S-3816.2

SENATE BILL 6645

State of Washington 58th Legislature 2004 Regular Session

By Senators Kastama, Rasmussen, Haugen and Shin

Read first time 01/28/2004. Referred to Committee on Judiciary.

AN ACT Relating to health care liability; amending RCW 4.24.250, 43.70.510, 70.41.200, 43.70.110, 43.70.250, 18.122.080, 18.122.140, 18.71.350, 18.57.245, 7.70.020, and 7.70.100; adding new sections to chapter 43.70 RCW; adding new sections to chapter 7.70 RCW; adding a new section to chapter 70.41 RCW; adding a new section to chapter 48.46 RCW; adding new sections to chapter 48.02 RCW; adding a new section to chapter 48.05 RCW; adding a new section to chapter 4.44 RCW; adding a new section to chapter 48.19 RCW; creating a new section; and prescribing penalties.

BE IT ENACTED BY THE LEGISLATURE OF THE STATE OF WASHINGTON:

Sec. 1. RCW 4.24.250 and 1981 c 181 s 1 are each amended to read as follows:

(1) Any health care provider as defined in RCW 7.70.020 (1) and (2) as now existing or hereafter amended who, in good faith, files charges or presents evidence against another member of their profession based on the claimed incompetency or gross misconduct of such person before a regularly constituted review committee or board of a professional society or hospital whose duty it is to evaluate the competency and qualifications of members of the profession, including limiting the

extent of practice of such person in a hospital or similar institution, or before a regularly constituted committee or board of a hospital whose duty it is to review and evaluate the quality of patient care, shall be immune from civil action for damages arising out of such activities. The proceedings, reports, and written records of such committees or boards, or of a member, employee, staff person, or investigator of such a committee or board, shall not be subject to subpoena or discovery proceedings in any civil action, except actions arising out of the recommendations of such committees or boards involving the restriction or revocation of the clinical or staff privileges of a health care provider as defined above.

(2) A coordinated quality improvement program maintained in accordance with RCW 43.70.510 or 70.41.200 may share information and documents, including complaints and incident reports, created specifically for, and collected and maintained by a coordinated quality improvement committee or committees or boards under subsection (1) of this section, with one or more other coordinated quality improvement programs for the improvement of the quality of health care services rendered to patients and the identification and prevention of medical malpractice. Information and documents disclosed by one coordinated quality improvement program to another coordinated quality improvement program and any information and documents created or maintained as a result of the sharing of information and documents are not subject to the discovery process and confidentiality shall be respected as required by subsection (1) of this section and by RCW 43.70.510(4) and 70.41.200(3).

Sec. 2. RCW 43.70.510 and 1995 c 267 s 7 are each amended to read as follows:

(1)(a) Health care institutions and medical facilities, other than hospitals, that are licensed by the department, professional societies or organizations, health care service contractors, health maintenance organizations, health carriers approved pursuant to chapter 48.43 RCW, and any other person or entity providing health care coverage under chapter 48.42 RCW that is subject to the jurisdiction and regulation of any state agency or any subdivision thereof may maintain a coordinated quality improvement program for the improvement of the quality of

health care services rendered to patients and the identification and prevention of medical malpractice as set forth in RCW 70.41.200.

(b) All such programs shall comply with the requirements of RCW 70.41.200(1)(a), (c), (d), (e), (f), (g), and (h) as modified to reflect the structural organization of the institution, facility, professional societies or organizations, health care service contractors, health maintenance organizations, health carriers, or any other person or entity providing health care coverage under chapter 48.42 RCW that is subject to the jurisdiction and regulation of any state agency or any subdivision thereof, unless an alternative quality improvement program substantially equivalent to RCW 70.41.200(1)(a) is developed. All such programs, whether complying with the requirement set forth in RCW 70.41.200(1)(a) or in the form of an alternative program, must be approved by the department before the discovery limitations provided in subsections (3) and (4) of this section and the exemption under RCW 42.17.310(1)(hh) and subsection (5) of this section shall apply. In reviewing plans submitted by licensed entities that are associated with physicians' offices, the department shall ensure that the exemption under RCW 42.17.310(1)(hh) and the discovery limitations of this section are applied only to information and documents related specifically to quality improvement activities undertaken by the licensed entity.

(2) Health care provider groups of ((~~ten~~)) two or more providers may maintain a coordinated quality improvement program for the improvement of the quality of health care services rendered to patients and the identification and prevention of medical malpractice as set forth in RCW 70.41.200. All such programs shall comply with the requirements of RCW 70.41.200(1)(a), (c), (d), (e), (f), (g), and (h) as modified to reflect the structural organization of the health care provider group. All such programs must be approved by the department before the discovery limitations provided in subsections (3) and (4) of this section and the exemption under RCW 42.17.310(1)(hh) and subsection (5) of this section shall apply.

(3) Any person who, in substantial good faith, provides information to further the purposes of the quality improvement and medical malpractice prevention program or who, in substantial good faith, participates on the quality improvement committee shall not be subject

to an action for civil damages or other relief as a result of such activity.

