Do you know how many judges have ruled one way or the other?

Mr. Osborne:
I do not. I do not know if those statistics are even available.

Senate Bill 292 extends the law. Yes, there are problems with the statute and Mr. Cotton went over those issues. I will address a few of those issues in my testimony.

Even though Nevada is in a good place and is stable with regard to doctors working in the State, S.B. 292 expands the cap to additional parties. I did not hear testimony today about the new language stating awarded damages must not exceed $350,000 regardless of the number of theories upon which liability may be based—not merely those issues related to professional malpractice.

For instance, in Las Vegas, Dr. Dipak Desai was convicted of murdering his patient. There is a $350,000 cap for murdering his patient because the verdict was based upon his treatment of the patient.

Chair Brower:
To be clear, the murder case is a criminal case. A wrongful death case would have a $350,000 cap.

Mr. Osborne:
Yes, but Dr. Desai was convicted of murdering his patient, so that would be considered part of the theory of the wrongful death.

Chair Brower:
Correct. And damages would be capped at $350,000.

Mr. Osborne:
Correct. The statute also shifts the costs of the malpractice from the negligent parties to the victim and then to the State. If there is no recovery and the victim becomes a ward of the State, that puts a burden on Nevada's Medicaid system.

Section 6 ...

Chair Brower:
Please clarify for the Committee if we are talking about noneconomic damages versus economic damages. A victim of medical malpractice—a plaintiff—can recover all economic damages, all past and future medical bills, all past and

future income loss; everything needed to make that plaintiff whole in terms of monetary loss. Is it correct to say the sky is the limit?

Mr. Osborne:
No, that is not necessarily correct.

Chair Brower:
Would a cap apply to economic damages under the statute?

Mr. Osborne:
That is taken on a case-by-case basis. Future medical expenses are not subject to the cap.

Chair Brower:
Is only pain and suffering subject to the cap?

Mr. Osborne:
It is not only pain and suffering. It is disability, disfigurement, loss of limbs; it is everything that the patient has experienced.

Chair Brower:
Everything that is unquantifiable.

Mr. Osborne:
No, not necessarily unquantifiable because the damage has to be quantified at some point. It has to have a price tag attached to it, for example, a medical bill. These are called special damages. The cap, as proposed, is arbitrary and one size fits all. No matter how many plaintiffs or how many defendants there are, the cap sits at $350,000.

Section 4 provides the trier of fact can consider any person who could have contributed to the negligence. I would like to emphasize the words "could have." There is no requirement of disclosure of this mystery person, but "any person" that is chosen "could have" it required. There has to be some level of proof or disclosure.

We spoke with Mr. Cotton about these issues and he has agreed to work on the language with us. The bill's language, as is, will further reduce the cap as well as other damages. For example, if it is found that a radiology technician

"could have" contributed to the negligence and is included in the verdict form, that will operate to further reduce the total amount. If this radiology technician is 50 percent responsible, the way S.B. 292 is written, the cap is then reduced 50 percent, which is not fair without any kind of proof or disclosure.

The bill allows for a person to be brought into a case to lower damages, but then a plaintiff cannot bring that person in for any other action. I am not sure of the purpose for doing that. You have responsibility, but then you say it cannot be used in any further way once it has been determined.

Section 6 amends NRS 41A.071, which is a preliminary procedural requirement. This is the affidavit of merit. At the beginning of a case, many key facts are unknown, especially when only a partial set of medical records is provided. Hospitals will not include an incident report or a current report; those reports are held back until after a case is filed.

For example, a patient is dropped while being moved from the gurney to the operating table. The patient's operation was for a deviated septum, but following the drop, he has a herniated disc. At this point, as the plaintiff's attorney, you do not know key information such as who was involved in the transfer or who actually dropped the patient. You have to go forward without knowing elements of that nature.

Section 6, subsection 4 of S.B. 292 discusses complying with Nevada Rules of Civil Procedure 16.1 at the initial pleading stage. Rule 16.1 of NRCP is the expert report requirement that is to be completed after the discovery process. The language of the bill requires the plaintiff to comply with this rule at the initial stage of proceedings, but that is simply not possible.

In section 9, the bill's sponsors want to add the language "provider of health care caused the" personal injury or death. The key word is "caused," which takes the rebuttable presumption, or the res ispa loquitur, out of play. In 23 years of practicing law, I have never seen a case that says the medical record provides the cause of subsequent injuries.

With S.B. 292, a plaintiff is asked to prove negligence without an expert, which simply cannot be done. A plaintiff has to provide for the cause of damage for the clear liability actions, but if an expert is used, a plaintiff no longer has that

rebuttable presumption. This is not a double-dip, as testified by the bill's sponsors.

Senator Ford:
There is a public policy issue to keeping doctors in Nevada. The division of $350,000 by the number of plaintiffs seems to accomplish that goal. Are there alternatives to this issue other than a cap?

Mr. Osborne:
Public policy also supports that when voters vote on something, they be aware of what they are actually voting on—which did not happen with Question No. 3.

You stated when you originally examined the language, you read the word "action" and did not fathom that negligence could be split. The Nevada Supreme Court also stated the language was deficient and could not stand. The Court also found the cap to be per plaintiff, per event and was not part of the amendment made.

Senator Ford:
Please restate your answer.

Mr. Osborne:
In *Jones v. Heller*, the order says nothing changed from prior statute—the prior statute being per plaintiff, per defendant—and each gets a separate cap. The Nevada Supreme Court found the per plaintiff, per defendant cap to still be in place, meaning multiple caps, not one cap for the entire case.

At the same time, however, the Justices cited two exceptions that were wrongly removed from the condensation and explanation of Question No. 3. The Justices wrote that neither the condensation nor the explanation accurately reflected that Question No. 3, upon passage, would remove the two statutory exceptions of gross negligence and exceptional circumstances shown by clear and convincing evidence.

Senator Ford:
Are there alternatives to this issue other than a cap?

Mr. Osborne:
The bill's sponsors testified Nevada is in a good place and premiums have been reduced by 50 percent. I am not sure why there needs to be an alternative. The statute does not compensate victims of meritorious cases that show their damages are over and above the $350,000 cap because that is the only time the cap operates.

If the jury does not find that a plaintiff's noneconomic damages are over and above the capped amount, the judge does not have to reduce anything down. The jury does not get to hear about the cap until after the trial is over.

Chair Brower:
Regarding *Jones v. Heller*, the order states it is unpublished and shall not be regarded as precedent and shall not be cited as legal authority, according to Supreme Court Rule 123. It is not a unanimous decision: signed by three justices, two dissenting in part and concurring in part. It is interesting that the order is dated September 18, 2004.

From the timing, it appears a challenge was made to Question No. 3 prior to the November 2004 election. The Court granted in part petition for a writ of mandamus, filed by those challenging the wording of Question No. 3. Nevertheless, Question No. 3 was on the ballot less than 2 months later. What happened between the date of the unpublished order and Election Day in 2004?

Mr. Osborne:
There was the initial majority decision, two comparing opinions and one dissenting. All Justices found the same thing with regard to the language—it was deficient. Justice William Maupin dissented only because of the timing.

It was too late to redo the ballot, so voters received the misinformed, deficient, cannot-stand language and then, on the back of the ballot, additional pages were added correcting the language.

Chair Brower:
Did the deficient language go to voters despite the Supreme Court's order?

Mr. Osborne:
Correct. The actual ballot that voters received had a note on the cover that said,

> Attention voter: after your sample ballot was printed, the Nevada Supreme Court ruled the wording originally submitted for the question and explanation for State Question No. 3 did not adequately, fairly or sufficiently describe the question and its ramifications. The revised State Question No. 3, its explanation and the arguments for and against the question are printed on the blue pages, 16A-16F, inserted after page 16.

Chair Brower:
I am not sure *Jones v. Heller* has the specific issue we are dealing with today.

Christian Morris (Nevada Justice Association):
I am a trial attorney. It is important to keep good doctors in Nevada. Lawyers do not like to sue doctors because doctors usually help people. Doctors cannot be sued unless there is an affidavit from an expert who has looked at the actions and agreed those actions are below the standard of care; this safeguard is already in place. Senate Bill 292 is not a clarification of statute but an expansion.

There is a cap of $350,000. I have not heard that 75 percent of judges say the law holds per event or per action and 25 percent say it is per plaintiff, per defendant. I practice in Las Vegas. I know some judges allow for it. I have always had judges allow per plaintiff, per defendant. There is a split, though.

Chair Brower:
Have you always held this view?

Ms. Morris:
In the time I have taken these cases, yes, that has always been my view, but I have not had many cases. I do not know of any statistics, but there is a disconnect as to how to apply the law.

Section 4 outlines the responsibility of a nonparty. If a facility has been found to be 90 percent responsible, that percentage should be allowed on the verdict form so the jury receives the full version of what happened.

The jury knows that another party has been found responsible, but the language in S.B. 292 states that a nonparty can be anyone—even someone not party to the action. This means that a doctor who is not involved in the case, who is not

named as a defendant and who has not had an opportunity to present himself or herself as a defendant can be listed in the verdict form. No doctor wants his or her name listed on the verdict form without a chance to defend himself or herself. No doctor wants to have a percentage of responsibility in a malpractice case to which he or she is a nonparty.

Section 5 states dismissal of an action is a bar to the filing of another action upon the same claim, but that does not mean the doctor will not be subjected to some sort of discipline from a medical board.

The language of the bill is not safe language that protects doctors; it actually exposes doctors to some degree.

Another thing …

Chair Brower:
Mr. Cotton, does the bill intend to have nonparties named on the verdict form?

Mr. Cotton:
The language in the bill is not clear.

Chair Brower:
We will address that language issue later.

Ms. Morris:
Another thing to consider is the affidavit requirement. The expert affidavit that is required in order to file a medical malpractice claim is based on information available at the beginning of the case. This information is limited in scope, and there is a 1-year statute of limitations.

Discovery is when medical records are gathered, depositions taken, written discovery done. An expert is disclosed 90 days before the end of discovery. An expert affidavit, a requirement of NRCP 16.1, has to fully state all opinions and the basis of such opinions to be presented at trial. One simply cannot ask for that initial expert affidavit in support of the complaint to fulfill the NRCP 16.1 obligation until the discovery process is complete.

It was testified that the nature of the misconduct needs to be made known. Misconduct which rises to the level of medical malpractice is stated in the

affidavit. It is unreasonable to ask an initial expert to apply all of his or her opinions before the case has even started. Existing law is sufficient, and the affidavit requirement should remain.

Lawrence Smith:
I am a member of the Nevada Justice Association, but I testify today representing myself.

Regarding section 4, where nonparties are allowed to be put on the verdict form, a nonparty virtually does not exist anymore; it is the law of unintended consequences.

Plaintiff attorneys who do not want to get sued for malpractice themselves later on are going to name every person who has a fingerprint anywhere on the care of their client. As such, S.B. 292 will create more litigation, not less. No plaintiff's attorney will take a chance on fault being attributed to those who are not already defending themselves because the plaintiff cannot collect.

If putting nonparties on the verdict form is allowed to stay, there will be an explosion of litigation within the same case—and other bills being heard this Session allow nonparties to be put on the verdict form. Every single person who has anything to do with the matter will have to be named in case the defendant blames him or her.

This situation will have to be approached carefully because individuals who may have even a slight amount of responsibility will have to be named. The focus is normally not on that, though. Normally, the plaintiff's attorney will only look at those who are the main cause of the incident; but if everybody is on the verdict form, then everybody will get invited to the party.

Chair Brower:
It works that way already.

Mr. Smith:
I work in this part of law daily, and that is not the way it works.

Chair Brower:
More often than not, it does work that way.

John Echeverria (Nevada Justice Association):
I am a personal injury and medical malpractice lawyer. I am not a member of the Nevada Justice Association, but the Association asked me to testify on the statute and S.B. 292.

If the goal of the bill is correct—that we are clarifying problems in statute—then I fully support S.B. 292. There is confusion in medical malpractice litigation, and this confusion leads to needless motions. I would like to see the law clarified.

The law does not need clarification with respect to the caps and the direction this bill takes those caps. The issue of caps is a policy argument. If we are just correcting technicalities, we need to focus on the difference in opinion between judges. It seems some judges have interpreted the code to read $350,000 per plaintiff, per defendant and others have read it to mean $350,000 for everybody.

The reason for the cap was to create some predictability for the purposes of insurance for doctors. With or without a cap, there can still be predictability in insuring doctors.

The insurance company that insures Doctor A and the insurance company that insures Doctor B are making the same analysis on risk. If Doctor A and Doctor B, each with their own insurance policies, are brought into the same malpractice case, both get the benefit of the $350,000 cap. The insurance companies write insurance policies based on an actuarial of a doctor's exposure. Senate Bill 292 addresses the actuarial issue to the benefit of the insurance companies—companies that continue to maintain a higher actuarial number.

The policy issue of $350,000 per plaintiff, per defendant is an argument for another bill and should not be the focus of S.B. 292. The problems with the rest of the bill revolve around language and how to interpret that language. Senate Bill 292 will create more litigation and more disputes on how to interpret its language.

Section 3 adds the language "regardless of the number of plaintiffs, defendants or theories upon which liability may be based." If the cap is applied to all theories upon which liability could be based, it would immunize a doctor from battery. An ear, nose and throat doctor who performs a colonoscopy—and has never been trained in that capacity—commits battery, and that is egregious.

That cause of action for battery should not be subject to the cap because that doctor performed something in which he or she has no training.

Chair Brower:
How does that square with the language that says "In an action for injury or death against a provider of health care based upon professional negligence … "?

Mr. Echeverria:
A battery is not professional negligence.

Chair Brower:
Is that a separate action?

Mr. Echeverria:
Yes, it is a separate cause of action, but it is covered by this limitation.

Chair Brower:
I will consider that further. Thank you.

Mr. Echeverria:
The real problem is in section 2. In addition to the arguments already raised, the main problem is two different words are being used to describe conduct: responsibility and fault. Responsibility and fault are two different concepts. That language needs to be rewritten.

Somebody may be responsible for an injury but not be legally at fault. It is a problem if a jury is entitled to assign a percentage of fault to someone who does not have legal responsibility.

Mr. Cotton stated the goal of the bill was to allow the defendant doctor to talk about the doctor who settled out. For example, Doctor A is found to be 90 percent negligent and settles out. The jury is not entitled to consider that when assessing the remaining 10 percent of fault. If the goal of the bill is to allow the defendant Doctor B to talk about defendant Doctor A, who settled out, that can be accomplished. Senate Bill 292 goes beyond that consideration and allows the jury to consider the conduct of a doctor who may not have ever even known he or she was listed and discussed in the case.

There are ways to solve Mr. Cotton's concerns, but this bill does not achieve that. This bill creates more problems.

Chair Brower:
Does naming the person on the verdict form differ from the classic empty chair defense?

Mr. Echeverria:
Yes. Statute states only the parties before the court are named.

Chair Brower:
That is the classic empty chair defense argument.

Mr. Echeverria:
Empty chair defense can be made, but there is no proof of it.

Chair Brower:
No appearance on the verdict form …

Mr. Echeverria:
Correct, but with S.B. 292, that person will be put on the verdict form and the jury will be asked to assess responsibility. The language about anybody being responsible could be a nurse who should have consulted with her peers or with the doctor but may not have been negligent in not doing so.

Not being forced to name the person who the defense wants to put on the ballot is also problematic. I would hate to be a doctor waking up one morning and seeing in the headlines that I was found 80 percent liable for Mr. Smith's death, never having known the case existed. Now I have adverse publicity and other problems. There are ways to solve these issues, and Mr. Cotton is willing to discuss how the language might be tightened up to accomplish his goals.

I agree with Ms. Piscevich that the definition of professional negligence should be tightened to specifically cover medical negligence. I am concerned some judges may interpret even more broadly the term "professional negligence."

I echo the concerns about the requirement of NRCP 16.1 regarding the filing of an affidavit prior to the filing of a lawsuit.

Mr. Cotton:
To rebut the concern that if the noneconomic cap of $350,000 remains and Nevada consequently ends up with wards of the State, I remind the Committee that economic losses are in addition to noneconomic losses.

If an injured party would have earned $3.5 million over a lifetime, then he or she will get $3.5 million plus $350,000 for noneconomic damages. If juries allocate responsibility properly and there is evidence of past and future medical expenses and past and future economic losses, the cap is not going to make anybody a ward of the State.

I disagree with the argument that several liability reduces the cap. If the defendant is 10 percent responsible, the plaintiff may only get $35,000 from that defendant, but that does not reduce the cap. That is allocating the percentage of damage. If the defendant causes 100 percent of the damage, 100 percent will be assessed. If it is 50 percent, it is 50 percent. The jury makes that determination once it has all of the evidence, not parts of it.

Chair Brower:
What about the issue of the nonparty being at portion fault?

Mr. Cotton:
The nonparties—whether done by other or done by name—do not have a reportable judgment against them. On one level, it is a jury allocation question and then, later on, on another level, the judge applies whatever verdict the jury found. A judgment is not entered against somebody named as a nonparty at fault. The doctors are not going to name a nurse as a nonparty who is 3 percent at fault. The rules of discovery cover this concern. If there is a belief that somebody caused the injury, that has be to disclosed, and disclosures are made throughout the course of litigation. If the plaintiffs choose to join the cases, they can.

Chair Brower:
You envision adding a person to a lawsuit if the plaintiff's lawyer agrees that the person has potential liability.

Mr. Cotton:
Correct. We do not want to have a situation where the plaintiff gets to decide who appears in front of the jury as opposed to who actually is responsible. If

plaintiffs choose not to join somebody or wait too long and have a statute of limitation problem on Doctor A, that should be a penalty on Doctor B, who remains in the case.

Chair Brower:
The jury verdict form will potentially name the person, but the ultimate judgment will not.

Mr. Cotton:
Correct. The ultimate judgment is never found against that person when it is allocated out that way for several liability. There will be no judgment entered against Doctor A. He may not be there, but there is not a judgment that he has to report to his insurance carrier or medical examiners board—or anyone else. This is just not done.

Senator Ford:
Can the defendant bring that person in as well?

Mr. Cotton:
It is not likely that person can be brought in on a third-party action.

Senator Ford:
It may not be likely, but is it possible?

Mr. Cotton:
I do not have the burden of proving who was damaged or how much that person was damaged …

Senator Ford:
That is true, but if you want to put that person on the verdict, you can bring the person in, correct?

Mr. Cotton:
Yes. In theory, you can bring them in as a party. Often, plaintiffs wait until the day before the statute has run out to sue somebody, and then it is too late to bring in someone.

Regarding the issue of the affidavit of merit, I wholeheartedly disagree. I get these types of affidavits constantly with verbiage such as "I am Joe Smith of

the University of California, Los Angeles. I have all this background and, in my opinion, these defendants caused this injury because they violated the standard of care." These affidavits do not offer anything more.

These types of attestations were clearly not the intent of the 2002 legislation where the affidavit was exchanged for the screening panel. The idea behind the 2002 legislation was you still have to get someone to say, "These defendants did the following acts and they violated the standard of care, by … " An attorney's access to a client's medical records can be made available with a HIPAA release. These records can be had 2 years before the filing and can be given to the experts.

If experts look at the medical record and cannot determine which doctor did something wrong, then those doctors should not be joined as a party to a lawsuit. To blanket-join four or five defendants, then weed them out and throw them off to the side during the process of discovery—because it is no sweat off the plaintiff's back to do that—is unfair to doctors who should not have been joined in the first place. Doctors have to report when they are joined in a case, whether or not their own responsibility is eventually dismissed.

Senator Ford:
How is this any different from an expert report?

Mr. Cotton:
Rule 16.1 of the Nevada Rules of Civil Procedure outlines all the theories and the facts that a case can be based upon. If the expert has the medical records, that expert can use those records to make a determination 6 months down the line. That future determination can be made at the time of filing and keep doctors from being exposed.

It is so easy to throw in four or five doctors and then dismiss them one at a time, but doctors are required to report when they are joined onto a case. That information goes to their insurance carriers and to the Board of Medical Examiners. Statute allows for defendants to be joined with a sloppy affidavit, and this is 180 degrees from what we intended when we dropped the screening panel.

Chair Brower:
Seeing no more business or public comment, I adjourn the meeting at 3:16 p.m.

RESPECTFULLY SUBMITTED:

_____
Cassandra Grieve,
Committee Secretary

APPROVED BY:

_____
Senator Greg Brower, Chair

DATE: _____

EXHIBIT SUMMARY				
Bill	**Exhibit**		**Witness or Agency**	**Description**
	A	1		Agenda
	B	8		Attendance Roster
S.B. 260	C	1	Mark Leon	Letter in Support
S.B. 260	D	2	Nevada Credit Union League	Letter in Opposition
S.B. 292	E	2	Keep Our Doctors In Nevada	Proposed Amendment
S.B. 292	F	2	Rudy Manthei	Support Testimony
S.B. 292	G	1	Nevada Mutual Insurance Company	Policy Rate Reductions Chart
S.B. 292	H	5	Fundamental Administrative Services, LLC	Proposed Amendment
S.B. 292	I	1	Darrin Cook	Written Testimony

PREPARED BY
RESEARCH DIVISION
LEGISLATIVE COUNSEL BUREAU
Nonpartisan Staff of the Nevada State Legislature

BILL SUMMARY

18th SPECIAL SESSION
OF THE NEVADA STATE LEGISLATURE

ASSEMBLY BILL 1
(Enrolled)

Topic

Assembly Bill 1 makes various changes related to medical and dental malpractice.

Summary

This bill limits civil damages in some emergency situations for care rendered gratuitously, limits noneconomic damages, addresses delays in bringing cases to trial, shortens the statute of limitations, requires pretrial settlement conferences, eliminates malpractice screening panels, regulates expert testimony, requires training for district judges who try malpractice cases, requires physicians and dentists to carry malpractice insurance with minimum limits in certain circumstances, requires the Board of Medical Examiners to submit periodic reports on disciplinary actions and malpractice cases, requires physicians and dentists to report malpractice claims and establishes the Repository for Health Care Assurance.

$50,000 Cap on Damages for Emergency Care

Assembly Bill 1 limits civil damages in certain emergencies to no more than $50,000 for any claimant. The limit applies to certain parties that in good faith render care or assistance made necessary by a "traumatic injury" demanding immediate medical attention, for which the patient enters the hospital through its emergency room or trauma center. A "traumatic injury" is defined as any acute injury, which, according to standardized criteria for triage in the field, involves a significant risk of death or the precipitation of complications or disabilities. The parties affected by this limit include:

- A hospital;
- An employee of a hospital who renders care or assistance to patients;
- A physician or dentist who renders care or assistance at a hospital, whether the care is gratuitous or for a fee; and
- A physician or dentist whose liability is not otherwise limited and who renders care or assistance at such a hospital, whether the care is gratuitous or for a fee.

This limitation on liability does not apply:

- If there is gross negligence or reckless, willful, or wanton conduct;
- To any act or omission in rendering care or assistance occurring after a patient is stabilized, unless surgery is required within a reasonable time after stabilization; and
- To any act or omission in rendering care or assistance that is unrelated to the original traumatic injury.

Total Immunity for Treatment in Governmental or Nonprofit Facilities

Assembly Bill 1 further provides that any licensed physician, osteopathic physician, or dentist who renders care at a health care facility of a governmental entity or a nonprofit organization is not liable for any civil damages if the care or assistance is rendered gratuitously, in good faith, and in a manner not amounting to gross negligence or reckless, willful, or wanton conduct.

$350,000 Cap on Noneconomic Damages

The bill establishes a general limit on the amount of noneconomic damages that may be awarded to a plaintiff in a malpractice action brought against a dentist, physician, hospital, or employee of a hospital. Noneconomic damages are defined to include damages for pain, suffering, inconvenience, physical impairment, disfigurement, and other nonpecuniary damages.

Unless certain exceptions apply, the noneconomic damages awarded to each injured plaintiff must not exceed $350,000. The exceptions to the $350,000 cap on noneconomic damages apply when the conduct of the defendant is grossly negligent or the court determines by clear and convincing evidence at trial that an award in excess of $350,000 for noneconomic damages is justified because of exceptional circumstances.

Subsection 3 of section 5 of the bill provides that in all cases of medical malpractice the amount of damages awarded to the plaintiff may not exceed the amount of money remaining under the professional liability insurance policy limit covering the defendant after subtracting the economic damages awarded to the plaintiff. In addition, a single defendant cannot be held liable for noneconomic damages in an amount that exceeds the defendant's professional liability insurance policy limit even if there is more than one plaintiff. Economic damages are defined as damages for medical treatment, care or custody, loss of earnings, and loss of earning capacity.

Moreover, A.B. 1 provides that in order for physicians, dentists, and osteopathic physicians to obtain the benefit of the $350,000 cap on noneconomic damages they must maintain professional liability insurance of not less than $1 million per occurrence and not less than $3 million in the aggregate.

Several Liability

The measure also provides that each defendant is individually liable for noneconomic damages only to the extent of that defendant's percentage of negligence, but is not jointly liable for the total amount of such damages. This provision applies to a certified nurse midwife and a certified registered nurse anesthetist, as well as to physicians, hospitals, and hospital employees.

Expediting Trials

Assembly Bill 1 also limits delays in bringing medical malpractice cases to trial. Cases filed between October 1, 2002, and October 1, 2005, must be dismissed if they are not brought to trial within three years unless good cause is shown for a delay. Cases filed on or after October 1, 2005, must be brought to trial within two years. Dismissal of an action bars the filing of another action upon the same claim. Assembly Bill 1 further requires dismissal of an action for medical or dental malpractice if the action is filed without an affidavit submitted by a qualified medical expert supporting the allegations.

The bill also requires district courts to adopt rules on or before March 1, 2003, to expedite medical and dental malpractice trials.

Pretrial Settlement Conferences

The bill requires that settlement conferences be held before a judge other than the judge assigned to the case. Each plaintiff, defendant, representative of the physician's or dentist's insurer, and each of their respective attorneys must attend and participate in the settlement conference. The judge presiding at the settlement conference must decide what information the parties may submit. The failure of any party, his insurer, or his attorney to participate is grounds for sanctions. The settlement conference replaces the medical and dental malpractice screening panels, which are eliminated.

Statute of Limitations

Additionally, A.B. 1 shortens the statute of limitations for commencing an action for injury or death that occur after October 1, 2002, from four years to three years, or two years after the plaintiff discovers or should have discovered the injury, whichever occurs first.

Expert Medical Testimony

Further, this measure specifies that expert medical testimony may only be given by a medical care provider who practices or practiced in an area substantially similar to the type of practice engaged in at the time of the alleged negligence.

Periodic Payment of Future Damages

Assembly Bill 1 also provides that future economic damages may be awarded in periodic payments by a means other than an annuity if the defendant posts an adequate bond or other security to ensure full payment by periodic payments of the damages. Upon termination of the payment of the periodic payments, the court shall order the return of the bond or other security to the defendant.

Special Training for Trial Judges

This measure requires the Supreme Court of Nevada to provide for training concerning the complex issues of medical malpractice litigation for each district judge to whom actions involving medical malpractice are assigned.

Malpractice Reporting Requirements

The Board of Medical Examiners must submit to the Governor and the Director of the Legislative Counsel Bureau a written report compiling disciplinary actions taken by the Board during the previous biennium against physicians for malpractice or negligence and other information reported to the Board. Additionally, the Court Administrator of the Supreme Court of Nevada must submit to the Governor and the Director of the Legislative Counsel Bureau a written report compiling the information pertaining to physicians and osteopathic physicians submitted by the clerks of the courts. These reports must include aggregate information for statistical purposes and exclude any identifying information related to a particular person.

Further, A.B. 1 strengthens requirements for physicians, osteopathic physicians, their insurers, a person, medical school, or medical facility to report to licensing boards actions that could be grounds for discipline, as well as all actions filed or claims submitted to arbitration or mediation for malpractice or negligence against the physician or osteopathic physician. The measure also requires similar reports from the clerks of the courts. Administrative fines of $10,000 may be imposed on certain parties for failure to comply.

Assembly Bill 1 also requires insurers to report to the Commissioner of Insurance within 30 days on a breach of professional duty by osteopathic physicians. Current law only applies to physicians. Additionally, the Commissioner of Insurance must report to the State Board of Osteopathic Medicine within 30 days after receiving the report of the insurer.

Medical Error Reporting

In addition, Assembly Bill 1 requires reporting of "sentinel events" to the Health Division of the Department of Human Resources. A "sentinel event" is defined as an unexpected occurrence involving death or serious physical or psychological injury or the risk thereof, including any process variation for which a recurrence would carry a significant chance of a serious adverse outcome. The term includes the loss of a limb or function. An employee of a medical facility must report "sentinel events" to the facility's patient safety officer within 24 hours. Subsequently, within 13 days, the patient safety officer must report the date, time, and description of the sentinel event to the Health Division. Medical facilities include hospitals, obstetric clinics, ambulatory surgery centers, and independent centers for emergency medical care.

Medical facilities must also notify patients affected by a sentinel event within seven days. However, the notification cannot be considered an acknowledgement or admission of liability.

To the extent of legislative appropriation and authorization, the Health Division must safely and confidentially maintain reports of sentinel events. The Division must also contract with a quality improvement organization to analyze and report trends regarding sentinel events. If the Health Division receives notice from a medical facility that it has taken corrective action to remedy the causes or contributing factors of a sentinel event, the Division must make a record of the information and ensure that the information is aggregated and does not reveal the identity of the person or facility.

In addition, the information concerning corrective actions must also be forwarded to the quality improvement organization. The findings of the organization regarding its analysis of aggregated trends of sentinel events must be forwarded to the new Repository for Health Care Assurance. To the extent of legislative appropriation and authorization, the Repository serves as a clearinghouse of information relating to aggregated trends of sentinel events. Assembly Bill 1 specifies that no report, document, recommendation, or any other material compiled pursuant to the reporting of sentinel events is admissible as evidence in any administrative or legal proceeding.

Patient Safety Plans and Committees

Further, Assembly Bill 1 requires medical facilities to develop internal patient safety plans in consultation with licensed health care professionals at the facility, which must be submitted for approval to the facility's governing board. Compliance with the plan is a condition of employment at the facility. Medical facilities must also establish patient safety committees to meet monthly. Each committee must receive reports relating to patient safety, make recommendations to reduce the number and severity of sentinel events, and report quarterly to the facility's governing body regarding the number of sentinel events and any recommendations to reduce the number and severity of such events.

No person involved in the reporting, transmitting, or compiling of information concerning sentinel events is subject to any criminal penalties or civil liability if the reporting, transmitting, or compiling is made without malice.

Whistle-blower Protections

Finally, Assembly Bill 1 includes "whistle-blower" protections for employees of medical facilities, physicians, and osteopathic physicians who report either: (1) a sentinel event to the Health Division; or (2) grounds for initiating discipline or information that raises questions regarding a physician's competence to a physician licensing board. The bill prohibits the medical facility or physician from retaliating or discriminating against an employee for these actions and from restricting the rights of an employee to make these reports or participate in any related investigation.

An employee of a medical facility who believes he has been unlawfully retaliated or discriminated against for making these reports may file an action in court for appropriate relief.

Effective Date

The majority of this measure is effective on October 1, 2002, while the medical error reporting provisions are effective on July 1, 2003.

Background Information

The State of Nevada is experiencing extreme difficulties attracting and maintaining a sufficient network of physicians to meet the needs of the residents of this state due to the escalating cost of obtaining professional liability insurance. The Governor of Nevada called a special session of the Legislature after it was determined that the shortage of physicians and the inability to attract new physicians to this state posed a serious threat to the health, welfare, and safety of the residents of the state. Subsequently, the Legislature enacted provisions to increase the availability and affordability of malpractice insurance while safeguarding the rights of patients and relatives to seek compensation for medical injuries.

Excerpts from the Senate Journal
Remarks and testimony
-- selections by Research Library staff

THE SECOND DAY

CARSON CITY(Tuesday), July 30, 2002

Senator Raggio moved that the Senate resolve itself into a Committee of the Whole for the purpose of considering Senate Bill No. 2.

Motion carried.

IN COMMITTEE OF THE WHOLE

At 8:11 a.m.

Senator Raggio presiding.

Senate Bill No. 2 considered.

The Committee of the Whole was addressed by Senator Raggio; Governor Kenny Guinn; Jan Needham, Principal Deputy Legislative Counsel; Bradley A. Wilkinson, Principal Deputy Legislative Counsel; Scott Young, Principal Research Analyst; Maury Astley, Executive Director, Nevada Dental Association; Robert Byrd, Chairman, Medical Liability Association of Nevada; J. R. Crockett, Jr., Nevada Trial Lawyers Association; Michael Daubs, M.D., Concerned Physicians of Nevada, Nevada Orthopedic Society; Denise Selleck Davis, Executive Director, Nevada Osteopathic Medical Association; Gus W. Flangas, Attorney, Physicians Task Force; Gerald Gillock, Nevada Trail Lawyers Association; David P. Haefner, Nevada Association of Nurse Anesthetists; Lonnie Hammergren, M.D., Neurosurgical Associates of Nevada; Ron Kendall, Patient, Carson City; Richard J. Legarza, General Counsel, Nevada State Board of Medical Examiners; Larry E. Lessly, Executive Director, Nevada State Board of Medical Examiners; Dan McBride, M.D., Nevada Mutual Liability Company; Robert McBeath, M.D., Nevada Medical Liability Physicians Task Force; Alice Molaky-Arman, Commission of Insurance; Jerry H. Mowbray, Attorney; Nancy Peverini, Legislative Counsel, Consumer Attorneys of California; Janice Pine, Saint Mary's Health Network; Jim Wadhams, American Insurance Association; Charles (Chip) Wallace, Nevada Mutual Insurance Company, Communications Director/cofounder; Bill M. Welch, President, CEO, Nevada Hospital Association.

Senator Raggio requested that all remarks on Senate Bill No. 2 be entered in the Journal.

SENATOR RAGGIO:

This committee will come to order. This is the Committee of the Whole, all Senate members participating, and today, the committee will continue its deliberations on Senate Bill No. 2. Our first order of business is to complete our discussion of sections 3, 4 and 5 addressing the caps on

noneconomic damages. After we have finished our discussions, we will deliberate and vote on those sections. Thereafter, the committee is going to proceed with a consideration of other sections of the bill. We posted an agenda with certain sections of the bill indicated for discussion today. If there is no violent disagreement on the rest of the provisions, we may be able to go through and consider other sections of the bill. I want to alert everyone in the legislative building that we may be able to take other sections of the bill, in addition to those designated on the agenda. I am going to ask that an amended agenda be posted indicating we will take up the issues, and in the order they will be taken up, as the committee is able to do so. I would like to utilize our time as efficiently as possible. I promise, we will not go beyond midnight tonight on any of these discussions.

I also want to commend the committee for the healthy, bipartisan manner in which it has conducted its deliberations and encourage continuation of that spirit. I want to express my appreciation to all our colleagues for their patience and attention to what was a very long day yesterday. We face an equally demanding schedule today. We will have to complete our work as well as entertain whatever the other House sends us. I am pleased, and I hope you are too, with the progress we have made, so far, on critical issues. With your approval, we will observe the same procedures employed yesterday. We will first hear presentations on these other issues by those in support of and those opposed to specific sections of the bill. Similarly, we will allow members of the majority and minority parties, on an equal basis, an opportunity to ask questions and make statements. Again, following questions and comments from members of the committee, we will invite any public input and deliberate and vote on any item under discussion.

When we go to our deliberations, that will be an appropriate time to propose any relevant and appropriate amendments. You can offer amendments in the form you want, subject to the bill drafter putting it into language deemed appropriate for the bill. Is that understood?

Yesterday, we asked for any necessary changes and were told there were some technical wrinkles, and Mr. Bradley went through some of those. It is the Chair's understanding there are more that need to be adjusted or changed. I am going to ask that we go back to Senate Bill No. 2 and have Mr. Bradley, again, indicate the suggested changes. We have representatives of the legal and medical professions here, today, to tell us about the changes in the language they feel are necessary.

BILL BRADLEY (Nevada Trial Lawyers):

Good morning, Senator Raggio, starting with section 3, line 9, page 3, the sentence should read: Economic damages includes damages for medical treatment, care or custody, the "and" is deleted, loss of earnings, and loss of earning capacity.

SENATOR RAGGIO:

Do both parties agree to that?

JOHN COTTON (Nevada Physicians Task Force):

Yes.

SENATOR RAGGIO:

All right. Next.

MR. BRADLEY:

Section 5, subsection 1, line 14, page 3, should read, "Except as otherwise provided in subsections 2 and 3."

SENATOR RAGGIO:

Is that agreed to?

MR. COTTON:

It is.

SENATOR RAGGIO:

All right.

MR. BRADLEY:
Section 5, subsection 1, line 16, page 3, states, "noneconomic damages awarded to each plaintiff." Insert "from each defendant" after the word "plaintiff."

SENATOR RAGGIO:
Is that agreed to?

MR. COTTON:
Yes, it is.

MR. BRADLEY:
Section 5, subsection 2, line 20, should read, "subsection" then insert, "1."

SENATOR RAGGIO:
Is that agreed to?

MR. COTTON:
Yes, it is.

MR. BRADLEY:
Do you need that clarified, Senator Mathews? It will read now, "subsection 1 and 3." While we are on that line, following "3," it will read, "the noneconomic damages awarded to a plaintiff" then insert, "from each defendant."

SENATOR RAGGIO:
Is that agreed to?

MR. COTTON:
It is.

MR. BRADLEY:
On line 21, section 5, subsection 2, the sentence will read, at the end of line 20, "must not exceed," and these words will be deleted, "the greater of $350,000 or."

SENATOR RAGGIO:
Is that agreed to?

MR. COTTON:
It is.

MR. BRADLEY:
Section 5, subsection 3, paragraph (h), line 40, will read, "A case in which, following return of a verdict," and insert the language "or a finding of damages in a bench trial."

SENATOR RAGGIO:
Is that agreed to?

MR. COTTON:
It is.

SENATOR RAGGIO:
All right, next change.

SENATOR NEAL:
I have a question regarding that language. As I understand the language, "a case in which, following return of the verdict or the finding of damage in a bench trial," are you leaving the language "by the jury" there also?

MR. BRADLEY:
I asked Mr. Cotton and I think a "verdict by the jury" is probably going to make it clear that it is a jury trial. Although a verdict is returned by a jury; I think "by the jury" will make it perfectly clear. "By the jury" should remain in the bill. Let me read it again. Line 40, section 5, subsection 3, paragraph (h),

"A case in which, following return of a verdict by the jury or a finding of damages in a bench trial". The next sentence, line 41, says, "determines, by clear and convincing evidence" then add the words "admitted at trial."

SENATOR RAGGIO:
Is that agreed to?

MR. COTTON:
It is.

MR. BRADLEY:
Line 42, paragraph (h), "$350,000 for noneconomic damages is justified" delete the words "under the" and include the words "as exceptional."

SENATOR RAGGIO:
As exceptional circumstances, is that how it is?

MR. BRADLEY:
Yes.

SENATOR RAGGIO:
Is that agreed to?

MR. COTTON:
It is.

MR. BRADLEY:
Before we leave section 5, because we discussed it, last night, regarding the policy language termination.

SENATOR RAGGIO:
Before you get there, is there any other language to be added in that?

MR. BRADLEY:
Yes, that is what I will be adding based on the recommendation of the Legislative Council Bureau, but I will let them worry about where to place it.

SENATOR RAGGIO:
What is the language both of you would like to have inserted?

MR. BRADLEY:
This section is not intended to limit the responsibility of any defendant for the total economic damages awarded.

SENATOR RAGGIO:
Is the substance of that agreeable to you?

MR. COTTON:
It is.

SENATOR RAGGIO:
If that or any of these suggested changes are approved as amendments, they will be subject to whatever the bill drafters feel is the necessary way to state them. Do you understand that?

MR. BRADLEY:
I understand that, Senator Raggio.

SENATOR RAGGIO:
In other words, they may not use this exact language, but they will draft the language so it is in the proper form.

MR. BRADLEY:
My only response is, we reserve our right to comment upon it.

SENATOR RAGGIO:
Absolutely, since this is a change, we would like an explanation of the intent of the language.

MR. BRADLEY:
Under this bill, the intent is that for any award, whether by jury or judge, of economic damages, those damages that are out-of-pocket expenses: medical bills, earnings, loss of earning capacity, nursing careûthe whole gamut of expenses associated with the care of an injured personûthe defendant against whom they were awarded is responsible for that entire award. There is no cap.

SENATOR RAGGIO:
Economic damages?

MR. BRADLEY:
That is correct. If there is a substantial economic award, the physician will remain obligated or the hospital will remain obligated, to pay that award unless there is a settlement.

MR. COTTON:
Our understanding of the intent of that clause, as we discussed and negotiated back and forth on language, is that we could have a number of different maladies that people could say would or would not fall within this category. We are defining a sort of catastrophic-type loss. Our belief was that if the Legislature adopted this position, and the judge applied the very stringent standards of clear and convincing evidence, as defined by the Supreme Court in a number of cases, and also to find exceptional circumstances which has also been very strictly confined, that in those exceptional cases where there is clear and convincing evidence, the judge would have that opportunity; but it would also set a definable standard and a very strict standard, that the Supreme Court has voiced itself upon a number of occasions. For that reason, rather than trying to delineate, we felt this might encompass those odd-ball cases that might be catastrophic in their own particular facts, but not on a necessarily average basis.

SENATOR RAGGIO:
I am asking about the language you are adding. What does this do? This section is not intended to limit the responsibility of any defendant for the total economic damage award.

MR. COTTON:
That language is intended to convey the understanding that the caps discussed in section 5 would be applied to noneconomic damages, and not to the hard economic damages as defined in this act.

SENATOR RAGGIO:
Do the bill drafters, or those who are going to charged with obtaining this amendment, if it is approved, have any questions on that?

BRADLEY A. WILKINSON (Principal Deputy Legislative Counsel):
No, Mr. Chairman.

SENATOR RAGGIO:
Are there any other changes you are recommending on which you jointly agree?

SENATOR NEAL:
Last night, when we were discussing the language on line 26, after "defendant," I am wondering why they are switching that language, now, to line 40 under paragraph (h).

SENATOR RAGGIO:
I think they said they did not know where it goes properly. They will leave that up to the bill drafters to determine where it goes in the section. Is that correct?

MR. BRADLEY:
I believe Senator Neal's question is different. He is asking about per each defendant. You are asking about the long sentence?

SENATOR RAGGIO:
You said last night you wanted it to follow paragraph (h). Is that correct, Senator Neal?

SENATOR NEAL:
Right.

MR. BRADLEY:
That is correct.

SENATOR RAGGIO:
I think there were some other questions in other sections as to the proper nomenclature on the insurance coverage.

MR. BRADLEY:
That is correct.

SENATOR COFFIN:
Do we know if we have agreement with the Assembly committee, at this point, on this language?

SENATOR RAGGIO:
They spent yesterday reviewing the bill. They are going to start today.

SENATOR COFFIN:
So they have not seen any of these.

SENATOR RAGGIO:
I just talked to the Speaker on that. They are going to have to make the same case there on that side. It is my understanding that wherever there is a reference in the bill to the amount of coverage, for example, on page 10, section 18, lines 25 and 26, that should say $1,000,000 per occurrence and $3,000,000 in the aggregate.

MR. COTTON:
Yes, Senator.

SENATOR RAGGIO:
There are several places where that language is there.

MR. COTTON:
It falls on page 10 and on page 13.

SENATOR RAGGIO:
Is that the way these policies are written? Is that the language in the policy?

MR. COTTON:
That is understandable language for people in that industry.

SENATOR RAGGIO:
Brad, you understand there are several sections that pertain to the minimum coverage that is required. Is that agreed on?

MR. COTTON:
That is agreed on.

SENATOR RAGGIO:
Wherever that appears in the bill. Any others?

MR. COTTON:
That will complete it, Senator Raggio.

SENATOR RAGGIO:
Are there questions from the committee on these proposed amendments?

SENATOR O'CONNELL:
I wonder if we could ask that the minutes on this hearing be verbatim so there is no misunderstanding.

SENATOR RAGGIO:
There will be a transcript of the recording of these statements. This is rather crucial. We will have minutes that are cleaned-up verbatim which is the standard for our Senate journals so there is not any misunderstanding.

SENATOR MILBURN:
Yes, thank you, Mr. Chairman. In subsection 3, paragraph (g), I have written in there, "The case in which the conduct of the defendant is determined to constitute gross malpractice, or clear and convincing evidence." Is that correct?

MR. BRADLEY:
No, the language in that particular subsection shall remain as written.

SENATOR MILBURN:
One other question, Mr. Bradley, when you say "per occurrence," what exactly does that mean? If a doctor has a problem with something found against him, is that per organ? Is it per occurrence, or does it encompass the whole?

MR. BRADLEY:
Insurance policies are written for doctors on the basis of an occurrence being an event that may cause multiple damages; it may cause multiple plaintiffs, but it is an occurrence and all the natural consequences arising out of that claim for that occurrence. In a year, based on their policy in the aggregate, they would be covered for additional occurrences up to the $3 million. For example, if they had three, $1 million occurrences during a year, they would have no coverage left at the end of that year.

SENATOR MILBURN:
So, one incident is an occurrence?

MR. BRADLEY:
Yes.

SENATOR RAGGIO:
Let me, again, ask for an explanation from both of you as to how you understand paragraph (h) to apply as an exemption.

MR. COTTON:
My understanding is, at the conclusion, the lion's share of these cases will be jury-verdict cases as opposed to a bench trial.

SENATOR RAGGIO:
It seems a little strange that a judge in a bench trial would make an award in excess of $350,000, and then make a finding of his own. It would seem automatic that he is going to make that finding if he has heard the case and determined damages to be within $50,000. He is going to say, "The reason I did that is because there was clear and convincing evidence." It seems almost superfluous under that circumstance, but I understand why it is in there.

MR. COTTON:
It is to a degree because in some bench trials, if they have a punitive damage aspect, they will make their finding, and then make a subsequent finding. My perception is that this would fall into that same category, although, those cases are very rarely tried.

SENATOR RAGGIO:
Let us have your understanding of how this will apply and in what type of situation.

MR. COTTON:

My understanding of the way it will apply is, that by excluding paragraphs (a) through (g) type situations, should physical injury be caused by the doctor's negligence resulting in enormous damages, exceptional circumstances and there is very strong evidence that this is something other than what normal negligence could cause, rather than being capped at $350,000, the judge could determine an exceptional amount of damages out of what otherwise would be normal damages for this type of injury. But, he has to find by clear and convincing evidence, presented to the jury in the judge's hearing, that there are exceptional circumstances, which fall into the range of catastrophic-type damages. He would have to make that finding by clear and convincing evidence that exceptional circumstances existed to find catastrophic damages had occurred.

SENATOR RAGGIO:
Do exceptional circumstances refer to the conduct of the practitioner? What would exceptional circumstances apply to? This would be a case, obviously, where there was not a finding of gross negligence. What would be the conduct of the practitioner under paragraph (h) that would bring this into focus?

MR. COTTON:
It would be negligence as opposed to gross malpractice on the part of the doctor. The type of damage incurred for that particular injury would have to be exceptional damage under the circumstances of the case, such as catastrophic-type damage resulting from an injury we are unable to identify here. There are cases like that where we would have to go back and pick and choose to name the type of injury; but without regard to the conduct of the doctor below a gross malpractice, it is exceptional and catastrophic damage that incurred. The judge has to make that determination before he can exercise this.

SENATOR RAGGIO:
Even in that case, would the limitations set forth in subsection 2 still be applicable?

MR. COTTON:
The judge would still not have the ability to go above the $1 million policy of the doctor.

SENATOR RAGGIO:
For that matter, to go above the hospital's policy. Mr. Bradley, do you concur with what he said, and do you want to add anything?

MR. BRADLEY:
I would like to add something.

SENATOR RAGGIO:
Do you concur?

MR. BRADLEY:
I concur with the language.

SENATOR RAGGIO:
I do not want any misunderstanding of what is being represented to the committee. What did Mr. Cotton say that is not to your understanding?

MR. BRADLEY:
I get worried when we talk about the $1 million policy limit.

SENATOR RAGGIO:
Isn't that what it says in subsection 2?

MR. BRADLEY:
The language we should be referring to is whatever the policy limit is.

MR. COTTON:
I agree that it should be whatever the policy is.

SENATOR RAGGIO:

Whatever the policy limit is. Okay.

MR. COTTON:
I would like to defer to Mr. Crockett for a moment because he has a good point to make that should be heard.

J. R. CROCKETT JR. (Nevada Trial Lawyers Association):
With regard to this language about exceptional circumstances, I think the drafter's intention, probably, was to deal, in part, with the constitutional issues in order to avoid, at least as pertaining to this section, the contention that this law is arbitrary in setting a cap. By allowing a judge to exercise discretion in exceptional circumstances, it vents on some of that charge by allowing the judge to make a determination, in the judge's discretion, that there are exceptional circumstances. Therefore the cap might otherwise be considered arbitrary and can be avoided in this particular case.

SENATOR RAGGIO:
Does anybody disagree with any of the statements being made to this committee at this time?

MR. COTTON:
No, we do not.

SENATOR RAGGIO:
Sometime, yesterday, some enterprising legislator sent out misinformation to a number of people indicating that this committee was about to process a bill in which a judge could override the verdict of a jury. That to me is clear and deliberate misinformation. That is not what I read paragraph (h) to say. This applies only when a jury or a bench trial returns a verdict or a judgment in excess of $350,000. Otherwise, I do not read in this bill that the judge can override the verdict of a jury. I would like some comment on that.

MR. BRADLEY:
We agree with you. The only premise being that a judge can always override a jury verdict.

SENATOR RAGGIO:
That is in the Civil Practice Actlif a judge finds there was not proper evidence.

MR. BRADLEY:
Absent that circumstance, your statement is correct.

SENATOR RAGGIO:
The information was sent out, much to the chagrin of this Chairman, because everybody was asked to contact me, as if I am the person driving this train. I may be an engineer, but I am not that kind of an engineer.

MR. BRADLEY:
Senator Raggio, we know the feeling about trying to deal with misinformation.

