SENATE STAFF ANALYSIS AND ECONOMIC IMPACT STATEMENT

(This document is based on the provisions contained in the legislation as of the latest date listed below.)

BILL: SB 2120

SPONSOR: Senator Peaden

SUBJECT: Medical Malpractice

DATE: March 17, 2003 REVISED: 03/20/03

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Munroe	Wilson	HC	Fav/2 amendments
2.			JU	
3.				
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I. Summary:

This bill changes who may give expert testimony in cases involving negligence of a health care provider by: narrowing the class of expert witnesses who can testify about the prevailing professional standard of care for a specialist, health professional, and general practitioner; providing for physicians licensed under ch. 458 or ch. 459, F.S., to give expert testimony, under certain conditions, regarding the standard of care for nurses, nurse practitioners and other listed medical support staff; and allowing expert testimony on the appropriate standard of care as to administrative and other nonclinical issues in hospitals and other health care or medical facilities from a person who has substantial knowledge about such matters. An expert witness in a medical malpractice action is prohibited from testifying on a contingency fee basis.

The bill extends the automatic extension of the statute of limitations from 90 days to 180 days, which is granted to claimants in medical malpractice actions to allow them time to complete the reasonable investigation required as part of the presuit screening process.

The bill establishes a mechanism and time frame for recommencing any medical negligence case that has been commenced in a state or federal court within the applicable statute of limitations and that has been discontinued or dismissed by the plaintiff. This privilege of renewal may be exercised only once.

A claimant is required to list in the notice of intent to initiate litigation for medical malpractice, if available, all known health care providers seen by the claimant for the injuries complained of subsequent to the alleged act of malpractice, all known health care providers during the 5-year period before the alleged act of malpractice, and copies of the medical records relied upon by the expert in signing the affidavit stating that there appears to be evidence of medical negligence.

Insurers are required, at or before the end of the 90-day presuit period, as part of the rejection of a claim, to submit a factual basis for any denial as part of the corroboration of a finding of a lack of reasonable grounds for medical negligence. The prospective defendant's insurer may make an offer "to arbitrate in which liability is deemed admitted and arbitration will be held" on the issue of damages. The bill requires the insurer's response to a claimant's notice of intent to initiate litigation to include a copy of any insurance policy and applicable policy limits. If the prospective defendant intends to deny liability should a lawsuit be filed notwithstanding a settlement offer, the insurer's response must include an affidavit that corroborates the lack of reasonable grounds for medical negligence and sets forth a factual basis for denial of liability. Any response must also include all affirmative defenses the prospective defendant intends to raise, and a corroborating expert witness affidavit for each potential defendant whom the responding defendant contends is liable for injuries complained of and who has not been sent a notice of intent to litigate by the claimant.

Informal discovery as a part of presuit is revised to allow parties to take sworn statements, including sworn statements from health care providers. Such sworn statements are admissible and discoverable. Parties may also obtain answers to written questions.

Parties to a medical negligence action are required to submit to mandatory mediation as outlined in the bill.

The bill provides that a hospital shall be exclusively liable for any negligent acts or omissions committed in the course of the rendering or failing to render medical care or treatment to a patient at the hospital who enters the hospital through its emergency room or trauma center for treatment of a sudden, unexpected situation or occurrence resulting in a serious medical condition demanding immediate medical attention. In holding hospitals exclusively liable for acts of medical negligence committed on hospital patients in emergency rooms, the legislative intent is to instill in hospitals the incentive to maximize the use of measures that will avoid the risk of injury and to ensure that the public receives the highest quality care.

Under the bill, a settlement agreement involving a medical malpractice claim must not prohibit any party to the agreement from discussing the settlement amount or the events giving rise to the claim.

The bill provides that any policy, written or oral, by a private or public educational institution; a private or public health care facility; a professional association; a pharmaceutical corporation; a manufacturer of a drug, medical product, or medical device; an insurer, self-insurance trust, risk retention group, joint underwriting association, fund, or similar entity; or a health maintenance organization, which prohibits or discourages providing expert testimony is against public policy and is void. A civil action is established to enforce the prohibition.

The definition of "medical expert" is revised. The bill revises the requirements for a court's review of a medical negligence claim or denial to determine if it rests on a reasonable basis.

In any medical malpractice action, the trier of fact is required to apportion the total fault only among the claimant and all joint tortfeasors who are parties to the action when the case is submitted to the jury for deliberation and the rendition of a verdict.

This bill amends sections 766.102, 766.104, 766.106, 766.110, 766.113, 766.202, 766.205, and 766.206, Florida Statutes.

This bill creates ss. 766.1045, 766.1095, and 766.115, F.S., and one undesignated section of law.

II. Present Situation:

Governor's Select Task Force on Healthcare Professional Liability Insurance

In recognition of the problems that health care providers are having with the affordability and availability of medical malpractice insurance, Governor Bush appointed the Governor's Select Task Force on Healthcare Professional Liability Insurance on August 28, 2002, to address the impact of skyrocketing liability insurance premiums on health care in Florida. The Task Force was charged with making recommendations to prevent a future rapid decline in accessibility and affordability of health care in Florida and was further charged to submit a report to the Governor, the President of the Senate, and the Speaker of the House of Representatives by January 31, 2003.

