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 564

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

SUBJECT: Medical Malpractice

DATE: March 26, 2003 REVISED: _____ _____ _____ _____

	ANALYST	STAFF DIRECTOR	REFERENCE	ACTION
1.	Munroe	Wilson	HC	Favorable/CS
2.			JU	
3.			AP	
4.			RC	
5.				
6.				

I. Summary:

The bill revises requirements for the awarding of damages in medical malpractice actions, if any defendant shows the court or arbitration panel a written release not to sue to any person in partial satisfaction of damages sued for, to require setoff for all sums received by the claimant, including economic and noneconomic damages, costs, and attorney's fees. Medical malpractice plaintiffs are required to execute a medical release that allows a defendant health care practitioner to conduct ex parte interviews with the claimant's treating physicians. 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 all other conditions of settlement before the conclusion of the presuit screening period. Factors to determine whether a professional liability insurer acted fairly and honestly towards its insured in coverage for medical negligence are specified. The definition of "similar health care provider" is revised for purposes of establishing the prevailing professional standard of care under the Medical Malpractice Act. The presuit expert's written opinion and statements are made subject to discovery. A procedure and requirements for presuit mediation are created. Parties to a medical negligence action are required to submit to mandatory mediation as outlined in the bill.

In medical malpractice voluntary binding arbitration, the claimant's recovery is limited to the damages the claimant is entitled to recover under general law, including the Wrongful Death Act. The definitions of "medical expert" and "periodic payment" are revised. The award of noneconomic damages is revised to provide an aggregate cap in cases involving multiple claimants for claims arising out of the same incident: in voluntary arbitration the cap is $250,000 and, at trial following a rejection of an offer to enter voluntary arbitration, the cap is $350,000.

The Good Samaritan Act is revised to extend immunity from civil liability to 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 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. Under the bill, such immunity applies to any act or omission of providing medical care or treatment, unless it was unrelated to the original medical emergency and unless there was a reckless disregard of the consequences.

The Good Samaritan Act is also revised to extend immunity from civil liability to any licensed or certified health care practititioner who provides medical care or treatment in a hospital to a patient or person 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 demonstrating a reckless disregard for the life or health of the victim. Such immunity does not apply to medical care or treatment unrelated to the original situation that demanded immediate medical attention. The term, "reckless disregard" is defined for purposes of extending such immunity.

The bill extends the waiver of sovereign immunity to certain health care professionals by revising the definition of "officer, employee, or agent" to include any health care professional when providing services in an emergency room or trauma center of a Florida-licensed hospital. The bill provides for periodic payment of future noneconomic damages, limits the claimant's ability to sell or assign the periodic payment and requires the periodic payment to last only as long as the claimant lives or the condition for which the award was made persists. The bill revises provisions for the trier of fact to itemize damages, as part of a verdict for medical malpractice actions, to include future losses. For medical negligence actions, the doctrine of joint and several liability is abolished and courts shall enter judgment on the basis of each party's percentage of fault. The bill provides a contingent effective date.

This bill amends sections 46.015, 456.057, 766.102, 766.104, 766.106, 766.108, 766.202, 766.207, 766.209, 768.041, 768.13, 768.28, 768.77, 768.78, and 768.81, Florida Statutes.

This bill creates s. 766.1065, F.S.

II. Present Situation:

Governor's Select Task Force on Healthcare Professional Liability Insurance

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

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

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

Recommendation 28. The Legislature should amend the statutes to allow *ex parte* communication between defense counsel for a defendant in a medical malpractice lawsuit and the plaintiff's treating physicians.

Recommendation 29. As an alternative, the Legislature may consider requiring the plaintiff to execute a medical information release when filing a lawsuit that would allow for the defendant to conduct *ex parte* interviews with the plaintiff's treating physicians only in areas potentially relevant to the plaintiff's alleged injury or illness.

Recommendation 30. The Legislature should examine ways to improve the use of in-kind experts at trial.

Recommendation 31. The Legislature should retain the definition of "reckless disregard," as that term is currently defined by statute, as it is sufficient.

Recommendation 32. The Legislature should repeal references to patient stabilization in section 768.13(2)(b)2a, Florida Statutes.