SENATOR RAGGIO:
That is not the case, and that information should not be out there for the public. This section does not authorize a judge, in this kind of a case, to override the jury verdict. Is that understood?

SENATOR O'CONNELL:
If I can make sure I am following what this language is about, it is not the action of the doctor; it is the outcome of the procedure.

MR. BRADLEY:
That is exactly correct, Senator O'Connell.

SENATOR O'DONNELL:
Can you walk me through a normal jury instruction from the judge? In other words, I want to know when paragraph (h) is going to come into play. I need to know when the jury comes back and says, "We

think the doctor has done some kind of malpractice here, and we are going to award $1,500,000." Do they know what they are awarding? Do they know whether they are awarding noneconomic damages or economic damages, and are they instructed as to what the caps are?

MR. BRADLEY:

First of all, the jury will not be instructed about the cap. Now, let me talk to you a little about jury instructions.

SENATOR O'DONNELL:

Why?

MR. BRADLEY:

There is an agreement that if we start informing juries of certain information, then juries should be informed of all information. For example, if the claim is against the doctor, but the doctor is insured, why are we suing the doctor? Why don't we just sue the insurance company? There are many things that a jury would, probably, need to be told about. The common law in our state, for a long time has been the opposite, as is the common law in a lot of states. The jury is there to focus on the liability and damages of the case and not be distracted by collateral evidence.

SENATOR RAGGIO:

His other question was does the verdict distinguish as to what part of it is economic and noneconomic.

MR. BRADLEY:

That is up to the style of the lawyer. Let me start with the process. At the conclusion of a trial, the judge says, "I am now going to send the jury home for the night, and I and the lawyers are going to settle the jury instructions." The instructions from the judge are the law that is to be applied to the case. They are given in a series of jury instructions that are uniform in the State of Nevada. In addition to those uniform instructions, both sides are entitled to offer special instructions that detail specific areas of law in that case. Those are called the jury instructions. The jury's role is to take the facts they have listened to in the courtroom, and then take the law the judge gives them and apply the facts they heard to the law given them by the judge in the form of jury instructions. Mr. Cotton and I will argue with the judge about the instructions I want given and the instructions he wants given. After the arguments, the judge says, "Okay, I've heard enough. These will be the instructions I am giving." Those are then given to the jury.

In this particular exception, there will be no instructions given to the jury. The jury comes back with a verdict. After the verdict is returned, there will be an opportunity for both sides to file post-verdict motions. If the lawyer representing the injured person feels this is a case of exceptional circumstances and if the lawyer feels it was proven by clear and convincing evidence, the lawyer will file a motion with the judge to ask that, under that finding, the award be above the $350,000.

SENATOR O'DONNELL:

Mr. Bradley, let me tell you what my concerns are. You have a jury that is not going to be instructed with the information regarding caps. The jury is going to come back and award $1,500,000. At that point, you know that you are going to get the jury's approval for more than the cap. You are going to know that the jury, although they have not been instructed about the cap, has awarded more than, say, even the policy limits and the cap combined, $1million for economic damages and $500,000 for noneconomic damages. At that point, you are going to know you can go for moreflat that point! But if you know that you are only going to get $1 million for economic damages and, say, $250,000 for noneconomic damages, then you know it is, probably, not worthwhile going ahead for more money.

MR. BRADLEY:

I did leave one important part out. Mr. Cotton and I also argue about what the verdict form will look like. We will be saying things like, "We need to break it down into the past damages which would include past economic and noneconomic awards, and future economic and noneconomic awards." There will be several questions, perhaps, that a jury is required to ask. Did you find Doctor A negligent? Did you find Doctor B negligent? Did you find Doctor C negligent? There is rather a long questionnaire the jury will answer and fill in the blanks where they fill in the numbers.

Senator O'Donnell, in your example, where the jury awards $1million in economic damages, the case is over if the doctor's policy limit is $1 million because the way this bill is written, once the economic damages reach the defendant's policy limit, that is all the plaintiff is going to be able to recover.

SENATOR O'DONNELL:
What if it is $2 million?

MR. BRADLEY:
As long as that statement is confined to economic damages. Using your example, as long as the award is for noneconomic damages, the way the statute is written, there will never be an award of more than $1 million in noneconomic damages.

SENATOR O'DONNELL:
Are economic damages above that?

MR. BRADLEY:
Economic damages are not capped. That was the specific intent of the language we gave you. Once again, this is a mistake we are all doing, I used the $1 million, but I do not want to focus on $1 million. It is the top of the policy limit of the defendant.

SENATOR RAGGIO:
However, if the economic damages are $1 million, that amount is deducted as to any noneconomic damages, so I think you made the point. You might collect more than $1 million for economic damages. Whatever that amount is would be deducted from any noneconomic damage award under this bill. Is that correct?

MR. COTTON:
As soon as you have an economic award, that is deducted from whatever the applicable policy is. It never can go above that for noneconomic damages. If the economic exceeds that policy amount, there is no award for noneconomic damages.

SENATOR RAGGIO:
In most cases, the special verdicts of the jury will reflect which portion is noneconomic and what is economic.

MR. COTTON:
With the statute, the way it is phrased, the courts will almost be mandated to have those broken down on verdict forms.

If I could address an issue brought up by Senator O'Donnell because it is an important issue to consider. The reason you do not instruct a jury on the cap, this is a problem that has arisen in some states, is because it has been found to be, at a minimum, a partial deprivation of a person's right to a jury trial. The logic of that being if you do not tell a jury about the cap, they will come back with an award. Then the legislative determination that they can only collect so much of that award has been made by the cap. If you instruct them that the cap is there, you have created an artificial ceiling on their jury award. Now they are saying somewhere between zero to $350,000, as opposed to whatever they might decide. You are restricting it to that extent which could, at least arguably by the plaintiff's bar in some states, create an artificially low verdict and deprive them of their jury right. A constitutional infirmity could result if you give those instructions to the jury.

SENATOR O'DONNELL:
You just made the argument against the constitutionality of this bill.

MR. COTTON:
I do not believe I have. The constitutionality of the bill is public intent and public need versus the need of the individual. That is the balancing test. You need to have the jury determine an award. The question is, how much collection of the amount determined is going to be allowed by the legislature of the state after the fact. The judge is the one that ends up imposing the caps, not the jury.

SENATOR O'DONNELL:

Mr. Bradley, I read in the newspaper where someone from the other side stated this bill is challengeable. With prior knowledge, do you know of anything in this bill that is construed as unconstitutional?

MR. BRADLEY:

No, however, the last time I looked at constitutional law was 21 years ago. I do not profess or try to lead anyone to believe that my opinion is worth the two pennies I have in my pocket. I do not practice in that area. It is a very specialized area.

MR. CROCKETT:

To add to what Mr. Bradley just said, the reason why no one can prognosticate whether a law would be found constitution or not by a court is because the court looks at the entire process that led up to the culmination of the vote and passage of the law. That is never done until it is done. No one can predict that.

SENATOR RAGGIO:

Also, I think the committee should be reminded that if there is an apparent, constitutional problem or infirmity here, our legislative counsel is mandated to advise us of that. We have not received that type of advice at this point. We have not finished processing the bill, but I think we can rely on our legislative counsel for that advice.

SENATOR NEAL:

Does the phrase "exceptional circumstances" have its basis in case law?

MR. BRADLEY:

No.

SENATOR NEAL:

It is just some dreamed up phrase by you guys?

SENATOR RAGGIO:

Since we are talking about terminology, give us your definitions as to what clear and convincing evidence means and how it differs from ordinary standards.

MR. BRADLEY:

There is a specific jury instruction on clear and convincing evidence. We did not bring the definition but can certainly get it. In a civil case, the typical standard for the burden of proof, that evidence which must be accepted, is what is known as "a preponderance of the evidence." If you take the scale of balance and it tips to one side or the other, 51-49 percent, that is a preponderance of the evidence. In a criminal case it is beyond a reasonable doubt—we are much more familiar with that statement. Clear and convincing evidence is above the tipping of preponderance of the evidence but not to the standard of beyond a reasonable doubt.

SENATOR RAGGIO:

Mr. Cotton, do you agree with that?

MR. COTTON:

I do. Also with the understanding from the history of the state in the Legislature and the Supreme Court, clear and convincing evidence is the same standard of evidence that is required before a jury gets punitive damages submitted to it which is of a significantly higher standard than the preponderance of the evidence. It is not beyond a reasonable doubt but it is down to the range of, say, could-reasonable-minds-differ type category. The instruction is very specific, but it is also a very stringent standard not often applied by the courts. Anybody involved in the system knows punitive damages are not often instructed upon.

SENATOR CARE:

With the discussion about conduct and in paragraph (g), gross malpractice, and the exceptional circumstances in paragraph (h), do we all agree that this bill does not contemplate the intentional tort with availability of punitive damages? This has nothing to do with that. Is that correct?

MR. COTTON:
That is correct.

SENATOR CARE:
Paragraph (h) only applies after the jury has returned the verdict. Somebody has to file a motion, more than likely it is going to be defense counsel seeking reduction of the award to $250,000. In fact, under MICRA in California, the jury can still come back with an award of $2 million, but there is the post-verdict motion to reduce it. I gather that is when you get into this discussion.

MR. COTTON:
As a practical matter, it would be the submission of a form of judgment to the court based upon the statute. The plaintiff would then have an opportunity to object to that form of judgment depending upon their position, but that is the way it would be submitted to the court as opposed to the court having another hearing with a more evidence. That is why we inserted the words "admitted at trial," as opposed to having a subsequent hearing, more affidavits and additional evidence.

SENATOR AMODEI:
Mr. Crockett, you have been talking about the record and potential constitutional issues. In view of testimony, yesterday, you made the statement that if this is ever challenged they will look at the continuum of everything that has gone on at the south end of the building as well as here. Do you have an opinion as to what you think of the record on this issue we are now discussing, particularly in view of some fairly powerful testimony by yourself and Mr. Hardy, in terms of leaving the door open for future challenges on the constitutionality of the cap.

MR. CROCKETT:
As Mr. Bradley said, I too am not a constitutional lawyer. My last contact with constitutional law was when I was in law school. There is a template applied when the court looks at this. The template is, any time you are going to restrict the rights of individuals, the court looks to see whether or not that restriction of individual rights, ostensibly for some improvement of the general welfare, is justifiable based upon the means chosen to do it; and whether or not the means chosen to accomplish that goal had a rational relationship to the objective; and whether or not it was what they called the least-drastic means to accomplish the goal. Those are the standards, the benchmarks. I do not know what would have to be established to show that to court satisfaction. Those are the ingredients they consider.

SENATOR AMODEI:
I understand that. I just want to narrow it to what is going on here. I understand the disclaimers for the constitutional law. Yesterday, I heard some powerful testimony that said caps are a very bad thing. I heard some powerful testimony on what was wrong with MICRA (Medical Injury Compensation Reform Act) in California. Do you feel the options, as a result of the record now before us, are still fully open to challenge the cap provision on a constitutional basis.

MR. CROCKETT:
I have always placed my confidence in the same constituents that elect people to the Legislature. Those same people who elect Assemblymen, Assemblywomen, and Senators are the same people who sit on juries and decide these cases. The same wisdom they have to make intelligent choices to elect you folks to Carson City is the wisdom I trust for them to make intelligent decisions in the courtroom. Philosophically, I believe caps on damages go against the grain of letting the jury make their decision. One of the reasons the jury is not told about the caps, in these cases, is so they can make a decision and award the full range of damages to which they believe the injured party is entitled. Then a template is applied on top of that verdict by the court, after the fact, and the damages are, in fact, carved down to fit within the caps, under a MICRA system, for example. The one thing that is done here, which I believe was designed to deal with the arbitrary nature of the cap, was the opportunity to allow the court to take into consideration exceptional circumstances and say, "I know we have these caps, but in this particular

situation I believe this case is entitled to go outside the caps and be exempt from them within the limits of the insurance policy, and therefore, I am going to allow it." I think that was designed to address constitutional issues. Does it pass constitutional muster? I don't know.

SENATOR AMODEI:
As a result of your testimony, do you think your options are open to challenge this, personally? Have you no opinion, or do you think you have done the best you can to foreclose your options based upon your background on these caps?

MR. CROCKETT:
I really do not have an opinion and do not have the necessary knowledge to answer that.

SENATOR AMODEI:
Thank you.

SENATOR TITUS:
I really do not think it is fair to ask people if they think this will be constitutional in the future, for a number of reasons. The constitution is a changing document. It is fluid, which is one of the strengths of the U.S. Constitution. Secondly, the judges who will be making these decisions are sometimes unpredictable, especially when you have elected judges. You never know what they are going to do. Who would have ever guessed that Scalia would abandon his position on state's rights in the Court's last decision after the election? Finally, I think one of the relationships you have to look at when you determine whether or not this is constitutional, is whether or not the policy merited the action. We do not know if insurance rates are going to go down as a result of this policy. That remains to be determined. I think it is unfair to ask the gentlemen before us if this is going to be constitutional or not.

MR. CROCKETT:
Senator Titus, I remember when I was in grade school, we had to learn to inject the phrase "under God" in the Pledge of Allegiance because the Supreme Court decided that was appropriate. Senator Wiener will recall that too. Now, we are told to withdraw it. That is constitutional law for you.

SENATOR RAGGIO:
I want to hear from somebody representing the insurance industry at this point.

MR. BRADLEY:
The only area where we did not explain the intent is with regard to the language, "per each defendant." Is everybody clear on why that new language was inserted?

We wanted to ensure that these awards, against the defendants, apply to each defendant in the action. If there is one health-care provider there will be one award, but if there are two, there will be one award against each of them, assuming the jury finds them responsible in some manner.

MR. COTTON:
On that issue, this is not a change from existing law as it stands today. Multiple defendants can be joined. It does not happen often, but today, there is the ability, with basically unlimited exposure, on the part of the multiple doctors joined. This would put the cap on that multiple exposure without regard to how many defendants are joined. Each defendant would have the benefit of their cap if they chose to join multiple defendants. Basically, it is no change at all to existing law in terms of the ability to join multiple defendants.

JIM WADHAMS (American Insurance Association):
I am here today on behalf of the American Insurance Association.

SENATOR RAGGIO:
Mr. Wadhams, you have been present during most of these hearings, heard the testimony and are familiar with the contents of the bill and its status as it is now being proposed.

MR. WADHAMS:
Yes.

SENATOR RAGGIO:

The obvious question is, since this whole crisis has arisen from a lack of available, if you will, or accessible medical malpractice coverage, are you prepared to state for the insurance industry what impact, if any, passage of this measure will have on that situation?

MR. WADHAMS:

I will do the best I can to address that, Senator. As everybody in this room and everybody in this process knows, this language has been available for a fairly short period of time. In reviewing it, and to the extent we can analyze it quickly, it appears that it will have a positive impact on insurance rates. The issue of constitutionality is critical. It is possible there will be an immediate benefit, and I do not mean by the next day, but over the course of the renewal cycle there will be a slight positive benefit. It will take a period of three to five years before these cases work through the process and it can be ascertained whether or not this actually reduces the amount of money that has to be spent. Unfortunately, this has to be rough, but the estimate is it would still, potentially, improve premiums. The question the committee is discussing regarding exceptions to the cap is difficult to answer. Do the exceptions erode the rule? I am having some actuaries analyze it, but it appears this would improve the situation in Nevada and, over the course of time, could result in significant rate improvement.

SENATOR RAGGIO:

Have you had any discussions with the companies that formed part of this group as to what the impact of a bill such as this would be?

MR. WADHAMS:

I had preliminary discussions prior to seeing the language. Now that the language is out, of course, the details have to be carefully analyzed. That process is taking place right now.

SENATOR RAGGIO:

I think the concern is we do not want to go through a procedure here, with the crisis that has been identified, and process a bill with language that has a number of exemptions from a limitation on damages dissimilar, for example, from the law that is now in California, called MICRA. To go through that process and find out it has little or no effect is wasting our time. We understand the rates are not going to go down immediately. Is there going to be any positive impact, in your opinion, within the foreseeable future, either on rate decreases, competition between insurance companies, availability of more insurance coverage and the prospect that the rate percentage of increases that have been experienced will be curtailed? I do not think anyone on this committee wants to go through this process with little or no effect as a result of our efforts.

MR. WADHAMS:

I appreciate what you are asking on behalf of the committee. Trying to make these determinations, on the spot, is difficult. In my opinion, based on my experience, this bill does improve the situation. I think you are asking for more quantification of that improvement than I am capable of giving you at this point in time. I think it improves the situation. It does add elements of predictability, which is the watchword for the insurance companies. If they cannot predict, they cannot price. This does improve predictability. Again, the discussion by the committee is what the actuaries have to assess and how the exceptions change the rule. I think there is improvement, Senator, but obviously, I cannot give you a number, say 40 percent, that this will improve rates 40 percent in three years.

SENATOR RAGGIO:

I guess it goes without saying that this is, obviously, much more than now exists because there is no cap whatsoever on noneconomic damages. That seems to be the crux of the argument. We are searching for a response that gives us reason to believe this will not be an act of no consequence.

MR. WADHAMS:

Let me say, the fact that you are placing caps in the circumstances, not in every one, there are exceptions to that, the existence of the caps gives an opportunity for negotiation.

SENATOR RAGGIO:

A cap of $1 million on noneconomic damages with a deduction for economic damages is a significant cap, is it not?

MR. WADHAMS:

It is a significant cap. The existence of the cap is itself significant. The question we are struggling with, and I think you are asking me, is can I quantify the value of the cap with the exceptions? Although, I can tell you I think it is significant and, assuming constitutionality, I think it will develop over time. However, I am afraid I cannot tell you what percentage it might be.

SENATOR RAGGIO:

When will the public see some kind of indication of a positive effect of any of this measure as a result of our efforts?

MR. WADHAMS:

That is an excellent question and slightly off the insurance subject. When physicians are comfortable and believe this has an impact, the public will see it by a decrease, or perhaps reversal, of their tendency to leave the State. That is the important issue. The physicians are asking me the same question: How much of an effect will this have and will it be sufficient? I have placed calls to try to get a more definitive answer.

SENATOR RAGGIO:

Let me follow that up with a question to the representative of the medical group regarding the opinion of Mr. Wadhams. Having heard this opinion, are you still comfortable in processing this bill with the language indicated here? Has it been discussed with those in the medical profession?

MR. COTTON:

It has, and once we got down to a bill we could present, it was also discussed with people in the insurance industry. I understand the reluctance of the insurance industry to tell you this will save 30 or 40 percent because they do not want to lock themselves in on some record on their billing. Over a period of time, we are hearing numbers in that range, with no final quantification determined until they can factor it into their computer program as to how much money they can make or lose on the deal.

Mr. Byrd, from the state-owned companies, indicated that in the next several months there might be an immediate drop for doctors and a long-term drop. When we start hearing this from several different sources in the insurance industry and re-insurers, this bill with caps on doctor's exposure will encourage re-insurers to come back into the State. It is much more palatable to re-insurers to come into a smaller state, such as Nevada, where they do not have so much risk to spread out like they do in southern California. We feel it will have a significant impact on premiums.

SENATOR RAGGIO:

Specifically, do members of the medical profession health provider groups that you represent understand this will, at best, likely take three to five years for these reductions to occur or, at least, a lessening of the percentage of increase in premium?

MR. COTTON:

From discussions we have had, it is understood there will be a short-term, small fall and several years will pass before the full impact will be felt. A large proportion of the doctors I represent are people committed to this community and willing to tough out a short period of time if there is a light at the end of the tunnel. I am running into problems persuading people to stick around if there is no light at the end of the tunnel. That is the issue right there. In my opinion, a lot of people will be sacrificing for a couple of years because of a long-term benefit and ability to stay here. I think that is the incentive we have in the bill.

SENATOR COFFIN:

I am prohibited from selling casualty products including medical malpractice of any kind. I do have experience in the business and know what you are trying to get at, and perhaps, this will help bring out better answers. My experience is that you cannot see an immediate drop because:

1. This bill is not retroactive. There are a lot of cases in the pipeline that will take years to resolve, and we do not know what the judgments will be. That is important because one of the factors companies base rates on is experience. Therefore, they will look at their experience and say, "Where are we with claims paid? We still need 'x' dollars of premium to help keep us from losing money, so we will keep our reinsurance companies interested in rewriting or backing us up on the book of business rewrite at a retail level."

2. There is light at the end of the tunnel for all physicians on this type of thing because there will be an expectation of some change. It will not happen for all doctors immediately. I might be wrong, and tell me if I am, but it seems to me that if a new doctor comes into practice with no cases, but is capable and goes into a profession of medium risk or high risk, he will probably get a lesser rate than the doctor in practice now if he is rated less, simply, because he had no malpractice claims against him. The new caps will apply to those people; therefore, recruiting doctors will be easier.

There are many elements in forming rates. Do not expect miracles, especially in high-risk areas that have claims pending, and those expecting to have claims pending within the tail of their lifetime contract. I am trying to shed some light on it, bearing in mind I do not practice this just as the lawyers do not practice constitutional law. This is along the same sort of caution Senator Titus brought up on the constitutional question. For some there might be benefit, for some there might not. A company will look at its total number of physicians and say, "Well, we are going to get a bunch of new physicians. They are not going to get claims, or maybe, they are going to get lesser claims." That could adjust the premium downward. It is looking at a rate manual and then deviating from it. They cannot give you an answer, today, but they can give you a probable answer. They cannot give you an exact answer. We would be foolish to expect an exact answer.

SENATOR CARE:

Mr. Wadhams, we have heard there are doctors who have never been sued, or are with groups that have never been sued. Cardiologists come to mind. I have a good friend who is a cardiologist who, until a month ago, was not affected by this crisis. It seems to me, with the immediate passage and enactment of this statute, those doctors who have never had a claim filed against them might see some immediate relief. I am confused at how premiums are figured when you have a doctor who has been sued several times, and then another doctor who has never been sued. I would like to know whether there would be a way to reassure a doctor who has never been sued that there would be an immediate benefit from this. Is that even possible?

MR. WADHAMS:

The physician community's risk is blended among physicians only. One of Nevada's problems is it is not only a small state but has relatively few physicians. It has been identified that we are 47th in the country, which is at the low end of physicians-per-population. What I mean by that is, we have relatively few physicians, and, if you take a specialty, it is even smaller. Clark County may have a total of 2,700 physicians; therefore, the dollar impact of medical malpractice claims and settlements is spread over a very small base. Senator Coffin is correct because we write claims-made policies in professional liability, as opposed to occurrence policies as we do in auto insurance. New practitioners will have a period over which their premium will go up because they have no activity for which a claim might be filed in their first year of practice. It is also correct, as Senator Coffin points out, that insurance companies are based upon experience. When we make a change, as is contemplated here today, it is not only going to be dependent upon the intent of the lawmakers making that change, but the actions of the judges in interpreting those changes. Until that shakes itself through the system, nobody will be able to predict how this will work in terms of the actual variation it might cause. From my experience in watching the insurance industry over almost 30 years, this is a risk improvement and should have some significant benefit. I am having a difficult time, and have had for the last several months, trying to get any quantification of that because the individual factors being considered by the committee are not separately identified. In discussing this with the physician community, it is understood that it will take time to see how judges interpret it and whether or not it is constitutional. I wish there was an easier answer but rates are based upon past experience, and until that past experience develops, one cannot have complete confidence to say rates will go down 30 or 40 percent.

We are talking about a static environment. I know all the legislators have been reading the paper about the economy. Depending upon the economy, this thing could change quickly either direction. If the economy gets worse, the situation may not improve. We have to look at this assuming everything else stays the same. I think this legislation improves the risk characteristics and gives some predictability. At this point, until I get more specific advice from individual insurance companies, I cannot give you a quantification of that. They would not be able to guarantee it until they see how it plays out.

MR. BRADLEY:
In anticipation of some of these questions, we provided an additional packet of documents, which are on your desk. These articles framed this debate. Many of you have heard us say and read in the newspapers, that we have a different opinion and believe it is closely tied to the economy. It is closely tied to the poor decisions made with respect to St. Paul. St. Paul was a huge contributor, which is the reason the Governor initiated an action against it. These articles help in framing the debate with respect to this issue.

MR. BRADLEY:
The last point I will make, as many of you are aware, is a much more prominent problem in southern Nevada. Northerners are not seeing the same instances by a long stretch.

SENATOR RAGGIO:
I am going to take some questions from those who have not previously asked any questions first.

SENATOR O'DONNELL:
Mr. Wadhams, if paragraph (h) was taken out of the bill, would that give you more encouragement in terms of reduction of premiums and payouts? Would it make it a little less onerous on insurance companies?

MR. WADHAMS:
Let me answer the first part of the question. Onerous is really not the issue. The issue is what they are going to have to pay. I think the simple answer is that if paragraph (h) was not there, it would be less of an exception to the rule of a cap. Intuitively, common sense would indicate that it would improve somewhat. I have listened Mr. Cotton and Mr. Bradley debate this, and Mr. Cotton has a great deal of experience. At this point in time, I am persuaded that the standards will not automatically be met immediately, and in the process of litigation that exception does not "eat" the rule, so to speak. The simple answer to your question is if that exception were not there, it would be one less exception to the rule.

SENATOR O'DONNELL:
Then the premiums would go lower.

MR. WADHAMS:
The tendency to improve the premium would be greater; that is correct, Senator.

SENATOR O'DONNELL:
Mr. Cotton, you are a defense attorney as well as a plaintiff attorney. Why did you acquiesce and agree to paragraph (h)?

MR. COTTON:
This is somewhat tied to the question asked of Mr. Wadhams. If I took out paragraphs (a), (b), (c), (d), (e), (f), or (g), it would have an impact on premiums. There is somewhat of a balance or tradeoff on constitutional issues and how you deal discriminatorily with people who have had catastrophic damages. You could have a situation where a person has an injury that is not organic brain damage or hemaplegia, but could result in catastrophic damages that could attack this act. The overall effect is that 95 percent of cases are not going to fall into that category or any of those categories. The fact remains there may be a claim out there that would subject this act to a constitutional challenge. I hate to think that whatever we end up with would be meaningless because we left in an exception that the one-percent case was be able to knock out the entire effect of what good we are trying to do. My concern in not having it in there is that it would subject us to greater attack on constitutionality. I happen to believe the way the act is

constructed, today, will withstand any constitutional challenge submitted to the Supreme Court, particularly with all the evidence submitted to the committee. The dramatic need in this State has been outlined, and I think it will be more than enough for the Supreme Court to sustain it.

MR. BRADLEY:

On the predictability issue, we are talking about a policy limit. As you know, we have maintained from the beginning that the policy limit is the cap, and has always been the cap. Paragraph (h) still deals with the policy limit, therefore, we have not changed the predictability issue here.

SENATOR O'DONNELL:

It does make it a bit more constitutional.

SENATOR WIENER:

Mr. Wadhams, I listened to the language used in your explanation of the hesitancy of the insurance industry to come forward with some statistics and predictions. I heard concern in your response regarding constitutionality, which has been voiced by both the panel and witnesses. I am concerned, as you said, that we will wait and see on constitutionality if it, indeed, becomes the policy or practice of a conservative industry. We are going to wait and see until it either does or does not happen, which may stand in the way of reducing premiums earlier. With the wait-and-see approach, rather than experience, there may be more time that passes before there may be a reduction of premiums based upon what we do here today. Can you respond to that?

MR. WADHAMS:

With permission from the Chair, I need to back up a bit to make sure I answer that question with the right background. At the Governor's hearing on March 4, 2002, the insurance companies indicated they were not interested in doing business in Clark County anymore because it is not predictable. It is like saying, I want to buy a house but do not know the price. You need to know the economics before you make commitments. It is just that simple. What you are attempting to do here is establish some economic parameters. It is not black and white. If it was legislated, the cost of construction would be reduced 80 percent, I could tell you with some certainty that your fire-insurance policy would go down. There are a lot of variables in liability insurance that are not directly related to what happens. It is how it is interpreted. It is the skill of the lawyers involved on that particular case.

Constitutionality is an issue. You have heard arguments that this is probably constitutional or might be, but until the Supreme Court makes that decision, we will not know. The issue with which I think the committee is struggling is: Is the improvement of the situation sufficient for the action being taken? Fortunately, I do not have to answer that question, you people do. However, I am comfortable in advising you, that this is an improvement in the situation because, until the economics begin to manifest themselves, there is no guarantee of how much relief or improvement will occur.

SENATOR SHAFFER:

Mr. Wadhams, there have been rumors that the Governor, depending upon passage of this proposed legislation, intends to direct the insurance commissioner to direct the providers to reduce their premiums by 25 percent. Being a previous insurance commissioner, can you comment as to whether or not that is realistic?

MR. WADHAMS:

Some of you have served in this body long enough to remember the passage of Senate Bill No. 220 when the Legislature rolled back auto insurance rates 20 percent across-the-board, which was declared unconstitutional. I am not saying this to challenge the issue, but this is a voluntary marketplace. Just as physicians cannot be forced to stay here, or lawyers for that matter, insurers are a business and here to make a profit. If they cannot make a profit, they will not be here. Therefore, rolling back rates is not appropriate. What you have in this law, and several members serve on the Commerce and Labor Committee, is rate regulation. I am absolutely certain the Governor will direct the insurance commissioner to evaluate the rates of each insurance company to make sure they are not excessive. It is possible some pressure could be brought, but basically, you cannot change the economics. You have to

see what they are. You must find out how much the house is worth before you decide whether or not you can buy it.

SENATOR RAGGIO:

Is it foreseeable, in any way, that insurance policies will be written excluding coverage for noneconomic damage?

MR. WADHAMS:

Those policies would not be approved for sale in the State, and quite frankly, I would be an expert witness saying it is inappropriate.

SENATOR COFFIN:

In 1989, the Legislature yielded to the temptation and passed Senate Bill No. 220 which fooled the public because it ended up, as I said at that time, being unconstitutional to mandate a lower rate. We cannot fool the doctors and the public saying this will lower their rates immediately. It will find its water level.

SENATOR MILBURN:

Mr. Cotton, regarding the testimony of the three to five year predictability that insurance rates would go down if all is well, how does that address our immediate need in southern Nevada regarding doctors who cannot wait three to five years, even though they see the light at the end of the tunnel.

MR. COTTON:

I cannot address the ones who cannot wait that long. The doctor's group, as a whole, indicated to me that there are significant numbers of doctors who, rather than leaving the state, would prefer to stay here. If they have a light at the end of the tunnel, they will do so. Part of the problem with large rates is the switchover from existing companies and doctor's having to buy tail coverage. They will have a one-time hit and have to absorb it, but if they see their experience change and exhaust the risk on their tail coverage, after the three to five year timeframe, this is when their premiums will start dropping.

If insurance companies have the ability in a noncatastrophic case to limit noneconomic damages to no more than $350,000, they will have a benchmark on which to draw the line. Today, it is unlimited, and they have nothing on which to base it. It is a floating number. Practically speaking, insurance companies are going to set rates high to protect themselves when they quote premiums. They now have something that will cap damages, but it takes time, trying lawsuits and negotiating settlements, to obtain real life experience. The practical impact of that cap gives some basis to the insurers to, at least, adjust their computer programs to where they can make profit and make things available. Doctors are willing to "eat" the tail coverage in order to stay here if somebody is willing to support them.

SENATOR RAGGIO:

As a representative of the committee's feelings, I offer this suggestion. If we go through this process, I suggest the insurance industry make a strong effort to see if some reasonable, immediate relief could be given to some of these excessive premiums in as short a time as possible. I think it would behoove the industry to show some recognition for this effort and, certainly, it would improve the public relations of the companies. We cannot order them to do it, but I would hope they derive a clear message that if we pass this proposal, with regard to the caps, even though we are only one of 50 states and among the smaller, the insurance industry would strive to do something to show some recognition of this effort and the fact that there is a crisis in southern Nevada. I do not expect a response, but I am sending a strong message. Down the road, there may be other issues in which the insurance industry is interested, and we would like to have some faith and credit in what their efforts are to achieve a result that is in the best interest of the people of this State.

SENATOR NEAL:

We do a lot of things in this Legislature and put all kinds of presumptions into law. Could we place a presumption, as part of this particular bill, that upon passage approval, from that day forward everyone affected by it would be presumed to have a zero-based rating?

MR. WADHAMS:

No, that would just duplicate what a predecessor body did. The answer to this question is, unfortunately, a bit more complex. You have a local company that was formed by physicians. There are over 300 of them who formed their own insurance company. I cannot speak for them other than to say, obviously, their interest is in protecting themselves at the lowest possible price. They have no outside stockholders and are not beholden to anyone else. The other problem is, medical malpractice insurance is not written by State Farm and Allstate. It is written by specialty companies typically formed by doctors in other states and all they write is medical malpractice insurance. I think the critical factor the physician community is seeking is having these physician-based medical malpractice carriers willing to come in and compete for business, again, and bring prices down. At this point in time, they are not. Unfortunately, they are not even here. I am speaking on behalf of an industry that is not here.

SENATOR RAGGIO:
Counsel advises me that type of language would be outside the call of the Governor's proclamation and would not be appropriate.

SENATOR NEAL:
It seems to me it is language that could be considered to lower the prices because they are saying that past claims would not be allowed to be included in writing future policies.

SENATOR RAGGIO:
I am going to rely on counsel.

SENATOR NEAL:
I think counsel is all wet.

SENATOR RAGGIO:
Until you show me your law degree, we will accept counsel's advice. I think it would first be appropriate to entertain a motion as to the amendments that were proposed in section 5. Is anyone on the committee uncertain of that language? Senator Neal, in the motion I ask you to accept an addition in terminology acceptable to the legislative counsel. We will have an opportunity to review the amendment when it is formally submitted if the motion is adopted. If any changes are necessary we will make them. No second is necessary to motions in the Committee of the Whole.

SENATOR NEAL:
So moved.

SENATOR RAGGIO:
Is there any discussion on the motion? All those in favor indicate by saying, aye; opposed, no. The motion is carried unanimously.

Does legal counsel have sufficient information to draft that amendment subject to approval of the final version of that amendment? Are there any other amendments proposed to the bill? If not, is there a motion to approve the bill as amended?

SENATOR RAWSON:
Are you taking this part of it, or the whole bill?

SENATOR RAGGIO:
I am sorry. I am talking about a motion to adopt sections 3, 4, and 5 of Senate Bill No. 2 as amended.

SENATOR CARE:
So moved.

SENATOR RAGGIO:
Is there any discussion? All those in favor indicate by saying, aye; opposed, no.
The motion is carried unanimously.

SENATOR NEAL:
Does this mean, if we do not adopt anything else, this will become law?

SENATOR RAGGIO:

We are going through the rest of the bill and do the same thing as we have been doing with each aspect of it. When we get to the final vote, we will ask for a motion to approve the entire bill with any amendments that have been adopted to any of the provisions, unless there is another suggestion.

We will proceed next with limiting liability for acts occurring in a government or non-profit center for treatment of trauma, which is in section 1 of Senate Bill No. 2. Are representatives going to speak to this issue? I hope both the medical and legal profession are available.

MR. BRADLEY:

An issue has arisen that has forced Mr. Cotton to leave the room, and I must leave the room as well.

SENATOR RAGGIO:

Do you want us to leave the room also? Is there any testimony on section 1? We had some collateral reference to this. Can someone represent the medical and legal professions in reference to agreed upon provisions regarding the effect of this bill? Let me ask staff as to the effect of section 1.

MR. WILKINSON:

Section 1 provides a limitation on liability of $50,000 in civil damages for care or assistance necessitated by a sudden, unexpected situation or occurrence resulting in a serious medical condition that demands immediate medical attention for which a patient enters a hospital through the emergency room or trauma center. Specifically, the people rendering the care who receive that limitation from liability are a non-profit trauma center, an employee of a non-profit trauma center, a physician or dentist who renders care or assistance in a non-profit trauma center, a physician or dentist whose liability is not limited pursuant to sovereign immunity who renders care or assistance in a governmental trauma center. Exceptions to that limitation on liability are any act that occurs after the patient has been stabilized and is capable of receiving medical treatment as a non-emergency patient, and any act or omission unrelated to the original medical emergency.

SENATOR RAGGIO:

Does this apply to the $50,000 cap for an occurrence within the trauma setting? Is it a cap on both economic and noneconomic damages?

MR. WILKINSON:

Yes, that is a cap of $50,000 total, in civil damages, for any act of negligence that does not cross to gross negligence.

SENATOR RAGGIO:

It is my understanding, under this provision, that the patient must enter the hospital through its emergency room or trauma center. Is that correct?

MR. WILKINSON:

That is correct.

SENATOR RAGGIO:

Can somebody define "trauma center?" It is the understanding of the Chair that there are three hospitals designated as trauma centers in this State, and that designation occurs from a professional association.

1. A Trauma-1 Center is currently at University Medical Center.
2. A Trauma-2 Center is presently designated at Washoe Medical Center in Reno.
3. A Trauma-3 Center is designated at Fallon Hospital.

Those are the only three designated trauma centers. Under this definition, as a non-profit organization in this bill, would each of those trauma centers qualify any person practicing in that trauma setting as being covered by this cap? Would somebody respond to that question?

GERALD GILLOCK (Nevada Trial Lawyers Association):

I participated in the Governor's task force and have been active in working on some of the language of this bill. This would definitely apply to those centers. I think the trauma centers are defined statutorily by the Nevada Revised Statutes. This would expand it only to the extent that it says, specifically, "non-profit

organization." I think that was added to further define what we are discussing. Basically, this would apply to both economic and noneconomic damages.

SENATOR RAGGIO:
There would be a $50,000 liability for each defendant as long as the occurrence was within the trauma setting.

MR. GILLOCK:
That is my understanding. As you know, the municipalities have a $50,000 waiver of sovereign immunity up to that amount; otherwise, there would be complete, sovereign immunity for their actions. This puts the person rendering care in those settings in the same standing as the hospital.

SENATOR RAGGIO:
The non-profit organization language is a requisite for this cap to apply.

MR. GILLOCK:
That is correct.

SENATOR RAGGIO:
It is my understanding that if another hospital which is not now non-profit, somehow achieves the designation of trauma center, the limit on liability would not be available. Is that correct?

MR. GILLOCK:
That is my understanding as well. I imagine you would have representatives of the hospitals here to testify on this issue. In looking at this provision, the doctors have had concern over the last few months. They have talked about the trauma centers having the $50,000 cap.

SENATOR RAGGIO:
That is why this is an important part of this bill. We need to have somebody from the medical organizations and hospitals appear here before we consider acting upon it. Can you, Mr. Gillock, represent this if it was part of an agreement that was structured or negotiated between those representing the medical and legal professions?

MR. GILLOCK:
Yes, Mr. Chairman.

SENATOR CARE:
There are references on page 2, lines 14 and 21, to "in a hospital" which literally means in a hospital. Are there ever circumstances where a trauma doctor would be treating a person in a mass disaster that has been referred to another hospital, or may be treating a person in an ambulance? Does this mean, actually, physically in the hospital? I can see that argument arising.

MR. GILLOCK:
Yes.

SENATOR CARE:
On line 48, "injury so as to affect the life or health of another person," does that contemplate loss of consortium where the life or health of a third party is affected?

MR. CROCKETT:
Yes, to the question regarding the trauma center. I need clarification as to the second part of the question.

SENATOR CARE:
Line 48 states: "injury so as to affect the life or health of another person." Referring to "another person," is that limited to the patient or can it contemplate a third party, such as a spouse. Loss of consortium comes to mind.

MR. GILLOCK:
This is a provision in the past that has applied. A person would have the same cause of actions they would ordinarily have but with the limitation. There could be a circumstance, for example, where a loss of consortium or wrongful death case could result.

SENATOR RAGGIO:
We want someone from the medical profession to prevent misunderstandings between your version and theirs. We will be in recess for ten minutes.

SENATOR RAGGIO:
This committee will come back to order. In order to proceed as expeditiously as possible, representatives of the medical and legal professions, as well as interested others, need to be here during the committee meeting. I realize the other house is also holding hearings; however, we need representatives here who can speak authoritatively for each of these professions while we go through the remaining sections of the bill. Is it understood, gentlemen, that we must have your presence here. We rely upon what you have to tell us about the issue.

We are discussing section 1 of Senate Bill No. 2 that limits liability for acts occurring in any governmental or non-profit center for trauma treatment. Senator Care had asked a question, as to the definition of "reckless, willful, or wanton conduct," which would exempt them from the proposed cap; and whether the language on page 2, line 48, "result in injury so as to affect the life or health of another person," would include something like loss of consortium. The Nevada Trial Lawyers said, in their opinion, that type of issue would be included as something that would be recoverable under that language.

SENATOR CARE:
That was my question, Mr. Chairman. Also, whether the language "in a hospital" meant physically in a hospital as opposed to a patient transported to a trauma center or overflow at a trauma center.

SENATOR RAGGIO:
I would like to have further response from either the legal or medical profession as to whether that is the understanding or agreement.

MR. GILLOCK:
This section concerns reckless, willful and wanton misconduct. If a wrongful death or catastrophic claim resulted, there would be a claim by a spouse for loss of consortium. On a wrongful death, it would be loss of society, comfort and companionship the normal aspects. The cap would not apply for that conduct. That represents the understanding we had between the parties.

MICHAEL DAUBS, M.D. (Concerned Physicians of Nevada and Nevada Orthopedic Society):
I am an orthopedic surgeon practicing in Las Vegas and involved with the trauma center.

SENATOR RAGGIO:
Can you speak authoritatively for the medical profession?

DR. DAUBS:
Yes, at this time.

SENATOR RAGGIO:
Is that also your understanding of what that language encompasses?

DR. DAUBS:
The conduct deemed "reckless, willful or wanton conduct by the physician" would fall out of the $50,000 cap.

SENATOR RAGGIO:
Is there anything in section 1 that is contrary to what your representatives negotiated in putting this bill together?

DR. DAUBS:

There are two issues at the UMC Trauma Center:

1. It is a state institution and is protected under the sovereign immunity cap.

2. The majority of physicians that provide trauma care and emergency room care, as well as indigent care at UMC, are not under that cap. Therefore, it represents a disproportionate risk to the physicians who are volunteering to cover patients there.

SENATOR RAGGIO:

Would the physicians who perform in the trauma center at that hospital be under this cap?

DR. DAUBS:

When we are on the trauma call schedule at UMC, we also cover the emergency room, which means we care for any indigents who come there as well. With those patients, we still have the same disproportionate risk, and that is a concern to physicians.

SENATOR RAGGIO:

Your point is, that this section does not cover, under this cap, physicians who are performing other services, even though they might be on duty at the trauma center. If they perform an act in the emergency room outside the trauma center, they are not under this special cap and remain liable, jointly and severally, for economic damage that occurs outside. That is my understanding of the bill.

DR. DAUBS:

It is my understanding. They are not protected.

SENATOR RAGGIO:

No doctors are protected under this act for economic damages. There is no cap on economic damage in the bill whatsoever. Is that correct? They remain under the proposed bill, jointly and severally, liable for economic damage. Is that correct?

MR. GILLOCK:

Not in the trauma center.

SENATOR RAGGIO:

I know. Forget the trauma center. I am talking about outside the trauma center.

MR. GILLOCK:

You are absolutely correct. There is no cap on economic damages. This provision, giving the surgeons and doctors the same protections as UMC, does include any damages. It says "civil damages." I believe section 2 addresses the issue of a patient who comes in through the emergency room. Section 2, line 26 says, "that in good faith renders care or assistance necessitated by a sudden unexpected situation or occurrence resulting in a serious medical condition demanding immediate attention, for which the patient enters the hospital through its emergency room or trauma center, may not be held liable for more than $50,000 in civil damages." That covers both economic and noneconomic damages.

SENATOR RAGGIO:

You are saying, even though the patient comes in and the designated trauma doctor treats that patient in the emergency room, it is still covered under this cap.

MR. GILLOCK:

That is what is says.

SENATOR RAGGIO:

I do not know whether they have a separate facility for the trauma center or emergency room, or whether the designation as a trauma center covers any part of the hospital as long as it is in a trauma setting.

MR. GILLOCK:

There is a separate facility but they are in close proximity to one another and a person can walk back and forth between them.

SENATOR RAGGIO:
Your understanding is, at UMC, if a trauma physician treats a person, whether in the designated trauma area or the emergency room under a trauma setting, the physician would be protected under the cap. Is that what you are telling us?

MR. GILLOCK:
As long as the care occurs before the patient is stabilized. In other words, the limitation provided under section 2, beginning on line 34, states: "The limitation on liability provided...does not apply to any act...rendering care...: (a)Which occurs after the patient is stabilized and is capable of receiving medical treatment as a nonemergency patient."

SENATOR RAGGIO:
Or, it is unrelated to the original medical emergency.

MR. GILLOCK:
That is correct.

SENATOR RAGGIO:
That is the language in section 2 (a). Dr. Daubs, do you want to comment on that?

DR. DAUBS:
There are many questions regarding stability. I am a spinal surgeon. Many times, trauma surgeons will stabilize the patient from a life-threatening situation. The patient could then, potentially, be transferred to another hospital with a broken spine that would be cared for by me. We feel there should be a continual process of trauma care at that institution. The other point is, as a private physician, I would take care of those patients at UMC as trauma patients, but they would receive follow up care at my office. We need some type of language that follow up care would continue. Obviously, as a physician, I feel the care should be continued until the patient is stable from their injury.

SENATOR RAGGIO:
Is there some language agreeable to both professions here? Can we accommodate that concern?

MR. GILLOCK:
I can affirmatively state, Mr. Chairman, there is no language available that would accommodate that, nor was that the intent at the time we agreed upon the language. It should be very clear that this occurs to treatment rendered in a trauma unit or emergency room, to someone who is not stabilized.

SENATOR RAGGIO:
Is there a clear understanding in the legal or medical profession as to what "stabilization of the patient" means? Given the example Dr. Daubs provided, what is your understanding regarding when a patient becomes stabilized?

MR. GILLOCK:
That is a medical term, not a legal term. I believe the significance that is, generally, attached to it is they are able to maintain life functions. Their vital signs are stabilized, and they are no longer in an "emergent" situation related to the original injury. However, I do not know, I am not a doctor.

SENATOR RAGGIO:
It is the Chair's understanding that this was designed to make certain that doctors authorized to be in a trauma center come into perilous, sudden, and emergency situations where they must act quickly and make prompt decisions. Under ordinary circumstances, they do not have an opportunity to make the kind of decisions that otherwise might be appropriate. There is a reason why we are talking about trauma centers where a person must act with real dispatch and get something done quickly to save a patient. I think all of us want to make sure that kind of care is available. We do not want to pass a bill where the language is so restrictive that we are not going to be able to ensure this kind of care under those exceptional, quick and decisive types of cases. We do not want to provide a disincentive for that kind of care to be given. Therefore, we need to know this will be addressed appropriately. When I hear

"stabilization," I would like to know what the doctors intend it to mean, and where it may need to be amended in some way.

DR. DAUBS:
My goal is to keep the Las Vegas trauma center open. The treatment of a trauma patient is a team effort and multiple specialists are involved. When a patient first comes in, the trauma surgeons are on the front line to stabilize them, but there are also neurosurgeons, spinal surgeons and orthopedic surgeons. Sometimes patients can be stabilized in the first half hour or during the first 24 hours, but still be critical from a blood pressure standpoint and some other issues. However, all the other factors or injuries need to be treated.

SENATOR RAGGIO:
As a medical doctor, what is your understanding of the term "stabilization?" What does it mean in medical parlance?

DR. DAUBS:
For me, a trauma patient being stabilized means all injuries have been addressed, and not just in the first half hour or hour. It means we have addressed their fractured bone, legs, everything. I would then consider them stabilized from their initial acute injuries.

SENATOR RAGGIO:
We seem to have a difference of opinion as to what stabilization in this bill means. I would like to hear more testimony.

SENATOR COFFIN:
Is it possible this language limits extending coverage to a venue to which a patient goes, when it might be true that many trauma doctors go to the scene of an accident and begin care at that location.

DR. DAUBS:
No, not in our system.

SENATOR COFFIN:
What if a doctor goes to a scene and addresses care, perhaps in an air ambulance, and it is not known whether the patient will go to the trauma center or emergency room until they arrive there? They may go to the trauma room first and then the emergency room, or vice versa. Are these potential confusions addressing this bill?

MR. GILLOCK:
This is addressed under the Good Samaritan statute. We already have a statute in place that gives them complete immunity in those situations.

SENATOR COFFIN:
There will be no splitting of hairs in terms of where a doctor or other caregiver enters into the scene?

DR. DAUBS:
It is also my opinion that would not be a consideration. I agree.

SENATOR COFFIN:
They do not go out and sometimes come back?

DR. DAUBS:
No, our system is set up where, we think, we can treat patients better at the trauma center. It is what we call "scoop and run," where we take the patient from the site of injury to the hospital as quickly as possible.

SENATOR RAGGIO:
Is the present language in the bill agreeable to everybody? Is there mutual understanding between the medical and legal professions?

DR. DAUBS:
I would say no at this time, but I think we can get together on this and change some of the language.

SENATOR RAGGIO:
We are going to have to do it this morning.

DR. DAUBS:
I understand that.

MR. GILLOCK:
This is the first I have heard a problem with the word "stabilize." The language was obtained from the doctor's representatives and placed in this bill. This is a term of art used by the medical profession, and since I have heard it all my life, I assumed they had an idea as to what it meant. We can work on further defining it.

SENATOR RAGGIO:
I am going to ask you to do that. I do not know when you are going to do it because we need your presence here while we go through the bill.

DR. DAUBS:
In all respect to Mr. Gillock, I disagree that the medical community was involved in the language on this part of the bill. When we looked at the details on this part of the bill, there were some immediate issues that would be of concern to a trauma surgeon such as myself.

MR. GILLOCK:
Perhaps, they could give me a definition of the word "stable," and we could insert it as an amendment.

SENATOR RAGGIO:
Is there a medical definition of the word "stabilization?"

DR. DAUBS:
No, I think it is a broad term.

SENATOR RAGGIO:
If this becomes a litigated matter, will there be a question of the judge advising the jury, for example, as to what the term means? Somebody is going to have to define this term.

MR. GILLOCK:
Assuming a trauma surgeon would get sued in these circumstances, which is highly unusual, there would be a medical doctor who would testify that the patient was stable or not stable, and the next question would be to tell the jury what is meant by stable. The determination would be made at that time.

