1 A bill to be entitled
2 An act relating to medical incidents; providing
3 legislative findings; amending s. 395.0191, F.S.; deleting
4 requirement that persons act in good faith to avoid
5 liability or discipline for their actions regarding the
6 awarding of staff membership or clinical privileges;
7 amending s. 395.1012, F.S.; requiring hospitals,
8 ambulatory surgical centers, and mobile surgical
9 facilities to establish patient safety plans and
10 committees; creating s. 395.1051, F.S.; providing for
11 notification of injuries in a hospital, ambulatory
12 surgical center, or mobile surgical facility; amending s.
13 456.041, F.S.; requiring additional information to be
14 included in health care practitioner profiles; providing
15 for fines; revising requirements for the reporting of paid
16 liability claims; amending s. 456.042, F.S.; requiring
17 health care practitioner profiles to be updated within a
18 specific time period; amending s. 456.049, F.S.; revising
19 requirements for the reporting of paid liability claims;
20 amending s. 456.057, F.S.; authorizing the Department of
21 Health to utilize subpoenas to obtain patient records
22 without patients' consent under certain circumstances;
23 amending s. 456.072, F.S.; authorizing the Department of
24 Health to determine administrative costs in disciplinary
25 actions; amending s. 456.073, F.S.; extending the time for
26 the Department of Health to refer a request for an
27 administrative hearing; amending s. 456.077, F.S.;
28 revising provisions relating to designation of certain
29 citation violations; amending s. 456.078, F.S.; revising
30 provisions relating to designation of certain mediation

31 offenses; creating s. 456.085, F.S.; providing for
32 notification of an injury by a physician; amending s.
33 458.331, F.S.; increasing the amount of paid liability
34 claims requiring investigation by the Department of
35 Health; revising the definition of "repeated malpractice"
36 to conform; creating s. 458.3311, F.S.; establishing
37 emergency procedures for disciplinary actions; amending s.
38 459.015, F.S.; increasing the amount of paid liability
39 claims requiring investigation by the Department of
40 Health; revising the definition of "repeated malpractice"
41 to conform; creating s. 459.0151, F.S.; establishing
42 emergency procedures for disciplinary actions; amending s.
43 461.013, F.S.; increasing the amount of paid liability
44 claims requiring investigation by the Department of
45 Health; revising the definition of "repeated malpractice"
46 to conform; amending s. 627.062, F.S.; prohibiting the
47 inclusion of payments made by insurers for bad faith
48 claims in an insurer's rate base; requiring certain rate
49 filings; creating s. 627.0662, F.S.; providing
50 definitions; requiring each medical liability insurer to
51 report certain information to the Office of Insurance
52 Regulation; providing for determination of whether
53 excessive profit has been realized; requiring return of
54 excessive amounts; amending s. 627.357, F.S.; deleting the
55 prohibition against formation of medical malpractice self-
56 insurance funds; providing requirements to form a self-
57 insurance fund; providing rulemaking authority to the
58 Financial Services Commission; creating s. 627.3575, F.S.;
59 creating the Health Care Professional Liability Insurance
60 Facility; providing purpose; providing for governance and

61 powers; providing eligibility requirements; providing for
62 premiums and assessments; providing for regulation;
63 providing applicability; specifying duties of the
64 Department of Health; providing for debt and regulation
65 thereof; amending s. 627.912, F.S.; requiring certain
66 claims information to be filed with the Office of
67 Insurance Regulation and the Department of Health;
68 providing for rulemaking by the Financial Services
69 Commission; creating s. 627.9121, F.S.; requiring certain
70 information relating to medical malpractice to be reported
71 to the Office of Insurance Regulation; providing for
72 enforcement; amending s. 766.106, F.S.; extending the time
73 period for the presuit screening period; providing
74 conditions for causes of action for bad faith against
75 insurers providing coverage for medical negligence;
76 revising provisions relating to a claimant's period to
77 file suit after rejection of a prospective defendant's
78 offer to admit liability and for arbitration on the issue
79 of damages; specifying consequences of failure to
80 cooperate on the part of any party during the presuit
81 investigation; providing factors to be considered with
82 respect to certain claims against bad faith against an
83 insurer; creating s. 766.1065, F.S.; requiring parties to
84 provide certain information to parties without request;
85 authorizing the issuance of subpoenas without case
86 numbers; requiring that parties and certain experts be
87 made available for deposition; providing for mandatory
88 presuit mediation; creating s. 766.1067, F.S.; providing
89 for mandatory mediation in medical negligence causes of
90 action; creating s. 766.118, F.S.; providing a limitation

91 on noneconomic damages which can be awarded in causes of
92 action involving medical negligence; amending s. 766.202,
93 F.S.; providing requirements for medical experts; amending
94 s. 766.203, F.S.; providing for discovery of opinions and
95 statements tendered during presuit investigation; amending
96 s. 766.207, F.S.; conforming provisions to the extension
97 in the time period for presuit investigation; requiring
98 the Department of Health to study the efficacy and
99 constitutionality of medical review panels; requiring a
100 report; amending s. 768.81, F.S.; providing that a
101 defendant's liability for damages in medical negligence
102 cases is several only; creating s. 1004.08, F.S.;
103 requiring patient safety instruction for certain students
104 in public schools, colleges, and universities; creating s.
105 1005.07, F.S.; requiring patient safety instruction for
106 certain students in nonpublic schools, colleges, and
107 universities; requiring a report by the Agency for Health
108 Care Administration regarding information to be provided
109 to health care consumers; requiring a report by the Agency
110 for Health Care Administration regarding the establishment
111 of a Patient Safety Authority; specifying elements of the
112 report; providing severability; providing for construction
113 of the act in pari materia with laws enacted during the
114 2003 Regular Session or the 2003 Special Session A of the
115 Legislature; providing an effective date.
116
117 Be It Enacted by the Legislature of the State of Florida:
118
119 Section 1. Findings.--

120 (1) The Legislature finds that Florida is in the midst of
121 a medical malpractice insurance crisis of unprecedented
122 magnitude.
123 (2) The Legislature finds that this crisis threatens the
124 quality and availability of health care for all Florida
125 citizens.
126 (3) The Legislature finds that the rapidly growing
127 population and the changing demographics of Florida make it
128 imperative that students continue to choose Florida as the place
129 they will receive their medical educations and practice
130 medicine.
131 (4) The Legislature finds that Florida is among the states
132 with the highest medical malpractice insurance premiums in the
133 nation.
134 (5) The Legislature finds that the cost of medical
135 malpractice insurance has increased dramatically during the past
136 decade and both the increase and the current cost are
137 substantially higher than the national average.
138 (6) The Legislature finds that the increase in medical
139 malpractice liability insurance rates is forcing physicians to
140 practice medicine without professional liability insurance, to
141 leave Florida, to not perform high-risk procedures, or to retire
142 early from the practice of medicine.
143 (7) The Legislature finds that there are certain elements
144 of damage presently recoverable that have no monetary value,
145 except on a purely arbitrary basis, while other elements of
146 damage are either easily measured on a monetary basis or reflect
147 ultimate monetary loss.

148 (8) The Governor created the Governor's Select Task Force
149 on Healthcare Professional Liability Insurance to study and make
150 recommendations to address these problems.
151 (9) The Legislature has reviewed the findings and
152 recommendations of the Governor's Select Task Force on
153 Healthcare Professional Liability Insurance.
154 (10) The Legislature finds that the Governor's Select Task
155 Force on Healthcare Professional Liability Insurance has
156 established that a medical malpractice crisis exists in the
157 State of Florida which can be alleviated by the adoption of
158 comprehensive legislatively enacted reforms.
159 (11) The Legislature finds that making high-quality health
160 care available to the citizens of this state is an overwhelming
161 public necessity.
162 (12) The Legislature finds that ensuring that physicians
163 continue to practice in Florida is an overwhelming public
164 necessity.
165 (13) The Legislature finds that ensuring the availability
166 of affordable professional liability insurance for physicians is
167 an overwhelming public necessity.
168 (14) The Legislature finds, based upon the findings and
169 recommendations of the Governor's Select Task Force on
170 Healthcare Professional Liability Insurance, the findings and
171 recommendations of various study groups throughout the nation,
172 and the experience of other states, that the overwhelming public
173 necessities of making quality health care available to the
174 citizens of this state, of ensuring that physicians continue to
175 practice in Florida, and of ensuring that those physicians have
176 the opportunity to purchase affordable professional liability

177 insurance cannot be met unless a cap on noneconomic damages in
178 an amount no higher than $250,000 is imposed.
179 (15) The Legislature finds that the high cost of medical
180 malpractice claims can be substantially alleviated by imposing a
181 limitation on noneconomic damages in medical malpractice
182 actions.
183 (16) The Legislature further finds that there is no
184 alternative measure of accomplishing such result without
185 imposing even greater limits upon the ability of persons to
186 recover damages for medical malpractice.
187 (17) The Legislature finds that the provisions of this act
188 are naturally and logically connected to each other and to the
189 purpose of making quality health care available to the citizens
190 of Florida.
191 (18) The Legislature finds that each of the provisions of
192 this act is necessary to alleviate the crisis relating to
193 medical malpractice insurance.
194 Section 2. Subsection (7) of section 395.0191, Florida
195 Statutes, is amended to read:
196 395.0191 Staff membership and clinical privileges.--
197 (7) There shall be no monetary liability on the part of,
198 and no cause of action for injunctive relief or damages shall
199 arise against, any licensed facility, its governing board or
200 governing board members, medical staff, or disciplinary board or
201 against its agents, investigators, witnesses, or employees, or
202 against any other person, for any action arising out of or
203 related to carrying out the provisions of this section, absent
204 ~~taken in good faith and without~~ intentional fraud ~~in carrying~~
205 ~~out the provisions of this section~~.
206 Section 3. Section 395.1012, Florida Statutes, is created

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

207 to read:

208 395.1012 Patient safety.--

209 (1) Each licensed facility shall adopt a patient safety
210 plan. A plan adopted to implement the requirements of 42 C.F.R.
211 s. 482.21 shall be deemed to comply with this requirement.

