By the Committee on Health, Aging, and Long-Term Care; and Senators Jones and Saunders

317-2720-03

1 A bill to be entitled
2 An act relating to medical malpractice;
3 providing legislative findings; amending s.
4 46.015, F.S.; revising requirements for setoffs
5 against damages in medical malpractice actions
6 if there is a written release or covenant not
7 to sue; creating s. 381.0409, F.S.; providing
8 that creation of the Florida Center for
9 Excellence in Health Care is contingent on the
10 enactment of a public-records exemption;
11 creating the Florida Center for Excellence in
12 Health Care; providing goals and duties of the
13 center; providing definitions; providing
14 limitations on the center's liability for any
15 lawful actions taken; requiring the center to
16 issue patient safety recommendations; requiring
17 the development of a statewide electronic
18 infrastructure to improve patient care and the
19 delivery and quality of health care services;
20 providing requirements for development of a
21 core electronic medical record; authorizing
22 access to the electronic medical records and
23 other data maintained by the center; providing
24 for the use of computerized physician order
25 entry systems; providing for the establishment
26 of a simulation center for high technology
27 intervention surgery and intensive care;
28 providing for the immunity of specified
29 information in adverse incident reports from
30 discovery or admissibility in civil or
31 administrative actions; providing limitations

1 on liability of specified health care
2 practitioners and facilities under specified
3 conditions; providing requirements for the
4 appointment of a board of directors for the
5 center; requiring the Department of Health to
6 submit a budget for financing of the operations
7 of the Florida Center for Excellence in Health
8 Care for approval by the Legislature; requiring
9 the Florida Center for Excellence in Health
10 Care to develop a business and financing plan;
11 authorizing state agencies to contract with the
12 center for specified projects; authorizing the
13 use of center funds and the use of state
14 purchasing and travel contracts for the center;
15 requiring the center to submit an annual report
16 and providing requirements for the annual
17 report; providing for the center's books,
18 records, and audits to be open to the public;
19 requiring the center to annually furnish an
20 audited report to the Governor and Legislature;
21 amending s. 395.004, F.S., relating to
22 licensure of certain health care facilities;
23 providing for discounted medical liability
24 insurance based on certification of programs
25 that reduce adverse incidents; authorizing the
26 Agency for Health Care Administration to adopt
27 rules for certification of quality improvement
28 programs; requiring the Office of Insurance
29 Regulation to consider certain information in
30 reviewing discounted rates; creating s.
31 395.0056, F.S.; requiring the Agency for Health

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

1 Care Administration to review complaints
2 submitted if the defendant is a hospital;
3 amending s. 395.0191, F.S.; deleting a
4 requirement that persons act in good faith to
5 avoid liability or discipline for their actions
6 regarding the awarding of staff membership or
7 clinical privileges; amending s. 395.0197,
8 F.S., relating to internal risk management
9 programs; requiring a system for notifying
10 patients that they are the subject of an
11 adverse incident; requiring an appropriately
12 trained person to give notice; requiring
13 licensed facilities to annually report certain
14 information about health care practitioners for
15 whom they assume liability; requiring the
16 Agency for Health Care Administration and the
17 Department of Health to annually publish
18 statistics about licensed facilities that
19 assume liability for health care practitioners;
20 repealing the requirement for licensed
21 facilities to notify the agency within 1
22 business day of the occurrence of certain
23 adverse incidents; requiring the agency to
24 forward adverse incident reports to the Florida
25 Center for Excellence in Health Care; repealing
26 s. 395.0198, F.S., which provides a public
27 records exemption for adverse incident
28 notifications; creating s. 395.1012, F.S.;
29 requiring facilities to adopt a patient safety
30 plan; providing requirements for a patient
31 safety plan; requiring facilities to appoint a

1 patient safety officer and a patient safety
2 committee and providing duties for the patient
3 safety officer and committee; amending s.
4 456.025, F.S.; eliminating certain restrictions
5 on the setting of licensure renewal fees for
6 health care practitioners; directing the Agency
7 for Health Care Administration to conduct or
8 contract for a study to determine what
9 information to provide to the public comparing
10 hospitals, based on inpatient quality
11 indicators developed by the federal Agency for
12 Healthcare Research and Quality; creating s.
13 395.1051, F.S.; requiring certain facilities to
14 notify patients about adverse incidents under
15 specified conditions; creating s. 456.0575,
16 F.S.; requiring licensed health care
17 practitioners to notify patients about adverse
18 incidents under certain conditions; amending s.
19 456.026, F.S., relating to an annual report
20 published by the Department of Health;
21 requiring that the department publish the
22 report to its website; requiring the department
23 to include certain detailed information;
24 amending s. 456.039, F.S.; revising
25 requirements for the information furnished to
26 the Department of Health for licensure
27 purposes; amending s. 456.041, F.S., relating
28 to practitioner profiles; requiring the
29 Department of Health to compile certain
30 specified information in a practitioner
31 profile; establishing a timeframe for certain

1 health care practitioners to report specified
2 information; providing for disciplinary action
3 and a fine for untimely submissions; deleting
4 provisions that provide that a profile need not
5 indicate whether a criminal history check was
6 performed to corroborate information in the
7 profile; authorizing the department or
8 regulatory board to investigate any information
9 received; requiring the department to provide
10 an easy-to-read narrative explanation
11 concerning final disciplinary action taken
12 against a practitioner; requiring a hyperlink
13 to each final order on the department's website
14 which provides information about disciplinary
15 actions; requiring the department to provide a
16 hyperlink to certain comparison reports
17 pertaining to claims experience; requiring the
18 department to include the date that a reported
19 disciplinary action was taken by a licensed
20 facility and a characterization of the
21 practitioner's conduct that resulted in the
22 action; deleting provisions requiring the
23 department to consult with a regulatory board
24 before including certain information in a
25 health care practitioner's profile; providing
26 for a penalty for failure to comply with the
27 timeframe for verifying and correcting a
28 practitioner profile; requiring the department
29 to add a statement to a practitioner profile
30 when the profile information has not been
31 verified by the practitioner; requiring the

1 department to provide, in the practitioner
2 profile, an explanation of disciplinary action
3 taken and the reason for sanctions imposed;
4 requiring the department to include a hyperlink
5 to a practitioner's website when requested;
6 providing that practitioners licensed under ch.
7 458 or ch. 459, F.S., shall have claim
8 information concerning an indemnity payment
9 greater than a specified amount posted in the
10 practitioner profile; amending s. 456.042,
11 F.S.; providing for the update of practitioner
12 profiles; designating a timeframe within which
13 a practitioner must submit new information to
14 update his or her profile; amending s. 456.049,
15 F.S., relating to practitioner reports on
16 professional liability claims and actions;
17 revising requirements for a practitioner to
18 report claims or actions for medical
19 malpractice; amending s. 456.051, F.S.;
20 establishing the responsibility of the
21 Department of Health to provide reports of
22 professional liability actions and
23 bankruptcies; requiring the department to
24 include such reports in a practitioner's
25 profile within a specified period; amending s.
26 456.057, F.S.; allowing the department to
27 obtain patient records by subpoena without the
28 patient's written authorization, in specified
29 circumstances; amending s. 456.063, F.S.;
30 authorizing regulatory boards or the department
31 to adopt rules to implement requirements for

1 reporting allegations of sexual misconduct;
2 amending s. 456.072, F.S.; providing for
3 determining the amount of any costs to be
4 assessed in a disciplinary proceeding; amending
5 s. 456.073, F.S.; authorizing the Department of
6 Health to investigate certain paid claims made
7 on behalf of practitioners licensed under ch.
8 458 or ch. 459, F.S.; amending procedures for
9 certain disciplinary proceedings; providing a
10 deadline for raising issues of material fact;
11 providing a deadline relating to notice of
12 receipt of a request for a formal hearing;
13 excepting gross or repeated malpractice and
14 standard-of-care violations from the 6-year
15 limitation on investigation or filing of an
16 administrative complaint; amending s. 456.077,
17 F.S.; providing a presumption related to an
18 undisputed citation; revising requirements
19 under which the Department of Health may issue
20 citations as an alternative to disciplinary
21 procedures against certain licensed health care
22 practitioners; amending s. 456.078, F.S.;
23 revising standards for determining which
24 violations of the applicable professional
25 practice act are appropriate for mediation;
26 amending ss. 458.311 and 459.0055, F.S.;
27 requiring that specified information be
28 provided to the Department of Health; amending
29 s. 458.320, F.S., relating to financial
30 responsibility requirements for medical
31 physicians; requiring maintenance of financial