SENATOR RAGGIO:
Is there a better word or phrase than "stabilization?"

DR. DAUBS:
I am not a lawyer and do not know what would pass the test.

SENATOR RAGGIO:
This is a medical term.

DR. DAUBS:
The issue in southern Nevada is all the physicians working in the trauma center must feel comfortable that they are on an even playing field. There are physicians employed by the State, with the medical school, that are under this cap. These physicians are part of a team, and if one team member is capped and the others are not, then that is an uneven playing field.

SENATOR RAGGIO:
It is going to apply the same way. If the doctors who are employed are under the $50,000 cap, it will apply the same way for doctors who are not employed and, as I understand it, are operating as a trauma doctor in the trauma setting until there is stabilization of the patient.

DR. DAUBS:
Correct. If we use the language of stability to mean the initial trauma surgeon has stabilized the patient from a blood pressure standpoint, all the rest of the physicians involved in the care of that patient, which we would still consider as trauma care, would not be covered.

SENATOR RAGGIO:
That is correct, but that is the way the bill is drafted.

DR. DAUBS:
That needs to be addressed.

SENATOR RAGGIO:
At this point the committee understands there is not agreement between the legal and medical professions on this language in the bill. We need to have some discussion on it. We will take questions on this aspect of it.

SENATOR MCGINNESS:
Unless I am reading this wrong, line 36, page 2, talks about the limitation, "Which occurs after the patient is stabilized and is capable of receiving medical treatment as a nonemergency patient, unless surgery is required as a result of the emergency within a reasonable time after the patient is stabilized, in which case the limitation on liability provided by subsection 1 applies to any act or omission in rendering care or assistance which occurs before the stabilization of the patient following surgery." It looks to me if a patient is stabilized in the trauma center or emergency room, then you, Dr. Daubs, are required to provide surgery. It looks like you are still covered by the cap until the patient is stabilized after the surgery.

DR. DAUBS:
That is correct. That is our understanding as well.

SENATOR MCGINNESS:
I would think that should cover you through the surgery after the point of the trauma.

DR. DAUBS:
It is broad rather than narrow.

SENATOR MCGINNESS:
I thought it covers you up to that point.

SENATOR RAGGIO:
The point is in subsection 2(a), even after stabilization, the cap would apply if there is surgery required as a result of the emergency, and it occurs within a reasonable time after stabilization. That is the point Senator McGinness is making. Does that alleviate some of your concerns?

DR. DAUBS:
I think, it addresses my concerns. I guess, the word "stabilize," medically, is such a broad word.

SENATOR RAGGIO:
That seems to be the agreement unless you can give us a better word. In any case, when it comes before the court or a jury, they will determine based upon expert testimony which would come from medical providers as to when stabilization actually occurred. In the opinion of the Chair, unless you have one, I do not think we can put some other definition of stabilization into this bill. I would guess it means something different in each case insofar as the patient is concerned. There may be some things, like blood pressure, heart rate, whatever, that may be taken into consideration as to stabilization, but most

courts or juries are going to rely on what medical testimony there is as to when stabilization occurred. Am I confused?

DR. DAUBS:
Could I have just a few minutes with our legal counsel before we completely agree on this?

SENATOR RAGGIO:
As I said, we need to proceed this morning, so make some arrangement to get this done.

DR. DAUBS:
It will be done quickly.

SENATOR RAGGIO:
Other questions? Senator Titus.

SENATOR TITUS:
If there is an accident on the highway and an ambulance picks you up, how is it determined whether you are taken to the trauma center or the emergency room at the nearest hospital?

DR. DAUBS:
There are several criteria used by doctors insofar as the mechanism of injury, what the damage is, and how critically injured the patient could be. They will call one of the emergency rooms, say, Sunrise or Valley Hospital in Las Vegas, and those physicians determine whether it could potentially be a serious injury, then trauma activation occurs.

SENATOR TITUS:
Have you fallen prey to the problem of divert with all emergency rooms? Would that be a problem with the trauma center?

DR. DAUBS:
Level one traumas may be on divert for the standard emergency room patient as any other hospital, but the trauma patient will go to the trauma center.

SENATOR TITUS:
In section 5 we added, "from each defendant." Does that apply here too? Do you get $50,000 from each person who is involved, and the hospital, or is $50,000 all you can get because it is a government entity or a nonprofit?

MR. GILLOCK:
No, it would be $50,000 from each tortfeasor.

SENATOR WIENER:
I have a concern about the provision raised by my colleague, Senator McGinness, to respond to Dr. Daubs' concerns. If subsequent surgery is required, the umbrella protection extends to it. I am concerned that because the protection extends to a subsequent surgery which may be a result of the original trauma, as a safety issue for the doctor and if it is a judgment call, there may be treatment that might address the issue as well, but surgery offers the protection. The treatment may be controversial versus surgery, which would be better protection in terms of the $50,000 cap.

DR. DAUBS:
Meaning that we need to treat the patient, but not necessarily with surgery?

SENATOR WIENER:
Right, and so the protection would not follow based on the language.

DR. DAUBS:
Those are concerns that need to be addressed to make all physicians who provide trauma care comfortable so they will continue to provide volunteer services at the trauma center.

SENATOR WIENER:

May I follow up on the word "volunteer." There is language in section 1 on lines 16 and 25, "gratuitous or for a fee." I want to be clear that "for a fee" is a fee paid from the nonprofit institution to the doctor, versus a fee that may mean the patient is insured and the fee would be coming from an insurance company. I am concerned that, at some point, there may be shifting of patients to the nonprofit or vice versa. Facility shifting is a concern.

MR. GILLOCK:

The reason that language is there is to eliminate the distinction between an indigent patient and a fee-paying patient. What this section basically does is take trauma surgeons out of the litigation process because no one will take cases through the litigation process, and through court, with a $50,000 cap. This includes not only gratuitous services but services where they receive a fee and send the bill to the patient. It includes all the services that were rendered during the trauma situation. That is the reason that language is there.

SENATOR RAWSON:

I wanted to reiterate, as you get together and discuss this, on lines 36 and 37, it is pretty definable whether a medical treatment is an emergency or not. This specifically talks about whether a person can receive medical treatment as a nonemergency patient; therefore, stabilization is fairly defined in this. I would hope you would go ahead with that.

I want to raise another issue. I do not want to confuse it and realize if there is no agreement, it is an issue that does not need to go any further. We have the potential for mass casualty or mass disaster which could be anything from a plane wreck to a terrorist incident that could easily overpower our trauma room. Consequently, other trauma rooms would become involved. There is a public purpose to make quick decisions and move those patients along. I am not trying to open up the full bore of profit trauma rooms, and so on, under normal circumstances, but in the mass casualty situation, it serves a public purpose to try and move those people through quickly. I would like to throw that issue out to both sides.

SENATOR RAGGIO:

I think that is an excellent suggestion because it could occur when there is a mass, catastrophic incident, such as a terrorist attack, or something. We certainly do not want to have a law that would provide a great disincentive for specialist medical providers to deliver that kind of service on a much needed, quick-action basis.

MR. GILLOCK:

We always base the future on the past. We have had those kinds of disasters in Las Vegas on a fairly consistent basis. We had the Pepcon explosion, the Hilton hotel fire, the MGM Grand fire, and there was absolutely no litigation arising out of any of those disasters against any surgeons or medical providers. Everybody in the community recognized the situation.

DR. DAUBS:

Obviously, if we had that protection, we would like it.

SENATOR O'DONNELL:

I will bring up an issue that I brought up before. It revolves around the $50,000 cap. I heard Mr. Gillock say, no attorney would take a case with the limitation of $50,000. It would never come to court because there is a $50,000 cap.

MR. GILLOCK:

I cannot say, there is not someone out there that might take the case, but I cannot imagine a doctor in a trauma situation with this cap ending up in the litigation process.

SENATOR O'DONNELL:

Do you find that really unfair if I, or any one of my children, were in a car accident that required trauma care, and because the trauma center is located on a government facility, I would be limited to, basically, no redress? I know how much it costs to go through a trial. I think the doctors feel differently

than what you are projecting. Doctors want medical malpractice insurance because they know if they are up until two o'clock in the morning, then have to get up at six o'clock in the morning for another surgery, are working back-to-back and happen to make a mistake, they want that patient covered.

MR. GILLOCK:

I think attorneys have to make the core issue balancing the needs of the communities. I have had the unfortunate experience of holding someone's hand in the trauma center and observed the patient being cared for at lightning speed. In arriving at this provision, we basically have recognized that these doctors move quickly, and unless they do something egregious, such as being drunk or doing something reckless, careless, or wanton, which is complete lack of any degree of care whatsoever, we must consider the issue. I am opposed to any cap on damages for any reason other than when eight people sitting in that box tell me, you win or you lose, and the person is entitled to as much compensation. Yes, I find this offensive, but I think we have to balance the issue. I went to the trauma center on the fourth of July weekend and made a great deal about the fact it was not open. I thought it was a horrible thing the doctors did in pulling out of the trauma center on that weekend. In looking back, I think they probably agree with me. I think we have a real balancing situation here, and it is unfortunate when someone does not have a remedy. We have some of the best trauma physicians in the country in Las Vegas.

SENATOR O'DONNELL:

I think I will get a medical bracelet that says, "Take me to Sunrise if I have a trauma."

SENATOR COFFIN:

Using Dr. Daubs as an example, as I understand it, you are a $350,000 capped doctor when you are practicing in your office. The minute you cross the street to the trauma unit from your office, you become a $50,000 capped doctor. Correct? You are a sovereign immunity doctor as you work on that person in the trauma unit. No disputes, so far?

DR. DAUBS:

No disputes, so far.

SENATOR COFFIN:

After you have worked on this person, it may happen that you will become that person's continuing-care physician. You have done the initial stabilization and may have performed surgery or one of several surgeries to come. When do you lose sovereign immunity protection under this bill as it is written?

DR. DAUBS:

My understanding is the day the patient walks into my office for follow up, whatever it is, I am not protected. This is of concern to me because care of a patient involves not only the initial surgery and stabilization, but also care until they are ultimately stabilized or well. That is what we do.

SENATOR COFFIN:

That is what, I think you were trying to get at in your earlier statement, but I could not quite understand it so I had to put it in layman's language.

DR. DAUBS:

As a private physician, I do not have a clinic at UMC. I volunteer at the trauma center, take care of patients, and they do their follow up in my office. It is a continuation of care. That is what we do. I think continual care should be covered after developing a relationship with that patient at the trauma center. There should be reasonable continuation under the initial cap. This would not include new issues such as a hand fracture or something of that nature. Continual care is standard for any type of surgery or treatment of a patient.

SENATOR COFFIN:

That is your opinion. I think that has to be worked out then.

MR. GILLOCK:

For the record, I think we could say that would be stretching the level playing field beyond any means of reality. I do not think that was the intent of this trauma bill. The intent was not to provide a doctor

total isolation in continued care of their patients. I think, what the Senate did earlier this morning and all day yesterday, sufficiently, addresses the issue.

SENATOR RAWSON:

Just as a clarification, it seems to me that the doctor in this follow-up care is not simply held to a higher standard, he is held to a standard of prudent care of an average practitioner in that specialty, or whatever. If a bad result stems from the action during the protected phase, it seems to me that is a non-suit issue. If a bad result comes after the follow-up care, then it is that level of standard care by which he is judged. I understand his desire to do that.

SENATOR RAGGIO:

You are right on the wording at the present time.

SENATOR NEAL:

Let me ask you a non-lawyer type question, if I may. The UMC hospital doctors work in the trauma area which is sometimes extended to the emergency room. Does this cover the doctors in the emergency room, who do not work trauma?

MR. CROCKETT:

Doctors who work for UMC are covered under the government immunity cap regardless of where they are working or what they are doing.

SENATOR NEAL:

I am concerned because the language on line 21 says, "Who renders care or assistance in a hospital or a governmental entity that has been designated as a center for the treatment of trauma" that language could be interpreted to eliminate doctors who do not work in the trauma situation.

MR. CROCKETT:

No, Senator, this is considered a further refinement of that. We know from other laws that all doctors who work at governmentally owned hospitals, UMC for example, are covered by the $50,000 sovereign immunity cap. This bill further refines that and includes doctors working in the trauma center who are not necessarily employees of UMC, those doctors are going to be extended that cap too.

SENATOR NEAL:

Dr. Daubs, if this was put into effect would you anticipate private hospitals, such as Sunrise, Valley and Women's Hospital, when confronted with an emergency-type situation, would tend to refer those individuals to emergency care at UMC to avoid being sued?

DR. DAUBS:

I do not see that happening because there are so many provisions that essentially categorize a trauma patient. However, should our valley grow as large as it may, should one of the other institutions open a trauma center, it should have the same protection.

SENATOR RAGGIO:

I think that opens a good question. Why is the bill limited to a nonprofit organization if, in fact, any hospital is designated as a center of treatment for trauma in the manner in which that is designated? The bill indicates the Administrator of the Health Division of the Department of Human Resources designates it. Why shouldn't this apply to any hospital that is designated as a trauma center under that process? Why should it just be a governmental or nonprofit hospital?

DAN MCBRIDE, M.D. (Nevada Mutual Liability Company):

I am a general surgeon in Las Vegas. I was one of the first traumas surgeons in Las Vegas, trained at the trauma center, and am a TLS-certified instructor. I no longer provide trauma service at UMC; however, we are called upon regularly to provide trauma care at every other facility in Las Vegas. A gunshot patient may be brought to any hospital, not necessarily by the EMS, but usually, by somebody in a drive-by shooting or a person who is shot at home is brought by car to Sunrise, Valley or Summerlin hospitals. That person is a trauma patient and is, every bit, an emergency as if they were brought to UMC. We have no sovereign coverage for taking care of that trauma patient, but his injury is just as

severe and life threatening. We cannot transfer that patient. That is a violation of federal law. It is an EMTALA (Emergency Medical Treatment and Active Labor Act) violation. Those patients must be cared for at the facility to which they are taken under emergency circumstances. In my opinion, all provisions and coverage supplied to the trauma physicians at UMC should be applied to emergency care at any facility in the State of Nevada. That would be the case in a mass-casualty circumstances.

SENATOR RAGGIO:
That is a suggestion then. Would you go further and say whether or not the facility has been designated as a trauma center? If the injury is something that is treated in an emergency room, would it not cover almost everything? Everybody comes into the emergency room, don't they?

DR. MCBRIDE:
They come into the emergency room, but in these circumstances, we are talking about essentially life-threatening injuries. We are not talking about a bump on the head. There are some artificial distinctions being made.

SENATOR RAGGIO:
Are you saying any cases where there is life-threatening injury, until the patient is stabilized, those ought to be under the same limitation on damages?

DR. MCBRIDE:
Correct. Even if you stabilize a patient, Senator Raggio, you are not allowed to transfer that patient to the county facility. You are responsible for that patient's care at the private facility until he is discharged.

SENATOR RAGGIO:
Is this something that was discussed in the process of negotiation considered, not considered or rejected? Do you know?

MR. CROCKETT:
That is why I was a little taken aback at it being brought up at this point. This language supposedly reflects the joint consensus of opinion.

SENATOR RAGGIO:
This committee is not bound by what was negotiated. We are trying to understand what was negotiated and why this bill is balanced as it is. That is the reason for the question.

MR. CROCKETT:
I did not mean to infer, in any way, that what we said has any binding effect on the Senate. I meant to say, in terms of the negotiations that went on between the parties that were discussing the bill drafting, and so forth, and the language to be included, all those issues were discussed.

SENATOR RAGGIO:
Why shouldn't this be provided? Why should it just be limited to a governmental or nonprofit, properly designated trauma center when a similar act or occurrence in another facility under the same circumstances would not be covered? What is the distinction?

MR. CROCKETT:
The distinction was the reason for closing the trauma center to begin with, as brought up by Dr. Daubs. A doctor can be working shoulder-to-shoulder in a surgical theater alongside other doctors, some of whom are employed by UMC and are, therefore, covered under the umbrella of the $50,000 sovereign immunity. Perhaps, Dr. Daubs happened to receive a call that day to come in, and he, as a private physician, is working alongside the UMC employee, but because he happens to be a private physician, he is on an unleveled playing field, as he refers to it. He would be treated differently. Because UMC had a sovereign-immunity cap of $50,000, which Dr. Daubs did not have as a private physician. The physicians felt they would, in fact, become a deep-pocket target because they did not have the cap, and therefore, people would look to them as a source of recovery since the $50,000 sovereign immunity cap was such a discouragement to suit. The surgeons refused to return to the trauma center and allow that situation to continue. They said they could not operate under that kind of pressure and should be treated

the same as their colleagues with whom they are working who are covered by that immunity. The trauma center at the government-immuned facility was singled out for treatment to specifically address the trauma center closure.

MR. GILLOCK:

One further comment, we must remember the sole purpose for the $50,000 sovereign-immunity limitation is to protect the public funds and public treasury of the State of Nevada and taxpayers' exposure. That is why the cap is there, and the only reason it is there. It would be a total catastrophe to anybody injured to extend that coverage to private hospitals and, all of a sudden, tell private hospitals they have the same protection as tax payers and public funds. I do not think that would stand constitutional muster.

SENATOR RAGGIO:

There are compelling arguments on both sides of this issue.

DR. MCBRIDE:

In most major metropolitan areas the size of Las Vegas, there is more than one trauma unit. There may be a level-1 trauma unit, or a level-2 trauma unit. In Tucson, Arizona, I believe, there are three. One is closing, then there will be two. One is a private facility, and one is a public facility. The care given to the public is the same in both facilities. There is no distinction made about the responsibilities of a physician.

SENATOR RAGGIO:

You wanted to go further and say that even if it was not designated as a trauma center, if they are treating the same kind of life-threatening injury, it should be covered. That is moving far beyond what is in this bill.

DR. MCBRIDE:

I understand, Senator, but yes, that is my belief and my feeling as a treating physician. We are on the line no matter where we are called.

DR. DAUBS:

Trauma center physicians at UMC are private, independent contractor physicians that are not covered by the cap of the emergency room physicians. There are some trauma surgeons that also fall under the cap, but they still carry insurance because they are not quite sure whether or not they are covered by the cap and need their own protection. If you are considering extending this, there are clear definitions in the statutes that define a trauma patient; however, that is another issue beyond this.

SENATOR RAGGIO:

Could there be some further agreement between the two groups?

DR. DAUBS:

Not in my opinion.

SENATOR RAGGIO:

We will take that under consideration. Are there other questions at this point? If not, are there any others who wish to offer testimony on this issue?

BILL WELCH (President, Nevada Hospital Association):

I want to thank you for the opportunity to speak. I would like to follow up on the prior discussion. The association has surveyed its membership, and we recommend modifying the language in sections 1 and 2 by eliminating the language that specifies the protection for trauma is limited solely to non-for-profit or public hospitals. As the discussion ensued, it was clearly demonstrated that trauma-level patients are presented at any medical facility. The issues that are associated with what is addressed here will potentially apply to those facilities as well. As physicians in the community recognize they will be protected in one environment only and not in another, we may find ourselves with a shifting of medical staff, which would limit the ability of patients to access health care across-the-board and throughout the

entire community. We recommend you limit it to patients who meet the NAC (Nevada Administrative Code) requirements for trauma, which is defined in the statutes.

SENATOR RAGGIO:
Is there a precise definition of a trauma-level patient?

MR. WELCH:
Both the NAC and the American College of Surgeons are used as the standards for establishing trauma designations.

SENATOR RAGGIO:
You would recommend the cap apply in any hospital with respect to a trauma-level patient care under the same limitations that a cap would apply up until stabilization or for the exception following surgery within a reasonable period. Is that what you are saying?

MR. WELCH:
That is correct, Senator Raggio.

JANICE PINE (Saint Mary's Health Network):
In lines 26, 27, 28 and 29, it would be easy to delete certain of those words and add: "An injury to a patient meeting trauma guidelines as defined by NAC." That would cover it.

SENATOR RAGGIO:
Do you differ from the definition we talked about with regard to a trauma-level patient? Is that different language or is it a different situation?

MS. PINE:
I think "a patient meeting trauma guidelines" would probably be cleaner. There are different levels of trauma centers, and the guidelines are the same for all the centers.

SENATOR RAGGIO:
Are you saying, essentially, the same thing as Mr. Welch?

MS. PINE:
Yes, I was just trying to offer you concise language.

SENATOR RAGGIO:
Is there any other testimony on section 1 of Senate Bill No. 2?

DR. MCBRIDE:
I am president of the Nevada chapter of the American College of Surgeons. They do trauma certification across the county for all trauma centers. Mr. Welch made a point that one problem may be a reduction in hospital staff from physicians wishing to protect themselves from possible liability exposure for taking care of trauma patients. Sunrise Hospital, the largest hospital in the State with the busiest emergency room, has the lowest number of general surgeons on its staff of any major hospital in Las Vegas. There are 16 general surgeons taking call. Surgeons have dropped off from staff, resigned and taken leaves of absence, precisely, for this reason. When the trauma center closed, trauma patients were taken to every facility in the Las Vegas area. My particular group was on call for five different hospitals. We were responsible for approximately 20 percent of the trauma patients at every facility, day or night, in addition to our other patients. When surgeons drop off from staff, there are fewer physicians to take calls. The physicians remaining on call must then assume the burden of care for these patients in addition to any contractual obligations or workload they already have. They do that based on their ethics and principals as physicians. It also exposes them to inordinate risk, non-compensated risk and non-voluntary risk.

SENATOR RAGGIO:
Under the Governor's proclamation the Legislature is authorized to consider limiting liability for acts occurring in a governmental or nonprofit center for the treatment of trauma. It would appear that if we attempted to extend this to other than governmental or nonprofit centers, it would require the Governor

to issue another proclamation authorizing us to pass that kind of legislation. If the committee wants to request that, we can pass it on to the Governor, but at the present time, it is outside the Governor's call unless I am told otherwise. What is the opinion of counsel?

DR. MCBRIDE:
I agree, Senator Raggio, and I urge this committee to do just that. Trauma patients are not distinguished by what facility they are in.

SENATOR RAGGIO:
We will take that under advisement, but at the present time, I would have to rule it out of order. Is that correct?

MR. WILKINSON:
Mr. Chairman, based on our review of case law in Nevada and other states concerning the issue of the call of the proclamation, I believe that would fall within the general subject matter of the proclamation from the Governor and would not be outside the call.

SENATOR RAGGIO:
Even though it says, "occurring in a governmental or nonprofit center?"

MR. WILKINSON:
There is some discretion in interpreting specific provisions of the proclamation. There is still room for some expansion.

SENATOR RAGGIO:
We will allow the testimony then. Is there any other public testimony at this point?

ROBERT A. OSTROVSKY (Lake Mead Hospital):
Lake Mead Hospital services a lot of trauma patients. We get many gunshot and stab wound victims because of the location of the hospital. They are trauma patients. I would urge you to consider what has been proposed, today, because, as even the trial lawyers admit, trauma surgeons work at lightning speed. They do not do the kind of workups that might be expected before surgery. They make last minute, quick decisions about what body parts to treat because they seem to be the most seriously injured, bypassing what may have turned out later to be the most serious injury. Regardless of whether a physician is standing in a profit or nonprofit hospital, we believe he or she makes the best medical decisions and faces the intended risks. We support the hospital association's position. Thank you.

SENATOR RAGGIO:
Is there any more testimony?

SENATOR COFFIN:
At what point does the Good Samaritan Law begin and end? Can doctors enter an emergency room or a non-trauma center and be under the protection of the Good Samaritan Law? Does that happen? Has it happened? Do we have any case law?

MR. GILLOCK:
The county commission can declare an emergency situation, and at that point, trauma surgeons come under the Good Samaritan Law.

MR. WILKINSON:
Mr. Chairman, NRS 41.505 is a Good Samaritan statute which provides that any person licensed under provisions of chapters 630, 632 or 633 of NRS, or a person coming from another state who has an equivalent license who renders emergency care assistance in an emergency, gratuitously and in good faith is not liable for civil damages as a result of any act or omission amounting to gross negligence in rendering emergency care. That does not excuse a physician or nurse from liability for damages resulting from acts or omissions occurring in a licensed medical facility relative to a person when there is a preexisting relationship as a patient. The key there is that these are services being rendered gratuitously and in good faith. There is no payment there.

SENATOR RAGGIO:
I am not clear on that explanation. NRS 41.505 applies to a person who gives instruction or provides supervision, for example, to an emergency medical attendant or registered nurse at the scene of an emergency or during the transportation of an ill or injured person from the scene of emergency and is not liable for damages unless there is gross negligence. Is that correct? Is that what it says? What does it say otherwise?

MR. WILKINSON:
That is actually subsection 1 you are reading. Subsection 2 is the provision to which I was referring.

SENATOR RAGGIO:
You are not liable for civil damages as a result of any act or omission if it is not gross negligence in rendering emergency care or assistance. Right? To provide or arrange for further medical treatment does not excuse a physician or nurse from liability for damages resulting from acts or omissions which occur in a licensed medical facility relative to any person with whom there is a preexisting relationship as a patient, but if there is no preexisting relationship, does it apply? That is the way I read it.

MR. WILKINSON:
The other key factor is that services are rendered gratuitously. That is in subsection 2.

SENATOR RAGGIO:
Gratuitously and in good faith, right?

MR. WILKINSON:
Correct.

SENATOR RAGGIO:
It applies if a person renders emergency care or assistance in an emergency, gratuitously and in good faith, and there is not a preexisting relationship between the physician and patient.

MR. WILKINSON:
That is correct.

SENATOR RAGGIO:
Does that answer your question?

SENATOR COFFIN:
Yes it does. It means a physician is being paid to be on emergency staff without recovery. Although, I suppose if a physician happened to be on the premises or nearby, was not being paid to either be on call or part of the emergency room team, happened to be called in immediately, had no connection to the patient and was not being paid a fee, that person would be covered.

SENATOR RAGGIO:
If it meets that definition.

SENATOR COFFIN:
It sounds like it is not in this law and would need a separate law.

SENATOR RAGGIO:
Was there some other comment here, Doctor?

DR. MCBRIDE:
I need some clarification on the Good Samaritan principal. Insofar as I am aware as a physician treating emergency patients, I have never been known to fall under the Good Samaritan cap or Good Samaritan provision providing emergency services when I am called upon at an emergency-room facility. I can understand it, as extended, if I see an accident by the side of the road or witness a traumatic incident somewhere, but in the emergency room setting, as far as I am concerned, the Good Samaritan law does not apply to us. I wish it would. I would encourage this body to endorse that principal if they

would, but I do not think that provides us any protection. If it did, there would be no need for a cap at UMC on trauma surgeons because they would already be provided for under the Good Samaritan Law.

SENATOR RAGGIO:
While we are on this subject, yesterday, while the Governor was here, there was some question to which he responded that has some relationship to what we are discussing. What about physicians who provide pro bono, services without compensation, gratuitously? I do not know what setting we are referring to, but where, for example, indigent patients or something of that kind are being cared for, there was some discussion about an immunity provision. Has there been some discussion on that? Is that a situation that needs to be addressed?

DR. MCBRIDE:
I would like to expand on it a little because you brought up a very good point yesterday. Call services for surgeons or any physician are compulsory in those circumstances. We do not have the choice of not taking call in an emergency room. It is part and provision of your staff privileges. We take call at all major hospitals. When we get called on a patient to provide emergency care for them, whether it is trauma or appendicitis or whatever, we take care of them.

SENATOR RAGGIO:
Is that gratuitous?

DR. MCBRIDE:
It is gratuitous in the sense that we do not ask them whether they have insurance or cash or how they are going to pay us. We have to take care of them, by law, and we do it by ethical standards as well. We cannot transfer that patient to another facility. We cannot send that patient to the county at UMC and say, "You do not have insurance. I am not seeing you." We are responsible for taking care of the indigent. That is gratuitous in the sense that we have no contractual arrangement with them. They can pay us if they choose to pay us. Most of the time they do show up in our office for a follow up visit, and we never see them again. That is part of what we do.

SENATOR RAGGIO:
I think we were talking about a situation where there was no payment of any kind, expected or not. Am I talking about two different things?

DR. DAUBS:
I basically and completely support the provision that the Governor was talking about as far as work at a clinic where we can do pro bono work.

SENATOR RAGGIO:
You do not get paid for that, do you?

DR. DAUBS:
No, and we would completely support that.

SENATOR RAGGIO:
That would not excuse you altogether if there were gross negligence or wanton reckless misconduct.

DR. DAUBS:
No, it would not, and we would agree with that. I think it allows us, and the lawyers have also agreed on this, to go into those clinics and treat those unfortunate patients who do not have care.

SENATOR RAGGIO:
I do not think that is covered in this bill, and I do not know whether or not it is covered under the existing proclamation. I think the Governor was amenable in his remarks to adding it as a part of the call. If there is no real disagreement over it, maybe something can be done.

DR. DAUBS:
We support that.

SENATOR RAGGIO:
Is there any objection to that?

MR. GILLOCK:
I think the countless hours spent getting this to you was designed to address the issues of the Governor's proclamation.

SENATOR RAGGIO:
I understand that, but we have limited time here. This is not a rubber-stamp body.

MR. GILLOCK:
I understand. That is why I cannot understand why, all of a sudden, Dr. McBride comes in with his "doctor's hat" and says, "We want to extend this to all private hospitals." Then in come the other doctors to say, "We want to go pro bono." We have to think through this because these have ramifications on people's rights.

SENATOR RAGGIO:
In fairness, I think I raised the issue of pro bono with the Governor, yesterday, which is why I asked the question, again, today. It sounded like there was not any real type of objection to that, but he will tell us if there is.

MR. GILLOCK:
I suggest we do not jump into something that will affect a lot of rights. Perhaps it is something we should address in a subsequent session. If we get into the pro bono issue, we must ask, where does it start and where does it end? I have no problem meeting with the doctors and attempting to resolve this, but I cannot make any representations to this committee that can be done in an hour or two or eight.

SENATOR RAGGIO:
While we are on that subject, is there, now, any remaining need to address the stabilization issue, or can we act on the bill as presently written? There was some ongoing discussion about that part of the bill.

MR. GILLOCK:
From the attorney's standpoint, we can act on the bill.

SENATOR RAGGIO:
What about the medical standpoint? I think we had a fairly complete discussion about this, and I am not going to go through it all again.

ROBERT MCBEATH, M.D. (Nevada Medical Liability Physicians Task Force):
Was it something specific?

SENATOR RAGGIO:
Section 1 provides the $50,000 cap in a trauma setting until the patient is stabilized. We discussed what stabilization meant, and I do not want to go through the whole dialogue. It is something that would be determined in each case. There is a medical understanding that medical experts would testify as to when stabilization occurs.

DR. MCBRIDE:
That is correct. There is no firm rule or pattern to determine what is a stable patient. The interpretation is subjective.

SENATOR RAGGIO:
Do we need to change this language? Is this something on which we agree?

DR. MCBRIDE:
I, personally, do not believe we need to change it. I think it should be in the opinion of the experts or treating physician as to what is stable.

SENATOR RAGGIO:
Doctor Daubs, do you disagree?

DR. DAUBS:
I would like to take 10 minutes with our counsel just to clarify.

SENATOR RAGGIO:
We do not have 10 minutes. Are there any other testimony or questions on this whole issue?

SENATOR SHAFFER:
I am curious whether the physicians working in the trauma center are paid on salary?

DR. DAUBS:
Typically, as a spinal surgeon, I am not on a stipend but paid for a 24 hour period: $41 an hour for 24-hour coverage. Should a patient have insurance, they are billed for treatment.

SENATOR SHAFFER:
If the patient needs follow up at the doctor's private office, can the doctor charge whatever fee he wanted?

DR. DAUBS:
Typically, how it works in the insurance industry, if a patient is billed for surgery, the care is continued for 90 days, and there is no other fee.

SENATOR RAWSON:
As proposed yesterday, I would like to ask the parties to consider some strict definitions on pro bono regarding free work in a medical and dental public facility. Not free work done in an office, not write off or bad debt, but where there are specific free clinics set up in a public facility to handle people with no other access, and there is no intent to ever bill. A tremendous public service could be done if we could open that aspect a little bit. I would like to ask the attorneys to consider some area of that.

MR. CROCKETT:
When you say "public facility," do you mean a government-owned facility?

SENATOR RAWSON:
Yes.

SENATOR RAGGIO:
A clinic of that nature.

SENATOR COFFIN:
I have a thought regarding a person switching from one liability cap to another. In the case of Dr. Daubs, if he is on call and takes a patient with a spinal injury that is covered under the cap at the trauma center, because of political practicalities and time limits, he probably would not be protected if he treats the person outside the hospital. I am inclined to think he will not win that battle. I think a person would remain in the hospital longer, incurring larger bills because that would protect the doctor. That is what I would do. As a physician, I would not recommend discharge until I knew the person was really stabilized and ready to come into my facility. Then, of course, there would be problems with the utilization-review people and the capacity of the hospital.

DR. MCBRIDE:
To wrap this up, from our perspective, a doctor's arrangement with a patient is basically a contract. If the doctor has agreed to take care of a patient in the hospital, he or she is required by law to continue the care outside the facility until the injury or condition is treated. It is called abandonment if a doctor does not treat or see a patient.

DR. DAUBS:
Ethically, it goes beyond that. We all feel an ethical obligation to treat those patients.

SENATOR RAGGIO:
I want to clear up another issue raised by staff. I asked Scott Young to address the "stacking" issue.

SCOTT YOUNG (Principal Research Analyst):

The stacking issue goes back to a response to Senator Care's question. In NRS 41.035, the statute that provides a $50,000 immunity cap to state entities and employees of political subdivisions. There is language that says the limitation provides a $50,000 cap exclusive of interest computed from the date of judgment to or for the benefit of any claimant. The understanding amongst the staff is it has been interpreted to allow multiple claimants, or plaintiffs, to each seek potentially $50,000. In the bill, on page 2, lines 30 and 31, the language speaks of not being held liable for more than $50,000 in civil damages as a result of any act or omission in rendering that care or assistance. The clarification we are seeking is whether the parties intend, under the language in the bill, to allow the potential for multiple claimants to seek $50,000 out of any individual occurrence. In other words, the language in the bill is meant to say there can only be a maximum recovery of $50,000 for any incident regardless of the number of claimants.

MR. GILLOCK:
The way I read it, there would be a $50,000 cap for civil damages resulting from any act or omission in rendering care. Therefore, any damages would be totally limited to $50,000. It changes under the section regarding reckless, willful and wanton misconduct.

SENATOR RAGGIO:
The question is whether there could be more than one plaintiff.

MR. GILLOCK:
More than one plaintiff, then there would be more than one $50,000 cap, yes.

SENATOR RAGGIO:
You are interpreting that to mean $50,000 for each plaintiff. Is that what you are saying?

MR. GILLOCK:
Right. That is not a change in the law. That is the way the law is now.

SENATOR RAGGIO:
We want to make it clear. Is it consistent with what is in the other provision?

MR. GILLOCK:
Since we are using different language, namely benefit of any claimant in NRS 41.035, we want to be sure we are not repeating that language in the bill. By the way, the provision in the bill would also be in chapter 41. We wanted to avoid any misunderstanding or confusion, perhaps by a court, why we used the language "benefit of any claimant" in one instance and did not repeat it in the other. Perhaps it would suggest to someone that we meant to treat plaintiffs differently. I think the intention was to make it consistent.

SENATOR RAGGIO:
Is that everybody's understanding?

MR. GILLOCK:
It was supposed to be made consistent with existing law.

SENATOR RAGGIO:
Is that the doctor's understanding?

DR. MCBRIDE:
We are not attorneys and the attorney who did the negotiating is not present. I would have to defer.

SENATOR RAGGIO:
I think the way we approached the cap situation as to each defendant and each party is pretty clear on the record; however, if we are going to amend it in any way, perhaps, the language should be clearer as to intent.

We will recess until 12:30 p.m., and in that period of time, I will ask the gentlemen to get together on these issues. The Chair anticipates that we will hear from you on any issues that have been raised as to whether or not they should be included in this measure. Specifically, whether or not this committee wants

to provide immunity in the type of pro-bono situation in a public facility, i.e. a clinic of some nature, to provide immunity for ordinary negligence not amounting to gross negligence, or something of that kind. Also, whether or not the bill should be amended to have the $50,000 cap also apply in a situation where a trauma-level patient is involved whether or not it is in a governmental or nonprofit facility. The committee may have other amendments they wish to propose and you will be informed regarding it.

If there is nothing else at this time, the committee is adjourned until 12:30 p.m.

SENATOR RAGGIO:

The Committee of the Whole will please come back to order. The committee has been provided a copy of the draft of the proposed amendment to Senate Bill No. 2 adopted this morning. Let the Chair know if there are any objections to the language appearing therein. I am going to ask either Brad or Jan where the suggested language, particularly where the section was not intended to limit the responsibility of any defendant for the total economic damages that are awarded, appears. Is it subsection 4? Has the audience, or the individuals at the witness table, had a chance to look at the proposed amendment?

MR. GILLOCK:

Yes, we have, Mr. Chairman, and we approve the language.

SENATOR RAGGIO:

How about the doctors?

GUS W. FLANGAS (Attorney, Physicians Task Force):

I was just handed a copy of the language. At this time, our group is still meeting to look over the language.

SENATOR RAGGIO:

I suggest, you get it to them quickly so we can make any needed changes. We will return to our discussion.

SENATOR SHAFFER:

Have we taken care of the anesthetists in the bill?

SENATOR RAGGIO:

Anesthesiologists?They are medical doctors. Does someone want to respond to that? Are they covered under this?

MR. GILLOCK:

Anesthesiologists would be covered. Under the statute, I think nurse anesthetists are generally considered to be nurse practitioners. I know they fall under the category of a medical-care provider.

SENATOR RAGGIO:

Did that respond to your question? All right. Let us return to our discussion on limiting liability for acts occurring in a governmental and nonprofit center for treatment of trauma. Is there anything further to be brought forth on that issue?

MR. GILLOCK:

At the direction of the Chair, I prepared and submitted a proposed draft of language for pro-bono services for staff to consider should the committee decide they would like to have it in the bill. We suggest the language be put in the existing section 1of the bill.

SENATOR RAGGIO:

Please read it into the record.

MR. GILLOCK:

It says, "When a physician or dentist provides care or assistance to patients without requesting or receiving or expecting compensation or consideration for said services in a clinic or public facility, that physician or dentist shall not be liable for civil damages as a result of any act or omission in rendering that care or assistance if the care or assistance is rendered in good faith and in a manner not amounting to gross negligence or reckless or willful or wanton conduct."

SENATOR RAGGIO:

It appears to the Chair, that language would meet the outline of the discussion subject to the bill drafter putting it into whatever language they deem necessary.

SENATOR WIENER:

I have a spelling correction if I may offer it. On line 3, "libel," should be "liable."

SENATOR RAGGIO:

Senator Wiener is correct. It should be "liable." Are there any further comments from the committee?

SENATOR O'CONNELL:

I believe, and Senator Care also mentioned this, that in lieu of the word "provide," you might want to use "rendered," which is the language used.

SENATOR RAGGIO:

If we accept the idea, it should be left to the discretion of the bill drafter to put it in suitable language. Are there any other comments?

SENATOR CARLTON:

During the break, I discussed this issue with a couple of proponents. Last session, there was a volunteer doctor's bill regarding practice in a federally qualified health facility. I know some of our community health centers are "look alikes" of that. I was curious whether or not they are provided the same accord under federal torts. I also found this will still be needed because there are organizations that do not meet federal standards. I would like that question answered.

MR. GILLOCK:

I have been seeking a copy of that bill but have not received it. It is my understanding the federal mandate applies to clinics other than federally owned and operated clinics in ensuring that indigent patients receive care. I do not know the breadth of that provision.

SENATOR RAGGIO:

Are there any other comments on this? Is there any other testimony to be presented on the issue of limiting liability for acts occurring in trauma centers?

MR. FLANGAS:

I am a native Nevadan, born in Ely, raised in Las Vegas, and have been down south for many years. The trauma center in Las Vegas is extremely crucial to that entire area, not only Las Vegas, but the surrounding towns as well. As you are well aware, the trauma center closed recently due to liability issues facing doctors who essentially volunteer their time to work there. When I say volunteer, I use the term loosely because doctors are not only volunteering they are actually paying to work at the trauma center. Their premiums increase when doctors put UMC on their insurance. Because of the essential nature of the trauma center, it is absolutely crucial that they fall under the liability cap offered at UMC. One of the issues facing doctors when they work at the trauma center is they are required not only to work at the trauma center while on call but they are also required to work in the emergency room as well. This is for a 24-hour period. Any bill should not only provide protection under the cap when they are working in the trauma center on trauma cases but should extend to any cases they deal with in the emergency room, whether trauma or non trauma. Again, they are essentially volunteering and paying an increased premium to be there.

In addition, once a doctor treats an individual, either in the trauma center or emergency room, the person treated becomes the doctor's patient. The doctor has a professional obligation to continue with that treatment. Therefore, after a doctor's 24-hour period in the trauma center, he must provide follow-up care. Follow-up care may be at the hospital at UMC and may include care several weeks later in the doctor's office. It is absolutely critical the caps apply to the doctor even when doing follow-up care in his office because he did not have the opportunity to choose the patient. The doctor received the patient because he was on call at the trauma center.

SENATOR RAGGIO:

We appreciate those remarks, but as we heard earlier, this whole bill has been the subject of lengthy negotiations between representatives of both the medical and legal professions. We have discussed, in depth, the applicability of the provision in section 2 where it applies the $50,000 cap limit in a trauma situation. That limited coverage is required until the patient is stabilized or if surgery is required as a result of the emergency within a reasonable time after the patient is stabilized. That apparently was the agreement, and I do not know whether it should be reopened. Although continuing care was suggested, there is a point where we need to draw the line. I do not want to re-plow ground that has already been covered.

MR. FLANGAS:

I understand that, Mr. Chairman, but this issue is so critical to Clark County and southern Nevada. It is an issue that will eventually permeate all through the State.

SENATOR RAGGIO:

I think the bigger issue is leaving the limited liability up to the point of stabilization, or the exception I stated. The bigger question is whether or not the same limitation on liability should be extended to physicians when they deal with a trauma-level patient, if that term is understood, when it occurs in a facility or hospital not designated as a trauma 1, 2, or 3 facility. I think that is the issue we really want to address at this point. I do not want to cut you off, but we have already plowed through this, however, I welcome your comments. I hope you understand.

MR. FLANGAS:

I appreciate that, Mr. Chairman, and support what you just mentioned. Because it is absolutely mandatory that a doctor who treats a person in the trauma center provide follow-up care, we are concerned the doctor might lose protection under the $50,000 cap by later seeing the patient in his office for something that happened at the trauma center.

SENATOR RAGGIO:

The physicians who are employed otherwise are not going to be involved in continuing care, therefore, the cap does not apply, as practical matter, once they leave the hospital. I am just trying to draw a parallel to some extent.

MR. FLANGAS:

A doctor who is not part of UMC and volunteers his time at the trauma center providing essential care is required to continue that care after his term of duty. It may be a couple of weeks before the doctor sees the patient in his office.

SENATOR RAGGIO:

Are you saying the doctor should remain under the cap if he commits an act of malpractice at that point?

MR. FLANGAS:

Yes, I am concerned the cap will not apply to something that happened at the trauma center by the fact that the doctor met with the patient two weeks later in his office to provide mandatory follow-up care.

SENATOR RAGGIO:

Under this bill, even in the trauma center and after the patient is stabilized, a doctor would lose the protection of the cap.

MR. FLANGAS:

That is another thing we would like to address. We would like to remove some of the language about stabilizing and put it to "once that person receives medical treatment."

SENATOR RAGGIO:

Let me understand, are you speaking on the official position of the medical profession on this issue?

MR. FLANGAS:

That is correct.

MR. GILLOCK:

Mr. Chairman, the reason trauma surgeons ceased working at the trauma center at UMC was they considered themselves the deep pocket due to the fact other employees had a $50,000 limitation. They said, "Pass tort reform," which this body did this morning, "or we will not go back to work." The Governor, at their behest, called the session. That is the reason for this provision. I think this language was well thought out, written and rewritten, both in conjunction with their legal representatives and the bill drafters for the Governor's committee. I would be opposed to continuing it to their offices. Today is the first time I have heard it suggested.

SENATOR CARE:

What happens in the event a patient is treated at the trauma center and when the time comes for follow-up care the physician is on vacation or unavailable? Would the cap cover a substitute physician?

MR. FLANGAS:

A substitute physician would not be covered by the cap.

SENATOR CARE:

That does not make sense. Why would one physician be covered by the cap and not the other?

MR. FLANGAS:

The person who is working in the trauma center is the one at risk. The point I am trying to make is, once a patient has been treated at the trauma center, a continuity of treatment is still required. I am concerned that when a doctor does the follow-up care after treating a patient at the trauma center, he may lose his liability protection for what happened at the trauma center.

SENATOR TITUS:

When you talk about volunteering, it seems to me I read in the paper, after the trauma center closed and there was negotiation, that they paid doctors $1,000 a day or $3,000 a day or $5,000 a day just to be on call to come back to the trauma center. Where does that fit into your notion of volunteering time? I do not understand that.

MR. FLANGAS:

That is the reason I used the term "volunteer" rather loosely in my earlier comment. The doctor's contract was $39 an hour to work the trauma center, which does not cover their overhead or expenses. The doctors are not only, using the term loosely, volunteering, but they are paying an increased premium to provide service at the trauma center.

SENATOR TITUS:

This morning we put caps in place. We have never had caps before. These are $350,000 caps, which are in the middle range of 16 or so states that have caps; therefore, a doctor's liability is already capped for anything outside the trauma center. That never existed before. As I understand it, MICRA and some of the other strict tort-reform bills do not have this special provision for trauma surgeons. Are we going above and beyond with this $50,000 protection? I know it is something we need to do because we should protect the trauma center, but let us not lose sight of the things we are doing in a positive way, as opposed to saying it is not enough.

MR. FLANGAS:

The bill provides caps, but you must bear in mind the caps are on noneconomic damages. Should there be economic damages, the surgeon, doctor or physician working at the trauma center is still liable for the economic damages which may exceed his coverage. That is why we are looking to fall under the $50,000 cap offered at UMC.

SENATOR TITUS:

That is an economic and noneconomic cap of $50,000. Correct?

MR. FLANGAS:

That is correct.

DR. DAUBS:

I would like to make a few comments on that. The issue at the trauma center is that the doctors want to be on level ground with the institution and the rest of the team members with whom they practice. That remains the crucial issue for us.

SENATOR TITUS:

I agree with that and support putting the trauma doctors under the $50,000 cap, however, expanding it so far beyond the trauma situation is troubling to me. There are so many intervening variables, and when you start expanding protection to follow-up care, I do not see how you can define it as a traumatic situation. That does not seem to put you on equal ground. It seems to give you far and away more protection than anyone else.

DR. DAUBS:

Speaking as a physician, I never think of a one-time visit as treating a patient. It is treating a patient over time. Let us say a person has a broken neck. I fix them, and they leave the hospital. I do not have a decision on those patients. They are on our doorstep. We take care of them, and we should because society needs it. My concern is, if I discover something in my office that is not right, something is dislodged or there is something that I need to fix, where does that fall? It is continual care, not an isolated event. After I treat a patient, I continue to care for them. From a physician's standpoint, it is not easy to ascertain whether an event occurred when a patient is quickly treated and stabilized. That is my concern, Senator.

SENATOR TITUS:

I understand and sympathize. It seems to me, if you fixed a broken neck and the patient came to you for follow up then you saw something wrong that happened in the trauma center, you would be protected by the $50,000 cap. Would you want malpractice that occurred in follow up to be under the $50,000 cap? That is not a traumatic situation.

DR. DAUBS:

I am asking for coverage on continuation of treatment provided at the trauma center as well as possible complications. If I found the patient also had a broken arm that needed to be addressed, I think, that would still be part of it. I would not expect a separate issue to be covered.

SENATOR TITUS:

Would it be covered the way you want the bill changed?

DR. DAUBS:

I think it would cover the issues treated at the trauma center in follow-up care. We look at it as follow-up care until the patient is stable. In my mind, a patient is well at the point I can discharge him and let him lead his life. I am not a lawyer. I am telling you my concerns from my standpoint.

MR. FLANGAS:

We would also add the statute be drafted to show follow-up care must be directly related to the treatment at the trauma center.

SENATOR RAGGIO:

A suggestion was made that limited liability coverage should also be extended, whether or not it is a trauma facility, to another facility if treatment is for, what one person called, a "trauma-level patient," or in another case, a "patient meeting trauma guidelines." Do those two terms mean essentially the same? What language identifies that type of patient? Can someone give us that information? Is there an understood meaning to those terms? Should we extend this beyond designated facilities? What is the best nomenclature to use for that type of patient?

MR. WELCH:

In response to your question, there are specific guidelines within the NAC that the Bureau of Licensure, which is the administrative code, that define trauma patients. That is used by emergency medical services for the purpose of transporting patients to the most appropriate setting based upon their injury or illness.

SENATOR RAGGIO:
Do we have a definition that would be workable for these circumstances?

MR. WILKINSON:
NAC 450B.770 provides the procedures for initial identification and care of patients with traumas. It sets out protocol in steps as to when patients need to go to trauma centers and when to transport them.

SENATOR RAGGIO:
What would be the correct term, a patient meeting the trauma guidelines or something like that?

MR. WILKINSON:
It is difficult to see exactly how this should be worded. There are a number of scenarios as to types of injuries, types of motor vehicle accidents and falls. I think we could put something together using that statute.

SENATOR RAGGIO:
If we process this section, would the committee be amenable to amending the language that would apply the $50,000 cap, under the same situation, to other facilities where the physician is treating patients that meet trauma guidelines, and under the same situation whether or not we decide it is up to the point of stabilization, or whatever. What is the committee's feeling? How many would be in favor of extending it in those facilities? Let us have a show of hands, please.

SENATOR COFFIN:
I would like to know the definition of "trauma." We still have not answered Dr. Daub's problem. We are getting the cart before the horse. If we want to let others in on it, we had better make sure we know what it is. We would then be extending that definition to those physicians in their private practice.