The Task Force had ten meetings at which it received testimony and discussed five major areas: (1) health care quality; (2) physician discipline; (3) the need for tort reform; (4) alternative dispute resolution; and (5) insurance premiums and markets. The final report of the Task Force includes findings and 60 recommendations to address the medical malpractice crisis in Florida. The reports and information received by the Task Force, as well as transcripts of the meetings, were compiled into thirteen volumes that accompany the main report.

The following recommendations relating to medical malpractice tort reform are included in the final report of the Task Force.

> *Recommendation 28.* The Legislature should amend the statutes to allow *ex parte* communication between defense counsel for a defendant in a medical malpractice lawsuit and the plaintiff's treating physicians.
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> *Recommendation 29.* As an alternative, the Legislature may consider requiring the plaintiff to execute a medical information release when filing a lawsuit that would allow for the defendant to conduct *ex parte* interviews with the plaintiff's treating physicians only in areas potentially relevant to the plaintiff's alleged injury or illness.
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> *Recommendation 30.* The Legislature should examine ways to improve the use of in-kind experts at trial.
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> *Recommendation 31.* The Legislature should retain the definition of "reckless disregard," as that term is currently defined by statute, as it is sufficient.
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> *Recommendation 32.* The Legislature should repeal references to patient stabilization in section 768.13(2)(b)2a, Florida Statutes.

Recommendation 33. The Legislature should amend section 768.28, Florida Statutes, to define healthcare professionals providing services in emergency rooms or trauma centers as agents of the state for purposes of sovereign immunity.

Recommendation 34. The Legislature should amend the statutes to allow the periodic payment of future non-economic damages.

Recommendation 35. The Legislature should amend the statutes to terminate the payment of future economic and non-economic damages upon the death of the plaintiff.

Recommendation 36. The Legislature should require experts reviewing pre-suit claims and defenses and rendering opinions be qualified, in that they possess similar if not identical credentials and expertise in the field of healthcare services of the defendant's particular specialty.

Recommendation 37. The Legislature should require the expert who reviews pre-suit claims and defenses and renders opinions be subject to discovery and his or her testimony be admissible in any future proceeding.

Recommendation 38. Joint liability has a negative impact on a medical malpractice insurer's ability to forecast future losses and contributes to the insurer's paid losses. Accordingly, the Legislature should amend section 768.81, Florida Statutes, to provide that a defendant's liability for both economic and non-economic damages be several only.

Recommendation 39. The Legislature should amend the set off statutes, sections 46.015 and 768.041, Florida Statutes, to clarify that set off amounts should be applied to jury damage awards, including both economic and non-economic damages, even when fault is several only.

Recommendation 40. The Legislature should encourage pre-suit mediation by providing for confidentiality of any pre-suit mediation in a medical malpractice case in the same manner as is provided for mediation occurring after suit is filed.

Recommendation 41. The Legislature should amend the mandatory mediation provisions of section 766.108, Florida Statutes, to require mediation within 120 days of filing suit and to provide sanctions if a good faith offer of settlement is refused.

Recommendation 42. The Legislature should not make admissible at trial the fact that mandatory mediation occurred or that offers of settlement were made, but should make this fact admissible for purposes of enforcing the attorney fees and costs. The mediator should maintain a report of the issues and facts presented at the mediation and the final settlement offers of each party at the mandatory mediation.

Recommendation 43. The Legislature should enact specific criteria similar to those in the offer of judgment statute to be considered by the court in making the determination as to how close in amount the judgment must be to the offer and the criteria to be used in

evaluating the amount of the attorney fees and costs to be awarded in addition to the standards generally considered in awarding fees and costs.

Recommendation 44. The Legislature should require the court to consider, in addition to all other criteria, whether the issues and facts presented at mediation were significantly the same issues presented at trial.

Recommendation 45. The Legislature should amend the definitions of "economic damages" and "non-economic damages" as provided in sections 766.202 and 766.207, Florida Statutes, to provide that such damages are recoverable in voluntary binding arbitration only if the claimant has the right to recover such damages under general law, including the Wrongful Death Act.

Recommendation 46. The Legislature should provide for an aggregate cap on non-economic damages in arbitrated cases of multiple defendants.

Presuit Notices of Intent, Unsworn Statements, and Arbitration in Medical Malpractice Actions

Chapter 766, F.S., entitled Medical Malpractice and Related Matters, provides for standards of recovery in medical negligence cases. Sections 766.106 and 766.203, F.S., provide a statutory scheme for presuit investigation and screening of medical malpractice claims. After completion of the presuit investigation by the claimant, pursuant to s. 766.203, F.S., a claimant must notify each prospective defendant of the claimant's intent to initiate litigation for medical malpractice prior to filing a lawsuit. To give a claimant sufficient time to comply with presuit screening procedures, s. 766.104(2), F.S., provides that the claimant, in an action for medical malpractice, may petition the court where the suit will be filed for an automatic 90-day extension of the statute of limitations which shall be granted without a court order, to be effective upon payment of the filing fee which may not exceed $25. Under s. 766.106(3), F.S., a suit may not be filed for a period of 90 days after the notice of intent is mailed to any prospective defendant. During the 90-day period, the defendant's insurer is required to conduct a review to determine the liability of the defendant. To facilitate the review, s. 766.106(6), F.S., requires the parties to engage in fairly extensive informal discovery.

