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 2 (ADD 0214–0416)

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MINUTES OF THE MEETING
OF THE
ASSEMBLY COMMITTEE ON MEDICAL MALPRACTICE ISSUES

Eighteenth Special Session
July 29, 2002

The Assembly Committee on Medical Malpractice Issues was called to order at 12:13 p.m., on Monday, July 29, 2002. Chairman Bernie Anderson presided in Room 4100 of the Legislative Building, Carson City, Nevada. The meeting was videoconferenced to Room 4401 of the Grant Sawyer Office Building in Las Vegas, Nevada. Exhibit A is the Agenda. Exhibit B is the Guest List. All exhibits are available and on file at the Research Library of the Legislative Counsel Bureau.

COMMITTEE MEMBERS PRESENT:

Mr. Bernie Anderson, Chairman
Ms. Barbara Buckley, Vice Chairman
Mr. Bob Beers
Mr. David Brown
Mrs. Barbara Cegavske
Mr. Joseph Dini, Jr.
Mr. Lynn Hettrick
Mrs. Ellen Koivisto
Ms. Sheila Leslie
Mr. Mark Manendo
Mr. John Marvel
Mr. John Oceguera
Ms. Genie Ohrenschall
Ms. Bonnie Parnell
Mr. Richard D. Perkins

COMMITTEE MEMBERS ABSENT:

None

GUEST LEGISLATORS PRESENT:

Assemblyman Doug Bache, District 11
Assemblyman John Carpenter, District 33

Assemblywoman Vonne Chowning, District 28
Assemblyman Jerry Claborn, District 19
Assemblyman Tom Collins, District 1
Assemblywoman Marcia de Braga, District 35
Assemblywoman Vivian Freeman, District 24
Assemblywoman Chris Giunchigliani, District 9
Assemblyman John Lee, District 3
Assemblywoman Kathy Martin, District 20
Assemblywoman Kathy McClain, District 15
Assemblyman Harry Mortenson, District 42
Assemblyman Dennis Nolan, District 13
Assemblyman David Parks, District 41
Assemblyman Bob Price, District 17
Assemblywoman Debbie Smith, District 30

STAFF MEMBERS PRESENT:

Allison Combs, Principal Research Analyst
Nicolas Anthony, Senior Research Analyst
Risa Lang, Principal Deputy Legislative Counsel
Kim Morgan, Chief Deputy Legislative Counsel
Cindy Clampitt, Committee Secretary
June Rigsby, Committee Secretary
Linda Smith, Committee Secretary

OTHERS PRESENT:

Charles Laws, Citizen and candidate for Governor
Lisa Black, Nevada Nurses' Association
Leann McElroy, City of Reno
Kevin Spitz, GEMP (not in registered lobbyist book; no phone number)
Stephanie Licht, Elko County
Jan Gilbert, Planned Parenthood
Pat Elzy, Planned Parenthood
Maureen Brower, Nevada Hospital Association (NHA), American Insurance Association (AIA), etc.
Dr. Lawson Richter, Physician
Pat Chao, Citizen
Dr. Lonnie Hammargren, Citizen
Jim Wadhams, American Insurance Association (AIA), Nevada Hospital Association (NHA), Nevada Independent Insurance Agents (NIIA)
Reverend Chester Richardson, Las Vegas Citizen
Victoria Riley, National Trial Lawyers Association

Dianne Meyer
Janet Markley
Susan Roe, Registered Nurse
Mary Walker, Carson Tahoe Hospital
Ron Kendall, Kendall & Associates, Inc
Larry Spitler, Nevada Associate Director, American Association of Retired Persons
Denell Hahn, Sunrise Hospital
Ann Lynch, Sunrise Hospital
Dr. Kenneth Sigelman, Consumer Attorneys of California
James De Roche, National Trial Lawyers Association
Dawnelle Keys, Citizen
Robbie Keys, Citizen
Edward Goodrich, Citizen
Thelma Clark, Las Vegas Citizen
Renee Williams

The meeting was called to order at 12:13 p.m. Chairman Bernie Anderson extended a welcome to committee members and guests. A quorum was present. Chairman Anderson explained the meeting was directed by the call of Governor Kenny Guinn, and the stated purpose of the hearing was to address the recent medical malpractice insurance crisis. Although precipitated by a critical situation in Las Vegas, Chairman Anderson explained their discussion and decision-making would have a statewide impact on the medical industry in Nevada.

Chairman Anderson voiced his expectation for courtesy and fair consideration of all points of view in what was expected to be an emotionally-charged forum. He emphasized that public testimony was critical to the process and cautioned his fellow assemblymen not to forget their duty to serve the public. He reminded members of the audience to sign in, if they expected to testify. It was essential that testimony be truthful and succinct, especially if a previous speaker had addressed the topic adequately. The record would be left open for purposes of allowing witnesses to submit copies of written testimony at the end of the day.

Chairman Anderson stated the first order of business would be the adoption of Standing Rules for the Medical Malpractice Issues Committee (Exhibit C). The Legislative Counsel Bureau staff would then present a brief overview of topics. Testimony would follow throughout the day as well as on Tuesday.

Chairman Anderson then called for a motion to adopt the Committee Rules; however, copies had not been distributed to members. Chairman Anderson

called the committee's attention to Standing Rule 42, adopted earlier on the Floor of the Assembly. He emphasized that Standing Rule 42 required all amendments be submitted through the Medical Malpractice Issues Committee.

Chairman Anderson introduced the Legislative Counsel Bureau staff, Allison Combs, Principal Research Analyst, and Nicolas Anthony, Senior Research Analyst. Ms. Combs distributed three volumes of background information compiled as the result of an interim study to address medical malpractice. Volume 1 (Exhibit D), entitled "Background Information On Medical Malpractice – Overview of the Work of the Legislative Subcommittee to Study Medical Malpractice," included a white paper summarizing key findings, the minutes of two meetings, and background information compiled by the subcommittee. Volume 2 (Exhibit E) and Volume 3 (Exhibit F) were each entitled "Background Information On Medical Malpractice."

Ms. Combs explained the volumes contained an overview of past legislative actions, comparative information on the insurance markets in Nevada and across the nation, an update on the recently created Medical Liability Association of Nevada, an overview of Nevada's current civil justice laws and a list of nationwide laws involving tort reforms, information on California's Medical Injury Compensation Reform Act of 1975, a national overview that highlighted caps on damages, comparative data on the functioning of medical liability screening panels in other states, data on Nevada claims with emphasis on Clark County, and an overview of the operation of the Nevada Board of Medical Examiners.

Chairman Anderson acknowledged the tremendous investment of time and effort by the Legislative Counsel Bureau staff. He commended the quality of the reports and voiced his confidence the data would prove to be essential in their discussions and decision-making processes.

Nicolas Anthony called the committee's attention to Volume 2 (Exhibit E) and offered to comment on the Nevada Civil Justice laws, the third tab in the document. A chart on page 73 summarized the statute of limitations, immunity from liability for certain emergency care, comparative negligence, medical malpractice panels, use of expert witnesses, patient consent, limits on punitive damages, damages from collateral sources, periodic payments for future damages, and damages in cases involving wrongful death. The fourth tab of Volume 2 (Exhibit E) contained a nationwide overview of tort laws (i.e., medical malpractice liability statutes) as published by the National Conference of State Legislatures (NCSL). Mr. Anthony predicted those topics would be prominent throughout the committee hearing. For easy reference, a copy of the *Nevada Revised Statutes* (NRS) 41 and 42, was included.

Chairman Anderson called for questions from the committee. Hearing none, he resumed discussion of the Standing Rules for the Committee on Medical Malpractice Issues (Exhibit C). Chairman Anderson called attention to Rule No. 4. In accordance with Assembly Standing Rule 42, he quoted the following: "Committee introduction of legislative measures and amendments will require a majority of the entire committee and require a committee from each such concurrent member to support final passage, a commitment of supporting final passage, the measures are adopted and amendments on the Floor of the Assembly as appropriate."

For clarification, Chairman Anderson explained that normally a committee member's vote indicated support for getting that piece of legislation out of committee to the floor. In the past, Chairman Anderson had requested of his committee members that if an individual would not be supporting the bill on the floor, that he informed the chairman in advance or refrained from voting. For purposes of the Medical Malpractice Issues Committee, a commitment to vote at the committee level equated to a commitment to support the bill and amendments on the floor, unless the chairman had been otherwise notified. As such, it was somewhat more formal than the normal Judiciary Committee voting process.

ASSEMBLYWOMAN BUCKLEY MOVED TO ADOPT THE STANDING RULES OF THE COMMITTEE ON MEDICAL MALPRACTICE ISSUES.

ASSEMBLYWOMAN CEGAVSKE SECONDED THE MOTION.

THE MOTION CARRIED UNANIMOUSLY BY ALL PRESENT.

Chairman Anderson called for a recess and asked for the committee to reconvene at 1:15 p.m. Witness testimony would commence following the recess.

At 1:33 p.m., Chairman Anderson called the committee meeting to order and invited the first witness to come forward.

Larry Spitler, Nevada Associate Director of Advocacy for the American Association of Retired Persons (AARP), read from a prepared statement (Exhibit G). He emphasized the great complexity of the issues and the need for equitable consideration of all stakeholders (businesses, healthcare professionals, and consumers). Mr. Spitler acknowledged that a crisis had brought the malpractice issue to prominence, but it was important to remember the underlying issue was to protect and improve health and access to care. In

his judgment, the central problem was not the tort system but preventable medical injury.

Mr. Spitler, on behalf of the AARP, recommended nine critical actions that would promote preventable medical injury and medical malpractice. They included the setting of national goals for patient safety, a mandatory nationwide reporting system of adverse events, voluntary reporting efforts, legislation to extend peer review protections, healthcare organization performance standards, promotion of patient safety performance standards, increased attention by the Food and Drug Administration (FDA) on the safe use of drugs, the development of a non-punitive system for reporting errors, and the institution of proven medication safety practices.

Mr. Spitler emphasized his opposition to actions that would impair the right of injured patients to full and just compensation for injuries resulting from inappropriate medical care. He concluded his testimony with a review of four key elements supported by the AARP (Exhibit G). The first was to promote access to the courts for all legitimate claims, including smaller malpractice claims, and to accelerate the resolution of cases. The second recommendation was to explore alternative dispute resolution systems for medical malpractice cases that could serve negligently injured patients better than the current system. The third element was to evaluate other promising systems of compensation for preventable medical injuries and to explore demonstration projects. His final recommendation was the establishment of malpractice insurance rates that fairly and accurately reflected claims experience.

Chairman Anderson called for questions. Assemblyman Brown requested clarification of the third key element, evaluation of other systems, and asked the witness if he had examples. Mr. Spitler explained the AARP Washington headquarters office was performing a nationwide information scan for demonstration projects. He suggested the Interim Committee on Medical Malpractice would also be investigating those systems. Chairman Anderson clarified that the Interim Committee, chaired by Senator Rawson, had finalized the report, and it was presented on Monday, July 21.

Susan Roe, a Registered Nurse and resident of Las Vegas, read testimony on behalf of her family. In 1998, Christopher Roe, age 14 years, was diagnosed with acute lymphocytic leukemia (ALL). Mrs. Roe stated her son suffered greatly and died unnecessarily as a result of their physician's negligence. Her family had been advised to follow a treatment protocol that was thought to be a better option for Christopher. The protocol had a divergence on the seventh day of chemotherapy treatment at which point a bone marrow screening would be performed. It was designed to determine if Christopher was a "slow

responder" (i.e., his cancerous cells were still evidenced in the marrow) or a "rapid early responder" (i.e., in remission). With sadness in her voice, Mrs. Roe explained that the final pathology report had not been examined, and, as a result of that oversight, the less aggressive path of treatment was selected for Christopher. He died within 9 months of diagnosis.

Mrs. Roe's personal research had revealed the expected course of the disease was generally 3-5 years and not 9 months. Additionally, the expected rate of survival was 80 percent. After obtaining copies of Christopher's laboratory test results, Mrs. Roe discovered he had twice the number of cancer cells in his bone marrow than she had originally been told. Further, the physicians had ignored signs and symptoms present at the time of diagnosis that would have dictated cranial radiation therapy in addition to chemotherapy.

Mrs. Roe concluded her remarks and emphasized the suffering Christopher had endured and the unmitigated grief her family was experiencing. Litigation became their only recourse and the most effective means to send an important message to the physicians. In the process of interviewing several lawyers, Mrs. Roe was advised the process would be long and arduous. Despite less than encouraging advice, the Roe family proceeded with legal action.

In her judgment, Mrs. Roe felt if the cap of $250,000 or $350,000 was enacted, it would be almost impossible to locate an attorney willing to take the case. Ordinary citizens would be denied access to the justice system. Additionally, medical malpractice judgments were reported to the National Physicians Data Bank and to the Nevada State Board of Medical Examiners. If there were no cases proceeding to court, there would be no mechanism to deal with a small number of incompetent physicians. Mrs. Roe stated one of her son's physicians admitted his awareness of the error one month after the point of Christopher's diagnosis. In her view, that was an egregious act of malpractice and denied her son a chance at survival. Despite the physician's admission of error, his affidavit stated the outcome would have been just as poor.

In conclusion, Mrs. Roe stated emphatically that Christopher Thomas Roe did not have a "bad outcome" as declared by his physician. He died on his sixteenth birthday. She appealed to the committee to help other families in their pursuit of justice.

Assemblywoman Cegavske expressed her sincere condolences to the witness and asked if the family's medical bills had been adequately covered. Mrs. Roe explained that, although many bills had been handled, the family had the misfortune of having ESEA self-funded insurance. The witness reminded the

committee there had been a past legal issue between the support staff of the Clark County School District and the ESEA insurance coverage. As a result, there was an outstanding claim of $135,000 owed to the University of Minnesota that ESEA denied due to a supposed lack of timely filing.

Chairman Anderson inquired if the Roe family had difficulty in locating an attorney to take the case. Mrs. Roe replied in the affirmative. Negligence was apparent; however, causation was a more difficult point to prove. The expert witness called to testify was the Chairman of the Children's Oncology Group for the United States. In his view, Christopher needed cranial radiation, an accepted standard of care. As a result of his expert testimony, the Roe family hired an attorney.

In closing, Mrs. Roe acknowledged the issue of causation was important; however, it served to give "free reign" to oncologists to choose treatment protocols and then later claim the expected outcome, from the point of diagnosis, was death.

In response to Chairman Anderson's request for an update on the case, Mrs. Roe stated the case had not yet come to trial and the next step was the Medical-Legal Screening Panel. The total elapsed time between searching for an attorney and the upcoming screening panel hearing was approximately one year. She explained that part of the delay occurred during the interviewing of three attorneys who held their files for a long period of time before rendering a decision on the merit of the case. The second attorney held the documents for seven months and then declared he had a conflict of interest and could not accept the case.

Chairman Anderson summarized by stating from the point of diagnosis to the upcoming appointment with the medical screening panel was approximately one year. Mrs. Roe clarified that Christopher died in the fall of 1999 and, as such, total elapsed time was three years and four months. Chairman Anderson thanked the witness for her testimony.

Assemblywoman Cegavske interjected with a request for a written copy of Larry Spitler's testimony.

Chairman Anderson called the next witness and, given the time constraints, he encouraged all witnesses to be as succinct as possible.

Lisa Black, the Executive Director of the Nevada Nurse's Association (NNA), read from prepared testimony (Exhibit H). In her view, all parties had common agreement that the issue of medical malpractice had reached a point of crisis,

one that required expeditious and fair handling. Ms. Black clarified her testimony was a mixture of both personal viewpoints as well as those of the NNA.

On the topic of civil justice reform, the Nurse's Association had not taken an official position on the issue of damage caps; however, her personal experience of becoming HIV and Hepatitis C positive compelled her to speak out on behalf of caps. Although Ms. Black admitted to lifetime medical benefits and unemployment compensation, there had been no provision for her pain and suffering, both described as severe and extreme. She stated emphatically that she found it repugnant that any group or person would set a dollar value on her life, regardless of amount. In her view, caps on awards could invite that judgment.

On the issue of insurance reform (Exhibit H), the Nevada Nurse's Association supported several points. The association agreed that the practice of setting insurance premiums for obstetricians based on the number of deliveries should be disallowed. If not amended, the association believed it would be improper to include the number of deliveries attended by Advance Practitioners of Nursing (APN) in the aggregate number of covered deliveries attended by a physician. Ms. Black explained Advance Practitioners of Nursing practiced in a collaborative role, not a supportive role, and they maintained their own liability insurance.

Regarding medical error reporting (Exhibit H), the Nevada Nurse's Association supported the development of an effective system of medical error reporting in Nevada. Ms. Black recommended implementing the guidelines set by the Institute of Medicine and developing a system that did not focus on the naming, blaming, or shaming of individual practitioners. The goal would be to identify the systems failures that harmed patients. In Ms. Black's view, punitive actions against practitioners would create an environment of covering up errors, and immunity to disciplinary actions and licensing actions should be instituted. In her view, that immunity would dovetail with and enhance whistle-blower provisions.

Ms. Black encouraged the committee to clearly define "an adverse event short of a sentinel event causing severe harm or death for the purposes of any legislation relevant to medical error reporting that may come out of this special session." On the somewhat unrelated subject of nursing shortages, she called the committee's attention to the fact that increasing the number of registered nurses in medical facilities was associated with a decreasing number of errors.

Chairman Anderson, citing a shortage of committee time, asked the witness to

conclude her testimony. Ms. Black summarized by commending the work of all parties who had contributed to solving the medical malpractice issue in Nevada.

Assemblywoman Leslie requested clarification on whether the medical malpractice reporting system would be mandatory or voluntary. Ms. Black responded that the Nevada Nurse's Association endorsed a mandatory system that protected the healthcare worker from being individually blamed, disciplined, or subjected to licensing sanctions. The reporting system should publish aggregate numbers and not reveal the individual caregiver's name.

Assemblywoman Cegavske inquired if it was known how many nurses statewide and nationally were cited in medical malpractice cases. Chairman Anderson suggested that data might be part of Assemblywoman Koivisto's subcommittee report. Ms. Black volunteered to address the question and explained the detailed information was included in the last meeting of the Interim Committee on Medical Malpractice. Chairman Anderson stated the Legislative Counsel Bureau Research Division would investigate the issue.

The next witness was Ms. Renee Williams, testifying on behalf of her daughter, Brianna Williams, a victim of medical malpractice. Before and after photographs of her daughter (Exhibit I) were submitted for the record. Ms. Williams described the series of events that followed what should have been a routine labor and delivery on November 7, 2000. Her daughter was now in a chronic vegetative state and required total care. In her judgment, the physicians and nurses ignored reports of post-delivery hemorrhaging and, as a result, Brianna Williams suffered permanent and severe brain injury. Ms. Williams stated her firm opposition to caps on damages and believed medical professionals should be held accountable.

Chairman Anderson asked the witness how long it took to find an attorney to take the malpractice case. Ms. Williams stated she worked for an attorney, and she had never received solid advice or help on the matter from that firm. She decided to interview a new attorney, and the total elapsed time was approximately 6 months to procure legal assistance.

Reverend Chester Richardson, a resident of Las Vegas and a Baptist minister, commenced testimony in support of caps on medical malpractice. He reminded the committee of the monetary caps awarded to the gaming industry when they appeared before the Nevada Legislature. Reverend Richardson voiced concern over doctors who turned away patients because of malpractice claim fears. He illustrated his point with the example of his teenage son who was severely injured as a victim of a drive-by shooting. He took his son to the Trauma Center in Las Vegas, and his son's life was saved.

Reverend Richardson summarized the heart of the issue as being people, such as his son, who needed service.

Chairman Anderson summarized the testimony by saying the witness appeared to be inspired by the opening and closing of the UMC Trauma Center in Las Vegas. He requested clarification if the witness's main concern was the need for the continuing operation of the trauma center or the proposed caps of $250,000. Reverend Richardson stated the trauma center should remain open at all costs. His second point related to his role as an advocate in the community for citizens who needed dental or medical treatment and could not find a doctor to accept their business.

Assemblywoman Koivisto requested research data on the number of lawsuits filed against the University Medical Center (UMC) Trauma Center. Chairman Anderson acknowledged her request. There being no additional questions, he recessed the committee hearing at 2:30 p.m. and announced the hearing would resume at 4:00 p.m. He suggested to committee members, with emphasis to Democratic members, to meet in their respective caucus groups for updates.

Chairman Anderson reconvened the Medical Malpractice Issues Committee at 4:29 p.m.

He announced that Senate and Assembly members had had an opportunity to meet with the Governor to discuss some compromise points that had been agreed to by both sides. That discussion led to the drafting of BDR 3-13 (Exhibit J) and introduction in the Senate. Chairman Anderson declared he would honor his promise to hear testimony from all witnesses. The contents of BDR 3-13 would be reviewed in testimony presented by Speaker Perkins and Assemblywoman Buckley. Chairman Anderson predicted the introduction of a very similar piece of legislation on the Assembly side at 8:00 a.m., Tuesday, July 30. Following that, the Assembly Committee on Medical Malpractice Issues (MMI) would reconvene to accept amendments. Any amendment to the document must come through the Assembly Committee on Medical Malpractice Issues. Public testimony would be welcome.

Charles Laws, citizen and candidate for the office of Governor, summarized his concerns to BDR 3-13. He alluded to Governor Guinn's public comment in which the Governor voiced his optimism that the bill would be essential to building a foundation for long-term solutions. Mr. Laws acknowledged the complexity of the process and agreed it was not an issue that could be solved during the special legislative session. He viewed the terms of BDR 3-13 as Band-Aids and aspirin attempting to treat a very dysfunctional system.

The crisis needed a sufficient period of diagnosis before solutions could be suggested and implemented.

Mr. Laws reminded the committee the citizens of Nevada were at the heart of the system and the sole motivation for all efforts. The citizens interacted with their insurers, healthcare providers, and with the legislators. As such, the complexity of those interactions dictated a thorough analysis and careful approach that appeared to be currently absent. Attorneys were players at multiple stages of the crisis. The full range of relationships had to be exposed before real progress could be made.

Regarding the issue of caps, Mr. Laws referred to it as an oxymoron. In his view it was not possible to suggest an economic means of balancing the damages of noneconomic concerns. Because the losses covered the spectrum of both physical and emotional harm, he suggested the committee consider the cost of therapy (e.g., grief counseling) to transition clients and their families through the trauma. Physicians who were accused of inflicting the damage also had need for counseling. Mr. Laws emphasized that compensation not be limited to monetary award, and that they can treat all parties as human beings and not bank accounts.

Chairman Anderson called for questions. There being none, he summoned the next witness. Many witnesses did not respond to his invitation to testify because they had left the room.

Ron Kendall, representing Kendall & Associates, commenced testimony on behalf of physicians. He called the committee's attention to his written testimony (Exhibit K) inspired by his personal experience. Although he was damaged by the healthcare system, Mr. Kendall voiced strong support for the good doctors who saved his life. In his view, the healthcare system was driven by exorbitant malpractice insurance rates that were creating an exodus out of Nevada of good healthcare providers. Mr. Kendall voiced his support of the tort reforms recommended by Governor Guinn that would impose a cap to match the California standard. He concluded by stating that the Nevada legislature had the ability to invoke mandatory binding arbitration that would help ensure a quality healthcare system in Nevada.

Chairman Anderson called for additional witnesses. Seeing none, he requested distribution of the Bill Draft Request (BDR) 3-13 document.

- BDR 3-13 -- Makes various changes related to medical and dental malpractice. (A.B. 1)

Speaker Perkins and Assemblywoman Buckley moved to the witness table and began an overview of the bill. Speaker Perkins explained the document was a bill draft request that would be introduced the following day as A.B. 1. He explained it was the product of many hours of discussion between legislative and executive branches and represented a consensus. It was not regarded as a perfect piece of legislation. Conspicuously absent from the bill draft request was the topic of insurance reform which he predicted would be a prominent issue in the 2003 session of the Nevada Legislature.

Speaker Perkins acknowledged there had been lengthy discussion of medical errors reporting and stated it was not fully addressed in the bill draft request. Because of the technical nature of that topic, the issue could not be fairly addressed in such a short amount of time. The topic would be handled at a later date.

Assemblywoman Buckley, representing Assembly District 8, echoed the sentiments of her fellow committee members in the need to meet in special session largely as the result of the St. Paul Insurance Company who eight months previous had ceased to provide coverage in Las Vegas. One of the insurance reforms that had been in the original Assembly bill draft, alluded to by Speaker Perkins, required that when insurance companies served a high proportion of the market that they had to give a minimum of 120 days' notice before withdrawing from the market. Assemblywoman Buckley assured the committee that would be a reform to be addressed during the 2003 Legislative Session.

In her judgment, the lack of planning opportunity caused by the abrupt withdrawal of the insurance carrier greatly compounded the situation. It catapulted the issue to the crisis point for southern Nevada doctors. When addressing the issue of insurance reform, Assemblywoman Buckley emphasized that lowering the premium costs had to be part of that future dialogue. The current mission, however, was to quickly bring a package for statewide implementation. She described the bill as a consensus bill and acknowledged input from many members of the legislature. On the topic of medical error reporting, Assemblywoman Buckley commented that was not yet part of the bill draft. She explained that during the last session, Assemblywoman Koivisto had sponsored a bill on that topic which had led to the interim study. Many of the findings of that interim committee had been captured in the proposed medical error-reporting document that would be available the following day.

Speaker Perkins commenced the explanation of BDR 3-13 (Exhibit J) by topic, referencing sections as appropriate. The first topic, civil justice reform, was described as containing a concept for fast-tracking medical malpractice cases

and streamlining the process. Speaker Perkins explained the need was predicated by great concerns over the delay in getting a medical malpractice case to trial, in some instances more than 5 years. He added that the state of Nevada had a Medical Screening Panel in place since 1985. The purpose of the panel was to ensure non-meritorious cases did not get taken to court; however, the efficacy of the panel had been questioned since its inception.

Assemblywoman Buckley explained the issue of expediting the handling of medical malpractice cases had been a prominent point of discussion in their committee meetings. All parties agreed that streamlining the process was necessary and would lower overall costs. Assemblywoman Buckley declared the proposed legislation would eliminate the existing Medical Screening Panel. For cases in progress, the plaintiff would be allowed to choose between the panel and proceeding to District Court. Referencing Section 7 (Exhibit J), Assemblywoman Buckley explained staggered implementation would efficiently move backlogged cases from the panel to the court. After October 2005, a case would have to be brought forward within two years, rather than the current 3-year deadline.

Assemblywoman Buckley called the committee's attention to the issues of mandatory settlement conferences and judicial training. All parties, including the plaintiff, the defendant, and the insurance companies, would be required to participate in a settlement conference before a district judge. Each judge would be trained in the complexity of medical malpractice cases. Assemblywoman Buckley credited Governor Guinn with the idea of training at the Judicial College.

Speaker Perkins resumed testimony and addressed the topic of the statute of limitations. The proposed legislation would dictate that cases involving injury or wrongful death must be brought within three years or within two years of the date of discovery – whichever occurred first. Requirements for expert witnesses would be strengthened. The judge would be required to dismiss with prejudice if the action was filed without an affidavit signed by a medical expert who practiced in a substantially similar area of medicine.

The most significant topic in the area of civil justice reform was described by Speaker Perkins to be monetary caps on noneconomic damages. He labeled it the cornerstone of the entire issue of medical malpractice reform. The proposed legislation would impose a cap of $350,000 on noneconomic damages in medical malpractice cases. For egregious cases of negligence (e.g., brain damage), the cap would be modified to $350,000 or the amount remaining in the policy after economic damages had been assessed. It would apply to cases of gross malpractice in which the court decided an award in excess of

$350,000 was justified. No single defendant would be liable to the plaintiffs in excess of his own policy limits.

Assemblywoman Buckley called the committee's attention to page 5 of BDR 3-13 (Exhibit J) for examples of egregious medical malpractice that could be exceptions to the monetary caps. In cases of clear and convincing evidence, the judge would be allowed a higher standard than the usual preponderance of the evidence standard, thereby permitting him to make an exception. As such, there would be some flexibility and judicial discretion.

Chairman Anderson called for agreement from the committee regarding questions. Assemblyman Beers requested clarification if the current testimony was simply an overview and if additional time would be spent later on each topic. Chairman Anderson replied in the affirmative.

Assemblywoman Buckley introduced the next major topic, protection of trauma center medical personnel. The proposed legislation would ensure that those personnel at non-profit hospitals were not unfairly responsible for large civil damages. It would further ensure that trauma centers in Nevada communities would remain open for business. The bill would codify the $50,000 state and county cap on damages. It would not change the status of trauma center personnel to county employees. The cap would no longer apply once the patient was stabilized or the emergency had passed. For the cap to apply, the medical care would have to be delivered in good faith and in a manner that did not result in gross negligence or reckless conduct.

Speaker Perkins clarified the rationale behind the need to retain and protect the trauma centers in Nevada. County facilities were limited in their liability to $50,000 under the governmental cap. Medical personnel working side by side with county employees had no such cap. That inequity created a fear among certain workers of being a greater risk for "deep pocket" monetary awards.

Speaker Perkins called the committee's attention to Section 6 covering joint and several liability. A defendant in a medical malpractice case would not be subject to deep pocket awards. He would be severally liable for noneconomic damages based upon his percentage of the negligence.

On the issue of periodic payments, Speaker Perkins clarified that the proposed legislation modified existing law which allowed for payment of future economic damages, either in lump sum or by annuity, for periodic payments. The bill would allow the court to order payment in the lump sum or in periodic payments. In the case of the latter, the award would be paid either by annuity or by other means if the defendant posted a bond or other security.

Sanctions against attorneys would be required in situations where non-meritorious cases were unreasonably pursued. The proposed legislation (Exhibit J) would revise existing Nevada law to require, instead of allow, the court to issue a sanction against an attorney in cases judged to have no merit. The attorney would be required to personally pay the costs, expenses, and attorney fees incurred as a result. Assemblywoman Buckley interjected there would be no cap in such instances.

Ms. Buckley called the committee's attention to Sections 18, 25, and 27 (Exhibit J) and the issue of mandatory insurance coverage. A physician would be prohibited from practicing medicine in Nevada unless he maintained liability insurance, described as a minimum of $1 million per person and $3 million per occurrence. Further, the bill provided statutory definitions of the terms "economic" and "noneconomic" damages. Regarding medical error reporting, Assemblywoman Buckley expressed her hope that a draft of that proposal would be available for review in the near future. The issue of medical error reporting had been prominent in interim committee discussions and was regarded as a critical part of preventative efforts.

Assemblywoman Buckley cited nationwide efforts and explained that prevention of medical errors was of highest priority in every state. Fourteen states currently had developed medical error reporting systems, with Pennsylvania heralded as being one of the best in the nation. Ms. Buckley reviewed some of the key elements, which included the system be a mandatory one, with a stated purpose to prevent and learn from mistakes – not to be punitive in nature. Compiling essential data of medical errors was viewed as the first step in prevention of future events.

Speaker Perkins summarized by stating their testimony had referenced the most important aspects of BDR 3-13 (Exhibit J). He acknowledged the need for public testimony and committee scrutiny as the amendments to the bill were drafted.

Assemblyman Hettrick requested clarification of wording in the economic damage section. The language did not refer to "person" but rather to the death of a parent, a spouse, or a child. He asked if that was the intent of the proposed law. Assemblywoman Buckley confirmed Mr. Hettrick's conclusion and added that current law governed the family relationship issues. The language of the bill reflected that practice.

Assemblyman Dini called the committee's attention to Section 18 and the language describing the requirements to carry $1 million - $3 million liability

insurance. Assemblyman Dini voiced concern over what could become an unfair burden to the rural areas of Nevada. Many of the rural hospitals hired the doctors and provided the malpractice insurance under which the doctors practiced.

Assemblywoman Buckley acknowledged the value of the question and recommended obtaining a decision from the Legal Division of the Legislative Counsel Bureau. In urban areas, doctors were already required to get liability insurance in order to have staff privileges at hospitals. Because the legislation would have statewide impact, Assemblywoman Buckley concurred it was important to ensure there would be no unintended consequences for the rural areas.

Assemblyman Marvel asked what the premium would be on a $1 million - $3 million policy. Assemblywoman Buckley responded by posing a question regarding the intended reduction in premiums as a result of the legislative reform. Physicians paid widely disparate amounts for the $1 million - $3 million coverage, and it generally depended upon the medical specialty. As a rule, trauma surgeons and obstetricians paid the highest premiums. There were differences across states.

Assemblyman Marvel echoed the concern of existing financial hardship to rural hospitals and the estimated fiscal impact of new law. Assemblywoman Buckley reiterated the issue needed more examination.

Chairman Anderson advised the committee of the recommendation to invite testimony from Mr. Welsh of the Rural Hospital Alliance.

Assemblyman Hettrick explained that some communities were served only by clinics and did not have the benefit of a hospital. He voiced confusion over coverage for treatment centers that were neither hospitals nor designated trauma centers. He added that Mr. Welch would probably provide clarification.

Chairman Anderson cited the example of the trauma center at Lake Tahoe, owned and operated by the Barton Memorial Hospital. Assemblyman Hettrick interjected a point regarding the crossing of state lines and the possibility that California law regulated some doctors. Chairman Anderson acknowledged that there are a variety of stakeholders, some of which may be unknown.

Assemblyman Dini posed a question about the impact to Washoe Medical Center and the difference in its status compared to UMC in Las Vegas. Chairman Anderson concurred with the distinction. Speaker Perkins offered to clarify the issue and stated that Washoe Medical Center would be covered. The

bill did not make a distinction between Level I, II, and III. Washoe was described as having a trauma center at a non-profit hospital. Chairman Anderson elaborated upon the distinction between public hospitals and private hospitals (e.g., Washoe Medical) that may be designated as a "for profit" rather than a public entity.

Speaker Perkins requested time to address a concept that had been overlooked in his testimony. He explained there were sections in the bill that dealt with medical error reporting designed to tighten existing law. The proposed legislation would require the reporting of medical errors by medical facilities and their employees within 24 hours. The report would be issued to a new state oversight agency that would be charged with analysis of methods to improve patient safety. The patient would be provided with as much information as necessary to make informed decisions regarding his/her treatment options. The patient would have the right to know if a facility or physician had a large number of reported errors.

Following informal discussion, Speaker Perkins clarified he was referring to language that would be included in an amendment. He apologized for the confusion. The reporting requirement was contained in the existing language in Section 19 (Exhibit J). Chairman Anderson reassured the committee that the language would be clarified during the upcoming line-by-line discussion.

Speaker Perkins concluded by saying that there had always been some law requiring medical error reporting; however, it had been determined that the reporting was not thorough. Additionally, stricter time limits and civil penalties for non-compliance in reporting were needed. Quality information was required to make public policy decisions.

Chairman Anderson acknowledged the testimony and volume of work performed by the staff in preparing information for the hearing. He announced the bill would be introduced the following day, and all amendments would come through the committee.

Risa Lang, Committee Counsel, submitted a document entitled "Summary of Senate Bill No. 2" (Exhibit L).

Senate Bill 2: Makes various changes related to medical and dental malpractice. (BDR 3-13)

Susan Roe's written testimony was submitted as Exhibit M.

The meeting was adjourned at 5:45 p.m.

RESPECTFULLY SUBMITTED:

June Rigsby
Transcribing Secretary

APPROVED BY:

Bernard J. Anderson Jr.
Assemblyman Bernie Anderson, Chairman

DATE: December 17, 2002

ASSEMBLY AGENDA

for the

COMMITTEE ON MEDICAL MALPRACTICE ISSUES

18TH SPECIAL SESSION OF THE NEVADA LEGISLATURE

Day Monday Date July 29, 2002 Time 11:00 a.m. Room 4100

Tentative

If you cannot attend the meeting, you can listen to it live over the Internet. The address for the legislative website is http://www.leg.state.nv.us. For audio broadcasts, click on the link "Listen to Live Meetings."

Note: We are pleased to make reasonable accommodations for members of the public who are disabled and wish to attend the meeting. If special arrangements for the meeting are necessary, please notify the Assembly Committee on Medical Malpractice Issues at (775) 684-8587.

PLEASE PROVIDE 25 COPIES OF YOUR EXHIBITS AND NOTES.

Note: Interested parties may observe the meeting and provide testimony through a simultaneous videoconference in Room 4401 of the Grant Sawyer Office Building, 555 East Washington Avenue, Las Vegas, Nevada.

Opening remarks by Chairman
Assemblyman Bernie Anderson, Chairman

Adoption of Committee Rules

Staff Presentation on Background Material Regarding Medical Malpractice

Testimony on Medical Malpractice Issues and Relevant Legislative Proposals

The following schedule is **tentative**:

11:20 - 1:00	Introduction and Overview of Legislative Proposals
1:00 - 1:30	Recess for Lunch
1:30 - 4:00	Medical Malpractice Insurance Coverage
4:00 - 5:00	Public Comment
5:00 - 6:00	Recess for Dinner
6:00 - 8:00	Medical Malpractice and Civil Justice Reforms

EXHIBIT A / AGENDA 20
MEDICAL MALPRACTICE ISSUES
ON 7/29/02

(1)

Guest List for MEDICAL MALPRACTICE ISSUES Committee Date 7/29/02, 20__

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
CHARLES LAWS	CITIZEN / CANDIDATE FOR GOV.	787-8990					✓
LISA BECK	NV. NURSES ASSOC	747-2335					✓
LEANN McELROY	CITY OF RENO						
Kevin Soliz	GEM P						
STEPHANIE LICHT	Elko County	753-6593					
John Bellect	PLAN	882-3440					
Pat ELLZY	Planned Parenthood	784-5500 ext 211					
MAUREEN BROWER	NNA AIACR	880-4538					

ORIGINAL—Secretary; YELLOW COPY—Chairman

EXHIBIT B / GUEST LIST
MEDICAL MALPRACTICE ISSUES
On 7/29/02

21 of 9

21

JOINT 10012

(2)

Guest List for MEDICAL MALPRACTICE ISSUES Committee Date 7-29, 2003

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
LAWSON RICHTER MD	SELF	501-4045					—
and CHAD	SELF	796 9997					✓
LONNIE HAMMARGREN	SELF	596-6669					

ORIGINAL—Secretary; YELLOW COPY—Chairman

EXHIBIT B

22

(Rev. 3-01)

(O) 425

13 of 19

(3)

Guest List for MEDICAL MALPRACTICE ISSUES Committee Date 7/29/02, 20__

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 Wadhams	AIA, NHA, NIA	702 850-8538					
Rev. Charles Richardson	The Richardson Family	702 400-3563					✓
VICTORIA RILEY	NTLA	775 883-3577					

ORIGINAL—Secretary; YELLOW COPY—Chairman

EXHIBIT B

Page 3 of 9

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(4)

Guest List for MEDICAL MALPRACTICE ISSUES Committee Date 7/29/02, 20

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
LARRY SPITLER	AARP	702 938 3236					✓
Jenice Dahn	Sunrise Hosp	702 565-2261					
Anya Lepner	" "	702 731-8018					
Dr. Kenneth Sigelman	Consumer Attorneys of California	(619) 238-3813					
JAMES DIPIETRO	SELF/NTLA	818/5574851					

ORIGINAL—Secretary; YELLOW COPY—Chairman

EXHIBIT B

8-4 of 9

24

(Rev. 3-01)

(O) 425

(5)

Guest List for MEDICAL MALPRACTICE ISSUES Committee Date 7/29/02, 20

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
DIANNE MEYER						✓	✓
JANET MARKLEY						✓	
SUSAN ROE						✓	✓
Mary Walker	QTH	752-4465					✓
RON KENDALL	SELF - (DOCTORS)	883-0906					✓

ORIGINAL—Secretary; YELLOW COPY—Chairman

03:5 of 7

EXHIBIT B

(6)

Guest List for MEDICAL MALPRACTICE ISSUES Committee Date 7/29/02, 20

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❖ PLEASE PRINT ❖

Name / Title	Representing	Phone No.	Bill No.	For	Against	Neutral	✓ If Speaking
DANIELLE KEYS		740 520-578					✓
ROBBIE KEYS		510 632-5863					
LONNIE HAMMARGREN	SELF						

ORIGINAL—Secretary; YELLOW COPY—Chairman

EXHIBIT B

6 of 9 6-6

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(7)

Guest List for MEDICAL MALPRACTICE ISSUES Committee Date 7/29/02, 20

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❖ PLEASE PRINT ❖

Name / Title	Representing	Phone No.	Bill No.	For	Against	Neutral	✓ If Speaking
[illegible]	SAC F	775-355-1887					✓

ORIGINAL—Secretary; YELLOW COPY—Chairman

EXHIBIT B

B-7 of 9

Guest List for MEDICAL MALPRACTICE ISSUES Committee Date 7/29/02, 20

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
MORTENSON, HARRY	ASSEMBLY						
BOB PRICE	ASSEMBLY DIST 17						
EBBIE SMITH	A.D. 30						

ORIGINAL—Secretary; YELLOW COPY—Chairman

B.8 dr 9

EXHIBIT B

Guest List for: ASSEMBLY MEDICAL MALPRACTICE **Date** 07/29/02

PLEASE LEAVE COPY OF PREPARED HANDOUTS WITH THE COMMITTEE SECRETARY

**** PLEASE PRINT CLEARLY ****

Name/Title	Representing	Phone No.	Bill No.	For	Against	Neutral	Check this box if Speaking
Thelma Clark		702-453-3453	[redacted]				✓

NOTE: This meeting was video-conferenced to the Legislative Counsel Bureau, Las Vegas Office.

