A bill to be entitled

An act relating to medical incidents; providing findings; amending s. 46.015, F.S.; providing for a setoff of amounts received by a claimant in settlements; authorizing settling defendants to assign rights of contribution; amending s. 120.57, F.S.; authorizing certain professional boards and the Department of Health to modify or reject findings of fact determined by an administrative law judge which relate to the standard of care; amending s. 120.65, F.S.; requiring the Division of Administrative Hearings to designate administrative law judges to preside over actions involving a health care practitioner; providing qualifications for such administrative law judges; amending s. 391.025, F.S.; providing that the Children's Medical Services Act applies to infants eligible for compensation under the Florida Birth-Related Neurological Injury Compensation Plan; amending s. 391.029, F.S.; providing that infants eligible for compensation under the Florida Birth-Related Neurological Injury Compensation Plan are eligible for the Children's Medical Services program; requiring the plan to reimburse the program for certain costs; providing a patient safety data privilege and providing requirements with respect thereto; amending s. 766.304, F.S.; providing that a claimant may not receive compensation from the Florida Birth-Related Neurological Injury Compensation Plan if damages are provided pursuant to a settlement or a final judgment in a civil action is entered; amending s. 766.305, F.S.; revising the information required to be included in a petition seeking recovery from the Florida Birth-Related

Neurological Injury Compensation Plan; revising requirements for the service of such petitions; requiring claimants to provide additional information to the executive director of the Florida Birth-Related Neurological Injury Compensation Association; amending s. 766.309, F.S.; authorizing the bifurcation of administrative proceedings regarding claims for recovery from the Florida Birth-Related Neurological Injury Compensation Plan; amending s. 766.31, F.S.; excluding Medicaid services from those compensable under the Florida Birth-Related Neurological Injury Compensation Plan; providing a death benefit under the plan in lieu of funeral expenses; providing that if there is an award of benefits under the plan, the claimants shall not be liable for any attorney's fees incurred in connection with the filing of a claim under ss. 766.301-766.316, F.S., other than those fees awarded under this section; amending s. 766.314, F.S.; correcting terminology; authorizing certain hospitals to pay assessments on behalf of certain health care professionals; providing for the dates of coverage of a participating physician; amending s. 391.035, F.S.; declaring certain physicians to be agents of the Department of Health for the purposes of s. 768.28, F.S., when providing services through the Children's Medical Services network; requiring indemnification of the state by such physicians; creating s. 395.0194, F.S.; authorizing the governing boards of hospitals to reject or modify medical staff recommendations or to take action where the medical staff has failed to act under certain circumstances; providing procedures for corrective or

disciplinary actions, including referral of such matters to a joint conference committee appointed by the governing board and the medical staff; providing for review and consideration of the recommendations of the joint conference committee by the governing board; amending s. 395.0197, F.S.; revising provisions relating to internal risk management programs; repealing s. 395.0198, F.S., relating to public records exemptions for notification of adverse incidents; creating s. 395.1012, F.S.; requiring hospitals, ambulatory surgical centers, and mobile surgical facilities to establish patient safety plans, officers, and committees; creating s. 395.1051, F.S.; providing for notification of injuries in a hospital, ambulatory surgical center, or mobile surgical facility; amending s. 415.1111, F.S.; providing that such section shall not apply to actions involving allegations of medical malpractice by a hospital; creating s. 408.932, F.S.; requiring certain health care facilities to provide notice of unanticipated outcomes of care which result in serious harm to the patient to patients or the patients' representatives; providing that such notice shall not constitute an acknowledgment or admission of guilt and shall not be introduced in any civil action; creating s. 456.0575, F.S.; requiring health care providers to provide notice of unanticipated outcomes of care which result in serious harm to the patient to patients or the patients' representatives; providing that such notice shall not constitute an acknowledgment or admission of guilt and shall not be introduced in any civil action; authorizing health care practitioner regulatory boards to adopt rules

to establish standards of practice for prescribing drugs to patients via the Internet; amending s. 456.039, F.S.; requiring additional information to be furnished to the Department of Health for licensure purposes; amending s. 456.049, F.S.; requiring the Department of Health to forward reports on professional liability claims and actions to the Office of Insurance Regulation; amending s. 456.057, F.S.; providing an exception to the confidentiality of medical information when a release has been provided; authorizing the Department of Health to utilize subpoenas to obtain patient records without patients' consent under certain circumstances; amending s. 456.063, F.S.; providing for adopting rules to implement requirements for reporting allegations of sexual misconduct; amending s. 456.072, F.S.; revising provisions assessing costs of disciplinary investigation and prosecution; changing the burden of proof in certain administrative actions; amending s. 456.073, F.S.; providing a deadline for raising issues of material fact; extending the time for the Department of Health to refer a request for an administrative hearing; amending s. 456.077, F.S.; revising provisions relating to designation of certain citation violations; amending s. 456.078, F.S.; providing that violations involving standard of care may be appropriate for mediation; revising provisions relating to designation of certain mediation offenses; amending s. 458.320, F.S.; providing that a hospital shall not be liable for the failure of a physician to meet financial responsibility requirements; amending s. 459.0085, F.S.; providing that a hospital shall not be liable for the

failure of a physician to meet financial responsibility requirements; amending s. 458.331, F.S., relating to grounds for disciplinary action of a physician; redefining the term "repeated malpractice"; revising the standards for the burden of proof in an administrative action against a physician; revising the minimum amount of a claim against a licensee which will trigger a departmental investigation; amending s. 459.015, F.S., relating to grounds for disciplinary action against an osteopathic physician; redefining the term "repeated malpractice"; revising the standards for the burden of proof in an administrative action against an osteopathic physician; amending conditions that necessitate a departmental investigation of an osteopathic physician; revising the minimum amount of a claim against a licensee which will trigger a departmental investigation; amending s. 460.413, F.S.; revising the standards for the burden of proof in an administrative action against a chiropractic physician; amending s. 461.013, F.S., relating to grounds for disciplinary action against a podiatric physician; redefining the term "repeated malpractice"; revising the minimum amount of a claim against a licensee which will trigger a departmental investigation; amending s. 466.028, F.S., relating to grounds for disciplinary action against a dentist or a dental hygienist; redefining the term "dental malpractice"; revising the minimum amount of a claim against a licensee which will trigger a departmental investigation; amending s. 624.155, F.S.; eliminating third-party actions against insurers in certain matters involving medical negligence; revising standards for

determination of bad faith by an insurer in medical liability cases; providing factors to be considered in determining whether an insurer has acted in bad faith in such cases; requiring the reporting of certain judgments to the Office of Insurance Regulation; providing a limitation on damages recoverable in certain bad faith actions; providing an exemption to certain insureds from judgment liens and execution in an amount equal to sums paid on behalf of such insured by a liability insurer; providing that no award for attorney's fees shall be enhanced by a contingency risk multiplier in certain actions relating to professional liability insurance coverage for medical negligence; providing for severability and applicability of the amendments to s. 624.155, F.S.; amending s. 627.062, F.S.; prohibiting the inclusion of payments made by insurers for bad faith claims in an insurer's rate base; requiring certain rate filings; amending s. 627.357, F.S.; deleting the prohibition against formation of medical malpractice self-insurance funds; providing requirements to form a self-insurance fund; providing rulemaking authority to the Financial Services Commission; amending s. 627.4147, F.S.; deleting the requirement that medical malpractice polices authorize the insurer to admit liability without the consent of the insured; amending s. 627.912, F.S.; requiring certain claims information to be filed with the Office of Insurance Regulation and the Department of Health; providing for rulemaking by the Financial Services Commission; increasing the limit on and making mandatory a fine against insurers for certain actions; creating s.

627.41493, F.S.; requiring a medical malpractice insurance rate rollback; providing a minimum percentage for the average reduction in rates; providing that the decrease in rates need not be uniform across specialties; providing for review of such rates; providing an exception to the minimum roll back required if any provision of this act is declared unconstitutional by a court of competent jurisdiction; creating s. 627.9121, F.S.; requiring certain information relating to medical malpractice to be reported to the Office of Insurance Regulation; providing for enforcement; amending s. 641.19, F.S.; providing that health care providers providing services pursuant to coverage provided under a health maintenance organization contract are not employees or agents of the health maintenance organization; amending s. 641.51, F.S.; providing that a health maintenance organization shall not have the right to control the professional judgment of a physician; providing that a health maintenance organization shall not be vicariously liable for the medical negligence of a health care provider; amending s. 766.102, F.S.; redefining the term "similar health care provider"; deleting authority for certain persons to testify as expert witnesses; amending s. 766.104, F.S.; providing that the presuit written expert opinion received by counsel for a claimant shall be subject to discovery; amending s. 766.106, F.S.; providing that the presuit written expert opinions received pursuant to s. 766.203, F.S., shall be subject to discovery and admissible in evidence; requiring medical malpractice claimants to execute a medical information release that allows a

defendant or his or her legal representative to conduct ex parte interviews with the claimant's treating physicians; amending s. 766.1115, F.S.; providing that certain university faculty providing health care services to patients of a public hospital shall not be considered agents of the hospital for the purposes of this section; amending s. 766.202, F.S.; redefining the terms "economic damages," "medical expert," "noneconomic damages," and "periodic payment"; amending s. 766.207, F.S.; providing for the applicability of the Wrongful Death Act and general law to arbitration awards; providing an aggregate cap on noneconomic damages which may be awarded in arbitration; providing that all future damages awarded in arbitration shall be paid by periodic payment and offset by future collateral source payments; amending s. 766.209, F.S.; providing an aggregate cap on noneconomic damages which may be awarded at trial where a claimant has rejected a defendant's offer to enter voluntary binding arbitration; creating s. 766.213, F.S.; providing for the termination of periodic payments for unincurred medical expenses upon the death of the claimant; providing for the payment of medical expenses incurred prior to the death of the claimant; amending s. 766.309, F.S.; requiring claimants filing suit for injuries determined to be compensable under the Florida Birth-Related Neurological Injury Compensation Plan to decline such benefits as a condition of proceeding to trial; providing a timeframe within which such declination must be made; amending s. 768.041, F.S.; providing for a setoff of amounts received by a claimant in settlements; authorizing settling

defendants to assign rights of contribution; amending s. 768.13, F.S.; revising guidelines for immunity from liability under the Good Samaritan Act; providing legislative intent and findings with respect to the provision of emergency medical services and care by care providers and with respect to public hospitals and affiliations with not-for-profit colleges and universities with medical schools and other health practitioner educational programs; amending s. 768.28, F.S., relating to waiver of sovereign immunity in tort actions; revising the definition of "officer, employee, or agent"; providing such immunity to certain colleges and universities affiliated with public hospitals while providing patient services; amending s. 768.77, F.S.; prescribing a method for itemization of specific categories of damages awarded in medical malpractice actions; creating s. 766.1067, F.S.; providing for mandatory mediation in medical negligence causes of action; creating s. 766.118, F.S.; providing a limitation on noneconomic damages which can be awarded in causes of action involving medical negligence; amending s. 768.78, F.S.; revising the means for compensating medical malpractice claimants for future economic and future noneconomic losses; conforming a cross reference; amending ss. 766.112 and 768.81, F.S.; providing that a defendant's liability for damages in medical negligence cases is several only; creating s. 1004.08, F.S.; requiring patient safety instruction for certain students in public schools, colleges, and universities; creating s. 1005.07, F.S.; requiring patient safety instruction for certain students in nonpublic

schools, colleges, and universities; requiring the Department of Health to study the efficacy and constitutionality of medical review panels; requiring a report; requiring a report by the Agency for Health Care Administration regarding information to be provided to health care consumers; requiring the Office of Program Policy Analysis and Government Accountability to study and report to the Legislature on requirements for coverage by the Florida Birth-Related Neurological Injury Compensation Association; requiring the Office of Program Policy Analysis and Government Accountability and the Office of the Auditor General to conduct an audit, as specified, and to report to the Legislature; requiring a report by the Agency for Health Care Administration regarding the establishment of a Patient Safety Authority; specifying elements of the report; creating the Medical Injury Nonjudicial Compensation Study Commission and providing for its membership, organization, and duties; authorizing public hearings; authorizing appointment of technical advisory committees; authorizing appointment of an executive director and the hiring of staff and consultants; authorizing per diem and reimbursement for travel expenses; requiring interim and final reports; providing for termination of the commission; providing severability; providing for construction of the act in pari materia with laws enacted during the 2003 Regular Session or the 2003 Special Session A of the Legislature; providing applicability; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Findings.--

(1) The Legislature finds that Florida is in the midst of a medical malpractice insurance crisis of unprecedented magnitude.

(2) The Legislature finds that this crisis threatens the quality and availability of health care for all Florida citizens.

(3) The Legislature finds that the rapidly growing population and the changing demographics of Florida make it imperative that students continue to choose Florida as the place they will receive their medical educations and practice medicine.

(4) The Legislature finds that Florida is among the states with the highest medical malpractice insurance premiums in the nation.

(5) The Legislature finds that the cost of medical malpractice insurance has increased dramatically during the past decade and both the increase and the current cost are substantially higher than the national average.

(6) The Legislature finds that the increase in medical malpractice liability insurance rates is forcing physicians to practice medicine without professional liability insurance, to leave Florida, to not perform high-risk procedures, and to retire early from the practice of medicine.

(7) The Legislature finds that there are certain elements of damage presently recoverable that have no monetary value, except on a purely arbitrary basis, while other elements of damage are either easily measured on a monetary basis or reflect ultimate monetary loss.

(8) The Governor created the Governor's Select Task Force on Healthcare Professional Liability Insurance to study and make recommendations to address these problems.

(9) The Legislature has reviewed the findings and recommendations of the Governor's Select Task Force on Healthcare Professional Liability Insurance.

(10) The Legislature finds that the Governor's Select Task Force on Healthcare Professional Liability Insurance has established that a medical malpractice crisis exists in the state which can be alleviated by the adoption of comprehensive legislatively enacted reforms.

(11) The Legislature finds that making high-quality health care available to the citizens of the state is an overwhelming public necessity.

(12) The Legislature finds that ensuring that physicians continue to practice in Florida is an overwhelming public necessity.

(13) The Legislature finds that ensuring the availability of affordable professional liability insurance for physicians is an overwhelming public necessity.

(14) The Legislature finds, based upon the findings and recommendations of the Governor's Select Task Force on Healthcare Professional Liability Insurance, the findings and recommendations of various study groups throughout the nation, and the experience of other states, that the overwhelming public necessities of making quality health care available to the citizens of this state, of ensuring that physicians continue to practice in Florida, and of ensuring that those physicians have the opportunity to purchase affordable professional liability insurance cannot be met unless a cap on noneconomic damages in

an amount no higher than $250,000 is imposed.

(15) The Legislature finds that the high cost of medical malpractice claims can be substantially alleviated by imposing a limitation on noneconomic damages in medical malpractice actions.

(16) The Legislature further finds that there is no alternative measure of accomplishing such result without imposing even greater limits upon the ability of persons to recover damages for medical malpractice.

(17) The Legislature finds that the provisions of this act are naturally and logically connected to each other and to the purpose of making quality health care available to the citizens of Florida.

(18) The Legislature finds that it is important to have a comprehensive bill with all issues resolved rather than separate bills.

(19) The Legislature finds that each of the provisions of this act is necessary to alleviate the crisis relating to medical malpractice insurance.

Section 2. Subsection (4) is added to section 46.015, Florida Statutes, to read:

46.015 Release of parties.--

(4)(a) At trial pursuant to a suit filed under chapter 766 or pursuant to s. 766.209, or in arbitration pursuant to s. 766.207, if any defendant shows the court that the plaintiff, or his or her legal representative, has delivered a written release or covenant not to sue to any person in partial satisfaction of the damages resulting from the same injury or injuries, the court shall set off this amount from the amount of any judgment to which the plaintiff would otherwise be entitled at the time

of rendering judgment, regardless of whether the jury has allocated fault to the settling defendant at trial.

(b) The amount of any setoff under this subsection shall include all sums received by the plaintiff, including economic and noneconomic damages, costs, and attorney's fees, and shall be applied against the total damages, after reduction for any comparative negligence of the plaintiff, rather than against the apportioned damages caused by a particular defendant.

(c) A defendant entering into a settlement agreement with a plaintiff may assign any right of contribution arising under s. 768.31 as a consequence of having paid more than his or her proportionate share of the entire liability.

Section 3. Paragraph (l) of subsection (1) of section 120.57, Florida Statutes, is amended to read:

120.57 Additional procedures for particular cases.--

(1) ADDITIONAL PROCEDURES APPLICABLE TO HEARINGS INVOLVING DISPUTED ISSUES OF MATERIAL FACT.--

(l)1. The agency may adopt the recommended order as the final order of the agency. The agency in its final order may reject or modify the conclusions of law over which it has substantive jurisdiction and interpretation of administrative rules over which it has substantive jurisdiction. When rejecting or modifying such conclusion of law or interpretation of administrative rule, the agency must state with particularity its reasons for rejecting or modifying such conclusion of law or interpretation of administrative rule and must make a finding that its substituted conclusion of law or interpretation of administrative rule is as or more reasonable than that which was rejected or modified. Rejection or modification of conclusions of law may not form the basis for rejection or modification of

findings of fact. The agency may not reject or modify the findings of fact unless the agency first determines from a review of the entire record, and states with particularity in the order, that the findings of fact were not based upon competent substantial evidence or that the proceedings on which the findings were based did not comply with essential requirements of law. The agency may accept the recommended penalty in a recommended order, but may not reduce or increase it without a review of the complete record and without stating with particularity its reasons therefor in the order, by citing to the record in justifying the action.

2. Notwithstanding subparagraph 1., as a matter of law, any decision involving the standard of care of a health care profession regulated by any board within the Department of Health is infused with overriding policy considerations that are best left to the regulatory board that has jurisdiction over that profession. When rejecting or modifying a recommended finding of fact in standard-of-care cases, the appropriate board within the Department of Health may reassess and resolve conflicting evidence in a recommended order based on the record in the case.

Section 4. Subsection (11) is added to section 120.65, Florida Statutes, to read:

120.65 Administrative law judges.--

(11) The Division of Administrative Hearings shall designate at least two administrative law judges who will specifically preside over actions involving a health care practitioner or profession as defined in s. 456.001. Each designated administrative law judge shall be a member of The Florida Bar in good standing and shall be a health care

practitioner or have experience in health care. The Division of Administrative Hearings and the Department of Health shall work cooperatively to enhance the effectiveness of disciplinary actions involving a health care practitioner or profession as defined in s. 456.001.