212 (2) Each licensed facility shall appoint a patient safety
213 officer and a patient safety committee, which shall include at
214 least one person who is neither employed by nor practicing in
215 the facility, for the purpose of promoting the health and safety
216 of patients, reviewing and evaluating the quality of patient
217 safety measures used by the facility, and assisting in the
218 implementation of the facility patient safety plan.

219 Section 4. Section 395.1051, Florida Statutes, is created
220 to read:

221 395.1051 Duty to notify patients.--Every licensed facility
222 shall inform each patient, or an individual identified pursuant
223 to s. 765.401(1), in person about unanticipated outcomes of care
224 that result in serious harm to the patient. Notification of
225 outcomes of care that result in harm to the patient under this
226 section shall not constitute an acknowledgement or admission of
227 liability, nor can it be introduced as evidence in any civil
228 lawsuit.

229 Section 5. Section 456.041, Florida Statutes, is amended
230 to read:

231 456.041 Practitioner profile; creation.--

232 (1)(a) Beginning July 1, 1999, the Department of Health
233 shall compile the information submitted pursuant to s. 456.039
234 into a practitioner profile of the applicant submitting the
235 information, except that the Department of Health may develop a
236 format to compile uniformly any information submitted under s.

237 456.039(4)(b). Beginning July 1, 2001, the Department of Health
238 may, and beginning July 1, 2004, shall, compile the information
239 submitted pursuant to s. 456.0391 into a practitioner profile of
240 the applicant submitting the information.
241 (b) Each practitioner licensed under chapter 458 or
242 chapter 459 must report to the Department of Health and the
243 Board of Medicine or the Board of Osteopathic Medicine,
244 respectively, all final disciplinary actions, sanctions by a
245 governmental agency or a facility or entity licensed under state
246 law, and claims or actions, as provided under s. 456.051, to
247 which he or she is subjected no later than 15 calendar days
248 after such action or sanction is imposed. Failure to submit the
249 requisite information within 15 calendar days in accordance with
250 this paragraph shall subject the practitioner to discipline by
251 the Board of Medicine or the Board of Osteopathic Medicine and a
252 fine of $100 for each day that the information is not submitted
253 after the expiration of the 15-day reporting period.
254 (c) Within 15 days after receiving a report under
255 paragraph (b), the department shall update the practitioner's
256 profile in accordance with the requirements of subsection (7).
257 (2) On the profile published under subsection (1), the
258 department shall indicate whether if the information provided
259 under s. 456.039(1)(a)7. or s. 456.0391(1)(a)7. is or is not
260 corroborated by a criminal history check conducted according to
261 this subsection. If the information provided under s.
262 456.039(1)(a)7. or s. 456.0391(1)(a)7. is corroborated by the
263 criminal history check, the fact that the criminal history check
264 was performed need not be indicated on the profile. The
265 department, or the board having regulatory authority over the
266 practitioner acting on behalf of the department, shall

CODING: Words stricken are deletions; words underlined are additions.

267 investigate any information received by the department or the
268 board when it has reasonable grounds to believe that the
269 practitioner has violated any law that relates to the
270 practitioner's practice.
271 (3) The Department of Health shall ~~may~~ include in each
272 practitioner's practitioner profile that criminal information
273 that directly relates to the practitioner's ability to
274 competently practice his or her profession. The department must
275 include in each practitioner's practitioner profile the
276 following statement: "The criminal history information, if any
277 exists, may be incomplete; federal criminal history information
278 is not available to the public." The department shall provide in
279 each practitioner profile, for every final disciplinary action
280 taken against the practitioner, a narrative description, written
281 in plain English, that explains the administrative complaint
282 filed against the practitioner and the final disciplinary action
283 imposed on the practitioner. The department shall include a
284 hyperlink to each final order listed on its Internet website
285 report of dispositions of recent disciplinary actions taken
286 against practitioners.
287 (4) The Department of Health shall include, with respect
288 to a practitioner licensed under chapter 458 or chapter 459, a
289 statement of how the practitioner has elected to comply with the
290 financial responsibility requirements of s. 458.320 or s.
291 459.0085. The department shall include, with respect to
292 practitioners subject to s. 456.048, a statement of how the
293 practitioner has elected to comply with the financial
294 responsibility requirements of that section. The department
295 shall include, with respect to practitioners licensed under
296 chapter 458, chapter 459, or chapter 461, information relating

297 to liability actions which has been reported under s. 456.049 or
298 s. 627.912 within the previous 10 years for any paid claim of
299 $50,000 or more ~~that exceeds $5,000~~. Such claims information
300 shall be reported in the context of comparing an individual
301 practitioner's claims to the experience of other practitioners
302 within the same specialty, or profession if the practitioner is
303 not a specialist~~, to the extent such information is available to~~
304 ~~the Department of Health~~. The department shall include a
305 hyperlink to all such comparison reports in such practitioner's
306 profile on its Internet website. If information relating to a
307 liability action is included in a practitioner's practitioner
308 profile, the profile must also include the following statement:
309 "Settlement of a claim may occur for a variety of reasons that
310 do not necessarily reflect negatively on the professional
311 competence or conduct of the practitioner. A payment in
312 settlement of a medical malpractice action or claim should not
313 be construed as creating a presumption that medical malpractice
314 has occurred."
315 (5) The Department of Health shall ~~may not~~ include the
316 date of a disciplinary action taken by a licensed hospital or an
317 ambulatory surgical center, in accordance with the requirements
318 of s. 395.0193, in the practitioner profile. Any practitioner
319 disciplined under paragraph (1)(b) must report to the department
320 the date the disciplinary action was imposed. The department
321 shall state whether the action is related to professional
322 competence and whether it is related to the delivery of services
323 to a patient.
324 (6) The Department of Health may include in the
325 practitioner's practitioner profile any other information that
326 is a public record of any governmental entity and that relates

327 to a practitioner's ability to competently practice his or her
328 profession. However, the department must consult with the board
329 having regulatory authority over the practitioner before such
330 information is included in his or her profile.
331 (7) Upon the completion of a practitioner profile under
332 this section, the Department of Health shall furnish the
333 practitioner who is the subject of the profile a copy of it. The
334 practitioner has a period of 30 days in which to review the
335 profile and to correct any factual inaccuracies in it. The
336 Department of Health shall make the profile available to the
337 public at the end of the 30-day period. The department shall
338 make the profiles available to the public through the World Wide
339 Web and other commonly used means of distribution.
340 (8) The Department of Health shall provide in each profile
341 an easy-to-read explanation of any disciplinary action taken and
342 the reason the sanction or sanctions were imposed.
343 (9)~~(8)~~ Making a practitioner profile available to the
344 public under this section does not constitute agency action for
345 which a hearing under s. 120.57 may be sought.
346 Section 6. Section 456.042, Florida Statutes, is amended
347 to read:
348 456.042 Practitioner profiles; update.--A practitioner
349 must submit updates of required information within 15 days after
350 the final activity that renders such information a fact. The
351 Department of Health shall update each practitioner's
352 practitioner profile periodically. An updated profile is subject
353 to the same requirements as an original profile with respect to
354 the period within which the practitioner may review the profile
355 for the purpose of correcting factual inaccuracies.

356 Section 7. Subsection (1) of section 456.049, Florida
357 Statutes, is amended, and subsection (3) is added to said
358 section, to read:
359 456.049 Health care practitioners; reports on professional
360 liability claims and actions.--
361 (1) Any practitioner of medicine licensed pursuant to the
362 provisions of chapter 458, practitioner of osteopathic medicine
363 licensed pursuant to the provisions of chapter 459, podiatric
364 physician licensed pursuant to the provisions of chapter 461, or
365 dentist licensed pursuant to the provisions of chapter 466 shall
366 report to the department any claim or action for damages for
367 personal injury alleged to have been caused by error, omission,
368 or negligence in the performance of such licensee's professional
369 services or based on a claimed performance of professional
370 services without consent if ~~the claim was not covered by an~~
371 ~~insurer required to report under s. 627.912 and~~ the claim
372 resulted in:
373 (a) A final judgment of $50,000 or more or, with respect
374 to a dentist licensed pursuant to chapter 466, a final judgment
375 of $25,000 or more ~~in any amount~~.
376 (b) A settlement of $50,000 or more or, with respect to a
377 dentist licensed pursuant to chapter 466, a settlement of
378 $25,000 or more ~~in any amount~~.
379 (c) A final disposition not resulting in payment on behalf
380 of the licensee.
381
382 Reports shall be filed with the department no later than 60 days
383 following the occurrence of any event listed in paragraph (a),
384 paragraph (b), or paragraph (c).