1 responsibility as a condition of licensure of
2 physicians; providing for payment of any
3 outstanding judgments or settlements pending at
4 the time a physician is suspended by the
5 Department of Health; requiring the department
6 to suspend the license of a medical physician
7 who has not paid, up to the amounts required by
8 any applicable financial responsibility
9 provision, any outstanding judgment,
10 arbitration award, other order, or settlement;
11 amending s. 459.0085, F.S., relating to
12 financial responsibility requirements for
13 osteopathic physicians; requiring maintenance
14 of financial responsibility as a condition of
15 licensure of osteopathic physicians; providing
16 for payment of any outstanding judgments or
17 settlements pending at the time an osteopathic
18 physician is suspended by the Department of
19 Health; requiring that the department suspend
20 the license of an osteopathic physician who has
21 not paid, up to the amounts required by any
22 applicable financial responsibility provision,
23 any outstanding judgment, arbitration award,
24 other order, or settlement; providing civil
25 immunity for certain participants in quality
26 improvement processes; defining the terms
27 "patient safety data" and "patient safety
28 organization"; providing for use of patient
29 safety data by a patient safety organization;
30 providing limitations on use of patient safety
31 data; providing for protection of

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

1 patient-identifying information; providing for
2 determination of whether the privilege applies
3 as asserted; providing that an employer may not
4 take retaliatory action against an employee who
5 makes a good-faith report concerning patient
6 safety data; requiring that a specific
7 statement be included in each final settlement
8 statement relating to medical malpractice
9 actions; amending s. 458.331, F.S., relating to
10 grounds for disciplinary action against a
11 physician; redefining the term "repeated
12 malpractice"; revising the minimum amount of a
13 claim against a licensee which will trigger a
14 departmental investigation; requiring
15 administrative orders issued by an
16 administrative law judge or board for certain
17 practice violations by physicians to specify
18 certain information; creating s. 458.3311,
19 F.S.; establishing emergency procedures for
20 disciplinary actions; amending s. 459.015,
21 F.S., relating to grounds for disciplinary
22 action against an osteopathic physician;
23 redefining the term "repeated malpractice";
24 amending conditions that necessitate a
25 departmental investigation of an osteopathic
26 physician; revising the minimum amount of a
27 claim against a licensee which will trigger a
28 departmental investigation; creating s.
29 459.0151, F.S.; establishing emergency
30 procedures for disciplinary actions; requiring
31 the Division of Administrative Hearings to

1 designate administrative law judges who have
2 special qualifications for hearings involving
3 certain health care practitioners; amending s.
4 461.013, F.S., relating to grounds for
5 disciplinary action against a podiatric
6 physician; redefining the term "repeated
7 malpractice"; amending the minimum amount of a
8 claim against such a physician which will
9 trigger a department investigation; requiring
10 administrative orders issued by an
11 administrative law judge or board for certain
12 practice violations by physicians to specify
13 certain information; creating s. 461.0131,
14 F.S.; establishing emergency procedures for
15 disciplinary actions; amending s. 466.028,
16 F.S., relating to grounds for disciplinary
17 action against a dentist or a dental hygienist;
18 redefining the term "dental malpractice";
19 revising the minimum amount of a claim against
20 a dentist which will trigger a departmental
21 investigation; amending s. 624.462, F.S.;
22 authorizing health care providers to form a
23 commercial self-insurance fund; amending s.
24 627.062, F.S.; providing additional
25 requirements for medical malpractice insurance
26 rate filings; providing that portions of
27 judgments and settlements entered against a
28 medical malpractice insurer for bad-faith
29 actions or for punitive damages against the
30 insurer, as well as related taxable costs and
31 attorney's fees, may not be included in an

1 insurer's base rate; providing for review of
2 rate filings by the Office of Insurance
3 Regulation for excessive, inadequate, or
4 unfairly discriminatory rates; requiring
5 insurers to apply a discount based on the
6 health care provider's loss experience;
7 requiring the Office of Program Policy Analysis
8 and Government Accountability to study and
9 report to the Legislature on requirements for
10 coverage by the Florida Birth-Related
11 Neurological Injury Compensation Association;
12 amending s. 627.357, F.S.; providing guidelines
13 for the formation and regulation of certain
14 self-insurance funds; amending s. 627.4147,
15 F.S.; revising certain notification criteria
16 for medical and osteopathic physicians;
17 requiring prior notification of a rate
18 increase; authorizing the purchase of insurance
19 by certain health care providers; creating s.
20 627.41491, F.S.; requiring the Office of
21 Insurance Regulation to require health care
22 providers to annually publish certain rate
23 comparison information; creating s. 627.41493,
24 F.S.; requiring a medical malpractice insurance
25 rate rollback; providing for subsequent
26 increases under certain circumstances;
27 requiring approval for use of certain medical
28 malpractice insurance rates; providing for a
29 mechanism to make effective the Florida Medical
30 Malpractice Insurance Fund in the event the
31 rollback of medical malpractice insurance rates

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

1 is not completed; creating the Florida Medical
2 Malpractice Insurance Fund; providing purpose;
3 providing governance by a board of governors;
4 providing for the fund to issue medical
5 malpractice policies to any physician
6 regardless of specialty; providing for
7 regulation by the Office of Insurance
8 Regulation of the Financial Services
9 Commission; providing applicability; providing
10 for initial funding; providing for tax-exempt
11 status; providing for initial capitalization;
12 providing for termination of the fund;
13 providing that practitioners licensed under ch.
14 458 or ch. 459, F.S., must, as a licensure
15 requirement, obtain and maintain professional
16 liability coverage; requiring the Office of
17 Insurance Regulation to order insurers to make
18 rate filings effective January 1, 2004, which
19 reflect the impact of the act; providing
20 criteria for such rate filing; amending s.
21 627.912, F.S.; revising the medical malpractice
22 closed claim reports that must be filed with
23 the Office of Insurance Regulation; applying
24 such requirements to additional persons and
25 entities; providing for access to Department of
26 Health to such reports; providing for the
27 imposition of a fine or disciplinary action for
28 failing to report; requiring reports to obtain
29 additional information; authorizing the
30 Financial Services Commission to adopt rules;
31 requiring the Office of Insurance Regulation to

1 prepare summaries of closed claim reports of
2 prior years and to prepare an annual report and
3 analysis of closed claim and insurer financial
4 reports; amending s. 766.102, F.S; revising
5 requirements for health care providers
6 providing expert testimony in medical
7 negligence actions; prohibiting contingency
8 fees for an expert witness; amending s.
9 766.106, F.S.; deleting provisions relating to
10 voluntary arbitration in conflict with s.
11 766.207, F.S.; creating s. 766.10651, F.S.;
12 providing for exclusive common law remedy for
13 bad faith against insurer for claims arising
14 from medical negligence; providing safe-harbour
15 period in which insurer not held to have acted
16 in bad faith; providing legislative intent;
17 providing for future repeal; amending s.
18 766.106, F.S.; revising requirements for
19 presuit notice and for an insurer's or
20 self-insurer's response to a claim; requiring
21 that a claimant provide the Agency for Health
22 Care Administration with a copy of the
23 complaint alleging medical malpractice;
24 requiring the agency to review such complaints
25 for licensure noncompliance; permitting written
26 questions during informal discovery; amending
27 s. 766.108, F.S.; providing for mandatory
28 mediation; creating s. 766.118, F.S.; providing
29 a maximum amount to be awarded as noneconomic
30 damages in medical negligence actions;
31 providing exceptions; providing for

