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: CS/SB 2-D

SPONSOR: Health, Aging, and Long-Term Care Committee and Senator Jones

SUBJECT: Medical Incidents

DATE: August 12, 2003 REVISED: _____ _____ _____ _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Munroe/Matthews/ Greenbaum	Wilson/Deffenbaugh/ Roberts	HC	Favorable/CS
2.				
3.				
4.				
5.				
6.				

I. Summary:

The bill amends the law affecting medical incidents in the areas of patient safety and improved quality of health care, insurance regulation, litigation, and the Florida Birth-Related Neurological Injury Compensation Association (NICA). Specifically, this bill makes changes as follows:

Patient Safety and Improved Quality of Health Care

Regulations regarding health care facilities

- Requires patient safety plans, including appointment of patient safety officers and committees, in hospitals, ambulatory surgical centers, and mobile surgical facilities;
- Deletes a requirement in s. 395.0191, F.S., that persons act in good faith to avoid liability or discipline for their actions regarding the awarding of staff membership or clinical privileges;
- Requires hospitals, ambulatory surgical centers, and mobile surgical facilities to report the name and judgments entered against health care practitioners for whom they assume liability;
- Deletes the requirement for licensed facilities to notify the Agency for Health Care Administration (AHCA) within 1 business day of the occurrence of certain adverse incidents;
- Establishes a privilege from discovery or introduction into evidence in any civil or administrative action for patient safety data. The terms “patient safety data” and “patient safety organization” are defined. A patient safety organization must promptly remove all patient-identifying information after receipt of a complete patient safety data report unless such organization is otherwise permitted by state or federal law to maintain such information;

- Requires health care facilities and practitioners to inform patients or their representatives of adverse medical incidents that result in harm to the patient; and
- Makes activities done pursuant to quality improvement review, evaluation, and planning in a state-licensed health care facility immune from civil liability.

Licensure requirements and regulations regarding health care professionals

- Revises practitioner profile elements and reporting requirements for physicians;
- Revises reporting requirements concerning professional liability claims against a licensee alleging medical malpractice;
- Requires that the 2 hours of continuing education in prevention of medical errors required for medical and osteopathic physicians and physician assistants include a course on misdiagnosed conditions;
- Requires the suspension of the license of a medical or osteopathic physician when judgments, arbitration awards, or settlement amounts have not been paid pursuant to statutory requirements;
- Revises financial responsibility requirements for medical and osteopathic physicians;
- Prohibits medical and osteopathic physicians from using financial responsibility coverage amounts to cover defense litigation costs or attorney fees in a medical malpractice action; and
- Removes the limitation of no more than 10 percent licensure fee increase from the previous biennium for practitioners.

State agency duties

- Revises requirements for the determination of conclusions of law and findings of fact by the Department of Health (DOH) or boards for standard of care violations involving practitioners under the department or boards' regulatory jurisdiction;
- Revises assessment of costs associated with a disciplinary action of a health care practitioner;
- Requires the Division of Administrative Hearings (DOAH) to designate at least two administrative law judges with certain qualifications to preside over actions involving health care practitioner discipline;
- Revises the rights of a respondent licensee in disciplinary cases to affirmatively require election of a formal hearing within 45 days after service of the administrative complaint rather than any circumstance during a proceeding in which a party raises an issue of disputed fact during an informal hearing;
- Requires AHCA to review copies of complaints alleging negligence filed against hospitals for noncompliance by the hospital with adverse incident reporting and licensure requirements and to proceed with disciplinary actions against such hospitals for noncompliance;
- Requires several reports to be prepared concerning health care professionals and claims against those licensees;
- Establishes emergency procedures for the discipline of medical physicians, osteopathic physicians, and podiatric physicians who have reported three closed malpractice claims within a 60-month period to the Office of Insurance Regulation (OIR);

- Authorizes DOH, notwithstanding the 6-year limitation on the investigation or filing of an administrative complaint, to investigate professional liability actions reported in the previous 6 years, rather than 10 years, for any paid claim exceeding $50,000;
- Revises requirements for alternative disciplinary procedures including mediation and citation offenses;
- Gives DOH additional subpoena power in prosecuting disciplinary cases;
- Revises the monetary thresholds for what constitutes gross or repeated malpractice for disciplinary purposes; and
- Requires DOH to study the current health care practitioner disciplinary process and report by January 1, 2004.

Agency studies and training programs

- Requires AHCA, in consultation with DOH and certain existing patient safety centers, to complete a study on the implementation requirements of establishing a statewide Patient Safety Authority. The proposed duties of the Patient Safety Authority are listed and the agency must complete its study and issue a report to the Legislature by February 1, 2004;
- Requires AHCA to conduct or contract for a study to determine if it is feasible to provide information to the public that will help them make better health care decisions regarding their choice of a hospital based on that facility's patient safety and quality performance;
- Requires the Office of Program Policy Analysis and Government Accountability (OPPAGA) and the Auditor General to conduct a study of practitioner disciplinary cases and closed claims; and
- Requires medical, nursing, and allied health training programs to include instruction in patient safety.

Medical Malpractice Insurance

Medical malpractice insurance

- Requires a rate freeze and mandatory rate filing to reflect the savings of the bill. Rates approved on or before July 1, 2003 for medical malpractice insurance remain in effect until the effective date of the new rate filing required by the act. Insurers must make a rate filing effective no later than January 1, 2004, to reflect the savings of the act, using the presumed factor established by OIR, or using a different factor if the insurer contends that the presumed factor results in a rate that is excessive, inadequate, or unfairly discriminatory, subject to prior approval by OIR. The new rate would apply to policies issued or renewed on or after the effective date of the act, requiring insurers to provide a refund for policies issued between the effective date of the act and the effective date of the rate filing;
- Requires medical malpractice insurers to notify insureds at least 60 days prior to the effective date of a rate increase and at least 90 days prior to cancellation or non-renewal;
- Provides that medical malpractice rate filings disapproved by the Office of Insurance Regulation may not be submitted to an arbitration panel, but would be subject to administrative review pursuant to ch. 120, F.S.;
- Requires medical malpractice insurers to notify policyholders upon making a rate filing that would have a statewide average increase of 25 percent or greater;

- Requires that medical malpractice insurers make a rate filing at least once annually, sworn to by at least two executive officers;
- Revises the rating standards for medical malpractice insurance to prohibit the inclusion of payments made by insurers for bad faith or punitive damages in the insurer's rate base. Such payments shall not be used to justify a rate or rate change;
- Requires OPAAGA to study the feasibility and merits of authorizing the Office of the Public Counsel to represent the public in medical malpractice rate matters;
- Revises the closed claim reporting requirements of s. 627.912, F.S., to: (1) require reporting by all types of insurance and self-insurance entities, including specified health care practitioners and facilities for claims not otherwise reported by an insurer; (2) include reports of claims resulting in non payment; (3) include professional license numbers; (4) provide for electronic access to DOH for all closed claim data and otherwise delete separate reporting to DOH; (5) increase penalties for non-reporting; (6) provide that violations by health care providers of reporting requirements constitutes a violation of their practice act; (7) require OIR to prepare an annual report analyzing the closed claim reports, financial reports submitted by insurers, approved rate filings and loss trends; (8) authorize the Financial Services Commission to adopt rules to require the reporting of data on open claims and reserves; and (9) maintain current law for provisions that apply to professional liability for attorneys so that the bill is limited to the single subject of "medical incidents";
- Authorizes a group of 10 or more health care providers to establish a commercial self-insurance fund for providing medical malpractice coverage; and
- Eliminates an existing prohibition against creating new medical malpractice self-insurance funds and authorizes the Financial Services Commission to adopt rules relating to such funds.

Medical Malpractice Liability and Litigation

Presuit process

- Redefines "health care provider" for those subject to presuit procedural requirements;
- Revises and enhances statutory criteria for who may be qualified to offer presuit corroborating medical expert opinions and expert witness testimony;
- Makes presuit medical expert opinions discoverable;
- Prohibits contingency fee agreements for expert witnesses;
- Requires attorneys to certify that expert witnesses are not guilty of fraud or perjury;
- Requires a claimant to execute a medical information release to authorize a defendant to take unsworn statements from a claimant's physician and prescribes the conditions and scope for the taking of these statements;
- Specifies potential sanctions if parties fail to cooperate with presuit investigations; and
- Requires DOH to study and report by December 31, 2003, on whether medical review panels should be created for use during the presuit process. If DOH recommends that such panels should be created, then the report must include draft legislation to implement that recommendation.

Suit

- Requires claimants to provide AHCA with a copy of a complaint against a hospital or ambulatory surgical center licensed under ch. 395, F.S.;
- Requires settlement forms to include boilerplate language regarding the implication of a decision to settle; and
- Requires specific itemization of damages, as part of a verdict for medical malpractice actions, to include break-out for future losses.

Caps on noneconomic damages

- *For an injury other than a permanent vegetative state, death or catastrophic injury*, noneconomic damages are capped at $500,000 from each *practitioner defendant,* but not to exceed $1 million from all practitioner defendants, regardless of the number of claimants. The noneconomic damages are capped at $750,000 per claimant but not to exceed $1.5 million from all *nonpractitioner defendants;*
- For *catastrophic injury* as found by the trier of fact and when the court determines manifest injustice would occur otherwise, noneconomic damages are capped at $1 million for the *injured patient* from all *practitioner defendants*, and at $1.5 million for the *injured patient* from all *nonpractitioner defendants*;
- *For permanent vegetative state or death*, noneconomic damages are capped at $1 million, regardless of the number of claimants and regardless of the number of *practitioner defendants*. The noneconomic damages are capped at $1.5 million from all *nonpractitioner defendants*, regardless of the number of claimants;
- For *any type of injury* resulting when a *practitioner provides emergency services* prior to stabilization in a hospital or of *life support services* including transportation, to someone with whom the practitioner has no pre-existing health care patient-practitioner relationship, noneconomic damages are capped $150,000 per claimant but not to exceed $300,000 aggregated for all claimants from all practitioner defendants;
- For *any type of injury* resulting when a *nonpractitioner provides emergency services prior to stabilization in a hospital or of prehospital emergency treatment pursuant to statutory obligations*, to someone with whom the nonpractitioner has no pre-existing health care patient- practitioner relationship, noneconomic damages are capped at $750,000 per claimant from all nonpractitioner defendants but not to exceed $1.5 million aggregated for all claimants from all nonpractitioner defendants;
- Allows for setoff against noneconomic damages exceeding the statutory caps, provided a reduction is made first for comparative fault;
- Requires reduction of any award for noneconomic damages by any settlement amount received in order to preclude recovery in excess of statutory cap;
- Clarifies that the caps on noneconomic damages applicable in medical negligence trials are applicable to trials that take place following a defendant's refusal to accept a claimant's offer of voluntary binding arbitration; and
- Caps recovery of noneconomic damages in voluntary binding medical negligence arbitration involving wrongful death.

Bad faith actions against insurers

- Provides that a professional liability insurer, for insuring medical negligence, may not be held to have acted in bad faith for failure to timely pay policy limits if it tenders its policy

limits and meets other reasonable conditions of settlement before the earlier of two events: the 210th day after service of the complaint or the 60th day after the conclusion of the deposition of parties and expert witnesses, the initial disclosure of witnesses and production of documents, and required mediation;
- Provides that the failure to tender policy limits is not presumptive of an insurer acting in bad faith and provides factors to be considered by the trier of fact in determining whether an insurer has acted in bad faith; and
- Provides that when an insurer tenders policy limits and such tender is accepted by the claimant, the insurer is entitled to a release of its insured.

Immunity
- Provides immunity from injunctive or civil relief, against any licensed facility or its board, board members or staff arising out of or relating to carrying out activities relating to staff membership or clinical privileges at a hospital, ambulatory surgical center, or mobile surgical facility, absent intentional fraud;
- Provides immunity from vicarious liability to insurers, prepaid limited health service organizations, and health maintenance organizations for the negligent acts of their employees or persons with whom they contract;
- Revises the circumstances under which immunity from civil liability under the Good Samaritan Act applies, by extending the immunity to any health care provider providing emergency services pursuant to obligations imposed by federal and state statutes and revises the definition of "reckless disregard" for purposes of extending such immunity; and by extending the immunity to any health care practitioner who is in a hospital and who voluntarily provides immediate emergency care or treatment to a non-patient of his or hers;
- Extends sovereign immunity to health care practitioners who have contractually agreed to act as agents of a state university board of trustees to provide medical services to a student-athlete for participation in or as a result of intercollegiate athletics; and
- Provides immunity for physicians performing high school examinations for student athletes by revising the requirements for the Florida High School Activities Association by-laws for participation in interscholastic athletics to require that an evaluation and history form incorporate recommendations of the American Heart Association for participation cardiovascular screening and removing standards by which certification is conducted.

Florida Birth-Related Neurological Injury Compensation Association

Florida Birth-Related Neurological Injury Compensation Association Program
- Adds infants who receive a NICA award to the Children's Medical Services (CMS) program, requires reimbursement to CMS for services, and makes the reimbursement eligible for federal matching funds;
- Clarifies that, if a claimant accepts an award from NICA, no civil action may be brought, and an award from NICA may not be made or paid if the claimant recovers in a civil action;
- Provides that medical records and related information in a claim are to be filed with NICA, rather than with DOAH, and be included within a current public records exemption;
- Authorizes an administrative law judge to bifurcate NICA proceedings;

- Limits NICA claimants liability for attorneys fees;
- Creates a $10,000 death benefit for an infant and strikes requirements to pay funeral expenses up to $1,500;
- Permits a hospital in a county of more than 1.1 million gross population as of January 1, 2003, to pay the NICA fee for participating physicians and midwives; and
- Requires OPPAGA to study the eligibility requirements for a birth to be covered under the Florida Birth-Related Neurological Injury Compensation Association and report to the Legislature by January 1, 2004.

This bill amends ss. 391.025, 391.029, 395.0191, 395.0197, 456.013, 456.025, 456.039, 456.041, 456.042, 456.049, 456.051, 456.057, 456.072, 456.073, 456.077, 456.078, 458.320, 458.331, 459.0085, 459.015, 461.013, 466.028, 624.462, 627.062, 627.357, 627.4147, 627.912, 641.19, 641.51, 766.102, 766.106, 766.108, 766.1115, 766.112, 766.113, 766.201, 766.202, 766.203, 766.206, 766.207, 766.209, 766.303, 766.304, 766.305, 766.309, 766.31, 766.314, 768.13, 768.21, 768.28, 768.77, and 1006.20, F.S.

This bill creates ss. 395.0056, 395.1012, 395.1051, 456.0575, 458.3311, 459.0151, 461.0131, 627.41495, 766.118, 766.1185, 766.2021, 768.0981, 1004.08, and 1005.07, F.S., and 18 undesignated sections of law.

This bill repeals s. 395.0198, F.S.

II. Present Situation:

Availability and Affordability of Medical Malpractice Insurance

Medical malpractice insurance covers doctors and other professionals in the medical field for liability claims arising from their treatment of patients. Rapidly rising medical malpractice insurance premiums and the departure of many insurance companies from the medical malpractice market have created a crisis of affordability and availability in many areas of the country, including Florida.

After almost a decade of essentially flat prices, medical malpractice insurance premiums began rising in 2000. According to the Department of Insurance (DOI), rate increases for physicians and surgeons from the top 15 professional liability insurers (ranked by direct written premium in Florida as reported December 31, 2001) ranged from a minimum of 33.5 percent to a maximum of 149.9 percent from January 1, 2001 through January 1, 2003. There was a 73 percent average rate increase, weighted for market share. Rate increases for the top three insurers ranged from 74.3 percent to 81.3 percent for the 2-year period.

In October 2002, DOI surveyed 18 insurers (top 15 malpractice writers in Florida and three other insurers known to be writing coverage) to determine the status of insurers departing the state and the status of insurers writing new business. Of the 18 insurers, five medical malpractice insurers had decided to no longer write any new or renewal business in Florida. Four additional insurers were not accepting any new business from physicians. Nine remaining insurers were still accepting new business in October 2002. As of February 28, 2003, the largest medical

malpractice insurer in the state, which had not been writing new business in October 2002, decided to resume writing new business.

While there is general agreement that medical malpractice insurance premiums have risen sharply and that physicians are having a more difficult time obtaining medical malpractice insurance coverage, there appears to be little agreement on the causes of these problems. Insurers and doctors blame "predatory" trial attorneys, "frivolous" law suits, and "out of control" juries for the spike in insurance premiums. Consumer groups accuse insurance companies of "price gouging" and cite "exorbitant" rates of medical errors. Plaintiffs' attorneys also point to medical errors, and to "predatory" pricing practices and bad business decisions of insurers during the 1990s.

There is also disagreement about possible solutions to these problems. Insurers and physicians demand tort reform: changes in the legal system that will limit the frequency of litigation and the amount of damage awards. Attorneys argue that past legal reform has unfairly blocked victims' access to the courts while doing nothing to bring down the costs of malpractice insurance. They see the solution in regulation of the insurance industry. Patient advocates focus on safety and suggest mandatory reporting of medical errors and a no-fault approach to victim compensation.

