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OVERVIEW OF MEDICAL MALPRACTICE SCREENING PANELS
(Chapter 41A of *Nevada Revised Statutes*)

Under Chapter 41A of *Nevada Revised Statutes* (NRS), Nevada has established screening panels for both medical and dental malpractice. This document provides a brief history and general overview of the screening panel, with a focus on medical malpractice, although the procedures for both types of malpractice (medical and dental) are similar. An overview of related issues under Chapter 41A are also included, including time within which an action must be commenced, evidence required to establish liability, and circumstances that legally constitute the consent of a patient.

Please note this document is only a summary of the statutory provisions governing the screening panel and does not include any procedures or regulations administered by Nevada's Division of Insurance. For specific information on a law, please consult the NRS.

I. BRIEF HISTORY OF MEDICAL MALPRACTICE SCREENING PANELS IN NEVADA[1]

Voluntary medical malpractice screening panels were created in the 1960s in both Reno and Las Vegas. These panels were comprised of members of the legal and medical communities and charged a small fee to consider claims.

Legislation from 1975 to 1979

In 1975, the Legislature statutorily established the joint medical-legal screening panels and required all medical malpractice claims to be submitted to these panels.[2] The executive secretary of the State Bar of Nevada and the Executive Director of the Nevada State Medical Association served as panel administrators. In 1977, the panels were expanded to include nurses, as well as attorneys and physicians, in cases involving nurses.[3] In 1979, hospital administrators were added to the panels for cases involving hospitals.[4]

1981 Legislative Actions

In 1981, the Legislature repealed its 1975 act and allowed the panels to revert to their original voluntary status.[5] Testimony before the April 29, 1981, hearing of the Senate Committee on Commerce and Labor indicated that the panels had not been effective.[6] Many cases were going to trial regardless of the panels' recommendations. In addition, the panels had large backlogs of cases, resulting in significant delays in processing malpractice actions. The Nevada State Medical Association testified at the hearing that doctors bore the burden of the cost of the panels, and noted that legislation proposed in 1979 to levy a fee on respondents was rejected.

1985 Legislative Actions

Four years later, in 1985, faced with a resurgence of the rapid increases in medical malpractice premiums, the Legislature recreated medial malpractice screening panels, with many modifications.[7] The Legislature reestablished panels in northern and southern Nevada, as had been the case under the former law that was repealed in 1981, to be administered by the Division of Insurance. The Legislature attempted to put some "teeth" into the law by requiring that if the panel found against the claimant, a $5,000 bond must be posted before proceeding to court, which would be forfeited if the claimant did not prevail. In addition, a fee of $250 must accompany the complaint. The bill also provided for the screening panel statute to expire in three years (1989) if not renewed by the Legislature.

1989 Legislative Actions

In 1989, the Legislature repealed the sunset provision in the screening panel statute and made extensive changes in the operation of the panels.[8] These changes included expanding the pool from which panel members were chosen (from 20 designees to 40) and limiting peremptory challenges for panel members. The bill also expanded the panels' access to relevant records and granted plaintiffs the opportunity to respond to allegations raised in the defendant's answer.

In addition, the 1989 legislation eliminated the requirement that the plaintiffs post a $5,000 bond before proceeding in court after an adverse finding by the panel, but provided that the successful litigant in those cases was entitled to attorney's fees and costs. Finally, the bill streamlined the panels' procedures, raised the filing fees for complaints and answers from $250 to $350, and extended the statute of limitations until 30 days after the decision of the panel.

1995 Legislative Actions

In 1995, the Legislature increased, from 40 to 60 for each profession, the number of attorneys and doctors designated to assist the Southern Medical-Legal Malpractice Screening Panels.[9] Other changes from 1995 included requiring that an affidavit from a medical expert accompany the complaint, or it may be summarily dismissed. In addition, the Division of Insurance is required to keep confidential the names of members selected for the screening panels. The bill also required that a person be named in the action before the screening panel in order to also be named in any subsequent action filed in court.

The 1995 Legislature appropriated $75,000 for an independent study of all open and closed claims for medical malpractice in Nevada over the last ten years. As a result of this study, Nevada's Division of Insurance is now required to track certain data regarding closed claims for medical malpractice, and provide a summary report to the Legislature prior to each session.