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

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

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

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

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

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

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

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

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

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

Recommendation 43. The Legislature should enact specific criteria similar to those in the offer of judgment statute to be considered by the court in making the determination as to how close in amount the judgment must be to the offer and the criteria to be used in evaluating the amount of the attorney fees and costs to be awarded in addition to the standards generally considered in awarding fees and costs.

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

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

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

Notices of Intent and Unsworn Statements in Medical Malpractice Actions

Chapter 766, F.S., entitled Medical Malpractice and Related Matters, provides for standards of

recovery 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 chapter 682, F.S., are applicable to the arbitration proceeding. The parties then provide written arguments to the arbitration panel and a one day hearing is subsequently held, wherein the rules of evidence and civil procedure do not apply. No later than two weeks after the hearing the arbitrators are required to notify the parties of their award and the court has jurisdiction to enforce any award.

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 not more than $125,000 noneconomic damages;
- Damages for future economic losses shall be awarded to be paid by periodic payments pursuant to s. 766.202(8) 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 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 an administrative law judge furnished by the Division of Administrative Hearings 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 the Division of Administrative Hearings 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 appeal 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

Chapter 766, F.S., provides for standards of recovery in medical negligence cases. Those standards 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 counsel has received a written opinion of an expert as defined in s. 766.102, F.S., that there appears to be evidence of medical negligence. The written opinion of the expert is not subject to discovery by an opposing party to the litigation. Section 766.102(2), F.S., sets forth the qualifications of the health care provider who may testify as an expert in a medical negligence action, and who, pursuant to s. 766.104(1), F.S., may provide an opinion supporting the attorney's good faith presuit belief that there has been medical negligence.

The purpose of s. 766.102(2), F.S., is to establish a relative standard of care for various categories and classifications of health care providers for the purpose of testifying in court. Accordingly, pursuant to s. 766.102(2)(c), F.S., any health care provider may testify as an expert if he or she is a similar health care provider to the provider accused of negligence. If the expert is not a similar health care provider, he or she may still testify if the court determines the expert

possesses sufficient training, experience and knowledge as a result of practice or teaching in the specialty of the defendant, or practice or teaching in a related field of medicine, such that the expert can testify to the prevailing professional standard of care in a given field of medicine. The expert must have had active involvement in the practice or teaching of medicine within the five year period before the incident giving rise to the claim.

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

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

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 her or his 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 reductions 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.[1]

[1] 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.

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.[2] 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.

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.[3] 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 non-economic damages, and to limit its applications as to economic damages. See ch. 99-225, L.O.F.; s. 768.81, F.S. As to economic damages, it established new limitations and maximum liability amounts, which increase with a defendant's share of fault and dependent on whether the

[2] *Acosta v. Richter*, 671 So.2d 149 (Fla. 1996).
[3] See *Fabre v. Marin*, 623 So.2d 1182, 1184 (Fla. 1993).

plaintiff was at fault or not. Section 768.81, F.S., requires the court to enter judgment based on fault of the parties rather than joint and several liability in negligence cases. Section 768.81(3), F.S., provides a formula to be used by the courts to apportion damages when the plaintiff is found to be at fault.

Section 768.81(5), F.S.,[4] 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

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

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 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 and 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 11.066, 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 the Department of Health, and any public defender or her or his 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.[5] 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 agency is susceptible of only one interpretation the court may decide the issue as a matter of law.[6]

III. Effect of Proposed Changes:

Section 1. Amends s. 46.015, F.S., to provide that at trial, arbitration or the rejection of an offer for arbitration in a medical malpractice action, if any defendant shows the court that the plaintiff, or his or her legal representative has delivered a written release or covenant not to sue to any person in partial satisfaction of the damages sued for, the court or arbitration panel shall set off this amount from the amount of any judgment or arbitration award to which the plaintiff would otherwise be entitled at the time of rendering the judgment or arbitration award, regardless of whether the jury has allocated fault to the settling defendant at trial and regardless of the theory of liability. The amount of the setoff must include all sums received by the plaintiff, including economic and noneconomic damages, costs, and attorney's fees.

Section 2. Amends s. 457.057, F.S., to create an exception to the requirements for health care practitioners to maintain the confidentiality of a patient's condition if pursuant to a medical negligence suit filed under ch. 766, F.S., in which the patient has executed, as a condition of filing the suit, a medical release that allows a defendant health care practitioner who is considered to be a health care provider under ch. 766, F.S., or his or her legal representative, to conduct ex parte interviews with the claimant's treating physicians. The ex parte interviews must be limited to areas that are potentially relevant to the claimant's alleged injury or illness.

