



Sub. H.B. 215*

125th General Assembly
(As Reported by H. Insurance)

Reps. Schmidt, Schneider, White, Collier, Peterson, Hollister, Kearns, Wagner, Faber, Gibbs, DeWine, Flowers, Taylor, Setzer, Raga, Reidelbach, Wolpert, Webster, Aslanides, Raussen, Daniels, Carmichael, Blasdel, Koziura, D. Evans, T. Patton, Sferra, Seaver, Hughes, Barrett, G. Smith, Driehaus, Woodard, Olman, Book, Brown

BILL SUMMARY

- Prohibits the use of a defendant's statement of sympathy as evidence in a medical liability action.
- Establishes qualifications for expert witnesses providing testimony in a medical liability action.
- Regulates the collection and disclosure of medical claims data by the Department of Insurance.
- Regulates defendants' use of affidavits of noninvolvement in medical claims.

CONTENT AND OPERATION

Medical liability actions

Evidence

(sec. 2317.43)

The bill prohibits the use of any statement of sympathy offered by a health care provider or an employee of a health care provider as evidence of an admission

* This analysis was prepared before the report of the House Insurance Committee appeared in the House Journal. Note that the list of co-sponsors and the legislative history may be incomplete.

of liability or an admission against interest in a civil action or related arbitration proceeding brought by an alleged victim of an unanticipated outcome of medical care. For this purpose, a statement of sympathy includes any and all statements, affirmations, gestures, or conduct expressing apology, sympathy, commiseration, condolence, compassion, or a general sense of benevolence that are made by a health care provider or an employee of a health care provider to the alleged victim, a relative of the alleged victim, or a representative of the alleged victim, in relation to the discomfort, pain, suffering, injury, or death of the alleged victim as the result of the unanticipated outcome of the medical care provided.

The bill defines the following terms used in this section:

(1) "Health care provider" includes health care practitioners, hospitals, ambulatory care facilities, long-term care facilities, pharmacies, and emergency facilities, as those terms are further defined in division (B)(5) of section 2317.02 of the Revised Code.

(2) "Relative" means a victim's spouse, parent, grandparent, stepfather, stepmother, child, grandchild, brother, sister, half brother, half sister, or spouse's parents. The term includes any of these relationships created as a result of an adoption. The term also includes any person who has a family-type relationship with the victim.

(3) "Representative" means a legal guardian, attorney, person designated to make decisions on behalf of a patient under a medical power of attorney, or any person recognized in law or custom as a patient's agent.

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

Expert witness competent to testify in a medical liability action; testimony

(secs. 2323.421 and 2743.43)

Current law deems persons competent to give expert testimony on liability issues in a medical claim, as a medical claim is defined in R.C. 2305.113 of Common Pleas Court Law, if the person is licensed to practice medicine and surgery, inclusive of osteopathic and podiatric medicine and surgery, by the state medical board of Ohio or the licensing authority of another state, and devotes three-fourths of the person's professional time to the active clinical practice of medicine and surgery or its instruction in an accredited university. The bill retains the qualifications currently needed by persons to give expert testimony in a medical claim, but adds the following additional qualifications.

Under the bill, a witness is not competent to give expert testimony in a medical claim unless the witness also practices in the same or a substantially similar specialty as the defendant. The bill prohibits a court from permitting an expert in one medical specialty to testify against a health care provider in another medical specialty, unless the expert shows both that the standards of care and practice in the two specialties are similar and that the expert has substantial familiarity between the specialties.

A witness also is not competent to give expert testimony in a medical claim, pursuant to the bill, unless the witness is certified in a medical specialty by a board recognized by the American Board of Medical Specialties or the American Board of Osteopathic Specialties as having acknowledged expertise and training directly related to the particular health care matter at issue.

Current law prohibits construing the above qualifications as limiting the power of a trial court to allow the testimony of any other expert witness that is relevant to the medical claim. The bill modifies this prohibition to provide that the qualifications for an expert witness established by the Revised Code do not limit the power of a trial court to allow the testimony of any other witness on a matter unrelated to the liability issues in the medical claim, when that testimony is relevant to the medical claim.

The bill permits the State Medical Board to discipline physicians licensed in another state who provide expert testimony in Ohio. The bill deems a person licensed by another state to practice medicine who testifies in Ohio as an expert witness on behalf of any party in any action against a physician for injury or death, whether the action is in contract or tort, arising out of the provision of or failure to provide health care services, as having a temporary license to practice medicine in Ohio for the purpose of providing the expert testimony. As a temporary licensee in Ohio, the witness is subject to the authority of and discipline ordered by the State Medical Board and the provisions in Chapter 4731. of the Revised Code that regulate physicians.

