A bill to be entitled

An act relating to medical incidents; providing legislative 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. 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; creating s. 395.0056, F.S.; requiring the Agency for Health Care Administration to review complaints submitted if the defendant is a hospital; amending s. 395.0191, F.S.; deleting requirement that persons act in good faith to avoid liability or discipline for their actions regarding the awarding of staff membership or clinical privileges; amending s. 395.0197, F.S.; revising provisions relating to internal risk management programs; requiring additional reports to and by the Department of Health and the Agency for Health Care Administration; 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 and committees; creating s. 395.1051, F.S.; requiring certain facilities to notify patients about

adverse incidents under specified conditions; amending s. 415.1111, F.S.; providing that such section shall not apply to actions involving allegations of medical malpractice; amending s. 456.013, F.S.; requiring certain information to be included in courses for health care practitioners relating to prevention of medical errors; amending s. 456.025, F.S.; eliminating certain restrictions on the setting of licensure renewal fees for health care practitioners; amending s. 456.039, F.S.; providing additional information required to be furnished to the Department of Health for licensure purposes; amending s. 456.041, F.S.; requiring additional information to be included in health care practitioner profiles; providing for fines; revising requirements for the reporting of paid liability claims; amending s. 456.042, F.S.; requiring health care practitioner profiles to be updated within a specific time period; amending s. 456.049, F.S.; revising requirements for the reporting of paid liability claims; amending s. 456.051, F.S.; establishing the responsibility of the Department of Health to provide reports of professional liability actions and bankruptcies; requiring the department to include such reports in a practitioner's profile within a specified period; amending s. 456.057, F.S.; authorizing the Department of Health to utilize subpoenas to obtain patient records without patients' consent under certain circumstances; creating s. 456.0575, F.S.; requiring licensed health care practitioners to notify patients about adverse incidents under certain conditions; amending s. 456.072, F.S.; providing for determining the amount of

any costs to be assessed in a disciplinary proceeding; prescribing the standard of proof in certain disciplinary proceedings; amending s. 456.073, F.S.; authorizing the Department of Health to investigate certain paid claims made on behalf of practitioners licensed under ch. 458 or ch. 459, F.S.; extending the time for the Department of Health to refer a request for an administrative hearing; providing that certain findings are findings of, not findings of fact; amending s. 456.077, F.S.; revising provisions relating to designation of certain citation violations; amending s. 456.078, F.S.; revising provisions relating to designation of certain mediation offenses; amending s. 458.320, F.S., relating to financial responsibility requirements for medical physicians; requiring the department to suspend the license of a medical physician who has not paid, up to the amounts required by any applicable financial responsibility provision, any outstanding judgment, arbitration award, other order, or settlement; amending s. 458.331, F.S.; increasing the amount of paid liability claims requiring investigation by the Department of Health; revising the definition of "repeated malpractice" to conform; requiring the inclusion of certain findings in certain orders issued by administrative law judges; revising the standards for the burden of proof in an administrative action against a physician; creating s. 458.3311, F.S.; establishing emergency procedures for disciplinary actions; amending s. 459.0085, F.S., relating to financial responsibility requirements for osteopathic physicians; requiring that the department suspend the license of an osteopathic

physician who has not paid, up to the amounts required by any applicable financial responsibility provision, any outstanding judgment, arbitration award, other order, or settlement; amending s. 459.015, F.S.; increasing the amount of paid liability claims requiring investigation by the Department of Health; revising the definition of "repeated malpractice" to conform; revising the standards for the burden of proof in an administrative action against an osteopathic physician; creating s. 459.0151, F.S.; establishing emergency procedures for disciplinary actions; amending s. 460.413, F.S., relating to grounds for disciplinary action against a chiropractic physician; revising the standards for the burden of proof in an administrative action against a chiropractic physician; amending s. 461.013, F.S.; increasing the amount of paid liability claims requiring investigation by the Department of Health; revising the definition of "repeated malpractice" to conform; 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 dentist which will trigger a departmental investigation; amending s. 624.155, F.S.; providing that an action for bad faith may not be brought against a medical malpractice insurer if such insurer offers to pay policy limits within a specified time period; providing for factors to be considered in determining whether a medical malpractice insurer has acted in bad faith; providing a limitation on the amount of damages which may be awarded to certain third parties in actions alleging

bad faith by a medical malpractice insurer; amending s. 624.462, F.S.; authorizing health care providers to form a commercial self-insurance fund; amending s. 627.062, F.S.; providing additional requirements for medical malpractice insurance rate filings; providing that portions of judgments and settlements entered against a medical malpractice insurer for bad faith actions or for punitive damages against the insurer, as well as related taxable costs and attorney's fees, may not be included in an insurer's rate base; providing for review of rate filings by the Office of Insurance Regulation for excessive, inadequate, or unfairly discriminatory rates; requiring insurers to apply a discount based on the health care provider's loss experience; requiring annual rate filings; requiring medical malpractice insurers to make rate filings effective January 1, 2004, which reflect the impact of this act; providing requirements for rate deviation by insurers; authorizing adjustments to filed rates in the event a provision of this act is declared invalid by a court of competent jurisdiction; 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; creating s. 627.3575, F.S.; creating the Health Care Professional Liability Insurance Facility; providing purpose; providing for governance and powers; providing eligibility requirements; providing for premiums and assessments; providing for regulation; providing rule adoption authority to the Financial Services Commission;

providing applicability; specifying duties of the Department of Health; providing for debt and regulation thereof; 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; requiring earlier notice of decisions to not renew certain insurance policies to insureds under certain circumstances; requiring prior notification of a rate increase; 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 a fine; 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; providing exceptions; amending s. 641.51, F.S.; proscribing a health maintenance organization’s 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; providing exceptions; amending s. 766.102, F.S; revising requirements for health care providers providing expert testimony in medical negligence actions; prohibiting contingency fees for an expert witness; amending s. 766.106, F.S.; requiring the

inclusion of additional information in presuit notices provided to defendants; extending the time period for the presuit screening period; providing that liability is deemed admitted when an offer is made by a defendant to arbitrate; specifying consequences of failure to cooperate on the part of any party during the presuit investigation; revising requirements for presuit notice and insurer or self-insurer response to a claim; permitting written questions during informal discovery; requiring a claimant to execute a medical release to authorize defendants in medical negligence actions to take unsworn statements from a claimant's treating physicians; imposing limits on such statements; creating s. 766.1065, F.S.; requiring parties to provide certain information to parties without request; authorizing the issuance of subpoenas without case numbers; requiring that parties and certain experts be made available for deposition; creating s. 766.1067, F.S.; providing for mandatory mediation in medical negligence causes of action; creating s. 766.118, F.S.; providing limitations on noneconomic damages which can be awarded in causes of action involving medical negligence; amending s. 766.202, F.S.; redefining the terms "economic damages," "medical expert," "noneconomic damages," and "periodic payment"; extending the definitions of economic and noneconomic damages to include any such damages recoverable under the Wrongful Death Act or general law; providing for periodic payments for future noneconomic damages; revising regulations of periodic payments; amending s. 766.203, F.S.; providing for discovery of opinions and statements tendered during presuit

investigation; amending s. 766.206, F.S.; providing for dismissal of a claim under certain circumstances; requiring the court to make certain reports concerning a medical expert who fails to meet qualifications; providing for retroactive application; amending s. 766.207, F.S.; conforming provisions to the extension in the time period for presuit investigation; providing for the applicability of the Wrongful Death Act and general law to arbitration awards; amending s. 766.209, F.S.; revising applicable damages available in voluntary binding arbitration relating to claims of medical negligence; 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. 766.304, 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; prohibiting the filing of civil actions under certain circumstances; 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 Florida Birth-Related Neurological Injury Compensation Association; amending s. 766.31, F.S.; providing a death benefit under the Florida Birth-Related Neurological Injury Compensation Plan in lieu of funeral expenses;

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. 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; amending s. 768.28, F.S., relating to waiver of sovereign immunity in tort actions; revising the definition of the term "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; amending s. 768.78, F.S.; correcting a cross reference; providing that a defendant may elect to make lump sum payments rather than periodic payments for either or both future economic and noneconomic damages; authorizing the payment of certain losses for a shorter period of time under certain circumstances; providing for modification of periodic payments or for requiring additional security by order of the court under certain circumstances; 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; amending s. 1006.20, F.S.; requiring completion of a uniform participation physical evaluation and history form incorporating recommendations of the American Heart Association; deleting revisions to procedures for students' physical examinations; deleting provisions requiring practitioners to certify that students are physically capable of participating in interscholastic athletic competition; defining the terms "patient safety data" and "patient safety organization"; providing for use of patient safety data by a patient safety organization; providing limitations on use of patient safety data; providing for protection of patient-identifying information; providing for determination of whether the privilege applies as asserted; providing that an employer may not take retaliatory action against an employee who makes a good faith report concerning patient safety data; requiring the Division of Administrative Hearings to designate administrative law judges who have special qualifications for hearings involving certain health care practitioners; requiring the Department of Health to study the efficacy and constitutionality of medical review panels; requiring a report; directing the Agency for Health Care Administration to conduct or contract for a study to determine what information to provide to the public comparing hospitals, based on inpatient quality indicators developed by the federal Agency for Healthcare Research and Quality; requiring a report by the Agency for Health Care Administration regarding the establishment of a

Patient Safety Authority; specifying elements of the report; 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; providing civil immunity for certain participants in quality improvement processes; requiring the Office of Program Policy Analysis and Government Accountability and the Office of the Auditor General to conduct an audit of the Department of Health's health care practitioner disciplinary process and certain closed claims and to report to the Legislature; creating a workgroup to study the health care practitioner disciplinary process; providing for workgroup membership; providing that the workgroup deliver its report by January 1, 2004; providing legislative findings and intent; providing a statement of legislative intent regarding the change in the standard of proof in disciplinary cases involving the suspension or revocation of a license; providing that the practice of health care is a privilege, not a right; providing that protecting patients overrides purported property interest in the license of a health care practitioner; providing that certain disciplinary actions are remedial and protective, not penal; providing that the Legislature specifically reverses case law to the contrary; reenacting ss. 624.488, F.S., 628.6016, F.S.; and s. 631.717, F.S., to incorporate by reference amendments to s. 624.155, F.S.; providing severability; providing for construction of the act in pari materia with laws enacted during the 2003 Regular Session, the 2003

Special Session A, or the 2003 Special Session B of the Legislature; 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, or 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 of Florida 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 this 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 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 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. 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.