One of the mechanisms of informal discovery is the taking of unsworn statements as provided in s. 766.106(7)(a), F.S. Currently, any party may require other parties to appear for the taking of an unsworn statement. Such statements may be used only for the purpose of presuit screening and are not discoverable or admissible in any civil action by any party. Non-parties cannot be required to have their unsworn statements taken.

At or before the end of the 90 day presuit screening period, the defendant's insurer must, pursuant to s. 766.106(3)(b), F.S., respond to the claimant by rejecting the claim, making a settlement offer, or making an offer of admission of liability and for arbitration on the issue of damages. As part of the insurer's investigation, the insurer must ascertain whether there are reasonable grounds to believe that the defendant was negligent in the care or treatment of the claimant and whether such negligence resulted in injury to the claimant. Corroboration of reasonable grounds to initiate medical negligence litigation by a medical expert is a component

of the presuit investigation process. Pursuant to s. 766.203(3), F.S, the insurer must have corroboration of the lack of reasonable grounds for medical negligence litigation, which must be provided with any response rejecting the claim by the defendant's submission of a verified written medical expert opinion.

After completion of the presuit investigation pursuant to s. 766.203, F.S., by the parties and any informal discovery pursuant to s. 766.106, F.S., any party may file a motion in the circuit court requesting the court to determine whether an opposing party's claim or denial rests on a reasonable basis. Pursuant to s. 766.206, F.S., the court's review ensures that a claim or denial of the claim has been preceded by a reasonable investigation and that the claim or denial rests on a reasonable basis.[1]

Section 766.205(4), F.S., provides that no statement, discussion, written document, report, or other work product generated solely by the presuit investigation process is discoverable or admissible in any civil action for any purpose by the opposing party.

If the defendant makes an offer to arbitrate, the claimant has 50 days, pursuant to s. 766.106(10), F.S., in which to accept or reject the offer. The claimant cannot force the defendant to arbitrate under s. 766.106, F.S. Acceptance of the offer waives recourse to any other remedy by the parties. The parties then have 30 days to settle the amount of damages and, if they cannot reach a settlement, they must proceed to binding arbitration to determine the amount of damages.

Pursuant to s. 766.106(12), F.S., the provisions of the Florida Arbitration Code contained in ch. 682, F.S., are applicable to the arbitration proceeding. The parties then provide written arguments to the arbitration panel and a one day hearing is subsequently held, wherein the rules of evidence and civil procedure do not apply. No later than two weeks after the hearing the arbitrators are required to notify the parties of their award and the court has jurisdiction to enforce any award.

Settlement Agreements

Section 766.113, F.S., provides that a settlement agreement involving a medical malpractice claim may not prohibit any party to the agreement from discussing with or reporting to the Division of Medical Quality Assurance the events giving rise to the claim. The division is within Department of Health and is responsible for investigating claims alleging professional misconduct of health care practitioners for which such practitioners may be subject to regulatory sanctions.

Expert Witnesses in Medical Malpractice Actions

In any action for recovery of damages based on the death or personal injury of any person in which it is alleged that such death or injury resulted from the negligence of a health care provider, the claimant has the burden of proving the alleged actions of the health care provider represented a breach of the prevailing standard of care for that health care provider

[1] See Wolfsen v. Applegate, 619 So.2d 1050, 1055 (Fla. 1st DCA 1993); *Duffy v. Brooker*, 614 So.2d 539 (Fla. 1st DCA 1993) review denied, 624 So.2d 267 (Fla.1993).

(s. 766.102(1), F.S.). The prevailing professional standard of care for a given health care provider is that level of care, skill, and treatment which, in light of all relevant, surrounding circumstances, is recognized as acceptable and appropriate by reasonably prudent similar health care providers.

Section 766.104(1), F.S., provides that no action shall be filed for personal injury or wrongful death arising out of medical negligence unless the attorney filing the action has made a reasonable investigation to determine there are grounds for a good faith belief that there has been negligence in the care or treatment of the claimant. This statute provides a safe harbor for the attorney's good faith determination, as good faith may be shown to exist if the claimant or his counsel has received a written opinion of an expert as defined in s. 766.102, F.S., that there appears to be evidence of medical negligence. The written opinion of the expert is not subject to discovery by an opposing party to the litigation. Section 766.102(2), F.S., sets forth the qualifications of the health care provider who may testify as an expert in a medical negligence action, and who, pursuant to s. 766.104(1), F.S., may provide an opinion supporting the attorney's good faith presuit belief that there has been medical negligence.

The purpose of s. 766.102(2), F.S., is to establish a relative standard of care for various categories and classifications of health care providers for the purpose of testifying in court. Accordingly, pursuant to s. 766.102(2)(c), F.S., any health care provider may testify as an expert if he or she is a similar health care provider to the provider accused of negligence. If the expert is not a similar health care provider, he or she may still testify if the court determines the expert possesses sufficient training, experience and knowledge as a result of practice or teaching in the specialty of the defendant, or practice or teaching in a related field of medicine, such that the expert can testify to the prevailing professional standard of care in a given field of medicine. The expert must have had active involvement in the practice or teaching of medicine within the five year period before the incident giving rise to the claim.