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

1 cost-of-living adjustments to such maximum
2 amount of noneconomic damages; providing that
3 caps on noneconomic damages do not apply to any
4 incident involving certain physicians under
5 certain circumstances; providing for future
6 repeal; amending s. 766.202, F.S.; redefining
7 the terms "economic damages," "medical expert,"
8 "noneconomic damages," and "periodic payment";
9 defining the term "health care provider";
10 amending s. 766.206, F.S.; providing for
11 dismissal of a claim under certain
12 circumstances; requiring the court to make
13 certain reports concerning a medical expert who
14 fails to meet qualifications; amending s.
15 766.207, F.S.; providing for the applicability
16 of the Wrongful Death Act and general law to
17 arbitration awards; amending s. 768.041, F.S.;
18 revising requirements for setoffs against
19 damages in medical malpractice actions if there
20 is a written release or covenant not to sue;
21 amending s. 768.13, F.S.; revising guidelines
22 for immunity from liability under the "Good
23 Samaritan Act"; amending s. 768.77, F.S.;
24 prescribing a method for itemization of
25 specific categories of damages awarded in
26 medical malpractice actions; amending s.
27 768.81, F.S.; requiring the trier of fact to
28 apportion total fault solely among the claimant
29 and joint tortfeasors as parties to an action;
30 preserving sovereign immunity and the
31 abrogation of certain joint and several

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

1 liability; requiring the Office of Program
2 Policy Analysis and Government Accountability
3 and the Office of the Auditor General to
4 conduct an audit of the health care
5 practitioner disciplinary process and closed
6 claims and report to the Legislature; creating
7 ss. 1004.08 and 1005.07, F.S.; requiring
8 schools, colleges, and universities to include
9 material on patient safety in their curricula
10 if the institution awards specified degrees;
11 amending s. 1006.20, F.S.; requiring completion
12 of a uniform participation physical evaluation
13 and history form incorporating recommendations
14 of the American Heart Association; deleting
15 revisions to procedures for students' physical
16 examinations; creating a workgroup to study the
17 health care practitioner disciplinary process;
18 providing for workgroup membership; providing
19 that the workgroup deliver its report by
20 January 1, 2004; creating s. 766.1065, F.S.;
21 providing for mandatory presuit investigations;
22 providing that certain records be provided to
23 opposing parties; providing subpoena power;
24 providing for sworn depositions of parties and
25 medical experts; providing for mandatory
26 in-person mediation if binding arbitration has
27 not been agreed to; providing for a mandatory
28 presuit screening panel hearing in the event of
29 mediation impasse; creating s. 766.1066, F.S.;
30 creating the Office of Presuit Screening
31 Administration; providing for a database of

1 volunteer panel members; prescribing
2 qualifications for panel membership; providing
3 a funding mechanism; providing panel
4 procedures; providing for determination and
5 recordation of panel findings; providing for
6 disposition of panel findings; providing
7 immunity from liability for panel members;
8 amending s. 456.013, F.S.; requiring, as a
9 condition of licensure and license renewal,
10 that physicians and physician assistants
11 complete a continuing education course relating
12 to misdiagnosed conditions; amending s.
13 766.209, F.S.; revising applicable damages
14 available in voluntary binding arbitration
15 relating to claims of medical negligence;
16 amending s. 391.025, F.S.; adding infants
17 receiving compensation awards as eligible for
18 Children's Medical Services health services;
19 amending s. 391.029, F.S.; providing financial
20 eligibility criteria for Children's Medical
21 Services; amending s. 766.304, F.S.; limiting
22 the use of civil actions when claimants accept
23 awards from the Florida Birth-Related
24 Neurological Injury Compensation Plan; amending
25 s. 766.305, F.S.; deleting requirement for
26 provision of certain information in a petition
27 filed with the Florida Birth-Related
28 Neurological Injury Compensation Plan;
29 providing for service of copies of such
30 petition to certain participants; requiring
31 that a claimant provide the Florida

1 Birth-Related Neurological Injury Compensation
2 Association with certain information within 10
3 days after filing such petition; amending
4 766.31, F.S.; providing for a death benefit for
5 an infant in the amount of $10,000; amending s.
6 766.314, F.S.; revising obsolete terms;
7 providing procedures by which hospitals in
8 certain counties may pay the annual fees for
9 participating physicians and nurse midwives;
10 providing for annually assessing participating
11 physicians; providing appropriations and
12 authorizing positions; providing for
13 construction of the act in pari materia with
14 laws enacted during the 2003 Regular Session or
15 a 2003 special session of the Legislature;
16 providing for severability; providing effective
17 dates.
18
19 Be It Enacted by the Legislature of the State of Florida:
20
21 Section 1. Findings.--
22 (1) The Legislature finds that Florida is in the midst
23 of a medical malpractice insurance crisis of unprecedented
24 magnitude.
25 (2) The Legislature finds that this crisis threatens
26 the quality and availability of health care for all Florida
27 residents.
28 (3) The Legislature finds that the rapidly growing
29 population and the changing demographics of Florida make it
30 imperative that students continue to choose Florida as the
31

1 place they will receive their medical educations and practice
2 medicine.
3 (4) The Legislature finds that Florida is among the
4 states with the highest medical malpractice insurance premiums
5 in the nation.
6 (5) The Legislature finds that the cost of medical
7 malpractice insurance has increased dramatically during the
8 past decade and both the increase and the current cost are
9 substantially higher than the national average.
10 (6) The Legislature finds that the increase in medical
11 malpractice liability insurance rates is forcing physicians to
12 practice medicine without professional liability insurance, to
13 leave Florida, to not perform high-risk procedures, or to
14 retire early from the practice of medicine.
15 (7) The Governor created the Governor's Select Task
16 Force on Healthcare Professional Liability Insurance to study
17 and make recommendations to address these problems.
18 (8) The Legislature has reviewed the findings and
19 recommendations of the Governor's Select Task Force on
20 Healthcare Professional Liability Insurance.
21 (9) The Legislature finds that the Governor's Select
22 Task Force on Healthcare Professional Liability Insurance has
23 established that a medical malpractice insurance crisis exists
24 in the State of Florida which can be alleviated by the
25 adoption of comprehensive legislatively enacted reforms.
26 (10) The Legislature finds that making high-quality
27 health care available to the people of this state is an
28 overwhelming public necessity.
29 (11) The Legislature finds that ensuring that
30 physicians continue to practice in Florida is an overwhelming
31 public necessity.

1 (12) The Legislature finds that ensuring the
2 availability of affordable professional liability insurance
3 for physicians is an overwhelming public necessity.
4 (13) The Legislature finds, based upon the findings
5 and recommendations of the Governor's Select Task Force on
6 Healthcare Professional Liability Insurance, the findings and
7 recommendations of various study groups throughout the nation,
8 and the experience of other states, that the overwhelming
9 public necessities of making quality health care available to
10 the people of this state, of ensuring that physicians continue
11 to practice in Florida, and of ensuring that those physicians
12 have the opportunity to purchase affordable professional
13 liability insurance cannot be met unless a cap on noneconomic
14 damages is imposed under certain circumstances.
15 (14) The Legislature finds that the high cost of
16 medical malpractice claims can be substantially alleviated, in
17 the short term, by imposing a limitation on noneconomic
18 damages in medical malpractice actions under certain
19 circumstances.
20 (15) The Legislature further finds that there is no
21 alternative measure of accomplishing such result without
22 imposing even greater limits upon the ability of persons to
23 recover damages for medical malpractice.
24 (16) The Legislature finds that the provisions of this
25 act are naturally and logically connected to each other and to
26 the purpose of making quality health care available to the
27 people of Florida.
28 Section 2. Subsection (4) is added to section 46.015,
29 Florida Statutes, to read:
30 46.015 Release of parties.--
31

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

1 (4)(a) At trial pursuant to a suit filed under chapter
2 766 or pursuant to s. 766.209, if any defendant shows the
3 court that the plaintiff, or his or her legal representative,
4 has delivered a written release or covenant not to sue to any
5 person in partial satisfaction of the damages sued for, the
6 court shall set off this amount from the total amount of the
7 damages set forth in the verdict and before entry of the final
8 judgment.
9 (b) The amount of any setoff under this subsection
10 shall include all sums received by the plaintiff, including
11 economic and noneconomic damages, costs, and attorney's fees.
12 Section 3. Effective upon this act becoming a law if
13 SB 4-C or similar legislation is adopted in the same
14 legislative session or an extension thereof and becomes law,
15 section 381.0409, Florida Statutes, is created to read:
16 381.0409 Florida Center for Excellence in Health
17 Care.--There is created the Florida Center for Excellence in
18 Health Care, which shall be responsible for performing
19 activities and functions that are designed to improve the
20 quality of health care delivered by health care facilities and
21 health care practitioners. The principal goals of the center
22 are to improve health care quality and patient safety. The
23 long-term goal is to improve diagnostic and treatment
24 decisions, thus further improving quality.
25 (1) As used in this section, the term:
26 (a) "Center" means the Florida Center for Excellence
27 in Health Care.
28 (b) "Health care practitioner" means any person as
29 defined under s. 456.001(4).
30 (c) "Health care facility" means any facility licensed
31 under chapter 395.

