GENERAL ASSEMBLY OF NORTH CAROLINA

SESSION 2007

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HOUSE BILL 1604

Short Title:	Civil Justice Improvement Act-2.	(Public)
Sponsors:	Representatives Hilton, Gillespie (Primary Sponsors); Avila, Blackwood, Brown, Clary, Cleveland, Current, Daughtridge, Dockham, Frye, Gulley, Holloway, Johnson, Justus, Kiser, Langdon, Lewis, McComas, McElraft, McGee, Neumann, Pate, Samuelson, Setzer, Steen, Tillis, Walend, West, and Wiley.	
Referred to:	Judiciary I, if favorable, Appropriations and, if favorable, to the Com on Finance.	

April 19, 2007

A BILL TO BE ENTITLED

AN ACT TO AMEND THE LAWS IMPACTING MEDICAL MALPRACTICE INSURANCE RATES TO IMPROVE THE COST OF PROVIDING HEALTH CARE IN NORTH CAROLINA AND TO APPROPRIATE FUNDS TO IMPLEMENT THE ACT.

The General Assembly of North Carolina enacts:

SECTION 1. G.S. 90-21.11 reads as rewritten:

"**§ 90-21.11. Definitions.**

As used in this Article, the ~~term "health care provider" means without limitation any person who pursuant to the provisions of Chapter 90 of the General Statutes is licensed, or is otherwise registered or certified to engage in the practice of or otherwise performs duties associated with any of the following: medicine, surgery, dentistry, pharmacy, optometry, midwifery, osteopathy, podiatry, chiropractic, radiology, nursing, physiotherapy, pathology, anesthesiology, anesthesia, laboratory analysis, rendering assistance to a physician, dental hygiene, psychiatry, psychology; or a hospital or a nursing home; or any other person who is legally responsible for the negligence of such person, hospital or nursing home; or any other person acting at the direction or under the supervision of any of the foregoing persons, hospital, or nursing home.~~

~~As used in this Article, the term "medical malpractice action" means a civil action for damages for personal injury or death arising out of the furnishing or failure to furnish professional services in the performance of medical, dental, or other health care by a health care provider.~~ following terms mean:

(1) Collateral source payments. – A payment for an expense for which recovery is permitted in a medical malpractice action that is made to or for the benefit of a plaintiff or is otherwise available to the plaintiff:
a. For medical expenses and disability payments under the federal Social Security Act, any federal, state, or local income disability act, or any other public program.
b. Under any health, sickness, or income disability insurance or automobile accident insurance that provides health benefits or income disability coverage, and any other similar insurance benefits available to the plaintiff, except life insurance.
c. Under any contract or agreement of any person, group, organization, partnership, or corporation to provide, pay for, or reimburse the costs of hospital, medical, dental, or health care services.
d. Under any contractual or voluntary wage continuation plan provided by an employer or other system intended to provide wages during a period of disability.
e. From any other source.

A collateral source payment does not include gifts, gratuitous contributions or assistance, or payments arising from assets of the plaintiff.

(2) Economic damages. – Damages to compensate for present and future medical costs, hospital costs, custodial care, rehabilitation costs, lost earnings, loss of bodily function, and any other pecuniary damages.

(3) Future economic damages. – Includes all economic damages for future medical treatment, care or custody, loss of future earnings, loss of bodily function, and any other pecuniary damages of the plaintiff following the date of the verdict or award.

(4) Health care provider. – Any person who, pursuant to the provisions of Chapter 90 of the General Statutes, is licensed, or is otherwise registered or certified to engage in the practice of or otherwise performs duties associated with any of the following: medicine, surgery, dentistry, pharmacy, optometry, midwifery, osteopathy, podiatry, chiropractic, radiology, nursing, physiotherapy, pathology, anesthesiology, anesthesia, laboratory analysis, rendering assistance to a physician, dental hygiene, psychiatry, psychology; or a hospital or a nursing home; or any other person who is legally responsible for the negligence of such person, hospital, or nursing home; or any other person acting at the direction or under the supervision of any of the foregoing persons, hospital, or nursing home.