(4) Information and documents, including complaints and incident reports, created specifically for, and collected, and maintained by a quality improvement committee are not subject to discovery or introduction into evidence in any civil action, and no person who was in attendance at a meeting of such committee or who participated in the creation, collection, or maintenance of information or documents specifically for the committee shall be permitted or required to testify in any civil action as to the content of such proceedings or the documents and information prepared specifically for the committee. This subsection does not preclude: (a) In any civil action, the discovery of the identity of persons involved in the medical care that is the basis of the civil action whose involvement was independent of any quality improvement activity; (b) in any civil action, the testimony of any person concerning the facts that form the basis for the institution of such proceedings of which the person had personal knowledge acquired independently of such proceedings; (c) in any civil action by a health care provider regarding the restriction or revocation of that individual's clinical or staff privileges, introduction into evidence information collected and maintained by quality improvement committees regarding such health care provider; (d) in any civil action challenging the termination of a contract by a state agency with any entity maintaining a coordinated quality improvement program under this section if the termination was on the basis of quality of care concerns, introduction into evidence of information created, collected, or maintained by the quality improvement committees of the subject entity, which may be under terms of a protective order as specified by the court; (e) in any civil action, disclosure of the fact that staff privileges were terminated or restricted, including the specific restrictions imposed, if any and the reasons for the restrictions; or (f) in any civil action, discovery and introduction into evidence of the patient's medical records required by rule of the department of health to be made regarding the care and treatment received.

(5) Information and documents created specifically for, and collected and maintained by a quality improvement committee are exempt from disclosure under chapter 42.17 RCW.

(6) A coordinated quality improvement program may share information and documents, including complaints and incident reports, created specifically for, and collected and maintained by a quality improvement committee or a peer review committee under RCW 4.24.250 with one or more other coordinated quality improvement programs maintained in accordance with this section or with RCW 70.41.200, for the improvement of the quality of health care services rendered to patients and the identification and prevention of medical malpractice. Information and documents disclosed by one coordinated quality improvement program to another coordinated quality improvement program and any information and documents created or maintained as a result of the sharing of information and documents are not subject to the discovery process and confidentiality shall be respected as required by subsection (4) of this section and RCW 4.24.250.

(7) The department of health shall adopt rules as are necessary to implement this section.

Sec. 3. RCW 70.41.200 and 2000 c 6 s 3 are each amended to read as follows:

(1) Every hospital shall maintain a coordinated quality improvement program for the improvement of the quality of health care services rendered to patients and the identification and prevention of medical malpractice. The program shall include at least the following:

(a) The establishment of a quality improvement committee with the responsibility to review the services rendered in the hospital, both retrospectively and prospectively, in order to improve the quality of medical care of patients and to prevent medical malpractice. The committee shall oversee and coordinate the quality improvement and medical malpractice prevention program and shall ensure that information gathered pursuant to the program is used to review and to revise hospital policies and procedures;

(b) A medical staff privileges sanction procedure through which credentials, physical and mental capacity, and competence in delivering health care services are periodically reviewed as part of an evaluation of staff privileges;

(c) The periodic review of the credentials, physical and mental capacity, and competence in delivering health care services of all persons who are employed or associated with the hospital;

(d) A procedure for the prompt resolution of grievances by patients or their representatives related to accidents, injuries, treatment, and other events that may result in claims of medical malpractice;

(e) The maintenance and continuous collection of information concerning the hospital's experience with negative health care outcomes and incidents injurious to patients, patient grievances, professional liability premiums, settlements, awards, costs incurred by the hospital for patient injury prevention, and safety improvement activities;

(f) The maintenance of relevant and appropriate information gathered pursuant to (a) through (e) of this subsection concerning individual physicians within the physician's personnel or credential file maintained by the hospital;

(g) Education programs dealing with quality improvement, patient safety, medication errors, injury prevention, staff responsibility to report professional misconduct, the legal aspects of patient care, improved communication with patients, and causes of malpractice claims for staff personnel engaged in patient care activities; and

(h) Policies to ensure compliance with the reporting requirements of this section.

(2) Any person who, in substantial good faith, provides information to further the purposes of the quality improvement and medical malpractice prevention program or who, in substantial good faith, participates on the quality improvement committee shall not be subject to an action for civil damages or other relief as a result of such activity.

(3) Information and documents, including complaints and incident reports, created specifically for, and collected, and maintained by a quality improvement committee are not subject to discovery or introduction into evidence in any civil action, and no person who was in attendance at a meeting of such committee or who participated in the creation, collection, or maintenance of information or documents specifically for the committee shall be permitted or required to testify in any civil action as to the content of such proceedings or the documents and information prepared specifically for the committee. This subsection does not preclude: (a) In any civil action, the discovery of the identity of persons involved in the medical care that is the basis of the civil action whose involvement was independent of any quality improvement activity; (b) in any civil action, the

testimony of any person concerning the facts which form the basis for the institution of such proceedings of which the person had personal knowledge acquired independently of such proceedings; (c) in any civil action by a health care provider regarding the restriction or revocation of that individual's clinical or staff privileges, introduction into evidence information collected and maintained by quality improvement committees regarding such health care provider; (d) in any civil action, disclosure of the fact that staff privileges were terminated or restricted, including the specific restrictions imposed, if any and the reasons for the restrictions; or (e) in any civil action, discovery and introduction into evidence of the patient's medical records required by regulation of the department of health to be made regarding the care and treatment received.

(4) Each quality improvement committee shall, on at least a semiannual basis, report to the governing board of the hospital in which the committee is located. The report shall review the quality improvement activities conducted by the committee, and any actions taken as a result of those activities.