Section 3. Amends s. 766.102, F.S., to revise the definition of "similar health care provider" for purposes of establishing the prevailing professional standard of care in medical malpractice actions if the health care provider whose negligence is claimed to have created the cause of action is not certified as a specialist by the appropriate American board and is not trained as a medical specialist. The current law requires a "similar health care provider" to be licensed, trained and experienced in the same discipline, and practice in the same or similar medical community. To qualify as a "similar health care provider" under the bill, one must also have, during the 5 years immediately preceding the date of the occurrence that is the basis for the action, engaged in any combination of the following: active clinical practice; instruction of students in an accredited health professional school or accredited residency program in the same

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

health profession as the health care provider against whom or on whose behalf the testimony is offered; or a clinical research program that is affiliated with a medical school or teaching hospital in the same health profession as the health care provider against whom or on whose behalf the testimony is offered.

Under current law, if the health care provider whose negligence is claimed to have created the cause of action is certified as a specialist by the appropriate American board and is trained and experienced in a medical specialty, or holds himself or herself out as a specialists, to qualify as a "similar health care provider" an individual must be trained and experienced in the same specialty and be certified by the appropriate American board in the same specialty. Under the bill, one must also have during the 5 years immediately preceding the date of the occurrence that is the basis for the action, engaged in any combination of the following: active clinical practice; instruction of students in an accredited health professional school or accredited residency program in the same health profession as the health care provider against whom or on whose behalf the testimony is offered; or a clinical research program that is affiliated with a medical school or teaching hospital in the same health profession as the health care provider against whom or on whose behalf the testimony is offered.

The bill deletes language that would allow a health care provider to testify as an expert in any action if he or she is *not* a "similar health care provider" but to the satisfaction of the court, possesses sufficient training, experience, and knowledge as a result of practice or teaching in a specialty of the defendant or practice or teaching in a related field of medicine so as to be able to provide expert testimony.

Section 4. Amends s. 766.104, F.S., to provide that, in medical negligence cases, the presuit expert's written opinion that there appears to be evidence of medical negligence shall be subject to discovery by an opposing party.

Section 5. Amends s. 766.106, F.S., to provide that the statements and opinions of the expert required for presuit investigation are subject to discovery and are admissible in any civil action for any purpose by any party. If an injured prospective claimant files a medical negligence suit, the claimant is required to execute a medical information release that allows a defendant or his or her legal representative to conduct ex parte interviews with the claimant's treating physicians. Such interviews must be limited to those areas that are potentially relevant to the claimant's alleged injury or illness.

In matters relating to professional liability insurance coverage for medical negligence, an insurer shall not be held to have acted in bad faith for failure to timely pay its policy limits if it tenders its policy limits and meets all other conditions of settlement before the conclusion of the presuit screening period provided for in this section. In all matters relating to professional liability insurance coverage for medical negligence, and in determining whether the insurer acted fairly and honestly towards its insured with due regard for her or his interest during the presuit process or after a complaint has been filed, the following factors must be considered: the insurer's willingness to negotiate with the claimant; the insurer's consideration of the advice of its defense counsel; the insurer's proper investigation of the claim; whether the insurer informed the insured of the offer to settle within the limits of coverage, the right to retain counsel, and risk of litigation; whether the insured denied liability or requested that the case be defended; and

whether the claimant imposed any condition, other than the tender of the policy limits, on the settlement of the claim.

Section 6. Creates s. 766.1065, F.S., to create a procedure for presuit mediation in a medical negligence action. After the completion of presuit investigation and any informal discovery, the parties or their designated representatives may submit the matter to presuit mediation to discuss the issues of liability and damages in an attempt to resolve the matter. The parties must:

- Agree on a mediator. If the parties are unable to agree on a mediator within 15 days after the parties agree to presuit mediation, the general counsel of the Department of Health must appoint a mediator from the list of certified circuit court mediators maintained by the chief judge of the circuit in which the suit may be filed.
- Set a date for presuit mediation.

The presuit mediation must be conducted in the following manner:

- Each party must ensure that all persons necessary for complete settlement authority are present.
- Each party must mediate in good faith.