(5) Insurer. – Every insurer, self-insurer, and risk retention group, as those terms are defined in Chapter 58 of the General Statutes, that provides professional malpractice insurance to health care providers in this State.

(6) Medical malpractice action. – A civil action for damages for personal injury or death arising out of the furnishing or failure to furnish professional services in the performance of medical, dental, or other health care by a health care provider.

(7) Noneconomic damages. – Includes all damages to compensate mental anguish; emotional distress; emotional pain and suffering; loss of consortium; loss of society, companionship, comfort, guidance, kindly offices, or advice; pain and suffering; inconvenience; disfigurement; loss of limbs or body parts; physical impairment; and any other nonpecuniary damages.

(8) Periodic payments. – The payment of money or delivery of other property to the plaintiff at regular intervals.

(9) Recovered. – The net sum recovered after deducting any disbursements or costs incurred in connection with the litigation, arbitration, or settlement of the claim. The sum recovered shall include any punitive damages awarded under Chapter 1D of the General Statutes."

SECTION 2. Article 1B of Chapter 90 of the General Statutes is amended by adding the following new sections to read:

"**§ 90-21.18. Limitation on noneconomic damages in medical malpractice actions.**

(a) In any medical malpractice action, the plaintiff may be entitled to recover noneconomic damages. The total amount of all noneconomic damages shall not exceed three hundred fifty thousand dollars ($350,000) per plaintiff.

(b) Any award of damages in a medical malpractice action shall be stated in accordance with G.S. 90-21.18C. If a jury is determining the facts, the court shall not instruct the jury with respect to the limit on noneconomic damages under subsection (a) of this section, and neither the attorney for any party nor a witness shall inform the jury or potential members of the jury panel of that limit. Notwithstanding the limits set forth in this section, if the negligence resulted in a persistent vegetative state or death, the total noneconomic damages recovered under this section shall not exceed five hundred thousand dollars ($500,000) per plaintiff.

"**§ 90-21.18A. Accounting for certain collateral source payments in medical malpractice actions.**

In any medical malpractice action, the court shall allow into evidence, if requested by a defendant, collateral source payments paid to or for the benefit of the plaintiff, or that are otherwise available to the plaintiff, related to the losses or damages alleged in the medical malpractice action. The court shall allow into evidence, if requested by the plaintiff, rights of subrogation of any collateral source.

"**§ 90-21.18B. Periodic payment of future economic damages in medical malpractice actions.**

(a) Upon the award of damages in any medical malpractice action, the presiding judge shall, at the request of either party, enter a judgment ordering that money damages or the equivalent for future economic damages of the plaintiff as awarded by the jury in accordance with G.S. 90-21.18C(a)(3) be paid at the election of the defendant against

whom the award was made by periodic payments rather than by a lump-sum payment when the award exceeds one hundred thousand dollars ($100,000) in future economic damages. In entering a judgment ordering the payment of future economic damages by periodic payments, the court shall make a specific finding of fact as to the dollar amount of periodic payments that will compensate the plaintiff for such future economic damages. As a condition to authorizing periodic payments of future economic damages, the court shall, in its order of judgment, require that such payments be made through the establishment of a trust fund or the purchase of an annuity for the life of the plaintiff or during the continuance of the compensable injury or disability of the plaintiff. The establishment of a trust fund or the purchase of an annuity, as approved by the court, shall satisfy the defendant's judgment for future economic damages.

(b) The judgment ordering the payment of future economic damages by periodic payments shall specify the recipient of the payments, the dollar amount of the payments, the interval between payments, and the number of payments or the period of time over which payment shall be made. Such payments shall only be subject to modification by the court in the event of the death of the plaintiff as provided in subsection (c) of this section.