Section 5. Subsection (1) of section 391.025, Florida Statutes, is amended to read:

391.025 Applicability and scope.--

(1) This act applies to health services provided to eligible individuals who are:

(a) Enrolled in the Medicaid program.~~;~~

(b) Enrolled in the Florida Kidcare program.~~; and~~

(c) Uninsured or underinsured, provided that they meet the financial eligibility requirements established in this act, and to the extent that resources are appropriated for their care.~~;~~ ~~and~~

(d) Infants who receive an award of compensation pursuant to s. 766.31(1).

Section 6. Paragraph (f) is added to subsection (2) of section 391.029, Florida Statutes, to read:

391.029 Program eligibility.--

(2) The following individuals are financially eligible for the program:

(f) An infant who receives an award of compensation pursuant to s. 766.31(1), provided the Florida Birth-Related Neurological Injury Compensation Association shall reimburse the Children's Medical Services Network the state's share of funding, which funding shall be used to obtain matching federal funds under Title XXI of the Social Security Act.

The department may continue to serve certain children with special health care needs who are 21 years of age or older and who were receiving services from the program prior to April 1, 1998. Such children may be served by the department until July 1, 2000.

Section 7. Patient safety data privilege.--

(1) As used in this section, the term:

(a) "Patient safety data" means reports made to patient safety organizations, including all health care data, interviews, memoranda, analyses, root cause analyses, products of quality assurance or quality improvement processes, corrective action plans, or information collected or created by a health care facility licensed under chapter 395, Florida Statutes, or a health care practitioner as defined in s. 456.001(4), Florida Statutes, as a result of an occurrence related to the provision of health care services which exacerbates an existing medical condition or could result in injury, illness, or death.

(b) "Patient safety organization" means any organization, group, or other entity that collects and analyzes patient safety data for the purpose of improving patient safety and health care outcomes and that is independent and not under the control of the entity that reports patient safety data.

(2) Patient safety data shall not be subject to discovery or introduction into evidence in any civil or administrative action.

(3) Unless otherwise provided by law, a patient safety organization shall promptly remove all patient-identifying information after receipt of a complete patient safety data report unless such organization is otherwise permitted by state

or federal law to maintain such information. Patient safety organizations shall maintain the confidentiality of all patient-identifying information and may not disseminate such information, except as permitted by state or federal law.

(4) The exchange of patient safety data among health care facilities licensed under chapter 395, Florida Statutes, or health care practitioners as defined in s. 456.001(4), Florida Statutes, or patient safety organizations which does not identify any patient shall not constitute a waiver of any privilege established in this section.

(5) Reporting of patient safety data to patient safety organizations does not abrogate obligations to make reports to the Department of Health, the Agency for Health Care Administration, or other state or federal regulatory agencies.

(6) An employer may not take retaliatory action against an employee who in good faith makes a report of patient safety data to a patient safety organization.

Section 8. Section 766.304, Florida Statutes, is amended to read:

766.304 Administrative law judge to determine claims.--The administrative law judge shall hear and determine all claims filed pursuant to ss. 766.301-766.316 and shall exercise the full power and authority granted to her or him in chapter 120, as necessary, to carry out the purposes of such sections. The administrative law judge has exclusive jurisdiction to determine whether a claim filed under this act is compensable. No civil action may be brought until the determinations under s. 766.309 have been made by the administrative law judge. If the administrative law judge determines that the claimant is entitled to compensation from the association, no civil action

may be brought or continued in violation of the exclusiveness of remedy provisions of s. 766.303. If it is determined that a claim filed under this act is not compensable, neither the doctrine of collateral estoppel nor res judicata shall prohibit the claimant from pursuing any and all civil remedies available under common law and statutory law. The findings of fact and conclusions of law of the administrative law judge shall not be admissible in any subsequent proceeding; however, the sworn testimony of any person and the exhibits introduced into evidence in the administrative case are admissible as impeachment in any subsequent civil action only against a party to the administrative proceeding, subject to the Rules of Evidence. An award ~~action~~ may not be awarded or paid ~~brought~~ under ss. 766.301-766.316 if the claimant recovers under a settlement or a final judgment is entered in a civil action. The division may adopt rules to promote the efficient administration of, and to minimize the cost associated with, the prosecution of claims.

Section 9. Section 766.305, Florida Statutes, is amended to read:

766.305 Filing of claims and responses; medical disciplinary review.--

(1) All claims filed for compensation under the plan shall commence by the claimant filing with the division a petition seeking compensation. Such petition shall include the following information:

(a) The name and address of the legal representative and the basis for her or his representation of the injured infant.

(b) The name and address of the injured infant.

(c) The name and address of any physician providing obstetrical services who was present at the birth and the name and address of the hospital at which the birth occurred.

(d) A description of the disability for which the claim is made.

(e) The time and place the injury occurred.

(f) A brief statement of the facts and circumstances surrounding the injury and giving rise to the claim.

~~(g) All available relevant medical records relating to the birth-related neurological injury, and an identification of any unavailable records known to the claimant and the reasons for their unavailability.~~

~~(h) Appropriate assessments, evaluations, and prognoses, and such other records and documents as are reasonably necessary for the determination of the amount of compensation to be paid to, or on behalf of, the injured infant on account of the birth-related neurological injury.~~

~~(i) Documentation of expenses and services incurred to date, which indicates any payment made for such expenses and services, and by whom.~~

~~(j) Documentation of any applicable private or governmental source of services or reimbursement relative to the impairments.~~

(2) The claimant shall furnish the division with as many copies of the petition as required for service upon the association, any physician and hospital named in the petition, and the Division of Medical Quality Assurance, along with a $15 filing fee payable to the Division of Administrative Hearings. Upon receipt of the petition, the division shall immediately serve the association, by service upon the agent designated to

accept service on behalf of the association, by registered or certified mail, and shall mail copies of the petition, by registered or certified mail, to any physician, health care provider, and hospital named in the petition, and furnish a copy by regular mail to the Division of Medical Quality Assurance, and the Agency for Health Care Administration.

(3) The claimant shall furnish to the executive director of the Florida Birth-Related Neurological Injury Compensation Association one copy of the following information which shall be filed with the association within 10 days after the filing of the petition as set forth in s. 766.305(1):

(a) All available relevant medical records relating to the birth-related neurological injury and an identification of any unavailable records known to the claimant and the reasons for their unavailability.

(b) Appropriate assessments, evaluations, and prognoses and such other records and documents as are reasonably necessary for the determination of the amount of compensation to be paid to, or on behalf of, the injured infant on account of the birth-related neurological injury.

(c) Documentation of expenses and services incurred to date, which indicates any payment made for such expenses and services and by whom.

(d) Documentation of any applicable private or governmental source of services or reimbursement relative to the impairments. The information contained in paragraphs (a)-(d) is confidential and exempt pursuant to the provisions of s. 766.315(5)(b).

(4)~~(3)~~ The association shall have 45 days from the date of service of a complete claim, filed pursuant to subsections (1) and (2), in which to file a response to the petition and to

submit relevant written information relating to the issue of whether the injury alleged is a birth-related neurological injury.

(5)~~(4)~~ Upon receipt of such petition, the Division of Medical Quality Assurance shall review the information therein and determine whether it involved conduct by a physician licensed under chapter 458 or an osteopathic physician licensed under chapter 459 that is subject to disciplinary action, in which case the provisions of s. 456.073 shall apply.

(6)~~(5)~~ Upon receipt of such petition, the Agency for Health Care Administration shall investigate the claim, and if it determines that the injury resulted from, or was aggravated by, a breach of duty on the part of a hospital in violation of chapter 395, it shall take any such action consistent with its disciplinary authority as may be appropriate.

(7)~~(6)~~ Any claim which the association determines to be compensable may be accepted for compensation, provided that the acceptance is approved by the administrative law judge to whom the claim for compensation is assigned.

Section 10. Subsection (4) is added to section 766.309, Florida Statutes, to read:

766.309 Determination of claims; presumption; findings of administrative law judge binding on participants.--

(4) If it is in the interest of judicial economy or if requested to by the claimant, the administrative law judge may bifurcate the proceeding, addressing compensability and notice pursuant to s. 766.316 first and addressing any award pursuant to s. 766.31 in a separate proceeding. The administrative law judge may issue a final order on compensability and notice which

is subject to appeal under s. 766.311, prior to issuance of an award pursuant to s. 766.31.

Section 11. Subsection (1) of section 766.31, Florida Statutes, is amended to read:

766.31 Administrative law judge awards for birth-related neurological injuries; notice of award.--

(1) Upon determining that an infant has sustained a birth-related neurological injury and that obstetrical services were delivered by a participating physician at the birth, the administrative law judge shall make an award providing compensation for the following items relative to such injury:

(a) Actual expenses for medically necessary and reasonable medical and hospital, habilitative and training, family residential or custodial care, professional residential, and custodial care and service, for medically necessary drugs, special equipment, and facilities, and for related travel. However, such expenses shall not include:

1. Expenses for items or services that the infant has received, or is entitled to receive, under the laws of any state or the Federal Government, including Medicaid, except to the extent such exclusion may be prohibited by federal law.

2. Expenses for items or services that the infant has received, or is contractually entitled to receive, from any prepaid health plan, health maintenance organization, or other private insuring entity.

3. Expenses for which the infant has received reimbursement, or for which the infant is entitled to receive reimbursement, under the laws of any state or the Federal Government, including Medicaid, except to the extent such exclusion may be prohibited by federal law.

4. Expenses for which the infant has received reimbursement, or for which the infant is contractually entitled to receive reimbursement, pursuant to the provisions of any health or sickness insurance policy or other private insurance program.

Expenses included under this paragraph shall be limited to reasonable charges prevailing in the same community for similar treatment of injured persons when such treatment is paid for by the injured person.

(b)1. Periodic payments of an award to the parents or legal guardians of the infant found to have sustained a birth-related neurological injury, which award shall not exceed $100,000. However, at the discretion of the administrative law judge, such award may be made in a lump sum.

2. A death benefit for the infant in an amount of $10,000 ~~Payment for funeral expenses not to exceed $1,500~~.

(c) Reasonable expenses incurred in connection with the filing of a claim under ss. 766.301-766.316, including reasonable attorney's fees, which shall be subject to the approval and award of the administrative law judge. In determining an award for attorney's fees, the administrative law judge shall consider the following factors:

1. The time and labor required, the novelty and difficulty of the questions involved, and the skill requisite to perform the legal services properly.

2. The fee customarily charged in the locality for similar legal services.

3. The time limitations imposed by the claimant or the circumstances.

4. The nature and length of the professional relationship with the claimant.

5. The experience, reputation, and ability of the lawyer or lawyers performing services.

6. The contingency or certainty of a fee.

If there is an award of benefits under the plan, the claimants shall not be liable for any attorney's fees incurred in connection with the filing of a claim under ss. 766.301-766.316 other than those fees awarded under this section.

Section 12. Subsection (4) and paragraph (a) of subsection (5) of section 766.314, Florida Statutes, are amended to read:

766.314 Assessments; plan of operation.--

(4) The following persons and entities shall pay into the association an initial assessment in accordance with the plan of operation:

(a) On or before October 1, 1988, each hospital licensed under chapter 395 shall pay an initial assessment of $50 per infant delivered in the hospital during the prior calendar year, as reported to the Agency for Health Care Administration; provided, however, that a hospital owned or operated by the state or a county, special taxing district, or other political subdivision of the state shall not be required to pay the initial assessment or any assessment required by subsection (5). The term "infant delivered" includes live births and not stillbirths, but the term does not include infants delivered by employees or agents of the board of trustees of a state university ~~Regents~~ or those born in a teaching hospital as defined in s. 408.07. The initial assessment and any assessment imposed pursuant to subsection (5) may not include any infant

born to a charity patient (as defined by rule of the Agency for Health Care Administration) or born to a patient for whom the hospital receives Medicaid reimbursement, if the sum of the annual charges for charity patients plus the annual Medicaid contractuals of the hospital exceeds 10 percent of the total annual gross operating revenues of the hospital. The hospital is responsible for documenting, to the satisfaction of the association, the exclusion of any birth from the computation of the assessment. Upon demonstration of financial need by a hospital, the association may provide for installment payments of assessments.

(b)1. On or before October 15, 1988, all physicians licensed pursuant to chapter 458 or chapter 459 as of October 1, 1988, other than participating physicians, shall be assessed an initial assessment of $250, which must be paid no later than December 1, 1988.

2. Any such physician who becomes licensed after September 30, 1988, and before January 1, 1989, shall pay into the association an initial assessment of $250 upon licensure.

3. Any such physician who becomes licensed on or after January 1, 1989, shall pay an initial assessment equal to the most recent assessment made pursuant to this paragraph, paragraph (5)(a), or paragraph (7)(b).

4. However, if the physician is a physician specified in this subparagraph, the assessment is not applicable:

a. A resident physician, assistant resident physician, or intern in an approved postgraduate training program, as defined by the Board of Medicine or the Board of Osteopathic Medicine by rule;

b. A retired physician who has withdrawn from the practice of medicine but who maintains an active license as evidenced by an affidavit filed with the Department of Health. Prior to reentering the practice of medicine in this state, a retired physician as herein defined must notify the Board of Medicine or the Board of Osteopathic Medicine and pay the appropriate assessments pursuant to this section;

c. A physician who holds a limited license pursuant to s. 458.317 and who is not being compensated for medical services;

d. A physician who is employed full time by the United States Department of Veterans Affairs and whose practice is confined to United States Department of Veterans Affairs hospitals; or

e. A physician who is a member of the Armed Forces of the United States and who meets the requirements of s. 456.024.

f. A physician who is employed full time by the State of Florida and whose practice is confined to state-owned correctional institutions, a county health department, or state-owned mental health or developmental services facilities, or who is employed full time by the Department of Health.

(c) On or before December 1, 1988, each physician licensed pursuant to chapter 458 or chapter 459 who wishes to participate in the Florida Birth-Related Neurological Injury Compensation Plan and who otherwise qualifies as a participating physician under ss. 766.301-766.316 shall pay an initial assessment of $5,000. However, if the physician is either a resident physician, assistant resident physician, or intern in an approved postgraduate training program, as defined by the Board of Medicine or the Board of Osteopathic Medicine by rule, and is supervised in accordance with program requirements established

by the Accreditation Council for Graduate Medical Education or the American Osteopathic Association by a physician who is participating in the plan, such resident physician, assistant resident physician, or intern is deemed to be a participating physician without the payment of the assessment. Participating physicians also include any employee of the board of trustees of a state university ~~Regents~~ who has paid the assessment required by this paragraph and paragraph (5)(a), and any certified nurse midwife supervised by such employee. Participating physicians include any certified nurse midwife who has paid 50 percent of the physician assessment required by this paragraph and paragraph (5)(a) and who is supervised by a participating physician who has paid the assessment required by this paragraph and paragraph (5)(a). Supervision for nurse midwives shall require that the supervising physician will be easily available and have a prearranged plan of treatment for specified patient problems which the supervised certified nurse midwife may carry out in the absence of any complicating features. Any physician who elects to participate in such plan on or after January 1, 1989, who was not a participating physician at the time of such election to participate and who otherwise qualifies as a participating physician under ss. 766.301-766.316 shall pay an additional initial assessment equal to the most recent assessment made pursuant to this paragraph, paragraph (5)(a), or paragraph (7)(b).

(d) Any hospital located in any county with a gross population in excess of 1.1 million as of January 1, 2003, as determined by the Agency for Health Care Administration, pursuant to the Health Care Responsibility Act, may elect to pay the fee for the participating physician and the certified nurse midwife

if the hospital first determines that the primary motivating purpose for making such payment is to ensure coverage for the hospital's patients under the provisions of ss. 766.301-766.316, provided no hospital may restrict any participating physician or certified nurse midwife, directly or indirectly, from being on the staff of hospitals other than the staff of the hospital making such payment. Each hospital shall file with the association an affidavit setting forth specifically the reasons why such hospital elected to make such payment on behalf of each participating physician and certified nurse midwife. The payments authorized pursuant to this paragraph shall be in addition to the assessment set forth in paragraph (5)(a).

(5)(a) Beginning January 1, 1990, the persons and entities listed in paragraphs (4)(b) and (c), except those persons or entities who are specifically excluded from said provisions, as of the date determined in accordance with the plan of operation, taking into account persons licensed subsequent to the payment of the initial assessment, shall pay an annual assessment in the amount equal to the initial assessments provided in paragraphs (4)(b) and (c). If the payment of such annual assessment by a participating physician is not received by the association by January 31 of any calendar year, the participating physician shall only qualify as a participating physician for that calendar year from the date the payment was received by the association. On January 1, 1991, and on each January 1 thereafter, the association shall determine the amount of additional assessments necessary pursuant to subsection (7), in the manner required by the plan of operation, subject to any increase determined to be necessary by the Department of Insurance pursuant to paragraph (7)(b). On July 1, 1991, and on

each July 1 thereafter, the persons and entities listed in paragraphs (4)(b) and (c), except those persons or entities who are specifically excluded from said provisions, shall pay the additional assessments which were determined on January 1. Beginning January 1, 1990, the entities listed in paragraph (4)(a), including those licensed on or after October 1, 1988, shall pay an annual assessment of $50 per infant delivered during the prior calendar year. The additional assessments which were determined on January 1, 1991, pursuant to the provisions of subsection (7) shall not be due and payable by the entities listed in paragraph (4)(a) until July 1.

Section 13. Subsection (4) is added to section 391.035, Florida Statutes, to read:

391.035 Provider qualifications.--

(4) A physician licensed under chapter 458 or chapter 459 who is approved by the department under this section shall be deemed an agent of the department and shall be covered by state liability protection in accordance with s. 768.28 when providing health care services to participants in accordance with department rules and guidelines and protocols of the Children's Medical Services. When such health care services are provided under contract with the department, the contract shall provide for the indemnification of the state by the agent for any liabilities incurred up to the limits set out in chapter 768.

Section 14. Section 395.0194, Florida Statutes, is created to read:

395.0194 Licensed facilities; quality assurance responsibilities of governing board.--

(1) A governing board's authority for the administration of the hospital is not limited by the authority of its medical

staff. Therefore, a governing board may reject or modify a medical staff recommendation or may, if the medical staff has failed to act, take action independent of the medical staff concerning medical staff membership, clinical privileges, peer review, patient safety, and quality assurance.

