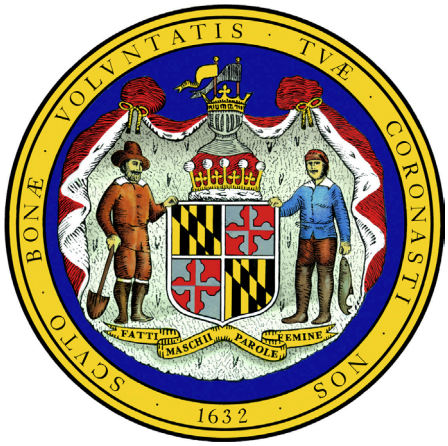
Governor's Task Force on Medical Malpractice and Health Care Access

Final Report



November, 2004

Robert L. Ehrlich, Jr
Governor

Judge Raymond G. Thieme
Task Force Chairman

REPORT OF THE GOVERNOR'S TASK FORCE ON MEDICAL MALPRACTICE AND HEALTH CARE ACCESS

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Table of Contents

EXECUTIVE SUMMARY

On June 25, 2004, Governor Robert L. Ehrlich, Jr., appointed the Governor's Task Force on Medical Malpractice and Health Care Access, composed of 22 members. The Governor appointed the task force because he believed that the State is facing a health care crisis due to the rising costs of malpractice insurance. These costs are threatening both the accessibility and affordability of health care in the State.

The Governor charged the task force with examining several issues, using as a starting point the legislation he introduced for the 2004 session, Senate Bill 193 and House Bill 287, the Maryland Medical Injury Compensation Reform Act. He also asked the task force to consider other issues including but not limited to legal reforms, patient safety, insurance issues, and alternative dispute resolution.

The task force began meeting in July 2004 and met 11 times during the summer and fall. The task force heard from a broad variety of interested parties. The following is a report of the findings and recommendations approved by a majority of the task force.

Economic Damages

Recommendation – That in any award for lost wages the plaintiff should not receive any amount that would have been paid as income tax if the wages had been earned.

Recommendation – That an award for past medical bills should only be for the actual amount paid or payable by the plaintiff or on the plaintiff's behalf by a third person.

Recommendation – That an award for future medical bills should more accurately reflect what will be paid by the plaintiff or on the plaintiff's behalf by limiting the payment to a standard such as Medicare rates, the rates charged by a health insurer, or the amount paid by the Workers' Compensation Commission.

Recommendation – That the amount of a plaintiff's recovery should be reduced by the amount of benefits to which the plaintiff is entitled under any governmental entitlement.

Recommendation – That the amount of a plaintiff's recovery should be reduced for past medical expenses paid on the plaintiff's behalf by means of a collateral source, unless there is the right to subrogation by the third party under federal law.

Cap on Noneconomic Damages

Recommendation – That the cap on noneconomic damages be reduced to $500,000 in medical malpractice cases.

Recommendation – That the annual $15,000 escalator in the cap on noneconomic damages be eliminated in medical malpractice cases.

Recommendation – That the double cap on noneconomic damages in death cases involving medical malpractice be eliminated.

Attorney's Fees

Recommendation - That legislation should be enacted limiting in medical malpractice cases a plaintiff's attorney's fees using a sliding scale similar to California and other states.

Recommendation – That fee splitting by plaintiff's attorneys in medical malpractice cases be limited to circumstances where and to the extent to which each attorney actually participates in the preparation and/or trial of the case.

Judgments

Recommendation – That large judgments for noneconomic damages and future economic damages should be required to be paid in the form of periodic payments.

Procedures

Recommendation – That the State should enact a rule of procedure similar to Federal Rule of Civil Procedure 68 allowing the defendant to make an offer of judgment and requiring a plaintiff who receives a judgment for less than the amount offered to pay all costs incurred after the offer was made.

Recommendation – That the statute establishing that there be only six jurors in civil cases be amended to conform to the provision of the Maryland Constitution requiring at least six jurors in a civil case, thereby allowing a trial judge to establish the number of jurors in a case.

Recommendation – That the venue for medical malpractice actions be the venue in which the health care was provided.

Recommendation – That the venue for bad faith actions involving actions by health care providers against their insurance carriers for wrongful failure to settle a medical malpractice case be the venue where the provider took out the insurance policy.

Liability

Recommendation – That hospitals and health care providers who provide care in compliance with the Federal Emergency Medical Treatment and Active Labor Act be liable only for acts of gross negligence.

Alternative Dispute Resolution

Recommendation – That the Health Claims Arbitration Office be abolished.

Recommendation – That there be established a statewide mediation program in the courts allowing parties to a medical malpractice action to engage in mediation at the earliest possible date.

Recommendation – That legislation be enacted allowing health care providers and patients to enter into agreements providing for binding arbitration of medical malpractice claims.

Recommendation – That the Court of Appeals Standing Committee on Rules of Practice and Procedure study and make recommendations concerning establishment of health courts.

Certificate of Qualified Expert

Recommendation – That if the Health Claims Arbitration Office is abolished, the certificate of qualified expert requirements under the Health Claims Arbitration Act be retained for court proceedings. Clerks of the circuit courts should be required to forward all certificates of merit to an appropriate unit of State government. This unit will be responsible for notifying the appropriate licensing boards of pending actions and judgments as required by law.

Recommendation – That the plaintiff's certificate of qualified expert specify the breach of the standard of care for each health care provider named as a defendant.

Recommendation – That the plaintiff in a medical malpractice case should be required to file with the court following completion of discovery an enhanced certificate of qualified expert specifying with detail each defendant's deviation from the standard of care.

Expert Witness

Recommendation – That the State should enact legislation similar to Virginia requiring an expert testifying to the standard of care in a medical malpractice action to have engaged in the clinical practice of medicine in the defendant's specialty or a related field of medicine within one year of the date of the alleged act or omission giving rise to the cause of action.

Recommendation – That if the defendant is board certified, an expert attesting to or testifying as to the standard of care must also be board certified in the same or a related specialty as the defendant.

Recommendation – That testimony by a health care provider as an expert witness on the standard of care in a medical malpractice case be considered the practice of medicine for purposes of disciplinary proceedings.

Recommendation – That the Department of Labor, Licensing, and Regulation study and report on whether life care experts should be licensed by the State.

Evidence

Recommendation – That the State should enact legislation similar to Colorado allowing a health care provider to make an apology or other benevolent gesture and making such a statement or gesture inadmissible in subsequent proceedings.

Recommendation – That evidence that a family member or other individual will provide unreimbursed care for the plaintiff be admissible for purposes of assessing the plaintiff's damages, and that this evidence may be considered by the court when deciding a motion for remittitur.

Insurance

Recommendation – That rate compression legislation not be enacted.

Recommendation – That each insurer providing medical malpractice liability insurance in the State be required to submit annually to the Maryland Insurance Administration a report detailing its operations and finances for the past year.

Patient Safety

Recommendation – That in a disciplinary proceeding before the Board of Physicians the State need only prove by a preponderance of evidence instead of by clear and convincing evidence that a physician violated the standard of care.

Recommendation - That hospitals failing to report to the Department of Health and Mental Hygiene adverse events involving death or serious disability be subject to a fine.

Recommendation – That in a judicial action following a final decision by a hospital or health care facility to limit, suspend, or revoke the credentials of a health care provider that the loser of the action be required to pay the winner's reasonable attorney's fees.

Alternatives to Litigation

Recommendation – That the Maryland Insurance Administration study and report on the concept of a no-fault birth-related neurological injury compensation fund.

Short-term Relief

Recommendation – That short-term relief, including a temporary funding mechanism to reduce premiums, should be adopted only in conjunction with a meaningful and comprehensive package of reforms that includes tort reform, and that short-term relief should not be adopted without a meaningful and comprehensive package of reforms that includes tort reform.

Recommendation – That if short-term relief including a temporary funding mechanism to reduce premiums, is adopted it should only be adopted with a sunset provision so that it terminates after an appropriate period of time.

Nursing Home and other High Risk Physicians and Practices

Recommendation – That the location and nature of a health care provider's practice should not affect the cost or availability of medical malpractice insurance.

INTRODUCTION

In the 2004 session of the General Assembly Governor Robert L. Ehrlich, Jr., introduced crossfiled bills, Senate Bill 193 and House Bill 287, entitled the Maryland Medical Injury Compensation Reform Act. Governor Ehrlich introduced these bills in response to concerns about the rising costs of medical malpractice liability insurance paid by health care providers and the impact of these rising costs on access to and quality of health care in the State. These bills both received unfavorable reports in the respective Senate and House committees. The House of Delegates did pass House Bill 1299 during the 2004 session, entitled Medical Malpractice Reforms and Task Force. This bill received an unfavorable report in the Senate Judicial Proceedings Committee.

On June 25, 2004, Governor Robert L. Ehrlich, Jr., appointed the Governor's Task Force on Medical Malpractice and Health Care Access, composed of 22 members. The Governor appointed the task force because he believed the rising costs of malpractice insurance were threatening both the accessibility and affordability of health care in the State. These increases are affecting doctors, nurse midwives, hospitals, nursing homes, assisted living facilities, and birthing centers. The Governor believed that the State was facing a crisis in health care.

The Governor charged the task force with examining several issues. As a starting point he asked the task force to review the legislation he introduced for the 2004 session, Senate Bill 193 and House Bill 287. Using these bills he requested that the task force consider changes to the current tort system. Secondly, he asked the task force to review current practices and laws relating to patient safety. Thirdly, he requested that the task force consider proposals considered but not passed by the General Assembly during the 2004 session that would have made changes to the laws relating to medical malpractice, including insurance law. The fourth issue he wanted the task force to consider was expanding the use of alternative dispute resolution to resolve cases. The Governor made it clear that by enumerating the above issues he did not intend to limit the scope of the task force.

The task force began meeting in July 2004 and met 11 times during the summer and fall. The task force heard from a broad variety of interested parties, including plaintiff and defense lawyers, a federal judge, structured settlement professionals, a life care expert, persons with expertise in alternative dispute resolution, and insurance consultants, and considered submissions from various interested parties, including victims of medical malpractice. In addition, the task force held a public hearing at which any interested person was given an opportunity to sign up and address the task force.

BACKGROUND

Maryland

This is the third medical malpractice crisis that the State has faced in the last 30 years. The first crisis occurred in the mid 1970s with the withdrawal from the State of the St. Paul Fire and Marine Insurance Company of Minnesota, the primary medical malpractice insurer in the State, following the denial by the Maryland Insurance Administration of a requested 48% rate increase. In response the General Assembly enacted legislation creating the Medical Mutual Liability Insurance Society of Maryland ("Medical Mutual"), a physician-owned mutual insurance company. The General Assembly also created the Health Claims Arbitration Office and required medical malpractice cases to be arbitrated before they could be tried in court.

In the early and mid-1980s malpractice premiums were again on the rise. Obstetricians, neurosurgeons, and other high risk specialties experienced premium increases ranging from 30% to 250%. Two study groups were appointed during this time. The Governor's Commission on Health Care Provider's Professional Liability Insurance studied the issue during the 1983 interim and reported its findings in January 1984. The Joint Executive/Legislative Task Force on Medical Malpractice Insurance met during the 1985 interim and reported its findings in December 1985. The most significant changes made during this time were: (1) establishing a $350,000 cap on noneconomic damages applicable to all tort cases; (2) allowing a reduction of damages in medical malpractice cases if the plaintiff has received benefits from a collateral source (e.g., health or disability insurance); and (3) lowering the statute of limitations for a minor to bring a claim for medical malpractice. Additional changes were made to the health claims arbitration process.

The medical malpractice insurance market stabilized in the late 1980s and remained stable through the 1990s. During the 1990s the most significant legal development concerned the cap on noneconomic damages. Chapter 477 of 1994 made three significant changes to the cap: (1) it raised the cap to $500,000; (2) it established a $15,000 annual escalator to the cap; and (3) it established a double cap in death cases, or a two-and-a-half times cap if there is more than one beneficiary in the wrongful death cases. In 2002 in *Piselli v. 75th Street Medical,* 371 Md. 188 (2002), the Court of Appeals held that the statute of limitations for minors in medical malpractice actions in § 5-109 of the Courts Article was unconstitutional.

The stability of the medical malpractice insurance market made for a competitive market. In 1995 there were 14 insurers writing physician malpractice insurance in the State. This led to fiercely competitive pricing on premiums. Profitability was made possible by slow claims growth coupled with favorable economic conditions.

According to the General Accounting Office, since 1999 medical malpractice premium rates have increased dramatically in a number of states.[1] While Maryland did not begin to experience these types of increases until the early 2000s Maryland has seen

[1] "Medical Malpractice – Implications of Rising Premiums on Access to Health Care," General Accounting Office (August 2003); "Medical Malpractice Insurance – Multiple Factors Have Contributed to Increased Premium Rates," General Accounting Office (June 2003)

significant increases in the last few years. The result of the increasing volatile market has been that since 1995 ten insurers have left the State, leaving only four insurers providing medical malpractice insurance to physicians.