(c) In any judgment that orders future economic damages payable in periodic payments, liability for payment of future economic damages not yet due shall terminate upon the death of the plaintiff; however, the court that rendered the original judgment may modify the judgment to provide that damages awarded for loss of future earnings shall not be reduced or payments terminated by reason of the death of the plaintiff, so long as the court finds that the proximate cause of the death was the negligence of the defendant that led to the award, but shall be paid to persons to whom the plaintiff owed a duty of support, as provided by law, immediately prior to the plaintiff's death.

(d) In the event the court finds that the defendant has exhibited a continuing pattern of failing to make the payment specified in subsection (a) of this section, the court shall find the defendant in contempt of court and, in addition to the required periodic payments, shall order the defendant to pay the plaintiff all damages caused by the failure to make such periodic payments, including court costs and attorneys' fees.

"**§ 90-21.18C. Verdicts and awards of damages in medical malpractice actions; form.**

(a) In any medical malpractice action, any verdict or award of damages, if supported by the evidence, shall indicate specifically what amount is awarded for each of all of the following:

(1) Noneconomic damages.

(2) Present economic damages.

(3) Future economic damages.

If applicable, the court shall instruct the jury on the definition of noneconomic damages and the definition of future economic damages. If applicable, the court shall instruct the jury that present economic damages are those damages for medical treatment, care or custody, loss of future earnings, loss of bodily function, and any other pecuniary damages of the plaintiff up to the date of the verdict or award.

(b) In any wrongful death medical malpractice action, any verdict or award of damages shall indicate specifically the amount of damages, if any, awarded for each of the elements of damages provided in G.S. 28A-12-2 for which there was evidence presented at trial. The verdict or award shall also specify the amount of noneconomic damages as provided in subsection (a) of this section.

"**§ 90-21.18D. Settlements in medical malpractice actions; reporting.**

(a) In any medical malpractice action in which the parties agree to settle the claim, the insurer for the health care provider shall report the settlement as required under G.S. 58-2-170. The insurer shall identify the amount of the settlement attributable to economic damages and provide documentation to substantiate that amount. A claim is settled if at any time after the claim is made and before, during, or after trial, the parties mutually agree to end the litigation in exchange for monetary payment.

(b) In any medical malpractice action in which the parties agree to settle the claim, the attorney for the plaintiff shall report the settlement to the Department of Insurance. The attorney shall certify the amount of the settlement proceeds received in reimbursement of any costs incurred in prosecution of the case, including separate amounts expended for expert witnesses, exhibits, travel, and all other categories of expenses which the attorney charges to the plaintiff, including documentation to substantiate that amount. Further, the attorney shall certify the amount of the settlement attributable to attorneys' fees. A claim is settled if at any time after the claim is made and before, during, or after trial, the parties mutually agree to end the litigation in exchange for monetary payment.

"**§ 90-21.18E. Regulation of contingency fees in medical malpractice actions.**

(a) No attorney shall contract for or collect a contingency fee for representing any person seeking damages in connection with a medical malpractice action in excess of the following limits:

(1) Forty percent (40%) of the first fifty thousand dollars ($50,000) recovered.

(2) Thirty-three and one-third percent (33 1/3%) of the next one hundred thousand dollars ($100,000) recovered.

(3) Twenty-five percent (25%) of the next four hundred fifty thousand dollars ($450,000) recovered.

(4) Fifteen percent (15%) of any amount for which the recovery exceeds six hundred thousand dollars ($600,000).

(b) The limits under subsection (a) of this section apply regardless of whether recovery is by settlement, arbitration, or judgment, or whether the person for whom the recovery is made is a responsible adult or a person who is under a disability as provided in G.S. 1-17.

(c) If periodic payments are awarded to the plaintiff pursuant to G.S. 90-21.18B, the court shall place a total value on these payments based upon the projected life expectancy of the plaintiff and use this amount in computing the total award from which attorneys' fees are calculated under this section."

