

Proponent Testimony of Ray Krncevic, Attorney at Tucker Ellis LLP

In Support of House Bill 7

Chairman Bacon, Ranking Member Thomas, and members of the Senate Judiciary Committee: My name is Ray Krncevic, and I am an attorney with the law firm of Tucker Ellis in Cleveland, Ohio, specializing in the field of medical malpractice litigation. Prior to joining my current firm, I served for ten years as in-house counsel for a major hospital system in Ohio. I am here today to offer proponent testimony on HB 7 on behalf of the Academy of Medicine of Cleveland and Northern Ohio, the Ohio Hospital Association, and the Ohio State Medical Association.

Many of the components of HB 7 have been considered by the General Assembly as part of tort reform bills in the past. This time around, what is important to note is the strong bipartisan support behind HB 7 when it passed the House in June of this year. Notably, the Ohio Alliance for Justice, which speaks on behalf of the plaintiff's bar in this state, and which has campaigned against the passage of prior tort reform bills, has taken a neutral stance on HB 7 as it sits before you now. This is a testament to the hard work by stakeholders on all sides in working to craft a bill that can enjoy broad bipartisan support, which notably does not include some earlier controversial provisions.

HB 7 contains a number of provisions that are reasonable measures to address certain gaps in the existing law and provide some meaningful and warranted protections for providers. I encourage the approval of this legislation, subject to the amendment advanced by Representative Cupp, by both this Committee and the full Senate prior to year's end.

The bill contains the following key provisions:

Apology In Event of Unanticipated Outcome (lines 585-668) – Existing law already prevents statements expressing apology, sympathy, condolence, or compassion from being admitted as evidence of liability or statement against

interest made by a provider to a patient or patient’s representative and that relate to the unanticipated outcome of medical care. The bill would add statements expressing “fault” or “error” to the list of protected statements, consistent with the recent Ohio Supreme Court decision of Stewart v. Vivian. The apology statute is intended to provide opportunities for healthcare providers to apologize and console patients without fear that their statements will be used against them in a malpractice suit. Many patients sue providers not for punitive reasons, but just so they can get answers to their questions and understand what happened. The bill will encourage a broader conversation between patients and physicians when an unanticipated outcome in medical care occurs, consistent with the Supreme Court’s recent holding.

Shotgun Lawsuits (lines 711-766) – This provision provides an alternative to the undesirable practice of “shotgunning” defendants in medical malpractice suits, in which numerous defendants are initially named in a lawsuit, even if they had little or no involvement in the care in question, and then subsequently dismissed from the case. Plaintiff’s counsel understandably resort to this method when their clients present them with a case just prior to the expiration of the statute of limitations, before counsel have adequate time to review the medical chart to assess whose care is actually at issue. This provision would give plaintiffs extra time to conduct such a review, and protect caregivers who have no material involvement in the case from the emotional trauma, stress, and expense that come with being named in a lawsuit. Existing law allows potential claimants to extend the statute of limitations on a malpractice claim by 180 days by providing written notice of their potential intent to sue, often referred to as a “180 day letter.” This bill does not alter that right in any way, but it does offer an alternate method: at the time of filing a complaint, if a 180 day letter has not already been served, then the plaintiff will be given an additional 180 days beyond the statute of limitations to add parties to the suit without a for-cause showing. As long as plaintiffs file within the one-year statute of limitations, they will be able to add defendants over the ensuing 180 days. Under this option, plaintiffs will not be prejudiced in any way, and medical providers whose care is not at issue, but whose names nevertheless appear in the patient’s chart, will be spared the burden of being sued, notifying their insurer, and retaining counsel.

Qualified Immunity for Providers in Limited Mental Health Situations (lines 556-584) – This provision addresses the difficult issue hospitals often face with patients having a suspected mental health issue who may pose a risk to their own safety or someone else’s. Current law provides a process for emergency involuntary psychiatric admission, commonly referred to as a “pink slip,” but patients’ conditions are often more nuanced and may not fit that statutory formula. Hospital personnel are then faced with a tough choice: hold these patients in the hospital against their will, even if they are medically cleared for discharge, and face a false imprisonment lawsuit? Or release them, and face a malpractice suit if the patient subsequently harms himself or someone else? Recognizing the difficulty of such situations, the law currently provides added protection in the form of qualified immunity for mental health providers. But there is no similar protection for all the other medical professionals who do not necessarily have specialized mental health training, yet find themselves trying to do the right thing in the same challenging dilemma.

HB 7 remedies this situation by extending qualified immunity to physicians, physician assistants, nurse practitioners, and hospitals if they believe that they are either discharging, or refusing to discharge, such patients “in the good faith exercise of professional judgment according to appropriate standards of professional practice.” This means that, if these medical professionals believe they are following appropriate standards in determining whether the patient does, or does not have, a mental health condition that threatens the safety of the patient or others, and act accordingly, they will be subject neither to civil damages nor disciplinary action by a licensing or regulatory body of the State. Importantly, this qualified immunity does not extend to injunctive relief, meaning that patients who believe, or whose families believe, that they are being wrongly held against their will can still petition a court to order their release from the hospital. In other words, this legislative change does nothing to restrict existing rights under the “pink slip” statute.

It is important to note that, above all, providers are trying to do the right thing for patients with mental health challenges. If these patients are ready to leave the

hospital, providers want to let them leave, but they want to do so in a manner that protects the safety of the patients and those around them.

Qualified Immunity for Providers during a Declared Disaster (lines 232-339) –

This provision provides qualified protection to certain health care providers and emergency medical technicians (“EMTs”) who provide emergency medical services, first-aid, or other emergency professional services to patients whose injuries or conditions result from a disaster that is declared as such by the federal, state, or local government. In those limited situations, care is often delivered in a chaotic environment, where staff and resources are stretched. Qualified immunity does not apply if the provider’s act or omission constitutes “reckless disregard” for the consequences to the patient. And though it is true that the ordinary standard of care contemplates what a reasonable provider would do under similar circumstances, it can be difficult for a jury to appreciate the environment in which care could be delivered in the event of a mass casualty event.

Insurance Company Payment Policies / Federal Regulations Do Not Establish Standard of Care (lines 669-710) –

This provision provides that any guideline, regulation, or standard under federal law, and any reimbursement determination or policy by an insurance company, are not admissible to establish the standard of care or breach thereof. It confirms the long-standing principle in Ohio law that medical professionals should be judged by their peers teaching or practicing in their respective clinical field, not by anyone else. In medical malpractice suits, the standard of care must continue to be established by a qualified medical expert who can speak to the level and type of care that a reasonably competent physician should have provided under the circumstances, not based on a reimbursement decision of a payer. The Centers for Medicare and Medicaid Services, as well as other public and private payers, are adopting payment policies that adjust or restrict payment to health care providers. These policies are being adopted as cost-management tools and were never intended to be used in legal proceedings to establish the standard of care. This provision will ensure that the numerous and varying payment policies implemented by government or private

payers are not used to establish the standard of care. Several other states have adopted similar provisions.

Mr. Chairman and members of the committee, thank you for the opportunity to testify. I would be happy to answer any questions.