National Trends

The experience in Maryland is similar to the experience of much of the rest of the country. In the 1970s much of the country first experienced a medical malpractice insurance crisis. The General Accounting Office states that physician-owned or operated insurers cover around 60% of the market. In Maryland, Medical Mutual has 75 to 80% of the market.

In its June 2003 report,[2] the Government Accounting Office reports that from 1992 to1998 medical malpractice premiums remained relatively flat. The report stated that "(s)ince 1999, medical malpractice premium rates have increased dramatically for physicians in some specialties in a number of states." The states of Pennsylvania and West Virginia have been among those particularly hard hit, with skyrocketing premiums and doctors engaging in job actions.

The report stated that many of these increases were "dramatic." Some rates in Pennsylvania rose by 165% for obstetricians, 130% for surgeons, and 130% for internists. Some states, however, such as California and Minnesota had only modest increases for these specialties.

The Congressional Budget Office states that "(o)n average, premiums for all physicians nationwide rose by 15% between 2000 and 2002 – nearly twice as fast as total health care spending per person."[3] The report states that the increases are even greater for certain specialties such as obstetricians, internists, and general surgeons. It goes on to state the following: "The available evidence suggests that premiums have risen both because insurance companies have faced increased costs to pay claims (from growth in malpractice awards) and because of reduced income from their investments and short-term factors in the insurance market."

Although there are several factors causing the increase in malpractice premiums, including a lower rate of return on investments, a less competitive market due to insurers leaving the field, and an increasing cost of reinsurance, the General Accounting Office found that "losses on medical malpractice claims—which make up the largest part of insurer costs – appear to be the primary driver of rate increases in the long run."[4]

According to the Congressional Budget Office report, the average malpractice payout has increased from $95,000 in 1986 to $320,000 in 2002. The average growth rate is 8%, twice the rate of inflation and more than the medical rate of inflation of 6.9%.

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[2] See Footnote 1

[3] "Limiting Tort Liability for Medical Malpractice," Congressional Budget Office, January 8, 2004.

[4] See Footnote 1

As is the case in Maryland, the report states that the rate of claims has remained relatively constant. Only about 30% of claims result in an insurance payout.

A report prepared by Tillinghast – Towers Perrin reports the following information on medical malpractice claims for the year 2002, based on statistics obtained from the Physician Insurers Association of America:

- 67.7% of all claims were dropped or dismissed;
- 4% resulted in a defense verdict;
- 27.3% were settled with a payment to the claimant; and
- 1% resulted in a plaintiff's verdict.[5]

Thus, over 70% of all claims result in no payments, and 80% of cases tried end in a defense verdict.

California Medical Injury Compensation Reform Act (MICRA)

California is one of six states identified by the American Medical Association as not being in crisis or showing problem signs of a medical malpractice insurance crisis. Many point to the California Medical Injury Compensation Reform Act of 1975, commonly known as MICRA, as the reason for the favorable insurance climate in California. MICRA contains the following basic provisions: (1) it limits noneconomic damages to $250,000; (2) it allows evidence of collateral source payments; (3) it limits plaintiff's attorney contingency fees; (4) it requires 90 days advance notice of a claim; (5) it establishes a statute of limitations of the lesser of one year from discovery of the injury or three years from the time of injury; (6) it requires payment of future economic damages over $50,000 in periodic amounts; and (7) it allows patients and providers to agree to resolve any future dispute through binding arbitration.

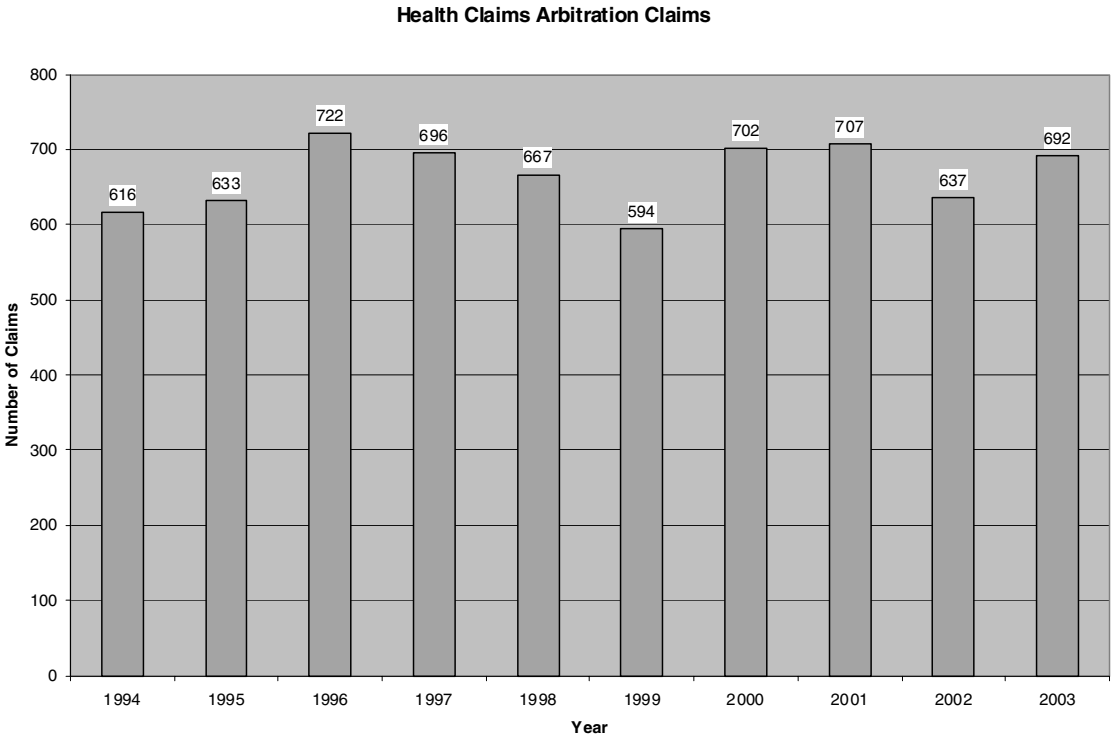
[5] "Medical Mutual Liability Insurance Society of Maryland: Review of 'The Facts about Medical Malpractice in Maryland' by Public Citizen," Tillinghast – Towers Perrin (October 27, 2003)

THE PROBLEM

Medical Malpractice Premiums and Increasing Liabilities

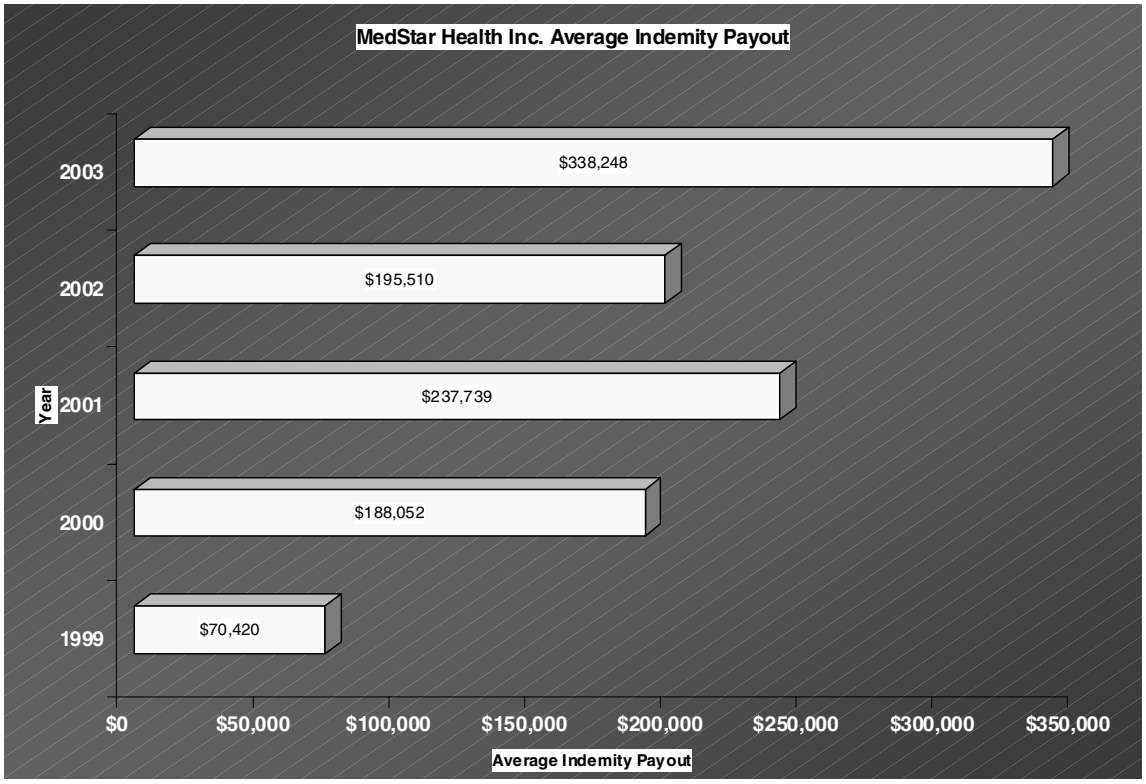
Unlike the medical malpractice insurance crisis in the 1980s, which saw the amount of claims filed with Health Claims Arbitration increase steadily from 326 claims filed in 1980 to 749 claims filed in 1986, the number of claims filed with Health Claims Arbitration Office in the past ten years has remained relatively constant, with claims generally ranging from 600 to 700 annually. The following graph shows this trend.

GRAPH 1



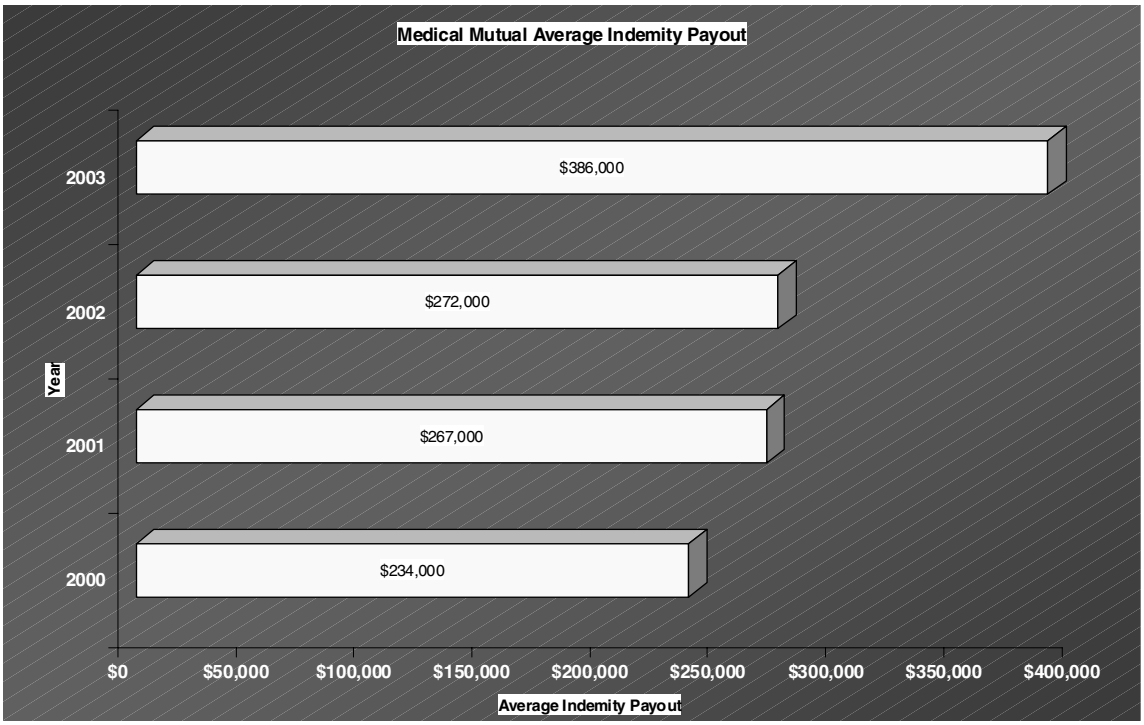
What has clearly increased is the average amount of indemnities paid on claims. The following chart shows the average amount of indemnities paid since 1999 for MedStar Health, Inc., which operates four hospitals in the State.

GRAPH 2



Medical Mutual's experience has been similar. From 1993 to 2000, the average claim paid fluctuated from $194,000 to $255,000. As Graph 3 illustrates, the average amount of indemnities paid began to rise in 2000.

GRAPH 3



In addition, Medical Mutual also saw the percentage of claims paid rise as well in 2003.

