Statement of the
Ohio State Medical Association and the Ohio Hospital Association
to the House Judiciary Committee

H.B. 7 – Medical Claims

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Chairman Butler and members of the House Judiciary Committee, my name is Tim Maglione and I am the Senior Director of Government Relations for the Ohio State Medical Association (OSMA). On behalf of the 16,000 members of the OSMA, I offer testimony today in support of H.B. 7, legislation that modifies laws relating to medical liability claims. Also testifying with me today is Bobbie Sprader, a partner with the Bricker & Eckler law firm and counsel to the OSMA and Ohio Hospital Association.

H.B. 7 includes 10 different medical liability reforms that represent an effort to achieve a goal of **eliminating unnecessary litigation** and to provide **further clarity, stability and predictability** to our medical and legal communities.

Reducing "Shotgun" Lawsuits (lines 739-784)

H.B. 7 proposes modifications to existing law with the goal of eliminating the undesirable practice of "shot gunning" defendants in medical claims. As you know, this is a process in which numerous defendants are initially named in a lawsuit, but subsequently dismissed from the case. The Plaintiffs' Bar contends that this current practice is necessitated because of several recent case law decisions. However, the result is unnecessary expenses to plaintiffs and pointless costs to physicians and their insurers, not to mention other adverse consequences to physicians associated with the reporting of lawsuits filed against them.

The proposed modifications seek to minimize the necessity for this practice by allowing plaintiffs a finite period to name additional defendants after the initial filing of a medical claim. The modifications would also impose upon plaintiffs the obligation to exercise due diligence to discover the basis for asserting claims against any such additional defendants within that period.

Under these proposed modifications:

- After an initial medical claim complaint is filed, the statute of limitations is tolled for a period of 180 days as to other potential defendants. The intent is to provide a limited period for plaintiffs to conduct formal discovery to determine whether to join additional defendants and comply with the affidavit of merit requirements to do so. (Additional defendants may only be added if the statute of limitations as to them had not already expired as of the time of the initial filing.)

- Joining additional defendants requires compliance with the requirements of affidavits of merit under Civil Rule 10.

- After the 180-day tolling period following the initial filing, no additional defendants may be joined unless it can be shown that "discovery" (currently defined by common law as a "cognizable event") of the additional claim and/or defendant occurred after the 180-day period and due diligence would not have disclosed such claim and/or potential defendant earlier. (Because plaintiffs will have formal powers of discovery following the initial filing, it is anticipated that circumstances allowing for joining of additional defendants beyond the 180-day tolling period will be infrequent.)

180-day Letter Service by Mail (lines 49-59)

Current law allows a plaintiff to extend the existing 1-year statute of limitations by 180-days by providing potential defendants a 180-day "intent to sue" notice. This notice requirement must be by personal service. H.B. 7 modifies the personal service requirement by permitting a potential plaintiff to send the required statutory notice by certified mail to potential defendants at one of four specified addresses.

Amendment of the Apology Statute (lines 580-654)

Ohio's apology statute currently declares any conduct expressing apology by a health care provider to a patient, a relative or representative of the patient following a medical error is inadmissible as evidence of liability or statement against interest.

The apology statute was first enacted in 2004 to provide opportunities for healthcare providers to apologize and console victims of unanticipated outcomes of medical care without fear that their statements will be used against them in a malpractice suit. Our thought on this was that the statute would allow a physician to show empathy by explaining, and taking responsibility for, unanticipated outcomes related to medical care.

As proponents of the original "I'm Sorry" legislation (HB 215, 125th General Assembly) we understood the apology statute to include statements of error or fault because the very definition of apology includes those elements:

- American Heritage Dictionary: "Apology. 1. An acknowledgement expressing regret or **asking pardon for a fault or offense**."
- Merriam-Webster: "Apology. * * * 2. An **admission of error** or discourtesy accompanied by an expression of regret."
- Oxford Dictionaries: "Apology. 1. A regretful **acknowledgment of an offense or failure**."

Further, then State Representative Jean Schmidt in her sponsor floor speech on HB 215 said the physician-patient protected disclosure provision "was patterned after Colorado's 'I'm Sorry' law" (and, as noted below, the Colorado statute includes protecting statements of fault).

But the courts have struggled with the scope of the apology statute, trying to distinguish fault statements and sympathy statements. This has led to an inconsistent application of the statute and confused fact-finders. For example:

- "I'm sorry you had a life-threatening reaction to the medication I prescribed."
- I did not expect the surgical procedure I performed to lead to these server complications."
- "I apologize that the transplant surgery that I recommended for your daughter was not successful."

Because of this grey area, many providers must tread very carefully when communicating to patients and the entire purpose of the statute is undermined.