(2) To the extent a governing board seeks to modify a medical staff recommendation, or where a medical staff has failed to act within 75 days after a request from the governing board to take action against, or with regard to, an individual physician concerning medical staff membership, clinical privileges, peer review, or quality assurance, a governing board may take action independent of the actions of the medical staff. If no existing bylaw provision exists and if, after any informal interview, the governing board determines that corrective or disciplinary action is necessary, it shall recommend such action to a six-member joint conference committee composed of three members of the governing board, to be appointed by the chair of the governing board, and three members of the medical staff, to be appointed by the chair or president of the medical staff. The joint conference committee shall, within 15 days after the governing board's decision, conduct a fair hearing in which the physician is entitled to be represented by counsel, to be afforded an opportunity to present oral and written argument in response to the corrective or disciplinary action proposed, and to comment upon and cross-examine witnesses and evidence against such physician and notify the governing board that the joint conference committee accepts, rejects, or cannot reach a majority consensus concerning the governing board's recommendation. If the joint conference committee's recommendation is to accept the governing board's

recommendation, the governing board's decision shall be final. If the joint conference committee rejects the governing board's recommendation and suggests an alternative corrective or disciplinary action, or finds that no corrective or disciplinary action is warranted, the governing board shall not unreasonably reject the joint conference committee's recommendation. If the joint conference committee cannot reach a majority consensus to either accept or reject the governing board's action concerning the fair hearing decision, the governing board's action shall be final. The governing board shall give full and complete consideration to the joint conference committee’s recommendations.

Section 15. Section 395.0197, Florida Statutes, is amended to read:

395.0197 Internal risk management program.--

(1) Every licensed facility shall, as a part of its administrative functions, establish an internal risk management program that includes all of the following components:

(a) The investigation and analysis of the frequency and causes of general categories and specific types of adverse incidents to patients.

(b) The development of appropriate measures to minimize the risk of adverse incidents to patients, including, but not limited to:

1. Risk management and risk prevention education and training of all nonphysician personnel as follows:

a. Such education and training of all nonphysician personnel as part of their initial orientation; and

b. At least 1 hour of such education and training annually for all personnel of the licensed facility working in clinical

areas and providing patient care, except those persons licensed as health care practitioners who are required to complete continuing education coursework pursuant to chapter 456 or the respective practice act.

2. A prohibition, except when emergency circumstances require otherwise, against a staff member of the licensed facility attending a patient in the recovery room, unless the staff member is authorized to attend the patient in the recovery room and is in the company of at least one other person. However, a licensed facility is exempt from the two-person requirement if it has:

a. Live visual observation;

b. Electronic observation; or

c. Any other reasonable measure taken to ensure patient protection and privacy.

3. A prohibition against an unlicensed person from assisting or participating in any surgical procedure unless the facility has authorized the person to do so following a competency assessment, and such assistance or participation is done under the direct and immediate supervision of a licensed physician and is not otherwise an activity that may only be performed by a licensed health care practitioner.

4. Development, implementation, and ongoing evaluation of procedures, protocols, and systems to accurately identify patients, planned procedures, and the correct site of the planned procedure so as to minimize the performance of a surgical procedure on the wrong patient, a wrong surgical procedure, a wrong-site surgical procedure, or a surgical procedure otherwise unrelated to the patient's diagnosis or medical condition.

(c) The analysis of patient grievances that relate to patient care and the quality of medical services.

(d) The development and implementation of an incident reporting system based upon the affirmative duty of all health care providers and all agents and employees of the licensed health care facility to report adverse incidents to the risk manager, or to his or her designee, within 3 business days after their occurrence.

(2) The internal risk management program is the responsibility of the governing board of the health care facility. Each licensed facility shall hire a risk manager, licensed under s. 395.10974, who is responsible for implementation and oversight of such facility's internal risk management program as required by this section. A risk manager must not be made responsible for more than four internal risk management programs in separate licensed facilities, unless the facilities are under one corporate ownership or the risk management programs are in rural hospitals.

(3) In addition to the programs mandated by this section, other innovative approaches intended to reduce the frequency and severity of medical malpractice and patient injury claims shall be encouraged and their implementation and operation facilitated. Such additional approaches may include extending internal risk management programs to health care providers' offices and the assuming of provider liability by a licensed health care facility for acts or omissions occurring within the licensed facility.

(4) The agency shall adopt rules governing the establishment of internal risk management programs to meet the needs of individual licensed facilities. Each internal risk

management program shall include the use of incident reports to be filed with an individual of responsibility who is competent in risk management techniques in the employ of each licensed facility, such as an insurance coordinator, or who is retained by the licensed facility as a consultant. The individual responsible for the risk management program shall have free access to all medical records of the licensed facility. The incident reports are part of the workpapers of the attorney defending the licensed facility in litigation relating to the licensed facility and are subject to discovery, but are not admissible as evidence in court. A person filing an incident report is not subject to civil suit by virtue of such incident report. As a part of each internal risk management program, the incident reports shall be used to develop categories of incidents which identify problem areas. Once identified, procedures shall be adjusted to correct the problem areas.

(5) For purposes of reporting to the agency pursuant to this section, the term "adverse incident" means an event over which health care personnel could exercise control and which is associated in whole or in part with medical intervention, rather than the condition for which such intervention occurred, and which:

(a) Results in one of the following injuries:

1. Death;

2. Brain or spinal damage;

3. Permanent disfigurement;

4. Fracture or dislocation of bones or joints;

5. A resulting limitation of neurological, physical, or sensory function which continues after discharge from the facility;

6. Any condition that required specialized medical attention or surgical intervention resulting from nonemergency medical intervention, other than an emergency medical condition, to which the patient has not given his or her informed consent; or

7. Any condition that required the transfer of the patient, within or outside the facility, to a unit providing a more acute level of care due to the adverse incident, rather than the patient's condition prior to the adverse incident;

(b) Was the performance of a surgical procedure on the wrong patient, a wrong surgical procedure, a wrong-site surgical procedure, or a surgical procedure otherwise unrelated to the patient's diagnosis or medical condition;

(c) Required the surgical repair of damage resulting to a patient from a planned surgical procedure, where the damage was not a recognized specific risk, as disclosed to the patient and documented through the informed-consent process; or

(d) Was a procedure to remove unplanned foreign objects remaining from a surgical procedure.

(6)(a) Each licensed facility subject to this section shall submit an annual report to the agency summarizing the incident reports that have been filed in the facility for that year. The report shall include:

1. The total number of adverse incidents.

2. A listing, by category, of the types of operations, diagnostic or treatment procedures, or other actions causing the injuries, and the number of incidents occurring within each category.

3. A listing, by category, of the types of injuries caused and the number of incidents occurring within each category.

4. A code number using the health care professional's licensure number and a separate code number identifying all other individuals directly involved in adverse incidents to patients, the relationship of the individual to the licensed facility, and the number of incidents in which each individual has been directly involved. Each licensed facility shall maintain names of the health care professionals and individuals identified by code numbers for purposes of this section.

5. A description of all malpractice claims filed against the licensed facility, including the total number of pending and closed claims and the nature of the incident which led to, the persons involved in, and the status and disposition of each claim.

6. The name and judgments entered against each health care practitioner for which the facility assumes liability pursuant to subsection (3).

Each report shall update status and disposition for all prior reports.

(b) The information reported to the agency pursuant to paragraph (a) which relates to persons licensed under chapter 458, chapter 459, chapter 461, or chapter 466 shall be reviewed by the agency. The agency shall determine whether any of the incidents potentially involved conduct by a health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 shall apply.

(c) The report submitted to the agency shall also contain the name and license number of the risk manager of the licensed facility, a copy of its policy and procedures which govern the measures taken by the facility and its risk manager to reduce

the risk of injuries and adverse incidents, and the results of such measures. The annual report is confidential and is not available to the public pursuant to s. 119.07(1) or any other law providing access to public records. The annual report is not discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or the appropriate regulatory board. The annual report is not available to the public as part of the record of investigation for and prosecution in disciplinary proceedings made available to the public by the agency or the appropriate regulatory board. However, the agency or the appropriate regulatory board shall make available, upon written request by a health care professional against whom probable cause has been found, any such records which form the basis of the determination of probable cause.

~~(7) The licensed facility shall notify the agency no later than 1 business day after the risk manager or his or her designee has received a report pursuant to paragraph (1)(d) and can determine within 1 business day that any of the following adverse incidents has occurred, whether occurring in the licensed facility or arising from health care prior to admission in the licensed facility:~~

~~(a) The death of a patient;~~

~~(b) Brain or spinal damage to a patient;~~

~~(c) The performance of a surgical procedure on the wrong patient;~~

~~(d) The performance of a wrong-site surgical procedure; or~~

~~(e) The performance of a wrong surgical procedure.~~

~~The notification must be made in writing and be provided by facsimile device or overnight mail delivery. The notification must include information regarding the identity of the affected patient, the type of adverse incident, the initiation of an investigation by the facility, and whether the events causing or resulting in the adverse incident represent a potential risk to other patients.~~

(7)~~(8)~~ Any of the following adverse incidents, whether occurring in the licensed facility or arising from health care prior to admission in the licensed facility, shall be reported by the facility to the agency within 15 calendar days after its occurrence:

(a) The death of a patient;

(b) Brain or spinal damage to a patient;

(c) The performance of a surgical procedure on the wrong patient;

(d) The performance of a wrong-site surgical procedure;

(e) The performance of a wrong surgical procedure;

(f) The performance of a surgical procedure that is medically unnecessary or otherwise unrelated to the patient's diagnosis or medical condition;

(g) The surgical repair of damage resulting to a patient from a planned surgical procedure, where the damage is not a recognized specific risk, as disclosed to the patient and documented through the informed-consent process; or

(h) The performance of procedures to remove unplanned foreign objects remaining from a surgical procedure.

The agency may grant extensions to this reporting requirement for more than 15 days upon justification submitted in writing by

the facility administrator to the agency. The agency may require an additional, final report. These reports shall not be available to the public pursuant to s. 119.07(1) or any other law providing access to public records, nor be discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or the appropriate regulatory board, nor shall they be available to the public as part of the record of investigation for and prosecution in disciplinary proceedings made available to the public by the agency or the appropriate regulatory board. However, the agency or the appropriate regulatory board shall make available, upon written request by a health care professional against whom probable cause has been found, any such records which form the basis of the determination of probable cause. The agency may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The agency shall review each incident and determine whether it potentially involved conduct by the health care professional who is subject to disciplinary action, in which case the provisions of s. 456.073 shall apply.

(8)~~(9)~~ The agency shall publish on the agency's website, no less than quarterly, a summary and trend analysis of adverse incident reports received pursuant to this section, which shall not include information that would identify the patient, the reporting facility, or the health care practitioners involved. The agency shall publish on the agency's website an annual summary and trend analysis of all adverse incident reports and malpractice claims information provided by facilities in their annual reports, which shall not include information that would identify the patient, the reporting facility, or the

practitioners involved. The purpose of the publication of the summary and trend analysis is to promote the rapid dissemination of information relating to adverse incidents and malpractice claims to assist in avoidance of similar incidents and reduce morbidity and mortality.

(9)~~(10)~~ The internal risk manager of each licensed facility shall:

(a) Investigate every allegation of sexual misconduct which is made against a member of the facility's personnel who has direct patient contact, when the allegation is that the sexual misconduct occurred at the facility or on the grounds of the facility.

(b) Report every allegation of sexual misconduct to the administrator of the licensed facility.

(c) Notify the family or guardian of the victim, if a minor, that an allegation of sexual misconduct has been made and that an investigation is being conducted.

(d) Report to the Department of Health every allegation of sexual misconduct, as defined in chapter 456 and the respective practice act, by a licensed health care practitioner that involves a patient.

(10)~~(11)~~ Any witness who witnessed or who possesses actual knowledge of the act that is the basis of an allegation of sexual abuse shall:

(a) Notify the local police; and

(b) Notify the hospital risk manager and the administrator.

For purposes of this subsection, "sexual abuse" means acts of a sexual nature committed for the sexual gratification of anyone

upon, or in the presence of, a vulnerable adult, without the vulnerable adult's informed consent, or a minor. "Sexual abuse" includes, but is not limited to, the acts defined in s. 794.011(1)(h), fondling, exposure of a vulnerable adult's or minor's sexual organs, or the use of the vulnerable adult or minor to solicit for or engage in prostitution or sexual performance. "Sexual abuse" does not include any act intended for a valid medical purpose or any act which may reasonably be construed to be a normal caregiving action.

(11)~~(12)~~ A person who, with malice or with intent to discredit or harm a licensed facility or any person, makes a false allegation of sexual misconduct against a member of a licensed facility's personnel is guilty of a misdemeanor of the second degree, punishable as provided in s. 775.082 or s. 775.083.

(12) If appropriate, a licensed facility in which sexual abuse occurs must offer the victim of sexual abuse testing for sexually transmissible diseases and shall provide all such testing at no cost to the victim.

(13) In addition to any penalty imposed pursuant to this section, the agency shall require a written plan of correction from the facility. For a single incident or series of isolated incidents that are nonwillful violations of the reporting requirements of this section, the agency shall first seek to obtain corrective action by the facility. If the correction is not demonstrated within the timeframe established by the agency or if there is a pattern of nonwillful violations of this section, the agency may impose an administrative fine, not to exceed $5,000 for any violation of the reporting requirements of this section. The administrative fine for repeated nonwillful

violations shall not exceed $10,000 for any violation. The administrative fine for each intentional and willful violation may not exceed $25,000 per violation, per day. The fine for an intentional and willful violation of this section may not exceed $250,000. In determining the amount of fine to be levied, the agency shall be guided by s. 395.1065(2)(b). ~~This subsection does not apply to the notice requirements under subsection (7)~~.

(14) The agency shall have access to all licensed facility records necessary to carry out the provisions of this section. The records obtained by the agency under subsection (6), subsection (7) ~~(8)~~, or subsection (9) ~~(10)~~ are not available to the public under s. 119.07(1), nor shall they be discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the agency or the appropriate regulatory board, nor shall records obtained pursuant to s. 456.071 be available to the public as part of the record of investigation for and prosecution in disciplinary proceedings made available to the public by the agency or the appropriate regulatory board. However, the agency or the appropriate regulatory board shall make available, upon written request by a health care professional against whom probable cause has been found, any such records which form the basis of the determination of probable cause, except that, with respect to medical review committee records, s. 766.101 controls.

(15) The meetings of the committees and governing board of a licensed facility held solely for the purpose of achieving the objectives of risk management as provided by this section shall not be open to the public under the provisions of chapter 286. The records of such meetings are confidential and exempt from s. 119.07(1), except as provided in subsection (14).

(16) The agency shall review, as part of its licensure inspection process, the internal risk management program at each licensed facility regulated by this section to determine whether the program meets standards established in statutes and rules, whether the program is being conducted in a manner designed to reduce adverse incidents, and whether the program is appropriately reporting incidents under this section.

(17) There shall be no monetary liability on the part of, and no cause of action for damages shall arise against, any risk manager, licensed under s. 395.10974, for the implementation and oversight of the internal risk management program in a facility licensed under this chapter or chapter 390 as required by this section, for any act or proceeding undertaken or performed within the scope of the functions of such internal risk management program if the risk manager acts without intentional fraud.

(18) A privilege against civil liability is hereby granted to any licensed risk manager or licensed facility with regard to information furnished pursuant to this chapter, unless the licensed risk manager or facility acted in bad faith or with malice in providing such information.

(19) If the agency, through its receipt of any reports required under this section or through any investigation, has a reasonable belief that conduct by a staff member or employee of a licensed facility is grounds for disciplinary action by the appropriate regulatory board, the agency shall report this fact to such regulatory board.

(20) It shall be unlawful for any person to coerce, intimidate, or preclude a risk manager from lawfully executing his or her reporting obligations pursuant to this chapter. Such

unlawful action shall be subject to civil monetary penalties not to exceed $10,000 per violation.

Section 16. Section 395.0198, Florida Statutes, is repealed.

Section 17. Section 395.1012, Florida Statutes, is created to read:

395.1012 Patient safety.--

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

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

Section 18. Section 395.1051, Florida Statutes, is created to read:

395.1051 Duty to notify patients.--Every licensed facility shall inform each patient, or an individual identified pursuant to s. 765.401(1), in person about unanticipated outcomes of care that result in serious harm to the patient. Notification of outcomes of care that result in harm to the patient under this section shall neither constitute an acknowledgement or admission of liability, nor be introduced as evidence in any civil lawsuit.

Section 19. Section 415.1111, Florida Statutes, is amended to read:

415.1111 Civil actions.--A vulnerable adult who has been

abused, neglected, or exploited as specified in this chapter has a cause of action against any perpetrator and may recover actual and punitive damages for such abuse, neglect, or exploitation. The action may be brought by the vulnerable adult, or that person's guardian, by a person or organization acting on behalf of the vulnerable adult with the consent of that person or that person's guardian, or by the personal representative of the estate of a deceased victim without regard to whether the cause of death resulted from the abuse, neglect, or exploitation. The action may be brought in any court of competent jurisdiction to enforce such action and to recover actual and punitive damages for any deprivation of or infringement on the rights of a vulnerable adult. A party who prevails in any such action may be entitled to recover reasonable attorney's fees, costs of the action, and damages. The remedies provided in this section are in addition to and cumulative with other legal and administrative remedies available to a vulnerable adult. Notwithstanding the foregoing, any civil action for damages against any licensee or entity who establishes, controls, conducts, manages, or operates a facility licensed under part II of chapter 400 relating to its operation of the licensed facility shall be brought pursuant to s. 400.023, or against any licensee or entity who establishes, controls, conducts, manages, or operates a facility licensed under part III of chapter 400 relating to its operation of the licensed facility shall be brought pursuant to s. 400.429. Notwithstanding the foregoing, any claim that qualifies as a claim for medical malpractice, as defined in s. 766.106(1)(a), against any licensee or entity who establishes, controls, conducts, manages, or operates a facility licensed under chapter 395 shall be brought pursuant to chapter

766. Such licensee or entity shall not be vicariously liable for the acts or omissions of its employees or agents or any other third party in an action brought under this section.

Section 20. Section 408.932, Florida Statutes, is created to read:

408.932 Duty to notify patients.--Each facility licensed by the Agency for Health Care Administration, except facilities licensed pursuant to chapter 395, shall inform each patient or the patient's representative in person about unanticipated outcomes of care which result in serious harm to the patient. Notification of outcomes of care which result in serious harm to the patient under this section shall neither constitute an acknowledgment or admission of liability nor be introduced as evidence in any civil lawsuit.