Medical Mutual began to increase premium rates at significant levels in 2003, with a 10% increase that year following years of much lower increases. In 2004 its rates rose 28%. In 2005 the increase will be 33%. In addition, in 2005 physicians insured by Medical Mutual will not receive the dividend they have received in the past, which this year was 14%. The result is a 47% increase for 2005. The bottom line is that medical malpractice rates for physician have doubled in the past three years. It is clear that the highest risk professions, specifically obstetricians, neurosurgeons, and emergency department physicians are taking the largest increases in the actual dollars paid for premiums.

Other physician insurers in the State have received or requested similar increases. NCRIC Group, Inc. just filed for a 25% increase effective for 2005. The Doctor's Company filed at the end of October for a 40% increase for 2005. GE Medical Protective received a 59.6% increase effective August 1, 2004.

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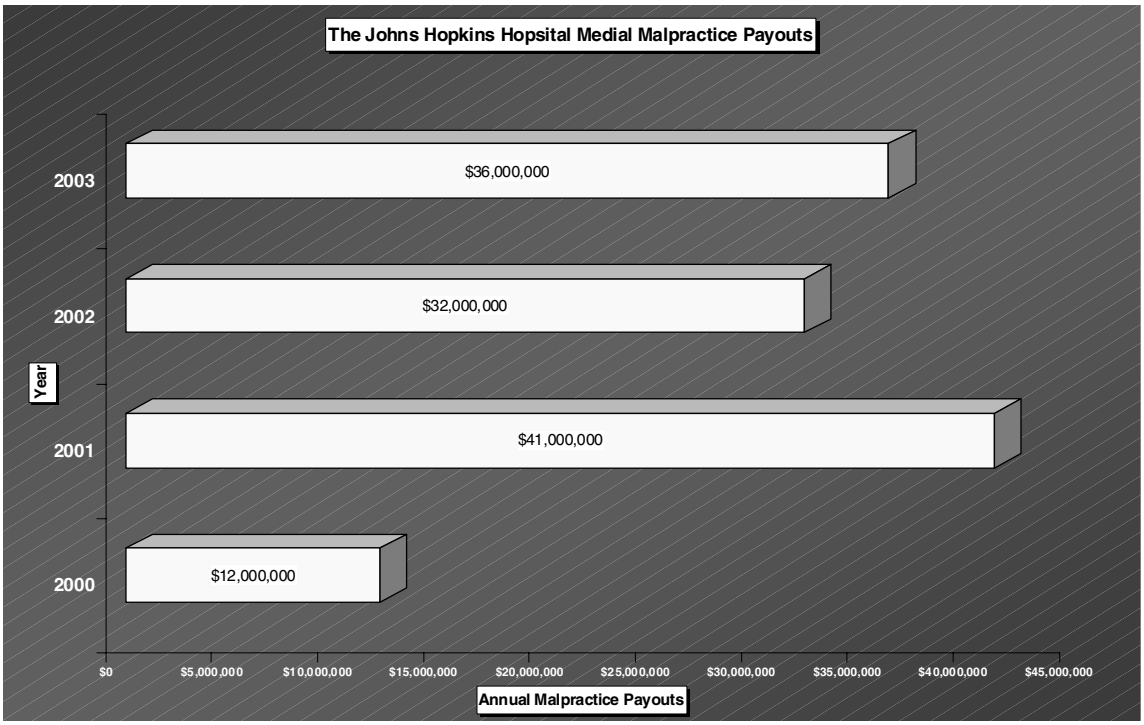
The claims for The Johns Hopkins Hospital follow suit. Graph 4 shows the annual medical malpractice payouts since 2000.

GRAPH 4



Further, in 2000, Hopkins had two payouts for more than $1 million. In 2001 Hopkins had 12 payouts for more than $1 million. In 2002 Hopkins made six payouts for more than $ 1million and in 2003 there were eight payouts for more than $1 million. Hopkins' medical malpractice rates rose 40% in 2002, 36% in 2003, and 33% in 2004.

Hopkins' experience is similar to other providers in that the number of claims being brought is not increasing. The number of claims being paid is also fairly constant, with 71 claims paid in 2000, 76 in 2001, an increase to 87 in 2002, and 67 in 2003. What is increasing, however, is the amount being paid on the claims that are paid.[6]

The University of Maryland Medical System is self-insured for both the hospital and the doctors. Its rate increases have averaged 15% a year for the past five years, which means the rates doubled in this time period. This equates to about 2 to 3% of operating costs. Its average indemnity paid during 2003 was $375,000, similar to both MedStar and Medical Mutual. Also, like the other providers it has not seen an increase in the number of claims filed.

[6] It is important to note that not all of these claims are medical malpractice claims. A small percentage is other types of liability claims, such as premises liability (e.g., slip and fall cases).

The experience of other Maryland hospitals is similar. Beginning in 2001, Maryland hospitals began to experience significant increases in their liability insurance rates. Between 2001 and 2003 rates increased 55%. In 2004 Maryland hospitals are paying $40 million more for malpractice insurance than they were in 2003.

Nursing homes have been particularly hard hit by the rise in malpractice premiums. Premiums for nursing homes in the State have risen from $4.5 million in 1998 to $21.6 million in 2003. Because two-thirds of nursing home patients are on Medicaid, about $17 million of these costs are paid for by the State Medicaid budget. These increases have been accompanied by lower amounts of coverage and higher deductibles.

Similar to obstetricians, nurse midwives have also seen major increases in their malpractice premiums. Some midwives have experienced rate increases of 100% or more. According to an article in the Frederick News-Post, because of the increase in medical malpractice premiums the last four midwives in Frederick County were laid off by their obstetrical practice. In June 2004 a birthing center operated by nurse midwives in Baltimore closed its practice due solely to rising malpractice premiums. It is fair to say that the future of independent birthing centers operated by nurse midwives is in doubt.

It is abundantly clear that these increases have already had an impact on access to health care in the State. According to an October 2004 survey of MedChi, the Maryland Medical Society, to which 774 physicians responded, many physicians have already taken steps to limit their practices. Thirty-six percent of respondents reported dropping lower paying healthcare plans. Twelve percent have dropped Medicaid, the lowest paying healthcare plan. This number is significant because it is likely that most physicians do not take Medicaid patients to begin with. Thirty-five percent stated that they are referring out complex cases, including obstetricians declining coverage for high risk pregnancies. Thirty-three percent have stopped performing certain services.

In addition, fewer physicians are willing to work in hospital emergency departments. Twenty-five percent of the MedChi respondents stated that they have reduced their calls to the emergency departments, resulting in fewer neurosurgeons, otolaryngologists, plastic surgeons, and general surgeons. A respondent from the Eastern Shore stated that there are no child psychiatrists and fewer psychiatrists taking emergency room calls. It is clear in general that the rural areas of the State will feel the impact on access to health care sooner than the urban and suburban areas.

The prospects for the future as indicated by the MedChi survey are even bleaker if the economics of physicians' practices do not change. Seventy-six percent of respondents plan to make further changes to their practices, including additional reductions in low paying healthcare plans and specifically Medicaid. Twenty-nine percent are considering closing their practices or retiring. Nineteen percent will discontinue high-risk services. Twelve percent will reduce their emergency room coverage. Sixteen percent will stop carrying medical malpractice insurance coverage altogether, while twenty-two percent intend to introduce surcharges for some services.

The Maryland Hospital Association reports that hospitals are experiencing problems due to the medical malpractice insurance crisis. In the past two years, 28% of hospitals report they have had to close units, shorten hours, or otherwise limit services. Four hospital emergency departments are having increasing difficulties in staffing emergency departments. Physicians at hospitals are limiting participation in Medicaid (35%), limiting procedures (40%), not covering emergency departments (25%), considering retiring early (44%), and considering dropping their medical malpractice coverage (48%).

The practice of defensive medicine is one of the consequences of the medical malpractice insurance crisis. Although the costs of defensive medicine may be difficult to quantify, testimony before the task force indicated that physicians uniformly practice defensive medicine by ordering unnecessary tests and procedures due to fear of a malpractice suit.

Physician Reimbursement

Probably the most significant change in the health care industry since the last medical malpractice insurance crisis in the 1980s has been the growth of the managed care industry for providing health care. Approximately 87% of the State's residents are covered by either a private or State-operated managed care organization. This system helps ensure the affordability of health care while ensuring that providers have a reliable patient base. The problem for providers is that the managed care reimbursements have not kept pace with the rapidly rising malpractice costs. Health care providers are prohibited from charging an additional fee in excess of any amount allowed under their contract with the managed care provider. In most businesses, rising costs are passed on to the consumer to the extent that the market will absorb those costs. Under the managed care system, only those amounts allowed by the managed care company are passed along to their customers. The health care provider must absorb the rest if the provider wants to remain part of the system.

It is clear, however, that simply raising reimbursement rates will not solve the problem. Raising reimbursement rates will result in increased health insurance rates. According to a recent report of the Maryland Health Care Commission, 12.8% of all Marylanders have no public or private health insurance.[7] Anecdotal evidence suggests that many of these individuals rely on hospital emergency departments for their health care needs (see discussion below on emergency department requirements). These individuals tend to be less healthy than the general population and wait longer before seeking care. Rising costs of health insurance will increase the number of uninsured, which will result in poorer health care and increased demands on hospital emergency departments. This is not a desirable result.

Testimony by David D. Wolf, Executive Vice President of CareFirst BlueCross BlueShield indicated that while medical malpractice rates are considered when setting reimbursement rates, CareFirst has not adjusted any reimbursements exclusively for this reason. Further, because of the smaller number of physicians in the rural areas they often find it necessary to pay higher reimbursements in these areas. While a number of factors go into setting reimbursements, the primary consideration is that they must remain competitive with the other managed care organizations in the market place, both in terms of reimbursements to providers and cost to consumers.

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[7] "Health Insurance Coverage in Maryland through 2002", Maryland Health Care Commission.

RECOMMENDATIONS

The task force makes the following recommendations by a majority vote of the task force:

Damages

The task force believes that every victim of medical malpractice deserves to be fully compensated for the victim's damages. A fundamental principle of the tort system is to place a plaintiff in the position the plaintiff would have been in but for the wrongful actions of the defendant. As discussed in further detail below, the task force finds that current law allows a plaintiff to be overcompensated for some damages. The recommendations below will establish reasonable guidelines for providing fair compensation for plaintiffs for both economic and noneconomic damages.

Economic Damages

Testimony before the task force indicated that it was the growth in economic damages that was the primary driver of the increase in claims costs. One of the major factors in the growth in economic damages is the use of life care planners. Within the past ten years life care planners have become prevalent in medical malpractice cases. These planners summarize the educational, vocational, social, and daily living needs of an individual who can only function with professional assistance. They serve to inflate the value of costs in two ways. First, they use the billed value of the goods or services, and not the actual costs. Second, their plans value care that is not currently being rendered and has not been ordered by a treating physician.

The following is an illustration presented by J. Mark Coulson, an attorney from Baltimore, of the use of inflated figures by life care planners in determining economic damages. When a case is brought for a child suffering from cerebral palsy, the needs of the child, who has had the condition since birth, are already being cared for. Because of the exorbitant costs involved, Medicaid is often the payor of medical bills. Further, because of the excellent services available in the State parents are typically satisfied with the level of care being provided.

In the litigation, however, the plaintiff submits evidence as if the child's needs would have to be taken care of at a billed amount, which is substantially higher than Medicaid costs and at more expensive facilities than Medicaid would allow. If the case is to be tried, these future costs are very great, much more than Medicaid would provide and pay. Even if the court would allow evidence of Medicaid (which is doubtful) the plaintiff claims that the child deserves better treatment than Medicaid provides. Fearing a large judgment, the carrier settles.

The plaintiff then puts the money into a special needs trust, which legally means the money is not considered an asset of the child's. This ensures that the child remains eligible for Medicaid, which continues to provide for the child's needs in the same way as it did before the suit was resolved. There is no change at all in how the child is cared for. The money in trust is used by the trustee to pay for other needs of the child, which can be

for anything from providing dental care and food to paying for vacations and other entertainment. On the death of the child, Medicaid will be reimbursed from the trust for its costs if there is any money remaining.

See further discussion of licensing of life care planners below under "Expert Witnesses." See further discussion of the cerebral palsy issue below under "Alternatives to Litigation."

Income Tax Consequences of Lost Wages

Under 26 U.S.C. § 104(a)(2) (Section 104(a)(2) of the Internal Revenue Code), "the amount of any damages (other than punitive damages) received…on account of personal physical injuries" is not considered income and is therefore not subject to taxation. Maryland law follows federal law in determining income for tax purposes. See § 10-203 of the Tax-General Article. It is clear that unless punitive damages are awarded, which does not happen in medical malpractice cases, judgments and settlements are not subject to taxation.

Under the Maryland Civil Pattern Jury Instructions § 10:27 a defendant is entitled to have the court instruct the jury that any compensatory damages are not subject to federal or State taxation. This instruction is not specific to the amount of lost wages. In claims for lost income it would seem more accurate for the jury to consider net income after taxes with the calculation provided to the jury rather than have the jury guess at the amount a plaintiff would have paid in taxes or in some cases simply ignore the instruction for fear that a wrong guess will harm the plaintiff.