H:/2002 Special Session/Session Sign In Sheet

8 of 9

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EXHIBIT C
7/29/02

RULES FOR THE ASSEMBLY STANDING COMMITTEE ON MEDICAL MALPRACTICE ISSUES
During the 18th Special Session

1. In accordance with Assembly Standing Rule 100, the precedence of parliamentary authority for the Committee is listed as follows in descending order of priority, except that any applicable rule of this Committee will precede Mason's Manual of Parliamentary Procedure:

   a. Constitution of the State of Nevada
   b. Nevada Revised Statutes
   c. Joint Rules of the Senate and Assembly
   d Standing Rules of the Nevada Assembly
   e. Rules of the Assembly Judiciary Committee
   f. Mason's Manual of Parliamentary Procedure

2. A majority of the members appointed to this Committee constitute a quorum. (8 members) A quorum must be present to take definitive action on a bill or resolution.

3. All motions require a second. If no second is received after a motion has been made, that motion must be declared invalid for lack of a second.

4. In accordance with Assembly Standing Rule 42, Committee introduction of legislative measures and amendments will require a majority of the entire Committee and requires a commitment from each such concurring member to support final passage of the measure or adoption of the amendment on the floor of the Assembly, as appropriate.

5. In accordance with Assembly Standing Rule 42, a motion to reconsider committee action on a bill or amendment requires a two-thirds majority of the entire committee. (10 members)

6. The duties of the Chairman, in addition to those provided in other rules, are:

   a. Preparing and distributing the Committee's agenda;
   b. Determining when final action is to be taken on measures, committee reports, and other business of the Committee;
   c. Preparing and submitting Committee reports;
   d. Preserving order and decorum and deciding all questions of order;
   e. Providing direction to Committee support staff;
   f. Calling recesses of the Committee as deemed necessary;
   g. Require minutes to be kept; and
   h. Reviewing and approving minutes of the Committee.

C 1 of 3

ASSEMBLY MEDICAL MALPRACTICE ISSUES
DATE 7/29/02 ROOM 4100 EXHIBIT C
SUBMITTED BY: NICK ANTHONY

7. In the absence of the Chairman, or upon the request of the Chairman, the Vice Chairman shall assume the duties of the Chairman.

8. A secretary of the Committee shall call the roll at the beginning of each meeting – noting members present, absent and excused. After causing a record to be made of each meeting, a Committee secretary shall prepare minutes and present them to the Chairman for his review and approval. The Committee secretaries are custodians of all records and minutes of the meetings until these documents are released to the custody of the Legislative Counsel Bureau.

9. If a member must leave a committee meeting for an extended period, the Chairman should be advised. Members not in attendance when a final action is taken on a measure will be marked absent for the vote.

10. Committee members shall, at all times, address the Chair for permission to be heard. All definite actions of the Committee may be taken by roll call vote at the discretion of the Chairman. All definite actions will be duly recorded by the Secretary and made a part of the Committee Minutes.

11. Unless a Committee member advises the Chair otherwise, it will be presumed that the members will vote during a floor session consistent with their vote in Committee.

12. Minority reports may be submitted in accordance with Mason's Manual, Section 674.

13. All meetings and deliberations of the Committee will be open to the general public and all members of the media. It is the intention of the Committee to create an atmosphere of courtesy, professionalism and equal interest in all persons who are testifying.

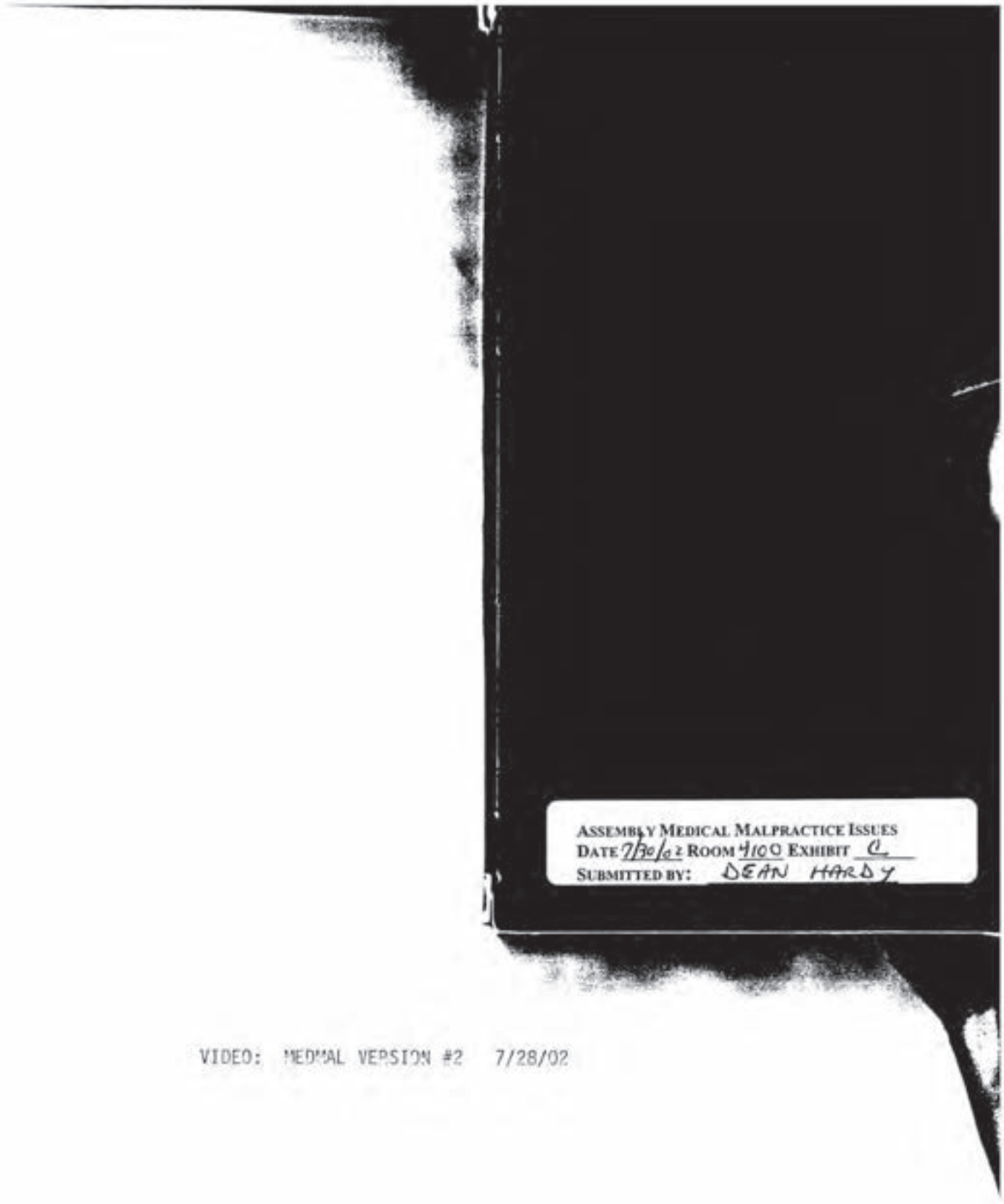
14. Witnesses before the Committee must address requests to testify to the Chair and will be recognized only by the Chair. Pursuant to NRS 218.5323, when the Chair deems necessary, persons wishing to testify will be sworn in. The Chair shall determine the order of speakers utilizing the guest list.

15. Subcommittees, created from time to time at the discretion of the Chairman, will be charged with considering bills or issues and providing recommendations to the Committee for action, if necessary.

16. Subcommittee meetings will be scheduled by the Subcommittee Chair after consulting with the Committee Chair. The proceedings of such subcommittees must shall be recorded.

17. All directions, assignments, or requests on behalf of the Committee must be communicated to its staff and to the personnel of the Legislative Counsel Bureau by the Chair of the Committee. A member of the Committee must submit such requests to the

Chair for transmittal to the staff of the Committee or to the personnel of the Legislative Counsel Bureau.



VIDEO: MEDMAL VERSION #2 7/28/02

BACKGROUND INFORMATION ON MEDICAL MALPRACTICE

Volume 1

Overview of the Work of the Legislative Subcommittee to Study Medical Malpractice

18th SPECIAL SESSION
JULY 29, 2002

BACKGROUND INFORMATION ON MEDICAL MALPRACTICE

Volume 2

18th SPECIAL SESSION
JULY 29, 2002

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ASSEMBLY MEDICAL MALPRACTICE ISSUES
DATE 7/29/02 ROOM 4100 EXHIBIT E
SUBMITTED BY: Allison Combs

BACKGROUND INFORMATION ON MEDICAL MALPRACTICE

Volume 3

18th SPECIAL SESSION
JULY 29, 2002

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ASSEMBLY MEDICAL MALPRACTICE ISSUES
DATE 7/29/02 ROOM 4100 EXHIBIT F
SUBMITTED BY: ALLISON COMMS

EXHIBIT G
7/29/02

AARP Nevada

AARP
TESTIMONY
NEVADA STATE LEGISLATURE – SPECIAL SESSION
JULY 29, 2002

GOOD MORNING. FOR THE RECORD MY NAME IS LARRY SPITLER AND I'M THE ASSOCIATE STATE DIRECTOR FOR ADVOCACY AT AARP NEVADA.

AARP IS A NONPROFIT MEMBERSHIP ORGANIZATION OF PERSONS 50 AND OLDER DEDICATED TO ADDRESSING THEIR NEEDS AND INTERESTS. IN NEVADA, AARP HAS MORE THAN 256,000 MEMBERS.

WE'RE HERE TODAY TO ADD OUR VOICE TO AN EXTREMELY COMPLEX ISSUE, MADE EVEN MORE DIFFICULT TO UNDERSTAND BY THE INNUNDATION OF INFORMATION FROM ALL THE PARTIES WHO HAVE BEEN MOST ACTIVE IN COMMUNICATING THEIR POSITION. POSITIONS WHICH HAVE, QUITE OFTEN, IMPLIED A RATHER SIMPLE SOLUTION TO A COMPLEX PROBLEM.

AS AVERAGE CITIZENS WE ALL WANT ACCESS TO GOOD MEDICAL CARE DELIVERED BY A QUALIFIED HEALTH CARE PROFESSIONAL AND, WE ALSO WANT ACCESS TO A FAIR JUDICIAL SYSTEM TO ADDRESS ISSUES WHEN NECESSARY.

TODAY, WE HOPE THAT YOU TAKE THE OPPORTUNITY TO STEP BACK, CONSIDER ALL THE ISSUES THAT BROUGHT US TO WHERE WE ARE TODAY AND PUT THE FACE OF YOUR NEIGHBOR, YOUR FRIEND,

G 1 OF 7

ASSEMBLY MEDICAL MALPRACTICE ISSUES
DATE 7/29/02 ROOM 4100 EXHIBIT G
SUBMITTED BY: LARRY SPITLER

5820 S. Eastern Avenue, Suite190 | Las Vegas, NV 89119 | 702-967-2277
James G. Parkel, President | William D. Novelli, Executive Director and CEO | www.aarp.org

AND THE AVERAGE CITIZENS THAT YOU REPRESENT ON EACH SEGMENT OF YOUR DELIBERATIONS. IT IS, IN THE END, YOUR SUCCESS IN DOING SO THAT WILL LEAD TO PUBLIC POLICY THAT TREATS BUSINESSES, HEALTH CARE PROFESSIONALS AND CONSUMERS EQUITABLY.

PERHAPS THE HARDEST PART OF THE ISSUE BEFORE US IS TRULY UNDERSTANDING IT – AND ALL THE COMPONENTS THAT HAVE BROUGHT ABOUT THE CRISIS FACING OUR COMMUNITY TODAY. AARP BELIEVES THE UNDERLYING ISSUE IS PROTECTING AND IMPROVING HEALTH AND ACCESS TO CARE.

FOR EXAMPLE, CONSIDER PREVENTABLE MEDICAL INJURY AND MEDICAL MALPRACTICE. PREVENTABLE MEDICAL INJURIES THAT ARE THE RESULT OF MEDICAL ERRORS ARE WIDESPREAD AND COSTLY. PREVENTABLE MEDICAL INJURIES ARE THOSE PATIENT INJURIES THAT RESULT FROM FLAWS IN THE COMPLEX INTERACTIONS AMONG SEVERAL HEALTH CARE PROFESSIONALS, AS WELL AS PROBLEMS AT THE INTERFACE BETWEEN PEOPLE AND SOPHISTICATED TECHNOLOGIES, PRODUCTS AND ORGANIZATIONAL SYSTEMS. THEY ALSO RESULT FROM INDIVIDUAL NEGLIGENCE, IMPAIRMENT, AND INCOMPETENCE.

IN 1999 THE INSTITUTE OF MEDICINE'S (IOM) COMMITTEE ON QUALITY OF HEALTH CARE IN AMERICA ISSUED A REPORT TITLED, "TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM." THE REPORT

ESTIMATED THAT BETWEEN 44,000 AND 98,000 PEOPLE DIE ANNUALLY AS A RESULT OF PREVENTABLE MEDICAL ERROR, MAKING IT ONE OF THE LEADING CAUSES OF DEATHS. COSTS ASSOCIATED WITH INJURIES RESULTING FROM ERRORS WERE ESTIMATED TO BE BETWEEN $17 BILLION AND $29 BILLION EACH YEAR.

IN THE PAST MOST DISCUSSIONS CONCERNING PREVENTABLE MEDICAL ERROR AND INJURY FOCUSED ON THE MEDICAL MALPRACTICE SYSTEM INSTEAD OF THE INJURY PROBLEM ITSELF. THE TORT SYSTEM HAS BEEN ATTACKED AS AN IMPORTANT SOURCE OF PROBLEMS IN AMERICA'S HEALTH CARE SYSTEM. IT HAS BEEN BLAMED FOR RISING HEALTH CARE COSTS FOR ITS PERCEIVED ENCOURAGEMENT OF DEFENSIVE MEDICINE AND CAUSING PROVIDERS TO PAY HIGH INSURANCE PREMIUMS. THE EVIDENCE, HOWEVER, SHOWS THAT THE RATE OF MEDICAL MALPRACTICE LITIGATION, WHEN COMPARED WITH THE INCIDENCE OF PREVENTABLE MEDICAL INJURY, IS QUITE LOW. A 1990 HARVARD UNIVERSITY STUDY FOUND THAT PATIENTS BROUGHT CLAIMS IN FEWER THAN ONE IN EIGHT CASES OF NEGLIGENTLY CAUSED MEDICAL INJURY. A 1997 STUDY FOUND AN EVEN LOWER CLAIMS RATE.

IT WOULD SEEM THEN, THAT THE CENTRAL PROBLEM IS NOT THE TORT SYSTEM BUT PREVENTABLE MEDICAL INJURY. OF COURSE THE LEGAL SYSTEM DOES SUFFER FROM DEFICIENCIES. PATIENTS WITH RELATIVELY SMALL CLAIMS, PARTICULARLY OLDER AND POOR PEOPLE,

CANNOT GAIN ACCESS TO COMPENSATION BECAUSE IT IS UNPROFITABLE FOR ATTORNEYS TO TAKE SUCH CASES UNDER THE CONTINGENT FEE SYSTEM. ONCE CLAIMANTS ARE IN THE SYSTEM, IT TAKES AN EXCESSIVELY LONG TIME FOR THEIR CASES TO BE RESOLVED. FINALLY, SUCCESSFUL CLAIMANTS RECEIVE ONLY ABOUT 40 CENTS FOR EVERY DOLLAR IN LIABILITY PREMIUMS PAID, WITH THE REST GOING TO LITIGATION COSTS AND INSURANCE COMPANY OVERHEAD.

IT SHOULD BE NOTED, HOWEVER, **THAT ALTHOUGH THE TORT SYSTEM IS IMPERFECT, IT IS NOT IRRATIONAL.** UNFOUNDED CLAIMS ARE FREQUENTLY NOT PAID, NOR ARE CLAIMANTS TYPICALLY OVERCOMPENSATED FOR THEIR INJURIES. IN FACT, CLAIMANTS TEND TO BE UNDERCOMPENSATED, PARTICULARLY THOSE WHO ARE THE MOST SERIOUSLY INJURED AND WHOSE DAMAGES ARE LARGEST.

A DIFFERENT KIND OF PROBLEM WITH THE CURRENT SYSTEM FOR ADDRESSING MEDICAL MALPRACTICE IS THAT IT DISCOURAGES THE REPORTING OF MEDICAL ERROR. THE TORT SYSTEM AND SOME OF ITS STAKEHOLDERS IMPEDED THE FLOW OF INFORMATION TO RESEARCHERS ATTEMPTING TO LEARN THE NATURE OF SYSTEMS DEFICIENCIES THAT LED TO PATIENT INJURIES. THAT INFORMATION IS ESSENTIAL BEFORE SYSTEMS CORRECTIONS CAN BE DEVISED.

IN REVIEWING PREVENTABLE MEDICAL INJURY AND MEDICAL MALPRACTICE, AARP SUPPORTS, AMONG OTHER MEASURES, EFFORTS

TO ELIMINATE ALL PREVENTABLE MEDICAL INJURY AND MEDICAL ACCIDENTS DUE TO PROCEDURAL ERRORS OR INADEQUACY. TO THIS END, AARP SUPPORTS NINE CRITICAL ACTIONS. IN THE INTEREST OF TIME, WE ARE SUBMITTING THEM IN WRITTEN TESTIMONY ONLY.

1. AARP SUPPORTS THE WORK OF THE CENTER FOR PATIENT SAFETY WITHIN THE AGENCY FOR HEALTH CARE RESEARCH AND QUALITY TO SET NATIONAL GOALS FOR PATIENT SAFETY, TRACK AND REPORT PROGRESS, GROW KNOWLEDGE AND UNDERSTANDING OF ERRORS THROUGH RESEARCH, FUNDING CENTERS OF EXCELLENCE, EVALUATING METHODS FOR IDENTIFYING AND PREVENTING ERRORS AND FUNDING DISSEMINATION AND COMMUNICATION ACTIVITIES TO PROMOTE PATIENT SAFETY;
2. NATIONWIDE MANDATORY REPORTING TO PROVIDE FOR THE COLLECTION OF STANDARDIZED INFORMATION BY STATE GOVERNMENTS ABOUT ADVERSE EVENTS THAT RESULT IN SERIOUS INJURY OR DEATH;
3. VOLUNTARY REPORTING EFFORTS;
4. LEGISLATION TO EXTEND PEER REVIEW PROTECTIONS TO DATA ON PATIENT SAFETY COLLECTED AND ANALYZED BY HEALTH CARE ORGANIZATIONS FOR INTERNAL USE OR SHARED WITH OTHERS SOLELY FOR THE PURPOSE OF IMPROVING SAFETY;
5. HEALTH CARE ORGANIZATION PERFORMANCE STANDARDS THAT FOCUS GREATER ATTENTION ON PATIENT SAFETY, WITH

REGULATORS AND ACCREDITORS REQUIRING THE IMPLEMENTATION OF MEANINGFUL PATIENT SAFETY PROGRAMS;

6. ACTIONS BY LICENSING BODIES TO PROMOTE PATIENT SAFETY PERFORMANCE STANDARDS FOR HEALTH CARE PROFESSIONALS;
7. INCREASED ATTENTION BY THE FOOD AND DRUG ADMINISTRATION TO THE SAFE USE OF DRUGS IN BOTH THE PREMARKETING AND POSTMARKETING PROCESSES;
8. ACTION BY HEALTH CARE ORGANIZATIONS AND THEIR AFFILIATED PROFESSIONALS TO MAKE PATIENT SAFETY A DECLARED AND SERIOUS AIM BY ESTABLISHING A DEFINED EXECUTIVE RESPONSIBILITY – AMONG THE MEASURES THEY SHOULD TAKE IS DEVELOPING AND IMPLEMENTING NONPUNITIVE SYSTEMS FOR REPORTING ERRORS WITHIN THE ORGANIZATION; AND
9. INSTITUTION OF PROVEN MEDICATION SAFETY PRACTICES.

AARP IS OPPOSED TO ACTIONS THAT WOULD IMPAIR THE RIGHT OF INJURED PATIENTS TO FULL AND JUST COMPENSATION FOR INJURIES RESULTING FROM INAPPROPRIATE MEDICAL CARE.

WITH REGARD TO THE CURRENT SYSTEM TO ADDRESS MEDICAL MALPRACTICE, AARP SUPPORTS FOUR KEY ELEMENTS:

1. REFORMS THAT WOULD PROMOTE ACCESS TO THE COURTS FOR ALL LEGITIMATE CLAIMS, INCLUDING SMALLER MALPRACTICE CLAIMS, AND ACCELERATE THE RESOLUTION OF CASES;

2. EXPLORATION OF ALTERNATIVE DISPUTE RESOLUTION SYSTEMS FOR MEDICAL MALPRACTICE CASES THAT COULD SERVE NEGLIGENTLY INJURED PATIENTS BETTER THAN THE CURRENT SYSTEM DOES;
3. EVALUATION OF OTHER PROMISING SYSTEMS OF COMPENSATION FOR PREVENTABLE MEDICAL INJURIES IN DEMONSTRATION PROJECTS; AND
4. MALPRACTICE INSURANCE RATES THAT FAIRLY AND ACCURATELY REFLECT CLAIMS EXPERIENCE.

WE THANK YOU FOR THE OPPORTUNITY TO SHARE OUR THOUGHTS WITH YOU ON THIS IMPORTANT ISSUE.

EXHIBIT H
7/29/02

NEVADA NURSES ASSOCIATION

P.O. Box 34660
Reno, NV 89533
Phone: (775) 747-2333
Fax: (775) 747-1337
Email: NNA@NVNurses.org
Internet: www.nvnurses.org

To: Select Committee on Medical Malpractice

From: Lisa Black, RN, Executive Director, Nevada Nurses Association

Date: July 29, 2002

Re: Medical Malpractice in Nevada

Mr. Chairman, members of the committee, for the record, I am Lisa Black. I am a Registered Nurse and the Executive Director of the Nevada Nurses Association. The Nevada Nurses Association would like to thank you for allowing us to address the committee on this critical issue that has brought us together for this historic second special session in a single legislative interim. Whatever your position on the subject matter, the one thing I think we can all safely agree on is that the issues to be brought before this committee present a crisis not only for the medical, nursing, and legislative communities, but also for the citizens of Nevada. This issue must be dealt with expediently, yet thoughtfully, to assure a fair resolution for all concerned.

In my testimony this afternoon, I'd like to just touch on some of the key areas that we see as germane to this issue as it affects the nursing and medical communities.

Civil Justice Reform

The Nevada Nurses Association has not taken an official position on any sort of damage caps; however, I would like to take a moment to share my personal perspective with this committee. Again, let me be very clear that this is my personal perspective, and is not in any way meant to reflect the views of the Nevada Nurses Association.

Many of the lawmakers on this committee are familiar with my personal situation. For those of you who are not, in 1997, I was infected with HIV and HCV from a needlestick injury that occurred in the course of my work as a Registered Nurse. Because a contentious and bitterly fought worker's compensation claim was ultimately decided in my favor, I will receive medical benefits for the rest of my life. Additionally, if I am unable to work, my lost wages will be replaced, albeit at a rate that equals 66 % of my 1997 earning level as there is currently no provision in place for adjustments to that figure. What is not included is compensation for pain and suffering and I assure you that I have suffered plenty both on a physical and on an emotional level since being diagnosed with HIV. However, any level of compensation I was ever to receive would not alleviate or mitigate that suffering; it is what it is regardless of any monetary award intended to compensate me for it. While I am reasonably well at this time and plan to remain so for a very long time, the cold reality of this diagnosis is that I will someday develop AIDS and die from this disease. While the statutes that govern worker's compensation law differ from those that govern civil tort action, I personally would find it repugnant for any entity to set a dollar value on my life, whatever the amount. This does not mean that I personally support or oppose caps on damages… it simply means that I don't see it as proper for any person or group of people to determine that my life is worth a set dollar amount. With that being said, I do appreciate the

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SUBMITTED BY: LISA BLACK

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predicament we face and the charge of this special session, and I reluctantly agree that the litigiousness of our society has made it necessary for us to do the unthinkable and place a dollar amount on human suffering. I do ask the committee, and those of all positions, however, to remain cognizant that we must balance action that will ensure the viability of our medical systems with sensitivity to those who have fallen victim to the system.

Insurance Reform

The Nevada Nurses Association supports actions relevant to insurance reform as proposed in multiple circles. One salient point that is made repeatedly is that liability insurance carriers have begun linking malpractice premiums for obstetricians to the number of deliveries attended by the practitioner. The Nevada Nurses Association supports the intent of the those who have sought to disallow this practice, as we are not aware of data that supports this cap. If it were determined, however, that this cap on deliveries must remain, we would offer that it is improper to include the number of deliveries attended by Advanced Practitioners of Nursing (APNs) in the aggregate number of covered deliveries attended by a physician. APNs practice in a collaborative and not a supervisory role with physicians and maintain their own liability insurance. To then include the deliveries attended by an APN in the number of physician-covered deliveries seems to be not only improper, but also unethical, and would seem to border on double billing for coverage.

Medical Error Reporting

The Nevada Nurses Association feels that it is essential to develop an effective system of medical error reporting in Nevada. We also believe that any system created must be in line with the recommendations of the Institute of Medicine and that such a system must not focus on the naming, blaming, and shaming of individual practitioners, but must seek to identify the systems failures that allow errors that harm patients to routinely occur and recur. Our suggestion would be that this committee consider language that would grant immunity from disciplinary and licensing sanctions for health care workers who self-report errors. This could easily work in tandem with whistleblower provisions for health care workers who report medical errors or malpractice. While it may not be legal, ethical, or acceptable, it is an unfortunate reality that for as long as health care workers are faced with disciplinary action and/or licensing sanctions for medical errors, they will remain reluctant to report them. We owe it to our patients to create an environment where we can learn from our errors, not one that encourages individual practitioners to be inclined to cover them up.

I would also ask that this committee clearly define an adverse event short of a sentinel event causing severe harm or death for the purposes of any legislation relevant to medical error reporting that may come out of this special session. The Nevada Nurses Association would propose that indices in the American Nurses Association's Nursing Sensitive Quality Indicators reports be included in these definitions of injuries that require further medical care. While I recognize and respect that the direction of this committee is not necessarily to address nurse staffing in medical facilities, it is widely reported that increasing numbers of Registered Nurses in medical facilities is associated with decreasing numbers of errors and adverse outcomes for patients. Some of the indices tracked by the American Nurses Association that are pertinent to this discussion are as follows:

- Nosocomial (Hospital Acquired) Infection Rate defined as the rate at which patients experience infections originating in the hospital.
- Patient Injury Rate defined as the rate at which patients fall or incur physical injuries unrelated to a surgical or diagnostic procedure during their hospital stay.
- Patient Satisfaction with Care

- Patient Satisfaction with Educational Information defined as the patient's opinion of how well they were educated about their condition and care requirements.
- Maintenance of Skin Integrity defined as the rate at which patients develop decubitus ulcers in the course of their hospital stay.
- Mix of RNs, LPNs, and Unlicensed Staff Caring for Patients

At the request of this committee, I would be happy to provide further information about the Nursing Quality Indicators at a time that would be appropriate for the committee to review.

Additionally, we would ask that any information provided to the public be made public in an aggregate form that does not name individual care providers. Publicly accessible information that names individual care providers would likely have a similar effect as disciplinary and or licensing sanctions for medical errors. Even the most conscientious of practitioners generally do not report errors if they will be subject to licensing and or disciplinary sanctions or public exposure if the opportunity exists to not report.

Consumer Protection

It has been mentioned that various entities are exploring the possibility of a rate rollback for affected practitioners following the implementation of any damage caps that come out of this session. The Nevada Nurses Association sees a rate rollback for physicians and other affected practitioners following the implementation of any damage caps as not only as a sound fiscal option, but also as the right thing to do. It is an indisputable fact that physicians in this state have seen their malpractice insurance rates skyrocket in the last year. It would make sense that if we are limiting their potential exposure in the form of caps on damages and instituting additional tort reform measures, then it would seem to follow that the premiums paid by physicians under a previous liability structure should be likewise addressed. We would like to offer that a number of Advanced Practitioners of Nursing have also seen rate increases stemming from the liability insurance crisis in our state, and that it may well be appropriate to include these practitioners in the provisions of any rollback that may be seen as appropriate.

Nevada physicians and health care practitioners should not bear the burden of poor investment decisions made by companies who insure them. It is appropriate that the insurance premium paid by a health care practitioner should be an accurate reflection of each practitioner's level of professional risk. It is improper for insurers to pass on their business losses to their customers, no matter what the reason for these losses.

In conclusion, the Nevada Nurses Association commends the work of all who have come together to address this access to care crisis in Nevada and I thank you for the opportunity to come before you today. The Nevada Nurses Association is ready to continue to work with all of you on this important issue to achieve solutions that will maintain the viability of our medical systems while not disadvantaging patients who are the unfortunate victims of medical malpractice in Nevada.

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SUBMITTED BY: RENEE WILLIAMS

AFTER DOCTOR

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AFTER DOCTOR

EXHIBIT J
7/29/02

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.

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ASSEMBLY MEDICAL MALPRACTICE ISSUES
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SUBMITTED BY: LCB STAFF

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; now, therefore,

THE PEOPLE OF THE STATE OF NEVADA, REPRESENTED IN SENATE AND ASSEMBLY, DO ENACT 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 2 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,

FLUSH *that in good faith renders care or assistance necessitated by a sudden, unexpected situation or occurrence resulting in a serious medical condition demanding immediate 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 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. 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. For the purposes of this section, "reckless, willful or wanton conduct," as it applies to a person to whom subsection 1 applies, 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.

Sec. 2. Chapter 41A of NRS is hereby amended by adding thereto the provisions set forth as sections 3 to 9, inclusive, of this act.

Sec. 3. *"Economic damages" includes damages for medical treatment, care or custody, and loss of earnings.*

Sec. 4. *"Noneconomic damages" includes damages to compensate for pain, suffering, inconvenience, physical impairment, disfigurement and other nonpecuniary damages.*

Sec. 5. *1. Except as otherwise provided in subsection 3, in an action for damages for medical malpractice or dental malpractice, the noneconomic damages awarded to each plaintiff must not exceed $350,000.*

2. In an action for damages for medical malpractice or dental malpractice, in the circumstances and types of cases described in subsection 3, the noneconomic damages

awarded to a plaintiff must not exceed the greater of $350,000 or 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.

3. 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, the court determines, by clear and convincing evidence, that an award in excess of $350,000 for noneconomic damages is justified under the circumstances.

4. 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. 6. *In an action for damages for medical malpractice, each defendant is liable for noneconomic damages severally only, and not jointly, to the plaintiff only for that portion of the judgment which represents the percentage of negligence attributable to the defendant.*

Sec. 7. *1. Upon the motion of any party or upon its own motion, unless good cause is shown for the delay, the court shall, after due notice to the parties, dismiss an action involving medical malpractice or dental malpractice if the action is not brought to trial within:*

(a) Three years after the date on which the action is filed, if the action is filed on or after October 1, 2002, but before October 1, 2005.

(b) Two years after the date on which the action is filed, if the action is filed on or after October 1, 2005.

2. Dismissal of an action pursuant to subsection 1 is a bar to the filing of another action upon the same claim for relief against the same defendants.

3. Each district court shall adopt court rules to expedite the resolution of an action involving medical malpractice or dental malpractice.

Sec. 8. *If an action for medical malpractice or dental malpractice is filed in the district court, the district court shall dismiss the action, without prejudice, if the action is filed without an affidavit, supporting the allegations contained in the action, submitted by a medical expert who practices in an area that is substantially similar to the type of practice engaged in at the time of the alleged malpractice.*

Sec. 9. *1. In an action for medical malpractice or dental malpractice, the plaintiff, the defendant, the representative of the physician's or dentist's insurer and their respective attorneys shall attend and participate in a settlement conference before a district judge, other than the judge assigned to the action, to ascertain whether the action may be settled by the parties before trial.*

2. The judge before whom the settlement conference is held:

(a) May, for good cause shown, waive the attendance of any party.

(b) Shall decide what information the parties may submit at the settlement conference.

3. The judge shall notify the parties of the time and place of the settlement conference.

4. The failure of any party or his attorney to participate in good faith in the settlement conference is grounds for sanctions against the party or his attorney, or both.

Sec. 10. NRS 41A.003 is hereby amended to read as follows:

41A.003 As used in this chapter, unless the context otherwise requires, the words and terms defined in NRS 41A.004 ~~[to 41A.013, inclusive,]~~ ***and 41A.009 and sections 3 and 4 of this act*** have the meanings ascribed to them in those sections.

Sec. 11. NRS 41A.097 is hereby amended to read as follows:

41A.097 1. Except as otherwise provided in subsection ~~[2,]~~ ***3,*** an action for injury or death against a provider of health care may not be commenced more than 4 years after the date of injury or 2 years after the plaintiff discovers or through the use of reasonable diligence should have discovered the injury, whichever occurs first, for:

(a) Injury to or the wrongful death of a person ~~[.]~~ ***occurring before October 1, 2002,*** based upon alleged professional negligence of the provider of health care;

(b) Injury to or the wrongful death of a person ***occurring before October 1, 2002,*** from professional services rendered without consent; or

(c) Injury to or the wrongful death of a person ***occurring before October 1, 2002,*** from error or omission in practice by the provider of health care.

2. ***Except as otherwise provided in subsection 3, an action for injury or death against a provider of health care may not be commenced more than 3 years after the date of injury or 2 years after the plaintiff discovers or through the use of reasonable diligence should have discovered the injury, whichever occurs first, for:***

(a) Injury to or the wrongful death of a person occurring on or after October 1, 2002, based upon alleged professional negligence of the provider of health care;

(b) Injury to or the wrongful death of a person occurring on or after October 1, 2002, from professional services rendered without consent; or

(c) Injury to or the wrongful death of a person occurring on or after October 1, 2002, from error or omission in practice by the provider of health care.

3. This time limitation is tolled ~~[:~~

~~(a) For]~~ *for* any period during which the provider of health care has concealed any act, error or omission upon which the action is based and which is known or through the use of reasonable diligence should have been known to him.

~~[(b) In any action governed by the provisions of NRS 41A.003 to 41A.069, inclusive, from the date a claimant files a complaint for review by a screening panel until 30 days after the date the panel notifies the claimant, in writing, of its findings. The provisions of this paragraph apply to an action against the provider of health care and to an action against any person, government or political subdivision of a government who is alleged by the claimant to be liable vicariously for the medical or dental malpractice of the provider of health care, if the provider, person, government or political subdivision has received notice of the filing of a complaint for review by a screening panel within the limitation of time provided in subsection 1.~~

~~3.]~~ *4.* For the purposes of this section, the parent, guardian or legal custodian of any minor child is responsible for exercising reasonable judgment in determining whether to prosecute any cause of action limited by subsection 1 ~~[.]~~ *or 2.* If the parent, guardian or custodian fails to

commence an action on behalf of that child within the prescribed period of limitations, the child may not bring an action based on the same alleged injury against any provider of health care upon the removal of his disability, except that in the case of:

(a) Brain damage or birth defect, the period of limitation is extended until the child attains 10 years of age.

(b) Sterility, the period of limitation is extended until 2 years after the child discovers the injury.

~~[4.]~~ *5.* As used in this section, "provider of health care" means a physician licensed under chapter 630 or 633 of NRS, dentist, registered nurse, dispensing optician, optometrist, registered physical therapist, podiatric physician, licensed psychologist, chiropractor, doctor of Oriental medicine, medical laboratory director or technician, or a licensed hospital as the employer of any such person.

Sec. 12. NRS 41A.100 is hereby amended to read as follows:

41A.100 1. Liability for personal injury or death is not imposed upon any provider of medical care based on alleged negligence in the performance of that care unless evidence consisting of expert medical testimony, material from recognized medical texts or treatises or the regulations of the licensed medical facility wherein the alleged negligence occurred is presented to demonstrate the alleged deviation from the accepted standard of care in the specific circumstances of the case and to prove causation of the alleged personal injury or death, except that such evidence is not required and a rebuttable presumption that the personal injury or death

was caused by negligence arises where evidence is presented that the personal injury or death occurred in any one or more of the following circumstances:

(a) A foreign substance other than medication or a prosthetic device was unintentionally left within the body of a patient following surgery;

(b) An explosion or fire originating in a substance used in treatment occurred in the course of treatment;

(c) An unintended burn caused by heat, radiation or chemicals was suffered in the course of medical care;

(d) An injury was suffered during the course of treatment to a part of the body not directly involved in the treatment or proximate thereto; or

(e) A surgical procedure was performed on the wrong patient or the wrong organ, limb or part of a patient's body.

2. ***Expert medical testimony provided pursuant to subsection 1 may only be given by a provider of medical care who practices in an area that is substantially similar to the type of practice engaged in at the time of the alleged negligence.***

3. As used in this section, "provider of medical care" means a physician, dentist, registered nurse or a licensed hospital as the employer of any such person.

Sec. 13. NRS 42.020 is hereby amended to read as follows:

42.020 1. Except as otherwise provided in subsection 2, in any action for damages for medical malpractice, the amount of damages, if any, awarded in the action must be reduced by the amount of any prior payment made by or on behalf of the provider of health care against

whom the action is brought to the injured person or to the claimant to meet reasonable expenses of medical care, other essential goods or services or reasonable living expenses.

2. In any action described in subsection 1 in which liability for medical malpractice is established or admitted, the court shall, before the entry of judgment, hold a separate hearing to determine if any expenses incurred by the claimant for medical care, loss of income or other financial loss have been paid or reimbursed as a benefit from a collateral source. If the court determines that a claimant has received such a benefit, the court shall reduce the amount of damages, if any, awarded in the action by the amount of the benefit. The amount so reduced must not include any amount for which there is a right of subrogation to the rights of the claimant if the right of subrogation is exercised by serving a notice of lien on the claimant before the settlement of or the entry of judgment in the action. Notice of the action must be provided by the claimant to any statutory holder of a lien.