Section 21. Section 456.0575, Florida Statutes, is created to read:

456.0575 Duty to notify patients.--Every licensed health care provider shall inform each patient or the patient's representative in person about unanticipated outcomes of care which result in serious harm to the patient. Notification of outcomes of care which result in serious harm to the patient under this section shall neither constitute an acknowledgment or admission of liability nor be introduced as evidence in any civil lawsuit.

Section 22. Each board within the Department of Health which has jurisdiction over health care practitioners who are authorized to prescribe drugs may adopt by rule standards of practice for practitioners who are under that board's jurisdiction for the safe and ethical prescription of drugs to patients via the Internet.

Section 23. Paragraph (a) of subsection (1) of section 456.039, Florida Statutes, is amended to read:

456.039 Designated health care professionals; information required for licensure.--

(1) Each person who applies for initial licensure as a physician under chapter 458, chapter 459, chapter 460, or chapter 461, except a person applying for registration pursuant to ss. 458.345 and 459.021, must, at the time of application, and each physician who applies for license renewal under chapter 458, chapter 459, chapter 460, or chapter 461, except a person registered pursuant to ss. 458.345 and 459.021, must, in conjunction with the renewal of such license and under procedures adopted by the Department of Health, and in addition to any other information that may be required from the applicant, furnish the following information to the Department of Health:

(a)1. The name of each medical school that the applicant has attended, with the dates of attendance and the date of graduation, and a description of all graduate medical education completed by the applicant, excluding any coursework taken to satisfy medical licensure continuing education requirements.

2. The name of each hospital at which the applicant has privileges.

3. The address at which the applicant will primarily conduct his or her practice.

4. Any certification that the applicant has received from a specialty board that is recognized by the board to which the applicant is applying.

5. The year that the applicant began practicing medicine.

6. Any appointment to the faculty of a medical school

which the applicant currently holds and an indication as to whether the applicant has had the responsibility for graduate medical education within the most recent 10 years.

7. A description of any criminal offense of which the applicant has been found guilty, regardless of whether adjudication of guilt was withheld, or to which the applicant has pled guilty or nolo contendere. A criminal offense committed in another jurisdiction which would have been a felony or misdemeanor if committed in this state must be reported. If the applicant indicates that a criminal offense is under appeal and submits a copy of the notice for appeal of that criminal offense, the department must state that the criminal offense is under appeal if the criminal offense is reported in the applicant's profile. If the applicant indicates to the department that a criminal offense is under appeal, the applicant must, upon disposition of the appeal, submit to the department a copy of the final written order of disposition.

8. A description of any final disciplinary action taken within the previous 10 years against the applicant by the agency regulating the profession that the applicant is or has been licensed to practice, whether in this state or in any other jurisdiction, by a specialty board that is recognized by the American Board of Medical Specialties, the American Osteopathic Association, or a similar national organization, or by a licensed hospital, health maintenance organization, prepaid health clinic, ambulatory surgical center, or nursing home. Disciplinary action includes resignation from or nonrenewal of medical staff membership or the restriction of privileges at a licensed hospital, health maintenance organization, prepaid health clinic, ambulatory surgical center, or nursing home taken

in lieu of or in settlement of a pending disciplinary case related to competence or character. If the applicant indicates that the disciplinary action is under appeal and submits a copy of the document initiating an appeal of the disciplinary action, the department must state that the disciplinary action is under appeal if the disciplinary action is reported in the applicant's profile.

9. Relevant professional qualifications as defined by the applicable board.

Section 24. Subsection (3) is added to section 456.049, Florida Statutes, to read:

456.049 Health care practitioners; reports on professional liability claims and actions.--

(3) The department shall forward the information collected under this section to the Office of Insurance Regulation.

Section 25. Subsection (6) and paragraph (a) of subsection (7) of section 456.057, Florida Statutes, are amended to read:

456.057 Ownership and control of patient records; report or copies of records to be furnished.--

(6) Except in a medical negligence action or administrative proceeding when a health care practitioner or provider is or reasonably expects to be named as a defendant, information disclosed to a health care practitioner by a patient in the course of the care and treatment of such patient is confidential and may be disclosed only to other health care practitioners and providers involved in the care or treatment of the patient, or if permitted by written authorization from the patient, ~~or~~ compelled by subpoena at a deposition, evidentiary hearing, or trial for which proper notice has been given, or related to a medical negligence suit filed under chapter 766 in

which the patient has executed, as a condition of filing the suit, a medical release that allows a defendant health care practitioner who is considered to be a health care provider under chapter 766, or his or her legal representative, to conduct ex parte interviews with the claimant's treating physicians, which interviews must be limited to areas that are potentially relevant to the claimant's alleged injury or illness.

(7)(a)1. The department may obtain patient records pursuant to a subpoena without written authorization from the patient if the department and the probable cause panel of the appropriate board, if any, find reasonable cause to believe that a health care practitioner has excessively or inappropriately prescribed any controlled substance specified in chapter 893 in violation of this chapter or any professional practice act or that a health care practitioner has practiced his or her profession below that level of care, skill, and treatment required as defined by this chapter or any professional practice act and also find that appropriate, reasonable attempts were made to obtain a patient release.

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

3. The department may obtain patient records, billing records, insurance information, provider contracts, and all

attachments thereto pursuant to a subpoena without written authorization from the patient if the department and probable cause panel of the appropriate board, if any, find reasonable cause to believe that a health care practitioner has submitted a claim, statement, or bill using a billing code that would result in payment greater in amount than would be paid using a billing code that accurately describes the services performed, requested payment for services that were not performed by that health care practitioner, used information derived from a written report of an automobile accident generated pursuant to chapter 316 to solicit or obtain patients personally or through an agent regardless of whether the information is derived directly from the report or a summary of that report or from another person, solicited patients fraudulently, received a kickback as defined in s. 456.054, violated the patient brokering provisions of s. 817.505, or presented or caused to be presented a false or fraudulent insurance claim within the meaning of s. 817.234(1)(a), and also find that, within the meaning of s. 817.234(1)(a), patient authorization cannot be obtained because the patient cannot be located or is deceased, incapacitated, or suspected of being a participant in the fraud or scheme, and if the subpoena is issued for specific and relevant records.

4. Notwithstanding subparagraphs 1.-3., when the department investigates a professional liability claim or undertakes action pursuant to s. 456.049 or s. 627.912, the department may obtain patient records pursuant to a subpoena without written authorization from the patient if the patient refuses to cooperate or attempts to obtain a patient release and failure to obtain the patient records would be detrimental to the investigation.

Section 26. Subsection (4) is added to section 456.063, Florida Statutes, to read:

456.063 Sexual misconduct; disqualification for license, certificate, or registration.--

(4) Each board, or the department if there is no board, may adopt rules to implement the requirements for reporting allegations of sexual misconduct, including rules to determine the sufficiency of the allegations.

Section 27. Subsection (4) of section 456.072, Florida Statutes, is amended, and subsection (7) is added to said section, to read:

456.072 Grounds for discipline; penalties; enforcement.--

(4) In any ~~addition to any other discipline imposed through~~ final order, or citation, entered on or after July 1, 2001, that imposes a penalty or other form of discipline pursuant to this section or ~~discipline imposed through final order, or citation, entered on or after July 1, 2001,~~ for a violation of any practice act, the board, or the department when there is no board, shall assess costs related to the investigation and prosecution of the case, including costs associated with an attorney's time. The amount of costs to be assessed shall be determined by the board, or the department when there is no board, following its consideration of an affidavit of itemized costs and any written objections thereto. In any case in which ~~where the board or the department imposes~~ a fine or assessment of costs imposed by the board or department ~~and the fine or assessment~~ is not paid within a reasonable time, such reasonable time to be prescribed in the rules of the board, or the department when there is no board, or in the order assessing such fines or costs, the department or the Department

of Legal Affairs may contract for the collection of, or bring a civil action to recover, the fine or assessment.

(7) In any formal administrative hearing conducted under s. 120.57(1), the department shall establish grounds for the discipline of a licensee by the greater weight of the evidence.

Section 28. Subsection (5) of section 456.073, Florida Statutes, is amended to read:

456.073 Disciplinary proceedings.--Disciplinary proceedings for each board shall be within the jurisdiction of the department.

(5)(a) A formal hearing before an administrative law judge from the Division of Administrative Hearings shall be held pursuant to chapter 120 if there are any disputed issues of material fact raised within 45 days after service of the administrative complaint. The administrative law judge shall issue a recommended order pursuant to chapter 120. If any party raises an issue of disputed fact during an informal hearing, the hearing shall be terminated and a formal hearing pursuant to chapter 120 shall be held.

(b) Notwithstanding s. 120.569(2), the department shall notify the Division of Administrative Hearings within 45 days after receipt of a petition or request for a hearing that the department has determined requires a formal hearing before an administrative law judge.

Section 29. Subsections (1) and (2) of section 456.077, Florida Statutes, are amended to read:

456.077 Authority to issue citations.--

(1) Notwithstanding s. 456.073, the board, or the department if there is no board, shall adopt rules to permit the issuance of citations. The citation shall be issued to the

subject and shall contain the subject's name and address, the subject's license number if applicable, a brief factual statement, the sections of the law allegedly violated, and the penalty imposed. The citation must clearly state that the subject may choose, in lieu of accepting the citation, to follow the procedure under s. 456.073. If the subject disputes the matter in the citation, the procedures set forth in s. 456.073 must be followed. However, if the subject does not dispute the matter in the citation with the department within 30 days after the citation is served, the citation becomes a public final order and does not constitute ~~constitutes~~ discipline for a first offense, but does constitute discipline for a second or subsequent offense. The penalty shall be a fine or other conditions as established by rule.

(2) The board, or the department if there is no board, shall adopt rules designating violations for which a citation may be issued. Such rules shall designate as citation violations those violations for which there is no substantial threat to the public health, safety, and welfare or no violation of standard of care involving injury to a patient. Violations for which a citation may be issued shall include violations of continuing education requirements; failure to timely pay required fees and fines; failure to comply with the requirements of ss. 381.026 and 381.0261 regarding the dissemination of information regarding patient rights; failure to comply with advertising requirements; failure to timely update practitioner profile and credentialing files; failure to display signs, licenses, and permits; failure to have required reference books available; and all other violations that do not pose a direct and serious threat to the health and safety of the patient or involve a

violation of standard of care that has resulted in injury to a patient.

Section 30. Subsections (1) and (2) of section 456.078, Florida Statutes, are amended to read:

456.078 Mediation.--

(1) Notwithstanding the provisions of s. 456.073, the board, or the department when there is no board, shall adopt rules to designate which violations of the applicable professional practice act, including standard of care violations, are appropriate for mediation. The board, or the department when there is no board, shall ~~may~~ designate as mediation offenses those complaints where harm caused by the licensee is economic in nature, except any act or omission involving intentional misconduct, ~~or~~ can be remedied by the licensee, is not a standard of care violation involving any type of injury to a patient, or does not result in an adverse incident. For the purposes of this section, an "adverse incident" means an event that results in:

(a) The death of a patient;

(b) Brain or spinal damage to a patient;

(c) The performance of a surgical procedure on the wrong patient;

(d) The performance of a wrong-site surgical procedure;

(e) The performance of a surgical procedure that is medically unnecessary or otherwise unrelated to the patient's diagnosis or medical condition;

(f) The surgical repair of damage to a patient resulting from a planned surgical procedure, which damage is not a recognized specific risk as disclosed to the patient and documented through the informed-consent process;

(g) The performance of a procedure to remove unplanned foreign objects remaining from a surgical procedure; or

(h) The performance of any other surgical procedure that breached the standard of care.

(2) After the department determines a complaint is legally sufficient and the alleged violations are defined as mediation offenses, the department or any agent of the department may conduct informal mediation to resolve the complaint. If the complainant and the subject of the complaint agree to a resolution of a complaint within 14 days after contact by the mediator, the mediator shall notify the department of the terms of the resolution. The department or board shall take no further action unless the complainant and the subject each fail to record with the department an acknowledgment of satisfaction of the terms of mediation within 60 days of the mediator's notification to the department. A successful mediation shall not constitute discipline. In the event the complainant and subject fail to reach settlement terms or to record the required acknowledgment, the department shall process the complaint according to the provisions of s. 456.073.

Section 31. Subsection (9) is added to section 458.320, Florida Statutes, to read:

458.320 Financial responsibility.--

(9) Nothing in this section shall be construed as creating a civil cause of action against any hospital as a result of the failure of any physician with staff privileges to comply with the requirements of this section.

Section 32. Subsection (9) of section 459.0085, Florida Statutes, is renumbered as subsection (10), and a new subsection (9) is added to said section to read:

459.0085 Financial responsibility.--

(9) Nothing in this section shall be construed as creating a civil cause of action against any hospital as a result of the failure of any physician with staff privileges to comply with the requirements of this section.

Section 33. Paragraph (t) of subsection (1) and subsections (3) and (6) of section 458.331, Florida Statutes, are amended to read:

458.331 Grounds for disciplinary action; action by the board and department.--

(1) The following acts constitute grounds for denial of a license or disciplinary action, as specified in s. 456.072(2):

(t) Gross or repeated malpractice or the failure to practice medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances. The board shall give great weight to the provisions of s. 766.102 when enforcing this paragraph. As used in this paragraph, "repeated malpractice" includes, but is not limited to, three or more claims for medical malpractice within the previous 5-year period resulting in indemnities being paid in excess of $50,000 ~~$25,000~~ each to the claimant in a judgment or settlement and which incidents involved negligent conduct by the physician. As used in this paragraph, "gross malpractice" or "the failure to practice medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances," shall not be construed so as to require more than one instance, event, or act. Nothing in this paragraph shall be construed to require that a physician be incompetent to

practice medicine in order to be disciplined pursuant to this paragraph.

(3) In any administrative action against a physician ~~which does not involve revocation or suspension of license~~, the division shall have the burden, by the greater weight of the evidence, to establish the existence of grounds for disciplinary action. ~~The division shall establish grounds for revocation or suspension of license by clear and convincing evidence.~~

(6) Upon the department's receipt from an insurer or self-insurer of a report of a closed claim against a physician pursuant to s. 627.912 or from a health care practitioner of a report pursuant to s. 456.049, or upon the receipt from a claimant of a presuit notice against a physician pursuant to s. 766.106, the department shall review each report and determine whether it potentially involved conduct by a licensee that is subject to disciplinary action, in which case the provisions of s. 456.073 shall apply. However, if it is reported that a physician has had three or more claims with indemnities exceeding $50,000 ~~$25,000~~ each within the previous 5-year period, the department shall investigate the occurrences upon which the claims were based and determine if action by the department against the physician is warranted.

Section 34. Paragraph (x) of subsection (1) and subsections (3) and (6) of section 459.015, Florida Statutes, are amended to read:

459.015 Grounds for disciplinary action; action by the board and department.--

(1) The following acts constitute grounds for denial of a license or disciplinary action, as specified in s. 456.072(2):

(x) Gross or repeated malpractice or the failure to

practice osteopathic medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar osteopathic physician as being acceptable under similar conditions and circumstances. The board shall give great weight to the provisions of s. 766.102 when enforcing this paragraph. As used in this paragraph, "repeated malpractice" includes, but is not limited to, three or more claims for medical malpractice within the previous 5-year period resulting in indemnities being paid in excess of $50,000 ~~$25,000~~ each to the claimant in a judgment or settlement and which incidents involved negligent conduct by the osteopathic physician. As used in this paragraph, "gross malpractice" or "the failure to practice osteopathic medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar osteopathic physician as being acceptable under similar conditions and circumstances" shall not be construed so as to require more than one instance, event, or act. Nothing in this paragraph shall be construed to require that an osteopathic physician be incompetent to practice osteopathic medicine in order to be disciplined pursuant to this paragraph. A recommended order by an administrative law judge or a final order of the board finding a violation under this paragraph shall specify whether the licensee was found to have committed "gross malpractice," "repeated malpractice," or "failure to practice osteopathic medicine with that level of care, skill, and treatment which is recognized as being acceptable under similar conditions and circumstances," or any combination thereof, and any publication by the board shall so specify.

(3) In any administrative action against a physician ~~which does not involve revocation or suspension of license~~, the

division shall have the burden, by the greater weight of the evidence, to establish the existence of grounds for disciplinary action. ~~The division shall establish grounds for revocation or suspension of license by clear and convincing evidence.~~

(6) Upon the department's receipt from an insurer or self-insurer of a report of a closed claim against an osteopathic physician pursuant to s. 627.912 or from a health care practitioner of a report pursuant to s. 456.049, or upon the receipt from a claimant of a presuit notice against an osteopathic physician pursuant to s. 766.106, the department shall review each report and determine whether it potentially involved conduct by a licensee that is subject to disciplinary action, in which case the provisions of s. 456.073 shall apply. However, if it is reported that an osteopathic physician has had three or more claims with indemnities exceeding $50,000 ~~$25,000~~ each within the previous 5-year period, the department shall investigate the occurrences upon which the claims were based and determine if action by the department against the osteopathic physician is warranted.

Section 35. Subsection (6) of section 460.413, Florida Statutes, is amended to read:

460.413 Grounds for disciplinary action; action by board or department.--

(6) In any administrative action against a chiropractic physician ~~which does not involve revocation or suspension of license~~, the department shall have the burden, by the greater weight of the evidence, to establish the existence of grounds for disciplinary action. ~~The department shall establish grounds for revocation or suspension of license by clear and convincing evidence.~~

Section 36. Paragraph (s) of subsection (1) and paragraph (a) of subsection (5) of section 461.013, Florida Statutes, are amended to read:

461.013 Grounds for disciplinary action; action by the board; investigations by department.--

(1) The following acts constitute grounds for denial of a license or disciplinary action, as specified in s. 456.072(2):

(s) Gross or repeated malpractice or the failure to practice podiatric medicine at a level of care, skill, and treatment which is recognized by a reasonably prudent podiatric physician as being acceptable under similar conditions and circumstances. The board shall give great weight to the standards for malpractice in s. 766.102 in interpreting this section. As used in this paragraph, "repeated malpractice" includes, but is not limited to, three or more claims for medical malpractice within the previous 5-year period resulting in indemnities being paid in excess of $50,000 ~~$10,000~~ each to the claimant in a judgment or settlement and which incidents involved negligent conduct by the podiatric physicians. As used in this paragraph, "gross malpractice" or "the failure to practice podiatric medicine with the level of care, skill, and treatment which is recognized by a reasonably prudent similar podiatric physician as being acceptable under similar conditions and circumstances" shall not be construed so as to require more than one instance, event, or act.