Defendant's affidavit of noninvolvement

(sec. 2323.45)

The bill permits a health care provider named as a defendant in a civil action based upon a medical claim to file a motion for dismissal of the claim with the presiding court, with an affidavit of noninvolvement accompanying the motion. For this purpose, the bill defines "health care provider" to include health care practitioners, hospitals, ambulatory care facilities, long-term care facilities, pharmacies, and emergency facilities, as those terms are further defined in division (B)(5) of section 2317.02 of the Revised Code. "Medical claim" means a claim or

derivative claim asserted in any civil action against a health care provider that arises out of the medical diagnosis, care, or treatment of any person.

If a defendant health care provider files a motion for dismissal with an affidavit of noninvolvement, the bill requires the defendant to provide written notice of the filing to all parties to the civil action. Prior to ruling on the defendant's motion for dismissal, the court is required to give all parties to the action not less than 30 days from the date that the parties were served with the notice to respond to the motion.

An affidavit of noninvolvement, under the bill, must set forth with particularity the facts that demonstrate that the defendant was misidentified or otherwise not involved individually or through the action of the defendant's agents or employees in the care and treatment of the plaintiff, was not obligated individually or through the defendant's agents or employees to provide for the care and treatment of the plaintiff, and could not have caused the alleged malpractice individually or through the defendant's agents or employees in any way.

The parties to the civil action are given the right to challenge the affidavit of noninvolvement by filing a motion and submitting an affidavit with the court that contradicts the assertions of noninvolvement made in the defendant's affidavit. The bill provides that if the affidavit is challenged, any party may request an oral hearing on the motion for dismissal. The court is required to hold a hearing, if one is requested, to determine if the defendant was involved, directly or indirectly, in the care and treatment of the plaintiff, or was obligated, directly or indirectly, for the care and treatment of the plaintiff. The court is required to consider the arguments of the parties and all of the evidence submitted by the parties under the bill's provisions, and may dismiss the civil action based upon the defendant's lack of involvement in the elements of the plaintiff's claim. The court is required to rule on all challenges to the affidavit of noninvolvement within 75 days after the defendant's filing of the affidavit. The bill provides that the court's dismissal of the claim against the defendant is upon the merits and without prejudice. In the event that subsequent discovery indicates involvement by the dismissed defendant, then upon the motion of any party the dismissed defendant will be reinstated as a party defendant by the court.

Under the bill, if the court determines that a health care provider named as a defendant has falsely filed or made false or inaccurate statements in an affidavit of noninvolvement, the court, upon a motion or upon the court's own initiative, must immediately reinstate the claim against that defendant, if the claim was previously dismissed. Reinstatement of a party is not barred by any statute of limitations defense that was not valid at the time the affidavit was filed.

The bill identifies acts constituting violations of these provisions and provides penalties for violations. In any action in which the court finds the defendant to have knowingly filed a false or inaccurate affidavit of noninvolvement, the court is required to impose upon the person who signed the affidavit or who represented the defendant, or both, an appropriate sanction, including, but not limited to, an order to pay to other parties to the claim the amount of the reasonable expenses that the parties incurred as a result of the filing of the false or inaccurate affidavit, including reasonable attorney fees. Similarly, in any action in which the court determines that a party falsely objected to a defendant's affidavit of noninvolvement, or knowingly provided an inaccurate statement regarding a defendant's affidavit, the court is required to impose upon the party or the party's counsel, or both, an appropriate sanction, including, but not limited to, an order to pay to the other parties to the claim the amount of the reasonable expenses that the parties incurred as a result of the submission of the false objection or inaccurate statement, including reasonable attorney fees.

Collection and disclosure of medical claims data

(sec. 3929.302)

The bill requires every authorized insurer, surplus lines insurer, risk retention group, self-insurer, the medical liability underwriting association (if created under provisions of the Revised Code), and any other entity that offers medical malpractice insurance in Ohio to report to the Department of Insurance at least annually regarding all medical, dental, optometric, and chiropractic claims filed against an insured located in Ohio, if the claim resulted in a final judgment or settlement in any amount or a final disposition resulting in no indemnity payment on behalf of the insured.

