# JOINT SUBCOMMITTEE STUDYING RISK MANAGEMENT PLANS FOR PHYSICIANS AND HOSPITALS SB 601 (2004)

http://dls.state.va.us/SB601.HTM
Monday, December 6, 2004, 1:30 p.m.
Fourth Floor East, General Assembly Building
Richmond, Virginia

Summary of Meeting

The joint subcommittee considered a list of 22 recommendations made to it. The joint subcommittee decided to introduce one omnibus bill and a resolution to continue the study for one year. The subcommittee discussed each recommendation and placed them in one of three categories: introduce as legislation in the 2005 General Assembly Session, refer for further study next year, or not recommend. In a number of instances the subcommittee asked interested parties to work together and come to a consensus on as many issues as possible.

1. Require an expert witness to certify prior to service of process on a defendant, that the standard of care was breached by the defendant which proximately caused damages.
***Discussion:*** *Questions arose as to what would happen if the expert witness did not qualify as an expert at trial. The response was that this would not matter if the affidavit was offered in good faith and if it was done in bad faith it would be an ethical violation. Concern was expressed about discovery problems and litigation over the qualifications of the expert. There was discussion about whether it is preferable for certification to occur prior to filing a pleading or prior to service on the defendant.*
***Recommendation:*** *Combine with No. 17, ask the interested parties (Medical Society of Virginia, Virginia Trial Lawyers, Association of Defense Attorneys) to work together on language to be included in legislation for the 2005 General Assembly Session.*

2. Provide that damages are not recoverable in a personal injury or wrongful death suit against a health care provider if the plaintiff left the medical facility against medical advice.
***Discussion:*** *This comes from Sawyer v. Comerci, 264 Va. 69 (2002), where a patient left the emergency room against medical advice. The court's refusal to allow an instruction on contributory negligence was one issue. Patients sometimes refuse to sign an informed refusal; to protect a physician the refusal to sign must be documented in the medical record.*
***Recommendation:*** *Ask the involved parties to look at the case and narrow the area of disagreement, work together on language to be included in legislation for the 2005 General Assembly Session .*

3. Allow evidence of collateral benefits at trial.
***Discussion:*** *Subcommittee was asked to look at benefits for Medicaid, Medicare or social security disability because they are paid by the government and are easily quantifiable and to allow the jury to be informed that those payments have been made on behalf of the plaintiff or that recovery be limited to those payment. This will not result in a direct reduction in medical malpractice premiums but it will more accurately reflect what is being paid out. This is included in California's MICRA plan. In many instances the payor has the right to be reimbursed out of the settlement.*
***Recommendation:*** *Not recommended at this time, keep on table for next year.*

4. Prohibit evidence of a physician saying "I am sorry" or apologizing to a patient from being admitted into evidence in any subsequent litigation as an admission of liability or admission against interest.
***Discussion:*** *To some patients, an apology is very important and is a condition of settlement. Doctors are sometimes advised not to apologize because it could be an admission of liability or an admission against interest. Other states have legislation that allows communication of an expression of condolence without admitting liability. Some members expressed concern that an apology could alert a patient to a medical malpractice case that would not otherwise be pursued.*
***Recommendation:*** *Ask interested parties to work together on language to be included in legislation for the 2005 General Assembly Session.*

5. Limit the professional liability insurance plan to be established and administered by the Division of Risk Management pursuant to SB 601 to true crisis situations (bankruptcy of carrier or carrier leaves market).
***Discussion:*** *Savings over a private insurance company would result from lower administrative costs and tax savings. Concerns were expressed about whether it would be difficult to determine what a crisis is, who would determine if there is a crisis and whether it would be possible to administer the professional liability insurance plan only if there is a crisis. Problem of adverse selection and potential impact on free market were discussed. No reason to limit the professional liability insurance plan at this time, eligibility criteria were discussed (and broadened from original version) last year when bill was developed.*
***Recommendation:*** *Not recommended at this time, keep on table for next year.*

6. Require all medical malpractice claims settled or adjudicated to final judgment and any such claim closed without payment, during each calendar year to be reported annually to the State Corporation Commission by the insurer of the health care provider.
***Discussion:*** *This provision was previously in the Code and was repealed in 1996. Since then the electronic transmission of information has improved, making the reporting requirement less burdensome. Having these statistics would be helpful to the Subcommittee and for other purposes. Bureau of Insurance will develop a uniform reporting form.*
***Recommended****: Draft bill to accomplish this.*

7. Require the Board of Medicine to evaluate the competency of a practitioner who has had five malpractice settlements or judgments in the most recent ten year period and require the Virginia State Bar to evaluate the competency of an attorney who has had five incidents of discipline, settlements or judgments in the most recent ten year period.
***Discussion:*** *The Virginia State Bar has a comprehensive investigative and disciplinary system for lawyers and it is not clear that including lawyers in this bill would positively impact medical malpractice issues. The Subcommittee discussed HB 1441 (2003) and SB 1334 (2003) which revised disciplinary procedures for persons licensed by the Board of Medicine.*
***Recommendation:*** *Not recommended.*

8. Mandate that all malpractice cases be heard by a malpractice review panel and provide consequences for a plaintiff who institutes a suit when the panel has found in favor of the defense.
***Discussion:*** *Use of panels has dropped significantly. Discussion included whether using a panel amounts to trying a case twice, increases costs, and burdens plaintiffs who are less able to afford two trials than an insurance company. Also discussed was the effect of having both expert witness certification and a panel, how to pick panel members and assuring that panels are fair. Whether something should be done to revamp panels, issues are complex. If panels are used the process should be meaningful.*
***Recommendation:*** *Not recommended at this time. The subcommittee will study the issue in its next year of study; the issue should be specifically mentioned in the study resolution.*