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

1 (d) "Health research entity" means any university or
2 academic health center engaged in research designed to
3 improve, prevent, diagnose, or treat diseases or medical
4 conditions or an entity that receives state or federal funds
5 for such research.
6 (e) "Patient safety data" means any data, reports,
7 records, memoranda, or analyses of patient safety events and
8 adverse incidents reported by a licensed facility pursuant to
9 s. 395.0197 which are submitted to the Florida Center for
10 Health Care Excellence or the corrective actions taken in
11 response to such patient safety events or adverse incidents.
12 (f) "Patient safety event" means an event over which
13 health care personnel could exercise control and which is
14 associated in whole or in part with medical intervention,
15 rather than the condition for which such intervention
16 occurred, and which could have resulted in, but did not result
17 in, serious patient injury or death.
18 (2) The center shall directly or by contract:
19 (a) Analyze patient safety data for the purpose of
20 recommending changes in practices and procedures which may be
21 implemented by health care practitioners and health care
22 facilities to prevent future adverse incidents.
23 (b) Collect, analyze, and evaluate patient safety data
24 submitted voluntarily by a health care practitioner or health
25 care facility. The center shall recommend to health care
26 practitioners and health care facilities changes in practices
27 and procedures that may be implemented for the purpose of
28 improving patient safety and preventing patient safety events.
29 (c) Foster the development of a statewide electronic
30 infrastructure that may be implemented in phases over a
31 multiyear period and that is designed to improve patient care

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

1 and the delivery and quality of health care services by health
2 care facilities and practitioners. The electronic
3 infrastructure shall be a secure platform for communication
4 and the sharing of clinical and other data, such as business
5 data, among providers and between patients and providers. The
6 electronic infrastructure shall include a "core" electronic
7 medical record. Health care practitioners and health care
8 facilities shall have access to individual electronic medical
9 records subject to the consent of the individual. Each health
10 insurer licensed under chapter 627 or chapter 641 shall have
11 access to the electronic medical records of its policyholders
12 and, subject to s. 381.04091, to other data if such access is
13 for the sole purpose of conducting research to identify
14 diagnostic tests and treatments that are medically effective.
15 Health research entities shall have access to the electronic
16 medical records of individuals, subject to the consent of the
17 individual and subject to s. 381.04091, and to other data if
18 such access is for the sole purpose of conducting research to
19 identify diagnostic tests and treatments that are medically
20 effective.
21 (d) Inventory hospitals to determine the current
22 status of implementation of computerized physician order entry
23 systems and recommend a plan for expediting implementation
24 statewide or, in hospitals where the center determines that
25 implementation of such systems is not practicable, alternative
26 methods to reduce medication errors. The center shall identify
27 in its plan any barriers to statewide implementation and shall
28 include recommendations to the Legislature of statutory
29 changes that may be necessary to eliminate those barriers.
30
31

1 (e) Establish a simulation center for high technology
2 intervention surgery and intensive care for use by all
3 hospitals.
4 (f) Identify best practices and share this information
5 with health care providers.
6
7 This section does not limit the scope of services provided by
8 the center with regard to engaging in other activities that
9 improve health care quality, improve the diagnosis and
10 treatment of diseases and medical conditions, increase the
11 efficiency of the delivery of health care services, increase
12 administrative efficiency, and increase access to quality
13 health care services.
14 (3) Notwithstanding s. 381.04091, the center may
15 release information contained in patient safety data to any
16 health care practitioner or health care facility when
17 recommending changes in practices and procedures which may be
18 implemented by such practitioner or facility to prevent
19 patient safety events or adverse incidents if the identity of
20 the source of the information and the names of persons have
21 been removed from such information.
22 (4) All information related to adverse incident
23 reports and all patient safety data submitted to or received
24 by the center shall not be subject to discovery or
25 introduction into evidence in any civil or administrative
26 action. Individuals in attendance at meetings held for the
27 purpose of discussing information related to adverse incidents
28 and patient safety data and meetings held to formulate
29 recommendations to prevent future adverse incidents or patient
30 safety events may not be permitted or required to testify in
31 any civil or administrative action related to such events.

1 There shall be no liability on the part of, and no cause of
2 action of any nature shall arise against, any employee or
3 agent of the center for any lawful action taken by such
4 individual in advising health practitioners or health care
5 facilities with regard to carrying out their duties under this
6 section. There shall be no liability on the part of, and no
7 cause of action of any nature shall arise against, a health
8 care practitioner or health care facility, or its agents or
9 employees, when it acts in reliance on any advice or
10 information provided by the center.
11 (5) The center shall be a nonprofit corporation
12 registered, incorporated, organized, and operated in
13 compliance with chapter 617, and shall have all powers
14 necessary to carry out the purposes of this section,
15 including, but not limited to, the power to receive and accept
16 from any source contributions of money, property, labor, or
17 any other thing of value, to be held, used, and applied for
18 the purpose of this section.
19 (6) The center shall:
20 1. Be designed and operated by an individual or entity
21 with demonstrated expertise in health care quality data and
22 systems analysis, health information management, systems
23 thinking and analysis, human factors analysis, and
24 identification of latent and active errors.
25 2. Include procedures for ensuring the confidentiality
26 of data which are consistent with state and federal law.
27 (7) The center shall be governed by a 10-member board
28 of directors.
29 (a) The Governor shall appoint two members
30 representing hospitals, one member representing physicians,
31 one member representing nurses, one member representing health

1 insurance indemnity plans, one member representing health
2 maintenance organizations, one member representing business,
3 and one member representing consumers. The Governor shall
4 appoint members for a 2-year term. Such members shall serve
5 until their successors are appointed. Members are eligible to
6 be reappointed for additional terms.
7 (b) The Secretary of Health or his or her designee
8 shall be a member of the board.
9 (c) The Secretary of Health Care Administration or his
10 or her designee shall be a member of the board.
11 (d) The members shall elect a chairperson.
12 (e) Board members shall serve without compensation but
13 may be reimbursed for travel expenses pursuant to s. 112.061.
14 (8) The Department of Health shall prepare a budget
15 for financing the center's operations subject to approval by
16 the Legislature which may be funded from General Revenue.
17 (9) The center shall develop a business and financing
18 plan to obtain funds through other means if funds beyond those
19 that are provided for in this subsection are needed to
20 accomplish the objectives of the center.
21 (10) The center may enter into affiliations with
22 universities for any purpose.
23 (11) Pursuant to s. 287.057(5)(f)6., state agencies
24 may contract with the center on a sole-source basis for
25 projects to improve the quality of program administration,
26 such as, but not limited to, the implementation of an
27 electronic medical record for Medicaid program recipients.
28 (12) All travel and per diem paid with center funds
29 shall be in accordance with s. 112.061.
30
31