Paragraphs 766.102(2)(a) and (b), F.S., define the term "similar health care provider" and classify health care providers as specialists and non-specialists. A specialist is one who is certified by the appropriate American board as a specialist, is trained and experienced as a medical specialist, or holds himself or herself out as a specialist. On the other hand, a non-specialist is a health care provider who meets none of the aforementioned criteria. For a specialist, a similar health care provider is one who is trained and experienced in the same specialty and is certified by the appropriate American board in the same specialty. For a non-specialist, a similar health care provider is one who is licensed by the appropriate regulatory agency of this state, is trained and experienced in the same discipline or school of practice, and practices in the same or similar medical community. If a health care provider provides treatment or diagnosis for a condition which is not in his or her specialty, a specialist trained in the treatment or diagnosis of that condition shall be considered a similar health care provider.

A great deal of litigation has occurred as a result of attempting to interpret and apply the provisions of s. 766.102(2), F.S. This is especially so in light of the fact that the terms "medical specialty", "specialty", "specialist", and "discipline or school of practice" are not defined anywhere. As a result, it is not uncommon for trial court judges to allow specialists to testify against non-specialists and general practitioners.

Liability of Health Care Facilities

All health care facilities, including hospitals and ambulatory surgical centers, as defined in ch. 395, F.S., have a duty to assure comprehensive risk management and the competence of their medical staff and personnel through careful selection and review, and are liable for a failure to exercise due care in fulfilling these duties. These duties include: the adoption of written procedures for the selection of staff members and a periodic review of the medical care and treatment rendered to patients by each member of the medical staff; the adoption of a comprehensive risk management program; and the initiation and diligent administration of medical review and risk management processes. Each such facility is liable for a failure to exercise due care in fulfilling one or more of these duties when such failure is a proximate cause of injury to a patient.

A Florida-licensed hospital is authorized under s. 766.110(2), F.S., to carry liability insurance or to adequately insure itself in an amount of not less than $1.5 million per claim or annually $5 million in the aggregate to cover all medical injuries to patients resulting from negligent acts or omissions on the part of those members of its medical staff who are covered thereby in furtherance of the requirements of ss. 458.320 and 459.0085, F.S. Sections 458.320 and 459.0085, F.S., require Florida-licensed allopathic physicians and osteopathic physicians to maintain malpractice insurance or other special financial responsibility to cover potential claims for medical malpractice as a condition of licensure, with specified exemptions.

Self-insurance coverage extended by a hospital under s. 766.110(2), F.S., to a member of a hospital's medical staff meets the financial responsibility requirements of ss. 458.320 and 459.0085, F.S., if the physician's coverage limits are not less than the minimum limits established in ss. 458.320 and 459.0085, F.S., and the hospital is a verified trauma center that has extended self-insurance coverage continuously to members of its medical staff for activities both inside and outside of the hospital. Any insurer authorized to write casualty insurance may make available, but is not required to write such coverage. The hospital may assess certain licensed physicians, nurses and dentists on an equitable and pro rata basis for a portion of the total hospital insurance cost for this coverage.

Joint and Several Liability

Under the doctrine of joint and several liability, all defendants are responsible for the plaintiff's damages regardless of the extent of each defendant's fault in causing the plaintiff's damages.[2] Under the doctrine of contributory negligence, any fault on the part of the plaintiff bars recovery. Various methods of apportioning damages have been used in Florida. Under the doctrine of comparative fault, each party is responsible to the extent of its proportion of fault and the court enters a judgment in a negligence case based on each party's proportion of liability. Until recently, the doctrine of joint and several liability applied to joint tortfeasors such that the court entered a judgment with respect to the economic damages against the party holding him or her responsible for those damages for all parties until the plaintiff recovered all damages completely.

[2] See *Fabre v. Marin*, 623 So.2d 1182, 1184 (Fla. 1993).

In a significant decision construing the interplay between the doctrines of joint and several liability and comparative fault, the Florida Supreme Court ruled in *Fabre v. Marin*, 623 So.2d 1182 (Fla.1993), that a defendant could apportion fault to non-party defendants. Specifically, the court held that, in determining non-economic damages, fault must be apportioned among all responsible entities who contribute to an accident even though not all of them were joined as defendants in the lawsuit. In *Nash v. Wells Fargo Guard Services*, Inc., 678 So.2d 1262 (Fla.1996), the Court subsequently clarified that, in order for a non-party to be included on a jury verdict form, the defendant must have pleaded the non-party's negligence as an affirmative defense and specifically identified the non-party. In addition, the defendant bears the burden of presenting evidence that the non-party's negligence contributed to the claimant's injuries. Some legal commentators have expressed concern that the *Fabre* and *Nash* decisions have resulted in plaintiffs bringing all potentially liable actors into lawsuits, some of whom might otherwise not have been named because it is likely they would have little or no liability.

However, in 1999, Florida law was amended to abolish the doctrine of joint and several liability for non-economic damages, and to limit its applications as to economic damages. See ch. 99-225, L.O.F.; s. 768.81, F.S. As to economic damages, it established new limitations and maximum liability amounts, which increase with a defendant's share of fault and dependent on whether the plaintiff was at fault or not. Section 768.81, F.S., requires the court to enter judgment based on fault of the parties rather than joint and several liability in negligence cases. Section 768.81(3), F.S., provides a formula to be used by the courts to apportion damages when the plaintiff is found to be at fault.