Thus, we believe the apology statute should be clarified. Otherwise, forcing health care providers or hospitals to parse their words to avoid lawsuits is, in and of itself, incompatible with the concessionary, open-mindset characteristic of the apologetic stance. The simple answer is to amend the apology statute to include the words "error" and "fault." By doing so, the amended apology statute will further open the lines of communication between patient and physician, provide clarity, stability and predictability to our medical and legal communities, and reduce overall lawsuits. These are certainly worthy objectives.

The following states have apology statutes that make a health care provider's statement of fault inadmissible:

Arizona:	"liability, responsibility"
Colorado:	"fault"
Connecticut:	"fault"
Georgia:	"mistake, error"
Massachusetts:	"mistake, error"
South Carolina:	"mistake, error"

Utah:	Sequence of and/or significance of events relating to the unanticipated outcome
Vermont:	30 days to offer a good faith explanation of how a medical error occurred

Prohibit the Introduction of "Phantom Damages" (lines 554-579; 713-738)

Ohio case law indicates that the appropriate measure of damages for economic loss in a tort action is "that which will compensate and make the plaintiff whole" and the appropriate calculation of compensatory damages will reflect "the actual loss" to the plaintiff.

In health care, "the actual loss" related to medical expenses can be confusing because the amount a medical provider accepts as full payment for medical care is most always different (and less) than the initially-billed amount.

For several years, courts have struggled with this issue, specifically regarding the question of the admissibility of billed charges v. the amount that was actually paid for medical services.

H.B. 7 attempts to settle this issue by making it clear that "billed charges" are not admissible as evidence of the reasonableness of medical charges. Instead, only the *actual* amount accepted as full payment for the medical services will be admissible as evidence of the reasonableness of medical charges.

Abrogation of the Loss of Chance Theory (lines 697-712)

H.B. 7 abolishes an Ohio Supreme Court created theory of tort liability called "loss of chance." This theory was created by an Ohio Supreme Court decision in 2006, back when the court was considered by many observers to be an activist court that routinely "legislated from the bench."

In our view, the holding erodes the well-established tort element that requires plaintiffs to prove that the defendant's alleged negligence more likely than not caused the plaintiff's injury. It permits an award of damages to a plaintiff for a reduced chance of recovery or survival, despite the likelihood he or she would not recover or survive regardless of the defendant's negligence.

As you know, traditionally, to prevail on a malpractice suit, a plaintiff must prove four elements: (1) the physician owed a duty of care to the patient, (2) the physician breached this duty, (3) the breach proximately caused the patient's injury and (4) this resulted in injury or harm to the patient.

Loss of chance eliminates the element of proximate cause, or (3) cited above. Instead of necessitating proof of reasonable probability that the defendant's negligence proximately caused the injury, the plaintiff - who is already terminally ill or incapable of recovery - need only show the defendant possibly reduced his or her chance of survival or recovery.

Allowing such a cause of action effectively shifts the burden of proof regarding causation to the defendant, invites the jury to indulge in speculation and conjecture, and permits a verdict based on *possibility* as opposed to *probability*.

The Texas Supreme Court noted in a case rejecting recovery for loss of chance that *"The 'more likely than not' standard is thus not some arbitrary, irrational benchmark for cutting off malpractice recoveries, but rather a fundamental prerequisite of an ordered system of justice."*

We agree with the Texas Court's views regarding the traditional concept of causation and would urge your support for the provision of H.B. 7 that abolishes the loss of chance theory of liability.

Insurance Reimbursement Polices Do Not Establish the Standard of Care (lines 655-696)

H.B. 7 will prohibit the use of insurer payment policies and guidelines from being used to establish the standard of care. With respect to this issue, the language merely states that federal care guidelines, quality criteria or insurer payment rules – whether mandated by the Affordable Care Act (ACA), another law or by insurers – do not establish a legal basis for negligence or the standard of care to determine medical liability.

To explain the rationale for this new provision, it is helpful to understand some of the payment reform activities currently occurring in our nation's health care system. For example, the Centers for Medicare and Medicaid Services (CMS), along with public and private insurers, have adopted payment policies that adjust or restrict payment to health care providers and hospitals related to certain events. Likewise, under the ACA, new regulations have been adopted regarding payment incentives when certain "performance metrics" have been achieved.

The OSMA and OHA have concerns that as these guidelines are more widely implemented, they will be used in legal proceedings as an indicator of medical negligence. Yet, these payment guidelines or performance incentives were never intended to be used in legal proceedings to establish the standard of care. Rather, they were simply created as cost-management tools for the federal government and other third-party payers.

H.B. 7 will make it clear that the development, recognition, promulgation or implementation of any guideline, regulation or other standard under the ACA, Medicare or Medicaid or insurer reimbursement determinations shall not be construed to establish the standard of care or duty of care owed and is not admissible as evidence in a civil or administrative proceeding.