Whatever the causes and solutions, the effects of the rising cost of medical malpractice insurance and the reduction in the availability of such coverage are being felt in Florida's health care system. There have been numerous reports of doctors discontinuing doing risky procedures, retiring prematurely, practicing without insurance, and leaving litigious areas of the state in an effort to deal with the price of liability coverage. In some cases, the decision of high risk specialists to reduce or eliminate their services has led to further reductions in services by hospitals. Some hospitals are discontinuing services such as maternity services and trauma services because of the high cost of malpractice coverage for the specialists needed to provide these services.

Reporting of Professional Liability Closed Claims

Certain insurers providing professional liability insurance to health care practitioners, and certain physicians and dentists licensed in Florida, are required to report liability claims, once they are closed, to various governmental agencies under state and federal law.

Section 627.912, F.S., requires each medical malpractice self-insurer and each insurer or joint underwriting association providing professional liability insurance to specified health care practitioners and facilities, health maintenance organizations, and members of the Florida Bar to report to DOI any claim or action for damages for personal injuries claimed to have been caused by error, omission, or negligence in the performance of such insured's professional services or based on a claimed performance of professional services without consent, if the claim resulted in:

- A final judgment in any amount; or
- A settlement in any amount.

DOI has applied the closed claim reporting requirements to those insurers over which they have regulatory control, i.e. authorized insurers that have a Certificate of Authority from DOI to write insurance in Florida. To the extent that health care providers are obtaining medical malpractice insurance through risk retention groups, surplus lines insurers, or offshore insurers, their closed claims are not being reported under s. 627.912, F.S. Also, claims attributable to health care practitioners who are not insured are not reported to DOI.

Under s. 456.049, F.S., Florida-licensed physicians and dentists must report to DOH any claim or action for damages for personal injury alleged to have been caused by error, omission, or negligence in the performance of such licensee's professional services or based on a claimed performance of professional services without consent if the claim was not covered by an insurer required to report under s. 627.912, F.S., and the claim resulted in:

- A final judgment in any amount;
- A settlement in any amount; or
- A final disposition not resulting in payment on behalf of the licensee.

The Health Care Quality Improvement Act of 1986 requires reporting of medical malpractice payments, sanctions taken by Boards of Medical Examiners, and professional review actions taken by health care entities to the National Practitioner Data Bank. Under 42 U.S.C. section 11131, each entity (including an insurance company) which makes payment under a policy of insurance, self-insurance, or otherwise in settlement (or partial settlement) of, or in satisfaction of a judgment in, a medical malpractice action or claim shall report information respecting the payment and circumstances thereof. The information to be reported includes:

- The name of any physician or licensed health care practitioner for whose benefit the payment is made;
- The amount of the payment;
- The name (if known) of any hospital with which the physician or practitioner is affiliated or associated;
- A description of the acts or omissions and injuries or illnesses upon which the action or claim was based; and
- Any other information that the Secretary of the U.S. Department of Health and Human Services determines is required for appropriate interpretation of the information reported.

Good Faith Dealings between an Insurer and Its Insured

Insurance policies which impose an obligation on the insurer to defend and indemnify its insured against liability obligate the insurer to a duty of good faith in the handling of the defense or settlement of claims against the insured.[1] If the insurer breaches its good faith duty, it may be liable for the amount of the judgment rendered against the insured which exceeds the limits of coverage under the insurance policy or contract with the insured. Florida law provides civil remedies by statute and at common law[2] for aggrieved litigants damaged by an insurer's failure

[1] See *Boston Old Colony Insurance Company v. Guitierrez*, 386 So.2d 459 (Fla. 1985).
[2] See *Thompson v. Commercial Union Insurance Co. of New York*, 250 So.2d 259 (Fla. 1971). The Florida Supreme Court declared that an insured or injured plaintiff has the right to sue and recover damages against the insurer for an excess of the policy limits, based on the alleged fraud or bad faith of the insurer in the conduct or handling of the defense of the insured's suit.

to handle the defense of or settle a claim of the insured. At common law as early as 1938, Florida courts have allowed third-party bad faith actions. Even though the tort of bad faith occurred between the insurer and its insured, Florida courts have permitted the injured third party to bring a bad faith action directly against the first party insurer because the injured third-party, as the beneficiary to the bad faith claim, is the real party in interest.[3]

In 1962, the Legislature enacted s. 624.155, F.S., which provides civil remedies to any person who has been damaged by an insurer who has not attempted to settle and pay a claim for policy benefits in good faith. Section 624.155(7), F.S., provides that the civil remedy in this section does not preempt any other remedy or cause of action provided for pursuant to any other statute or pursuant to the common law of this state. Any person may obtain a judgment under either the common-law remedy of bad faith or the statutory remedy, but shall not be entitled to a judgment under both remedies. In addition, the section has been interpreted to allow a litigant to choose between his common law and statutory remedies for bad faith. Under s. 624.155(4), F.S., punitive damages are recoverable for the acts of the insurer which give rise to violation in such frequency as to indicate a general business practice and if the acts: are willful, wanton, and malicious; in reckless disregard for the rights of any insured; or in reckless disregard for the rights of the beneficiary under a life insurance contract.

Insurance Rate Standards

All property and casualty insurers authorized to do business in the state are required to file rates for approval with DOI either 90 days before the proposed effective date ("file and use") or 30 days after the rate filing is implemented ("use and file").[4] Under the "file and use" option, the department may finalize its review by issuing a notice of intent to approve or disapprove within 90 days after receipt of the filing. These notices are "agency action" for purposes of the Administrative Procedure Act, and give the insurer the right to choose an administrative hearing or binding arbitration. Prior to approving or disapproving a rate filing, the department may request additional supporting information for the filing from the insurer, but such a request does not toll the 90-day review period. If the department fails to issue a notice of intent to approve or disapprove within the 90-day review period, the filing is deemed approved. Under the "use and file" option, an insurance company may be ordered by the department to refund a portion of the rate to the policyholders in the form of a credit or refund if it is found to be excessive.

The department may disapprove a rate filing if it determines such rates to be "excessive, inadequate, or unfairly discriminatory." These terms are defined in the Florida Statutes in the following manner:[5]

(a) Rates are "excessive" if they are likely to produce a profit from Florida business that is unreasonably high in relation to the risk involved in the class of business or if expenses are unreasonably high in relation to services rendered.[6]

[3] See *Auto Mutual Indemnity Co. v. Shaw*, 134 Fla. 815, 184 So. 852 (1938) and *State Farm Mutual Automobile Ins. Co. v. Laforet*, 658 So.2d 55, 58 (Fla. 1995).
[4] See s. 627.062, F.S.
[5] See s. 627.062, F.S.
[6] Rates are also *excessive* if, among other things, the rate structure established by a stock company provides for replenishment of surpluses from premiums, when the replenishment is attributable to investment losses.

(b) Rates are "inadequate" if they are clearly insufficient, together with investment income attributable to them, to sustain projected losses and expenses in the class of business to which they apply. Also, rates are deemed "inadequate" as to premium charged to a risk if discounts or credits are allowed which exceed a reasonable reflection of expense savings and expected loss experience from the risk.

(c) Rates are "unfairly discriminatory" as to a risk if the application of premium discounts, credits, or surcharges among such risks does not bear a reasonable relationship to the expected loss and expense experience among the various risks.[7]

In making its rating decision, the department must consider, in accordance with generally accepted and reasonable actuarial techniques, 13 factors which affect the insurer's rate filing including: past and prospective loss experience, expenses, market competition for the risk insured, investment income, the reasonableness of the judgment reflected in the rate filing, dividends, the adequacy of loss reserves, cost of reinsurance, trend factors, catastrophe hazards, profits, medical services (if applicable), and other relevant factors which impact upon the frequency or severity of claims or upon expenses.

Medical Malpractice Self-Insurance Funds

Section 627.357, F.S., once authorized the establishment of medical malpractice self-insurance funds. In 1992, the statute was amended to provide that no such funds could be formed after October 1, 1992. Currently there are only two funds in existence: the South Pinellas Medical Malpractice Risk Management Trust Fund, and the Central Dade Medical Malpractice Risk Management Trust Fund.

A Medical Malpractice Risk Management Trust Fund is authorized to purchase insurance, specific excess insurance, and aggregate excess insurance. The fund is authorized to hire consultants for loss prevention and claims management coordination, and pay claims; the "prudent" investment of trust funds is also authorized. DOI is directed to adopt rules to implement the section including ensuring the funds meet a requirement that a trust fund maintain sufficient reserve to cover contingent liabilities in the event of dissolution.

The funding of a Medical Malpractice Risk Management Trust Fund is provided by premiums paid by members. Additionally, each member has a contingent assessment liability to pay actual losses when there is a deficiency due to claims or liquidation. DOI must review and approve all expense factors related to rates before a new rate can be implemented. For the department to approve rates and the associated expense factors, the rates must be justified and reasonable for the benefits and services provided.

The Governor's Select Task Force on Healthcare Professional Liability Insurance found that removing the limitation on the creation of Medical Malpractice Risk Management Trust Funds would provide an additional opportunity for medical facilities and providers to have insurance rather than go without insurance, quit practicing medicine, or reduce services provided.

[7] A rating plan, including discounts, credits, or surcharges, shall be deemed *unfairly discriminatory* if it fails to clearly and equitably reflect consideration of the policyholder's participation in a risk management program.

Additionally, the creation of these funds would increase the opportunities to ensure that injured parties are compensated.

The current law also allows for the formation of commercial self-insurance funds pursuant to ss. 624.460-624.488, F.S., as approved by OIR. These funds may be formed for property and casualty insurance, including medical malpractice, but in practice have been limited to providing workers' compensation coverage. No such funds have been formed to provide medical malpractice insurance. The law allows a medical malpractice self-insurance trust fund organized under s. 627.357, F.S., (discussed above) to form a commercial self-insurance fund. Otherwise, such funds may be formed only by a not-for-profit trade association, industry association, or professional association of employers or professionals which (1) has a constitution or bylaws, (2) is incorporated in Florida, (3) has been organized for purposes other than that of obtaining or providing insurance, and (4) has operated in good faith for a continuous period of 1 year (or by at least 10 condominium associations meeting certain requirements). In general, there are greater solvency-related requirements for forming a commercial self-insurance fund, as compared to the former medical malpractice self-insurance trust funds.

A commercial self-insurance fund must be operated by a board of trustees which must be responsible for appointing independent certified public accountants, legal counsel, actuaries, and investment advisers as needed; for approving payment of dividends to members; and for contracting with an administrator authorized under s. 626.88, F.S., to administer the affairs of the fund. A majority of the trustees or directors must be owners, partners, officers, directors, or employees of one or more members of the fund. Requirements also include: (1) an indemnity agreement binding each fund member to individual, several, and proportionate liability; (2) a plan of risk management which has established measures to minimize the frequency and severity of losses; (3) proof of competent and trustworthy persons to administer or service the fund; (4) an aggregate net worth of all members of at least $500,000; (5) a combined ratio of current assets to current liabilities of more than 1 to 1; (6) a deposit of cash or securities, or a surety bond, of $100,000; (7) specific and aggregate excess insurance with limits and retention levels satisfactory to the department (office); (8) a fidelity bond or insurance providing coverage of at least 10 percent of the funds handled annually by the fund; (9) a plan of operation designed to provide sufficient revenues to pay current and future liabilities, as determined in accordance with sound actuarial principles, and a statement by an actuary to that effect; and (10) such additional information as OIR may reasonably require.

After certification, additional requirements are imposed related to restrictions on premiums that may be written, annual reports, dividends, assessments, and approval of forms and rates. Rates may not be excessive, inadequate, or unfairly discriminatory and must be filed with OIR for approval. But, the standard for excessiveness is limited to a determination of whether the expense factors are not justified or are not reasonable for the benefits and services provided. A fund has the burden of proving that a rate filed is adequate if, during the first 5 years of issuing policies, the fund files a rate that is below the rate for loss and loss adjustment expenses for the same type and classification of insurance that has been filed by the Insurance Services Office and approved by OIR (ss. 625.460-624.482, F.S.).

Florida Birth-Related Neurological Injury Compensation Association

The Tort and Insurance Reform Act of 1986 created the Academic Task Force for Review of the Insurance and Tort Systems. A major concern of the Task Force was the increasing unavailability of obstetric services to women in Florida. The significant increase in malpractice insurance premiums caused many physicians to cease the practice of obstetrics, creating a shortage of professionals to provide care for expectant mothers. To combat this health care delivery crisis, the Task Force recommended that the Legislature implement a no-fault plan of compensation for catastrophic birth-related neurological injuries.

In response to the recommendations, the Legislature enacted the Florida Birth-Related Neurological Injury Compensation Act in 1988 (ss. 766.301-766.316, F.S.). NICA provides compensation, regardless of fault, for specific birth-related neurological injuries.

Participating hospitals and physicians are immune from liability under medical malpractice for claims covered by NICA. A birth-related neurological injury is defined to mean:

> [I]njury to the brain or spinal cord of a live infant weighing at least 2,500 grams for a single gestation or, in the case of a multiple gestation, a live infant weighing at least 2,000 grams at birth caused by oxygen deprivation or mechanical injury occurring in the course of labor, delivery, or resuscitation in the immediate post delivery period in a hospital, which renders the infant permanently and substantially mentally and physically impaired. This definition shall apply to live births only and shall not include disability or death caused by genetic or congenital abnormality.

The Florida Supreme Court has ruled that in order for an infant to qualify under the above definition, the infant must be both mentally and physically impaired, not just one or the other.[8] If the administrative law judge finds that the statutory criteria are satisfied, then the infant, as well as the infant's parents or legal guardians, are entitled to the award of specifically defined, but limited, financial benefits without regard to fault (s. 766.31, F.S.).

In the 14 years NICA has been in place, 161 cases have been accepted and there are presently 87 current open cases. Reports reflect an average of $3 million per case is set aside based on actuarial data evaluating the lifetime care of the child, the medical fragility of the child, and the premise that as the child ages, care becomes more expensive.

The Governor's Select Task Force on Healthcare Professional Liability Insurance heard testimony about the high premium costs for medical malpractice coverage for obstetricians and the effects that high premium costs are having on these physicians and hospitals. The Task Force suggested that modifications to the eligibility requirements for NICA, such as changing the birth weights and changing the requirement that the infant be "mentally *and* physically" impaired to "mentally *or* physically" impaired might encourage greater participation. The broadening of the definition of eligible claimants may provide a reasonable alternative and likewise create a stopgap to the insurance crisis facing physicians providing obstetrical services. However, any

[8] See *Florida Birth-Related Neurological Injury Compensation Association v. Florida Division of Administrative Hearings,* 686 So.2d 1349, (1997).

changes that open the program up to more claims would have to be evaluated for the level of financial assessments that would be required on hospitals and physicians.

Notices of Intent and Unsworn Statements in Medical Malpractice Actions

Chapter 766, F.S., entitled Medical Malpractice and Related Matters, provides for recovery of damages in medical negligence cases. Section 766.106, F.S., provides a statutory scheme for presuit screening of medical malpractice claims. After completion of the presuit investigation 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. 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. If the defendant makes an offer to arbitrate, the claimant has 50 days, pursuant to s. 766.106(10), F.S., 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 1-day hearing is subsequently held, wherein the rules of evidence and civil procedure do not apply. No later than 2 weeks after the hearing the arbitrators are required to notify the parties of their award and the court has jurisdiction to enforce any award.

Voluntary Binding Arbitration under Chapter 766, Florida Statutes

In 1988, the Legislature enacted sweeping medical malpractice reforms. Sections 48-59 of chapter 88-1, Laws of Florida, currently located in ss. 766.201-766.212, F.S., created additional presuit requirements and voluntary binding arbitration of medical negligence claims. The Legislature expressed its intent that arbitration provide:

- Substantial incentives for both claimants and defendants to submit their cases to binding arbitration, thus reducing attorney's fees, litigation costs, and delay;
- A conditional limitation on noneconomic damages where the defendant concedes willingness to pay economic damages and reasonable attorney's fees; and

- Limitations on the noneconomic damages components of large awards to provide increased predictability of outcome of the claims resolution process for insurer anticipated losses planning, and to facilitate early resolution of medical negligence claims.