SENATOR RAGGIO:
I want to find out whether there is an amenable committee on whatever we decide limitations are under this cap, whether to the point of stabilization or whether it goes further than that. Is there a feeling on the committee to extend it beyond facilities officially designated as trauma centers?

SENATOR COFFIN:
I would tell you maybe. I have an open mind as I told the representative from the Hospital Association. But, I want to know more about the definition of "trauma" in the statutes.

SENATOR RAGGIO:
That is just what I asked Mr. Wilkinson. So, can you give us any further definition of that?

SENATOR COFFIN:
There must be phases of trauma. Phases that are progressively less threatening where we can make a $50,000 doctor a $350,000 doctor. If I hear those things, then I can say to you, "yes, I am leaning toward the thought" or, "no, I am not leaning toward it."

SENATOR RAWSON:
I am wondering if we can provide some level of comfort in our definitions. Physicians are concerned there might be some tie to future bad results due to follow-up care. I suggest we put in the language some rebuttable presumption or clarifying language that indicates a presumption that the person was covered under the cap, unless there is a clear example of malpractice afterward. If whatever standard or legal language is used is clarified, everyone should be made comfortable.

SENATOR RAGGIO:
Are you talking about whether it goes beyond stabilization?

SENATOR RAWSON:
Yes.

SENATOR RAGGIO:
Whatever we decide on the trauma situation, how many on the committee want to consider extending it to other facilities rather than just trauma 1, trauma 2 and trauma 3 designations? How many want to

extend it to other facilities under the same conditions? Let us have a show of hands on that. Apparently, there is a majority of the committee who would want to do that; therefore, assuming we process it further, that would be included in an amendment.

SENATOR COFFIN:
That was not in the form of a motion. You were just testing the waters to go further. I may go there with you, but I still want to know what those waters are.

SENATOR RAGGIO:
I just wanted to decide how many wanted to consider it. Otherwise, we will just reject it.

SENATOR COFFIN:
Obviously, you have enough to consider it.

SENATOR RAGGIO:
Apparently, the majority wants to do that.

SENATOR TITUS:
I realize this came up when I was meeting with Assembly leadership, and I apologize for that. I would like the record to show that I object to this. I think it broadens the scope beyond what the Governor said. He said we would look at governmental entities and nonprofits, and now we are broadening it to include profits. If we cannot broaden the insurance part to look at insurance reform when all of this discussion has been about insurance and, obviously, that is a big part of the problem, I do not think we should be broadening this either without the Governor saying he will broaden his proclamation. I just want the record to show that.

SENATOR RAGGIO:
Counsel has told us that, in their opinion, this would be within the scope. If it is, that is fine.

SENATOR TITUS:
I realize that, but I object.

SENATOR RAGGIO:
Let us go to the bigger question. Are we going to change the language in section 1 to go beyond the cap applying only to the point of stabilization, or in the one exception where surgery is required as a result of emergency within a reasonable time after the patient is stabilized; or is there other language that should be added to it? We thought there was agreement between the legal and medical representatives on the language. We are now told there is not. We are going to have to make some decision if we process the bill as to whether or not to accept this language or amend it in some way. Is there a suggestion from the committee?

SENATOR RAWSON:
Can we give some level of comfort here? I think the policy as presented in the language is pretty clear-cut. They want to give the cap in an emergency situation, but at some point, it is no longer an emergency situation and normal rules should prevail. In the event there is a bad result later, can we set a higher standard or some standard that is clear and convincing that the problem developed in after care, not from initial care? Does that give any level of comfort?

SENATOR RAGGIO:
What would be your specific suggestion, if any?

SENATOR RAWSON:
I am talking about adding simple language that, in the event of future litigation arising out of this trauma situation, it would be presumed to be a result of initial trauma; in other words, under the cap unless it is demonstrated clearly otherwise, or to some clear and convincing level.

SENATOR RAGGIO:
Can counsel suggest any way to accommodate that suggestion?

MR. WILKINSON:
I believe we could draft language that would carry out the concept. I might need to talk a little more about exactly how it would work. It seems to me that you are saying in the event someone filed an action and there had been subsequent care, there would be a rebuttable presumption that the injury arose out of the original care as opposed to the subsequent care.

SENATOR COFFIN:
I think Senator Rawson said the original causation could last for years. As a layman, I think of my own experience with a fractured spine. At first you are stabilized to make sure you are alive and not bleeding to death; then your fracture is stabilized; then there is usually an operation, but not always; then you get to another point, perhaps what is called in layman's terms, the therapeutic phase. At this point you are dealing with the same original injury, but now a whole set of different decisions are made. I think I could go along with extending coverage through a period of entering into a new phase of treatment.

Dr. Daubs, in your profession, is there perhaps a term that defines a phase or change in treatment wherein a doctor might be responsible for an error made in therapy for the original injury because that injury may have been treated for years. This cannot be an open ended, forever, kind of exemption. There must be a bright-line definition somewhere.

DR. DAUBS:
I agree with you, Senator. It is not my or my colleagues' intent to not be responsible for decisions we may make later.

SENATOR COFFIN:
It is on the same injury now, the same spot.

DR. DAUBS:
I have a difficult time saying exactly what the wording would be, or with a specific time. I think if you put language that it is the original injury; I really have a hard time with that. I do not know what the legalities would be.

SENATOR COFFIN:
My back is still sore. I still need therapy.

DR. DAUBS:
I think that should not be applicable. If you just want a time, it usually takes about 3 months.

SENATOR RAGGIO:
Are we trying to say something like, "continuing care required as a direct result of a procedure that occurred in the trauma setting."

DR. DAUBS:
Yes, the incident, I guess, is the word.

MR. GILLOCK:
Mr. Chairman, the language negotiated with the doctors covers it, I believe, in section 2(a), which points out the time at which the cap no longer applies.

SENATOR RAGGIO:
What line are you on?

MR. GILLOCK:
I am on line 36. It says, "which occurs after the patient is stabilized and is capable of receiving medical treatment as a nonemergency patient." Once we have cleared the patient through the emergency, they are covered under the cap, under tort reform, that was passed earlier today.

SENATOR RAGGIO:
I understand that, but would you object to having it only apply if the occurrence was during the trauma setting and any continuing care required as a result of that procedure directly?

MR. GILLOCK:
I think it is overly broad because a lot of negligence occurs during follow up. The only exposure they would have, for example, would be failure to find an infection.

SENATOR RAGGIO:
We are trying to reach a situation in which the first priority would be to assure that capable and qualified practitioners are available to serve in trauma settings. We ought to be able to provide some assurance that even though a person reaches stabilization, he or she can still be in rather severe circumstances, and the doctor is required, ethically and otherwise, to continue the care for a period of time directly related to what occurred in the trauma setting. That is my understanding.

MR. GILLOCK:
I suggest the language be to the effect that the cap will apply to any act while treating the patient at the trauma center, even if the symptoms of the action do not appear until later. Do you see what I am saying? Maybe they have done something negligent at the trauma center that does not become visible until 6 to 8 months later. They would still be under the cap if the act occurred at the trauma center. If the patient came to their office, was injected with a dirty needle and got an infection, the negligence would have occurred at the doctor's office and would fall under the cap. If you say they are going to provide follow-up care for that condition, you have eliminated negligent acts that occur outside the emergency situation. However, if you say it occurred at the trauma center, even if the symptoms do not appear later, there is rebuttable presumption the act occurred at the hospital.

SENATOR RAWSON:
If we use the language, "rebuttable presumption," it would allow the patient, or their representatives, to prove something if it is clearly demonstrable.

MR. GILLOCK:
That would probably solve the problem. I think, we could work through it.

MR. FLANGAS:
The proposal just offered will not resolve the problem. What Senator Rawson set forward addresses the problem adequately. It protects the doctor for follow-up care and gives rebuttable presumption that says it is presumed that any injury happened while the procedure was performed at the trauma center. If it can be shown by some standard of evidence there was negligence that occurred during follow-up care unrelated to what happened at the trauma center, the physician would be under his or her own insurance and proceed accordingly.

SENATOR RAGGIO:
How would you suggest we state the rebuttable presumption if we process this item?

MR. FLANGAS:
Something similar to Senator Rawson's suggestion. You would have to put in the statute that they remain under the cap for follow-up care. I have some language that is fairly close.

SENATOR RAGGIO:
Let us try to accommodate their concerns as well as yours. Try to meet in the court with a rebuttable presumption of what? Give us some language.

MR. FLANGAS:
The language could say, "the limitation on liability provided pursuant to this section shall include all necessary and related follow-up care provided by the physician or dentist whether the follow-up care is provided at the hospital or at the physician's or dentist's office."

SENATOR RAWSON:
Can we have staff repeat the way he phrased it.

MR. WILKINSON:
I did not have this worked out exactly. I was writing, "in the event of litigation, rebuttable presumption as created that injury was a result of the original medical condition for which the person sought assistance." I am changing that slightly. I did not really finish it the first time around.

SENATOR RAGGIO:
I think what we are all trying to say is, if the original procedure occurred in the trauma center, or in a trauma setting, there will be a presumption that any damage resulting from continued care directly related to that procedure will be within the limits of liability. That is rebuttable presumption; therefore, they can rebut to show that the negligence, if it is that, was not directly related to the procedure that occurred in the trauma setting. I think that is what you are both trying to get at.

MR. GILLOCK:
I think so too; Mr. Chairman. We should simply add a sentence that, should the injury be as a result of negligence occurring independent of the original treatment, it shall not be covered by the $50,000 cap. That would cover it.

SENATOR COFFIN:
I am not an attorney or a doctor, and I do not know some of the terms you have been using.

SENATOR RAGGIO:
Rebuttable presumption means that it is presumed, in this case, if an injury occurred during continued care of a condition resulting from the original procedure, it is still covered under the cap. That is rebuttable, and they can bring in evidence to show it was not directly related to that, or something of that kind. They can rebut that presumption. They both seem to think that is adequate.

SENATOR COFFIN:
I have to think in terms of anecdotes, so forgive me for my shortcomings all you professionals. Let us suppose that John, in his practice, has got me fixed up, at least as far as my injury, and I am able to walk and do every function that was damaged to a reasonable degree. Now, we get into a therapy phase, and he provides the wrong therapy or gets me started on the wrong therapy. It is the same injury, but a different phase of treatment. Which standard should he be held to under the proposed language?

SENATOR RAGGIO:
I am not proposing the language. I am restating the language.

SENATOR RAWSON:
As I see this situation, down the road, you were reasonably comfortable, but now, you are in therapy. There is a wrong decision made and that is under the other cap. It is not under the $50,000 limit.

SENATOR COFFIN:
Even though it is the same injury?

SENATOR RAWSON:
It is the same injury, but it is a different decision process and a different phase of it.

SENATOR RAGGIO:
I will accept a motion to amend section 1 to extend the limit to other than designated trauma centers to include hospitals or facilities involving a patient who meets the trauma guidelines and to add the language establishing a rebuttable presumption for continuing care beyond stabilization or other period which is now applicable. I would accept a motion to that effect.

SENATOR O'CONNELL:
So moved.

SENATOR RAGGIO:
Is there any discussion on the motion?

SENATOR CARE:

If you are hit by a car, you can sue depending upon policy limits or whatever various amounts and damages are available. If you are hit by a cop, you are capped at $50,000. That is unfair, but that is the way it is. I understand the situation with the trauma center and have read most of the material given me, but I do not recall reading anywhere any discussion about the need to expand any trauma solution to institutions other than UMC or the designated nonprofit governmental entities that handle trauma patients. Yet, now, we have done that. If you read that in conjunction with the other part of the amendment where you get into follow up and therapy, it is not too difficult to foresee the situation where someone goes to Sunrise, Lake Meade or Valley for trauma and the doctor is covered by the $50,000 cap to include, to some degree depending on the circumstances, the follow up. I thought I knew what the agenda was going to be when I came up here, and I will tell you that it looks to me as though there is a situation happening where an entity or an interest group has decided to take advantage, spontaneously, of the situation by expanding the agenda. Frankly, before I came up here, I was disgusted by the public debate between trial lawyers, doctors and others. I pretty much tuned it out a month ago. I have seen some of it here today. I hope you all keep to the agenda as it was supposed to be and not try to slip something in that was not contemplated when the Governor originally proclaimed this special session. Thank you, Mr. Chairman.

SENATOR RAGGIO:

A good example would be someone suffering a gunshot wound. The person may not necessarily be taken to the trauma center, but may be taken to a private facility. The same $50,000 limit ought to be applicable to the doctor who treats that person under the trauma guidelines to the extent that it applies otherwise. That is where I would justify it.

SENATOR CARE:

I raised that issue this morning when I talked about the patient who is being transported. The question began when I said, are we going to stick with the language "in the hospital" because that language is specifically in section 1, twice. That is why I raised the issue. I appreciate the Chairman's comments, but it seems to me that this is an item you can legitimately raise in a regular session. It would seem to me, from what I have seen, that we have gone far a field, but I appreciate your consideration.

SENATOR RAGGIO:

Are there any other comments or discussion on that motion?

SENATOR RAWSON:

There ought to be a little closer definition of trauma designation.

SENATOR RAGGIO:

My suggestion would be, if this motion passes, that we will have the same opportunity to review the amendment as we did earlier.

SENATOR RAWSON:

The physicians may be able to help. There are level-1 and level-2 trauma centers, and from that, I would presume there are level-1 and level-2 traumas. We ought to be talking about life-threatening trauma here, really emergent trauma, not just every emergency.

SENATOR RAGGIO:

Is there a definition of level-1 and level-2 trauma?

SENATOR RAWSON:

I would be talking about life-threatening or emergent situations.

SENATOR RAGGIO:

Let us have that included in the motion. Is that satisfactory? Is there any further discussion?

SENATOR O'DONNELL:

I will support the motion; however, let me just say this, I think what we are having trouble with is the fact that we are not treating everyone equally. Under the constitution of the United States of America, everybody is supposed to be treated equally. However, if you go to a county hospital, you only get a $50,000 limitation for liability. If you go to any other hospital, you might get a $350,000 liability for pain and suffering, or beyond, depending on the extent of the injury. What we are trying to grapple with here is whether we should help the doctors or lawyers instead of helping the patient. The problem is a crisis because doctors are leaving. If we do not do something, it is going to get worse quickly. I am going to support this motion, but I would really like to address the fact that we are treating patients differently and giving them different levels of compensation for the same treatment. That is blatantly unfair and un-American.

SENATOR NEAL:

Again, as a non-lawyer speaking, as I understand the question being proposed, we are attempting to run section 2 into sections 3, 4, and 5, which we have already discussed in terms of the liability issues involving doctors. We are now trying to extend the $50,000 cap found within government hospitals to individuals that would normally have to come under the sections we have already adopted. I agree with Senator Care that we seem to have gone far a field on this particular issue. If we want to limit this to three levels of trauma, then why don't we say that, leave it at that and not try to extend this into the doctor's office or the doctor's house or places like that. We have language that was agreed to which stated clearly in section 1, line 14, "in the hospital," described in paragraph (a), and whether care or assistance was rendered gratuitously or for a fee. I think that language should be controlling, and we should not go outside of that because once we get to the point where we begin to add everything to this bill, we will be here until next week. I won't be here until next week because I am planning to leave here at the end of this week.

SENATOR RAGGIO:

The motion, as the Chair understands it, does not extend this limited liability to a setting other than a hospital. You mentioned a doctor's house, or something of that kind, but it extended it only to a hospital providing it is a patient meeting the trauma guidelines, which will appear in the amendment when it is shown to us. Are there any other comments?

SENATOR MCGINNESS:

I thought we were talking about extending this to all emergency and trauma centers.

SENATOR RAGGIO:

The bill now does that, and it would be included in the amendment that it would cover all trauma centers, and also apply to other hospitals even though they are not designated officially as trauma centers if a situation is such and the patient meets the trauma guidelines.

SENATOR MCGINNESS:

Does the motion also cover extended care being requested by the doctor?

SENATOR RAGGIO:

That is the rebuttable resumption. Yes, it is in the motion.

SENATOR MCGINNESS:

I would feel better if the two things were separated; although, I will support them. I think the language in section 1 is sort of a middle ground, and now, we are going a beyond that.

SENATOR RAGGIO:

If the Senator who made the motion wants to separate the motions, it is fine with the Chair. Senator O'Connell, do you want the motion as is, or do you want it separated? We can try the motion as is.

SENATOR O'CONNELL:
That would be my preference, Mr. Chairman.

SENATOR RAGGIO:
No further discussion. All in favor, indicate aye. Those opposed. Let the record reflect those Senators who voted no on the motion are Senators Care, Carlton, Mathews, McGinness, Neal, Titus and Wiener. The motion carries.

SENATOR AMODEI:
I would wrap up, Mr. Chairman, by saying that if we start creating different levels of immunity and excusal within health-care providing facilities within the State, you will have serious staffing problems in those that do not have them. If we are going to create them with level-1, -2, or -3 trauma centers, we have the obligation to take a look at it from an operational side and say, "What are we doing to those areas that do not have, or those facilities that are not designated a level-1, -2, or -3 center. What are we doing to those staff care providers? What are we doing in those communities? What are we encouraging them to do in order to get those potential patients to facilities that do enjoy this so they do not have to worry about that?" I think we have learned that lesson with what has gone on at UMC. That does not lead to any specific answer, but the operational concerns are something we need to think about in terms of setting the policy.

SENATOR RAGGIO:
If the motion is now part of the bill, for example, this would cover a situation at Carson-Tahoe Hospital where, if somebody came in with a gunshot wound, as I suggested, it would be covered.

JAN NEEDHAM (Principal Deputy Legislative Counsel):
As a point of clarification, we were discussing clarifying this provision to make sure the $50,000 cap was for each claimant so it would be consistent with existing law.

SENATOR RAGGIO:
Is that the understanding of everybody, for each claimant?

MR. FLANGAS:
If we are going to do what was included in the amendment, we have to rewrite the whole section because the section, the way it is written, does not limit it to trauma patients. It says all patients. You have limited the liability of all the hospitals for any patient admitted to a $50,000 cap.

SENATOR RAWSON:
No, the amendment dealt with that as a special case. The amendment, as worded, used this language and was then extended for the trauma patients in other hospitals.

SENATOR RAGGIO:
That is the intent of the amendment. I am going to ask the bill drafters to prepare a draft of the amendment and distribute it. We will consider any objection to the amendment.

SENATOR MATHEWS:
Will we have an opportunity to discuss the amendment after it is in written form?

SENATOR RAGGIO:
We will have the opportunity to determine whether or not the amendment, as drafted, is compatible with the action of the committee. Are there other amendments to the bill? Is there additional testimony on section 1? I will now take a motion to adopt section 1 as amended.

SENATOR RAWSON:
I move to adopt section 1 of Senate Bill No. 2 as amended.

SENATOR RAGGIO:
All in favor say, aye; any opposed?
The motion is carried. Senators Carlton and Neal voted no.

We have reached another milestone. For a bill that was considered pretty well acceptable, we are moving right along. The next items for discussion are sections 4 and 6, adopting a several liability standard for medical malpractice cases when noneconomic damages are considered.

SENATOR NEAL:
Could we, at some point, have the Research Division give us a list of all the hospitals in the state that would now be included under the provision we just adopted.

SENATOR RAGGIO:
We will ask the Research Division to compile it. Let us go to presentations on sections 4 and 6. I will ask Mr. Wilkinson to give us a general overview. We would like to know how this bill, as proposed in sections 4 and 6, differs, if at all, from what is now the law and what is now the law in California under MICRA, the reform act.

MR. WILKINSON:
Section 6 of the bill provides that in an action for damages for medical malpractice each defendant is liable for noneconomic damages severally only, not jointly, to the plaintiff only for the portion of the judgment which represents the percentage of negligence attributable to the defendant. Currently, in Nevada, in an action for medical malpractice, a defendant would be jointly and severally liable for the entirety of the judgment, which would mean a plaintiff could collect up to 100 percent of the judgment from any defendant regardless of the specific percentage of negligence attributable to that defendant. That applies to both economic and noneconomic damages. What this would do is provide for several liability with respect to noneconomic damages which would mean each defendant would only be liable for that specific percentage of negligence attributed to him by the jury.

SENATOR RAGGIO:
As I understand it, as a practical matter, when a jury is asked to return a verdict, they will be asked to return a special verdict which indicates the percentage of negligence of a particular defendant where there are multiple defendants in a medical malpractice case. As an illustration, if Doctor A is one of the defendants and the jury finds, and the court accepts, the verdict that that particular defendant is 25 percent responsible for the malpractice, if this is enacted, the defendant doctor or practitioner, as the case may be, would be responsible for 25 percent of the damages which were assessed. Is that the understanding of everybody? It has not changed with respect to economic damage. This is only on noneconomic damages.

MR. GILLOCK:
That is the understanding.

SENATOR RAGGIO:
Is that your understanding, Mr. Flangas?

MR. FLANGAS:
That is my understanding of the bill.

SENATOR RAGGIO:
Do you want to make the presentation on this? Is this the provision that, in the negotiations, was agreed to by all sides to the discussion?

MR. GILLOCK:
This was agreed to by all sides to the discussion.

SENATOR RAGGIO:
How does this differ from the California MICRA situation? What is the law there?

MR. GILLOCK:
I think it is the same as California MICRA in terms of each person only being severally responsible, separately responsible for their share of noneconomic damages based on their share of the liability. If a physician were sued whom the jury determined, even though he was one of four physicians who were named in a lawsuit, was negligent free, he would not have to pay any portion.

SENATOR RAGGIO:
Mr. Echeverria, can you quickly tell us whether we are on track here.

JOHN ECHEVERRIA (Nevada Trial Lawyers Association):
The abrogation of joint and several liability in California was not part of the MICRA package.

SENATOR RAGGIO:
I misspoke. What is the situation there?

MR. ECHEVERRIA:
It was done by a proposition or an initiative. This states, as I understand it, the California version of joint and several liability.

SENATOR RAGGIO:
On noneconomic damages as well as economic damages?

MR. ECHEVERRIA:
There is several liability as to noneconomic damages and joint liability as to economic damages in California and under this bill.

SENATOR RAGGIO:
This will bring us in line with current law in California.

MR. ECHEVERRIA:
Yes.

SENATOR RAGGIO:
That is what I was asking.

MR. ECHEVERRIA:
As to medical negligence cases.

SENATOR RAGGIO:
Medical malpractice. Is that your understanding of this, Mr. Flangas?

MR. FLANGAS:
That is correct, Mr. Chairman. It is not part of the original MICRA package in California. It was a separate proposition. This is on line.

SENATOR RAGGIO:
Does either group have anything further to present on this?

MR. FLANGAS:
No, thank you, Mr. Chairman.

SENATOR RAGGIO:
Are there any statements or questions from the committee?

SENATOR CARE:
In reviewing case law, I have three questions.
1. How would comparative negligence play into this?
2. What do you do when you have joint tortfeasors, and there is a settlement agreement, and one of the defendants agrees to, in essence, pay a greater figure in a settlement agreement that, down the road, there is a judgment that is much smaller?
3. What does this do to vicarious liability? That is to say, when one of the defendants is an employee of the hospital and the jury says, 25 percent is the fault of the employee, 25 percent is the hospital, this, that, and the other. Would the hospital still be liable for the 25 percent portion of the judgment that goes to the employee?
Those are the three issues I see here.

MR. CROCKETT:

The three points you raised were comparative negligence, settlements with multiple defendants and vicarious liability.

1. It will not have any impact on comparative negligence. There will be a change in the law because it used to be that joint and several liability only existed in medical malpractice cases where the plaintiff was completely blame free. If you had an unconscious plaintiff on the operating table and negligence was performed, everybody understood the plaintiff could not be negligent because he was unconscious, he was asleep. Under those circumstances, liability was joint and several. The proposed change would say that from now on it is only several as to noneconomic and joint as to economic. Under existing law, if a plaintiff was in a circumstance where they could be comparatively negligent, joint and several went out the window and liability was proportioned based upon the plaintiff's contributory negligence and everybody else's contribution. This changes the law in that respect. Old law, comparative negligence did away with joint and several; new law, whether the plaintiff was comparatively negligent or not, does not alter the joint and several responsibility. Does that answer your question?

2. On settlements with joint tortfeasors, I know you are an attorney, and you see all the multiple layers that this creates, and it does, and the permutations are way too numerous to even begin to discuss here. All I can say is, if you settle with one defendant in a multiple defendant situation, negotiations always completely reopen when you come to the second defendant to talk because everybody wants to talk about what effect the previous settlement had upon the second settlement.

SENATOR RAGGIO:

We are going to have a discussion on collateral torts soon.

MR. CROCKETT:

You are right. Mr. Gillock reminded me of one thing that must be done in order for a defendant to be given a complete release from a settlement when they have multiple defendants. You have to go to court and get what is called a good-faith settlement approval to make sure the court sees that one defendant did not quickly settle out under the pretense they were paying their full and fair share. The court guards against that being a sham or a rouse. You cannot get a complete release unless the court approves that it was what they call a good-faith settlement. That will remain. Nothing is done to change that. Does that answer the question?

The third point about vicarious liability, the employer of a negligent employee is always responsible for that employee's negligence as long as the negligence was in the course and scope of the employment. There may be a circumstance where, on top of that, the employer could be negligent for something they did directly, separate and apart from their employment. In that case, they would have responsibility for the employee's negligence, and they would have responsibility for their own negligence. An example would be, if a nurse were negligent in something she did which fell below standard that caused injury or death to a patient. If she was working the course and scope of her employment, her employer is vicariously liable for her actions. But if her employer supplied her with a negligently maintained piece of equipment that was not properly cared for by a different department of the hospital and also contributed to the problem, the employer would be directly responsible to the injured party for the employer's direct negligence on that equipment. This deals with the question you posed: What if the employer is responsible for the employee's negligence and their own direct negligence? In which case they would be responsible for both.

SENATOR CARE:

We are just trying to get some legislative intent here. That is the way I read it, and if the doctor's read it that way, as well, I am satisfied.

MR. FLANGAS:

I agree with his definitions.

SENATOR RAGGIO:

Are there any other questions or statements on this?

SENATOR WIENER:

Does vicarious liability create two causes of action?

MR. CROCKETT:
Yes, it does because each one is free standing. For example, if you only had the nursing negligence, that would be one claim. If you only had the un-maintained equipment, that would be one claim. The fact that they both happen to coexist at the same time does not deny their two separate existences.

SENATOR RAGGIO:
Is there any additional public testimony on this?

SENATOR NEAL:
You seem to have gotten into agency in your explanation of the employee-employer relationship. I would assume, based on the employee committing an act of negligence that led to an injured person, the employee, in this case, would not escape full liability.

MR. CROCKETT:
You mean in terms of the cap discussed earlier?

SENATOR NEAL:
Yes.

MR. CROCKETT:
No, the employee is covered by benefit of that cap too.

SENATOR RAGGIO:
Is there any additional public testimony on the issue on several liability for noneconomic damages? Are there any amendments to be suggested by the committee? Is there a motion to approve adoption of section 6 and section 4 as it relates to section 6?

SENATOR RAWSON:
So moved.

SENATOR RAGGIO:
There is a motion by Senator Rawson for approval. Is there discussion on the motion?

DAVID P. HAEFNER (Nevada Association of Nurse Anesthetists):
I am a certified registered nurse anesthetist. I would like to make a point of clarification, and ask the committee for a point of clarification, as it pertains to section 6. I am from Las Vegas and the chief nurse anesthetist at Lake Mead Hospital. Mr. Gillock stated that nurse anesthetists are nurse practitioners. They are not. Certified Registered Nurse Anesthetists (CRNA) are recognized in Nevada Revised Statutes. I believe, the statute is NRS 632.034. Members of the committee were responsible for that statute in the 1989 and 1991 Legislature. The point I would like to clarify is, do these caps apply to nurse anesthetists? The reason I ask is because we serve an urban area at Lake Mead. In addition to that, the entire rural area of Nevada is served almost exclusively by certified registered nurse anesthetists. There are four nurse anesthetists in Elko. By September 1, there will be six. There are two in Ely, two in Winnemucca and two in Fallon. Without them, there will be no surgery whatsoever. If we are left as a deep pocket and not left in these caps, I feel the rural areas could be at risk of losing those providers.

SENATOR RAGGIO:
I think the testimony we heard and relied on was that you were included.

MR. HAEFNER:
I would like a point of clarification for the record.

SENATOR RAGGIO:
Can staff help us on that? Does anyone know the answer?

MR. WILKINSON:
I think the discussion of nurse anesthetists came up in the context of section 1 pertaining to caps in trauma centers.

MR. HAEFNER:
Mr. Gillock said we were nurse practitioners. We are not.

MR. GILLOCK:
I think, I said they were medical care providers.

MR. WILKINSON:
With respect to section 6 and several liability for noneconomic damages, that applies to an action for medical malpractice which is defined as a case involving a physician, hospital, or employee of a hospital, basically the same things that are before the screening panel today.

MR. HAEFNER:
I understand that, but we are not employees of the hospital. I had to settle a malpractice suit two months ago because the physician did not have insurance. He did not notify his carrier. The carrier refused, and he was at fault. Because of joint and several, I would have been on the hook for the entire judgment had it gone to court. The arbitrator, Mr. Bonjover, told me, "I can't believe how unfair this is for you, but if you don't settle, you are looking at a million-dollar settlement." That is my concern with joint and several.

SENATOR RAGGIO:
Is there a suggestion? Do the legal representatives or doctors have some desire to assist and clarify this situation?

MR. GILLOCK:
I think he could take a great deal of solace in the provisions of section 6 wherein he would be only severally liable on an action for medical malpractice.

SENATOR RAGGIO:
Does section 6 apply to certified registered nurse anesthetists?

MR. GILLOCK:
It does not say that. I guess I have not addressed it before.

SENATOR RAGGIO:
Apparently, it does not. Should they be included?

MR. FLANGAS:
I would think they would need to be included, Mr. Chairman.

SENATOR RAGGIO:
Is it the sense of the committee that if we say this group should be included, there will be a long list of other groups that we need to think about?

MR. HAEFNER:
Off hand, the only other group I can think of would probably be nurse midwives. I think all nurse practitioners probably come under the employee, but I could be wrong. Nurse practitioners must have collaborating physicians. CRNAs, by NRS, may administer anesthesia to anyone in the state that is licensed as a physician, dentist or podiatrist.

SENATOR RAGGIO:
I am told by counsel that in all our discussions, particularly under sections 3, 4, and 5, and now 6, that these caps and restrictive limitations apply only to hospitals, physicians, and employees of hospitals. Your group would not be covered as it stands right now under that situation. It would be up to this committee as to whether there ought to be any others included within these limitations. Is that permissible under the Governor's proclamation?

MS. NEEDHAM:
Since these seem to be limited to physicians and hospitals, there is a question as to whether they could be included.

SENATOR RAGGIO:
Do you understand what I am saying? The Governor's proclamation limits us to the matters we can consider. We can, of course, suggest to the Governor that something else be included, but at this point in time, we are precluded from considering that matter.

SENATOR O'DONNELL:
I think if we do not include these critical caregivers who work side-by-side with doctors, they will then become the deep pocket. I would like to suggest we approach the Governor, in a kind way, as we see this in a new light, and ask him to reconsider that.

SENATOR TOWNSEND:
I guess the question is for staff. If both houses pass something that is not quite inside the proclamation limits and the Governor signs it, is it void?

SENATOR NEAL:
No.

SENATOR TOWNSEND:
Why don't we just put in what we want to put in.

SENATOR RAGGIO:
I haven't seen Senator Neal's law degree.

SENATOR TOWNSEND:
I am just trying to be practical.

SENATOR NEAL:
My law degree comes from 30 years of serving in this body and having five special sessions under my belt.

SENATOR RAGGIO:
Then I would question the credibility of your degree. Let us ask counsel. The question was, if we pass something that is not within the Governor's proclamation and he signs the bill, constitutionally, could it be challenged, or does the Governor have to send a subsequent proclamation? As I read the Constitution, the Governor may do that even while we are in special session.

MR. WILKINSON:
If something is passed that is outside the call, the fact that the Governor signs it does not render it constitutional. It would still be subject to challenge.

SENATOR RAGGIO:
You are overruling Senator Neal, as I understand it.

MR. WILKINSON:
That is correct.

SENATOR MATHEWS:
Within the action, we extended the $50,000 liability limit, is that outside the call?

SENATOR RAGGIO:
We got advice from counsel that it was, in their opinion, reasonably within the call. That is why we proceeded. If there is a motion to adopt section 6, and it passes, I will honor a motion to request the Governor to issue a new proclamation that would include, as I understand the request, certified registered nurse anesthetists and midwives. It is my understanding that we can do that. We can at least ask the Governor to issue a proclamation to that effect.
Is there a motion to adopt section 6?

SENATOR TOWNSEND:
I move to adopt section 6 of Senate Bill No. 2.

SENATOR RAGGIO:
Is there further discussion on that motion?

SENATOR CARE:
To lay down the legislative intent, may the parties submit documents. We have not discussed the necessity to adopt section 6 and I think we need that for legislative intent.

SENATOR RAGGIO:
Is it in the backup material? I think there is something from the legislative subcommittee. Is there something in here on several liability?

MR. GILLOCK:
I think the doctors are the ones who were strong behind wanting this. Perhaps Mr. Flangas has some material for the record that reflects our agreement.

SENATOR RAGGIO:
Could you make a representation for the record that would justify a public purpose in adopting this section.

MR. FLANGAS:
As we stated earlier and as has been established, this was not really part of the original MICRA package, however, it is considered under what is called MICRA plus. This was an additional measure that was added some years ago in California that has resulted in a downward movement of insurance premiums.

SENATOR RAGGIO:
Is that a concise enough statement for you?
On the motion, all in favor indicate, aye; any opposed.
The motion is carried unanimously.
I forgot to take up the language on the pro-bono situation. The language given to us in our discussions essentially reads, "When a physician or dentist provides care or assistance to patients without requesting, receiving or expecting compensation or consideration for said services in a clinic or public facility, that physician or dentist shall not be liable for civil damages as a result of any act or omission in rendering," and there was some discussion about that word, "care or providing care or assistance if the care or assistance is rendered in good faith and in a manner not amounting to gross negligence or reckless, willful or wanton conduct." I think that was generally agreed upon. Is that correct?

MR. GILLOCK:
That is correct, Mr. Chairman.

SENATOR RAGGIO:
Is there a motion to adopt that provision?

SENATOR RAWSON:
I move to adopt the provision.

SENATOR RAGGIO:
Is there any further discussion on the motion? Hearing none, all in favor say, aye; any opposed.
The motion is carried unanimously.
I do not know where that goes in the bill, but I will leave it to the bill drafters. We are ready now to go to presentations regarding review of the medical and dental screening panels.

SENATOR TOWNSEND:
Do you want a motion with regard to midwives and certified registered nurse anesthetists?

SENATOR RAGGIO:
I'm sorry I overlooked that. I will take a motion.

SENATOR TOWNSEND:
I would move that we ask the Governor for an addition to the proclamation to include those two in our deliberations.

SENATOR RAGGIO:
There is a motion to request the Governor, in essence, to issue a call or proclamation to add that item for potential consideration by the Legislature. Is there further discussion? All in favor indicate aye, any opposed.
The motion is carried unanimously.

SENATOR RAGGIO:
We will now go to the issue on medical and dental screening panels. It is the Chair's understanding that it involves sections 10, 11, 17, 24, 35 and 38. Does the committee need a recess before we go into this phase? We ask the representatives of both the legal and medical professions to be available for this discussion and any others who have an interest.
Let me ask counsel, do you know the status of the amendment that we approved on section 1?

MS. NEEDHAM:
Yes, I e-mailed the request to the Legal Division, and they began working on it immediately.

SENATOR RAGGIO:
While we are waiting on this other issue, Senator Rawson, you indicated some language to be proposed as an addition to the preamble. Do we have a copy of it?

SENATOR RAWSON:
Yes, Mr. Chairman, I will have it passed out now. What I am proposing is on page 1 of the bill, in the preamble, that we add another "whereas." The idea of this is to develop a rational relationship and help in the constitutionality. It would read, "Whereas it is recognized the patients who have been injured by medical malpractice must be afforded appropriate access to legal remedies for their injuries and the judicial discretion to render decisions in malpractice actions involving exceptional circumstances must be preserved." The idea is that we are being a bit restrictive in this legislation, and this would demonstrate that we are still trying to protect judicial option and people's right to redress.

SENATOR RAGGIO:
Unless there is an objection, I will accept a motion to amend the preamble with this language.

SENATOR RAWSON:
So moved.

SENATOR RAWSON:
The motion is by Senator Rawson. Is there any discussion?

SENATOR CARE:
I appreciate the spirit in which this is offered, but I must tell you, with the buzz going on in the building right now, I would have to see the final bill we are voting on before I could agree to this language. Thank you.

SENATOR RAWSON:
In response to that, I appreciate the concern. Certainly, in the final analysis, we have to look at the bill and all pieces of it to approve it or not. I am presenting this with the idea of trying to strengthen it as we go, piece-by-piece to strengthen it. I am sure all of us will reserve that right to the end, whether or not it is acceptable.

SENATOR RAGGIO:
Is there any further discussion on the motion? All in favor indicate, aye; any opposed.
Senators Care and Carlton voted no.
The motion is carried.

SENATOR NEAL:
I do not think the Democratic side had an amendment. Everything we proposed seemed to be outside the call.

SENATOR RAGGIO:
If you make one that is, we will accept it.

SENATOR RAWSON:
While we are waiting, may we ask questions about section 11, subsection 3.

SENATOR RAGGIO:
Is this under the agenda item we are discussing?

SENATOR RAWSON:
Yes.

SENATOR RAGGIO:
Let us have Mr. Wilkinson give us an overview of the sections involved. As I understand it, they are sections 10, 11, 17, 24, 35 and 38. What is the effect if we adopt the changes reflected in this measure as to medical and dental screening panels.

MR. WILKINSON:
These sections repeal the existence of the screening panel, basically, for actions that are pending before the panel in which the panel has not made a determination. A claimant will have the opportunity to continue on and have a determination made by the panel and a repeal of these provisions will not have any effect on that particular case. A claimant can also decide not to proceed with the panel, at which case the claimant can file an action in the district court.

SENATOR RAGGIO:
This would become effective October 1, 2002, if enacted.

MR. WILKINSON:
That is correct.

SENATOR RAGGIO:
What does the change do to cases that occur before October 1, 2002?

MR. WILKINSON:
Section 38 of the bill addresses cases that are currently pending. If those cases have already had a determination made by the screening panel, then the repeal of this section is not relevant. For cases that are currently pending, the claimant has the right to opt in or opt out of the screening panel provisions.

SENATOR RAGGIO:
Is that up to the claimant?

MR. WILKINSON:
That is up the claimant, yes. If the claimant decides to opt out, files an action in the court and prevails at trial, the claimant is also entitled to taxes, costs and the fee paid to the division for filing the complaint.

SENATOR RAGGIO:
What else?

MR. WILKINSON:
Section 11 is one of the sections pertaining to the screening panel, but I believe we are going to be addressing the subject of changing the statute of limitations as a separate issue.

SENATOR RAGGIO:
That is why I wanted you to give an overview of the whole thing. Is that also in that section?

MR. WILKINSON:
That is section 11. Basically, all we are doing in these sections is repealing all the provisions pertaining to the screening panel, and the other sections have internal references to provisions specifically

SENATOR RAGGIO:
What happens to cases occurring after October 1, 2002?

MR. WILKINSON:
After October 1, 2002, somebody would simply file an action in district court. We have other changes pertaining to actions for medical or dental malpractice that are filed after the effective date of this bill, but I believe those were going to be addressed at a later time.

SENATOR RAGGIO:
I think, even though there are statute-of-limitation changes, we had better understand what is in these sections.

MR. WILKINSON:
After the screening panel is repealed, one of the new sections pertaining to this type of action is section 7, which provides for fast tracking of these actions. It provides for mandatory dismissal of medical or dental malpractice cases if they are not brought to trial within three years after the date on which they are filed, until 2005. On October 1, 2005, the period will be shortened to two years. Dismissal of an action is a bar to filing another action; therefore, it is a mandatory dismissal unless good cause is shown for the delay by the plaintiff. This section also provides that the district court will adopt court rules to expedite the resolution of an action involving medical or dental malpractice.

SENATOR RAGGIO:
Is that called "fast tracking?"

MR. WILKINSON:
That is correct.

SENATOR RAGGIO:
Section 11 states provisions that provide the statute of limitations. One is for three years after the date of injury, or two years after discovery. Is that correct?

MR. WILKINSON:
That is correct.

SENATOR RAGGIO:
Is that the whole change?

MR. WILKINSON:
The other change in section 11, where the language is stricken, is referring to the tolling of the statute of limitations while the complaint is pending before the screening panel. Since the screening panel is being done away with, the tolling provision is no longer necessary.

SENATOR RAGGIO:
What about section 12?

MR. WILKINSON:
Let me go back to section 9. Section 9 provides that in any actions for medical or dental malpractice, the plaintiff, the defendant, the representative of the physician or dentist insurer and their attorneys are required to attend the mandatory settlement conference before a district judge, other than the judge assigned to the case.

SENATOR RAGGIO:
That is actually outside of the scope, isn't it? I jumped into section 12. I guess we should be looking at sections 10, 11, and 17. What about section 17 as it applies to the medical/dental panel?

MR. WILKINSON:
Section 17 is an internal reference to the medical/dental screening panel which will no longer be relevant after it is repealed.

SENATOR RAGGIO:
Section 24 strikes existing language as to screening panels?

MR. WILKINSON:
That is correct.

SENATOR RAGGIO:
Section 35?

MR. WILKINSON:
Section 35 is the section that actually repeals all the sections. Section 38 is the transitory provision which provides the right to opt in or out.

SENATOR RAGGIO:
We now have representatives from both the medical and legal professions here. We are dealing with the issues in the bill regarding review of the medical and dental screening panel. Let me ask you gentlemen, is the language in the bill that, in essence repeals for future cases the medical and dental screening panel, something that is agreed upon between the two professions as this bill is processed?

MR. GILLOCK:
Yes, it reflects an agreement reached by the parties.

SENATOR RAGGIO:
Mr. Flangas, is that your understanding?

MR. FLANGAS:
That is correct.

SENATOR RAGGIO:
Is there anything in the language addressing this in any of those sections that needs to be amended in any way?

MR. GILLOCK:
No, Mr. Chairman.

SENATOR RAGGIO:
How about the medical side? Mr. Cotton, we want to welcome you back. We are looking at the review of the medical and dental screening panels in the applicable sections. The Chair just inquired whether or not any language in sections 10, 11, 17, 24, 35 or 38, which deal with the medical or dental screening panel, in essence repealing it as to actions occurring after October 1 of this year, needs to be amended or changed.

MR. COTTON:
I have no amendment language this morning because I have had only 5 minutes to think in the last several days. I perceive a logistical problem with all of these issues coming out at once as opposed to staggered in terms of the load on the courts and the practical load on plaintiffs and defense lawyers.

SENATOR RAGGIO:
The claimants have an option if they have an existing case. Is that correct?

MR. COTTON:
My understanding is they do.

SENATOR RAGGIO:
Is there a problem with opting out of the screening panel?

MR. COTTON:

There are about 250 cases sitting in a panel right now. If they all decide to opt out on October 1, 2002, we would have a load of 254 cases dumped on the court system and attorneys with a fast track on top of that. This would probably create a severe problem with administration of the court system with these cases.

SENATOR RAGGIO:
Fast tracking would mean they would have to accommodate, to the best of their ability, giving them a priority. Is that your understanding?

MR. COTTON:
My understanding is there is a priority system.

SENATOR RAGGIO:
The court is supposed to adopt rules for that purpose under this bill.

MR. COTTON:
As long as we have that understanding, the court will adopt rules along those lines. Other than that I have no problem with the language.

SENATOR RAGGIO:
Is there anything we can do otherwise?

MR. COTTON:
The only mechanism is something about which I would have to talk to plaintiff's counsel in order to set some time frames for the cases to come out in a more orderly fashion should they elect out, based on data filings or something along those lines, so we would not theoretically have 254 cases coming out of it. We may well have 200. That is a significant load on a judiciary with about 18 or 19 judges, all at once, even if we put them into a try-to-do-your-best effort to get them moving. In one day, a significant load of cases could be filed which would have a significant impact on the entire court system.

SENATOR RAGGIO:
What comes to your mind as a possible solution?

MR. COTTON:
We should establish some type of standard movement out on a month-by-month basis per date of filing. For example, if they are filed in May 2001, those cases could come out the next month. The next cases could come out, if they opted out, and filed by month. Then they would basically be coming out at the pace they come out today. They would not all be coming out on top of the court system all at once. That is my concern.

SENATOR RAGGIO:
Does that make sense to you, Mr. Gillock?

MR. GILLOCK:
I believe we have already accommodated that concern in this bill, under section 7, referred to by legislative counsel earlier. Section 7(a) says: "Three years from the date the action is filed if the action is filed on or before October 1, 2002 but after October 1, 2005." We have given a three-year period to get the cases into court for those cases presently filed or that will be filed before 2002. The cases filed after 2005 will have to go to court in a period of two years. Even though 250 cases sound like a lot, we have over 25 courts, so that is only 10 cases a court, if you want to break it down that way. I know it is an additional load on the court system, but I believe the reason we negotiated the three-year period before we set in the fast-tracking system was so we would accommodate those additional cases.

SENATOR RAGGIO:
That is dismissal if the case is not brought to trial, but sometimes it is not within control of either the defendant or plaintiff, is it?

MR. GILLOCK:

That is what I mean. Let's take a hypothetical case. It comes out of the panel, either you bring it out of the panel or you file a new case tomorrow or October 15 or 16. The court has three years to adjust its calendar and modify its case schedules to accommodate the cases; whereas, if it is filed later, they have only two years to fit it into the system.

SENATOR RAGGIO:

My impression was the so-called fast-tracking procedure was not tied to the motion for dismissal.

MR. GILLOCK:

In the bill, it is tied to the motion for dismissal. It says the court shall set substantial rules to adopt this expedited resolution schedule.

SENATOR RAGGIO:

I understand that. That is the fast tracking. His concern is we have 250 cases now pending, more or less, within the process of the medical and dental screening panels. If they opt out, as they are entitled to do under the language of this bill, all at once, there is no way all those cases could probably be brought to trial within three years, is there?

MR. GILLOCK:

I would think so. If there are 250 cases filed to come out, historically, there would only be two to five percent that would go to court and trial.

SENATOR RAGGIO:

I am not that familiar with the trial calendars in Clark County. What is the usual delay once it gets out of the screening panel?

MR. COTTON:

Once it gets out of the screening panel, if it is not an aged person or someone dying, it can run out to a three- to five-year timeframe. Plus there are other cases, for example, construction defect cases and others, backing up the system. That is my only concern. They are backed up right now. I tried a case two weeks ago that had been in there for six years.

MR. GILLOCK:

The purpose of the fast-tracking system is to get the insurance companies' money back to them faster. I became a proponent of the fast tracking, three-year system at the insistence of Mr. Cotton.

SENATOR RAGGIO:

Wait a minute. That went by me. The purpose of the fast track is to get the insurance companies' money back to them?

MR. GILLOCK:

That is right. One of the reasons insurance companies complain about the situation in Nevada is due to the length of time it takes to get money back, three to five years as to which Mr. Cotton just referred, because during that time, they have to reserve a loss. If they post a reserve, the loss has to stay posted for three to five years. It was Mr. Cotton's suggestion that we fast track these cases similar to another state with which he works.

SENATOR RAGGIO:

There seems to be general agreement that medical and dental screening panels have not been as effective as originally hoped. That is generally the understanding. You think it's better to fast track these actions and have more certainty of an earlier trial date. I guess we are ready to, maybe, adopt this language, but now we have some hesitancy that, as a practical matter, the language will not accommodate this. Can you help us here so we can move along?

MR. GILLOCK:

I would suggest if a case is filed before a medical/dental screening panel before the year 2000, of which there are many cases, that it come out of the panel and be set for trial within the next two years.

Then if it is filed before the panel after the year 2000, the court, at its discretion, could extend the three-year period up to the year 2006.

MR. COTTON:
I think that would expand the time enough to give some realistic adjustments by the court if a lot of these cases come out.

SENATOR RAGGIO:
Do we have the right to dictate to a court in statute?

MR. GILLOCK:
We have the right to dictate it as long as we give them the discretion, at the agreement of either court or counsel, to modify it.

SENATOR RAGGIO:
Does counsel agree with that? Please indicate that Ms. Needham nodded yes.

MR. GILLOCK:
We have a provision in Nevada where if someone is over 70, or expected to die within 1 year, they get preferential setting. We would want to still have that available.

MR. WILKINSON:
Would you please repeat the question?

SENATOR RAGGIO:
As recommended, do we have the right to include a provision that cases filed before the panel prior to October 1, 2000, would be set for trial within three years if they opt out. Any filed after October 1, 2000, would be brought to trial within four years from October 1, 2006, unless they qualify for one of the systems with priority settings.
Mr. Gillock and Mr. Cotton will you both get together and put it in writing if it is to be considered by this committee, and then we will look at it.

MR. GILLOCK:
We can do that.

SENATOR NEAL:
There is a mandatory requirement that judges be trained in handling malpractice cases in section 15. Where would this fit, in terms of dumping all these cases into the judicial system? Would the training come before, during or would there be a period time in which it would take place?

SENATOR RAGGIO:
Would counsel answer that question?

MR. WILKINSON:
Section 15 requires the Supreme Court to adopt court rules providing for mandatory, appropriate training concerning complex issues of medical malpractice litigation for each district judge of whom actions involving medical malpractice are assigned. Basically, this provision leaves to the discretion of the court the method by which this training is going to occur and what the training is going to consist of. Certainly, there are already judges who have training and experience in medical malpractice actions, so they may not require the same sort of training. This is left up to the discretion of the court as to exactly how it will occur.

SENATOR NEAL:
I understand that, but after listening to the attorneys, my concern is that there is already a backlog of these cases, and I understand them to be saying, there are 254 cases now before the screening panel which within the next three years will be dumped into the court system. We also require judges to be trained and mandated, according to this language, that the Supreme Court will establish the rules for training. Are we saying we will, leave it at that and not do anything or put a time limit on it since we are trying to help the system get these cases resolved?