All of the following information must be in the report to the Department of Insurance under the bill:

- (1) The name, address, health care provider professional license number, and specialty coverage of the insured.
- (2) The insured's policy number.
- (3) The date of the occurrence that created the claim.
- (4) The name and address of the injured person.
- (5) The date that the claim was filed.
- (6) The injured person's age and sex.

(7) The total number, names, and health care provider professional license numbers of all defendants involved in the claim.

(8) The date and amount of the judgment, if any, including a description of the portion of the judgment that represents economic loss, non-economic loss and, if applicable, punitive damages.

(9) In the case of a settlement, the date and amount of the settlement, the injured person's incurred and anticipated medical expenses, wage loss, and other expenses.

(10) The loss adjustment expense paid to defense counsel, plaintiff's counsel if available, and all other allocated loss adjustment expenses paid.

(11) The date and reason for final disposition, if no judgment or settlement occurred.

(12) A summary of the occurrence that created the claim, including all of the following information:

(a) The name of the institution, if any, and the location within the institution where the injury occurred;

(b) The final diagnosis for which treatment was sought or rendered, including the patient's actual condition;

(c) The operation, diagnostic, or treatment procedure causing the injury;

(d) A description of the principal injury that gave rise to the claim;

(e) The safety management steps that have been taken by the insured to make similar occurrences or injuries less likely in the future.

(13) Any other information required by the Superintendent of Insurance pursuant to rules adopted in accordance with the Administrative Procedure Act.

The Superintendent is authorized by the bill to prescribe the format and the manner in which the information described is reported. The Superintendent may, by rule adopted in accordance with the Administrative Procedure Act, prescribe the frequency that the information must be reported. The Superintendent also is authorized to designate one or more licensed rating organizations or other agencies to assist in gathering the required information and making compilations thereof.

The Superintendent is required to fine any party that fails to timely submit the required report \$500. The bill provides that the fines are to be paid into the state treasury to the credit of the Department of Insurance Operating Fund.

There is no liability under the bill on the part of, and no cause of action of any nature against, any person or entity reporting under these provisions or the reporting person's or entity's agents or employees. Also, there is no liability on the part of, and no cause of action of any nature against, the Department of Insurance and its employees for any action taken that is authorized under these provisions.

Except as otherwise specifically provided, all information reported to the Department of Insurance pursuant to the bill is confidential and privileged and is not a public record as defined in section 149.43 of the Revised Code. The information provided is not subject to discovery or subpoena and is not to be made public by the Superintendent or any other person.

The bill requires the Department of Insurance to prepare an annual report that summarizes the claims reported under the bill. The annual report must summarize the closed claim reports received by the Department on a statewide basis, and also by specialty and geographic region. Individual claims data is not to be released in the annual report. Copies of the report are to be provided to the members of the General Assembly.

For this purpose, medical, dental, optometric, and chiropractic claims include those claims filed with a medical malpractice insurer against an insured located in this state that either meet the definition of a "medical claim," "dental claim," "optometric claim," or "chiropractic claim" under the Common Pleas Courts Law, or that have not been asserted in any civil action but otherwise meet the definitions in the Common Pleas Courts Law.

Current law, section 2303.23 of the Revised Code, requires the clerks of all Courts of Common Pleas to submit annual reports to the Department of Insurance with information on medical liability claims. The bill repeals that section.

Recommendations of the General Assembly

(Sections 3 and 4)

The bill includes recommendations that would not, however, be enacted into the Revised Code. The bill states, "The General Assembly respectfully requests the Supreme Court to require a plaintiff filing a medical liability claim to include a certificate of expert review with the complaint or to file the certificate of expert review with the court within thirty days after the filing of the claim. The General Assembly respectfully requests that the certificate of expert review

require the signature of an expert witness from the same specialty as the defendant; said witness shall be required to meet the evidentiary and case law requirements of a medical expert capable of testifying at trial. A certificate of expert review should be required to state with particularity the expert's familiarity with the applicable standard of care, the expert's qualifications, the expert's opinion as to how the applicable standard of care was breached, and the expert's opinion as to how the breach resulted in the injury or death."

The bill also states, "The General Assembly respectfully requests the Supreme Court to amend the Rules of Civil Procedure to incorporate the mandatory discovery disclosure rules embodied in Rule 26 of the Federal Rules of Civil Procedure."

HISTORY

ACTION	DATE	JOURNAL ENTRY
Introduced	06-06-03	p. 549
Reported, H. Insurance	---	---

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