385 (3) The department shall forward the information collected
386 under this section to the Office of Insurance Regulation.
387 Section 8. Paragraph (a) of subsection (7) of section
388 456.057, Florida Statutes, is amended to read:
389 456.057 Ownership and control of patient records; report
390 or copies of records to be furnished.--
391 (7)(a)1. The department may obtain patient records
392 pursuant to a subpoena without written authorization from the
393 patient if the department and the probable cause panel of the
394 appropriate board, if any, find reasonable cause to believe that
395 a health care practitioner has excessively or inappropriately
396 prescribed any controlled substance specified in chapter 893 in
397 violation of this chapter or any professional practice act or
398 that a health care practitioner has practiced his or her
399 profession below that level of care, skill, and treatment
400 required as defined by this chapter or any professional practice
401 act and also find that appropriate, reasonable attempts were
402 made to obtain a patient release.
403 2. The department may obtain patient records and insurance
404 information pursuant to a subpoena without written authorization
405 from the patient if the department and the probable cause panel
406 of the appropriate board, if any, find reasonable cause to
407 believe that a health care practitioner has provided inadequate
408 medical care based on termination of insurance and also find
409 that appropriate, reasonable attempts were made to obtain a
410 patient release.
411 3. The department may obtain patient records, billing
412 records, insurance information, provider contracts, and all
413 attachments thereto pursuant to a subpoena without written
414 authorization from the patient if the department and probable

415 cause panel of the appropriate board, if any, find reasonable
416 cause to believe that a health care practitioner has submitted a
417 claim, statement, or bill using a billing code that would result
418 in payment greater in amount than would be paid using a billing
419 code that accurately describes the services performed, requested
420 payment for services that were not performed by that health care
421 practitioner, used information derived from a written report of
422 an automobile accident generated pursuant to chapter 316 to
423 solicit or obtain patients personally or through an agent
424 regardless of whether the information is derived directly from
425 the report or a summary of that report or from another person,
426 solicited patients fraudulently, received a kickback as defined
427 in s. 456.054, violated the patient brokering provisions of s.
428 817.505, or presented or caused to be presented a false or
429 fraudulent insurance claim within the meaning of s.
430 817.234(1)(a), and also find that, within the meaning of s.
431 817.234(1)(a), patient authorization cannot be obtained because
432 the patient cannot be located or is deceased, incapacitated, or
433 suspected of being a participant in the fraud or scheme, and if
434 the subpoena is issued for specific and relevant records.
435 4. Notwithstanding subparagraphs 1.-3., when the
436 department investigates a professional liability claim or
437 undertakes action pursuant to s. 456.049 or s. 627.912, the
438 department may obtain patient records pursuant to a subpoena
439 without written authorization from the patient if the patient
440 refuses to cooperate or attempts to obtain a patient release and
441 failure to obtain the patient records would be detrimental to
442 the investigation.
443 Section 9. Subsection (4) of section 456.072, Florida
444 Statutes, is amended to read:

445 456.072 Grounds for discipline; penalties; enforcement.--
446 (4) In any ~~addition to any other discipline imposed~~
447 ~~through~~ final order, or citation, entered on or after July 1,
448 2001, that imposes a penalty or other form of discipline
449 pursuant to this section or ~~discipline imposed through final~~
450 ~~order, or citation, entered on or after July 1, 2001,~~ for a
451 violation of any practice act, the board, or the department when
452 there is no board, shall assess costs related to the
453 investigation and prosecution of the case, including costs
454 associated with an attorney's time. The amount of costs to be
455 assessed shall be determined by the board, or the department
456 when there is no board, following its consideration of an
457 affidavit of itemized costs and any written objections thereto.
458 In any case in which ~~where the board or the department imposes~~ a
459 fine or assessment of costs imposed by the board or department
460 ~~and the fine or assessment~~ is not paid within a reasonable time,
461 such reasonable time to be prescribed in the rules of the board,
462 or the department when there is no board, or in the order
463 assessing such fines or costs, the department or the Department
464 of Legal Affairs may contract for the collection of, or bring a
465 civil action to recover, the fine or assessment.
466 Section 10. Subsection (5) of section 456.073, Florida
467 Statutes, is amended to read:
468 456.073 Disciplinary proceedings.--Disciplinary
469 proceedings for each board shall be within the jurisdiction of
470 the department.
471 (5)(a) A formal hearing before an administrative law judge
472 from the Division of Administrative Hearings shall be held
473 pursuant to chapter 120 if there are any disputed issues of
474 material fact. The administrative law judge shall issue a

475 recommended order pursuant to chapter 120. If any party raises
476 an issue of disputed fact during an informal hearing, the
477 hearing shall be terminated and a formal hearing pursuant to
478 chapter 120 shall be held.
479 (b) Notwithstanding s. 120.569(2), the department shall
480 notify the Division of Administrative Hearings within 45 days
481 after receipt of a petition or request for a hearing that the
482 department has determined requires a formal hearing before an
483 administrative law judge.
484 Section 11. Subsections (1) and (2) of section 456.077,
485 Florida Statutes, are amended to read:
486 456.077 Authority to issue citations.--
487 (1) Notwithstanding s. 456.073, the board, or the
488 department if there is no board, shall adopt rules to permit the
489 issuance of citations. The citation shall be issued to the
490 subject and shall contain the subject's name and address, the
491 subject's license number if applicable, a brief factual
492 statement, the sections of the law allegedly violated, and the
493 penalty imposed. The citation must clearly state that the
494 subject may choose, in lieu of accepting the citation, to follow
495 the procedure under s. 456.073. If the subject disputes the
496 matter in the citation, the procedures set forth in s. 456.073
497 must be followed. However, if the subject does not dispute the
498 matter in the citation with the department within 30 days after
499 the citation is served, the citation becomes a public final
500 order and does not constitute ~~constitutes~~ discipline for a first
501 offense, but does constitute discipline for a second or
502 subsequent offense. The penalty shall be a fine or other
503 conditions as established by rule.

504 (2) The board, or the department if there is no board,
505 shall adopt rules designating violations for which a citation
506 may be issued. Such rules shall designate as citation violations
507 those violations for which there is no substantial threat to the
508 public health, safety, and welfare or no violation of standard
509 of care involving injury to a patient. Violations for which a
510 citation may be issued shall include violations of continuing
511 education requirements; failure to timely pay required fees and
512 fines; failure to comply with the requirements of ss. 381.026
513 and 381.0261 regarding the dissemination of information
514 regarding patient rights; failure to comply with advertising
515 requirements; failure to timely update practitioner profile and
516 credentialing files; failure to display signs, licenses, and
517 permits; failure to have required reference books available; and
518 all other violations that do not pose a direct and serious
519 threat to the health and safety of the patient or involve a
520 violation of standard of care that has resulted in injury to a
521 patient.
522 Section 12. Subsections (1) and (2) of section 456.078,
523 Florida Statutes, are amended to read:
524 456.078 Mediation.--
525 (1) Notwithstanding the provisions of s. 456.073, the
526 board, or the department when there is no board, shall adopt
527 rules to designate which violations of the applicable
528 professional practice act are appropriate for mediation. The
529 board, or the department when there is no board, shall ~~may~~
530 designate as mediation offenses those complaints where harm
531 caused by the licensee is economic in nature, except any act or
532 omission involving intentional misconduct, ~~or~~ can be remedied by
533 the licensee, is not a standard of care violation involving any

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

534 type of injury to a patient, or does not result in an adverse
535 incident. For the purposes of this section, an "adverse
536 incident" means an event that results in:
537 (a) The death of a patient;
538 (b) Brain or spinal damage to a patient;
539 (c) The performance of a surgical procedure on the wrong
540 patient;
541 (d) The performance of a wrong-site surgical procedure;
542 (e) The performance of a surgical procedure that is
543 medically unnecessary or otherwise unrelated to the patient's
544 diagnosis or medical condition;
545 (f) The surgical repair of damage to a patient resulting
546 from a planned surgical procedure, which damage is not a
547 recognized specific risk as disclosed to the patient and
548 documented through the informed-consent process;
549 (g) The performance of a procedure to remove unplanned
550 foreign objects remaining from a surgical procedure; or
551 (h) The performance of any other surgical procedure that
552 breached the standard of care.
553 (2) After the department determines a complaint is legally
554 sufficient and the alleged violations are defined as mediation
555 offenses, the department or any agent of the department may
556 conduct informal mediation to resolve the complaint. If the
557 complainant and the subject of the complaint agree to a
558 resolution of a complaint within 14 days after contact by the
559 mediator, the mediator shall notify the department of the terms
560 of the resolution. The department or board shall take no further
561 action unless the complainant and the subject each fail to
562 record with the department an acknowledgment of satisfaction of
563 the terms of mediation within 60 days of the mediator's

564 notification to the department. A successful mediation shall not
565 constitute discipline. In the event the complainant and subject
566 fail to reach settlement terms or to record the required
567 acknowledgment, the department shall process the complaint
568 according to the provisions of s. 456.073.
569 Section 13. Section 456.085, Florida Statutes, is created
570 to read:
571 456.085 Duty to notify patients.--Every physician licensed
572 under chapter 458 or chapter 459 shall inform each patient, or
573 an individual identified pursuant to s. 765.401(1), in person
574 about unanticipated outcomes of care that result in serious harm
575 to the patient. Notification of outcomes of care that result in
576 harm to the patient under this section shall not constitute an
577 acknowledgement or admission of liability, nor can it be
578 introduced as evidence in any civil lawsuit.
579 Section 14. Paragraph (t) of subsection (1) and subsection
580 (6) of section 458.331, Florida Statutes, are amended to read:
581 458.331 Grounds for disciplinary action; action by the
582 board and department.--
583 (1) The following acts constitute grounds for denial of a
584 license or disciplinary action, as specified in s. 456.072(2):
585 (t) Gross or repeated malpractice or the failure to
586 practice medicine with that level of care, skill, and treatment
587 which is recognized by a reasonably prudent similar physician as
588 being acceptable under similar conditions and circumstances. The
589 board shall give great weight to the provisions of s. 766.102
590 when enforcing this paragraph. As used in this paragraph,
591 "repeated malpractice" includes, but is not limited to, three or
592 more claims for medical malpractice within the previous 5-year
593 period resulting in indemnities being paid in excess of $50,000