(5) The department of health shall adopt such rules as are deemed appropriate to effectuate the purposes of this section.

(6) The medical quality assurance commission or the board of osteopathic medicine and surgery, as appropriate, may review and audit the records of committee decisions in which a physician's privileges are terminated or restricted. Each hospital shall produce and make accessible to the commission or board the appropriate records and otherwise facilitate the review and audit. Information so gained shall not be subject to the discovery process and confidentiality shall be respected as required by subsection (3) of this section. Failure of a hospital to comply with this subsection is punishable by a civil penalty not to exceed two hundred fifty dollars.

(7) The department, the joint commission on accreditation of health care organizations, and any other accrediting organization may review and audit the records of a quality improvement committee or peer review committee in connection with their inspection and review of hospitals. Information so obtained shall not be subject to the discovery process, and confidentiality shall be respected as required by subsection (3) of this section. Each hospital shall produce and make accessible to the

department the appropriate records and otherwise facilitate the review and audit.

(8) A coordinated quality improvement program may share information and documents, including complaints and incident reports, created specifically for, and collected and maintained by a quality improvement committee or a peer review committee under RCW 4.24.250 with one or more other coordinated quality improvement programs maintained in accordance with this section or with RCW 43.70.510, for the improvement of the quality of health care services rendered to patients and the identification and prevention of medical malpractice. Information and documents disclosed by one coordinated quality improvement program to another coordinated quality improvement program and any information and documents created or maintained as a result of the sharing of information and documents are not subject to the discovery process and confidentiality shall be respected as required by subsection (3) of this section and RCW 4.24.250.

(9) Violation of this section shall not be considered negligence per se.

Sec. 4. RCW 43.70.110 and 1993 sp.s. c 24 s 918 are each amended to read as follows:

(1) The secretary shall charge fees to the licensee for obtaining a license. After June 30, 1995, municipal corporations providing emergency medical care and transportation services pursuant to chapter 18.73 RCW shall be exempt from such fees, provided that such other emergency services shall only be charged for their pro rata share of the cost of licensure and inspection, if appropriate. The secretary may waive the fees when, in the discretion of the secretary, the fees would not be in the best interest of public health and safety, or when the fees would be to the financial disadvantage of the state.

(2) Except as provided in section 6 of this act, fees charged shall be based on, but shall not exceed, the cost to the department for the licensure of the activity or class of activities and may include costs of necessary inspection.

(3) Department of health advisory committees may review fees established by the secretary for licenses and comment upon the appropriateness of the level of such fees.

Sec. 5. RCW 43.70.250 and 1996 c 191 s 1 are each amended to read as follows:

It shall be the policy of the state of Washington that the cost of each professional, occupational, or business licensing program be fully borne by the members of that profession, occupation, or business. The secretary shall from time to time establish the amount of all application fees, license fees, registration fees, examination fees, permit fees, renewal fees, and any other fee associated with licensing or regulation of professions, occupations, or businesses administered by the department. In fixing said fees, the secretary shall set the fees for each program at a sufficient level to defray the costs of administering that program and the patient safety fee established in section 6 of this act. All such fees shall be fixed by rule adopted by the secretary in accordance with the provisions of the administrative procedure act, chapter 34.05 RCW.

NEW SECTION. **Sec. 6.** A new section is added to chapter 43.70 RCW to read as follows:

(1) The secretary shall increase the licensing fee established under RCW 43.70.110 for health care professionals and facilities designated in subsection (2) of this section by one percent of the amount of the applicable annual licensing fee. Proceeds of the patient safety fee must be dedicated to patient safety and medical error reduction efforts that have been proven to improve the quality of care provided by health care professionals and facilities.

(2) Health care professionals and facilities subject to the one percent patient safety fee include:

(a) Health care professionals licensed under Title 18 RCW; and

(b) Hospitals licensed under chapter 70.41 RCW, psychiatric hospitals licensed under chapter 71.12 RCW, and ambulatory diagnostic, treatment, or surgical facilities licensed under chapter 70.41 RCW.

(3) Patient safety fee proceeds must be administered by the department, in consultation with established patient safety coalitions. Proceeds will be distributed in the form of grants, loans, or other appropriate arrangements to support strategies that have been proven to reduce medical errors and enhance patient safety. In developing criteria, for the award of grants, loans, or other funding arrangements under this section, the department shall rely upon evidence-based

practices to improve patient safety that have been identified and recommended by governmental and private organizations, including but not limited to:

(a) The federal agency for health care quality and research;

(b) The federal institute of medicine; and

(c) The joint commission on accreditation of health care organizations.

NEW SECTION. **Sec. 7.** A new section is added to chapter 7.70 RCW to read as follows:

(1) Except for early offers, as defined in RCW 7.70.020, one percent of the present value of the settlement or verdict in any action for damages based upon injuries resulting from health care shall be deducted from the settlement or verdict as a patient safety fee. Proceeds of the patient safety fee will be distributed by the department of health in the form of grants, loans, or other appropriate arrangements to support strategies that have been proven to reduce medical errors and enhance patient safety.

(2) Patient safety fees shall be transmitted to the secretary of the department of health for deposit into the patient safety account established in section 9 of this act.

(3) The supreme court shall by rule adopt procedures to implement this section.