All aspects of presuit mediation which are not specifically established for mediation by this subsection must be conducted according to the rules of practice and procedure adopted by the Supreme Court of Florida. If the parties do not settle the case pursuant to mediation, the last offer of the defendant made at mediation must be recorded by the mediator in a written report that states the amount of the offer, the date the offer was made in writing, and the date the offer was rejected. The mediator must maintain a report of the issues and facts presented at mediation and the final settlement offers of each party at the mediation. If the matter subsequently proceeds to trail, the court must consider whether issues and facts presented at mediation were significantly the same as those at trial. The presuit mediation must be confidential as required in court-ordered mediation under s. 44.102, F.S., except as otherwise provided.

Section 7. Amends s. 766.108, F.S., to require the parties to a medical negligence action to, within 120 days after the suit is filed, conduct mandatory mediation in accordance with s. 44.102, F.S., if voluntary binding arbitration has not been agreed to by the parties. The Florida Rules of Civil Procedure apply to mandatory mediation held by parties to a medical negligence action. At the conclusion of the mediation, the mediator must record the final demand and final offer to provide to the court upon the rendering of a judgment.

If the claimant who rejects the final offer of settlement made during the mediation does not obtain a judgment more favorable than the offer, the court shall assess the mediation costs and reasonable costs, expenses, and attorney's fees that were incurred after the date of mediation. The assessment attaches to the proceeds of the claimant and is attributable to any defendant whose final offer was more favorable than the judgment. If the judgment obtained at trial is not more favorable to a defendant than the final demand for judgment made by the claimant to the defendant during mediation, the court must assess the defendant for the mediation costs and reasonable costs, expenses, and attorney's fees that were incurred after the date of mediation. The final offer and final demand made during mediation are the only offer and demand that the

court may consider in assessing costs, expenses, attorney's fees, and prejudgment interest. A subsequent offer or demand by either party is inapplicable to the determination of whether sanctions will be assessed by the court. Notwithstanding any law to the contrary, s. 45.061, F.S., which deals with offers of settlement and s. 768.79, F.S., which deals with offers of judgment and demands for judgments, do not apply to medical negligence or to wrongful death cases arising out of medical negligence causes of action.

Section 8. Amends s. 766.202, F.S., to revise the definitions relating to medical negligence actions. The definitions for "economic damages" and "noneconomic damages" are revised to provide that the claimant's recovery is limited to the extent the claimant is entitled to recover such damages under general law, including the Wrongful Death Act. The Wrongful Death Act does not provide the full range of economic damages as those recoverable under the voluntary binding arbitration provisions of the medical malpractice act. The loss of earning capacity, past and future medical expenses, past and future loss of services as elements of damages are not available under the Wrongful Death Act. The damages recoverable under the Wrongful Death Act are limited by s. 768.21, F.S. Under the Wrongful Death Act, each survivor may recover the value of lost support and services from the date of the decedent's injury to her or his death, and future loss of support and services from the date of death and reduced to present value; and the estate may recover the decedent's loss of earnings, loss of prospective net accumulations, and medical or funeral expenses. The Florida Supreme Court found that "[u]nlike the Medical Malpractice Act, the Wrongful Death Act does not provide claimants with such a full range of economic damages."[7]

The definition of "medical expert" is revised to mean a person duly and regularly engaged in the practice of his or her profession who holds a health care professional degree from a university or college and who meets the requirements of an expert witness as set forth in s. 766.102, F.S. Language requiring a medical expert to have had special professional training and experience or one possessed of special health care knowledge or skill about the subject upon which he or she is called to testify or provide an opinion is eliminated.

The definition of "periodic payment" is revised to include the award of future noneconomic damages. A specific finding must be made of the dollar amount of periodic payments which will compensate for future damages after offset for collateral sources and after having been reduced to present value. A periodic payment must be structured to last as long as the claimant lives or the condition of the claimant for which the award was made persists, whichever may be shorter, but without regard for the number of years awarded. A periodic payment no longer has to have the total dollar amount of the periodic payments equal to the dollar amount of all such future damages before any reduction to present value.