Section 766.207, F.S., provides for voluntary binding arbitration of medical negligence claims. Upon completion of presuit investigation with preliminary reasonable grounds for a medical negligence claim intact, either party may elect to have damages determined by an arbitration panel. The opposing party may accept the offer of voluntary binding arbitration and the acceptance is a binding commitment to comply with the decision of the arbitration panel. Arbitration precludes recourse to any other remedy by the claimant against any participating defendant. Voluntary binding arbitration is undertaken with the understanding that:

- Net economic damages shall be awardable, including, but not limited to, past and future medical expenses and 80 percent of wage loss and loss of earning capacity, offset by any collateral source payments;
- Noneconomic damages shall be limited to a maximum of $250,000 per incident, and shall be calculated on a percentage basis with respect to capacity to enjoy life, so that a finding that the claimant's injuries resulted in a 50-percent reduction in his or her capacity to enjoy life would warrant an award of no more than $125,000 in noneconomic damages;
- Damages for future economic losses shall be awarded to be paid by periodic payments pursuant to s. 766.202(8), F.S., and shall be offset by future collateral source payments;
- Punitive damages shall not be awarded;
- The defendant shall be responsible for the payment of interest on all accrued damages with respect to which interest would be awarded at trial;
- The defendant shall pay the claimant's reasonable attorney's fees and costs, as determined by the arbitration panel, but in no event more than 15 percent of the award, reduced to present value;
- The defendant shall pay all of the costs of the arbitration proceeding and the fees of all the arbitrators other than the administrative law judge;
- Each defendant who submits to arbitration shall be jointly and severally liable for all damages assessed under this section;
- The defendant's obligation to pay the claimant's damages shall be for the purpose of arbitration under this section only;
- A defendant's or claimant's offer to arbitrate shall not be used in evidence or in argument during any subsequent litigation of the claim following the rejection thereof;
- The fact of making or accepting an offer to arbitrate shall not be admissible as evidence of liability in any collateral or subsequent proceeding on the claim;
- Any offer by a claimant to arbitrate must be made to each defendant against whom the claimant has made a claim;
- Any offer by a defendant to arbitrate must be made to each claimant who has joined in the notice of intent to initiate litigation;
- A defendant who rejects a claimant's offer to arbitrate shall be subject to the claim proceeding to trial without limitation on damages, and the claimant, upon proving medical negligence, shall be entitled to recover prejudgment interest and reasonable attorney's fees up to 25 percent of the award reduced to present value;

- A claimant who rejects a defendant's offer to arbitrate shall be subject to damages awardable at trial being limited to net economic damages, plus noneconomic damages not to exceed $350,000 per incident;
- The hearing shall be conducted by all of the arbitrators, but a majority may determine any question of fact and render a final decision;
- The chief arbitrator shall decide all evidentiary matters; and
- Voluntary binding arbitration does not preclude settlement at any time by mutual agreement of the parties.

Section 766.207, F.S., also specifies that the arbitration panel is composed of three arbitrators: one selected by the claimant, one selected by the defendant, and one administrative law judge furnished by DOAH who shall serve as the chief arbitrator. This section specifies how arbitrators are to be selected if there are multiple plaintiffs or multiple defendants, requires independence of arbitrators, specifies the rate of compensation for arbitrators, and authorizes DOAH to promulgate rules for voluntary binding arbitration.

Section 766.208, F.S., establishes the procedures for arbitration to allocate responsibility among multiple defendants, when there is a dispute among the defendants as to the apportionment of the damages that are awarded by the voluntary binding arbitration panel under s. 766.207, F.S. This section provides for a separate arbitration panel and binding arbitration proceeding for apportioning financial responsibility among multiple defendants.

Section 766.209, F.S., specifies the effects of failure to offer or accept voluntary binding arbitration. Voluntary binding arbitration is an alternative to jury trial and does not supersede the right of any party to a jury trial. If neither party requests or agrees to voluntary binding arbitration, the claim proceeds to trial or to any other available legal alternative. If a defendant rejects a claimant's offer to arbitrate, the claim proceeds to trial without limitation on damages, and the claimant, upon proving medical negligence, is entitled to recover prejudgment interest and reasonable attorney's fees up to 25 percent of the award reduced to present value. If a claimant rejects a defendant's offer to arbitrate, damages awardable at trial are limited to net economic damages, plus noneconomic damages not to exceed $350,000 per incident.

Section 766.21, F.S., authorizes the administrative law judge serving as chief arbitrator on an arbitration panel to dissolve the panel and request appointment of a new panel if he or she determines that agreement cannot be reached. The administrative law judge serving as chief arbitrator on a panel arbitrating the allocation of responsibility among multiple defendants is authorized to dissolve the panel and declare the proceedings concluded if he or she determines that agreement cannot be reached.

Section 766.211, F.S., requires the defendant to pay the arbitration award, including interest at the legal rate, to the claimant within 20 days after the determination of damages by the arbitration panel or submit any dispute among multiple defendants to arbitration. Starting 90 days after the award, interest at the rate of 18 percent per year begins to accrue.

Section 766.212, F.S., provides for appeal of arbitration awards and allocation of financial responsibility among multiple defendants. An appeal does not stay an arbitration award. The district court of appeals may order a stay to prevent manifest injustice. Any party to an

arbitration proceeding may enforce an arbitration award or an allocation of financial responsibility by filing a petition in the circuit court for the circuit in which the arbitration took place.

Expert Witnesses in Medical Malpractice Actions

Standards of recovery in medical negligence cases are found in s. 766.102, F.S. 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 (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 or her 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 5-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. 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. The terms "medical specialty," "specialty," "specialist," and "discipline or school of practice" are not defined in the statutes. As a result, it is not uncommon for trial court judges to allow specialists to testify against non-specialists and general practitioners.

Setoff of Settlement Proceeds

Section 46.015, F.S., provides that if any person at trial shows that a plaintiff has delivered a written release or covenant not to sue to any person in partial satisfaction of the damages sued for, the court shall set off this amount from the amount of any judgment to which the plaintiff would be otherwise entitled at the time of the rendering of judgment. Section 768.041, F.S., provides that at trial, if any defendant shows the court that the plaintiff, or any person lawfully on his or her behalf, has delivered a release or covenant not to sue to any person, firm, or corporation in partial satisfaction of the damages sued for, the court shall set off this amount from the amount of any judgment to which the plaintiff would be otherwise entitled. The Florida Supreme Court has addressed whether a non-settling defendant is entitled to setoff or a reduction of damages based on payments by settling defendants in excess of their liability as apportioned by the jury. The court held that the setoff statutes apply to economic damages as found by the jury but not to noneconomic damages.[9]

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.[10] 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. However, in 1999, Florida law was amended to abolish the doctrine of joint and several liability for noneconomic damages, and to limit its application to economic damages.[11] Regarding economic damages, it established new limitations and maximum liability amounts, which increase with a defendant's share of fault and is dependent on whether the plaintiff was at fault

[9] See *Wells v. Tallahassee Memorial Regional Medical Center, Inc.*, 659 So.2d 249 (Fla. 1995). See also *Gouty v. Schnepel*, 795 So.2d 959 (Fla. 2001) in which the Florida Supreme Court held the setoff statutes do not apply to reduce a non-settling defendant's payment for liability. See *D'Angelo v. Fitzmaurice*, 832 So.2d 135, (2nd DCA 2002), in which the Second District Court of Appeals extended *Gouty* and held that setoff was not appropriate when a settling party was not placed on the jury verdict form.

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

[11] See ch. 99-225, L.O.F.; s. 768.81, F.S.

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.,[12] 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.

Itemized Verdicts and Alternative Methods of Payment of Damage Awards

Section 768.77, F.S., currently requires the jury in a civil trial to itemize the damages it awards to the plaintiff. The jury must separately determine the amounts for economic, noneconomic, and punitive damages, if any, and separately enter those amounts on the verdict form.
Section 768.78, F.S., currently requires the trier of fact in any action for damages based on personal injury or wrongful death arising out of medical malpractice, to make an award intended to compensate the claimant for future economic losses by one of the following means: the defendant may make a lump-sum payment; or the court shall, at the request of either party, enter a judgment ordering future economic damages as itemized by the jury pursuant to s. 768.77, F.S., to be paid by periodic payments rather than lump sum. "Periodic payment" is defined to mean provision for the spreading of future economic damage payments, in whole or in part, over a period of time, as follows:

- A specific finding of the dollar amount of periodic payment which will compensate for future damages after offset by collateral sources must be made;
- The defendant must post a bond or security to assure full payment of these damages awarded. The bond must be written by a company that is rated A+ by Bests. If the defendant is unable to adequately assure full payment of the damages, all damages reduced to present value shall be paid to the claimant; and
- The provision for payment of future damages must specify the recipient or recipients of payments.

Good Samaritan Act

Section 768.13, F.S., the "Good Samaritan Act," provides immunity from civil liability to:

- Any persons, including those licensed to practice medicine, who gratuitously and in good faith render emergency care or treatment either in direct response to emergency situations related to and arising out of a state of emergency which has been declared pursuant to s. 252.36, F.S., or at the scene of an emergency outside of a hospital, doctor's office, or other place having proper medical equipment;
- Any hospital, any employee of such hospital working in a clinical area within the facility and providing patient care, and any person licensed to practice medicine who in good faith renders medical care or treatment necessitated by a sudden, unexpected situation or

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

occurrence resulting in a serious medical condition demanding immediate medical attention, for which the patient enters the hospital through its emergency room or trauma center, or necessitated by a declared public health emergency. The act does not extend immunity from liability to acts of medical care or treatment *after stabilization* of the patient, unless surgery is required as a result of the emergency within a reasonable time after the patient is stabilized, in which case the immunity applies to any act or omission of medical care or treatment which occurs prior to stabilization of the patient following the surgery;

- Any person who is licensed to practice medicine, while acting as a staff member or with professional clinical privileges at a nonprofit medical facility, other than a hospital, or while performing health screening services for care and treatment provided gratuitously in such capacity; or
- Any person, including those licensed to practice veterinary medicine, who gratuitously and in good faith renders emergency care or treatment to an injured animal at the scene of an emergency on or adjacent to a roadway.

Section 768.13, F.S., establishes standards of conduct for each of these categories, in order for the immunity from liability to apply.

Sovereign Immunity

Article X, s. 13, of the State Constitution, authorized the Florida Legislature in 1868 to waive sovereign immunity by stating that, "Provision may be made by general law for bringing suit against the state as to all liabilities now existing or hereafter originating." The doctrine of sovereign immunity prohibits lawsuits in state court against a state government and its agencies and subdivisions without the government's consent. Section 768.28, F.S., provides that sovereign immunity for tort liability is waived for the state and its agencies and subdivisions. Section 768.28(5), F.S., imposes a $100,000 limit on the government's liability to a single person. For claims arising out of a single incident, the limit is $200,000. Section 768.28, F.S., outlines requirements for claimants alleging an injury by the state or its agencies. Section 1.066, F.S., requires a claimant to petition the Legislature in accordance with its rules, to seek an appropriation to enforce a judgment against the state or state agency. The exclusive remedy to enforce damage awards that exceed the recovery cap is by an act of the Legislature through the claims bill process. A claim bill is a bill that compensates an individual or entity for injuries or losses occasioned by the negligence or error of a public officer or agency.

Section 768.28(9), F.S., defines "officer, employee, or agent" to include, but not be limited to, any health care provider when providing services pursuant to s. 766.1115, F.S., any member of the Florida Health Services Corps, as defined in s. 381.0302, F.S., who provides uncompensated care to medically indigent persons referred by DOH, and any public defender or his or her employee or agent, including among others, an assistant public defender and an investigator.

The second form of sovereign immunity potentially available to private entities under contract with the government is set forth in s. 768.28(9), F.S. It states that agents of the state or its subdivisions are not personally liable in tort; instead, the government entity is held liable for its agent's torts. The factors required to establish an agency relationship are: (1) acknowledgment by the principal that the agent will act for him; (2) the agent's acceptance of the undertaking; and

(3) control by the principal over the actions of the agent.[13] The existence of an agency relationship is generally a question of fact to be resolved by the fact-finder based on the facts and circumstances of a particular case. In the event, however, that the evidence of an agency is susceptible of only one interpretation the court may decide the issue as a matter of law.[14]

General Regulatory Provisions for Health Care Practitioners

Chapter 456, F.S., provides the general regulatory provisions for health care professions within the Division of Medical Quality Assurance at DOH. Section 456.001, F.S., defines "health care practitioner" to mean any person licensed under ch. 457, F.S., (acupuncture); ch. 458, F.S., (medicine); ch. 459, F.S., (osteopathic medicine); ch. 460, F.S., (chiropractic medicine); ch. 461, F.S., (podiatric medicine); ch. 462, F.S., (naturopathic medicine); ch. 463, F.S., (optometry); ch. 464, F.S., (nursing); ch. 465, F.S., (pharmacy); ch. 466, F.S., (dentistry and dental hygiene); ch. 467, F.S., (midwifery); part I, II, III, IV, V, X, XIII, or XIV of ch. 468, F.S., (speech-language pathology and audiology, nursing home administration, occupational therapy, radiologic technology, respiratory therapy, dietetics and nutrition practice, athletic trainers, and orthotics, prosthetics, and pedorthics); ch. 478, F.S., (electrology or electrolysis); ch. 480, F.S., (massage therapy); part III or IV of ch. 483, F.S., (clinical laboratory personnel or medical physics); ch. 484, F.S., (opticianry and hearing aid specialists); ch. 486, F.S., (physical therapy); ch. 490, F.S., (psychology); and ch. 491, F.S., (psychotherapy).

Disciplinary Procedures

Section 456.073, F.S., sets forth procedures DOH must follow in order to conduct disciplinary proceedings against practitioners under its jurisdiction. The department, for the boards under its jurisdiction, must investigate all written complaints filed with it that are legally sufficient. Complaints are legally sufficient if they contain facts, which, if true, show that a licensee has violated any applicable regulations governing the licensee's profession or occupation. Even if the original complainant withdraws or otherwise indicates a desire that the complaint not be investigated or prosecuted to its completion, the department at its discretion may continue its investigation of the complaint. The department may investigate anonymous, written complaints or complaints filed by confidential informants if the complaints are legally sufficient and the department has reason to believe after a preliminary inquiry that the alleged violations are true. If the department has reasonable cause to believe that a licensee has violated any applicable regulations governing the licensee's profession, it may initiate an investigation on its own. When investigations of licensees within the department's jurisdiction are determined to be complete and legally sufficient, the department is required to prepare, and submit to a probable cause panel of the appropriate board, if there is a board, an investigative report along with a recommendation of the department regarding the existence of probable cause. A board has discretion over whether to delegate the responsibility of determining probable cause to the department or to retain the responsibility to do so by appointing a probable cause panel for the board. The determination as to whether probable cause exists must be made by majority vote of a probable cause panel of the appropriate board, or by the department if there is no board or if the board has delegated the probable cause determination to the department.

[13] *Goldschmidt v. Holman,* 571 So.2d 422 (Fla. 1990).
[14] *Campbell v. Osmond*, 917 F. Supp. 1574, 1583 (M.D. Fla. 1996). See also *Stoll v. Noel*, 694 So.2d 701 (Fla. 1997).

The licensee who is the subject of the complaint must be notified regarding the department's investigation of alleged violations that may subject the licensee to disciplinary action. When the department investigates a complaint, it must provide the subject of the complaint or his or her attorney a copy of the complaint or document that resulted in the initiation of the investigation. Within 20 days after the service of the complaint, the subject of the complaint may submit a written response to the information contained in the complaint. The department may conduct an investigation without notification to the licensee if the act under investigation is a criminal offense. If the department's secretary or his or her designee and the chair of its probable cause panel agree, in writing, that notification to the licensee of the investigation would be detrimental to the investigation, then the department may withhold notification of the licensee.

If the licensee who is the subject of the complaint makes a written request and agrees to maintain the confidentiality of the information, the licensee may review the department's complete investigative file. The licensee may respond within 20 days of the licensee's review of the investigative file to information in the file before it is considered by the probable cause panel. Complaints and information obtained by the department during its investigations are exempt from the public records law until 10 days after probable cause has been found to exist by the probable cause panel or the department, or until the subject of the investigation waives confidentiality. If no probable cause is found to exist, the complaints and information remain confidential in perpetuity.

When the department presents its recommendations regarding the existence of probable cause to the probable cause panel of the appropriate board, the panel may find that probable cause exists or does not exist, or it may find that additional investigative information is necessary in order to make its findings regarding probable cause. Probable cause proceedings are exempt from the noticing requirements of ch. 120, F.S. After the panel convenes and receives the department's final investigative report, the panel may make additional requests for investigative information. Section 456.073(4), F.S., specifies time limits within which the probable cause panel may request additional investigative information from the department and within which the probable cause panel must make a determination regarding the existence of probable cause. Within 30 days of receiving the final investigative report, the department or the appropriate probable cause panel must make a determination regarding the existence of probable cause. The secretary of the department may grant an extension of the 15-day and 30-day time limits outlined in s. 456.073(4), F.S. If the panel does not issue a letter of guidance or find probable cause within the 30-day time limit as extended, the department must make a determination regarding the existence of probable cause within 10 days after the time limit has elapsed.

Instead of making a finding of probable cause, the probable cause panel may issue a letter of guidance to the subject of a disciplinary complaint. Letters of guidance do not constitute discipline. If the panel finds that probable cause exists, it must direct the department to file a formal administrative complaint against the licensee under the provisions of ch. 120, F.S. The department has the option of not prosecuting the complaint if it finds that probable cause has been improvidently found by the probable cause panel. In the event the department does not prosecute the complaint on the grounds that probable cause was improvidently found, it must refer the complaint back to the board that then may independently prosecute the complaint. The department must report to the appropriate board any investigation or disciplinary proceeding not before DOAH under ch. 120, F.S., or otherwise not completed within 1 year of the filing of the

complaint. The appropriate probable cause panel then has the option to retain independent legal counsel, employ investigators, and continue the investigation, as it deems necessary.
When an administrative complaint is filed against a licensee based on an alleged disciplinary violation, the subject of the complaint is informed of his or her right to request an informal hearing if there are no disputed issues of material fact, or a formal hearing if there are disputed issues of material fact or the subject disputes the allegations of the complaint. The licensee may waive his or her rights to object to the allegations of the complaint, which allows the department to proceed with the prosecution of the case without the licensee's involvement. Once the administrative complaint has been filed, the licensee has 21 days to respond to the department. If the subject of the complaint and the department do not agree in writing that there are no disputed issues of material fact, s. 456.073(5), F.S., requires a formal hearing before a hearing officer of DOAH under ch. 120, F.S. The hearing provides a forum for the licensee to dispute the allegations of the administrative complaint.