3. If future economic damages are awarded in an action for medical malpractice, the ~~[award must be paid, at the election of the claimant:]~~ ***court may, at the request of the claimant, order the award to be paid:***

(a) In a lump sum which has been reduced to its present value as determined by the trier of fact and approved by the court; or

(b) Subject to the provisions of ~~[subsection 5,]~~ ***subsections 5 and 6 and the discretion of the court, in periodic payments either*** by an annuity purchased to provide periodic payments ~~[.]~~ ***or by other means if the defendant posts an adequate bond or other security to ensure full payment by periodic payments of the damages awarded by the judgment.***

FLUSH As used in this subsection, "future economic damages" includes damages for future medical treatment, care or custody, and loss of future earnings.

4. If the claimant ~~[elects to receive]~~ ***receives*** periodic payments pursuant to paragraph (b) of subsection 3, the award must not be reduced to its present value. The amount of the periodic payments must be equal to the total amount of all future damages awarded by the trier of fact and approved by the court. The period for which the periodic payments must be made must be determined by the trier of fact and approved by the court. Before the entry of judgment, each party shall submit to the court a plan specifying the recipient of the payments, the amount of the payments and a schedule of periodic payments for the award. Upon receipt and review of the plans, the court shall specify in its judgment rendered in the action the recipient of the payments, the amount of the payments and a schedule of payments for the award.

5. If an annuity is purchased pursuant to paragraph (b) of subsection 3, the claimant shall select the provider of the annuity. Upon purchase of the annuity, the claimant shall:

(a) Execute a satisfaction of judgment or a stipulation for dismissal of the claim with prejudice; and

(b) Release forever the defendant and his insurer, if any, from any obligation to make periodic payments pursuant to the award.

6. ***If the defendant posts a bond or other security pursuant to paragraph (b) of subsection 3, upon termination of the payment of periodic payments of damages, the court shall order the return of the bond or other security, or as much as remains, to the defendant.***

7. As used in this section:

(a) "Benefit from a collateral source" means any money, service or other benefit which is paid or provided or is reasonably likely to be paid or provided to a claimant for personal injury or wrongful death pursuant to:

(1) A state or federal act which provides benefits for sickness, disability, accidents, loss of income or workers' compensation;

(2) A policy of insurance which provides health benefits or coverage for loss of income;

(3) A contract of any group, organization, partnership or corporation which provides, pays or reimburses the cost of medical, hospital or dental benefits or benefits for loss of income; or

(4) Any other publicly or privately funded program which provides such benefits.

(b) "Medical malpractice" has the meaning ascribed to it in NRS 41A.009.

Sec. 14. NRS 1.360 is hereby amended to read as follows:

1.360 Under the direction of the supreme court, the court administrator shall:

1. Examine the administrative procedures employed in the offices of the judges, clerks, court reporters and employees of all courts of this state and make recommendations, through the chief justice, for the improvement of those procedures;

2. Examine the condition of the dockets of the courts and determine the need for assistance by any court;

3. Make recommendations to and carry out the directions of the chief justice relating to the assignment of district judges where district courts are in need of assistance;

4. Develop a uniform system for collecting and compiling statistics and other data regarding the operation of the state court system and transmit that information to the supreme court so that proper action may be taken in respect thereto;

5. Prepare and submit a budget of state appropriations necessary for the maintenance and operation of the state court system and make recommendations in respect thereto;

6. Develop procedures for accounting, internal auditing, procurement and disbursement for the state court system;

7. Collect statistical and other data and make reports relating to the expenditure of all public money for the maintenance and operation of the state court system and the offices connected therewith;

8. Compile statistics from the information required to be maintained by the clerks of the district courts pursuant to NRS 3.275 and make reports as to the cases filed in the district courts;

9. Formulate and submit to the supreme court recommendations of policies or proposed legislation for the improvement of the state court system;

10. On or before January 1 of each year, submit to the director of the legislative counsel bureau a written report compiling the information submitted to the court administrator pursuant to NRS 3.243, 4.175 and 5.045 during the immediately preceding fiscal year; ~~[and]~~

11. ***On or before February 15 of each odd-numbered year, submit to the governor and to the director of the legislative counsel bureau for transmittal to the next regular session of the legislature a written report compiling the information submitted by clerks of courts to the court administrator pursuant to NRS 630.307 and section 30 of this act which includes only***

aggregate information for statistical purposes and excludes any identifying information related to a particular person; and

12. Attend to such other matters as may be assigned by the supreme court or prescribed by law.

Sec. 15. Chapter 3 of NRS is hereby amended by adding thereto a new section to read as follows:

The supreme court shall provide by court rule for mandatory appropriate training concerning the complex issues of medical malpractice litigation for each district judge to whom actions involving medical malpractice are assigned.

Sec. 16. NRS 7.085 is hereby amended to read as follows:

7.085 If a court finds that an attorney has:

1. Filed, maintained or defended a civil action or proceeding in any court in this state and such action or defense is not well-grounded in fact or is not warranted by existing law or by an argument for changing the existing law that is made in good faith; or

2. Unreasonably and vexatiously extended a civil action or proceeding before any court in this state,

FLUSH

the court ~~[may]~~ ***shall*** require the attorney personally to pay the additional costs, expenses and attorney's fees reasonably incurred because of such conduct.

Sec. 17. NRS 49.245 is hereby amended to read as follows:

49.245 There is no privilege under NRS 49.225 or 49.235:

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

2. As to communications made in the course of a court-ordered examination of the condition of a patient with respect to the particular purpose of the examination unless the court orders otherwise.

3. As to written medical or hospital records relevant to an issue of the condition of the patient in any proceeding in which the condition is an element of a claim or defense.

4. In a prosecution or mandamus proceeding under chapter 441A of NRS.

5. As to any information communicated to a physician in an effort unlawfully to procure a dangerous drug or controlled substance, or unlawfully to procure the administration of any such drug or substance.

6. As to any written medical or hospital records which are furnished in accordance with the provisions of NRS 629.061.

7. As to records that are required by chapter 453 of NRS to be maintained.

8. ~~[In a review before a screening panel pursuant to NRS 41A.003 to 41A.069, inclusive. —9.]~~ If the services of the physician are sought or obtained to enable or aid a person to commit or plan to commit fraud or any other unlawful act in violation of any provision of chapter 616A, 616B, 616C, 616D or 617 of NRS which the person knows or reasonably should know is fraudulent or otherwise unlawful.

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 person; and

2. Not less than $3,000,000 per occurrence.

Sec. 19. NRS 630.130 is hereby amended to read as follows:

630.130 1. In addition to the other powers and duties provided in this chapter, the board shall:

(a) Enforce the provisions of this chapter;

(b) Establish by regulation standards for licensure under this chapter;

(c) Conduct examinations for licensure and establish a system of scoring for those examinations;

(d) Investigate the character of each applicant for a license and issue licenses to those applicants who meet the qualifications set by this chapter and the board; and

(e) Institute a proceeding in any court to enforce its orders or the provisions of this chapter.

2. ***On or before February 15 of each odd-numbered year, the board shall submit to the governor and to the director of the legislative counsel bureau for transmittal to the next regular session of the legislature a written report compiling:***

(a) Disciplinary action taken by the board during the previous biennium against physicians for malpractice or negligence; and

(b) Information reported to the board during the previous biennium pursuant to NRS 630.3067, subsections 2 and 3 of NRS 630.307 and NRS 690B.045.

FLUSH ***The report must include only aggregate information for statistical purposes and exclude any identifying information related to a particular person.***

3. The board may adopt such regulations as are necessary or desirable to enable it to carry out the provisions of this chapter.

Sec. 20. NRS 630.267 is hereby amended to read as follows:

630.267 1. Each holder of a license to practice medicine must, on or before July 1 of each alternate year:

(a) Submit the statement required pursuant to NRS 630.197; ~~[and]~~

(b) ***Submit a list of all actions filed or claims submitted to arbitration or mediation for malpractice or negligence against him during the previous 2 years; and***

(c) Pay to the secretary-treasurer of the board the applicable fee for biennial registration. This fee must be collected for the period for which a physician is licensed.

2. When a holder of a license fails to pay the fee for biennial registration and submit the statement required pursuant to NRS 630.197 after they become due, his license to practice medicine in this state is automatically suspended. The holder may, within 2 years after the date his license is suspended, upon payment of twice the amount of the current fee for biennial registration to the secretary-treasurer and submission of the statement required pursuant to NRS 630.197 and after he is found to be in good standing and qualified under the provisions of this chapter, be reinstated to practice.

3. The board shall make such reasonable attempts as are practicable to notify a licensee:

(a) At least once that his fee for biennial registration and the statement required pursuant to NRS 630.197 are due; and

(b) That his license is suspended.

FLUSH A copy of this notice must be sent to the Drug Enforcement Administration of the United States Department of Justice or its successor agency.

Sec. 21. NRS 630.3062 is hereby amended to read as follows:

630.3062 The following acts, among others, constitute grounds for initiating disciplinary action or denying licensure:

1. Failure to maintain timely, legible, accurate and complete medical records relating to the diagnosis, treatment and care of a patient.

2. Altering medical records of a patient.

3. Making or filing a report which the licensee knows to be false, failing to file a record or report as required by law or willfully obstructing or inducing another to obstruct such filing.

4. Failure to make the medical records of a patient available for inspection and copying as provided in NRS 629.061.

5. Failure to ~~[report any claim for malpractice or negligence filed against the licensee and the subsequent disposition thereof within 90 days after the:~~

~~(a) Claim is filed; and~~

~~(b) Disposition of the claim.]~~ ***comply with the requirements of NRS 630.3067.***

6. Failure to report any person the licensee knows, or has reason to know, is in violation of the provisions of this chapter or the regulations of the board.

Sec. 22. NRS 630.3067 is hereby amended to read as follows:

630.3067 ~~[Under the provisions of NRS 690B.045, the]~~

1. The insurer of a physician licensed under this chapter and the physician must report to the board any ***action filed or*** claim ***submitted to arbitration or mediation*** for malpractice or negligence ***against the physician*** and the settlement, award, judgment or other disposition ~~[thereof.]~~ ***of the action or claim within 30 days after:***

(a) The action was filed or the claim was submitted to arbitration or mediation; and

(b) The disposition of the action or claim.

2. The board shall report any failure to comply with subsection 1 by an insurer licensed in this state to the division of insurance of the department of business and industry. If, after a hearing, the division of insurance determines that any such insurer failed to comply with the requirements of subsection 1, the division may impose an administrative fine of not more than $10,000 against the insurer for each such failure to report. 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.

Sec. 23. NRS 630.307 is hereby amended to read as follows:

630.307 1. Any person, medical school or medical facility that becomes aware that a person practicing medicine or respiratory care in this state has, is or is about to become engaged

in conduct which constitutes grounds for initiating disciplinary action shall ~~[forthwith]~~ file a written complaint with the board ~~[.]~~ ***within 30 days after becoming aware of the conduct.***

2. Any hospital, clinic or other medical facility licensed in this state, or medical society, shall ~~[forthwith]~~ report to the board any change in a physician's privileges to practice medicine while the physician is under investigation and the outcome of any disciplinary action taken by that facility or society against the physician concerning the care of a patient or the competency of the physician ~~[.]~~ ***within 30 days after the change in privileges is made or disciplinary action is taken. The board shall report any failure to comply with this subsection by a hospital, clinic or other medical facility licensed in this state to the health division of the department of human resources. If, after a hearing, the health division determines that any such facility or society failed to comply with the requirements of this subsection, the division may impose an administrative fine of not more than $10,000 against the facility or society for each such failure to report. 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.***

3. The clerk of every court shall ~~[forthwith]~~ report to the board any finding, judgment or other determination of the court that a physician, physician assistant or practitioner of respiratory care:

(a) Is mentally ill;

(b) Is mentally incompetent;

(c) Has been convicted of a felony or any law governing controlled substances or dangerous drugs;

(d) Is guilty of abuse or fraud under any state or federal program providing medical assistance; or

(e) Is liable for damages for malpractice or negligence ~~[.]~~,

FLUSH ***within 45 days after such a finding, judgment or determination is made.***

4. The board shall keep information received pursuant to this section confidential unless a court of competent jurisdiction issues a subpoena compelling the release of such information.

5. On or before January 15 of each year, the clerk of each court shall submit to the office of court administrator created pursuant to NRS 1.320 a written report compiling the information that the clerk reported during the previous year to the board regarding physicians pursuant to paragraph (e) of subsection 3.

Sec. 24. NRS 630.364 is hereby amended to read as follows:

630.364 1. Any person or organization who furnishes information concerning an applicant for a license or a licensee in good faith and without malicious intent in accordance with the provisions of this chapter is immune from any civil action for furnishing that information.

2. The board and any of its members and its staff, counsel, investigators, experts, committees, panels, hearing officers and consultants are immune from any civil liability for:

(a) Any decision or action taken in good faith and without malicious intent in response to information acquired by the board.

(b) Disseminating information concerning an applicant for a license or a licensee to other boards or agencies of the state, the attorney general, any hospitals, medical societies, insurers, employers, patients and their families or any law enforcement agency.

~~[3. A screening panel or any of its members, acting pursuant to NRS 41A.003 to 41A.069, inclusive, that initiates or assists in any proceeding concerning a claim of malpractice against a physician is immune from any civil action for that initiation or assistance or any consequential damages, if the panel or members acted without malicious intent.]~~

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 person; and

2. Not less than $3,000,000 per occurrence.

Sec. 26. Chapter 633 of NRS is hereby amended by adding thereto the provisions set forth as sections 27 to 30, inclusive, of this act.

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 person; and

2. Not less than $3,000,000 per occurrence.

Sec. 28. *1. On or before February 15 of each odd-numbered year, the board shall submit to the governor and to the director of the legislative counsel bureau for transmittal to the next regular session of the legislature a written report compiling:*

(a) Disciplinary action taken by the board during the previous biennium against osteopathic physicians for malpractice or negligence; and

(b) Information reported to the board during the previous biennium pursuant to NRS 690B.045, section 29 of this act and subsections 2 and 3 of section 30 of this act.

2. The report must include only aggregate information for statistical purposes and exclude any identifying information related to a particular person.

Sec. 29. *1. The insurer of an osteopathic physician licensed under this chapter and the osteopathic physician must report to the board any action filed or claim submitted to arbitration or mediation for malpractice or negligence against the osteopathic physician and the settlement, award, judgment or other disposition of the action or claim within 30 days after:*

(a) The action was filed or the claim was submitted to arbitration or mediation; and

(b) The disposition of the action or claim.

2. The board shall report any failure to comply with subsection 1 by an insurer licensed in this state to the division of insurance of the department of business and industry. If, after a hearing, the division of insurance determines that any such insurer failed to comply with the requirements of subsection 1, the division may impose an administrative fine of not more than $10,000 against the insurer for each such failure to report. 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.

Sec. 30. *1. Any person, medical school or medical facility that becomes aware that a person practicing osteopathic medicine in this state has, is or is about to become engaged in conduct which constitutes grounds for initiating disciplinary action shall file a written complaint with the board within 30 days after becoming aware of the conduct.*

2. Any hospital, clinic or other medical facility licensed in this state, or medical society, shall report to the board any change in an osteopathic physician's privileges to practice osteopathic medicine while the osteopathic physician is under investigation and the outcome of any disciplinary action taken by that facility or society against the osteopathic physician concerning the care of a patient or the competency of the osteopathic physician within 30 days after the change in privileges is made or disciplinary action is taken. The board shall report any failure to comply with this subsection by a hospital, clinic or other medical facility licensed in this state to the health division of the department of human resources. If, after a hearing, the health division determines that any such facility or society failed to comply with the requirements of this subsection, the division may impose an administrative fine of not more than $10,000 against the facility or society for each such failure to report. 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.

3. The clerk of every court shall report to the board any finding, judgment or other determination of the court that an osteopathic physician or osteopathic physician's assistant:

(a) Is mentally ill;

(b) Is mentally incompetent;

(c) Has been convicted of a felony or any law governing controlled substances or dangerous drugs;

(d) Is guilty of abuse or fraud under any state or federal program providing medical assistance; or

(e) Is liable for damages for malpractice or negligence,

FLUSH *within 45 days after such a finding, judgment or determination is made.*

4. The board shall keep information received pursuant to this section confidential unless a court of competent jurisdiction issues a subpoena compelling the release of such information.

5. On or before January 15 of each year, the clerk of every court shall submit to the office of court administrator created pursuant to NRS 1.320 a written report compiling the information that the clerk reported during the previous year to the board regarding osteopathic physicians pursuant to paragraph (e) of subsection 3.

Sec. 31. NRS 633.471 is hereby amended to read as follows:

633.471 1. Except as otherwise provided in subsection 3 and in NRS 633.491, every holder of a license issued under this chapter, except a temporary or a special license, may renew his license on or before January 1 of each calendar year after its issuance by:

(a) Applying for renewal on forms provided by the board;

(b) Submitting the statement required pursuant to NRS 633.326;

(c) Paying the annual license renewal fee specified in this chapter; ~~[and]~~

(d) ***Submitting a list of all actions filed or claims submitted to arbitration or mediation for malpractice or negligence against him during the previous year; and***

(e) Submitting verified evidence satisfactory to the board that in the year preceding the application for renewal he has attended courses or programs of continuing education approved by the board totaling a number of hours established by the board which must not be less than 35 hours nor more than that set in the requirements for continuing medical education of the American Osteopathic Association.

2. The secretary of the board shall notify each licensee of the requirements for renewal not less than 30 days before the date of renewal.

3. Members of the Armed Forces of the United States and the United States Public Health Service are exempt from payment of the annual license renewal fee during their active duty status.

Sec. 32. NRS 633.511 is hereby amended to read as follows:

633.511 The grounds for initiating disciplinary action pursuant to this chapter are:

1. Unprofessional conduct.

2. Conviction of:

(a) A violation of any federal or state law regulating the possession, distribution or use of any controlled substance or any dangerous drug as defined in chapter 454 of NRS;

(b) A felony;

(c) A violation of any of the provisions of NRS 616D.200, 616D.220, 616D.240 or 616D.300 to 616D.440, inclusive; or

(d) Any offense involving moral turpitude.

3. The suspension of the license to practice osteopathic medicine by any other jurisdiction.

4. Gross or repeated malpractice, which may be evidenced by claims of malpractice settled against a practitioner.

5. Professional incompetence.

6. Failure to comply with the requirements of section 29 of this act.

Sec. 33. NRS 690B.045 is hereby amended to read as follows:

690B.045 Except as more is required in NRS 630.3067 ~~[,]~~ ***and section 29 of this act:***

1. Each insurer which issues a policy of insurance covering the liability of a practitioner licensed pursuant to chapters 630 to 640, inclusive, of NRS for a breach of his professional duty toward a patient shall report to the board which licensed the practitioner within 30 days each settlement or award made or judgment rendered by reason of a claim, if the settlement, award or judgment is for more than $5,000, giving the name and address of the claimant and the practitioner and the circumstances of the case.

2. A practitioner licensed pursuant to chapters 630 to 640, inclusive, of NRS who does not have insurance covering liability for a breach of his professional duty toward a patient shall report to the board which issued his license within 30 days of each settlement or award made or judgment rendered by reason of a claim, if the settlement, award or judgment is for more than

$5,000, giving his name and address, the name and address of the claimant and the circumstances of the case.

3. These reports are public records and must be made available for public inspection within a reasonable time after they are received by the licensing board.

Sec. 34. NRS 690B.050 is hereby amended to read as follows:

690B.050 1. Each insurer which issues a policy of insurance covering the liability of a physician licensed under chapter 630 of NRS ***or an osteopathic physician licensed under chapter 633 of NRS*** for a breach of his professional duty toward a patient shall report to the commissioner within 30 days each settlement or award made or judgment rendered by reason of a claim, giving the name and address of the claimant and physician and the circumstances of the case.

2. The commissioner shall report to the board of medical examiners ~~[,]~~ ***or the state board of osteopathic medicine, as applicable,*** within 30 days after receiving the report of the insurer, each claim made and each settlement, award or judgment.

Sec. 35. NRS 41A.0043, 41A.005, 41A.008, 41A.013, 41A.016, 41A.019, 41A.023, 41A.024, 41A.026, 41A.029, 41A.033, 41A.036, 41A.039, 41A.043, 41A.046, 41A.049, 41A.051, 41A.053, 41A.056, 41A.059, 41A.069 and 631.377 are hereby repealed.

Sec. 36. The amendatory provisions of sections 1 to 6, inclusive, and 11 of this act apply only to a cause of action that accrues on or after October 1, 2002.

Sec. 37. The amendatory provisions of sections 7, 8, 12 and 17 apply only to an action filed on or after October 1, 2002.

Sec. 38. 1. Notwithstanding the repeal of NRS 41A.0043, 41A.005, 41A.008 and 41A.013 to 41A.069, inclusive, if a claimant has filed a complaint with the division of insurance of the department of business and industry pursuant to NRS 41A.039 before October 1, 2002, and a determination has not been made by the screening panel as provided in NRS 41A.003 to 41A.069, inclusive, before October 1, 2002, the claimant may elect:

(a) To have a determination made by the screening panel as provided in NRS 41A.003 to 41A.069, inclusive. If the claimant elects to have a determination made by the screening panel, the provisions of NRS 41A.003 to 41A.069, inclusive, shall be deemed to continue to apply to the claim and to any subsequent action filed in the district court. If the claimant wishes to elect to have a determination made by the screening panel, the claimant must, before December 1, 2002, file written notice of that fact with the division. If the claimant fails to provide such written notice, the claimant shall be deemed to have elected to have no further action taken by the screening panel concerning the complaint.

(b) To have no further action taken by the screening panel concerning the complaint. If the claimant elects to have no further action taken by the screening panel concerning the complaint, the division and the screening panel shall not take any further action with respect to the complaint, and the claimant may file an action in the district court.

2. Notwithstanding the repeal of NRS 41A.0043, 41A.005, 41A.008 and 41A.013 to 41A.069, inclusive, and the amendment of paragraph (b) of subsection 2 of NRS 41A.097, if a claimant elects:

(a) To have a determination made by the screening panel, the tolling of the time limitation provided for review of the complaint by the screening panel pursuant to NRS 41A.097 shall be deemed to continue to apply until 30 days after the date on which the screening panel notifies the claimant, in writing, of its findings.

(b) To have no further action taken by the screening panel concerning the complaint, the tolling of the time limitation provided for review of the complaint by the screening panel pursuant to NRS 41A.097 ceases on December 1, 2002.

3. If a claimant:

(a) Elects to have no further action taken by the screening panel concerning the complaint;

(b) Files an action in the district court; and

(c) Prevails at the trial of the action,

FLUSH the claimant is entitled to tax, as costs, the fee paid to the division pursuant to NRS 41A.039 for filing the complaint.

Sec. 39. On or before March 1, 2003, pursuant to subsection 3 of section 7 of this act, each district court in this state shall adopt court rules to expedite the resolution of an action involving medical malpractice or dental malpractice.

Sec. 40. This act becomes effective on October 1, 2002.

LEADLINES OF REPEALED SECTIONS

41A.0043 "Dentist" defined.

41A.005 "Division" defined.

41A.008 "Health care records" defined.

41A.013 "Physician" defined.

41A.016 Submission of case to screening panel required before suit may be filed; admissibility in court of findings of screening panel.

41A.019 Creation of tentative screening panels.

41A.023 Designation of members.

41A.024 Courses of instruction for members.

41A.026 Election of chairmen; applicability of rules.

41A.029 Requirements regarding open meetings do not apply to meetings of screening panels.

41A.033 Administrative duties and powers of division.

41A.036 Deposit of money received by division with state treasurer; payment of administrative costs of screening panel.

41A.039 Submission of claim to screening panel: Complaint; answer; response to answer; service of pleadings; fees.

41A.043 Selection of members for particular screening panel.

41A.046 Subpoenas: Powers and duties of division; enforcement.

41A.049 Hearing by screening panel: Time for holding; materials for consideration; findings.

41A.051 Hearing by screening panel: Preferential scheduling for certain elderly claimants and claimants who suffer from terminal illness or condition.

41A.053 Early disclosure of medical or dental records prohibited; penalty.

41A.056 Effect of decision of screening panel.

41A.059 Conference for settlement of claim: Attendance; powers and duties of judge; effect of failure to settle.

41A.069 Instructions to jury.

631.377 Screening panel immune from civil action.

7/29/02

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.

J -1- OF 34

ASSEMBLY MEDICAL MALPRACTICE ISSUES
DATE 7/29/02 ROOM 4100 EXHIBIT J
SUBMITTED BY: LCB STAFF

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EXHIBIT K
7/29/02

July 29, 2002

To: Nevada State Legislative Committee to Study Medical Malpractice

I am here because I was damaged by the health care system. I lost my business & almost lost my life. I'm willing to give up any and all damage rewards to fight to keep the good doctors who have saved my life and continue to provide quality health care.

Our health care system is driven by exorbitant malpractice insurance rates driving good health care providers out of the state.

I am asking for tort reforms to match the Governor's recommendation, to impose a cap that meets the California standard to ensure that we do have a quality health care System.

You have the ability to turn a sow's ear into a silk purse by invoking mandatory binding arbitration that would go further to ensure that Nevada can become the pristine quality health care system for the nation.

Ron Kendall
P.O. Box 21970
Carson City, NV 89721
(775) 883-0906
e-mail: ronk@aci.net

E3

K 1 OF 4

ASSEMBLY MEDICAL MALPRACTICE ISSUES
DATE 7/29/02 ROOM 4100 EXHIBIT K
SUBMITTED BY: RON KENDALL

Overhaul the Medical System

Medical errors arose as a result of my same day sinus surgery on July 13, 2000. Due to the surgeon's failure to react to abnormal pre-surgery blood work and act on my repeated phone calls for help indicating that I was sick on July 17th I had a seizure. Emergency-room blood tests show that I had salt deficiency as well as an infection picked up from surgery.

During the period July 17,2000, through Sept. 2, 2000 (a period of six weeks), hospitals used insurance funding manipulation to transfer me to three different facilities. The seriousness of the medical errors, in my case, occurred due to diagnostic error with misdiagnosis leading to an incorrect choice of therapy, failure to use an indicated diagnostic test, misinterpretation of test results and failure to act on abnormal results. Lacking valid test results attending physicians were operating under a false assumption that I was suffering from brain damage. One year later, I requested detailed statements from those three facilities

- That information determined they had dispensed 51separate medications to me.
- The drugs that were administered erased my memory and mental process.
- I could not read, write, operate a telephone or recognize family & friends.

It will be a surprise for you to know that the established medical system prohibited my regular physicians to care for me. Since integrated alternative medicine has been marginalized by the same established medical system, it was only after I returned home that he was able to save my life. He used detox procedures to remove me from all of those drugs and order a diagnostic brain scan test. The results indicated there was no brain damage. After the removal of those drugs it took more than a year to recover from the loss of my memory and mental process.

Recently, the Service Employees International Union (SEIU's) Nurse Alliance and the Nevada Nurses Association maintained in their testimony before numerous legislative committees and regulatory bodies, that medical errors are on the rise as hospital administrators continue to short staff units. Cutting cost by reducing the nurse-to-patient ratio could be tantamount to creating even more medical errors.

What will it take to address medical errors & improve quality care?

Consider the failures of the audit and administration of ENRON, the incompetence associated with air security and recognize the similarities of secrecy and the total lack of information concerning the health care system. Based on my own experience with the failures of mainstream medicine, I strongly believe it is time for a thorough evaluation of our health care system to include a vital cost/benefit analysis:

- Pharmaceutical cost as a percentage of total medical cost
- Health insurance cost as a percentage of total medical cost
- Consideration of methods for lowering malpractice insurance premiums by: instituting mandatory arbitration & tort reform.
- Institute a means of collecting useful medical error statistics for public dissemination
- Set minimum staff-to-patient ratios
- Establish a Real Nevada Patients Bill of Rights! (Version supported by the SEIU Nurse Alliance)
  - Cover everyone who has insurance
  - Guarantee consumer's access to the health care they need
  - Let doctors make the best medical decisions
  - Hold health plans accountable when care is wrongfully denied or limited
  - Ensure whistleblower protection for health care workers who advocate for patients
  - Allow consumer's appeal to a neutral third-party when care is denied.

I find it incredible when I consider public information available for sports, auto sales, etc.... while medical error information is withheld from the public. Without that information we are unable to discern the "good, the bad, or the ugly" choices to make for our health care. Are we benefiting from quality care or are we paying for a "pig in a poke". Yes, we need a review here in Nevada, but a study staffed by experienced Doctors, Nurses & Accountants armed with integrity & the desire to change the system based on the Hippocratic oath. These changes could turn a sow's ear into a silk purse & place Nevada as the leading state for health care.

Rather than direct my anger at the medical system through a lawsuit, I want to use that energy to focus on changes that must be made with our voices to the state legislature.
Evil occurs when a good man does nothing. I invite you to join me in the efforts of the Nurse Alliance & ask others to demand changes in the medical system.

Follow the essence of the original Hippocratic oath: "First do no harm."

Medical errors due to lack of information

BY RON KENDALL
For the Appeal

Medical errors arose as a result of my same-day sinus surgery on July 13, 2000. Due to the surgeon's failure to react to abnormal pre-surgery blood work and act on my repeated phone calls for help indicating that I was sick on July 17, I had a seizure.

Emergency-room blood tests show that I had salt deficiency as well as an infection picked up from surgery.

During the period July 17 through Sept. 2, 2000 (a period of six weeks), hospitals used insurance funding manipulation to transfer me to three different facilities.Attending physicians misdiagnosed my illness. One year later, I requested detailed statements from those three facilities.

■ That information determined they had dispensed 51 separate medications to me.

■ The drugs that were administered erased my memory and mental process.

■ I could not read, write, operate a telephone or recognize family and friends.

It will be a surprise for you to know that the established medical system prohibited my regular physicians to care for me. Since integrated alternative medicine has been marginalized by the same established medical system, it was only after I returned home that he was able to save my life.

He used detox procedures to remove me from all of those drugs and order a diagnostic brain scan test. The results indicated there was no brain damage. After the removal of those drugs, it took more than a year to recover from the loss of my memory and mental process.

Recently, the Services Employees International Union Nurse Alliance and the Nevada Nurses Association maintained in their testimony before numerous legislative committees and regulatory bodies, that medical errors are on the rise as hospital administrators continue to short-staff units. Cutting cost by reducing the nurse-to-patient ratio could be tantamount to creating even more medical errors.

What will it take to address medical errors and improve quality care?

Consider the failures of the audit and administration of Enron, the incompetence associated with air security and recognize the similarities of secrecy and the total lack of information concerning the health care system. Based on my own experience with the failures of mainstream medicine, I strongly believe it is time for a thorough evaluation of our health care system to include a vital cost/benefit analysis:

■ Pharmaceutical cost as a percentage of total medical cost

■ Health insurance costs as a percentage of total medical cost

■ Consideration of methods for lowering malpractice insurance premiums by instituting mandatory arbitration and tort reform.

■ Institute a means of collecting useful medical error statistics for public dissemination

■ Set minimum staff-to-patient ratios

■ Establish a real Nevada Patients Bill of Rights (Version supported by the SEIU Nurse Alliance)

■ Cover everyone who has insurance

■ Guarantee consumer's access to the health care they need

■ Let doctors make the best medical decisions

■ Hold health plans accountable when care is wrongfully denied or limited

Guest Opinion

• Ensure whistle blower protection for health care workers who advocate for patients

Allow consumer's appeal to a neutral third party when care is denied.

I find it incredible when I consider public information available for sports, auto sales, etc. while medical error information is withheld from the public. Without that information, we are unable to discern the "good, the bad or the ugly" choices to make for our health care. Are we benefiting from quality care or are we paying for a "pig in a poke?"

Yes, we need a review here in Nevada, but a study staffed by experienced doctors, nurses and accountants armed with integrity and the desire to change the system based on the Hippocratic oath. These changes could turn a sow's ear into a silk purse and place Nevada as the leading state for health care.

Rather than direct my anger at the medical system through a lawsuit, I want to use that energy to focus on changes that must be made with our voices to the state Legislature.

Evil occurs when a good man does nothing. I invite you to join me in the efforts of the Nurse Alliance and ask others to demand changes in the medical system.

Follow the essence of the original Hippocratic oath: "First do no harm."

Ron Kendall is a 13-year Carson City resident, a software programmer whose firm is Kendall & Associates Inc., and retired from the Marine Corps in 1975.

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EXHIBIT C
7/29/02

Summary of Senate Bill No. 2

Section 1 of the bill amends chapter 41 of NRS to provide that, with some exceptions: (1) a nonprofit hospital which has been designated as a center for the treatment of trauma; (2) an employee of such a hospital who renders care or assistance to patients; (3) a physician or dentist who renders care or assistance in such a hospital; and (4) a physician or dentist whose liability is not limited as a result of his employment by the state or a political subdivision of the state who renders care or assistance in a hospital of a governmental entity that has been designated as a center for the treatment of trauma, who renders care or assistance necessitated by a sudden, unexpected situation or occurrence resulting in a serious medical condition that demands immediate medical attention, may not be held liable for more than $50,000 in 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, willful or wanton conduct to a patient who entered the hospital through its emergency room or trauma center. Subsection 2 of this section provides that the limitation on liability does not apply to acts or omissions which occur 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 addition, the limitation on liability does not apply to an act or omission that is unrelated to the original medical emergency.

Sections 2 through 9, inclusive, of the bill and section 35 of the bill make various changes concerning actions for medical malpractice and dental malpractice. Section 35 of the bill repeals provisions of NRS relating to medical and dental malpractice screening panels, thereby eliminating those panels. The repealed provisions created the panels, authorized the actions of the panels, set forth requirements, duties, powers and procedures for the panels, set forth requirements for a settlement conference and jury instructions relating to cases addressed by the panels, and provided immunity for the panels. Section 38 of the bill 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. Essentially, the plaintiff in any such matter may choose to have the panel continue to address the matter or may choose to remove the matter from the panel and instead file a case in district court.

Sections 3 and 4 of the bill define the terms "economic damages" and "noneconomic damages" for the purposes of chapter 41A which governs actions for medical or dental malpractice. Economic damages include damages for medical treatment, care or custody and loss of earnings. 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.

E7

L1 OF 8

ASSEMBLY MEDICAL MALPRACTICE ISSUES
DATE 7/29/02 ROOM 4100 EXHIBIT L
SUBMITTED BY: RISA LANG

Section 5 of the bill 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. Subsections 2 and 3 of section 5 of the bill provide that in medical or dental malpractice actions involving certain circumstances and types of cases such as where the conduct of the defendant is grossly negligent, organic brain damage, hemaplegia, paraplegia or quadraplegia result, a parent, spouse or child dies, total blindness results, a person loses a limb or becomes sterile, or the court determines that an award in excess of $350,000 for noneconomic damages is justified, the noneconomic damages are limited to the greater of $350,000 or 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, irrespective of the number of plaintiffs in an action, in no event may a single defendant be liable to the plaintiffs in the aggregate in excess of the professional liability insurance policy limit covering the defendant.

Section 6 of the bill provides that in an action for damages for medical malpractice, each defendant is liable for noneconomic damages severally only for the portion of the judgment representing the percentage of negligence attributable to him, and is not jointly liable for the noneconomic damages. Statutory law in California sets forth a similar provision concerning liability of defendants in that state. Several liability is, "[l]iability that is separate and distinct from another's liability, so that the plaintiff may bring a separate action against one defendant without joining the other liable parties." Black's Law Dictionary 926 (7th ed. 1999).

Joint and several liability is, "[l]iability that may be apportioned either among two or more parties or to only one or a few select members of the group, at the adversary's discretion. Thus, each liable party is individually responsible for the entire obligation, but a paying party may have a right of contribution and indemnity from nonpaying parties." Id. This type of liability is commonly referred to as the "deep pocket rule" because a plaintiff may recover the entire amount of the obligation from the wealthiest defendant regardless of that defendant's actual amount of fault.

Nevada generally follows the common law rule that "liability [is] joint and several where two or more tortfeasors caused injury through their combined or concurrent tortious conduct." Buck v. Greyhound Lines, 105 Nev. 756, 764 (1989). The Nevada Legislature, by enacting NRS 41.141, "modified the common law rule in situations where the injured plaintiff was partly responsible for his own injuries." Id. Specifically, NRS 41.141 provides that, with certain exceptions, defendants will be severally liable in actions where comparative negligence is raised as a defense. Id.

Section 7 of the bill 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 the bill requires a district court in which an action for medical malpractice or dental malpractice is filed to dismiss the action without prejudice if the action is filed without an affidavit, submitted by a medical expert who practices in a relevant area, that supports the allegations.

Section 9 of the bill requires the plaintiff in a medical or dental malpractice action, the defendant, a representative of the physician's or dentist's insurer, and their attorneys to attend and participate in a settlement conference before a district judge other than the judge assigned to the action, to ascertain whether the action may be settled by the parties before trial. The judge before whom the settlement conference is held may waive the attendance of a party for good cause shown. In addition, the judge is required to decide what information the parties may submit at the settlement conference. The failure of a party or his attorney to participate in good faith is grounds for sanctions.

Section 11 of the bill amends NRS 41A.097 concerning the time within which certain actions for injury or death against certain providers of health care may be commenced. The times currently set forth in this section are maintained for injuries or wrongful deaths which occur before October 1, 2002, so that the actions may not be commenced more than 4 years after the date of injury or 2 years after the plaintiff discovers or should have discovered the injury, whichever occurs first. The amendments to this section provide that for injuries or wrongful deaths which occur on or after October 1, 2002, these certain actions may not be commenced more than 3 years after the date of injury or 2 years after the plaintiff discovers or should have discovered the injury, whichever occurs first. Paragraph (b) of subsection 3 of NRS 41A.097 was deleted because it related only to medical and dental malpractice screening panels, which have been eliminated. Subsection 2 of section 38 of the bill sets forth the manner in which the limitations set forth in NRS 41A.097 apply to matters that have been filed with but not completed by the screening panel.

Section 12 of the bill amends NRS 41A.100 which currently provides that, with certain exceptions, liability for personal injury or death may not be imposed upon certain providers of medical care based on alleged negligence in the performance of that care unless evidence consisting of expert medical testimony, material from recognized medical texts or treatises, or the regulations of the licensed medical facility wherein the alleged

negligence occurred is presented to demonstrate a deviation from the accepted standard of care and to prove causation. This section is amended to provide that any expert medical testimony presented pursuant to this section may only be given by a provider of medical care who practices in an area that is substantially similar to the type of practice engaged in at the time of the alleged negligence.

Section 13 of the bill amends NRS 42.020 which sets forth the provisions for the payment of future economic damages. NRS 42.020 currently provides that such damages must be paid either in a lump sum or by an annuity purchased to provide periodic payments, at the election of the claimant. Section 13 of the bill changes these provisions so that the court now has discretion, at the request of the claimant, to order the award to be paid in a lump sum or in periodic payments. In addition, this section provides that if the award will be paid in periodic payments, it may be paid either: (1) by the purchase of an annuity; or (2) by other means if the defendant posts an adequate bond or security to ensure full payment of the damages. The manner in which the periodic payments are to be made is also left to the discretion of the court.

Section 14 of the bill amends NRS 1.360 to require the Court Administrator to submit to the Governor and to the Legislature a biennial report that compiles information submitted by court clerks relating to findings, judgments or other determinations by courts of liability by physicians and osteopathic physicians for malpractice or negligence. The report must include only aggregate information for statistical purposes and must exclude any identifying information that relates to a particular person.

Section 15 of the bill creates a new section in chapter 3 of NRS dealing with district courts requiring certain district judges to receive training concerning the complex issues involved in medical malpractice litigation. Specifically, section 15 of the bill requires the Nevada Supreme Court to provide by court rule appropriate training for each district judge to whom such actions are assigned.