A defendant that elects to make periodic payments of either or both future economic or future noneconomic losses may contractually obligate a company that is authorized to do business in Florida and rated by A.M. Best Company as A+ or higher to make those periodic payments on its behalf. Under the bill, the defendant that opts to make periodic payments to satisfy a judgment is no longer required to post a bond or other alternatives to assure full payment of damages

[7] See *St Mary's Hospital v. Phillipe*, 769 So.2d 961, 972-973 (Fla. 2000) in which the Florida Supreme held that in medical malpractice arbitration, the medical malpractice statute should determine how economic damages are calculated.

awarded. Upon joint petition to a court by the defendant and the company that is contractually obligated to make the periodic payments, the court must discharge the defendant from any further obligations to the claimant for those future economic and future noneconomic damages that are to be paid by the company. A bond or security may not be required of any defendant or company that is obligated to make periodic payments. If upon petition by a claimant who is receiving periodic payments, and a court finds there is substantial, competent evidence that the defendant responsible for the periodic payments cannot adequately assure full and continuous payments or that the company obligated to make the payments has been rated by A.M. Best as B+ or lower, and that doing so is in the best interest of the claimant, the court may require the defendant or company to provide additional financial security as the court determines reasonable under the circumstances.

The provision for periodic payments must be structured to specify the recipient of the payments, the address to which payments are to be delivered, and the amount and intervals of payment. In any one year, any payment or payments may not exceed the amount intended by the trier of fact to be awarded each year, offset for collateral sources. A periodic payment may not be accelerated, deferred, increased, or decreased except by court order based upon the mutual consent and agreement of the claimant, the defendant, whether or not discharged, and the company obligated to make the periodic payments. The claimant may not sell, mortgage, encumber, or anticipate the periodic payments or any part thereof, by assignment or otherwise.

Section 9. 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.

The Wrongful Death Act (ss. 768.16 – 768.27, F.S.) does not provide the full range of economic damages as those recoverable under the voluntary binding arbitration provisions of the medical malpractice act. The loss of earning capacity, past and future medical expenses, past and future loss of services as elements of damages are not available under the Wrongful Death Act. The damages recoverable under the Wrongful Death Act are limited by s. 768.21, F.S. Under the Wrongful Death Act, each survivor may recover the value of lost support and services from the date of the decedent's injury to her or his death, and future loss of support and services from the date of death and reduced to present value; and the estate may recover the decedent's loss of earnings, loss of prospective net accumulations, and medical or funeral expenses. The Florida Supreme Court found that "[u]nlike the Medical Malpractice Act, the Wrongful Death Act does not provide claimants with such a full range of economic damages."[8]

The award of noneconomic damages in the bill is revised to provide an aggregate cap of $250,000 in cases involving multiple claimants so that regardless of the number of individual claimants, the total noneconomic damages that may be awarded for all claims arising out of the same incident, including claims under the Wrongful Death Act, shall be limited to a maximum of $250,000. Damages for future noneconomic losses in addition to 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 payments.

[8] See *St Mary's Hospital v. Phillipe*, 769 So.2d 961, 972-973 (Fla. 2000) in which the Florida Supreme held that in medical malpractice arbitration, the medical malpractice statute should determine how economic damages are calculated.

Section 10. Amends s. 766.209, F.S., relating to the effects of the failure to offer or accept voluntary binding arbitration, to impose a limitation on the award of noneconomic damages. If the claimant rejects a defendant's offer to enter voluntary binding arbitration, regardless of the number of individual claimants, the total noneconomic damages awardable at trial for all claims arising out of the same incident, including claims under the Wrongful Death Act, shall be limited to a maximum of $350,000.[9]

Section 11. Amends s. 768.041, F.S., relating to releases or covenants not to sue, to provide that at trial, arbitration or at trial after the rejection of an offer for arbitration in a medical malpractice action, if any defendant shows the court that the plaintiff, or his or her legal representative, has delivered a written release or covenant not to sue to any person in partial satisfaction of the damages sued for, the court or arbitration panel shall set off this amount from the amount of any judgment or arbitration award to which the plaintiff would otherwise be entitled at the time of rendering the judgment or arbitration award, regardless of whether the jury has allocated fault to the settling defendant at trial and regardless of the theory of liability. The amount of the setoff must include all sums received by the plaintiff, including economic and noneconomic damages, costs, and attorney's fees.

Section 12. Amends s. 768.13, F.S., the Good Samaritan Act, to revise the circumstances under which immunity from civil liability is extended to 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 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. Under the bill, such immunity applies to any act or omission of providing medical care or treatment, unless it was unrelated to the original medical emergency and unless there was a reckless disregard of the consequences.