The language in H.B. 7 is modeled after a similar provision in the ACA. Additionally, comparable proposals have been enacted in Florida, Idaho and Georgia.

It should be noted that this provision does not change the traditional requirement of establishing the standard of care in medical liability cases. The standard of care will still be established with a qualified medical expert who can opine as to the level and type of care that a reasonably competent and skilled health care professional should have provided under the circumstances.

Nursing Home Plan of Care (lines 139-146)

The proposed change to 2305.113(E)(3) to the definition of "Medical Claim" is a technical one made to avoid unintended confusion caused by a recent change in that definition as it relates to claims brought against hospitals and other providers.

Last year, the nursing home community sought, and the legislature enacted, a change in the definition of "Medical Claim" under which the term "care" was replaced with "plan of care." However, while in a nursing home setting the term "plan of care" has a widely recognized meaning, the same is not true for hospitals and other providers.

Therefore, to avoid confusion for non-nursing home providers, the suggested change in H.B. 7 would revert the definition back to its former and well-understood definition for non-nursing home providers, while keeping the definition unchanged for nursing home providers.

Maintaining the Confidentiality of Peer Review Records (lines 390-402)

The proposed change to 2305.252(C) would codify a common practice that currently consumes a lot of unnecessary resources. Under current practice, if a law enforcement agency, state agency or licensing board requests information from a peer review file for purposes of an investigation, the information is often provided, and the provider and government agency negotiate to ensure the information remains confidential. Such negotiation consumes legal resources for both the provider and the governmental agency.

The proposed change to this section simply codifies that when information from a peer review file is shared with an investigator, those records retain their peer review protections and the recipient of the records is required to take appropriate steps to ensure their confidentiality.

Disaster Standard of Care (lines 239-313)

Proposed 2305.2311 would provide limited qualified protection for health care providers who deliver health care services during a disaster, where an event has occurred that has caused widespread injury, illness or loss of life. In those limited situations, care is often delivered in a chaotic environment, where staff and resources are stretched. In such situations, we believe the health care providers providing services should receive some limited immunity, as long as the provider's act or omission does not constitute "reckless disregard" for the consequences on the health or life of the patient.

The Ohio Supreme Court has defined “reckless” conduct to be “characterized by the conscious disregard of or indifference to a known or obvious risk of harm to another that is unreasonable under the circumstances and is substantially greater than negligent conduct.”

Though it is true that the ordinary standard of care contemplates what a reasonable provider would do under similar circumstances, it is difficult for a jury to appreciate the environment in which care could be delivered in the event of a mass casualty event.

This issue has been consistently raised for many years by members of Emergency Preparedness Committees. As you know, hospitals and other stakeholders have invested significant resources into Emergency Preparedness activities in terms of staff training, acquisition of equipment, development of emergency plans, resource allocation plans, etc. A constant fear from the providers on the ground who would provide care in response to a disaster is that they will be faced with significant liability for care delivered in a chaotic, unpredictable environment in the aftermath of a mass casualty event. The provider community believes it is appropriate to provide qualified immunity to those providers as long they do not act with reckless disregard for the consequences of their action or omission.

Mental Health Patient Discharge/Retention (lines 525-553)

The proposed change to 2305.51 addresses a particularly difficult issue in the hospital setting when dealing with a patient with mental health issues.

Often a patient seeking medical care in a hospital (often in the emergency department) also suffers from mental health problems. When the patient’s medical conditions are treated and the patient is *medically* approved to be discharged, the patient may still be suffering from mental health problems that could result in the patient harming himself or someone else. In those situations, if the hospital does not have a psychiatric unit or does not have capacity in their psychiatric unit, the hospital is stuck with two undesirable choices:

- Discharge the patient because their medical condition has been sufficiently treated and there is no medical reason to keep them at the hospital, even though the patient may pose a threat to himself or others; or
- Do not discharge the patient because of fear that the mental health condition could result in harm to the patient or others. However, by not discharging the patient, the hospital risks a claim for false imprisonment.

The proposed change in this section would grant immunity to health care providers who, in the good faith exercise of their professional judgment, and consistent with appropriate standards of professional practice, decide to either:

- Refuse to discharge the patient due to a mental health condition that threatens the safety of the patient or others; or

- Discharge the patient whom the provider believes does not have a mental health condition that threatens the safety of the patient or others.

Providers do not want to retain patients indefinitely under this provision. They want to keep them at the facility long enough to contact next of kin or other caregivers who can assist in ensuring the discharged patient, and those around them, are safe.

Conclusion

Mr. Chairman, again, this legislative proposal represents an effort to achieve a goal of eliminating unnecessary litigation and to provide further clarity, stability and predictability to our medical and legal communities. The OSMA and OHA have come together to work toward this common objective.

Chairman Butler, thank you again for the opportunity to comment on H.B. 7 and we would welcome any questions or comments that you or the Committee may have.