594 ~~$25,000~~ each to the claimant in a judgment or settlement and
595 which incidents involved negligent conduct by the physician. As
596 used in this paragraph, "gross malpractice" or "the failure to
597 practice medicine with that level of care, skill, and treatment
598 which is recognized by a reasonably prudent similar physician as
599 being acceptable under similar conditions and circumstances,"
600 shall not be construed so as to require more than one instance,
601 event, or act. Nothing in this paragraph shall be construed to
602 require that a physician be incompetent to practice medicine in
603 order to be disciplined pursuant to this paragraph.
604 (6) Upon the department's receipt from an insurer or self-
605 insurer of a report of a closed claim against a physician
606 pursuant to s. 627.912 or from a health care practitioner of a
607 report pursuant to s. 456.049, or upon the receipt from a
608 claimant of a presuit notice against a physician pursuant to s.
609 766.106, the department shall review each report and determine
610 whether it potentially involved conduct by a licensee that is
611 subject to disciplinary action, in which case the provisions of
612 s. 456.073 shall apply. However, if it is reported that a
613 physician has had three or more claims with indemnities
614 exceeding <u>$50,000</u> ~~$25,000~~ each within the previous 5-year
615 period, the department shall investigate the occurrences upon
616 which the claims were based and determine if action by the
617 department against the physician is warranted.
618 Section 15. Section 458.3311, Florida Statutes, is created
619 to read:
620 <u>458.3311 Emergency procedures for disciplinary</u>
621 <u>action.--Notwithstanding any other provision of law to the</u>
622 <u>contrary:</u>

623 (1) Each physician must report to the Department of Health
624 any judgment for medical negligence levied against the
625 physician. The physician must make the report no later than 15
626 days after the exhaustion of the last opportunity for any party
627 to appeal the judgment or request a rehearing.
628 (2) No later than 30 days after a physician has, within a
629 60-month period, made three reports as required by subsection
630 (1), the Department of Health shall initiate an emergency
631 investigation and the Board of Medicine shall conduct an
632 emergency probable cause hearing to determine whether the
633 physician should be disciplined for a violation of s.
634 458.331(1)(t) or any other relevant provision of law.
635 Section 16. Paragraph (x) of subsection (1) and subsection
636 (6) of section 459.015, Florida Statutes, are amended to read:
637 459.015 Grounds for disciplinary action; action by the
638 board and department.--
639 (1) The following acts constitute grounds for denial of a
640 license or disciplinary action, as specified in s. 456.072(2):
641 (x) Gross or repeated malpractice or the failure to
642 practice osteopathic medicine with that level of care, skill,
643 and treatment which is recognized by a reasonably prudent
644 similar osteopathic physician as being acceptable under similar
645 conditions and circumstances. The board shall give great weight
646 to the provisions of s. 766.102 when enforcing this paragraph.
647 As used in this paragraph, "repeated malpractice" includes, but
648 is not limited to, three or more claims for medical malpractice
649 within the previous 5-year period resulting in indemnities being
650 paid in excess of $50,000 ~~$25,000~~ each to the claimant in a
651 judgment or settlement and which incidents involved negligent
652 conduct by the osteopathic physician. As used in this paragraph,

653 "gross malpractice" or "the failure to practice osteopathic
654 medicine with that level of care, skill, and treatment which is
655 recognized by a reasonably prudent similar osteopathic physician
656 as being acceptable under similar conditions and circumstances"
657 shall not be construed so as to require more than one instance,
658 event, or act. Nothing in this paragraph shall be construed to
659 require that an osteopathic physician be incompetent to practice
660 osteopathic medicine in order to be disciplined pursuant to this
661 paragraph. A recommended order by an administrative law judge or
662 a final order of the board finding a violation under this
663 paragraph shall specify whether the licensee was found to have
664 committed "gross malpractice," "repeated malpractice," or
665 "failure to practice osteopathic medicine with that level of
666 care, skill, and treatment which is recognized as being
667 acceptable under similar conditions and circumstances," or any
668 combination thereof, and any publication by the board shall so
669 specify.
670 (6) Upon the department's receipt from an insurer or self-
671 insurer of a report of a closed claim against an osteopathic
672 physician pursuant to s. 627.912 or from a health care
673 practitioner of a report pursuant to s. 456.049, or upon the
674 receipt from a claimant of a presuit notice against an
675 osteopathic physician pursuant to s. 766.106, the department
676 shall review each report and determine whether it potentially
677 involved conduct by a licensee that is subject to disciplinary
678 action, in which case the provisions of s. 456.073 shall apply.
679 However, if it is reported that an osteopathic physician has had
680 three or more claims with indemnities exceeding $50,000 ~~$25,000~~
681 each within the previous 5-year period, the department shall
682 investigate the occurrences upon which the claims were based and

683 determine if action by the department against the osteopathic
684 physician is warranted.
685 Section 17. Section 459.0151, Florida Statutes, is created
686 to read:
687 459.0151 Emergency procedures for disciplinary
688 action.--Notwithstanding any other provision of law to the
689 contrary:
690 (1) Each osteopathic physician must report to the
691 Department of Health any judgment for medical negligence levied
692 against the physician. The osteopathic physician must make the
693 report no later than 15 days after the exhaustion of the last
694 opportunity for any party to appeal the judgment or request a
695 rehearing.
696 (2) No later than 30 days after an osteopathic physician
697 has, within a 60-month period, made three reports as required by
698 subsection (1), the Department of Health shall initiate an
699 emergency investigation and the Board of Osteopathic Medicine
700 shall conduct an emergency probable cause hearing to determine
701 whether the physician should be disciplined for a violation of
702 s. 459.015(1)(x) or any other relevant provision of law.
703 Section 18. Paragraph (s) of subsection (1) and paragraph
704 (a) of subsection (5) of section 461.013, Florida Statutes, are
705 amended to read:
706 461.013 Grounds for disciplinary action; action by the
707 board; investigations by department.--
708 (1) The following acts constitute grounds for denial of a
709 license or disciplinary action, as specified in s. 456.072(2):
710 (s) Gross or repeated malpractice or the failure to
711 practice podiatric medicine at a level of care, skill, and
712 treatment which is recognized by a reasonably prudent podiatric

CODING: Words stricken are deletions; words underlined are additions.

713 physician as being acceptable under similar conditions and
714 circumstances. The board shall give great weight to the
715 standards for malpractice in s. 766.102 in interpreting this
716 section. As used in this paragraph, "repeated malpractice"
717 includes, but is not limited to, three or more claims for
718 medical malpractice within the previous 5-year period resulting
719 in indemnities being paid in excess of $50,000 ~~$10,000~~ each to
720 the claimant in a judgment or settlement and which incidents
721 involved negligent conduct by the podiatric physicians. As used
722 in this paragraph, "gross malpractice" or "the failure to
723 practice podiatric medicine with the level of care, skill, and
724 treatment which is recognized by a reasonably prudent similar
725 podiatric physician as being acceptable under similar conditions
726 and circumstances" shall not be construed so as to require more
727 than one instance, event, or act.
728 (5)(a) Upon the department's receipt from an insurer or
729 self-insurer of a report of a closed claim against a podiatric
730 physician pursuant to s. 627.912, or upon the receipt from a
731 claimant of a presuit notice against a podiatric physician
732 pursuant to s. 766.106, the department shall review each report
733 and determine whether it potentially involved conduct by a
734 licensee that is subject to disciplinary action, in which case
735 the provisions of s. 456.073 shall apply. However, if it is
736 reported that a podiatric physician has had three or more claims
737 with indemnities exceeding $50,000 ~~$25,000~~ each within the
738 previous 5-year period, the department shall investigate the
739 occurrences upon which the claims were based and determine if
740 action by the department against the podiatric physician is
741 warranted.

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

742 Section 19. Subsections (7), (8), and (9) are added to
743 section 627.062, Florida Statutes, to read:
744 627.062 Rate standards.--
745 (7) Notwithstanding any other provision of this section,
746 in matters relating to professional liability insurance coverage
747 for medical negligence, any portion of a judgment entered as a
748 result of a statutory or common-law bad faith action and any
749 portion of a judgment entered that awards punitive damages
750 against an insurer may not be included in the insurer's rate
751 base and may not be used to justify a rate or rate change. In
752 matters relating to professional liability insurance coverage
753 for medical negligence, any portion of a settlement entered as a
754 result of a statutory or common-law bad faith action identified
755 as such and any portion of a settlement wherein an insurer
756 agrees to pay specific punitive damages may not be used to
757 justify a rate or rate change. The portion of the taxable costs
758 and attorney's fees that is identified as being related to the
759 bad faith and punitive damages in these judgments and
760 settlements may not be included in the insurer's rate base and
761 may not be utilized to justify a rate or rate change.
762 (8) Each insurer writing professional liability insurance
763 coverage for medical negligence must make a rate filing under
764 this section with the Office of Insurance Regulation at least
765 once each calendar year.
766 (9) Medical malpractice insurance companies shall submit a
767 rate filing to the Office of Insurance Regulation no earlier
768 than 30 days, but no later than 120 days, after the date upon
769 which this act becomes law.
770 Section 20. Section 627.0662, Florida Statutes, is created
771 to read:

772 627.0662 Excessive profits for medical liability insurance
773 prohibited.--
774 (1) As used in this section:
775 (a) "Medical liability insurance" means insurance that is
776 written on a professional liability insurance policy issued to a
777 health care practitioner or on a liability insurance policy
778 covering medical malpractice claims issued to a health care
779 facility.
780 (b) "Medical liability insurer" means any insurance
781 company or group of insurance companies writing medical
782 liability insurance in this state and does not include any self-
783 insurance fund or other nonprofit entity writing such insurance.
784 (2) Each medical liability insurer shall file with the
785 Office of Insurance Regulation, prior to July 1 of each year on
786 forms prescribed by the office, the following data for medical
787 liability insurance business in this state. The data shall
788 include both voluntary and joint underwriting association
789 business, as follows:
790 (a) Calendar-year earned premium.
791 (b) Accident-year incurred losses and loss adjustment
792 expenses.
793 (c) The administrative and selling expenses incurred in
794 this state or allocated to this state for the calendar year.
795 (d) Policyholder dividends incurred during the applicable
796 calendar year.
797 (3)(a) Excessive profit has been realized if there has
798 been an underwriting gain for the 3 most recent calendar-
799 accident years combined which is greater than the anticipated
800 underwriting profit plus 5 percent of earned premiums for those
801 calendar-accident years.