SECTION 3. Article 4 of Chapter 8C of the General Statutes is amended by adding a new section to read:

"**Rule 414. Evidence of medical expenses.**

In any action brought against a health care provider pursuant to Article 1B of Chapter 90 of the General Statutes, evidence offered to prove past medical expenses may include all bills reasonably paid or incurred and a statement of the amounts actually necessary to satisfy the bills that have been incurred. Evidence of source of payment and rights of subrogation related to the payment shall be admissible."

SECTION 4. G.S. 1-289 reads as rewritten:

"**§ 1-289. Undertaking to stay execution on money judgment.**

(a) If the appeal is from a judgment directing the payment of money, it does not stay the execution of the judgment unless a written undertaking is executed on the part of the appellant, by one or more sureties, to the effect that if the judgment appealed from, or any part thereof, is affirmed, or the appeal is dismissed, the appellant will pay the amount directed to be paid by the judgment, or the part of such amount as to which the judgment shall be affirmed, if affirmed only in part, and all damages which shall be awarded against the appellant upon the appeal, except as provided in subsection (b) and (b1) of this section. Whenever it is satisfactorily made to appear to the court that since the execution of the undertaking the sureties have become insolvent, the court may, by rule or order, require the appellant to execute, file and serve a new undertaking, as above. In case of neglect to execute such undertaking within twenty days after the service of a copy of the rule or order requiring it, the appeal may, on motion to the court, be dismissed with costs. Whenever it is necessary for a party to an action or proceeding to give a bond or an undertaking with surety or sureties, he may, in lieu thereof, deposit with the officer into court money to the amount of the bond or undertaking to be given. The court in which the action or proceeding is pending may direct what disposition shall be made of such money pending the action or proceeding. In a case where, by this section, the money is to be deposited with an officer, a judge of the court, upon the application of either party, may, at any time before the deposit is made, order the money deposited in court instead of with the officer; and a deposit made pursuant to such order is of the same effect as if made with the officer. The perfecting of an appeal by giving the undertaking mentioned in this section stays proceedings in the court below upon the judgment appealed from; except when the sale of perishable property is directed, the court below may order the property to be sold and the proceeds thereof to be deposited or invested, to abide the judgment of the appellate court.

(b) If the appellee in a civil action brought under any legal theory obtains a judgment directing the payment or expenditure of money in the amount of twenty five million dollars ($25,000,000) or more, and the appellant seeks a stay of execution of the judgment within the period of time during which the appellant has the right to pursue appellate review, including discretionary review and certiorari, the amount of the undertaking that the appellant is required to execute to stay execution of the judgment during the entire period of the appeal shall be twenty five million dollars ($25,000,000).

(b1) If the appellee in any medical malpractice action, as defined in G.S. 90-21.11, obtains a judgment directing the payment or expenditure of money, and the appellant seeks a stay of execution of the judgment within the period of time during which the appellant has the right to pursue appellate review, including discretionary review and

certiorari, the amount of the undertaking that the appellant is required to execute to stay execution of the judgment during the entire period of the appeal shall be the lesser of the amount of the judgment or the amount of the appellant's medical malpractice insurance coverage applicable to the action.

(c) If the appellee proves by a preponderance of the evidence that the appellant for whom the undertaking has been limited under subsection (b) or (b1) of this section is, for the purpose of evading the judgment, (i) dissipating its assets, (ii) secreting its assets, or (iii) diverting its assets outside the jurisdiction of the courts of North Carolina or the federal courts of the United States other than in the ordinary course of business, then the limitation in ~~subsection (b)~~subsections (b) and (b1) of this section shall not apply and the appellant shall be required to make an undertaking in the full amount otherwise required by this section."

SECTION 5. G.S. 1-17(b) reads as rewritten:

"(b) Notwithstanding the provisions of subsection (a) of this section, an action on behalf of a minor for malpractice arising out of the performance of or failure to perform professional services shall be commenced within the limitations of time specified in G.S. 1-15(c), except that if those time limitations expire before the minor attains the full age of 19 years, the action may be brought before the minor attains the full age of 19 ~~years.~~years, but in no event may an action arising from birth-related injuries be commenced more than 10 years from the last act of the defendant giving rise to the cause of action."