Recommendation – That in any award for lost wages the plaintiff should not receive any amount that would have been paid as income tax if the wages had been earned.

Past Medical Bills

Currently, a plaintiff will submit to the jury the actual billed amount for medical bills incurred. The law requires expert testimony that the billed amount was fair, necessary, and reasonable. Both the plaintiff and the defendant are entitled to submit evidence on whether a bill is fair, necessary, and reasonable. Whether the actual amount paid by an insurer is admissible on this issue seems doubtful, and is possibly a violation of the rule that collateral sources (payments to a plaintiff from another source, for example by a health or disability insurer) are generally inadmissible.

Recommendation – That an award for past medical bills should only be for the actual amount paid or payable by the plaintiff or on the plaintiff's behalf by a third person.

Future Medical Bills

There are similar considerations regarding payment of future medical bills. Currently, these medical bills are assessed under the fair, necessary, and reasonable standard without regard to the actual amount that will be paid by the plaintiff. There should be an objective standard used to assess these damages.

Recommendation – That an award for future medical bills should more accurately reflect what will be paid by the plaintiff or on the plaintiff's behalf by limiting the payment to a standard such as Medicare rates, the rates charged by a health insurer, or the amount paid by the Workers' Compensation Commission.

Collateral Source for Governmental Benefits

As discussed above, in tort cases the collateral source rule prohibits the introduction and use of evidence regarding other sources of income to which a plaintiff is entitled under a statute, insurance policy, or other contract that will compensate a plaintiff for damages. The underlying theory of the collateral source rule is that the defendant should not benefit because of the planning of the plaintiff, who may have paid for the benefits.

The collateral source rule essentially allows the plaintiff to be overcompensated, i.e., to be put in a better position economically than before the injury. This rule has been criticized for this reason, but is still the law of the State in most cases. Under §§ 3-2A-05 and 3-2A-06 of the Courts Article, an arbitration panel and a court may reduce a plaintiff's damages to the extent they have been paid or will be by a collateral source. Testimony before the task force, however, indicated there were no instances where an award or judgment had been reduced under these statutes.

For governmental benefits, including Medicaid and the federal Individuals with Disabilities Education Act,[8] the plaintiff has done no planning to obtain these benefits. The plaintiff is entitled to them under the law. Therefore, one of the rationales for the collateral source rule is nonexistent in this regard and should be abrogated. If a governmental entity is entitled to subrogation for certain amounts paid on behalf of a person, the rule should apply only to the extent that the governmental entity has a subrogated interest.

Recommendation – That the amount of a plaintiff's recovery should be reduced by the amount of benefits to which the plaintiff is entitled under any governmental entitlement.

Collateral Source Rule – Past Medical Bills

Under current law the arbitration panel or court may reduce a plaintiff's damages to the extent they have been paid or will be paid under a statute, insurance policy, or contract. The task force recommended above that the plaintiff be reimbursed for past medical bills only for the amount actually owed or paid on the plaintiff's behalf. As an

[8] Title 20, Chapter 33 of the United States Code

collateral source rule regarding past medical bills. This provision was included in House Bill 1299 of 2004. Some of the costs of the malpractice crisis would be borne by the managed care organizations. Any provision drafted to accomplish this must ensure that it is not intended to affect subrogation rights provided under federal law.

Recommendation – That the amount of a plaintiff's recovery should be reduced for past medical expenses paid on the plaintiff's behalf by means of a collateral source, unless there is the right to subrogation by the third party under federal law.

Cap on Noneconomic Damages

Generally

Noneconomic damages are commonly referred to as damages for pain and suffering. Section 11-108(a)(2) of the Courts Article provides the following definition.

"Noneconomic damages" means:

1. In an action for personal injury, pain, suffering, inconvenience, physical impairment, disfigurement, loss of consortium, or other nonpecuniary injury; and

2. In an action for wrongful death, mental anguish, emotional pain and suffering, loss of society, companionship, comfort, protection, care, marital care, parental care, filial care, attention, advice, counsel, training, guidance, or education, or other noneconomic damages authorized under Title 3, Subtitle 9 of this article."

Noneconomic damages are intended to compensate damages that are unquantifiable economically. Economic damages measure actual economic loss and, in medical malpractice cases, are primarily composed of lost wages and medical bills.

A cap on noneconomic damages was first enacted by Chapter 639 of 1986. The legislation provided for a $350,000 cap. In 1993 the Court of Appeals held in the case of *United States v. Streidel,* 329 Md. 533 (1993) that the cap on noneconomic damages did not apply to wrongful death cases. This prompted the General Assembly in 1994 to make the following changes to the cap on noneconomic damages: (1) the cap was increased from $350,000 to $500,000; (2) an annual $15,000 escalator was added to the cap; and (3) the cap was made applicable to wrongful death cases (see the discussion below on the applicability of the cap in death cases). The current cap is $650,000.

Although the task force finds that noneconomic damages do serve a valid purpose, further limitations are needed in order to address the current crisis.

Recommendation – That the cap on noneconomic damages be reduced to $500,000 in medical malpractice cases.

Recommendation – That the annual $15,000 escalator in the cap on noneconomic damages be eliminated in medical malpractice cases.

Death Cases

History of Wrongful Death Actions

Under the common law that existed prior to 1852, Maryland did not have a cause of action for recovery of damages by the relative of one killed by the negligence of another. *McKeon v. State, for the use of Conrad,* 211 Md. 437, 442 (1956). In 1852, the Maryland legislature enacted Chapter 299 of the Acts of 1852, which provided an action at law for economic loss for the benefit of a wife, husband, parent and child of a person whose death was caused by the wrongful act, neglect or default of another. *Id.* The enactment is generally referred to as Lord Campbell's Act.[9] *Id.* at 440. In 1937, the Maryland legislature added to the list of persons entitled to recover the mother of an illegitimate child; and in 1952, the Maryland legislature added to the list of persons entitled to recover relatives of the decedent (secondary beneficiaries) who met certain dependency qualifications, but only if there was no surviving wife, husband, parent, or child. *Id.* at 442.

The enactment was amended in 1969 to allow for the recovery of solatium damages (i.e., noneconomic damages of the beneficiary) in the case of death of a minor child or spouse, revoking the rule that wrongful death damages were limited to pecuniary loss. *Todd v. Weikle,* 36 Md. App. 663, 680 (1977). In 1975, the Act was amended to provide for the recovery of solatium damages by a minor for death of a parent. *Id.* at 679. The critical point was a minor child in both cases. A parent could not recover for the death of an adult child nor could an adult child recover for the death of a parent.

In 1983 the Act was amended to permit parents to recover solatium damages for the death of an unmarried adult child age 21 years or younger or an adult child of any age for whom the parent contributed 50% or more to the child's support. As discussed above, in 1994 the General Assembly applied the cap on noneconomic damages to wrongful death actions.

In 1997 the Act was amended to eliminate the requirement of minority or contribution to support. A parent could recover solatium for the death of an adult child and an adult child could recover solatium for the death of a parent regardless of the age of the child in either situation. Also the statute was amended to include not only secondary beneficiaries who were wholly dependent upon the decedent but those who were "substantially dependent" upon the decedent. *Ditto v. Stoneberger,* 145 Md. App. 469, 482 (2002).[10]

Survival Action

As discussed above, a wrongful death action is brought by certain statutory beneficiaries for injuries they sustained as a result of the death. A wrongful death action is not an action for the decedent's injuries. A survival action is a personal injury action

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[9] The Wrongful Death Act of 1852 was essentially derived from the English Lord Campbell's Act of 1847. *Potomac Elec. Power Co. v. Smith,* 79 Md. App. 591, 619, *cert. den'd,* 317 Md. 393 (1989), *overruled on other grounds, U.S. v. Streidel,* 329 Md. 533, 620 A.2d 905 (1993).

[10] Current Maryland law regarding wrongful death actions is found in Title 3, Subtitle 9 of the Courts Article.

brought by the personal representative of the decedent's estate for injuries the decedent sustained before the decedent's death.[11] In a medical malpractice case, these injuries include lost wages, medical bills, and the noneconomic damages (e.g., pain and suffering) of the decedent. The damages accrue from the time of the injury up to the time of the decedent's death, and terminate at that point.

Noneconomic Damages Cap in Death Cases

In death cases, there are usually two causes of action: (1) the survival action brought by the personal representative of the decedent for the decedent's injuries; and (2) the wrongful death action brought by the statutory beneficiaries of the decedent for their injuries. There are different caps in these two actions. The survival action has one cap, currently $650,000. The wrongful death action has a separate $650,000 cap if there is one wrongful death beneficiary and a 150% cap totaling $975,000 if there is more than one wrongful death beneficiary. In death cases the total cap is therefore either $1.3 million or $1.625 million, depending on whether there are one or more than one beneficiaries. This is commonly referred to as the "double cap," although in fact the cap is a two-and-a-half times cap in many cases.

Conclusion

It is clear that in the past 35 years the General Assembly has greatly expanded the scope of the wrongful death statute, primarily by increasing the categories of claimants who qualify for noneconomic damages. Further, there is no long-standing tradition of awarding noneconomic damages in these cases.

Testimony before the task force indicated that the impact of the double cap in death cases is felt most strongly in hospitals and nursing homes. Eliminating the double cap and applying a single cap of $500,000 in death cases would be of particular benefit to these facilities.

Recommendation – That the double cap on noneconomic damages in death cases involving medical malpractice be eliminated.

Attorney's Fees

Contingency Fees

The economic burden of the current malpractice insurance crisis is being borne solely by health care providers. The increases in indemnities paid are benefiting economically both the plaintiffs and plaintiff's attorneys. Testimony by Mr. Paul Bekman, a plaintiff's attorney from Baltimore, before the task force indicated that the standard contingency fee for a medical malpractice case ranged from 33 1/3% to 40%, with some contracts requiring payment of 33 1/3% in a case that settles and 40% in a case that is tried. Other testimony indicated that 40% contingency fees are now the general rule in these cases.

[11] § 6-401 of the Courts and Judicial Proceedings Article provides for survival actions. This statute changed the common law rule under which certain actions by or against individuals abated with death. See § 7-401(y) of the Estates and Trusts Article, which allows a personal representative of a decedent's estate to prosecute a survival action.

A contingency fee is usually deducted from the total amount of the settlement or judgment. Following this deduction, the attorney then deducts costs incurred in prosecuting the case (e.g., expert witness fees, discovery expenses, preparation of exhibits). These costs can vary widely, and may exceed $200,000 in complex cases. A plaintiff can expect to receive less than 50 cents on the dollar from a settlement or judgment.

This task force has recommended changes to the amount of compensation to which a plaintiff is entitled for both economic and noneconomic damages. These changes with regard to economic damages will more accurately compensate a plaintiff for damages sustained, thereby advancing the goal of the tort system of ensuring that a plaintiff is returned to the position he or she would have been in but for the injury. It is clear, however, that a plaintiff will receive less compensation under these changes than under current law.

The Rand Institute for Civil Justice report "Capping Non-Economic Damages in Medical Malpractice Trials, California Jury Verdicts Under MICRA" discusses in part the relationship between lowering the cap on noneconomic damages and legislation limiting attorney contingency fees. The report reaches the obvious conclusion that plaintiffs will bear the burden of lowering the cap on noneconomic damages if attorney's fees remain uncapped. If attorney's fees are also capped, plaintiffs will receive a larger share of any judgment.

The findings of the Rand report are clearly applicable to the above recommendations concerning both economic and noneconomic damages. That is, if you limit the plaintiff's damages without capping attorney's fees, the plaintiff will bear the brunt of the reduction. It seems fair for the plaintiff's attorney also to contribute in order that the plaintiff receive adequate compensation for any injuries.

The following figures will illustrate how the system has changed in the last ten years in economic terms. In 1993, Medical Mutual paid indemnities totaling $24.7 million. The total plaintiff's attorney's fees paid on this amount would have ranged from $8.2 million to $9.7 million (assuming contingency fees ranging from 33-1/3% to 40%). In this year total defense costs were $14.1 million. Assuming that 70% of this amount went to pay defense attorney's fees (with the remainder going primarily to expert witness fees and related expenses), approximately $9.8 million was paid to defense counsel. In 2003, Medical Mutual paid indemnities of $75.7 million. This would have resulted in plaintiff's attorney's fees ranging from $25.2 million to $30.3 million, more than tripling the amount from 1993. During this same time total defense costs increased to $17.6 million, of which about $12.3 million were defense counsel fees, a 25% increase in ten years.

Seventeen states currently have statutes that specifically limit the amount of plaintiff's attorney contingency fees. Eleven of these states have statutes that establish

limits specifically in medical malpractice cases, although two of these statutes have been declared unconstitutional by the state courts. The other six states have limits that are applicable to a broader category of cases than medical malpractice. In addition, six other states provide for some general court oversight regarding contingency fees.