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Finally, in 1995, the screening panels were expanded to include claims of malpractice involving dentists.[10] The provisions involving dentists were scheduled to sunset on July 1, 1999, but the 1999 Legislature repealed this sunset.[11]

1997 Legislative Actions

In 1997, the Legislature adopted a recommendation of the study involving closed claims for medical malpractice. As a result, the Commissioner of Insurance is required to collect and maintain specified information regarding each closed claim for medical malpractice filed against physicians and surgeons in Nevada. The Commissioner must submit to the Legislature a summary of the information prior to each legislative session.[12]

The 1997 Legislature also adopted legislation requested by the Commissioner of Insurance and supported by the Nevada Trial Lawyers Association and the Nevada State Medical Association to streamline the procedures governing the screening panels.[13] This legislation:

- Extends (from 30 to 90 days) the time within which a person must file an answer to a malpractice complaint.

- Provides that a respondent who fails to file an answer within the required time period may not participate in any conference held to resolve any issues as to challenges for cause.

- Extends (from 21 to 30 days) the time within which a person must file a response to the allegations of an answer.

- Allows the Division of Insurance to authorize an extension of these time limits if all the parties to the action agree.

The Legislature also provided that any parties represented by the same attorney are deemed to be one party for the purpose of determining the distribution of peremptory challenges in the impaneling of a screening panel, and prohibited a screening panel from considering challenges concerning any relevant statute of limitation relating to a claim before the panel.

Finally, the 1997 Legislature also extended (from 30 to 60 days) the time within which a settlement conference for claims the panel determines may involve malpractice must be held.[14]

1999 Legislative Actions

In 1999, the Legislature specified that any finding by a screening panel that it is unable to reach a decision on the issue of malpractice is not admissible in court. The 1999 Legislature also required the Division of Insurance to give preference in scheduling cases before the screening panel to individuals whose age or medical condition raises a substantial medical doubt that the claimant will survive until a determination is made by the panel.[15]

II. OVERVIEW OF STATUTORY PROVISIONS GOVERNING MALPRACTICE SCREENING PANELS

Medical malpractice is defined as the failure of a physician, hospital, or employee of a hospital, in rendering services, to use reasonable care, skill, or knowledge ordinarily used under similar circumstances.[16] Before a cause of action for malpractice is filed in court, it must be submitted to a screening panel, and any action filed without going first to a screening panel is subject to dismissal.[17] The written findings of the panel are admissible in court, with the exception of any findings of a panel that is unable to reach a decision on the issue of medical malpractice.

A. Responsibilities of the Division of Insurance

The Division of Insurance, through its Commissioner, is responsible for the following:

1. Maintaining a list of the names of the attorneys, physicians, dentists, administrators of hospitals, and persons employed by hospitals in management positions on the northern tentative screening panel and on the southern tentative screening panel;

2. Selecting the members of the screening panels;

3. Scheduling the hearings for those panels;

4. Obtaining, before or after the filing of the complaint, such health care records, dental records, statements of policy and procedure, and other materials as may be required by the parties or the screening panel in connection with the claim; and

5. Charging and collecting a reasonable fee for copying materials produced under subpoena.[18]

The Division is also authorized to act as follows to facilitate the operation of the panels:

1. For good cause shown, authorize a continuance for the proceedings involving a screening panel;

2. Adopting such rules of practice and procedure as are necessary to carry out its duties pursuant to NRS 41A.003 to 41A.069, inclusive (Actions for Malpractice); and

3. Issue subpoenas required by the screening panel to compel the attendance of expert witnesses and the production of books, papers, health care records, statements of policy and procedure, or other materials. If a person fails to comply with a subpoena, the Division of Insurance may petition the district court for an order compelling attendance or production of materials.[19]

B. Filing of the Complaint, the Answer, and the Response

Claims of medical malpractice are presented to a screening panel by filing a complaint with the Division of Insurance, accompanied by a clear and concise statement of the facts of the case.[20] If the complaint is filed without an affidavit from a medical expert supporting the allegations, the screening panel may dismiss it. Only parties named in the complaint may be named as a party in a subsequent civil action filed in district court.[21]

Within 90 days, the person against whom the complaint is made (the respondent) must file an answer with the Division of Insurance. The Division may authorize an extension only if all parties stipulate to the extension. Within 35 days after the time expires for filing the answer, the Division of Insurance holds a conference to resolve any issues as to challenges for cause of persons on the tentative screening panel. Failure to file an answer within the required timeframe results in the exclusion of the respondent from participation in this conference.[22]

The claimant may respond to the answer, but must do so within 30 days. The response may only address the allegations of the answer or any accompanying affidavit. The Division may not accept answers and responses that are not timely filed unless otherwise stipulated to by all parties.