(5)(a) Upon the department's receipt from an insurer or self-insurer of a report of a closed claim against a podiatric physician pursuant to s. 627.912, or upon the receipt from a claimant of a presuit notice against a podiatric physician pursuant to s. 766.106, the department shall review each report

and determine whether it potentially involved conduct by a licensee that is subject to disciplinary action, in which case the provisions of s. 456.073 shall apply. However, if it is reported that a podiatric physician has had three or more claims with indemnities exceeding $50,000 ~~$25,000~~ each within the previous 5-year period, the department shall investigate the occurrences upon which the claims were based and determine if action by the department against the podiatric physician is warranted.

Section 37. Paragraph (x) of subsection (1) of section 466.028, Florida Statutes, is amended to read:

466.028 Grounds for disciplinary action; action by the board.--

(1) The following acts constitute grounds for denial of a license or disciplinary action, as specified in s. 456.072(2):

(x) Being guilty of incompetence or negligence by failing to meet the minimum standards of performance in diagnosis and treatment when measured against generally prevailing peer performance, including, but not limited to, the undertaking of diagnosis and treatment for which the dentist is not qualified by training or experience or being guilty of dental malpractice. For purposes of this paragraph, it shall be legally presumed that a dentist is not guilty of incompetence or negligence by declining to treat an individual if, in the dentist's professional judgment, the dentist or a member of her or his clinical staff is not qualified by training and experience, or the dentist's treatment facility is not clinically satisfactory or properly equipped to treat the unique characteristics and health status of the dental patient, provided the dentist refers the patient to a qualified dentist or facility for appropriate

treatment. As used in this paragraph, "dental malpractice" includes, but is not limited to, three or more claims within the previous 5-year period which resulted in indemnity being paid, or any single indemnity paid in excess of $25,000 ~~$5,000~~ in a judgment or settlement, as a result of negligent conduct on the part of the dentist.

Section 38. Section 624.155, Florida Statutes, is amended to read:

624.155 Civil remedy.--

(1) Any person may bring a civil action against an insurer when such person is damaged:

(a) By a violation of any of the following provisions by the insurer:

1. Section 626.9541(1)(i), (o), or (x);

2. Section 626.9551;

3. Section 626.9705;

4. Section 626.9706;

5. Section 626.9707; or

6. Section 627.7283.

(b) By the commission of any of the following acts by the insurer:

1. Not attempting in good faith to settle claims when, under all the circumstances, it could and should have done so, had it acted fairly and honestly toward its insured and with due regard for her or his interests;

2. Making claims payments to insureds or beneficiaries not accompanied by a statement setting forth the coverage under which payments are being made; or

3. Except as to liability coverages, failing to promptly settle claims, when the obligation to settle a claim has become

reasonably clear, under one portion of the insurance policy coverage in order to influence settlements under other portions of the insurance policy coverage.

Notwithstanding the provisions of the above to the contrary, a person pursuing a remedy under this section need not prove that such act was committed or performed with such frequency as to indicate a general business practice.

(2) In matters relating to professional liability insurance coverage for medical negligence, only the insured may bring a civil action against an insurer when such person is damaged:

(a) By a violation of any of the following provisions by the insurer:

1. Section 626.9541(1)(i), (o), or (x);

2. Section 626.9551;

3. Section 626.9705;

4. Section 626.9706;

5. Section 626.9707; or

6. Section 627.7283.

(b) By the commission of any of the following acts by the insurer:

1. Not attempting in good faith to settle claims when, under all the circumstances, it could and should have done so, had it acted fairly and honestly toward its insured and with due regard for her or his interests, provided that in any action, whether under statute or common law, against a liability insurer for alleged failure to settle a claim against its insured:

a. The duty of good faith and fairly and honestly dealing with its insured requires the insurer to provide a defense for

its insured to give the insured's interests consideration at least equal to its interests and the interests of all its policyholders in deciding whether to litigate or settle a claim.

b. An insurer need not submit to demands for settlement within the policy limit simply because there is a possibility of an excess verdict. The insurer must have had a reasonable opportunity to settle the claim within the policy limits during the life of the claim.

c. An insurer shall not be held in bad faith if it tenders its policy limits at least 120 days prior to trial in the underlying case giving rise to a bad faith claim.

d. Factors to be considered in determining whether the insurer dealt with its insured in good faith include:

(I) The insurer's willingness to negotiate with the claimant.

(II) The insurer's proper investigation of the claim.

(III) The insurer's consideration of the advice of its defense counsel.

(IV) Whether the insurer informed the insured of the offer to settle within the limits of coverage, the right to retain personal counsel, and the risks of litigation.

(V) Whether the insured denied liability or requested that the case be defended.

(VI) Whether the claimant imposed any condition, other than tender of policy limits, as to settlement of the claim.

e. In the event that an insurer is found to have breached its duty to settle on behalf of an insured, the insurer is responsible to pay on behalf of the insured as to such judgment only the applicable policy limits and amount of the excess judgment that the insured can demonstrate could have been

satisfied from the attachment or forced sale of property of the insured, absent insurance coverage. The court shall enter judgment against the insurer after conducting an inquiry to ascertain the future value of the underlying excess judgment. The inquiry shall include the use of expert testimony on the issues of future income of the insured, accumulation of attachable assets by the insured, and the probability of collecting the underlying excess judgment from the insured absent liability insurance coverage. The insured shall be deemed not to have waived any exemption from forced sale or attachment available to the insured or insured's spouse under state law, federal law, or law applicable in the jurisdiction where the property is located. This limitation shall not be construed to limit rights or obligations of the insured or insurer other than as specified herein.

f. As to any judgment entered against an insured covered by a liability insurance policy, the judgment debtor is hereby granted an exemption under chapter 55, and from any liens or execution of such judgment, in an amount equal to all sums that have been paid on his or her behalf by a liability insurer. All such sums shall be recorded by the judgment creditor in a manner that reflects an equivalent partial or total satisfaction of the judgment.

g. Any judgment entered against a liability insurer and any portion of a settlement designated as damage for breach of this subparagraph shall be reported by the insurer to the Office of Insurance Regulation and the office shall conduct such investigation and impose such penalties as it determines to be appropriate for any violation of the insurance code.

2. Making claims payments to insureds or beneficiaries not

accompanied by a statement setting forth the coverage under which payments are being made.

An insured pursuing a remedy under this subsection need not prove that such act was committed or performed with such frequency as to indicate a general business practice. Nothing in this subsection shall be construed to prohibit an insured from assigning the cause of action to an injured third party claimant for the insurer's failure to act fairly and honestly towards its insured and with due regard for the insured's interest.

(3)~~(2)~~(a) As a condition precedent to bringing an action under this section, the department and the insurer must have been given 60 days' written notice of the violation. If the department returns a notice for lack of specificity, the 60-day time period shall not begin until a proper notice is filed.

(b) The notice shall be on a form provided by the department and shall state with specificity the following information, and such other information as the department may require:

1. The statutory provision, including the specific language of the statute, which the insurer allegedly violated.

2. The facts and circumstances giving rise to the violation.

3. The name of any individual involved in the violation.

4. Reference to specific policy language that is relevant to the violation, if any. If the person bringing the civil action is a third party claimant, she or he shall not be required to reference the specific policy language if the insurer has not provided a copy of the policy to the third party claimant pursuant to written request.

5. A statement that the notice is given in order to perfect the right to pursue the civil remedy authorized by this section.

(c) Within 20 days of receipt of the notice, the department may return any notice that does not provide the specific information required by this section, and the department shall indicate the specific deficiencies contained in the notice. A determination by the department to return a notice for lack of specificity shall be exempt from the requirements of chapter 120.

(d) No action shall lie if, within 60 days after filing notice, the damages are paid or the circumstances giving rise to the violation are corrected.

(e) The insurer that is the recipient of a notice filed pursuant to this section shall report to the department on the disposition of the alleged violation.

(f) The applicable statute of limitations for an action under this section shall be tolled for a period of 65 days by the mailing of the notice required by this subsection or the mailing of a subsequent notice required by this subsection.

(4)~~(3)~~ Upon adverse adjudication at trial or upon appeal, the insurer shall be liable for damages, together with court costs and reasonable attorney's fees incurred by the plaintiff; however, in any action under this section relating to professional liability insurance coverage for medical negligence, no award for attorney’s fees shall be enhanced by a contingency risk multiplier.

(5)~~(4)~~ No punitive damages shall be awarded under this section unless the acts giving rise to the violation occur with

such frequency as to indicate a general business practice and these acts are:

(a) Willful, wanton, and malicious;

(b) In reckless disregard for the rights of any insured; or

(c) In reckless disregard for the rights of a beneficiary under a life insurance contract.

Any person who pursues a claim under this subsection shall post in advance the costs of discovery. Such costs shall be awarded to the insurer if no punitive damages are awarded to the plaintiff.

(6)~~(5)~~ This section shall not be construed to authorize a class action suit against an insurer or a civil action against the department, its employees, or the Insurance Commissioner, or to create a cause of action when a health insurer refuses to pay a claim for reimbursement on the ground that the charge for a service was unreasonably high or that the service provided was not medically necessary.

(7)~~(6)~~ In the absence of expressed language to the contrary, this section shall not be construed to authorize a civil action or create a cause of action against an insurer or its employees who, in good faith, release information about an insured or an insurance policy to a law enforcement agency in furtherance of an investigation of a criminal or fraudulent act relating to a motor vehicle theft or a motor vehicle insurance claim.

(8)~~(7)~~ The civil remedy specified in this section does not preempt any other remedy or cause of action provided for pursuant to any other statute or pursuant to the common law of

this state. Any person may obtain a judgment under either the common-law remedy of bad faith or this statutory remedy, but shall not be entitled to a judgment under both remedies. This section shall not be construed to create a common-law cause of action. The damages recoverable pursuant to this section shall include those damages which are a reasonably foreseeable result of a specified violation of this section by the insurer and may include an award or judgment in an amount that exceeds the policy limits.

Section 39. If any provision of the changes to s. 624.155, Florida Statutes, contained in this act or the application thereof to any person or circumstance is held invalid, the invalidity shall not affect other provisions or applications relating to the changes to s. 624.155, Florida Statutes, contained in this act, provided said provisions can be given effect without the invalid provision or application, and to this end, the provisions of this act and changes to s. 624.155, Florida Statutes, contained in this act are declared severable.

Section 40. The amendments to s. 624.155, Florida Statutes, contained in this act shall apply to all actions where the presuit period contained in chapter 766 is not complete or where claimant has not demanded the limits of the insurance coverage, whichever is later.

Section 41. Subsections (7), (8), and (9) are added to section 627.062, Florida Statutes, to read:

627.062 Rate standards.--

(7) Notwithstanding any other provision of this section, in matters relating to professional liability insurance coverage for medical negligence, any portion of a judgment entered as a result of a statutory or common-law bad faith action and any

portion of a judgment entered that awards punitive damages against an insurer may not be included in the insurer's rate base and may not be used to justify a rate or rate change. In matters relating to professional liability insurance coverage for medical negligence, any portion of a settlement entered as a result of a statutory or common-law bad faith action identified as such and any portion of a settlement wherein an insurer agrees to pay specific punitive damages may not be used to justify a rate or rate change. The portion of the taxable costs and attorney's fees that is identified as being related to the bad faith and punitive damages in these judgments and settlements may not be included in the insurer's rate base and may not be utilized to justify a rate or rate change.

(8) Each insurer writing professional liability insurance coverage for medical negligence must make a rate filing under this section with the Office of Insurance Regulation at least once each calendar year.

(9) Medical malpractice insurance companies shall submit a rate filing to the Office of Insurance Regulation no earlier than 30 days, but no later than 120 days, after the date upon which this act becomes law.

Section 42. Subsection (10) of section 627.357, Florida Statutes, is amended to read:

627.357 Medical malpractice self-insurance.--

(10)(a) An application to form a self-insurance fund under this section must be filed with the Office of Insurance Regulation.

(b) The Office of Insurance Regulation must ensure that self-insurance funds remain solvent and provide insurance coverage purchased by participants. The Financial Services

Commission may adopt rules pursuant to ss. 120.536(1) and 120.54 to implement this subsection ~~A self-insurance fund may not be formed under this section after October 1, 1992~~.

Section 43. Subsection (1) of section 627.4147, Florida Statutes, is amended to read:

627.4147 Medical malpractice insurance contracts.--

(1) In addition to any other requirements imposed by law, each self-insurance policy as authorized under s. 627.357 or insurance policy providing coverage for claims arising out of the rendering of, or the failure to render, medical care or services, including those of the Florida Medical Malpractice Joint Underwriting Association, shall include:

(a) A clause requiring the insured to cooperate fully in the review process prescribed under s. 766.106 if a notice of intent to file a claim for medical malpractice is made against the insured.

~~(b)1. Except as provided in subparagraph 2., a clause authorizing the insurer or self-insurer to determine, to make, and to conclude, without the permission of the insured, any offer of admission of liability and for arbitration pursuant to s. 766.106, settlement offer, or offer of judgment, if the offer is within the policy limits. It is against public policy for any insurance or self-insurance policy to contain a clause giving the insured the exclusive right to veto any offer for admission of liability and for arbitration made pursuant to s. 766.106, settlement offer, or offer of judgment, when such offer is within the policy limits. However, any offer of admission of liability, settlement offer, or offer of judgment made by an insurer or self-insurer shall be made in good faith and in the best interests of the insured.~~

~~2.a. With respect to dentists licensed under chapter 466, a clause clearly stating whether or not the insured has the exclusive right to veto any offer of admission of liability and for arbitration pursuant to s. 766.106, settlement offer, or offer of judgment if the offer is within policy limits. An insurer or self-insurer shall not make or conclude, without the permission of the insured, any offer of admission of liability and for arbitration pursuant to s. 766.106, settlement offer, or offer of judgment, if such offer is outside the policy limits. However, any offer for admission of liability and for arbitration made under s. 766.106, settlement offer, or offer of judgment made by an insurer or self-insurer shall be made in good faith and in the best interest of the insured.~~

~~b. If the policy contains a clause stating the insured does not have the exclusive right to veto any offer or admission of liability and for arbitration made pursuant to s. 766.106, settlement offer or offer of judgment, the insurer or self-insurer shall provide to the insured or the insured's legal representative by certified mail, return receipt requested, a copy of the final offer of admission of liability and for arbitration made pursuant to s. 766.106, settlement offer or offer of judgment and at the same time such offer is provided to the claimant. A copy of any final agreement reached between the insurer and claimant shall also be provided to the insurer or his or her legal representative by certified mail, return receipt requested not more than 10 days after affecting such agreement.~~

(b)~~(c)~~ A clause requiring the insurer or self-insurer to notify the insured no less than 60 days prior to the effective date of cancellation of the policy or contract and, in the event

of a determination by the insurer or self-insurer not to renew the policy or contract, to notify the insured no less than 60 days prior to the end of the policy or contract period. If cancellation or nonrenewal is due to nonpayment or loss of license, 10 days' notice is required.

Section 44. Subsections (1) and (4) and paragraph (n) of subsection (2) of section 627.912, Florida Statutes, are amended to read:

627.912 Professional liability claims and actions; reports by insurers.--

(1)(a) Each self-insurer authorized under s. 627.357 and each insurer or joint underwriting association providing professional liability insurance to a practitioner of medicine licensed under chapter 458, to a practitioner of osteopathic medicine licensed under chapter 459, to a podiatric physician licensed under chapter 461, to a dentist licensed under chapter 466, to a hospital licensed under chapter 395, to a crisis stabilization unit licensed under part IV of chapter 394, to a health maintenance organization certificated under part I of chapter 641, to clinics included in chapter 390, to an ambulatory surgical center as defined in s. 395.002, or to a member of The Florida Bar shall report in duplicate to the Department of Insurance any claim or action for damages for personal injuries claimed to have been caused by error, omission, or negligence in the performance of such insured's professional services or based on a claimed performance of professional services without consent, if the claim resulted in:

1.~~(a)~~ A final judgment in any amount.

2.~~(b)~~ A settlement in any amount.

Reports shall be filed with the department.

(b) In addition to the requirements of paragraph (a), if the insured party is licensed under chapter 395, chapter 458, chapter 459, chapter 461, or chapter 466, the insurer shall report in duplicate to the Office of Insurance Regulation any other disposition of the claim, including, but not limited to, a dismissal. If the insured is licensed under chapter 458, chapter 459, or chapter 461, any claim that resulted in a final judgment or settlement in the amount of $50,000 or more shall be reported to the Department of Health no later than 30 days following the occurrence of that event. If the insured is licensed under chapter 466, any claim that resulted in a final judgment or settlement in the amount of $25,000 or more shall be reported to the Department of Health no later than 30 days following the occurrence of that event ~~and, if the insured party is licensed under chapter 458, chapter 459, chapter 461, or chapter 466, with the Department of Health, no later than 30 days following the occurrence of any event listed in paragraph (a) or paragraph (b)~~. The Department of Health shall review each report and determine whether any of the incidents that resulted in the claim potentially involved conduct by the licensee that is subject to disciplinary action, in which case the provisions of s. 456.073 shall apply. The Department of Health, as part of the annual report required by s. 456.026, shall publish annual statistics, without identifying licensees, on the reports it receives, including final action taken on such reports by the Department of Health or the appropriate regulatory board.

(2) The reports required by subsection (1) shall contain:

(n) Any other information required by the department to analyze and evaluate the nature, causes, location, cost, and

damages involved in professional liability cases. The Financial Services Commission shall adopt by rule requirements for additional information to assist the Office of Insurance Regulation in its analysis and evaluation of the nature, causes, location, cost, and damages involved in professional liability cases reported by insurers under this section.

(4) There shall be no liability on the part of, and no cause of action of any nature shall arise against, any insurer reporting hereunder or its agents or employees or the department or its employees for any action taken by them under this section. The department shall ~~may~~ impose a fine of $250 per day per case, but not to exceed a total of $10,000 ~~$1,000~~ per case, against an insurer that violates the requirements of this section. This subsection applies to claims accruing on or after October 1, 1997.