Recommendation - That legislation should be enacted limiting in medical malpractice cases a plaintiff's attorney's fees in medical malpractice cases using a sliding scale similar to California and other states.

Fee Splitting

One of the primary drivers of the increase in contingency fees from 33 1/3% to 40% has been the result of lawyer referral fees. It is a common practice for lawyers who do not handle medical malpractice cases to refer these cases to lawyers who do specialize in this area. For simply referring a case a lawyer will negotiate a fee agreement with the other lawyer, which range from 25% to 50% of any fee for a settlement or judgment. The referring attorney is not obligated to perform any actual work on the case. In order to justify paying this amount and still make a profit, malpractice lawyers have raised their contingency fees. If this practice of referring cases for a percentage of a fee without performing any work is prohibited, a malpractice lawyer whose fee is limited by the proposed fee schedule will be ensured of a reasonable fee for the work performed.

Recommendation – That fee splitting by plaintiff's attorneys in medical malpractice cases be limited to circumstances where and to the extent to which each attorney actually participates in the preparation and/or trial of the case.

Periodic Payment of Judgments

Ms. Jamie L. Kormann, Regional Vice President of Brant Hickey & Associates, gave a presentation to the task force on structured settlements. She stated that a 1992 study of California's workers' compensation claimants showed that 30% of claimants dissipated a lump sum payment within two months and that 90% of claimants had spent a lump sum payment within five years. Similarly the task force heard anecdotal evidence concerning claimants in medical malpractice cases who within a few years of receiving a lump sum payment contacted the health care provider wanting to know when they would receive the rest of their money, only to be told that they had received all of their money.

This has serious public policy implications. Payments in serious medical malpractice cases often are intended to provide continuing care for the plaintiff for life. If the money is dissipated before the death of the plaintiff, in many cases the State will assume the responsibility for the care of the plaintiff through Medicaid and other programs. Further, Ms. Kormann testified that there are cases where a plaintiff's lawyer has been sued for legal malpractice for failing to advise the client of the financial alternatives available to ensure a steady income stream for the future.

Twenty states have laws providing for the payment of large judgments in periodic payments. Maryland currently has a law allowing a court or arbitration panel to order payment of future economic damages in the form of an annuity or other periodic payments.

The advantages of paying judgments in the form of an annuity paid for by the defendant are threefold. First, an annuity can ensure that the plaintiff receives a constant stream of income for life. Under current law, the jury makes their own assessment of how long the plaintiff will live and need care. If the jury underestimates the plaintiff's life span, even a prudent plaintiff will spend all of the money awarded before the end of the plaintiff's life. If the jury or panel overestimates the plaintiff's life span the defendant will overpay for the amount of care actually needed. An annuity lasts for the life of the plaintiff and therefore provides care for the time it is needed.

Secondly, an annuity will usually result in a cost savings for the defendant. An annuity company will assess the plaintiff's rated age, and estimate the plaintiff's life span. To the extent that a jury or panel has overestimated the plaintiff's life span the annuity company will provide an annuity that provides for the amount of care that the jury decided the plaintiff needs, but at a lesser cost by making its own estimate of the plaintiff's life expectancy.

Thirdly, under § 104(a)(2) of the Internal Revenue Code, any damages other than punitive damages received either as a lump sum or periodic payment are not considered income for income tax purposes. This is not the case for income received if the plaintiff receives a lump sum payment and then purchases an annuity or otherwise invests the money.

Recommendation – That large judgments for noneconomic damages and future economic damages should be required to be paid in the form of periodic payments.

Procedures

Offer of Judgment

The Honorable Paul W. Grimm, United States Magistrate Judge, gave a presentation to the task force on Federal Rule of Civil Procedure 68, the offer of judgment rule. This rule reads as follows:

"At any time more than ten days before the trial begins, a party defending against a claim may serve upon the adverse party an offer to allow judgment to be taken against the defending party for the money or property or to the effect specified in the offer, with costs then accrued. If within 10 days after the service of the offer the adverse party serves written notice that the offer is accepted, either party may then file the offer and notice of acceptance together with proof of service thereof and thereupon the clerk shall enter judgment. An offer not accepted shall be deemed withdrawn and evidence thereof is not admissible except in a proceeding to determine costs. If the judgment finally obtained by the offeree is not more favorable than the offer, the offeree must pay the costs incurred after the making of the offer. The fact that an offer is made but not accepted does not preclude a subsequent offer. When the liability of one party to another has been determined by verdict or order or judgment, but the amount or extent of the liability remains to be determined by further proceedings, the party adjudged liable may make an offer of judgment, which shall have the same effect as an offer made before trial if it is served within a reasonable time not less than 10 days prior to the commencement of hearings to determine the amount or extent of liability."

This rule was initially adopted in 1937 and the current language was adopted in 1946. Judge Grimm stated that there were several important facets of the rule. First, it only applied to parties defending a claim, including counter defendants and cross defendants. There is no mechanism for a plaintiff to make an offer of judgment. Secondly, the rule does not apply to cases where there is a defense verdict. It only applies if the plaintiff wins but receives less than the amount offered by the defendant. Third, there is no requirement that an offer be reasonable. Because the rule is inapplicable in case of a defense verdict, however, there is little incentive for a defendant to make a nominal offer. Fourth, ordinarily the prevailing party is entitled to costs. If an offer of judgment is made and the plaintiff prevails but is awarded less than the offer, then the defendant is entitled to costs from the time the offer was made. These costs do not include attorney's fees. Fifth, if the underlying statute allows a prevailing party to an award of attorney's fees the following situation will prevail if an offer of judgment is made. If the plaintiff is entitled to attorney's fees but is awarded an amount less than the offer of judgment, the plaintiff will only be entitled to attorney's fees incurred before the offer of judgment was made.

Recommendation – That the State should enact a rule of procedure similar to Federal Rule of Civil Procedure 68 allowing the defendant to make an offer of judgment and requiring a plaintiff who receives a judgment for less than the amount offered to pay all costs incurred after the offer was made.

Number of Jurors

Up until 1992 under Article 5 of the Maryland Declaration of Rights, in cases where there was the right to a jury trial people in the State were entitled to a 12-person jury. The number of 12 jurors was based on the English Common Law and was the law in Maryland since the founding of the colony.

Before the 1960s, the number of 12 jurors was sacrosanct. In the 1960s and 1970s the United States Supreme Court sanctioned as constitutional in both criminal and civil proceedings juries composed of less than 12 jurors. Whether a jury composed of less than six jurors is a valid cross-section of the community is questionable.

In 1992 the voters of the State approved a constitutional amendment providing that a civil jury be composed of "at least 6 jurors."[12] Also in 1992, § 8-306 of the Courts Article was enacted which states: "In a civil action in which a jury trial is permitted, the jury shall consist of 6 jurors."

In 2000, the American College of Trial Lawyers called on the federal courts to return to 12-person juries, stating: "Common sense tells us that a larger jury is more likely to be truly representative of the many and varied views and attributes of the community from which it is drawn. Only a larger jury, in other words, can speak with the authentic voice of the community at large."[13] They further felt that six-person juries could be more easily swayed by a single dominant juror, stating that "simulation studies

[12] Article 5 of the Maryland Declaration of Rights

[13] "Report on the Importance of the Twelve-Member Civil Jury in the Federal Courts" American College of Trial Lawyers (2000)

suggest that smaller juries are more susceptible to being swayed by a single assertive member. This is a matter of concern, for domination by a single juror threatens the rationality and fairness of the jury's decision-making process." An article in the January-February 2003 magazine Judicature states that "six-person juries may be more variable in their assessment of damage awards."[14]

There are also more practical issues with the current limitation of six jurors. Most civil cases are heard by more than six jurors, with the additional jurors designated as alternate jurors. An alternate juror sits through the same testimony as a regular juror, but will only participate in the decision if one of the regular jurors must be excused from the case. Otherwise, the alternate jurors are released before the jury begins its deliberations. It seems wasteful of the alternate juror's time not to allow those jurors to participate after sitting through a case.

Although a return to 12-person juries may not be feasible, allowing juries composed of more than six persons would be beneficial.

Recommendation – That the statute establishing that there be only six jurors in civil cases be amended to conform to the provision of the Maryland Constitution requiring at least six jurors in a civil case, thereby allowing a trial judge to establish the number of jurors in a case.

Venue – Medical Malpractice Actions

Under current Maryland law plaintiffs are provided several options on which county to file a cause of action.[15] The task force felt that the appropriate venue for bringing a cause of action was the county where the health care was provided.

Recommendation – That the venue for medical malpractice actions be the venue in which the health care was provided.

Venue – Bad Faith Actions

If an insurer has the opportunity to settle a claim within policy limits but fails to do so, the insurer may be sued by its insured if there is an award or judgment in excess of policy limits. These are called bad faith claims. Testimony indicated that the health care provider will frequently assign the cause of action to the plaintiff in the underlying medical malpractice case who will then pursue the cause of action. Current Maryland law allows a bad faith action to be brought in the county where the insurer has its place of business. This may be a different county from where the malpractice action was brought or where the health care provider took out the medical malpractice policy. House Bill 1299 of 2004 would have established venue for bad faith actions in the county where the underlying medical malpractice action was brought. This task force makes the following recommendation.

[14] "The Effects of Jury-Aid Innovations on Juror Performance in Complex Civil Trials," FosterLee and Horowitz, Judicature (January/February 2003)
[15] See §§ 6-201 and 6-202 of the Courts and Judicial Proceedings Article

Recommendation – That the venue for bad faith actions involving actions by health care providers against their insurance carriers for wrongful failure to settle a medical malpractice case be the venue where the provider took out the insurance policy.

Limited Immunity – Care Required By Federal Law

The Federal Emergency Medical Treatment and Active Labor Act[16] is a federal law which requires hospitals that receive Medicare funds to treat individuals who come to the hospital with an emergency medical condition regardless of their ability to pay. If the hospital is capable of providing the necessary emergency care to a patient and an emergency medical condition is found to exist, the hospital is prohibited from refusing to provide any treatment to the individual or from transferring the patient to another medical facility without good cause. Thus, an appropriate medical screening must be provided to every person who comes to an emergency treatment center in order to determine whether an emergency medical condition exists or, in the case of a pregnant woman, whether labor is imminent. In either instance, the hospital must treat and stabilize the patient prior to discharge or transfer, except under certain limited circumstances. A hospital or physician who fails to comply with this Act is subject to civil fines, civil actions, and other sanctions.

Sections 5-603, 5-606, and 5-607 of the Courts Article provide immunity for simple negligence to health care providers who are acting without compensation to provide services at emergency scenes, through charitable organizations, or at volunteer sports programs. These laws would not apply to hospital emergency room situations. Because federal law does not allow a hospital or physician any discretion on screening and, if required, treating individuals who come to an emergency department presumably needing emergency care, it is appropriate to provide additional protection to these hospitals and providers under these circumstances.

Recommendation – That hospitals and health care providers who provide care in compliance with the Federal Emergency Medical Treatment and Active Labor Act be liable only for acts of gross negligence.

Alternative Dispute Resolution

Health Claims Arbitration Office

The Health Claims Arbitration Office was established in 1976. The purpose of the office was to arbitrate medical malpractice claims. An arbitration panel consisting of an attorney, a health care provider, and a member of the public decides issues of liability and damages. Either party has the right to appeal the decision of the arbitration panel to court. In court the case is tried *de novo*; the arbitration panel decision, however, is presumed to be correct in court.

The hope was that many cases would be resolved at the arbitration level. This turned out not to be the case, as most claims were appealed to court after the arbitration proceeding. The arbitration proceeding became an additional layer of expense and delay essentially resulting in two trials, one before the arbitration panel and the second in court.

[16] 42 U.S.C. § 1395dd

In 1987 legislation was enacted allowing all parties mutually to waive arbitration of the claim, allowing it to go directly to court. In 1995 legislation was enacted allowing either the claimant or the defendant unilaterally to waive arbitration and proceed directly to court.

The task force heard from Harry L. Chase, Director of the Health Claims Arbitration Office. Mr. Chase presented testimony that 20% of all claims are resolved at the office. It appears that the vast majority of these cases, however, are cases involving claimants who are not represented by an attorney and who fail to file the necessary certificate of qualified expert. For all of year 2003 and for 2004 to date there have been no panel closings of cases. When asked whether he thought the office was effective, Mr. Chase stated that because of the unilateral waiver law it was not. He advocated repeal of the unilateral waiver law and strengthening of the office.

The task force agrees with the recommendation and reasoning contained in the Report of The Commission on the Structure and Efficiency of State Government to abolish this office: "While it appears that the agency is run in an efficient manner by a seasoned and talented Director, the passage of time and events has undermined the ability of the agency effectively to satisfy the legislative intent in its creation."

Recommendation – That the Health Claims Arbitration Office be abolished.