NEW SECTION. **Sec. 8.** A new section is added to chapter 43.70 RCW to read as follows:

The secretary may solicit and accept grants or other funds from public and private sources to support patient safety and medical error reduction efforts under RCW 43.70.110, 43.70.250, and sections 6 and 7 of this act. Any grants or funds received may be used to enhance these activities as long as program standards established by the secretary are maintained.

NEW SECTION. **Sec. 9.** A new section is added to chapter 43.70 RCW to read as follows:

The patient safety account is created in the custody of the state treasurer. All receipts from the fees created in sections 6 and 7 of this act must be deposited into the account. Expenditures from the

account may be used only for the purposes of RCW 43.70.110, 43.70.250, and sections 6 through 8 of this act. Only the secretary or the secretary's designee may authorize expenditures from the account. The account is subject to allotment procedures under chapter 43.88 RCW, but an appropriation is not required for expenditures.

Sec. 10. RCW 18.122.080 and 1991 c 3 s 263 are each amended to read as follows:

(1) The secretary shall issue a license or certificate, as appropriate, to any applicant who demonstrates to the secretary's satisfaction that the following requirements have been met:

(a) Graduation from an educational program approved by the secretary or successful completion of alternate training meeting established criteria;

(b) Successful completion of an approved examination; ((~~and~~))

(c) Successful completion of any experience requirement established by the secretary; and

(d) Except for funeral directors licensed under chapter 18.39 RCW, embalmers licensed under chapter 18.39 RCW, and veterinarians licensed under chapter 18.92 RCW, successful completion of a two-hour course relating to the prevention of medical errors. The course shall be approved by the department and shall include information concerning error reduction and prevention and patient safety. Any course completed by physicians licensed under chapter 18.71 RCW or physician assistants licensed under chapter 18.71A RCW shall also include information relating to the five most misdiagnosed conditions during the previous biennium, as determined by the medical quality assurance commission.

(2) The secretary shall establish by rule what constitutes adequate proof of meeting the criteria.

(3) In addition, applicants shall be subject to the grounds for denial of a license or certificate or issuance of a conditional license or certificate under chapter 18.130 RCW.

(4) The secretary shall issue a registration to any applicant who completes an application which identifies the name and address of the applicant, the registration being requested, and information required by the secretary necessary to establish whether there are grounds for

denial of a registration or issuance of a conditional registration under chapter 18.130 RCW.

Sec. 11. RCW 18.122.140 and 1991 c 3 s 267 are each amended to read as follows:

The secretary shall establish by rule the procedural requirements and fees for renewal of a credential. Except for funeral directors, embalmers, and veterinarians, renewal of a health profession's license or certification requires successful completion of a two-hour course relating to the prevention of medical errors. The two-hour course counts towards the total number of continuing education hours, if any, required for the profession. The course must be approved by the department and include information concerning error reduction and prevention and patient safety. Any course completed by physicians licensed under chapter 18.71 RCW or physician assistants licensed under chapter 18.71A RCW must also include information relating to the five most misdiagnosed conditions during the previous biennium, as determined by the medical quality assurance commission. Failure to renew shall invalidate the credential and all privileges granted by the credential. If a license or certificate has lapsed for a period longer than three years, the person shall demonstrate competence to the satisfaction of the secretary by taking continuing education courses, or meeting other standards determined by the secretary.

Sec. 12. RCW 18.71.350 and 1994 sp.s. c 9 s 333 are each amended to read as follows:

(1)(a) Every institution or organization providing professional liability insurance to physicians shall send a complete report to the commission of all malpractice settlements, awards, or payments ((~~in excess of twenty thousand dollars~~)) as a result of a claim or action for damages alleged to have been caused by an insured physician's incompetency or negligence in the practice of medicine. ((~~Such institution or organization shall also report the award, settlement, or payment of three or more claims during a five-year time period as the result of the alleged physician's incompetence or negligence in the practice of medicine regardless of the dollar amount of the award or payment~~)) A final disposition of a medical malpractice claim resulting in no payment on behalf of the insured must also be reported.

(b) Each physician must report any claim or action for damages described in (a) of this subsection if the claim is not otherwise required to be reported by an institution or organization providing professional liability insurance.

(2)(a) Reports required by this section shall be made within sixty days of the date of the settlement or verdict. Failure to comply with this section is punishable by a civil penalty not to exceed two hundred fifty dollars.

(b) Reports required by this section must include:

(i) The name, address, health care provider professional license number, and specialty, if applicable;

(ii) The date of the occurrence that created the claim;

(iii) The name and address of the injured person. This information is confidential and must not be disclosed by the commission except for disclosure to the insurance commissioner. This information may be used by the commission for identifying multiple or duplicate claims arising out of the same occurrence;

(iv) The date of suit, if filed;

(v) The injured person's age and sex;

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

(vii) The date and amount of judgment or settlement, if any, including the itemization of the verdict; and

(viii) A summary of the occurrence that created the claim, including:

(A) The name of the health care facility, if any, where the injury occurred;

(B) The final diagnosis for which treatment was sought or rendered;

(C) A description of the misdiagnosis, if made, of the patient's actual condition;

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

(E) A description of the principal injury giving rise to the claim;

(F) Any steps that have been taken to make similar occurrences or injuries less likely in the future; and

(G) Any other information required by the commission.

(3) The commission shall provide all information acquired under subsection (2) of this section to the insurance commissioner annually.