802 (b) As used in this subsection with respect to any 3-year
803 period, "anticipated underwriting profit" means the sum of the
804 dollar amounts obtained by multiplying, for each rate filing of
805 the insurer group in effect during such period, the earned
806 premiums applicable to such rate filing during such period by
807 the percentage factor included in such rate filing for profit
808 and contingencies, such percentage factor having been determined
809 with due recognition to investment income from funds generated
810 by business in this state. Separate calculations need not be
811 made for consecutive rate filings containing the same percentage
812 factor for profits and contingencies.
813 (4) Each medical liability insurer shall also file a
814 schedule of medical liability insurance loss in this state and
815 loss adjustment experience for each of the 3 most recent
816 accident years. The incurred losses and loss adjustment expenses
817 shall be valued as of March 31 of the year following the close
818 of the accident year, developed to an ultimate basis, and at two
819 12-month intervals thereafter, each developed to an ultimate
820 basis, to the extent that a total of three evaluations is
821 provided for each accident year. The first year to be so
822 reported shall be accident year 2004, such that the reporting of
823 3 accident years will not take place until accident years 2005
824 and 2006 have become available.
825 (5) Each insurer group's underwriting gain or loss for
826 each calendar-accident year shall be computed as follows: the
827 sum of the accident-year incurred losses and loss adjustment
828 expenses as of March 31 of the following year, developed to an
829 ultimate basis, plus the administrative and selling expenses
830 incurred in the calendar year, plus policyholder dividends
831 applicable to the calendar year, shall be subtracted from the

832 calendar-year earned premium to determine the underwriting gain
833 or loss.
834 (6) For the 3 most recent calendar-accident years, the
835 underwriting gain or loss shall be compared to the anticipated
836 underwriting profit.
837 (7) If the medical liability insurer has realized an
838 excessive profit, the office shall order a return of the
839 excessive amounts to policyholders after affording the insurer
840 an opportunity for hearing and otherwise complying with the
841 requirements of chapter 120. Such excessive amounts shall be
842 refunded to policyholders in all instances unless the insurer
843 affirmatively demonstrates to the office that the refund of the
844 excessive amounts will render the insurer or a member of the
845 insurer group financially impaired or will render it insolvent.
846 (8) The excessive amount shall be refunded to
847 policyholders on a pro rata basis in relation to the final
848 compilation year earned premiums to the voluntary medical
849 liability insurance policyholders of record of the insurer group
850 on December 31 of the final compilation year.
851 (9) Any return of excessive profits to policyholders under
852 this section shall be provided in the form of a cash refund or a
853 credit towards the future purchase of insurance.
854 (10)(a) Cash refunds to policyholders may be rounded to
855 the nearest dollar.
856 (b) Data in required reports to the office may be rounded
857 to the nearest dollar.
858 (c) Rounding, if elected by the insurer group, shall be
859 applied consistently.
860 (11)(a) Refunds to policyholders shall be completed as
861 follows:

CODING: Words stricken are deletions; words underlined are additions.

862 1. If the insurer elects to make a cash refund, the refund
863 shall be completed within 60 days after entry of a final order
864 determining that excessive profits have been realized; or
865 2. If the insurer elects to make refunds in the form of a
866 credit to renewal policies, such credits shall be applied to
867 policy renewal premium notices which are forwarded to insureds
868 more than 60 calendar days after entry of a final order
869 determining that excessive profits have been realized. If an
870 insurer has made this election but an insured thereafter cancels
871 his or her policy or otherwise allows the policy to terminate,
872 the insurer group shall make a cash refund not later than 60
873 days after termination of such coverage.
874 (b) Upon completion of the renewal credits or refund
875 payments, the insurer shall immediately certify to the office
876 that the refunds have been made.
877 (12) Any refund or renewal credit made pursuant to this
878 section shall be treated as a policyholder dividend applicable
879 to the year in which it is incurred, for purposes of reporting
880 under this section for subsequent years.
881 Section 21. Subsection (10) of section 627.357, Florida
882 Statutes, is amended to read:
883 627.357 Medical malpractice self-insurance.--
884 (10)(a) An application to form a self-insurance fund under
885 this section must be filed with the Office of Insurance
886 Regulation.
887 (b) The Office of Insurance Regulation must ensure that
888 self-insurance funds remain solvent and provide insurance
889 coverage purchased by participants. The Financial Services
890 Commission may adopt rules pursuant to ss. 120.536(1) and 120.54

891 to implement this subsection ~~A self-insurance fund may not be~~
892 ~~formed under this section after October 1, 1992~~.
893 Section 22. Section 627.3575, Florida Statutes, is created
894 to read:
895 627.3575 Health Care Professional Liability Insurance
896 Facility.--
897 (1) FACILITY CREATED; PURPOSE; STATUS.--There is created
898 the Health Care Professional Liability Insurance Facility. The
899 facility is intended to meet ongoing availability and
900 affordability problems relating to liability insurance for
901 health care professionals by providing an affordable, self-
902 supporting source of excess insurance coverage for those
903 professionals who are willing and able to self-insure for
904 smaller losses. The facility shall operate on a not-for-profit
905 basis. The facility is self-funding and is intended to serve a
906 public purpose but is not a state agency or program, and no
907 activity of the facility shall create any state liability.
908 (2) GOVERNANCE; POWERS.--
909 (a) The facility shall operate under a seven-member board
910 of governors consisting of the Secretary of Health, three
911 members appointed by the Governor, and three members appointed
912 by the Chief Financial Officer. The board shall be chaired by
913 the Secretary of Health. The secretary shall serve by virtue of
914 his or her office, and the other members of the board shall
915 serve terms concurrent with the term of office of the official
916 who appointed them. Any vacancy on the board shall be filled in
917 the same manner as the original appointment. Members serve at
918 the pleasure of the official who appointed them. Members are not
919 eligible for compensation for their service on the board, but
920 the facility may reimburse them for per diem and travel expenses

921 at the same levels as are provided in s. 112.061 for state
922 employees.
923 (b) The facility shall have such powers as are necessary
924 to operate as an insurer, including the power to:
925 1. Sue and be sued.
926 2. Hire such employees and retain such consultants,
927 attorneys, actuaries, and other professionals as it deems
928 appropriate.
929 3. Contract with such service providers as it deems
930 appropriate.
931 4. Maintain offices appropriate to the conduct of its
932 business.
933 5. Take such other actions as are necessary or appropriate
934 in fulfillment of its responsibilities under this section.
935 (3) COVERAGE PROVIDED.--The facility shall provide
936 liability insurance coverage for health care professionals. The
937 facility shall allow policyholders to select from policies with
938 deductibles of $25,000 per claim, $50,000 per claim, and
939 $100,000 per claim and with coverage limits of $250,000 per
940 claim and $750,000 annual aggregate and $1 million per claim and
941 $3 million annual aggregate. To the greatest extent possible,
942 the terms and conditions of the policies shall be consistent
943 with terms and conditions commonly used by professional
944 liability insurers.
945 (4) ELIGIBILITY; TERMINATION.--
946 (a) Any health care professional is eligible for coverage
947 provided by the facility if the professional at all times
948 maintains either:

949 1. An escrow account consisting of cash or assets eligible
950 for deposit under s. 625.52 in an amount equal to the deductible
951 amount of the policy; or
952 2. An unexpired, irrevocable letter of credit, established
953 pursuant to chapter 675, in an amount not less than the
954 deductible amount of the policy. The letter of credit shall be
955 payable to the health care professional as beneficiary upon
956 presentment of a final judgment indicating liability and
957 awarding damages to be paid by the physician or upon presentment
958 of a settlement agreement signed by all parties to such
959 agreement when such final judgment or settlement is a result of
960 a claim arising out of the rendering of, or the failure to
961 render, medical care and services. Such letter of credit shall
962 be nonassignable and nontransferable. Such letter of credit
963 shall be issued by any bank or savings association organized and
964 existing under the laws of this state or any bank or savings
965 association organized under the laws of the United States that
966 has its principal place of business in this state or has a
967 branch office which is authorized under the laws of this state
968 or of the United States to receive deposits in this state.
969 (b) The eligibility of a health care professional for
970 coverage terminates upon:
971 1. The failure of the professional to comply with
972 paragraph (a);
973 2. The failure of the professional to timely pay premiums
974 or assessments; or
975 3. The commission of any act of fraud in connection with
976 the policy, as determined by the board of governors.
977 (c) The board of governors, in its discretion, may
978 reinstate the eligibility of a health care professional whose

979 eligibility has terminated pursuant to paragraph (b) upon
980 determining that the professional has come back into compliance
981 with paragraph (a) or has paid the overdue premiums or
982 assessments. Eligibility may be reinstated in the case of fraud
983 only if the board determines that its initial determination of
984 fraud was in error.
985 (5) PREMIUMS; ASSESSMENTS.--
986 (a) The facility shall charge the actuarially indicated
987 premium for the coverage provided and shall retain the services
988 of consulting actuaries to prepare its rate filings. The
989 facility shall not provide dividends to policyholders, and, to
990 the extent that premiums are more than the amount required to
991 cover claims and expenses, such excess shall be retained by the
992 facility for payment of future claims. In the event of
993 dissolution of the facility, any amounts not required as a
994 reserve for outstanding claims shall be transferred to the
995 policyholders of record as of the last day of operation.
996 (b) In the event that the premiums for a particular year,
997 together with any investment income or reinsurance recoveries
998 attributable to that year, are insufficient to pay claims
999 arising out of claims accruing in that year, the facility shall
1000 levy assessments against all of its policyholders in a uniform
1001 percentage of premium. Each policyholder's assessment shall be
1002 such percentage of the premium that policyholder paid for
1003 coverage for the year to which the insufficiency is
1004 attributable.
1005 (c) The policyholder is personally liable for any
1006 assessment. The failure to timely pay an assessment is grounds
1007 for suspension or revocation of the policyholder's professional
1008 license by the appropriate licensing entity.