Section 768.81(5), F.S.,[3] provides that notwithstanding any law to the contrary, in any action for damages for personal injury or wrongful death arising out of medical malpractice, whether in tort or contract, when an apportionment of damages pursuant to this subsection is attributed to a statutory teaching hospital, the court shall enter judgment against the statutory teaching hospital on the basis of such party's percentage of fault and not on the basis of the doctrine of joint and several liability. Subsection (2) of s. 766.112, F.S., also provides that a claimant's sole remedy to collect a judgment or settlement against a board of trustees of a state university in a medical malpractice action is through the legislative claim bill process as provided in s. 768.28, F.S.

III. Effect of Proposed Changes:

Section 1. Amends s. 766.102, F.S., effective upon this act becoming a law and applicable to causes of action filed on or after July 1, 2003, to tighten the criteria for determining the relative standard of care in medical negligence cases for the various categories and classifications of health care providers. Currently, s. 766.102(2), F.S., provides definitions of "similar health care provider" for purposes of experts who may testify regarding the prevailing professional standard of care for a particular health care provider. The courts have interpreted these provisions broadly, so that it is not uncommon for a specialist to testify against a general practitioner or a specialist in one field to testify against a specialist in another field.

To bill deletes the existing definitions in s. 766.102(2), F.S., and states that "a person may not give expert testimony concerning the prevailing professional standard of care unless that person

[3] An identical provision exists in s. 766.112(1), F.S.

is a licensed health care provider and meets" certain specified criteria. The listed criteria are narrower in scope than the criteria currently identified in s. 766.102(2), F.S. If the person against whom, or on whose behalf, the testimony is offered is a specialist, the bill provides that the expert must:

- Specialize in the same specialty as the party 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 complaint and have prior experience treating similar patients.

Furthermore, in the three years immediately preceding the date of the occurrence that is the subject of the action, the expert must have devoted professional time to the active clinical practice in, or the consultation of, the same or similar health profession or, if the health care provider is a specialist, the same or similar specialty. The expert can also testify if the professional time requirement is met by teaching students in an accredited health professional school or accredited residency program in the same or similar health profession or specialty. Also, the professional time requirement can be met in a clinical research program affiliated with an accredited medical or health professional school, a teaching hospital, or an accredited residency or clinical research program in the same or similar health profession or specialty.

Currently, there is no professional time requirement that a similar specialist must meet before being allowed to testify for or against another similar specialist. Accordingly, the field of specialist experts will be narrowed. Additionally, the current provisions in s. 766.102(2)(c), F.S., allow a dissimilar specialist to testify against or for a dissimilar specialist or nonspecialist if the court determines the expert has "sufficient training, experience, and knowledge as a result of practice or teaching...[and] such training, experience, or knowledge [is] a result of the active involvement in the practice or teaching of medicine within the 5 year period before the incident giving rise to the claim." The bill provides no such similar discretionary language but does state that a trial court judge can qualify an expert witness on grounds other than the qualifications in this section. This provision arguably gives the court just as much discretion, if not more, than that currently provided in s. 766.102, F.S.

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

- Active clinical practice or consultation as a general practitioner;
- Instruction of students in an accredited health professional school or accredited residency program in the general practice of medicine; or
- A clinical research program that is affiliated with an accredited medical school or teaching hospital and that is in the general practice of medicine.

As stated previously, current s. 766.102(2)(c), F.S., gives the court broad discretion when determining whether an expert can testify, if the expert is not a similar health care provider. This has resulted in specialists testifying against general practitioners on a routine basis. The bill attempts to eliminate this from occurring by expressly providing that an expert can only testify

against or for a general practitioner if that expert has devoted his or her professional time to practicing, consulting, teaching or conducting clinical research in general medicine. However, a new subsection (6) provides that "[t]his section does not limit the power of the trial court to disqualify or qualify an expert witness on grounds other than the qualifications in this section." This language could also allow the court to qualify an expert who might not otherwise be qualified and, arguably, gives the court more discretion than that which is currently provided in s. 766.102 (2)(c), F.S.

The bill also provides that health care providers who treat or diagnose patients for conditions not within their specialty will be subject to having specialists in that area testify for or against them as a similar health care provider.

The bill also adds a new subsection for expert testimony concerning the applicable standard of care for nurses, nurse practitioners, certified registered nurse anesthetists, certified registered nurse midwives, physician assistants and "other medical support staff." The bill provides that, notwithstanding the other expert qualifications contained in s. 766.102(2), F.S., a physician licensed under chapter 458 or chapter 459, F.S., who qualifies as an expert under the section, and who by reason of active clinical practice or instruction of students has knowledge of the applicable standard of care for the persons listed above, may give expert testimony with respect to the standard of care of such medical support staff.

Another new subsection created by the bill concerns expert testimony against hospitals and other health care or medical facilities. The bill provides that a person may give expert testimony on the appropriate standard of care as to administrative and other nonclinical issues if the person has substantial knowledge, by virtue of his or her training and experience, concerning the standard of care among hospitals, or health care or medical facilities of the same type as the hospital, health care facility, or medical facility whose actions or inactions are the subject of the testimony. The standard of care must be for hospitals, health care facilities, or medical facilities which are located in the same or similar communities at the time of the alleged act giving rise to the cause of action.

The bill adds a new subsection which states an expert witness in a medical malpractice action may not testify on a contingent fee basis.