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

Section 4. 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 5. Section 395.0056, Florida Statutes, is created to read:

395.0056 Litigation notice requirement.--Upon receipt of a copy of a complaint filed against a hospital as a defendant in a medical malpractice action as required by s. 766.106(2), the agency shall:

(1) Review its adverse incident report files pertaining to the licensed facility that is the subject of the complaint to determine whether the facility timely complied with the requirements of s. 395.0197.

(2) Review the incident that is the subject of the complaint and determine whether it involved conduct by a licensee which is potentially subject to disciplinary action.

Section 6. Subsection (7) of section 395.0191, Florida Statutes, is amended to read:

395.0191 Staff membership and clinical privileges.--

(7) There shall be no monetary liability on the part of, and no cause of action for injunctive relief or damages shall

arise against, any licensed facility, its governing board or governing board members, medical staff, or disciplinary board or against its agents, investigators, witnesses, or employees, or against any other person, for any action arising out of or related to carrying out the provisions of this section, absent ~~taken in good faith and without~~ intentional fraud ~~in carrying out the provisions of this section~~.

Section 7. 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. Each licensed facility shall annually report to the agency and the department the name and judgments entered against each health care practitioner for which it assumes liability. The agency and the department, in their respective annual reports, shall include statistics that report the number of licensed facilities that assume such liability and the number of health care practitioners, by profession, for whom the facilities assume liability.

(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)~~(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).~~

(13)~~(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.

(14)~~(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 (13) ~~(14)~~.

(15)~~(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.

(16)~~(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.

(17)~~(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.

(18)~~(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.

(19)~~(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 8. Section 395.0198, Florida Statutes, is repealed.

Section 9. 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 10. 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 adverse incidents that result in serious harm to the patient. Notification of outcomes of care that result in harm to the patient under this section shall not constitute an acknowledgement or admission of liability, nor can such notifications be introduced as evidence.

Section 11. 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. 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. Notwithstanding the provisions of this section, any claim that qualifies as a claim for medical malpractice, as defined in s. 766.106(1)(a), shall be brought pursuant to chapter 766.

Section 12. Subsection (7) of section 456.013, Florida Statutes, is amended to read:

456.013 Department; general licensing provisions.--

(7) The boards, or the department when there is no board, shall require the completion of a 2-hour course relating to prevention of medical errors as part of the licensure and renewal process. The 2-hour course shall count towards the total number of continuing education hours required for the profession. The course shall be approved by the board or department, as appropriate, ~~and~~ shall include a study of root-cause analysis, error reduction and prevention, and patient safety, and shall contain information relating to the five most misdiagnosed conditions during the previous biennium, as determined by the board or department. If the course is being offered by a facility licensed pursuant to chapter 395 for its employees, the board may approve up to 1 hour of the 2-hour course to be specifically related to error reduction and prevention methods used in that facility.

Section 13. Subsection (1) of section 456.025, Florida Statutes, is amended to read:

456.025 Fees; receipts; disposition.--

(1) It is the intent of the Legislature that all costs of regulating health care professions and practitioners shall be borne solely by licensees and licensure applicants. It is also the intent of the Legislature that fees should be reasonable and not serve as a barrier to licensure. Moreover, it is the intent

of the Legislature that the department operate as efficiently as possible and regularly report to the Legislature additional methods to streamline operational costs. Therefore, the boards in consultation with the department, or the department if there is no board, shall, by rule, set renewal fees which:

(a) Shall be based on revenue projections prepared using generally accepted accounting procedures;

(b) Shall be adequate to cover all expenses relating to that board identified in the department's long-range policy plan, as required by s. 456.005;

(c) Shall be reasonable, fair, and not serve as a barrier to licensure;

(d) Shall be based on potential earnings from working under the scope of the license;

(e) Shall be similar to fees imposed on similar licensure types;

~~(f) Shall not be more than 10 percent greater than the fee imposed for the previous biennium;~~

(f)~~(g)~~ Shall not be more than 10 percent greater than the actual cost to regulate that profession for the previous biennium; and

(g)~~(h)~~ Shall be subject to challenge pursuant to chapter 120.

Section 14. 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 15. Section 456.041, Florida Statutes, is amended to read:

456.041 Practitioner profile; creation.--

(1)(a) Beginning July 1, 1999, the Department of Health shall compile the information submitted pursuant to s. 456.039 into a practitioner profile of the applicant submitting the information, except that the Department of Health may develop a format to compile uniformly any information submitted under s. 456.039(4)(b). Beginning July 1, 2001, the Department of Health may, and beginning July 1, 2004, shall, compile the information submitted pursuant to s. 456.0391 into a practitioner profile of the applicant submitting the information.

(b) Each practitioner licensed under chapter 458 or chapter 459 must report to the Department of Health and the Board of Medicine or the Board of Osteopathic Medicine, respectively, all final disciplinary actions, sanctions by a governmental agency or a facility or entity licensed under state law, and claims or actions, as provided under s. 456.051, to which he or she is subjected no later than 15 calendar days after such action or sanction is imposed. Failure to submit the requisite information within 15 calendar days in accordance with this paragraph shall subject the practitioner to discipline by the Board of Medicine or the Board of Osteopathic Medicine and a fine of $100 for each day that the information is not submitted after the expiration of the 15-day reporting period.

(c) Within 15 days after receiving a report under paragraph (b), the department shall update the practitioner's profile in accordance with the requirements of subsection (7).

(2) On the profile published under subsection (1), the department shall indicate whether ~~if~~ the information provided under s. 456.039(1)(a)7. or s. 456.0391(1)(a)7. is or is not corroborated by a criminal history check conducted according to this subsection. ~~If the information provided under s. 456.039(1)(a)7. or s. 456.0391(1)(a)7. is corroborated by the criminal history check, the fact that the criminal history check was performed need not be indicated on the profile.~~ The department, or the board having regulatory authority over the practitioner acting on behalf of the department, shall investigate any information received by the department or the board when it has reasonable grounds to believe that the practitioner has violated any law that relates to the practitioner's practice.

(3) The Department of Health shall ~~may~~ include in each practitioner's practitioner profile that criminal information that directly relates to the practitioner's ability to competently practice his or her profession. The department must include in each practitioner's practitioner profile the following statement: "The criminal history information, if any exists, may be incomplete; federal criminal history information is not available to the public." The department shall provide in each practitioner profile, for every final disciplinary action taken against the practitioner, a narrative description, written in plain English, that explains the administrative complaint filed against the practitioner and the final disciplinary action imposed on the practitioner. The department shall include a hyperlink to each final order listed on its Internet website report of dispositions of recent disciplinary actions taken against practitioners.

(4) The Department of Health shall include, with respect to a practitioner licensed under chapter 458 or chapter 459, a statement of how the practitioner has elected to comply with the financial responsibility requirements of s. 458.320 or s. 459.0085. The department shall include, with respect to practitioners subject to s. 456.048, a statement of how the practitioner has elected to comply with the financial responsibility requirements of that section. The department shall include, with respect to practitioners licensed under chapter 458, chapter 459, or chapter 461, information relating to liability actions which has been reported under s. 456.049 or s. 627.912 within the previous 10 years for any paid claim of $50,000 or more ~~that exceeds $5,000~~. Such claims information shall be reported in the context of comparing an individual practitioner's claims to the experience of other practitioners within the same specialty, or profession if the practitioner is not a specialist~~, to the extent such information is available to the Department of Health~~. The department shall include a hyperlink to all such comparison reports in such practitioner's profile on its Internet website. If information relating to a liability action is included in a practitioner's practitioner profile, the profile must also include the following statement: "Settlement of a claim may occur for a variety of reasons that do not necessarily reflect negatively on the professional competence or conduct of the practitioner. A payment in settlement of a medical malpractice action or claim should not be construed as creating a presumption that medical malpractice has occurred."

(5) The Department of Health shall ~~may not~~ include the date of a disciplinary action taken by a licensed hospital or an

ambulatory surgical center, in accordance with the requirements of s. 395.0193, in the practitioner profile. Any practitioner disciplined under paragraph (1)(b) must report to the department the date the disciplinary action was imposed. The department shall state whether the action is related to professional competence and whether it is related to the delivery of services to a patient.

(6) The Department of Health may include in the practitioner's practitioner profile any other information that is a public record of any governmental entity and that relates to a practitioner's ability to competently practice his or her profession. However, the department must consult with the board having regulatory authority over the practitioner before such information is included in his or her profile.

(7) Upon the completion of a practitioner profile under this section, the Department of Health shall furnish the practitioner who is the subject of the profile a copy of it. The practitioner has a period of 30 days in which to review the profile and to correct any factual inaccuracies in it. The Department of Health shall make the profile available to the public at the end of the 30-day period. The department shall make the profiles available to the public through the World Wide Web and other commonly used means of distribution.

(8) The Department of Health shall provide in each profile an easy-to-read explanation of any disciplinary action taken and the reason the sanction or sanctions were imposed.

(9)~~(8)~~ Making a practitioner profile available to the public under this section does not constitute agency action for which a hearing under s. 120.57 may be sought.

Section 16. Section 456.042, Florida Statutes, is amended

to read:

456.042 Practitioner profiles; update.--A practitioner must submit updates of required information within 15 days after the final activity that renders such information a fact. The Department of Health shall update each practitioner's practitioner profile periodically. An updated profile is subject to the same requirements as an original profile with respect to the period within which the practitioner may review the profile for the purpose of correcting factual inaccuracies.