Statewide Mediation

The task force heard testimony on mediation. Rachel Wohl of the Court's Mediation and Conflict Resolution Office discussed the current role that mediation and other alternative dispute resolution processes play in the court system. Ms. Wohl also discussed the role of mediation in medical malpractice cases and the mediation provision contained in House Bill 1299 of 2004. She testified that the first step in the mediation process would be to determine how much discovery would be needed in order for there to be effective mediation. She stated that there were two problems with House Bill 1299. The first was that the parties should have the ability to select their own mediator. Secondly, the bill proposed that mediation should be done through the Health Claims Arbitration Office when the case was already proceeding in court. She stated that this would interfere with the court system.

Professor Roger Wolfe of the University of Maryland School of Law also spoke in favor of mandatory mediation in medical malpractice cases. He thought the courts should establish standards on the qualifications of mediators. He also objected to sending cases to mediation at the Health Claims Arbitration Office after they were being litigated in court, stating that this would result in delay and unnecessary duplication of work.

Richard Kidwell of the task force described the mediation process currently used at The Johns Hopkins Hospital. Hopkins has a provision in its contracts with patients that require the parties to mediate a case before it is filed in court. A judge of the Circuit Court for Baltimore City upheld the validity of that contractual provision. The parties split the costs of the mediation. If necessary they can engage in limited discovery before mediation. In 2003 Hopkins successfully mediated 21 out of 24 cases.

The task force believes that mediation early in the process can lead to a quicker resolution of some cases. This will have the benefit of compensating injured plaintiffs more quickly while saving all parties litigation expenses. It is possible that early mediation could lead to lower settlements to the extent that some plaintiffs are looking more for an apology and a full explanation of the occurrence instead of compensation, and would rather not go through the whole litigation process. In some cases minimal discovery will be needed before mediation. In other cases fuller discovery will be necessary in order for mediation to be effective. The task force believes that the courts can adequately deal with these matters.

Recommendation – That there be established a statewide mediation program in the courts allowing parties to a medical malpractice action to engage in mediation at the earliest possible date.

Binding Arbitration

Roger Wolfe of the University of Maryland School of Law discussed binding arbitration laws. Some states have laws that allow a health care provider to require binding arbitration of a dispute, including a claim for medical malpractice. With binding arbitration the decision of the arbitration panel is essentially final. There is no trial in court after arbitration and there are only limited grounds for appealing to a court. These agreements require a party to give up the right to a jury trial. Professor Wolfe stated that the validity of these laws has been viewed differently in different states. He stated that a law such as one in Illinois that contained a provision allowing a patient up to 60 days after treatment to cancel the agreement would be more likely to be upheld by the courts.

Recommendation – That legislation be enacted allowing health care providers and patients to enter into agreements providing for binding arbitration of medical malpractice claims.

Health Courts

In Maryland several of the larger counties have a Family Law Division and Business Courts. These courts are designed to have judges with interest and expertise handle these matters. Medical malpractice cases involve some extremely complex medical issues. Although most of the cases that are tried go before juries, there are many crucial decisions made by judges regarding evidence, expert witnesses, and pretrial motions. The task force believes that in light of the serious public policy issues raised by the current crisis and the complexity of the issues involved that serious consideration should be given to the establishment of health courts.

Recommendation – That the Court of Appeals Standing Committee on Rules of Practice and Procedure study and make recommendations concerning establishment of health courts.

Certificate Of Qualified Expert

Retention of Certificate of Qualified Expert

The task force recommended above that the Health Claims Arbitration Office be abolished. There is an important component to this office that should be retained. Current law requires parties to file with the director within certain time frames a certificate of qualified expert attesting to the departure from or compliance with the standard of care, as applicable. In cases involving physicians, the director must forward the certificates to the Board of Physicians.

This certificate requirement ensures that a health care provider who is not a party has reviewed the claim. It helps ensure that completely spurious claims do not go forward. It also provides a mechanism for the Board of Physicians to receive notice of a claim.

These procedures should be retained. The parties should be required to file their certificates of qualified experts in court. The clerks of the courts should send copies of these notices to an appropriate unit of State government for both record keeping purposes and also for forwarding appropriate cases to the Board of Physicians.

Recommendation – That if the Health Claims Arbitration Office is abolished the certificate of qualified expert requirements under the Health Claims Arbitration Act be retained for court proceedings. Clerks of the circuit courts should be required to forward all certificates of qualified expert to an appropriate unit of State government. This unit will be responsible for notifying the appropriate licensing boards of pending actions and judgments as required by law.

Contents of Certificate of Qualified Expert

The certificate of qualified expert law ensures that most baseless cases are dismissed early in the proceedings. The task force did hear, however, of cases where several health care providers were named in a suit where it was possible that some adverse event had occurred, but where it was very clear that not all of the defendants were involved in the adverse event. They may have been present at some stage of the treatment or been consulted, but were in no way involved in the treatment resulting in the adverse event.

The case of *D'Angelo v. St. Agnes HealthCare, Inc.,* 157 Md.App. 631, decided on July 15, 2004, is a case in point. In *D'Angelo*, the plaintiffs filed a medical malpractice claim naming 31 defendants, including 29 physicians. The plaintiffs filed their certificate of qualified expert attested to by two qualified experts who concluded that the injuries were caused by negligence but failed to state who among the 31 defendants departed from the standard of care or that the departure was the proximate cause of the injuries. The Circuit Court for Baltimore City dismissed the complaint on the basis that the plaintiffs failed to comply with the certificate requirements.

On appeal to the Court of Special Appeals, the plaintiffs argued that they were not required to file a certificate saying who violated the standard of care. The Court of Special Appeals disagreed and affirmed the trial court's dismissal stating: "Although (the plaintiffs) do not say so specifically, they apparently interpret the Act as requiring the expert to certify that someone (as yet unknown) breached the applicable standard and that someone's deviation from the appropriate standard of care proximately caused medical injury. If such an interpretation were sanctioned, the certificate requirement would amount to a useless formality that would in no way help weed out nonmeritorious claims."

The task force agrees with the reasoning of the Court of Special Appeals. Plaintiffs should know who violated the standard of care when they file a claim. The Court of Special Appeals stated the matter succinctly when they said that the approach "utilized ('Sue first and find out who is liable later') was not within either the 'letter' or 'spirit' of the certificate requirement."

Recommendation – That the plaintiff's certificate of qualified expert specify the breach of the standard of care for each health care provider named as a defendant.

Supplemental Certificate of Qualified Expert

House Bill 1299 of 2004 contained a provision that would have required a plaintiff to file, within 15 days after discovery and mediation are completed, a supplemental certificate of a qualified expert that contains specific allegations, such as the specific injury, standard of care, the basis for alleging that standard of care, and the expert's qualifications to testify. The purpose of this requirement was to require the plaintiff after having obtained all information about the case to specify the factual basis for the alleged breach of the standard of care and the cause of the injuries.

Recommendation – That the plaintiff in a medical malpractice case should be required to file with the court following completion of discovery an enhanced certificate of qualified expert specifying with detail each defendant's deviation from the standard of care.

Expert Witnesses

Clinical Practice

Current Maryland law seeks to discourage the use of professional experts in medical malpractice cases. A professional expert is an individual who devotes a substantial amount of time to consulting and testifying on medical malpractice cases. Section 3-2A-04 of the Courts Article provides that: "The attesting expert may not devote annually more than 20 percent of the expert's professional activities to activities that directly involve testimony in personal injury actions." The Court of Appeals in *Witte v. Azarian,* 369 Md. 518 (2002) narrowly construed this provision. In this case the plaintiff's expert on orthopedics testified that he hadn't performed any surgery for 11 years, 90% of his patients were involved in some sort of litigation, and that 60% of his patients came from attorneys or workers' compensation insurance carriers. The Court of Appeals held that only those activities that directly relate to testimony such as travel time

to testify, preparation for testimony, assistance with discovery, and actual time testifying in trials or depositions counted toward the 20% requirement.

The use of professional experts is a matter of concern. The certificate of qualified expert requirements are designed to have an individual who is actually engaged in the practice of health care provide an independent assessment of the facts of the case. When the experts no longer actively participate in health care and treatment and spend a substantial amount of time in litigation-related activities, this serves to undermine the policy against having professional experts.

Recommendation – That the State should enact legislation similar to Virginia requiring an expert testifying to the standard of care in a medical malpractice action to have engaged in the clinical practice of medicine in the defendant's specialty or a related field of medicine within one year of the date of the alleged act or omission giving rise to the cause of action.

Board Certification

The task force further believes that attesting experts should have the same or similar expertise as the defendant in a case. It makes no sense to allow a general practitioner to testify as to the standard of care applicable to a specialist. A health care provider's standard of care should be judged by another having the same or similar expertise.

Recommendation – That if the defendant is board certified an expert attesting to or testifying as to the standard of care must also be board certified in the same or a related specialty as the defendant.

Testimony as Practice of Medicine

House Bill 1262/Senate Bill 896 (both failed) were introduced in the 2004 session. These bills would have provided that testimony regarding an opinion concerning medical treatment or care would be considered the practice of medicine for purposes of licensing and disciplinary proceedings in the State. Although the task force discussed whether an out-of-state practitioner should be required to be licensed in the State before being qualified to testify as an expert the task force makes no recommendation on this issue.

The task force finds that a physician who testifies in the State as to the standard of care in the State: (1) should know what the appropriate standard of care is in the State or locale; and (2) should be subject to appropriate disciplinary proceedings by the Board of Physicians if they testify falsely or fraudulently.

Recommendation – That testimony by a health care provider as an expert witness on the standard of care in a medical malpractice case be considered the practice of medicine for purposes of disciplinary proceedings.

Licensing of Life Care Planners

The use of life care planners has become prevalent in the last 10 years. These planners summarize the educational, vocational, social, and daily living needs of an

individual who can only function with professional assistance. The life care planners also project the long term costs of care and establish rehabilitative goals, while coordinating future care providers in order to best assure a continued recovery. There is a Commission on Health Care Certification located in Virginia which examines and certifies life care planners. This commission first started testing in this area in 1996. The University of Florida also offers programs in this field. Kennedy-Western University and Kaplan University offer home study programs in life care planning.

Sheryl S. Ranson, Ph.D., a certified life care planner testified before the task force concerning the role of a life care planner in medical malpractice litigation. She stated that there are probably several hundred life care planners in the nation. Although not all of these are certified they will be allowed to testify if a court finds that they are otherwise qualified.

Testimony before the task force indicated that the use of life care planners was a significant factor in driving the increase in economic damage awards. See the discussion above under "Economic Damages." Although the use of life care planners appears to be a legitimate exercise in deciding the amount of care that a plaintiff will need, the lack of standards for determining who is qualified as a life care planner is troubling. In light of the impact that life care planners are having on the amounts of settlements and judgments, this issue deserves careful scrutiny.

Recommendation – That the Department of Labor, Licensing, and Regulation study and report on whether life care experts should be licensed by the State.

Evidence

Benevolent Gestures

In a written statement submitted to the Task Force, Sorrel King, Patient Safety Advocate and founder of the Josephine King Pediatric Patient Safety Foundation, stated that there are three things that a victim of medical malpractice desires. The first is an apology. The second is a full explanation of what happened. The third is an assurance that steps will be taken to ensure that the occurrence will not be repeated. This sentiment is echoed by other patient safety advocates.

The current tort system provides major disincentives for a health care provider making any of those statements to a patient. This applies even in situations where the provider feels that all appropriate steps were taken, yet the patient dies or suffers serious disability. To apologize, explain, or provide assurance will be viewed as an admission of fault and used against the provider in a subsequent proceeding.

In mediation any statements made by the parties are confidential and cannot be used against the party. In this context an apology can be made. With limited exceptions such as the Hopkins program discussed above, mediation does not occur until after discovery is complete and parties are preparing for trial. This is often several years after the occurrence and of course does not avoid litigation.

Colorado has recently enacted legislation allowing a health care provider to apologize and even to acknowledge fault to a patient without fear that the statement will be used against the provider. Oregon has a similar statute. An article in the 2004 American Bar Association Journal entitled "Law and Sympathy" states: "A good deal of evidence suggests that apologies can reduce the value of lawsuits."[17] It is clear that plaintiffs will still demand compensation for their injuries. As with mediation, however, this type of law may help resolve cases earlier and begin the healing process sooner.

Recommendation – That the State should enact legislation similar to Colorado allowing a health care provider to make an apology or other benevolent gesture and making such a statement or gesture inadmissible in subsequent proceedings.

Uncompensated Care

When a life care planner assesses an individual's needs the planner will assign a monetary value for all services and items that the individual will need. It is not unusual, however, for some of these services to be provided by a family member of the individual. For instance, an individual may need 24-hour per day live-in attendant care that is valued at $150 per day. The individual may have been receiving part-time paid attendant care while the individual's spouse had been providing the remainder of the care. The spouse further may have no intention of having someone live-in to provide care. Testimony before the task force indicated that some courts were not considering this issue, comparing it to the collateral source rule. Under these circumstances, it seems appropriate that a court or arbitration panel be able to consider these facts when deciding the amount of and whether to remit damages.