SECTION 6. G.S. 58-2-170 reads as rewritten:

"**§ 58-2-170. Annual statements by professional liability insurers; medical malpractice claim reports.**

(a) In addition to the financial statements required by G.S. 58-2-165, every insurer, self-insurer, and risk retention group that provides professional liability insurance in the State shall file with the Commissioner, on or before the first day of February in each year, in form and detail as the Commissioner prescribes, a statement showing the items set forth in subsection (b) of this section, as of the preceding 31st day of December. The annual statement shall not be reported or disclosed to the public in a manner or format which identifies or could reasonably be used to identify any individual health care provider or medical center. The statement shall be signed and sworn to by the chief managing agent or officer of the insurer, self-insurer, or risk retention group, before the Commissioner or some officer authorized by law to administer oaths. The Commissioner shall, in December of each year, furnish to each such person that provides professional liability insurance in the State forms for the annual statements. The Commissioner may, for good cause, authorize an extension of the report due date upon written application of any person required to file. An extension is not valid unless the Commissioner's authorization is in writing and signed by the Commissioner or one of his deputies.

(b) The statement required by subsection (a) of this section shall contain:

(1) Number of claims pending at beginning of year;

(2) Number of claims pending at end of year;

(3) Number of claims paid;

(4) Number of claims closed no payment;
(5) Number and amounts of claims in court in which judgment ~~paid:~~ was entered, the amount of the judgment, and the actual amount paid on the judgment or in settlement of the judgment. For both the amount of the judgment and the actual amount paid, provide the:
a. Highest amount
b. Lowest amount
c. Average amount
d. Median amount;
(6) Number and amounts of claims out of court in which settlement paid:
a. Highest amount
b. Lowest amount
c. Average amount
d. Median amount;
(7) Average amount per claim set up in reserve;
(8) Total premium collection;
(9) Total expenses less reserve expenses; and
(10) Total reserve expenses.

(b1) The Commissioner shall analyze the reports described in subsections (a) and (b) of this section and shall file statistical and other summaries with the General Assembly no later than March 1 of each year. Summaries filed by the Commissioner pursuant to this subsection shall include all of the following:
(1) Any trends noted or observed from the data.
(2) All actions taken by the Commissioner in response to these trends.
(3) Any legislative or other recommendations from the Commissioner with respect to actions by the General Assembly in response to these trends.

(c) Every insurer, self-insurer, and risk retention group that provides professional liability insurance to health care providers in this State shall file, within 90 days following the request of the Commissioner, a report containing information for the purpose of allowing the Commissioner to analyze claims. The report shall be in the form prescribed by the Commissioner. The form prescribed by the Commissioner shall be a form that permits the public inspection, examination, or copying of any information contained in the report: Provided, however, that any data or other characteristics that identify or could be used to identify the names or addresses of the claimants or the names or addresses of the individual health care provider or medical center against whom the claims are or have been asserted or any data that could be used to identify the dollar amounts involved in such claims shall be treated as privileged information and shall not be made available to the public. The Commissioner shall analyze these reports and shall file statistical and other summaries based on these reports with the General Assembly as soon as practicable after receipt of the reports. The Commissioner shall assess a penalty against any person that willfully fails to file a report required by this subsection. Such penalty shall be one thousand dollars ($1,000) for each day after the due date of the report that the person willfully fails to file: Provided, however, the

penalty for an individual who self insures shall be two hundred dollars ($200.00) for each day after the due date of the report that the person willfully fails to file: Provided, however, that upon the failure of a person to file the report as required by this subsection, the Commissioner shall send by certified mail, return receipt requested, a notice to that person informing him that he has 10 business days after receipt of the notice to either request an extension of time or file the report. The Commissioner may, for good cause, authorize an extension of the report due date upon written application of any person required to file. An extension is not valid unless the Commissioner's authorization is in writing and signed by the Commissioner or one of his deputies.