Section 17. Subsection (1) of section 456.049, Florida Statutes, is amended, and subsection (3) is added to said section, to read:

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

(1) Any practitioner of medicine licensed pursuant to the provisions of chapter 458, practitioner of osteopathic medicine licensed pursuant to the provisions of chapter 459, podiatric physician licensed pursuant to the provisions of chapter 461, or dentist licensed pursuant to the provisions of chapter 466 shall report to the department any claim or action for damages for personal injury alleged to have been caused by error, omission, or negligence in the performance of such licensee's professional services or based on a claimed performance of professional services without consent if ~~the claim was not covered by an insurer required to report under s. 627.912 and~~ the claim resulted in:

(a) A final judgment of $50,000 or more or, with respect to a dentist licensed pursuant to chapter 466, a final judgment of $25,000 or more ~~in any amount~~.

(b) A settlement of $50,000 or more or, with respect to a

dentist licensed pursuant to chapter 466, a settlement of $25,000 or more ~~in any amount~~.

(c) A final disposition not resulting in payment on behalf of the licensee.

Reports shall be filed with the department no later than 60 days following the occurrence of any event listed in paragraph (a), paragraph (b), or paragraph (c).

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

Section 18. Section 456.051, Florida Statutes, is amended to read:

456.051 Reports of professional liability actions; bankruptcies; Department of Health's responsibility to provide.--

(1) The report of a claim or action for damages for personal injury which is required to be provided to the Department of Health under s. 456.049 or s. 627.912 is public information except for the name of the claimant or injured person, which remains confidential as provided in ss. 456.049(2)(d) and 627.912(2)(e). The Department of Health shall, upon request, make such report available to any person. The department shall make such report available as a part of the practitioner's profile within 45 calendar days after receipt.

(2) Any information in the possession of the Department of Health which relates to a bankruptcy proceeding by a practitioner of medicine licensed under chapter 458, a practitioner of osteopathic medicine licensed under chapter 459, a podiatric physician licensed under chapter 461, or a dentist licensed under chapter 466 is public information. The Department

of Health shall, upon request, make such information available to any person. The department shall make such report available as a part of the practitioner's profile within 45 calendar days after receipt.

Section 19. Paragraph (a) of subsection (7) of section 456.057, Florida Statutes, is amended to read:

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

(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 20. Section 456.0575, Florida Statutes, is created to read:

456.0575 Duty to notify patients.--Every licensed health care practitioner shall inform each patient, or an individual identified pursuant to s. 765.401(1), in person about adverse incidents that result in serious harm to the patient. Notification of outcomes of care that result in harm to the patient under this section shall not constitute an acknowledgement of admission of liability, nor can such notifications be introduced as evidence.

Section 21. 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 addition to any other discipline imposed through final order, or citation, entered on or after July 1, 2001, 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. Such costs related to the investigation and prosecution include, but are not limited to, salaries and benefits of personnel, costs related to the time spent by the attorney and other personnel working on the case, and any other expenses incurred by the department for the case. The board, or the department when there in no board, shall determine the amount of costs to be assessed after its consideration of an affidavit of itemized costs and any written objections thereto. In any case where the board or the department imposes a fine or assessment 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 22. Subsections (1) and (5) of section 456.073, Florida Statutes, as amended by section 1 of chapter 2003-27, Laws of Florida, are amended to read:

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

(1) The department, for the boards under its jurisdiction, shall cause to be investigated any complaint that is filed before it if the complaint is in writing, signed by the complainant, and legally sufficient. A complaint filed by a state prisoner against a health care practitioner employed by or otherwise providing health care services within a facility of the Department of Corrections is not legally sufficient unless there is a showing that the prisoner complainant has exhausted all available administrative remedies within the state correctional system before filing the complaint. However, if the Department of Health determines after a preliminary inquiry of a state prisoner's complaint that the practitioner may present a serious threat to the health and safety of any individual who is not a state prisoner, the Department of Health may determine legal sufficiency and proceed with discipline. The Department of

Health shall be notified within 15 days after the Department of Corrections disciplines or allows a health care practitioner to resign for an offense related to the practice of his or her profession. A complaint is legally sufficient if it contains ultimate facts that show that a violation of this chapter, of any of the practice acts relating to the professions regulated by the department, or of any rule adopted by the department or a regulatory board in the department has occurred. In order to determine legal sufficiency, the department may require supporting information or documentation. The department may investigate, and the department or the appropriate board may take appropriate final action on, a complaint even though the original complainant withdraws it or otherwise indicates a desire not to cause the complaint to be investigated or prosecuted to completion. The department may investigate an anonymous complaint if the complaint is in writing and is legally sufficient, if the alleged violation of law or rules is substantial, and if the department has reason to believe, after preliminary inquiry, that the violations alleged in the complaint are true. The department may investigate a complaint made by a confidential informant if the complaint is legally sufficient, if the alleged violation of law or rule is substantial, and if the department has reason to believe, after preliminary inquiry, that the allegations of the complainant are true. The department may initiate an investigation if it has reasonable cause to believe that a licensee or a group of licensees has violated a Florida statute, a rule of the department, or a rule of a board. The department may investigate information filed pursuant to s. 456.041(4) relating to liability actions with respect to practitioners licensed under

chapter 458 or chapter 459 which have been reported under s. 456.049 or s. 627.912 within the previous 6 years for any paid claim that exceeds $50,000. Except as provided in ss. 458.331(9), 459.015(9), 460.413(5), and 461.013(6), when an investigation of any subject is undertaken, the department shall promptly furnish to the subject or the subject's attorney a copy of the complaint or document that resulted in the initiation of the investigation. The subject may submit a written response to the information contained in such complaint or document within 20 days after service to the subject of the complaint or document. The subject's written response shall be considered by the probable cause panel. The right to respond does not prohibit the issuance of a summary emergency order if necessary to protect the public. However, if the secretary, or the secretary's designee, and the chair of the respective board or the chair of its probable cause panel agree in writing that such notification would be detrimental to the investigation, the department may withhold notification. The department may conduct an investigation without notification to any subject if the act under investigation is a criminal offense.

(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. The determination of whether a licensee has violated the laws and rules regulating the profession, including a determination of the reasonable standard of care, is a conclusion of law to be determined by the board, or department when there is no board, and is not a finding of fact to be determined by an administrative law judge. 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 23. 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 24. 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 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 25. Present subsection (8) of section 458.320, Florida Statutes, is renumbered as subsection (9), and a new subsection (8) is added to said section, to read:

458.320 Financial responsibility.--

(8) Notwithstanding any other provision of this section, the department shall suspend the license of any physician against whom has been entered a final judgment, arbitration award, or other order or who has entered into a settlement agreement to pay damages arising out of a claim for medical malpractice, if all appellate remedies have been exhausted and payment up to the amounts required by this section has not been made within 30 days after the entering of such judgment, award, or order or agreement, until proof of payment is received by the department or a payment schedule has been agreed upon by the physician and the claimant and presented to the department. This subsection does not apply to a physician who has met the financial responsibility requirements in paragraphs (1)(b) and (2)(b).

Section 26. 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. 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 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 must 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 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 27. Section 458.3311, Florida Statutes, is created to read:

458.3311 Emergency procedures for disciplinary action.--Notwithstanding any other provision of law to the contrary:

(1) Each physician must report to the Department of Health any judgment for medical negligence levied against the physician. The physician must make the report no later than 15 days after the exhaustion of the last opportunity for any party to appeal the judgment or request a rehearing.

(2) No later than 30 days after a physician has, within a 60-month period, made three reports as required by subsection (1), the Department of Health shall initiate an emergency investigation and the Board of Medicine shall conduct an emergency probable cause hearing to determine whether the

physician should be disciplined for a violation of s. 458.331(1)(t) or any other relevant provision of law.

Section 28. Present 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) Notwithstanding any other provision of this section, the department shall suspend the license of any osteopathic physician against whom has been entered a final judgment, arbitration award, or other order or who has entered into a settlement agreement to pay damages arising out of a claim for medical malpractice, if all appellate remedies have been exhausted and payment up to the amounts required by this section has not been made within 30 days after the entering of such judgment, award, or order or agreement, until proof of payment is received by the department or a payment schedule has been agreed upon by the osteopathic physician and the claimant and presented to the department. This subsection does not apply to an osteopathic physician who has met the financial responsibility requirements in paragraphs (1)(b) and (2)(b).

Section 29. 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 30. Section 459.0151, Florida Statutes, is created to read:

459.0151 Emergency procedures for disciplinary action.--Notwithstanding any other provision of law to the contrary:

(1) Each osteopathic physician must report to the Department of Health any judgment for medical negligence levied against the physician. The osteopathic physician must make the report no later than 15 days after the exhaustion of the last opportunity for any party to appeal the judgment or request a rehearing.

(2) No later than 30 days after an osteopathic physician has, within a 60-month period, made three reports as required by

subsection (1), the Department of Health shall initiate an emergency investigation and the Board of Osteopathic Medicine shall conduct an emergency probable cause hearing to determine whether the physician should be disciplined for a violation of s. 459.015(1)(x) or any other relevant provision of law.

Section 31. 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 32. 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 33. 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 34. Subsections (2) through (7) of section 624.155, Florida Statutes, are renumbered as subsections (3) through (8), respectively, and a new subsection (2) is added to said section to read:

624.155 Civil remedy.--

(2) In all matters under this section relating to professional liability insurance coverage for medical negligence, and in determining whether the insurer acted fairly

and honestly towards its insured with due regard for her or his interest:

(a)1. An insurer shall not be held in bad faith for failure to pay its policy limits if it offers to pay policy limits by the earlier of either:

a. The 365th day after service of the complaint in the medical negligence action upon the insured. The time period specified in this sub-subparagraph shall be extended by an additional 60 days upon motion of the insurer if the court finds that, at any time during such period and after the 305th day after service of the complaint, the claimant provided new information relating to the identity or testimony of any witnesses or the identity of any additional claimants or defendants. Such an extension may be ordered each time the claimant provides such new information after the 305th day after service of the complaint and before expiration of the time period provided in this sub-subparagraph, including any extensions thereof; or

b. The 60th day after the conclusion of all of the following:

(I) Deposition of all defendants named in the complaint or amended complaint.