Under current law the immunity does not apply to damages as a result of any act or omission of providing medical care or treatment which occurs after the patient is stabilized and is capable of receiving medical treatment as a nonemergency patient, unless surgery is required as a result of the emergency within a reasonable time after the patient is stabilized, in which case the immunity provided applies to any act or omission of providing medical care or treatment which occurs prior to the stabilization of the patient following the surgery.

Immunity from civil liability is extended to any licensed or certified health care practititioner who provides medical care or treatment in a hospital to a patient or person 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 demonstrating a reckless disregard for the life or health of the victim. Such immunity does not apply to medical care or treatment unrelated to the original situation that demanded immediate medical attention. "Reckless disregard" means conduct that a health care provider knew or should have known, at the time such services were rendered, would be likely to result in injury so as to affect the life or

[9] See *St Mary's Hospital v. Phillipe*, 769 So.2d 961, 972-973 (Fla. 2000) in which the Florida Supreme held that in medical malpractice arbitration, the medical malpractice statute should determine how economic damages are calculated.

health of another, taking into account the following, to the extent they may be present: the extent or serious nature of the circumstances prevailing; the lack of time or ability to obtain appropriate consultation; the lack of a prior patient-physician relationship; the inability to obtain an appropriate medical history of the patient; and the time constraints imposed by coexisting emergencies.

Section 13. Amends s. 768.28, F.S., to extend the waiver of sovereign immunity to certain health care professionals by revising the definition of "officer, employee or agent" to include any health care professional when providing services in an emergency room or trauma center of a Florida-licensed hospital.

Section 14. Amends s. 768.77, F.S., to provide that in any action for damages based on personal injury or wrongful death arising out of medical malpractice, whether in tort or contract, to which the requirements of part II, ch. 768, F.S., applies, in which the trier of fact determines that liability exists on the part of the defendant, the trier of fact shall, as part of the verdict, itemize the amounts to be awarded to the claimant in 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 not reduced to present value, and the number or years or part thereof which the award is intended to cover; and
- Amounts awarded to the claimant for punitive damages, if applicable.

To conform to the award of damages in periodic payments, the trier of fact in any action for damages arising out of medical malpractice would as part of the verdict now have to itemize for amounts intended for the claimant for past economic losses, future economic losses, past noneconomic losses, and future noneconomic losses.

Section 15. Amends s. 768.78, F.S., relating to alternative methods of payment of damage awards in medical negligence actions, to provide for the option of periodic payments of future noneconomic damages.

The defendant, if determined by the court to be financially capable or adequately insured, may elect to use periodic payments to satisfy in whole or in part the assessed future economic and future noneconomic losses awarded by the trier of fact after offset for collateral sources for so long as the claimant lives or the condition for which the award was made persists, whichever period may be shorter, but without regard for the number of years awarded by the trier of fact. The court may review, and unless clearly unresponsive to the future needs of the claimant, approve the amounts and schedule of periodic payments proposed by the defendant. Upon motion of the defendant, and establishment by substantial competent evidence of either the death of the claimant or that the condition for which the award was made no longer persists, the court shall enter an order terminating the periodic payments effective as of the date of death of the claimant or the date the condition for which the award was made no longer exists.

A defendant that elects to make periodic payments of either or both future economic or future noneconomic losses may contractually obligate a company that is authorized to do business in

Florida and rated by A.M. Best Company as A+ or higher to make those periodic payments on its behalf. Upon notice of a defendant's election to make periodic payments, the claimant may request that the court modify the periodic payments to reasonably provide for attorney's fees, however the modification may not increase the amount that the defendant would have been obligated to pay if no modification was made.

Under the bill, the defendant that opts to make periodic payments to satisfy a judgment is no longer required to post a bond or other alternatives to assure full payment of damages awarded. Upon joint petition to a court by the defendant and the company that is contractually obligated to make the periodic payments, the court must discharge the defendant from any further obligations to the claimant for those future economic and future noneconomic damages that are to be paid by the company. A bond or security may not be required of any defendant or company that is obligated to make periodic payments. If upon petition by a claimant who is receiving periodic payments, and a court finds there is substantial, competent evidence that the defendant responsible for the periodic payments cannot adequately assure full and continuous payments or that the company obligated to make the payments has been rated by A.M. Best as B+ or lower, and that doing so is in the best interest of the claimant, the court may require the defendant or company to provide additional financial security as the court determines reasonable under the circumstances.