Section 16 of the bill amends NRS 7.085, which currently *authorizes* the courts to impose certain sanctions against 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 the existing law that is made in good faith, or who unreasonably and vexatiously extends a civil action. Currently, NRS 7.085 *authorizes* a court to require such an attorney personally to pay the additional costs, expenses and attorney's fees reasonably incurred as a result of those actions. Section 16 of the bill amends this section to *require* a court to impose those sanctions against an attorney who violates the provisions of the statute.

Section 17 of the bill amends NRS 49.245 to remove subsection 8 because it related only to medical and dental malpractice screening panels, which have been eliminated.

Section 18 of the bill adds a new section to chapter 630 of NRS to prohibit a physician licensed pursuant to that chapter from practicing medicine unless he maintains

professional liability insurance in the amount of at least $1,000,000 per person and at least $3,000,000 per occurrence.

Section 19 of the bill 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.

Section 20 of the bill 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.

Section 21 of the bill 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.

Section 22 of the bill 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.

Section 23 of the bill 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.

Section 24 of the bill amends NRS 630.364 to remove subsection 3 because it related only to medical and dental malpractice screening panels, which have been eliminated.

Section 25 of the bill adds a new section to chapter 631 of NRS to prohibit a dentist licensed pursuant to chapter 631 of NRS from practicing dentistry unless he maintains professional liability insurance in the amount of at least $1,000,000 per person and at least $3,000,000 per occurrence.

Section 27 of the bill adds a new section to chapter 633 of NRS to prohibit a osteopathic physician licensed pursuant to chapter 633 of NRS from practicing osteopathic medicine unless he maintains professional liability insurance in the amount of at least $1,000,000 per person and at least $3,000,000 per occurrence.

Section 28 of the bill 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.

Section 29 of the bill 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.

Section 30 of the bill 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.

Section 31 of the bill 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.

Section 32 of the bill 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.

Section 33 of the bill provides 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.

Section 34 of the bill requires 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.

Section 35 of the bill repeals the screening panels for medical and dental malpractice in chapter 41A of NRS. Note that NRS 631.377 is repealed because the entire section relates to screening panels for dental malpractice.

Section 36 of the bill limits the applicability of the caps, liability of defendants, and limitations on commencement of actions provisions in sections 1 to 6, inclusive, and 11 of the bill to actions which accrue on or after October 1, 2002.

Section 37 of the bill limits the applicability of the certain new procedural provisions to actions filed on or after October 1, 2002.

Section 38 of the bill 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.

Section 39 of the bill sets March 1, 2003, as the deadline for district courts to adopt the rules to expedite the resolution of medical and dental malpractice cases required by section 7 of the bill.

Section 40 of the bill sets the effective date for the bill as October 1, 2002.

EXHIBIT M

Mr. Chairman, I would like to thank you and the members of the committee for allowing me to address you.

My name is Susan Roe. I have been a Registered Nurse for nearly thirty years and have worked in Las Vegas for twenty-three years.

In the summer of 1998 I remember thinking to myself, how fortunate our family was. Our children, then 14 and 16, had gotten through childhood well and safe! Just a few months later our son, Christopher was diagnosed with childhood cancer. Thinking as a mom I had always thought, it can't happen to us. Thinking as a nurse, it had been my worst nightmare!!

Our lives, as we knew them changed on that day of diagnosis, January 4, 1999. Chris had leukemia.

It is our belief, that our 16 year-old son Christopher suffered greatly and died due to his physicians' negligence.

His oncologists urged us to place Chris on an investigational protocol of the Children's Cancer Group, an international organization that does childhood cancer research. The physician explained that children treated on protocols did significantly better that those who were not. After the first 7 days of treatment with chemotherapy, the protocol called for divergence in therapies based upon a bone marrow biopsy. Rapid early responders were to get standard therapy; slow early responders were to get augmented therapy including cranial radiation. The physicians themselves reviewed the preliminary slides, and apparently made their crucial decision based on that, rather than waiting for the final pathologist's report, the standard for any cancer decision-making process. They chose the less aggressive arm of the protocol.

After our son died, I felt compelled to see if I could find an explanation for our my son died within nine months of diagnosis, since Chris' physicians, stated that in 1999, approximately 80 percent of the children with acute lymphocytic leukemia survived.

I was appalled that I had asked on at least three subsequent occasions during his treatment to tell me how the decision about the turning point in the protocol had been made, and had not been told the truth! Not only did the physicians conspire to keep the information from us, but, far worse, they had

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failed to make adjustments to the correct path of the protocol to give Chris the best chance of survival.

Additionally, I found that they also had ignored signs and symptoms present at the time of diagnosis that called for more aggressive therapy with cranial radiation in addition to chemotherapy whether or not he had been treated on any protocol. To the best of our knowledge the critical protocol deviation has never been reported to the study group, which will effect thousands of children's treatment in the future.

Money will never bring our family's beloved son, brother, and grandson back to this world. We are painfully aware of that, as only a family of a person who died due to negligence can be. It will not make us forget the torment he went through before he died. Unfortunately, litigation is truly the only way to get these physicians' attention, and to be a brutal reminder that they need to be more careful with children's lives.

About a year after Chris' death one of his physicians actually had the audacity to ask me if he could honor our son at his foundation banquet. It was before he knew we were looking into filing a lawsuit in district court. I asked, "Do you really think that would be appropriate given the circumstances? Not surprisingly he has not asked again.

The way the pair of physicians could have honored our son, would have been to treat him the way they promised when the physician as principal investigator signed his protocol.

We interviewed several lawyers before deciding upon our current representation. Although I was now sure of a grave mistake had occurred, it was not our finding that that attorneys were clamoring to take any malpractice case that came their way. They asked very pointed questions and emphasized to us that it was a very difficult process to even file a complaint with the court, and that it was an arduous, frustrating, and painful process to achieve a resolution.

We persisted because Christopher's physicians need to be held accountable for their actions.

If tort reform is passed with a cap of $250,000 or even $350,000, it will be difficult, if not impossible to find an attorney to take a complex case. Many

hours of investigation, research and planning are involved to get a case to the court. It will take away ordinary citizens access to our justice system.

Medical malpractice judgments are reported to the National Physicians Data Bank, and to the Nevada State Board of Medical Examiners. If there *are* no cases, there will be no reporting and no mechanism for the small handful of poor physicians to be discovered and dealt with.

I urge you to support the bill drafted by Assemblywoman Barbara Buckley which calls for a fast track in the courts for medical malpractice cases, more realistic caps on damages that specifically target egregious injuries and most of all calls for a timely, mandatory system for medical error reporting.

In one of the physician's affidavits addressing the complaint, he admitted that the error had been made, and stated that he regretted not following through with getting Christopher on the correct portion of his protocol when he discovered the error had been made approximately one month after our son's initial diagnosis. Again we were shocked to discover that although they were aware of their mistake within one month of diagnosis but had made no effort to correct it! Although the physician admitted that the error was made, and that our son should have received the proper treatment, his affidavit states it would have made no difference in Chris' "poor outcome."

"Outcome" is a euphemistic term used in medicine to describe whether or not the patient dies, or has severely disabling problems. Outcome is not a word that a family relates to when it comes to the loss or disability of a loved family member.

Christopher Thomas Roe did not have a poor outcome. He died. Chris died on his 16th birthday. Please help those citizens, now and in the future, whose families have been injured by medical negligence. Thank you for allowing me to speak.

Susan Roe
7/29/02
Addressing the Nevada State Assembly Committee on Medical Malpractice Reform

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MINUTES OF THE MEETING
OF THE
ASSEMBLY COMMITTEE ON MEDICAL MALPRACTICE ISSUES

Eighteenth Special Session
July 30, 2002

The Assembly Committee on Medical Malpractice Issues was called to order at 9:53 a.m., on Tuesday, July 30, 2002. Chairman Bernie Anderson presided in Room 4100 of the Legislative Building, Carson City, Nevada. The meeting was videoconferenced to Room 4401 of the Grant Sawyer Office Building in Las Vegas, Nevada. Exhibit A is the Agenda. Exhibit B is the Guest List. All exhibits are available and on file at the Research Library of the Legislative Counsel Bureau.

COMMITTEE MEMBERS PRESENT:

Mr. Bernie Anderson, Chairman
Ms. Barbara Buckley, Vice Chairman
Mr. Bob Beers
Mr. David Brown
Mrs. Barbara Cegavske
Mr. Joseph Dini, Jr.
Mr. Lynn Hettrick
Mrs. Ellen Koivisto
Ms. Sheila Leslie
Mr. Mark Manendo
Mr. John Marvel
Mr. John Oceguera
Ms. Genie Ohrenschall
Ms. Bonnie Parnell
Mr. Richard D. Perkins

GUEST LEGISLATORS PRESENT:

Assemblywoman Sharron Angle, Assembly District 29
Assemblyman Doug Bache, Assembly District 11
Assemblywoman Merle Berman, Assembly District 2
Assemblyman Greg Brower, Assembly District 37
Assemblyman John Carpenter, Assembly District 33

Assemblywoman Vonne Chowning, Assembly District 28
Assemblyman Jerry Claborn, Assembly District 19
Assemblyman Tom Collins, Assembly District 1
Assemblywoman Marcia de Braga, Assembly District 35
Assemblywoman Vivian Freeman, Assembly District 24
Assemblywoman Chris Giunchigliani, Assembly District 9
Assemblyman David Goldwater, Assembly District 10
Assemblyman Don Gustavson, Assembly District 32
Assemblyman David E. Humke, Assembly District 26
Assemblyman John Lee, Assembly District 3
Assemblywoman Kathy Martin, Assembly District 20
Assemblywoman Kathy McClain, Assembly District 15
Assemblyman Roy Neighbors, Assembly District 36
Assemblyman Dennis Nolan, Assembly District 13
Assemblyman Davis Parks, Assembly District 41
Assemblyman Bob Price, Assembly District 17
Assemblywoman Debbie Smith, Assembly District 30

STAFF MEMBERS PRESENT:

Nicolas Anthony, Senior Research Analyst
Allison Combs, Principal Research Analyst
Risa Lang, Principal Deputy Legislature Counsel
Cindy Clampitt, Committee Secretary
June Rigsby, Committee Secretary
Linda Smith, Committee Secretary

OTHERS PRESENT:

Robin Keith, President of the Nevada Rural Hospital Partners and the Liability Cooperative of Nevada
Bill Welch, President and Chief Executive Officer, Nevada Hospital Association
Bill Bradley, Nevada Trial Lawyers' Association
John Cotton, Nevada Physicians' Task Force
Gus Flangas, Attorney, Nevada Physicians' Task Force
Dean Hardy, Nevada Trial Lawyers' Association
Jim Crockett, Nevada Trial Lawyers' Association and member of the National Board of Trial Advocacy
Matthew Sharp, Nevada Trial Lawyers' Association
Dr. Maury Astley, Executive Director, Nevada Dental Association
Edward Goodrich, representing himself

Larry Leslie, Executive Director, Nevada State Board of Medical Examiners
Richard LeGarza, General Counsel, Nevada State Board of Medical Examiners
Lisa Black, representing the Nevada Nurses' Association
Carin Ralls, Operators' Union 3 and a Registered Nurse
Dr. Curtis Brown, Physician
Dr. Paul Stumpf, General Surgeon
John Yacenda, Chairman, Subcommittee to Study a Reporting System for Nevada
Robert Byrd, Chairman, Medical Liability Association of Nevada
Jim Wadhams, representing the American Insurance Association
Dr. Paul Stewart, Secretary-Treasurer, Nevada State Board of Medical Examiners

Chairman Anderson called the meeting to order at 9:53 a.m. and all members were present. He announced the committee would be hearing testimony for A.B. 1.

Assembly Bill 1: Makes various changes related to medical and dental malpractice. (BDR 3-13)

Chairman Anderson informed the committee Assemblyman Greg Brower wished to have his name added as a sponsor of the bill and asked Assemblyman Hettrick to explain.

Assemblyman Hettrick explained Assemblyman Brower had wished to review the bill before adding his name as a sponsor.

Chairman Anderson stated at the close of the committee hearing on July 29, 2002, there were questions still pending including what effect the legislation would have on rural hospitals.

Ms. Robin Keith, President of the Nevada Rural Hospital Partners and the Liability Cooperative of Nevada (LICON), expressed appreciation for the interest of the committee on how A.B. 1 might affect the rural hospitals in the state. She explained Nevada Rural Hospital Partners was a voluntary consortium of all 11 of Nevada's small, rural, and not-for-profit hospitals. LICON was a self-funded insurance trust that provided professional liability insurance coverage for member hospitals and the physicians employed by each. LICON was formed approximately 14 years previous as a means of stabilizing the cost of, and access to, professional liability coverage. Ms. Keith noted that all nine eligible hospitals were members of LICON. The two non-participating members sought coverage from a different source. Both hospitals were owned by larger

hospitals and received their coverage from their parent hospitals.

Ms. Keith stated that to the extent A.B. 1 helped to ensure continued access to hospitals and physicians, it had parallel benefits across the state in urban and rural areas. The limiting factors of the bill were also limiting across the state; thus, Ms. Keith felt the bill did not discriminate against rural hospitals. Ms. Keith stated her organizations were actively working with the hospital association to clarify some parts of the bill.

Assemblyman Marvel noted there had been an additional protection for government-employed physicians and asked if that would affect the rural hospitals. Ms. Keith responded it would have an effect. She noted the facility in Fallon, Nevada, was a designated level-four trauma center. The current ownership was a not-for-profit system and through Section 2 of A.B. 1 its physicians would enjoy the protection of the governmental cap. However, that facility was for sale and it was possible it could be purchased by a for-profit system; in which case, under the language of A.B. 1, it would not be eligible for the governmental cap. She opined that the physicians practicing in Fallon should not be "penalized" because of the ownership of the hospital. The protection should be attached to all designated trauma centers, regardless of ownership.

Assemblyman Marvel asked if the Fallon facility was the only one in that situation and Ms. Keith answered it was the only rural hospital in that situation.

Chairman Anderson asked how long the facility in Churchill County had been up for sale. Ms. Keith replied the attempt to sell had encompassed approximately one year.

Assemblywoman Parnell asked if the recent changes in the status of the Carson-Tahoe Hospital would cause it to be adversely affected by the bill. Ms. Keith asked if Assemblywoman Parnell was referring to the trauma situation and explained that Carson-Tahoe Hospital was not a designated trauma center so the consequences would not apply to it.

Chairman Anderson clarified that Churchill, Washoe, and Clark Counties had the only designated trauma centers in the state. Ms. Keith concurred.

Assemblyman Hettrick stated at the previous day's hearing he had questioned whether the limit established in A.B. 1, which required a physician to have liability coverage in the amounts of $1 million for each person and $3 million for each occurrence, would in any way impact the smaller hospitals that might be providing insurance for physicians who worked at those institutions; and

whether it would have a negative impact on the financial stability of any of the rural hospitals or clinics in some of the smaller communities. Ms. Keith explained that from a rural hospital perspective there would be no adverse impact because similar limits had already been in place for some time as a requirement of the current carrier. She added, she had spoken with Mr. Roger Vollker, Executive Director of the Great Basin Primary Care Association, to which the clinics belonged. He had informed her the federally qualified healthcare clinics, known as FQHC's, covered their physicians through a federal program so the bill did not affect them. She was not aware of whether community health centers would be affected.

Assemblyman Hettrick made the assumption that any facility affiliated with a major hospital, profit or nonprofit, would be under the same coverages. He added, there was some indication that the current wording of A.B. 1 would tend to make hospitals be the "deep pocket" of liability insurance funding. He asked if Ms. Keith felt the wording of the bill would push liability toward the hospitals and if that would have an impact on the smaller rural hospitals and their ability to be financially stable. Ms. Keith replied there was some language in the bill that was of concern. Her concern was with the issue of the cap on noneconomic damages. The organizations she represented supported the concept of a cap on noneconomic damages and greatly appreciated the change in joint and several liability language that made them responsible for only that portion of an incident created by the institution. The specific concern was that the actual cap would become the limit of the liability policy.

Assemblyman Hettrick opined the bill would tend to move malpractice cases away from the physicians and toward the hospitals and asked if a fallout result might become the curtailment of access to medical care in some of the rural areas. Ms. Keith replied that some facilities were always operating close to their budget limits; however, the rural institutions had been successful with the liability pool for insurance coverage. She explained part of the reason was that a number of the hospitals in the pool were protected by the $50,000 cap and because of aggressive risk management practices. She concluded an adverse financial effect was possible.

Assemblyman Marvel asked how much liability insurance rural hospitals were currently carrying. Ms. Keith replied the coverage limits varied from facility to facility ranging from $5 million to $30 million depending on the size of the facility.

Chairman Anderson asked for clarification that the $3 million policy requirement in the bill would not set a higher exposure standard for rural institutions. Ms. Keith stated the limits required in the bill were those required of physicians.

She added, the hospitals carried coverage in excess of the requirements of the bill. Chairman Anderson reiterated he was attempting to ascertain whether the provisions of the bill would put the rural hospitals at a greater risk than their current levels. Ms. Keith replied the Chair was technically correct; however, in a practical sense, the sources of damage, such as the incentive of who was looked to for payment of damages, might change somewhat as a result of the bill. Chairman Anderson asked and Ms. Keith concurred that the issue could possibly be an arguable point.

Assemblyman Dini clarified his belief that an institution, such as South Lyon Medical Center, paid the malpractice insurance premium for the doctors who worked at the facility and Ms. Keith agreed. Assemblyman Dini asked if the bill would, in any way, affect the amounts currently being paid by the hospital per physician. He followed with a question of whether the bill would place an added burden or whether it would be the same burden. Ms. Keith replied it would be the same burden.

Chairman Anderson asked if there were any other questions from the committee and having none asked if Mr. Welch had anything to add to Ms. Keith's testimony.

Mr. Bill Welch, President and Chief Executive Officer, Nevada Hospital Association, stated his association supported the passage of meaningful tort reform that would help alleviate the current problems. He noted he and Ms. Keith had collaborated on her testimony.

Assemblyman Anderson stated the committee would move to an explanation of the bill. Chairman Anderson suggested those present at the witness table move through A.B. 1 section-by-section, beginning with the first three sections.

Mr. Bill Bradley, Nevada Trial Lawyers' Association (NTLA), introduced Matt Sharp, also of the Nevada Trial Lawyers' Association.

Mr. Bradley explained A.B. 1, Section 1, addressed the trauma center issue in southern Nevada by imposing limitations on victims of negligence in trauma centers. It would provide a cap of $50,000 that was already in existence to the state, counties, and cities under the doctrine of sovereign immunity. The section stated a person treated under very emergent circumstances, who would claim they were a victim of medical malpractice, despite the medical malpractice policy limits of the doctors involved, would be limited to $50,000 irrespective of whether the damages were economic or noneconomic in nature. The provision did not consider fault or degree of damages.

Section 2 contained technical amendments to the Nevada Revised Statutes (NRS).

In Section 3, the first definition was for "economic damages." He explained medical malpractice cases were a type of tort claim and explained the types of damages a jury could award in tort cases. A victim of someone else's negligence was entitled to recover their past and future medical bills and their past and future wage loss, including the ability or inability to earn a living.

Economic damages were defined as damages for medical treatment, care or custody, and loss of earnings. The NTLA had agreed with physicians who desired an amendment to the definition deleting at Section 3, line 10, page 3, the word "and"; then following the words "loss of earnings" add "and loss of earning capacity." The amendment had already been approved in the Senate. Mr. Bradley further explained economic damages as those damages that represented out-of-pocket expenses needed for care of an injured victim plus the expense associated with their loss of ability to earn a living and the loss of wages during their injury and recovery periods.

Mr. Bradley stated economic and noneconomic damages were further broken into past and future damages. Past damages, whether economic or not, represented the damages inflicted upon a patient from the time of the medical malpractice until the time of the trial. Future damages included those from the end of the trial through the anticipated life expectancy of the victim. Past awards included a levy of interest because they represented money already taken away from the victim. Future damages would not include interest because the damages had not yet occurred.

Mr. John Cotton, Nevada Physicians' Task Force, concurred with the amendment language.

Mr. Gus Flangas, Attorney, Nevada Physicians' Task Force, also concurred with the language as presented by Mr. Bradley.

Assemblywoman Ohrenschall asked Mr. Bradley to repeat the explanation regarding interest accrual. Mr. Bradley explained interest was awarded on past damages because it represented the amount of money awarded to a victim, but not paid for a period of years from the time of the filing of a complaint until a judgment was returned. Assemblywoman Ohrenschall asked if interest was also accrued on the loss of earning capacity as opposed to simply loss of wages. Mr. Bradley replied interest would be applied if there was a loss of earning capacity during the period a victim was awaiting commencement of a trial.

Chairman Anderson stated the committee had been focusing on the pain and suffering elements related to caps so that amendment must have stemmed from an unintended consequence. Mr. Bradley concurred. Chairman Anderson asked for clarification that the amendment would not change existing law with regard to what damages were allowed. Mr. Bradley agreed.

Chairman Anderson asked Mr. Bradley to continue with the explanation of the next three sections of A.B. 1. Mr. Bradley agreed, noting that Section 5 might entail a more lengthy discussion.

Mr. Bradley related Section 4 contained the definition of noneconomic damages often referred to as the "pain and suffering" component of awards. He added the lawyers and physicians were in agreement on that language.

In Section 5, agreement on a language amendment had been reached. At Section 5, line 14, add "subsections 2 and 3" where currently only subsection 3 was shown.

Section 5, line 16, should read, "noneconomic damages awarded to each plaintiff from each defendant."

At Section 5, subsection 2, line 20, should read "subsection 1 and 3." After the number "3" it should read, "the noneconomic damages awarded to a plaintiff from each defendant."

At Section 5, subsection 2, line 21, after the word "exceed" remove the words, "the greater of $350,000 or." Chairman Anderson repeated the new language after the word plaintiff in line 20; "from each defendant must not exceed the amount of money remaining." Mr. Bradley affirmed that reading. The Chair asked that the bill drafters make sure the language coincided with proper bill language. Mr. Bradley noted there appeared to be some concern in the Senate about the proposed language mutually agreed upon by the attorneys and the physicians. As part of the amendment, Chairman Raggio directed that if the bill drafters did not like the suggested language, it only be changed in a way that reflected the intent of the proposal and all parties would be given an opportunity to view the final language before it was adopted. Chairman Anderson noted legislators tended to rely upon language proposed by the Legislative Counsel Bureau (LCB) staff.

Mr. Bradley stated the next amendment generated some concern about where it should be inserted. It would either become a new section in front of Section 3 or a new section in front of Section 4. He noted placement was not as

important as the wording of the language. The proposed amendment would state, "This section is not intended to limit the responsibility of any defendant for the total economic damages awarded."

Further, A.B. 1, Section 5, subsection 3, subparagraph H, line 40, should read, "A case in which, following return of a verdict by the jury or a finding of damages in a bench trial." Also, in subparagraph H, line 42, it should read, "$350,000 for noneconomic damages is justified." Delete the words, "under the" and replace with, "as exceptional." Mr. Bradley clarified, the complete sentence would read, "A case which, following the return of a verdict by the jury, or a finding of damages in a bench trial, the court determines by clear and convincing evidence that an award in excess of $350,000, for noneconomic damages is justified as exceptional circumstances." He stated that concluded the agreed upon language changes in Section 5 of A.B. 1.

Chairman Anderson asked that Section 5 be explained to the committee.

Mr. Cotton explained the intent of Section 5 was that, rather than try to delineate every conceivable injury that could occur, they identified the very distinct injuries of brain damage, blindness, and others that were fairly obvious, and then allowed that the only time an exception would be involved was in a case where, by clear and convincing evidence a judge found there were exceptional circumstances in that particular case in the area of catastrophic damage occurring from the injury. It did not address the conduct of the doctor or hospital involved. Mr. Cotton stated the phrasing formed a very restrictive "catchall" limited to cases with a catastrophic impact.

Assemblywoman Buckley asked if the physicians felt the section provided a good balance for the state with the overall size of the cap and the exceptions provided in the bill. Mr. Cotton replied the physicians he represented would prefer to have a fixed, lower cap, but they recognized the concerns through the opinions of the public and others that their preference might not be fair in all circumstances. The goal, however, was to retain doctors who were practicing in the state and could be accomplished by protecting doctors' personal assets by a policy limit cap in most cases. In addition, the doctors desired the adoption of meaningful legislation under the current crisis that would allow outside insurance companies to begin writing coverage in the state and provide competition to realign the premium structure in the state. That was a particular problem within Clark County. The physicians were not initially agreeable to any exception in the bill, unless insurance representatives perceived the exceptions as a significant move to show stable levels upon which to base premium structures. In discussion with others, there was indication that the language would result in appreciable changes over a period of 3-to-4 years.

Assemblywoman Buckley asked if the amended language in A.B. 1, Section 5, was perceived as fair and Mr. Cotton replied affirmatively.

Chairman Anderson asked if the committee could anticipate a 4-to-5 year waiting period before the insurance actuarial tables would reflect the provisions addressed by the bill. Mr. Cotton explained there would possibly be some short-term savings and then there would be a wait for a pattern of cases and awards to build before there would be any significant movement in insurance premiums. He added that was not an abnormal result within the insurance industry. He noted that even if the bill reflected a cap of $5, there would not be an immediate impact on premiums. The Chair confirmed, even if the cap was significantly lowered there would be a waiting period of 2 to 3 years to see what the actuarial tables would show.

Mr. Cotton noted another issue that should be seriously confronted was the fact there were only about three companies that were writing medical malpractice policies within the state, thus there was no incentive to provide any form of competition. Chairman Anderson confirmed it was the hope of the physicians that the insurance market would be broadened by the bill and Mr. Cotton agreed.

Mr. Bradley suggested the committee spend some time discussing how the provisions would actually work and Chairman Anderson requested that he continue with the explanation of the bill.

Mr. Bradley stated A.B. 1, Section 6, contained the amendment to the doctrine of joint and several liability. The language was modeled after the Medical Insurance Comprehensive Reform Act (MICRA) established in California. The section made any healthcare provider jointly and severally liable for the economic damages incurred in a case, but only severally liable for the noneconomic damages. He explained that of the economic damages awarded to a claimant, if there was more than one defendant, such as multiple doctors or a doctor and a hospital, the bill stated irrespective of the percentage of fault of each defendant, each healthcare provider would be responsible for all of the economic damages awarded to the claimant. He noted that was the current law within the state. Under the noneconomic damages, the responsibility to pay the amount of the award was based on the percentage of fault of each particular healthcare provider.

Mr. Bradley explained if $100,000 in noneconomic damages was awarded in a case and one healthcare provider was found 70 percent at fault and the other was found 30 percent at fault, the first would pay $70,000 and the second

would pay $30,000.

Assemblyman Marvel asked if the determination of percentages was subjective or if there was a rule to follow. Mr. Bradley replied a jury made the determination. Typically all evidence was presented by the attorneys for each side at trial, and at the conclusion, the judge would meet with all attorneys for the settling of instructions. In any case heard before a jury, the jury was provided with jury instructions at the end of the trial. Nevada law provided for a uniform set of jury instructions such as: how to elect a foreman of the jury; how to treat a corporation; and how sympathy, passion, and prejudice were excluded from decisions; among others. Additionally, the attorneys would argue about certain jury instructions specific to the case from each side. The judge would determine the final instructions given to a jury, including instructions about economic and noneconomic damages. In the attorneys' closing arguments the economic and noneconomic damages were presented by each side again. The court also had a sheet containing a series of questions for the jury, called a verdict form, that contained such questions as:

- Do you find that the care provided by the doctor fell below the standard of care of a reasonably prudent physician under the same or similar circumstances;
- Do you find that the care of the second physician was below the standard of care of a similar physician;
- Do you find that the plaintiff was injured by the physician;
- What do you find as the amount of the economic damages;
- What do you find as the reasonable value of the physical and mental pain, suffering, disability, and anguish;
- Break down the amount into past and future damages; and
- Do you feel the plaintiff was partially at fault for his or her own disability.

The end result of the verdict form, if it was done appropriately, would give a good understanding of the intent of the jury. The final calculations were made either by the judge or the jury, depending on where the trial was held. Six out of eight jurors must agree on those apportionments of fault.

Assemblyman Marvel asked how many of such determinations went to appeal. Mr. Bradley replied, the vast majority were appealed, however, at the same time negotiations were ongoing creating an opportunity to resolve the case before an appeal went before the higher court.

Chairman Anderson recessed the meeting at 11:02 a.m. The meeting reconvened at 11:58 a.m.

Mr. Dean Hardy, representing the Nevada Trial Lawyers' Association, stated he was prepared to speak generally about the bill, but first he would like to present a videotape for the committee. He introduced Diane Meyer, an alleged victim of malpractice, and a speaker on the video.

The video titled, "MedMal Version #2 – 7-28-02," (Exhibit C) portrayed three people affected by alleged medical malpractice. The first case portrayed was of a gentleman who went to a doctor for a needle biopsy of the chest. Apparently, the patient complained that he was having problems breathing and according to the speaker, who was the wife of the patient, the doctor's response was that the patient should "suck it up" because they were almost done. The end result was that the aorta had been punctured several times and the patient died.

The second case was that of a baby who was born at full term. The speaker was the mother of the child and stated she had asked the doctor if she could have a caesarean section to which the doctor replied he preferred to induce labor. The mother stated she was unaware the doctor would not be present the entire time she was in labor. The father explained the child was expected to go home in the normal manner and all was in readiness. The mother said the baby was born not breathing, had a seizure, and severe life-long problems had occurred.

Ms. Meyer appeared as the third case in the video stating her husband had taken her to the emergency room and she was the only patient there at the time. She stated she was very ill and could not get the attention of anyone to assist her. After examination, she was diagnosed with a small kidney stone, given some medication and sent home. Within 1.5 weeks she had lost her legs and her doctors had considered taking her hands as well.

The video summarized the fact that patients and their families who were affected by malpractice were affected for the rest of their lives.

Chairman Anderson expressed deep sympathy to Ms. Meyer for what had happened to her. He stated nearly every member of the committee could probably relate some incident regarding a family member that had been harmed at some time. He related a call from his sister-in-law prior to the legislative session to remind him of how she had lost her hands and feet as a result of medical malpractice. Ms. Meyer stated she had wanted to speak before the committee to stress her viewpoint; victims of malpractice were real people. She noted that while her medical and prosthetic needs would always be met, somewhere along the line victims of malpractice wanted to hear that someone

was held responsible for mistakes being made. She opined the term "pain and suffering" expressed the vast changes made in a life by certain circumstances.

Chairman Anderson stated it took a great deal of courage to appear before a committee. He added he could only, in a small way, appreciate what the victims of malpractice dealt with daily.

Mr. Hardy introduced Jim Crockett, who also represented the NTLA. Mr. Hardy stated he did not bring witnesses or the videotape to play on the emotions of the committee so that perhaps a trial lawyer could earn a larger fee. He stated his purpose was that not only did their stories break his heart, but also that there was an assault on the justice system. He opined the justice system was being trampled. He explained, when the peoples' access to a trial by jury was limited it broke his heart. He emphasized the Constitution was not a technicality. He added, he was a Nevadan first and a trial lawyer second, and if he thought what he did for a living compromised healthcare he would change his livelihood. He acknowledged doctors needed to have available and affordable malpractice insurance and acknowledged the efforts of the Governor in creating a state insurance company. He stated, to fix the problem one must understand what created it in the first place.

Mr. Hardy stressed the data collected did not support that the civil justice system was the sole blame for the demonstrable and significant increase doctors in southern Nevada were facing in their malpractice insurance rates. He asked if it was a coincidence that St. Paul, the single largest insurer in southern Nevada who controlled 60 percent of the market share, and during the economic downturn of the last quarter of 2001, decided to no longer offer insurance in Nevada as well as every other state across the union. He stated it seemed unlikely that a civil justice crisis was created at the same time. He stressed the committee could not look solely to the civil justice system for a solution to the situation doctors were facing.

Mr. Hardy informed the committee that on Friday, July 26, 2002, in California, two of the larger insurers of medical malpractice in that state, asked for double-digit rate increases. Norcal asked for a 13 percent rate increase and MIEC asked for a 10 percent increase. Mr. Hardy concluded the problems facing the committee were truly complex.

Chairman Anderson expressed his appreciation for the personal testimonies and the video provided and explained the committee needed to continue their study of A.B. 1. He was most concerned that the public should have an opportunity to be heard. He noted that whatever venue created the crisis there was indeed a crisis in southern Nevada when a trauma center was closed and the public lost

access to healthcare when they needed it most. He recognized the physicians' profession was one of compassion and dedication.

Mr. Jim Crockett, Nevada Trial Lawyers' Association, and a member of the National Board of Trial Advocacy, explained he represented private citizens exclusively and some of his practice was devoted to malpractice issues. He addressed the committee regarding the constitutionality of any law passed by the legislature. He noted the same people who comprised the electorate who chose the legislators were the same people who sat on juries and made decisions in malpractice insurance cases.

For a law to pass constitutional muster when the ability of a person to present their case before a jury was impaired, a court would review the impairment of the individual's rights to seek full redress without any limitations upon the jury's ability to consider all relevant issues and the public benefit purported as a result of that law. The current problem was that there was no credible evidence to suggest that the civil justice system was the root of the current evil. He provided the committee with a booklet entitled, "The Reality about Medical Malpractice Law" (Exhibit D). He referred to the bar graph on page 2 that showed the average liability premium for a general surgeon in 2001. In states without caps on damages the average nationwide premium was $26,144 per year. For states with caps on damages, the premium was $26,746 per year. He noted that meant general surgeons paid an average of $650 more for coverage in those states with a cap on malpractice damages.

Secondly, Mr. Crockett noted Governor Guinn instituted a suit through the State of Nevada against St. Paul Insurance Company alleging that St. Paul created the insurance crisis by underpricing itself in the market. The suit alleged the company did a bad job of underwriting doctors and then, by pulling their coverage out of the state, caused irreparable harm to the insurance market within the state. He added there was no question that the rates doctors were paying was outrageous, but the question was what caused the problem.

The third indicator that the civil justice system was not the culprit was that Congress empowered the Government Accounting Office to investigate the insurance industry to see if their accounting practices were at the root of current problems. He acknowledged there was always room for improvement in the legal system, but when addressing constitutional issues, he asked the committee to keep focused narrowly on the Governor's proclamation to address the crisis. Mr. Crockett added the committee needed to discover what led to the closure of the southern Nevada trauma center and he opined broad changes in tort reform were not needed that encompassed every aspect of the civil justice system without legitimate justification.

Chairman Anderson noted questions of constitutionality were always of interest to him. He acknowledged California had responded to a medical malpractice crisis in its state. He added the cap was subsequently found constitutional under the U.S. Constitution because it had a legitimate purpose based upon legislative action and was rationally related to achieve the purpose of that legislation. He suggested the burning question that would ultimately be placed before the Nevada Supreme Court, based upon whatever action the Nevada Legislature took in special session, was: 1) Was there going to be a response from insurance companies to reduce rates. If there was no response to reduce rates then, 2) Constitutional scholars would say there was a crisis and the solution did not produce a result and therefore the caps did not have a place. He asked if that was a fair statement. Mr. Hardy replied testimony had been heard earlier from Mr. Wadhams, who was currently not present, that suggested A.B. 1 would have some positive effect on insurance rates for doctors. From their perspective, the bill would help to stabilize and reduce insurance rates because there was a cap on the most vague aspect of damages – noneconomic damages. He added that Mr. Byrd, Chairman and Chief Executive Officer of the state insurance company implemented by the Governor, had testified before the Senate also suggesting the bill would have a positive effect on insurance rates. Mr. Hardy stated trial lawyers recognized the political reality of the situation requiring something to be done. He expressed hope that what was accomplished during the session would have the desired effect.

Mr. Crockett concluded by stating it was his sincere hope the legislature was not driven by concerns expressed through the media. He added the media should focus their attention on the insurance industry, rather than the civil justice system, to answer the question of "if" something was done, would the insurance companies respond with a quantifiable change.

The Chair asked if there were questions for the witnesses relative to the constitutionality of the outcome of current legislation.

Assemblyman Hettrick stated he appreciated the comments, but the legislature was not in session to assess blame, rather to find a way to lower the cost of medical malpractice insurance so it would be affordable and allow citizens, particularly in southern Nevada, access to healthcare. Secondly, it seemed that if whatever legislation passed did not result in lowering of insurance premiums, then it would not stand the constitutional test of being effective legislation and would be ruled against. He added that did not mean legislation should not be passed. It should be passed and results of the outcome observed. He acknowledged the crisis was an extremely complex issue, but it appeared something must be done to lower the cost of insurance or the state would continue to lose doctors.

Assemblyman Hettrick explained he could only see two ways to reduce the cost of insurance. 1) Reduce the number of incidents, and 2) Reduce the cost per incident. He stressed there was no other way. He asked what the number of incidents were, acknowledging that human beings would make errors. He asked how to reduce the incidence of errors. He agreed with Ms. Meyer that she could not get her legs back, but the issue was, there had to be economical medical care and access for Nevadans.

Mr. Crockett stated he had not used the word "blame" in his testimony. He added his comments went to a purely constitutional perspective. A court would look at whether the object of legislation was responsible for the ills that were being addressed. He stressed legal caps would not address the issue of frequency of incidents of malpractice. He added caps only addressed severity of an issue and were necessary for only the most severe injuries. He stated he had only brought up the insurance industry in addressing constitutionality to say it would be wonderful if the insurance industry could be held accountable and commit a specific kind of rate reduction or that they would address rate reduction based upon the rates prior to the current crisis. Mr. Crockett noted Mr. Hardy was not a malpractice lawyer and under the current issues of coincidence, not just September 11th or Wall Street, issues were coming to light, but WorldCom and Enron were all developing in the fall and winter of 2001; yet those issues were only currently coming to light. It was one of the things that prompted Congress to instruct the Government Accounting Office to investigate the insurance industry for the accounting practices to see if those had created the current, national crisis. He added the insurance industry were the ones who were telling doctors who had never experienced a medical malpractice claim and had a history of being an excellent physician, that their premium would jump from $42,000 per year to $126, 000 per year.

Assemblyman Hettrick acknowledged he had not meant to put the word "blame" in Mr. Crockett's mouth; in fact, Mr. Hardy had actually used the term, "sole blame." He added, in terms of timing, the legislature had been looking at tort reform longer than since the advent of September 11th. He noted there had been multiple bills proposed by multiple persons to address tort reform. He commented on the double-digit rate increase requests in California. To go 13 percent up from a $42,000 premium was a great deal different than to go from $42,000 to $126,000. There was a magnitude of change that must be recognized. The California requests might relate to inflation alone, depending on when the last rate increases had been allowed. He stressed the legislature was not trying to assess blame, but rather to find a way to affordable premiums in Nevada.

Chairman Anderson stated malpractice was more than someone making an error; it was someone making a mistake that should have been avoided because of a healthcare provider doing their job. It was an avoidable mistake caused through negligence. One of the frustrations dealing with any legislation involving tort claims was the demonstrable ability to someone of whether an event was an identifiable event and whether it could have been avoided. If that could be proven, it would not be considered an accident. Mr. Hardy stated he was comfortable with the comments by the Chair and Assemblyman Hettrick. He was comfortable that the legislative deliberations would produce a bill that addressed the issue and it was a tough job.