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

1 (13) The center may use state purchasing and travel
2 contracts and the state communications system in accordance
3 with s. 282.105(3).
4 (14) The center may acquire, enjoy, use, and dispose
5 of patents, copyrights, trademarks, and any licenses,
6 royalties, and other rights or interests thereunder or
7 therein.
8 (15) The center shall submit to the Governor, the
9 President of the Senate, and the Speaker of the House of
10 Representatives no later than October 1 of each year a report
11 that includes:
12 (a) The status report on the implementation of a
13 program to analyze data concerning adverse incidents and
14 patient safety events.
15 (b) The status report on the implementation of a
16 computerized physician order entry system.
17 (c) The status report on the implementation of an
18 electronic medical record.
19 (d) Other pertinent information relating to the
20 efforts of the center to improve health care quality and
21 efficiency.
22 (e) A financial statement and balance sheet.
23
24 The initial report shall include any recommendations that the
25 center deems appropriate regarding revisions in the definition
26 of adverse incidents in s. 395.0197 and the reporting of such
27 adverse incidents by licensed facilities.
28 (16) The center may establish and manage an operating
29 fund for the purposes of addressing the center's cash-flow
30 needs and facilitating the fiscal management of the
31 corporation. Upon dissolution of the corporation, any

1 remaining cash balances of any state funds shall revert to the
2 General Revenue Fund, or such other state funds consistent
3 with appropriated funding, as provided by law.
4 (17) The center may carry over funds from year to
5 year.
6 (18) All books, records, and audits of the center
7 shall be open to the public unless exempted by law.
8 (19) The center shall furnish an audited report to the
9 Governor and Legislature by March 1 of each year.
10 (20) In carrying out this section, the center shall
11 consult with and develop partnerships, as appropriate, with
12 all segments of the health care industry, including, among
13 others, health practitioners, health care facilities, health
14 care consumers, professional organizations, agencies, health
15 care practitioner licensing boards, and educational
16 institutions.
17 Section 4. Subsection (3) is added to section 395.004,
18 Florida Statutes, to read:
19 395.004 Application for license, fees; expenses.--
20 (3) A licensed facility may apply to the agency for
21 certification of a quality improvement program that results in
22 the reduction of adverse incidents at that facility. The
23 agency, in consultation with the Office of Insurance
24 Regulation, shall develop criteria for such certification. The
25 agency may adopt rules pursuant to ss. 120.536(1) and 120.54
26 to specify criteria under which a licensed facility may apply
27 for and receive certification of a quality improvement
28 program. Insurers shall file with the Office of Insurance
29 Regulation a discount in the rate or rates applicable for
30 medical liability insurance coverage to reflect the
31 implementation of a certified program. In reviewing insurance

1 company filings with respect to rate discounts authorized
2 under this subsection, the Office of Insurance Regulation
3 shall consider whether, and the extent to which, the program
4 certified under this subsection is otherwise covered under a
5 program of risk management offered by an insurance company or
6 self-insurance plan providing medical liability coverage.
7 Section 5. Section 395.0056, Florida Statutes, is
8 created to read:
9 395.0056 Litigation notice requirement.--Upon receipt
10 of a copy of a complaint filed against a hospital as a
11 defendant in a medical malpractice action as required by s.
12 766.106(2), the agency shall:
13 (1) Review its adverse incident report files
14 pertaining to the licensed facility that is the subject of the
15 complaint to determine whether the facility timely complied
16 with the requirements of s. 395.0197; and
17 (2) Review the incident that is the subject of the
18 complaint and determine whether it involved conduct by a
19 licensee which is potentially subject to disciplinary action.
20 Section 6. Subsection (7) of section 395.0191, Florida
21 Statutes, is amended to read:
22 395.0191 Staff membership and clinical privileges.--
23 (7) There shall be no monetary liability on the part
24 of, and no cause of action for injunctive relief or damages
25 shall arise against, any licensed facility, its governing
26 board or governing board members, medical staff, or
27 disciplinary board or against its agents, investigators,
28 witnesses, or employees, or against any other person, for any
29 action arising out of or related to carrying out the
30 provisions of this section, absent ~~taken in good faith and~~
31

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

1 ~~without~~ intentional fraud ~~in carrying out the provisions of~~
2 ~~this section~~.
3 Section 7. Subsections (1), (3), (7), (8), (9), (10),
4 (11), (12), (13), (14), and (15) of section 395.0197, Florida
5 Statutes, are amended to read:
6 395.0197 Internal risk management program.--
7 (1) Every licensed facility shall, as a part of its
8 administrative functions, establish an internal risk
9 management program that includes all of the following
10 components:
11 (a) The investigation and analysis of the frequency
12 and causes of general categories and specific types of adverse
13 incidents to patients.
14 (b) The development of appropriate measures to
15 minimize the risk of adverse incidents to patients, including,
16 but not limited to:
17 1. Risk management and risk prevention education and
18 training of all nonphysician personnel as follows:
19 a. Such education and training of all nonphysician
20 personnel as part of their initial orientation; and
21 b. At least 1 hour of such education and training
22 annually for all personnel of the licensed facility working in
23 clinical areas and providing patient care, except those
24 persons licensed as health care practitioners who are required
25 to complete continuing education coursework pursuant to
26 chapter 456 or the respective practice act.
27 2. A prohibition, except when emergency circumstances
28 require otherwise, against a staff member of the licensed
29 facility attending a patient in the recovery room, unless the
30 staff member is authorized to attend the patient in the
31 recovery room and is in the company of at least one other

1 person. However, a licensed facility is exempt from the
2 two-person requirement if it has:
3 a. Live visual observation;
4 b. Electronic observation; or
5 c. Any other reasonable measure taken to ensure
6 patient protection and privacy.
7 3. A prohibition against an unlicensed person from
8 assisting or participating in any surgical procedure unless
9 the facility has authorized the person to do so following a
10 competency assessment, and such assistance or participation is
11 done under the direct and immediate supervision of a licensed
12 physician and is not otherwise an activity that may only be
13 performed by a licensed health care practitioner.
14 4. Development, implementation, and ongoing evaluation
15 of procedures, protocols, and systems to accurately identify
16 patients, planned procedures, and the correct site of the
17 planned procedure so as to minimize the performance of a
18 surgical procedure on the wrong patient, a wrong surgical
19 procedure, a wrong-site surgical procedure, or a surgical
20 procedure otherwise unrelated to the patient's diagnosis or
21 medical condition.
22 (c) The analysis of patient grievances that relate to
23 patient care and the quality of medical services.
24 (d) A system for informing a patient or an individual
25 identified pursuant to s. 765.401(1) that the patient was the
26 subject of an adverse incident, as defined in subsection (5).
27 Such notice shall be given by an appropriately trained person
28 designated by the licensed facility as soon as practicable to
29 allow the patient an opportunity to minimize damage or injury.
30 (e)~~(d)~~ The development and implementation of an
31 incident reporting system based upon the affirmative duty of

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

1 all health care providers and all agents and employees of the
2 licensed health care facility to report adverse incidents to
3 the risk manager, or to his or her designee, within 3 business
4 days after their occurrence.
5 (3) In addition to the programs mandated by this
6 section, other innovative approaches intended to reduce the
7 frequency and severity of medical malpractice and patient
8 injury claims shall be encouraged and their implementation and
9 operation facilitated. Such additional approaches may include
10 extending internal risk management programs to health care
11 providers' offices and the assuming of provider liability by a
12 licensed health care facility for acts or omissions occurring
13 within the licensed facility. Each licensed facility shall
14 annually report to the agency and the Department of Health the
15 name and judgments entered against each health care
16 practitioner for which it assumes liability. The agency and
17 Department of Health, in their respective annual reports,
18 shall include statistics that report the number of licensed
19 facilities that assume such liability and the number of health
20 care practitioners, by profession, for whom they assume
21 liability.
22 ~~(7) The licensed facility shall notify the agency no~~
23 ~~later than 1 business day after the risk manager or his or her~~
24 ~~designee has received a report pursuant to paragraph (1)(d)~~
25 ~~and can determine within 1 business day that any of the~~
26 ~~following adverse incidents has occurred, whether occurring in~~
27 ~~the licensed facility or arising from health care prior to~~
28 ~~admission in the licensed facility:~~
29 ~~(a) The death of a patient;~~
30 ~~(b) Brain or spinal damage to a patient;~~
31

~~(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

1 not a recognized specific risk, as disclosed to the patient
2 and documented through the informed-consent process; or
3 (h) The performance of procedures to remove unplanned
4 foreign objects remaining from a surgical procedure.
5
6 The agency may grant extensions to this reporting requirement
7 for more than 15 days upon justification submitted in writing
8 by the facility administrator to the agency. The agency may
9 require an additional, final report. These reports shall not
10 be available to the public pursuant to s. 119.07(1) or any
11 other law providing access to public records, nor be
12 discoverable or admissible in any civil or administrative
13 action, except in disciplinary proceedings by the agency or
14 the appropriate regulatory board, nor shall they be available
15 to the public as part of the record of investigation for and
16 prosecution in disciplinary proceedings made available to the
17 public by the agency or the appropriate regulatory board.
18 However, the agency or the appropriate regulatory board shall
19 make available, upon written request by a health care
20 professional against whom probable cause has been found, any
21 such records which form the basis of the determination of
22 probable cause. The agency may investigate, as it deems
23 appropriate, any such incident and prescribe measures that
24 must or may be taken in response to the incident. The agency
25 shall review each incident and determine whether it
26 potentially involved conduct by the health care professional
27 who is subject to disciplinary action, in which case the
28 provisions of s. 456.073 shall apply. The agency shall forward
29 a copy of all reports of adverse incidents submitted to the
30 agency by hospitals and ambulatory surgical centers to the
31 Florida Center for Excellence in Health Care, as created in s.