(II) Deposition of all claimants named in the complaint or amended complaint or, in the case of a corporate defendant, deposition of a designated representative.

(III) Deposition of all of the claimant’s expert witnesses.

(IV) Deposition of treating physicians identified by the claimant as witnesses for trial.

(V) Disclosure of witnesses and production of documents.

(VI) Mediation.

2. Either party may request that the court enter an order finding that the other party has unnecessarily or inappropriately delayed any of the events specified in sub-subparagraph 1.b. If the court finds that the claimant was responsible for such unnecessary or inappropriate delays, sub-subparagraph 1.a. shall not apply to the insurer's offer to pay. If the court finds that the defendant or insurer was responsible for such unnecessary or inappropriate delays, sub-subparagraph 1.b. shall not apply to the insurer's offer to pay.

3. The fact that the insurer did not offer to pay policy limits during the time periods specified in this paragraph is not presumptive evidence that the insurer acted in bad faith.

(b) When paragraph (a) does not apply, the court, in determining whether an insurer has acted in bad faith, shall consider:

1. The insurer's willingness to negotiate with the claimant in anticipation of settlement.

2. The insurer's consideration of the advice of the insured's defense counsel.

3. The propriety of the insurer's methods of investigating and evaluating the claim.

4. Whether the insurer informed the insured of the offer to settle within the limits of coverage, the right to retain personal counsel, and the risk of litigation.

5. Whether the insured denied liability or requested that the case be defended after the insurer fully advised the insured as to the facts and risks.

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

7. Whether the claimant provided relevant information to the insurer on a timely basis.

8. Whether and when other defendants in the case settled or were dismissed from the case.

9. Whether there were multiple claimants seeking, in the aggregate, compensation in excess of policy limits from the defendant or the defendant's insurer.

10. Whether the insured misrepresented material facts to the insurer or made material omissions of fact to the insurer.

Upon motion of either party for good cause shown, the court may allow consideration of such additional factors as it determines to be relevant.

(c) In an action under this section brought by any person other than the insured or a third-party claimant to whom the insured has assigned his or her cause of action under paragraph (d), damages may not exceed the lesser of:

1. An amount equal to the insured's policy limits; or

2. An amount equal to the excess judgment in the action for medical negligence.

(d) Nothing in this subsection shall be construed to prohibit an insured from assigning a cause of action to a third-party claimant for the insurer's failure to act fairly and honestly towards its insured with due regard for the insured's interest.

(e) The award of damages under this subsection to all first-party claimants and third-party claimants combined shall not be in an aggregate amount exceeding the excess judgment.

Section 35. Subsection (2) of section 624.462, Florida Statutes, is amended to read:

624.462 Commercial self-insurance funds.--

(2) As used in ss. 624.460-624.488, "commercial self-insurance fund" or "fund" means a group of members, operating individually and collectively through a trust or corporation, that must be:

(a) Established by:

1. A not-for-profit trade association, industry association, or professional association of employers or professionals which has a constitution or bylaws, which is incorporated under the laws of this state, and which has been organized for purposes other than that of obtaining or providing insurance and operated in good faith for a continuous period of 1 year;

2. A self-insurance trust fund organized pursuant to s. 627.357 and maintained in good faith for a continuous period of 1 year for purposes other than that of obtaining or providing insurance pursuant to this section. Each member of a commercial self-insurance trust fund established pursuant to this subsection must maintain membership in the self-insurance trust fund organized pursuant to s. 627.357; ~~or~~

3. A group of 10 or more health care providers, as defined in s. 627.351(4)(h); or

4.~~3.~~ A not-for-profit group comprised of no less than 10 condominium associations as defined in s. 718.103(2), which is incorporated under the laws of this state, which restricts its membership to condominium associations only, and which has been organized and maintained in good faith for a continuous period of 1 year for purposes other than that of obtaining or providing insurance.

(b)1. In the case of funds established pursuant to

subparagraph (a)2. or subparagraph (a)4.~~3.~~, operated pursuant to a trust agreement by a board of trustees which shall have complete fiscal control over the fund and which shall be responsible for all operations of the fund. The majority of the trustees shall be owners, partners, officers, directors, or employees of one or more members of the fund. The trustees shall have the authority to approve applications of members for participation in the fund and to contract with an authorized administrator or servicing company to administer the day-to-day affairs of the fund.

2. In the case of funds established pursuant to subparagraph (a)1. or subparagraph (a)3., operated pursuant to a trust agreement by a board of trustees or as a corporation by a board of directors which board shall:

a. Be responsible to members of the fund or beneficiaries of the trust or policyholders of the corporation;

b. Appoint independent certified public accountants, legal counsel, actuaries, and investment advisers as needed;

c. Approve payment of dividends to members;

d. Approve changes in corporate structure; and

e. Have the authority to contract with an administrator authorized under s. 626.88 to administer the day-to-day affairs of the fund including, but not limited to, marketing, underwriting, billing, collection, claims administration, safety and loss prevention, reinsurance, policy issuance, accounting, regulatory reporting, and general administration. The fees or compensation for services under such contract shall be comparable to the costs for similar services incurred by insurers writing the same lines of insurance, or where available such expenses as filed by boards, bureaus, and associations

designated by insurers to file such data. A majority of the trustees or directors shall be owners, partners, officers, directors, or employees of one or more members of the fund.

Section 36. Subsections (7), (8), and (9) are added to section 627.062, Florida Statutes, to read:

627.062 Rate standards.--

(7)(a) The provisions of this subsection apply only with respect to rates for medical malpractice insurance and shall control to the extent of any conflict with other provisions of this section.

(b) Any portion of a judgment entered or settlement paid as a result of a statutory or common-law bad faith action and any portion of a judgment entered which awards punitive damages against an insurer may not be included in the insurer's rate base and shall not be used to justify a rate or rate change. Any common-law bad faith action identified as such and any portion of a settlement entered as a result of a statutory or 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 which 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.

(c) Upon reviewing a rate filing and determining whether the rate is excessive, inadequate, or unfairly discriminatory, the Office of Insurance Regulation shall consider, in accordance with generally accepted and reasonable actuarial techniques, past and present prospective loss experience, either using loss experience solely for this state or giving greater credibility

to this state's loss data.

(d) Rates shall be deemed excessive if, among other standards established by this section, the rate structure provides for replenishment of reserves or surpluses from premiums when the replenishment is attributable to investment losses.

(e) The insurer must apply a discount or surcharge based on the health care provider's loss experience or shall establish an alternative method giving due consideration to the provider's loss experience. The insurer must include in the filing a copy of the surcharge or discount schedule or a description of the alternative method used and must provide a copy of such schedule or description, as approved by the office, to policyholders at the time of renewal and to prospective policyholders at the time of application for coverage.

(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)(a) Medical malpractice insurance companies shall submit a rate filing effective January 1, 2004, 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 which reduces rates by a presumed factor that reflects the impact the changes contained in all medical malpractice legislation enacted by the Florida Legislature in 2003 will have on such rates, as determined by the Office of Insurance Regulation. In determining the presumed factor, the office shall use generally accepted actuarial techniques and standards provided in this section in determining the expected impact on losses, expenses, and

investment income of the insurer. Inclusion in the presumed factor of the expected impact of such legislation shall be held in abeyance during the review of such measure's validity in any proceeding by a court of competent jurisdiction.

(b) Any insurer or rating organization that contends that the rate provided for in subsection (1) is excessive, inadequate, or unfairly discriminatory shall separately state in its filing the rate it contends is appropriate and shall state with specificity the factors or data that 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 provided in this section in making any filing pursuant to this subsection. The Office of Insurance Regulation shall review each such exception and approve or disapprove it prior to use. It shall be the insurer's burden to actuarially justify any deviations from the rates filed under subsection (1). Each insurer or rating organization shall include in the filing the expected impact of all malpractice legislation enacted by the Florida Legislature in 2003 on losses, expenses, and rates. If any provision of this act is held invalid by a court of competent jurisdiction, the department shall permit an adjustment of all rates filed under this section to reflect the impact of such holding on such rates so as to ensure that the rates are not excessive, inadequate, or unfairly discriminatory.

Section 37. 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 38. Section 627.3575, Florida Statutes, is created to read:

627.3575 Health Care Professional Liability Insurance Facility.--

(1) FACILITY CREATED; PURPOSE; STATUS.--There is created the Health Care Professional Liability Insurance Facility. The facility is intended to meet ongoing availability and affordability problems relating to liability insurance for health care professionals by providing an affordable, self-supporting source of professional liability insurance coverage with a high deductible for those professionals who are willing and able to self-insure for smaller losses. The facility shall operate on a not-for-profit basis. The facility is self-funding and is intended to serve a public purpose but is not a state agency or program, and no activity of the facility shall create any state liability.

(2) GOVERNANCE; POWERS.--

(a) The facility shall operate under a seven-member board of governors consisting of the Secretary of Health, three members appointed by the Governor, and three members appointed by the Chief Financial Officer. The board shall be chaired by the Secretary of Health. The secretary shall serve by virtue of his or her office, and the other members of the board shall

serve terms concurrent with the term of office of the official who appointed them. Any vacancy on the board shall be filled in the same manner as the original appointment. Members serve at the pleasure of the official who appointed them. Members are not eligible for compensation for their service on the board, but the facility may reimburse them for per diem and travel expenses at the same levels as are provided in s. 112.061 for state employees.

(b) The facility shall have such powers as are necessary to operate as an insurer, including the power to:

1. Sue and be sued.

2. Hire such employees and retain such consultants, attorneys, actuaries, and other professionals as it deems appropriate.

3. Contract with such service providers as it deems appropriate.

4. Maintain offices appropriate to the conduct of its business.

5. Take such other actions as are necessary or appropriate in fulfillment of its responsibilities under this section.

(3) COVERAGE PROVIDED.--The facility shall provide liability insurance coverage for health care professionals. The facility shall allow policyholders to select only from policies with deductibles of $25,000 per claim, $50,000 per claim, and $100,000 per claim and with coverage limits of $250,000 per claim and $750,000 annual aggregate and $1 million per claim and $3 million annual aggregate. To the greatest extent possible, the terms and conditions of the policies shall be consistent with terms and conditions commonly used by professional liability insurers.