SENATOR RAWSON:
As a practical matter, we have to deal with this issue whenever we make a change. We have to deal with the training, and it simply has to be worked out whenever we do it. I am asking whether this has to be a stopper?

MR. COTTON:
In Clark County, and Mr. Gillock can correct me if I am wrong, I think we have conservatively anywhere between six to eight judges of the judiciary who are experienced in medical malpractice and have handled and tried a number of cases over the past four or five years. There could be some allocation of cases, instantaneously, to judges who already have some background experience, and training could be implemented at a later date. I believe there are enough experienced judges to handle the initial thrust of cases referred to by Mr. Gillock.

SENATOR RAWSON:
Does that give some level of comfort?

SENATOR NEAL:
I hope so. I would not like to be voting on something that will clog the system by saying the judges must have training, and when we put it into law, if they do not have the training, I would assume the citizens would have some type of recourse.

MR. GILLOCK:
If we pass that statute, the Supreme Court would then have the duty to determine what additional training is necessary.

SENATOR RAGGIO:
They would pass a rule. They would enact a rule.

MR. GILLOCK:
It would simply be attending a series of classes at the judge's college. I agree with Mr. Cotton that we have several judges experienced in handling these cases. In fact, as a practical aspect, one of the most recent judges who has only been on the bench 2 weeks, I understand did a really good job in handling a very complex malpractice case. I think it is something the court would work out.

SENATOR NEAL:
So you don't see a problem in terms of backlog and clogging the system.

MR. GILLOCK:
No, I do not.

SENATOR RAGGIO:
Let me indicate that Mr. Anderson, Chair of the Assembly Select Committee, indicated there is a problem getting representatives from either the medical or legal profession in both Houses to these hearings. Obviously, there are more than one of you on each side. Therefore, I think you need to accommodate both Houses in this regard. I would suggest you decide who is your authoritative representative to appear in both Houses. You may have to do this at the same time.

MR. GILLOCK:
They decided I was most qualified and wanted me to stay here.

SENATOR CARE:
One of the experiences I enjoy least is when I go to court, and before the case gets called, the judge calls me to the bench and says, "Did you know what you were doing because this has had such an effect on me or us?" I guess we are not going to hear from any chief judges today. Has anyone consulted the judiciary regarding their attitude about the mechanisms in this bill, including the motion to dismiss with prejudice, getting rid of the screening panel, increasing the caseload and mandatory training?

MR. GILLOCK:

For the record, I have discussed this issue briefly with two judges. Mandatory dismissals create a severe hardship, more so on the parties than the court. In Clark County, the court has developed an overflow system whereby a court may not handle the case assigned to it but may assign it to another department to accommodate the overflow. They have also found they can set between 15 and 20 cases for the same Monday morning and only have one or two that are either ready to go or do not resolve by settlement. The court takes the cases in which they are less intimately involved in terms of actual knowledge on substantive motions, and then move those cases. It has been working.

MR. COTTON:

If I may respond, Senator Care. I talked with several judges in Clark County, including one heading the committee on court rules, voicing my concern about delays in Clark County and proposed fast-track regulations. I was about ready to take them to the court and give them to the judge when I ended up here. They are very much in favor of anything that will expedite the entire process. I can speak from my own personal experience in working under the statutes of the court rules in Arizona under fast track. It moves cases along and stops a lot of dilatory conduct on the part of lawyers. It gets things brought to a point. It also has mandatory settlement conferences where, quite frankly, a good share of cases are resolved rather than clogging the court system. This is part of the reason I have been advocating and trying to work with Mr. Gillock. For the past year, we have discussed ways to speed these things up because we are both frustrated with the way the system stands today.

SENATOR CARE:

Why not have a three-year rule for all civil cases, instead of five? Why limit it to medical malpractice?

MR. COTTON:

I, personally, have no problem with that. My problem is that I do not deal enough outside of medical malpractice and corporate litigation that I could speak for everyone else on their cases.

SENATOR RAGGIO:

Is there any more testimony? Is there additional public testimony on this issue? The issue is medical and dental screening panels, and/or the issue in section 15 in regard to the Supreme Court providing training by court rule.

MAURY ASTLEY (Executive Director, Nevada Dental Association):

We appreciate being considered in this legislation, particularly, on behalf of oral surgeons. At this time, most dentists are not affected by the issue, but we know the bill is needed. However, we would like to retain the dental-screening panel which has been effective for us. We have not seen the kind of complaints being experienced by the medical side on this issue. There are approximately 150 to 200 medical cases per year while there are seven to eight dental cases per year. We would rather not be thrown into the mix of a back load of 200 court cases on medical malpractice if there is a way to keep the dental-screening panel. We think it has served a good purpose. It also has helped when patients call our association regarding their choices, and we tell them they can go through this process or the peer-review process. They can still go through the dental-screening panel or sue. They have those options. This was originally a medical-screening panel, and you may recall, we were added. In 1999, the sunset was removed so we could be a permanent part of this. It has been effective for us, and we urge you to retain the dental-screening panel.

SENATOR RAGGIO:

Let me ask the legal profession representative. What is your feeling about retaining the panel for dental malpractice?

MR. GILLOCK:

I have no problem retaining it for dental malpractice. I do not know how it would work administratively for the state. An agency would have to be developed to handle seven or eight cases. If the dental-screening panel could be maintained at another agency, or a sub-agency of the insurance commissioner's office, or something, it could still be maintained without present staffing levels. Perhaps, it would be financially possible. I have no problem with it. Obviously, when you see seven or eight

cases, there are few instances where a dentist has a case where the injuries are substantial enough for people to pursue them in court.

SENATOR RAGGIO:

We recently authorized addition of personnel to beef up the number of panels for this purpose. I know the Commissioner of Insurance is here. Would you, or someone from your office, care to comment on this? It has been suggested that the bill would ultimately do away with the existing panel and a request has been made that it be retained but only for dental malpractice.

ALICE MOLASKY-ARMAN (Commissioner of Insurance):

We came before the Interim Finance Committee in June and sought four positions to be dedicated to the screening-panel process because we felt, with those additional staff members, perhaps we could make the process more efficient. We had, and still have, a tremendous backlog. Additional staff were approved. However, pending the special legislative session, we have not filled the positions and do not intend to, of course, until we know the outcome of the panel. At the present time, our staff in Las Vegas consists of two-and-one-half people, a research analyst, an administrative assistant and a half-time legal secretary. In the north, it consists of a half-time legal secretary. All in all, our existing staff consists of three persons. I cannot say that number of staff would be necessary for the number of dental cases we are seeing. I know we currently have 27 total cases regarding dental liability between both northern and southern Nevada. Five of those seven have already gone through the panel process to the point where they are ready for a panel to be calendared—three in the north and two in the south. In fact, as we speak, the two in the south may have already been set for a panel hearing. I am not certain as to the aging of those cases. The oldest active case for dental goes back to one that was filed January 26, 2001.

SENATOR RAGGIO:

You are looking at something like 27 cases proceeding through the process, and you are requesting the dental-screening panel be retained. The lawyers are telling us they see no major problem if that were done. We just did away with the medical-screening panel for medical malpractice. Am I hearing this right? The Commissioner of Insurance is telling us that, presently, there is something like three-and-one-half staff currently assigned to this process.

MS. MOLASKY-ARMAN:

A total of three.

SENATOR RAGGIO:

That may not be necessary if it is just the dental-screening panel. Am I hearing this right?

MR. GILLOCK:

I understand that Mr. Mobray, who has more involvement with dental-screening panel cases, may disagree with my position.

JERRY H. MOWBRAY (Attorney):

I practice in Reno. I have known many of you over the years through the practice of law and other areas as well. Over the last ten years, I filed at least ten medical malpractice cases and received large verdicts on some of them. In fact, one of the cases on which I obtained a verdict is the reason dentists were put in the screening panel. What the screening panel has considered in dental malpractice cases are not large damages cases. They are $50,000 cases. We have heard testimony as to the expensiveness of this litigation. One of the reasons filings have gone down on dental malpractice cases is not because there are no meritorious cases. When a person sees a lawyer and requests them to look at a case, the case will be reviewed by a dentist who might say it is meritorious but the damages will be only $25,000 or $30,000. The prospective client will be told it will cost at least $10,000 to get the case through the panel, and another $15,000 to $25,000 to try the case. As a result of the cost factor, the client will spend $8 to get $7 back. What the panel has done for people injured as a result of dental malpractice is due to 90 percent of dental malpractice cases having a value of less than $25,000 to $30,000. Those cases are not filed because it is not economically feasible to go to court due to such an expensive process. The dental association wants it in there because they know when injured people see an attorney they will be told what I explained to you. Quite frankly, I was contacted by people who work in the office of the

Commissioner of Insurance when the initial dental malpractice legislation had a sunset provision put on it. It was enacted in 1995, and the sunset expired it in 1999. People in the office of the Commissioner of Insurance were calling attorneys and asking them to testify at the Legislature to get rid of the panel. There are few dental cases, and existing ones are small damage cases. It was a classic example of people having their right to go to court taken away. If a person comes in with a $50,000 case and you say it will cost $30,000 in costs just to get the case ready for trial, there is nothing left for the client. A dental malpractice crisis has never been demonstrated.

SENATOR RAGGIO:
You said you have been operating under that situation.

MR. MOWBRAY:
Since the dental malpractice panel has been put into effect, I have filed a total of three cases since 1995.

SENATOR RAGGIO:
Is that when we put dentists under that?

MR. MOWBRAY:
They became effective October 1, 1995. A lawyer doing malpractice work has to tell the client that should they have a claim of $50,000, they will be upside down in the case with no recourse. That is reality when trying these cases. They are expensive. I think the Governor's suggestion to eliminate panels for physicians, as well as dentists, is a good proposition. I would also like to point out, before the screening panel was made applicable to dentists, there was not a flood of litigation against dentists in either Washoe or Clark County. There have been a lot less cases since then because of the chilling effect of the cost involved in presenting the case to the panel.

SENATOR CARE:
I listened to the Governor's remarks yesterday and have heard other comments in passing about the need to get rid of the screening panel, or words to that effect. Looking at a case annotation under NRS 418.016, Jane v McFarland, 109 Nevada 465, 1993, that says the purpose of screening panels is to minimize frivolous suits against doctors to encourage settlement and lower the cost of malpractice premiums and health care. It seems to me, the only reason to get rid of screening panels is because they are doing what they were intended to do. I have not heard any testimony about how the original legislation of screening panels is not decreasing the number of frivolous lawsuits. There has been nothing on that. I certainly want to hear something about that before I vote on this.

MS. MOLASKY-ARMAN:
When the dental panel was formed in 1995, we did not receive any additional staff at that time because of it. I want to assure Mr. Mowbray that if anyone called from my office advocating either in favor of the panel insofar as dentists are concerned, or in opposition, they had no authority to do so. I would like you to know that because we did not take an advocacy position on that.

MR. GILLOCK:
Throughout the last four months, physicians have taken a very vocal position about the fact, based upon the statistics of the screening panel, that they are not discouraging frivolous lawsuits. They said a large percentage of the number of panel findings that come out with a no vote still go to court. I think insurance companies for defendants, Mr. Cotton can speak to this, feel the expense of the screening panel has not really ferreted out caseseven though defendants, as well as plaintiffs, are required to spend $20,000 to $30,000.

SENATOR RAGGIO:
The concerns they have expressed, here and elsewhere, is that the majority of cases where negligence is not found or it is determined it exists, are filed. Cases in which there is no decision, and that may be a lot, still go to trial.

MR. GILLOCK:

Perhaps, I was not clear when I said no findings. When a panel comes out with a finding of no negligence, there is still a large percentage going to trial. That is why doctors insisted the screening panel was not doing its job. As a result of negotiations with that group, we came to the conclusion that we would do away with the screening panel, put them on a fast track and give the court the option to develop rules specifically for medical malpractice in order to cut expense and maximize the speed to get the cases to trial.

In answer to Senator Care's question, you can find people on both sides of the issue as to whether or not it screens out frivolous lawsuits. Certainly doctors are saying it is not doing the job.

SENATOR CARE:

With no screening panel, the plaintiff will have no choice but to file a lawsuit. It would seem to me the advantage of the screening panel is like arbitration under the mandatory program. If you win, lose or whatever, it gives you some idea whether you ought to request a trial de novo. It gives you something to think about. I would think the screening panel would serve the same purpose, but we hear we need to get rid of it for doctors but keep it for dentists. Last session, we had a bill that would have created a screening panel for construction defect litigation that I thought was a fairly worthwhile idea. Now, I do not know if I have any faith in panels at all.

MR. GILLOCK:

In my experience many cases have been resolved faster before the screening panel because, in order to prevent a lawsuit being filed, insurance companies move more quickly. Under the provisions of this emergency measure, an affidavit would be required of a physician in the same or similar field to be filed with the complaint at court or it will be subject to dismissal. I think insurance companies will address these cases faster. There may be as many as ten cases that have been settled and resolved regardless of the degree of negligence or clarity of the issues under the screening panel. Cases have been filed and just sit until the screening panel heard the case. This way they will not have that choice. Therefore, I think a lot of cases will be resolved faster. The delay at the panel at present is anywhere from eight to 18 months.

MS. MOLASKY-ARMAN:

I would like to correct the number of dental cases I gave you are ready for the medical panel in northern Nevada. The actual total number of dental cases is 12 not 27.

SENATOR RAGGIO:

Is there any more testimony on this subject, either the medical or dental screening panels or the Supreme Court rule on training of judges?

SENATOR NEAL:

I would move to adopt sections 10, 11, 17, 24, 35 and 38, along with section 15, of Senate Bill No. 2.

SENATOR RAGGIO:

Leave section 15 out of the motion. The other sections pertain to the medical/dental screening panel. The motion would be to adopt the existing language in those sections. Does everybody understand the motion? The effect of that motion would be to do away, under the applicable schedule in the bill, with medical and dental screening panels. The motion would also include, in section 11, the time limits for commencing actions and, in section 17, the language that removed the reference. What about the statute of limitations? What section is that in? Where are the motion for dismissal, the statute of limitations commencing in action and the motion for dismissal within three years? That is in section 7.

The motion will also include section 7. Then section 24 is deleting reference to the screening panel. Section 35 is the repealer section, and section 38 is the transitory language. Does the committee fully understand the motion? Is there any discussion on the motion?

SENATOR CARE:

I was wondering if Mr. Wilkinson could discuss section 36, which is the effective date of the bill. It discusses actions that accrue on or after October 1, 2002, as opposed to the language in section 11, which discusses wrongful death or an injury that occurs on or after October 1, 2002. My question is, what does this do to the injury that occurs before October 1 of this year, but the injury is not discovered or does not manifest itself until February 2005? How does that fit with what we are about to do?

MR. GILLOCK:

That would still fall under the old statute of limitations, and the screening panel provisions. Since we are abolishing the screening panel, it would go away unless they filed the action before October 1, 2002. I think that provision has to be the way it is in order to preserve the constitutionality of the statute.

MR. WILKINSON:

I believe that analysis is correct with respect to the applicability of that section.

SENATOR RAGGIO:

It applies to sections 1 to 6 inclusive, and section 11, providing that those sections only apply to a cause of action that occurs on or after October 1 of this year. Is that your reading of it? Does that satisfy you, Senator Care?

MR. GILLOCK:

Yes, Mr. Chairman.

SENATOR CARE:

Yes, Mr. Chairman.

SENATOR NEAL:

Could we include that as part of the motion?

SENATOR RAGGIO:

I think since that applies otherwise to other sections, once we go through all these amendments and have a final bill, we can adopt all the remaining sections, and that would be inclusive. Would that be appropriate?

On the motion, all in favor indicate aye. Any opposed.

The motion is carried unanimously.

The posted agenda allows us to take up any and all provisions of the bill. We will try to do that as we go along. Therefore, I will ask for a motion on section 15, on which we had a discussion.

SENATOR TOWNSEND:

I move to adopt section 15 of Senate Bill No. 2.

SENATOR RAGGIO:

Is there any discussion on that motion? We are dealing with section 15, the Supreme Court providing, by court rule, for appropriate training concerning complex issues of medical malpractice litigation. Is there any public testimony on section 15? On the motion, all in favor indicate aye. Are there any opposed.

The motion is carried unanimously.

Let us go now to the item regarding strengthening reporting requirements relating to disciplinary actions, claims, settlements and awards against physicians. This is dealt with in sections 14, 19, 20, 21, 22, 23, 29, 30, 31, 32, 33 and 34 of Senate Bill No. 2. Since you are both present, I am going to ask you gentlemen to give us your understanding of what the effect of the language would be with respect to the reporting requirements relating to disciplinary actions, claims, settlements and awards. Who would like to discuss this?

MR. GILLOCK:

I think the purpose is to strengthen the reporting requirements to gain additional accountability and better tracking of physicians and any tracking of, what we might want to call, a bad doctor, of which there are very few I might add. We want to be sure this system is put into place in order that

responsibilities of the hospitals and courts are coordinated. The court has a responsibility to report to state agencies which coordinate the reporting system. We have present with us someone who would like to address that as well. Nancy Peverini is familiar with the reporting systems in California and other states. She wants to briefly address the issues.

NANCY PEVERINI (Legislative Counsel, Consumer Attorneys of California):
We worked on this issue in California for quite a long time. I want to point out that when the MICRA statute passed in 1975 in California there were two components. One was the tort reform portion, and the other portion was to beef up medical board reporting and the ability to discipline doctors. On the one hand, there would be tort reform; on the other hand, the public should be protected by a substantial ability of the medical board to review and receive information about physicians who have not acted appropriately. I would like to point out on this section that these provisions, although necessary, I think are inadequate. In California, the fine for hospitals that fail to provide medical reporting is $50,000. The $10,000 level was found inadequate, and it was raised. Further, the public in California has access through a website to the medical board regarding disciplinary actions and information the board has received. Therefore, a member of the public can access the website and look up information about a physician. It is important for the public to be able to protect themselves with information in order to choose a doctor who could best help their family.

SENATOR RAGGIO:
I am not sure I followed everything. Are you suggesting changes to the language in the bill?

MS. PEVERINI:
I do not speak for the Nevada Trial Lawyers Association, but I think the $10,000 fine for failure to report is inadequate. I recommend an increase to $50,000, which is consistent with California's law for hospitals that fail to report changes in physician privileges.

SENATOR RAGGIO:
The sanctions in this bill were imposed on hospitals, was it not, and upon insurance companies?

MS. PEVERINI:
Yes.

SENATOR RAGGIO:
There was no fine on doctors in this bill. Am I correct in that? What is the sanction on doctors who fail to report?

MR. COTTON:
My understanding is that it does not involve sanctions involving doctors; it is hospitals, societies or insurance.

SENATOR RAGGIO:
Is the $10,000 fine for each occurrence?

MR. COTTON:
That is the way it is worded.

MS. PEVERINI:
I am pointing out that under the similar law in California, if a hospital has a change in physician privilege, the fine for failure to report is $50,000.

SENATOR RAGGIO:
What is your feeling on that? Nobody is here representing the hospitals or insurance companies. Is this what was agreed upon?

MR. GILLOCK:
I will make that representation for the committee. This reflects an agreement and discussion with all parties involved in drafting this.

SENATOR RAGGIO:
Let us go through it so we know what we are talking about. I know it will take a little time, but let us look at it. Section 14 is the first reference. Is that correct?

MR. COTTON:
That is correct.

SENATOR RAGGIO:
The new language indicates that by February 15 of every odd-numbered year the court administrator will submit to the Governor and Legislature, for the next regular session, a written report compiling information submitted by the clerks of the court for statistical purposes. There will be no information with regard to particular doctors. This is for statistical purposes. That is the purpose of section 14. If I am not reading it right or understanding it right or the committee does not understand, let us know as we go along. Is that your understanding of the purpose of section 14?

MR. COTTON:
Yes Mr. Chairman, that is our understanding.

SENATOR RAGGIO:
Is section 19 talking about the Board of Medical Examiners? Is that correct? That board is required by the same date to submit to the Governor and Legislature any report of disciplinary action taken against a physician for malpractice or negligence. That is strictly disciplinary action, right?

MR. GILLOCK:
That is correct.

SENATOR RAGGIO:
Any information that is reported to the board during that 2-year period pursuant to those sections will include information for statistical purposes. I do not know which specific sections they are. Somebody will have to tell us. What kind of information is required under those sections?

MR. WILKINSON:
The information referred to are actions or claims of malpractice filed against the physician and the disposition of those claims.

SENATOR RAGGIO:
Is that your understanding, gentlemen?

MR. GILLOCK:
Yes, Mr. Chairman.

MR. COTTON:
NRS 630.307, subsections 2 and 3, refer to suspension of privileges and disabilities, mental and otherwise, of doctors on staff.

SENATOR RAGGIO:
Has this been agreed to?

MR. COTTON:
That is my understanding.

SENATOR RAGGIO:
Section 20.

SENATOR CARLTON:
Before we go on, I want to make it clear that this information is not available to the public. It is information disclosed just for statistical and demographic reasons.

MR. GILLOCK:
That is my understanding. Therefore, the board, the Governor and the Legislative Council Bureau have information available as to whether or not additional action would be warranted or necessary. There

was a communication mix up that was not discovered until the malpractice crisis came into being. The courts, for example, did not realize there was a statute requiring them to report cases to the Board of Medical Examiners. They were called on the phone the other day and asked, "Where are all the cases for the last 13 years?" They said, "I don't know what are you talking about?" They were then informed. There was a total mix up between the court and the board. We are doing this to strengthen that coordination and communication.

SENATOR CARLTON:
As a consumer, could I contact the board and get information about what doctors have behaved or misbehaved?

MR. GILLOCK:
Under this statute, a consumer could not get information regarding a particular doctor. There is already an existing statute, and this is adding some beefed-up language. The use of the information does not change in terms of the outside public. My understanding is it is for the purpose of the legislature and executive branch to develop policy in the future.

SENATOR CARE:
How can the information be confidential when the clerks forward information that is gathered from public documents—complaints, answers, affidavits attached to motions, this, that, and the other. How can that be deemed confidential?

MR. GILLOCK:
As it practically exists, a person can sit down with their computer and go through court files and, in fact, find out how many cases have been filed at district court level against a particular physician. I think the disposition of some cases by way of settlement are subject to very stringent confidentiality agreements, and so forth. Therefore, state agencies have not been given access to this information.

SENATOR RAGGIO:
Section 20, with the new language, requires physicians to submit a list of all actions filed or claims submitted to arbitration or mediation during the two-year period for either malpractice or negligence, whether or not there is a settlement. Is that correct?

MR. GILLOCK:
That is correct.

SENATOR RAGGIO:
It would be required of the physician himself or herself. Section 21 is the disciplinary action section where you can be denied licensure. Do doctors have to be licensed every year? What is the situation?

MR. WILKINSON:
It is a biennial registration every two years.

SENATOR RAGGIO:
This would provide, as a matter of discipline, failure to comply with the requirements of NRS 630.3067. That is the same reference we had in section 19. Is that correct?

MR. WILKINSON:
That is correct. The effect of this provision is to also shorten the reporting period from 90 days to 30 days.

SENATOR RAGGIO:
Section 22 applies to the insurance company. Do you want to brief us on this? What does this change?

MR. WILKINSON:
Section 22 of the bill amends NRS 630.3067 to clarify that insurers and physicians must report to the Board of Medical Examiners any action filed within 30 days.

SENATOR RAGGIO:
Both the insurance company and the physician?

MR. WILKINSON:
That is correct. Both have to report within 30 days after an action is filed or a claim is submitted to arbitration. They also have to report the disposition of that action or claim. A further requirement is the Board of Medical Examiners report any failure to comply with that subsection by an insurer to the Division of Insurance which then, following a hearing, can impose an administrative fine of not more than $10,000 against the insurer for each such failure to report.

SENATOR RAGGIO:
If an insurance company fails to report all that information to the Division of Insurance, there is a hearing. After that hearing, if it is determined there was failure to comply, the division may impose a fine of not more than $10,000. Is that correct?

MR. WILKINSON:
That is correct.

SENATOR RAGGIO:
Is there any sanction if the doctor does not file the information?

MR. COTTON:
If they do not report it within the two-year timeframe, the insurer has the penalty.

SENATOR RAGGIO:
That was the previous reference we had.

MR. COTTON:
Right.

SENATOR RAGGIO:
What is the effect of section 23? A hospital, clinic, or other medical facility has the same requirement to report within 30 days if there is a change in privileges or disciplinary action is taken, and that is reported to whom, the health division?

MR. WILKINSON:
That is reported to the Board of Medical Examiners. If they fail to make that report again, they report that to the health division.

SENATOR RAGGIO:
What society does that refer to?

MR. COTTON:
A medical society.

SENATOR RAGGIO:
If there is a hearing and they determine that the facility, the hospital or other has failed to comply, they may impose a fine up to $10,000. Is that the understanding?

MS. PEVERINI:
This is one of the provisions on which I was focusing. It is crucial should this legislature decide to pass some type of cap, there be public protection by the medical board. We found in California a strong hammer was required to get hospitals to report changes in status. The medical board does not have the ability to track and monitor repeat offenders, people who need to be disciplined and weeded out of the system. We found it important to increase penalties to encourage hospitals to do the right thing.

SENATOR RAGGIO:
At the present time, we do not have anything in this State. This has been hammered out to some extent by agreement, and I think the feeling would be that we start somewhere. You know, $50,000 in California is peanuts compared to $10,000 in Nevada.

SENATOR TITUS:
I agree it should be higher. We should do an amendment to raise the fine, maybe, not to $50,000 but more than $10,000. Sometimes, they will pay $10,000 just to get rid of the nuisance. At the very least, I think there should be a graduated fine if there is more than one offense.

MR. COTTON:
I represent a lot of doctors in disciplinary-type actions with hospitals and have found there is little hesitation in reporting them to the board because then I end up dealing with the board. I have not experienced gross delays. Most of the time, it is a clerical error when they do not get reported, and $10,000 is pretty hefty for what is probably a clerical error under the circumstances. I have not seen any intentional, non-reporting of doctors. Plus, there are other provisions wherein doctors have to report it themselves under those circumstances. The combination would still have impact with a $10,000 fine.

SENATOR TITUS:
What about increasing it to $25,000 for the second or third offense?

MR. COTTON:
I suspect the medical board has enough sanction ability of various other varieties, that should they find a hospital deliberately doing something like that, the hospital would probably have some difficulty with its license.

SENATOR TITUS:
Is that true?

MS. PEVERINI:
That has not been our experience in California. We have had whole hearings from our business and professions committee regarding detailed problems with hospitals not recording.

SENATOR TITUS:
Can the medical board comment on this?

SENATOR TOWNSEND:
The medical board has no jurisdiction over facilities. It has to report this to the board of health or health division in the Department of Human Resources. That division then takes action over the hospital. So it would have to be the State Health Division.

SENATOR TITUS:
Who takes the license away?

SENATOR TOWNSEND:
That would be the State Health Division.

SENATOR RAGGIO:
That is whom this is reported to?

SENATOR TITUS:
Maybe we should hear from them if they take the license away.

SENATOR RAGGIO:
We are trying to avoid departure as much as possible from what has been agreed upon. We might see if this works, and if it does not, we can always augment the penalty for subsequent offenses.

SENATOR TITUS:
I appreciate that. This points out "no more than $10,000," so it might not even be $10,000. We do not want to cause complications by changing what has been agreed upon, but as we have seen throughout the course of the day, very little that has been agreed upon has stuck. When somebody makes a suggestion, other than certain parties, it is not appropriate, but when others make it, it is.

SENATOR RAGGIO:
I do not think that is the case here. I think we have been operating pretty well on a bipartisan basis.

We have so much to do. Let us continue with section 23. What is the additional change in subsections 3, 4 and 5. Again, we are talking about the Board of Medical Examiners, the clerk of the court in section 3 reports to the board, that is in the law now, if made within 45 days. Is that the change?

MR. WILKINSON:
That is correct.

SENATOR RAGGIO:
How about subsection 4?

MR. WILKINSON:
The board keeps that information confidential unless a court issues a subpoena compelling its release, and subsection 5 provides that the clerks will submit that to the office of the court administrator, which is serving as the clearinghouse for that sort of information.

SENATOR RAGGIO:
That addresses, in part, some of the questions Senator Care and Senator Carlton had about information being kept confidential. Were you concerned about whether these are public records? It looks like it is reachable by subpoena to compel the release of information.

SENATOR CARE:
I see that, Mr. Chairman. Specifically, it was the information culled from documents filed publicly, that information being considered confidential.

SENATOR RAGGIO:
Would that address it under those circumstances? As I understand it then, if this were processed, the information would be confidential regardless of public record status unless it is reached by subpoena. That is the way I would read it. Is that correct?

MR. WILKINSON:
That is correct, Mr. Chairman.

SENATOR TOWNSEND:
The Board of Medical Examiners, or any other licensing board, are required under our current statute to report publicly any actions they take over a licensee. That is public information and a subpoena is not needed to get it. It is not always posted, but if you ask, that is something we tried to accomplish in the last legislative session. I think there is probably a great deal of support for having public notice. If disciplinary action is taken, it should be publicly noticed on a website, or whatever. That is current public information by all licensing boards once disciplinary action or a ruling has been made. Complaints are not public, but actions by a board are.

SENATOR RAGGIO:
Scott Young has provided the information on Nevada's hospitals with emergency departments. They are: Battle Mountain General Hospital, Battle Mountain; Boulder City Hospital, Inc., Boulder City; Carson-Tahoe Hospital, Carson City; Churchill Community Hospital, Fallon; Desert Springs Hospital, Las Vegas; Grover C. Dils Medical Center and SNF, Caliente; Humboldt General Hospital/Harmony Manor, Winnemucca; Incline Village Community Hospital, Incline Village; Lake Mead Hospital Medical Center, North Las Vegas; Mount Grant General Hospital, Hawthorne; Mountainview Hospital, Las Vegas; Northeastern Nevada Regional Hospital, Elko; Northern Nevada Medical Center, Sparks; Nye Regional Medical Center and Skilled Nursing Facility, Tonopah; Pershing General Hospital, Lovelock; Saint Mary's Regional Medical Center, Reno; South Lyon Medical Center, Yerington; St. Rose Dominican Hospital, Henderson; St. Rose Dominican Siena Campus, Henderson; Summerlin Hospital Medical Center, LLC, Las Vegas; Tahoe Pacific Hospital, Sparks; University Medical Center of Southern Nevada, Las Vegas; Valley Hospital Medical Center, Las Vegas; William Bee Ririe Hospital, Ely and Washoe Medical Center, Inc., Reno.

What about remaining sections 29, 30, 31, and 32?

MR. WILKINSON:

The remainder of the sections merely mirror the current provisions for other physicians and apply them to osteopathic physicians who were not previously covered by any of these provisions.

SENATOR RAGGIO:
Is there any other testimony on these sections pertaining to the reporting requirements?

DENISE SELLECK DAVIS (Executive Director, Nevada Osteopathic Medical Association):
We are neither represented by the coalition or a part of it. We find no objection to this. Our licensing is done yearly, and we operate under a separate board. Our board works hard to see that all complaints are answered. They work in a fast and competent manner and do a very good job at disciplining physicians.

SENATOR RAGGIO:
What do you find objectionable if these requirements are applied to osteopaths?

MS. DAVIS:
Nothing at all.

SENATOR RAGGIO:
You are satisfied and comfortable with the language. Is there any other testimony on these issues strengthening the reporting requirements? The sections involved are sections 14, 19, 20, 21, 22, 23, 29, 30, 31, 32, 33 and 34. Is there any more testimony on those sections?

LARRY E. LESSLY (Executive Director, Nevada State Board of Medical Examiners):
Mr. Richard Legarza, our General Counsel, is present, as is Dr. Paul Stewart, our Secretary-Treasurer, and Dr. Donald Bettler, who is a public member of the board and not a physician. With respect to those sections that pertain to the Nevada State Board of Medical Examiners, we support them. There are a couple of language issues that Mr. Legarza can address, but we agree with the concept here.

RICHARD J. LEGARZA (General Counsel, Nevada State Board of Medical Examiners):
Look at sections 20 and 22, which are the requirements for reporting.

SENATOR RAGGIO:
Is it the requirement that a doctor physician can submit a list of claims in action?

MR. LEGARZA:
Correct. The language is, "submitted to arbitration or mediation." I think that was housecleaning and, maybe, was in an original bill. I do not think there is mediation and arbitration involved anymore in these things. That would be in sections 20 and 22 where the language is, "must report things that have been arbitrated or mediated." I think an initial draft included some mediation or arbitration, but I do not see that anywhere in the current legislation. It may be redundant language.

MR. WILKINSON:
I am not certain I understand exactly what the point is.

MR. LEGARZA:
As I see it, this bill does not talk about arbitration or mediation.

SENATOR RAGGIO:
This is the original bill.

MR. LEGARZA:
There is no arbitration or mediation in this bill other than requiring people to report. Are they going to be arbitrating or mediating?

MR. WILKINSON:
No, they are required to report if a claim is submitted to arbitration or mediation. There is no mandatory basis for that occurring.

SENATOR RAGGIO:
But it can occur.

MR. LEGARZA:
With respect to section 22, I have a question in regard to where it says, "The insurer and the physician licensed under the chapter must report to the board for malpractice or negligence against the physician and the settlement or award or judgment of disposition of the action or a claim within 30 days after the action was filed or the claim was submitted to arbitration or mediation and the disposition of the action or claim." If that is conjunctive then, they have the right to wait until the claim has been disposed of. I would suggest you consider changing the language to, "The action was filed within 30 days the action being filed or submitted to arbitration or mediation and/or the disposition of the action or claim, whichever occurs first."

SENATOR RAGGIO:
I think that is a valid point. When is the requirement to file this? Is it 30 days after the action was filed or the claim was submitted, or do they wait until the disposition? Or is there a requirement that both of those things be filed within 30 days?

MR. WILKINSON:
The requirement is that both be filed within 30 days. Thirty days after filing of a claim or after it is submitted to arbitration.

SENATOR RAGGIO:
There is a double requirement that when the action is filed or a claim is submitted for this purpose, it has to be reported within 30 days, and then after there is a disposition, that has to be filed within 30 days. That is my understanding.

MR. LEGARZA:
With all due respect, I disagree with that legal construction, be that as it may. If you are talking about giving the information to the Board of Medical Examiners as soon as possible, why not get it upon the time of filing, which is in another section where the courts are required to notify the board after a disposition of the case? Why not make that when the case is filed?

SENATOR RAGGIO:
I think this gives them a reasonable time to do that; otherwise, we would say within an hour, or two days, or something. I think it is just a matter of 30 days, whether that is a reasonable time or not is not my decision.

MR. LEGARZA:
That is all I have.

SENATOR O'DONNELL:
I think it would be far more efficient if you had the court notify the medical board, as well as the Legislature, or whatever else they must report to, instead of having one entity report to the medical board then the medical board has to report it to somebody else. Why not have it go to two places at one time? Change the other part of the law.

SENATOR RAGGIO:
Are there any comments? Is there any other public testimony?

SENATOR RAWSON:
There is a reason for the medical board to have the information. There is also a reason for the other entities to have the information. I think that is why there is the double requirement there.

RON KENDALL (Patient, Carson City):
I would like to share my thoughts. Two years ago, I went in for a simple, same-day sinus surgery, which turned out to be a medical disaster. Four days later, I had a seizure. Over a six-week period in three different hospitals, it was determined I had electrolyte deficiency and infection. One year later, I got my mind back, put the records together and found I had 51 different medications over a six-week

period. After I was home, I was detoxed, did not have brain damage and am happy to report I am healthy, wealthy and wise. Do I have a lawsuit? I probably do. People have said I do, but I will not go there. That is not anything I want to pursue. My mantra is that evil occurs when a good man does nothing. I am at that point where I can talk to others and make it known what is wrong with our medical system. It is not the doctors. Doctors are good doctors. There may be some bad doctors. The main thing I am concerned about is malpractice insurance. It is exorbitant. Doctors are leaving the State, and that affects all of us. My question is, are attorneys and accountants required to carry malpractice insurance? You may not be able to answer that, but I think it is worthwhile to think about it.

SENATOR RAGGIO:
I do not know if attorneys are required to, but I think it would be a foolish attorney that did not. Is there a requirement for attorneys to carry malpractice insurance?

MR. WILKINSON:
Not that I am aware of.

SENATOR RAGGIO:
I don't know about accountants.

MR. KENDALL:
I am not trying to direct this at any particular profession, but I think it odd that doctors are targeted. There are doctors who are leaving because medical malpractice insurance fees are so high. It does not make sense to me. It seems a better way to do this would be mandatory, binding arbitration. I know that has been discussed, but this is something I would ask you to think about. It might be a more effective, reasonable and economic way to handle the problem. I could go on with many more things that I see wrong with the medical system, but I will not do that. This is the one message I wanted to get out. I appreciate your time and patience to listen to my concerns. Believe me, this is not directed at anything other than the system itself.

One other thing I will mention is we have a shortage of nurses and that needs to be taken care of. I spent time in the Marine Corps, and I can tell you that it is the NCOs that make or break an organization. In the medical system, it is the nurses that will make or break an organization. You do away with that; you cut down on it, and you are shooting yourself in the foot. Thank you very much.

SENATOR RAGGIO:
Did Senator Mathews tell you to say that about the nurses?

SENATOR MATHEWS:
I said, Amen! I wrote that!

SENATOR RAGGIO:
Your ideas are certainly good. We have covered some of this in previous discussion. Some of these issues are not within our province during this special session, but I am sure this issue will be revisited at length during the regular session that convenes in February. You might make yourself available at that time.

MR. KENDALL:
Perhaps, you could think about reducing the cap on the malpractice insurance and what a new doctor, is it $1,000,000 minimum, has to come up with?

SENATOR RAGGIO:
Under this bill, it would be required, to keep their license, to have a minimum amount of $1 million per occurrence and $3 million in the aggregate.

MR. KENDALL:
The truth of the matter is, I am not an accountant, but if you study the cost to the patient to pick up the slack, in the end, we are paying for it.

SENATOR RAGGIO:
I think there will be a lot more accountants these days having malpractice insurance.

MR. KENDALL:

I wanted to start with Enron and Worldcom. That was a blessing for us because it was a wake-up call. We now have our own wake-up call right here with malpractice.

SENATOR RAGGIO:

Thank you for your time. Is there any more public testimony? We are dealing with reporting requirements. Is there any other discussion?

SENATOR CARE:

I should have asked this of Mr. Cotton, who is a lawyer and also represents doctors. It seems to me section 5 of Senate Bill No. 2 provides doctors something that is given to no other profession, and that is caps. We do not do this for attorneys, veterinarians, accountants or anybody else. A result of high insurance premiums, part of which as I understand it, comes from the so-called rare, bad doctor. Under this bill there is nothing that enhances a future patient's, or potential patient's, ability to find out something about a doctor in which he may or may not have an interest. Mr. Cotton, you are an attorney; do you know Martindale Hubbell? Our peers rate us "A," "B," "C," or "no rating," and the public can find it out. I do not think doctors have the equivalent. How do I find out anything about a doctor I am thinking about using? What do I do? There is no Better Business Bureau I can go to. There is nothing. There ought to be something.

MR. COTTON:

In the Las Vegas area, there is an annual poll by doctors of other doctors who they consider the best in Las Vegas. They vote, and most of the categories of physicians list anywhere between 10 to 20 different doctors. That is the only thing of which I am aware at the present time. I am not aware of any regulations that would open up practitioner data banks or anything of that nature. That may be a subject for a different day.

SENATOR CARLTON:

Earlier, I asked these gentlemen and Mr. Lessly about the reporting factors. They were right, and yet, they were wrong. A bill was passed last time that doctors have to report. However, in pulling up the web page and looking at the names of the doctors and information provided, a consumer cannot distinguish what a doctor is being disciplined for regarding a medical procedure. If it was a revocation or a violation, they were supposed to hand something over. Information is available if a doctor misbehaved in another state, but there is no information on how the doctor may have been cleared or disciplined in an actual medical procedure. I believe the public is more interested in how doctors behave in their actual practice.

MR. LESSLY:

We have a toll-free number, statewide, and any citizen can pick up the phone and call us. We will tell you where a doctor went to medical school, when he was licensed, his specialty, where his office is and any reported malpractice. I believe you are getting ready to strengthen the reporting process to us. We will tell you whether we have ever taken disciplinary action against a physician and send a copy of the complaint and the order setting out exactly what happened with that physician. We have a website, up and running, that tells about disciplinary actions through our newsletters. Check that website next month because it is being upgraded to the point that you will be able to get more specific disciplinary action.

SENATOR CARE:

When you say any person who makes the phone call can find out about malpractice, are you talking about a judgment or a complaint?

MR. LESSLY:

Whatever has been reported to us by the insurance carriers, hospitals or courts. I think that will get better if this legislation is passed. We cannot tell you for certain that it is complete because we cannot guarantee all those reports have been made to us.

SENATOR O'CONNELL:

Would you mind giving us the toll-free number?

MR. LESSLY:
To tell you the truth, I do not know it.

SENATOR RAGGIO:
Is there any more public testimony on this phase of the bill? Are there any proposed amendments to this portion of the bill? I will take a motion to adopt sections 14, 19, 20, 21, 22, 23, 29, 30, 31, 32, 33 and 34 of Senate Bill No. 2, all regarding the strengthening of the reporting requirements relating to disciplinary actions, claims, settlements and/or awards against physicians.

SENATOR O'CONNELL:
So moved.

SENATOR RAGGIO:
Is there any discussion on the motion? All in favor of the motion indicate, aye; opposed.
The motion is carried unanimously.
Next, we are going to address section 13, which allows for periodic payment of future damages. We are going to recess until 6 p.m. I ask that any authoritative representative of the insurance companies be present at that time. I want further testimony from them on the effect of this bill, and we will also continue in the evening to take up any additional sections of the bill. Hopefully, we can conclude it this evening. I want to compliment you all on asking good questions, and I think we have made considerable progress up to this point. Is there anything further before we recess? Otherwise this committee is in recess until 6 p.m.
The Committee of the Whole will please come back to order. First of all, has the committee had time to review this proposed amendment that covers the trauma setting as well as the pro-bono situation? I am told that the Governor will specifically include the language covering both of these in a new proclamation. Do you want more time to look at this language?

MR. GILLOCK:
No, I have read the language and it seems to be consistent with the actions of the committee. The only thing I think we want to be sure of is that we have the presumption language that Senator Rawson sought be put in there. The Good Samaritan applies fully.

SENATOR RAGGIO:
We can wait on this. Do you think we will have that this evening, or are we going to wait until later?

MS. NEEDHAM:
Senator, we are working on that now. As long as we are in here, I think you can have them later.

SENATOR RAGGIO:
The definitions of trauma that are in the NRS as well as references in the administrative code have been distributed to the committee. Let us go next to section 13 which allows a judge, at the discretion of either party, to enter a judgment providing for periodic payment of future damages. I am not certain the bill is drafted that way. Is it drafted to read "at the request of the claimant?" No? Counsel will you enlighten us on what this provides?

MR. WILKINSON:
Mr. Chairman, under the current law a claimant can request an award be made in the lump sum or through an annuity. The change that is made in the bill is that at the request of the claimant the court has the discretion to decide whether the payments for future economic damages will be made in a lump sum, in an annuity, through the posting of a bond or other security by the defendant. The discretion as to whether that occurs lies with the court rather than being at the election of the claimant.

SENATOR RAGGIO:
I think, originally, it was contemplated that either party could make the request. This bill would continue the present situation where any election has to be made by the claimant. It gives the judge the discretion as to the manner and the posting of the security. Is that correct?

MR. GILLOCK:

Yes, Mr. Chairman. What this bill does is it gives the claimant the authority to ask the court for that, but what it really adds is the opportunity for the defendant in subsection 6 to post a bond or surety if the court so directs and allows them to do that. This was language that was agreed upon by both representatives of the legal and the medical field. It is part of the negotiated agreement that leads to the language contained not only in this section but the other sections. We feel it is in the best interests of the claimant who may need lump sums as opposed to long-term payments and to have that decision making process in their own hands.

SENATOR RAGGIO:

Unless the claimant requests otherwise, the claimant will get the reward in a lump sum.

MR. GILLOCK:

That would be correct.

SENATOR O'DONNELL:

This goes to the heart of an award to an individual. If you have a fixed-dollar award of $500,000, it is periodically paid without any escalator, without any interest on that award. The present value of the $500,000 paid out over a 10-year time frame is still $500,000. Now, an annuity is different from what I am reading here, correct me if I am mistaken. The present value of an annuity will be greater than the $500,000. In other words, when you get an award, you get a certain, fixed amount of money, but if you get that over time without interest, then you are penalizing the victim and penalizing the lawyer because the lawyer is not going to get as much. Is that what this says?

MR. GILLOCK:

I do not believe so, Senator. I think that what this does is it allows an annuity to be purchased. In subsection 5, it says, "If an annuity is purchased pursuant to paragraph (b) of subsection 3, the claimant shall select the provider of the annuity." What it does is that it gives the claimant the opportunity to have an investment that falls under court supervision. It is a tool that some claimants need to have available to them. They and their representatives need to make that decision. As to the present value, I think it works a bit to the opposite. The present value of $500,000 would be $300,000 not more than.

SENATOR O'DONNELL:

It would be less than, but the award is a $500,000 award.

MR. GILLOCK:

The award would be a $500,000 award, and it is assumed the annuity would make it so that the plaintiff would receive more than the $500,000. They would be getting the benefit of the investment.

SENATOR O'DONNELL:

But, as I read this language, and I would invite you to read it as well, in subsection 5, it talks about an annuity. It is specific in the word "annuity." However, in subsection 6, it looks at the words "bond," we all know what that is, and "other security" which could be anything. What you are allowing the court to do for the victim is post a security or a bond paid out over time. It does not mention anything about interest.

MR. GILLOCK:

I think the intent of this amendment is to place an annuity or a bond under court supervision, but at the same time, what it does is the most significant aspect of this provision is it releases forever the defendant and his insurer from any obligation to make periodic payments pursuant to the award. The claimants would be concerned about the defendant's insurance company having control over or being responsible for making them additional payments when it became necessary for them to go to court to get justice in the first place. What this does is to allow the court to give them this annuity and, at the same time, terminate any responsibility for the physician to the plaintiff.

SENATOR RAGGIO:

We should not loose sight, Senator and those who are addressing this, of the existing law that is not being changed. It pertains to periodic payments and provides in subsection 4, "that if a claimant receives

periodic payment, the award must not be reduced to its present value." The amounts of periodic payments are equal to the total amount of all future damages. The authority for an annuity is in existing law. What this adds, is that the court has the right or the defendant has the right if the request is made under subsection 3, paragraph (b). The court has the discretion to require an annuity. That is existing law, or by other means of a bond. This gives an alternative to the annuity that it can either be a bond or security to ensure full payment. There is post judgment interest. How is that affected in any way by this? Is the interest continuing to run on periodic payments?

MR. GILLOCK:

Mr. Chairman, it is my understanding that once the election is made then the defendant and his insurance company is relieved from any responsibility under the judgment. There would be a satisfaction of judgment filed with the court, and the funds would be dispersed either through, a: a lump sum which has been reduced to present value or b: an annuity. The post judgment interest would stop at that point, and the claimant would begin getting investment on their annuity or their lump sum investment.

SENATOR RAGGIO:

Do you understand it that way too, Mr. Cotton?

MR. COTTON:

I understand the mechanics of it to be that same way. It would factor into that in that once the payments start to be made, the total lump sum that is going to be paid out into an annuity situation is going to cover that anyway.

SENATOR RAGGIO:

You represent the claimant. Is that a good arraignment for the claimant?

MR GILLOCK:

It can very well be in many circumstances. You might have a minor child who has parents in whom you have questionable confidence. You want to be certain you are protecting that child, or you might have a senior citizen who needs continued care. It could well be a tool that would be very effective.

SENATOR TOWNSEND:

Thank you, Mr. Chairman. I know that this is not changing the current structure, but I am a little confused as to what the benefit is currently visa-vi the rising cost of premiums.

Let me be specific, I would think that the way to help the premium problem as well as the claimant's needs would be that payments would be made in the following manor: they would all be periodic except for expenses the claimant incurred to bring the action, lawyer fees etc. to be paid in a lump sum. The remainder would be paid in installments over time including interest to make certain economic damages were covered every month, whatever they were, unless the court said it is in the best interest of the claimant that it be paid entirely in a lump sum.

There are two things here. One, you must be able to cover your expense of bringing the action, then two, you must make certain the claimant gets their economic damages paid for each month because those encompass many things, usually substantial medical care. The court would have the jurisdiction to say, "Whatever remains to be paid out in periodic payments could be paid in a lump sum upon the claimant filing with the court."

I think your point is well made. I am not certain someone would always ask for a periodic payment if they do not know that it might be in their best interest. I think it should be flipped because it gets their expenses paid. It protects the claimant to get all of their economic costs paid out over time to make certain their medical expenses are paid, unless the court decides it is in their interest that the rest of it is paid.

That is what I am asking. I think it is backwards. I am trying to be logical and make certain their expenses are paid, their costs incurred to bring the action are paid and the remainder for their economic benefits be paid unless the court decides it is in their interest that they receive the remainder in a lump sum.

MR. CROCKETT:

Mr. Chairman, rather than have the court or the government be that paternalistic, where they dictate that, the existing law and this law allow the latitude of choice. If you have a situation as Mr. Gillock described where you need to protect against the risk of imprudent investment or you have a senior citizen who is single and does not have anyone else to administer over their needs or to watch over them and you need a court appointed guardian to watch over their funds, then a structured pay-out may be the best approach. However, if you have someone who is a sophisticated person who may want to take the lump sum, invest it and who may choose to buy an annuity or may choose to buy a certificate of deposit, that person may say, "do not tell me how to invest my money. I am a sophisticated person. I can take care of it." This allows both options without paternalistically telling someone "you must do it a certain way."

SENATOR TOWNSEND:

Mr. Chairman. I do not disagree with Mr. Crockett, I am just making certain in my own mind the claimant's expenses are always prepaid based on what it costs to bring the action and that there is money there so that their needs were met unless they go to the court and request that they manage their own money. The importance is to make certain that the claimant not only paid his expenses, which are usually incurred by your firms, experts, etc., to bring the action, but that there is enough money so at the time they will have their needs met. I am thinking of the worse case scenarios.