Section 2. Amends s. 766.104, F.S., effective upon this act becoming a law and applicable to notices of intent to litigate and responses mailed on or after July 1, 2003, to extend the automatic extension of the statute of limitations from 90 days to 180 days, which is granted to claimants in medical malpractice actions to allow them time to complete the reasonable investigation required as part of the presuit screening process.

Section 3. Creates s. 766.1045, F.S., effective upon this act becoming a law and applicable to notices of intent to litigate and responses mailed on or after July 1, 2003, to provide that when any medical negligence case has been commenced in a state or federal court within the applicable statute of limitations and the plaintiff discontinues or dismisses the case, it may be recommenced in a court of this state or in federal court either within the original applicable period of limitations or within 6 months after the discontinuance or dismissal, whichever occurs later. This privilege of renewal may be exercised only once.

Section 4. Amends s. 766.106, F.S., effective October 1, 2003, and applicable to notices of intent to litigate sent on or after October 1, 2003, to require the claimant to list in the notice of intent to initiate litigation for medical malpractice, if available, all known health care providers seen by the claimant for the injuries complained of subsequent to the alleged act of malpractice, all known health care providers during the 5-year period before the alleged act of malpractice, and copies of the medical records relied upon by the expert in signing the affidavit. The requirement of providing the list of known health care providers as part of the notice of intent to initiate litigation may not serve as grounds for imposing sanctions for failure to provide presuit discovery.

The bill amends requirements for the prospective defendant insurer's response to the claimant during the presuit period to require the insurer, at or before the end of the 90 days, as part of the rejection of a claim, to submit a factual basis for any denial as part of the corroboration of a finding of a lack of reasonable grounds for medical negligence in accordance with s. 766.203(3), F.S. Under the bill, the prospective defendant's insurer may make an offer "to arbitrate in which liability is deemed admitted and arbitration will be held" on the issue of damages. Under the current law, the defendant's insurer may make "an offer of admission of liability and for arbitration on the issue of damages."

The bill also requires the insurer's response to include a copy of any insurance policy and applicable policy limits. If the prospective defendant intends to deny liability should a lawsuit be filed notwithstanding a settlement offer, the insurer's response must include an affidavit that corroborates the lack of reasonable grounds for medical negligence and sets forth a factual basis of denial of liability. Any response must also include all affirmative defenses the prospective defendant intends to raise, and a corroborating expert witness affidavit for each potential defendant whom the responding defendant contends is liable for injuries complained of and who has not been sent a notice of intent to litigate by the claimant.

The bill revises one of the mechanisms to complete informal discovery to allow parties to take sworn statements rather than unsworn statements. Under the bill, parties will also be able to obtain answers to written questions.[4] Any party may request answers to written questions, which may not exceed 30, including subparts, and which shall be responded to within 20 days after receipt.

The bill would allow the taking of sworn statements of any party or health care provider. A party desiring to take the sworn statement of any party or health care provider must provide reasonable written notice and opportunity to be present to all parties. The notice must state the time and place for taking the statement and name and address of the party or health care provider to be examined. The examination of any party or health care provider must be done at the same time by all parties. Any party or health care provider may be represented by counsel at the taking of a sworn statement. Sworn statements may be recorded electronically, stenographically, or on videotape. The taking of sworn statements is subject to the provisions of the Florida Rules of

[4] See Section 766.106(7), F.S. and Fla.R.Civ.P. 1.650(c) which provides that "[u]pon receipt by a prospective defendant of a notice of intent to initiate litigation, the parties may obtain presuit screening discovery by one or more of the following methods: unsworn statements upon oral examination; production of documents or things; and physical examinations. Unless otherwise provided in this rule, the parties shall make discoverable information available without formal discovery. Evidence of failure to comply with this rule may be grounds for dismissal of claims or defenses ultimately asserted."

Civil Procedure and may be terminated for abuses. The taking of a sworn statement during presuit screening does not preclude a party from updating the statement by deposition.

Section 5. Creates s. 766.1095, F.S., effective July 1, 2003, and applicable to cases filed on or after July 1, 2003, to require the parties to a medical negligence action to, within 120 days after the suit is filed, conduct mandatory mediation in accordance with s. 44.102, F.S., if voluntary binding arbitration has not been agreed to by the parties. The Florida Rules of Civil Procedure apply to mandatory mediation held by parties to a medical negligence action. At the conclusion of the mediation, the mediator must record the final demand and final offer to provide to the court upon the rendering of a judgment.

If a claimant rejects the final offer of settlement made during the mediation and does not obtain a judgment more favorable than the offer, the court shall assess the claimant the mediation costs and reasonable costs, expenses, and attorney's fees that were incurred after the date of mediation. The assessment attaches to the proceeds of the claimant and is attributable to any defendant whose final offer was more favorable than the judgment. If the judgment obtained at trial is not more favorable to a defendant than the final demand for judgment made by the claimant to the defendant during mediation, the court must assess the defendant for the mediation costs and reasonable costs, expenses, and attorney's fees that were incurred after the date of mediation. The final offer and final demand made during mediation are the only offer and demand that the court may consider in assessing costs, expenses, attorney's fees, and prejudgment interest. A subsequent offer or demand by either party is inapplicable to the determination of whether sanctions will be assessed by the court. Notwithstanding any law to the contrary, s. 45.061, F.S., which deals with offers of settlement, and s. 768.79, F.S., which deals with offers of judgment and demands for judgments, do not apply to medical negligence or to wrongful death cases arising out of medical negligence causes of action.