(d) Every person that self-insures against professional liability in this State shall provide the Commissioner with written notice of such self-insurance, which notice shall include the name and address of the person self-insuring. This notice shall be filed with the Commissioner each year for the purpose of apprising the Commissioner of the number and locations of persons that self-insure against professional liability."

SECTION 7. G. S. 1A-1, Rule 42(b), reads as rewritten:

"(b) Separate trials.

(1) The court may in furtherance of convenience or to avoid prejudice and shall for considerations of venue upon timely motion order a separate trial of any claim, cross-claim, counterclaim, or third-party claim, or of any separate issue or of any number of claims, cross-claims, counterclaims, third-party claims, or issues.

(2) Upon motion of any party in an action that includes a claim commenced under Article 1G of Chapter 90 of the General Statutes involving a managed care entity as defined in G.S. 90-21.50, the court shall order separate discovery and a separate trial of any claim, cross-claim, counterclaim, or third-party claim against a physician or other medical provider.

(3) Upon motion of any party in a medical malpractice action commenced under Article 1B of Chapter 90 of the General Statutes wherein the plaintiff alleges damages greater than one hundred thousand dollars ($100,000), the court shall order separate trials for the issue of liability and the issue of damages. Evidence relating solely to pecuniary damages shall not be admissible until the trier of fact has determined that the defendant is liable for medical malpractice. The same trier of fact that tried the issues relating to liability shall try the issues relating to damages."

SECTION 8. G.S. 1A-1, Rule 9(j), reads as rewritten:

"(j) Medical malpractice. – Any complaint alleging medical malpractice by a health care provider as defined in G.S. 90-21.11 in failing to comply with the applicable standard of care under G.S. 90-21.12 shall be dismissed unless:

(1) The pleading specifically has attached a sworn affidavit from a person who is reasonably expected to qualify as an expert witness under Rule 702 of the Rules of Evidence that asserts that the medical care ~~has~~ and all medical records pertaining to the alleged injury then available to the

plaintiff after reasonable inquiry have been reviewed by ~~a person who is reasonably expected to qualify as an expert witness under Rule 702 of the Rules of Evidence and who~~the person, and the person is willing to testify that the medical care did not comply with the applicable standard of care;

(2) The pleading specifically has attached a sworn affidavit from a person that the complainant will seek to have qualified as an expert witness by motion under Rule 702(e) of the Rules of Evidence that asserts that the medical care ~~has~~ and all medical records pertaining to the alleged injury then available to the plaintiff after reasonable inquiry have been reviewed by ~~a person that the complainant will seek to have qualified as an expert witness by motion under Rule 702(e) of the Rules of Evidence and who~~the person, and the person is willing to testify that the medical care did not comply with the applicable standard of care, and the motion is filed with the complaint; or

(3) The pleading alleges facts establishing negligence under the existing common-law doctrine of res ipsa loquitur.

Upon motion by the complainant prior to the expiration of the applicable statute of limitations, a resident judge of the superior court for a judicial district in which venue for the cause of action is appropriate under G.S. 1-82 or, if no resident judge for that judicial district is physically present in that judicial district, otherwise available, or able or willing to consider the motion, then any presiding judge of the superior court for that judicial district may allow a motion to extend the statute of limitations for a period not to exceed 120 days to file a complaint in a medical malpractice action in order to comply with this Rule, upon a determination that good cause exists for the granting of the motion and that the ends of justice would be served by an extension. The plaintiff shall provide, at the request of the defendant, proof of compliance with this subsection through up to ten written interrogatories, the answers to which shall be verified by the expert required under this subsection. These interrogatories do not count against the interrogatory limit under Rule 33."