Sec. 13. RCW 18.57.245 and 1986 c 300 s 10 are each amended to read as follows:

(1)(a) Every institution or organization providing professional liability insurance to osteopathic physicians shall send a complete report to the board of all malpractice settlements, awards, or payments ((~~in excess of twenty thousand dollars~~)) as a result of a claim or action for damages alleged to have been caused by an insured physician's incompetency or negligence in the practice of osteopathic medicine. ((~~Such institution or organization shall also report the award, settlement, or payment of three or more claims during a year as the result of the alleged physician's incompetence or negligence in the practice of medicine regardless of the dollar amount of the award or payment~~)) A final disposition of a claim resulting in no payment on behalf of the insured must also be reported.

(b) Each physician must report any claim or action for damages described in (a) of this subsection if the claim is not otherwise required to be reported by an institution or organization providing professional liability insurance.

(2)(a) Reports required by this section shall be made within sixty days of the date of the settlement or verdict. Failure to comply with this section is punishable by a civil penalty not to exceed two hundred fifty dollars.

(b) Reports required by this section must include:

(i) The name, address, health care provider professional license number, and specialty, if applicable;

(ii) The date of the occurrence that created the claim;

(iii) The name and address of the injured person. This information is confidential and must not be disclosed by the board except for disclosure to the insurance commissioner. This information may be used by the board for identifying multiple or duplicate claims arising out of the same occurrence;

(iv) The date of suit, if filed;

(v) The injured person's age and sex;

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

(vii) The date and amount of judgment or settlement, if any, including the itemization of the verdict; and

(viii) A summary of the occurrence that created the claim, including:

(A) The name of the health care facility, if any, where the injury occurred;

(B) The final diagnosis for which treatment was sought or rendered;

(C) A description of the misdiagnosis, if made, of the patient's actual condition;

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

(E) A description of the principal injury giving rise to the claim;

(F) Any steps that have been taken to make similar occurrences or injuries less likely in the future; and

(G) Any other information required by the board.

(3) The board shall provide all information acquired under subsection (2) of this section to the insurance commissioner annually.

NEW SECTION. **Sec. 14.** A new section is added to chapter 70.41 RCW to read as follows:

(1) All hospitals licensed under this chapter must annually report to the insurance commissioner the following information regarding malpractice settlements, awards, or payments as a result of a claim or action for damages alleged to have been caused by the hospital's negligence:

(a) The name, address, and health care facility's professional license number;

(b) The date of the occurrence that created the claim;

(c) The name and address of the injured person. This information may be used for identifying multiple or duplicate claims arising out of the same occurrence;

(d) The date of suit, if filed;

(e) The injured person's age and sex;

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

(g) The date and amount of judgment or settlement, if any, including the itemization of the verdict; and

(h) A summary of the occurrence that created the claim, including:

(i) The final diagnosis for which treatment was sought or rendered;

(ii) A description of the misdiagnosis, if made, of the patient's actual condition;

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

(iv) A description of the principal injury giving rise to the claim;

(v) Any steps that have been taken to make similar occurrences or injuries less likely in the future; and

(vi) Any other information required by the insurance commissioner.

(2) A final disposition of a medical malpractice claim resulting in no payment on behalf of the hospital must also be reported.

(3) Failure to comply with this section is punishable by a civil penalty not to exceed two hundred fifty dollars.

NEW SECTION. **Sec. 15.** A new section is added to chapter 48.46 RCW to read as follows:

(1) All health maintenance organizations registered under this chapter must annually report to the commissioner the following information regarding malpractice settlements, awards, or payments as a result of a claim or action for damages alleged to have been caused by the hospital's negligence:

(a) The name and address of the health maintenance organization;

(b) The date of the occurrence that created the claim;

(c) The name and address of the injured person. This information may be used for identifying multiple or duplicate claims arising out of the same occurrence;

(d) The date of suit, if filed;

(e) The injured person's age and sex;

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

(g) The date and amount of judgment or settlement, if any, including the itemization of the verdict; and

(h) A summary of the occurrence that created the claim, including:

(i) The final diagnosis for which treatment was sought or rendered;

(ii) A description of the misdiagnosis, if made, of the patient's actual condition;

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

(iv) A description of the principal injury giving rise to the claim;

(v) Any steps that have been taken to make similar occurrences or injuries less likely in the future; and

(vi) Any other information required by the commissioner.

(2) A final disposition of a medical malpractice claim resulting in no payment on behalf of the health maintenance organization must also be reported.

(3) Failure to comply with this section is punishable by a civil penalty not to exceed two hundred fifty dollars.

NEW SECTION. **Sec. 16.** A new section is added to chapter 48.02 RCW to read as follows:

Beginning in 2005, the commissioner shall prepare an annual report that summarizes and analyzes the claim reports for medical malpractice filed by: Institutions or organizations providing professional liability insurance to physicians or osteopathic physicians; physicians or osteopathic physicians; hospitals licensed under chapter 70.41 RCW; and health maintenance organizations registered under chapter 48.46 RCW. The report must include an analysis of closed claim reports of prior years, if available, in order to show trends in the frequency and amount of claims payments, the itemization of economic and noneconomic damages, the nature of the errant conduct, and such other information as the commissioner determines is illustrative of the trends in closed claims.