MR. COTTON:

The practical problem is that the requests are almost never made. I think the Chairman mentioned he thought it was at the request of either party and that the court could award it, but as a practical matter, I do not know that the requests are made that often. I think, along the terms you were talking about, if it was down to a savings situation and if the party requested it and it was paid up front, that might have some impact, but I do not know if it has a huge impact.

SENATOR O'DONNELL:

When you post a bond, you do not have to put up the money. You just have to post a bond proving you can put up the money. A bond is different than actual cash. If you ask the court for a $500,000 bond to be paid out over 10 years that person may get $50,000 per year for 10 years. The time value of money does not equate to the $500,000 award. Basically, the victim technically gets paid less in real money.

MR. CROCKETT:

The bond is much like an appeal bond. It is designed to establish security so that the person knows that there will be enough to pay off. It is not in the precise amount of the judgment. Instead, what is analyzed is what will be the total payout on this judgment in the course of time. It is a bond to guarantee payment of the total sum. It is not a bond in the amount of the judgment. You mentioned that a bond is just proof you could pay the money. It most definitely has to be so heavily collateralized that as far as the injured party is concerned, they do not have to worry about it because the bond will take care of them if all else fails.

SENATOR O'DONNELL:

Where did this language on subsection 6 come from? Did it come from the attorneys or did it come from the doctors?

MR. CROCKETT:

All I know is, it was agreed to by both parties.

SENATOR O'DONNELL:

But you do not know where it came from.

MR. CROCKETT:

If it was agreed to by both parties, it is a joint product.

MR. GILLOCK:

The way I recall how this language came down, was that the defendants and the plaintiffs representatives worked diligently on subsection 3 and subsection 3, paragraph (b) to make certain that they reflected a situation where the court would have the authority in the right cases to issue the bond and the surety. That was one of the requirements that the medical group really wanted in there. It would give the court the discretion to let the defendant and his insurer out of this equation. Once they were satisfied, there would be payment.

SENATOR O'DONNELL:

All right.

SENATOR RAGGIO:

Any other questions or comments. Any public testimony on this portion of the bill? Any amendments required on section 13? If not, I will accept a motion. Motion was made by Senator Rawson to adopt the language in section 13. Is there discussion on that motion? All in favor indicate by saying, aye; any opposed.

Motion is carried unanimously.

We will address the one word change in section 16 in the existing law. This is on the issue of making it mandatory for an attorney to personally pay additional costs, expenses and fees if there is unreasonable conduct defined as "unreasonably and vexatiously extending a civil action" that is existing law. Presently, the court may do this. This change as we understand it, "would mandate the court to require an attorney to pay that upon a finding that the filing of an action is not well grounded in fact, is not warranted or made in good faith or is unreasonable and vexatious in extending a civil action." That is existing language. As I understand it, what this does is that instead of giving the court discretion, if the court makes that finding and the court would have to make that finding, then it would be mandatory as a sanction against that attorney. Is that the understanding?

MR. GILLOCK:

Mr. Chairman, it is my understanding that this could be called the "frivolous law-suit provision." The only thing different is that you will notice in subsection 1 it says, "files, maintained or defended a civil action" because it has been found over time that in many instances there may be a great deal of expense that was unnecessary and has accrued as a result of vexatious actions by a defendant or defendant's council. This is language that was agreed upon by the parties and applies both ways.

SENATOR RAGGIO:

As I would understand this, I want to be careful how I phrase this, there can be attorneys who over the course of time and I think they become known to their colleagues and we have had screening panels for example that file cases whether or not there has been any finding, and probably some of their own colleagues feel that a lot of those cases are vexatious or frivolous and are not brought in good faith or, for that matter, defended in good faith. That is existing language. Is that what we are after?

MR. BRADLEY:

Senator Raggio, because I was involved, I know the word was changed from "may" to "shall" to take away the discretion of the judge. If the judge feels that there was that type of conduct, he must require an attorney to pay.

SENATOR RAGGIO:

Isn't that what I said? I think that is what I understand. I wanted to make certain all the members of the committee had that same impression. Is there any need to change this language? Is there any public testimony on this matter?

SENATOR CARLTON:

Could you give me an example, as a lay person, as to what vexatious may be.

MR. GILLOCK:

Mr. Chairman, in response to that question, it would be actions that are used to receive some type of revenge or to take some type of action that is not warranted under the circumstances. It runs up the

litigation expenses causing the parties to expend funds that would not be necessary to spend. For example, suppose you file a lawsuit and someone decides they want to make it difficult for you. You had a grade-school teacher in New York, and you had a high-school teacher in Los Angeles. Because they had questions about how well you might do in the future and because you said in your moving papers that you intend to become rehabilitated and that you were going to obtain further education, the attorney would go to New York and take the deposition of your grade-school teacher, and go to California to take the deposition of your high-school teacher. All of this could be deemed by the court to be unnecessary and very expensive. That would be the type of conduct we would be trying to prevent.

MR. COTTON:

We find that in both sides of the issue, whether plaintiffs and defendants, that you do have cases that periodically come up that are truly spite cases on one side or the other. They are "I- don't-like-that-person" cases, and they will go forward. Some of those are fairly obvious. On the whole, most of the cases are not going to be in that situation. I have had panel cases where there were 16 or more defendants, and when we came out of the panel, there were only two doctors who were actually sued. Now, that the panel is being eliminated, sending a case direct to litigation, our intent was to make certain we do not end up with this grab-bag of every doctor who happens to appear on a record end up in district court. Someone must do their homework before they file a lawsuit. It was our intent, in looking at this, that there would be some teeth in the law that would serve the same purpose as the screening panel.

SENATOR RAGGIO:

Mr. Echeverria, is this peculiar to Nevada, or do they have this in California, also?

MR. ECHEVERRIA:

Fortunately, I have not had experience with this section in California.

SENATOR RAGGIO:

Does California have anything similar to this?

MR. ECHEVERRIA:

Not that I am aware of. There is something in California similar to our Rule 11.

SENATOR RAGGIO:

This is existing language. It will still require a finding by the judge if that exists and if he does make that finding then it is mandatory.

SENATOR CARE:

Thank you, Mr. Chairman. I was not here in 1995 when the current statute was enacted, but I think I have heard discussion of this when it came out of the Senate Judiciary Committee. This is one subject the chairman of the committee, Senator James, and I have always agreed on. Give more discretion to the court, but now we are taking discretion away from the court. We always hear about the frivolous lawsuit, and I always say the frivolous lawsuit is any time you get sued. That is a frivolous lawsuit. A lawsuit with merit is when you sue the other person. That is a good lawsuit.

Have any of you or your colleagues ever filed a motion for sanctions under the existing statute. If you did what happened? Were you denied the sanctions and why? If you got the sanctions, I would like to know who were the other attorneys. Does anyone really use this thing? There are no case annotations in this statute. There is also rule 11 under discovery. There is already a mechanism in place. Mr. Gillock, you have talked about going to New York for a deposition, but the discovery commissioner can handle that. You have a protective order. You can seek sanctions.

MR. GILLOCK:

I have sought sanctions in many cases, and I have also, though not under this rule or this statute, sought sanctions under Rule 11 and had the court grant sanctions and grant substantial fees in instances where the discovery was propounded and the depositions were deemed not to have been warranted. But, I think that one of the reasons that this language is requested by the defense when we started these negotiations was because we do not really have a track record on this. The doctors have been saying in

the press, "frivolous, frivolous, frivolous," so we said if there are frivolous lawsuits, then we are going to give you a tool to help us take care of that problem.

MR. BRADLEY:

In response to Senator Care's question, I brought this statute to the attention of two prominent medical-malpractice defense lawyers within the last 30 days because of this discussion. Neither one of them were aware that the statue existed. They are both planning on using them in cases, and we offered, on behalf of our organization, to provide experts in their cases.

SENATOR RAGGIO:

Any other testimony? I will accept a motion by Senator Townsend to adopt the language in section 16. Any discussion? All in favor indicate, aye; any opposed?

Motion is carried unanimously.

Section 8 is new language where an action is brought and filed in district court for malpractice, the court must dismiss the action without prejudice. That means, it can be brought, again, before the court if the action is filed without an affidavit supporting the allegations contained in the action, which is submitted by, a medical expert practicing in an area substantially similar to the type of practice engaged in at the time of the alleged malpractice. May we have your comments on this change? The change was agreed to in the negotiations. Is that correct?

MR. BRADLEY:

Yes, that is right Mr. Chairman. This was introduced because of the abolition of the screening panel. The screening panel files are required and the expert affidavit is subject to dismissal. We want to make certain that when there was a complaint filed that it is filed in good faith. The way to do that is with a summary affidavit from an expert in a substantially similar area indicating that the expert has reviewed the record.

SENATOR RAGGIO:

If there were an action against an orthopedic surgeon, you would expect that an affidavit would be required from someone who was an orthopedic surgeon.

MR. BRADLEY:

That is correct.

SENATOR RAGGIO:

Or some similar doctor, if there is one. It could not be a general practitioner.

MR. BRADLEY:

Agreed. For example, spinal surgery, both orthopedic and neurosurgeons do the same type of surgery, someone who is familiar with the same standard of care.

SENATOR CARE:

Thank you, Mr. Chairman. If you file a lawsuit and if there is no screening panel, the clerk is not going to know, who, then, makes the determination that this expert is the expert required under this section. When is that determination made? As I read this phrase, "medical expert who practices," I wonder about the medical school professor who does not practice or the recently retired doctor who is not practicing. Can he not be an expert witness?

MR. BRADLEY:

Those are both good points. We have tried to work on this a bit, but we have not had much progress. A recently retired, or someone in a medical school setting, if they meet the other qualifications, we believe would be appropriate for an expert.

MR. COTTON:

Mr. Gillock and I were just discussing that if we change the word on page 4, line 34, it will make more sense.

SENATOR RAGGIO:

What would you suggest.

MR. COTTON:
In response to Senator Care's question, change it to "practiced" with a "d" at the end instead of "practices."

SENATOR RAGGIO:
He could be a professor who may not be engaged in practice.

MR. COTTON:
No, it is that they practiced or that they qualified at the time of the alleged malpractice. If they were practicing in 1998, but they may be retired, today, they would still have been practicing at that time.

MR. GILLOCK:
Basically, the intent of this language was to change the existing situation.

SENATOR RAGGIO:
I think the point has been well made. Let us say, you have a person who is a fellow in the American College of Surgeons, and yet, he may not practice in that area. He may not have practiced in that area at the time of the incident and is now a professor at the university medical school, but he is a fellow. Should not that person be sufficient for this purpose?

MR. COTTON:
There is a problem with that situation. I have had it happen several times in the last six months. One doctor was a neurosurgeon who had not practiced for 20 years before the incident occurred. He was a neurosurgeon, but he had not practiced for 20 years.

SENATOR RAGGIO:
I suppose you could have a neurosurgeon who did not qualify to be a fellow in the academy even though the doctor is practicing. Could you?

MR. COTTON:
Yes, you could. The problem is the 20-year differential. There have been so many changes in practice that have taken place, the doctor would be too remote from the time of the incident. Our concern is that a person could be called in who really did not have knowledge of what was going on at that time. That is not an unusual event to see that happen.

SENATOR RAGGIO:
How are we going to solve this?

MR. BRADLEY:
If the committee is willing to give some recognition to a retired physician then we could say something along the line of, "who practices or practiced." If the concern is that you want to avoid that 20-year lapse, it is going to be very difficult.

SENATOR RAGGIO:
What can you agree on to help us?

MR. COTTON:
I think what Mr. Bradley said, "practiced or practices," line 34.

SENATOR RAGGIO:
You would add, "who practiced or who practices in an area." Is that satisfactory to you?

MR. COTTON:
Yes.

MR. BRADLEY:
Yes.

SENATOR CARE:

How is the determination of whether this medical expert is indeed an expert is made. If I have an expert who files an affidavit attached to the complaint, does that mean I can use him as an expert in the trial. Are there different standards for that? Who says, "Yes, this is an expert?"

MR. COTTON:

The judge almost always has to make that determination even at the time of trial. They always determine whether or not someone qualifies to testify as an expert in a medical malpractice case. Today, they have to do that. The standards have been established for that in a lot of different cases and decisions. They will be familiar with the standard, which has to apply whether they did it at the beginning with the filing of the complaint or five minutes after they have been on the witness stand. Either way, they have to make that determination on a fairly well defined standard recognized by the judges.

SENATOR RAGGIO:

Section 12 concerns the medical expert testimony. Is that same issue involved here? Expert medical testimony in a trial, is that right, "may only be given by a provider of medical care who practices in an area substantially similar." Should that have that change in it?

MR. GILLOCK:

Mr. Chairman, yes. Section 12 is the existing law with the adding of "expert." I think we need to make that change again on line 44, "who practiced or who practices."

SENATOR RAGGIO:

Can we take care of that too, Mr. Cotton?

MR. COTTON:

I think that will be appropriate.

SENATOR COFFIN:

How much does it cost to get someone to do the action in section 8 since it is a little different from what we are presently doing? Now you are talking about finding someone who is going against one of his/her colleagues perhaps in this community or in the community in which the action took place.

MR. BRADLEY:

It is important that this discussion takes place. If you go to a full-blown affidavit, it is a $3,000 to $5,000 minimum cost. The problem is the only thing that is available is the medical record. This was one of the shortcomings of the screening panel. We believe it is unfair to require a full-blown affidavit because there is such limited information available in the record without the ability to ask anyone what happened and why was there not any records for this past day. We would like to see more of a summary affidavit. This is meant to serve, along with the lawyer pays, as a deterrent to just filing an action to extort or do something that is not done in good faith. To go too far would defeat it. I hope it is the intent of this body not to turn this into a war at the beginning of a case as to whether this expert was qualified or not.

SENATOR COFFIN:

It worries me a bit because you are either going to have to spend a lot of money or you are going to have to find a character out of a John Grisham novel to fill this role.

MR. BRADLEY:

I will tell you, we are finding younger physicians in specialties are more willing to get involved. However, at the same time, you are seeing universities sending out protocols that their physicians are no longer allowed to serve as experts. It is a challenge to get a good expert. If you have good contacts and you are respected on both sides, as Mr. Cotton is and as we are, you can get them. It is expensive. Again, let us not turn it into a battle on the front end.

SENATOR COFFIN:

This does not compel that the person had to have examined all of the documents.

MR. BRADLEY:

This affidavit should say that they have reviewed the medical records, and based on that limited information, it is that expert's opinion that there is a meritorious case.

MR. COTTON:
Our position is not that.

The panel is removed. The panel was perceived by this Legislature as an impediment to frivolous litigation. Our position is they need a substantive affidavit from an expert. That money does have to be expended on the front end in a meaningful fashion with an affidavit supporting their allegations of negligence. Not just an "I-think-this-person-committed-malpractice affidavit." This is going to turn us backward on what we are attempting to do by removing the panel. We are going to experience high-volume filings if they can get by with a $500, one-line affidavit.

SENATOR COFFIN:
What does it cost now to file?

MR. COTTON:
The screening panel has a true-thought process where they are trying to persuade two lawyers and three doctors to rule in their favor so they can get a favorable finding. So am I. It is the same thing in that situation. Practically speaking, a one-line affidavit is not going to be particularly successful. Our position is that this is the same substantive type of affidavit that will be required at the panel in order to pass muster on this dismissal.

SENATOR COFFIN:
Is this going to wrap up the cost for the initial entry into the legal system?

MR. COTTON:
Much the same way it wraps up the costs of the screening panel that was part of the intent of the screening panel that they did have to have expert affidavits. It was a requirement that they would have accompaniment of an affidavit by an expert, and the practical impact of not having one would be a result of finding a no reasonable probability of malpractice. This is basically the only guard we have against a jacking up of filings and cases. If there is no impediment at all on the front end of these cases, there are a number of lawyers out there who file a lot of claims if they can get by cheap to get it on file and to see if they can move the case in that direction. That is something we were very intent about trying to avoid. If we are not going to have the panel, then it had to be substantive at that point. The reality is, they can find experts. That happens on a regular basis on a meritorious case.

SENATOR COFFIN:
This is the equivalent of a huge filing fee.

MR. COTTON:
It is the equivalent of the screening panel costs that they incurred anyway.

SENATOR RAGGIO:
It was required in a screening process?

MR. COTTON:
They had to have an affidavit of an expert for the screening panel. Not only, an affidavit, but one that would prove to six people that they had a case. They had to run that cost up already.

SENATOR RAGGIO:
I would think as a practical matter unless a claimant could get some kind of testimony like that in affidavit form, I do not think many cases would be able to proceed. There would have to be something like that. Wouldn't there?

MR. BRADLEY:
Yes, however, realizing that only the medical records are available when that large affidavit comes in, now, you have something that has the ability to be subject to impeachment because the records were not thorough. There are problems produced by this, and I am trying to avoid that huge battle. If you have

two or three defendants and you need to bring in an orthopedic surgeon, a trauma surgeon and a specialized nurse, you can spend $3000 to $5,000. It becomes very expensive.

MR. COTTON:

The practical matter is, the medical records were all that they had available at the screening panel. They needed to submit a substantive affidavit in order to prevail. Those costs have been present in the system since 1985 or whenever that act took place and are a barrier to frivolous litigation in the medical malpractice field. It is something perceived strongly, not just by the doctors but by the panel, as keeping the numbers of claims down when the frequency rating is calculated on these things. This is an essential issue. If we are going to drop the panel and then turn around and increase the frequency, we are defeating the whole purpose of trying to cut down on litigation. In my opinion, it is a serious mistake to not have both sides. Eliminate the panel, but require a substantive affidavit. If someone is going to pursue a case anyway, they are going to have to get an expert who is going to review all the records and substantively come up with legitimate opinions as opposed to a one-page affidavit saying, "I think there is reasonable probability of malpractice." Then 16 months later, they come in with a different expert that now has a substantive affidavit as opposed to knowing in good faith in a strong affidavit from an expert that they had a legitimate case from the time that they filed.

SENATOR CARE:

Because the statute does not impose the limitation, I am assuming the expert can be outside the jurisdiction or from outside the State. We all understand that this expert can then be called to trial by the defense if they chose to do so. Is that correct?

MR. BRADLEY:

No, if I bring an expert in and he is from out of state, there is no way Mr. Cotton can bring him in also.

SENATOR CARE:

Let us say there is a jurisdictional issue with another county, perhaps. If I file a lawsuit and I list an affidavit expert, the opposing party may want to depose him to testify at trial.

MR. BRADLEY:

If I continue to use him as an expert through the course of the trial and disclose him, but Mr. Cotton is correct. At the screening panel, we have to file an affidavit and so did the defense. If we are going to be required to file one along the lines that Mr. Cotton says, then what is good for the goose is good for the gander.

SENATOR CARE:

What are you going to do on the case where you have multiple causes of action? Malpractice is one of, say, five causes of action. That complaint still has to have the affidavit?

MR. BRADLEY:

No, the question in the case is whether the care of the defendant was below the standard of care. That is the determining factor. You are looking at the potential of who may be in a case. There could be a loss of consortia claim, or there could be many children who are asking for a wrongful death claim, but those are separate causes of action. You do not need experts on those. You need experts to look at the standard of care of the defendants involved.

SENATOR O'CONNELL:

Would this language prevent one side or the other from having the expert be a person who does nothing but make their living traveling around being an expert witness.

MR. BRADLEY:

There are those experts, and they are available to both sides. Mr. Cotton is smart enough not to bring any professional witness into his cases, and most of us are smart enough not to bring them in, because they do not withstand cross-examination very well. If you show that out of their income tax return of $180,000 a year, $170,000 was made testifying across the country. It is not a wise decision to bring in that kind of a witness.

SENATOR MILBURN:
On the question of verbiage on section 8, you said, "practiced or is practicing." That still does not negate the doctor who practiced 20 years ago and who is not practicing now. What about "recently" practiced?

MR. COTTON:
The tail end of that is "at the time of the alleged malpractice."

SENATOR MILBURN:
Clarified, thank you.

SENATOR RAGGIO:
Is there any other public testimony on either section 8 or section 12? Any amendments required on either of those sections? I will accept a motion from Senator Rawson to approve the language as amended in section 8 and section 12. Add the words "practiced or practices or is practicing." All in favor indicate, aye; any opposed? Senator Coffin voted "no."
The motion carried.
The last item we are going to look at is the settlement-conference language in section 9, page 4, of the bill. This is entirely new language. Gentlemen, please explain this section.

MR. GILLOCK:
Mr. Chairman, under section 9, under the new rules, we will have a mandatory settlement conference. At that point, the settlement conference would be of no benefit to anyone if the party was allowed to attend without their insurance company representative. That is the rule. What we want to do is add "all the defendants representatives" because the language on line 38 failed to put in "a hospital's," and opposed to saying "hospital or doctor," we should say "all the parties should attend and all defendants insurance companies."

SENATOR RAGGIO:
Are you suggesting some additional language?

MR. COTTON:
On line 38 where it says "physicians of dentists insurer" if we just said "defendant(s) insurer" that would encompass all of the defendants.

SENATOR RAGGIO:
That would cover any medical provider. If it were a hospital, their insurer also would have to attend.

MR. COTTON:
I think as a practical matter even outside of those cases with hospital, doctor or dentist, there may be entities that are not necessarily healthcare providers. When there is a problem with having a settlement conference and you do not make all of the defendants show up, it ends up being somewhat meaningless. I think we should say "defendant's insurer."

SENATOR RAGGIO:
If we enact this, does the court have the right to compel the attendance of the insurer and the attorneys who are not parties to the action? Would this language suffice?

MR. BRADLEY:
We think that is a good recommendation. We would encourage that. We would also suggest that on page 5, subsection 4, the sentence read "the failure of any party, his insurer or his attorney" without getting into the issue of bad faith. This is not intent.

SENATOR RAGGIO:
Mr. Cotton, do you agree to that?

MR. COTTON:
I think that would be appropriate.

SENATOR CARE:

You are familiar with the Nevada Supreme Court's mandate. If they want to, they can call a settlement conference. The language "participate in good faith" is actually in the Supreme Court ruling, only for matters on appeal. The settlement judges in those matters are not lawyers; they are attorneys. I am referring to the Supreme Court settlement conferences. My question is, why is it necessary that the settlement judge actually be a district court judge? There are plenty of attorneys who will not have an interest. They could do a good job presiding over a settlement conference.

MR. BRADLEY:

You need the black robe because the person who is a sitting judge brings a certain decorum, respect and experience as a judge. The parties are more impressed by that authority. Plus, that judge is sitting in the same district and has experience with juries in that district, has experience with the parties and has experience knowing what juries do. We would strongly suggest staying with this "district court judge."

SENATOR CARE:

I would suggest that you expand that. You probably all knew him, the late Judge Becko from Tonopah was outside Clark County, but I had him as a settlement judge once. There are many senior judges, retired judges who do not set on the bench now, but would make excellent settlement judges.

MR. BRADLEY:

They would and we stipulate to them all the time, but I do not think so for this purpose. We can always stipulate to someone else, but if we do not stipulate, it ought to be a district court judge who is experienced in that district.

SENATOR RAGGIO:

Is there any public testimony on section 9? Questions from the committee? Are there any other amendments to be suggested? Senator Rawson moved to approve section 9 with the amendments changing line 38 by changing "physicians or dentists" to "defendant's insurer" and adding in subsection 4 to include the insurer as well. Is that the understanding?

MR. BRADLEY:

That is correct.

SENATOR RAGGIO:

Any discussion? If not, all in favor say, aye; any opposed?

The motion is carried unanimously.

Let us look at amending section 1 of the Senate Bill No. 2. We need to receive the language which we authorized on continuing care. Aside from that, is there any objection to this language?

SENATOR TITUS:

I was speaking with Dr. Paul Stewart from the board and said there are different levels of trauma. There is severe trauma, which is the most serious type of trauma. Is there a definition somewhere that is more accurate than this "life threatening medical condition?" Could we use that severe trauma definition?

SENATOR RAGGIO:

These are all of the latest definitions, as I understand it.

DR. MCBRIDE:

Trauma is identified in severity on an EMS categorization based on someone's vital signs and presentation in the field. You do not have a categorization based on type of injury, per se. It is intrusion into a vehicle, death of a passenger, rollover etc. There is no distinct category you can place on that. Severe, life-threatening emergency would, in my opinion, serve as a better phrase, a better categorization of this type of patient.

SENATOR TITUS:

When I asked the question earlier, about how do they know whether to take you to an emergency room or to a trauma center and you said they call in and are given certain information, is there a point at which someone goes to the most serious type of trauma center and someone goes to an emergency room?

DR. MCBRIDE:

Yes, if you are involved in a car accident, bump your head on a steering wheel and have a small bruise, they are not going to take you to a trauma center. If you have a crush injury, closed-head injury, are unconscious, someone has died at the scene and have to be extricated from the vehicle with the jaws-of-life, or there are unstable vital signs, then you are transported to the trauma center. If you have a sprained ankle, then you will be treated and released or taken to the facility of your choice.

SENATOR TITUS:

This is a call between the EMT and whomever they call in the emergency room. There is no definition?

DR. MCBRIDE:

The definition is based on the factors I outlined which would be: a rollover accident, death of a passenger, unstable vital signs, blood pressure below 90/60, unconscious patient, obvious dismemberment, etc. Those are definite indications which are met and not only do they take you to the trauma center but they radio ahead and activate the trauma team telling them you are coming in with severe, life-threatening injuries that require everyone to be there.

SENATOR TITUS:

I worry that this definition "acute, life-threatening medical condition demanding immediate attention" could be interpreted to include something such as swallowing a piece of steak and just needing the Heimlich Maneuver and that situation suddenly becomes trauma and could be life threatening. Is that really trauma?

DR. MCBRIDE:

Correct, but, at that point, you make that distinction later. You determine what the mechanism was later. If it turned out that someone swallowed a piece of steak, fell, hit their head and you think they have a closed-head injury when, actually, they were choking on something, that is something you find out later. You take care of the patient and determine the circumstances later.

SENATOR TITUS:

Anyone who goes to the emergency room thinks their situation is traumatic, or they would not be there. They think they are having a heart attack because they have chest pains. It could be potentially life threatening so they go to an emergency room. Suddenly, everything that goes to the emergency room will come under this definition of trauma. It seems to me there ought to be a more specific definition if it really exists. As written, I think this means just about anything in an emergency room.

MR. BRADLEY:

Senator Titus has made a good point. As an example, a middle-aged man or woman with chest pain is brought to the hospital and the decision is made not to have an EKG and they are sent home with some antacid. They die at home of a massive heart attack. I do not think you intend to include that, based on how I heard your definition. It is too broad, now, for our concerns.

SENATOR RAGGIO:

We were trying to address the same occurrences, which are presently, now, covered under the language if they are in a trauma center. We are trying to make it the same. Is this the same?

MR. GILLOCK:

Having been here this afternoon and having heard the testimony, I agree with that. I think this definition does open this up to a hospital attempting to get the $50,000 cap on every single person who walks into their emergency room if a problem develops in their treatment. I think we need to have language like that.

SENATOR RAGGIO:

Is that what the existing language in the bill does as far as the designated trauma center is concerned?

MR. GILLOCK:

No, we are talking about those patients who are treated by a trauma team, which has been activated. That is what the original intent of the language, we submitted, originally did. It was only after we started trying to expand it that we ran into this problem. The definition of severe trauma and a case where a trauma team is activated as a trauma team could be added that would narrow this down. As I indicated this afternoon, we are opening this up to a severe, constitutional attack because a $50,000 cap is a waiver of sovereign immunity. It is not meant to be a cap on damages.

DR. MCBRIDE:

We make an artificial distinction between a patient who is struck in the head with a baseball bat verses a patient with a ruptured aneurysm in his brain. That one is more deserving of emergency care than the other, or that one should be covered under a cap and one should be excluded under a cap. Under both circumstances, the neurosurgeon is called in to take care of that patient regardless of the mechanism of injury. The mechanism of injury should not be determinant factor as to what renders emergency care under circumstances from which they provide gratuitous care or required, compulsory call.

SENATOR TITUS:

A definition was handed to me. A patient with a major trauma is defined as "someone who has sustained an acute injury which has the potential of being fatal or producing a major disability and a champion trauma score of less than 11 or an injury severity score that is greater than 15." Is this not a more specific definition? This is in NAC 450b.796.

MR. COTTON:

The problem we are running into is that we are not going to be able to get any doctors to go to the UMC trauma center or their emergency room for an acute life-threatening situation if they are going to be perceived as the deep pockets for the $50,000 cap for the hospital. This is the problem we are running into. They need the protection. "Acute, life-threatening medical condition requiring immediate medical attention" is a fairly definable term. I have doctors who I cannot legally advise to walk down there and expose themselves to liability in a situation where they are working trying to help out in the emergency room and trauma center of county and non-profit institutions.

SENATOR TITUS:

The trauma center at UMC is the highest-level trauma center. We are covering them under the $50,000 cap, and we are trying to expand that $50,000 cap to people who do the same thing in other emergency rooms. Why will you not define what they do in an emergency room as trauma at the same level you define it for the UMC, government facility? Is not that what we are talking about?

DR. MCBRIDE:

Perhaps, I can clarify that. In general, if a patient is brought to UMC with a life threatening injury as you describe, that patient would be picked up and transported by the EMS service. In general, a patient, who is brought to Sunrise, Desert Springs or a community hospital such as Sparks, who presents a life threatening emergency from a traumatic incident, either injured themselves at home, was brought in by a family member, was a victim of a drive-by shooting or someone who basically comes to an emergency without the services of an EMS service, may be as critically injured, but they will not be scored appropriately by the passerby who picks them up. To acquire a definition that is based upon strict emergency medical personnel's criteria, documented on a chart, is something that will not be obtainable.

SENATOR RAWSON:

It seems to me that if someone comes into the emergency room and they are stable, this is a non-issue. It is already in the definition that we have talked about. If it is a life-threatening situation and they are unstable, until they are stabilized, that is what we are really talking about. We have defined that.

DR. MCBRIDE:

Correct. That is one of the things we are trying to address. From a physician's point of view, someone may be stable, en route from the accident either by helicopter or by ambulance. They are in the emergency room. Their vital signs are stable. Then ten minutes later, they have crashed. Their spleen, liver and aorta have ruptured, and all of a sudden the stability that you documented initially is no longer

there. It is a fluid state. To try to narrow this down and to be too precise about it results in potential harm to patients.

SENATOR RAWSON:

If they overlook the heart attack by not doing the appropriate tests, I suppose, we would then have an issue of gross negligence. It seems to me that some things speak well for themselves.

MR. BRADLEY:

Senator Rawson, absolutely not. When I gave you the example last night, all of you looked at me and said, "Well, that is gross malpractice for flipping an x-ray." Mr. Cotton will tell you that in the 20 years he has been practicing, he has never seen a case of gross malpractice nor in the 20 years I have been practicing, have I. If you do not get an EKG, Senator Rawson, that is not gross malpractice or anywhere near to it.

SENATOR RAWSON:

In the spirit of what we are trying to do. We are not trying to exempt every failure to diagnose a heart attack that comes into any emergency room. We are trying to define this as the seriously injured person.

SENATOR RAGGIO:

The intent of the committee, and let me get back to that premise, was to afford the same liability limit under the same circumstances when it occurs outside of a designated trauma center and in another hospital. That is what we asked for. It appears to me that is what this does.

How many cases are there going to be? Our biggest concern is driven by the fact that unless we provide some kind of a limit, a cap, on those who have to perform in a trauma setting, whether it is in a designated trauma center or in another facility, we are not going to have these doctors willing to do this.

I brought up the case of the gunshot wound. Are we going to make that doctor tell them to take that patient across town, 20 miles, when they could take him across the street or down the block to a hospital just because they are afraid they may be under this type of cap? That is what we are trying to get to. Let us not be picky about this. Let us look at this realistically. We are trying to give them the same protection under the same circumstances. Why are we arguing about that?

MR. BRADLEY:

Because, we will be doing exactly what Senator Rawson said. Even Senator Rawson was saying a "serious" medical injury. If that is the intent, here, that is something that is much better than this language, which will do exactly what Senator Rawson said and exonerate each and every chest pain and traumatic injury.

SENATOR RAGGIO:

I cannot see what you are saying. What am I saying that is erroneous? This bill covers a trauma-designated facility. Does it not?

MR. BRADLEY:

Yes.

SENATOR RAGGIO:

It provides a limit of liability. We have all agreed to that. We have all agreed that is what the bill does under its present state. This amendment would provide the same limit of liability for the same activity in the same or similar setting for those cases.

DR. MCBRIDE:

I cannot think of a single circumstance where a physician would mistake a heart attack for a stab wound to the chest or a traumatic injury to the chest. The distinctions they are making where you would treat someone with an abdominal complaint versus someone who has been involved by history either in an accident of some sortla fall, a motor vehicle accident, a gunshot wound, a stab woundlthose are not going to be distinctions that are difficult to make. Your point is, the injury is the same no matter where they are taken. To be at Valley Hospital, which is 500 yards away from UMC, and not be covered for providing emergency care to a trauma patient but providing that level of cap coverage at UMC across the

parking lot is an artificial distinction. It punishes a surgeon who is providing emergency care to the best of his circumstances.

MR. GILLOCK:

The definition is missing the word "trauma" or "a qualified trauma patient." We are not concerned about the trauma surgeon who is placing himself on the firing line. We are concerned about the hospital being a safe haven.

SENATOR RAGGIO:

I think that is what the bill drafters did. They assumed this language met the definition of a qualified trauma patient. Can I hear from the bill drafters on this?

MS. NEEDHAM:

Yes, Mr. Chairman. If you use the word "trauma," you are going to have to define it in some manor. We cannot just say "severe trauma." We have to define that somehow.

MR. COTTON:

We have a definition of the hospital as "designated as a center for the treatment of trauma." In section 2, we say "acute, life-threatening medical conditions demanding immediate medical attention." If my clients cannot go into that situation as "on-call doctors" willing to take the 3:00 a.m., 4:00 a.m. call or whenever it is, and to sacrifice their own time to go in there, they are going to come to me. This is not a doctors' decision to close trauma centers. I will take the blame for that because I would commit malpractice if I told the doctor to walk in there and do that, exposing himself to liability on a pro-bono, initial run down there to try to help someone. It does not make sense for these people to risk their entire career and everything they have worked for as a service to our community. That is my understanding of what we were trying to accomplish. I believe we have.

SENATOR RAGGIO:

Does the committee feel this proposed amendment meets the sense of the amendment? Is the committee willing to accept this language and this amendment?

SENATOR O'DONNELL:

Maybe, I can come up with a compromise here. I think the problem is that we have a $50,000 cap, which is a safe haven, extending out to all of the hospitals. There is an appetite in this committee to do that. However, on balance, maybe it would behoove us to look at, for just this instance, raising the sovereign cap to $100,000 to equate better those individuals who have to go to one facility or the other. I do not know if there is an appetite in this committee to do this or not. We can argue until the cows come home as to whether or not we should extend this immunity cap to the other hospitals. What you are basically doing is saying, "Should we give these people immunity?" These people do not have immunity, and that is not fair. Maybe, a compromise is to look at a $100,000 cap and to extend it. I would go for that.

MR. BRADLEY:

By using the language, you are using with the cap of $50,000. You are probably better off saying, "It is the intent to give them immunity," because that is what you are doing here. It is over in the emergency room, and if that is the intent of this committee, that is fine. I agree with the bill drafter. We feel "trauma" should be in here. We think that is the intent. That was always the intent of the original bill. Frankly, if we are going to be required to go out and get a $3,000, $5,000 or $7,000 affidavit, we are down to $43,000, so just give them immunity.

SENATOR RAGGIO:

Is this proposed amendment before us acceptable to the committee? Does it conform to the motion that the committee adopted? Show of hands in favor, opposed. This will be the amendment acceptable to the committee.

We still need the language on the other motion that was adopted on "rebut table presumption." That covers, to the Chair's understanding, all of the issues in the bill. I would like to call on Mr. Wadhams. He has indicated to me he has more recent information that has come to his attention. I understand it is

related to the Assembly. The issue is, the effect of this measure if it is adopted as far as the insurance carriers and those companies are concerned. What is the newest information on that?

MR. WADHAMS:

I spoke earlier this morning and promised that, when I had more technical or current information, I would bring that information back to the committee.

SENATOR RAGGIO:

Your testimony, as I recall, particularly in reference to section 5, was that even though it was not a complete cap, you felt there was a substantial impact that would result if we would adopt this measure. It might not be reflected immediately, and there might not be a reduction in either the premiums or in a reduction in the rate of increase in the premiums over a period of three to five years. That it might not be felt, but that it would increase the potential for competition and also would have that kind of a salutary impact. The doctors organization's representatives felt that even though it would not have an immediate impact, there was light at the end of the tunnel with this kind of an action. What can you tell us at this point?

MR. WADHAMS:

Let me restate that a little. The variation is just a bit off of that. I do feel that this package is positive and does improve the situation. What I was concerned about, particularly under careful questioning by various members of your committee, was on the caps themselves. How much would these change premiums? I have received an oral opinion from one actuary that they feel the exceptions eliminate the value of the caps as to rates. I felt it was incumbent to bring that information back since the committee was concerned about the value of the caps. That is a part of the bill as a whole.

SENATOR RAGGIO:

Would you reiterate that again? Your information that came back from the companies was to what effect because of the caps?

MR. WADHAMS:

It has been difficult to get information, but I did get a phone call from one actuary shortly after I left the committee who said in their view that the exceptions would eliminate the value of the caps in section 5.

SENATOR RAGGIO:

It would, according to that opinion, have no impact on the issue we are addressing. We are talking about providing a climate as a result of our actions that would assure, as much as possible, that accessible and affordable medical malpractice coverage would be available.

MR. WADHAMS:

Yes, Mr. Chairman, I understand that is the task before this committee. I do not have the technical information in hand. My opinion on the bill, as a whole, is still that it is a positive step and does have an impact. The particular question in section 5 where I was testifying was focusing on the value of the caps. The committee had some concerns about the exceptions.

SENATOR RAGGIO:

You said you heard from one company. Which company?

MR. WADHAMS:

The actuary for Nevada Mutual Insurance Company.

SENATOR RAGGIO:

Is that a company now doing business in the State.

MR. WADHAMS:

It is a company that was just formed to do business in the State and has approximately 300 physicians. They have a representative here, not an actuary but a representative, who could speak.

SENATOR RAGGIO:
Is he here now?

MR. WADHAMS:
Yes, he is here.

SENATOR RAGGIO:
Mr. Wallace, youare familiar with the contents of the bill with regard to section 5, at least the version which has been adopted by this committee.

CHARLES "CHIP" WALLACE (Nevada Mutual Insurance Company, Communications Director/cofounder):
Yes, Mr. Chairman, that is the language I referred to last night. I absolutely concur with Mr. Wadhams.

SENATOR RAGGIO:
What does that mean? In your opinion as far as the company you represent and speak for, what do you think the effect the language on the cap with the exemptions indicated will have on your company's ability to provide affordable and accessible medical malpractice coverage.

MR. WALLACE:
The language is too constraining or liberal at its worst. It provides too many loopholes, and because of that, it negates the value of the cap. In conversations I had today, there will be a 2 percent net effect on the cost of the premium.

SENATOR RAGGIO:
You mean the present high level of premiums would be reduced by only 2 percent, immediately or over a period of time?

MR. WALLACE:
That is over a period of time.

SENATOR RAGGIO:
What portions of the exemptions in section 5 does your company feel caused this opinion to occur?

MR. WALLACE:
It is not our company. However, using the video as a demonstration, if we look at each of those cases, such as when a patient is septic and their life is saved but they are left a double amputee, they now breach the $350,000 cap, for example. To answer your question, in gross, all of the exceptions contained in that bill negate the value of the cap.

SENATOR RAGGIO:
Let me press this a bit. I know you are speaking for only one company. Mr. Wadhams, have you heard from any other company representatives on this?

MR. WADHAMS:
The only other information I received was from a trade association which I do not represent made up of physician-based insurers. They expressed a similar opinion as to the caps.

SENATOR RAGGIO:
For the same reason he expressed?

MR. WADHAMS:
Yes, Mr. Chairman.

SENATOR RAGGIO:
This is very disillusioning to this committee. I assume the Governor has also been given this information. For us to go through all of this procedure with a representation from the legal profession, the medical profession based on what I understood to be some representation either formally or informally from the insurance industry, that if we did this, this would result in a very much improved

environment that would cause relief from the increasingly high cost of medical malpractice premiums at least in the foreseeable future. That was my understanding during discussions with the Governor, with members of the other house, that the bill here before us with the $350,000 cap, albeit the exemptions, was going to have a salutary effect. It was going to be perceived in that fashion. At the present time, we do not have any cap whatsoever on noneconomic damages. This provides a cap of some sort. I admit there is a list of exceptions, but where did we get off this track or where did we begin this process under a false assumption that there would be a result?

MR. WALLACE:

Mr. Chairman, I can only respond as a businessman. This is my second insurance company in the young career I have built at 37 years old. I built an HMO when I was 28 years old.

With all do respect, we sought legal counsel and coupled with that I sought out insurance experts with current-day experience. In this project, in forming a malpractice company, we found someone who happened to be one of the founding members of E.W. Blanche, the largest re-insurer in the United States. In the combined partnership and with the directors of this company, they have placed over 43 percent of the re-insurance in the United States. They were not available right away. Unfortunately, that is why it took the project so long to get off the ground. When they were available, we chose that expertise. Unfortunately, with three days notice, they were not available to come to Carson City. We have asked them to engage conversation within the industry to garner some off-the-cuff support, some blanket answer, I could come in here with in response to Senator Care and Senator Townsend's request. I have been at this since I left here, yesterday, trying to get some support. I was looking for a voice to say we would save 10 percent off this current bill, and I was unable to find it.

I think this is an excellent framework. This is not something the Governor put out in five minutes. They worked long and hard on this.

SENATOR RAGGIO:

We do not want to leave here with the belief and understanding and with the affected medical providers understanding that we have done something in an unusual special session called for this purpose, and then find out after we leave here that the insurance companies feel we have done nothing or almost nothing. That it is not going to result in any improvement in the situation.

We are faced with a crisis, apparently, in southern Nevada that may result in a statewide crisis where doctors who are affected by high increases in their premiums are leaving the State. We are not going to have doctors who provide services particularly for pregnant women, the OB/GYN, trauma physicians and whoever else may be experiencing these high premiums. You are here, and I hate to ride you or anyone else, but this is disappointing at this stage of these proceedings to know that we have come this far, spent this amount of money with this effort, the doctors are expecting for us to do something, only to find out that nothing has been changed. What am I missing out of this?

MR. WALLACE:

Nothing. I just hung up the phone with a surgeon at Sunrise Hospital in Las Vegas. They have a copy of this bill and are reacting emotionally. We are all here trying to negotiate and come up with a reasonable compromise. It is difficult if you have never been a part of this system to appreciate that.

SENATOR RAGGIO:

You are here with Mr. Wadhams. There is $350,000 cap with a limit of policy coverage in noneconomic damages. Let us look at the exceptions. I do not think anyone will argue, nor would any insurance company argue, that in a case in which there is gross malpractice that case should not fall under the cap. Would that be because we provide an exemption for gross malpractice? What would be your opinion on that?

MR. WADHAMS:

My opinion is that it should not have an effect. You just heard testimony from two experienced attorneys who have not seen gross malpractice, so that should not be a problem, Mr. Chairman.

SENATOR RAGGIO:
If we had a cap of $350,000 and the only exception was for gross malpractice, what, in your opinion, would that do as far as the insurance companies are concerned?

MR. WADHAMS:
I would have to defer to an insurance company actuary to make that estimate. I can speak from my experience, and I think that by eliminating the exceptions except for gross negligence, that changes it closer to the MICRA statute in California. The change is dramatic.

SENATOR RAGGIO:
What if we had paragraph (h) which is "any case where the jury comes back with a judgment in excess of $350,000 for exceptional circumstances and the judge finds there is clear and convincing evidence." I do not know if you were here, but I think it was explained, earlier, that the language would protect against a constitutional challenge. Does that make sense?

MR. WADHAMS:
Mr. Chairman, I did hear that testimony. It was, at least, compelling if not persuasive.

SENATOR RAGGIO:
That could cover a lot of situations. If I recall the testimony, we were talking about the exceptional circumstances that were a result of the situation, rather than the conduct of the doctor. These circumstances resulted in a decision by the jury. The jury returning a verdict would not know the cap limit. They are not told that. Let us say we did not put the other list of special damages in the bill, we just limited the exceptions to paragraphs (g) and (h). What would that do?

MR. WALLACE:
I agree at a minimum the testimony was compelling regarding paragraph (h). However, it is also quite compelling when you are talking to a surgeon who is taking care of crack babies trying to save their lives and is engaged in frivolous lawsuits by mothers who have been found guilty of gross child neglect. It is difficult for me to look a physician in the eye and say, "this is not a loophole; this is a constitutional formality, and you are not going to get raked over the coals."

SENATOR RAGGIO:
In some states, where they have passed a generic cap without exception, unlike in California as you know, those courts have held the caps to be unconstitutional. We do not want to do that either. We do not want to pass something here that will not pass constitutional muster, or a challenge of that kind.

MR. WALLACE:
I think we need to be careful.

SENATOR RAGGIO:
They are not in this dimension, here. I am only asking at what point in our effort is this going to be a product that helps us reach this goal. The goal is to have insurance companies available to provide reasonable and affordable coverage for events of this nature.

DR. MCBRIDE:
I will put on my insurance company hat as the Chairman of Nevada Mutual Liability. The problem with trying to quote actuarial rates based upon the list of exclusions included in this bill under a $350,000 cap in comparing that to a strict cap, such as MICRA of $250,000, the list of exclusions precludes any actuarial ability to make a determination that this would result in lower rates. If you struck out the exceptions, then you would have something that actuarially would stand up to what MICRA has right now. It may not be the same level of reduction that you have seen in California, but you could reasonably predict that there would be a reduction in rates based on the level of the cap that is included in this bill.

If you include paragraph (h) with exceptional circumstance and strike all the other exceptions, the attorneys could argue that every one of those exceptions is now included under paragraph (h).

SENATOR RAGGIO:

I think that is true, but there would have to be finding that the award in excess of $350,000 was supported by clear and convincing evidence. It is not exactly the same. There is a higher level of a standard of evidence that would be required for the judge to do that. It would seem to me, since we are arguing this, that if we pass the bill and delete paragraphs (a) through (f) and left as exceptions paragraphs (g) and (h), that should put the bill in a posture to make it more likely that there would be this type of coverage. Tell me if I am in error.

MR. WALLACE:

I believe that, in the direction you are going, we are getting closer to something I would be more comfortable selling not to just our company but within the industry. However, when we are talking about age justified under these circumstances, can we be more specific, gross neglect, gross negligence?

SENATOR COFFIN:

When Mr. Wadhams stated he had spoken to an actuary, I was hoping it was for a large company with experience. I had expected someone to step forward when Mr. Wadhams said he had spoken to an actuary. Are you an actuary, Mr. Wallace?

MR. WALLACE:

No, Senator.

SENATOR COFFIN:

You did not say you were not an actuary when you stood up. You indicated you were director of communications. I guess you are a salesman?

MR. WALLACE:

I feel like it today.

SENATOR COFFIN:

I want to know what your qualifications are to determine what rates are. This is a serious matter. You have expressed a strong opinion that lead to an intense discussion and formation of opinion, and yet, I suspect you are not qualified, other than in opinion, to really tell us whether this is going to add or subtract to rates. Any person can see if you cut out some benefits you are going to change a rate, but you are not an actuary. You work for a small company with no loss experience. You have marketing experience, but you are not a fellow of the actuarial society. You are not qualified, if I might say that, not as an insult, but I want to establish for the record your qualifications.

MR. WALLACE:

You are absolutely correct, and I do not believe anyone in this room is an actuary. However, I have, in good faith, engaged the market as I promised to the Senators at this hearing as I was requested under testimony yesterday. I would not arbitrarily do this.

SENATOR COFFIN:

What I was getting at was that your statements in the beginning set a tone, and I think we should have determined your qualifications, simply, because I think this bill has been worked on and worked over, and now, all of a sudden, you come in at the last minute with an opinion.

We all know this is not going to reduce rates immediately. I think that Mr. Wadhams' initial word when asked this morning about what the results would be, was the one word answer "predictability," I think. It is in your interests since you are an owner, I gather, or have a stake or interest in reducing these rates.

MR. WALLACE:

No, Senator, that is counter. Absolutely, I disagree with you with all respect. Would it not behoove me to keep rates exploited and as high as possible?

SENATOR COFFIN:

I am not sure what your position is. Are you are a salaried person?

MR. WALLACE:
Yes, I am salaried, and it is capped under an arrangement with a management company.

SENATOR COFFIN:
Did you talk to an actuary when Mr. Wadhams asked you to get some information? Which actuary did you speak with?

MR. WALLACE:
Yes, sir, however, I am not a shareholder. I raised almost $3,000,000 for this project. I do not own one share of stock.

SENATOR COFFIN:
He is not answering.

MR. WALLACE:
I will answer. I was answering your previous assertion, and I want to clarify to the panel so it is clearly stated.

SENATOR COFFIN:
I need to know if you talked to the consultant. The company probably has a consulting actuary.

MR. WALLACE:
Yes, sir.

SENATOR COFFIN:
And who is that?

MR. WALLACE:
I spoke to Andrew O'Brien who is one of the directors of the company.

SENATOR COFFIN:
Is he a fellow? Is he a member of the FSA? Is he a person you found?

MR. WALLACE:
The person I found is absolutely credible. He has the most where-with-all in the industry. I would not be willing to attest to his credentials, specifically, as to whether he has his LUTC or is a fellow member actuary.

SENATOR COFFIN:
LUTC is life underwriter training. It is not it at all.

MR. WALLACE:
I apologize, I meant fellow.

SENATOR COFFIN:
The reason you have to withstand some scrutiny, here, for your statements is because by stepping up to the podium, you portrayed yourself as an actuary.

MR. WALLACE:
I have not portrayed myself as an actuary.