C. Fees Charged

A fee of $350 must be paid when filing a complaint or an answer. No fee is charged for filing the response. The fees must not be charged or collected more than once from any party or for the filing of any complaint, regardless of the number of parties joined in the complaint. The Commissioner is authorized to refer any person who fails to pay a required fee to the Attorney General for collection of the fee and any costs incurred.[23]

The fees, and any other money the Division receives in relation to the operation of the panels under Chapter 41A of NRS, are deposited with the State Treasurer and credited to the Division's account in the State General Fund. The administrative costs for the panels are paid from this account.[24]

D. Location, Composition, and Selection of Screening Panels

The northern screening panel sits in Reno, and hears claims from Carson City and Churchill, Douglas, Elko, Eureka, Humboldt, Lander, Lyon, Mineral, Pershing, Storey, and White Pine Counties. The southern screening panel sits in Las Vegas and hears claims arising in Clark, Esmeralda, Lincoln, and Nye Counties.[25]

1. Tentative Screening Panel

The pool (tentative screening panel) from which panel members for cases involving medical malpractice are selected is created as follows:

- **Attorneys**—The Board of Governors of the Nevada Trial Lawyers Association is authorized to designate 40 of its members to serve on the tentative northern panel and 60 of its members to serve on the tentative southern panel.

- **Physicians**—The Executive Committee of the Nevada State Medical Association is authorized to designate 40 of its members to serve on the tentative northern panel and 60 of its members to serve on the tentative southern panel.

- **Hospital Administrators**—The Nevada Hospital Association may designate 40 administrators of hospitals and hospital employees in management positions to serve as *nonvoting* members of the tentative screening panels.

The appointments are for one-year terms, and each designee must attend a course of instruction arranged by the Commissioner of Insurance before serving on a particular screening panel.[26]

2. *Composition and Selection of a Panel*

Panels involving medical malpractice are composed of three physicians and three attorneys.[27] If a hospital is also named in the complaint, one designee of the Nevada Hospital Association also serves on the panel as a nonvoting member. The members of the screening panel are responsible for electing their own chairman.[28]

The Division of Insurance randomly selects the members after holding a conference to resolve issues involving challenges for cause. The conference is held 35 days after the time expires for filing the answer to the complaint. Parties may challenge any person on the tentative screening panel for cause on the same grounds as those used to challenge jurors. Each party is also entitled to three peremptory challenges to both the list of attorneys selected and the list of physicians selected, but in cases in which there are two or more claimants or respondents, they are collectively limited to six preemptory challenges.

Once the members are selected, the Division notifies the members and, if any one declines to serve, a replacement is randomly selected from the list of eligible members. The names of the members selected are confidential. If no attorney or no physician on the list remains eligible to serve after challenges for cause or peremptory challenges, the Division notifies the Nevada Trial Lawyers Association or the Nevada State Medical Association, which must immediately designate a replacement. Only the designees of these associations may serve on the medical screening panel.[29]

E. Hearings of the Screening Panel

The screening panel must hear claims within 30 days after it is selected.[30] However, the Division may give preference in scheduling for certain claimants who are 70 years of age or older, or who suffer from an illness or condition that raises a substantial medical doubt that the

claimant will survive until the panel makes its determination.[31] Nevada's Open Meeting Law does not apply to meetings of the screening panels.[32]

After considering all documentary material, the screening panel determines whether there is a reasonable probability that the acts complained of constitute medical malpractice and that the claimant was injured from those acts. The panel may not consider legal issues or arguments or any challenges concerning any relevant statute of limitation.[33]

F. Written Findings

Within five days after the review, the written findings based upon a vote of the members of the screening panel (by written ballot) must be rendered.[34] The written findings must be in one of the following three forms:

- **Reasonable Probability of Malpractice:** "Based upon a review of the materials submitted by the parties and the testimony of medical or other experts (if any were called) we find that *there is a reasonable probability of medical malpractice and the claimant was injured thereby.*"

  This finding is admissible at trial. However, no other evidence concerning the screening panel or its deliberation is admissible, and no member of the panel may be called to testify at trial.[35]

  If the panel makes a finding that there is a reasonable probability of malpractice, a conference for settlement is held. An overview of the procedures involved is provided section II.G. of this document.[36]

- **No Reasonable Probability of Malpractice:** "Based upon a review of the materials submitted by the parties and the testimony of medical or other exerts (if any were called) we find that there is *no reasonable probability of medical malpractice.*"

  This finding also is admissible at trial. Again, no other evidence concerning the screening panel or its deliberation is admissible, and no member of the panel may be called to testify at trial.