SECTION 9. G.S. 90-14(a) reads as rewritten:

"(a) The Board shall have the power to place on probation with or without conditions, impose limitations and conditions on, admonish, publicly reprimand, publicly censure, assess monetary redress, issue public letters of concern, mandate free medical services, require satisfactory completion of treatment programs or remedial or educational training, fine, deny, annul, suspend, or revoke a license, or other authority to practice medicine in this State, issued by the Board to any person who has been found by the Board to have committed any of the following acts or conduct, or for any of the following reasons:

(1) Immoral or dishonorable conduct.

(2) Producing or attempting to produce an abortion contrary to law.

(3) Made false statements or representations to the Board, or who has willfully concealed from the Board material information in connection with an application for a license.

(4) Repealed by Session Laws 1977, c. 838, s. 3.

(5) Being unable to practice medicine with reasonable skill and safety to patients by reason of illness, drunkenness, excessive use of alcohol, drugs, chemicals, or any other type of material or by reason of any physical or mental abnormality. The Board is empowered and authorized to require a physician licensed by it to submit to a mental or physical examination by physicians designated by the Board before or after charges may be presented against the physician, and the results of the examination shall be admissible in evidence in a hearing before the Board.

(6) Unprofessional conduct, including, but not limited to, departure from, or the failure to conform to, the standards of acceptable and prevailing medical practice, or the ethics of the medical profession, irrespective of whether or not a patient is injured thereby, or the committing of any act contrary to honesty, justice, or good morals, whether the same is committed in the course of the physician's practice or otherwise, and whether committed within or without North Carolina. The Board shall not revoke the license of or deny a license to a person solely because of that person's practice of a therapy that is experimental, nontraditional, or that departs from acceptable and prevailing medical practices unless, by competent evidence, the Board can establish that the treatment has a safety risk greater than the prevailing treatment or that the treatment is generally not effective.

(7) Conviction in any court of a crime involving moral turpitude, or the violation of a law involving the practice of medicine, or a conviction of a felony; provided that a felony conviction shall be treated as provided in subsection (c) of this section.

(8) By false representations has obtained or attempted to obtain practice, money or anything of value.

(9) Has advertised or publicly professed to treat human ailments under a system or school of treatment or practice other than that for which the physician has been educated.

(10) Adjudication of mental incompetency, which shall automatically suspend a license unless the Board orders otherwise.

(11) Lack of professional competence to practice medicine with a reasonable degree of skill and safety for patients. In this connection the Board may consider repeated acts of a physician indicating the physician's failure to properly treat a patient. The Board may, upon reasonable grounds, require a physician to submit to inquiries or examinations, written or oral, as the Board deems necessary to determine the professional qualifications of such licensee. In order to annul, suspend, deny, or revoke a license of an accused person, the Board shall find by the greater weight of the evidence that the care

provided was not in accordance with the standards of practice for the procedures or treatments administered.

(11a) Not actively practiced medicine or practiced as a physician assistant, or having not maintained continued competency, as determined by the Board, for the two-year period immediately preceding the filing of an application for an initial license from the Board or a request, petition, motion, or application to reactivate an inactive, suspended, or revoked license previously issued by the Board. The Board is authorized to adopt any rules or regulations it deems necessary to carry out the provisions of this subdivision.

(12) Promotion of the sale of drugs, devices, appliances or goods for a patient, or providing services to a patient, in such a manner as to exploit the patient, and upon a finding of the exploitation, the Board may order restitution be made to the payer of the bill, whether the patient or the insurer, by the physician; provided that a determination of the amount of restitution shall be based on credible testimony in the record.

(13) Having a license to practice medicine or the authority to practice medicine revoked, suspended, restricted, or acted against or having a license to practice medicine denied by the licensing authority of any jurisdiction. For purposes of this subdivision, the licensing authority's acceptance of a license to practice medicine voluntarily relinquished by a physician or relinquished by stipulation, consent order, or other settlement in response to or in anticipation of the filing of administrative charges against the physician's license, is an action against a license to practice medicine.