Recommendation – That evidence that a family member or other individual will provide unreimbursed care for the plaintiff be admissible for purposes of assessing the plaintiff's damages, and that this evidence may be considered by the court when deciding a motion for remittitur.

Insurance

Rate Compression

During the 2004 session, the General Assembly considered House Bill 1300/Senate Bill 545 (both failed). These bills would have provided that if an insurer charges different rates for different medical specialties or combinations of medical specialties, the base rate paid by the highest-rated medical specialty or combination of medical specialties may not be greater than 600% of the base rate paid by the lowest-rated medical specialty or combination of medical specialties. Medical Mutual currently has an 800% spread between its lowest risk and highest risk physicians (technically there may be a 1300% difference, but this is only for certain part-time policies at the low-risk end). These rate compression bills would have the effect of forcing the low-risk doctors to pay more for their insurance in order to subsidize the high-risk doctors who would pay less.

Jay Angoff, former Insurance Commissioner for Missouri, testified as to the value of rate compression. The lowest risk physicians with Medical Mutual, comprising nearly 75% of their insureds, would see their premiums increase by $2,875 (this would be in

[17] "Law and Sympathy," Steven Keeva, American Bar Association Journal (August 2004)

addition to any general increase, which for 2005 is 47%). Obstetricians, comprising 4.2% of the total, would see their premiums decrease by over $46,000. Neurosurgeons, comprising 1% of the total, would see their rates fall by over $18,000. This he asserted would take the pressure off of the high-risk doctors who have experienced the brunt of the premium increases.

Pamela Randi Johnson, Associate Commissioner of the Maryland Insurance Administration, spoke in opposition to rate compression. She stated that federal law provides for risk retention groups.[18] These groups act as insurers but are not subject to regulation by state insurance administrations, including review and approval of rates. The excess insurance carrier for The Johns Hopkins Hospital, the second largest insurer in the State, is a risk retention group. Rate compression would artificially raise the premiums for nearly 75% of the physicians insured by Medical Mutual. This would provide an opportunity for a risk retention group to enter the market and under cut the rates charged by Medical Mutual. Because of federal preemption, the Maryland Insurance Administration would have no authority to require them to insure high-risk physicians or to regulate the rates that they charge. If such a risk retention group entered the market and many low-risk physicians left Medical Mutual this could lead to the destabilization and eventual downfall of the company.

The task force agrees with the assessment of the Maryland Insurance Administration. In the past 30 years the State has faced two insurance crises that had far-reaching consequences. The first was when GEICO became insolvent. The second was when St. Paul's stopped writing medical malpractice premiums in the State in 1975. This of course led to the establishment of Medical Mutual. The State should not adopt rate compression because of the risk it presents to the solvency of Medical Mutual. In addition, the task force has serious reservations about the wisdom of requiring lower risk physicians to subsidize high-risk physicians.

Recommendation – That rate compression legislation not be enacted.

Report by Maryland Insurance Administration

House Bill 1299 of 2004 would have required each insurer providing professional liability insurance to a health care provider in the State to submit to the Maryland Insurance Commissioner information on claims experience, costs, settlements, reserves, and any other information relating to malpractice claims as prescribed by the Insurance Commissioner in regulations. On September 1 of each year, the Insurance Commissioner would have been required to report on the availability of health care malpractice and other liability insurance in the State to the General Assembly.

A similar requirement had been in the law from 1986 to 2001. This report provided a mechanism to review the effectiveness of changes to the tort law on medical malpractice insurance. An annual review of this information would be of value to policy makers.

[18] Liability Risk Retention Act, 15 U.S.C. §§ 3901 through 3906

Recommendation – That each insurer providing medical malpractice liability insurance in the State be required to submit annually to the Maryland Insurance Administration a report detailing its operations and finances for the past year.

Patient Safety

Introduction

In 1999 the Institute of Medicine released its report "To Err is Human, Building a Safer Healthcare System." This report estimated that there are at least 44,000 and possibly as many as 98,000 deaths annually in the country due to medical malpractice. Although this estimate of deaths is controversial,[19] the report has been a call to action in the patient safety field. Within two weeks of the report's release, Congress began hearings and the President ordered a government-wide study of the feasibility of implementing the report's recommendations.

One of the key findings of the report is that systems errors are mainly responsible for preventable injuries: "(T)he majority of medical errors do not result from individual recklessness or the actions of a particular group – this is not a 'bad apple' problem. More commonly, errors are caused by faulty systems, processes, and conditions that lead people to make mistakes or fail to prevent them." This report made a variety of recommendations on how to address the issue of medical errors.

Although no studies have been done of the incidence of the number of deaths in Maryland due to malpractice it is clear that these events do occur. The task force received written testimony from Sorrel King, a patient safety advocate and founder of the Josephine King Pediatric Patient Safety Foundation. Her 18-month old daughter Josie died on February 22, 2001, due to medical errors committed at Johns Hopkins Hospital. Consistent with the conclusion of the Institute of Medicine, Josie's death was caused by a systems failure described by Mrs. King as "a cascade of medical errors." The task force also received a letter from Mrs. Rita P. Smith whose husband died in a Maryland hospital due to a failure to provide proper care.

In addition, Attorney General J. Joseph Curran, Jr., addressed the task force on issues relating to patient safety. Daniel O'Brien, Assistant Attorney General for the Department of Health and Mental Hygiene, also addressed these issues.

Maryland's Response

Maryland has taken a variety of steps to address this problem. In 2001 the General Assembly required the Maryland Health Care Commission (MHCC) to study the feasibility of developing a system for reducing incidences of preventable adverse medical events. The report to the legislature, submitted in January 2003, included the following key ideas:

[19] See "Deaths Due to Medical Errors are Exaggerated in Institute of Medicine Report," McDonald, et al, Journal of American Medical Association (July 5, 2000)

- Look to Veterans Administration as a model;
- Promote systems change – intentionally unsafe acts of individual providers remain under the authority of Health Occupation boards;
- Design a plan that builds on/improves existing structures;
- Emphasize improving quality of care by encouraging voluntary reporting and a non-punitive culture to uncover potential systems errors before they happen;
- Strengthen accountability for adverse events that result in death or serious disability by mandating that these events be reported to the Department of Health and Mental Hygiene; and
- Start with hospitals and nursing homes and incrementally expand to other types of facilities/offices.

Maryland's Patient Safety Strategy: A Three-Pronged Approach

Objective	**Prong 1**: Mandatory Reporting – limited to adverse events resulting in death or serious disability	**Prong 2**: Promote data systems and advanced technologies to improve care	**Prong 3**: Promote voluntary reporting of de-identified; information on all adverse events and near misses; educate providers
Implementing Agency	Department of Health and Mental Hygiene	Maryland Health Care Commission – Certificate of Need Program (CON); Hospital and Nursing Home Performance Guides Health Services Cost Review Commission (HSCRC) – hospital rate allowances for technological/quality improvement	Maryland Patient Safety Center (designation awarded to Delmarva Foundation and Maryland Hospital Association - May 17, 2004)
Affected Entity	Hospitals and potentially other licensed facilities	All facilities regulated by CON and hospitals that are rate regulated	Hospitals, nursing homes, and potentially all facilities

To implement Prong 1, the Department of Health and Mental Hygiene and the Office of Health Care Quality adopted regulations in March 2004 requiring identification, reporting, notification, root cause analysis of adverse events involving death or serious injury, and follow-up on investigations if necessary.

For Prong 2 the Maryland Health Care Commission (MHCC) recommended revising the State Health Plan standards for approving a certificate of need to include a preference for those capital projects that seek to prevent human error such as projects that increase standardization of equipment or reduce the possibility of infection and, on another front, expanding consumer information related to the quality of health care through the Commission's public performance evaluation reports. The MHCC also recommended the Health Services Cost Review Commission(HSCRC) consider providing financial rewards or support to facilities that promote safety initiatives or need means to improve safety and to collect data on the results of changes designed to enhance patient safety.

To implement Prong 3, the Maryland Patient Safety Center was established. Chapter 126 of 2003 allows a center to be designated by MHCC as Maryland Patient Safety Center to have medical review committee status, i.e., confidential "protected," preferably de-identified reporting. In June 2004 MHCC announced award of Maryland Patient Safety Center designation to a joint proposal from the Maryland Hospital Association and Delmarva Foundation in affiliation with the Johns Hopkins University School of Medicine and University of Maryland School of Medicine, Health Facilities Association of Maryland, and Lifespan.

The goals of the Maryland Patient Safety Center are as follows:

- Develop a grassroots model for building consensus to improve patient safety in Maryland healthcare settings, with maximum participation from hospitals and nursing homes;
- Promote a "culture of safety" that encourages systems improvements instead of faulting individuals;
- Collect, analyze, and share appropriate information about adverse events and near misses;
- Develop and provide education for health care professionals, hospital, and nursing home staff and health care providers, including sharing "better practices" from Maryland and worldwide;
- Sponsor patient safety collaboratives that will bring together providers and national experts to focus on specific process improvements; and
- Lead applied research to find and implement safer processes and practices in Maryland.

Board of Physicians

In 2003, Chapter 252 of the Acts of the General Assembly (Senate Bill 500) substantially altered the law, including the name, of the Board of Physicians. The membership of the board was increased from 15 to 21 members, including the addition of three more consumer members (for a total of five) and a public member. The Act requires the completion of peer review cases within 90 days. The Board of Physicians reports that the Delmarva Foundation and the Maryland Psychiatric Society are now averaging 56 days to complete peer reviews, down from 364 days before the passage of the Act. Of the 1,626 complaints filed or pending in fiscal 2004, a total of 1,561 cases were closed.

Chapter 252 also requires the board to maintain physician profiles of malpractice payouts. The board must maintain a list of licensees who have a final judgment or arbitration award against them in the past 10 years. The profile must also list the names of licensees with three or more settlements or judgments of $150,000 or greater within the past five years. The board is required to investigate any physician with three or more settlements or judgments of $150,000 or greater for care rendered within the past five years or with a settlement or judgment of $1 million or more for care rendered within the past five years, and has discretion to investigate any malpractice claim or settlement. A total of 213 payouts were reported to the board in 2003.

Among the changes in Chapter 252 was the lowering of the evidentiary standard for disciplinary hearings from the clear and convincing evidence standard to the lesser preponderance of the evidence standard. For the following charges, however, the standard remained the clear and convincing evidence standard: (1) failure to meet appropriate standards for the delivery of quality care; or (2) failure to meet appropriate standards for the delivery of quality radiation oncology/therapy technology care, medical radiation technology care, or nuclear medicine technology care.

The task force finds that it is inappropriate to have a higher standard of proof for disciplinary proceedings involving standard of care violations than for all other disciplinary proceedings. There are currently adequate due process provisions in the law to ensure that a physician is adequately protected from arbitrary actions, including the requirement that there be two reviewers in each peer review case, with a third reviewer in those instances where the two reviewers disagree.

Recommendation – That in a disciplinary proceeding before the Board of Physicians the State need only prove by a preponderance of evidence instead of by clear and convincing evidence that a physician violated the standard of care.

Sanctions for Hospital's Failure to Report Adverse Events

Under current Maryland regulations, hospitals are required to report to the Department of Health and Mental Hygiene adverse events involving death or serious disability. Although license sanctions are available, the law does not provide a monetary sanction for a hospital that fails to report. The task force finds that having a fine for failure to report these events will encourage additional reporting and is an appropriate punishment for this violation.

Recommendation - That hospitals failing to report to the Department of Health and Mental Hygiene adverse events involving death or serious disability be subject to a fine.

Attorney's Fees in Hospital Privilege Cases

Every hospital has a medical review committee that is charged with duties that include evaluating the qualifications, competence, and performance of providers of health. If a hospital decides that a health care provider is not providing competent care the matter will be referred to the medical review committee. After following appropriate procedures, including appropriate peer review, the committee can then take appropriate action, which may consist of revoking the privileges of the health care provider to provide services at the hospital.

On some occasions when a medical review committee has decided to revoke a provider's privileges or take other disciplinary action, the provider has sued the hospital in court. The hospital almost always prevails in these actions, but they are lengthy and expensive. The task force finds that requiring the loser of such an action to pay for the winner's attorney's fees would help ensure that only meritorious actions are brought.

Recommendation – That in a judicial action following a final decision by a hospital or health care facility to limit, suspend, or revoke the credentials of a health care

provider that the loser of the action be required to pay the winner's reasonable attorney's fees.