  If the panel makes a finding that there is no reasonable probability of malpractice, and the claimant files an action in court, the defendant must be awarded reasonable costs and attorney's fees incurred if the claimant does not receive a judgment in his favor.[37]

- **No Decision:** "Based upon a review of the materials submitted by the parties and the testimony of medical or other experts (if any were called) we are *unable to reach a decision on the issue of medical malpractice.*"

The written findings of a panel that is unable to reach a decision on the issue of medical malpractice are not admissible in court.[38]

G. Required Settlement Conference in Cases Involving Reasonable Probability of Malpractice that Proceed to Court

If the screening panel finds in favor of the claimant and a cause of action involving medical malpractice is subsequently filed in district court, a settlement conference before a district judge is required.[39] The judge assigned to the settlement conference must be randomly selected by the clerk of the court and must not be the same judge assigned to the case. The following parties and their respective attorneys must attend the conference, but the judge for good cause shown, may waive their attendance:

- The plaintiff;
- The defendant;
- The representative of the physician's insurer; and
- If applicable, the hospital's insurer.

Through the settlement conference, the judge must determine the amount of the plaintiff's damages. A notice to the clerk that the case must be scheduled for a conference must accompany the defendant's responsive pleading. The clerk immediately notifies the judge, who notifies the parties (within seven days) of the time and place of the conference, which must be held no later than 60 days after the notice is received.

For good cause shown, the judge may grant one continuance for not more than 15 days. Within 15 days after the conference, the judge must determine (solely from the information submitted at the conference) the reasonable value of the claim for purposes of settlement. Within 14 days after receiving the judge's determination, the defendant must either: (1) offer the plaintiff that amount; or (2) reject the determination. If the determination is rejected and the plaintiff is awarded a greater amount, the plaintiff must also be awarded reasonable costs and attorney's fees incurred after the date of the rejection.

Within 14 days after receiving the defendant's offer of the judicial amount, the plaintiff must accept or reject the offer. If the offer is rejected and the plaintiff subsequently receives a lesser amount, the defendant must be awarded reasonable costs and attorney's fees incurred after the date of the rejection.

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III. LIMITATIONS ON COMMENCING AN ACTION

Certain actions for injury or death against a physician (or other provider of health care[40]) must be commenced not more than four years after the date of the injury ***or*** two years after the plaintiff either discovers or through the use of reasonable diligence should have discovered the injury, ***whichever occurs first***.[41] This limitation applies to an action for injury to or the wrongful death of a person that is:

1. Based upon alleged professional negligence of the physician (or provider of health care);

2. From professional services rendered without consent; or

3. From error or omission in the practice by the physician (or provider of health care).

Tolling of the Limitation

This limitation is tolled during the medical screening panel process, from the date the complaint is filed until 30 days after the panel notifies the claimant in writing of its findings. The limitation is also tolled for any period during which the physician (or provider of health care) concealed any act, error, or omission upon which the action is based, ***and*** which is known, or through the use of reasonable diligence should have been known, to him.

Actions Involving Minor Children

Parents, guardians, or legal custodians of a minor child are responsible for determining whether to prosecute this type of action, and if the period within which to commence the action passes, the child may not bring the action based upon the alleged injury against any physician, except in the case of the following:

1. Brain damage or birth defect. In this case, the period of limitation is extended until the child attains ten years of age.

2. Sterility. In this case, the period of limitation is extended until two years after the child discovers the injury.

IV. EVIDENCE REQUIRED TO IMPOSE LIABILITY

Nevada law specifies the evidence that must be presented to impose liability on a physician (or a "provider of medical care"[42]) for personal injury or death. To impose such liability, evidence consisting of the following must be presented to demonstrate the alleged deviation from the accepted standard of care in the specific case and to prove causation of the alleged personal injury or death:

- Expert medical testimony;
- Material from recognized medical texts or treatises; or
- Regulations of the licensed medical facility where the alleged negligence occurred.