(4) ELIGIBILITY; TERMINATION.--

(a) Any health care professional is eligible for coverage provided by the facility if the professional at all times maintains either:

1. An escrow account consisting of cash or assets eligible for deposit under s. 625.52 in an amount equal to the deductible amount of the policy; or

2. An unexpired, irrevocable letter of credit, established pursuant to chapter 675, in an amount not less than the deductible amount of the policy. The letter of credit shall be payable to the health care professional as beneficiary upon presentment of a final judgment indicating liability and awarding damages to be paid by the physician or upon presentment of a settlement agreement signed by all parties to such agreement when such final judgment or settlement is a result of a claim arising out of the rendering of, or the failure to render, medical care and services. Such letter of credit shall be nonassignable and nontransferable. Such letter of credit shall be issued by any bank or savings association organized and existing under the laws of this state or any bank or savings association organized under the laws of the United States that has its principal place of business in this state or has a branch office which is authorized under the laws of this state or of the United States to receive deposits in this state.

(b) The eligibility of a health care professional for coverage terminates upon:

1. The failure of the professional to comply with paragraph (a);

2. The failure of the professional to timely pay premiums or assessments; or

3. The commission of any act of fraud in connection with the policy, as determined by the board of governors.

(c) The board of governors, in its discretion, may reinstate the eligibility of a health care professional whose eligibility has terminated pursuant to paragraph (b) upon determining that the professional has come back into compliance with paragraph (a) or has paid the overdue premiums or assessments. Eligibility may be reinstated in the case of fraud only if the board determines that its initial determination of fraud was in error.

(5) PREMIUMS; ASSESSMENTS.--

(a) The facility shall charge the actuarially indicated rate for the coverage provided plus a component for debt service and shall retain the services of consulting actuaries to prepare its rate filings. The facility shall not provide dividends to policyholders, and, to the extent that premiums are more than the amount required to cover claims and expenses, such excess shall be retained by the facility for payment of future claims. In the event of dissolution of the facility, any amounts not required as a reserve for outstanding claims shall be transferred to the policyholders of record as of the last day of operation.

(b) In the event that the premiums for a particular year, together with any investment income or reinsurance recoveries attributable to that year, are insufficient to pay losses arising out of claims accruing in that year, the facility shall levy assessments against all of the persons who were its policyholders in that year in a uniform percentage of premium. Each policyholder's assessment shall be such percentage of the premium that policyholder paid for coverage for the year to

which the insufficiency is attributable.

(c) The policyholder is personally liable for any assessment. The failure to timely pay an assessment is grounds for suspension or revocation of the policyholder's professional license by the appropriate licensing entity.

(6) REGULATION; APPLICABILITY OF OTHER STATUTES.--

(a) The facility shall operate pursuant to a plan of operation approved by order of the Office of Insurance Regulation of the Financial Services Commission. The board of governors may at any time adopt amendments to the plan of operation and submit the amendments to the Office of Insurance Regulation for approval.

(b) The facility is subject to regulation by the Office of Insurance Regulation of the Financial Services Commission in the same manner as other insurers, except that, in recognition of the fact that its ability to levy assessments against its own policyholders is a substitute for the protections ordinarily afforded by such statutory requirements, the facility is exempt from statutory requirements relating to surplus as to policyholders.

(c) The facility is not subject to part II of chapter 631, relating to the Florida Insurance Guaranty Association.

(d) The Financial Service Commission may adopt rules to provide for the regulation of the facility consistent with the provisions of this section.

(7) STARTUP PROVISIONS.--

(a) It is the intent of the Legislature that the facility begin providing coverage no later than January 1, 2004.

(b) The Governor and the Chief Financial Officer shall make their appointments to the board of governors of the

facility no later than August 1, 2003. Until the board is appointed, the Secretary of Health may perform ministerial acts on behalf of the facility as chair of the board of governors.

(c) Until the facility is able to hire permanent staff and enter into contracts for professional services, the office of the Secretary of Health shall provide support services to the facility.

(d) In order to provide startup funds for the facility, the board of governors may incur debt or enter into agreements for lines of credit, provided that the sole source of funds for repayment of any debt is future premium revenues of the facility. The amount of such debt or lines of credit may not exceed $10 million.

Section 39. 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 90 ~~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 90 ~~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.

(d) A clause requiring the insurer or self-insurer to notify the insured no less than 60 days prior to the effective date of a rate increase. The provisions of s. 627.4133 shall apply to such notice and to the failure of the insurer to provide such notice to the extent not in conflict with this section.

Section 40. 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 41. 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 42. 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) Except in cases in which the health care provider is an employee of the health maintenance organization, the fact that the 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 the health care provider and the health

maintenance organization for purposes of vicarious liability for the medical negligence of the 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 43. 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. Except in cases in which the health care provider is an employee of the health maintenance organization, the health maintenance organization shall not be vicariously liable for the medical negligence of the health care provider, whether such claim is alleged under a theory of actual agency, apparent agency, or employer-employee relationship.

Section 44. Section 766.102, Florida Statutes, is amended to read:

766.102 Medical negligence; standards of recovery; expert witness.--

(1) In any action for recovery of damages based on the death or personal injury of any person in which it is alleged that such death or injury resulted from the negligence of a health care provider as defined in s. 768.50(2)(b), the claimant shall have the burden of proving by the greater weight of evidence that the alleged actions of the health care provider represented a breach of the prevailing professional standard of care for that health care provider. The prevailing professional standard of care for a given health care provider shall be that level of care, skill, and treatment which, in light of all relevant surrounding circumstances, is recognized as acceptable and appropriate by reasonably prudent similar health care providers.

~~(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.~~

~~(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.~~

~~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.~~

(2)~~(3)~~(a) If the injury is claimed to have resulted from the negligent affirmative medical intervention of the health

care provider, the claimant must, in order to prove a breach of the prevailing professional standard of care, show that the injury was not within the necessary or reasonably foreseeable results of the surgical, medicinal, or diagnostic procedure constituting the medical intervention, if the intervention from which the injury is alleged to have resulted was carried out in accordance with the prevailing professional standard of care by a reasonably prudent similar health care provider.

(b) The provisions of this subsection shall apply only when the medical intervention was undertaken with the informed consent of the patient in compliance with the provisions of s. 766.103.

(3)~~(4)~~ The existence of a medical injury shall not create any inference or presumption of negligence against a health care provider, and the claimant must maintain the burden of proving that an injury was proximately caused by a breach of the prevailing professional standard of care by the health care provider. However, the discovery of the presence of a foreign body, such as a sponge, clamp, forceps, surgical needle, or other paraphernalia commonly used in surgical, examination, or diagnostic procedures, shall be prima facie evidence of negligence on the part of the health care provider.

(4)~~(5)~~ The Legislature is cognizant of the changing trends and techniques for the delivery of health care in this state and the discretion that is inherent in the diagnosis, care, and treatment of patients by different health care providers. The failure of a health care provider to order, perform, or administer supplemental diagnostic tests shall not be actionable if the health care provider acted in good faith and with due regard for the prevailing professional standard of care.

(5) A person may not give expert testimony concerning the prevailing professional standard of care unless that person is a licensed health care provider and meets the following criteria:

(a) If the party against whom or on whose behalf the testimony is offered is a specialist, the expert witness must:

1. Specialize in the same specialty as the party against whom or on whose behalf the testimony is offered; or

2. Specialize in a similar specialty that includes the evaluation, diagnosis, or treatment of the medical condition that is the subject of the claim and have prior experience treating similar patients.

(b) Has devoted professional time during the 3 years immediately preceding the date of the occurrence that is the basis for the action to:

1. The active clinical practice of, or consulting with respect to, the same or similar health profession as the health care provider against whom or on whose behalf the testimony is offered and, if that health care provider is a specialist, the active clinical practice of, or consulting with respect to, the same or similar specialty that includes the evaluation, diagnosis, or treatment of the medical condition that is the subject of the claim and have prior experience treating similar patients;

2. The instruction of students in an accredited health professional school or accredited residency program in the same or similar health profession in which the health care provider against whom or on whose behalf the testimony is offered and, if that health care provider is a specialist, an accredited health professional school or accredited residency or clinical research program in the same or similar specialty; or

3. A clinical research program that is affiliated with an accredited medical school or teaching hospital and that is in the same or similar health profession as the health care provider against whom or on whose behalf the testimony is offered and, if that health care provider is a specialist, a clinical research program that is affiliated with an accredited health professional school or accredited residency or clinical research program in the same or similar specialty.

(c) If the party against whom or on whose behalf the testimony is offered is a general practitioner, the expert witness must have devoted professional time during the 5 years immediately preceding the date of the occurrence that is the basis for the action to:

1. Active clinical practice or consultation as a general practitioner;

2. Instruction of students in an accredited health professional school or accredited residency program in the general practice of medicine; or

3. A clinical research program that is affiliated with an accredited medical school or teaching hospital and that is in the general practice of medicine.

(6) A physician licensed under chapter 458 or chapter 459 who qualifies as an expert witness under subsection (5) and who, by reason of active clinical practice or instruction of students, has knowledge of the applicable standard of care for nurses, nurse practitioners, certified registered nurse anesthetists, certified registered nurse midwives, physician assistants, or other medical support staff may give expert testimony in a medical malpractice action with respect to the standard of care of such medical support staff.

(7) Notwithstanding subsection (5), in a medical malpractice action against a hospital, health care facility, or medical facility, a person may give expert testimony on the appropriate standard of care as to administrative and other nonclinical issues if the person has substantial knowledge, by virtue of his or her training and experience, concerning the standard of care among hospitals, health care facilities, or medical facilities of the same type as the hospital, health care facility, or medical facility whose acts or omissions are the subject of the testimony and which are located in the same or similar communities at the time of the alleged act giving rise to the cause of action.