381.0409, for analysis by experts who may make recommendations regarding the prevention of such incidents. Such information shall remain confidential as otherwise provided by law.

(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.

1 (d) Report to the Department of Health every
2 allegation of sexual misconduct, as defined in chapter 456 and
3 the respective practice act, by a licensed health care
4 practitioner that involves a patient.
5 (10)~~(11)~~ Any witness who witnessed or who possesses
6 actual knowledge of the act that is the basis of an allegation
7 of sexual abuse shall:
8 (a) Notify the local police; and
9 (b) Notify the hospital risk manager and the
10 administrator.
11
12 For purposes of this subsection, "sexual abuse" means acts of
13 a sexual nature committed for the sexual gratification of
14 anyone upon, or in the presence of, a vulnerable adult,
15 without the vulnerable adult's informed consent, or a minor.
16 "Sexual abuse" includes, but is not limited to, the acts
17 defined in s. 794.011(1)(h), fondling, exposure of a
18 vulnerable adult's or minor's sexual organs, or the use of the
19 vulnerable adult or minor to solicit for or engage in
20 prostitution or sexual performance. "Sexual abuse" does not
21 include any act intended for a valid medical purpose or any
22 act which may reasonably be construed to be a normal
23 caregiving action.
24 (11)~~(12)~~ A person who, with malice or with intent to
25 discredit or harm a licensed facility or any person, makes a
26 false allegation of sexual misconduct against a member of a
27 licensed facility's personnel is guilty of a misdemeanor of
28 the second degree, punishable as provided in s. 775.082 or s.
29 775.083.
30 (12)~~(13)~~ In addition to any penalty imposed pursuant
31 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

1 against whom probable cause has been found, any such records
2 which form the basis of the determination of probable cause,
3 except that, with respect to medical review committee records,
4 s. 766.101 controls.
5 (14)~~(15)~~ The meetings of the committees and governing
6 board of a licensed facility held solely for the purpose of
7 achieving the objectives of risk management as provided by
8 this section shall not be open to the public under the
9 provisions of chapter 286. The records of such meetings are
10 confidential and exempt from s. 119.07(1), except as provided
11 in subsection(13)~~(14)~~.
12 Section 8. Section 395.0198, Florida Statutes, is
13 repealed.
14 Section 9. Section 395.1012, Florida Statutes, is
15 created to read:
16 395.1012 Patient safety.--
17 (1) Each licensed facility must adopt a patient safety
18 plan. A plan adopted to implement the requirements of 42
19 C.F.R. part 482.21 shall be deemed to comply with this
20 requirement.
21 (2) Each licensed facility shall appoint a patient
22 safety officer and a patient safety committee, which shall
23 include at least one person who is neither employed by nor
24 practicing in the facility, for the purpose of promoting the
25 health and safety of patients, reviewing and evaluating the
26 quality of patient safety measures used by the facility, and
27 assisting in the implementation of the facility patient safety
28 plan.
29 Section 10. Subsection (1) of section 456.025, Florida
30 Statutes, is amended to read:
31 456.025 Fees; receipts; disposition.--

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

1 (1) It is the intent of the Legislature that all costs
2 of regulating health care professions and practitioners shall
3 be borne solely by licensees and licensure applicants. It is
4 also the intent of the Legislature that fees should be
5 reasonable and not serve as a barrier to licensure. Moreover,
6 it is the intent of the Legislature that the department
7 operate as efficiently as possible and regularly report to the
8 Legislature additional methods to streamline operational
9 costs. Therefore, the boards in consultation with the
10 department, or the department if there is no board, shall, by
11 rule, set renewal fees which:
12 (a) Shall be based on revenue projections prepared
13 using generally accepted accounting procedures;
14 (b) Shall be adequate to cover all expenses relating
15 to that board identified in the department's long-range policy
16 plan, as required by s. 456.005;
17 (c) Shall be reasonable, fair, and not serve as a
18 barrier to licensure;
19 (d) Shall be based on potential earnings from working
20 under the scope of the license;
21 (e) Shall be similar to fees imposed on similar
22 licensure types;
23 ~~(f) Shall not be more than 10 percent greater than the~~
24 ~~fee imposed for the previous biennium;~~
25 (f)~~(g)~~ Shall not be more than 10 percent greater than
26 the actual cost to regulate that profession for the previous
27 biennium; and
28 (g)~~(h)~~ Shall be subject to challenge pursuant to
29 chapter 120.
30 Section 11. (1) The Agency for Health Care
31 Administration shall conduct or contract for a study to

1 determine what information is most feasible to provide to the
2 public comparing state-licensed hospitals on certain inpatient
3 quality indicators developed by the federal Agency for
4 Healthcare Research and Quality. Such indicators shall be
5 designed to identify information about specific procedures
6 performed in hospitals for which there is strong evidence of a
7 link to quality of care. The Agency for Health Care
8 Administration or the study contractor shall refer to the
9 hospital quality reports published in New York and Texas as
10 guides during the evaluation.
11 (2) The following concepts shall be specifically
12 addressed in the study report:
13 (a) Whether hospital discharge data about services can
14 be translated into understandable and meaningful information
15 for the public.
16 (b) Whether the following measures are useful consumer
17 guides relating to care provided in state-licensed hospitals:
18 1. Inpatient mortality for medical conditions;
19 2. Inpatient mortality for procedures;
20 3. Utilization of procedures for which there are
21 questions of overuse, underuse, or misuse; and
22 4. Volume of procedures for which there is evidence
23 that a higher volume of procedures is associated with lower
24 mortality.
25 (c) Whether there are quality indicators that are
26 particularly useful relative to the state's unique
27 demographics.
28 (d) Whether all hospitals should be included in the
29 comparison.
30 (e) The criteria for comparison.
31

1 (f) Whether comparisons are best within metropolitan
2 statistical areas or some other geographic configuration.
3 (g) Identification of several websites to which such a
4 report should be published to achieve the broadest
5 dissemination of the information.
6 (3) The Agency for Health Care Administration shall
7 consider the input of all interested parties, including
8 hospitals, physicians, consumer organizations, and patients,
9 and submit the final report to the Governor and the presiding
10 officers of the Legislature by January 1, 2004.
11 Section 12. Section 395.1051, Florida Statutes, is
12 created to read:
13 395.1051 Duty to notify patients.--An appropriately
14 trained person designated by each licensed facility shall
15 inform each patient, or an individual identified pursuant to
16 s. 765.401(1), in person about adverse incidents that result
17 in serious harm to the patient. Notification of outcomes of
18 care that result in harm to the patient under this section
19 shall not constitute an acknowledgement or admission of
20 liability, nor can it be introduced as evidence.
21 Section 13. Section 456.0575, Florida Statutes, is
22 created to read:
23 456.0575 Duty to notify patients.--Every licensed
24 health care practitioner shall inform each patient, or an
25 individual identified pursuant to s. 765.401(1), in person
26 about adverse incidents that result in serious harm to the
27 patient. Notification of outcomes of care that result in harm
28 to the patient under this section shall not constitute an
29 acknowledgement of admission of liability, nor can such
30 notifications be introduced as evidence.
31