The report shall be published without identifying licensees or other proprietary or confidential information. The report must be posted on the web site of the office of the insurance commissioner.

NEW SECTION. **Sec. 17.** A new section is added to chapter 48.02 RCW to read as follows:

The commissioner shall, subject to appropriation from the legislature, provide medical malpractice liability insurance grants to qualified physicians. The medical malpractice liability insurance grants must be used exclusively for providing relief for the payment of medical malpractice insurance premiums.

Physicians licensed under chapter 18.71 RCW who in 2003 treated a patient population composed of at least twenty percent medicaid

recipients and whose medical malpractice liability premium, upon renewal on or after January 1, 2004, increased at least twenty percent over the amount paid by that practitioner in 2003 may apply to the office of the insurance commissioner for a grant for the purpose of providing relief towards the payment of medical malpractice insurance premiums. In 2005 and 2006, the percentage of medicaid recipients treated and the premium increase must be calculated using the preceding year's information as the base year. This grant program is not available after 2006.

Any application for the grant must be made to the commissioner in a form and manner prescribed by the commissioner. The application must contain information regarding the percentage of the applicant's patient population that are medicaid recipients, the medical malpractice liability insurance premium paid by the applicant, and other information required by the commissioner. The commissioner shall rule on the application within sixty days.

The commissioner shall consult with the department of social and health services and the department of health to develop the eligibility criteria for these grants and shall expedite the availability of this grant program.

An applicant must receive a grant if the commissioner finds that the applicant has satisfied the eligibility criteria, except that the grant may not exceed fifty percent of the increase from the preceding year's premium.

The commissioner shall keep a running total of all grants allowed under this section during each fiscal year. The commissioner may not allow any grants that would allow the total to exceed five million dollars in any fiscal year.

Sec. 18. RCW 7.70.020 and 1995 c 323 s 3 are each amended to read as follows:

((~~As used in this chapter~~)) The definitions in this section apply throughout this chapter unless the context clearly requires otherwise.

(1) "Catastrophic injury" means a permanent impairment constituted by:

(a) A spinal cord injury involving severe paralysis of an arm, a leg, or the trunk;

(b) An amputation of an arm, a hand, a foot, or a leg involving the effective loss of use of that appendage;

(c) Severe brain or closed-head injury as evidenced by:

(i) Severe sensory or motor disturbances;

(ii) Severe communication disturbances;

(iii) Severe complex integrated disturbances of cerebral function;

(iv) Severe episodic neurological disorders; or

(v) Other severe brain and closed-head injury conditions at least as severe in nature as listed in (c)(i) through (iv) of this subsection;

(d) Second-degree or third-degree burns of twenty-five percent or more of the total body surface or third-degree burns of five percent or more to the face and hands;

(e) Blindness, defined as complete and total loss of vision; or

(f) Loss of reproductive organs that results in an inability to procreate.

(2) "Early offer" means an offer made after an occurrence that may give rise to an action based in tort, contract, or otherwise, for damages arising from injury occurring as a result of health care, by any potentially responsible party within sixty days after a claim is filed or one hundred twenty days after the act or omission alleged to have caused the injury or condition, to compensate a claimant for reasonable economic loss, including future economic loss, plus a reasonable hourly fee for the claimant's attorney.

(3) "Health care provider" means either:

((~~(1)~~)) (a) A person licensed by this state to provide health care or related services, including, but not limited to, a licensed acupuncturist, a physician, osteopathic physician, dentist, nurse, optometrist, podiatric physician and surgeon, chiropractor, physical therapist, psychologist, pharmacist, optician, physician's assistant, midwife, osteopathic physician's assistant, nurse practitioner, or physician's trained mobile intensive care paramedic, including, in the event such person is deceased, his or her estate or personal representative;

((~~(2)~~)) (b) An employee or agent of a person described in ((~~part (1) above~~)) (a) of this subsection, acting in the course and scope of his or her employment, including, in the event such employee or agent is deceased, his or her estate or personal representative; or

((~~(3)~~)) (c) An entity, whether or not incorporated, facility, or institution employing one or more persons described in ((~~part (1) above~~)) (a) of this subsection, including, but not limited to, a hospital, clinic, health maintenance organization, or nursing home; or an officer, director, employee, or agent thereof acting in the course and scope of his or her employment, including in the event such officer, director, employee, or agent is deceased, his or her estate or personal representative.

(4) "Medical expert" means a licensed health care provider regularly engaged in the practice of his or her profession who meets the following criteria:

(a) If the health care provider against whom or on whose behalf the testimony is offered is a specialist, the medical expert must:

(i) Specialize in the same specialty as the health care provider against whom or on whose behalf the testimony is offered; or specialize in a similar specialty that includes the evaluation, diagnosis, or treatment of the medical condition that is the subject of the claim and have prior experience treating similar patients; and

(ii) Have devoted professional time during the three years immediately preceding the date of the occurrence that is the basis for the action to:

(A) The active clinical practice of, or consulting with respect to, the same or similar specialty that includes the evaluation, diagnosis, or treatment of the medical condition that is the subject of the claim and have prior experience treating similar patients;

(B) Instruction of students in an accredited health professional school or accredited residency or clinical research program in the same or similar specialty; or

(C) A clinical research program that is affiliated with an accredited health professional school or accredited residency or clinical research program in the same or similar specialty.