Section 45. Section 627.41493, Florida Statutes, is created to read:

627.41493 Insurance rates.--

(1) On or before July 1, 2003, an insurer providing professional liability insurance coverage for medical negligence shall make a rate filing effective no later than October 1, 2003, reducing rates for professional liability coverage for medical negligence to the rate in effect on April 1, 2003, reduced by an aggregate factor of 20 percent to reflect the impact this act will have on reducing the cost of claims. Nothing in this subsection shall require an insurer to provide the 20 percent reduction in rates equally among all policies and risk classifications. Insurers must demonstrate to the Office of Insurance Regulation using generally accepted actuarial techniques that any rate reductions by policy limits and risk

classifications are in accordance with s. 627.062 and will result in an aggregate rate reduction of 20 percent. Alternatively, for professional liability insurance coverage for medical negligence with policy limits of $250,000 per claim and annual aggregate limits of $750,000, an insurer shall make a rate filing effective no later than October 1, 2003, reducing rates to the rate in effect on April 1, 2003 reduced by a factor of 20 percent and an comparable factor for other limits of coverage to reflect the impact of the provisions of this act.

(2) Any insurer or rating organization which contends that the rate provided for in subsection (1) is excessive, inadequate, unfairly discriminatory, or too low to allow a reasonable rate of return shall separately state in its filing the rate it contends is appropriate and shall state with specificity the factors or data which it contends should be considered in order to produce such appropriate rate. The insurer or rating organization shall be permitted to use all of the generally accepted actuarial techniques as provided in s. 627.062 in making any filing pursuant to this subsection. The Office of Insurance Regulation shall review each filing and approve or disapprove it pursuant to the provisions of s. 627.062. Such filings shall be deemed approved on November 1, 2003, unless by such date the department has issued a notice of intent to disapprove the filing. Each insurer or rating organization shall include in the filing the expected impact on losses, expenses, and rates of the provision contained in this act. If any measure contained in this act is held unconstitutional by a court of competent jurisdiction, the office shall permit an adjustment of rates under this section to reflect the impact of such holding on such rates, so as to

ensure that the rates are not excessive, inadequate, unfairly discriminatory, or too low to allow a reasonable rate of return. The expected rate impact of any specific measure contained in the act shall be held in abeyance during the review of such measure's constitutionality in any proceeding by a court of competent jurisdiction.

Section 46. Section 627.9121, Florida Statutes, is created to read:

627.9121 Required reporting of claims; penalties.--Each entity that makes payment under a policy of insurance, self-insurance, or otherwise in settlement, partial settlement, or satisfaction of a judgment in a medical malpractice action or claim that is required to report information to the National Practitioner Data Bank under 42 U.S.C. s. 11131 must also report the same information to the Office of Insurance Regulation. The office shall include such information in the data that it compiles under s. 627.912. The office must compile and review the data collected pursuant to this section and must assess an administrative fine on any entity that fails to fully comply with such reporting requirements.

Section 47. Subsections (12), (13), and (18) of section 641.19, Florida Statutes, are amended to read:

641.19 Definitions.--As used in this part, the term:

(12) "Health maintenance contract" means any contract entered into by a health maintenance organization with a subscriber or group of subscribers to provide coverage for comprehensive health care services in exchange for a prepaid per capita or prepaid aggregate fixed sum.

(13) "Health maintenance organization" means any organization authorized under this part which:

(a) Provides, through arrangements with other persons, emergency care, inpatient hospital services, physician care including care provided by physicians licensed under chapters 458, 459, 460, and 461, ambulatory diagnostic treatment, and preventive health care services.~~;~~

(b) Provides, ~~either directly or~~ through arrangements with other persons, health care services to persons enrolled with such organization, on a prepaid per capita or prepaid aggregate fixed-sum basis.~~;~~

(c) Provides, ~~either directly or~~ through arrangements with other persons, comprehensive health care services which subscribers are entitled to receive pursuant to a contract.~~;~~

(d) Provides physician services, by physicians licensed under chapters 458, 459, 460, and 461, directly through physicians who are either employees or partners of such organization or under arrangements with a physician or any group of physicians.~~; and~~

(e) If offering services through a managed care system, then the managed care system must be a system in which a primary physician licensed under chapter 458 or chapter 459 and chapters 460 and 461 is designated for each subscriber upon request of a subscriber requesting service by a physician licensed under any of those chapters, and is responsible for coordinating the health care of the subscriber of the respectively requested service and for referring the subscriber to other providers of the same discipline when necessary. Each female subscriber may select as her primary physician an obstetrician/gynecologist who has agreed to serve as a primary physician and is in the health maintenance organization's provider network.

(f) The fact that a health maintenance organization arranges for the provision of health care services under this chapter does not create an actual agency, apparent agency, or employer-employee relationship between a health care provider and a health maintenance organization for purposes of vicarious liability for the medical negligence of a health care provider.

(18) "Subscriber" means an entity or individual who has contracted, or on whose behalf a contract has been entered into, with a health maintenance organization for health care coverage ~~services~~ or other persons who also receive health care coverage ~~services~~ as a result of the contract.

Section 48. Subsection (3) of section 641.51, Florida Statutes, is amended to read:

641.51 Quality assurance program; second medical opinion requirement.--

(3) The health maintenance organization shall not have the right to control the professional judgment of a physician licensed under chapter 458, chapter 459, chapter 460, or chapter 461 concerning the proper course of treatment of a subscriber ~~shall not be subject to modification by the organization or its board of directors, officers, or administrators, unless the course of treatment prescribed is inconsistent with the prevailing standards of medical practice in the community~~. However, this subsection shall not be considered to restrict a utilization management program established by an organization, or to affect an organization's decision as to payment for covered services. A health maintenance organization shall not be vicariously liable for the medical negligence of a health care provider, whether such claim is alleged under a theory of employer-employee, actual agency, or apparent agency.

Section 49. Subsection (2) of section 766.102, Florida Statutes, is amended to read:

766.102 Medical negligence; standards of recovery.--

(2)(a) If the health care provider whose negligence is claimed to have created the cause of action is not certified by the appropriate American board as being a specialist, is not trained and experienced in a medical specialty, or does not hold himself or herself out as a specialist, a "similar health care provider" is one who:

1. Is licensed by the appropriate regulatory agency of this state.~~;~~

2. Is trained and experienced in the same discipline or school of practice.~~; and~~

3. Practices in the same or similar medical community.

4. Has, during the 5 years immediately preceding the date of the occurrence that is the basis for the action, engaged in any combination of the following:

a. Active clinical practice;

b. Instruction of students in an accredited health professional school or accredited residency program in the same health profession as the health care provider against whom or on whose behalf the testimony is offered; or

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

(b) If the health care provider whose negligence is claimed to have created the cause of action is certified by the appropriate American board as a specialist, is trained and experienced in a medical specialty, or holds himself or herself

out as a specialist, a "similar health care provider" is one who:

1. Is trained and experienced in the same specialty.~~; and~~

2. Is certified by the appropriate American board in the same specialty.

3. Has, during the 5 years immediately preceding the date of the occurrence that is the basis for the action, engaged in any combination of the following:

a. Active clinical practice in the same specialty or a similar specialty that includes the evaluation, diagnosis, or treatment of the medical condition or procedure that is the subject of the action;

b. Instruction of students in an accredited health professional school or accredited residency program in the same health profession and the same or similar specialty as the health care provider against whom or on whose behalf the testimony is offered; or

c. A clinical research program that is affiliated with an accredited medical school or teaching hospital and that is in the same health profession and the same or similar specialty as the health care provider against whom or on whose behalf the testimony is offered and that is in the general practice of medicine.

However, if any health care provider described in this paragraph is providing treatment or diagnosis for a condition which is not within his or her specialty, a specialist trained in the treatment or diagnosis for that condition shall be considered a "similar health care provider."

~~(c) The purpose of this subsection is to establish a relative standard of care for various categories and classifications of health care providers. Any health care provider may testify as an expert in any action if he or she:~~

~~1. Is a similar health care provider pursuant to paragraph (a) or paragraph (b); or~~

~~2. Is not a similar health care provider pursuant to paragraph (a) or paragraph (b) but, to the satisfaction of the court, possesses sufficient training, experience, and knowledge as a result of practice or teaching in the specialty of the defendant or practice or teaching in a related field of medicine, so as to be able to provide such expert testimony as to the prevailing professional standard of care in a given field of medicine. Such training, experience, or knowledge must be as a result of the active involvement in the practice or teaching of medicine within the 5-year period before the incident giving rise to the claim.~~

Section 50. Subsection (1) of section 766.104, Florida Statutes, is amended to read:

766.104 Pleading in medical negligence cases; claim for punitive damages; authorization for release of records for investigation.--

(1) No action shall be filed for personal injury or wrongful death arising out of medical negligence, whether in tort or in contract, unless the attorney filing the action has made a reasonable investigation as permitted by the circumstances to determine that there are grounds for a good faith belief that there has been negligence in the care or treatment of the claimant. The complaint or initial pleading shall contain a certificate of counsel that such reasonable

investigation gave rise to a good faith belief that grounds exist for an action against each named defendant. For purposes of this section, good faith may be shown to exist if the claimant or his or her counsel has received a written opinion, which shall ~~not~~ be subject to discovery by an opposing party, of an expert as defined in s. 766.102 that there appears to be evidence of medical negligence. If the court determines that such certificate of counsel was not made in good faith and that no justiciable issue was presented against a health care provider that fully cooperated in providing informal discovery, the court shall award attorney's fees and taxable costs against claimant's counsel, and shall submit the matter to The Florida Bar for disciplinary review of the attorney.

Section 51. Paragraph (a) of subsection (7) of section 766.106, Florida Statutes, is amended, and subsection (13) is added to said section, to read:

766.106 Notice before filing action for medical malpractice; presuit screening period; offers for admission of liability and for arbitration; informal discovery; review.--

(7) Informal discovery may be used by a party to obtain unsworn statements, the production of documents or things, and physical and mental examinations, as follows:

(a) *Unsworn statements.*--Any party may require other parties to appear for the taking of an unsworn statement. Such statements may be used only for the purpose of presuit screening and are not discoverable or admissible in any civil action for any purpose by any party. However, the statements and opinions of the expert required by s. 766.203 are subject to discovery and are admissible in any civil action for any purpose by any party. A party desiring to take the unsworn statement of any

party must give reasonable notice in writing to all parties. The notice must state the time and place for taking the statement and the name and address of the party to be examined. Unless otherwise impractical, the examination of any party must be done at the same time by all other parties. Any party may be represented by counsel at the taking of an unsworn statement. An unsworn statement may be recorded electronically, stenographically, or on videotape. The taking of unsworn statements is subject to the provisions of the Florida Rules of Civil Procedure and may be terminated for abuses.

(13) If an injured prospective claimant serves a notice of intent to initiate litigation or files suit under this chapter, the claimant must execute a medical information release that allows a defendant or his or her legal representative to conduct ex parte interviews with the claimant's treating physicians, which interviews must be limited to those areas that are potentially relevant to the claimant's alleged injury or illness.

Section 52. Subsection (11) of section 766.1115, Florida Statutes, is amended to read:

766.1115 Health care providers; creation of agency relationship with governmental contractors.--

(11) APPLICABILITY.--This section applies to incidents occurring on or after April 17, 1992. This section does not apply to any health care contract entered into by the Department of Corrections which is subject to s. 768.28(10)(a). This section does not apply to any affiliation agreement or contract to provide comprehensive health care services entered into by a medical school to provide patient services to patients of public hospitals that is subject to s. 768.28(10)(e). Nothing in this

section in any way reduces or limits the rights of the state or any of its agencies or subdivisions to any benefit currently provided under s. 768.28.

Section 53. Subsections (3), (5), (7), and (8) of section 766.202, Florida Statutes, are amended to read:

766.202 Definitions; ss. 766.201-766.212.--As used in ss. 766.201-766.212, the term:

(3) "Economic damages" means financial losses that ~~which~~ would not have occurred but for the injury giving rise to the cause of action, including, but not limited to, past and future medical expenses and 80 percent of wage loss and loss of earning capacity, to the extent the claimant is entitled to recover such damages under general law, including the Wrongful Death Act.

(5) "Medical expert" means a person duly and regularly engaged in the practice of his or her profession who holds a health care professional degree from a university or college and who meets the requirements of an expert witness as set forth in s. 766.102 ~~has had special professional training and experience or one possessed of special health care knowledge or skill about the subject upon which he or she is called to testify or provide an opinion~~.

(7) "Noneconomic damages" means nonfinancial losses which would not have occurred but for the injury giving rise to the cause of action, including pain and suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of capacity for enjoyment of life, and other nonfinancial losses, to the extent the claimant is entitled to recover such damages under general law, including the Wrongful Death Act.

(8) "Periodic payment" means provision for the structuring of future economic and future noneconomic damages payments, in

whole or in part, over a period of time, as follows:

(a) A specific finding must be made of the dollar amount of periodic payments which will compensate for these future damages after offset for collateral sources and after having been reduced to present value ~~shall be made~~. A periodic payment must be structured to last as long as the claimant lives or the condition of the claimant for which the award was made persists, whichever may be shorter, but without regard for the number of years for which future damages are awarded. The total dollar amount of the periodic payments shall equal the dollar amount of all such future damages before any reduction to present value.

(b) A defendant that elects to make periodic payments of either or both future economic or future noneconomic losses may contractually obligate a company that is authorized to do business in this state and rated by A.M. Best Company as A+ or higher to make those periodic payments on its behalf. Upon a joint petition by the defendant and the company that is contractually obligated to make the periodic payments, the court shall discharge the defendant from any further obligations to the claimant for those future economic and future noneconomic damages that are to be paid by that company by periodic payments.

(c) A bond or security may not be required of any defendant or company that is obligated to make periodic payments pursuant to this section; however, if, upon petition by a claimant who is receiving periodic payments pursuant to this section, the court finds that there is substantial, competent evidence that the defendant that is responsible for the periodic payments cannot adequately ensure full and continuous payments thereof or that the company that is obligated to make the

payments has been rated by A.M. Best Company as B+ or lower, and that doing so is in the best interest of the claimant, the court may require the defendant or the company that is obligated to make the periodic payments to provide such additional financial security as the court determines to be reasonable under the circumstances.

(d) The provision for the periodic payments must specify the recipient or recipients of the payments, the address to which the payments are to be delivered, and the amount and intervals of the payments; however, in any one year, any payment or payments may not exceed the amount intended by the trier of fact to be awarded that year, offset for collateral sources. A periodic payment may not be accelerated, deferred, increased, or decreased, except by court order based upon the mutual consent and agreement of the claimant, the defendant, whether or not discharged, and the company that is obligated to make the periodic payments, if any; nor may the claimant sell, mortgage, encumber, or anticipate the periodic payments or any part thereof, by assignment or otherwise. ~~The defendant shall be required to post a bond or security or otherwise to assure full payment of these damages awarded. A bond is not adequate unless it is written by a company authorized to do business in this state and is rated A+ by Best's. If the defendant is unable to adequately assure full payment of the damages, all damages, reduced to present value, shall be paid to the claimant in a lump sum. No bond may be canceled or be subject to cancellation unless at least 60 days' advance written notice is filed with the court and the claimant. Upon termination of periodic payments, the security, or so much as remains, shall be returned to the defendant.~~

~~(c) The provision for payment of future damages by periodic payments shall specify the recipient or recipients of the payments, the dollar amounts of the payments, the interval between payments, and the number of payments or the period of time over which payments shall be made.~~

Section 54. Subsection (7) of section 766.207, Florida Statutes, is amended to read:

766.207 Voluntary binding arbitration of medical negligence claims.--

(7) Arbitration pursuant to this section shall preclude recourse to any other remedy by the claimant against any participating defendant, and shall be undertaken with the understanding that damages shall be awarded as provided by general law, including the Wrongful Death Act, subject to the following limitations:

(a) Net economic damages shall be awardable, including, but not limited to, past and future medical expenses and 80 percent of wage loss and loss of earning capacity, offset by any collateral source payments.

(b) Noneconomic damages shall be limited to a maximum of $250,000 per incident, and shall be calculated on a percentage basis with respect to capacity to enjoy life, so that a finding that the claimant's injuries resulted in a 50-percent reduction in his or her capacity to enjoy life would warrant an award of not more than $125,000 noneconomic damages. Regardless of the number of individual claimants or defendants, the total noneconomic damages that may be awarded for all claims arising out of the same incident, including claims under the Wrongful Death Act, shall be limited to a maximum of $250,000.

(c) Damages for future economic and future noneconomic

losses shall be awarded to be paid by periodic payments pursuant to s. 766.202(8) and shall be offset by future collateral source payments.

(d) Punitive damages shall not be awarded.

(e) The defendant shall be responsible for the payment of interest on all accrued damages with respect to which interest would be awarded at trial.

(f) The defendant shall pay the claimant's reasonable attorney's fees and costs, as determined by the arbitration panel, but in no event more than 15 percent of the award, reduced to present value.

(g) The defendant shall pay all the costs of the arbitration proceeding and the fees of all the arbitrators other than the administrative law judge.

(h) Each defendant who submits to arbitration under this section shall be jointly and severally liable for all damages assessed pursuant to this section.

(i) The defendant's obligation to pay the claimant's damages shall be for the purpose of arbitration under this section only. A defendant's or claimant's offer to arbitrate shall not be used in evidence or in argument during any subsequent litigation of the claim following the rejection thereof.

(j) The fact of making or accepting an offer to arbitrate shall not be admissible as evidence of liability in any collateral or subsequent proceeding on the claim.

(k) Any offer by a claimant to arbitrate must be made to each defendant against whom the claimant has made a claim. Any offer by a defendant to arbitrate must be made to each claimant who has joined in the notice of intent to initiate litigation,

as provided in s. 766.106. A defendant who rejects a claimant's offer to arbitrate shall be subject to the provisions of s. 766.209(3). A claimant who rejects a defendant's offer to arbitrate shall be subject to the provisions of s. 766.209(4).

(l) The hearing shall be conducted by all of the arbitrators, but a majority may determine any question of fact and render a final decision. The chief arbitrator shall decide all evidentiary matters.

The provisions of this subsection shall not preclude settlement at any time by mutual agreement of the parties.

Section 55. Paragraph (a) of subsection (4) of section 766.209, Florida Statutes, is amended to read:

766.209 Effects of failure to offer or accept voluntary binding arbitration.--

(4) If the claimant rejects a defendant's offer to enter voluntary binding arbitration:

(a) The damages awardable at trial shall be limited to net economic damages, plus noneconomic damages not to exceed $350,000 per incident. Regardless of the number of individual claimants or defendants, the total noneconomic damages that may be awarded for all claims arising out of the same incident, including claims under the Wrongful Death Act, shall be limited to a maximum of $350,000. The Legislature expressly finds that such conditional limit on noneconomic damages is warranted by the claimant's refusal to accept arbitration, and represents an appropriate balance between the interests of all patients who ultimately pay for medical negligence losses and the interests of those patients who are injured as a result of medical negligence.