1 Section 14. Section 456.026, Florida Statutes, is
2 amended to read:
3 456.026 Annual report concerning finances,
4 administrative complaints, disciplinary actions, and
5 recommendations.--The department is directed to prepare and
6 submit a report to the President of the Senate and the Speaker
7 of the House of Representatives by November 1 of each year.
8 The department shall publish the report to its website
9 simultaneously with delivery to the President of the Senate
10 and the Speaker of the House of Representatives. The report
11 must be directly accessible on the department's Internet
12 homepage highlighted by easily identifiable links and buttons.
13 In addition to finances and any other information the
14 Legislature may require, the report shall include statistics
15 and relevant information, profession by profession, detailing:
16 (1) The number of health care practitioners licensed
17 by the Division of Medical Quality Assurance or otherwise
18 authorized to provide services in the state, if known to the
19 department.
20 (2)~~(1)~~ The revenues, expenditures, and cash balances
21 for the prior year, and a review of the adequacy of existing
22 fees.
23 (3)~~(2)~~ The number of complaints received and
24 investigated.
25 (4)~~(3)~~ The number of findings of probable cause made.
26 (5)~~(4)~~ The number of findings of no probable cause
27 made.
28 (6)~~(5)~~ The number of administrative complaints filed.
29 (7)~~(6)~~ The disposition of all administrative
30 complaints.
31 (8)~~(7)~~ A description of disciplinary actions taken.

(9) For licensees under chapter 458, chapter 459, chapter 461, or chapter 466, the professional liability claims and actions reported pursuant to s. 627.912. This information must be provided in a separate section of the report restricted to providing professional liability claims and actions data.

(10)~~(8)~~ A description of any effort by the department to reduce or otherwise close any investigation or disciplinary proceeding not before the Division of Administrative Hearings under chapter 120 or otherwise not completed within 1 year after the initial filing of a complaint under this chapter.

(11)~~(9)~~ The status of the development and implementation of rules providing for disciplinary guidelines pursuant to s. 456.079.

(12)~~(10)~~ Such recommendations for administrative and statutory changes necessary to facilitate efficient and cost-effective operation of the department and the various boards.

Section 15. 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

1 Health, and in addition to any other information that may be
2 required from the applicant, furnish the following information
3 to the Department of Health:
4 (a)1. The name of each medical school that the
5 applicant has attended, with the dates of attendance and the
6 date of graduation, and a description of all graduate medical
7 education completed by the applicant, excluding any coursework
8 taken to satisfy medical licensure continuing education
9 requirements.
10 2. The name of each hospital at which the applicant
11 has privileges.
12 3. The address at which the applicant will primarily
13 conduct his or her practice.
14 4. Any certification that the applicant has received
15 from a specialty board that is recognized by the board to
16 which the applicant is applying.
17 5. The year that the applicant began practicing
18 medicine.
19 6. Any appointment to the faculty of a medical school
20 which the applicant currently holds and an indication as to
21 whether the applicant has had the responsibility for graduate
22 medical education within the most recent 10 years.
23 7. A description of any criminal offense of which the
24 applicant has been found guilty, regardless of whether
25 adjudication of guilt was withheld, or to which the applicant
26 has pled guilty or nolo contendere. A criminal offense
27 committed in another jurisdiction which would have been a
28 felony or misdemeanor if committed in this state must be
29 reported. If the applicant indicates that a criminal offense
30 is under appeal and submits a copy of the notice for appeal of
31 that criminal offense, the department must state that the

1 criminal offense is under appeal if the criminal offense is
2 reported in the applicant's profile. If the applicant
3 indicates to the department that a criminal offense is under
4 appeal, the applicant must, upon disposition of the appeal,
5 submit to the department a copy of the final written order of
6 disposition.
7 8. A description of any final disciplinary action
8 taken within the previous 10 years against the applicant by
9 the agency regulating the profession that the applicant is or
10 has been licensed to practice, whether in this state or in any
11 other jurisdiction, by a specialty board that is recognized by
12 the American Board of Medical Specialties, the American
13 Osteopathic Association, or a similar national organization,
14 or by a licensed hospital, health maintenance organization,
15 prepaid health clinic, ambulatory surgical center, or nursing
16 home. Disciplinary action includes resignation from or
17 nonrenewal of medical staff membership or the restriction of
18 privileges at a licensed hospital, health maintenance
19 organization, prepaid health clinic, ambulatory surgical
20 center, or nursing home taken in lieu of or in settlement of a
21 pending disciplinary case related to competence or character.
22 If the applicant indicates that the disciplinary action is
23 under appeal and submits a copy of the document initiating an
24 appeal of the disciplinary action, the department must state
25 that the disciplinary action is under appeal if the
26 disciplinary action is reported in the applicant's profile.
27 9. Relevant professional qualifications as defined by
28 the applicable board.
29 Section 16. Section 456.041, Florida Statutes, is
30 amended to read:
31 456.041 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 shall ~~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 compile the information submitted pursuant to s. 456.0391 into a practitioner profile of the applicant submitting the information.

(b) Within 30 calendar days after receiving an update of information required for the practitioner's profile, 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 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

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

1 must include in each practitioner's practitioner profile the
2 following statement: "The criminal history information, if
3 any exists, may be incomplete; federal criminal history
4 information is not available to the public." The department
5 shall provide in each practitioner profile, for every final
6 disciplinary action taken against the practitioner, an
7 easy-to-read narrative description that explains the
8 administrative complaint filed against the practitioner and
9 the final disciplinary action imposed on the practitioner. The
10 department shall include a hyperlink to each final order
11 listed in its website report of dispositions of recent
12 disciplinary actions taken against practitioners.
13 (4) The Department of Health shall include, with
14 respect to a practitioner licensed under chapter 458 or
15 chapter 459, a statement of how the practitioner has elected
16 to comply with the financial responsibility requirements of s.
17 458.320 or s. 459.0085. The department shall include, with
18 respect to practitioners subject to s. 456.048, a statement of
19 how the practitioner has elected to comply with the financial
20 responsibility requirements of that section. The department
21 shall include, with respect to practitioners licensed under
22 ~~chapter 458, chapter 459, or~~ chapter 461, information relating
23 to liability actions which has been reported under s. 456.049
24 or s. 627.912 within the previous 10 years for any paid claim
25 that exceeds $5,000. The department shall include, with
26 respect to practitioners licensed under chapter 458 or chapter
27 459, information relating to liability actions which has been
28 reported under ss. 456.049 and 627.912 within the previous 10
29 years for any paid claim that exceeds $100,000.Such claims
30 information shall be reported in the context of comparing an
31 individual practitioner's claims to the experience of other

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

1 practitioners within the same specialty, or profession if the
2 practitioner is not a specialist~~, to the extent such~~
3 ~~information is available to the Department of Health~~. The
4 department must provide a hyperlink in such practitioner's
5 profile to all such comparison reports.If information
6 relating to a liability action is included in a practitioner's
7 practitioner profile, the profile must also include the
8 following statement: "Settlement of a claim may occur for a
9 variety of reasons that do not necessarily reflect negatively
10 on the professional competence or conduct of the practitioner.
11 A payment in settlement of a medical malpractice action or
12 claim should not be construed as creating a presumption that
13 medical malpractice has occurred."
14 (5) The Department of Health shall ~~may not~~ include the
15 date of a hospital or ambulatory surgical center disciplinary
16 action taken by a licensed hospital or an ambulatory surgical
17 center, in accordance with the requirements of s. 395.0193, in
18 the practitioner profile. The department shall state whether
19 the action related to professional competence and whether it
20 related to the delivery of services to a patient.
21 (6) The Department of Health may include in the
22 practitioner's practitioner profile any other information that
23 is a public record of any governmental entity and that relates
24 to a practitioner's ability to competently practice his or her
25 profession. ~~However, the department must consult with the~~
26 ~~board having regulatory authority over the practitioner before~~
27 ~~such information is included in his or her profile.~~
28 (7) Upon the completion of a practitioner profile
29 under this section, the Department of Health shall furnish the
30 practitioner who is the subject of the profile a copy of it
31 for review and verification. The practitioner has a period of