CODING: Words stricken are deletions; words underlined are additions.

1009 (6) REGULATION; APPLICABILITY OF OTHER STATUTES.--
1010 (a) The facility shall operate pursuant to a plan of
1011 operation approved by order of the Office of Insurance
1012 Regulation of the Financial Services Commission. The board of
1013 governors may at any time adopt amendments to the plan of
1014 operation and submit the amendments to the Office of Insurance
1015 Regulation for approval.
1016 (b) The facility is subject to regulation by the Office of
1017 Insurance Regulation of the Financial Services Commission in the
1018 same manner as other insurers, except that, in recognition of
1019 the fact that its ability to levy assessments against its own
1020 policyholders is a substitute for the protections ordinarily
1021 afforded by such statutory requirements, the facility is exempt
1022 from statutory requirements relating to surplus as to
1023 policyholders.
1024 (c) The facility is not subject to part II of chapter 631,
1025 relating to the Florida Insurance Guaranty Association.
1026 (7) STARTUP PROVISIONS.--
1027 (a) It is the intent of the Legislature that the facility
1028 begin providing coverage no later than January 1, 2004.
1029 (b) The Governor and the Chief Financial Officer shall
1030 make their appointments to the board of governors of the
1031 facility no later than August 1, 2003. Until the board is
1032 appointed, the Secretary of Health may perform ministerial acts
1033 on behalf of the facility as chair of the board of governors.
1034 (c) Until the facility is able to hire permanent staff and
1035 enter into contracts for professional services, the office of
1036 the Secretary of Health shall provide support services to the
1037 facility.

1038 (d) In order to provide startup funds for the facility,
1039 the board of governors may incur debt or enter into agreements
1040 for lines of credit, provided that the sole source of funds for
1041 repayment of any debt is future premium revenues of the
1042 facility. The amount of such debt or lines of credit may not
1043 exceed $10 million.
1044 Section 23. Subsection (1) and paragraph (n) of subsection
1045 (2) of section 627.912, Florida Statutes, are amended to read:
1046 627.912 Professional liability claims and actions; reports
1047 by insurers.--
1048 (1)(a) Each self-insurer authorized under s. 627.357 and
1049 each insurer or joint underwriting association providing
1050 professional liability insurance to a practitioner of medicine
1051 licensed under chapter 458, to a practitioner of osteopathic
1052 medicine licensed under chapter 459, to a podiatric physician
1053 licensed under chapter 461, to a dentist licensed under chapter
1054 466, to a hospital licensed under chapter 395, to a crisis
1055 stabilization unit licensed under part IV of chapter 394, to a
1056 health maintenance organization certificated under part I of
1057 chapter 641, to clinics included in chapter 390, to an
1058 ambulatory surgical center as defined in s. 395.002, or to a
1059 member of The Florida Bar shall report in duplicate to the
1060 Department of Insurance any claim or action for damages for
1061 personal injuries claimed to have been caused by error,
1062 omission, or negligence in the performance of such insured's
1063 professional services or based on a claimed performance of
1064 professional services without consent, if the claim resulted in:
1065 1.(a) A final judgment in any amount.
1066 2.(b) A settlement in any amount.
1067

1068 Reports shall be filed with the department.
1069 (b) In addition to the requirements of paragraph (a), if
1070 the insured party is licensed under chapter 395, chapter 458,
1071 chapter 459, chapter 461, or chapter 466, the insurer shall
1072 report in duplicate to the Office of Insurance Regulation any
1073 other disposition of the claim, including, but not limited to, a
1074 dismissal. If the insured is licensed under chapter 458, chapter
1075 459, or chapter 461, any claim that resulted in a final judgment
1076 or settlement in the amount of $50,000 or more shall be reported
1077 to the Department of Health no later than 30 days following the
1078 occurrence of that event. If the insured is licensed under
1079 chapter 466, any claim that resulted in a final judgment or
1080 settlement in the amount of $25,000 or more shall be reported to
1081 the Department of Health no later than 30 days following the
1082 occurrence of that event ~~and, if the insured party is licensed~~
1083 ~~under chapter 458, chapter 459, chapter 461, or chapter 466,~~
1084 ~~with the Department of Health, no later than 30 days following~~
1085 ~~the occurrence of any event listed in paragraph (a) or paragraph~~
1086 ~~(b)~~. The Department of Health shall review each report and
1087 determine whether any of the incidents that resulted in the
1088 claim potentially involved conduct by the licensee that is
1089 subject to disciplinary action, in which case the provisions of
1090 s. 456.073 shall apply. The Department of Health, as part of the
1091 annual report required by s. 456.026, shall publish annual
1092 statistics, without identifying licensees, on the reports it
1093 receives, including final action taken on such reports by the
1094 Department of Health or the appropriate regulatory board.
1095 (2) The reports required by subsection (1) shall contain:
1096 (n) Any other information required by the department to
1097 analyze and evaluate the nature, causes, location, cost, and

1098 damages involved in professional liability cases. The Financial
1099 Services Commission shall adopt by rule requirements for
1100 additional information to assist the Office of Insurance
1101 Regulation in its analysis and evaluation of the nature, causes,
1102 location, cost, and damages involved in professional liability
1103 cases reported by insurers under this section.
1104 Section 24. Section 627.9121, Florida Statutes, is created
1105 to read:
1106 627.9121 Required reporting of claims; penalties.--Each
1107 entity that makes payment under a policy of insurance, self-
1108 insurance, or otherwise in settlement, partial settlement, or
1109 satisfaction of a judgment in a medical malpractice action or
1110 claim that is required to report information to the National
1111 Practitioner Data Bank under 42 U.S.C. s. 11131 must also report
1112 the same information to the Office of Insurance Regulation. The
1113 office shall include such information in the data that it
1114 compiles under s. 627.912. The office must compile and review
1115 the data collected pursuant to this section and must assess an
1116 administrative fine on any entity that fails to fully comply
1117 with such reporting requirements.
1118 Section 25. Subsections (3) and (4) and paragraph (a) of
1119 subsection (10) of section 766.106, Florida Statutes, are
1120 amended, and subsections (13), (14), and (15) are added to said
1121 section, to read:
1122 766.106 Notice before filing action for medical
1123 malpractice; presuit screening period; offers for admission of
1124 liability and for arbitration; informal discovery; review.--
1125 (3)(a) No suit may be filed for a period of 180 ~~90~~ days
1126 after notice is mailed to any prospective defendant. During the
1127 180-day ~~90-day~~ period, the prospective defendant's insurer or

1128 self-insurer shall conduct a review to determine the liability
1129 of the defendant. Each insurer or self-insurer shall have a
1130 procedure for the prompt investigation, review, and evaluation
1131 of claims during the 180-day ~~90-day~~ period. This procedure shall
1132 include one or more of the following:
1133 1. Internal review by a duly qualified claims adjuster;
1134 2. Creation of a panel comprised of an attorney
1135 knowledgeable in the prosecution or defense of medical
1136 malpractice actions, a health care provider trained in the same
1137 or similar medical specialty as the prospective defendant, and a
1138 duly qualified claims adjuster;
1139 3. A contractual agreement with a state or local
1140 professional society of health care providers, which maintains a
1141 medical review committee;
1142 4. Any other similar procedure which fairly and promptly
1143 evaluates the pending claim.
1144
1145 Each insurer or self-insurer shall investigate the claim in good
1146 faith, and both the claimant and prospective defendant shall
1147 cooperate with the insurer in good faith. If the insurer
1148 requires, a claimant shall appear before a pretrial screening
1149 panel or before a medical review committee and shall submit to a
1150 physical examination, if required. Unreasonable failure of any
1151 party to comply with this section justifies dismissal of claims
1152 or defenses. There shall be no civil liability for participation
1153 in a pretrial screening procedure if done without intentional
1154 fraud.
1155 (b) At or before the end of the 180 ~~90~~ days, the insurer
1156 or self-insurer shall provide the claimant with a response:
1157 1. Rejecting the claim;

2. Making a settlement offer; or

3. Making an offer of admission of liability and for arbitration on the issue of damages. This offer may be made contingent upon a limit of general damages.

(c) The response shall be delivered to the claimant if not represented by counsel or to the claimant's attorney, by certified mail, return receipt requested. Failure of the prospective defendant or insurer or self-insurer to reply to the notice within 180 ~~90~~ days after receipt shall be deemed a final rejection of the claim for purposes of this section.

(d) Within 30 days after ~~of~~ receipt of a response by a prospective defendant, insurer, or self-insurer to a claimant represented by an attorney, the attorney shall advise the claimant in writing of the response, including:

1. The exact nature of the response under paragraph (b).

2. The exact terms of any settlement offer, or admission of liability and offer of arbitration on damages.

3. The legal and financial consequences of acceptance or rejection of any settlement offer, or admission of liability, including the provisions of this section.