However, this evidence is not required in the following cases, in which there is a rebuttable presumption that the personal injury or death was caused by negligence:

- A foreign substance other than medication or a prosthetic device was unintentionally left within the patient's body following surgery;
- An explosion or fire originating in a substance used in treatment occurred in the course of treatment;
- An unintended burn caused by heat, radiation, or chemicals was suffered in the course of medical care;
- An injury was suffered during the course of treatment to a part of the body that was not directly involved in the treatment, or proximate thereto; or
- A surgical procedure was performed on the wrong patient or the wrong organ, limb, or part of a patient's body.

V. CONSENT OF THE PATIENT

Nevada law provides that a licensed physician has conclusively obtained the consent of the patient if he has done the following:

1. Explained to the patient in general terms without specific details, the procedures to be undertaken;
2. Explained to the patient alternative methods of treatment, if any, and their general nature;
3. Explained to the patient that there may be risks, together with the general nature and extent of the risks involved, without enumerating such risks; ***and***
4. Obtained the signature of the patient to a statement containing an explanation of the procedure, alternative methods of treatment, and risks involved.[43]

Implied Consent

In addition to other circumstances in which implied consent is established under Nevada law, consent to a medical or surgical procedure is implied if:

1. In competent medical judgment, the proposed medical or surgical procedure is reasonably necessary and any delay in performing the procedure could reasonably be expected to result in death, disfigurement, impairment of faculties or serious bodily harm; ***and***

2. A person authorized to consent is not readily available.

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[1] Much of the historical information is extracted from the Report of the Legislative Commission's Subcommittee to Study Claims for Medical Malpractice (Bulletin No. 97-2).
[2] Senate Bill 409, Chapter 302, *Statutes of Nevada 1975.*
[3] Assembly Bill 267, Chapter 481, *Statutes of Nevada 1977.*
[4] Assembly Bill 546, Chapter 368, *Statutes of Nevada 1979.*
[5] Assembly Bill 183, Chapter 327, *Statutes of Nevada 1981.*
[6] Minutes of the Senate Committee on Commerce and Labor, April 29, 1981.
[7] Assembly Bill 696, Chapter 620, *Statutes of Nevada 1985.*
[8] Senate Bill 83, Chapter 193, *Statutes of Nevada 1989.*
[9] Assembly Bill 520, Chapter 686, *Statutes of Nevada 1995.*
[10] Senate Bill 129, Chapter 621, *Statutes of Nevada 1995.*
[11] Assembly Bill 25, Chapter 5, *Statutes of Nevada 1999.*
[12] Assembly Bill 136, Chapter 201, *Statutes of Nevada 1997.*
[13] Assembly Bill 577, Chapter 327, *Statutes of Nevada 1997.*
[14] Assembly Bill 192, Chapter 135, *Statutes of Nevada 1997.*
[15] Senate Bill 479, Chapter 132, *Statutes of Nevada 1999.*
[16] NRS 41A.009.
[17] NRS 41A.016.
[18] NRS 41A.033.
[19] NRS 41A.033 and NRS 41A.046.
[20] NRS 41A.039.
[21] NRS 41A.056.
[22] NRS 41A.039 and NRS 41A.043.
[23] NRS 41A.039.
[24] NRS 41A.036.
[25] NRS 41A.019.
[26] NRS 41A.023 and NRS 41A.024.
[27] NRS 41A.043.
[28] NRS 41A.026.
[29] NRS 41A.043.
[30] NRS 41A.049.
[31] NRS 41A.051.
[32] NRS 41A.029.
[33] NRS 41A.049.
[34] NRS 41A.049
[35] NRS 41A.016.
[36] NRS 41A.056
[37] NRS 41A.056.

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[38] NRS 41A.016.
[39] NRS 41A.056 and NRS 41A.059.
[40] Under NRS 41A.097, for the purpose of this statute only (limitation of actions), a "provider of health care" means a physician licensed under Chapter 630 or 633 of NRS, dentist, registered nurse, dispensing optician, optometrist, registered physical therapist, podiatric physician, licensed psychologist, chiropractor, doctor of Oriental medicine, medical laboratory director or technician, or a licensed hospital as the employer of any such person.
[41] NRS 41A.097.
[42] Under NRS 41A.100, for the purposes of this statute only (evidence), a "provider of medical care" means a physician, dentist, registered nurse, or a licensed hospital as the employer of any such person.
[43] NRS 41A.110.