At any point before an administrative hearing is held, the licensee and the department may reach a settlement. The settlement is prepared by the prosecuting attorney and sent to the appropriate board. The board may accept, reject, or modify the settlement offer. If accepted, the board may issue a final order to dispose of the complaint. If rejected or modified by the board, the licensee and department may renegotiate a settlement or the licensee may request a formal hearing. If a hearing is held, the hearing officer makes findings of fact and conclusions of law that are placed in a recommended order. The licensee and the department's prosecuting attorney may file exceptions to the hearing officer's findings of facts. The boards resolve the exceptions to the hearing officer's findings of facts when they issue a final order for the disciplinary action.

The boards within DOH have the status of an agency for certain administrative actions, including licensee discipline. A board may issue an order imposing discipline on any licensee under its jurisdiction as authorized by the profession's practice act and the provisions of ch. 456, F.S. Typically, boards are authorized to impose the following disciplinary penalties against licensees: (1) refusal to certify, or to certify with restrictions, an application for a license; (2) suspension or permanent revocation of a license; (3) restriction of practice or license; (4) imposition of an administrative fine for each count or separate offense; (5) issuance of a reprimand or letter of concern; (6) placement of the licensee on probation for a specified period of time and subject to specified conditions; or (7) corrective action.

Alternatives to Disciplinary Actions

Notwithstanding s. 456.073, F.S., the board, or department if there is no board, must adopt rules to permit the issuance of citations. The citation must clearly state that the subject may choose, in lieu of accepting the citation, to follow the standard procedures for a disciplinary action under s. 456.073, F.S. If the subject does not dispute the matter in the citation within 30 days after the citation is served, the citation becomes a final order and constitutes discipline. The penalty for a citation must be a fine or other conditions as established by rule.

Notwithstanding s. 456.073, F.S., the board or department if there is no board, must adopt rules to designate which violations of the applicable practice act are appropriate for mediation. They may designate as mediation offenses those complaints where harm caused by the licensee is economic in nature or can be remedied by the licensed health care practitioner.

Administrative Law

Except as provided in the specified exceptions in ss. 120.80 and 120.81, F.S., an administrative law judge assigned by DOAH must conduct all hearings involving the substantial interests of a party affected by an agency action except for hearings before agency heads or a member thereof.[15] In disciplinary cases involving professionals licensed by DOH, formal hearings may not be conducted by the Secretary of DOH, or a board or member of a board within DOH for matters relating to the regulation of professions.[16] For disciplinary cases involving licensed health care practitioners under the Division of Medical Quality Assurance within DOH, a formal hearing before an administrative law judge from DOAH must be held pursuant to the Administrative Procedure Act (ch. 120, F.S.), if there are any disputed issues of material fact.[17] The administrative law judge must issue a recommended order pursuant to ch. 120, F.S. If any party raises an issue of disputed fact during an informal hearing, the hearing must be terminated and a formal hearing pursuant to ch. 120, F.S., must be held.

When an administrative complaint is filed against a subject based on an alleged disciplinary violation, the subject of the complaint is informed of his or her right to request an informal hearing if there are no disputed issues of material fact, or a formal hearing if there are disputed issues of material fact or the subject disputes the allegations of the complaint.[18] The subject may waive his or her rights to object to the allegations of the complaint, which allows the department to proceed with the prosecution of the case without the licensee's involvement. Once the administrative complaint has been filed, the licensee has 21 days to respond to the department.

When an administrative complaint involving a licensed health care practitioner is referred to DOAH, the affected party is granted a de novo hearing involving disputed issues of fact to be conducted by an administrative law judge. After hearing the evidence presented in the case, the administrative law judge renders a recommended order that includes findings of fact, conclusions of law, and a recommended penalty or disposition.[19] The board or DOH, as appropriate, may adopt the recommended order, or may reject or modify the findings of fact.[20] Findings of fact in a recommended order may not be rejected or modified unless the department (board or DOH) states with particularity in its final order that the findings were not based upon competent substantial evidence or that the proceedings on which the findings are based did not comply with the essential requirements of law.[21] The department is not permitted to weigh the evidence, judge the credibility of the witnesses, or interpret the evidence to fits its ultimate conclusions.[22] The

[15] See s. 120.57(1)(a), F.S.
[16] See s. 120.80(15), F.S. See also s. 120.80(4)(b), F.S., which contains a similar provision prohibiting the Secretary of the Department of Business and Professional Regulation (DBPR) or any board or member of a board within the department from conducting formal hearings for matters relating to the regulation of professions by DBPR.
[17] See s. 456.073(5), F.S.
[18] See s. 456.073(5), F.S. See also s. 120.60(5), F.S., which provides that in a proceeding, which involves the revocation, suspension, annulment, or withdrawal of any license, the agency must serve an administrative complaint and must provide the licensee an opportunity to request a hearing pursuant to ss. 120.569 and 120.57, F.S.
[19] See s. 120.57(1)(k), F.S.
[20] Boards are agencies for purposes of disciplinary action pursuant to s. 120.57, F.S.
[21] See s. 120.57(1)(l), F.S.
[22] See *Gross v. Department of Health*, 819 So.2d 997, 1001 (Fla. 5th DCA 2002).

agency may not rely on its own expertise to reverse the administrative law judge's finding that a particular statute was violated.[23]

One exception under which an agency may reverse an administrative law judge is under the "deference rule." The "deference rule" recognizes that policy considerations left to the discretion of an agency may take precedence over findings of fact by an administrative law judge. The rule provides that matters that are susceptible to ordinary methods of proof, such as determining the credibility of witnesses or the weight to accord evidence, are factual matters to be determined by the hearing officer. On the other hand, matters infused with overriding policy considerations are left to agency discretion.[24]

In cases involving issues that are determinable by ordinary methods of proof through the weighing of evidence and the judging of the credibility of witnesses, courts in Florida have held that such functions are "solely the prerogative of the hearing officer as finder of fact.[25] Courts have generally held that the issue of whether an individual violated a statute by breaching the applicable standard of care is a factual issue that is susceptible to ordinary methods of proof and is an issue that is not infused with policy considerations."[26] The Third District Court of Appeal in wrestling with this issue declared that:

> [I]t is settled Florida doctrine that the rule which ascribes effect to an agency's determination of ultimate 'facts' on a subject about which it may rightfully claim expert insight, which originated in McDonald v. Department of Banking and Finance, 346 So.2d 569, 579 (Fla. 1st DCA 1977), is not applicable to disciplinary proceedings in general, and to ones like this which are based upon an alleged breach of a broad standard of conduct in particular. In such an instance, the issue of whether the licensee's conduct was indeed in violation of a statutory standard is one of fact which not only must be established by 'conventional' proof, but as to which the prosecuting agency bears a significantly enhanced burden.[27]

The court was concerned that in disciplinary proceedings, the board has the burden of proving the applicable standard of conduct by competent substantial evidence and made a distinction between evidence which substantially supports conventional forms of regulatory action and evidence which is required to support substantially "a retrospective characterization of conduct

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[23] *Id* .at 1001.

[24] See *Baptist Hosp., Inc. v. Department of Health & Rehabilitative Servs*., 500 So.2d 620, 623 (Fla. 1st DCA 1986) and *McDonald v. Department of Banking & Finance*, 346 So.2d 569 (Fla. 1st DCA 1977).

[25] Id. at 1003. See also, *B.B. v. Department of Health &Rehabilitative Servs.*, 542 So.2d 1362, 1364 (Fla. 3d DCA 1989) (quoting *Holmes v. Turlington*, 480 So.2d 150, 153 (Fla. 1st DCA 1985).

[26] *Id.* at 1003. The court also noted that whether a doctor deviated from the applicable standard of care is an issue of fact to be determined by the administrative judge. See also *Hoover v. Agency for Health Care Admin.*, 676 So.2d 1380 (Fla. 3d DCA 1996); *Nest v. Department of Prof'l Regulation, Bd. Of Med. Exam'rs*, 490 So.2d 987 (Fla. 1st DCA 1986); *Holmes; Johnston v. Department of Prof'l Regulation, Bd. Of Med Exam'rs*, 456 So.2d 939 (Fla. 1st DCA 1984); *Bush v. Brogan*, 725 So.2d 1237 (Fla. 2d DCA 1999).

[27] *Cohn v. Department of Prof'l Regulation*, 477 So.2d 1039, 1046 (Fla. 3d DCA 1985).

requiring suspension or revocation of the actor's license." The court held that an agency may not rely upon its own expertise to retrospectively reverse a hearing officer's finding of no violation.[28]

A conclusion of law that is based on the application of rules of law is also issued as part of the hearing officer's order and, up until recent changes in the law, did not come to the agency with a presumption of correctness. The reviewing agency was free to disagree with the hearing officer's conclusions of law and could substitute its own. In 1999, the Legislature further narrowed an agency's authority to reject or modify a hearing officer's recommended conclusions of law by requiring that the agency state with particularity its reason for rejecting or modifying the recommended conclusion of law and by requiring that the agency find that its substituted conclusion of law is as, or more, reasonable than the rejected or modified conclusion.[29] Further, the agency in its final order may reject or modify only those conclusions of law over which the agency has substantive jurisdiction.[30]

Practitioner Profiles

Section 456.039, F.S., requires each licensed physician, osteopathic physician, chiropractic physician, and podiatric physician to submit specified information which, beginning July 1, 1999, has been compiled into practitioner profiles to be made available to the public. The information must include: graduate medical education; hospitals at which the physician has privileges; the address at which the physician will primarily conduct his or her practice; specialty certification; the year the physician began practice; faculty appointments; a description of any criminal offense committed; a description of any final disciplinary action taken within the most recent 10 years; and professional liability closed claims reported to DOI within the most recent 10 years exceeding $5,000. In addition the physician may submit: professional awards and publications; languages, other than English, used by the physician to communicate with patients; and an indication of whether the physician participates in the Medicaid program. Each person who applies for initial licensure as a medical physician, osteopathic physician, chiropractic physician, or podiatric physician must, at the time of application, and, in conjunction with the renewal of the license, submit the information required for practitioner profiles.

Centers for Patient Safety

One entity in Florida has been designated as a national center for patient safety. A partnership between the University of South Florida, Health Sciences Center and the Veteran's Health Administration has resulted in the formal designation of the University of South Florida as the State's only National Center for Patient Safety Research and Evaluation by the Federal Agency for Healthcare Research and Quality, and of the partnership as a National Patient Safety Center of Inquiry by the Veteran's Administration.

In 2002, the Florida State University, College of Medicine established a Center on Patient Safety to promote and conduct research and education designed to reduce medical errors and increase

[28] *Id.* at 1047. See also *Heifetz v. Department of Business Regulation*, 475 So.2d 1277 (Fla. 1st DCA 1985); *Purvis v Professional Regulation*, 461 So.2d 134 (Fla. 1st DCA 1984); *Johnston v. Department of Professional Regulation*, 456 So.2d 939 (Fla. 1st DCA 1984); *Sneij v. Department of Professional Regulation*, 454 So.2d 795 (Fla. 3d DCA 1984).
[29] See Section 6, chapter 99-379, Laws of Florida.
[30] Id.

healthcare quality. The Center on Patient Safety at Florida State uses research data as the basis for wider discussions toward formulating a state and national agenda for patient safety research and medical error reduction and to stimulate increased funding in this area. The Center on Patient Safety promotes a reduction of medical errors by providing leadership and policy expertise, professional advocacy, tools and education, and by creating alliances and partnerships.

Adverse Incident Reporting

Hospitals, ambulatory surgical centers, and mobile surgical facilities must be licensed under ch. 395, F.S. Chapter 395, F.S., imposes requirements on these facilities that include inspection and accreditation, and reporting of adverse incidents that result in serious patient injury. Hospitals, ambulatory surgical centers, and mobile surgical facilities, under s. 395.0197(8), F.S., must report the following incidents within 15 calendar days after they occur to AHCA: death of a patient; brain or spinal damage to a patient; performance of a surgical procedure on the wrong patient; performance of a wrong-site surgical procedure; performance of a wrong surgical procedure; performance of a surgical procedure that is medically unnecessary or otherwise unrelated to the patient's diagnosis or medical condition; surgical repair of damage resulting to the patient from a planned surgical procedure where damage is not a recognized specific risk, as disclosed to the patient and documented through the informed consent process; or performance of procedures to remove unplanned foreign objects remaining in a patient following surgery.

Under s. 395.0197(8), F.S., the incident reports filed with AHCA may not be made available to the public under s. 119.07(1), F.S., or any other law providing access to public records, nor be discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by DOH or the appropriate regulatory board. The incident reports may not be made available to the public as part of the records of investigation for and prosecution in disciplinary proceedings that are made available to the public. DOH or the appropriate regulatory board must make available, upon written request by a health care professional against whom probable cause has been found, any such records which form the basis of the determination of probable cause. DOH must review each incident and determine whether it potentially involved conduct by the health care professional who is subject to disciplinary action under the provisions of s. 456.073, F.S.

Section 400.147, F.S., requires nursing homes to have an internal risk management and quality assurance program and report adverse incidents to AHCA.

Sections 458.351 and 459.026, F.S., require any medical physician, osteopathic physician, or physician assistant to notify DOH of any adverse incident that involved the physician or physician assistant which occurred on or after January 1, 2000, in any office maintained by the physician for the practice of medicine that is not licensed under ch. 395, F.S. The sections require any medical physician, osteopathic physician, or physician assistant to notify the department in writing and by certified mail of the adverse incident within 15 days after the adverse incident occurred. The notice must be postmarked within 15 days after the adverse incident occurred.

Confidentiality of Patient Records

Section 456.057, F.S., provides that medical records are confidential and, absent certain exceptions, they cannot be shared with or provided to anyone without the consent of the patient. Subsection (5) identifies the circumstances when medical records may be released without written authorization from the patient. The circumstances are as follows:

- To any person, firm, or corporation that has procured or furnished such examination or treatment with the patient's consent;
- When compulsory physical examination is made pursuant to Rule 1.360, Florida Rules of Civil Procedure, in which case copies of the medical records shall be furnished to both the defendant and the plaintiff;
- In any civil or criminal action, unless otherwise prohibited by law, upon the issuance of a subpoena from a court of competent jurisdiction and proper notice to the patient or the patient's legal representative by the party seeking such records; or
- For statistical and scientific research, provided the information is abstracted in such a way as to protect the identity of the patient or provided written permission is received from the patient or the patient's legal representative.

The Florida Supreme Court has addressed the issue of whether a health care provider, absent any of the above-referenced circumstances, can disclose confidential information contained in a patient's medical records as part of a medical malpractice action.[31] The court ruled that, pursuant to s. 455.241, F.S., (the predecessor to current s. 456.057(6), F.S.), only a health care provider who is a defendant, or reasonably expects to become a defendant, in a medical malpractice action can discuss a patient's medical condition. The court also held that the health care provider can only discuss the patient's medical condition with his or her attorney in conjunction with the defense of the action. The court determined that a defendant's attorney cannot have ex parte discussions about the patient's medical condition with any other treating health care provider.

Under s. 456.057(7), F.S., DOH may obtain patient records pursuant to a subpoena without written authorization from the patient, if the department and the probable cause panel of the appropriate board find reasonable cause to believe that a health care practitioner has excessively or inappropriately prescribed any controlled substance violating ch. 893, F.S, relating to controlled substances or any professional practice act, or that a health care practitioner has practiced his or her profession below that level of care, skill, and treatment required by law and also find that reasonable attempts were made to obtain a patient release.

The department may obtain patient records and insurance information pursuant to a subpoena without written authorization from a patient if the department and the probable cause panel of the appropriate board, if any, find reasonable cause to believe that a health care practitioner has provided inadequate medical care based on the termination of insurance and also find that reasonable attempts were made to obtain a patient release.

The department may obtain patient records, billing records, insurance information, and provider contracts pursuant to a subpoena without written authorization from the patient if the department and probable cause panel of the appropriate board, if any, find reasonable cause to believe that a

[31] *Acosta v. Richter*, 671 So.2d 149 (Fla. 1996).

health care practitioner has submitted a claim, statement, or bill using a billing code that would result in payment greater in amount than would be paid using the appropriate billing code; used information derived from an automobile accident report to solicit or obtain patients personally or through an agent; solicited patients fraudulently; received a kickback; violated patient brokering provisions; presented a false or fraudulent insurance claim; or patient authorization cannot be obtained because the patient cannot be located or is deceased, incapacitated, or suspected of being a participant in the fraud or scheme; and if the subpoena is issued for specific and relevant records.