4. An evaluation of the time and likelihood of ultimate success at trial on the merits of the claimant's action.

5. An estimation of the costs and attorney's fees of proceeding through trial.

(4) The notice of intent to initiate litigation shall be served within the time limits set forth in s. 95.11. However, during the 180-day ~~90-day~~ period, the statute of limitations is tolled as to all potential defendants. Upon stipulation by the parties, the 180-day ~~90-day~~ period may be extended and the statute of limitations is tolled during any such extension. Upon

1188 receiving notice of termination of negotiations in an extended
1189 period, the claimant shall have 60 days or the remainder of the
1190 period of the statute of limitations, whichever is greater,
1191 within which to file suit.
1192 (10) If a prospective defendant makes an offer to admit
1193 liability and for arbitration on the issue of damages, the
1194 claimant has 50 days from the date of receipt of the offer to
1195 accept or reject it. The claimant shall respond in writing to
1196 the insurer or self-insurer by certified mail, return receipt
1197 requested. If the claimant rejects the offer, he or she may then
1198 file suit. Acceptance of the offer of admission of liability and
1199 for arbitration waives recourse to any other remedy by the
1200 parties, and the claimant's written acceptance of the offer
1201 shall so state.
1202 (a) If rejected, the offer to admit liability and for
1203 arbitration on damages is not admissible in any subsequent
1204 litigation. Upon rejection of the offer to admit liability and
1205 for arbitration, the claimant has 60 days from receipt of the
1206 rejection of the offer to admit liability and for arbitration,
1207 60 days from the date of the declaration of impasse during
1208 presuit mediation conducted pursuant to s. 766.1065, or the
1209 remainder of the period of the statute of limitations, whichever
1210 period is greater, in which to file suit.
1211 (13) In matters relating to professional liability
1212 insurance coverage for medical negligence, an insurer shall not
1213 be held in bad faith for failure to timely pay its policy limits
1214 if it tenders its policy limits and meets all other conditions
1215 of settlement prior to the conclusion of the presuit screening
1216 period provided for in this section.
1217 (14) Failure to cooperate on the part of any party during

1218 the presuit investigation may be grounds to strike any claim
1219 made, or defense raised, by such party in suit.
1220 (15) In all matters relating to professional liability
1221 insurance coverage for medical negligence, and in determining
1222 whether the insurer acted fairly and honestly towards its
1223 insured with due regard for her or his interest during the
1224 presuit process or after a complaint has been filed, the
1225 following factors shall be considered:
1226 (a) The insurer's willingness to negotiate with the
1227 claimant;
1228 (b) The insurer's consideration of the advice of its
1229 defense counsel;
1230 (c) The insurer's proper investigation of the claim;
1231 (d) Whether the insurer informed the insured of the offer
1232 to settle within the limits of coverage, the right to retain
1233 personal counsel, and risk of litigation;
1234 (e) Whether the insured denied liability or requested that
1235 the case be defended; and
1236 (f) Whether the claimant imposed any condition, other than
1237 the tender of the policy limits, on the settlement of the claim.
1238 Section 26. Section 766.1065, Florida Statutes, is created
1239 to read:
1240 766.1065 Mandatory staging of presuit investigation and
1241 mandatory mediation.--
1242 (1) Within 30 days after service of the presuit notice of
1243 intent to initiate medical malpractice litigation, each party
1244 shall voluntarily produce to all other parties, without being
1245 requested, any and all medical, hospital, health care, and
1246 employment records concerning the claimant in the disclosing
1247 party's possession, custody, or control, and the disclosing

1248 party shall affirmatively certify in writing that the records
1249 produced include all records in that party's possession,
1250 custody, or control or that the disclosing party has no medical,
1251 hospital, health care, or employment records concerning the
1252 claimant.
1253 (a) Subpoenas may be issued according to the Florida Rules
1254 of Civil Procedure as though suit had been filed for the limited
1255 purpose of obtaining copies of medical, hospital, health care,
1256 and employment records of the claimant. The party shall indicate
1257 on the subpoena that it is being issued in accordance with the
1258 presuit procedures of this section and shall not be required to
1259 include a case number.
1260 (b) Nothing in this section shall limit the ability of any
1261 party to use any other available form of presuit discovery
1262 available under this chapter or the Florida Rules of Civil
1263 Procedure.
1264 (2) Within 60 days after service of the presuit notice of
1265 intent to initiate medical malpractice litigation, all parties
1266 must be made available for a sworn deposition. Such deposition
1267 may not be used in a civil suit for medical negligence.
1268 (3) Within 120 days after service of the presuit notice of
1269 intent to initiate medical malpractice litigation, each party's
1270 corroborating expert, who will otherwise be tendered as the
1271 expert complying with the affidavit provisions set forth in s.
1272 766.203, must be made available for a sworn deposition.
1273 (a) The expenses associated with the expert's time and
1274 travel in preparing for and attending such deposition shall be
1275 the responsibility of the party retaining such expert.
1276 (b) An expert shall be deemed available for deposition if
1277 suitable accommodations can be made for appearance of said

CODING: Words ~~stricken~~ are deletions; words underlined are additions.

1278 expert via real-time video technology.
1279 (4) Within 180 days after service of the presuit notice of
1280 intent to initiate medical malpractice litigation, all parties
1281 shall attend in-person mandatory mediation in accordance with s.
1282 44.102 if binding arbitration under s. 766.106 or s. 766.207 has
1283 not been agreed to by the parties. The Florida Rules of Civil
1284 Procedure shall apply to mediation held pursuant to this
1285 section.
1286 Section 27. Section 766.1067, Florida Statutes, is created
1287 to read:
1288 766.1067 Mandatory mediation after suit is filed.--Within
1289 120 days after suit being filed, unless such period is extended
1290 by mutual agreement of all parties, all parties shall attend in-
1291 person mandatory mediation in accordance with s. 44.102 if
1292 binding arbitration under s. 766.106 or s. 766.207 has not been
1293 agreed to by the parties. The Florida Rules of Civil Procedure
1294 shall apply to mediation held pursuant to this section.
1295 Section 28. Section 766.118, Florida Statutes, is created
1296 to read:
1297 766.118 Determination of noneconomic damages.--With
1298 respect to a cause of action for personal injury or wrongful
1299 death resulting from an occurrence of medical negligence,
1300 including actions pursuant to s. 766.209, damages recoverable
1301 for noneconomic losses to compensate for pain and suffering,
1302 inconvenience, physical impairment, mental anguish,
1303 disfigurement, loss of capacity for enjoyment of life, and all
1304 other noneconomic damages shall not exceed $250,000, regardless
1305 of the number of claimants or defendants involved in the action.
1306 Section 29. Subsection (5) of section 766.202, Florida
1307 Statutes, is amended to read:

1308 766.202 Definitions; ss. 766.201-766.212.--As used in ss.
1309 766.201-766.212, the term:
1310 (5) "Medical expert" means a person familiar with the
1311 evaluation, diagnosis, or treatment of the medical condition at
1312 issue who:
1313 (a) Is duly and regularly engaged in the practice of his
1314 or her profession, ~~who~~ holds a health care professional degree
1315 from a university or college, and has had special professional
1316 training and experience; or
1317 (b) Has ~~one possessed of~~ special health care knowledge or
1318 skill about the subject upon which he or she is called to
1319 testify or provide an opinion.
1320
1321 Such expert shall certify that he or she has similar credentials
1322 and expertise in the area of the defendant's particular practice
1323 or specialty, if the defendant is a specialist.
1324 Section 30. Subsections (2) and (3) of section 766.203,
1325 Florida Statutes, are amended to read:
1326 766.203 Presuit investigation of medical negligence claims
1327 and defenses by prospective parties.--
1328 (2) Prior to issuing notification of intent to initiate
1329 medical malpractice litigation pursuant to s. 766.106, the
1330 claimant shall conduct an investigation to ascertain that there
1331 are reasonable grounds to believe that:
1332 (a) Any named defendant in the litigation was negligent in
1333 the care or treatment of the claimant; and
1334 (b) Such negligence resulted in injury to the claimant.
1335
1336 Corroboration of reasonable grounds to initiate medical
1337 negligence litigation shall be provided by the claimant's

1338 submission of a verified written medical expert opinion from a
1339 medical expert as defined in s. 766.202(5), at the time the
1340 notice of intent to initiate litigation is mailed, which
1341 statement shall corroborate reasonable grounds to support the
1342 claim of medical negligence. This opinion and statement are
1343 subject to discovery.
1344 (3) Prior to issuing its response to the claimant's notice
1345 of intent to initiate litigation, during the time period for
1346 response authorized pursuant to s. 766.106, the defendant or the
1347 defendant's insurer or self-insurer shall conduct an
1348 investigation to ascertain whether there are reasonable grounds
1349 to believe that:
1350 (a) The defendant was negligent in the care or treatment
1351 of the claimant; and
1352 (b) Such negligence resulted in injury to the claimant.
1353
1354 Corroboration of lack of reasonable grounds for medical
1355 negligence litigation shall be provided with any response
1356 rejecting the claim by the defendant's submission of a verified
1357 written medical expert opinion from a medical expert as defined
1358 in s. 766.202(5), at the time the response rejecting the claim
1359 is mailed, which statement shall corroborate reasonable grounds
1360 for lack of negligent injury sufficient to support the response
1361 denying negligent injury. This opinion and statement are subject
1362 to discovery.
1363 Section 31. Subsections (2) and (3) of section 766.207,
1364 Florida Statutes, are amended to read:
1365 766.207 Voluntary binding arbitration of medical
1366 negligence claims.--
1367 (2) Upon the completion of presuit investigation with