The provision for periodic payments must be structured to specify the recipient of the payments, the address to which payments are to be delivered, and the amount and intervals of payment. In any one year, any payment or payments may not exceed the amount intended by the trier of fact to be awarded each year, offset for collateral sources. A periodic payment may not be accelerated, deferred, increased, or decreased except by court order based upon the mutual consent and agreement of the claimant, the defendant, whether or not discharged, and the company obligated to make the periodic payments. The claimant may not sell, mortgage, encumber, or anticipate the periodic payments or any part thereof, by assignment or otherwise.

"Periodic payment" is defined to mean the payment of money or delivery of other property to the claimant at regular intervals. Legislative intent is provided to authorize and encourage the payment of awards for future economic and future noneconomic losses by periodic payment to meet the continuing needs of the patient while eliminating the misdirection of such funds for purposes not intended by the trier of fact.

Section 16. Amends s. 768.81, F.S., to extend a requirement for the apportionment of damages on the basis of comparative fault that is currently limited to tortfeasors that are teaching hospitals to all medical malpractice tortfeasors so that in any action for damages for personal injury or wrongful death arising out of medical malpractice, whether in contract or tort, the court shall enter judgment on the basis of each party's percentage of fault and not on the basis of the doctrine of joint and several liability.

Section 17. Provides a contingent effective date that the act take effect upon becoming a law if SB 560, SB 562, and SB 566 or similar legislation is adopted in the same legislative session or an extension thereof and becomes law.

IV. Constitutional Issues:

A. Municipality/County Mandates Restrictions:

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

B. Public Records/Open Meetings Issues:

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

C. Trust Funds Restrictions:

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

D. Other Constitutional Issues:

Under the bill, the award of noneconomic damages is revised to provide an aggregate cap in cases involving multiple claimants for claims arising out of the same incident: in voluntary arbitration the cap is $250,000 and, at trial following a rejection of an offer to enter voluntary arbitration, the cap is $350,000.

Section 766. 207, F.S.,[10] provides that 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 not more than $125,000 noneconomic damages. In St. Mary's Hospital, Inc. v. Phillipe,[11] 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.

The court held that the statute meant 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.

[10] See also Section 766.209, which provides that a claimant at trial following a rejection of an offer to enter voluntary arbitration shall be subject to damages awardable at trial being limited to net economic damages, plus noneconomic damages not to exceed $350,000 per incident.
[11] See supra.

The requirement in the bill for claimants in medical negligence suits to execute a medical release that allows a defendant or his or her legal representative to conduct ex parte interviews may raise privacy issues under the Florida Constitution and applicable federal law.

V. Economic Impact and Fiscal Note:

A. Tax/Fee Issues:

None.

B. Private Sector Impact:

Persons injured by the malpractice of health care providers in emergency rooms or trauma centers of a Florida-licensed hospital, will have their recovery capped at the limits authorized under s. 768.28, F.S., and will have to seek a claim bill for the excess judgment or settlement.

Medical malpractice claimants will have their damage awards reduced by setoffs, which currently would not otherwise reduce their awards.

Medical malpractice claimants whose claims are arbitrated may have their claims reduced to conform to the element of damages awardable under the Wrongful Death Act.

Multiple medical malpractice claimants whose claims arise out of the same incident will have their pro rata share of the damage award reduced in voluntary arbitration or at trial following the rejection of an offer to arbitrate.

Claimants subject to periodic payments for medical malpractice damage awards will no longer have the option of receiving a lump-sum payment and may no longer assign or sell their rights to the periodic payment.

Medical malpractice defendants will no longer be required to post a bond or other financial security and may opt to pay claimants by periodic payment rather than lump-sum.

C. Government Sector Impact:

The state government will incur additional costs to investigate and cover the claims for health care providers providing services in an emergency room or trauma center in Florida. It is unclear which state agency or local government will be responsible for monitoring the claims of such providers and handling the defense of such claims. It is unclear which governmental entity will be responsible for claims administration and management for those providers who are already covered by sovereign immunity.

VI. Technical Deficiencies:

None.

VII. Related Issues:

The bill provides two definitions for "periodic payment", one for purposes of medical malpractice actions under ch. 766, F.S., and one for purposes of alternative damages awarded in ch. 768, F.S.

VIII. Amendments:

None.