SENATOR RAGGIO:
He said he had spoken with an actuary.

MR. WALLACE:
Yes, I stated my position up front. If that position as Communications Director is misleading, I certainly apologize to this panel. In no way should a person who mandates as a position of communications for a company ever assert that they are an actuary.

SENATOR COFFIN:
We should probe a little further into this because we need some actuarial advice. I do not think we have it. I think that would be helpful for us before we make a decision.

SENATOR RAGGIO:

Let me ask this, Senator Coffin, is Mr. Bob Byrd here? Mr. Wallace would you step aside for a moment, please. Mr. Byrd, please come down to the podium and state your title, affiliation, and your experience?

ROBERT BYRD, (Medical Liability Association of Nevada, Chairman)

Currently, I serve as Chairman of the Board of the Medical Liability Association of Nevada. Previously, prior to retirement, I spent 23 years as CEO, President and Chairman of the Board of Nevada Medical Liability Insurance Company. In that capacity, I carried the final word on all large cases. I reviewed all claims in the State of Nevada presented to our company. I personally was involved in excess of 1,100 settlements or non-settlements, the final disposition of claims. Those are Nevada claims. I have some qualifications as to what this bill will do. I am not an actuary, but I do have a significant background in medical malpractice.

SENATOR RAGGIO:

Are you familiar with the bill, what is provided in the bill, and what we have been discussing on the cap with the exceptions as indicated?

MR. BYRD:

Yes, I am.

SENATOR RAGGIO:

Do you have an opinion?

MR. BYRD:

I was originally asked to state an opinion on this bill based on a description of what the bill contained by a group of attorneys who had been working on it at the request of Governor Guinn. In addition to that, I was asked to state that same opinion to a group of doctors who were also working on it. That was yesterday morning. I believe that their representation as to the contents of the bill, which I had not seen at that time in all meaningful ways, were accurate. I said without qualification, "This is meaningful tort reform."

I would be happy to answer any questions as to why I came to that conclusion. I am still of that same opinion.

SENATOR RAGGIO:

Please tell us why you came to that opinion.

MR. BYRD:

I came to that opinion primarily because it changes the playing field. Instead of working uphill all day, we have a more level playing field in the settlement environment. It is that settlement environment which I think is the key issue and has not been addressed to my knowledge by anyone who has spent any time in it from the insurance companies' standpoint.

Actuaries do not settle cases. They respond and analyze what happens after the case. CEOs do not normally spend time settling cases, nor do marketing representatives. It is very difficult to find someone who's feet are in the trench and who really knows what happens when that case is before them. Today, if we have a case where we believe, and I am using "we" as an insurance company, that there is no culpability, or very questionable culpability, one in which we cannot recommend to the doctor that he settle, but where the damages are very severe or moderately severe, we have to tell that doctor that if we go to court, and he does not want to admit culpability and we agree with that, that case if we lose it could exceed his policy limits.

SENATOR RAGGIO:

You are talking about the area of noneconomic damages.

MR. BYRD:

I am talking about final settlement, noneconomic or economic.

SENATOR RAGGIO:
Our cap is limited to noneconomic.

MR. BYRD:
Yes, I understand that. I am trying to explain what the environment is, today, prior to this bill. If that doctor says, "My personal assets are at risk if we lose that case," and there is no guarantee in a disputed case that you will win it, "I hereby demand that you settle this case without regard to culpability. I demand you protect me. That is what I paid you to do." The insurance company is saying, "I have a case I should be defending. I cannot go to court. The courts are denied to me because if I do go and I lose, for this is a huge judgment, I am going to end up paying the whole thing. I will settle, now, if I can for something within the policy limits." All too often, that is the case. Now, with this bill and the same situation arises, I have some measure of what that final responsibility may be. I have a predictable environment. I have something I can price. Something I can make judgments on. It is a significant change in the settlement environment. That is very important.

SENATOR RAGGIO:
However, I want to make the distinction again that the policy limit only applies, as I understand the bill, to the noneconomic damages.

MR. BYRD:
The cap only applies to noneconomic damages, that is correct. However, the maximum responsibility will be $1 million unless economic damages exceed that amount.

SENATOR RAGGIO:
Am I missing something here? You are talking about the overall settlement. The overall settlement including both economic and noneconomic damages, as I understand it, is not limited to the policy limit. Is that correct? No? Tell me why? On economic and noneconomic, it says under subsection 2 "in an action for damages for medical malpractice the noneconomic damages awarded must not exceed the amount of money remaining under the policy after subtracting the economic damages awarded to the plaintiff." If the economic damages are $2 million the judgment will be $2 million.

MR. BYRD:
That is correct. The noneconomic damages are not a factor in that.

SENATOR RAGGIO:
At least, you are going to know that in a settlement that the top will be $1 million, but that only applies to the noneconomic damage.

MR. BYRD:
Correct, however, I can still measure those economic damages. I still know what my exposure will be. I do not have that unknown.

SENATOR RAGGIO:
Then, I know, I am reading the bill right.

MR. BYRD:
Yes, you are, Mr. Chairman.

LONNIE HAMMERGREN, M.D. (Neurosurgical Associates of Nevada):
I testified, yesterday, in relation to the exemptions on the cap and how I thought they made it difficult. I will tell you specifically why. The ones excluded are the high-ticket items. With an OB/GYN, where the child, whether brain injured at birth, injured by infection or whether the mother took cocaine, whatever it was, had brain damage, it has caused huge settlements. I understand about the $1,000,000 cap in these discussions. These are the high-ticket items that include paralysis and blindness. That is why they were included for strictly economic reasons. That is why they were exempted. They thought the money would come from lawsuits. That was the only reason to exclude those high-ticket items.

My father was president of Casualty Underwriters Insurance Company in St. Paul, Minnesota. I was a licensed insurance agent in Minnesota. I bought my Nevada medical liability policy from Bob Byrd 20

years ago. I have testified here before on malpractice issues seven years ago. I currently am president of another Nevada medical malpractice insurance company called Nevada Doctors Mutual. We were late in the game. Nevada Mutual got funding from hospitals and other sources, but otherwise we are fully licensed to solicit insurance in the State of Nevada. I am the president of that company. We have no capital, and therefore, we are not selling any policies. I have been studying this particular problem. What has proven that works is MICRA because we have 20-plus years experience with it. As I said before, the lawyers proved their own point when they said MICRA does not work. One lawyer stated his son had died, and he wanted a malpractice lawsuit filed in California, but he could not find an attorney to sue for malpractice because there was not enough money in it for the attorneys taking the case. That shows MICRA works.

SENATOR RAGGIO:

Mr. Byrd, can you tell us if you would recommend any change in the language in section 5 that would make this more appealing to the insurance companies to provide adequate and affordable coverage?

MR. BYRD:

That is a very difficult question. If I had my druthers, I would eliminate all of the exceptions. That would make it a stronger bill. You can take paragraph (h) out, it would make the bill better. I do not think you can predict how this bill will come out and how it is going to effect the prices and the availability of insurance until after we have had a long time working with it. One of the things worrying me is the elimination of the medical equal screening panel. I think the frequency of claims will change. Only time will tell for certain as to how much frequency will change. The bill can be made stronger by the elimination of one or more points, but I could not pick one that would be more appropriate than another.

SENATOR CARE:

Thank you, Mr. Chairman. Let me put this in perspective from my personal point of view. My wife and daughter are in a resort in Tucson. I flew out of that resort in Tucson Sunday night to come here. I have read, studied and deciphered everything that has come across my desk or come through the mail. I have sat here. I have been non-partisan. I am philosophically opposed to caps. Today, I voted for caps. I have been a part of the give and take here. I am dumbfounded that we get to this point in the proceedings and no one in this building seems to have an idea as to what impact this legislation, as it is now before us, will have on insurance rates. I am appalled at that. I heard Dr. Kahn say, yesterday, there are studies out there somewhere, I do not know if he sited the source, that if you raise a cap a certain number of dollars, then the rates will go up a certain percentage. I do not know where he got that. I cannot believe that there are not people standing by who have looked at other jurisdictions and who have seen exceptions, have seen cap numbers go up and down and have some idea of what this legislation will do. I am insulted.

MR. WADHAMS:

Senator, I guess I need to shoulder some of that burden. I appear in front of this committee routinely. I try to bring as current information as I can pertaining to the bill as it first appeared yesterday afternoon. I do apologize. No insult is intended.

As you can see, there are differing opinions on this. I can only say that my personal opinion is that the bill has a positive impact. Can it be made more positive? Yes. You see differences here. One key difference, this gentleman sitting immediately to my right has had experience in the Nevada marketplace. Unfortunately, many others who are casting opinions are doing it, not based upon Nevada experience. That is the point I believe to be important. We have to see how these things work. You have to try to anticipate how they are going to work. Hopefully, we can get enough information so that you can make that decision. I apologize.

SENATOR RAGGIO:

Is it practical to expect that in a short period of time you could get any additional information that would be more helpful to this committee in making a decision?

MR. WADHAMS:

The difficulty is that we have very few insurance companies that are active. It has been very difficult, like pulling teeth. That is the job I took on in behalf of several of the groups trying to do this, trying to get the information. The carriers that were active have stated they do not have an interest now. That is what makes it difficult.

SENATOR RAGGIO:

So they do not have an interest in coming into this market regardless of what is done here. Is that what you are saying?

MR. WADHAMS:

No, well, the hope is that if something is done, they will become active again. But, it is difficult to get them to participate. They have indicated they have no interest in the marketplace. We have one active company. I will do the best I can to get more detailed information. I wish it were like auto insurance where we have dozens of companies with lots of information.

DR. MCBRIDE:

I spoke to the actuary, Andrew O'Brien who Mr. Wallace spoke to as well. We discussed the provisions of this bill. The problem in interpreting what actions this bill might have on future rates is that he said it would take, and he is an actuary and I am not, at least two to four weeks of study. They would have to take the provisions in this bill and apply them retrospectively to every case in Nevada over the past 10 years to come out with any reasonable assessment of what actuarial standards would be with these provisions. In the timeframe we have here, that is impossible. With respect to Senator Care, we apologize for not having the information more timely than that, but we did not have this information until yesterday, ourselves. We had no way of looking at the provisions of this bill and the exclusions. The only thing that we were told was that based on the MICRA statute if you took those cap numbers at $250,000, $350,000, etc., you could then extrapolate to reasonable reductions in the Nevada current insurance rates and make an estimate in a predictable manor. Based upon that data, if you take a strict $350,000 cap without the exclusions, you could reasonably estimate that insurance rates would come down significantly in the range of approximately 20-25 percent. That is a guess and do not hold me to it. That is an approximate, and it is the last data that we have based on taking information that we know exists from other markets.

SENATOR TITUS:

Thank you, Mr. Byrd, for being here. I think you are the expert on this, and we appreciate hearing from you. We hear a lot about how we only had this bill a few days, how we did not have time to get people here. But the interim committee has been meeting for months and we have been trying to get insurance companies to show up. It was almost the point of having to issue a subpoena to get them to come and testify. The reason for that is that insurance companies are very wise. They know they are not popular. No one likes insurance companies. Everyone loves his/her doctor. You put your doctors out on the front line to carry the water for the insurance companies.

It amazes me, Mr. Wallace, that your math is very murky when you talk about what kind of benefits will accrue. You say, "Well, we do not know. It depends on the economy. It could be this. It could be that." Yet when you talk about why this will not work, you are very authoritative and say, specifically, "Oh, it will only raise it about 2 percent." I do not know why your math is good in some instances and so bad in others.

I have not heard anything about what is going to be the reduction in the rates for trauma doctors. We know absolutely that is a $50,000 cap, no exceptions. There should be drastic reductions in insurance rates, but I have not heard anyone mention that contribution we have made.

DR. MCBRIDE:

I would like to respond to your last point on the reductions for trauma doctors. "Trauma doctors" is a generic designation for a number of different types of physicians: neurosurgeons, spine surgeons, general surgeons, orthopedic surgeons and emergency room physicians. I wish I could be more specific with you. We have seen such volatility in this market and such volatility in the legal climate in this State that

you cannot make any predictions based on any cap at this point. The circumstances have changed in the last several years.

SENATOR TITUS:

I think that is very different from what you have been saying. You cannot make any prediction based on any cap including MICRA $250,000, including a hard $350,000, including $350,000 with this. You just said that you cannot make any prediction with this. You also said that your actuary said it would take you two to four weeks to figure out what the impact of this bill would be. That is a lot different from coming before us now at this late date and saying, "this will not make a bit of difference. Get rid of those exceptions, because it will not help." I think those are two very different kinds of answers. Which is it? I think it is the former and not the latter.

DR. MCBRIDE:

Let me retract some of my last statement, it was made in the heat of the moment. I am not an actuary, and I do not want to present myself as one. I would love to get the information to you as accurately as possible. What I can tell you is that the circumstances we presently face in this State make it difficult to predict with any accuracy how the rates will be affected. You are making legislation that is dramatically different from legislation that has been in place for years and has been shown to work and effectively lower rates. When you change the recipe so drastically, you alter it so completely as to make it unrecognizable, and therefore, with all deference to you, I cannot tell you that these rates will go down, and our actuary cannot tell you based on these circumstances that they will go down significantly.

SENATOR TITUS:

How can you compare the Nevada market across the board to the California market and say if you put in place in Nevada what they have in California, that you will have the exact same results here? Is that not just as spurious a finding?

DR. MCBRIDE:

I would argue that standard of care in California and the qualifications of physicians and the kind of injuries or illnesses treated in California mirror Nevada exactly. We are held to the standard of care that California physicians operate under. Why would it not make sense to hold us to the same standards of liability exposure?

SENATOR TITUS:

I am talking about the numbers of doctors, the market and the rates. Surely, you cannot say that those things are not part of the equation.

DR. MCBRIDE:

The other element is the unpredictability in the Nevada market. This is a very small market. We have approximately 2,700 physicians in the southern Nevada area. It is difficult to make accurate predictions based on a small market share.

SENATOR RAGGIO:

Any other questions?

I am going to state my opinion on this point, because, like Senator Care, I feel somewhat used in this process. We have come to this point after two full, long days and evenings. We know the work we have gone through and the effort put forth. I am trying to keep my calm as I discuss this. I am definitely upset. Our purpose, here, is not to help lawyers. It is not to help doctors financially. We are here to help the public who needs to have adequate and affordable health care. We need to have the availability of health care, particularly, in these critical areas of practice we are hearing about. I do not want to repeat myself or take the committee's time.

Frankly, I am disappointed in some of the presentations on all sides of this issue. We were led to believe that there was a complete accord between all parties that would result in the goal being reached. That goal was to meet the crisis, to provide an atmosphere where there would be affordable insurance coverage for medical malpractice for practitioners who were faced with a crisis. Streams of doctors are indicating that they are going to retire from practice or remove themselves from caring, particularly, for expectant mothers. I have heard from large numbers of patients who say they cannot get care. We

thought we were coming here for a special session because we thought we had the means to provide something that would be adequate, but we could have waited until the next regular session and argued this for months. We have to leave here with a bill, with a cap of some kind on noneconomic damages stated in a form that is most likely to achieve that result.

The way we have this in the bill, now, does not do that. In subsection 3, we list all of these exceptions. I am not going to look at it from the standpoint of the insurance companies or doctors or lawyers, but from the perception of the public to whom we have the responsibility to serve, mindful that every one of these exceptions is a catastrophic event for the individual or for the family of the individual. We have tried to understand that and to consider that. We have imposed the cap and provided the exceptions in two areas, a case in which the conduct of the defendant is determined to constitute gross malpractice. I do not think anyone can argue with that, or paragraph (h), a case in which following the return by the jury or a finding by a court in a bench trial, a case in which that verdict or determination determines by clear and convincing evidence which is a higher standard, that an award in excess of $350,000 for noneconomic damages is justified under exceptional circumstances.

If we limit the exceptions to those two areas without all of these other specific instances, we would accomplish the goal as far as we possibly can. The reason for that is that under the language in paragraph (h) almost all of those other specified injuries could or would constitute exceptional circumstances. We said this did not apply to the conduct of the doctor but to the circumstances of the result. The difference would be that in those cases, and the jury is not told there is a cap on noneconomic damages, the jury could return a judgment in excess of $350,000. The court would have to find, and there would be an additional standard there, that the verdict in excess of the cap was justified by clear and convincing evidence.

Maybe it is not a lot of movement, but I think it covers the situation well from all aspects, and having listened to all this for two days, it would seem to me that it would be the best that we could do. Other than that, I imagine someone could argue we could just pass a generic cap at $350,000.

The reason I am suggesting paragraph (h) is that we have heard enough evidence that it is a safety valve. That type of language would be a defense to a constitutional challenge. That would be my suggestion. If we just pass a generic cap of $350,000, with the chances likely that it would be ruled unconstitutional, we will have achieved nothing. If we pass a bill in the form that it is, it seems to me the likelihood is not great that there is going to be much relief or change made. There is not going to be a reasonable assurance of reduction in the future of insurance premiums. I have given a long oration because I am thinking as I am talking, but I think that is where I would go with this measure. Maybe, that is something no one likes, so maybe, that is a good idea.

SENATOR O'DONNELL:

Thank you, Mr. Chairman. I am perplexed as you are regarding this whole issue. I understand that although an insurance company may be willing to come up here to testify as to the actuarial data they may be able to hold, they may look at Nevada and not want to do business here. Why would they even bother to employ an actuary to take the time to look at the bill to determine whether or not they would lose money or reduce premiums if they were to do business here? It is ridiculous to think they are going to come to the table to tell us. We have very few companies left in Nevada.

I think your comments regarding taking out the exceptions is a common-sense approach to determining the value of a premium. If we cap this at $350,000 and we use paragraphs (g) and (h) as responsible pieces of legislation to allow the courts and the judges to determine what is reasonable and acceptable, then I have to believe, as an elected official, that we will reduce the premiums and take the pressure off physicians to move out of state because they cannot afford to do business here anymore. I am going to go with my gut feeling. We have to do the hard job of deciding this. My decision has been made. I am going to go with stripping off all of these exceptions and allowing the courts to determine those cases. I will leave paragraph (h) which allows the courts discretion on what may be beyond the scope of the $350,000 cap.

SENATOR SCHNEIDER:

Mr. Chairman, thank you. You know we cannot go home and have the trauma center shut down, have OB/GYNs not working. What is it going to take to get the insurance companies back here? What do we

have to do to sweeten the pot? I sat on a committee with Senator O'Connell. Is the State going to have to write the insurance? Are we in the business? If the insurance companies do not come back, then we are going to have to. Mr. Chairman, we have to entice the insurance companies back. I am not going home without healthcare for my constituents.

SENATOR RAWSON:
I would move that on section 5, subsection 3, that we strip out paragraphs (a) through (f).

SENATOR RAGGIO:
That we delete lines 31 through 37 of the bill?

SENATOR RAWSON:
That is correct. We had one other issue they were developing language for, but let us deal with this.

SENATOR RAGGIO:
All right. Discussion?

SENATOR COFFIN:
As this discussion has ensued and there have been opinions expressed by members of the committee they will vote for the bill because these first five or six listed damages were limited and will be stripped out, does that have an impact on the decision of a judge or any court on the efficacy of awarding a plaintiff under paragraphs (g) and (h)? In other words, would it exclude the first three, (a) though (f) by taking them out? Will the action of this committee indicate or send a signal to the courts that these are things that are not to be considered as something that would fall under paragraph (h)? We are establishing that intent. We want to make certain that the judge could still award in these cases if that judge felt a need to do so. Can we get an opinion on that?

MR. WILKINSON:
Mr. Chairman, Senator Coffin, in that circumstance in which a judge were attempting to interpret the language of the statute, the judge may wish to look at the legislative history and seeing that language deleted may factor that in, in interpreting the meaning of the statute as it exists.

SENATOR COFFIN:
I am not certain what that answer means. It sounds to as if a claim originating off of one of the first six or seven accidents listed is being excluded from consideration.

SENATOR RAGGIO:
Since I brought this up, for the purposes of the legislative history, it would be my understanding that under paragraph (h) the language that we said justified as exceptional circumstances could necessarily include any of those types of injuries that we are suggesting be deleted as specific injuries and would not be limited merely to those injuries. The difference is that in that situation if any one of those injuries occurred and the court felt in its opinion that those were exceptional circumstances, there would have to be a finding by the court under clear and convincing evidence standards, we heard discussed here, that the award in excess of $350,000 was justified. I want to make that clear, if we do this, that is the legislative history on this. The intent is not to say those cannot under any situation be considered as exceptional circumstances.

SENATOR CARE:
Mr. Chairman, for the record for legislative intent, I want to say I read it the same way. We should not overlook the fact that we are sending these judges to malpractice school. As an example, loss of a limb, there will be cases when someone has lost two limbs as opposed to someone who has lost one limb. That situation would engage the court's employment of the higher standard. I read it the same way.

SENATOR TITUS:
Thank you, I find myself in the very unusual position of defending the Governor's bill. The Governor said, today, on television that you have to have a heart. We know that all good policy is a result of compromise, give and take, by partisanship, lots of different interests at the table, and it all works out in some kind of compromise. The Governor's original bill was a good compromise. It combined head with

heart. It was smart in that it put caps in place for trauma doctors and other doctors. It created a predictable community, a predictable environment. It would work to, and I believe we have heard enough evidence, bring down rates. In the long run, it was the light at the end of the tunnel. The bill that the Governor proposed also had heart. It recognized that there are certain circumstances that should not have the price cap of $350,000 imposed. You tell the parents of a dead child, "Sorry, that is capped." Or you tell a person, like the lady who was here who lost both legs, "Sorry, that is capped." The Governor's bill was a good bill. It was a compromise bill. It should be left the way it is, sent down the hall without that amendment.

SENATOR RAGGIO:

I can only respond to that by saying I do not think that is the situation because if we did it this way the jury is going to hear these cases. They are not going to be told there is a cap of $350,000 for brain damage or total blindness or any things which we all agree are catastrophic. They can return their verdict. Then the court can say that regardless of a $350,000 cap and in finding clear and convincing evidence can sustain that verdict and let it stand. I would take exception to the comments. I think we are improving on the Governor's bill. We are not excluding those kinds of things. We are not putting a lesser value on any of this. We are making the bill, and the result we are all trying to reach, a lot more achievable. I do not think it is appropriate to say we are not approaching it with heart. We are trying to accommodate that, but at the same time, if we pass a bill that does not have any effective result, then we are not accomplishing anything.

SENATOR NEAL:

Mr. Chairman, you and I have been around here for a long time. We have dealt with this particular language, and I have dealt with the likes of Harvey Whittemore for years, and I know the tricks he writes into the various laws that come before us. One of the things about this language, and I do not have any problem with eliminating paragraphs (a) through (f) because under our rule of law whatever is stated, excluded or anything might appear somewhere in the future is the problem of not having all of the statutes before us. If we go with the language that is now being proposed in paragraphs (g) and (h), there is nothing in other parts of the statute that impacts what we are doing. I would like the legal staff to give me a clarification of that.

MR. WILKINSON:

I do not believe there is another statute elsewhere in NRS that would effect this in a way that has not been discussed here today.

SENATOR NEAL:

Understanding that, I would like that to become part of the intent of the proposal because if that is, then we might be hung out to dry in the future. We will get home and someone will look at this and tell us we did something we did not intend to do. I do not want to be faced with that because I had that happen during the first few sessions that I participated in. I voted on bills I thought I had read, correctly, then found out we were talking about something else. I just wanted to make that clear that under our rule of law that the language that we are now proposing does not have anything that would impact that language in any other part of our statute. This is what I have heard our legal staff say. Do you agree, too, Ms. Needham?

MS. NEEDHAM:

(Nods affirmatively.)

SENATOR O'DONNELL:

I hope I can convince the Minority Leader with my experience. I am the father of a dead child. I lost my child in 1987 from congenital heart disease. I have to ask whether or not he would have had the doctors who took care of him for the six years of his life, if we do not do something now, if we do not do something for the State of Nevada. In today's situation, my son might not have had those doctors. My son would have had to take many more trips to UCLA. It tore our family apart, and I do not want that. That is why I did this.

SENATOR RAWSON:

Clarification, that language included the language as we have amended it already. I want that to be clear.

SENATOR RAGGIO:

All those in favor say, aye; all opposed. Senator Titus voted no.

The motion carried.

The only thing remaining is the language on the rebuttable presumption. Do we have that available? It is in section 1. Please look at it and at subsection 4. I will read it into the record.

"If

(a) A physician or dentist provides follow-up care to a patient to whom he rendered care or assistance pursuant to subsection 1 or 2;

(b) A medical condition arises during the course of the follow-up care that is directly related to the original medical condition for which care or assistance was rendered pursuant to subsection 1 or 2;

(c) The patient files an action for malpractice based on the medical condition that arises during the course of the follow-up care, there is a rebuttable presumption that the medical condition was caused by the care or assistance rendered pursuant to subsection 1 and 2 and that the limitation on liability provided by subsection 1 or 2 applies with respect to the medical condition that arises during the course of the follow-up care."

MR. GILLOCK:

Mr. Chairman, I think we need to take "dentist" out of paragraph (a) because I do not think we have even talked about a dentist providing trauma care. That definitely needs to be removed.

SENATOR RAGGIO:

Would there be an oral surgeon involved in a catastrophic accident? It does not hurt to leave it in there if that should occur, does it?

MR. GILLOCK:

I assume if a dentist is part of a trauma team then they might. I cannot envision that happening. A dentist is different than an oral-maxillary surgeon.

MR. COTTON:

We need to leave the flexibility open. There are situations where a dentist or an oral-maxillary surgeon would treat a patient.

SENATOR RAGGIO:

I would rather not make changes if it is not absolutely necessary.

MR. COTTON:

The language is fine.

SENATOR RAGGIO:

Are there any objections from the committee? I will take a motion from Senator Rawson to adopt the proposed amendment to section 1 of Senate Bill No. 2.

Any objections? All those in favor indicate, aye; all those opposed. Senators Carlton, Titus and Care voted no.

The motion carries.

It is the Chair's understanding that we can now consider a motion to adopt Senate Bill No. 2 with the action previously taken on the sections which have been adopted and on the amendments which have been adopted.

Senator Rawson moved to amend, and do pass as amended, Senate Bill No. 2.

SENATOR TITUS:

I am going to abstain from this motion until I see the bill on the floor. We will go back to the floor to vote on it again. Is that correct?

SENATOR RAGGIO:
At some point tomorrow morning, we will have the bill in its final form.

MS. NEEDHAM:
You will have the amendment. You will need to adopt it, and then the bill will go to reprint.

SENATOR RAGGIO:
With that understanding, all those in favor, indicate, aye; all those, opposed. Senator Titus abstained from the vote.

Motion carried.

On the motion of Senator Jacobsen, the committee did rise and report back to the Senate.

18th Special Legislative Session
Senate
7-30-02

SENATE COMMITTEE OF THE WHOLE

DATE: July 30, 2002
TIME: 8;00 a.m.

✓1. Continued Discussion of, and Vote on, sections 3,4 and 5 of S.B. 2: *Regarding Establishing Limits on the Amount of Non-economic Damages in Medical Malpractice Cases*

✓2. Presentations Regarding section 1 of S.B. 2: *Limiting Liability for Acts Occurring in a Governmental or Non-profit Center for Treatment of Trauma*

Questions and Statements by Committee Members Regarding Section 1 of S.B. 2

Public Comment Regarding section 1 of S.B. 2

Vote on section 1 of S.B. 2

✓3. Presentations Regarding sections 4 and 6 of S.B. 2: *Adopting a Several Liability Standard for Medical Malpractice Cases When Non-economic Damages are Considered*

Questions and Statements by Committee Members Regarding sections 4 and 6 of S.B. 2

Public Comment Regarding sections 4 and 6 of S.B. 2

Vote on sections 4 and 6 of S.B. 2

4. Presentations Regarding sections 10, 11, 17, 24, 35 and 38 of S.B. 2: *Regarding Review of the Medical and Dental Screening Panels*

Questions and Statements by Committee Members Regarding sections 10, 11, 17, 24, 35 and 38 of S.B. 2

Public Comment Regarding sections 10, 11, 17, 24, 35 and 38 of S.B. 2

Vote on sections 10, 11, 17, 24, 35 and 38 of S.B. 2

5. Presentations Regarding sections 14, 19, 20, 21, 22, 23, 29, 29, 30, 31, 32, 33 and 34 of S.B. 2: *Regarding Strengthening the Reporting Requirements Relating to Disciplinary Actions, Claims, Settlements and /or Awards Against Physicians*

Questions and Statements by Committee Members Regarding sections 14, 19, 20, 21, 22, 23, 29, 29, 30, 31, 32, 33 and 34 of S.B. 2

Public Comment Regarding sections 14, 19, 20, 21, 22, 23, 29, 29, 30, 31, 32, 33 and 34 of S.B. 2

Vote on sections 4, 19, 20, 21, 22, 23, 29, 29, 30, 31, 32, 33 and 34 of S.B. 2

6. Time Permitting, the Committee may also hear Presentations on section 11 of S.B. 2: *Regarding Shortening the Time Period Within Which a Medical Malpractice Case May be Filed* and;

Section 13 of S.B. 2: *Regarding Allowing a Judge, at the Discretion of Either Party, to Enter a Judgment Providing for Periodic Payment of Future Damages.*

And any other provisions of the bill.

The presentations will be followed by questions and statements of members on each section, public comment and a vote by the committee on each section.

Proposed Amendment to S.B. 2

Sec. 3. *"Economic damages" includes damages for medical treatment, care or custody, loss of earnings and loss of earning capacity.*

Sec. 5. *1. Except as otherwise provided in subsection 2 and except as further limited in subsection 3, in an action for damages for medical malpractice or dental malpractice, the noneconomic damages awarded to each plaintiff from each defendant must not exceed $350,000.*

2. In an action for damages for medical malpractice or dental malpractice, the limitation on noneconomic damages set forth in subsection 1 does not apply in the following circumstances and types of cases:

(a) Organic brain damage;

(b) Hemaplegia, paraplegia or quadraplegia;

(c) Death of a parent, spouse or child;

(d) Total blindness;

(e) Actual physical loss of a limb, including a foot or hand;

(f) Permanent loss or damage to a reproductive organ resulting in sterility;

(g) A case in which the conduct of the defendant is determined to constitute gross malpractice; or

(h) A case in which, following return of a verdict by the jury or a finding of damages in a bench trial, the court determines, by clear and convincing evidence admitted at trial, that an award in excess of $350,000 for noneconomic damages is justified because of exceptional circumstances.

3. In an action for damages for medical malpractice or dental malpractice, in the circumstances and types of cases described in subsections 1 and 2, the noneconomic damages awarded to each plaintiff from each defendant must not exceed the amount of money remaining under the professional liability insurance policy limit covering the defendant after subtracting the economic damages awarded to that plaintiff. Irrespective of the number of plaintiffs in the action, in no event may any single defendant be liable to the plaintiffs in the aggregate in excess of the professional liability insurance policy limit covering that defendant.

4. This section is not intended to limit the responsibility of any defendant for the total economic damages awarded.

5. For the purposes of this section:

(a) "Gross malpractice" means failure to exercise the required degree of care, skill or knowledge which amounts to:

(1) A conscious indifference to the consequences which may result from the gross malpractice; and

(2) A disregard for and indifference to the safety and welfare of the patient.

(b) "Organic brain damage" means the person has documented organically caused, permanently impaired cognitive capacity rendering him incapable of making independent, responsible life decisions or permanently incapable of independently conducting the activities of the person's normal daily living.

(c) "Total blindness" means a person's visual acuity with correcting lenses does not exceed 20/200 in the better eye, or whose vision in the better eye is restricted to a field which subtends an angle of not greater than 20°.

Sec. 18. Chapter 630 of NRS is hereby amended by adding thereto a new section to read as follows:

A physician licensed pursuant to this chapter shall not practice medicine in this state unless he maintains professional liability insurance in an amount of:

1. *Not less than $1,000,000 per occurrence; and*
2. *Not less than $3,000,000 in the aggregate.*

Sec. 25. Chapter 631 of NRS is hereby amended by adding thereto a new section to read as follows:

A dentist licensed pursuant to this chapter shall not practice dentistry in this state unless he maintains professional liability insurance in an amount of:

1. *Not less than $1,000,000 per occurrence; and*
2. *Not less than $3,000,000 in the aggregate.*

Sec. 27. *An osteopathic physician licensed pursuant to this chapter shall not practice osteopathic medicine in this state unless he maintains professional liability insurance in an amount of:*

1. *Not less than $1,000,000 per occurrence; and*
2. *Not less than $3,000,000 in the aggregate.*

JUL 31 2002

2002 SPECIAL SESSION (18th) A SB2 2

Amendment No. 2

Senate Amendment to Senate Bill No. 2	(BDR 3-13)
Proposed by: Committee of the Whole	
Amendment Box:	
Resolves Conflicts with: N/A	
Amends: Summary: No Title: No Preamble: Amend Joint Sponsorship: No	

ASSEMBLY ACTION	Initial and Date	SENATE ACTION	Initial and Date
Adopted ☐ Lost ☐		Adopted ☐ Lost ☐	
Concurred In ☐ Not ☐		Concurred In ☐ Not ☐	
Receded ☐ Not ☐		Receded ☐ Not ☐	

Amend section 1, page 2, line 6, by deleting "**2**" and inserting "***3***".

Amend section 1, page 2, line 15, after "***whether***" by inserting "***or not***".

Amend section 1, page 2, line 30, by deleting:

"***as a result***" and inserting:

"***, exclusive of interest computed from the date of judgment, to or for the benefit of any claimant arising out***".

Amend section 1, page 2, line 34, after "**2.**" by inserting:

"***Except as otherwise provided in subsection 3 and NRS 41.505:***

(a) A hospital other than a hospital described in paragraph (a) of subsection 1;

(b) An employee of a hospital described in paragraph (a); and

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LH/BJE Date: 7/30/2002

S.B. No. 2—Makes various changes related to medical and dental malpractice.

(c) A physician or dentist licensed under the provisions of chapter 630, 631 or 633 of NRS who renders care or assistance in a hospital described in paragraph (a), whether or not the care or assistance was rendered gratuitously or for a fee,

FLUSH ***that in good faith renders care or assistance necessitated by a sudden, unexpected situation or occurrence resulting in an acute life-threatening medical condition demanding immediate medical attention, for which the patient enters the hospital through its emergency room, may not be held liable for more than $50,000 in civil damages, exclusive of interest computed from the date of judgment, to or for the benefit of any claimant arising out of any act or omission in rendering that care or assistance if the care or assistance is rendered in good faith and in a manner not amounting to gross negligence or reckless, willful or wanton conduct.***

3.".

Amend section 1, page 2, line 40, by deleting "***subsection 1***" and inserting:

"***subsections 1 and 2***".

Amend section 1, page 2, line 44, by deleting "***3.***" and inserting:

"***4. If:***

(a) A physician or dentist provides follow-up care to a patient to whom he rendered care or assistance pursuant to subsection 1 or 2;

(b) A medical condition arises during the course of the follow-up care that is directly related to the original medical condition for which care or assistance was rendered pursuant to subsection 1 or 2; and

(c) The patient files an action for malpractice based on the medical condition that arises during the course of the follow-up care,

FLUSH *there is a rebuttable presumption that the medical condition was caused by the care or assistance rendered pursuant to subsection 1 or 2 and that the limitation on liability provided by subsection 1 or 2 applies with respect to the medical condition that arises during the course of the follow-up care.*

5.".

Amend section 1, page 2, line 45, after "*1*" by inserting "*or 2*".

Amend the bill as a whole by adding a new section designated sec. 1.5, following section 1, to read as follows:

"**Sec. 1.5.** NRS 41.505 is hereby amended to read as follows:

41.505 1. Any physician or registered nurse who in good faith gives instruction or provides supervision to an emergency medical attendant or registered nurse, at the scene of an emergency or while transporting an ill or injured person from the scene of an emergency, is not liable for any civil damages as a result of any act or omission, not amounting to gross negligence, in giving that instruction or providing that supervision. An emergency medical attendant, registered nurse or licensed practical nurse who obeys an instruction given by a physician, registered nurse or licensed practical nurse and thereby renders emergency care, at the scene of an emergency or while transporting an ill or injured person from the scene of an emergency, is not liable for any civil damages as a result of any act or omission, not amounting to gross negligence, in rendering that emergency care.

2. Except as otherwise provided in subsection 3, any person licensed under the provisions of chapter 630, 632 or 633 of NRS and any person who holds an equivalent license issued by another state, who renders emergency care or assistance in an emergency, gratuitously and in good faith, is

not liable for any civil damages as a result of any act or omission, not amounting to gross negligence, by him in rendering the emergency care or assistance or as a result of any failure to act, not amounting to gross negligence, to provide or arrange for further medical treatment for the injured or ill person. This section does not excuse a physician or nurse from liability for damages resulting from his acts or omissions which occur in a licensed medical facility relative to any person with whom there is a preexisting relationship as a patient.

3. Any person licensed under the provisions of chapter 630, 632 or 633 of NRS and any person who holds an equivalent license issued by another state who renders emergency obstetrical care or assistance to a pregnant woman during labor or the delivery of the child is not liable for any civil damages as a result of any act or omission by him in rendering that care or assistance if:

(a) The care or assistance is rendered in good faith and in a manner not amounting to gross negligence or reckless, willful or wanton conduct;

(b) The person has not previously provided prenatal or obstetrical care to the woman; and

(c) The damages are reasonably related to or primarily caused by a lack of prenatal care received by the woman.

FLUSH A licensed medical facility in which such care or assistance is rendered is not liable for any civil damages as a result of any act or omission by the person in rendering that care or assistance if that person is not liable for any civil damages pursuant to this subsection and the actions of the medical facility relating to the rendering of that care or assistance do not amount to gross negligence or reckless, willful or wanton conduct.

4. Any person licensed under the provisions of chapter 630, 632 or 633 of NRS and any person who holds an equivalent license issued by another state who:

(a) Is retired or otherwise does not practice on a full-time basis; and

(b) Gratuitously and in good faith, renders medical care within the scope of his license to an indigent person,

FLUSH is not liable for any civil damages as a result of any act or omission by him, not amounting to gross negligence or reckless, willful or wanton conduct, in rendering that care.

5. ***Any person licensed to practice medicine under the provisions of chapter 630 or 633 of NRS or licensed to practice dentistry under the provisions of chapter 631 of NRS, who renders care or assistance to a patient at a health care facility of a governmental entity or a nonprofit organization, is not liable for any civil damages as a result of any act or omission by him in rendering that care or assistance if the care or assistance is rendered gratuitously, in good faith and in a manner not amounting to gross negligence or reckless, willful or wanton conduct.***

6. As used in this section:

(a) "Emergency medical attendant" means a person licensed as an attendant or certified as an emergency medical technician, intermediate emergency medical technician or advanced emergency medical technician pursuant to chapter 450B of NRS.

(b) "Gratuitously" has the meaning ascribed to it in NRS 41.500.

(c) "Health care facility" has the meaning ascribed to it in NRS 449.800.".

Amend sec. 3, page 3, by deleting line 10 and inserting:

"***treatment, care or custody, loss of earnings and loss of earning capacity.***".

Amend sec. 5, pages 3 and 4, by deleting lines 14 through 47 on page 3 and lines 1 through 11 on page 4, and inserting:

"Sec. 5. *1. Except as otherwise provided in subsection 2 and except as further limited in subsection 3, in an action for damages for medical malpractice or dental malpractice, the noneconomic damages awarded to each plaintiff from each defendant must not exceed $350,000.*

2. In an action for damages for medical malpractice or dental malpractice, the limitation on noneconomic damages set forth in subsection 1 does not apply in the following circumstances and types of cases:

(a) A case in which the conduct of the defendant is determined to constitute gross malpractice; or

(b) A case in which, following return of a verdict by the jury or a finding of damages in a bench trial, the court determines, by clear and convincing evidence admitted at trial, that an award in excess of $350,000 for noneconomic damages is justified because of exceptional circumstances.

3. In an action for damages for medical malpractice or dental malpractice, in the circumstances and types of cases described in subsections 1 and 2, the noneconomic damages awarded to each plaintiff from each defendant must not exceed the amount of money remaining under the professional liability insurance policy limit covering the defendant after subtracting the economic damages awarded to that plaintiff. Irrespective of the number of plaintiffs in the action, in no event may any single defendant be liable to the plaintiffs in the aggregate in excess of the professional liability insurance policy limit covering that defendant.

4. This section is not intended to limit the responsibility of any defendant for the total economic damages awarded.

5. For the purposes of this section "gross malpractice" means failure to exercise the required degree of care, skill or knowledge which amounts to:

(a) A conscious indifference to the consequences which may result from the gross malpractice; and

(b) A disregard for and indifference to the safety and welfare of the patient.".

Amend sec. 6, page 4, line 12, before "*In*" by inserting "*1.*".

Amend sec. 6, page 4, between lines 15 and 16, by inserting:

"*2. As used in this section, "medical malpractice" means the failure of a physician, hospital, employee of a hospital, certified nurse midwife or certified registered nurse anesthetist in rendering services, to use the reasonable care, skill or knowledge ordinarily used under similar circumstances.*".

Amend sec. 8, page 4, line 34, after "*practices*" by inserting:

"*or has practiced*".

Amend sec. 9, page 4, by deleting lines 37 and 38 and inserting:

"*malpractice, each plaintiff, each defendant, the representative of each defendant's insurer, and their respective attorneys shall attend*".

Amend sec. 9, page 5, line 1, after "*party*" by inserting:

"*, his insurer*".

Amend sec. 10, page 5, lines 6 and 7, by deleting "*and 41A.009*" and inserting:

"*, 41A.009 and 41A.013,*".

Amend sec. 12, page 6, line 45, after "*practices*" by inserting:

"*or has practiced*".

Amend sec. 18, page 10, line 25, by deleting "***person;***" and inserting "***occurrence;***".

Amend sec. 18, page 10, line 26, by deleting "***per occurrence.***" and inserting:

"***in the aggregate.***".

Amend sec. 25, page 13, line 40, by deleting "***person;***" and inserting "***occurrence;***".

Amend sec. 25, page 13, line 41, by deleting "***per occurrence.***" and inserting:

"***in the aggregate.***".

Amend sec. 27, page 13, line 47, by deleting "***person;***" and inserting "***occurrence;***".

Amend sec. 27, page 13, line 48, by deleting "***per occurrence.***" and inserting:

"***in the aggregate.***".

Amend sec. 35, page 17, line 1, by deleting "41A.013,".

Amend sec. 38, page 17, line 11, by deleting "41A.013" and inserting "41A.016".

Amend sec. 38, page 17, line 33, by deleting "41A.013" and inserting "41A.016".

Amend the leadlines of repealed sections by deleting the leadline of NRS 41A.013.

Amend the preamble of the bill, page 1, by deleting line 7 and inserting:

"of Nevada; and

WHEREAS, It is recognized that patients who have been injured by medical malpractice must be afforded appropriate access to legal remedies for their injuries and that judicial discretion to render decisions in malpractice actions involving exceptional circumstances must be preserved; now, therefore,".

ASSEMBLY BILL NO. 1–ASSEMBLYMEN PERKINS, BUCKLEY, ANDERSON, HETTRICK, CEGAVSKE, ANGLE, ARBERRY, BACHE, BEERS, BERMAN, BROWER, BROWN, CARPENTER, CHOWNING, CLABORN, COLLINS, DE BRAGA, DINI, FREEMAN, GIBBONS, GIUNCHIGLIANI, GOLDWATER, GUSTAVSON, HUMKE, KOIVISTO, LEE, LESLIE, MANENDO, MARTIN, MARVEL, MCCLAIN, MORTENSON, NEIGHBORS, NOLAN, OCEGUERA, OHRENSCHALL, PARKS, PARNELL, PRICE, SMITH, TIFFANY AND WILLIAMS

JULY 30, 2002

Referred to Committee on Medical Malpractice Issues

SUMMARY—Makes various changes related to medical and dental malpractice. (BDR 3-17)

FISCAL NOTE: Effect on Local Government: No.
Effect on the State: No.

EXPLANATION – Matter in ***bolded italics*** is new; matter between brackets **[~~omitted material~~]** is material to be omitted.

AN ACT relating to malpractice; limiting the liability of certain medical providers for negligent acts under certain circumstances; establishing a limitation on the amount of noneconomic damages that may be awarded in an action for medical malpractice or dental malpractice; providing for several liability of a defendant for noneconomic damages in an action for medical malpractice; making various changes concerning the payment of future economic damages in actions for medical malpractice; providing for the mandatory dismissal of an action for medical malpractice or dental malpractice under certain circumstances; repealing the provisions pertaining to the use of screening panels for an action for medical malpractice or dental malpractice; revising the statute of limitations for filing an action for medical malpractice or dental malpractice; making various other changes concerning actions for medical malpractice or dental malpractice; requiring certain district judges to receive training concerning the complex issues involved in medical malpractice litigation; requiring courts to impose certain sanctions on attorneys in certain circumstances; making various changes relating to the reporting of claims of malpractice or negligence; and providing other matters properly relating thereto.

WHEREAS, The State of Nevada is experiencing extreme difficulties attracting and maintaining a sufficient network of physicians to meet the needs of the residents of this state; and

WHEREAS, The Nevada Legislature has determined that the shortage of physicians and the inability to attract new physicians to this state pose a serious threat to the health, welfare and safety of the residents of the State of Nevada; and

PLEASE PRINT

Guest List for _____ Committee Date July 30, 2002

PLEASE LEAVE A COPY OF PREPARED HANDOUTS WITH THE COMMITTEE SECRETARY

❖ PLEASE PRINT ❖

Name / Title	Representing	Phone No.	~~Bill No.~~	For	Against	Neutral	✓ If Speaking
JOHN ECHEVERRIA	NTLA	786-4800	2				
DEAN HARDY	NTLA	8833571	2				
Bill Bradley	NTLA	335-9999	2				
T ANNARGREN							
Jim Wadhams	AZA, NJA, NHA	202 860-2508	2				
Jim Crockett	NTLA	775 8835577	2				
John COTTON	Nevada Physicians Task Force	786-367-9993	2				
GERALD GALLOWAY	NTLA	702-383-1492	2				
Michael Daubs	Consortium Physicians of Nevada Nevada Orthopaedic ~~Hospital~~ Society	702-399-1098					
James C. Pyne	Saint Mary's	770-3522	2				
Bill M. Welch	NHA	827-0184					
Robert OSTROUSKY	Lake Mead Hospital	951-2156					
Gus W. Flangas	Attorney for Physicians Task Force	307-9500	2				

ORIGINAL—Secretary; YELLOW COPY—Chairman

268

EXHIBIT B

Guest List for Committee of the Whole Committee Date July 30, 2002

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Name / Title	Representing	Phone No.	Bill No.	For	Against	Neutral	✓ If Speaking
VID F. HAEFNER	NV ASSOC. OF NURSE ANESTHETISTS	702 795-8881	SB2			✓	✓
Maury Astley	NV Dental assoc.	702-271 0233	SB2				✓

ORIGINAL—Secretary; YELLOW COPY—Chairman

EXHIBIT B

692

Guest List for Committee of the Whole Committee Date July 30, 2002

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Name / Title	Representing	Phone No.	Bill No.	For	Against	Neutral	✓ If Speaking
Ron Kendall	Self	883-0906					✓

ORIGINAL—Secretary; YELLOW COPY—Chairman

EXHIBIT B

270

Guest List for Committee of the Whole Committee Date July 30, 2002

PLEASE LEAVE A COPY OF PREPARED HANDOUTS WITH THE COMMITTEE SECRETARY

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Name / Title	Representing	Phone No.	Bill No.	For	Against	Neutral	✓ If Speaking
J. KIRK WOOLLEY	ASSOCIATION of NEV PLY & SHNG						✓

ORIGINAL—Secretary; YELLOW COPY—Chairman

EXHIBIT B

Guest List for Committee of the Whole Committee Date July 30, 2002

PLEASE LEAVE A COPY OF PREPARED HANDOUTS WITH THE COMMITTEE SECRETARY

❖ PLEASE PRINT ❖

Name / Title	Representing	Phone No.	Bill No.	For	Against	Neutral	✓ If Speaking
Jim Cratcoat	NRA	702 8833577					

ORIGINAL—Secretary; YELLOW COPY—Chairman

EXHIBIT B

2172

Sign in Sheet for Testimony: 7-30-02

- Jerry H. Mowbray
  - Attorney
- Robert McBeath, MD
  - Nevada Medical Liability Physicians Task Force
- Dan McBride, MD
  - Physician – Chairman of Nevada Mutual Insurance Co.
- Gerald Gillock
  - Attorney
- Jim Wadhams
  - Attorney
- Robert Byrd
  - Chairman of the Board for Medical Liability Insurance Co. of Nevada
- J. Kirk Woolley
  - Executive Director of Association of Nevada Physicians and Surgeons
- Ron Kendall
  - Former Patient
- Alice A. Molasky – Arman
  - Commissioner – Division of Insurance
- Maury Astley
  - Executive Director – Nevada Dental Association
- David P. Haefner
  - Certified Registered Nurse Anesthetist
- Michael Duabs, MD
  - Physician – UMC, Nevada Orthopedic Society
- Chip Wallace
  - Nevada Mutual Insurance Co.

SB2

JUL 2 9 2001

Raggio

SUMMARY—Makes various changes related to medical and dental malpractice. (BDR 3-13)

FISCAL NOTE: Effect on Local Government: No.

Effect on the State: No.

AN ACT relating to malpractice; limiting the liability of certain medical providers for negligent acts under certain circumstances; establishing a limitation on the amount of noneconomic damages that may be awarded in an action for medical malpractice or dental malpractice; providing for several liability of a defendant for noneconomic damages in an action for medical malpractice; making various changes concerning the payment of future economic damages in actions for medical malpractice; providing for the mandatory dismissal of an action for medical malpractice or dental malpractice under certain circumstances; repealing the provisions pertaining to the use of screening panels for an action for medical malpractice or dental malpractice; revising the statute of limitations for filing an action for medical malpractice or dental malpractice; making various other changes concerning actions for medical malpractice or dental malpractice; requiring certain district judges to receive training concerning the complex issues involved in medical malpractice litigation; requiring courts to impose certain sanctions on attorneys in certain circumstances; making various changes relating to the reporting of claims of malpractice or negligence; and providing other matters properly relating thereto.