Financial Responsibility and Closed Claims

Sections 458.320 and 459.0085, F.S., require Florida-licensed allopathic and osteopathic physicians to maintain professional liability insurance or other specified financial responsibility to cover potential claims for medical malpractice as a condition of licensure, with specified exemptions. Physicians who have hospital privileges must maintain professional liability insurance or other financial responsibility to cover an amount not less than $250,000 per claim. Physicians without hospital privileges must carry sufficient insurance or other financial responsibility in coverage amounts of not less than $100,000 per claim. Physicians who do not carry professional liability insurance must provide notice to their patients. A physician is said to be "going bare" when that physician has elected not to carry professional liability insurance. Physicians who go bare must either provide notice by posting a sign which is prominently displayed in the reception area and clearly noticeable by all parties or provide a written statement to each patient. Such sign or statement must state:

> Under Florida law, physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. YOUR DOCTOR HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This is permitted under Florida law subject to certain conditions. Florida imposes penalties against noninsured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is provided pursuant to Florida law.

With specified exceptions, DOH must suspend on an emergency basis, any licensed allopathic or osteopathic physician who fails to satisfy a medical malpractice claim against him or her within specified time frames.

Section 627.912, F.S., requires insurers to report "closed claims" that involve any action for damage for personal injuries in the performance of professional services by a Florida-licensed medical physician, osteopathic physician, podiatric physician, dentist, hospital, crisis stabilization unit, health maintenance organization, ambulatory surgical center, or attorney to DOI. DOH must review each closed claim involving a Florida-licensed medical physician, osteopathic physician, podiatric physician, or dentist and determine whether any of the incidents that resulted in the claim involved conduct by the licensed health care practitioner that is subject to disciplinary action.

Section 456.049, F.S., requires medical physicians, osteopathic physicians, physician assistants, podiatric physicians, and dentists to report "closed claims" for damages for personal injury that

are alleged to have been caused by the negligence of the practitioner that are not covered by an insurer and reported as a closed claim under s. 627.912, F.S., to DOH. Section 456.051, F.S., specifies that "closed claims" reported under s. 456.049 and s. 627.912, F.S., to DOH are public information except for the name of the claimant or injured person. Any information that DOH possesses that relates to a bankruptcy proceeding by a medical physician, osteopathic physician, physician assistant, podiatric physician, or dentist is public information.

Discipline for Gross or Repeated Malpractice

Sections 458.331 and 459.015, F.S., provide grounds for which an allopathic or osteopathic physician may be subject to discipline by his or her board. Allopathic and osteopathic physicians may be subject to discipline for gross or repeated malpractice or the failure to practice medicine with that level of care, skill, and treatment recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances. "Repeated malpractice" includes, but is not limited to, three or more claims for medical malpractice within the previous 5-year period resulting in indemnities being paid in excess of $25,000. If it is reported that a physician has had three or more claims with indemnities exceeding $25,000 each within the previous 5-year period, DOH must investigate the occurrences upon which the claims were based and determine if action by the department against the physician is warranted.

Similarly, s. 461.013, F.S., provides that a podiatric physician may be subject to discipline for gross or repeated malpractice or the failure to practice podiatric medicine at a level of care, skill, and treatment which is recognized by a reasonably prudent podiatric physician as being acceptable under similar circumstances and conditions. "Repeated malpractice" includes but is not limited to, three or more claims for medical malpractice within the previous 5-year period resulting in indemnities being paid in excess of $10,000. A dentist is subject to discipline for "dental malpractice" which includes but is not limited to, three or more claims within the previous 5-year period which resulted in indemnity being paid, or any single indemnity paid in excess of $5,000 in a judgment or settlement, as a result of negligent conduct on behalf of the dentist.

HMO Liability

In *Villazon v. Prudential Health Care Plan*, Inc.,[32] the Florida Supreme Court held that section 514(a) of the Employee Retirement Income Security Act (ERISA) did not preempt a plaintiff's claim against an HMO (health maintenance organization) claiming that the HMO was vicariously liable for the asserted medical malpractice of treating physicians precluding summary judgment. In *Villazon*, the trial court entered summary judgment in favor of the HMO which was affirmed on appeal by the district court of appeal. The Supreme Court rejected the HMO's preemption defense and on appeal held that the plaintiff's complaint for vicarious liability which was based upon allegations of negligent failure to provide adequate medical treatment for his wife's cancer is not subject to ERISA conflict preemption and therefore precluded summary judgment. The plaintiff based his vicarious liability claim against the defendant on allegations that agents or apparent agents of the defendant made negligent treatment decisions in caring for

[32] *Villazon v. Prudential Health Care Plan*, Inc., 2003 WL 1561528 (Fla.).

the plaintiff's deceased wife. The court held that ERISA does not preempt state law that regulates the provision of adequate medical treatment.

In *Villazon*, the court cited three theories upon which vicarious liability was sought to be imposed: a nondelegable duty under the Health Maintenance Organization Act (ss. 641.17 – 641.3923, F.S.); common law actual agency; and common law apparent agency. In rejecting the nondelegable duty theory, the court held that state law does not create a private right of action for damages based upon an alleged violation of its requirements. The court concluded that sufficient record evidence has been adduced to withstand the defendant-HMO's motion for summary judgment with respect to the claim of vicarious liability. With regard to this issue, the court remanded the case to the district court for further proceedings to determine whether the defendant can be held vicariously liable for the alleged medical negligence of its member physicians when providing service pursuant to the defendant-HMO under theories of actual agency.

Governor's Select Task Force on Healthcare Professional Liability Insurance

In recognition of the problems 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 13 volumes that accompany the main report.

III. Effect of Proposed Changes:

Section 1. Provides 18 legislative findings regarding the crisis relating to medical malpractice insurance, including:

- Florida is in the midst of a medical malpractice insurance crisis of unprecedented magnitude and this crisis threatens the quality and availability of health care for all Florida citizens;
- The rapidly growing population and changing demographics of Florida make it imperative that students continue to choose Florida as the state in which to receive their medical educations, and practice medicine;
- The increase in medical malpractice liability insurance rates is forcing physicians to practice medicine without professional liability insurance, to leave Florida, to not perform high-risk procedures, or to retire early from the practice of medicine;

- The Governor's Select Task Force on Healthcare Professional Liability Insurance has established that a medical malpractice insurance crisis exists in Florida which can be alleviated by the adoption of comprehensive legislatively enacted reforms;
- There is an overwhelming public necessity to make high-quality health care available to the citizens of this state, to ensure that physicians continue to practice in Florida, and to ensure the availability of affordable professional liability insurance for physicians; and
- These overwhelming public necessities cannot be met unless a cap on noneconomic damages is imposed.

Section 2. Creates s. 395.0056, F.S., to provide that when AHCA receives, pursuant to s. 766.106, F.S., a complaint alleging medical malpractice filed against a hospital, it is to review its files to determine whether the hospital has complied with the adverse incident reporting requirements of s. 395.0197, F.S., and whether the incident that is the basis for the complaint can be the subject of a disciplinary proceeding.

Section 3. Amends s. 395.0191, F.S., to provide that there will be no cause of action for *injunctive relief* or damages against any licensed facility, its governing board, board members, or staff arising out of or relating to carrying out activities relating to staff membership or clinical privileges at a hospital, ambulatory surgical center, or mobile surgical facility, absent intentional fraud. The condition that the immunity applies only if the action is taken in good faith is deleted.

Section 4. Amends s. 395.0197, F.S., revising the requirements for the internal risk management program that every hospital, ambulatory surgical center, or mobile surgical facility must implement to: require facilities to report to AHCA and DOH the name and judgments entered against each health care practitioner for which it assumes liability; and require a facility to have a system by which the patient, patient's family member, or patient's designated representative is notified that the patient was the subject of an adverse incident. The bill deletes the requirement that a hospital, ambulatory surgical center, or mobile surgical facility must notify AHCA within 1 business day after the risk manager becomes aware that an adverse incident occurred. With this change, AHCA would receive notification within 15 calendar days, as provided in this section.

Section 5. Repeals s. 395.0198, F.S., which provides a public records exemption for information contained in a notification of an adverse incident that a hospital, ambulatory surgical center, or mobile surgical facility must report to AHCA within 1 business day after the risk manager becomes aware that the incident occurred. This exemption is scheduled for repeal on October 2, 2003 unless it is reenacted by the Legislature.

Section 6. Creates s. 395.1012, F.S., to require each licensed hospital, ambulatory surgical center, and mobile surgical facility to adopt a patient safety plan. Any plan adopted to implement the requirements of 42 CFR, part 482.21[33] shall be deemed to comply with this requirement. Each licensed facility must appoint a patient safety officer and a patient safety committee. The officer and committee must promote the health and safety of patients, review and evaluate the

[33] 42 CFR part 482.21 requires hospitals, as a condition of participation in the Medicare program, to develop, implement, and maintain an effective, ongoing, hospital-wide, data-driven quality assessment and performance improvement program. The hospital's governing body must ensure that the program reflects the complexity of the hospital's organization and services; involves all hospital departments and services (including those services furnished under contract or arrangement); and focuses on indicators related to improved health outcomes and the prevention and reduction of medical errors.

quality of patient safety measures used by the facility, and assist in the implementation of the facility safety plan.

Section 7. Creates s. 395.1051, F.S., to require an appropriately trained person designated by each facility licensed under ch. 395, F.S., to inform each patient or personal representative of the patient of adverse incidents that result in harm to the patient. Such notice does not constitute acknowledgement or admission of liability nor can it be introduced as evidence.

Section 8. Creates s. 456.0575, F.S., to require every Florida-licensed health care practitioner to inform each patient or personal representative of the patient of adverse incidents that result in harm to the patient. Such notice does not constitute acknowledgement or admission of liability nor can it be introduced as evidence.

Section 9. Creates an undesignated section of law to extend immunity from civil liability to each member of, or health care professional consultant to, any committee, board, group, commission, or other entity for any act, decision, omission, or utterance done or made in the performance of his or her duties while serving as a member or consultant to such committee, board, group, commission, or other entity established and operated for purposes of quality improvement review, evaluation, and planning in a state licensed health care facility. The act, decision, omission, or utterance may not be made or done in bad faith or with malicious intent. Such entities must function primarily to review, evaluate, or make recommendations relating to:

- The duration of patient stays in health care facilities;
- The professional services furnished with respect to the medical, dental, psychological, podiatric, chiropractic, or optometric necessity for such services;
- The purpose of promoting efficient use of available health care facilities and services;
- The adequacy or quality of professional services;
- The competency and qualifications for professional staff privileges;
- The reasonableness or appropriateness of charges made by or on behalf of health care facilities; or
- Patient safety.

The committee, board, group, commission, or other entity must be established in accordance with requirements of the Joint Commission on Accreditation of Healthcare Organizations, established and duly constituted by one or more public or licensed private hospitals or behavioral health agencies, or established by a governmental agency.

Section 10. Creates an undesignated section of law to establish a privilege from discovery or introduction into evidence in any civil or administrative action for patient safety data. The terms "patient safety data" and "patient safety organization" are defined.

A patient safety organization must promptly remove all patient-identifying information after receipt of a complete patient safety data report unless such organization is otherwise permitted by state or federal law to maintain such information. The exchange of patient safety data among health care providers or patient safety organizations which does not identify any patient shall not constitute a waiver of any privilege established under this section. Reports of patient safety data to patient safety organizations do not abrogate obligations to make reports to DOH, AHCA, or

other state or federal regulatory agencies. Employers are prohibited from taking retaliatory actions against an employee who in good faith makes a report of patient safety data to a patient safety organization. The patient safety privilege does not make information, documents or records otherwise available from original sources immune from discovery or use in any civil or administrative action because they were collected, analyzed, or presented to a patient safety organization. The privilege does not prevent any person who testifies before a patient safety organization or members of the organization from testifying about any matter within his or her knowledge.

Section 11. Amends s. 456.013, F.S., to require the Board of Medicine and the Board of Osteopathic Medicine to include information related to the five most misdiagnosed conditions during the previous biennium, as determined by the board, in the already required 2-hour continuing education course relating to prevention of medical errors.

Section 12. Amends s. 456.025, F.S., relating to DOH's or a board's authority to set license renewal fees for health care practitioners within the department's Division of Medical Quality Assurance, to delete the provision that limits the department's or board's authority to set license renewal fees which are no more than ten percent greater than the fee imposed during the previous 2-year licensure period.

Section 13. Amends s. 456.039, F.S., relating to practitioner profiles, to require licensed physicians to provide to DOH relevant professional qualifications, as defined by the applicable board, to be included in that physician's profile.

Section 14. Amends s. 456.041, F.S., relating to practitioner profiles, to require DOH to develop a format to compile uniformly any information submitted by certain health care practitioners. DOH must update the practitioner profile within 30 calendar days with information that the practitioner is required to provide and verify. Each profile must indicate whether the criminal history information included in the practitioner profile is, or is not, corroborated by a criminal history check. The department or the board having regulatory authority over the practitioner must investigate any information received, and the limitations under current law which narrow such investigations to "reasonable grounds to believe that the practitioner has violated any law that relates to the practitioner's practice" are deleted.

The department must provide in each practitioner profile an easy-to-read narrative description of every final disciplinary action taken against the practitioner that explains the administrative complaint and the final discipline imposed on the practitioner. The department must include a hyperlink to each final order listed in its website report of dispositions of recent disciplinary actions taken against practitioners. Professional liability claims reported by medical physicians and osteopathic physicians during the previous 10 years that exceed $100,000 must be included in the practitioner profile. The department must include a hyperlink to comparison reports of closed claims filed against a practitioner in the practitioner's profile.

The department must include in the practitioner profiles the date of any disciplinary action taken by a licensed hospital or ambulatory surgical center against a practitioner. The department must state whether the action related to professional competence and whether it related to the delivery of services to a patient.

DOH would no longer have to consult with the board having jurisdiction over a practitioner to include information in the practitioner's profile that is a public record and relates to the practitioner's ability to competently practice his or her profession. The department must make a practitioner's profile available at the end of a 30-day period under which the practitioner may review and verify the factual accuracy of the contents of the profile. The practitioner is required to review and verify the accuracy of his or her profile and is made subject to a fine of up to $100 per day for a failure to verify the profile contents and to correct any factual errors in his or her profile within the 30-day period.

DOH must include a statement in each profile that has not been reviewed by the practitioner stating that the practitioner has not verified the information contained in the profile. Each profile must contain an easy-to-read explanation of any disciplinary action taken and the reason that sanctions were imposed. DOH may provide one link in each profile to a practitioner's professional website if the practitioner requests that such a link be included in his or her profile.

Section 15. Amends s. 456.042, F.S., to require a practitioner to submit updates of required information within 15 days after the final activity that renders such information a fact. An updated profile is subject to the same requirements as an original profile.

Section 16. Amends s. 456.049, F.S., to delete the requirement in current law for health care practitioners to report closed claims to DOH, and cross-references the requirement in s. 627.912, F.S., that such practitioners report closed claims to OIR.

Section 17. Amends s. 456.051, F.S., to require DOH, within 30 calendar days of its receipt, to make available as part of a practitioner's profile any report of a claim for damages filed with the department by a practitioner or his or her insurer as a closed claim or any bankruptcy proceeding involving the practitioner that the department has obtained.

Section 18. Amends s. 456.057, F.S., relating to ownership and control of patient records, to authorize DOH to obtain patient records pursuant to subpoena without written authorization from the patient when DOH investigates a professional liability claim or undertakes action based on its receipt of information in a professional liability claim, if the patient refuses to cooperate. The department's access to the patient records is also conditioned on a showing by the department of its attempt to obtain a patient release and the failure to obtain the patient records would be detrimental to the investigation.

Section 19. Amends s. 456.072, F.S., to authorize health care practitioner regulatory boards or DOH to determine the amount of costs related to investigation and prosecution to be assessed in disciplinary cases involving a health care practitioner after its consideration of an affidavit of itemized costs and any written objections thereto. Such costs related to the investigation and prosecution include, but are not limited to, salaries and benefits of personnel, costs related to the time spent by an attorney and other personnel working on a case, and any other expenses incurred by the department for the case.

Section 20. Amends s. 456.073, F.S., to provide that DOH may investigate, notwithstanding an existing 6-year statute of limitations on the investigation or filing of administrative complaints, paid liability claims information about medical and osteopathic physicians that have been

reported within the previous 6 years where the indemnity paid is greater than $50,000. The determination of whether a licensee has violated the laws and rules regulating the profession, including a determination of the reasonable standard of care, is a conclusion of law and not a finding of fact. The right of a licensed health care practitioner to elect a formal hearing is revised from any circumstance during a proceeding in which a party raises an issue of disputed fact during an informal hearing to affirmatively require the licensee to dispute an issue of material fact and request a formal hearing within 45 days after service of the administrative complaint.

Section 21. Amends s. 456.077, F.S., to specify that the issuance of a citation may not include standard of care violations involving patient injury and that each citation issued to a licensed health care practitioner by DOH for a first offense, and not disputed by the practitioner, does not constitute discipline for a first offense. However, such a citation does constitute discipline for a second or subsequent offense.