Mr. Crockett stated, with regard to the medical malpractice issue, his purpose in providing testimony was to identify issues the NTLA had become aware of in their research as to potential pitfalls. He addressed the Chair's comments regarding mistakes and their preventability. In order to establish a recovery system that would only compensate for mistakes made, it would completely change the legal system to a "no-fault" system. If a person had a bad result because of medical treatment, regardless of the cause, they would be compensated according to some schedule similar to workman's compensation. He stated that was not the way the civil justice system worked. He added the system did not require a doctor to perform at the level of an "A+" physician. Under the current system, if a doctor had complied with the standard of care that his colleagues might consider a "C-" grade, that was not negligent regardless of the result. He stated that was exactly the argument every defense attorney made in every malpractice case. Only when other expert doctors in the same field went to court and testified a certain doctor fell below the minimum acceptable standard of care, was negligence present.

Assemblyman Marvel stated September 11th was not the turning point for malpractice insurance premiums. In 1995 he, as primarily a representative of rural areas, had submitted a bill that was parallel to California's Medical Injury Compensation Reform Act (MICRA). He brought the bill because of the need to attract doctors, especially those specializing in obstetrics and gynecology (OB/GYN), to the rural areas and stated at that time there was not as much of a crisis.

Assemblywoman Parnell asked if the committee would be hearing from Mr. Wadhams and the insurance industry that day. The Chair replied the great tragedy was that an Interim Committee, in front of whom the insurance industry was to have appeared, had to be postponed due to the call of the Governor to the 18th Special Legislative Session. He added some members of the insurance industry had chosen to appear in the Senate committee currently underway. He

added there were no representatives of the insurance industry or the Physician's Task Force listed on the guest list for either the previous or current day of hearings in the Assembly. He noted he had talked to Mr. Wadhams briefly and would attempt to have some of those representatives present before the end of deliberations.

Assemblywoman Parnell stated perhaps other members of the committee would feel as she did, that unless the insurance industry presented testimony to the committee in the near future, she would wish to make a statement for the record before the end of deliberations.

Assemblyman Brown stated, according to the constitutional issue, referring to the bar graph included in Exhibit D if, in comparing states with and without damage caps, that the current configuration was somewhat due to the fact that states with caps had probably gone through somewhat of a crisis. He asked if, in fact, rates had stabilized after experiencing dramatic increases such as had recently been seen in Nevada. Mr. Crockett replied the reason the graph showed 2001 figures was those were supposed to be pre-crisis rates. Assemblyman Brown suggested the intent of the graph was to say there were states with caps, but the physicians still paid on average, a higher premium. He suggested that could be a persuasive argument in terms of the efficacious nature of tort caps. He asked if those states with caps were experiencing a radical increase in premiums, thus causing caps to be enacted. He suggested a state that did not quickly get a handle on premiums, saw premiums shoot past those of other states. He added perhaps after caps were enacted premiums in those states leveled off. That might explain why states with caps had a higher premium. Mr. Crockett replied he did not know if that was an accurate assumption or not because the chart reflected premiums for the calendar year 2001. Whatever had taken place in the states prior to that year had a long history, but in 2001 a comparison of the rates was accurate. Mr. Crockett stated when President Bush was governor of Texas in 1995, he was successful in urging passage of medical malpractice tort reform and yet Texas physicians were closing their practices at the same time as those in southern Nevada. He opined that was an overt indicator that tort reform had not solved the issue in Texas.

Chairman Anderson referred to Volume III of the "Background Information on Medical Malpractice" (Exhibit E), that contained information on states finding caps unconstitutional. States with caps on damages had no case law to back it up, and constitutional questions were based on statutory case law.

Assemblyman Beers stated in review of Exhibit E, regarding the obstetric and gynecological rates listed, they were considerably below what the private sector

was able to find within the last 3 to 4 months. They were also considerably below what the new, state-owned system was able to provide. He noted if the problem was the mismanagement of insurance companies, the new, state-owned insurance company would not have the bad investment history and would be able to offer rates at least competitive with those listed in Exhibit E. He asked how the rates were developed within the state-owned company. Mr. Crockett replied he had heard, as a member of the Governor's Task Force and in talking to the individuals connected with the state program, that when the state program saw the rates last being charged by the St. Paul Company, they knew those were too much, but they felt they could not go too much below that to work successfully with the actuarial numbers. He said that also agreed with the Governor's suit against St. Paul that stated as a result of St. Paul's pricing policies to grab 60 percent of the market, the other insurance companies would either lose their customers to St. Paul or they would have to drop their prices to hold their market share even though it was not a high enough premium to cover the inherent risk. St. Paul created a vacuum in the market. The Doctors' Insurance Company had 31 percent of the market prior to St. Paul insuring in the state. The St. Paul introductory move was to buy up The Doctors' Insurance Company, which had been a successful small business. The Doctor's Insurance Company market share dropped to 9 percent. He concluded the media was reporting rate increases up to 296 percent. In actuality, that figure represented quotes for coverage and Alice Molasky, Nevada Insurance Commissioner, was quoted in the Las Vegas Review Journal as saying she was successful in negotiating with The Doctors' Insurance Company to reduce rates from as high as 296 percent to 50 percent and the article noted those percentages were a matter of record with the Insurance Commission. That article was placed on page 4 of the newspaper, yet on the front page of the same paper was an article stating 150 doctors were leaving the state because their rates were projected to triple. He asked at what point discussions could get down to actual rates charged and quit dealing with projections.

Assemblyman Brown referred to testimony in favor of amendatory language, the added language of "from each defendant" in Section 5, line 16, of A.B. 1. He asked in what percentage of cases were a single plaintiff versus those cases with multiple plaintiffs and the same for cases with a single defendant versus those with multiple defendants. Mr. Crockett asked for clarification of the question; was it what percentage of cases involved single defendants versus multiple defendants. Assemblyman Brown agreed. Mr. Crockett stated he did not have those percentages. Assemblyman Brown added he would also like the percentage for single versus multiple plaintiffs. Mr. Crockett stated he did not have those figures either. Chairman Anderson stated he was not sure, given the time constraints of the special session, whether it would be possible to research those figures in time to be useful.

Mr. Hardy offered to do research on the question and at least come up with some approximate numbers. Assemblyman Brown acknowledged he was only looking for rough numbers.

Assemblywoman Cegavske provided written testimony for the committee from Dr. Paul Chao, who needed to leave before his testimony was allowed. The Chair agreed to enter the written testimony into the record (Exhibit F). Dr. Chao made several points in his written testimony:

- Many doctors were leaving the state as a result of the rise in malpractice insurance rates. In fact he, himself, would leave if his premium as an OB/GYN doctor reached $100,000 per year or more.

- He had seen a figure quoted for cost of the special legislative session of $160,000 and noted his malpractice insurance premium coverage in the next year could reach $130,000.

- An average OB/GYN doctor delivered 240 babies per year. Since his personal malpractice insurance premiums were based on the number of babies delivered and his rate was limited to 125 babies per year he had accepted no new patients since May 2002, and did not expect to accept any until at least September 2002.

- He noted the Governor's statement of the previous day that the bill might provide a cap of $50,000 for doctors performing pro bono work in trauma centers. He asked that that provision be extended to all doctors and explained he had three cases the previous weekend when he was on call as part of his agreement with the hospitals in which he worked.

- He described the fact that none of the three cases had insurance or prenatal care and had come to emergency to deliver their babies. The first had a previous caesarian section and he was compelled to perform a second section without knowing the location of incisions made during the first surgery. In the second case, the mother had cocaine and marijuana in her blood system and the baby was delivered having withdrawal symptoms. The third case was a mother experiencing her sixth birth. The mother was overweight and the baby appeared large. The head presented, but the shoulders were stuck. Dr. Chao eventually got the shoulders to come through, but the hips then stuck. The baby was born with a bruise on the nipple where Dr. Chao had had to grasp it to complete the birth. He explained those were all pro bono cases and he was responsible for what happened to those children as a result of birth for the next 11 years.

Chairman Anderson explained the procedure for presentation of written testimony and other materials to the committee. He recessed the committee at 1:11 p.m.

Chairman Anderson reconvened the committee at 2:45 p.m. and asked Mr. Bradley to reconfirm the proposed language changes in the bill up to the end of Section 5 of A.B. 1. Mr. Bradley and the Chair went through the proposed changes and discovered one discrepancy. Mr. Bradley stated the amended sentence at Section 5, subsection 3, paragraph H, line 40, should read "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 . . ."

Chairman Anderson asked for confirmation that there were no proposed amendments to A.B. 1, Section 6, and Mr. Bradley agreed. Assemblyman Hettrick had also requested the addition of Assemblyman Brower's name to the face of the bill. Chairman Anderson stood ready for a motion to approve Sections 1 through 6 of A.B. 1 as amended. Mr. Bradley asked that the documents provided by the NTLA, including a chart of the leading causes of death in the United States, the publication, The Insurance Cycle (The Reform Cycle), and the document entitled, "Bad Business Decisions by Insurers Reap Havoc on the Insurance Industry" be included in the record as Exhibits G, H, and I respectively. The Chair concurred.

Assemblyman Hettrick noted that Rule 4 of the Assembly Medical Malpractice Issues Committee (Exhibit J) stated that members supporting an amendment or a legislative measure were expected to support final adoption on the Floor of the Assembly. He asked for clarification that a vote on the first six sections of the bill, without hearing the remainder of the bill, would not obligate members to support the total bill at a later time. The Chair stated it was his intent to find agreement on the first six sections of the bill and then, as other sections of the bill were agreed upon in logical groups, so that the same sections did not need to be repeatedly referred to. Then a final vote would be taken for the purpose of making a recommendation of amend and do pass to the floor. The final vote would be the recorded vote obligating members of the committee.

ASSEMBLYMAN DINI MOVED TO ACCEPT THE ADDITION OF ASSEMBLYMAN BROWER'S NAME TO THE FACE OF A.B. 1 AND THE PROPOSED AMENDMENT LANGUAGE IN SECTIONS 1 THROUGH 6 OF THE BILL AS PROPOSED BY MR. COTTON AND MR. BRADLEY.

ASSEMBLYWOMAN BUCKLEY SECONDED THE MOTION.

THE MOTION PASSED UNANIMOUSLY.

The Chair asked Mr. Bradley to explain Sections 7 through 9 of A.B. 1. Mr. Bradley stated further in the bill, the Medical Malpractice Screening Panel was abolished as of October 1, 2002, for all cases in which the plaintiff "opted out" of the panel. Because those cases would then be moved into district courts, there was a desire to get those particular cases heard in an efficient manner. Under current law, from the time a case was filed in district court, the party had 5 years until the trial had to begin and Section 7 provided a method to expedite cases being referred to the courts from the panel. Mr. Bradley explained that section would stop much of the negotiations and stipulations for continuances that typically occurred in such cases.

Mr. Bradley explained from October 1, 2002, to October 1, 2005, the bill would allow 3 years to move cases through the litigation process. That time frame targeted the cases coming from the screening panel and then, after October 1, 2005, all cases of malpractice would have to be heard in a 2-year time frame, rather than the existing 5-year period. Mr. Bradley stated the intent of Section 7, subparagraph 2, was to preclude someone from dropping a case and then trying to file a second case against the same defendants. Subsection 3 instructed each district court to adopt rules to expedite malpractice cases. Mr. Bradley explained Arizona had a fast-track system that placed very stringent procedures on attorneys, which made administration of a claim in the court system more efficient. The intent of subsection 3 directed Nevada to adopt rules to achieve the same outcome.

Assemblywoman Parnell stated her only concern was that in previous testimony a number of people had expressed difficulty in finding an attorney to represent them, and then experienced a very long period of time where an attorney might hold a claimant's information before deciding not to take a case. She asked if, under the bill, the court could take such circumstances into consideration and grant an exception. Mr. Bradley stated the bill would require that attorneys made expeditious decisions about whether they would take a case. However, because the screening panel was going away, a case would be moved more quickly, the case would actually move through the system faster than was currently happening under the screening panel.

Assemblyman Beers asked if the fast tracking would mean a shortened statute of limitations. Mr. Bradley stated that would not be affected by Section 7. He explained that provision was discussed in Section 11 of A.B. 1. Section 7 dealt specifically with the time frame between when a case was filed and when it was completed in the district court system.

Chairman Anderson asked for clarification that a case under review by the medical screening panel might take 2 to 3 years to be heard and would be heard under a much tighter time frame under the bill. Mr. Bradley stated once a client was in the court system, their day in court would happen within 3 years for the initial cases and those filed later would be heard within 2 years.

Chairman Anderson asked if Section 8 provided for expert verification of evidence. Mr. Bradley stated under current rules with the screening panel an attorney was mandated, subject to dismissal, to provide an affidavit of a physician. In filings at the district court level a requirement had been made that a summary affidavit from a physician in the same area of expertise who reviewed the records and based on that review, affirmed that the case was meritorious. He noted the NTLA believed there needed to be a deterrent from cases being filed in order to get a quick settlement. The requirement that an expert in the same or similar circumstance review the records would ensure the records would continue to be reviewed by an expert before they were filed. Chairman Anderson clarified the section required review of the records by someone practicing in a similar area of expertise. Mr. Bradley noted the language stated the expertise must be in a field "substantially similar" and explained if a case was filed against an obstetrician, the expert for review must be someone very familiar with the field of obstetrics.

Chairman Anderson asked if it was currently difficult to find such experts and Mr. Bradley replied specific medical experts had always been difficult to find. He stressed Section 8 of A.B. 1 was not intended to mean a doctor who served in the same locality as a defendant, but someone perhaps from a different state who practiced in the same field of medicine.

Assemblyman Dini stated he had heard rumors that the dentists were not happy about the abolishment of the screening panel. Chairman Anderson had requested the Executive Director of the State Dental Association to be present and explained his intent was to complete review of the sections of the bill that dealt with the screening panel prior to that testimony.

Matthew Sharp, Nevada Trial Lawyers' Association, stated A.B. 1, Section 9, mandated an early settlement conference after a complaint had been filed and after a defendant had an opportunity to respond. The intent was to provide for early case resolution to:

- Assess the liability of the defendant before the judge;
- To provide early resolution to see if a case with merit could be resolved through a fair settlement; and

- If a case was not meritorious, that the judge could instruct the attorney representing a plaintiff that the case should not be filed.

Mr. Sharp stated under Section 9, subsection 4, the judge would have the authority to issue sanctions against any party who did not participate in a settlement conference in good faith. There had been a concern regarding the screening panel that some of the legitimate cases were not being settled quickly and also, that some of the cases that had made their way through the panel should not have been filed in district court. He commented a similar program had been instrumented in Washoe County and had been very successful.

Chairman Anderson asked if it was the last hope for a plaintiff when a judge stated a case did not appear to have merit. Mr. Sharp replied no one could force a lawyer to dismiss a case, however, the court had inherent remedies. If a judge decided a case was without merit and an attorney decided to proceed anyway, the attorney could be personally sanctioned for the attorney fees. As a practical matter, a legitimate attorney would probably not continue in pursuit of such a case. Chairman Anderson rebutted that in his reading of the bill, it seemed to "carry a heavier hammer" than existing law in terms of moving forward than under previous provisions. Mr. Sharp agreed. He added, by providing a judge the inherent authority to regulate the settlement conference stronger results would occur.

Assemblyman Dini asked if there was some standard or guide for filing "in good faith" either in Nevada Revised Statutes or in Nevada case law. Mr. Sharp replied there was no specific standard but judges had experience in trying to resolve cases. When a party did not come to a settlement agreement in good faith, in his experience, the judge levied sanctions with a heavy hand.

Chairman Anderson asked if Section 10 was a bill drafter question and Mr. Sharp agreed.

Mr. Sharp stated A.B. 1, Section 11, was intended to deal with the problem of elimination of the screening panel and implementation of the reform of the bill. Section 11, subsection 1, paragraphs A through C, dealt with the statute of limitations and when it would apply in certain cases. Those cases occurring before October 1, 2002, would be subjected to the old law and those causes of action occurring after October 1, 2002, would be subjected to the new law. He explained that if a doctor committed malpractice on the current date and injured a patient, that case would be considered under the prior law.

Mr. Sharp stated Section 11, subsection 2, made a distinction that no action would be brought excluding certain minor claims more than 3 years after the

commencement of the malpractice. Chairman Anderson anticipated the section was included to avoid a situation of "ex post facto." He explained rules could not be changed one day and made to apply to an event that occurred at an earlier time. He asked what would happen if a person received treatment from a physician in mid-September, the law took effect October 1, 2002, and where that case would fall if, in January 2003, the person decided the treatment he/she received in mid-September caused problems. He asked if it would fall under the new fast-track system or, if the plaintiff found an attorney, would be placed under the review of the medical screening panel.

Mr. Sharp replied it was his understanding that such a case would initially be filed before the screening panel and then once the law changed, that party would have the option of "opting out" of the screening panel. Mr. Sharp stressed that currently a client had 2 years from the point they knew or should have known they were an alleged victim of malpractice and no more than 4 years from the date of the malpractice. He explained traditionally there could be a difference between when an act was committed and when the client discovered they had been an alleged victim of malpractice. The law had always recognized that the statute of limitations did not begin until a person knew they had a cause of action. Currently, if the act of malpractice occurred in 1998 and the person did not find out about it for 5 years they could not bring a cause of action. In Section 11, subsection 2, the bill would reduce the requirement that a complaint be filed no more than 4 years from the date of the malpractice to 3 years.

Mr. Sharp moved to Section 12, subsection 2, that was similar to Section 8. That section set forth the type of medical testimony that could be provided in a courtroom. Section 12, subsection 2, required any expert medical testimony to be given by a provider of medical care who practiced in an area substantially similar to the type of practice engaged in by the defendant at the time of the alleged negligence.

Chairman Anderson asked if Section 12 completed references regarding the screening panel. He asked Mr. Sharp to step away for a few moments to hear testimony from the Nevada Dental Association regarding the screening panel.

Dr. Maury Astley, Executive Director, Nevada Dental Association, testified that the main damage done by A.B. 1 was in Section 35, where the medical screening panel was actually deleted. He expressed appreciation that dentists had been included in the discussions of the medical malpractice issue although they were not currently having the same degree of problems experienced in the remainder of the medical community.

Dr. Astley urged the committee to retain the medical screening panel. He stated about 150 to 200 cases per year went through the medical screening panel and approximately 7 or 8 of those cases were dental in nature.

Dr. Astley stated the dentists felt the screening panel was working for them in preventing frivolous lawsuits and served to direct people to a peer review committee for dentists. He stated many people went to the peer review committee first, although they retained the option of being heard before the medical screening panel. Further, neither members nor patients had complained about the process of the medical screening panel. He requested if it was not feasible for the remainder of the medical community, that the screening panel be retained for dentists.

Chairman Anderson stated he had been very supportive of adding dentists to the screening panel. He asked if the screening panel was deleted, whether the dentists would not still experience the same speedier resolution that it was hoped the legislation would bring to the medical doctors. If not, the matter would appear again before the legislature. Dr. Astley stated he was hopeful that the process would be expedited under the bill for both the patient and the dentist, although dentists preferred retention of the screening panel because it had worked effectively for them.

Assemblyman Beers asked if oral surgeons were affected under the bill provisions. Dr. Astley replied oral surgeons could hold either a medical or dental license dependent somewhat on the kind of work they performed. He added that one insurance company covered most dental practices in the state and that company did offer coverage to oral surgeons if they were operating under their dental license. If they were operating under their medical license, they generally went to a medical malpractice insurer.

Assemblyman Beers asked if oral surgeons would be included in the bill if they operated under their medical license. Dr. Astley replied oral surgeons were covered under the bill in either case.

Assemblywoman Parnell stated she had not been uncomfortable with the language of the bill deleting the screening panel because doctors had stated it did take an extremely long time and added to the expense of a case to go before the screening panel. She asked for clarification that that was not the case where dentists were brought before the screening panel. Dr. Astley replied affirmatively, although he noted dental cases comprised only a small portion of the cases heard. He added in the 3 years he had been part of the association, he had not heard any complaints through the dental association from patients dealing with the screening panel and the peer review committee.

Assemblywoman Parnell concluded she would hope the committee could look at separating the medical and dental entities with regard to the screening panel. Chairman Anderson stated that would be a point for the committee to consider and Dr. Astley offered his assistance in working out a solution.

Chairman Anderson asked if anyone else was present who wished to testify on Sections 7 through 11 of A.B. 1.

Assemblyman Dini asked if dentists would fall equally under the provisions of Section 9 with physicians, regarding settlement conferences. Mr. Sharp stated dental malpractice would be subject to mandatory settlement conferences. Assemblyman Dini noted if the screening panel were abolished, the settlement conferences would still be an additional step for dentists before a case went to court. Mr. Sharp agreed, noting dentists would also be subject to the fast-track system.

Assemblyman Dini asked if the provision of the settlement conferences and the fast-track system would offset the need for the screening panel. Dr. Astley replied it was his understanding that those sections did cover dentists and was preferable to a long malpractice suit. The dentists' experiences were less involved to move through the medical screening panel than to go through a court process.

Chairman Anderson said the clear choice before the committee was that if the screening panel was eliminated in its entirety, then the sections dealing with fast track and settlement hearings would need to clearly apply to dentists as well as physicians. Mr. Sharp agreed. He noted the historical background of the screening panel was for medical malpractice and dental malpractice had been added at a later time. He stated the complete elimination of the screening panel and replacement with the settlement conferences would provide a quick and perhaps less costly resolution for dentists.

Chairman Anderson expressed his feeling that all the committee members were sensitive to the dental issue and whatever the final solution was, it would apply to them. The bill would not expand the medical professions that would have access to the screening panel, but at the same time it was not excluding anyone who currently had access to the panel. Mr. Sharp agreed.

Mr. Sharp returned to explanations of A.B. 1, at Section 12, subsection 2. He explained subsection 2 dealt with the use of expert medical testimony during trial with regard to medical malpractice and was similar to a complaint filing that required an affidavit from an expert in a substantially similar field. There must also be an expert from a substantially similar field when a case went to trial.

Chairman Anderson referred to page 6, line 44, and asked, in light of testimony from the dental association, if dentists were excluded by the use of the term "medical expert" on that line. Ms. Lang replied the section was acceptable because the definition of a provider of medical care included dentists.

Mr. Sharp related Section 13, subsection 3 of A.B. 1, dealt with periodic payments. He explained the law was changed so that at the conclusion of a case the claimant might request periodic payment. He explained when a case proceeded to trial and economic losses were present, typically future losses, an economist would be asked to testify as to the value of the loss and it would then be discounted to a present dollar value. Then the jury would specify an award of the defined present value of the loss. Under the bill, the claimant might request a periodic payment and the court, at its discretion, could order either periodic payment in the form of an annuity or by other means, such as a bond posted by the defendant, to secure the economic loss. The purpose of the change was that if a claimant desired periodic payments, it would protect their ability to recover damages.

Assemblyman Hettrick noted he had been informed at one point that the doctors understood Section 13 of the bill was to allow for requests, with discretion of the court, by either party for periodic payments. He asked for testimony from a physician that they were satisfied with the current form of the Section 13 language. Chairman Anderson responded, Mr. Cotton, an attorney representing the physicians, had chosen to be elsewhere for other matters concerning the proposed legislation.

Assemblyman Beers asked if both houses were hearing the same bill and making amendments to it at the same time. Chairman Anderson responded the Senate was hearing S.B. 2, and the Assembly was hearing A.B. 1, which had both begun with the same language.

Senate Bill 2: Makes various changes related to medical and dental malpractice. (BDR 3-13)

Assemblyman Hettrick stated he had received an e-mail message that the Senate had amended the trauma center section of the bill, which would mean that section of the bill, which had already been voted on, would have to be revisited. While both bills had been drafted the same, as testimony and actions moved forward, both houses were no longer looking at the same bill. He stated that while Mr. Sharp was presenting the bill from what he perceived was agreed-upon language, it was possible the committee would need to go through the bill again with testimony from the doctors indicating agreement. Chairman

Anderson opined that each house was given an exact bill to introduce so that each house could proceed with what they felt was necessary to improve the bill, including a major element of medical error reporting that the Assembly felt was needed. He stated the other option would be the exercise of the legislative power of subpoena, but that would likely delay the process even further. His intent was to go forward with the testimony of Mr. Sharp rather than use the power of subpoena.

Assemblyman Hettrick stated he did not disagree with the Chair regarding review of the Assembly bill, however, he was concerned that without someone representing the physicians present to concur with the testimony being presented, the committee might need to re-hear certain portions of the bill again to assure accord on certain issues.

Assemblyman Dini agreed with the intent of the Chair to hear the Assembly version of the bill and amend it as necessary and move it to the Floor of the Assembly. Then the two bills could begin to be compared and worked toward an accord. The Chair stated it was his desire to provide a forum for everyone who wished to speak on the bill to have an opportunity to do so and ensure the basic questions Assembly members might have on the bill were addressed. He explained Mr. Sharp had been part of a meeting the previous evening with Mr. Bradley and Mr. Cotton to come to agreement on amendatory language. Chairman Anderson asked security staff to contact their counterpart in the Senate to ask one of the attorneys for the physicians to attend the Assembly Committee on Malpractice Issues and express their views. The Chair recessed the committee at 3:46 p.m.

Chairman Anderson reconvened the committee at 4:04 p.m. and stated that some members of the committee had raised concerns regarding the agreed language for Sections 1 through 13 of A.B. 1 was perhaps, not the intent of certain interest groups when the legislation was drafted. He thanked Mr. Sharp for taking the committee through Sections 7 through 13 of the bill. He stated the committee was not trying to foreshadow what might be suggested, but rather, the existing language in front of the committee.

Mr. Gus Flangas, an attorney representing the Physicians' Task Force, introduced himself for the record. The Chair explained there were no suggested language changes in Sections 7, 8, 9, 10, and 11 of the bill. Mr. Flangas replied the Section 7 language was agreed upon with the exception of the fact that there were currently 250 cases before the medical screening panel and they were concerned that 250 cases would be dumped directly into the court system all at one time. It had been suggested in the Senate to stagger the movement of cases by allowing cases filed in a given month to be moved in a

specific month. He gave the example of cases filed with the screening panel in May of 2002 would be moved to the district court system in June and so forth. He added it was not a substantive change of language in the statutes, but simply to aid the court system in handling the influx of cases from the screening panel.

Chairman Anderson stated he had been somewhat concerned about the issue of "ex post facto" and asked if a person had a case already on file, whether that person would have a reasonable expectation that their case would be heard before the medical screening panel. Mr. Flangas replied it was his understanding that a claimant would have that right, however; the claimant would also have a right to "opt out" of the screening panel under the provisions of the bill. Chairman Anderson confirmed a claimant could move to the new fast-track court system or choose to have the case remain in the medical screening panel. Mr. Flangas agreed. The Chair restated the concern of the Physicians' Task Force that the court calendar might be inundated from cases moving from the screening panel. Mr. Flangas agreed and noted allowing a staggered entry of cases into the court system could alleviate the concern.

Mr. Bradley testified if a claimant were to file a claim in the next 4 months with the screening panel and then "opt out" to the court system he was not sure how the situation would be handled. He asked if the claimant would not be allowed to file a case with the screening panel or would the court refuse to handle the case for a while. Chairman Anderson posed his earlier question of Mr. Sharp concerning a claimant who visited his/her physician in a non-emergency on September 20, 2002, and received treatment. As a result of that treatment the claimant had some adverse reaction leading to other complications and to a determination of having had a misdiagnosis. Since the treatment itself had taken place before the effective date of the statute what would the claimant's options then become. He stated testimony led him to believe the claimant would have dual options of either being heard under the medical screening panel or had the choice of moving into the new system of a court hearing. He asked if that was correct.

Mr. Bradley stated if a claimant sought treatment in September 2002, and did not realize an injury had occurred until after the effective date of the statute, and since the cause of action accrued before the effective date of the statute, it was their understanding the claimant could file his/her case with the court, but be heard according to the provisions of law in effect prior to October 2002.

The Chair asked if a claimant had already filed a case, but the panel had yet to meet on the case and the October deadline passed, where the case would go. Mr. Bradley replied the claimant had the option to "opt out" if a case was filed

between the current date and October 2002. The claimant would be required to file with the screening panel and then the claimant would be required to make a decision to "opt out" or go forward with the case before the screening panel. A decision to "opt out" would require the case to be filed in district court and be subject to the fast-track rules, all under the law as it existed currently. If the claimant opted to remain in the screening panel through completion of the case, the claimant would then have 30 days to file an appeal of the screening panel decision, if necessary, with the district court and still proceed under the pre-October 2002 law.

Mr. Bradley stressed the question of accrual of an incident was very important because of the concern with the bill addressing certain retroactivity. He stated his belief that the intent from all sides was not to infringe upon that retroactivity. He added, Mr. Flangas' testimony concerned if a claimant filed between the current time period and the effective date of the statute, there was a proposal to introduce the pending cases in a staggered system to the courts. That would cause some delay in the fast-track system because of the 250 currently pending cases. He stated he was not aware of the intent of the physicians on that issue.

Mr. Flangas stated language was presently being drawn up to address the staggered case option and when that language was finalized he would like to present it to the Assembly committee for consideration.

Chairman Anderson specified A.B. 1 was introduced so that while the Senate was proceeding at its own rate on their bill, S.B. 2, through a Committee of the Whole, the Assembly Committee on Medical Malpractice Issues was dealing with any proposed amendments to the Assembly version of the bill. Therefore, it was important that legal staff be made familiar with any kind of bill draft language that might be suggested. He asked if there was currently agreed-upon amendment language addressing the issue of staggering the cases entering the court system. Mr. Flangas replied he was not the person drafting the language, and that others were writing the draft at the present time.

Assemblyman Oceguera stated he had discussed Section 13 of A.B. 1 with Mr. Sharp during the recess and he would like to relate that discussion to the committee. Chairman Anderson asked him to wait until Assemblyman Hettrick's earlier concerns with Sections 7 through 11 were addressed.

Assemblyman Hettrick restated his concern that the committee should receive assurance that both the NTLA and the physicians agreed to the language of Sections 7 through 11 of A.B. 1. According to Mr. Flangas' testimony there was indeed a change in Section 7 that was forthcoming. He asked if there was

agreement by all the parties to Sections 8, 9, and 11. Section 10 was simply a technical adjustment issue. Mr. Flangas stated the interested parties were jointly discussing amendatory language for Section 7 and a draft would be made available as soon as possible.

Mr. Bradley stated the idea of staggering entrance of the 250 current malpractice cases into the district court system had been broached and seemed to have some merit and discussions were beginning from that point.

Mr. Bradley stated he did have one small amendment to Section 9 that had already been mutually agreed to by all parties. At Section 9, page 4, line 38, the bill discussed those who were mandated to attend a settlement conference. The bill mandated the representative of the physician's or dentist's insurer and their respective attorneys. Language should include "physician's, hospital's, or dentist's." He explained, if a case involved hospital or dental care those entities also needed representation at any settlement hearing.

Chairman Anderson asked the committee if there were any questions regarding Section 12 of the bill and hearing none, asked Mr. Bradley to continue with an explanation of A.B. 1 beginning with Section 13.

Mr. Bradley stated there were no changes proposed to Section 13. The Chair noted Section 13 allowed payments to be made to claimants either in a lump sum or through periodic payments. If periodic payments were authorized they were required to be paid through an annuity or by other means of a defendant posting an adequate bond. He asked if that was fairly close to current procedures and Mr. Bradley confirmed that it was.

Assemblyman Beers stated it was his understanding that the periodic payments would be allowed by either a request of the plaintiff or the defendant and that the physicians had agreed to that intent. He asked if there had been a change. Mr. Bradley stated that had been correct in initial discussions, but the language had been changed to only pertain to the claimant. Assemblyman Beers asked if the physicians had agreed to the change. Mr. Bradley stated they had agreed. Mr. Flangas also concurred on the language.

Assemblyman Brown asked if there were currently jurisdictions where either the plaintiff or defendant could make that request of the court. Mr. Flangas stated he would have to research the answer to that question. He added the state of California provided for periodic payments, but he was unsure whether that was at the request of the defendant, the plaintiff, or whether periodic payments were mandatory. Assemblyman Brown said he would await the answer.

Assemblyman Beers stated presumably if a claimant elected to receive their settlement as a lump sum and lived longer than the actuarial tables, the claimant would actually lose money. If a claimant selected to take the settlement as a periodic payment and lived for a shorter period than the amortization of the actuarial tables, he asked if they would lose that way as well. Mr. Bradley replied if the settlement was taken in a lump sum and invested there might not be a loss.

Assemblyman Beers rebutted with his assumption that actual lump sum settlements were discounted for life expectancy. Mr. Bradley replied when a settlement was projected over time it was discounted to present value and a lump sum awarded. That money, if invested, would grow over time so if the claimant should die before the projected age, the properly invested funds would continue to grow for the heirs.

Assemblyman Beers asked if a claimant elected a periodic payment instead and then expired, whether the settlement would continue to be paid to the heirs. Mr. Bradley replied guaranteed payments allowed continuation of the payments.

Chairman Anderson referred Assemblyman Brown to Volume 2 of the background material submitted to the committee on July 29, 2002 (Exhibit K), for an amendment to his earlier question. He noted behind the National Conference of State Legislature tab on page 128, it listed the mandatory periodic payments required in various states. He noted the document contained a breakdown of mandatory, discretionary, and main disbursements.

Mr. Bradley stressed Section 13 of the bill was not really discussed between the parties when the bill was being put together. It was a section Governor Guinn had requested and felt very strongly about.

Assemblyman Brown asked how attorney's fees were paid in a malpractice settlement. Mr. Bradley responded the attorney could elect to have their fees paid before the remainder of a settlement was used to purchase an annuity. Assemblyman Brown asked what happened in a bonded situation. Mr. Bradley noted in that case, attorney fees would be addressed as they were currently being done – based on the contingency fee contract – would be paid, and the plaintiff would receive the remainder of the award through a bond.

Mr. Bradley stated Section 14 of A.B. 1, contained a requirement that in odd numbered years for information to be provided from the clerks of the courts to the court administrator and ultimately to the director of the Legislative Counsel Bureau on the aggregate information compiled on such cases. Chairman Anderson confirmed the information would be reported as an aggregate number.

Chairman Anderson acknowledged there were some concerns about the reporting requirements and Mr. Bradley agreed.

Mr. Bradley explained Section 15 was a section that the Governor regarded emphatically. It required that district court judges receive appropriate mandatory training in the area of medical malpractice litigation. There had been no disagreement on the language.

Assemblyman John Carpenter, Assembly District 33, testified regarding concerns related to Section 15 of the bill. The Chair asked that his testimony be recorded verbatim.

> I have some concerns in regard to the mandatory training for district court judges. In the rural areas, in some of the districts there is only one judge and in many of the rural districts there were only two. I do not know whether all the judges would go to training or whether there was a medical malpractice trial only once every 2 or 3 years. It could work a burden on the judges if they had not been to the training and they would have to bring another judge in who had the training or it went to the situation where hopefully a trial was held before the judge that the person voted for and elected.
>
> I don't know how this could get changed. I guess I could see the reasoning where there was a family court judge experienced in that; or whether there would be a circuit rider judge to go around the rural areas to handle such cases.

Chairman Anderson stated he believed the current practice was for new judges to go through a level of training. He requested Ms. Lang to explain further.

Risa Lang, Principal Deputy Legislative Counsel, explained Section 15 required the Supreme Court, by rule, to mandate appropriate training so the language would allow the Supreme Court to make any adjustments necessary for the rural judges. The bill did not actually dictate what training had to be provided or how many hours or how often training was mandated. It only told the Supreme Court that the legislature wanted some type of training for judges hearing medical malpractice cases.

Assemblyman Carpenter stated:

> The bill stated there was a rule for mandatory appropriate

> training for each district judge whose actions involved medical malpractice. I don't know how much would be involved. If it was a couple days or something, that would be no problem, but if it was a lengthy training situation, it might present some problems in the rural area. Hopefully the bill would give the court discretion to have the training so that it worked in all areas.

Chairman Anderson acknowledged the problem in rural areas and suggested there was an equally large problem in Clark County, where there were 16 judges or more and where the majority of such cases were filed. They would need to be prepared to handle the cases. He felt the Supreme Court would consider the specific circumstances involved in its court rule.

Mr. Bradley explained Section 16 of A.B. 1. He noted many years previous the trial lawyers had sponsored a bill that was passed and was called, "The Lawyer Pays." That bill provided if a lawyer engaged in a vexatious or frivolous filing or defense of such an action, the court could find the lawyer for either side personally responsible for fees and costs of trial. A.B. 1 strengthened the law to change "that the court may sanction" to "the court shall sanction." He noted all parties agreed on the language.

Chairman Anderson confirmed the intent of the section was to mandate the finding against attorneys and stressed mandatory language was a big issue with certain judges.

Mr. Bradley requested that Sections 18, 19, 20, and 21 be briefed together. The Chair asked for clarification of whether Mr. Bradley was suggesting the committee take a vote on those sections. Mr. Bradley replied he would like to cover the explanation of the sections together because they were brief and there were no proposed changes to the language. The Chair concurred after a poll of the committee.

Mr. Bradley apologized, stating there was one small change in Section 18. He explained Section 18 was a new requirement for physicians and dentists licensed pursuant to NRS Chapter 630 forbidding practice of their profession without liability insurance limits of $1 million per person. At page 10, line 25, the word "person" should be changed to "occurrence." Line 26 read "per occurrence." The word "occurrence" would be deleted and replaced by the words "in the aggregate." Mr. Bradley explained both of those changes mimicked language used in a professional liability policy.

Mr. Bradley said the same changes would need to be made in Section 25, lines 40 and 41, and also in Section 27, lines 47 and 48.

Assemblyman Beers posed a question regarding Sections 18 and 25. He noted in Section 1, page 2, line 14, the bill talked about professionals licensed under Chapters 630, 631, or 633 of NRS. Section 18 talked about those licensed under NRS Chapter 630. Section 25 talked about those licensed under NRS Chapter 631 and asked if Section 27 needed to be changed as well. Mr. Bradley explained the changes only made the same requirements for doctors, dentists, and osteopaths. Assemblyman Beers confirmed that the same changes were needed at Section 27, lines 47 and 48. Mr. Bradley agreed.

Mr. Bradley stated Section 19 contained the reporting requirements where the Nevada State Board of Medical Examiners shall be reporting information regarding disciplinary actions against physicians. A report would be made in each odd-numbered year to the Legislative Counsel Bureau. The language would increase confidentiality of information about individual claims. He opined the concern could be worked out very easily. He added, he did not feel it was ever the intent to prevent access to the Nevada State Board of Medical Examiners information to learn about a particular physician's claims history as was made available under current practices.

Chairman Anderson asked if Section 19 was the area in which Assemblywoman Koivisto had concerns. He suggested the committee continue its review of Section 19 before amendments were proposed.

Mr. Bradley testified that Section 20 of A.B. 1 required holders of a license to practice medicine to submit a list of all actions filed or claims submitted to arbitration or mediation for malpractice or negligence against them during the past 2 years.

The Chair called witnesses to the table who had concerns regarding Section 19 of the bill.

Mr. Edward Goodrich, representing himself, provided his background to the committee. He was neither a doctor nor a lawyer. He explained he was the son of a general surgeon and although there were many superb doctors in the world; as he was growing up he heard about lawyers and malpractice suits every day at the dinner table and the pain it caused physicians. He also heard and witnessed how the medical community converged and protected each other when threatened with litigation.

Mr. Goodrich testified that as an adult he personally experienced a malpractice situation. He went to a hospital with chest pains. His electrocardiogram was normal. A blood enzyme test was not run and his doctor diagnosed indigestion

and sent him home. He explained he was sick for 3 or 4 days. Later, at his annual physical, his doctor told him he had had a major heart attack. Subsequent examination revealed that he was approximately 50 percent disabled because of his heart. He also had an aneurysm (ballooning of the left ventricle) and if that burst he would die within a few minutes.

Mr. Goodrich explained he chose not to file a malpractice suit because he was comfortable in the knowledge that, should he file a suit, he would not necessarily get the care he needed in the future. He would be refused treatment.