* 3 - 1 3 *

274

* Same as introduced bill - SB 2

Comparison of Assembly Bill No. 1 (First Reprint) and Senate Bill No. 2 (Proposed First Reprint with Amendment No. 2)

Preamble: The last 3 "whereas" clauses of A.B. 1, relating to the medical errors provisions, are not contained in S.B. 2. The last "whereas" clause of S.B. 2, relating to appropriate access to legal remedies in malpractice actions, is not in A.B. 1.

Section 1 of A.B. 1 corresponds with section 1 of S.B. 2: Adds new section to chapter 41 of NRS (Actions and Proceedings in Particular Cases Concerning Persons). Limits the liability of certain medical providers for negligent acts under certain circumstances.

A.B. 1: 1. Subsection 1 provides a $50,000 cap on civil damages for care or assistance rendered (in good faith and not amounting to gross negligence or "reckless, willful or wanton conduct" and necessitated by a sudden, unexpected situation or occurrence resulting in a serious medical condition demanding immediate medical assistance for which the patient entered the hospital through the emergency room or trauma center) by:

(a) A nonprofit hospital designated as a trauma center;

(b) Employees of such a nonprofit hospital;

(c) Physicians, dentists and osteopathic physicians who render care or assistance in such a hospital (gratuitously or for a fee); and

(d) Physicians, dentists and osteopathic physicians whose liability is not otherwise limited by NRS 41.032 to 41.0337, inclusive, (sovereign immunity) and who render care or assistance in a hospital of a governmental entity designated as a trauma center (gratuitously or for a fee).

2. Subsection 2 provides that the $50,000 cap does not apply to:

(a) Acts or omissions which occur after the patient is stabilized and receiving treatment as a nonemergency patient unless surgery is required as a result of the emergency within a reasonable time; or

(b) Acts or omissions not related to the original medical emergency.

3. Subsection 3 provides a definition for the term "reckless, willful or wanton conduct."

S.B. 2: Section 1 of S.B. 2 contains all of the provisions of section 1 of A.B. 1 (although reorganized) with the following differences:

1. The language establishing the $50,000 cap was changed to make the language match the $50,000 limitation on awards of tort damages against governmental entities in NRS 41.035. This change results in the exclusion of post judgment interest from the $50,000 cap so that the cap will be interpreted in the same manner as the cap in NRS 41.035 ($50,000 per claimant and per claim, regardless of the number of governmental actors).

2. A new subsection 2 was added to provide a $50,000 cap on civil damages for care or assistance rendered (in good faith and not amounting to gross negligence or "reckless, willful or wanton conduct" and necessitated by a sudden, unexpected situation or occurrence resulting in an acute life threatening medical condition demanding immediate

medical assistance for which the patient entered the hospital through the emergency room) by:

(a) Any hospital not described in paragraph (a) of subsection 1;

(b) Employees of such a hospital; and

(c) Physicians, dentists and osteopathic physicians who render care or assistance in such a hospital (gratuitously or for a fee).

3. A new subsection 4 was added to create a rebuttable presumption that a medical condition which arises during the course of follow-up care that is directly related to the original medical condition for which care or assistance was rendered pursuant to subsection 1 or 2 was caused by the care or assistance rendered pursuant to subsection 1 or 2, and that the limitation on liability applies in any action for malpractice based on the medical condition that arises during the course of follow-up care.

Section 2 of A.B. 1 corresponds with section 2 of S.B. 2: Directory language adding new sections (3 t 9) to chapter 41A of NRS (Actions for Medical or Dental Malpractice).

S.B. 2: Identical.

Section 3 of A.B. 1 corresponds with section 3 of S.B. 2: Defines "economic damages" for the purposes of chapter 41A of NRS. Economic damages include damages for medical treatment, care or custody, loss of earnings and loss of earning capacity.

S.B. 2: Identical.

Section 4 of A.B. 1 corresponds with section 4 of S.B. 2: Defines "noneconomic damages" for the purposes of chapter 41A. of NRS. Noneconomic damages include damages to compensate for pain, suffering, inconvenience, physical impairment, disfigurement and other nonpecuniary damages. Generally, these are damages which compensate a plaintiff for losses that do not have a fixed amount, such as pain or suffering. In addition to damages to compensate the person directly injured by the malpractice, these damages may include compensation for losses that occur to others who were affected by the malpractice, such as loss of consortium or comfort.

S.B. 2: Identical.

Section 5 of A.B. 1 corresponds with section 5 of S.B. 2: Establishes a general limit on the amount of noneconomic damages that may be awarded to a plaintiff in an action for dental malpractice or medical malpractice that is brought against a dentist, physician, hospital or employee of a hospital. Specifically, section 5 provides that, unless certain exceptions apply, in an action for damages for medical malpractice or dental malpractice, the noneconomic damages awarded to each injured plaintiff must not exceed $350,000. Subsection 2 of section 5 of the bill provides for certain exceptions to the $350,000 cap on noneconomic damages for medical or dental malpractice actions where the injury involves organic brain damage, hemaplegia, paraplegia or quadraplegia, where a parent, spouse or child dies, total blindness results, a person loses a limb or becomes sterile, where the conduct of the defendant is grossly negligent or the court determines by clear and convincing evidence at trial that an award in excess of $350,000 for noneconomic damages is justified because of exceptional circumstances. Subsection 3 of section 5 of the bill provides that in all cases of medical malpractice the amount of damages awarded to the plaintiff may not

exceed the amount of money remaining under the professional liability insurance policy limit covering the defendant after subtracting the economic damages awarded to the plaintiff. In addition, a single defendant cannot be held liable for noneconomic damages in an amount which exceeds his professional liability insurance policy limit even if there is more than one plaintiff.

S.B.2: Limits the exceptions to cases where the conduct of the defendant is determined to constitute gross malpractice and where the court determines by clear and convincing evidence at trial that an award in excess of $350,000 for noneconomic damages is justified because of exceptional circumstances.

Section 6 of A.B. 1 corresponds with section 6 of S.B. 2: Provides for several liability for noneconomic damages in an action for medical malpractice.

S.B. 2: Identical, except expands the definition of "medical malpractice" to provide for several liability in an action for malpractice brought against a certified nurse midwife or a certified registered nurse anesthetist.

Section 7 of A.B. 1 corresponds with section 7 of S.B. 2: requires a court to dismiss an action involving medical malpractice or dental malpractice if the action is not brought to trial in a timely manner, unless good cause is shown for the delay. Specifically, such an action must be dismissed if it is not brought to trial within 3 years after the date on which it was filed if it is filed between October 1, 2002, and October 1, 2005. If the action is filed on or after October 1, 2005, it must be dismissed if it is not brought to trial within 2 years after the date on which it was filed. Dismissal of an action pursuant to this section is a bar to the filing of another action upon the same claim for relief against the same defendants. Finally, this section requires each district court to adopt court rules to expedite the resolution of a medical or dental malpractice action. Section 39 of the bill sets March 1, 2003, as the deadline for district courts to adopt these rules.

Section 8 of A.B. 1 corresponds with section 8 of S.B. 2: Requires the plaintiff in an action for medical malpractice or dental malpractice to file an affidavit submitted by a medical expert who practices in an area that is substantially similar to the type of practice that the defendant engaged in at the time of the alleged malpractice.

S.B. 2: Identical, except provides that a medical expert who ***has practiced*** in the appropriate area, but who no longer actively practices in that area, may also submit the required affidavit

Section 9 of A.B. 1 corresponds with section 9 of S.B. 2: Requires, in a medical or dental malpractice action, all parties to the action and their insurers and attorneys to participate in a settlement conference. Provides that failure of a party or his attorney to participate in good faith is grounds for sanctions.

S.B. 2: Specifically requires each plaintiff, each defendant, the representative of each defendant's insurer and their attorneys to participate in a settlement conference. Provides that failure of a party, his insurer, or his attorney to participate in good faith is grounds for sanctions.

Section 10 of A.B. 1 corresponds with section 10 of S.B. 2: Ensures that the definitions set forth in sections 3 and 4 of the bill apply to all of the provisions in chapter 41A of NRS, and changes references to reflect the repeal of various sections from chapter 41A of NRS.

S.B. 2: Does not reflect repeal of NRS 41A.013 defining "physician."

Section 11 of A.B. 1 corresponds with section 11 of S.B. 2: Revises the times within which certain actions for injury or death may be brought against certain providers of health care by decreasing the general limitation from 4 years after the date of injury to 3 years after the date of injury.

S.B. 2: Identical.

Section 12 of A.B. 1 corresponds with section 12 of S.B. 2: Provides that expert medical testimony may only be given by a provider of medical care who practices in an area that is substantially similar to the type of practice that the defendant engaged in at the time of the alleged negligence.

S.B. 2: Identical, except provides that a provider of medical care who ***has practiced*** in the appropriate area, but who no longer actively practices in that area, may also give expert medical testimony.

Section 13 of A.B. 1 corresponds with section 13 of S.B. 2: Changes provisions concerning the payment of future economic damages in actions for medical malpractice so that the court has discretion, at the request of the claimant, to order the award to be paid in a lump sum or in periodic payments. Provides that if the award will be paid in periodic payments it may be paid either by the purchase of an annuity or by other means, if the defendant posts an adequate bond or security.

S.B. 2: Identical.

Section 14 of A.B. 1 corresponds with section 14 of S.B. 2: Requires the Court Administrator to submit a biennial report to the Governor and the Legislature including information relating to findings, judgments and other court determinations of the liability of physicians and osteopathic physicians for malpractice or negligence.

S.B. 2: Identical.

Section 15 of A.B. 1 corresponds with section 15 of S.B. 2: Adds new section to chapter 3 of NRS (Remedies, Special Actions and Proceedings): requires district judges to whom medical malpractice actions are assigned to receive training concerning the complex issues involved in such actions.

S.B. 2: Identical.

Section 16 of A.B. 1 corresponds with section 16 of S.B. 2: Requires a court to sanction an attorney who files, maintains or defends any civil action or proceeding which is not well-grounded in fact or warranted by existing law or an argument for changing existing law made in good faith, or who unreasonably and vexatiously extends any civil action or proceeding.

S.B. 2: Identical.

Section 17 of A.B. 1 corresponds with section 17 of S.B. 2: Removes a provision of NRS concerning the screening panels for medical and dental malpractice.

S.B. 2: Identical.

Section 18 of A.B. 1 (no corresponding section in S.B. 2): Directory language adding new sections (19 to 43) to chapter 439 of NRS (Administration of Public Health).

Section 19 of A.B. 1 (no corresponding section in S.B. 2): General definition section.

Section 20 of A.B. 1 (no corresponding section in S.B. 2): Defines "incident." This is a key definition because it describes one of the type of medical errors that medical facility personnel must report , i.e., things which occur in connection with the treatment of a patient at a medical facility. An "incident" is basically a "close call," i.e., a patient could have been injured but was not, in actuality. Note that the medical errors reporting provisions (§§ 18-46) model a similar Pennsylvania proposal (PA House Bill No. 1802).

Section 21 of A.B. 1 (no corresponding section in S.B. 2): Defines "medical facility." Thus, the requirements regarding medical error reporting only apply to personnel of hospitals, as defined in NRS 449.012, an obstetric center, as defined in NRS 449.0155, and a surgical center for ambulatory patients, as defined in NRS 449.019.

Section 22 of A.B. 1 (no corresponding section in S.B. 2): Defines "patient."

Section 23 of A.B. 1 (no corresponding section in S.B. 2): Defines "patient safety officer."

Section 24 of A.B. 1 (no corresponding section in S.B. 2): Defines "provider of health care."

Section 25 of A.B. 1 (no corresponding section in S.B. 2): Defines "repository."

Section 26 of A.B. 1 (no corresponding section in S.B. 2): Defines "serious event." This is another key definition because it describes the second type of medical error that medical facility personnel must report, i.e., things which occur in connection with the treatment of a patient at a medical facility. A "serious event" is defined as something that either: (1) causes the death of the patient; or (2) compromises the patient's safety and causes an "unanticipated injury" requiring them to need further treatment.

Section 27 of A.B. 1 (no corresponding section in S.B. 2): Defines "treatment."

Section 28 of A.B. 1 (no corresponding section in S.B. 2): Defines "unanticipated injury."

Section 29 of A.B. 1 (no corresponding section in S.B. 2): Creates the repository for health care quality assurance ("repository") within the health division. In Pennsylvania, this entity is called the health care quality assurance authority ("HCQAA"). The

"repository" is the main entity involved in receiving reports of incidents and serious events, and disseminating information regarding serious events in ONLY an aggregated format. Reported incidents are used internally with respect to the generation of recommendations for medical facilities (as are reports of serious incidents), but no information regarding incidents is disseminated in any form.

Section 30 of A.B. 1 (no corresponding section in S.B. 2): Sets forth the main requirement to report incidents and serious events which occur at medical facilities. The basic rule is that incidents and serious events must be reported to the repository by medical facility personnel within 24 hours after their occurrence has been discovered. Within that 24-hour timeframe, the normal procedure is that the discovering employee notifies the medical facility's "patient safety officer" ("PSO") within 6 hours, and then the PSO notifies the repository within 18 hours, for a total allowed time of 24 hours. If the PSO is the person who first becomes aware of the incident or serious event, the PSO has a straight 24 hour period to notify the repository. This way, the repository gets the information within 24 hours, regardless of who actually first becomes aware of the incident or serious event. Exactly how the repository is to be notified is not specified, but the administrator of the health division is required to prescribe the method of notification. (Corresponds to PA House Bill § 308.)
In addition, this section requires the administrator of the health division to conduct follow-up surveys with medical facility employees who report incidents and serious events. The follow-up survey is specifically geared toward finding out whether a reporting employee: (1) was retaliated against or disciplined for reporting an incident or serious event; and (2) knows of any remedial or corrective action taken by the applicable medical facility in response to the incident or serious event reported by the employee.

Section 31 of A.B. 1 (no corresponding section in S.B. 2): Requires the repository to maintain and safeguard the reports of incidents and serious events that it receives and the responses from the follow-up surveys. This is modeled on a similar section of NRS pertaining to the central repository for Nevada records of criminal history (NRS 179A.080(1)).

Section 32 of A.B. 1 (no corresponding section in S.B. 2): Requires the health division (of which the repository is a part) to contract out to impartial independent contractors, other than a provider of health care, for the performance of various functions, including the processing of data regarding reports of incidents and serious events, the processing of data from the follow-up surveys, the analysis of that data, and the transmission of recommendations to the repository. (PA House Bill § 304(a)(5)).

Section 33 of A.B. 1 (no corresponding section in S.B. 2): Describes the process of how recommendations for changes in health care practices and procedures are considered and approved. Regarding approval, a recommendation is first received by the repository from the independent contractor, the recommendation is then evaluated by the repository and transmitted to the administrator (of the health division), who has the ultimate say in approving or disapproving the recommendation. When a recommendation is evaluated by the repository or considered for recommendation by the administrator, certain factors must

be considered, including the likelihood of improving patient safety, feasibility, and cost impacts. (PA House Bill § 304(a)(6)-(7)).

Section 34 of A.B. 1 (no corresponding section in S.B. 2): Describes the process of how approved recommendations for changes in health care practices and procedures are transmitted to medical facilities.

Section 35 of A.B. 1 (no corresponding section in S.B. 2): Requires patients who have been involved in a serious event to be so notified by the relevant medical facility within 7 days after the fact. The notifying is actually done by a person designated to perform that duty by the medical facility. The person so designated may or may not be the same person as the Patient Safety Officer. The provisions specifies that this notification MUST NOT be considered an acknowledgment or admission of liability. (PA House Bill § 308(b)). Note that "incidents" are not reported to the patient.

Section 36 of A.B. 1 (no corresponding section in S.B. 2): Allows interested persons and entities to get from the repository the information received by the repository in the form of the reports on incidents and serious events. Interested persons and entities can only get at information in an aggregated form (e.g., state trends or trends within a particular geographic region), such that no information can be given out to the public in a form in which individual persons or medical facilities are named. This section references chapter 239 of NRS, basically making the repository's collected information available as public records, subject to the limitations described above. That chapter allows the imposition of a reasonable fee in connection with providing copies of information. Specifically, this section requires the repository to produce additional reports and documents which are based on the reports on incidents and serious events that the repository receives, but to make only information regarding serious events available to the public in various aggregated forms.

Section 37 of A.B. 1 (no corresponding section in S.B. 2): Provides that none of the information reported, created or compiled pursuant to these provisions may be used in any administrative or court proceeding as evidence. (PA House Bill § 311(a)).

Section 38 of A.B. 1 (no corresponding section in S.B. 2): Requires each medical facility to develop and comply with an internal safety plan.

Section 39 of A.B. 1 (no corresponding section in S.B. 2): Requires each medical facility to designate a patient safety officer.

Section 40 of A.B. 1 (no corresponding section in S.B. 2): Requires each medical facility to establish a safety committee.
Directs the administrator of the health division to tailor the safety committee requirements for application in smaller medical facilities.

Section 41 of A.B. 1 (no corresponding section in S.B. 2): Provides generally that persons are not criminally or civilly liable in defamation-type actions where they have,

without malice, reported, transmitted or disseminated information regarding incidents or serious events. (Modeled on NRS 616D.020.)

Section 42 of A.B. 1 (no corresponding section in S.B. 2): Allows the administrator of the health division to impose a fine of not more than $1,000 against a medical facility for violations of these provisions by the medical facility or by members of its staff. Provides for a hearing to protest the fine if the medical facility desires a hearing. This section was modeled on NRS 118B.251.

Section 43 of A.B. 1 (no corresponding section in S.B. 2): Requires the adminstrator of the health division to adopt regulation to carry out the medical error reporting provisions.

Section 44 of A.B. 1 (no corresponding section in S.B. 2): Directory language adding new sections (45 and 46) to chapter 449 of NRS (Medical and Other Related Facilities).

Section 45 of A.B. 1 (does not correspond with S.B. 2): Prohibits a medical facility from retaliating or discriminating against an employee of the medical facility who in good faith:

1. Reports to the Board of Medical Examiners or the State Board of Osteopathic Medicine information relating to the conduct of a physician or osteopathic physician which may constitute grounds for initiating disciplinary action against the physician or which otherwise raises a reasonable question regarding the competence of the physician to practice medicine with reasonable skill and safety to patients.
2. Reports an incident or serious event to the repository for health care quality assurance.
3. Cooperates or otherwise participates in an investigation or proceeding conducted by the Board of Medical Examiners, the State Board of Osteopathic Medicine or another governmental entity relating to physician's conduct.

Section 46 of A.B. 1 (does not correspond with S.B. 2): Authorizes an employee of a medical facility who has been retaliated or discriminated against for action specified in section 45 to file an action in court. If the court determines that a violation occurred, the court may award damages and interest and may grant equitable relief. Requires an action for a violation be brought within 2 years after the date of the last event constituting the alleged violation for which the action was brought. Provides that a medical facility which retaliates or discriminates against an employee is subject to a civil penalty of not more than $10,000 for each violation.

Section 47 of A.B. 1 (no corresponding section in S.B. 2): Directory language adding new section (48, 49 and 50) to chapter 630 of NRS (Physicians, Physician Assistants and Practitioners of Respiratory Care)

Section 48 of A.B. 1 (does not correspond with S.B. 2): Prohibits a physician from retaliating or discriminating against an employee of the physician who in good faith:

1. Reports to the Board of Medical Examiners information relating to the conduct of the physician which may constitute grounds for initiating disciplinary action against the physician or which otherwise raises a reasonable question regarding the competence of the physician to practice medicine with reasonable skill and safety to patients.

2. Reports an incident or serious event to the repository for health care quality assurance.

3. Cooperates or otherwise participates in an investigation or proceeding conducted by the Board of Medical Examiners or another governmental entity relating to physician's conduct.

Section 49 of A.B. 1 (does not correspond with S.B. 2): Authorizes an employee of a physician who has been retaliated or discriminated against for action specified in section 48 to file an action in court. If the court determines that a violation occurred, the court may award damages and interest and may grant equitable relief. Requires an action for a violation be brought within 2 years after the date of the last event constituting the alleged violation for which the action was brought. Provides that a physician who retaliates or discriminates against an employee is subject to a civil penalty of not more than $10,000 for each violation.

Section 50 of A.B. 1 corresponds with section 18 of S.B. 2: Establishes minimum amount of professional liability insurance for physician licensed pursuant to chapter 630 of NRS at $1,000,000 per occurrence and $3,000,000 in the aggregate.

S.B. 2: Identical.

Section 51 of A.B. 1 corresponds with section 19 of S.B. 2: Amends NRS 630.130 to require the Board of Medical Examiners to submit to the Governor and the Legislature a biennial written report compiling: (1) disciplinary action taken by the Board during the previous biennium against physicians for malpractice or negligence; (2) information reported to the Board during the previous biennium relating to claims for malpractice or negligence made against physicians and the settlement, award, judgment or other disposition of the claims; (3) information reported to the Board during the previous biennium relating to changes in physicians' privileges to practice medicine and certain disciplinary actions taken against physicians; and (4) information reported to the Board by a court during the previous biennium concerning a determination that a physician, physician assistant or practitioner of respiratory care is mentally ill or incompetent, has been convicted of a felony or any law governing controlled substances or dangerous drugs, is guilty of abuse or fraud under any state or federal program providing medical assistance, or is liable for damages for malpractice or negligence. The report must include only aggregate information for statistical purposes and exclude any identifying information related to a particular person.

S.B. 2: Identical.

Section 52 of A.B. 1 corresponds with section 20 of S.B. 2: Amends NRS 630.267 to require physicians, as a condition of biennial registration, to submit to the Board of Medical Examiners a list of all actions filed or claims submitted to arbitration or mediation against the holder for malpractice or negligence during the previous 2 years.

S.B. 2: Identical.

Section 53 of A.B. 1 corresponds with section 21 of S.B. 2: Amends NRS 630.3062, which lists grounds for disciplinary action against all persons licensed pursuant to chapter 630 of NRS, to provide instead that a physician's failure to comply with a requirement

relating to the reporting of claims for malpractice and negligence against the physician as set forth in NRS 630.3067 is grounds for initiating disciplinary action or denying licensure. The section still makes a failure to report those claims to the Board of Medical Examiners in a timely manner a ground for initiating disciplinary action against a physician, but the 90-day reporting that had been in this section has been changed to 30 days in the amendment to NRS 630.3067

S.B. 2: Identical.

Section 54 of A.B. 1 corresponds with section 22 of S.B. 2: Amends NRS 630.3067 to clarify that insurers of physicians and the physicians must report to the Board of Medical Examiners any action filed or any claim submitted to arbitration or mediation for the malpractice or negligence of the physician and the settlement, award, judgment or other disposition of the action or claim within 30 days after the action was filed or the claim was submitted to arbitration or mediation, and within 30 days after the disposition of the action or claim. The references are to "action filed" and "claim submitted to arbitration or mediation" because, as noted above, this bill repeals the screening panels. This section also requires the Board to report any failure of an insurer to comply with this section to the Division of Insurance of the Department of Business and Industry ("Division"). If the Division determines that an insurer failed to comply with this section, the Division may impose an administrative fine of not more than $10,000 against the insurer for each such failure to report and, if the administrative fine is not paid when due, the fine must be recovered in a civil action brought by the Attorney General on behalf of the Division.

S.B. 2: Identical.

Section 55 of A.B. 1 corresponds with section 23 of S.B. 2: Amends NRS 630.307 to clarify certain deadlines for the reporting to the Board of Medical Examiners of certain conduct that may constitute grounds for disciplinary action against a person practicing medicine or respiratory care, and the reporting of changes in a physician's privileges to practice medicine and the outcome of disciplinary action taken against a physician. The section also provides a civil penalty of not more than $10,000 for certain facilities that fail to make the required reports concerning a change to a physician's privileges and the outcome of disciplinary action taken against the physician. In addition, this section requires the Board to keep information received pursuant to the section confidential. Finally, this section requires each court clerk to submit to the Office of Court Administrator an annual compilation of findings, judgments, and determinations of courts of liability by physicians for malpractice or negligence that the court clerks had reported to the Board of Medical Examiners during the previous year.

S.B. 2: Identical.

Section 56 of A.B. 1 corresponds with section 24 of S.B. 2: amends NRS 630.364 to remove subsection 3 because it related only to medical and dental malpractice screening panels, which have been eliminated.

S.B. 2: Identical.

Section 57 of A.B. 1 corresponds with section 25 of S.B. 2: Establishes minimum amount of professional liability insurance for dentist licensed pursuant to chapter 631 of NRS at $1,000,000 per occurrence and $3,000,000 in the aggregate.

S.B. 2: Identical.

Section 58 of A.B. 1 (no corresponding section in S.B. 2): Directory language adding new sections (59 to 64) to chapter 633 of NRS (Osteopathic Medicine).

Section 59 of A.B. 1 (does not correspond with S.B. 2): Prohibits an osteopathic physician from retaliating or discriminating against an employee of the osteopathic physician who in good faith:

1. Reports to the State Board of Osteopathic Medicine information relating to the conduct of the osteopathic physician which may constitute grounds for initiating disciplinary action against the osteopathic physician or which otherwise raises a reasonable question regarding the competence of the osteopathic physician to practice medicine with reasonable skill and safety to patients.
2. Reports an incident or serious event to the repository for health care quality assurance.
3. Cooperates or otherwise participates in an investigation or proceeding conducted by the State Board of Osteopathic Medicine or another governmental entity relating to osteopathic physician's conduct.

Section 60 of A.B. 1 (does not correspond with S.B. 2): Authorizes an employee of an osteopathic physician who has been retaliated or discriminated against for action specified in section 59 to file an action in court. If the court determines that a violation occurred, the court may award damages and interest and may grant equitable relief. Requires an action for a violation be brought within 2 years after the date of the last event constituting the alleged violation for which the action was brought. Provides that a physician who retaliates or discriminates against an employee is subject to a civil penalty of not more than $10,000 for each violation.

Section 61 of A.B. 1 corresponds with section 27 of S.B. 2: Establishes minimum amount of professional liability insurance for osteopathic physician licensed pursuant to chapter 633 of NRS at $1,000,000 per occurrence and $3,000,000 in the aggregate.

S.B. 2: Identical.

Section 62 of A.B. 1 corresponds with section 28 of S.B. 2: Adds a new section to chapter 633 to require the State Board of Osteopathic Medicine to submit to the Governor and the Legislature a biennial written report compiling: (1) disciplinary action taken by the Board during the previous biennium against osteopathic physicians for malpractice or negligence; (2) information reported to the Board during the previous biennium relating to claims for malpractice or negligence made against osteopathic physicians and the settlement, award, judgment or other disposition of the claims; (3) information reported to the Board during the previous biennium relating to changes in osteopathic physicians' privileges to practice osteopathic medicine and certain disciplinary actions taken against osteopathic physicians; and (4) information reported to the Board by a court during the previous biennium concerning a determination that an osteopathic physician or osteopathic physician's assistant is mentally ill or incompetent, has been convicted of a felony or any law governing controlled substances or dangerous drugs, is guilty of abuse or fraud under

any state or federal program providing medical assistance, or is liable for damages for malpractice or negligence. The report must include only aggregate information for statistical purposes and exclude any identifying information related to a particular person. This section is modeled after NRS 630.130 from the chapter concerning physicians, physician assistants and practitioners of respiratory care.

S.B. 2: Identical.

Section 63 of A.B. 1 corresponds with section 29 of S.B. 2: Adds a new section to chapter 633 to require that insurers of osteopathic physicians and the osteopathic physicians to report to the State Board of Osteopathic Medicine any action filed or any claim submitted to arbitration or mediation for the osteopathic physician's malpractice or negligence and the settlement, award, judgment or other disposition of the action or claim within 30 days after the action was filed or the claim was submitted to arbitration or mediation and within 30 days after the disposition of the action or claim. In addition this section requires the State Board of Osteopathic Medicine to report any failure of an insurer to comply with this section to the Division of Insurance of the Department of Business and Industry ("Division"). If the Division determines that an insurer failed to comply with this section, the Division may impose an administrative fine of not more than $10,000 against the insurer for each such failure to report and, if the administrative fine is not paid when due, the fine must be recovered in a civil action brought by the Attorney General on behalf of the Division. This section is modeled after NRS 630.3067 concerning physicians.

S.B. 2: Identical.

Section 64 of A.B. 1 corresponds with section 30 of S.B. 2: Adds a new section to chapter 633 to require the reporting of certain conduct that may constitute grounds for disciplinary action and claims for malpractice or negligence against osteopathic physicians by any person, certain facilities and court clerks to the State Board of Osteopathic Medicine by a specified deadline. The section also provides a civil penalty of not more than $10,000 for certain facilities that fail to make the required reports concerning a change to an osteopathic physician's privileges and the outcome of disciplinary action taken against the osteopathic physician. In addition, this section requires the Board to keep information received pursuant to the section confidential. Finally, this section requires each court clerk to submit to the Office of Court Administrator an annual compilation of findings, judgments, and determinations of courts of liability by osteopathic physicians for malpractice or negligence that the court clerks had reported to the State Board of Osteopathic Medical Examiners during the previous year. This section is modeled after NRS 630.307 concerning physicians, physician assistants and practitioners of respiratory care.

S.B. 2: Identical.

Section 65 of A.B. 1 corresponds with section 31 of S.B. 2: Amends NRS 633.471 to require osteopathic physicians and osteopathic physician's assistants, as a condition of renewal of their licenses, to submit to the State Board of Osteopathic Medicine a list of all actions filed or claims submitted to arbitration or mediation against the licensee for malpractice or negligence during the previous year.

S.B. 2: Identical.

Section 66 of A.B. 1 corresponds with section 32 of S.B. 2: Amends NRS 633.511 to provide that an osteopathic physician's failure to report the initiation or disposition of actions or claims of malpractice or negligence in a timely manner to the State Board of Osteopathic Medicine is a ground for initiating disciplinary action.

S.B. 2: Identical.

Section 67 of A.B. 1 corresponds with section 33 of S.B. 2: Amends NRS 690B.045 to provide a reference to section 29 of this bill to indicate that there are more requirements for insurers in section 29 relating to the reporting of actions or claims of malpractice or negligence against osteopathic physicians to the State Board of Osteopathic Medicine.

S.B. 2: Identical.

Section 68 of A.B. 1 corresponds with section 34 of S.B. 2: Amends NRS 690B.050 to require insurers to report to the Commissioner of Insurance each settlement, award or judgment relating to a claim of malpractice against an osteopathic physician. Note that this section currently only requires insurers to report to the Insurance Commissioner claims of malpractice against physicians. The section also requires the insurance commissioner to report these reports from insurers regarding the malpractice of osteopathic physicians to the State Board of Osteopathic Medicine.

S.B. 2: Identical.

Section 69 of A.B. 1 corresponds with section 35 of S.B. 2: Repeals the screening panels for medical and dental malpractice.

S.B. 2: Does not repeal NRS 41A.013 defining "physician."

Section 70 of A.B. 1 corresponds with section 36 of S.B. 2: Limits the applicability of the caps, liability of defendants, and limitations on commencement of actions provisions to actions which accrue on or after October 1, 2002.

S.B. 2: Identical.

Section 71 of A.B. 1 corresponds with section 37 of S.B. 2: Limits the applicability of the certain new procedural provisions to actions filed on or after October 1, 2002.

S.B. 2: Identical.

Section 72 of A.B. 1 corresponds with section 38 of S.B. 2: Sets forth transitory provisions to address matters filed with but not completed by the medical and dental malpractice screening panels as of October 1, 2002.

S.B. 2: Identical, except that the references to the repeal of NRS 41A.013 are removed as S.B. 2 does not repeal NRS 41A.013 defining "physician."

Section 73 of A.B. 1 corresponds with section 39 of S.B. 2: Sets March 1, 2003, as the deadline for district courts to adopt the rules to expedite the resolution of medical and dental malpractice cases.

S.B. 2: Identical.

Section 74 of A.B. 1 (no corresponding section in S.B. 2): Specifies date by which a medical facility is required to submit its patient safety plan to the repository for health care quality assurance.

Section 75 of A.B. 1 corresponds with section 40 of S.B. 2: Sets the effective date for the provisions of the bill [Note: The provisions that appear in both bills are effective on October 1, 2002; the provisions found in A.B. 1 that are not included in S.B. 2 are effective July 1, 2003.]

Section 1.5. of S.B. 2 (no corresponding section in A.B.1): This section amends NRS 41.505 to provide total immunity from liability to medical doctors, osteopathic physicians and dentists who provide care or assistance at a nonprofit or governmental health care facility for any such care or assistance rendered to a patient free of charge as long as the as long as it is rendered in good faith and in a manner that does not amount to gross negligence.

Expecting

When a physician or dentist provides care or assistance to patients without requesting or receiving compensation or consideration for said services in a clinic or public facility, that physician or dentist shall not be liable for civil damages as a result any act or omission in rendering that care or assistance if the care or assistance is rendered in good faith and in a manner not amounting to gross negligence or reckless, willful or wanton conduct.

7-30-02

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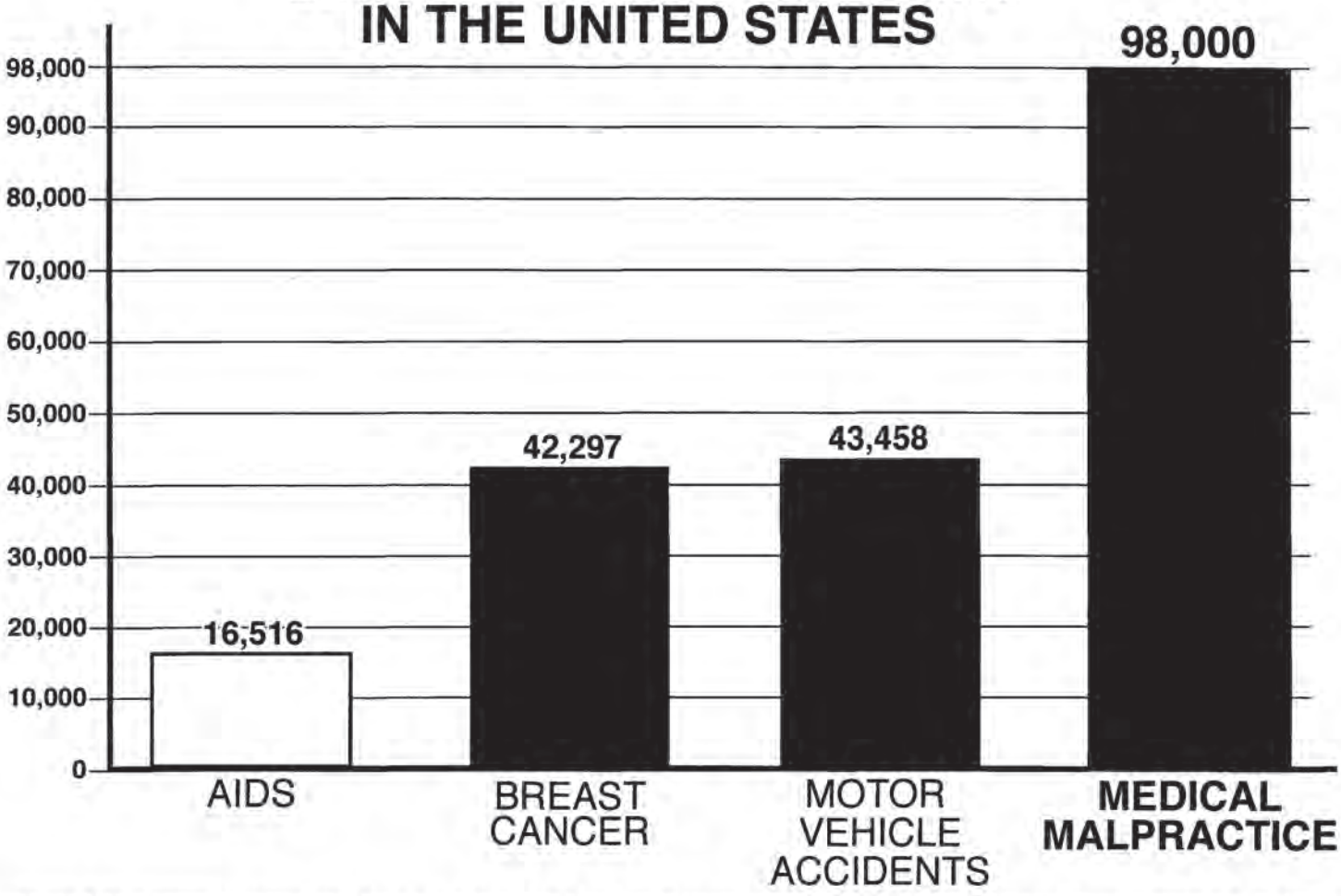
LEADING CAUSES OF DEATH IN THE UNITED STATES



Source: Kohn, Corrigan, Donaldson, Eds., *To Err is Human; Building a Safer Health System*, Institute of Medicine, National Academy Press: Washington, D. C., 1999

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TortSource

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American Bar Association

The Insurance Cycle [The Reform Cycle]

Joanne Doroshow

The tort "reform" movement of the last two decades has turned the civil justice system into a battleground. Founded in 1986, the American Tort Reform Association (ATRA), with the backing of 300 corporate, professional, and insurance trade organization members, boasts that most states have enacted some form of tort reform—laws that restrict the rights of injured consumers to sue and be fully compensated for their injuries.

In the mid-1980s, manufacturers, municipalities, doctors, nurse-midwives, daycare centers, nonprofit groups, and many other commercial customers of liability insurance were faced with skyrocketing insurance rates, coverage reductions, and arbitrary policy cancellations. Many could not find coverage at any price.

Insurance companies said costs were being driven up by an "explosion" in litigation and claimed "frivolous lawsuits" and "out of control" juries were forcing them to make insurance unaffordable or even unavailable. They told state legislatures around the country that the only way to ease this crisis was to limit tort laws, to make it more difficult for sick and injured consumers to sue and be compensated by wrongdoers in court.

But what ultimately proved to be the true cause of the "liability insurance crisis" of the mid-1980s was not the legal system at all. Study after study that examined the property/casualty insurance industry found the same result: The "insurance crisis" was actually a self-inflicted phenomenon caused by the mismanaged underwriting practices of the industry itself.

The past few years, when the economy for the most part was booming, have found state court tort filings stable or declining. Only 10 percent of injured people file claims for compensation, and just 2 percent file lawsuits. Nearly eight times as many patients suffer an injury from negligent medical treatment than ever file a claim. Punitive damages are rarely awarded, and liability insurance costs for businesses are minuscule and dropping. The premium-gouging cash-flow underwriting practices of the insurance industry have been widely exposed. With these facts in mind, it may be hard to understand why tort reform remains on the national agenda.

By 1985 interest rates had dropped, and investment income had decreased accordingly. The industry responded by sharply increasing premiums and reducing availability of coverage, creating a "liability insurance crisis." As *Business Week* explained in a January 1987 editorial,

> Even while the industry was blaming its troubles on the tort system, many experts pointed out that its problems were largely self-made. In previous years the industry had slashed prices competitively to the point that it incurred enormous losses. That, rather than excessive jury awards, explained most of the industry's financial difficulties.

The National Association of Attorneys General and state commissions in New Mexico, Michigan, and Pennsylvania reached similar conclusions. Even the insurance industry admitted this internally. In 1986 Maurice R. Greenberg, president and CEO of American International Group, Inc., told an insurance audience in Boston that the industry's problems were due to price cuts taken "to the point of absurdity" in the early 1980s. Had it not been for these cuts, he said, "there would not be 'all this hullabaloo' about the tort system."

Same as exhibit 7-29-02
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7-30-02

Nevada Revised Statute Definition of Trauma and
Certain Nevada Administrative Code Definitions Related to Trauma

NRS 450B.105 "Trauma" defined.
"Trauma" means any acute injury which, according to standardized criteria for triage in the field, involves a significant risk of death or the precipitation of complications or disabilities.

(Added to NRS by 1987, 1042)

NAC 450B.798 "Patient with trauma" defined.
"Patient with trauma" means a person who has sustained injury and meets the triage criteria used to evaluate the condition of the patient.

(Added to NAC by Bd. of Health, eff. 3-15-88)

NAC 450B.770 Procedures for initial identification and care of patients with traumas.
A person providing emergency medical care to a patient at the scene of an injury shall use the following procedures to identify and care for patients with traumas:

1. Step 1: If a patient's airway is obstructed or he has cardiac-pulmonary arrest, he must be transported to the nearest center for the treatment of trauma if the time required to transport the patient is not more than 10 minutes. If the time required to transport the patient is more than 10 minutes, the patient must be transported to the nearest hospital or center for the treatment of trauma. If the patient does not have an obstructed airway or is not in cardiac-pulmonary arrest, the person providing emergency medical care shall measure the patient's vital signs and level of consciousness.

2. Step 2: If the patient's:

(a) Glasgow Coma Score is not more than 13;

(b) Systolic blood pressure is less than 90;

(c) Respiratory rate is less than 10 or greater than 29; or

(d) Champion trauma score is less than 14,

the patient must be transported to a center for the treatment of trauma. If not, the person providing emergency medical care shall assess the patient's condition based upon the degree of injury to the anatomy and the mode of injury.

3. Step 3: If the patient:

(a) Has a penetrating injury to the chest, abdomen, head, neck or groin;

(b) Has at least two proximal long bone fractures;

(c) Has a combination of burns over at least 15 percent of his body or on his face or in an airway;

(d) Has a flail chest;

(e) Has acute paralysis; or

(f) Has experienced a high-impact blow to the body which may include:

(1) A fall of at least 20 feet;

(2) A motor vehicle accident in which:

(I) The motor vehicle was traveling at a speed of at least 20 miles per hour when it crashed, resulting in at least 30 inches of damage to the body of the motor vehicle;

(II) The front axle of the motor vehicle was displaced toward the rear;

(III) There was an 18-inch intrusion into the passenger's compartment where the patient was riding or a 24-inch intrusion on the opposite side of the motor vehicle;

(IV) The patient was ejected from the motor vehicle;

(V) The motor vehicle rolled over; or

(VI) A person riding in the motor vehicle with the patient died as a result of the accident; or

(3) Being struck as a pedestrian by a vehicle traveling at a speed of at least 20 miles per hour,

the patient must be transported to a center for the treatment of trauma.

4. Step 4: If the patient is less than 5 years of age or more than 55 years of age or is known to have a cardiac or respiratory disease, the person providing emergency medical care shall communicate with a physician at a center for the treatment of trauma to determine the need to transport the patient to that center.

5. If the person providing emergency medical care is not certain whether to transport the patient to a center for the treatment of trauma, he shall transport the patient to a center pursuant to NAC 450B.772.

(Added to NAC by Bd. of Health, eff. 3-15-88)

NAC 450B.786 "Center for the treatment of trauma" defined.

"Center for the treatment of trauma" means a general hospital licensed in this state which has been designated as a level I, II, III or IV center by the administrator of the health division, pursuant to the provisions of NAC 450B.780 to 450B.875, inclusive.

(Added to NAC by Bd. of Health, eff. 3-15-88; A 10-22-93; 11-1-95)

7-30-02

PROPOSED AMENDMENT TO SENATE BILL NO. 2

Amend section 1 of the bill to read as follows:

Section 1. Chapter 41 of NRS is hereby amended by adding thereto a new section to read as follows:

1. Except as otherwise provided in subsection 3 and NRS 41.505:

(a) A hospital which has been designated as a center for the treatment of trauma by the administrator of the health division of the department of human resources pursuant to NRS 450B.237 and which is a nonprofit organization;

(b) An employee of a hospital described in paragraph (a) who renders care or assistance to patients;

(c) A physician or dentist licensed under the provisions of chapter 630, 631 or 633 of NRS who renders care or assistance in a hospital described in paragraph (a) whether the care or assistance was rendered gratuitously or for a fee; and

(d) A physician or dentist licensed under the provisions of chapter 630, 631 or 633 of NRS:

(1) Whose liability is not otherwise limited pursuant to NRS 41.032 to 41.0337, inclusive; and

(2) Who renders care or assistance in a hospital of a governmental entity that has been designated as a center for the treatment of trauma by the administrator of the health division of the department of human resources pursuant to NRS 450B.237, whether or not the care or assistance was rendered gratuitously or for a fee,

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that in good faith renders care or assistance necessitated by a sudden, unexpected situation or occurrence resulting in a serious medical condition demanding immediate

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medical attention, for which the patient enters the hospital through its emergency room or trauma center, may not be held liable for more than $50,000 in civil damages ~~[as a result]~~ *, exclusive of interest computed from the date of judgment, to or for the benefit of any claimant arising out of any act or omission in rendering that care or assistance if the care or assistance is rendered in good faith and in a manner not amounting to gross negligence or reckless, willful or wanton conduct.*

2. Except as otherwise provided in subsection 3 and NRS 41.505:

(a) A hospital other than a hospital described in paragraph (a) of subsection 1;

(b) An employee of a hospital described in paragraph (a); and

(c) A physician or dentist licensed under the provisions of chapter 630, 631 or 633 of NRS who renders care or assistance in a hospital described in paragraph (a) whether or not the care or assistance was rendered gratuitously or for a fee,

that in good faith renders care or assistance necessitated by a sudden, unexpected situation or occurrence resulting in an acute life threatening medical condition demanding immediate medical attention, for which the patient enters the hospital through its emergency room, may not be held liable for more than $50,000 in civil damages, exclusive of interest computed from the date of judgment, to or for the benefit of any claimant arising out of any act or omission in rendering that care or assistance if the care or assistance is rendered in good faith and in a manner not amounting to gross negligence or reckless, willful or wanton conduct.

3. The limitation on liability provided pursuant to this section does not apply to any act or omission in rendering care or assistance:

(a) Which occurs after the patient is stabilized and is capable of receiving medical treatment as a nonemergency patient, unless surgery is required as a result of the emergency within a reasonable time after the patient is stabilized, in which case the limitation on liability provided by subsection 1 applies to any act or omission in rendering care or assistance which occurs before the stabilization of the patient following the surgery; or

(b) Unrelated to the original medical emergency.

~~3.~~ 4. For the purposes of this section "reckless, willful or wanton conduct," as it applies to a person to whom subsections 1 and 2 apply, shall be deemed to be that conduct which the person knew or should have known at the time he rendered the care or assistance would be likely to result in injury so as to affect the life or health of another person, taking into consideration to the extent applicable:

(a) The extent or serious nature of the prevailing circumstances;

(b) The lack of time or ability to obtain appropriate consultation;

(c) The lack of a prior medical relationship with the patient;

(d) The inability to obtain an appropriate medical history of the patient; and

(e) The time constraints imposed by coexisting emergencies.

Amend the bill as a whole by adding a new section to the bill to read as follows:

Sec. X. NRS 41.505 is hereby amended to read as follows:

41.505 1. Any physician or registered nurse who in good faith gives instruction or provides supervision to an emergency medical attendant or registered nurse, at the scene

of an emergency or while transporting an ill or injured person from the scene of an emergency, is not liable for any civil damages as a result of any act or omission, not amounting to gross negligence, in giving that instruction or providing that supervision. An emergency medical attendant, registered nurse or licensed practical nurse who obeys an instruction given by a physician, registered nurse or licensed practical nurse and thereby renders emergency care, at the scene of an emergency or while transporting an ill or injured person from the scene of an emergency, is not liable for any civil damages as a result of any act or omission, not amounting to gross negligence, in rendering that emergency care.

2. Except as otherwise provided in subsection 3, any person licensed under the provisions of chapter 630, 632 or 633 of NRS and any person who holds an equivalent license issued by another state, who renders emergency care or assistance in an emergency, gratuitously and in good faith, is not liable for any civil damages as a result of any act or omission, not amounting to gross negligence, by him in rendering the emergency care or assistance or as a result of any failure to act, not amounting to gross negligence, to provide or arrange for further medical treatment for the injured or ill person. This section does not excuse a physician or nurse from liability for damages resulting from his acts or omissions which occur in a licensed medical facility relative to any person with whom there is a preexisting relationship as a patient.

3. Any person licensed under the provisions of chapter 630, 632 or 633 of NRS and any person who holds an equivalent license issued by another state who renders emergency obstetrical care or assistance to a pregnant woman during labor or the delivery

of the child is not liable for any civil damages as a result of any act or omission by him in rendering that care or assistance if:

(a) The care or assistance is rendered in good faith and in a manner not amounting to gross negligence or reckless, willful or wanton conduct;

(b) The person has not previously provided prenatal or obstetrical care to the woman; and

(c) The damages are reasonably related to or primarily caused by a lack of prenatal care received by the woman.

FLUSH A licensed medical facility in which such care or assistance is rendered is not liable for any civil damages as a result of any act or omission by the person in rendering that care or assistance if that person is not liable for any civil damages pursuant to this subsection and the actions of the medical facility relating to the rendering of that care or assistance do not amount to gross negligence or reckless, willful or wanton conduct.

4. Any person licensed under the provisions of chapter 630, 632 or 633 of NRS and any person who holds an equivalent license issued by another state who:

(a) Is retired or otherwise does not practice on a full-time basis; and

(b) Gratuitously and in good faith, renders medical care within the scope of his license to an indigent person,

FLUSH is not liable for any civil damages as a result of any act or omission by him, not amounting to gross negligence or reckless, willful or wanton conduct, in rendering that care.

5. ***Any person licensed to practice medicine under the provisions of chapter 630 or 633 of NRS or licensed to practice dentistry under the provisions of chapter 631 of***

NRS, who renders care or assistance to a patient at a health care facility of a governmental entity or a nonprofit organization, is not liable for any civil damages as a result of any act or omission by him in rendering that care or assistance if the care or assistance is rendered gratuitously, in good faith and in a manner not amounting to gross negligence or reckless, willful or wanton conduct.

6. As used in this section:

(a) "Emergency medical attendant" means a person licensed as an attendant or certified as an emergency medical technician, intermediate emergency medical technician or advanced emergency medical technician pursuant to chapter 450B of NRS.

(b) "Gratuitously" has the meaning ascribed to it NRS 41.500.

(c) "Health care facility" has the meaning ascribed to it in NRS 449.800.