Section 22. Amends s. 456.078, F.S., to revise designation of violations of professional practice that are appropriate for mediation. A professional board, or DOH if there is no board, must designate as a mediation offense, an offense that is economic in nature except for intentional misconduct; that can be remedied by the licensee; that is not a standard of care violation involving injury to the patient; and that does not result in an adverse incident as defined in the bill. A successful mediation does not constitute discipline.

Section 23. Amends s. 458.320, F.S., relating to the financial responsibility requirements for medical physicians to require a physician to demonstrate financial responsibility as a condition of maintaining an active license. Medical physicians who choose to demonstrate financial responsibility by obtaining and maintaining professional liability coverage or establishing an irrevocable letter of credit or escrow account may not use the monies for litigation costs or attorney's fees for the defense of any medical malpractice claim. Medical physicians who perform surgery in an ambulatory surgical center are required to establish financial responsibility by one of several specified methods.

If any judgments or settlement are pending at the time that a physician has his license suspended, those judgments or settlements must be paid as required by this section unless otherwise mutually agreed upon by the parties. This requirement does not abrogate a judgment debtor's obligation to satisfy the entire amount of any judgment. Any physician who is not actively practicing in Florida who resumes or initiates practice in Florida must fulfill the financial responsibility requirements of this section before doing so.

Notwithstanding any other provision of this section, DOH must suspend the license of any physician against whom has been entered a final judgment, arbitration award, or other order or who has entered into a settlement agreement to pay damages arising out of a claim for medical malpractice, if all appellate remedies have been exhausted and payment up to amounts required by this section has not been made within 30 days after the entering of such judgment, award, or order or agreement, until proof of payment is received by DOH. This requirement does not apply to a physician who has met the financial responsibility requirements by retaining and maintaining professional liability coverage.

Section 24. Amends s. 459.0085, F.S., relating to the financial responsibility requirements for osteopathic physicians, to require an osteopathic physician to demonstrate financial responsibility as a condition of maintaining an active license. Osteopathic physicians who obtain professional liability insurance coverage or establishing an irrevocable letter of credit or escrow account may not use the monies for litigation costs or attorney's fees for the defense of any medical malpractice claim. Osteopathic physicians who perform surgery in an ambulatory surgical center are required to establish financial responsibility by one of several specified methods.

If any judgments or settlement are pending at the time that an osteopathic physician has his or her license suspended, those judgments or settlements must be paid as required by this section unless otherwise mutually agreed upon by the parties. This requirement does not abrogate a judgment debtor's obligation to satisfy the entire amount of any judgment. Any osteopathic physician who is not actively practicing in Florida who resumes or initiates practice in Florida must fulfill the financial responsibility requirements of this section before doing so.

Notwithstanding any other provision of this section, DOH must suspend the license of any osteopathic physician against whom has been entered a final judgment, arbitration award, or other order or who has entered into a settlement agreement to pay damages arising out of a claim for medical malpractice, if all appellate remedies have been exhausted and payment up to amounts required by this section has not been made within 30 days after the entering of such judgment, award, or order or agreement, until proof of payment is received by DOH or a payment schedule has been agreed upon by the osteopathic physician and the claimant and presented to DOH. This requirement does not apply to an osteopathic physician who has met financial responsibility requirements by retaining and maintaining professional liability coverage.

Section 25. Amends s. 458.331, F.S., to increase the threshold amount of liability claims for establishment of gross or repeated malpractice by a medical physician from $25,000 to $50,000 of indemnities paid within a 5-year period. To conform, the threshold amount for medical physician closed claims that must be investigated by DOH is increased from $25,000 to $50,000. A recommended order by an administrative law judge or a final order by the board finding malpractice must specify whether the licensee was found to have committed "gross malpractice," "repeated malpractice," or "failure to practice medicine with that level of care, skill and treatment which is recognized as being acceptable under similar conditions and circumstances."

Section 26. Creates s. 458.3311, F.S., to establish emergency procedures for disciplinary action. No later than 30 days after a third report of a professional liability claim against a licensed medical physician has been submitted within a 60-month period, DOH must initiate an emergency investigation and the Board of Medicine must conduct an emergency probable cause hearing to determine whether the physician should be disciplined for gross or repeated malpractice or "failure to practice medicine with that level of care, skill, and treatment recognized as acceptable."

Section 27. Amends s. 459.015, F.S., to increase the threshold amount of liability claims for establishment of gross or repeated malpractice by an osteopathic physician from $25,000 to $50,000 of indemnities paid within a 5-year period. To conform, the threshold amount for

osteopathic physician closed claims that must be investigated by DOH is increased from $25,000 to $50,000.

Section 28. Creates s. 459.0151, F.S., to establish emergency procedures for disciplinary action. No later than 30 days after a third report of a professional liability claim against a licensed osteopathic physician has been submitted within a 60-month period, DOH must initiate an emergency investigation and the Board of Medicine must conduct an emergency probable cause hearing to determine whether the physician should be disciplined for gross or repeated malpractice or failure to practice osteopathic medicine with that level of care, skill, and treatment which is recognized as being acceptable under similar conditions and circumstances.

Section 29. Amends s. 461.013, F.S., to increase the threshold amount of liability claims for establishment of gross or repeated malpractice by a podiatric physician from $10,000 to $50,000 of indemnities paid within a 5-year period. To conform, the threshold amount for podiatric physician closed claims that must be investigated by DOH is increased from $25,000 to $50,000. A recommended order by an administrative law judge or a final order by the board finding malpractice must specify whether the licensee was found to have committed "gross malpractice," "repeated malpractice," or "failure to practice medicine with that level of care, skill and treatment which is recognized as being acceptable under similar conditions and circumstances."

Section 30. Creates s. 461.0131, F.S., to establish emergency procedures for disciplinary action. No later than 30 days after a third report of a professional liability claim against a licensed podiatric physician has been submitted within a 60-month period, DOH must initiate an emergency investigation and the Board of Medicine must conduct an emergency probable cause hearing to determine whether the physician should be disciplined for gross or repeated malpractice or failure to practice medicine with that level of care, skill, and treatment which is recognized as being acceptable under similar conditions and circumstances.

Section 31. Amends s. 466.028, F.S., to increase the threshold amount from $5,000 to $25,000 of indemnities paid within a 5-year period for purposes of defining "dental malpractice" applicable to a ground for discipline relating to being guilty of incompetence or negligence by failure to meet minimum standards of performance in the practice of dentistry.

Section 32. Creates an undesignated section of law to require DOAH to designate at least two administrative law judges with certain qualifications to preside over actions involving health care practitioner discipline.

Section 33. Creates s. 1004.08, F.S., to require each public school, college, and university that offers degrees in medicine, nursing, or allied health to include in the curricula applicable to such degrees material on patient safety, including patient safety improvement. Material must include, but need not be limited to, effective communication and teamwork; epidemiology of patient injuries and medical errors; medical injuries; vigilance, attention and fatigue; checklists and inspections; automation, technological, and computer support; psychological factors in human error; and reporting systems.

Section 34. Creates s. 1005.07, F.S., to require each private school, college, and university that offers degrees in medicine, nursing, or allied health to include in the curricula applicable to such

degrees material on patient safety, including patient safety improvement. Material must include, but need not be limited to, effective communication and teamwork; epidemiology of patient injuries and medical errors; medical injuries; vigilance, attention and fatigue; checklists and inspections; automation, technological, and computer support; psychological factors in human error; and reporting systems.

Section 35. Creates an undesignated section of law to require AHCA to conduct or contract for a study to determine what information is most feasible to provide the public to compare state-licensed hospitals on certain inpatient quality indicators developed by the federal Agency for Healthcare Research and Quality. AHCA or the study contractor must refer to hospital quality reports published in New York and Texas as a guide during the evaluation. The concepts that the study must address are specified. AHCA must consider the input of interested parties, including hospitals, physicians, consumer organizations, and patients. AHCA must submit the final report to the Governor and the presiding officers of the Legislature by January 1, 2004.

Section 36. Creates an undesignated section of law requiring a comprehensive study and report on the establishment of a patient safety authority. AHCA, in consultation with DOH and the existing patient safety centers in the state universities, is required to study the implementation requirements of establishing a statewide patient safety authority. AHCA will examine and evaluate a patient safety authority that would directly, by contract, or through a consortium of university patient safety authorities:

- Analyze patient safety data and quality and patient safety indicators;
- Collect, analyze, and evaluate patient safety data submitted voluntarily by a health care practitioner or health care facility;
- Foster the development of a statewide electronic infrastructure that is designed to improve patient care and the delivery and quality of health care services by health care facilities and practitioners;
- Inventory hospitals to determine the current status of computerized physician order entry systems or other technological patient safety systems and recommend a plan for expediting implementation statewide. AHCA must identify barriers to the implementation and make recommendations to the Legislature of the statutory changes necessary to eliminate the barriers;
- Identify best practices and share this information with health care providers;
- Assess the patient safety culture at volunteering hospitals;
- Develop core competencies in patient safety; and provide continuing medical education regarding patient safety;
- Provide continuing medical education regarding patient safety to health care practitioners; and
- Engage in other activities that improve health care quality, the delivery of health care services, and increase access to quality health care.

AHCA shall consider ways in which a Patient Safety Authority could facilitate the development of no-fault demonstration projects as a means of reducing and preventing medical errors and promoting patient safety. AHCA shall seek information and advice from and consult with hospitals, physicians, other health care providers, attorneys, consumers, and individuals involved with and knowledgeable about patient safety and quality of care initiatives. The Patient Safety

Authority should be designed and operated by an entity with expertise in particular areas and have procedures for ensuring confidentiality, timeliness, and independence.

AHCA shall complete its study and issue a report by to the Legislature by February 1, 2004. In its report, AHCA shall include specific findings, recommendations, and proposed legislation.

Section 37. Requires OPPAGA and the Office of the Auditor General to conduct an audit of DOH's health care practitioner disciplinary process and closed claims that are filed with the department under s. 627.912, F.S., and to submit a report to the Legislature by January 1, 2005.

Section 38. Creates an undesignated section of law to require DOH to convene a workgroup no later than September 1, 2003, to study the current health care practitioner disciplinary process. Provides for membership of the workgroup and requires the sponsoring organization to assume the costs of its member's participation in the workgroup. The workgroup is to submit its report no later than January 1, 2004, to the Governor, the President of the Senate, and the Speaker of the House of Representatives.

Section 39. Amends s. 624.462, F.S., to allow ten or more health care providers to form a commercial self-insurance fund under ss. 624.460-624.488, F.S., for the purpose of providing medical malpractice coverage. The definition of health care provider that is cited in s. 627.351(4)(h), F.S., includes a hospital, physician, osteopath, chiropractor, naturopath, nurse, midwife, clinical laboratory, physician assistant, physical therapist, physical therapist assistant, health maintenance organization, ambulatory surgical center, blood bank, plasma center, industrial clinic, renal dialysis facility, and other medical facilities meeting certain criteria, as well as professional associations, partnerships, corporations, joint ventures, or other associations for professional activity by health care providers. The bill, in effect, allows ten or more health care providers to form a commercial self-insurance fund, where today such a fund for medical malpractice could be formed only if it is formed by a not-for-profit trade association, industry association, or professional association of employers or professionals which has a constitution or bylaws, which is incorporated in Florida, and which has been organized for purposes other than that of obtaining or providing insurance and operated in good faith for a continuous period of 1 year. Otherwise, all of the current requirements for such a fund, as described in the Present Situation section of this analysis, would continue to apply.

Section 40. Amends s. 627.062, F.S., relating to rate filings for property, casualty, and surety insurance, including medical malpractice insurance, to create additional requirements for rate filings of medical malpractice insurers.

The bill provides that an insurer that makes a medical malpractice rate filing, would not be permitted to require arbitration of the rate filing if the rate filing is disapproved by OIR. An insurer is currently allowed to require arbitration after "any action with respect to a rate filing that constitutes agency action," which would no longer apply to rate filings for medical malpractice. The insurer would still have the option of an administrative hearing pursuant to chapter 120, F.S.

A medical malpractice insurer would be prohibited from including in the base rate or from using to justify a rate or rate change:

- A portion of a judgment or settlement paid as a result of statutory or common law bad faith actions of the insurer;
- A portion of a judgment in which punitive damages were awarded against the insurer; or
- Taxable costs or attorneys fees which relate to the assessing of damages against the insurer for bad faith actions.

Rate filing for medical malpractice insurance would also be subject to the following:

- In determining whether a rate is excessive, inadequate, or discriminatory, OIR must consider loss experience solely for Florida or give greater credibility to Florida loss experience;
- Rates must be deemed excessive if the rate structure provides for replenishment of reserves or surpluses from premiums when the replenishment is attributable to investment losses;
- The insurer must apply a discount or surcharge to the rate based on the health care provider's loss experience; and
- Insurers would be required to make a rate filing that is sworn to by at least two executive officers of the insurer at least once each year.

This section is further amended to impose a rate freeze and a mandatory rate filing to reflect the savings of the bill, as follows:

- Rates approved on or before July 1, 2003, for medical malpractice insurance remain in effect until the effective date of the new rate filing required by the act;
- Insurers must make a rate filing effective no later than January 1, 2004, to reflect the savings of the act, using the presumed factor that must be established by OIR within 60 days of the bill's effective date, or using a different factor if the insurer contends that the presumed factor results in a rate that is excessive, inadequate, or unfairly discriminatory, subject to prior approval by OIR;
- The new rate would apply to policies issued or renewed on or after the effective date of the act, requiring insurers to provide a refund for policies issued between the effective date of the act and the effective date of the rate filing;
- If the courts invalidate any provision of the act, OIR must permit an adjustment of all medical malpractice rates filed under this section to reflect such holding so as to ensure that the rates are not excessive, inadequate, or unfairly discriminatory; and
- The determination by OIR of the presumed factor that reflects the savings of this act would not be a rule or order subject to the provisions of ch. 20, F.S. However, each insurer is permitted to make a rate filing that justifies use of a different factor. If the office contracts with a consultant to assist it in determining the presumed factor, the contract would be exempt from the competitive bidding requirements of s. 287.057, F.S., in order to help ensure that the office can meet its 60-day deadline to determine the factor.

Section 41. Creates an undesignated section of law which requires OPPAGA to study the feasibility and merits of authorizing the Office of the Public Counsel to represent the public in medical malpractice rate matters.

Section 42. Amends s. 627.357, F.S., to eliminate a prohibition against creating medical malpractice self-insurance funds after October 1, 1992. Such funds could again be licensed, upon approval by OIR. The Financial Services Commission must adopt rules to ensure that medical malpractice self-insurance funds remain solvent.

Section 43. Amends s. 627.4147, F.S., relating to medical malpractice insurance contracts, to require the insurer or self-insurer to notify the insured no less than 90 days, rather than 60 days, prior to the effective date of cancellation or nonrenewal of a policy or contract. In addition, the insurer or self-insurer must provide 60-days notice prior to the effective date of a rate increase. Currently, under s. 627.4133, F.S., all property and casualty insurers, including medical malpractice insurers, must provide at least 45-days written notice of the renewal premium.

The changes to s. 627.4147, F.S., apply to policies issued or renewed after October 1, 2003.

Section 44. Creates s. 627.41495, F.S., to require medical malpractice insurers or self-insurance funds to mail notice of a rate filing to its policyholders or members upon filing a proposed rate change which would result in an average statewide increase of 25 percent or more. The rate filing must be available for public inspection.

Section 45. Amends s. 627.912, F.S., to revise the requirement for the reporting of closed medical malpractice claims to OIR to: (1) require reporting by all types of licensed and approved insurance and self-insurance entities, including specified health care practitioners and facilities for claims not otherwise reported by an insurer; (2) include reports of claims resulting in non-payment; (3) include the professional license numbers in the reports; (4) delete the requirement for filing a copy of the judgment or settlement; (5) provide for electronic access to DOH for all closed claim data and otherwise delete separate reporting by practitioners to DOH; (6) require OIR to impose a fine for violation by insurance and self-insurance entities, up to $10,000; (7) provide that violations by health care providers of reporting requirements constitutes a violation of their practice act; (8) require OIR to prepare an annual report analyzing the closed claim reports, financial reports submitted by insurers, approved rate filings and loss trends; (9) require OIR to prepare statistical summaries of the closed claims reports for medical malpractice for each year that the reports have been filed; (10) make the summaries and closed claims reports available on the Internet by July 1, 2005; and (11) authorize the Financial Services Commission to adopt rules to require the reporting of data on open claims and reserves. Closed claim reports must be filed with OIR no later than 30 days following the occurrence of specified events listed in the section.

OIR shall prepare an annual report by October 1 of each year, beginning in 2004, which shall be available on the Internet, which summarizes and analyzes the closed claim reports and the annual financial reports filed by insures writing medical malpractice insurance in Florida. The report must include: (1) an analysis of closed claim reports of prior years in order to show trends in the frequency and amount of claims payments; (2) the itemization of economic and noneconomic damages; (3) the nature of the errant conduct; and (4) such other information that OIR determines is illustrative of the trends in closed claims. The report must also analyze the state of the medical malpractice insurance market in Florida including: (1) an analysis of the financial reports of those insurers with a combined market share of at least 80 percent of the net written premium in the state for medical malpractice for the prior calendar year; (2) loss ratio analysis

for medical malpractice written in Florida; and (3) a profitability analysis of each such insurer. The report shall compare the ratios for medical malpractice in Florida compared to other states, based on financial reports filed with the National Association of Insurance Commissioners and such other information that OIR deems relevant.