Alternatives to Litigation

No-fault Birth-related Neurological Injury Compensation Fund

The task force heard a presentation from Andrew D. Freeman, Esq., and John M. Freeman, M.D., on the concept of adopting a no-fault birth-related neurological injury compensation fund.[20] The purpose of this fund would be to provide care for all children born with cerebral palsy. They testified that there are approximately 150 babies born with cerebral palsy in the State annually. It is possible that in up to six (four percent) of these cases there was malpractice. About 12 to15 of these cases will end up receiving compensation through litigation. Those that recover receive less than 40% expended on the case, with the remainder going to attorney's fees and other litigation-related expenses. Approximately 60% of the malpractice premiums paid by obstetricians go to cover cerebral palsy suits. Their conclusion was that the current system is ineffective and inefficient both in providing compensation and in deterring bad medicine.

Their premise was that all children with cerebral palsy have similar needs, regardless of the cause. A no-fault system could compensate all of these children in a manner that is fairer and less expensive than the current system. The system would not provide noneconomic damages. Cases where there was medical negligence could be referred to the appropriate licensing board for disciplinary action.

They criticized the Florida and Virginia models that attempted to establish a fund for cerebral palsy children on the grounds that they were too restrictive and allowed a mechanism for a family to opt out of the system.

In addition to this proposal, the task force also discussed the notion of having a Workers' Compensation type of model for all medical malpractice cases. No state has gone to this type of system.

Although the task force found the Freemans' arguments to be intriguing, it is clear that further details on the costs and mechanics of such a system are needed. The Freemans proposed that there be a surcharge on each birth to go into the fund. It is unclear who should pay this charge, whether this is the best way to provide funds, and what the overall amount needed for the fund is. The task force did not have sufficient information on these matters to recommend for or against adoption of the system they proposed.

Recommendation – That the Maryland Insurance Administration study and report on the concept of a no-fault birth-related neurological injury compensation fund.

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[20] See "No-Fault Cerebral Palsy Insurance: An Alternative to the Obstetrical Malpractice Lottery," Andrew D. Freeman and John M. Freeman, Journal of Health Politics, Policy and Law (Winter 1989); "No-fault Birth-related Neurologic Injury Compensation: Perhaps Its Time Has Come, Again," John M. Freeman and Andrew D. Freeman, Forum (February 2003)

Short-term Relief

The task force recognizes that there may be a need for some kind of funding mechanism to assist health care providers before the long-term solutions become effective. The task force, however, unanimously adopted the following two recommendations.

Recommendation – That short-term relief, including a temporary funding mechanism to reduce premiums, should be adopted only in conjunction with a meaningful and comprehensive package of reforms that includes tort reform, and that short-term relief should not be adopted without a meaningful and comprehensive package of reforms that includes tort reform.

Recommendation – That if short-term relief, including a temporary funding mechanism to reduce premiums, is adopted it should only be adopted with a sunset provision so that it terminates after an appropriate period of time.

Nursing Homes and Other High Risk Physicians and Practices

The task force heard testimony that Medical Mutual planned to impose a 20% surcharge on physicians if 10 to 30% of their practice involved geriatric patients in nursing homes and would not renew physicians whose practice was over 30% in this area. Although the task force recognizes the liability issues facing nursing homes and nursing home physicians, the task force felt that the proposed action by Medical Mutual was not appropriate.

Recommendation – That the location and nature of a health care provider's practice should not affect the cost or availability of medical malpractice insurance.

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Federal Individuals with Disabilities Education Act, Title 20, Chapter 33 of the United States Code

Federal Liability Risk Retention Act, 15 U.S.C. §§ 3901 through 3906

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BILLS

House Bill 287/ Senate Bill 193 of 2004 - Maryland Medical Injury Compensation Reform Act

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APPENDIX I

STATE OF MARYLAND
OFFICE OF THE GOVERNOR

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TTY USERS CALL VIA MD RELAY

July 9, 2004

The Honorable Raymond G. Thieme, Jr.
1796 Chesapeake Place
Pasadena, MD 21122

Dear Judge Thieme:

I am pleased that you have agreed to be the Chairman of the Governor's Task Force on Medical Malpractice and Health Care Access. As you know, the rising costs of malpractice insurance are threatening both the affordability and accessibility of health care in the State. Malpractice premiums of the Medical Mutual Liability Insurance Society, the largest insurer of doctors in the State, have risen nearly 70% in the past two years. High risk specialties, in particular, obstetricians, neurologists, and orthopedic surgeons suffered from some of the most drastic rate increases. The rate hikes are a direct result of rising jury verdicts, which lead in turn to increased malpractice settlements.

It is not just doctors, however, who are seeing huge increases in premiums. Nurse midwives, hospitals, nursing homes, assisted living facilities, and birthing centers are also seeing their premiums skyrocket. It is clear that the citizens of Maryland are facing a crisis in health care.

There are several aspects to this issue that the Task Force will examine. First, we would like the Task Force to consider changes to the current tort system. During the 2004 session of the General Assembly, the Administration sponsored legislation that would have required judgments over a certain amount to be paid as annuities and established an offer of judgment provision modeled after Federal Rule of Civil Procedure 68. We expect the Task Force to review this bill as a central part of the deliberations.

Second, the Task Force will review current practices and laws relating to patient safety. Innocent victims suffer injuries as a result of medical negligence and, accordingly, must be compensated. Conversly, we must not forget that considering the current trend, thousands of pregnant women may be left without the services of an obstetrician. In light of these serious, conflicting concerns, we must do everything possible to minimize the possibility of mistakes and ensure that negligent health care providers are appropriately disciplined.

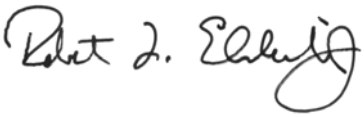
Third, there were several proposals considered but not passed by the General Assembly during the 2004 session that would have made changes to insurance law. You have read about various proposals to establish a fund to help defray the costs of malpractice insurance. If this approach is to be considered, an adequate and reliable funding source is essential. There may be other proposals that should be considered to encourage other insurers to enter the Maryland market.

Fourth, the Task Force will consider expanding the use of alternative dispute resolution. Mediation and arbitration have proven to be successful in a variety of matters, resolving many cases, including medical malpractice cases. If these processes resolve cases without expenses associated with a trial, money will be distributed to injured victims more quickly at a cost savings for both sides.

By enumerating the above issues we do not intend to limit the scope of the Task Force. Undoubtedly there are other innovative ideas to be considered, including laws from other states. We anticipate the Task Force will meet approximately every two weeks from July until November with a report date of November 15, 2004.

We appreciate your willingness to take on this vital task.

Very truly yours,



Robert L. Ehrlich, Jr.
Governor

APPENDIX II

GOVERNOR'S TASK FORCE ON MEDICAL MALPRACTICE AND HEALTH CARE ACCESS

AGENDA FOR TUESDAY, JULY 13, 2004

(1) Greetings from Governor Robert L. Ehrlich, Jr.

(2) Introductions

(3) Overview of Medical Malpractice Issues and Presentation of House Bill 287/Senate Bill 193 of 2004 – Maryland Medical Injury Compensation Reform Act – Donald J. Hogan, Jr., Counsel to Task Force

(4) Discussion of Task Force Schedule and Related Issues

GOVERNOR'S TASK FORCE ON MEDICAL MALPRACTICE AND HEALTH CARE ACCESS

AGENDA FOR TUESDAY, JULY 27, 2004

(1) Impact of Rising Malpractice Costs on Medicaid – John Folkemer, Executive Director of Office of Planning and Finance, Department of Health and Mental Hygiene

(2) Roundtable Discussion on Impact of Rising Malpractice Costs – Task Force Members

GOVERNOR'S TASK FORCE ON MEDICAL MALPRACTICE AND HEALTH CARE ACCESS

AGENDA FOR TUESDAY, AUGUST 10, 2004

(1) Presentation by David L. Murray, President and CEO of Medical Mutual Liability Insurance Society of Maryland

(2) Presentation by Maryland Insurance Administration

(3) Discussion of Future Topics for Consideration by the Task Force

GOVERNOR'S TASK FORCE ON MEDICAL MALPRACTICE AND HEALTH CARE ACCESS

AGENDA FOR TUESDAY, AUGUST 24, 2004

Overview of a Medical Malpractice Case

(1) Plaintiff's case - Paul D. Bekman, Esq., Plaintiff's Trial Attorney

(2) Defense case – Albert D. Brault, Esq., and Richard P. Kidwell, Esq.,

(3) Role of Judiciary - Honorable Stuart Berger, Associate Judge of the Circuit Court for Baltimore City and the Honorable Kathleen Gallogly Cox, Associate Judge of the Circuit Court for Baltimore County

GOVERNOR'S TASK FORCE ON MEDICAL MALPRACTICE AND HEALTH CARE ACCESS

AGENDA FOR TUESDAY, SEPTEMBER 7, 2004

(1) Impact of Medical Malpractice Crisis on Rates of Reimbursement of Health Care Providers and Availability of Health Care

The Honorable Nelson J. Sabatini – Medicare and Medicaid Reimbursements

Mr. Robert Murray, Executive Director of Health Services Cost Review Commission – Hospital Services

Mr. David D. Wolf, Executive Vice President for Medical System and Corporate Development for CareFirst BlueCross BlueShield

(2) Annuities and Structured Settlements – Jamie Kormann, Regional Vice President of B.H. & A. Settlements

GOVERNOR'S TASK FORCE ON MEDICAL MALPRACTICE AND HEALTH CARE ACCESS

AGENDA FOR TUESDAY, SEPTEMBER 21, 2004

(1) Life Care Experts – Sheryl Ranson, Ph.D., Certified Life Care Planner, Certified Vocational Rehabilitation Counselor, Licensed Mental Health Counselor

(2) Insurance Issues – Jay Angoff, esq., Roger Brown & Associates in Jefferson City, Missouri; former Missouri Insurance Commissioner

(3) Additional Insurance Issues – P. Randi Johnson, Associate Commissioner of Maryland Insurance Administration
   a. Update on Medical Mutual Liability Insurance Society of Maryland Rate Increase
   b. Rate Compression (Senate Bill 545/House Bill 1300 of 2004)
   c. California Proposition 103

(4) Expert Medical Testimony - P. Randi Johnson, Associate Commissioner of Maryland Insurance Administration
   a. Enhanced Certificate of Merit (HB 1299 of 2004)
   b. Practice of Medicine (House Bill 1262/Senate Bill 896 of 2004)
   c. Require clinical practice of expert (Va. Code Ann. § 8.01-581.20)

GOVERNOR'S TASK FORCE ON MEDICAL MALPRACTICE AND HEALTH CARE ACCESS

AGENDA FOR TUESDAY, OCTOBER 5, 2004

(1) Offer of Judgment – Paul W. Grimm, United States Magistrate Judge

(2) Alternatives to Litigation - No-fault Birth-related Neurologic Injury Compensation – John M. Freeman, MD and Andrew D. Freeman, Esq.

(3) Alternative Dispute Resolution
   a. Health Claims Arbitration Office – Harry L. Chase, Esq.
   b. Judicial Mediation and Conflict Resolution Office (MACRO) – Rachel Wohl, Esq., Executive Director
   c. Center for Dispute Resolution at the University of Maryland (C-DRUM) – Roger Wolfe, Esq., Professor of Law, University of Maryland School of Law
   d. Johns Hopkins Hospital Mediation Program – Richard P. Kidwell, Esq.

(4) Benevolent Gestures Legislation – Richard P. Kidwell, Esq.

GOVERNOR'S TASK FORCE ON MEDICAL MALPRACTICE AND HEALTH CARE ACCESS

AGENDA FOR TUESDAY, OCTOBER 12, 2004

Subject: Public Hearing

GOVERNOR'S TASK FORCE ON MEDICAL MALPRACTICE AND HEALTH CARE ACCESS

AGENDA FOR TUESDAY, OCTOBER 19, 2004

(1) The Honorable J. Joseph Curran, Jr., Attorney General

(2) Economic Damages in Medical Malpractice Cases – J. Mark Coulson, Esq., Miles and Stockbridge

(3) Patient Safety Issues

  (a) Sorrel King – Patient Safety Advocate; Josephine King Pediatric Patient Safety Foundation*

  (b) Physician Discipline and Malpractice Claims - C. Irving Pinder, Jr., Executive Director, and Marie Savage of the Board of Physicians; Daniel J. O'Brien, Jr., Principal Counsel to the Department of Health and Mental Hygiene, Office of the Attorney General

  (c) Medical Errors Reporting - William F. Minogue, Director, Maryland Patient Safety Center; Barbara McLean, Executive Director, Maryland Health Care Commission; and Carol Benner, Director, Office of Health Care Quality

* Due to a scheduling conflict, Mrs King was unable to attend the hearing. Her written testimony was distributed to the members.

GOVERNOR'S TASK FORCE ON MEDICAL MALPRACTICE AND HEALTH CARE ACCESS

AGENDA FOR TUESDAY, OCTOBER 26, 2004

Subject: Work Session

GOVERNOR'S TASK FORCE ON MEDICAL MALPRACTICE AND HEALTH CARE ACCESS

AGENDA FOR MONDAY, NOVEMBER 1, 2004

Subject: Work Session