(14) The failure to respond, within a reasonable period of time and in a reasonable manner as determined by the Board, to inquiries from the Board concerning any matter affecting the license to practice medicine.

(15) The failure to complete an amount not to exceed 150 hours of continuing medical education during any three consecutive calendar years pursuant to rules adopted by the Board.

(a1) As used in subsection (a) of this section, the following apply:

(1) Censure the accused physician. – A censure is a written form of discipline more serious than a reprimand issued in cases in which a physician has committed one or more of the acts or conduct as set forth in subsection (a) of this section and has caused significant harm or potential significant harm to a patient, the profession, or members of the public, but the protection of the patient or public does not require suspension of the physician's license.

(2) Reprimand the accused physician. – A reprimand is a written form of discipline more serious than an admonition issued in cases in which a physician has committed one or more of the acts or conduct as set forth

in subsection (a) of this section, but the protection of the public does not require a censure. A reprimand shall generally be reserved for cases in which the physician's conduct has caused harm or potential harm to a patient, the profession, or members of the public.

(3) Admonish the accused physician. – An admonishment is a written form of discipline imposed in cases in which a physician has committed a minor act or conduct as set forth in subsection (a) of this section.

(a2) Actions taken by the Board to deny a license, to suspend a license, to censure a physician, and to reprimand a physician under subsection (a) of this section shall be a matter of public record under Chapter 132 of the General Statutes.

(a3) The Board may, in its discretion and upon such terms and conditions and for such period of time as it may prescribe, restore a license so revoked or otherwise acted upon, except that no license that has been revoked shall be restored for a period of two years following the date of revocation."

SECTION 10. G.S. 90-15.1 reads as rewritten:

"**§ 90-15.1. Registration every year with Board.**

Every person licensed to practice medicine by the North Carolina Medical Board shall register annually with the Board within 30 days of the person's birthday. A person who registers with the Board shall report to the Board the person's name and office and residence address and any other information required by the Board, and shall pay a registration fee of ~~one hundred seventy-five dollars ($175.00),~~up to two hundred fifty dollars ($250.00), except those who have a limited license to practice in a medical education and training program approved by the Board for the purpose of education or training shall pay a registration fee of one hundred twenty-five dollars ($125.00) and those who have a limited volunteer license shall pay an annual registration fee of twenty-five dollars ($25.00). A physician who is not actively engaged in the practice of medicine in North Carolina and who does not wish to register the license may direct the Board to place the license on inactive status. For purposes of annual registration, the Board shall use a simplified registration form which allows registrants to confirm information on file with the Board. A physician who fails to register as required by this section shall pay an additional fee of fifty dollars ($50.00) to the Board. The license of any physician who fails to register and who remains unregistered for a period of 30 days after certified notice of the failure is automatically inactive. Except as provided in G.S. 90-12(d), a person whose license is inactive shall not practice medicine in North Carolina nor be required to pay the annual registration fee. Upon payment of all accumulated fees and penalties, the license of the physician may be reinstated, subject to the Board requiring the physician to appear before the Board for an interview and to comply with other licensing requirements. The penalty may not exceed the maximum fee for a license under G.S. 90-13."

SECTION 11. There is appropriated from the General Fund to the Department of Insurance the sum of twenty-five thousand dollars ($25,000) for the 2007-2008 fiscal year to implement the provisions of Section 6 of this act.

SECTION 12. The provisions of this act are severable. If any portion of this act is declared unconstitutional or unenforceable or if the application of a portion of this act to any person or circumstances is held invalid, then the remaining portions of this act shall remain valid and enforceable.

SECTION 13. This act becomes effective October 1, 2008. G.S. 90-21.18, 90-21.18A, 90-21.18B, 90-21.18C, 90-21.18D, and 90-21.18E, as enacted by Section 2 of this act, apply to causes of actions arising on or after that date and to contingency fee agreements entered into on or after that date.