Mr. Goodrich said that in his reveiw of A.B. 1 and hearing committee members express their desire to get to the heart of the crisis, he suggested the heart of the crisis was not necessarily establishment of limits on noneconomic damages. He noted the bill required a finding by a jury that a case represented "real" malpractice. He added that meant a doctor made an error, either by their action or their lack of action, and left someone grievously disabled in some manner for the rest of their lives. Mr. Goodrich opined the medical community, in an effort to protect their own, let such errors go unpunished, leaving it for a jury to determine punishment and discipline.

To appropriately consider noneconomic limits the legislature needed to get to the root of the problem. It was his opinion that medical peer review boards did not have enough authority, incentive, or power to effectively police poorly performing doctors. He suggested all other problems under consideration by the legislature branched from that root issue. He asked the committee to consider the establishment of, or changing the licensing board into, a medical peer review board that had real authority to suspend or deny any doctor the practice of medicine while they were under investigation, the subpoena power to obtain records from other cases, and give the board the incentive to effectively police the profession, much as Congress had made heads of companies responsible for their actions recently. He stated peer review boards were basically a governing and quality assurance authority. He added, if the legislature could establish effective policing of the profession, then a balance would be struck between the competing interests in terms of noneconomic damages. He concluded, if there were less "bad" doctors in the profession, then there would be less pressure for lawsuits and noneconomic limits.

Chairman Anderson acknowledged Mr. Goodrich's position and stated he was looking forward to some of the potential whistleblower protections and medical reporting questions Assemblywoman Koivisto had sponsored in previous legislative sessions and had hoped would move across to the current bill.

Chairman Anderson asked Mr. Bradley to confirm Section 21 contained deletion language and Mr. Bradley agreed.

Mr. Bradley testified Section 22 of A.B. 1 contained reporting requirements for the insurers of malpractice and that of physicians to report actions filed and claims submitted to arbitration or mediation within 30 days after the disposition of the action or claim. He noted current law established no time frame. The section ensured that before information was forgotten or became stale, it was forwarded to the appropriate collecting agency.

Chairman Anderson noted the section also established a penalty against an insurer who failed to submit the required report. Mr. Bradley agreed. Mr. Flangas was in accord.

Mr. Bradley explained Section 23 would speed up the reporting to the Nevada State Board of Medical Examiners for a medical facility or school who became aware of a person who had become engaged in conduct that would entail a disciplinary action. He added current law established no time frame and the bill would require a time limit for reporting of 30 days from the time a person became aware of such actions.

Mr. Bradley stated Section 23, subsection 2, established the same requirement when a physician's privileges had been changed in some way. Failure to report would result in a $10,000 fine. Subsection 4 would maintain the confidentiality regarding any disciplinary action taken unless it was released by order of a subpoena. The Chair noted it also mandated the 45 day time limit that the court clerk had to report to the medical board. Mr. Bradley stated the section required a written report to the office of the court administrator. Mr. Bradley reminded the committee, better information had been obtained from the court clerks in recent history and the bill provision simply ensured the information would be kept in a safe place where it was easily accessed.

The Chair asked if Section 24 removed the medical screening panel. Mr. Bradley replied Section 24 did not delete the panel; it only deleted certain language arising from the screening panel. He added removal of the panel was further on in the bill. The Chair confirmed Section 24 was not a substantive change, but a technical change relative to the screening panel. Mr. Bradley agreed.

Mr. Bradley informed the committee that Sections 25, 26, and 27 of A.B. 1 had already been discussed. Chairman Anderson noted Section 25 required dentists to carry malpractice insurance in the amounts of $1 million and $3 million and asked if dentists were currently required to carry those amounts. Mr. Flangas

replied dentists were currently required to carry those amounts. The Chair asked if the provisions would cause the dentists to increase their coverage. Mr. Bradley replied agreement on the section was present when testimony was given before the Senate, but at the present time there was not agreement on the language of Section 25 in A.B. 1. Mr. Flangas noted there was currently not an agreement on Sections 18, 25, and 27, which all addressed the limits of malpractice coverage required.

Chairman Anderson asked Mr. Bradley to explain the nature of the disagreement over the language of the three sections. Mr. Bradley replied the physicians believed they should not be mandated to carry malpractice insurance. Mr. Flangas agreed.

Chairman Anderson asked for clarification of the matter as it was handled under current law. Mr. Bradley replied that current law did not mandate the carrying of malpractice insurance. Those sections of the bill contained information submitted by the Governor and agreed upon in the Senate hearing of their bill. He added he had recently been notified that agreement no longer existed.

Assemblyman Dini asked what percentage of physicians did not carry malpractice insurance. Mr. Flangas stated he did not currently have that statistic. Mr. Bradley stated, based on his experience, the issue was not so much the percentage, but the inequity that those not covered worked upon the physicians who did carry coverage. When two doctors were involved in the negligent care of a patient and one carried malpractice insurance and the other did not because the "bad" physician did not have coverage, the financial burden fell on the good physician. He added, the logic behind the agreement in the Senate was that the provision would actually help protect "good" physicians.

Assemblyman Dini asked how a doctor could afford not to carry malpractice insurance if he had any cases and "how many 'dummy' corporations a doctor had to set up to avoid their responsibility." Mr. Flangas replied, with all due respect, he did not believe doctors were setting up "dummy" corporations to avoid their obligations as a physician; in fact, it would run contrary to the law, because a corporation could not be established to avoid possible malpractice. He added most doctors, if not all, did carry malpractice insurance and carried limits as high as they could afford. He explained the current disagreement from the physicians was they did not want to be mandated by law to carry such policies because of the present state of the insurance system. Setting of a minimum figure for insurance policies, with the present state of malpractice premiums, could cause doctors who had a claim against them to possibly not be able to afford $1 million and $3 million coverage.

Mr. Bradley added that when a physician applied for privileges at any of the hospitals he was aware of, the hospital privilege requirements included a provision that the physician maintain medical malpractice insurance in the amounts referenced in the bill.

Assemblyman Dini noted any physicians in the rural areas of the state, in his experience, who did not carry malpractice coverage, were those who did not stay around very long. Mr. Bradley agreed and added it was unfortunate that those doctors were the ones who hurt the good doctors.

Chairman Anderson asked if it was true that the three trauma centers in the state required their doctors to carry insurance as a part of their privileges. Mr. Bradley agreed. The Chair noted not all the doctors working in trauma centers were medical doctors; some were osteopathic physicians. Mr. Bradley replied all the physicians who worked in a trauma center typically had privileges, and if privileges were granted they were required to maintain insurance coverage. The Chair concluded the number of physicians who did not carry malpractice insurance would be a very small percentage.

Chairman Anderson asked if there was concern stemming from the rising cost of malpractice insurance, in which some physicians would be caught without availability of an insurance carrier for a window of time. Mr. Flangas replied the issue was not the availability of an insurance provider; rather it was the amount of insurance specified. The Chair asked if the $1 million requirement was the issue and Mr. Flangas agreed.

Mr. Bradley continued his explanation of Section 28 of A.B. 1, which contained a reporting requirement from the Nevada State Board of Medical Examiners to the Governor and the director of the Legislative Counsel Bureau. It required reports of disciplinary actions taken against osteopaths. He added, all the sections dealing with reporting language were intended to ensure the requirements were the same for osteopaths and medical physicians. He noted Sections 28, 29, 30, and 31 repeated the earlier sections for physicians and included the same fines.

Chairman Anderson noted Assemblyman Manendo had been out of the room and had concerns regarding Sections 25 and 27. He informed Assemblyman Manendo the language in those sections had suggested amendments to agree with the language changes in Section 18 of the bill.

Assemblyman Manendo asked for clarification in Sections 25 and 27; that the language was changed to, "per occurrence." Mr. Bradley replied the language was changed to "per occurrence" and "in the aggregate" respectively.

Mr. Bradley noted while he was testifying before the committee on the reporting requirements, the representatives of the Nevada State Board of Medical Examiners were testifying in the Senate on some procedural issues that needed to be addressed regarding reporting requirements.

Mr. Bradley testified that Section 32 addressed potential grounds for disciplinary action by expanding the list to include failure to comply with the reporting requirements.

Section 33 cleaned up the language from Section 29 dealing with insurers reporting settlements to the Nevada State Board of Examiners.

Chairman Anderson noted the executive director and the general counsel of the Nevada State Board of Medical Examiners had just arrived.

Mr. Larry Leslie, Executive Director, Nevada State Board of Medical Examiners, introduced Mr. Richard LeGarza, General Counsel for the board, and Dr. Paul Stewart, Secretary-Treasurer of the board.

The Chair explained the committee was reviewing Sections 29, 30, and 31 of A.B. 1 that established some medical reporting requirements over which it was thought there were some concerns by the physicians.

Mr. Leslie testified the board had no problems with any of the reporting provisions and, in fact, were in favor of the reporting provisions. The Chair said it had been his understanding perhaps some additional language was needed in those sections to ensure the board was getting the information necessary in a timely fashion. Mr. Leslie replied the only recommendation made in the Senate had been to allow the courts to report the filing of medical malpractice issues to the board immediately instead of the 30 days specified in the bills. He reported there appeared to be no appetite for that change in the Senate and the board felt the other reporting requirements actually strengthened the position of the board regarding discipline of physicians.

Mr. Richard LeGarza, General Counsel, Nevada State Board of Medical Examiners, testified regarding Section 23 of A.B. 1. He noted subsection 3, paragraph E, required the court to report a physician who was found liable for malpractice or negligence to the board within 45 days. Chairman Anderson confirmed he was referring to page 13, lines 6 and 7. Mr. LeGarza agreed and noted the suggestion made in the Senate related to their understanding of the intent of the reporting requirements was to provide information to the Nevada State Board of Medical Examiners as soon as possible. He noted the court

reporting requirement was to occur after a judgment had been rendered and there had been a finding and specified that time frame would already occur approximately 4 years after the actual occurrence of malpractice or negligence. The board's suggestion to the Senate had been to require the courts to report to the board within 45 days of the filing of a case for causative action. A similar requirement was already in place for the insurers and the physicians. The Chair noted the draft amendment might address those issues.

Mr. Leslie reported the board had some input they wished to supply for Section 18 of the bill and the Chair responded that section had already been reviewed, but it might be revisited.

Mr. Sharp, representing the NTLA, explained Section 34 of A.B. 1 simply extended the reporting requirements to osteopaths. He added the requirement addressed the insurance companies. The Chair confirmed that section mirrored current law and Mr. Sharp replied it simply added osteopaths to existing requirements.

Mr. Sharp stated Section 35 repealed the medical screening panel. Chairman Anderson confirmed that was the section that actually removed the screening panel and provisions were made relative to the stepped-in requirements earlier in the bill. Mr. Sharp agreed.

Mr. Sharp said Section 36 specified Sections 1 through 6 of the act applied to a cause of action arising after October 1, 2002.

Section 38 specified the election process regarding plaintiffs "opting in or out" of the panel. The Chair noted the final section specified the bill would become effective October 1, 2002, and Mr. Sharp agreed.

Chairman Anderson recessed the committee at 5:25 p.m. and reconvened at 5:52 p.m. He announced he wanted to afford the same opportunities to any members of the Assembly that had been afforded to Assemblyman Carpenter to place their comments regarding the bill on record.

Assemblywoman Sharron Angle, Assembly District 29, testified concerning tort reform. She expressed her support of tort reform for physicians and added she had heard from the public that tort reform was needed in other areas as well. She stated some of those who had approached her included scuba diving instructors, operators of businesses such as Port of Subs, and contractors in the building industry.

She expressed her hope that A.B. 1 would be just the beginning of real reform in Nevada litigation. Chairman Anderson agreed that we all lived in a litigious society. He added "carpe diem" or the theory of "let the buyer beware," was always one of the issues when dealing with tort.

Chairman Anderson stressed when people dealt with a doctor, it was usually from a position of great trust and everyone expected "A+" care because of that trust. While doctors might only need to perform at a "C+" level in the legal arena, the patients who placed their lives in the hands of doctors expected the very best.

Mr. Bradley referred to Exhibit H, which comprised a packet of newspaper articles and requested permission to read a few quotes from the exhibit. The Chair stated as a part of the exhibit they would become a part of the record.

Chairman Anderson supplied a proposed amendment to A.B. 1 (Exhibit L) and introduced Assemblywoman Koivisto as the sponsor of the amendment. He explained she had chaired the Assembly Health and Human Services Committee in the Seventy-First Legislative Session. He asked her to brief the committee on the proposed amendment.

Assemblywoman Ellen Koivisto, Assembly District 14, explained the proposed amendment was modeled after the medical errors reporting system that had become effective in March 2002, in Pennsylvania. Testimony before the present committee had indicated a need for a medical errors reporting system. The Bureau of Licensure and Certification was unable to assess whether a medical error problem existed in Nevada because they had no data. No agency or system in the state identified and tracked medical errors or adverse events.

Assemblywoman Koivisto stated in September 2000, the National Summit on Medical Errors and Patient Safety, along with testimony from the consumer perspective indicated the healthcare system was uncoordinated, confusing, and potentially dangerous. One consumer recommendation from the summit was to examine how consumers were informed of a responsibility to report medical errors and whether regulating agencies even understood their own responsibilities. It also defined the ethical responsibility and accountability of hospitals to patients who were victims of medical errors.

She continued, it was stated and emphasized in the Institute of Medicine Report that most medical errors were system errors, not attributed to individual negligence or misconduct. It suggested the key to reducing errors was to focus on systems of delivering care and not blame individuals. System improvements could reduce error rates. Research from the Agency for Healthcare Research

and Quality documented the rate of healthcare errors was far higher than the error rate in other industries.

Assemblywoman Koivisto testified errors occurred due to poor system design and organizational factors similar to any other industry. Healthcare workers were placed in systems and settings where errors were bound to happen. Systems were designed to achieve a particular set of goals that inadvertently produced a certain level of errors. She explained healthcare workers were sometimes expected to work 24-hour shifts to ensure patients were cared for and received a continuity of care.

She stated the awareness of the problem of medical errors and any subsequent solutions must be improved not only among physicians, nurses, pharmacists, dentists, and other healthcare providers but also among patients, policy makers, and many other stakeholders of the healthcare community. She suggested a cultural change needed to take place to allow the stakeholders to talk about errors and recognize that errors were mostly a part of faulty systems and system designs, not individual failures.

Assemblywoman Koivisto stressed the public expected and had a right to information that would demonstrate the healthcare delivery system was as safe as possible. Data and information was needed in support of efforts to learn why errors occurred and what changes would help to prevent them. Both needs could only be met through the development of an effective data collection system.

Assemblywoman Koivisto explained portions of the amendment, (Exhibit L) beginning at page 9. She stated it provided any report or information was made available only in an aggregate format and would not identify a specific person or medical facility. Any report, recommendation, or other information was not admissible in evidence during any administrative or legal proceeding.

Section 41, Page 12 specified no person was subject to any criminal penalty or civil liability for liable, slander, or any similar cause of action in tort, if they, without malice, reported an incident or serious event. She added, the language of the remainder of the reporting requirements followed that provision.

Assemblywoman Koivisto stated people who reported incidents, or whistleblowers, were protected against retaliation in subsection 2, page 14. A person who reported an incident and was retaliated against also had the right to report the retaliation.

She suggested the committee would hear the protections were unnecessary because facilities already reported to the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). She acknowledged that was true, because facilities that provided Medicare and Medicaid services had to be accredited under JCAHO. However, JCAHO had a voluntary form of self-regulation for which hospitals paid a fee. The reporting system required in the proposed amendment to A.B. 1 would be a mandatory reporting system.

She asked the committee to consider that since 1995, JCAHO had reviewed reports of 1,745 sentinel events from nearly 5,000 hospitals accredited by them. In comparison, the New York mandatory system received more than 21,000 reports in year 2000 alone. Assemblywoman Koivisto said mandatory systems were intended to assist states in fulfilling their legal responsibilities for facility licensure and oversight. The public looked to government to ensure the healthcare system took necessary steps to assure care safety. She suggested states had already yielded considerable oversight by accepting JCAHO accreditation surveys as full or partial compliance with state licensure requirements. She added, reporting provided states an important window into hospital patient safety activities and system weaknesses they might not otherwise have.

Assemblywoman Koivisto stressed medical error reporting should not be, and in the amendment, was not, a punitive system. She added the purpose of medical error reporting was to find where problems existed in the system and fix them so errors did not reoccur. Reporting was a patient safety issue.

Chairman Anderson reiterated his desire to allow opportunity for anyone with a desire to do so, to appear before the committee.

He noted the Legislative Counsel Bureau, Legal Division, had provided the committee with copies of "A Breakdown of Medical Error Provisions" (Exhibit M).

Assemblywoman Buckley told the committee that when the Governor and the Majority Leaders from the Senate and the Assembly were creating the template for the legislature to consider, their discussions included the fact that the prevention of medical errors was an important component of any piece of legislation that might be passed. Everyone had agreed the Pennsylvania model of error reporting, in his or her opinion, was the best model to follow. She added a few hospitals had indicated concerns with the whole system of medical error reporting and that they would like certain aspects changed. Leadership had agreed to try to work with the representatives to somewhat modify the requirements. Everyone felt if medical errors were prevented malpractice

insurance premiums would be greatly reduced.

Chairman Anderson concurred that in the interest of public safety, medical error reporting and prevention were clearly important. He noted Assemblywoman Koivisto had indicated representatives of the Nevada Nurses' Association had testimony in support of the amendment regarding whistleblower provisions they wanted to place on the record.

Ms. Lisa Black, representing the Nevada Nurses' Association, presented what her organization felt were key points of the protections. She stated it was imperative for some type of medical error reporting system in Nevada to identify system failures that contributed to medical errors in the care environment. The Nevada Nurses' Association wholeheartedly supported the bill as written.

Ms. Black stated one concern was that whatever reporting system was established, it must provide protections for those who reported medical errors. She explained that as much as whistleblowers were perhaps not politically correct if healthcare workers who reported errors did not have protection, errors would simply not be reported. She added A.B. 1 included fairly significant protections for those who did report errors.

In terms of follow up, one important point in the bill was that through the central repository created, employees who reported errors would be ensured protection. It could be said that retaliatory action was not allowed, but the bill would provide a mechanism to determine if retaliatory action had taken place. It would also help determine if healthcare workers were being sanctioned in terms of licensure because they had reported an error. Also, and most importantly, follow up would determine if the healthcare worker who reported an error had seen any remediation to reduce that error.

She noted there had been some discussions on whether there would actually be a central repository or whether the agency reported to would fall under another existing agency or board. The association felt strongly that the unit created should be a completely separate entity from any already in existence.

Chairman Anderson stated, in terms of supporting the record, if Ms. Black had written testimony it should be submitted very soon. He directed the secretary to leave the record open for the written testimony of Ms. Black, which was submitted later in the day as Exhibit N.

Ms. Carin Ralls, Operators' Union 3 and a registered nurse, expressed the union's support of the amendment to A.B. 1. Medical errors did need to be reported without the fear of retaliation. Nurses would not have to consider their

livelihood before making a report.

Mr. Bill Welch, President and Chief Executive Officer, Nevada Hospital Association, testified the association had not had an opportunity to completely review the amendment. They hoped to find some collaborative language that would address the issues raised by Assemblywoman Koivisto, as well as those of the hospital community.

Mr. Welch expressed concern regarding:

- Compromising the confidentiality process within a hospital setting;
- Potential compromise of the peer review process which hampered the hospital's ability from a risk management standpoint;
- The proposal was duplicative of the current voluntary and mandatory reporting processes; and
- The proposal was extremely costly, not only for the healthcare community and organizations, but for state agencies that would be tasked with additional oversight authority.

Mr. Welch related testimony had indicated the reporting requirements were important in the reduction of medical error occurrences; however, in testimony in interim committees, studies from a number of states with mandatory medical error reporting were presented. He had asked questions and conducted research to attempt to determine what medical error mandatory reporting systems had done to reduce the occurrence of medical error incidents. He had not found any study indicating mandatory reporting measurably reduced the occurrence of medical errors.

Mr. Welch stated that finding led to a discussion of cost versus benefit. He said the committee should recognize that the requirements would produce a costly process that would be borne by all entities, including the patients. He questioned the ultimate value of the requirements. Hospitals were very concerned about the quality of care and the safety of patients in their facilities. Testimony in prior legislative sessions and during interim studies had addressed the concern.

Mr. Welch offered to provide his written testimony and a summary of testimony that had been presented over the previous 6 months on the mandatory medical error reporting issue. He stated the overall testimony demonstrated the voluntary reporting processes already in place in hospitals were intended to attempt assurance of safe, quality patient care. He offered to provide copies of the forms used, the policies and procedures, the studies

developed, and the plans for correction developed from the process. He acknowledged time would not likely permit legislators to do a thorough review of the material, but expressed the hope it could be scanned before final decisions were made. The documents were later provided as Exhibit O.

Mr. Welch stated as testimony was presented to the interim subcommittee, the subcommittee reached the conclusion that mandatory reports did not demonstrate a measurable value for Nevada. However, understanding that issues and concerns had continued to be raised, he stated the association had, over the past 24 hours, tried to gather representatives from the entire hospital community to develop language they could work with. Discussions had led to almost agreed-upon language, however, the bill and amendment presented to the committee was far more extensive than the association had been led to believe so he was not prepared at the present to provide any specific amendments. The format they had used was different than that which had been presented to the committee.

Mr. Welch explained that those involved in the discussion group had not been aware of certain components presented to the committee. He stressed their group would continue to work on an accord document to find a reasonable middle ground. He assured the committee the Nevada Hospital Association was equally, if not more, concerned about safe, quality care because they would ultimately be the ones held responsible if that care was not present.

Chairman Anderson expressed his appreciation of the hard work Mr. Welch and those he represented, including the rural areas, were doing to review the reporting and medical error questions. He concurred with Assemblywoman Buckley's comments on the proposed amendment before the committee. He noted he had heard earlier testimony on the question in another committee, he had similar concerns, and had been approached by several individuals who questioned whether the Nevada State Board of Medical Examiners and the reporting requirements were sufficient to guarantee patients quality care.

Mr. Welch replied the members of his group were working on proposed language and would continue to do so and return with their proposals for the committee. Chairman Anderson acknowledged the Chair would leave the record open for Mr. Welch to submit materials to be included in the record up through 10 a.m. the following morning. Documents were submitted on the morning of July 31, 2002, and included in the record as Exhibit P.

The Chair opened the hearing for committee questions of Assemblywoman Koivisto.

Assemblyman Hettrick asked how long the Pennsylvania model of reporting had been in effect. Assemblywoman Koivisto replied the Pennsylvania bill was passed in March 2002.

Assemblyman Hettrick referred to the amendment (Exhibit L), page 3, Section 30, subsection 3, which stated, "The administrator shall prescribe . . ." He asked who the administrator was employed by. He asked if it was the administrator of the repository, the administrator of the Nevada Board of Medical Examiners, the Health Patient Safety Office, or to whom the section referred. Assemblywoman Koivisto replied it was her understanding the administrator would probably be the administrator of the repository.

Assemblyman Hettrick stated the question was not a major point until he read Exhibit L, Section 32, subsection 4, page 5, where it stated, "The administrator determines necessary . . ." Section 3 stated, "The repository shall . . ." and he asked how the administrator was determined to be qualified to require certain reporting.

Assemblywoman Koivisto stated the amendment required the administrator of the Health Division, Department of Human Resources (DHR), to prescribe the method of notification. Assemblyman Hettrick said he presumed that meant the administrator worked for the Health Division, DHR. He asked if the amendment would depend on regulation to assure the administrator was qualified to perform some of the required duties such as determining necessary or advisable provisions of additional services. The amendment stated the repository "shall" conduct an evaluation of the recommendations. He noted the amendment did not identify whom in the repository would be responsible for conducting an evaluation of the recommendations. The Chair stated that portion of the amendment was cross-referenced to Section 35 of A.B. 1, which dealt with those specifications.

Assemblywoman Buckley explained, as had been stated by Assemblywoman Koivisto, the LCB Legal Division had designed the amendment to be similar to the Pennsylvania legislation. The intent was for the administrator of the Health Division, DHR, to establish the guidelines and contract out duties. She noted the "Medical Error Provision Summary" (Exhibit M), Section 32, page 2, required the Health Division, DHR, to contract with impartial persons, probably using a regulation process and possibly a request for proposal (RFP) to ensure that the body was independent and possessed the proper qualifications to conduct the determinations.

Assemblywoman Buckley further explained, the intent was rather than create a whole new state bureaucracy, the requirements would be contracted out.

She noted a comparison of the Pennsylvania statutes used the term "authority" because that term was heavily used in the East. The term "repository" was used more often in Nevada statutes.

Assemblyman Hettrick agreed the process would likely be established through regulation and reiterated that in Section 38, subsection 2, page 9, of the amendment to A.B. 1, it stated, "The administrator, by regulation, shall prescribe the contents of a patient safety plan." The draft did not address what qualifications would be required of the administrator.

Assemblyman Hettrick stated he had some concern for the definition of the term, "incident," and he would like to see that tightened up to be clearer than stating, " . . . cause the patient to suffer an unanticipated injury." The current language seemed to require the reporting of even very minor events. His concern was that the terminology was so broad a person could be accused of not reporting an incident. Also, some of the reporting under the current language would be so meaningless that it would simply make "busy work." He stressed the amendment had some potential, but it needed to be tightened up as much as possible.

Chairman Anderson remarked he had heard discussions of the amendatory language previously, and the idea that made the most sense to him was that workplace safety needed to become a standard without being a threat; thus, a reporting requirement that was not threatening to the reporter was absolutely essential. Also, the "near misses" of those things that were medically harmful were in the same category and increased the possibility for the elimination of some of the medical errors that happened.

The Chair stressed if a system only required reporting of those incidents that were serious, the process moved from being proactive to reactive. He suggested the most beneficial effect of the amendment was that it was a proactive piece of legislation for public safety.

Chairman Anderson called the physicians in the audience to the witness table.

Dr. Curtis Brown, Physician, testified he was a third generation Nevadan and was board certified in Emergency Medicine and worked at Washoe Regional Medical Center. He related that testimony throughout the day had indicated the crisis was primarily in southern Nevada and from his viewpoint that was not the case.

Dr. Brown testified Washoe Regional Medical Center would see approximately 70,000 patients through their Emergency Department in 2002. When he first

started, approximately 11 years previous, the department saw about 55,000 patients.

Dr. Brown stated the malpractice insurance premium for his group of doctors increased 130 percent in the current year. The previous year's policy included a zero deductible provision and to keep the group's rate within 130 percent of the previous year's premium they had to accept a $125,000 deductible. He explained his group had a very good insurance rating with no catastrophic cases in the $8 to $10 million range. He noted his group included 14 full-time equivalent physicians. He concluded his testimony stating the things happening in Las Vegas were happening in Reno as well.

Assemblyman Beers asked when Dr. Brown's group had found out about the 130 percent increase in their malpractice premium. Dr. Brown explained the group had belonged to the St. Paul Insurance Company and when they no longer insured within Nevada, the group started looking for new coverage, knowing their premiums would likely be higher. He stated there were not many companies to choose from and the options for his group were either to move out of state, or find someone to insure them.

Assemblyman Beers asked in what time period the group had known about the increase in their premiums. Dr. Brown replied the group had changed insurance companies in March 2002.

Dr. Paul Stumpf, a General Surgeon, testified he had practiced in Reno for the past 8 years and was both board certified by the American Board of Surgery and by the American College of Surgeons. He concurred with Dr. Brown that a problem existed in northern Nevada, as well as southern Nevada.

Dr. Stumpf stated in 2001 his malpractice insurance premium was $21,000 per year for $2 million/$5 million policy. As of 2002, the carrier, Interstate Insurance Company, a smaller company, informed his group they were also leaving the state in the early spring. The group had to locate another carrier in a short period of time and their current malpractice insurance premium was $57,000 for each partner in the group – a rate increase of 150 percent. The new policy only carried $1 million/$3 million limits with a $50,000 deductible. For his 10-member group the total premium was over $375,000 per year, not including each physician's need to hold $50,000 for the deductible to cover them in case a suit was brought against them.

Assemblywoman Parnell asked Dr. Stumpf if his group had received a quote at that point in time from the Nevada medical liability group that had just been created. Dr. Stumpf replied the group had researched the new agency and

felt there was some question about how it would be put into effect; and with issues about the risk pool being generated they elected not to access that option. Additionally, because there were several pending malpractice claims within the group, they had to beg for a company to insure them. Eventually, through the urging of their insurance agent, their insurance company had agreed to the new rate.

Assemblywoman Parnell asked again whether Dr. Stumpf's group had ever requested a quote from the state liability group and Dr. Stumpf replied they had not.

The Chair expressed appreciation for the witnesses who spent the entire day in the audience of the committee and acknowledged their time came at a great sacrifice. Also, he appreciated the profession they served and their dedication to their patients.

Assemblywoman Buckley stated legislators had been studying the relationship between some of the increased rates from new insurers against claims history, once the St. Paul Company had ceased coverage in Nevada. She asked if either of the witnesses had malpractice claims against them personally that might have caused the new premium quotes to skyrocket. Dr. Stumpf replied he had no claims against him personally, but because he belonged to a 10-member group who covered each other's patients they received their rate based on the entire group.

Assemblywoman Buckley asked if his reply meant there were other claims against other members in the group. Dr. Stumpf replied there were pending claims, but no settlements had been made.

Dr. Brown stated the claims factor had not affected the rates of his group, because they had no outstanding large claims against them at the time, nor had they had any large judgments against them in the past. The rate reflected simply what they were able to find in the market available in the state. He added, when his group was shopping for their new policy and the group could not go forward without medical malpractice insurance coverage, the state had not finalized its program. Additionally, they would not have been able to practice within the hospital facility without malpractice coverage.

Assemblywoman Buckley ascertained whether Dr. Brown had any judgments against him personally. Dr. Brown emphasized he had never had a judgment placed against him. He explained the insurer had not looked at that issue; rather, the overall history of the group, which had been very, very good.

Dr. Stumpf emphasized even other surgical groups in the Reno area, who were not with an insurance company that pulled out of the state, had been quoted 10 to 15 percent increases in their malpractice premiums across the board. He noted some of the groups did not have a pending renewal date until in the late fall and were unsure what would happen with their premiums.

Assemblywoman Buckley related when the crisis first began looming in southern Nevada and several of doctors had issued statements they would be closing practices in the state, she had gone to the Nevada State Board of Medical Examiners and looked up their records, only to find they were some of the physicians with the most claims against them. She had been curious whether rates went up based on claims history but acknowledged there were numerous doctors with spotless records who also experienced very high increases in their premium rates.

The Chair recognized Mr. John Yacenda, who had served as Chairman of the Subcommittee to Study a Reporting System for Nevada.

Mr. Yacenda testified his remarks would be based on his capacity as the chairman of the subcommittee. He alluded to earlier testimony and stated his subcommittee had found that no research supported a reduction in medical errors as a result of mandatory or voluntary reporting requirements. Mr. Yacenda commented the subcommittee also found that the hospitals and JCAHO facilities went to extreme efforts and concentration on patient safety. With that said, there were a number of items in A.B. 1 that were very consistent with the research and finding of the subcommittee.

Mr. Yacenda stated the subcommittee had issued a recommendation very similar to the proposal for a repository.

- Whistleblower protections in the bill were very consistent with testimony before the subcommittee;
- The aggregate data reports were very consistent;
- The confidentiality of reported information – very consistent; and
- Contracting out the repository for collection and analysis of data with a party outside the state agency – also consistent with subcommittee recommendations.

Mr. Yacenda explained there were several of issues based on the subcommittee hearings and considerations that raised issues with the bill. The definition of an incident to be reported was found by the subcommittee to be very difficult. The amendment language really referred to near misses and those were very difficult

to qualify or define. He provided an example that a near miss might be a patient on 5 milligrams of Coumadin a day and was given 10 milligrams one day, but given the proper dosage the next day. That patient would be considered a near miss but the incident would probably never create a problem. Therefore, that language in the amendment would probably need to be narrowed.

The other concern related to the process to be followed when recommendations, created by a contractor about medical practice, would be reported to the repository for subsequent review and then the repository would advance the review to the administrator of the Health Division, DHR, after they conducted a study of the incident. He explained the whole issue was not that it was a bad process, but it would require highly skilled medical professionals at each review along the way. He stressed decisions were being made about medical practice and what would happen in a clinical setting.

Mr. Yacenda said that concluded his testimony regarding the proposed amendment to A.B. 1.

Assemblywoman Leslie referred to Mr. Yacenda's example of a patient on Coumadin and noted that particular drug, at that particular time, might not have placed the patient in jeopardy at the time. The problem was that differing amounts of a medication were being given because of something such as a nurse not being able to read a doctor's handwriting. The incident might indicate something worthy of a review and asked Mr. Yacenda to comment. Mr. Yacenda responded, in fact, through the technological and system changes more and more hospitals were using, those kinds of mistakes were easy to prevent. He asked why would they need to rediscover existing technology. Assemblywoman Leslie rebutted the point and said the legislature wanted to ensure those technologies were being discovered and addressed and there was currently no such mechanism in place.

Chairman Anderson informed the committee that Mr. Anthony, Senior Research Analyst, provided information relative to the definition of "administrator." In NRS 439.005 administrator was defined and the qualifications of administrator were further defined in NRS 439.090. He commented the bill drafters had clearly anticipated the question that arose as a result of the proposed amendment.

Assemblywoman Buckley raised a point for the LCB Research and Legal Divisions to review concerning A.B. 1. The Chair agreed.

Assemblywoman Buckley referred to A.B. 1, page 13, line 8, that stated, "The board shall keep information received pursuant to this section confidential."

She was unclear whether the statement was referring to information the clerk of the court was required to report in paragraph 3, because that information was already public record and therefore should not be made confidential. She stressed it would not be the intent to keep public records confidential. The Chair specified Assemblywoman Buckley was referring to Section 23, subsection 4, page 13, of the bill. He confirmed that section referred back to paragraph E in the bill and stated that was the question to be posed to the legal staff.

Assemblywoman Cegavske asked for clarification on the specific portion of the bill under question. The Chair stated page 13, line 7, required the courts to submit information within 45 days to the board. He asked Assemblywoman Buckley to clarify her question for staff. She restated her question that Section 23, subsection 4 of A.B. 1 stated, "The board shall keep information received pursuant to this section confidential unless a court of competent jurisdiction issues a subpoena compelling the release of such information." She believed the section was not intended to make any information not currently confidential to become so. She stressed the intent of the legislation was not to add secrecy, but instead be more open with information.

Ms. Lang explained the provision was stated in both Sections 23 and 30 of the bill. Section 30, page 15, was identical applying to osteopathic physicians. She stated it would be simple to amend the language to clarify the sections did not apply to any information that was otherwise available to the public.

Assemblywoman Buckley clarified, if the change was made, would it make any information confidential that was currently open to the public, besides the court records. Ms. Lang replied she did not think it would.

Mr. Robert Byrd, Chairman, Medical Liability Association of Nevada, explained that the quasi-state organization was providing medical malpractice insurance to Nevada physicians. His background included 23 years as a chief executive officer and president of Nevada Medical Liability Insurance Company. His responsibilities included final decision making for approximately 1,100 malpractice cases of any size and policy limits cases.

Chairman Anderson asked Mr. Byrd to address his position on A.B. 1 for the record:

> I was asked July 29, 2002, by Governor Guinn to visit with the attorneys and physicians to answer a simple question. Was the bill meaningful tort reform? After it was described to me, my reaction was that it was meaningful tort reform. By that, I mean

> after a period of time, and after it is tested, I expect insurers to come back into the market. I expect the prices to come down; to what extent I have no way of predicting. I do expect reductions in prices and an increase in competition.

Speaker Perkins stated, given the testimony the committee had received from Mr. Byrd, notwithstanding any of the remainder of the work the committee had done, and given the activities in the building at present, those comments might be the most important words heard recently.

Speaker Perkins asked Mr. Byrd, whose credentials were not in question, if he was confident in the statements he had just made. He asked if Mr. Byrd was confident that, after a testing process of elements of the bill, that the malpractice insurance market would stabilize, rates would be reduced and competition would increase.

Mr. Byrd emphasized he felt quite confident in those outcomes.

> I have heard remarks today that many representatives of the insurance industry, including actuaries, chief executive officers, and marketing representatives, have said this bill was not worth very much. I would represent that there were probably not many of those individuals who had spent much time in the claims environment or in the claim management system. If they did, they would find that this bill provided a much more level playing field. It provides predictability and it provides structure. It is not perfect and it could be made a lot stronger, but overall, it is a very significant change and a quantum leap from where we are. That is very important.

Speaker Perkins noted a person in almost any industry could have different opinions of a particular issue. He asked if Mr. Byrd felt there were others in his industry that would concur with his opinion.

Mr. Byrd replied, if he were able to discuss the bill with them, they would be convinced the bill represented very meaningful tort reform.

Speaker Perkins had been discouraged earlier in the day, as he had heard a number of people in the halls talking about the bill and stating that Governor Guinn's bill would not accomplish the things Mr. Byrd had stated would likely occur. That seemed to create a firestorm among some of the medical community in Las Vegas. If Mr. Byrd's testimony could be imparted to those people to give them some comfort, it would be a major advance in the

legislative process.

Speaker Perkins stressed, he had not wanted to come to the legislature and process a bill that was not going to accomplish the goals stated by Mr. Byrd and his comments were extraordinarily important to the Speaker.

Assemblywoman Parnell asked how many physicians in Nevada had taken advantage of Mr. Byrd's quasi-state insurance program since its inception in approximately April 2002. Mr. Byrd replied as of July 26, 2002, there had been 229 physicians covered representing approximately $5 million in premiums.

Mr. Jim Wadhams appeared on behalf of the American Insurance Association, which he explained was a trade association of property and casualty insurance companies, most of which were companies of the stature of Fireman's Fund and Hartford. Those companies did not typically write malpractice insurance. He explained he had been asked to become part of the legislative process by the Governor, the Plaintiff's Bar, the Defense Bar, and the physicians, because it was difficult to find local people who could compile or attempt coordination of information, particularly since the St. Paul Insurance Company pulled out of the state.

Mr. Wadhams said the insurance companies testified in March 2002, at a hearing convened by the Governor, that they were not interested in doing business in Clark County. They had lost money and the market there had become unprofitable.

He assumed lack of predictability was what the committee was attempting to address to provide some satisfaction to physicians. He quoted some physicians as saying they saw a light at the end of the tunnel. In that light, it was his opinion that perception would be in the eye of the beholder.

Mr. Wadhams stated in his first review of the bill, it was his opinion the bill represented a significant and a positive step in the process. He stressed he was not an actuary, but simply a coordinator of information and attempting to obtain the information from carriers who were otherwise uninterested in the issue. He had obtained information after he had been pressed in his Senate testimony about the tort caps in Section 5, regarding how much premium rates would be reduced as a result of the cap.

Mr. Wadhams stated an actuary for one of the insurance companies indicated he felt the exceptions in the cap section of the bill mitigated any positive impact of the caps. He stressed it was only one person's view and did not change his own overall opinion that the bill represented a positive step.

Mr. Wadhams stressed that local companies controlled by local physicians had a commitment to understand the legal process, the courts, and the lawyers, and that seemed to be the primary prescription for success. Mr. Byrd's comments had to be accorded some deference because of his personal experience in the Nevada marketplace; and with no disrespect to the national and regional companies Nevada possessed a very small marketplace for them. Credibility had to rest with those who had conducted their business within the state for some period of time and Mr. Byrd fell in that category.

In conclusion, while there were issues within the bill, it was a positive step and it would represent a change. Whether that was sufficient to please the physicians, he would have to defer to them.