(8) If a health care provider described in subsection (5), subsection (6), or subsection (7) is providing evaluation, treatment, or diagnosis for a condition that is not within his or her specialty, a specialist trained in the evaluation, treatment, or diagnosis for that condition shall be considered a similar health care provider.

(9)~~(6)~~(a) In any action for damages involving a claim of negligence against a physician licensed under chapter 458, osteopathic physician licensed under chapter 459, podiatric physician licensed under chapter 461, or chiropractic physician licensed under chapter 460 providing emergency medical services in a hospital emergency department, the court shall admit expert medical testimony only from physicians, osteopathic physicians, podiatric physicians, and chiropractic physicians who have had substantial professional experience within the preceding 5 years while assigned to provide emergency medical services in a hospital emergency department.

(b) For the purposes of this subsection:

1. The term "emergency medical services" means those medical services required for the immediate diagnosis and treatment of medical conditions which, if not immediately diagnosed and treated, could lead to serious physical or mental disability or death.

2. "Substantial professional experience" shall be determined by the custom and practice of the manner in which emergency medical coverage is provided in hospital emergency departments in the same or similar localities where the alleged negligence occurred.

(10) In any action alleging medical malpractice, an expert witness may not testify on a contingency fee basis.

(11) Any attorney who proffers a person as an expert witness pursuant to this section must certify that such person has not been found guilty of fraud or perjury in any jurisdiction.

(12) This section does not limit the power of the trial court to disqualify or qualify an expert witness on grounds other than the qualifications in this section.

Section 45. Subsections (2), (3), (4), and (7) of section 766.106, Florida Statutes, are amended, and subsections (13) and (14) are 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.--

(2)(a) After completion of presuit investigation pursuant to s. 766.203 and prior to filing a claim for medical malpractice, a claimant shall notify each prospective defendant by certified mail, return receipt requested, of intent to initiate litigation for medical malpractice. Notice to each

prospective defendant must include, if available, a list of all known health care providers seen by the claimant for the injuries complained of subsequent to the alleged act of malpractice, a list of all known health care providers during the 2-year period prior to the alleged act of malpractice who treated or evaluated the claimant, and copies of all of the medical records relied upon by the expert in signing the affidavit. The requirement of providing the list of known health care providers may not serve as grounds for imposing sanctions for failure to provide presuit discovery.

(b) Following the initiation of a suit alleging medical malpractice with a court of competent jurisdiction, and service of the complaint upon a defendant, the claimant shall provide a copy of the complaint to the Department of Health. The requirement of providing the complaint to the Department of Health does not impair the claimant's legal rights or ability to seek relief for his or her claim. The Department of Health shall review each incident and determine whether it involved conduct by a licensee which is potentially subject to disciplinary action, in which case the provisions of s. 456.073 apply.

(3)(a) No suit may be filed for a period of 120 ~~90~~ days after notice is mailed to any prospective defendant. During the 120-day ~~90-day~~ period, the prospective defendant's insurer or self-insurer shall conduct a review to determine the liability of the defendant. Each insurer or self-insurer shall have a procedure for the prompt investigation, review, and evaluation of claims during the 120-day ~~90-day~~ period. This procedure shall include one or more of the following:

1. Internal review by a duly qualified claims adjuster;

2. Creation of a panel comprised of an attorney

knowledgeable in the prosecution or defense of medical malpractice actions, a health care provider trained in the same or similar medical specialty as the prospective defendant, and a duly qualified claims adjuster;

3. A contractual agreement with a state or local professional society of health care providers, which maintains a medical review committee;

4. Any other similar procedure which fairly and promptly evaluates the pending claim.

Each insurer or self-insurer shall investigate the claim in good faith, and both the claimant and prospective defendant shall cooperate with the insurer in good faith. If the insurer requires, a claimant shall appear before a pretrial screening panel or before a medical review committee and shall submit to a physical examination, if required. Unreasonable failure of any party to comply with this section justifies dismissal of claims or defenses. There shall be no civil liability for participation in a pretrial screening procedure if done without intentional fraud.

(b) At or before the end of the 120 ~~90~~ days, the insurer or self-insurer shall provide the claimant with a response:

1. Rejecting the claim;

2. Making a settlement offer; or

3. Making an offer to arbitrate, in which case liability is deemed admitted and arbitration will be held only ~~of admission of liability and for arbitration~~ on the issue of damages. This offer may be made contingent upon a limit of general damages.

(c) The response shall be delivered to the claimant if not

represented by counsel or to the claimant's attorney, by certified mail, return receipt requested. Failure of the prospective defendant or insurer or self-insurer to reply to the notice within 120 ~~90~~ days after receipt shall be deemed a final rejection of the claim for purposes of this section.

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

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

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

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

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

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

(4) The notice of intent to initiate litigation shall be served within the time limits set forth in s. 95.11. However, during the 120-day ~~90-day~~ period, the statute of limitations is tolled as to all potential defendants. Upon stipulation by the parties, the 120-day ~~90-day~~ period may be extended and the statute of limitations is tolled during any such extension. Upon receiving notice of termination of negotiations in an extended period, the claimant shall have 60 days or the remainder of the period of the statute of limitations, whichever is greater, within which to file suit.

(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. 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.

(b) *Documents or things.*--Any party may request discovery of documents or things. The documents or things must be produced, at the expense of the requesting party, within 20 days after the date of receipt of the request. A party is required to produce discoverable documents or things within that party's possession or control.

(c) *Physical and mental examinations.*--A prospective defendant may require an injured prospective claimant to appear for examination by an appropriate health care provider. The defendant shall give reasonable notice in writing to all parties as to the time and place for examination. Unless otherwise impractical, a prospective claimant is required to submit to only one examination on behalf of all potential defendants. The

practicality of a single examination must be determined by the nature of the potential claimant's condition, as it relates to the liability of each potential defendant. Such examination report is available to the parties and their attorneys upon payment of the reasonable cost of reproduction and may be used only for the purpose of presuit screening. Otherwise, such examination report is confidential and exempt from the provisions of s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

(d) Written questions.--Any party may request answers to written questions, the number of which may not exceed 30, including subparts. A response must be made within 20 days after receipt of the questions.

(13) Failure to cooperate on the part of any party during the presuit investigation may be grounds to strike any claim made, or defense raised, by such party in suit.

(14) The claimant must execute a medical information release that allows a defendant or his or her legal representative to obtain unsworn statements of the claimant's treating physicians, which statements must be limited to those areas that are potentially relevant to the claim of personal injury or wrongful death. A defendant must give reasonable notice to the claimant before obtaining unsworn statements from a claimant's treating physician.

Section 46. Section 766.1065, Florida Statutes, is created to read:

766.1065 Mandatory staging of presuit investigation and mandatory mediation.--

(1) Within 30 days after service of the presuit notice of intent to initiate medical malpractice litigation, each party

shall voluntarily produce to all other parties, without being requested, any and all medical, hospital, health care, and employment records concerning the claimant in the disclosing party's possession, custody, or control, and the disclosing party shall affirmatively certify in writing that the records produced include all records in that party's possession, custody, or control or that the disclosing party has no medical, hospital, health care, or employment records concerning the claimant.

(a) Subpoenas may be issued according to the Florida Rules of Civil Procedure as though suit had been filed for the limited purpose of obtaining copies of medical, hospital, health care, and employment records of the claimant. The party shall indicate on the subpoena that it is being issued in accordance with the presuit procedures of this section and shall not be required to include a case number.

(b) Nothing in this section shall limit the ability of any party to use any other available form of presuit discovery available under this chapter or the Florida Rules of Civil Procedure.

(2) Within 60 days after service of the presuit notice of intent to initiate medical malpractice litigation, all parties must be made available for a sworn deposition. Such deposition may not be used in a civil suit for medical negligence.

(3) Within 90 days after service of the presuit notice of intent to initiate medical malpractice litigation, each party's corroborating expert, who will otherwise be tendered as the expert complying with the affidavit provisions set forth in s. 766.203, must be made available for a sworn deposition.

(a) The expenses associated with the expert's time and

travel in preparing for and attending such deposition shall be the responsibility of the party retaining such expert.

(b) An expert shall be deemed available for deposition if suitable accommodations can be made for appearance of said expert via real-time video technology.

Section 47. 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 48. Section 766.118, Florida Statutes, is created to read:

766.118 Determination of noneconomic damages.--

(1) With respect to a cause of action for personal injury or wrongful death arising from medical negligence by physicians licensed under chapter 458 or chapter 459, regardless of the number of such defendant physicians, noneconomic damages, as defined in s. 766.202(7), shall not exceed $250,000 per claimant, provided that the total noneconomic damages recoverable by all claimants from all such physicians shall not exceed $500,000.

(2) With respect to a cause of action for personal injury or wrongful death arising from medical negligence by defendants other than physicians licensed under chapter 458 or chapter 459, regardless of the number of such nonphysician defendants, noneconomic damages, as defined in s. 766.202(7), shall not

exceed $250,000 per claimant, provided that the total noneconomic damages recoverable by all claimants from all such nonphysician defendants shall not exceed $500,000.

(3) Notwithstanding subsections (1) and (2), with respect to a cause of action for personal injury or wrongful death arising from medical negligence by physicians licensed under chapter 458 or chapter 459 providing emergency services and care, as defined in s. 395.002(10), regardless of the number of such defendant physicians, noneconomic damages, as defined in s. 766.202(7), shall not exceed $100,000 per claimant, provided that the total noneconomic damages recoverable by all claimants from all such physicians shall not exceed $250,000.

(4) Notwithstanding subsections (1) and (2), with respect to a cause of action for personal injury or wrongful death arising from medical negligence by defendants, other than physicians licensed under chapter 458 or chapter 459, providing emergency services and care pursuant to obligations imposed by ss. 395.1041 and 401.45, regardless of the number of such nonphysician defendants, noneconomic damages, as defined in s. 766.202(7), shall not exceed $250,000 per claimant, provided that the total noneconomic damages recoverable by all claimants from all such nonphysician defendants shall not exceed $500,000.