Section 56. Section 766.213, Florida Statutes, is created to read:

766.213 Periodic payment of damages upon death of claimant.--Any portion of a periodic payment made pursuant to a settlement or jury award or pursuant to mediation or arbitration which is attributable to medical expenses that have not yet been incurred shall terminate upon the death of the claimant. Any outstanding medical expenses incurred prior to the death of the claimant shall be paid from that portion of the periodic payment attributable to medical expenses.

Section 57. Subsection (4) is added to section 766.309, Florida Statutes, to read:

766.309 Determination of claims; presumption; findings of administrative law judge binding on participants.--

(4) If the claim is determined to be compensable, and the claimants have the option of proceeding to circuit court either against a party who failed to give the notice required under s. 766.316, or under the exception provided in s. 766.303(2) for bad faith or malicious purpose or willful and wanton disregard of human rights, safety, or property, then the claimants must elect either to:

(a) Accept the benefits provided under the plan, and be barred from filing a civil action arising out of or related to a medical malpractice claim with respect to the birth-related neurological injury; or

(b) Decline the benefits provided under the plan and proceed in circuit court. Such election shall be made within 60 days from the date the order of the administrative law judge becomes final, including any appeal, and shall be binding on the claimants.

Section 58. Subsection (4) is added to section 768.041, Florida Statutes, to read:

768.041 Release or covenant not to sue.--

(4)(a) At trial pursuant to a suit filed under chapter 766, or at trial pursuant to s. 766.209, if any defendant shows the court that the plaintiff, or his or her legal representative, has delivered a written release or covenant not to sue to any person in partial satisfaction of damages resulting from the same injury or injuries, the court shall set off this amount from the amount of any judgment to which the plaintiff would otherwise be entitled at the time of rendering judgment, regardless of whether the jury has allocated fault to the settling defendant at trial.

(b) The amount of the setoff must include all sums received by the plaintiff, including economic and noneconomic damages, costs, and attorney's fees, and shall be applied against the total damages, after reduction for any comparative negligence of the plaintiff, rather than against the apportioned damages caused by a particular defendant.

(c) A defendant entering into a settlement agreement with a plaintiff may assign any right of contribution arising under section 768.31, as a consequence of having paid more than his or her proportionate share of the entire liability.

Section 59. Subsection (2) of section 768.13, Florida Statutes, is amended to read:

768.13 Good Samaritan Act; immunity from civil liability.--

(2)(a) Any person, including those licensed to practice medicine, who gratuitously and in good faith renders emergency care or treatment either in direct response to emergency

situations related to and arising out of a public health emergency declared pursuant to s. 381.00315, a state of emergency which has been declared pursuant to s. 252.36 or at the scene of an emergency outside of a hospital, doctor's office, or other place having proper medical equipment, without objection of the injured victim or victims thereof, shall not be held liable for any civil damages as a result of such care or treatment or as a result of any act or failure to act in providing or arranging further medical treatment where the person acts as an ordinary reasonably prudent person would have acted under the same or similar circumstances.

(b)1. Any health care provider, including a hospital licensed under chapter 395, providing emergency services pursuant to obligations imposed by 42 U.S.C. s. 1395dd, s. 395.401, s. 395.1041, or s. 401.45 ~~any employee of such hospital working in a clinical area within the facility and providing patient care, and any person licensed to practice medicine who in good faith renders medical care or treatment necessitated by a sudden, unexpected situation or occurrence resulting in a serious medical condition demanding immediate medical attention, for which the patient enters the hospital through its emergency room or trauma center, or necessitated by a public health emergency declared pursuant to s. 381.00315~~ shall not be held liable for any civil damages as a result of such medical care or treatment unless such damages result from providing, or failing to provide, medical care or treatment under circumstances demonstrating a reckless disregard for the consequences so as to affect the life or health of another. A health care provider under this paragraph does not include a licensed health care practitioner who is providing emergency services to a person

with whom the practitioner has an established provider-patient relationship outside of the emergency room setting.

2. The immunity provided by this paragraph applies ~~does not apply~~ to damages as a result of any act or omission of providing medical care or treatment, including diagnosis:

a. Which occurs prior to the time ~~after~~ the patient is stabilized and is capable of receiving medical treatment as a nonemergency patient, unless surgery is required as a result of the emergency within a reasonable time after the patient is stabilized, in which case the immunity provided by this paragraph applies to any act or omission of providing medical care or treatment which occurs prior to the stabilization of the patient following the surgery.~~; or~~

b. Which is related ~~Unrelated~~ to the original medical emergency.

3. For purposes of this paragraph, "reckless disregard" as it applies to a given health care provider rendering emergency medical services shall be such conduct that ~~which~~ a health care provider knew or should have known, at the time such services were rendered, created an unreasonable risk of injury so as to affect the life or health of another, and such risk was substantially greater than that which is necessary to make the conduct negligent. ~~would be likely to result in injury so as to affect the life or health of another, taking into account the following to the extent they may be present;~~

~~a. The extent or serious nature of the circumstances prevailing.~~

~~b. The lack of time or ability to obtain appropriate consultation.~~

~~c. The lack of a prior patient-physician relationship.~~

~~d. The inability to obtain an appropriate medical history of the patient.~~

~~e. The time constraints imposed by coexisting emergencies.~~

4. Every emergency care facility granted immunity under this paragraph shall accept and treat all emergency care patients within the operational capacity of such facility without regard to ability to pay, including patients transferred from another emergency care facility or other health care provider pursuant to Pub. L. No. 99-272, s. 9121. The failure of an emergency care facility to comply with this subparagraph constitutes grounds for the department to initiate disciplinary action against the facility pursuant to chapter 395.

(c)1. Any health care practitioner as defined in s. 456.001(4) who is in a hospital attending to a patient of his or her practice or for business or personal reasons unrelated to direct patient care, and who voluntarily responds to provide care or treatment to a patient with whom at that time the practitioner does not have a then-existing health care patient-physician relationship, and when such care or treatment is necessitated by a sudden or unexpected situation or by an occurrence that demands immediate medical attention, shall not be held liable for any civil damages as a result of any act or omission relative to that care or treatment, unless that care or treatment is proven to amount to conduct that is willful and wanton and would likely result in injury so as to affect the life or health of another.

2. The immunity provided by this paragraph does not apply to damages as a result of any act or omission of providing medical care or treatment unrelated to the original situation that demanded immediate medical attention.

3. For purposes of this paragraph, the Legislature's intent is to encourage health care practitioners to provide necessary emergency care to all persons without fear of litigation as described in this paragraph.

~~(c) Any person who is licensed to practice medicine, while acting as a staff member or with professional clinical privileges at a nonprofit medical facility, other than a hospital licensed under chapter 395, or while performing health screening services, shall not be held liable for any civil damages as a result of care or treatment provided gratuitously in such capacity as a result of any act or failure to act in such capacity in providing or arranging further medical treatment, if such person acts as a reasonably prudent person licensed to practice medicine would have acted under the same or similar circumstances.~~

Section 60. Legislative findings and intent.--

(1) EMERGENCY SERVICES AND CARE.--

(a) The Legislature finds and declares it to be of vital importance that emergency services and care be provided by hospitals, physicians, and emergency medical services providers to every person in need of such care.

(b) The Legislature finds that emergency services and care providers are critical elements in responding to disaster and emergency situations that might affect our local communities, state, and country.

(c) The Legislature recognizes the importance of maintaining a viable system of providing for the emergency medical needs of the state's residents and visitors.

(d) The Legislature and the Federal Government have required such providers of emergency medical services and care

to provide emergency services and care to all persons who present to hospitals seeking such care.

(e) The Legislature finds that the Legislature has further mandated that prehospital emergency medical treatment or transport may not be denied by emergency medical services providers to persons who have or are likely to have an emergency medical condition.

(f) Such governmental requirements have imposed a unilateral obligation for emergency services and care providers to provide services to all persons seeking emergency care without ensuring payment or other consideration for provision of such care.

(g) The Legislature also recognizes that emergency services and care providers provide a significant amount of uncompensated emergency medical care in furtherance of such governmental interest.

(h) The Legislature finds that a significant proportion of the residents of this state who are uninsured or are Medicaid or Medicare recipients are unable to access needed health care because health care providers fear the increased risk of medical malpractice liability.

(i) The Legislature finds that such patients, in order to obtain medical care, are frequently forced to seek care through providers of emergency medical services and care.

(j) The Legislature finds that providers of emergency medical services and care in this state have reported significant problems with both the availability and affordability of professional liability coverage.

(k) The Legislature finds that medical malpractice liability insurance premiums have increased dramatically, and a

number of insurers have ceased providing medical malpractice insurance coverage for emergency medical services and care in this state. This results in a functional unavailability of medical malpractice insurance coverage for some providers of emergency medical services and care.

(l) The Legislature further finds that certain specialist physicians have resigned from serving on hospital staffs or have otherwise declined to provide on-call coverage to hospital emergency departments due to increased medical malpractice liability exposure created by treating such emergency department patients.

(m) It is the intent of the Legislature that hospitals, emergency medical services providers, and physicians be able to ensure that patients who might need emergency medical services treatment or transportation or who present to hospitals for emergency medical services and care have access to such needed services.

(2) PUBLIC HOSPITALS AND AFFILIATIONS WITH NOT-FOR-PROFIT COLLEGES AND UNIVERSITIES WITH MEDICAL SCHOOLS AND OTHER HEALTH CARE PRACTITIONER EDUCATIONAL PROGRAMS.--

(a) The Legislature finds that access to quality, affordable health care for all Floridians is a necessary goal for the state and that public hospitals play an essential role in providing access to comprehensive health care services.

(b) The Legislature further finds that access to quality health care at public hospitals is enhanced when public hospitals affiliate and coordinate their common endeavors with medical schools. These affiliations have proven to be an integral part of the delivery of more efficient and economical health care services to patients of public hospitals by offering

quality graduate medical education programs to resident physicians who provide patient services at public hospitals. These affiliations ensure continued access to quality comprehensive health care services for Floridians and, therefore, should be encouraged in order to maintain and expand such services.

(c) The Legislature finds that when medical schools affiliate or enter into contracts with public hospitals to provide comprehensive health care services to patients of public hospitals, they greatly increase their exposure to claims arising out of alleged medical malpractice and other allegedly negligent acts because some colleges and universities and their medical schools and employees do not have the same level of protection against liability claims as governmental entities and their public employees providing the same patient services to the same public hospital patients.

(d) The Legislature finds that the high cost of litigation, unequal liability exposure, and increased medical malpractice insurance premiums have adversely impacted the ability of some medical schools to permit their employees to provide patient services to patients of public hospitals. This finding is consistent with the report issued in April 2002 by the American Medical Association declaring Florida to be one of 12 states in the midst of a medical liability insurance crisis. The crisis in the availability and affordability of medical malpractice insurance is a contributing factor in the reduction of access to quality health care in the state, which has declined significantly. In 1988, 33 hospitals were owned or operated by the state and local governments or established as taxing districts. In 1991, that number had dropped to 28. In

2001, only 18 such hospitals remained, seven of which are concentrated in one county. If corrective action is not taken, this health care crisis will lead to a continued reduction of patient services in public hospitals.

(e) The Legislature finds that the public is better served and will benefit from corrective action to address the foregoing concerns. It is imperative that the Legislature further the public benefit by conferring sovereign immunity upon colleges and universities, their medical schools, and their employees when, pursuant to an affiliation agreement or a contract to provide comprehensive health care services, they provide patient services to patients of public hospitals.

(f) It is the intent of the Legislature that colleges and universities that affiliate with public hospitals be granted sovereign immunity under s. 768.28, Florida Statutes, in the same manner and to the same extent as the state and its agencies and political subdivisions. It is also the intent of the Legislature that employees of colleges and universities that provide patient services to patients of a public hospital be immune from lawsuits in the same manner and to the same extent as employees and agents of the state and its agencies and political subdivisions and, further, that they shall not be held personally liable in tort or named as a party defendant in an action while performing patient services except as provided in s. 768.28(9)(a), Florida Statutes.

Section 61. Paragraph (b) of subsection (9) of section 768.28, Florida Statutes, is amended, and paragraph (e) is added to subsection (10) of said section, to read:

768.28 Waiver of sovereign immunity in tort actions; recovery limits; limitation on attorney fees; statute of

limitations; exclusions; indemnification; risk management programs.--

(9)

(b) As used in this subsection, the term:

1. "Employee" includes any volunteer firefighter.

2. "Officer, employee, or agent" includes, but is not limited to, any employee of a medical school or other health care practitioner training program in a college or university that enters into an affiliation agreement or contract to allow its employees to provide patient services to patients treated at a public statutory teaching hospital or other health care facility owned by a governmental entity or at other locations under contract with a governmental entity to provide patient services to patients at such facility pursuant to paragraph (10)(e); any faculty member or other health care professional, practitioner, or ancillary caregiver or employee of a college or university or its medical school that enters into an affiliation agreement or a contract to provide comprehensive health care services with a public hospital or its governmental owner, and who provides patient services to patients of a public hospital pursuant to paragraph (10)(e); any health care provider when providing services pursuant to s. 766.1115;~~,~~ any member of the Florida Health Services Corps, as defined in s. 381.0302, who provides uncompensated care to medically indigent persons referred by the Department of Health;~~,~~ ~~and~~ any public defender or her or his employee or agent, including, among others, an assistant public defender and an investigator; and any emergency health care provider acting pursuant to obligations imposed by ss. 395.1041, 395.401, and 401.45. Except for persons or entities that are otherwise covered under this section,

emergency health care providers shall be considered agents of the State of Florida, Department of Health, and shall indemnify the state for the reasonable costs of defense and indemnity payments, if any, up to the liability limits set forth in this chapter. For purposes of this subsection, the term "emergency health care providers" includes all persons and entities covered under or providing services pursuant obligations imposed by ss. 395.1041, 395.401, and 401.45. Such emergency health care providers shall include an emergency medical services provider licensed under chapter 401 and persons operating as employees or agents of such emergency medical services provider; a hospital licensed under chapter 395 and persons operating as employees or agents of such hospital; a physician or dentist licensed under chapter 458, chapter 459, chapter 460, chapter 461, or chapter 466; a physician assistant licensed under chapter 458 or chapter 459; an emergency medical technician or paramedic certified under chapter 401; a registered nurse, nurse midwife, licensed practical nurse, or advanced registered nurse practitioner licensed or registered under part I of chapter 464; a midwife licensed under chapter 467; a health care professional association and its employees or agents or a corporate medical group and its employees or agents; any student or medical resident who is enrolled in an accredited program or licensed program that prepares the student for licensure or certification in any one of the professions listed in this subsection; the program that prepares the student for licensure or certification; any entity responsible for training of the student or medical resident; and any other person or entity that is providing services pursuant to obligations imposed by s. 395.1041 or s. 401.45. For purposes of this subsection,

"emergency medical services" means ambulance assessment, treatment, or transport services provided pursuant to obligations imposed by s. 395.1041 or s. 401.45; all screening, examination, and evaluation by a physician, hospital, or other person or entity acting pursuant to obligations imposed by s. 395.1041; and the care, treatment, surgery, or other medical services provided, whether as an outpatient or inpatient, to relieve or eliminate the emergency medical condition, including all medical services to eliminate the likelihood that the emergency medical condition will deteriorate or recur without further medical attention within a reasonable period of time.

(10)

(e) Any not-for-profit college or university with a medical, dental, or nursing school, or any other academic program of medical education that is accredited by any association, agency, council, commission, or accrediting body recognized by the state as a condition for licensure of its graduates, that has entered into an affiliation agreement or a contract to allow its faculty, its health care professionals, practitioners, and ancillary caregivers, and its employees to provide patient services to hospital patients treated at a public hospital shall, along with the employees of such medical or other school or program, be deemed agents of the governmental entity responsible for the public hospital for purposes of this section and shall be immune from liability for torts in the same manner and to the same extent as the state and its agencies and subdivisions while providing patient services. For the purpose of this paragraph, "public hospital" means a statutory teaching hospital or any other health care facility owned or used by the state or by a county, municipality, public authority, special

taxing district with health care responsibilities, or other local governmental entity or at other locations under contract with the governmental entity. For the purpose of this paragraph, "patient services" includes comprehensive health care services as defined in s. 641.19, including related administrative services to patients of a public hospital and the supervision of interns, residents, and fellows providing patient services to patients of a public hospital and access to participation in medical research protocols. No such employee or agent of a college or university or their medical schools or other health care practitioner educational schools or programs shall be personally liable in tort or named as a party defendant in any action arising from the provision of services to patients in a public hospital, except as provided in s. 768.28(9)(a).

Section 62. Section 768.77, Florida Statutes, is amended to read:

768.77 Itemized verdict.--

(1) Except as provided in subsection (2), in any action to which this part applies in which the trier of fact determines that liability exists on the part of the defendant, the trier of fact shall, as a part of the verdict, itemize the amounts to be awarded to the claimant into the following categories of damages:

(a)~~(1)~~ Amounts intended to compensate the claimant for economic losses.~~;~~

(b)~~(2)~~ Amounts intended to compensate the claimant for noneconomic losses.~~; and~~

(c)~~(3)~~ Amounts awarded to the claimant for punitive damages, if applicable.

(2) In any action for damages based on personal injury or wrongful death arising out of medical malpractice, whether in tort or contract, to which this part applies in which the trier of fact determines that liability exists on the part of the defendant, the trier of fact shall, as a part of the verdict, itemize the amounts to be awarded to the claimant into the following categories of damages:

(a) Amounts intended to compensate the claimant for:

1. Past economic losses.

2. Future economic losses, not reduced to present value, and the number of years or part thereof which the award is intended to cover.

(b) Amounts intended to compensate the claimant for:

1. Past noneconomic losses.

2. Future noneconomic losses, not reduced to present value, and the number of years or part thereof which the award is intended to cover.

(c) Amounts awarded to the claimant for punitive damages, if applicable.

Section 63. Section 766.1067, Florida Statutes, is created to read:

766.1067 Mandatory mediation after suit is filed.--Within 120 days after suit being filed, unless such period is extended by mutual agreement of all parties, all parties shall attend in-person mandatory mediation in accordance with s. 44.102 if binding arbitration under s. 766.106 or s. 766.207 has not been agreed to by the parties. The Florida Rules of Civil Procedure shall apply to mediation held pursuant to this section.