Section 6. Amends s. 766.110, F.S., effective July 1, 2003, and applicable to causes of action arising on or after July 1, 2003, to provide that a hospital shall be exclusively liable for any negligent acts or omissions committed in the course of the rendering or failing to render medical care or treatment to a patient at the hospital who enters the hospital through its emergency room or trauma center for treatment of a sudden, unexpected situation or occurrence resulting in a serious medical condition demanding immediate medical attention. The liability of the hospital does not apply to damages as a result of any act or omission of providing medical care or treatment which is unrelated to the original medical emergency or which occurs after the patient is stabilized and is capable of receiving medical treatment as a nonemergency patient, unless surgery is required as a result of the emergency within a reasonable time after the patient is stabilized, in which case the exclusive liability applies to any act or omission of medical care or treatment which occurs prior to stabilization of the patient following the surgery.

The exclusive remedy for injury or damages suffered as a result of medical negligence in emergency care committed at a hospital shall be against the hospital. No cause of action shall lie against a health care provider, whether employed by the hospital or not, and no such health care provider shall be held liable nor shall fault be attributed to the health care provider for any act of medical negligence for which the hospital is liable. Such health care provider shall be considered an adverse witness in a medical negligence action for any injury or damage suffered as a result of any act, event, or omission of action in the scope of the provider's employment or function. This

provision does not limit in any way any liability to which the hospital may be subject under any other provision of law.

A hospital, under its liability insurance, may provide for a deductible amount to be applied against any individual health care provider found liable in a law suit in tort or for breach of contract for an act of medical negligence for which the hospital is not exclusively liable. In holding hospitals exclusively liable for acts of medical negligence committed on hospital patients in emergency rooms, the legislative intent is to instill in each hospital the incentive to maximize the use of measures that will avoid the risk of injury and to ensure that the public receives the highest quality care obtainable from hospitals.

Section 7. Amends s. 766.113, F.S., effective upon this act becoming a law and applicable to notices of intent to litigate and responses mailed on or after July 1, 2003, to provide that a settlement agreement involving a medical malpractice claim shall not prohibit any party to the agreement from discussing the settlement amount or the events giving rise to the claim.

Section 8. Creates s. 766.115, F.S., effective upon this act becoming a law and applicable to causes of action filed on or after July 1, 2003, to provide that any policy, written or oral, by a private or public educational institution; a private or public health care facility; a professional association; a pharmaceutical corporation; a manufacturer of a drug, medical product, or medical device; an insurer, self-insurance trust, risk retention group, joint underwriting association, fund or similar entity; or a health maintenance organization, which prohibits or discourages providing expert testimony is against public policy and is void.

The bill authorizes any person to bring a civil action to: enjoin a person or entity that has prohibited or discouraged anyone from providing expert testimony; or to obtain a civil penalty on any person or entity that has prohibited or discouraged anyone from providing expert testimony. The civil penalty may be no greater than $10,000 for each violation. A showing of proof that the prohibited policy exists creates a rebuttable presumption that the existence of the policy caused irreparable injury to the claimant. The defendant institution has the burden of proving by a preponderance of the evidence that the claimant was not injured by demonstrating that in the absence of the policy, the witness would nevertheless have not allowed himself or herself to be retained by the claimant. The prevailing party shall be awarded reasonable attorney's fees and costs in any civil action involving an alleged violation in which a person or entity has prohibited or discouraged anyone from providing expert testimony where an injury has occurred. The award of fees and costs shall become part of the judgment and subject to execution as provided by law.

Section 9. Amends s. 766.202, F.S., effective upon this act becoming a law and applicable to causes of action filed on or after July 1, 2003, to revise the definition of "medical expert" to mean a person duly and regularly engaged in the practice of his or her profession who holds a health care professional degree from a university or college and has special training, knowledge, or experience about the subject upon which he or she is called to provide an opinion and who is familiar with the evaluation, diagnosis, or treatment of the medical condition at issue. Such expert must certify that he or she has had experience in the evaluation, diagnosis, or treatment of this condition. In order to avoid the appearance of impropriety, a medical expert opinion submitted on behalf of a defendant may not be provided by a member of the same self-insurance trust or risk retention group as the defendant, or by a health care provider who is employed by

the same employer as the defendant or in a professional association, partnership, or joint venture with the defendant. Language requiring the medical expert to possess special health care knowledge or skill is eliminated.

Section 10. Amends s. 766.205, F.S., effective upon this act becoming a law and applicable to notices of intent to litigate and responses mailed on or after July 1, 2003, to make sworn statements taken pursuant to presuit informal discovery subject to discovery and admissible in any civil action. It would in effect, allow a party to depose the witness or corroborating expert who has made sworn statements pursuant to s. 766.106(7)(a), F.S. Under current law, unsworn statements made by the corroborating experts as part of presuit are considered privileged.[5]

Section 11. Amends s. 766.206, F.S., effective upon this act becoming a law and applicable to causes of action filed on or after that date, to revise the requirements for a court's review of a medical negligence claim or denial to determine if it rests on a reasonable basis. As part of proceeding under s. 766.206, F.S., the court must additionally ensure that the claimant has completed a review of the claim and has obtained a verified written medical expert opinion by an expert witness as defined in s. 766.202, F.S.