Chairman Anderson explained one of the concerns of the committee in earlier testimony dealt with the reality that benefits from the legislation would not be seen immediately. Although it would not be seen in the near future, passage of the legislation would send a clear signal that Nevada consisted of a predictable market for physicians. Mr. Wadhams concurred.

Chairman Anderson asked Mr. Wadhams, from his experience in the insurance industry, what would represent a reasonable time period before possible movements in rates would be seen. Mr. Byrd replied that several factors were involved. It depended on the date the legislation became effective and how much time existed for current pending claims to be filed. He suggested there might be a large influx of claims trying to beat the effective date of the law. Once the industry was working within the parameters of the bill, after 3 years they should have a good idea as to the impact of the legislation. The Chair noted that was consistent with earlier statements.

Assemblywoman Buckley said she had heard a comment attributed to an actuary discussing whether or not the cap in the consensus bill brought by the Governor would lower premiums. In the course of the Medical Malpractice Interim Subcommittee, they heard time and time again that tort reform should not be passed with the expectation of lowering insurance premiums. American Insurance Association executives were quoted as saying the industry never promised tort reform would achieve specific premium savings. Instead, the interim committee was told tort reform would lead to a more stable environment in the future and perhaps future premium increases would not be as high. They testified they could not promise premium savings, and in fact, in some states that did not have caps the premiums were higher than in states with caps and there were many factors that could contribute to high premiums. She asked if that was a fair summary of the interim testimony.

Mr. Byrd responded that was exactly what the insurance industry had been saying. He represented to the committee there was one principal reason they had taken that posture. The companies had been under tremendous pressure to somehow predict, with a certain degree of reliability, how much premiums would go down if a specific type of legislation were passed. They truly were not able to make that prediction until they saw how the legislation affected the market. He could not criticize the current position of the insurance companies.

Chairman Anderson asked if there was anyone else in the audience that had any further new information or statements they felt must be placed in the record. There being none, he moved back to committee discussion of the bill, noting they had already taken a vote to add a name to the sponsors of A.B. 1, and approved Sections 1 through 6. He reiterated the proposed amendments to the bill from that point:

- Section 9, page 4, line 38 add after the word "physicians" comma (,) hospitals, or dentists;
- Section 18, page 10, line 25, "Not less than $1 million per," drop the word "person" and substitute the word "occurrence";
- Section 18, page 10, line 26, "Not less than $3 million per," drop the words "per occurrence" and replace with, "in the aggregate";
- Section 25, page 13, lines 40 and 41, change identically to those in Section 18;
- Section 27, page 13, lines 47 and 48, change identically to those in Sections 18 and 25; and
- The amendment (Exhibit L) as submitted by Assemblywoman Koivisto that renumbered Sections 18 through 39 as Sections 53 through 75 and added a new section following Section 17. The amendment would not disturb Sections 18, 25, and 27.

The Chair asked staff for concurrence and expressed his concern that the amendment not conflict with Sections 18, 25, and 27 in terms of language and amounts. He clarified those sections would simply be moved to occur later in the bill. Ms. Lang agreed.

The Chair stood ready to entertain a motion adopting the Koivisto amendment and then to take an overall motion to bind the members of the committee to their vote upon the floor.

ASSEMBLYWOMAN OHRENSCHALL MOVED TO AMEND A.B. 1 AS WAS EXPLAINED BY THE CHAIR.

Chairman Anderson reiterated the amendments and clarified for staff the motion would not consider Assemblywoman Buckley's clarifying language regarding public records.

Assemblywoman Parnell asked for clarification regarding the rules of the committee. She asked if she voted affirmatively in the two motions to come before the committee, it would mean she would be bound to vote affirmatively on the floor to get the bill to a conference committee or moved to the Senate. She stated that would not necessarily guarantee how she would vote when presented with the final piece of legislation.

The Chair responded an affirmative vote for the amendment on the floor was not in any way binding on the legislator's vote on the Floor of the Assembly. A motion made to amend and do pass the bill from committee would be considered a binding vote on the Floor of the Assembly.

Assemblywoman Parnell clarified the affirmative vote on the second motion would be a binding vote only in regard to sending the bill to the conference committee or to the Senate. The Chair confirmed an affirmative vote would not bind a future vote in a conference committee.

Assemblyman Hettrick expressed concern that the minority membership and perhaps some of the majority members would be more comfortable if they could vote to move the bill to the floor and then have the ability to see the reprinted amendatory language before a further binding vote. Chairman Anderson stated it was an assumption of the committee he typically chaired, that bill draft language would clarify the language of Nevada law and if it did not express the intent when the reprint was viewed, questions were to be brought forward. The short answer to Assemblyman Hettrick's question was "absolutely." The intent was to move the bill to the bill drafters so they could work on the formal language that would become a part of the bill reprint. He asked if Speaker Perkins agreed with that synopsis. Speaker Perkins concurred.

ASSEMBLYWOMAN BUCKLEY SECONDED THE OHRENSCHALL MOTION.

THE MOTION PASSED UNANIMOUSLY.

The Chair stood ready to accept a motion to amend and do pass A.B. 1.

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ASSEMBLYWOMAN KOIVISTO MOVED TO AMEND AND DO PASS A.B. 1 SUBJECT TO THE CONSISTENCY OF THE REPRINT LANGUAGE.

ASSEMBLYWOMAN LESLIE SECONDED THE MOTION.

Assemblyman Beers expressed encouragement from the testimony of insurance representatives who stated that the proposed legislation would in fact reduce premiums. He stated his ultimate decision would be based upon whether the physicians had heard and believed the testimony before the committee. He related he had visited a doctor's office before traveling to Carson City and the doctor had told him that he was sitting on a job offer while waiting to see the outcome of the legislative session.

Assemblyman Beers asked for clarification that a vote in committee was not binding on the Floor of the Assembly, because he was comfortable moving the amended bill out of committee for purposes of additional discussion. The Chair clarified "a vote here, subject to the reprint being correct, barring a few technical corrections, would be binding."

Assemblyman Beers clarified that he had the ability to reserve the right to change his mind later in the process. Research staff agreed with the Chair and Assemblyman Beers further clarified, that would leave him the option of abstaining from the vote in committee. The Chair concurred that an abstention in the committee vote would make him a free agent on the floor.

Speaker Perkins stated he was pleased that the committee had arrived at a vote in such a short period of time. He acknowledged a lot of time and energy had allowed that to occur. He added the 18th Special Legislature had been convened to reach just such a point and no one was present to satisfy any particular group of interests, but to serve the citizens each represented and he was of the opinion the bill met that purpose.

Speaker Perkins was concerned that a number of physicians in southern Nevada appeared to have been duped by very large, and in his opinion, greedy insurance companies who had released much information to create fear within the community contrary to testimony before the committee. He stressed passage of the bill would be a historic step in the state. He noted research documentation he had been provided indicated the cap specified in the bill would become the fourth-lowest cap in the United States and thus he believed it represented meaningful tort reform. He emphasized he for one, was happy to vote in favor of the product before the committee, knowing the members would end up in conference with the Senate with a package to address the crisis issue

in the state.

Assemblyman Hettrick agreed with Speaker Perkins that the committee was making a large, positive step. He did have concern that moves were happening very quickly, as they must, in attempting to deal with a crisis. He stated at the present moment, for all members to be bound by their vote in the committee to support passage of the measure on the floor, was beyond what could be reasonably expected. There was further information from the Governor and from the Senate his party members would like to consider before they committed to an obligatory vote on the Floor of the Assembly. Based on the decision on Committee Rule 4, he would have to abstain from voting on the motion before the committee. He in no way wanted his comments to be construed as a partisan step, rather that the members had the need to hear other information that might be proposed.

Chairman Anderson acknowledged the Speaker had reminded him, the committee could change the Committee Standing Rules (Exhibit J), which would require a two-thirds vote.

Speaker Perkins reported in consultation with legal counsel, the reason the rule was brought was to avoid unnecessary bill drafting and lengthening of the process. The committee could still follow the spirit of the rule and allow members the ability to revisit their concerns on the floor and not violate Nevada Assembly Rule 42. He opined it was allowable for the committee to take the vote and have a different opinion when they got to the floor.

Chairman Anderson accepted that, on the advice of legal staff, committee members were not bound to their committee vote. He stressed any amendments to the bill could only go to the floor through the committee. He stated members could vote their position any way they liked, but as a courtesy to the Chair and to the other members, the Chair should be informed, before a change in vote on the floor, of that intent.

Assemblyman Dini stated there was an informal, understood rule, that if a vote was changed the member, as a courtesy, should approach the Chair with their intent.

Assemblywoman Buckley stated she would be supporting the motion currently on the table. She stated the piece of legislation before the committee was significant in its breadth, as it put Nevada in the forefront of preventing malpractice by requiring strict reporting of medical errors and a way to examine systems to ensure that healthcare was improved. By adoption of protections for trauma surgeons, joint and several liability, and a balanced cap, the

committee had done well for the citizens of the state. She added, there would still be conference committees, and further opportunities to hear input. She said the result could be that the measure under consideration would become a "best start" and they would hear other testimony that would encourage them to adopt further refinements to the bill, such as the earlier discussion regarding the intent not to keep certain information confidential.

The cap was unique in that it capped small cases, but at the same time provided an overall cap so that the physician was only liable up to the limit of his/her insurance policy. The balance achieved was very complex and not many had read it yet. The legislative process would allow time for reading of the revised bill and provision of input to allow the legislature to make the best decision.

Assemblywoman Buckley noted she was pleased by the compromise proposal conceived by the Senate and the Assembly, and the Governor was on the way to achieve its goal.

Assemblyman Dini stated when the legislative journey began he had stated he wanted to see some meaningful tort reform and help physicians. He added that rural areas had experienced a shortage of doctors over a long period of time and he would like to see Las Vegas and Reno areas not have a shortage of the necessary physicians.

Assemblyman Dini added he was not completely in agreement with the medical error reporting provisions. He expressed the hope in a conference committee that further work could be done with hospitals to result in something more workable for them. He noted he could vote no on the motion, but he would not poison the bill because of a "no" vote from him. The bill was on the right track.

Assemblyman Beers stated he had heard the previous evening similar comments to those made by Assemblywoman Buckley and he had walked away concerned that the bill would actually cap economic damages. He noted it was easy on a first or careless reading of the bill to come to that conclusion. He stressed that was not what the bill achieved and if it did, it would be a grievous injury to Nevada citizens. He directed his next comment to press representatives and stated the bill would take analysis, thinking, and reading, because the bill represented a complex solution that sounded like it had never been tried before. He was intrigued by the proposal; nevertheless, the key issue to him was the special interests he did represent, which were the citizens in his district, and he acknowledged the citizens were speaking very loud and clear on the issue.

Chairman Anderson opined the nature of the Assembly body was that they all were a special interest group representing their constituents. He added that was why the members were sent to Carson City. He felt very strongly that the Assembly members represented the voice of the people.

Assemblywoman Ohrenschall thanked the Chair and all members of the committee for the free flow of discussions to best serve the people of Nevada. She had begun by thinking that because of the time limits a meaningful discussion would not take place. However, they had managed to hold meaningful discussions of all sides of the issues.

Chairman Anderson placed the Koivisto/Leslie amend and do pass motion of A.B. 1 of the special session to the Floor of the Assembly. The only caveat on the motion was relative to the reprint of the bill. He noted the committee was present in its entirety.

THE MOTION WAS PASSED UNANIMOUSLY.

Chairman Anderson recessed the committee at 7:58 p.m.

Mr. Bill Bradley submitted a document entitled, "The Liability Insurance Crisis – Déjà vu All Over Again," (Exhibit Q), which was not discussed.

The committee in its entirety reconvened behind the Bar of the Assembly at 9:49 p.m. for the purpose of adjournment with the intent to reconvene at 9:30 a.m. on July 31, 2002.

RESPECTFULLY SUBMITTED:

Cindy Clampitt
Transcribing Secretary

APPROVED BY:

Assemblyman Bernie Anderson, Chairman

DATE: December 17, 2002

Assembly Bill No. 289–Assemblymen Mastroluca, Carlton; and Atkinson

Joint Sponsors: Senators Wiener; and Schneider

CHAPTER.....

AN ACT relating to dietetics; providing for the licensure of dietitians by the State Board of Health; prohibiting a person from engaging in the practice of dietetics without a license issued by the Board; setting forth the grounds for disciplinary action against a licensed dietitian; providing a penalty; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

This bill provides for the licensing and regulation of the practice of dietetics by the State Board of Health. The practice of dietetics is the performance of acts of assessment, evaluation, diagnosis, counseling, intervention, monitoring or treatment of a person relating to nutrition, food, biology, and behavior to achieve and maintain proper nourishment and care of the health of the person.

Sections 2-10 and 20-31 of this bill regulate the activities of persons who engage in the practice of dietetics and include provisions concerning: (1) applications for and renewals of a license to engage in the practice of dietetics; and (2) the duties and scope of practice of a licensed dietitian.

Sections 18 and 33 of this bill require the Board to charge and collect certain fees relating to the issuance of licenses and to carry out its other duties.

Section 23 of this bill authorizes the Board to issue a provisional license to a person who does not meet all the qualifications for licensure under certain circumstances. **Section 24** of this bill authorizes the Board to issue a temporary license to a person for the limited purpose of treating patients in this State for a limited period under certain circumstances.

Sections 34-44 of this bill govern disciplinary proceedings against a licensed dietitian and authorize the Board to suspend or revoke a license or deny an application for a license under certain circumstances. **Section 45** of this bill prohibits a person who is not licensed pursuant to the provisions of this bill from acting or holding himself or herself out as a licensed dietitian. **Section 46** of this bill provides that a violation of any provision of this bill is a misdemeanor and, in addition to any criminal penalty that may be imposed, authorizes the Board to impose a civil penalty for each violation.

Sections 47-51 and 58-60 of this bill include licensed dietitians in the definition of "provider of health care" to ensure that licensed dietitians comply with the same requirements for standards of care, medical records and medical devices as other providers of health care such as doctors or nurses.

Sections 52-54 of this bill require a licensed dietitian to report suspected incidents of abuse or neglect of an older or vulnerable person, and require a report to be forwarded to the Board if a licensed dietitian is suspected of abuse or neglect of an older or vulnerable person.

Section 64 of this bill requires the Board to grant a license to engage in the practice of dietetics to a person who does not meet the qualifications for licensure but who was engaged in the practice of dietetics in this State before 2012 and meets certain other requirements.

EXPLANATION – Matter in ***bolded italics*** is new; matter between brackets ~~[omitted material]~~ is material to be omitted.

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

Section 1. Title 54 of NRS is hereby amended by adding thereto a new chapter to consist of the provisions set forth as sections 1.5 to 46, inclusive, of this act.

Sec. 1.5. ***The Legislature hereby declares that the practice of dietetics is a learned profession affecting the safety, health and welfare of the public and is subject to regulation to protect the public from the practice of dietetics by unqualified and unlicensed persons and from unprofessional conduct by persons licensed to practice dietetics.***

Sec. 2. ***As used in this chapter, unless the context otherwise requires, the words and terms defined in sections 3 to 8, inclusive, of this act have the meanings ascribed to them in those sections.***

Sec. 3. ***"Board" means the State Board of Health.***

Sec. 4. ***"Licensed dietitian" means a person licensed pursuant to this chapter to engage in the practice of dietetics or to provide nutrition services, including, without limitation, medical nutrition therapy.***

Sec. 4.5. ***"Medical nutrition therapy" means the use of nutrition services by a licensed dietitian to manage, treat or rehabilitate a disease, illness, injury or medical condition of a patient.***

Sec. 5. ***"Nutrition services" means the performance of acts designated by the Board which are within the practice of dietetics.***

Sec. 6. ***1. "Practice of dietetics" means the performance of any act in the nutrition care process, including, without limitation, assessment, evaluation, diagnosis, counseling, intervention, monitoring and treatment, of a person which requires substantial specialized judgment and skill based on the knowledge, application and integration of the principles derived from the sciences of food, nutrition, management, communication, biology, behavior, physiology and social science to achieve and maintain proper nourishment and care of the health of the person.***

2. The term does not include acts of medical diagnosis.

Sec. 7. (Deleted by amendment.)

Sec. 8. ***"Registered dietitian" means a person who is registered as a dietitian by the Commission on Dietetic Registration of the American Dietetic Association.***

Sec. 9. ***1. The provisions of this chapter do not apply to:***

(a) Any person who is licensed or registered in this State as a physician pursuant to chapter 630, 630A or 633 of NRS, dentist, nurse, dispensing optician, optometrist, occupational therapist, practitioner of respiratory care, physical therapist, podiatric physician, psychologist, marriage and family therapist, chiropractor, athletic trainer, massage therapist, perfusionist, doctor of Oriental medicine in any form, medical laboratory director or technician or pharmacist who:

(1) Practices within the scope of that license or registration;

(2) Does not represent that he or she is a licensed dietitian or registered dietitian; and

(3) Provides nutrition information incidental to the practice for which he or she is licensed or registered.

(b) A student enrolled in an educational program accredited by the Commission on Accreditation for Dietetics Education of the American Dietetic Association, if the student engages in the practice of dietetics under the supervision of a licensed dietitian or registered dietitian as part of that educational program.

(c) A registered dietitian employed by the Armed Forces of the United States, the United States Department of Veterans Affairs or any division or department of the Federal Government in the discharge of his or her official duties, including, without limitation, the practice of dietetics or providing nutrition services.

(d) A person who furnishes nutrition information, provides recommendations or advice concerning nutrition, or markets food, food materials or dietary supplements and provides nutrition information, recommendations or advice related to that marketing, if the person does not represent that he or she is a licensed dietitian or registered dietitian. While performing acts described in this paragraph, a person shall be deemed not to be engaged in the practice of dietetics or the providing of nutrition services.

(e) A person who provides services relating to weight loss or weight control through a program reviewed by and in consultation with a licensed dietitian or physician or a dietitian licensed or registered in another state which has equivalent licensure requirements as this State, as long as the person does not change the services or program without the approval of the person with whom he or she is consulting.

2. As used in this section, "nutrition information" means information relating to the principles of nutrition and the effect of nutrition on the human body, including, without limitation:

(a) Food preparation;

(b) Food included in a normal daily diet;

(c) Essential nutrients required by the human body and recommended amounts of essential nutrients, based on nationally established standards;

(d) The effect of nutrients on the human body and the effect of deficiencies in or excess amounts of nutrients in the human body; and

(e) Specific foods or supplements that are sources of essential nutrients.

Sec. 10. *1. The purpose of licensing dietitians is to protect the public health, safety and welfare of the people of this State.*

2. Any license issued pursuant to this chapter is a revocable privilege.

Secs. 11-16. (Deleted by amendment.)

Sec. 17. *1. The Board shall make and keep a complete record of all its proceedings pursuant to this chapter, including, without limitation:*

(a) A file of all applications for licenses pursuant to this chapter, together with the action of the Board upon each application;

(b) A register of all licensed dietitians in this State; and

(c) Documentation of any disciplinary action taken by the Board against a licensee.

2. The Board shall maintain in its main office a public docket or other record in which it shall record, from time to time as made, the rulings or decisions upon all complaints filed with the Board and all investigations instituted by it, upon or in connection with which any hearing has been held or in which the licensee charged has made no defense.

Sec. 18. *1. The Board may:*

(a) Adopt regulations establishing reasonable standards:

(1) For the denial, renewal, suspension and revocation of, and the placement of conditions, limitations and restrictions upon, a license to engage in the practice of dietetics.

(2) Of professional conduct for the practice of dietetics.

(b) Investigate and determine the eligibility of an applicant for a license pursuant to this chapter.

(c) Carry out and enforce the provisions of this chapter and the regulations adopted pursuant thereto.

2. The Board shall adopt regulations establishing reasonable:

(a) Qualifications for the issuance of a license pursuant to this chapter.

(b) Standards for the continuing professional competence of licensees. The Board may evaluate licensees periodically for compliance with those standards.

3. The Board shall adopt regulations establishing a schedule of reasonable fees and charges for:

(a) Investigating licensees and applicants for a license pursuant to this chapter;

(b) Evaluating the professional competence of licensees;

(c) Conducting hearings pursuant to this chapter;

(d) Duplicating and verifying records of the Board; and

(e) Surveying, evaluating and approving schools and courses of dietetics,

➥ and may collect the fees established pursuant to this subsection.

4. The Board may adopt such other regulations as it determines necessary to carry out the provisions of this chapter relating to the practice of dietetics.

Sec. 19. *The Board may:*

1. Accept gifts or grants of money to pay for the costs of administering the provisions of this chapter.

2. Enter into contracts with other public agencies and accept payment from those agencies to pay the expenses incurred by the Board in carrying out the provisions of this chapter relating to the practice of dietetics.

Sec. 19.5. *1. The Board may establish a Dietitian Advisory Group consisting of persons familiar with the practice of dietetics to provide the Board with expertise and assistance in carrying out its duties pursuant to this chapter. If a Dietitian Advisory Group is established, the Board shall:*

(a) Determine the number of members;

(b) Appoint the members;

(c) Establish the terms of the members; and

(d) Determine the duties of the Dietitian Advisory Group.

2. Members of a Dietitian Advisory Group established pursuant to subsection 1 serve without compensation.

Sec. 20. *1. An applicant for a license to engage in the practice of dietetics in this State must submit to the Board a completed application on a form prescribed by the Board. The application must include, without limitation, written evidence that the applicant:*

(a) Is 21 years of age or older.

(b) Is of good moral character.

(c) Has completed a course of study and holds a bachelor's degree or higher in human nutrition, nutrition education, food

and nutrition, dietetics, food systems management or an equivalent course of study approved by the Board from a college or university that:

(1) Was accredited, at the time the degree was received, by a regional accreditation body in the United States which is recognized by the Council for Higher Education Accreditation, or its successor organization, and the United States Department of Education; or

(2) Is located in a foreign country if the application includes the documentation required by section 21 of this act.

(d) Has completed not less than 1,200 hours of training and experience within the United States in the practice of dietetics under the direct supervision of a licensed dietitian, registered dietitian or a person who holds a doctorate degree in human nutrition, nutrition education, food and nutrition, dietetics or food systems management from a college or university that is:

(1) Accredited by a regional accreditation body in the United States which is recognized by the Council for Higher Education Accreditation, or its successor organization, and the United States Department of Education; or

(2) Located in a foreign country if the application includes the documentation required by section 21 of this act.

(e) Has successfully completed the Registration Examination for Dietitians administered by the Commission on Dietetic Registration of the American Dietetic Association.

(f) Meets such other reasonable requirements as prescribed by the Board.

2. Each applicant must remit the applicable fee required pursuant to this chapter with the application for a license to engage in the practice of dietetics in this State.

3. Each applicant shall submit to the Central Repository for Nevada Records of Criminal History two complete sets of fingerprints for submission to the Federal Bureau of Investigation for its report. The Central Repository for Nevada Records of Criminal History shall determine whether the applicant has been convicted of a crime listed in paragraph (a) of subsection 1 of NRS 449.188 and immediately inform the Board of whether the applicant has been convicted of such a crime.

Sec. 21. *1. If an applicant for a license to engage in the practice of dietetics is a graduate of a college or university located in a foreign country, the applicant must include with his or her application a written statement or other proof from the Council for Higher Education Accreditation or its successor organization that*

the degree is equivalent to a degree issued by a college or university accredited by a regional accreditation body in the United States which is recognized by the Council for Higher Education Accreditation, or its successor organization, and the United States Department of Education.

2. If an applicant for a license to engage in the practice of dietetics completed his or her hours of training and experience under the supervision of a person who holds a doctorate degree conferred by a college or university located in a foreign country, the applicant must include with his or her application a written statement or other proof from the Council for Higher Education Accreditation or its successor organization that the degree held by the person who supervised the training and experience is equivalent to a degree issued by a college or university accredited by a regional accreditation body in the United States which is recognized by the Council for Higher Education Accreditation, or its successor organization, and the United States Department of Education.

Sec. 22. *1. A person who has the education and experience required by section 20 of this act but who has not passed the examination required for licensure may engage in the practice of dietetics under the direct supervision of a licensed dietitian who is professionally and legally responsible for the applicant's performance.*

2. A person shall not engage in the practice of dietetics pursuant to subsection 1 for a period of more than 1 year.

Sec. 23. *1. Upon application and payment of the applicable fee required pursuant to this chapter, the Board may grant a provisional license to engage in the practice of dietetics in this State to an applicant who provides evidence to the Board that the applicant has completed a course of study and holds a bachelor's degree or higher in human nutrition, nutrition education, food and nutrition, dietetics, food systems management or an equivalent course of study approved by the Board from a college or university that:*

(a) Was accredited, at the time the degree was received, by a regional accreditation body in the United States which is recognized by the Council for Higher Education Accreditation, or its successor organization, and the United States Department of Education; or

(b) Is located in a foreign country if the application includes the documentation required by section 21 of this act.

2. A provisional license is valid for 1 year after the date of issuance. A provisional license may be renewed for not more than 6 months if the applicant submits evidence satisfactory to the Board for the failure of the applicant to obtain a license to engage in the practice of dietetics during the time the applicant held the provisional license.

3. A person who holds a provisional license may engage in the practice of dietetics only under the supervision of a licensed dietitian.

Sec. 24. *1. Upon application and payment of the applicable fee required pursuant to this chapter, the Board may grant a temporary license to engage in the practice of dietetics in this State to a person who holds a corresponding license in another jurisdiction if:*

(a) The corresponding license is in good standing; and

(b) The requirements for licensure in the other jurisdiction are substantially equal to the requirements for licensure in this State.

2. A temporary license may be issued for the limited purpose of authorizing the licensee to treat patients in this State.

3. A temporary license is valid for the 10-day period designated on the license.

Sec. 25. (Deleted by amendment.)

Sec. 26. *1. In addition to any other requirements set forth in this chapter:*

(a) An applicant for the issuance of a license to engage in the practice of dietetics in this State shall include the social security number of the applicant in the application submitted to the Board.

(b) An applicant for the issuance or renewal of a license to engage in the practice of dietetics in this State shall submit to the Board the statement prescribed by the Division of Welfare and Supportive Services of the Department of Health and Human Services pursuant to NRS 425.520. The statement must be completed and signed by the applicant.

2. The Board shall include the statement required pursuant to subsection 1 in:

(a) The application or any other forms that must be submitted for the issuance or renewal of the license; or

(b) A separate form prescribed by the Board.

3. A license to engage in the practice of dietetics may not be issued or renewed by the Board if the applicant:

(a) Fails to submit the statement required pursuant to subsection 1; or

(b) Indicates on the statement submitted pursuant to subsection 1 that the applicant is subject to a court order for the support of a child and is not in compliance with the order or a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order.

4. If an applicant indicates on the statement submitted pursuant to subsection 1 that the applicant is subject to a court order for the support of a child and is not in compliance with the order or a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order, the Board shall advise the applicant to contact the district attorney or other public agency enforcing the order to determine the actions that the applicant may take to satisfy the arrearage.

Sec. 27. *1. A licensed dietitian shall provide nutrition services to assist a person in achieving and maintaining proper nourishment and care of his or her body, including, without limitation:*

(a) Assessing the nutritional needs of a person and determining resources for and constraints in meeting those needs by obtaining, verifying and interpreting data;

(b) Determining the metabolism of a person and identifying the food, nutrients and supplements necessary for growth, development, maintenance or attainment of proper nourishment of the person;

(c) Considering the cultural background and socioeconomic needs of a person in achieving or maintaining proper nourishment;

(d) Identifying and labeling nutritional problems of a person;

(e) Recommending the appropriate method of obtaining proper nourishment, including, without limitation, orally, intravenously or through a feeding tube;

(f) Providing counseling, advice and assistance concerning health and disease with respect to the nutritional intake of a person;

(g) Establishing priorities, goals and objectives that meet the nutritional needs of a person and are consistent with the resources of the person, including, without limitation, providing instruction on meal preparation;

(h) Treating nutritional problems of a person and identifying patient outcomes to determine the progress made by the person;

(i) Planning activities to change the behavior, risk factors, environmental conditions or other aspects of the health and nutrition of a person, a group of persons or the community at large;

(j) Developing, implementing and managing systems to provide care related to nutrition;

(k) Evaluating and maintaining appropriate standards of quality in the services provided;

(l) Accepting and transmitting verbal and electronic orders from a physician consistent with an established protocol to implement medical nutrition therapy; and

(m) Ordering medical laboratory tests relating to the therapeutic treatment concerning the nutritional needs of a patient when authorized to do so by a written protocol prepared or approved by a physician.

2. A licensed dietitian may use medical nutrition therapy to manage, treat or rehabilitate a disease, illness, injury or medical condition of a patient, including, without limitation:

(a) Interpreting data and recommending the nutritional needs of the patient through methods such as diet, feeding tube, intravenous solutions or specialized oral feedings;

(b) Determining the interaction between food and drugs prescribed to the patient; and

(c) Developing and managing operations to provide food, care and treatment programs prescribed by a physician, physician assistant, dentist, advanced practitioner of nursing or podiatric physician that monitor or alter the food and nutrient levels of the patient.

3. A licensed dietitian shall not provide medical diagnosis of the health of a person.

Sec. 28. (Deleted by amendment.)

Sec. 29. ***1. Except as otherwise provided in subsection 2, the Board may waive any requirement of section 20 or 23 of this act for an applicant who proves to the satisfaction of the Board that his or her education and experience are substantially equivalent to the education and experience required by the respective section.***

2. The Board may waive the requirement of an examination that is set forth in section 20 of this act in accordance with regulations adopted by the Board that prescribe the circumstances under which the Board may waive the requirement of the examination.

Sec. 30. (Deleted by amendment.)

Sec. 31. *1. A license to engage in the practice of dietetics expires 2 years after the date of issuance.*

2. The Board may renew a license if the applicant:

(a) Submits a completed written application and the appropriate fee required pursuant to this chapter;

(b) Submits documentation of completion of such continuing training and education as required by regulations adopted by the Board;

(c) Has not committed any act which is grounds for disciplinary action, unless the Board determines that sufficient restitution has been made or the act was not substantially related to the practice of dietetics;

(d) Submits information that the credentials of the applicant are in good standing; and

(e) Submits all other information required to complete the renewal.

3. The Board shall require a licensed dietitian who fails to submit an application for the renewal of his or her license within 2 years after the date of the expiration of the license to take the examination required by section 20 of this act before renewing the license.

Sec. 32. *The Board shall act upon an application for a license submitted pursuant to this chapter without unnecessary delay. If an applicant is found qualified, the applicant must be issued a license to engage in the practice of dietetics.*

Sec. 33. *1. The Board shall adopt regulations establishing reasonable fees for:*

(a) The examination of an applicant for a license;

(b) The issuance of a license;

(c) The issuance of a provisional license;

(d) The issuance of a temporary license;

(e) The renewal of a license;

(f) The late renewal of a license;

(g) The reinstatement of a license which has been suspended or revoked; and

(h) The issuance of a duplicate license or for changing the name on a license.

2. The fees established pursuant to subsection 1 must be set in such an amount as to reimburse the Board for the cost of carrying out the provisions of this chapter, except that no such fee may exceed $250.

Sec. 34. *1. The Board may deny, refuse to renew, revoke or suspend any license applied for or issued pursuant to this chapter,*

or take such other disciplinary action against a licensee as authorized by regulations adopted by the Board, upon determining that the licensee:

(a) Is guilty of fraud or deceit in procuring or attempting to procure a license pursuant to this chapter.

(b) Is guilty of any offense:

(1) Involving moral turpitude; or

(2) Relating to the qualifications, functions or duties of a licensee.

(c) Uses any controlled substance, dangerous drug as defined in chapter 454 of NRS, or intoxicating liquor to an extent or in a manner which is dangerous or injurious to any other person or which impairs his or her ability to conduct the practice authorized by the license.

(d) Is guilty of unprofessional conduct, which includes, without limitation:

(1) Impersonating an applicant or acting as proxy for an applicant in any examination required pursuant to this chapter for the issuance of a license.

(2) Impersonating another licensed dietitian.

(3) Permitting or allowing another person to use his or her license to engage in the practice of dietetics.

(4) Repeated malpractice, which may be evidenced by claims of malpractice settled against the licensee.

(5) Physical, verbal or psychological abuse of a patient.

(6) Conviction for the use or unlawful possession of a controlled substance or dangerous drug as defined in chapter 454 of NRS.

(e) Has willfully or repeatedly violated any provision of this chapter.

(f) Is guilty of aiding or abetting any person in violating any provision of this chapter.

(g) Has been disciplined in another state in connection with the practice of dietetics or has committed an act in another state which would constitute a violation of this chapter.

(h) Has engaged in conduct likely to deceive, defraud or endanger a patient or the general public.

(i) Has willfully failed to comply with a regulation, subpoena or order of the Board.

2. In addition to any criminal or civil penalty that may be imposed pursuant to this chapter, the Board may assess against and collect from a licensee all costs incurred by the Board in connection with any disciplinary action taken against the licensee,

including, without limitation, costs for investigators and stenographers, attorney's fees and other costs of the hearing.

3. For the purposes of this section, a plea or verdict of guilty or guilty but mentally ill or a plea of nolo contendere constitutes a conviction of an offense. The Board may take disciplinary action pending the appeal of a conviction.

Sec. 35. *1. If the Board receives a copy of a court order issued pursuant to NRS 425.540 that provides for the suspension of all professional, occupational and recreational licenses, certificates and permits issued to a person who is the holder of a license issued pursuant to this chapter, the Board shall deem the license issued to that person to be suspended at the end of the 30th day after the date on which the court order was issued unless the Board receives a letter issued to the holder of the license by the district attorney or other public agency pursuant to NRS 425.550 stating that the holder of the license has complied with the subpoena or warrant or has satisfied the arrearage pursuant to NRS 425.560.*

2. The Board shall reinstate a license issued pursuant to this chapter that has been suspended by a district court pursuant to NRS 425.540 if:

(a) The Board receives a letter issued by the district attorney or other public agency pursuant to NRS 425.550 to the person whose license was suspended stating that the person whose license was suspended has complied with the subpoena or warrant or has satisfied the arrearage pursuant to NRS 425.560; and

(b) The person whose license was suspended pays the appropriate fee required pursuant to this chapter.

Sec. 36. *1. If any member of the Board or a Dietitian Advisory Group established pursuant to section 19.5 of this act becomes aware of any ground for initiating disciplinary action against a licensee, the member shall file an administrative complaint with the Board.*

2. As soon as practical after receiving an administrative complaint, the Board shall:

(a) Notify the licensee in writing of the charges against him or her, accompanying the notice with a copy of the administrative complaint; and

(b) Forward a copy of the complaint to the Commission on Dietetic Registration of the American Dietetic Association or its successor organization for investigation of the complaint and request a written report of the findings of the investigation or, to the extent money is available to do so, conduct an investigation of

the complaint to determine whether the allegations in the complaint merit the initiation of disciplinary proceedings against the licensee.

3. Written notice to the licensee may be served by delivering it personally to the licensee, or by mailing it by registered or certified mail to the last known residential address of the licensee.

4. If the licensee, after receiving a copy of the administrative complaint pursuant to subsection 1, submits a written request, the Board shall furnish the licensee with a copy of each communication, report and affidavit in the possession of the Board which relates to the matter in question.

5. If, after an investigation conducted by the Board or receiving the findings from an investigation of the complaint from the Commission on Dietetic Registration of the American Dietetic Association or its successor organization, the Board determines that the administrative complaint is valid, the Board shall hold a hearing on the charges at such time and place as the Board prescribes. If the Board receives a report pursuant to subsection 5 of NRS 228.420, the hearing must be held within 30 days after receiving the report. If requested by the licensee, the hearing must be held within the county in which the licensee resides.

Sec. 37. *The Board may delegate its authority to conduct hearings pursuant to section 36 of this act concerning the discipline of a licensee to a hearing officer. The hearing officer has the powers of the Board in connection with such hearings, and shall report to the Board his or her findings of fact and conclusions of law within 30 days after the final hearing on the matter. The Board may take action based upon the report of the hearing officer, refer the matter to the hearing officer for further hearings or conduct its own hearings on the matter.*

Sec. 38. *The Board may:*

1. Issue subpoenas for the attendance of witnesses and the production of books, papers and documents; and

2. Administer oaths when taking testimony in any matter relating to the duties of the Board.

Sec. 39. *1. The district court in and for the county in which any hearing is held by the Board may compel the attendance of witnesses, the giving of testimony and the production of books, papers and documents as required by any subpoena issued by the Board.*

2. In case of the refusal of any witness to attend or testify or produce any books, papers or documents required by a subpoena,

the Board may report to the district court in and for the county in which the hearing is pending, by petition setting forth:

(a) That due notice has been given of the time and place of attendance of the witness or the production of books, papers or documents;

(b) That the witness has been subpoenaed in the manner prescribed by this chapter; and

(c) That the witness has failed and refused to attend or produce the books, papers or documents required by the subpoena before the Board in the cause or proceeding named in the subpoena, or has refused to answer questions propounded to him or her in the course of the hearing,

➥ and ask an order of the court compelling the witness to attend and testify or produce the books, papers or documents before the Board.

3. The court, upon petition of the Board, shall enter an order directing the witness to appear before the court at a time and place to be fixed by the court in the order, the time to be not more than 10 days after the date of the order, to show cause why the witness has not attended or testified or produced the books, papers or documents before the Board. A certified copy of the order must be served upon the witness.

4. If it appears to the court that the subpoena was regularly issued by the Board, the court shall enter an order that the witness appear before the Board at the time and place fixed in the order and testify or produce the required books, papers or documents. Upon failure to obey the order, the witness must be dealt with as for contempt of court.

Sec. 40. ***1. The Board shall render a decision on any administrative complaint within 60 days after the final hearing thereon. For the purposes of this subsection, the final hearing on a matter delegated to a hearing officer pursuant to section 37 of this act is the final hearing conducted by the hearing officer unless the Board conducts a hearing with regard to the administrative complaint.***

2. The Board shall notify the licensee of its decision in writing by certified mail, return receipt requested. The decision of the Board becomes effective on the date the licensee receives the notice or on the date the Board receives a notice from the United States Postal Service stating that the licensee refused to accept delivery or could not be located.

Sec. 41. (Deleted by amendment.)

Sec. 42. *1. Any licensee whose license is revoked by the Board may apply for reinstatement of the license pursuant to regulations adopted by the Board.*

2. The Board may reinstate the license upon compliance by the licensee with all requirements for reinstatement established by regulations adopted by the Board and payment of the applicable fee required pursuant to this chapter.

Sec. 43. *1. Except as otherwise provided in this section and NRS 239.0115, any records or information obtained during the course of an investigation by the Board and any record of the investigation are confidential.*

2. Any complaint or other document filed by the Board to initiate disciplinary action and all documents and information considered by the Board when determining whether to impose disciplinary action are public records.

3. This section does not prevent or prohibit the Board from communicating or cooperating with another licensing board or any agency that is investigating a licensee, including a law enforcement agency.

Sec. 44. *If the Board, based on evidence satisfactory to it, believes that any person has violated or is about to violate any provision of this chapter, the terms of any license, or any order, decision, demand or requirement, or any part thereof, the Board may bring an action, in the name of the Board, in the district court in and for the county in which the person resides, against the person to enjoin the person from continuing the violation or engaging in any act that constitutes such a violation. The court may enter an order or judgment granting such injunctive relief as it determines proper, but no such injunctive relief may be granted without at least 5 days' notice to the opposite party.*

Sec. 45. *If a person is not licensed to engage in the practice of dietetics pursuant to this chapter, or if a person's license to engage in the practice of dietetics has been suspended or revoked by the Board, the person shall not:*

1. Engage in the practice of dietetics;

2. Use in connection with his or her name the words or letters "L.D.," "licensed dietitian" or any other letters, words or insignia indicating or implying that he or she is licensed to engage in the practice of dietetics, or in any other way, orally, or in writing or print, or by sign, directly or by implication, use the word "dietetics" or represent himself or herself as licensed or qualified to engage in the practice of dietetics in this State; or

3. List or cause to have listed in any directory, including, without limitation, a telephone directory, his or her name or the name of his or her company under the heading "Dietitian" or any other term that indicates or implies that he or she is licensed or qualified to engage in the practice of dietetics in this State.