The bill maintains the substance of the current closed claim reporting requirements, including penalties that apply to claims for professional liability against members of the Florida Bar, so that the bill does not extend beyond the single subject of "medical malpractice."

Section 46. Amends s. 641.19, F.S., relating to health maintenance organizations, to revise the definition of "health maintenance contract" to mean any contract entered into by an HMO with a subscriber or group of subscribers to provide *coverage for* comprehensive health care services in exchange for a prepaid per capita or prepaid aggregate fixed sum. The term, "health maintenance organization" is revised to mean any organization authorized under ch. 641 F.S., which provides, *through arrangements with other persons*, emergency care, inpatient hospital services, physician care, ambulatory diagnostic treatment, and preventive health care services. Except in cases in which a health care provider is an employee of an HMO, the fact that an HMO arranges for the provision of health care services does not create an actual agency, apparent agency, or employer-employee relationship between the health care provider and the HMO for purposes of vicarious liability for the medical negligence of the health care provider. The term, "subscriber" is revised to mean an entity or individual who has contracted, or on whose behalf a contract has been entered into, with an HMO for health care *coverage* rather than *services* or other persons who also receive health *coverage* rather than *services* as a result of the contract.

Section 47. Amends s. 641.51, F.S., relating to HMO requirements for a quality assurance program and a second medical opinion, to revise requirements under which an HMO is prohibited from controlling the professional judgment of a physician. The HMO may not have the right to control the professional judgment of medical physicians, osteopathic physicians, chiropractic physicians, or podiatric physicians concerning the proper course of treatment of a subscriber. Such prohibition does not affect an HMO's decision as to payment for covered services. Except in cases in which the health care provider is an employee of the HMO, the HMO shall not be vicariously liable for the medical negligence of the health care provider, whether such claim is alleged under a theory of actual agency, apparent agency, or employer-employee relationship.

Section 48. Amends s. 766.102, F.S., relating to the burden of proof and the standards of recovery in medical negligence claims. First the statutory cross-reference to s. 768.50(2)(b), F.S., for purposes of defining "health care provider" is replaced with a statutory cross-reference to s. 766.202(4), F.S., which creates a definition for health care provider. Section 768.50(2)(b), F.S., was repealed in 1986, but remained a part of the existing statute by incorporation. The new definition for health care provider is almost entirely based on the old definition of health care provider but updated to include some additional providers. This has significance in that it sets forth who is entitled to presuit notice and requirements.

This section is also revised to replace language regarding corroborating medical opinions and expert witness testimony in medical negligence claims and actions. A health care provider will no longer be able to testify as to prevailing standard of care as an expert merely on the basis of

having sufficient training, experience or knowledge through practice or teaching in a related field of medicine. The criteria for who may offer a corroborating medical expert opinion or expert witness testimony is enhanced to require that the person have the same or similar in-kind training, experience, practice, education, and certification and licensure as the person against or on whose behalf the opinion or testimony is being offered. The applicable set of criteria depends on whether the incident involves a specialist, general practitioner or someone other than a specialist or general practitioner.

Specifically, if the incident involves a specialist, the expert witness must specialize in the same or a similar specialty and must have devoted professional time during the 3 previous years to active clinical practice or consultation with the same or similar health professionals, or to teaching in the same or a similar health profession at an accredited health profession school or residency program, or to clinical research at a program at an accredited health professional or teaching hospital in the same or a similar specialty. If the incident involves a general practitioner, then the expert witness must have devoted professional time within the 5 preceding years to active clinical practice or consultation, to academic teaching at an accredited health professional school or residency program, or to clinical research at an accredited medical school or teaching hospital. If the incident involves someone other than a specialist or general practitioner, the expert witness must have devoted professional time during the 3 previous years to active clinical practice or consultation with the same or similar health profession, to teaching in an accredited residency program in the same or a similar health profession, or to clinical research at an accredited medical school or teaching hospital.

If the incident involves a support medical staff such as a nurse, nurse practitioner, nurse midwife, or physician assistant, a medical or osteopathic physician can be qualified to testify as an expert witness as to the applicable standard of care for such medical staff. Any person can testify to the applicable standard of care relating to administrative and other nonclinical issues if the incident involves a health care or medical facility and if the proffered person has substantial knowledge of such matters. If the incident involves a health care provider who evaluated, diagnosed, or treated a condition outside his or her specialty, the person who offers the corroborating medical opinion or testify against or on the health care provider's behalf must be qualified as a specialist in that area.

Under the bill, an expert witness may not testify on a contingency basis and must be certified by the attorney that he or she has not been found guilty of fraud or perjury in any jurisdiction. An expert witness can be qualified to testify by the court on grounds other than the statutory criteria. This latter provision may represent a logistical problem in that the reporting entity, the court, may also qualify an expert witness on grounds other than the statutory criteria enumerated in s. 766.102(12), F.S.

Section 49. Amends s. 766.106, F.S., relating to presuit notice and screening requirements for medical negligence claims. This section clarifies that a claim for medical negligence and a claim for medical malpractice mean the same thing. This section is reorganized to include subheadings and to clarify the connection between presuit investigation and discovery processes in this section and ss. 766.203 and 766.204, F.S. Additionally subsections (10)-(12) of this section relating to voluntary binding arbitration have been deleted as these provisions were superseded by the enactment of ss. 766.207-766.212, F.S.

All presuit notices of intent to litigate sent on or after that date must also include: (1) a list of all known health care providers seen by the claimant subsequent to the injury giving rise to the claim of malpractice, (2) a list of all known health care providers who evaluated or treated the claimant during the 2 previous years, and (3) copies of all medical records relied upon by the expert witness who verified the medical malpractice claim.

Additionally, any party can submit for response a maximum of 30 questions including subparts. A response is due within 20 days after receipt of the questions. The claimant must execute a medical information release that allows a prospective defendant or his or her legal representative to take unsworn statements of the claimant's treating physicians. The procedural requirements associated with the taking of a statement of any party apply. Additionally it is emphasized that the claimant or the claimant's legal representative must be given reasonable notice and opportunity to be heard and attend. The statements must be limited to those areas that are potentially relevant to the claim of personal injury or wrongful death. A prospective defendant may take unsworn statements from a claimant's treating physicians.

Whereas current law only requires a copy of a complaint for medical negligence against a licensed person to be sent to DOH, the bill will also require a copy of the complaint to be sent to AHCA if the complaint is against a hospital, ambulatory surgical center, or mobile surgical facility. AHCA must review the complaint to see if it involves conduct by a licensed facility which may be subject to an administrative sanction**.** Failure to cooperate on the part of any party involved in the presuit investigation may be grounds to strike any claim made or defense raised by such party in the suit.

Section 50. Amends s. 766.108, F.S., to require mandatory mediation in medical negligence actions if voluntary binding arbitration has not been agreed to by the parties. Within 120 days after suit is filed, the parties shall attend in-person mediation in accordance with s. 44.102, F.S. The Florida Rules of Civil Procedure will apply to such mediation.

Section 51. Amends s. 766.1115, F.S., relating to agency relationship with specified governmental contractors, to change references to "medical malpractice" to "medical negligence."

Section 52. Amends s. 766.112, F.S., relating to comparative fault to change references to "medical malpractice" to "medical negligence."

Section 53. Amends s. 766.113, F.S., relating to settlement agreements, requiring each final settlement relating to medical negligence to include the following statement: "The decision to settle a case may reflect the economic practicalities pertaining to the cost of litigation and is not, alone, an admission that the insured failed to meet the required standard of care applicable to the patient's treatment. The decision to settle a case may be made by the insurance company without consulting its client for input, unless otherwise provided by the insurance policy."

Section 54. Creates s. 766.118, F.S., which imposes a statutory scheme for caps on noneconomic damages in medical negligence claims based on the nature of injury, category of defendant, and type of health care services. The caps apply as follows:

For an injury other than a permanent vegetative state, death or catastrophic injury, the noneconomic damages are capped at:

- $500,000 from each *practitioner defendant* but not to exceed $1 million from all *practitioner defendants*, regardless of the number of claimants, and
- $750,000 per claimant but not to exceed $1.5 million from all *nonpractitioner defendants*.

For an injury deemed to be a *catastrophic injury* as found by the trier of fact and when the court determines manifest injustice would occur otherwise, noneconomic damages are capped at:

- $1 million for the *injured patient* from all *practitioner defendants*, and
- $1.5 million for the *injured patient* from all *nonpractitioner defendants*.

For an injury that results in a permanent vegetative state or death, the noneconomic damages are capped at:

- $1 million, regardless of the number of claimants and regardless of the number of *practitioner defendants*, and
- $1.5 million from all *nonpractitioner defendants*, regardless of the number of claimants.

For *any type of injury* resulting from a *practitioner's provision of emergency services* in a hospital or of *life support services* including transportation, to someone with whom the practitioner has no pre-existing health care patient-practitioner relationship, noneconomic damages are capped at $150,000 per claimant but not to exceed $300,000 aggregated for all claimants from all practitioner defendants, and regardless of the nature of the injury. This cap only applies to limit noneconomic damages awards for injuries arising from emergency care or treatment given or omitted prior to patient stabilization or if surgery is needed, stabilization after surgery.

For *any type of injury* resulting from a *nonpractitioner's provision of emergency services in a hospital or of prehospital emergency treatment pursuant to statutory obligations*, to someone with whom the practitioner has no pre-existing health care patient-practitioner relationship, noneconomic damages are capped at $750,000 per claimant from all nonpractitioner defendants but not to exceed $1.5 million aggregated for all claimants from all nonpractitioner defendants regardless of the nature of the injury. This cap only applies to limit noneconomic damages awards for injuries arising from emergency care or treatment given or omitted prior to patient stabilization or if surgery is needed, stabilization after surgery.

The *practitioner* is defined to include a medical, osteopathic, chiropractic, podiatric, and naturopathic physician; optometrist and ophthalmologist; dentist; midwife; physical therapist; and all persons who are assistants and licensed under the respective field. A *catastrophic injury* is defined as a permanent impairment constituted by spinal cord injury resulting in paralysis; limb amputation resulting in loss of use; severe brain or closed-head injury evidenced by neurological, sensory, or motor disorders or disturbances; second- or third-degree burns over 25 percent of body or third-degree burns to 5 percent or more of face and hands; complete and total loss of vision; and loss of reproductive organs resulting in an inability to procreate.

As for setoffs, a *nonpractitioner* defendant may now receive a full setoff for payment made by a *practitioner* defendant in medical negligence claims involving the provision of emergency services regardless of whether the other practitioner defendant was at fault or not. Additionally, in order to ensure strict adherence to the statutory caps scheme, the court must reduce an award of noneconomic damages that exceeds the statutory cap for the particular category of defendant and injury. This reduction is to occur only after the court reduces any amount for the comparative fault of the claimant as applied to economic damages under s. 768.81, F.S., but before a reduction is made for setoffs provided in ss. 46.015 and 768.041, F.S.

Section 55. Creates an undesignated section of law to provide legislative findings regarding emergency services and care.

Section 56. Creates s. 766.1185, F.S., relating to bad faith actions. A safe harbor is created for medical professional liability insurers from actions based upon allegations of bad faith efforts for failure to settle a claim within policy limits during a certain period after the service of the complaint. Factors for determining whether an insurer acted in bad faith are provided. In determining whether the insurer could and should have settled the claim within the policy limits had it acted fairly and honestly towards its insured with due regard for the insured's interest, an insurer may not be held in bad faith for failure to pay its policy limits if it tenders its policy limits and meets other reasonable conditions of settlement by the earlier of two dates:

1. The 210th day after service of the complaint upon the insured healthcare provider in a medical negligence action. The date may be extended by 60 days by the court in the event it finds upon motion by the insurer that the claimant has amended his or her witness list or provided new evidence, either of which materially alters the value of the claim or the theory of the case; or
2. The 60th day after the conclusion of all of the following activities: the deposition of all claimants, defendants, expert witnesses, the initial disclosure of witnesses and documents, and the mediation required under s. 766.108, F.S.

This section provides that the fact that an insurer has not tendered policy limits is not presumptive evidence that the insurer has acted in bad faith.

Additionally, in those circumstances when the periods described above are not applicable, this section provides factors by which the trier of fact can determine whether an insurer has acted in bad faith. These factors consider the insurer's and the insured's actions as well as other activities or circumstances attendant to the claim.

If a party to a medical negligence action amends its witness list after the complaint is served, that party must provide a copy of the amended witness list to the insurer of the defendant healthcare provider.

The provisions of s. 624.155, F.S., relating to civil remedies for bad faith activities of insurance companies, apply in cases brought pursuant to that section unless specifically controlled by this section.

Finally, this section provides when an insurer tenders its policy limits and the claimant accepts such a tender, the insurer is entitled to a release from its insured.

Section 57. Amends s. 766.201, F.S., relating to legislative findings and intent, to change references to "medical malpractice" to "medical negligence."

Section 58. Amends s. 766.202, F.S., to revise the definitions relating to medical negligence claims. The terms "economic damages" and "noneconomic damages" are redefined to provide that the claimant's recovery is limited to the extent the claimant is entitled to recover such damages under general law,[34] including the Wrongful Death Act. This may reduce the scope of economic damages recoverable as the damages recoverable under the Wrongful Death Act in s. 768.21, F.S., are narrower in scope than that which may be currently recovered in a medical negligence claim under ch. 766, F.S. The loss of earning capacity, past and future medical expenses, and past and future loss of services as elements of damages are not available under the Wrongful Death Act. This means that the elements of economic and noneconomic damages awardable in medical malpractice arbitration or in a suit following a failure to accept or offer arbitration for a claim of a medically negligent death would be governed by the Wrongful Death Act under ss. 768.16-768.27, F.S. The Wrongful Death Act permits recovery of economic damages such as loss of support and services as related to objectively-quantifiable monetary losses and noneconomic damages such as pain and suffering. The Wrongful Death Act does not allow recovery of noneconomic damages such as disability or physical impairment, disfigurement, mental anguish, inconvenience, loss of capacity to enjoy life, humiliation, injury to reputation, shame, hurt feelings, and other pecuniary losses. Moreover, adult children of wrongfully deceased parents and parents of wrongfully deceased adult children in medical negligence actions are also barred from recovering mental pain and suffering damages.

By applying the damage elements of the Wrongful Death Act to medical malpractice arbitration cases or suits following failure to accept or offer arbitration, this new provision would appear to pre-empt the provision in s. 766.209(3)(a), F.S., in which a defendant who refuses a claimant's offer of voluntary arbitration in a medical negligence death could be liable subject to the limitation on noneconomic damages in s. 766.118, F.S., created by the bill. Therefore, under the new provision, there would be an incentive for the defendant in a wrongful medical negligence death action to always offer arbitration because whether the claimant refused or accepted, the defendant's liability would be limited to net economic damages involving past and future loss support and services, lost earnings, medical and funeral expenses, and noneconomic damages of mental pain and suffering. If the medical negligence claim for wrongful death involved a parent of a wrongfully deceased adult child or an adult child of a wrongfully deceased parent, the defendant would not be liable for any noneconomic damages.

The term "health care provider" is defined to include specified health care facilities, health care practitioners, clinical laboratories, health maintenance organizations, and certain entities organized for professional activity by health care providers.

The term "medical expert" is redefined to mean someone 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 who meets the requirements of an expert witness as cross-referenced to the new

[34] A law that operates universally throughout the state, uniformly upon subjects as they may exist throughout the state, or uniformly within a permissible classification is a general law. See *City of Miami v. McGrath*, 824 So.2d 143 (Fla. 2002), citing to *State ex rel. Landis v. Harris,* 120 Fla. 555, 163 So. 237 (Fla.1934).

criteria set forth in s. 766.102, F.S. This revision will have the effect of enhancing the criteria for persons who may provide a corroborating medical expert opinion in the presuit process as to a medical malpractice claim.

Section 59. Creates s. 766.2021, F.S., to provide that an entity licensed or certificated under ch. 624, 636, or 641, F.S., (insurers, prepaid limited health service organizations, HMOs, or prepaid health clinics) shall not be liable for the medical negligence of a health care provider with whom the licensed or certificated entity has entered into a contract in any amount greater than the amount of damages that may be imposed by law directly upon the health care provider. Any suit against one of these licensed or certificated entities will be subject to the requirements of ch. 766, F.S., relating to medical negligence.

Section 60. Amends s. 766.203, F.S., related to presuit investigation of medical negligence claims, to require the expert opinions required by this section to be subject to discovery.

Section 61. Amends s. 766.206, F.S., 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 a 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. This same judicial review must be conducted of 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 rather than just the response as is currently provided in law. 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. A court may not consider the testimony of an expert whose medical opinion attached to a presuit notice or a defendant's response to reject a claim has been previously disqualified three times.

Section 62. Amends s. 766.207, F.S., relating to voluntary binding arbitration of medical negligence claims, to provide that any damages awarded pursuant to arbitration must be awarded as provided by general law, including the Wrongful Death Act, subject to limitations.