(b) If the health care provider against whom or on whose behalf the testimony is offered is a general practitioner, the medical expert must have devoted professional time during the five years immediately preceding the date of the occurrence that is the basis for the action to:

(i) The active clinical practice or consultation as a general practitioner;

(ii) The instruction of students in an accredited health professional school or accredited residency program in the general practice of medicine; or

(iii) A clinical research program that is affiliated with an accredited medical school or teaching hospital and that is in the general practice of medicine.

(c) If the health care provider against whom or on whose behalf the testimony is offered is a health care provider other than a specialist or a general practitioner, the medical expert must have devoted professional time during the three years immediately preceding the date of the occurrence that is the basis for the action to:

(i) The active clinical practice of, or consulting with respect to, the same or similar health profession as the health care provider against whom or on whose behalf the testimony is offered;

(ii) The instruction of students in an accredited health professional school or accredited residency program in the same or similar health profession in which the health care provider against whom or on whose behalf the testimony is offered; or

(iii) A clinical research program that is affiliated with an accredited medical school or teaching hospital and that is in the same or similar health profession in which the health care provider against whom or on whose behalf the testimony is offered.

(d) A physician licensed under chapter 18.71 or 18.57 RCW who qualifies as a medical expert under this subsection (4) and who, by reason of active clinical practice or instruction of students, has knowledge of the applicable standard of care for registered nurses, advanced registered nurse practitioners, licensed practical nurses, licensed midwives, physician assistants, or other medical support staff may give expert testimony in a medical negligence action with respect to the standard of care of such medical support staff.

(5) "Nonpractitioner" means an entity licensed under chapter 48.46 or 70.41 RCW.

(6) "Practitioner" includes any person licensed under chapter 18.71, 18.57, 18.25, 18.22, 18.32, 18.36A, 18.50, 18.53, or 18.74 RCW. "Practitioner" also includes any association, corporation, firm, partnership, or other business entity under which such a practitioner practices or any employee of such a practitioner or entity acting in the scope of his or her employment.

NEW SECTION. **Sec. 19.** A new section is added to chapter 7.70 RCW to read as follows:

(1) After an occurrence that may give rise to an action based in tort, contract, or otherwise, for damages arising from injury occurring as a result of health care, any potentially responsible party has the option to make an early offer within sixty days after a claim is filed or one hundred twenty days after the act or omission alleged to have caused the injury or condition, to compensate a claimant for reasonable economic loss, including future economic loss, plus a reasonable hourly fee for the claimant's attorney.

(2) No early offer, less than economic damages plus fifty percent of the cap on noneconomic damages that would apply if the plaintiff refused an early offer and proceeded to trial under subsection (9) of this section, shall be made for an act or omission resulting in the death of a patient.

(3) A claimant that accepts an early offer is prohibited from filing a claim against any other health care provider or facility for damages arising from the same injury.

(4) A claimant may extend the time for receiving an early offer specified in subsection (1) of this section.

(5) No early offer by any prospective defendant is admissible in any civil action.

(6) Future economic losses shall be payable to a claimant under this section as such losses occur. If any potentially allegedly responsible party disputes the future economic losses, then the dispute shall be resolved by binding arbitration with the claimant selecting the arbitrator, if only one arbitrator is used, or two arbitrators, if a panel of three arbitrators is used.

(7) If there are multiple potentially allegedly responsible parties and there is a dispute among these parties as to their relative contribution to the payment of future economic losses, the dispute shall be resolved through binding arbitration.

(8) A claimant has ninety days to accept the early offer. A failure to accept the early offer within ninety days is deemed a rejection.

(9) A claimant may reject an early offer and elect to bring or maintain a civil action. Upon rejection of the early offer, a claimant

who proceeds through trial and receives a judgment may recover economic damages as determined by the trier of fact and noneconomic damages only to the extent of the following:

(a) For injuries that result in a permanent vegetative state or death, or for catastrophic injuries, noneconomic damages may not exceed:

(i) One million dollars from practitioner defendants, regardless of the number of practitioner defendants or claimants;

(ii) One million five hundred thousand dollars from all nonpractitioner defendants, regardless of the number of nonpractitioner defendants or claimants.

(b) For injuries other than permanent vegetative state, death, or catastrophic injury, noneconomic damages may not exceed:

(i) Five hundred thousand dollars from each practitioner defendant, not to exceed one million dollars from all practitioner defendants, regardless of the number of practitioner defendants or claimants;

(ii) Seven hundred fifty thousand dollars per claimant from each nonpractitioner defendant, not to exceed one million five hundred thousand dollars from all nonpractitioner defendants, regardless of the number of defendants or claimants.

(c) For injuries resulting from emergency services, noneconomic damages may not exceed:

(i) One hundred fifty thousand dollars per claimant, regardless of the number of practitioner defendants. However, the total noneconomic damages recoverable by all claimants from all such practitioners may not exceed three hundred thousand dollars;

(ii) Seven hundred fifty thousand dollars per claimant, regardless of the number of nonpractitioner defendants. However, the total noneconomic damages recoverable by all claimants from all such nonpractitioners may not exceed one million five hundred thousand dollars.

(10) The noneconomic limitations listed in subsection (9) of this section must be adjusted annually for inflation.