Sec. 46. ***1. A person who violates any provision of this chapter or any regulation adopted pursuant thereto is guilty of a misdemeanor.***

2. In addition to any criminal penalty that may be imposed pursuant to subsection 1, the Board may, after notice and hearing, impose a civil penalty of not more than $100 for each such violation. For the purposes of this subsection, each day on which a violation occurs constitutes a separate offense, except that the aggregate civil penalty that may be imposed against a person pursuant to this subsection may not exceed $10,000.

Sec. 47. NRS 629.031 is hereby amended to read as follows:

629.031 Except as otherwise provided by a specific statute:

1. "Provider of health care" means a physician licensed pursuant to chapter 630, 630A or 633 of NRS, physician assistant, dentist, licensed nurse, dispensing optician, optometrist, practitioner of respiratory care, registered physical therapist, podiatric physician, licensed psychologist, licensed marriage and family therapist, licensed clinical professional counselor, chiropractor, athletic trainer, perfusionist, doctor of Oriental medicine in any form, medical laboratory director or technician, pharmacist ***, licensed dietitian*** or a licensed hospital as the employer of any such person.

2. For the purposes of NRS 629.051, 629.061 and 629.065, the term includes a facility that maintains the health care records of patients.

Sec. 48. NRS 7.095 is hereby amended to read as follows:

7.095 1. An attorney shall not contract for or collect a fee contingent on the amount of recovery for representing a person seeking damages in connection with an action for injury or death against a provider of health care based upon professional negligence in excess of:

(a) Forty percent of the first $50,000 recovered;

(b) Thirty-three and one-third percent of the next $50,000 recovered;

(c) Twenty-five percent of the next $500,000 recovered; and

(d) Fifteen percent of the amount of recovery that exceeds $600,000.

2. The limitations set forth in subsection 1 apply to all forms of recovery, including, without limitation, settlement, arbitration and judgment.

3. For the purposes of this section, "recovered" means the net sum recovered by the plaintiff after deducting any disbursements or costs incurred in connection with the prosecution or settlement of the claim. Costs of medical care incurred by the plaintiff and general and administrative expenses incurred by the office of the attorney are not deductible disbursements or costs.

4. As used in this section:

(a) "Professional negligence" means a negligent act or omission to act by a provider of health care in the rendering of professional services, which act or omission is the proximate cause of a personal injury or wrongful death. The term does not include services that are outside the scope of services for which the provider of health care is licensed or services for which any restriction has been imposed by the applicable regulatory board or health care facility.

(b) "Provider of health care" means a physician licensed under chapter 630 or 633 of NRS, dentist, registered nurse, dispensing optician, optometrist, registered physical therapist, podiatric physician, licensed psychologist, chiropractor, doctor of Oriental medicine, medical laboratory director or technician, ***licensed dietitian*** or a licensed hospital and its employees.

Sec. 49. NRS 41A.017 is hereby amended to read as follows:

41A.017 "Provider of health care" means a physician licensed under chapter 630 or 633 of NRS, dentist, licensed nurse, dispensing optician, optometrist, registered physical therapist, podiatric physician, licensed psychologist, chiropractor, doctor of Oriental medicine, medical laboratory director or technician, ***licensed dietitian*** or a licensed hospital and its employees.

Sec. 50. NRS 42.021 is hereby amended to read as follows:

42.021 1. In an action for injury or death against a provider of health care based upon professional negligence, if the defendant so elects, the defendant may introduce evidence of any amount payable as a benefit to the plaintiff as a result of the injury or death pursuant to the United States Social Security Act, any state or federal income disability or worker's compensation act, any health, sickness or income-disability insurance, accident insurance that provides health benefits or income-disability coverage, and any contract or agreement of any group, organization, partnership or corporation to provide, pay for or reimburse the cost of medical, hospital, dental or other health care services. If the defendant elects to introduce such evidence, the plaintiff may introduce evidence of

any amount that the plaintiff has paid or contributed to secure the plaintiff's right to any insurance benefits concerning which the defendant has introduced evidence.

2. A source of collateral benefits introduced pursuant to subsection 1 may not:

(a) Recover any amount against the plaintiff; or

(b) Be subrogated to the rights of the plaintiff against a defendant.

3. In an action for injury or death against a provider of health care based upon professional negligence, a district court shall, at the request of either party, enter a judgment ordering that money damages or its equivalent for future damages of the judgment creditor be paid in whole or in part by periodic payments rather than by a lump-sum payment if the award equals or exceeds $50,000 in future damages.

4. In entering a judgment ordering the payment of future damages by periodic payments pursuant to subsection 3, the court shall make a specific finding as to the dollar amount of periodic payments that will compensate the judgment creditor for such future damages. As a condition to authorizing periodic payments of future damages, the court shall require a judgment debtor who is not adequately insured to post security adequate to assure full payment of such damages awarded by the judgment. Upon termination of periodic payments of future damages, the court shall order the return of this security, or so much as remains, to the judgment debtor.

5. A judgment ordering the payment of future damages by periodic payments entered pursuant to subsection 3 must specify the recipient or recipients of the payments, the dollar amount of the payments, the interval between payments, and the number of payments or the period of time over which payments will be made. Such payments must only be subject to modification in the event of the death of the judgment creditor. Money damages awarded for loss of future earnings must not be reduced or payments terminated by reason of the death of the judgment creditor, but must be paid to persons to whom the judgment creditor owed a duty of support, as provided by law, immediately before the judgment creditor's death. In such cases, the court that rendered the original judgment may, upon petition of any party in interest, modify the judgment to award and apportion the unpaid future damages in accordance with this subsection.

6. If the court finds that the judgment debtor has exhibited a continuing pattern of failing to make the periodic payments as specified pursuant to subsection 5, the court shall find the judgment

debtor in contempt of court and, in addition to the required periodic payments, shall order the judgment debtor to pay the judgment creditor all damages caused by the failure to make such periodic payments, including, but not limited to, court costs and attorney's fees.

7. Following the occurrence or expiration of all obligations specified in the periodic payment judgment, any obligation of the judgment debtor to make further payments ceases and any security given pursuant to subsection 4 reverts to the judgment debtor.

8. As used in this section:

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

(b) "Periodic payments" means the payment of money or delivery of other property to the judgment creditor at regular intervals.

(c) "Professional negligence" means a negligent act or omission to act by a provider of health care in the rendering of professional services, which act or omission is the proximate cause of a personal injury or wrongful death. The term does not include services that are outside the scope of services for which the provider of health care is licensed or services for which any restriction has been imposed by the applicable regulatory board or health care facility.

(d) "Provider of health care" means a physician licensed under chapter 630 or 633 of NRS, dentist, licensed nurse, dispensing optician, optometrist, registered physical therapist, podiatric physician, licensed psychologist, chiropractor, doctor of Oriental medicine, medical laboratory director or technician, ***licensed dietitian*** or a licensed hospital and its employees.

Sec. 51. NRS 200.471 is hereby amended to read as follows:

200.471 1. As used in this section:

(a) "Assault" means:

(1) Unlawfully attempting to use physical force against another person; or

(2) Intentionally placing another person in reasonable apprehension of immediate bodily harm.

(b) "Officer" means:

(1) A person who possesses some or all of the powers of a peace officer;

(2) A person employed in a full-time salaried occupation of fire fighting for the benefit or safety of the public;

(3) A member of a volunteer fire department;

(4) A jailer, guard or other correctional officer of a city or county jail;

(5) A justice of the Supreme Court, district judge, justice of the peace, municipal judge, magistrate, court commissioner, master or referee, including a person acting pro tempore in a capacity listed in this subparagraph; or

(6) An employee of the State or a political subdivision of the State whose official duties require the employee to make home visits.

(c) "Provider of health care" means a physician, a perfusionist or a physician assistant licensed pursuant to chapter 630 of NRS, a practitioner of respiratory care, a homeopathic physician, an advanced practitioner of homeopathy, a homeopathic assistant, an osteopathic physician, a physician assistant licensed pursuant to chapter 633 of NRS, a podiatric physician, a podiatry hygienist, a physical therapist, a medical laboratory technician, an optometrist, a chiropractor, a chiropractor's assistant, a doctor of Oriental medicine, a nurse, a student nurse, a certified nursing assistant, a nursing assistant trainee, a dentist, a dental hygienist, a pharmacist, an intern pharmacist, an attendant on an ambulance or air ambulance, a psychologist, a social worker, a marriage and family therapist, a marriage and family therapist intern, a clinical professional counselor, a clinical professional counselor intern ***, a licensed dietitian*** and an emergency medical technician.

(d) "School employee" means a licensed or unlicensed person employed by a board of trustees of a school district pursuant to NRS 391.100.

(e) "Sporting event" has the meaning ascribed to it in NRS 41.630.

(f) "Sports official" has the meaning ascribed to it in NRS 41.630.

(g) "Taxicab" has the meaning ascribed to it in NRS 706.8816.

(h) "Taxicab driver" means a person who operates a taxicab.

(i) "Transit operator" means a person who operates a bus or other vehicle as part of a public mass transportation system.

2. A person convicted of an assault shall be punished:

(a) If paragraph (c) or (d) does not apply to the circumstances of the crime and the assault is not made with the use of a deadly weapon or the present ability to use a deadly weapon, for a misdemeanor.

(b) If the assault is made with the use of a deadly weapon or the present ability to use a deadly weapon, for a category B felony by imprisonment in the state prison for a minimum term of not less

than 1 year and a maximum term of not more than 6 years, or by a fine of not more than $5,000, or by both fine and imprisonment.

(c) If paragraph (d) does not apply to the circumstances of the crime and if the assault is committed upon an officer, a provider of health care, a school employee, a taxicab driver or a transit operator who is performing his or her duty or upon a sports official based on the performance of his or her duties at a sporting event and the person charged knew or should have known that the victim was an officer, a provider of health care, a school employee, a taxicab driver, a transit operator or a sports official, for a gross misdemeanor, unless the assault is made with the use of a deadly weapon or the present ability to use a deadly weapon, then for a category B felony by imprisonment in the state prison for a minimum term of not less than 1 year and a maximum term of not more than 6 years, or by a fine of not more than $5,000, or by both fine and imprisonment.

(d) If the assault is committed upon an officer, a provider of health care, a school employee, a taxicab driver or a transit operator who is performing his or her duty or upon a sports official based on the performance of his or her duties at a sporting event by a probationer, a prisoner who is in lawful custody or confinement or a parolee, and the probationer, prisoner or parolee charged knew or should have known that the victim was an officer, a provider of health care, a school employee, a taxicab driver, a transit operator or a sports official, for a category D felony as provided in NRS 193.130, unless the assault is made with the use of a deadly weapon or the present ability to use a deadly weapon, then for a category B felony by imprisonment in the state prison for a minimum term of not less than 1 year and a maximum term of not more than 6 years, or by a fine of not more than $5,000, or by both fine and imprisonment.

Sec. 52. NRS 200.5093 is hereby amended to read as follows:

200.5093 1. Any person who is described in subsection 4 and who, in a professional or occupational capacity, knows or has reasonable cause to believe that an older person has been abused, neglected, exploited or isolated shall:

(a) Except as otherwise provided in subsection 2, report the abuse, neglect, exploitation or isolation of the older person to:

(1) The local office of the Aging and Disability Services Division of the Department of Health and Human Services;

(2) A police department or sheriff's office;

(3) The county's office for protective services, if one exists in the county where the suspected action occurred; or

(4) A toll-free telephone service designated by the Aging and Disability Services Division of the Department of Health and Human Services; and

(b) Make such a report as soon as reasonably practicable but not later than 24 hours after the person knows or has reasonable cause to believe that the older person has been abused, neglected, exploited or isolated.

2. If a person who is required to make a report pursuant to subsection 1 knows or has reasonable cause to believe that the abuse, neglect, exploitation or isolation of the older person involves an act or omission of the Aging and Disability Services Division, another division of the Department of Health and Human Services or a law enforcement agency, the person shall make the report to an agency other than the one alleged to have committed the act or omission.

3. Each agency, after reducing a report to writing, shall forward a copy of the report to the Aging and Disability Services Division of the Department of Health and Human Services and the Unit for the Investigation and Prosecution of Crimes.

4. A report must be made pursuant to subsection 1 by the following persons:

(a) Every physician, dentist, dental hygienist, chiropractor, optometrist, podiatric physician, medical examiner, resident, intern, professional or practical nurse, physician assistant licensed pursuant to chapter 630 or 633 of NRS, perfusionist, psychiatrist, psychologist, marriage and family therapist, clinical professional counselor, clinical alcohol and drug abuse counselor, alcohol and drug abuse counselor, athletic trainer, driver of an ambulance, advanced emergency medical technician ***, licensed dietitian*** or other person providing medical services licensed or certified to practice in this State, who examines, attends or treats an older person who appears to have been abused, neglected, exploited or isolated.

(b) Any personnel of a hospital or similar institution engaged in the admission, examination, care or treatment of persons or an administrator, manager or other person in charge of a hospital or similar institution upon notification of the suspected abuse, neglect, exploitation or isolation of an older person by a member of the staff of the hospital.

(c) A coroner.

(d) Every person who maintains or is employed by an agency to provide personal care services in the home.

(e) Every person who maintains or is employed by an agency to provide nursing in the home.

(f) Every person who operates, who is employed by or who contracts to provide services for an intermediary service organization as defined in NRS 427A.0291.

(g) Any employee of the Department of Health and Human Services.

(h) Any employee of a law enforcement agency or a county's office for protective services or an adult or juvenile probation officer.

(i) Any person who maintains or is employed by a facility or establishment that provides care for older persons.

(j) Any person who maintains, is employed by or serves as a volunteer for an agency or service which advises persons regarding the abuse, neglect, exploitation or isolation of an older person and refers them to persons and agencies where their requests and needs can be met.

(k) Every social worker.

(l) Any person who owns or is employed by a funeral home or mortuary.

5. A report may be made by any other person.

6. If a person who is required to make a report pursuant to subsection 1 knows or has reasonable cause to believe that an older person has died as a result of abuse, neglect or isolation, the person shall, as soon as reasonably practicable, report this belief to the appropriate medical examiner or coroner, who shall investigate the cause of death of the older person and submit to the appropriate local law enforcement agencies, the appropriate prosecuting attorney, the Aging and Disability Services Division of the Department of Health and Human Services and the Unit for the Investigation and Prosecution of Crimes his or her written findings. The written findings must include the information required pursuant to the provisions of NRS 200.5094, when possible.

7. A division, office or department which receives a report pursuant to this section shall cause the investigation of the report to commence within 3 working days. A copy of the final report of the investigation conducted by a division, office or department, other than the Aging and Disability Services Division of the Department of Health and Human Services, must be forwarded within 30 days after the completion of the report to the:

(a) Aging and Disability Services Division;

(b) Repository for Information Concerning Crimes Against Older Persons created by NRS 179A.450; and

(c) Unit for the Investigation and Prosecution of Crimes.

8. If the investigation of a report results in the belief that an older person is abused, neglected, exploited or isolated, the Aging and Disability Services Division of the Department of Health and Human Services or the county's office for protective services may provide protective services to the older person if the older person is able and willing to accept them.

9. A person who knowingly and willfully violates any of the provisions of this section is guilty of a misdemeanor.

10. As used in this section, "Unit for the Investigation and Prosecution of Crimes" means the Unit for the Investigation and Prosecution of Crimes Against Older Persons in the Office of the Attorney General created pursuant to NRS 228.265.

Sec. 53. NRS 200.50935 is hereby amended to read as follows:

200.50935 1. Any person who is described in subsection 3 and who, in a professional or occupational capacity, knows or has reasonable cause to believe that a vulnerable person has been abused, neglected, exploited or isolated shall:

(a) Report the abuse, neglect, exploitation or isolation of the vulnerable person to a law enforcement agency; and

(b) Make such a report as soon as reasonably practicable but not later than 24 hours after the person knows or has reasonable cause to believe that the vulnerable person has been abused, neglected, exploited or isolated.

2. If a person who is required to make a report pursuant to subsection 1 knows or has reasonable cause to believe that the abuse, neglect, exploitation or isolation of the vulnerable person involves an act or omission of a law enforcement agency, the person shall make the report to a law enforcement agency other than the one alleged to have committed the act or omission.

3. A report must be made pursuant to subsection 1 by the following persons:

(a) Every physician, dentist, dental hygienist, chiropractor, optometrist, podiatric physician, medical examiner, resident, intern, professional or practical nurse, perfusionist, physician assistant licensed pursuant to chapter 630 or 633 of NRS, psychiatrist, psychologist, marriage and family therapist, clinical professional counselor, clinical alcohol and drug abuse counselor, alcohol and drug abuse counselor, athletic trainer, driver of an ambulance, advanced emergency medical technician ***, licensed dietitian*** or other person providing medical services licensed or certified to practice in this State, who examines, attends or treats a vulnerable person who appears to have been abused, neglected, exploited or isolated.

(b) Any personnel of a hospital or similar institution engaged in the admission, examination, care or treatment of persons or an administrator, manager or other person in charge of a hospital or similar institution upon notification of the suspected abuse, neglect, exploitation or isolation of a vulnerable person by a member of the staff of the hospital.

(c) A coroner.

(d) Every person who maintains or is employed by an agency to provide nursing in the home.

(e) Any employee of the Department of Health and Human Services.

(f) Any employee of a law enforcement agency or an adult or juvenile probation officer.

(g) Any person who maintains or is employed by a facility or establishment that provides care for vulnerable persons.

(h) Any person who maintains, is employed by or serves as a volunteer for an agency or service which advises persons regarding the abuse, neglect, exploitation or isolation of a vulnerable person and refers them to persons and agencies where their requests and needs can be met.

(i) Every social worker.

(j) Any person who owns or is employed by a funeral home or mortuary.

4. A report may be made by any other person.

5. If a person who is required to make a report pursuant to subsection 1 knows or has reasonable cause to believe that a vulnerable person has died as a result of abuse, neglect or isolation, the person shall, as soon as reasonably practicable, report this belief to the appropriate medical examiner or coroner, who shall investigate the cause of death of the vulnerable person and submit to the appropriate local law enforcement agencies and the appropriate prosecuting attorney his or her written findings. The written findings must include the information required pursuant to the provisions of NRS 200.5094, when possible.

6. A law enforcement agency which receives a report pursuant to this section shall immediately initiate an investigation of the report.

7. A person who knowingly and willfully violates any of the provisions of this section is guilty of a misdemeanor.

Sec. 54. NRS 200.5095 is hereby amended to read as follows:

200.5095 1. Reports made pursuant to NRS 200.5093, 200.50935 and 200.5094, and records and investigations relating to those reports, are confidential.

2. A person, law enforcement agency or public or private agency, institution or facility who willfully releases data or information concerning the reports and investigation of the abuse, neglect, exploitation or isolation of older persons or vulnerable persons, except:

(a) Pursuant to a criminal prosecution;

(b) Pursuant to NRS 200.50982; or

(c) To persons or agencies enumerated in subsection 3,

➥ is guilty of a misdemeanor.

3. Except as otherwise provided in subsection 2 and NRS 200.50982, data or information concerning the reports and investigations of the abuse, neglect, exploitation or isolation of an older person or a vulnerable person is available only to:

(a) A physician who is providing care to an older person or a vulnerable person who may have been abused, neglected, exploited or isolated;

(b) An agency responsible for or authorized to undertake the care, treatment and supervision of the older person or vulnerable person;

(c) A district attorney or other law enforcement official who requires the information in connection with an investigation of the abuse, neglect, exploitation or isolation of the older person or vulnerable person;

(d) A court which has determined, in camera, that public disclosure of such information is necessary for the determination of an issue before it;

(e) A person engaged in bona fide research, but the identity of the subjects of the report must remain confidential;

(f) A grand jury upon its determination that access to such records is necessary in the conduct of its official business;

(g) Any comparable authorized person or agency in another jurisdiction;

(h) A legal guardian of the older person or vulnerable person, if the identity of the person who was responsible for reporting the alleged abuse, neglect, exploitation or isolation of the older person or vulnerable person to the public agency is protected, and the legal guardian of the older person or vulnerable person is not the person suspected of such abuse, neglect, exploitation or isolation;

(i) If the older person or vulnerable person is deceased, the executor or administrator of his or her estate, if the identity of the person who was responsible for reporting the alleged abuse, neglect, exploitation or isolation of the older person or vulnerable person to the public agency is protected, and the executor or administrator is

not the person suspected of such abuse, neglect, exploitation or isolation; or

(j) The older person or vulnerable person named in the report as allegedly being abused, neglected, exploited or isolated, if that person is not legally incompetent.

4. If the person who is reported to have abused, neglected, exploited or isolated an older person or a vulnerable person is the holder of a license or certificate issued pursuant to chapters 449, 630 to 641B, inclusive, or 654 of NRS, ***or sections 1.5 to 46, inclusive, of this act, the*** information contained in the report must be submitted to the board that issued the license.

Secs. 55-57. (Deleted by amendment.)

Sec. 58. NRS 372.7285 is hereby amended to read as follows:

372.7285 1. In administering the provisions of NRS 372.325, the Department shall apply the exemption to the sale of a medical device to a governmental entity that is exempt pursuant to that section without regard to whether the person using the medical device or the governmental entity that purchased the device is deemed to be the holder of title to the device if:

(a) The medical device was ordered or prescribed by a provider of health care, within his or her scope of practice, for use by the person to whom it is provided;

(b) The medical device is covered by Medicaid or Medicare; and

(c) The purchase of the medical device is made pursuant to a contract between the governmental entity that purchases the medical device and the person who sells the medical device to the governmental entity.

2. As used in this section:

(a) "Medicaid" means the program established pursuant to Title XIX of the Social Security Act, 42 U.S.C. §§ 1396 et seq., to provide assistance for part or all of the cost of medical care rendered on behalf of indigent persons.

(b) "Medicare" means the program of health insurance for aged persons and persons with disabilities established pursuant to Title XVIII of the Social Security Act, 42 U.S.C. §§ 1395 et seq.

(c) "Provider of health care" means a physician licensed pursuant to chapter 630, 630A or 633 of NRS, perfusionist, dentist, licensed nurse, dispensing optician, optometrist, practitioner of respiratory care, registered physical therapist, podiatric physician, licensed psychologist, licensed audiologist, licensed speech pathologist, licensed hearing aid specialist, licensed marriage and family therapist, licensed clinical professional counselor,

chiropractor ***, licensed dietitian*** or doctor of Oriental medicine in any form.

Sec. 59. NRS 374.731 is hereby amended to read as follows:

374.731 1. In administering the provisions of NRS 374.330, the Department shall apply the exemption to the sale of a medical device to a governmental entity that is exempt pursuant to that section without regard to whether the person using the medical device or the governmental entity that purchased the device is deemed to be the holder of title to the device if:

(a) The medical device was ordered or prescribed by a provider of health care, within his or her scope of practice, for use by the person to whom it is provided;

(b) The medical device is covered by Medicaid or Medicare; and

(c) The purchase of the medical device is made pursuant to a contract between the governmental entity that purchases the medical device and the person who sells the medical device to the governmental entity.

2. As used in this section:

(a) "Medicaid" means the program established pursuant to Title XIX of the Social Security Act, 42 U.S.C. §§ 1396 et seq., to provide assistance for part or all of the cost of medical care rendered on behalf of indigent persons.

(b) "Medicare" means the program of health insurance for aged persons and persons with disabilities established pursuant to Title XVIII of the Social Security Act, 42 U.S.C. §§ 1395 et seq.

(c) "Provider of health care" means a physician licensed pursuant to chapter 630, 630A or 633 of NRS, perfusionist, dentist, licensed nurse, dispensing optician, optometrist, practitioner of respiratory care, registered physical therapist, podiatric physician, licensed psychologist, licensed audiologist, licensed speech pathologist, licensed hearing aid specialist, licensed marriage and family therapist, licensed clinical professional counselor, chiropractor ***, licensed dietitian*** or doctor of Oriental medicine in any form.

Sec. 60. NRS 442.003 is hereby amended to read as follows:

442.003 As used in this chapter, unless the context requires otherwise:

1. "Advisory Board" means the Advisory Board on Maternal and Child Health.

2. "Department" means the Department of Health and Human Services.

3. "Director" means the Director of the Department.

4. "Fetal alcohol syndrome" includes fetal alcohol effects.

5. "Health Division" means the Health Division of the Department.

6. "Obstetric center" has the meaning ascribed to it in NRS 449.0155.

7. "Provider of health care or other services" means:

(a) A clinical alcohol and drug abuse counselor who is licensed, or an alcohol and drug abuse counselor who is licensed or certified, pursuant to chapter 641C of NRS;

(b) A physician or a physician assistant who is licensed pursuant to chapter 630 or 633 of NRS and who practices in the area of obstetrics and gynecology, family practice, internal medicine, pediatrics or psychiatry;

(c) A licensed nurse;

(d) A licensed psychologist;

(e) A licensed marriage and family therapist;

(f) A licensed clinical professional counselor;

(g) A licensed social worker; ~~[or]~~

(h) ***A licensed dietitian; or***

(i) The holder of a certificate of registration as a pharmacist.

Sec. 61. NRS 608.0116 is hereby amended to read as follows:

608.0116 "Professional" means pertaining to an employee who is licensed or certified by the State of Nevada for and engaged in the practice of law or any of the professions regulated by chapters 623 to 645, inclusive, 645G and 656A of NRS ~~[.]~~ ***and sections 1.5 to 46, inclusive, of this act.***

Sec. 62. Section 26 of this act is hereby amended to read as follows:

Sec. 26. 1. In addition to any other requirements set forth in this chapter ~~[:~~

~~(a) An applicant for the issuance of a license to engage in the practice of dietetics in this State shall include the social security number of the applicant in the application submitted to the Board.~~

~~(b) An]~~ ***, an*** applicant for the issuance or renewal of a license to engage in the practice of dietetics in this State shall submit to the Board the statement prescribed by the Division of Welfare and Supportive Services of the Department of Health and Human Services pursuant to NRS 425.520. The statement must be completed and signed by the applicant.

2. The Board shall include the statement required pursuant to subsection 1 in:

(a) The application or any other forms that must be submitted for the issuance or renewal of the license; or

(b) A separate form prescribed by the Board.

3. A license to engage in the practice of dietetics may not be issued or renewed by the Board if the applicant:

(a) Fails to submit the statement required pursuant to subsection 1; or

(b) Indicates on the statement submitted pursuant to subsection 1 that the applicant is subject to a court order for the support of a child and is not in compliance with the order or a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order.

4. If an applicant indicates on the statement submitted pursuant to subsection 1 that the applicant is subject to a court order for the support of a child and is not in compliance with the order or a plan approved by the district attorney or other public agency enforcing the order for the repayment of the amount owed pursuant to the order, the Board shall advise the applicant to contact the district attorney or other public agency enforcing the order to determine the actions that the applicant may take to satisfy the arrearage.

Sec. 63. (Deleted by amendment.)

Sec. 63.5. Except for the suspension of a license pursuant to section 35 of this act, no disciplinary action may be initiated, investigated or imposed pursuant to sections 1.5 to 46, inclusive, of this act before July 1, 2013.

Sec. 64. Notwithstanding the provisions of section 20 of this act, the State Board of Health shall grant a license to engage in the practice of dietetics in this state without examination to a person who:

1. Was engaged in the practice of dietetics in this State on or before January 1, 2012;

2. Submits an application for a license to the Board on or before January 1, 2013; and

3. Presents proof that the person:

(a) Is a registered dietitian; or

(b) Meets the education and experience requirements set forth in section 20 of this act.

Sec. 65. 1. This section and sections 11 and 63 of this act become effective upon passage and approval.

2. Sections 1 to 10, inclusive, 12 to 61, inclusive, 63.5 and 64 of this act become effective on July 1, 2011, for the purpose of adopting regulations and carrying out any other administrative tasks, and on January 1, 2012, for all other purposes.

3. Section 62 of this act becomes effective on the date on which the provisions of 42 U.S.C. § 666 requiring each state to establish procedures under which the state has authority to withhold or suspend, or to restrict the use of professional, occupational and recreational licenses of persons who:

(a) Have failed to comply with a subpoena or warrant relating to a proceeding to determine the paternity of a child or to establish or enforce an obligation for the support of a child; or

(b) Are in arrears in the payment for the support of one or more children,

➥ are repealed by the Congress of the United States.

4. Sections 35 and 62 of this act expire by limitation on the date 2 years after the date on which the provisions of 42 U.S.C. § 666 requiring each state to establish procedures under which the state has authority to withhold or suspend, or to restrict the use of professional, occupational and recreational licenses of persons who:

(a) Have failed to comply with a subpoena or warrant relating to a proceeding to determine the paternity of a child or to establish or enforce an obligation for the support of a child; or

(b) Are in arrears in the payment for the support of one or more children,

➥ are repealed by the Congress of the United States.

Senate Bill No. 292–Senator Roberson

CHAPTER.....

AN ACT relating to civil actions; providing immunity from civil actions for a board of trustees of a school district or the governing body of a charter school under certain circumstances; revising the applicability of certain provisions of existing law pertaining to certain civil actions involving negligence; revising provisions governing the limitation on the amount of noneconomic damages that may be awarded in certain civil actions; making various other changes relating to certain actions involving negligence; and providing other matters properly relating thereto.

Legislative Counsel's Digest:

Section 1 of this bill provides that a board of trustees of a school district or the governing body of a charter school is not liable for any civil damages arising from any act or omission by a person employed by or volunteering at a school-based health center. **Section 1** also defines "school-based health center" for such purposes.

Existing law defines "medical malpractice," "dental malpractice" and "professional negligence" and contains various provisions relating to civil actions involving claims of medical malpractice, dental malpractice and professional negligence. (Chapter 41A of NRS) This bill removes references in existing law to medical malpractice and dental malpractice and replaces those references with references to professional negligence. **Section 1.5** of this bill also revises the definition of professional negligence to incorporate provisions of the previously used definition of medical malpractice.

Existing law defines the term "provider of healthcare" for the purposes of certain civil actions involving professional negligence. (NRS 41A.017) **Section 2** of this bill revises that definition to include certain other professionals who provide health care and to include clinics, surgery centers and other entities that employ physicians and other such persons.

Existing law limits the amount of noneconomic damages that may be awarded in an action for injury or death against a provider of health care based upon professional negligence. (NRS 41A.035) **Section 3** of this bill limits the total noneconomic damages that may be awarded in such an action to $350,000, regardless of the number of plaintiffs, defendants or theories of liability.

Existing law establishes a rebuttable presumption in actions for negligence against providers of medical care that the personal injury or death was caused by negligence when certain injuries are sustained. (NRS 41A.100) **Section 9** of this bill provides that the rebuttable presumption does not apply in an action in which: (1) a plaintiff submits an affidavit or designates an expert witness to establish that a provider of health care deviated from the accepted standard of care; or (2) expert medical testimony is used to establish a claim of professional negligence.

EXPLANATION – Matter in *bolded italics* is new; matter between brackets [~~omitted material~~] is material to be omitted.

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

Section 1. Chapter 41 of NRS is hereby amended by adding thereto a new section to read as follows:

1. The board of trustees of a school district or the governing body of a charter school that allows or establishes a school-based health center is not liable for any civil damages as a result of any act or omission by a person employed by or volunteering for or affiliated with a school-based health center or a sponsoring entity of the school-based health center.

2. As used in this section, "school-based health center" means a health center located on or in school grounds, property, buildings or any other school district facilities for the purpose of rendering care or services to any person.

Sec. 1.3. NRS 41A.003 is hereby amended to read as follows:

41A.003 As used in this chapter, unless the context otherwise requires, the words and terms defined in NRS [~~41A.004~~] *41A.007* to 41A.017, inclusive, have the meanings ascribed to them in those sections.

Sec. 1.5. NRS 41A.015 is hereby amended to read as follows:

41A.015 "Professional negligence" means [~~a negligent act or omission to act by~~] *the failure of* a provider of health care *,* in [~~the~~] rendering [~~of professional~~] services, [~~which act or omission is the proximate cause of a personal injury or wrongful death. The term does not include services that are outside the scope of services for which the provider of health care is licensed or services for which any restriction has been imposed by the applicable regulatory board or health care facility.~~] *to use the reasonable care, skill or knowledge ordinarily used under similar circumstances by similarly trained and experienced providers of health care.*

Sec. 2. NRS 41A.017 is hereby amended to read as follows:

41A.017 "Provider of health care" means a physician licensed [~~under~~] *pursuant to* chapter 630 or 633 of NRS, *physician assistant,* dentist, licensed nurse, dispensing optician, optometrist, registered physical therapist, podiatric physician, licensed psychologist, chiropractor, doctor of Oriental medicine, medical laboratory director or technician, licensed dietitian or a licensed hospital *, clinic, surgery center, physicians' professional corporation or group practice that employs any such person* and its employees.

Sec. 3. NRS 41A.035 is hereby amended to read as follows:

41A.035 In an action for injury or death against a provider of health care based upon professional negligence, the injured plaintiff may recover noneconomic damages, but the amount of noneconomic damages awarded in such an action must not exceed $350,000 ~~[.]~~ *, regardless of the number of plaintiffs, defendants or theories upon which liability may be based.*

Sec. 4. (Deleted by amendment.)

Sec. 5. NRS 41A.061 is hereby amended to read as follows:

41A.061 1. Upon the motion of any party or upon its own motion, unless good cause is shown for the delay, the court shall, after due notice to the parties, dismiss an action involving ~~[medical malpractice or dental malpractice]~~ *professional negligence* if the action is not brought to trial within ~~[:~~

~~(a) Three years after the date on which the action is filed, if the action is filed on or after October 1, 2002, but before October 1, 2005.~~

~~(b) Two]~~ *3* years after the date on which the action is filed . ~~[, if the action is filed on or after October 1, 2005.]~~

2. Dismissal of an action pursuant to subsection 1 is a bar to the filing of another action upon the same claim for relief against the same defendants.

3. Each district court shall adopt court rules to expedite the resolution of an action involving ~~[medical malpractice or dental malpractice.]~~ *professional negligence.*

Sec. 6. NRS 41A.071 is hereby amended to read as follows:

41A.071 If an action for ~~[medical malpractice or dental malpractice]~~ *professional negligence* is filed in the district court, the district court shall dismiss the action, without prejudice, if the action is filed without an affidavit ~~[, supporting]~~ *that:*

1. Supports the allegations contained in the action ~~[.]~~ *;*

2. Is submitted by a medical expert who practices or has practiced in an area that is substantially similar to the type of practice engaged in at the time of the alleged ~~[malpractice.]~~ *professional negligence;*

3. Identifies by name, or describes by conduct, each provider of health care who is alleged to be negligent; and

4. Sets forth factually a specific act or acts of alleged negligence separately as to each defendant in simple, concise and direct terms.

Sec. 7. NRS 41A.081 is hereby amended to read as follows:

41A.081 1. In an action for ~~[medical malpractice or dental malpractice,]~~ *professional negligence,* all the parties to the action,

the insurers of the respective parties and the attorneys of the respective parties shall attend and participate in a settlement conference before a district judge, other than the judge assigned to the action, to ascertain whether the action may be settled by the parties before trial.

2. The judge before whom the settlement conference is held:

(a) May, for good cause shown, waive the attendance of any party.

(b) Shall decide what information the parties may submit at the settlement conference.

3. The judge shall notify the parties of the time and place of the settlement conference.

4. The failure of any party, the party's insurer or the party's attorney to participate in good faith in the settlement conference is grounds for sanctions, including, without limitation, monetary sanctions, against the party or the party's attorney, or both. The judges of the district courts shall liberally construe the provisions of this subsection in favor of imposing sanctions in all appropriate situations. It is the intent of the Legislature that the judges of the district courts impose sanctions pursuant to this subsection in all appropriate situations to punish for and deter conduct which is not undertaken in good faith because such conduct overburdens limited judicial resources, hinders the timely resolution of meritorious claims and increases the costs of engaging in business and providing professional services to the public.

Sec. 8. NRS 41A.085 is hereby amended to read as follows:

41A.085 1. In an action for damages for ~~[medical malpractice or dental malpractice]~~ ***professional negligence*** in which the defendant is insured pursuant to a policy of insurance covering the liability of the defendant for a breach of the defendant's professional duty toward a patient:

(a) At any settlement conference, the judge may recommend that the action be settled for the limits of the policy of insurance.

(b) If the judge makes the recommendation described in paragraph (a), the defendant is entitled to obtain from independent counsel an opinion letter explaining the rights of, obligations of and potential consequences to the defendant with regard to the recommendation. The insurer shall pay the independent counsel to provide the opinion letter described in this paragraph, except that the insurer is not required to pay more than $1,500 to the independent counsel to provide the opinion letter.

2. The section does not:

(a) Prohibit the plaintiff from making any offer of settlement.

(b) Require an insurer to provide or pay for independent counsel for a defendant except as expressly provided in this section.

Sec. 9. NRS 41A.100 is hereby amended to read as follows:

41A.100 1. Liability for personal injury or death is not imposed upon any provider of ~~[medical]~~ ***health*** care based on alleged negligence in the performance of that care unless evidence consisting of expert medical testimony, material from recognized medical texts or treatises or the regulations of the licensed medical facility wherein the alleged negligence occurred is presented to demonstrate the alleged deviation from the accepted standard of care in the specific circumstances of the case and to prove causation of the alleged personal injury or death, except that such evidence is not required and a rebuttable presumption that the personal injury or death was caused by negligence arises where evidence is presented that the ***provider of health care caused the*** personal injury or death occurred in any one or more of the following circumstances:

(a) A foreign substance other than medication or a prosthetic device was unintentionally left within the body of a patient following surgery;

(b) An explosion or fire originating in a substance used in treatment occurred in the course of treatment;

(c) An unintended burn caused by heat, radiation or chemicals was suffered in the course of medical care;

(d) An injury was suffered during the course of treatment to a part of the body not directly involved in the treatment or proximate thereto; or

(e) A surgical procedure was performed on the wrong patient or the wrong organ, limb or part of a patient's body.

2. Expert medical testimony provided pursuant to subsection 1 may only be given by a provider of ~~[medical]~~ ***health*** care who practices or has practiced in an area that is substantially similar to the type of practice engaged in at the time of the alleged negligence.

3. ~~[As used in this section, "provider of medical care" means a physician, dentist, registered nurse or a licensed hospital as the employer of any such person.]~~ ***The rebuttable presumption pursuant to subsection 1 does not apply in an action in which a plaintiff submits an affidavit pursuant to NRS 41A.071, or otherwise designates an expert witness to establish that the specific provider of health care deviated from the accepted standard of care.***

4. Nothing in this section shall be construed to preclude any party to the suit from designating and presenting expert testimony

as to the legal or proximate cause of any alleged personal injury or death.

Sec. 10. NRS 3.029 is hereby amended to read as follows:

3.029 *1.* The Supreme Court shall provide by court rule for mandatory appropriate training concerning the complex issues of ~~[medical malpractice]~~ litigation *alleging professional negligence* for each district judge to whom actions involving ~~[medical malpractice]~~ *professional negligence* are assigned.

2. As used in this section, "professional negligence" has the meaning ascribed to it in NRS 41A.015.

Sec. 11. The amendatory provisions of this act apply to a cause of action that accrues on or after the effective date of this act.

Sec. 12. NRS 41A.004, 41A.009 and 41A.013 are hereby repealed.

Sec. 13. This act becomes effective upon passage and approval.