Section 64. Section 766.118, Florida Statutes, is created to read:

766.118 Determination of noneconomic damages.--With respect to a cause of action for personal injury or wrongful death resulting from medical negligence, including actions pursuant to s. 766.209, damages recoverable for noneconomic losses to compensate for pain and suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of capacity for enjoyment of life, and all other noneconomic damages shall not exceed $250,000, regardless of the number of claimants or defendants involved in the action.

Section 65. Paragraph (a) of subsection (1) and subsection (2) of section 768.78, Florida Statutes, are amended to read:

768.78 Alternative methods of payment of damage awards.--

(1)(a) In any action to which this part applies in which the court determines that an award to compensate the claimant includes future economic losses which exceed $250,000, payment of amounts intended to compensate the claimant for these losses shall be made by one of the following means, unless an alternative method of payment of damages is provided in this section:

1. The defendant may make a lump-sum payment for all damages so assessed, with future economic losses and expenses reduced to present value; or

2. Subject to the provisions of this subsection, the court shall, at the request of either party, unless the court determines that manifest injustice would result to any party, enter a judgment ordering future economic damages, as itemized pursuant to s. 768.77(1)(a), in excess of $250,000 to be paid in whole or in part by periodic payments rather than by a lump-sum payment.

(2)(a) In any action for damages based on personal injury or wrongful death arising out of medical malpractice, whether in tort or contract, in which the trier of fact makes an award to compensate the claimant for future economic or future noneconomic losses, payment of amounts intended to compensate the claimant for these future losses shall be made by one of the following means:

1. The defendant may elect to make a lump-sum payment for the ~~all damages so assessed, with~~ future economic or future noneconomic losses, or both, after offset for collateral sources and after having been ~~and expenses~~ reduced to present value by the court based upon competent, substantial evidence presented to it by the parties; or

2. The defendant, if determined by the court to be financially capable or adequately insured, may elect to use periodic payments to satisfy in whole or in part the assessed future economic and future noneconomic losses awarded by the trier of fact after offset for collateral sources for so long as the claimant lives or the condition for which the award was made persists, whichever period may be shorter, but without regard for the number of years awarded by the trier of fact. The court shall review and, unless clearly unresponsive to the future needs of the claimant, approve the amounts and schedule of the periodic payments proposed by the defendant. Upon motion of the defendant, whether or not discharged from any obligation to make the payments pursuant to paragraph (b), and the establishment by substantial, competent evidence of either the death of the claimant or that the condition for which the award was made no longer persists, the court shall enter an order terminating the periodic payments effective as of the date of the death of the

claimant or the date the condition for which the award was made no longer persisted ~~The court shall, at the request of either party, enter a judgment ordering future economic damages, as itemized pursuant to s. 768.77, to be paid by periodic payments rather than lump sum~~.

(b) A defendant who elects to make periodic payments of future economic or future noneconomic losses, or both, may contractually obligate a company that is authorized to do business in this state and rated by A.M. Best Company as A+ or higher to make those periodic payments on its behalf. Upon a joint petition by the defendant and the company that is contractually obligated to make the periodic payments, the court shall discharge the defendant from any further obligations to the claimant for those future economic and future noneconomic damages that are to be paid by that company by periodic payments.

(c) Upon notice of a defendant's election to make periodic payments pursuant to this section, the claimant may request that the court modify the periodic payments to reasonably provide for attorney's fees; however, a court may not make any such modification that would increase the amount the defendant would have been obligated to pay had no such adjustment been made.

(d) A bond or security may not be required of any defendant or company that is obligated to make periodic payments pursuant to this section; however, if, upon petition by a claimant who is receiving periodic payments pursuant to this section, the court finds that there is substantial, competent evidence that the defendant who is responsible for the periodic payments cannot adequately ensure full and continuous payments thereof or that the company that is obligated to make the

payments has been rated by A.M. Best Company as B+ or lower, and that doing so is in the best interest of the claimant, the court may require the defendant or the company that is obligated to make the periodic payments to provide such additional financial security as the court determines to be reasonable under the circumstances.

(e) The provision for the periodic payments must specify the recipient or recipients of the payments, the address to which the payments are to be delivered, and the amount and intervals of the payments; however, in any one year any payment or payments may not exceed the amount intended by the trier of fact to be awarded each year, offset for collateral sources. A periodic payment may not be accelerated, deferred, increased, or decreased, except by court order based upon the mutual consent and agreement of the claimant, the defendant, whether or not discharged, and the company that is obligated to make the periodic payments, if any; nor may the claimant sell, mortgage, encumber, or anticipate the periodic payments, or any part thereof, by assignment or otherwise.

(f) For purposes of this section, the term "periodic payment" means the payment of money or delivery of other property to the claimant at regular intervals.

(g) It is the intent of the Legislature to authorize and encourage the payment of awards for future economic and future noneconomic losses by periodic payments to meet the continuing needs of the patient while eliminating the misdirection of such funds for purposes not intended by the trier of fact.

~~(b) For purposes of this subsection, "periodic payment" means provision for the spreading of future economic damage~~

~~payments, in whole or in part, over a period of time, as follows:~~

~~1. A specific finding of the dollar amount of periodic payments which will compensate for these future damages after offset for collateral sources shall be made. The total dollar amount of the periodic payments shall equal the dollar amount of all such future damages before any reduction to present value.~~

~~2. The defendant shall be required to post a bond or security or otherwise to assure full payment of these damages awarded. A bond is not adequate unless it is written by a company authorized to do business in this state and is rated A+ by Best's. If the defendant is unable to adequately assure full payment of the damages, all damages, reduced to present value, shall be paid to the claimant in a lump sum. No bond may be canceled or be subject to cancellation unless at least 60 days' advance written notice is filed with the court and the claimant. Upon termination of periodic payments, the security, or so much as remains, shall be returned to the defendant.~~

~~3. The provision for payment of future damages by periodic payments shall specify the recipient or recipients of the payments, the dollar amounts of the payments, the interval between payments, and the number of payments or the period of time over which payments shall be made.~~

Section 66. Subsection (1) of section 766.112, Florida Statutes, is amended to read:

766.112 Comparative fault.--

(1) Notwithstanding <u>any provision of</u> ~~anything in~~ law to the contrary, in an action for damages for personal injury or wrongful death arising out of medical malpractice, whether in contract or tort, ~~when an apportionment of damages pursuant to~~

~~this section is attributed to a teaching hospital as defined in s. 408.07,~~ the court shall enter judgment ~~against the teaching hospital~~ on the basis of each ~~such~~ party's percentage of fault and not on the basis of the doctrine of joint and several liability.

Section 67. Subsection (5) of section 768.81, Florida Statutes, is amended to read:

768.81 Comparative fault.--

(5) Notwithstanding any provision of ~~anything in~~ law to the contrary, in an action for damages for personal injury or wrongful death arising out of medical malpractice, whether in contract or tort, ~~when an apportionment of damages pursuant to this section is attributed to a teaching hospital as defined in s. 408.07,~~ the court shall enter judgment ~~against the teaching hospital~~ on the basis of each ~~such~~ party's percentage of fault and not on the basis of the doctrine of joint and several liability.

Section 68. Section 1004.08, Florida Statutes, is created to read:

1004.08 Patient safety instructional requirements.--Every public school, college, and university that offers degrees in medicine, nursing, and allied health shall include in the curricula applicable to such degrees material on patient safety, including patient safety improvement. Materials shall include, but need not be limited to, effective communication and teamwork; epidemiology of patient injuries and medical errors; vigilance, attention, and fatigue; checklists and inspections; automation and technological and computer support; psychological factors in human error; and reporting systems.

Section 69. Section 1005.07, Florida Statutes, is created to read:

1005.07 Patient safety instructional requirements.--Every nonpublic school, college, and university that offers degrees in medicine, nursing, and allied health shall include in the curricula applicable to such degrees material on patient safety, including patient safety improvement. Materials shall include, but need not be limited to, effective communication and teamwork; epidemiology of patient injuries and medical errors; vigilance, attention, and fatigue; checklists and inspections; automation and technological and computer support; psychological factors in human error; and reporting systems.

Section 70. (1) The Department of Health shall study and report to the Legislature as to whether medical review panels should be included as part of the presuit process in medical malpractice litigation. Medical review panels review a medical malpractice case during the presuit process and make judgments on the merits of the case based on established standards of care with the intent of reducing the number of frivolous claims. The panel's report could be used as admissible evidence at trial or for other purposes. The department's report should address:

(a) Historical use of medical review panels and similar pretrial programs in this state, including the mediation panels created by chapter 75-9, Laws of Florida.

(b) Constitutional issues relating to the use of medical review panels.

(c) The use of medical review panels or similar programs in other states.

(d) Whether medical review panels or similar panels should be created for use during the presuit process.

(e) Other recommendations and information that the department deems appropriate.

(f) In submitting its report with respect to paragraphs (a)-(c), the department should identify at a minimum:

1. The percentage of medical malpractice claims submitted to the panels during the time period the panels were in existence.

2. The percentage of claims that were settled while the panels were in existence and the percentage of claims that were settled in the 3 years prior to the establishment of such panels or, for each panel which no longer exists, 3 years after the dissolution of such panels.

3. In those state where panels have been discontinued, whether additional safeguards have been implemented to avoid the filing of frivolous lawsuits and what those additional safeguards are.

4. How the rates for medical malpractice insurance in states utilizing such panels compares with the rates in states not utilizing such panels.

5. Whether, and to what extent, a finding by a panel is subject to review and the burden of proof required to overcome a finding by the panel.

(2) If the department finds that medical review panels or a similar structure should be created in this state, it shall include draft legislation to implement its recommendations in its report.

(3) The department shall submit its report to the Speaker of the House of Representatives and the President of the Senate no later than December 31, 2003.

Section 71. The Agency for Health Care Administration is directed to study the types of information the public would find relevant in the selection of hospitals and physicians. The agency shall review and recommend appropriate methods of collection, analysis, and dissemination of that information. The agency shall complete its study and report its findings and recommendations to the Speaker of the House of Representatives and the President of the Senate by January 15, 2004.

Section 72. The Office of Program Policy Analysis and Government Accountability shall complete a study of the eligibility requirements for a birth to be covered under the Florida Birth-Related Neurological Injury Compensation Association and submit a report to the Speaker of the House of Representatives and the President of the Senate by January 1, 2004, recommending whether or not the statutory criteria for a claim to qualify for referral to the Florida Birth-Related Neurological Injury Compensation Association under s. 766.302, Florida Statutes, should be modified.

Section 73. The Office of Program Policy Analysis and Government Accountability and the Office of the Auditor General must jointly conduct an audit of the Department of Health's health care practitioner disciplinary process and closed claims that are filed with the department under s. 627.912, Florida Statutes. The Office of Program Policy Analysis and Government Accountability and the Office of the Auditor General shall submit a report to the Speaker of the House of Representatives and the President of the Senate by January 1, 2004.

Section 74. Comprehensive study and report on the creation of a Patient Safety Authority.--

(1) The Agency for Health Care Administration, in consultation with the Department of Health, is directed to study the need for, and the implementation requirements of, establishing a Patient Safety Authority. The authority would be responsible for performing activities and functions designed to improve patient safety and the quality of care delivered by health care facilities and health care practitioners.

(2) In undertaking its study, the agency shall examine and evaluate a Patient Safety Authority that would, either directly or by contract:

(a) Analyze information concerning adverse incidents reported to the Agency for Health Care Administration pursuant to s. 395.0197, Florida Statutes, for the purpose of recommending changes in practices and procedures that may be implemented by health care practitioners and health care facilities to prevent future adverse incidents.

(b) Collect, analyze, and evaluate patient safety data submitted voluntarily by a health care practitioner or health care facility. The authority would communicate to health care practitioners and health care facilities changes in practices and procedures that may be implemented for the purpose of improving patient safety and preventing future patient safety events from resulting in serious injury or death. At a minimum, the authority would:

1. Be designed and operated by an individual or entity with demonstrated expertise in health care quality data and systems analysis, health information management, systems thinking and analysis, human factors analysis, and identification of latent and active errors.

2. Include procedures for ensuring its confidentiality, timeliness, and independence.

(c) Foster the development of a statewide electronic infrastructure, which would be implemented in phases over a multiyear period, that is designed to improve patient care and the delivery and quality of health care services by health care facilities and practitioners. The electronic infrastructure would be a secure platform for communication and the sharing of clinical and other data, such as business data, among providers and between patients and providers. The electronic infrastructure would include a core electronic medical record. Health care providers would have access to individual electronic medical records, subject to the consent of the individual. The right, if any, of other entities, including health insurers and researchers, to access the records would need further examination and evaluation by the agency.

(d) Foster the use of computerized physician medication ordering systems by hospitals that do not have such systems and develop protocols for these systems.

(e) Implement paragraphs (c) and (d) as a demonstration project for Medicaid recipients.

(f) Identify best practices and share this information with health care providers.

(g) Engage in other activities that improve health care quality, improve the diagnosis and treatment of diseases and medical conditions, increase the efficiency of the delivery of health care services, increase administrative efficiency, and increase access to quality health care services.

(3) The agency shall also consider ways in which a Patient Safety Authority would be able to facilitate the development of

no-fault demonstration projects as means to reduce and prevent medical errors and promote patient safety.

(4) The agency shall seek information and advice from and consult with hospitals, physicians, other health care providers, attorneys, consumers, and individuals involved with and knowledgeable about patient safety and quality-of-care initiatives.

(5) In evaluating the need for, and the operation of, a Patient Safety Authority, the agency shall determine the costs of implementing and administering an authority and suggest funding sources and mechanisms.

(6) The agency shall complete its study and issue a report to the Speaker of the House of Representatives and the President of the Senate by February 1, 2004. In its report, the agency shall include specific findings, recommendations, and proposed legislation.

Section 75. (1) The Medical Injury Nonjudicial Compensation Study Commission is created. The commission shall be composed of 12 voting members, four of whom are appointed by the Governor, four of whom are appointed by the President of the Senate, and four of whom are appointed by the Speaker of the House of Representatives. In addition, the Attorney General or his or her designee shall serve as an ex officio nonvoting member of the commission. The Governor's appointments must include at least one appointment from each of the following groups: physicians, hospitals, attorneys, and consumers. The President of the Senate and the Speaker of the House of Representatives shall each select one appointee from each of the groups listed and, in addition, shall appoint two members from their respective chambers of the Legislature to serve on the

commission as ex officio nonvoting members. Appointments under this subsection shall be made within 60 days after this act becomes law, and the first meeting of the commission shall be held no later than 60 days thereafter. The chair of the commission shall be elected from the voting members by the majority of the membership at its first meeting. Any vacancy occurring in the membership of the commission shall be filled in the same manner as the original appointment.

(2) Each voting member of the commission is entitled to one vote, and action of the commission requires a two-thirds vote of the members present. However, action of the commission may be taken only at a meeting at which a majority of the voting members of the commission are present.

(3)(a) The commission shall recommend statutory changes needed to accomplish the following:

1. Implementation of the "provider-based early payment" model for medical injury compensation recommended by the Institute of Medicine of the National Academy of Sciences and contained in the report entitled "Fostering Rapid Advances in Health Care."

2. Implementation of the "statewide administrative resolution" model for medical injury compensation recommended by the Institute of Medicine of the National Academy of Sciences and contained in the report entitled "Fostering Rapid Advances in Health Care."

3. Implementation of a nonjudicial compensation model for medical injuries in a teaching hospital or public hospital covered under sovereign immunity.

4. Implementation of any other nonjudicial compensation model for medical injuries that the commission deems

appropriate.

(b) Contingency fees for attorneys should be eliminated from the claims bill process in these models, if the claims bill process is used.

(c) In determining what changes in law are needed to implement nonjudicial compensation programs for medical injuries that result from avoidable errors, the following should be considered:

1. How avoidable errors would be determined.

2. How patients would be immediately compensated for injuries according to schedules that calculate economic and noneconomic damages.

3. How the tort system should be revised.

4. How exceptions to the nonjudicial system would be created to give persons access to the tort system for injuries due to intentional harm or due to reckless disregard for practicing within the standard of care.

5. How individuals and organizations who implement a nonjudicial program would be protected from legal liability.

6. How health insurers and others who pay the costs incurred by patients who have suffered compensable injuries would be protected from lawsuits.

7. How appropriate communications such as mediated discussions between health care providers and patients following the occurrence of an avoidable injury would be protected so that they do not increase a provider's financial liability or legal liability.

8. How oversight mechanisms would be established to ensure that avoidable injuries are detected and disclosed.

9. How other necessary elements of a nonjudicial

compensation program would be implemented.

(4) The commission may hold public hearings as it deems necessary.

(5) The commission shall, by February 1, 2004, provide to the President of the Senate, the Speaker of the House of Representatives, and the Governor an interim report of its recommendations. A final written report shall be provided to the same officers by June 30, 2004, with findings and recommendations for all the issues identified in subsection (3), including recommendations for any needed statutory changes.

(6) The commission may establish and appoint any necessary technical advisory committees. Commission members, and the members of any technical advisory committees that are appointed, shall not receive remuneration for their services, but are entitled to be reimbursed by the Department of Legal Affairs for travel or per diem expenses in accordance with chapter 112, Florida Statutes. Public officers and employees shall be reimbursed by their respective agencies in accordance with chapter 112, Florida Statutes.

(7) The commission may select an executive director, who shall report to the commission and serve at its pleasure, and may hire staff needed to accomplish the goals of this section. The commission may hire consultants for the analysis of specific issues.

(8) Each commission member may receive per diem and expenses for travel, as provided in s. 112.061, Florida Statutes, while carrying out official business of the commission.

(9) The commission shall continue in existence until its objectives are achieved, but not later than June 30, 2004.

Section 76. If any provision of this act or the application thereof to any person or circumstance is held invalid, the invalidity does not affect other provisions or applications of the act which can be given effect without the invalid provision or application, and to this end the provisions of this act are declared severable.

Section 77. If any law amended by this act was also amended by a law enacted at the 2003 Regular Session of the Legislature or at the 2003 Special Session A of the Legislature, such laws shall be construed as if they had been enacted at the same session of the Legislature, and full effect shall be given to each if possible.

Section 78. This act shall take effect upon becoming a law and, except as otherwise provided in this act, shall apply to all actions filed after the effective date of the act.