9. Establish a $250,000 cap on non-economic damages.
***Recommendation:*** *Not recommended at this time, keep on table for next year.*

10. Establish a limit on attorneys' fees.
***Recommendation:*** *Not recommended at this time, keep on table for next year.*

11. Eliminate the rule that prohibits treating physicians from testifying in medical malpractice cases involving their patients.
***Discussion:*** *There are treating physicians who are not defendants and there is variation in the information that can be elicited from them. There is a lack of agreement on what is fact and what is opinion. Physician-patient confidentiality is a consideration.*
***Recommendation:*** *Interested parties will develop consensus language.*

12. Allow defense attorneys to interview or speak with other health care providers of the patient/plaintiff.
***Discussion:*** *This item goes with no. 11.*
***Recommendation:*** *Not recommended at this time, keep on table for next year.*

13. Revise the definition of "malpractice" in § 8.01-581.1 to include any "action or claim of any description or kind whatsoever."
***Discussion:*** *There have been several medical malpractice cases filed as breech of contract or battery to avoid the cap.*
***Recommendation:*** *Concept acceptable but this language is too broad; ask interested parties to narrow the scope and agree on language to be included in legislation for the 2005 General Assembly Session.*

14. Allow malpractice cases to be filed only in the venue jurisdiction where the medical care was delivered to plaintiff and provide that the statute of limitations is not tolled if the suit is filed in the wrong jurisdiction, except where excusable error was made.
***Discussion:*** *HB 1127 (2004) changed Category B venue to include counties or cities in which the defendant regularly conducts substantial business activity rather that counties or cities in which the defendant regularly conducts affairs or business activity.*
***Recommendation:*** *Not recommended at this time, see how 2004 legislation works, keep on table for next year.*

15. Repeal subsection C of § 8.01-581.20, which limits each party to two expert witnesses.
***Discussion:*** *There is no Daubert rule (allows judge to decide if the testimony from an expert witness is relevant and reliable) in Virginia. Defendants feel trial court should be able to manage experts, this is an arbitrary limit that allows a plaintiff to prevail if there are two experts that agree. Plaintiffs see as a cost containment bill.*
***Recommendation:*** *Not recommended.*

16. Allow depositions to serve as the basis for granting a motion for summary judgment or striking evidence in a medical malpractice case.
***Discussion:*** *Defendants feel it is necessary in order to reform medical malpractice. Plaintiffs feel that there will be numerous summary judgment motions based on depositions and it will raise litigation costs.*
***Recommendation:*** *Not recommended at this time, keep on table for next year.*

17. Require the plaintiff, prior to filing suit, to secure admissible medical expert opinion that there has been a breach of the applicable standard of care.
***Recommendation:*** *See item one.*

18. Revise § 8.01-401.1 for medical malpractice cases only to permit the text of medical literature to be submitted to the jury as an exhibit, to allow qualification of medical literature as "authoritative" by the experts for the party proposing the exhibit literature, and shortening the time for disclosure of such literature to 10 days before trial.
***Discussion:*** *Defendants want the jury to be able to get medical literature and to be able to cross examine experts even if the expert does not think the medical literature is an authoritative source. Plaintiffs say 10 days is not long enough to review literature, 30 day rule we have now is fine. Only those statements you designate are read in, jurors should not have to go through long medical articles. Present statute is good.*
***Recommendation:*** *Not recommended at this time, keep on table for next year.*

19. Require the Executive Secretary of the Supreme Court to develop a case summary form to be completed by the plaintiff and filed with the initial pleading in each civil case in the circuit court. The form should include the name and address of the plaintiff and defendant, the type of case, the final disposition and if the action is a medical malpractice action, the profession and specialty of the health care professional. The Executive Secretary will produce reports from the information in the automated system.
***Discussion:*** *Purpose is to gather statistics, see what specialties are most affected.*
***Recommendation:*** *Not recommended at this time, keep on table for next year.*

20. In practice areas where medical malpractice insurance rates are particularly egregious, require the State Corporation Commission to review rates based on loss experience in Virginia and not from other states. Medical malpractice insurance for the practice areas will be removed from "file and use" category and be made subject to rate regulation (as workers' compensation insurance, for example). Rates will then be set based on the loss experience from Virginia.
***Discussion:*** *Discussion of SCC rate study (Analysis of Medical Professional Liability Rates for Physicians and Surgeons), known as the Mercer Report, completed in December, 2003.*
***Recommendation:*** *Write a letter to the SCC asking for the gathering of this information, report to Subcommittee next year.*

21. Prohibit any entity from mandating that physicians carry limits equal to or greater than the current malpractice cap.
***Discussion:*** *Virginia hospitals seem to be the only hospitals in the country that require a physician, as a condition of practicing at the hospital, carry a $2/$6 million policy. Hospitals in other states seem to require $1/$3million. The average loss is $200,000. Hospitals are limiting their liability by requiring physicians to have insurance that exceeds the $1.75 million cap. A policy of $2/$6 million costs 25-30 percent more than a $1/$3 million. Hospitals do not have an incentive to terminate an incompetent physician. Discussion of whether this would lead to lower costs, whether other disciplinary methods would be more effective and whether $2/$6 million policies would still be available if hospitals were not allowed to require them.*
***Recommendation:*** *Ask interested parties to agree on a bill that applies to all medical facilities. Allow the medical facilities to require $1/$3 million policy.*

22. Draft a study resolution to continue the Joint Subcommittee Studying Risk Management Plans for Physicians and Hospitals for another year.
***Recommendation:*** *Recommended.*