Sec. 20. RCW 7.70.100 and 1993 c 492 s 419 are each amended to read as follows:

(1) <u>No action based upon a health provider's professional negligence may be commenced unless the defendant has been given at</u>

least ninety days' notice of the intention to commence the action. If the notice is served within ninety days of the expiration of the applicable statute of limitations, the time for the commencement of the action must be extended ninety days from the service of the notice.

(2) The provisions of subsection (1) of this section are not applicable with respect to any defendant whose name is unknown to the plaintiff at the time of filing the complaint and who is identified therein by a fictitious name.

(3) The ninety days' notice must be accompanied by the claimant's submission of a verified written statement from a medical expert, as defined in RCW 7.70.020, opining that there are reasonable grounds to support the claim of medical negligence.

(4) After the filing of the ninety-day presuit notice, and before a superior court trial, all causes of action, whether based in tort, contract, or otherwise, for damages arising from injury occurring as a result of health care provided after July 1, 1993, shall be subject to mandatory mediation prior to trial.

((~~(2)~~)) (5) The supreme court shall by rule adopt procedures to implement mandatory mediation of actions under this chapter. The rules shall address, at a minimum:

(a) Procedures for the appointment of, and qualifications of, mediators. A mediator shall have experience or expertise related to actions arising from injury occurring as a result of health care, and be a member of the state bar association who has been admitted to the bar for a minimum of five years or who is a retired judge. The parties may stipulate to a nonlawyer mediator. The court may prescribe additional qualifications of mediators;

(b) Appropriate limits on the amount or manner of compensation of mediators;

(c) The number of days following the filing of a claim under this chapter within which a mediator must be selected;

(d) The method by which a mediator is selected. The rule shall provide for designation of a mediator by the superior court if the parties are unable to agree upon a mediator;

(e) The number of days following the selection of a mediator within which a mediation conference must be held;

(f) A means by which mediation of an action under this chapter may

be waived by a mediator who has determined that the claim is not appropriate for mediation; and

(g) Any other matters deemed necessary by the court.

((~~(3)~~)) (6) Mediators shall not impose discovery schedules upon the parties.

NEW SECTION. **Sec. 21.** A new section is added to chapter 48.05 RCW to read as follows:

Every institution or organization providing professional liability insurance to physicians, licensed under chapter 18.71 or 18.57 RCW, shall not use the ninety days' notice required in section 23 of this act as grounds for rate adjustments or medical malpractice liability insurance or in the approval or renewal of a policy.

NEW SECTION. **Sec. 22.** A new section is added to chapter 7.70 RCW to read as follows:

Any statement of apology made by a health provider regarding an adverse outcome is not discoverable or admissible in any civil action for any purpose by the opposing party.

NEW SECTION. **Sec. 23.** A new section is added to chapter 7.70 RCW to read as follows:

The court shall, in any action under this chapter that proceeds to trial, require that at the close of all evidence and prior to final arguments to the jury, the plaintiff and defendant each submit to the court in sealed form the amount of damages they contend the plaintiff is entitled to recover if the jury finds that the defendant is liable for the plaintiff's damages. The sealed amount of damages must be unsealed by the court and the parties informed of each amount of damages. The amount of damages submitted may not be amended after being unsealed by the court. The parties may argue to the jury the amount of damages proposed in their final arguments. If the plaintiff is found to be entitled to a recovery of damages, then the issue submitted to the jury on damages shall be whether the jury finds for the plaintiff's submission on damages or for the defendant's submission on damages. The jury may not return a verdict for any other amount. Any other finding by the jury on the issue of damages shall be grounds for mistrial.

If, under section 19(9) of this act, a limitation on noneconomic damages applies, then the jury shall not be informed of the limitation and the court must adjust the award for noneconomic damages to comply with section 19(9) of this act.

NEW SECTION. **Sec. 24.** A new section is added to chapter 4.44 RCW to read as follows:

In any action for damages for injury or death occurring as a result of health care brought under chapter 7.70 RCW, in which the trier of fact determines that liability exists on the part of the defendant, the trier of fact shall, as a part of the verdict, itemize the amounts to be awarded to the claimant into the following categories of damages:

(1) Amounts intended to compensate the claimant for:

(a) Past economic losses; and

(b) Future economic losses; and the number of years or part thereof that the award is intended to cover;

(2) Amounts intended to compensate the claimant for:

(a) Past noneconomic losses; and

(b) Future noneconomic losses and the number of years or part thereof that the award is intended to cover.

NEW SECTION. **Sec. 25.** The department of health must study the current health care practitioner disciplinary process and report to the legislature no later than December 31, 2005.

NEW SECTION. **Sec. 26.** A new section is added to chapter 48.19 RCW to read as follows:

(1) Within ten days of receiving a filing from an insurer for policies pertaining to medical malpractice for physicians and surgeons, hospitals, other health care professions, and other health care facilities for a rate change that equals or exceeds fifteen percent of the then applicable rate, the commissioner shall notify the public on the office of the insurance commissioner's web site of any application by an insurer for a rate change and provide written notification of the rate change filing to any trade association or organization that represents health care providers and any member of the public who requests placement on a mailing list maintained by the commissioner for this purpose.

(2) An insured health care provider, the health care provider's representative, or an association of health care providers, may request a hearing within thirty days after public notice. The commissioner must either grant the hearing or determine not to grant the hearing and issue written findings in support of that decision.

(3) Hearings and other administrative proceedings arising under this section must be conducted under chapter 34.05 RCW.

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