The bill requires the court, in reviewing the defendant's response, to ensure that the defendant has completed a review of the claim and has obtained a verified written medical expert opinion by an expert witness as defined in s. 766.202, F.S. The bill revises the sanction for any defendant who is not in compliance to require the court to strike the defendant's pleading. The sanction for noncompliance by a defendant under the current law is to strike the defendant's response to the claimant's claim.

Under the bill, the court is directed to report to the Division of Medical Quality Assurance any medical expert submitting an opinion who did not meet the expert witness qualifications in s. 766.202(5), F.S. The court shall, rather than may, refuse to consider the testimony of an expert whose medical expert witness opinion attached to any notice of intent or to any response rejecting a claim has been disqualified three times.

Section 12. Creates an undesignated section, to require, notwithstanding any provision of law to the contrary, in an action for damages for personal injury or wrongful death arising out of medical malpractice, whether in contract or tort, the trier of fact to apportion the total fault only among the claimant and all joint tortfeasors who are parties to the action when the case is submitted to the jury for deliberation and the rendition of a verdict.

Section 13. Provides an effective date upon becoming a law, except as otherwise provided in the bill.

[5] See s. 766.205(4), F.S., and *Watkins v. Rosenthal*, 637 So.2d 993 (Fla. 3d DCA 1994).

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

The provisions of this bill have no impact on municipalities and the counties under the requirements of Article VII, s. 18 of the Florida Constitution.

B. Public Records/Open Meetings Issues:

The provisions of this bill have no impact on public records or open meetings issues under the requirements of Art. I, s. 24(a) and (b) of the Florida Constitution.

C. Trust Funds Restrictions:

The provisions of this bill have no impact on the trust fund restrictions under the requirements of Article III, Subsection 19(f) of the Florida Constitution.

D. Other Constitutional Issues:

Section 8 of the bill provides that any policy, written or oral, by a private or public educational institution; a private or public health care facility; a professional association; a pharmaceutical corporation; a manufacturer of a drug, medical product, or medical device; an insurer, self-insurance trust, risk retention group, joint underwriting association, fund, or similar entity; or a health maintenance organization, which prohibits or discourages providing expert testimony is against public policy and is void. Such activity may be categorized as commercial free speech. Applicable case law has held that, as long as commercial speech describes lawful activity and is truthful and not fraudulent or misleading, it is entitled to the protections of the First Amendment of the United States Constitution. To regulate or ban commercial speech, the government must have substantial governmental interest which is directly advanced by the restriction, and must demonstrate that there is a reasonable fit between the legislature's ends and narrowly tailored means chosen to accomplish those ends. In enacting or enforcing a restriction on commercial speech, the government need not select the least restrictive means, but rather must tailor its restriction to meet the desired objective. See *Central Hudson Gas Electric Corp. v. Public Service Comm'n of New York*, 447 U.S. 557, 100 S.Ct. 2243, 65 L.Ed.2d 341 (1980). Applicable case law describes various regulatory safeguards which the state may impose in place of a total ban on commercial speech, such as requiring a disclaimer to ensure that the consumer is not misled. See *Abramson v. Gonzalez*, 949 F.2d 1567 (11th Cir. 1992).

V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

The bill's provisions relating to the notice of intent will result in a greater number of sworn statements being taken in the presuit screening process. This could result in more claims being settled prior to filing lawsuits. The precise impact cannot be determined.

The provision that provides that any policy, written or oral, by a private or public educational institution; a private or public health care facility; a professional association; a pharmaceutical corporation; a manufacturer of a drug, medical product, or medical device; an insurer, self-insurance trust, risk retention group, joint underwriting association, fund, or similar entity; or a health maintenance organization, which prohibits or discourages providing expert testimony is against public policy and is void, will require such entities to incur costs to comply.

C. Government Sector Impact:

None.

VI. Technical Deficiencies:

None.

VII. Related Issues:

The bill does not define the terms "specialist," "general practitioner" or "specialty." The lack of definition of these same terms has created some confusion for the trial and appellate courts.[6]

VIII. Amendments:

#1 by Health, Aging and, Long-Term Care:
Deletes provisions that would make a hospital exclusively liable for any negligent acts or omissions committed in the course of rendering or failing to render medical care or treatment to a patient at the hospital who enters the hospital through it emergency room or trauma center for treatment of a sudden, unexpected situation or occurrence resulting in a serious medical condition demanding immediate medical attention. (WITH TITLE AMENDMENT).

#2 by Health, Aging and, Long-Term Care:
Amends the "Good Samaritan Act" to extend immunity from civil liability to any licensed or certified health care practitioner who provides medical care or treatment in a hospital to a patient or person with whom the practitioner does not have a preexisting provider-patient relationship when such care or treatment is necessitated by a sudden or unexpected situation or by an occurrence that demands immediate medical attention. The immunity does not apply to damages as a result of medical care or treatment unrelated to the original situation that demanded immediate medical attention. (WITH TITLE AMENDMENT)

[6] See *Catron v. Roger Bohn, D.C, P.A.*, 580 So.2d 814 (Fla. 2d DCA 1991).