(5) For the purpose of determining the limitations on noneconomic damages set forth in this section, the term "physician licensed under chapter 458 or chapter 459" includes any person for whom a physician licensed under chapter 458 or chapter 459 is vicariously liable and any person whose liability is based solely on such person being vicariously liable for the actions of a physician licensed under chapter 458 or chapter 459 or the actions of a person for whom a physician licensed under

chapter 458 or chapter 459 is vicariously liable.

(6) This section shall not apply to actions governed by s. 768.28.

Section 49. 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 ~~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 and future noneconomic losses may contractually obligate a company that is authorized to do business in this state 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 or the company that is responsible for the periodic payments cannot adequately ensure full and continuous payments thereof, 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 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. ~~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 50. Subsections (2) and (3) of section 766.203, Florida Statutes, are amended to read:

766.203 Presuit investigation of medical negligence claims and defenses by prospective parties.--

(2) Prior to issuing notification of intent to initiate medical malpractice litigation pursuant to s. 766.106, the claimant shall conduct an investigation to ascertain that there are reasonable grounds to believe that:

(a) Any named defendant in the litigation was negligent in the care or treatment of the claimant; and

(b) Such negligence resulted in injury to the claimant.

Corroboration of reasonable grounds to initiate medical negligence litigation shall be provided by the claimant's submission of a verified written medical expert opinion from a medical expert as defined in s. 766.202(5), at the time the notice of intent to initiate litigation is mailed, which statement shall corroborate reasonable grounds to support the claim of medical negligence. This opinion and statement are subject to discovery.

(3) Prior to issuing its response to the claimant's notice of intent to initiate litigation, during the time period for response authorized pursuant to s. 766.106, the defendant or the defendant's insurer or self-insurer shall conduct an investigation to ascertain whether there are reasonable grounds to believe that:

(a) The defendant was negligent in the care or treatment of the claimant; and

(b) Such negligence resulted in injury to the claimant.

Corroboration of lack of reasonable grounds for medical negligence litigation shall be provided with any response rejecting the claim by the defendant's submission of a verified written medical expert opinion from a medical expert as defined in s. 766.202(5), at the time the response rejecting the claim is mailed, which statement shall corroborate reasonable grounds for lack of negligent injury sufficient to support the response denying negligent injury. This opinion and statement are subject to discovery.

Section 51. Section 766.206, Florida Statutes, is amended to read:

766.206 Presuit investigation of medical negligence claims and defenses by court.--

(1) After the completion of presuit investigation by the parties pursuant to s. 766.203 and any informal discovery pursuant to s. 766.106, any party may file a motion in the circuit court requesting the court to determine whether the opposing party's claim or denial rests on a reasonable basis.

(2) If the court finds that the notice of intent to initiate litigation mailed by the claimant is not in compliance with the reasonable investigation requirements of ss. 766.201-766.212, including a review of the claim and a verified written medical expert opinion by a medical expert as defined in s. 766.202, the court shall dismiss the claim, and the person who mailed such notice of intent, whether the claimant or the claimant's attorney, shall be personally liable for all attorney's fees and costs incurred during the investigation and evaluation of the claim, including the reasonable attorney's fees and costs of the defendant or the defendant's insurer.

(3) If the court finds that the response mailed by a

defendant rejecting the claim is not in compliance with the reasonable investigation requirements of ss. 766.201-766.212, including a review of the claim and a verified written medical expert opinion by a medical expert as defined in s. 766.202, the court shall strike the defendant's pleading. ~~response, and~~ The person who mailed such response, whether the defendant, the defendant's insurer, or the defendant's attorney, shall be personally liable for all attorney's fees and costs incurred during the investigation and evaluation of the claim, including the reasonable attorney's fees and costs of the claimant.

(4) If the court finds that an attorney for the claimant mailed notice of intent to initiate litigation without reasonable investigation, or filed a medical negligence claim without first mailing such notice of intent which complies with the reasonable investigation requirements, or if the court finds that an attorney for a defendant mailed a response rejecting the claim without reasonable investigation, the court shall submit its finding in the matter to The Florida Bar for disciplinary review of the attorney. Any attorney so reported three or more times within a 5-year period shall be reported to a circuit grievance committee acting under the jurisdiction of the Supreme Court. If such committee finds probable cause to believe that an attorney has violated this section, such committee shall forward to the Supreme Court a copy of its finding.

(5)(a) If the court finds that the corroborating written medical expert opinion attached to any notice of claim or intent or to any response rejecting a claim lacked reasonable investigation, or that the medical expert submitting the opinion did not meet the expert witness qualifications as set forth in s. 766.202(5), the court shall report the medical expert issuing

such corroborating opinion to the Division of Medical Quality Assurance or its designee. If such medical expert is not a resident of the state, the division shall forward such report to the disciplining authority of that medical expert.

(b) The court shall ~~may~~ refuse to consider the testimony or opinion attached to any notice of intent or to any response rejecting a claim of ~~such~~ an expert who has been disqualified three times pursuant to this section.

Section 52. Subsections (2), (3), and (7) of section 766.207, Florida Statutes, are amended to read:

766.207 Voluntary binding arbitration of medical negligence claims.--

(2) Upon the completion of presuit investigation with preliminary reasonable grounds for a medical negligence claim intact, the parties may elect to have damages determined by an arbitration panel. Such election may be initiated by either party by serving a request for voluntary binding arbitration of damages within 120 ~~90~~ days after service of the claimant's notice of intent to initiate litigation upon the defendant. The evidentiary standards for voluntary binding arbitration of medical negligence claims shall be as provided in ss. 120.569(2)(g) and 120.57(1)(c).

(3) Upon receipt of a party's request for such arbitration, the opposing party may accept the offer of voluntary binding arbitration within 30 days. However, in no event shall the defendant be required to respond to the request for arbitration sooner than 120 ~~90~~ days after service of the notice of intent to initiate litigation under s. 766.106. Such acceptance within the time period provided by this subsection shall be a binding commitment to comply with the decision of the

arbitration panel. The liability of any insurer shall be subject to any applicable insurance policy limits.

(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.

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

(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 53. Paragraph (a) of subsection (3) of section

766.209, Florida Statutes, is amended to read:

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

(3) If the defendant refuses a claimant's offer of voluntary binding arbitration:

(a) The claim shall proceed to trial ~~without limitation on damages~~, and the claimant, upon proving medical negligence, shall be entitled to recover prejudgment interest, and reasonable attorney's fees up to 25 percent of the award reduced to present value. Noneconomic damages at trial are subject to the limitations in s. 766.118.

Section 54. 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 55. 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, or if the claimant accepts an award issued pursuant to s. 766.31, 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 56. 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 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 57. 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, 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, 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.

Section 58. 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 received by the association by January 31 of any calendar year, the participating physician shall qualify as a participating physician for that entire calendar year. If the payment is received after 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 59. 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 60. 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.

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) 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 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.

(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 paragraph (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; and

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; and

2. Future noneconomic losses and the number of years or part thereof which the award is intended to cover; and

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

if applicable.

Section 63. Subsection (2) and paragraph (a) of subsection (1) of section 768.78, Florida Statutes, is 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 either or both the ~~all damages so assessed, with~~ future economic

and future noneconomic losses 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, but without regard for the number of years awarded by the trier of fact. The court shall review and approve the amounts and schedule of the periodic payments proposed by the defendant, or modify such amounts and schedule, so that they are fair and equitable to the claimant under all the facts and circumstances.

(b) A defendant that elects to make periodic payments of either or both future economic and future noneconomic losses may contractually obligate a company that is authorized to do business in this state 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 hereto, 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 or the company that is responsible for the periodic payments cannot adequately ensure full and continuous payments thereof, 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 ~~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) 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 64. Subsection (1) of section 766.112, Florida Statutes, is amended to read:

766.112 Comparative fault.--

(1) 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 65. 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 66. 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 67. 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 68. Paragraph (c) of subsection (2) of section 1006.20, Florida Statutes, as amended by section 2 of chapter 2003-129, Laws of Florida, is amended to read:

1006.20 Athletics in public K-12 schools.--

(2) ADOPTION OF BYLAWS.--

(c) The organization shall adopt bylaws that require all students participating in interscholastic athletic competition or who are candidates for an interscholastic athletic team to satisfactorily pass a medical evaluation each year prior to participating in interscholastic athletic competition or

engaging in any practice, tryout, workout, or other physical activity associated with the student's candidacy for an interscholastic athletic team. Such medical evaluation can only be administered by a practitioner licensed under the provisions of chapter 458, chapter 459, chapter 460, or s. 464.012, and in good standing with the practitioner's regulatory board. The bylaws shall establish requirements for eliciting a student's medical history and performing the medical evaluation required under this paragraph, which shall include a physical assessment of the student's physical capabilities to participate in interscholastic athletic competition as contained in a uniform preparticipation physical evaluation and history form. The evaluation form shall incorporate the recommendations of the American Heart Association for participation cardiovascular screening and shall provide a place for the signature of the practitioner performing the evaluation with an attestation that each examination procedure listed on the form was performed by the practitioner or by someone under the direct supervision of the practitioner. The form shall also contain a place for the practitioner to indicate if a referral to another practitioner was made in lieu of completion of a certain examination procedure. The form shall provide a place for the practitioner to whom the student was referred to complete the remaining sections and attest to that portion of the examination. The preparticipation physical evaluation form shall advise students to complete a cardiovascular assessment and shall include information concerning alternative cardiovascular evaluation and diagnostic tests. ~~Practitioners administering medical evaluations pursuant to this subsection must, at a minimum, solicit all information required by, and perform a physical~~

~~assessment according to, the uniform preparticipation form referred to in this paragraph and must certify, based on the information provided and the physical assessment, that the student is physically capable of participating in interscholastic athletic competition. If the practitioner determines that there are any abnormal findings in the cardiovascular system, the student may not participate until a further cardiovascular assessment, which may include an EKG, is performed which indicates that the student is physically capable of participating in interscholastic athletic competition.~~ Results of such medical evaluation must be provided to the school. No student shall be eligible to participate in any interscholastic athletic competition or engage in any practice, tryout, workout, or other physical activity associated with the student's candidacy for an interscholastic athletic team until the results of the medical evaluation ~~clearing the student for participation~~ have ~~has~~ been received and approved by the school.