1368 preliminary reasonable grounds for a medical negligence claim
1369 intact, the parties may elect to have damages determined by an
1370 arbitration panel. Such election may be initiated by either
1371 party by serving a request for voluntary binding arbitration of
1372 damages within 180 ~~90~~ days after service of the claimant's
1373 notice of intent to initiate litigation upon the defendant. The
1374 evidentiary standards for voluntary binding arbitration of
1375 medical negligence claims shall be as provided in ss.
1376 120.569(2)(g) and 120.57(1)(c).
1377 (3) Upon receipt of a party's request for such
1378 arbitration, the opposing party may accept the offer of
1379 voluntary binding arbitration within 30 days. However, in no
1380 event shall the defendant be required to respond to the request
1381 for arbitration sooner than 180 ~~90~~ days after service of the
1382 notice of intent to initiate litigation under s. 766.106. Such
1383 acceptance within the time period provided by this subsection
1384 shall be a binding commitment to comply with the decision of the
1385 arbitration panel. The liability of any insurer shall be subject
1386 to any applicable insurance policy limits.
1387 Section 32. (1) The Department of Health shall study and
1388 report to the Legislature as to whether medical review panels
1389 should be included as part of the presuit process in medical
1390 malpractice litigation. Medical review panels review a medical
1391 malpractice case during the presuit process and make judgments
1392 on the merits of the case based on established standards of care
1393 with the intent of reducing the number of frivolous claims. The
1394 panel's report could be used as admissible evidence at trial or
1395 for other purposes. The department's report should address:

1396 (a) Historical use of medical review panels and similar
1397 pretrial programs in this state, including the mediation panels
1398 created by chapter 75-9, Laws of Florida.
1399 (b) Constitutional issues relating to the use of medical
1400 review panels.
1401 (c) The use of medical review panels or similar programs
1402 in other states.
1403 (d) Whether medical review panels or similar panels should
1404 be created for use during the presuit process.
1405 (e) Other recommendations and information that the
1406 department deems appropriate.
1407 (f) In submitting its report with respect to (a)-(c), the
1408 Department should identify at a minimum:
1409 1. The percentage of medical malpractice claims submitted
1410 to the panels during the time period the panels were in
1411 existence.
1412 2. The percentage of claims that were settled while the
1413 panels were in existence and the percentage of claims that were
1414 settled in the 3 years prior to the establishment of such panels
1415 or, for each panel which no longer exists, 3 years after the
1416 dissolution of such panels.
1417 3. In those state where panels have been discontinued,
1418 whether additional safeguards have been implemented to avoid the
1419 filing of frivolous lawsuits and what those additional
1420 safeguards are.
1421 4. How the rates for medical malpractice insurance in
1422 states utilizing such panels compares with the rates in states
1423 not utilizing such panels.

1424 5. Whether, and to what extent, a finding by a panel is
1425 subject to review and the burden of proof required to overcome a
1426 finding by the panel.
1427 (2) If the department finds that medical review panels or
1428 a similar structure should be created in this state, it shall
1429 include draft legislation to implement its recommendations in
1430 its report.
1431 (3) The department shall submit its report to the Speaker
1432 of the House of Representatives and the President of the Senate
1433 no later than December 31, 2003.
1434 Section 33. Subsection (5) of section 768.81, Florida
1435 Statutes, is amended to read:
1436 768.81 Comparative fault.--
1437 (5) Notwithstanding anything in law to the contrary, in an
1438 action for damages for personal injury or wrongful death arising
1439 out of medical malpractice, whether in contract or tort, when an
1440 apportionment of damages pursuant to this section is attributed
1441 to a teaching hospital as defined in s. 408.07, the court shall
1442 enter judgment against the teaching hospital on the basis of
1443 each such party's percentage of fault and not on the basis of
1444 the doctrine of joint and several liability.
1445 Section 34. Section 1004.08, Florida Statutes, is created
1446 to read:
1447 1004.08 Patient safety instructional requirements.--Every
1448 public school, college, and university that offers degrees in
1449 medicine, nursing, and allied health shall include in the
1450 curricula applicable to such degrees material on patient safety,
1451 including patient safety improvement. Materials shall include,
1452 but need not be limited to, effective communication and
1453 teamwork; epidemiology of patient injuries and medical errors;

1454 vigilance, attention, and fatigue; checklists and inspections;
1455 automation and technological and computer support; psychological
1456 factors in human error; and reporting systems.
1457 Section 35. Section 1005.07, Florida Statutes, is created
1458 to read:
1459 1005.07 Patient safety instructional requirements.--Every
1460 nonpublic school, college, and university that offers degrees in
1461 medicine, nursing, and allied health shall include in the
1462 curricula applicable to such degrees material on patient safety,
1463 including patient safety improvement. Materials shall include,
1464 but need not be limited to, effective communication and
1465 teamwork; epidemiology of patient injuries and medical errors;
1466 vigilance, attention, and fatigue; checklists and inspections;
1467 automation and technological and computer support; psychological
1468 factors in human error; and reporting systems.
1469 Section 36. The Agency for Health Care Administration is
1470 directed to study the types of information the public would find
1471 relevant in the selection of hospitals. The agency shall review
1472 and recommend appropriate methods of collection, analysis, and
1473 dissemination of that information. The agency shall complete its
1474 study and report its findings and recommendations to the
1475 Legislature by January 15, 2004.
1476 Section 37. Comprehensive study and report on the creation
1477 of a Patient Safety Authority.--
1478 (1) The Agency for Health Care Administration, in
1479 consultation with the Department of Health, is directed to study
1480 the need for, and the implementation requirements of,
1481 establishing a Patient Safety Authority. The authority would be
1482 responsible for performing activities and functions designed to

CODING: Words stricken are deletions; words underlined are additions.

1483 improve patient safety and the quality of care delivered by
1484 health care facilities and health care practitioners.
1485 (2) In undertaking its study, the agency shall examine and
1486 evaluate a Patient Safety Authority that would, either directly
1487 or by contract:
1488 (a) Analyze information concerning adverse incidents
1489 reported to the Agency for Health Care Administration pursuant
1490 to s. 395.0197, Florida Statutes, for the purpose of
1491 recommending changes in practices and procedures that may be
1492 implemented by health care practitioners and health care
1493 facilities to prevent future adverse incidents.
1494 (b) Collect, analyze, and evaluate patient safety data
1495 submitted voluntarily by a health care practitioner or health
1496 care facility. The authority would communicate to health care
1497 practitioners and health care facilities changes in practices
1498 and procedures that may be implemented for the purpose of
1499 improving patient safety and preventing future patient safety
1500 events from resulting in serious injury or death. At a minimum,
1501 the authority would:
1502 1. Be designed and operated by an individual or entity
1503 with demonstrated expertise in health care quality data and
1504 systems analysis, health information management, systems
1505 thinking and analysis, human factors analysis, and
1506 identification of latent and active errors.
1507 2. Include procedures for ensuring its confidentiality,
1508 timeliness, and independence.
1509 (c) Foster the development of a statewide electronic
1510 infrastructure, which would be implemented in phases over a
1511 multiyear period, that is designed to improve patient care and
1512 the delivery and quality of health care services by health care

1513 facilities and practitioners. The electronic infrastructure
1514 would be a secure platform for communication and the sharing of
1515 clinical and other data, such as business data, among providers
1516 and between patients and providers. The electronic
1517 infrastructure would include a core electronic medical record.
1518 Health care providers would have access to individual electronic
1519 medical records, subject to the consent of the individual. The
1520 right, if any, of other entities, including health insurers and
1521 researchers, to access the records would need further
1522 examination and evaluation by the agency.
1523 (d) Foster the use of computerized physician medication
1524 ordering systems by hospitals that do not have such systems and
1525 develop protocols for these systems.
1526 (e) Implement paragraphs (c) and (d) as a demonstration
1527 project for Medicaid recipients.
1528 (f) Identify best practices and share this information
1529 with health care providers.
1530 (g) Engage in other activities that improve health care
1531 quality, improve the diagnosis and treatment of diseases and
1532 medical conditions, increase the efficiency of the delivery of
1533 health care services, increase administrative efficiency, and
1534 increase access to quality health care services.
1535 (3) The agency shall also consider ways in which a Patient
1536 Safety Authority would be able to facilitate the development of
1537 no-fault demonstration projects as means to reduce and prevent
1538 medical errors and promote patient safety.
1539 (4) The agency shall seek information and advice from and
1540 consult with hospitals, physicians, other health care providers,
1541 attorneys, consumers, and individuals involved with and

CODING: Words stricken are deletions; words underlined are additions.

1542 knowledgeable about patient safety and quality-of-care
1543 initiatives.
1544 (5) In evaluating the need for, and the operation of, a
1545 Patient Safety Authority, the agency shall determine the costs
1546 of implementing and administering an authority and suggest
1547 funding sources and mechanisms.
1548 (6) The agency shall complete its study and issue a report
1549 to the Legislature by February 1, 2004. In its report, the
1550 agency shall include specific findings, recommendations, and
1551 proposed legislation.
1552 Section 38. If any provision of this act or the
1553 application thereof to any person or circumstance is held
1554 invalid, the invalidity does not affect other provisions or
1555 applications of the act which can be given effect without the
1556 invalid provision or application, and to this end the provisions
1557 of this act are declared severable.
1558 Section 39. If any law amended by this act was also
1559 amended by a law enacted at the 2003 Regular Session of the
1560 Legislature or at the 2003 Special Session A of the Legislature,
1561 such laws shall be construed as if they had been enacted at the
1562 same session of the Legislature, and full effect shall be given
1563 to each if possible.
1564 Section 40. This act shall take effect upon becoming a law
1565 and shall apply to all actions filed after the effective date of
1566 the act.