Section 63. Amends s. 766.209, F.S., to provide that, in the event a defendant in a medical malpractice case refuses a claimant's offer of voluntary binding arbitration, the claim may proceed to trial and the claimant(s) may recover damages including noneconomic damages as limited by s. 766.118, F.S.

Section 64. Creates s. 768.0981, F.S., to provide that an entity licensed or certificated under ch. 624, 636, or 641, F.S., (insurers, prepaid limited health service organizations, HMOs, or prepaid health clinics) shall not be liable for the medical negligence of a health care provider with whom the licensed or certificated entity has entered into a contract unless the licensed or certificated entity expressly directs or exercises actual control over the specific conduct that caused injury.

Section 65. Amends s. 768.13, F.S, the Good Samaritan Act, to revise the circumstances under which immunity from civil liability is extended to specified health care providers. Immunity from civil liability is extended to:

1. Any health care provider, including a hospital, providing emergency services pursuant to obligations imposed by state or federal law, for any civil damages resulting from such medical care or treatment unless such medical care or treatment or the failure to provide such care or treatment under the circumstances demonstrated a reckless disregard for the consequences so as to affect the life or health of another. Such immunity applies to treatment which is related to the original medical emergency and rendered prior to the time that the patient is stabilized and capable of receiving medical treatment as a non-emergency patient. "Reckless disregard" is revised for purposes of the application of the immunity to mean emergency medical services that a health care provider knew or should have known at the time services are rendered created unreasonable risk of injury so as to affect the life or health of another, and such risk was substantially greater than that which necessary to make the conduct negligent; and
2. Any health care practitioner who is in a hospital attending to a patient of his or her practice or for business or personal reasons unrelated to direct patient care, and who voluntarily responds to provide care or treatment to a patient with whom the practitioner has no 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, unless the care or treatment is proven to amount to conduct that is willful and wanton and would likely result in injury so as to affect the life and health of another. Such immunity does not apply to medical care or treatment unrelated to the original situation that demanded immediate medical attention. Legislative intent is expressed to encourage health care practitioners to provide necessary emergency care to all persons without fear of litigation.

The provision extending immunity to physicians acting as staff members or with clinical privileges at a nonprofit medical facility other than a hospital or while performing health screening services and providing treatment or care gratuitously is deleted.

Section 66. Amends s. 768.21, F.S., relating to damages, to change references to "medical malpractice" to "medical negligence."

Section 67. Amends s. 768.28, F.S., to provide sovereign immunity to a health care practitioner, defined in s. 456.001(4), F.S., who has contractually agreed to act as an agent of a state university board of trustees to provide medical services to a student-athlete for participation in or as a result of intercollegiate athletics, to include team practices, training, and competitions.

Section 68. Amends s. 768.77, F.S., to provide a distinct itemization scheme for verdicts rendered in medical negligence actions. The trier of fact must itemize the amounts to be awarded to the claimant into the following categories of damages:

- Amounts intended to compensate the claimant for past economic losses and future economic losses, not reduced to present value, and the number of years or part thereof which the award is intended to cover;

- Amounts intended to compensate the claimant for past noneconomic losses and future noneconomic losses, and the number of years or part thereof which the award is intended to cover; and
- Amounts awarded to the claimant for punitive damages, if applicable.

Section 69. Creates an undesignated section of law to clarify that nothing in the bill is intended to constitute a waiver of limited sovereign immunity as may be otherwise available or applicable, or to undo the statutory abrogation of joint and several liability that statutory teaching hospitals and state university boards of trustees currently enjoy under s. 766.112, F.S., that only holds them liable on the basis of their own fault.

Section 70. Amends s. 1006.20, F.S., to revise requirements for the Florida High School Activities Association by-laws for participation in interscholastic athletics to require that an evaluation and history form incorporate recommendations of the American Heart Association for participation cardiovascular screening. The bill deletes a requirement for the physician to certify that the student meets the minimum standards established by the association.

Section 71. Creates an undesignated section of law which directs DOH to study and report to the Legislature whether medical review panels should be included as part of the presuit process in medical malpractice litigation. Provides for those items which the report must address. Provides that if the department finds that medical review panels or a similar structure should be created in Florida, the report must include draft legislation to implement its recommendations in its report. The department shall submit its report to the Speaker of the House of Representatives and the President of the Senate no later than December 31, 2003.

Section 72. Amends s. 391.025, F.S., to provide that infants who receive an award under NICA are eligible for Children's Medical Services.

Section 73. Amends s. 391.029, F.S., to require that an infant who receives an award under NICA must reimburse the CMS Network the state's share of funding, which must thereafter be used to obtain matching federal funds under Title XXI of the Social Security Act.

Section 74. Amends 766.303, F.S., relating to NICA, to change references to "medical malpractice" to "medical negligence."

Section 75. Amends s. 766.304, F.S., related to NICA to clarify that if a claimant accepts an award from NICA, no civil action may be brought. The bill further clarifies that an award from NICA may not be made or paid if the claimant recovers under a settlement, as well as a final judgment, in a civil action.

Section 76. Amends s. 766.305, F.S., to provide that medical records related to a birth-related neurological injury and related assessments, evaluations, and other records necessary for the determination of the amount of compensation to be paid would no longer be required to be filed with DOAH as part of the initial petition seeking compensation. Instead, the claimant would be required to file such information with NICA within 10 days after filing the petition. Such information would be deemed to be confidential and exempt under the current public records exemption provided in s. 766.315(5)(b), F.S., which provides that a claim file in the possession

of the association is confidential and exempt until termination of litigation or settlement of the claim, except that medical records and other portions of the claim file may remain confidential and exempt as otherwise provided by law.

Section 77. Amends s. 766.309, F.S., to authorize the administrative law judge to bifurcate the NICA proceeding addressing compensability and notice pursuant to s. 766.316, F.S., first, and addressing an award pursuant to s. 766.31, F.S., if any, in a separate proceeding. The judge may do so if it is in the interest of judicial economy or if requested by the claimant.

Section 78. Amends s. 766.31, F.S., to provide a NICA recipient a death benefit of $10,000 in lieu of funeral expenses of $1,500. The bill also specifies that the claimant is not liable for any expenses, including attorneys' fees, incurred in connection with the filing of a NICA claim, other than those expenses awarded, if there is a final determination of compensability and the claimants accept an award.

Section 79. Amends s. 766.314, F.S., to specify that hospitals located in a county with a population in excess of 1.1 million as of January 1, 2003, may elect to pay the fee for the participating physician and the certified nurse midwife, under certain conditions. The bill also specifies that if payment of an annual assessment by a physician is received by January 31, the physician qualifies as a participating physician for the entire year, but payments after this date would qualify the physician only from the date the payment was received.

Section 80. Creates an undesignated section of law to require OPPAGA to complete a study of the eligibility requirements for a birth to be covered under NICA and to submit a report with recommendations to the Legislature by January 1, 2004.

Section 81. Appropriates $687,786 from the Medical Quality Assurance Trust Fund to DOH and authorizes seven positions in the department and appropriates $1,629,994 from the Health Care Trust Fund to AHCA and authorizes 11 positions at AHCA for the purpose of implementing the bill during the 2003-2004 fiscal year.

Section 82. Appropriates $1.45 million from the Insurance Regulatory Trust Fund in the Department of Financial Services to OIR for the purpose of implementing this act during the 2003-2004 fiscal year.

Section 83. Appropriates $850,000 in non-recurring General Revenue funds to AHCA for implementing patient safety initiatives during the 2003-2004 fiscal year.

Section 84. Provides that if any law is amended by this act that was also amended by a law enacted in the 2003 Regular Session of the Legislature or a 2003 special session, such laws must be construed as if they had been enacted during the same session of the Legislature, and full effect should be given to each if that is possible.

Section 85. Provides for severability of the provisions of the act in the event that any provision of the act is held invalid.

Section 86. Provides legislative intent that, to the extent not prohibited by the state or federal constitution, the provisions of this act apply to prior medical incidents, except that the amendments to ch. 766, F.S., shall apply only to any medical incident for which a notice of intent to initiate litigation is mailed on or after the effective date of this act.

Section 87. Provides that the bill shall take effect September 15, 2003, unless otherwise expressly provided in the bill.

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 bill deletes a requirement that a NICA claimant submit medical records and assessments to DOAH. The bill requires instead that such records be submitted to NICA and provides that the records will be confidential and exempt from the public records law under the exemption for medical records in NICA claim files in s. 766.315, F.S.

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 54 of the bill creates s. 766.118, F.S., to limit recovery of noneconomic damages for a claim regardless of the number of claimants. This section may implicate equal protection concerns under the Florida Constitution. In *St. Mary's Hospital, Inc. v. Phillipe*, 769 So.2d 961 (Fla. 2000) the Florida Supreme Court considered whether the "per incident" language in the voluntary arbitration statute under the Medical Malpractice Act meant that each claimant could recover the full $250,000 or whether all claimants in a single incident must divide $250,000. In *St. Mary's*, a woman died during childbirth due to medical malpractice. After arbitration under the medical malpractice statute, her husband was awarded $250,000 in noneconomic damages and each of her four surviving children was awarded $175,000. The court had to decide whether the statute permitted that award or whether the total noneconomic damages were capped at $250,000 aggregated for all the claimants. The court interpreted the statute to mean that each claimant was entitled to recover up to $250,000 *per incident*. To hold otherwise, the court said, would raise equal protection concerns because a claimant's recovery would be limited simply because there were multiple claimants in a given case.

To the extent section 54 of the bill bars full recovery of noneconomic damages in excess of the new statutory caps without providing a reasonable alternative remedy or commensurate benefit, a person's constitutional right of access to seek full redress in the

courts may be implicated. The test for assuring the right of access to the courts was declared in *Kluger v. White*, 281 So.2d 1, 4 (Fla. 1973) in which the Florida Supreme Court held that the Legislature is without power to abolish or otherwise restrict a statutory law right that predated the adoption of the constitution or a common law right without providing a reasonable alternative remedy or commensurate benefit, unless there is a showing of an overpowering public necessity to limit or abolish such right and no alternative remedy of meeting such public necessity exists. *See also Smith v. Department of Insurance*, 507 So.2d 1080, 1089 (Fla. 1987).[35]

V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

Section 12 of the bill deletes the provision that limits DOH or a board's authority to set license renewal fees which are no more than ten percent greater than the fee imposed during the previous 2-year licensure period.

B. Private Sector Impact:

Section 40 freezes medical malpractice rates at the levels approved on or before July 1, 2003 until the effective date of a required new rate filing. The new rate filing must be effective no later than January 1, 2004, and must reflect the presumed savings of the act, as calculated by OIR, and requires refunds for those policies that were issued on or after the effective date of the act. If an insurer contends that the rate using the presumed factor would be inadequate, excessive, or unfairly discriminatory, the insurer may make a rate filing that justifies the rate it contends is appropriate, subject to prior approval by OIR.

Section 54 of the bill which creates s. 766.118, F.S., imposes a $300,000 cap on noneconomic damages aggregated for all claimants and all practitioners when the damages result from the provision of emergency services. The change may remove any incentive for this category of practitioner defendants who might otherwise offer to arbitrate a medical negligence claim as the current statutory cap on noneconomic damages when a claimant refuses to arbitrate is $350,000 per incident.

The bill contains a number of provisions that will benefit health care providers by extending immunity or limiting liability in scenarios such as emergency assistance by a practitioner in a Code Blue situation, emergency services in a hospital or en route to a hospital, high school and university physical examinations, and health care services under an HMO.

Hospitals will incur costs to implement a patient safety plan, and to inform patients of unanticipated outcomes of care. Costs could also increase due to greater requirements for data analysis and potentially increased fines.

[35] In *Smith*, the Florida Supreme Court declared a $450,000 cap on noneconomic damages unconstitutional as the Legislature failed to provide a reasonable alternative remedy or commensurate benefit other than indicate the legislative scheme *may* benefit the tort victim. Id. at 1089.

There could be an increase in risk management and patient safety information available to consumers, purchasers and payers.

Private schools, colleges, and universities offering degrees in medicine, nursing, or allied health will incur costs to include material in curricula on patient safety.

C. Government Sector Impact:

OPPAGA/Auditor General
OPPAGA and the Office of the Auditor General will incur costs to jointly conduct an audit of DOH's disciplinary process and the closed claims filed with the department.

OPPAGA will incur costs to study the feasibility of authorizing the Office of Public Counsel to represent the public in medical malpractice rate matters.

OPPAGA will also incur costs to study the eligibility requirements for a birth to be covered under NICA.

Public Education
Public schools, colleges, and universities offering degrees in medicine, nursing, or allied health will incur costs to include material in curricula on patient safety.

Department of Health
DOH will incur costs associated with the study on the establishment of presuit panels.

DOH has indicated that it will incur costs to implement the additional reporting, monitoring, enforcement and publishing requirements for practitioner profiles as revised under the bill. DOH estimates that it will need seven positions and incur costs for profile system maintenance and data confirmation mailings and postage totaling $687,786 for fiscal year 2003-2004 and $654,510 for fiscal year 2004-2005.

The bill appropriates $687,786 from the Medical Quality Assurance Trust Fund to DOH and authorizes seven positions for the purpose of implementing the bill during fiscal year 2003-2004.

Agency for Health Care Administration
The bill provides for an appropriation of $1,629,994 from the Health Care Trust Fund to AHCA. Eleven positions (for a total of $679,994 for year 1) are authorized for the purpose of implementing this act during the 2003-2004 fiscal year. The bill appropriates $350,000 to AHCA to conduct the consumer hospital study, and $600,000 to study the establishment of a patient safety authority.

An additional $850,000 in non-recurring General Revenue funds is appropriated to AHCA for the purpose of implementing patient safety initiatives.

Office of Insurance Regulation
OIR provided the following estimates of the bill's fiscal impact, based on a preliminary review of the bill:

OPS Funds:
$700,000 to provide for re-engineering of the closed claim data base to provide more comprehensive controls and edits to ensure complete and accurate reporting from all parties. Currently submissions are by diskette and mailed to OIR. This cost includes web-enabling the filing process such that entities reporting can submit required claim data via the internet.

$150,000 for technology to interface with the DOH, to provide DOH with electronic access to the OIR closed claim database, as required.

$300,000 to secure the services of a consulting actuary to compile a statistical summary and analysis of approximately 25 years of closed claim data contained in the closed claim database. Although the reporting requirements have been changed over the years, this analysis could also serve as a predicate for the annual reports required prospectively (see below).

$100,000 on a recurring basis to secure the services, annually, of a consulting actuary responsible for preparing an annual report which would include: (1) analysis of prior and current years' close claim data; (2) analysis of financial reports (annual and quarterly) of the majority of insurer's in the market; and (3) a summary of previous calendar year rate filings submitted to OIR.

$200,000 to contract with a consulting actuary and a consulting attorney for determining the presumed factor that reflects the impact on medical malpractice rates of the changes contained in this act.

VI. Technical Deficiencies:

None.

VII. Related Issues:

Section 20 of the bill revises requirements for the determination of a conclusion of law and findings of fact by DOH or boards for standard of care violations involving practitioners under the department's or board's regulatory jurisdiction. The bill does not define what constitutes a standard of care violation. Under the Administrative Procedure Act, a conclusion of law that interprets the statutes and rules of an agency is within the substantive jurisdiction of an agency. In 1999, the Legislature further narrowed an agency's authority to reject or modify a hearing officer's recommended conclusions of law by requiring that the agency state with particularity its reason for rejecting or modifying the recommended conclusion of law and by requiring that the agency find that its substituted conclusion of law is as, or more, reasonable than the rejected or modified conclusion. Under s. 120.57(1)(e)3, F.S., if an agency improperly rejects an administrative law judge's determinations regarding an unadopted rule, a court in review may set

aside the agency action and award attorney's fees to the prevailing party. "Although it is generally held that an agency has wide discretion in interpreting a statute which it administers, this discretion is somewhat more limited where the statute being interpreted authorizes sanctions or penalties against a person's professional license. Statutes providing for revocation or suspension of a license to practice are deemed penal in nature and must be strictly construed, with any ambiguity interpreted in favor of the licensee."[36]

Section 48 of the bill amends s. 766.102, F.S., to revise the criteria for who may be qualified to offer the presuit corroborating medical opinion or expert witness testimony based on whether the person against or on whose behalf the testimony is being offered is a specialist, general practitioner or someone other than a specialist or general practitioner. The terms "specialist" and "general practitioner" is not defined in statute which may raise ambiguity as to how a person may be qualified for those health care professions not so clearly delineated.

Section 2 of the bill requires AHCA to receive and review a copy of a medical negligence complaint against a health care provider it regulates. A statutory cross-reference may be needed regarding AHCA's authority to discipline facilities it regulates based on a medical negligence claim against that facility.

VIII. Amendments:

None.

[36] See *Whitaker v. Department of Insurance*, 680 So.2d 528 (Fla. 1st DCA 1996), citing *Elmariah v. Department of Prof. Reg., Bd. of Medicine*, 574 So.2d 164, 165 (Fla. 1st DCA 1990).