Section 69. 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 or a health care practitioner as defined in section 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. However, information, documents, or records otherwise available from original sources are not immune from discovery or use in any civil or administrative action merely because they were also collected, analyzed, or presented to a patient safety organization. Any person who testifies before a patient safety organization or who is a member of such a group may not be prevented from testifying as to matters within his or her knowledge, but he or she may not be asked about his or her testimony before a patient safety organization or the opinions formed by him or her as a result of the hearings.

(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 or health care practitioners as defined in section 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) Reports 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 70. The Division of Administrative Hearings shall designate at least two administrative law judges who shall specifically preside over actions involving the Department of Health or boards within the Department of Health. Each designated administrative law judge must be a member of The Florida Bar in good standing and must have legal, managerial, or clinical experience in issues related to health care or have attained board certification in health care law from The Florida Bar.

Section 71. (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 (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 72. (1) The Agency for Health Care Administration shall conduct or contract for a study to determine what information is most feasible to provide to the public comparing state-licensed hospitals on certain inpatient quality indicators developed by the federal Agency for Healthcare Research and Quality. Such indicators shall be designed to identify information about specific procedures performed in hospitals for which there is strong evidence of a link to quality of care. The Agency for Health Care Administration or the study contractor shall refer to the hospital quality reports published in New York and Texas as guides during the evaluation.

(2) The following concepts shall be specifically addressed in the study report:

(a) Whether hospital discharge data about services can be translated into understandable and meaningful information for the public.

(b) Whether the following measures are useful consumer guides relating to care provided in state-licensed hospitals:

1. Inpatient mortality for medical conditions;

2. Inpatient mortality for procedures;

3. Utilization of procedures for which there are questions of overuse, underuse, or misuse; and

4. Volume of procedures for which there is evidence that a higher volume of procedures is associated with lower mortality.

(c) Whether there are quality indicators that are particularly useful relative to the state's unique demographics.

(d) Whether all hospitals should be included in the

comparison.

(e) The criteria for comparison.

(f) Whether comparisons are best within metropolitan statistical areas or some other geographic configuration.

(g) Identify several websites to which such a report should be published to achieve the broadest dissemination of the information.

(3) The Agency for Health Care Administration shall consider the input of all interested parties, including hospitals, physicians, consumer organizations, and patients, and submit the final report to the Governor and the presiding officers of the Legislature by January 1, 2004.

Section 73. 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)1. As a statewide goal of reducing the occurrence of

medication error, inventory hospitals to determine the current status of implementation of computerized physician medication ordering systems, barcode point of care systems, or other technological patient safety implementation, and recommend a plan for expediting implementation statewide or, in hospitals where the agency determines that implementation of such systems is not practicable, alternative methods to reduce medication errors. The agency shall identify in its plan any barriers to statewide implementation and shall include recommendations to the Legislature of statutory changes that may be necessary to eliminate those barriers. The agency will review newly developed plans for compliance with statewide initiatives and to determine both the commitment of the health care facility staff and the capability of the facility to successfully coordinate and implement these plans, especially from a technological perspective.

2. “Medication error” is any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional, patient, or consumer. Such events may be related to professional practice, health care products, health care procedures, and health care systems, each of which may include the prescribing of medications and order communications; product labeling; product packaging; the nomenclature, compounding, dispensing, distribution, administration, and use of medications; and education and monitoring related thereto.

(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 Legislature by February 1, 2004. In its report, the agency shall include specific findings, recommendations, and proposed legislation.

Section 74. 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 Legislature by January 1, 2004, recommending whether 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 75. Civil immunity for members of or consultants to certain boards, committees, or other entities.--

(1) Each member of, or health care professional consultant to, any committee, board, group, commission, or other entity shall be immune from civil liability for any act, decision, omission, or utterance done or made in performance of his or her duties while serving as a member of or consultant to such committee, board, group, commission, or other entity established and operated for purposes of quality improvement review, evaluation, and planning in a state-licensed health care facility. Such entities must function primarily to review, evaluate, or make recommendations relating to:

(a) The duration of patient stays in health care facilities;

(b) The professional services furnished with respect to the medical, dental, psychological, podiatric, chiropractic, or optometric necessity for such services;

(c) The purpose of promoting the most efficient use of available health care facilities and services;

(d) The adequacy or quality of professional services;

(e) The competency and qualifications for professional staff privileges;

(f) The reasonableness or appropriateness of charges made by or on behalf of health care facilities; or

(g) Patient safety, including entering into contracts with patient safety organizations.

(2) Such committee, board, group, commission, or other entity must be established in accordance with state law or in accordance with requirements of the Joint Commission on

Accreditation of Healthcare Organizations, established and duly constituted by one or more public or licensed private hospitals or behavioral health agencies, or established by a governmental agency. To be protected by this section, the act, decision, omission, or utterance may not be made or done in bad faith or with malicious intent.

Section 76. 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 section 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 Legislature by January 1, 2005.

Section 77. No later than September 1, 2003, the Department of Health shall convene a workgroup to study the current health care practitioner disciplinary process. The workgroup shall include a representative of the Administrative Law section of The Florida Bar, a representative of the Health Law section of The Florida Bar, a representative of the Florida Medical Association, a representative of the Florida Osteopathic Medical Association, a representative of the Florida Dental Association, a member of the Florida Board of Medicine who has served on the probable cause panel, a member of the Board of Osteopathic Medicine who has served on the probable cause panel, and a member of the Board of Dentistry who has served on the probable cause panel. The workgroup shall also include one consumer member of the Board of Medicine. The Department of Health shall present the findings and recommendations to the Governor, the President of the Senate, and the Speaker of the

House of Representatives no later than January 1, 2004. The sponsoring organizations shall assume the costs of their representatives.

Section 78. 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. The Legislature finds that providers of emergency medical services and care are critical elements in responding to disaster and emergency situations that might affect our local communities, state, and country. The Legislature recognizes the importance of maintaining a viable system of providing for the emergency medical needs of residents of this state and visitors to this state. 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 themselves to hospitals seeking such care. 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. Such governmental requirements have imposed a unilateral obligation for providers of emergency medical services and care to provide services to all persons seeking emergency care without ensuring payment or other consideration for provision of such care. The Legislature also recognizes that providers of emergency medical services and care provide a significant amount of uncompensated emergency medical care in furtherance of such governmental interest. 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. Such patients, in order to obtain medical care, are frequently forced to seek care through providers of emergency medical services and care. Providers of emergency medical services and care in this state have reported significant problems with both the availability and affordability of professional liability coverage. Medical malpractice liability insurance premiums have increased dramatically and a number of insurers have ceased providing medical malpractice coverage for emergency medical services and care in this state. This results in a functional unavailability of malpractice coverage for some providers of emergency medical services and care. 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. 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 themselves to hospitals for emergency medical services and care have access to such needed services.

Section 79. Legislative intent.--The Legislature declares that reducing the burden of proof in medical disciplinary cases to the level of greater weight of the evidence is necessary to protect the health, safety, and welfare of medical patients in the state. The Legislature declares that there is an overwhelming public necessity to protect medical patients which far overrides any purported property interest in a license to

practice in this state held by a licensed health care practitioner. Furthermore, the Legislature declares that it is a privilege, not a right, to practice as a health care professional in this state and that disciplinary action relating to scope of practice issues in particular is remedial and protective, not penal, in nature. The Legislature specifically reverses case law to the contrary.

Section 80. For the purpose of incorporating the amendment to section 624.155, Florida Statutes, in references thereto, subsection (1) of section 624.488, Florida Statutes, is reenacted to read:

624.488 Applicability of related laws.--In addition to other provisions of the code cited in ss. 624.460-624.488:

(1) Sections 624.155, 624.308, 624.414, 624.415, and 624.416(4); ss. 624.418-624.4211, except s. 624.418(2)(f); and s. 624.501;

apply to self-insurance funds. Only those sections of the code that are expressly and specifically cited in ss. 624.460-624.489 apply to self-insurance funds.

Section 81. For the purpose of incorporating the amendment to section 624.155, Florida Statutes, in references thereto, subsection (1) of section 628.6016, Florida Statutes, is reenacted to read:

628.6016 Applicability of related laws.--In addition to other provisions of the code cited in ss. 628.6011-628.6018:

(1) Sections 624.155, 624.308, 624.414, 624.415, and 624.416(4); ss. 624.418-624.4211, except s. 624.418(2)(f); ss. 624.464, 624.468(1), (2), (4), (6), and (11), 624.472, 624.473, 624.474, 624.480, 624.482, 624.484, 624.486, and 624.501;

apply to assessable mutual insurers; however, ss. 628.255, 628.411, and 628.421 do not apply. No section of the code not expressly and specifically cited in ss. 628.6011-628.6018 applies to assessable mutual insurers. The term "assessable mutual insurer" shall be substituted for the term "commercial self-insurer" as appropriate.

Section 82. For the purpose of incorporating the amendment to section 624.155, Florida Statutes, in references thereto, Subsection (11) of section 631.717, Florida Statutes, is reenacted to read:

631.717 Powers and duties of the association.--

(11) The association shall not be liable for any civil action under s. 624.155 arising from any acts alleged to have been committed by a member insurer prior to its liquidation; however, this subsection does not affect the association's obligation to pay valid claims presented to it.

Section 83. 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 84. If any law amended by this act was also amended by a law enacted at the 2003 Regular Session, the 2003 Special Session A, or the 2003 Special Session B 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 85. This act shall take effect upon becoming a law

and shall apply to any cause of action accruing under chapter 766, Florida Statutes, after that date, unless otherwise provided herein, except that the amendments to section 624.155, Florida Statutes, provided in this act shall apply to any medical incident for which a notice of intent to initiate litigation is mailed on or after the effective date of this act.