1 30 days in which to review and verify the contents of the
2 profile and to correct any factual inaccuracies in it. The
3 Department of Health shall make the profile available to the
4 public at the end of the 30-day period regardless of whether
5 the practitioner has provided verification of the profile
6 content. A practitioner shall be subject to a fine of up to
7 $100 per day for failure to verify the profile contents and to
8 correct any factual errors in his or her profile within the
9 30-day period.The department shall make the profiles
10 available to the public through the World Wide Web and other
11 commonly used means of distribution. The department must
12 include the following statement, in boldface type, in each
13 profile that has not been reviewed by the practitioner to
14 which it applies: "The practitioner has not verified the
15 information contained in this profile."
16 (8) The Department of Health must provide in each
17 profile an easy-to-read explanation of any disciplinary action
18 taken and the reason the sanction or sanctions were imposed.
19 (9) The Department of Health may provide one link in
20 each profile to a practitioner's professional website if the
21 practitioner requests that such a link be included in his or
22 her profile.
23 (10)~~(8)~~ Making a practitioner profile available to the
24 public under this section does not constitute agency action
25 for which a hearing under s. 120.57 may be sought.
26 Section 17. Section 456.042, Florida Statutes, is
27 amended to read:
28 456.042 Practitioner profiles; update.--A practitioner
29 must submit updates of required information within 15 days
30 after the final activity that renders such information a fact.
31 The Department of Health shall update each practitioner's

1 practitioner profile periodically. An updated profile is
2 subject to the same requirements as an original profile ~~with~~
3 ~~respect to the period within which the practitioner may review~~
4 ~~the profile for the purpose of correcting factual~~
5 ~~inaccuracies~~.
6 Section 18. Section 456.049, Florida Statutes, is
7 amended to read:
8 456.049 Health care practitioners; reports on
9 professional liability claims and actions.--
10 ~~(1)~~ Any practitioner of medicine licensed pursuant to
11 the provisions of chapter 458, practitioner of osteopathic
12 medicine licensed pursuant to the provisions of chapter 459,
13 podiatric physician licensed pursuant to the provisions of
14 chapter 461, or dentist licensed pursuant to the provisions of
15 chapter 466 shall report to the Office of Insurance Regulation
16 ~~department~~ any claim or action for damages for personal injury
17 alleged to have been caused by error, omission, or negligence
18 in the performance of such licensee's professional services or
19 based on a claimed performance of professional services
20 without consent pursuant to ~~if the claim was not covered by an~~
21 ~~insurer required to report under~~ s. 627.912. ~~and the claim~~
22 ~~resulted in:~~
23 ~~(a) A final judgment in any amount.~~
24 ~~(b) A settlement in any amount.~~
25 ~~(c) A final disposition not resulting in payment on~~
26 ~~behalf of the licensee.~~
27
28 ~~Reports shall be filed with the department no later than 60~~
29 ~~days following the occurrence of any event listed in paragraph~~
30 ~~(a), paragraph (b), or paragraph (c).~~
31 ~~(2) Reports shall contain:~~

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

1 ~~(a) The name and address of the licensee.~~
2 ~~(b) The date of the occurrence which created the~~
3 ~~claim.~~
4 ~~(c) The date the claim was reported to the licensee.~~
5 ~~(d) The name and address of the injured person. This~~
6 ~~information is confidential and exempt from s. 119.07(1) and~~
7 ~~shall not be disclosed by the department without the injured~~
8 ~~person's consent. This information may be used by the~~
9 ~~department for purposes of identifying multiple or duplicate~~
10 ~~claims arising out of the same occurrence.~~
11 ~~(e) The date of suit, if filed.~~
12 ~~(f) The injured person's age and sex.~~
13 ~~(g) The total number and names of all defendants~~
14 ~~involved in the claim.~~
15 ~~(h) The date and amount of judgment or settlement, if~~
16 ~~any, including the itemization of the verdict, together with a~~
17 ~~copy of the settlement or judgment.~~
18 ~~(i) In the case of a settlement, such information as~~
19 ~~the department may require with regard to the injured person's~~
20 ~~incurred and anticipated medical expense, wage loss, and other~~
21 ~~expenses.~~
22 ~~(j) The loss adjustment expense paid to defense~~
23 ~~counsel, and all other allocated loss adjustment expense paid.~~
24 ~~(k) The date and reason for final disposition, if no~~
25 ~~judgment or settlement.~~
26 ~~(l) A summary of the occurrence which created the~~
27 ~~claim, which shall include:~~
28 ~~1. The name of the institution, if any, and the~~
29 ~~location within such institution, at which the injury~~
30 ~~occurred.~~
31

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

1 ~~2. The final diagnosis for which treatment was sought~~
2 ~~or rendered, including the patient's actual condition.~~
3 ~~3. A description of the misdiagnosis made, if any, of~~
4 ~~the patient's actual condition.~~
5 ~~4. The operation or the diagnostic or treatment~~
6 ~~procedure causing the injury.~~
7 ~~5. A description of the principal injury giving rise~~
8 ~~to the claim.~~
9 ~~6. The safety management steps that have been taken by~~
10 ~~the licensee to make similar occurrences or injuries less~~
11 ~~likely in the future.~~
12 ~~(m) Any other information required by the department~~
13 ~~to analyze and evaluate the nature, causes, location, cost,~~
14 ~~and damages involved in professional liability cases.~~
15 Section 19. Section 456.051, Florida Statutes, is
16 amended to read:
17 456.051 Reports of professional liability actions;
18 bankruptcies; Department of Health's responsibility to
19 provide.--
20 (1) The report of a claim or action for damages for
21 personal injury which is required to be provided to the
22 Department of Health under s. 456.049 or s. 627.912 is public
23 information except for the name of the claimant or injured
24 person, which remains confidential as provided in ss.
25 456.049(2)(d) and 627.912(2)(e). The Department of Health
26 shall, upon request, make such report available to any person.
27 The department shall make such report available as a part of
28 the practitioner's profile within 30 calendar days after
29 receipt.
30 (2) Any information in the possession of the
31 Department of Health which relates to a bankruptcy proceeding

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

1 by a practitioner of medicine licensed under chapter 458, a
2 practitioner of osteopathic medicine licensed under chapter
3 459, a podiatric physician licensed under chapter 461, or a
4 dentist licensed under chapter 466 is public information. The
5 Department of Health shall, upon request, make such
6 information available to any person. The department shall make
7 such report available as a part of the practitioner's profile
8 within 30 calendar days after receipt.
9 Section 20. Paragraph (a) of subsection (7) of section
10 456.057, Florida Statutes, is amended to read:
11 456.057 Ownership and control of patient records;
12 report or copies of records to be furnished.--
13 (7)(a)1. The department may obtain patient records
14 pursuant to a subpoena without written authorization from the
15 patient if the department and the probable cause panel of the
16 appropriate board, if any, find reasonable cause to believe
17 that a health care practitioner has excessively or
18 inappropriately prescribed any controlled substance specified
19 in chapter 893 in violation of this chapter or any
20 professional practice act or that a health care practitioner
21 has practiced his or her profession below that level of care,
22 skill, and treatment required as defined by this chapter or
23 any professional practice act and also find that appropriate,
24 reasonable attempts were made to obtain a patient release.
25 2. The department may obtain patient records and
26 insurance information pursuant to a subpoena without written
27 authorization from the patient if the department and the
28 probable cause panel of the appropriate board, if any, find
29 reasonable cause to believe that a health care practitioner
30 has provided inadequate medical care based on termination of
31

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

1 insurance and also find that appropriate, reasonable attempts
2 were made to obtain a patient release.
3 3. The department may obtain patient records, billing
4 records, insurance information, provider contracts, and all
5 attachments thereto pursuant to a subpoena without written
6 authorization from the patient if the department and probable
7 cause panel of the appropriate board, if any, find reasonable
8 cause to believe that a health care practitioner has submitted
9 a claim, statement, or bill using a billing code that would
10 result in payment greater in amount than would be paid using a
11 billing code that accurately describes the services performed,
12 requested payment for services that were not performed by that
13 health care practitioner, used information derived from a
14 written report of an automobile accident generated pursuant to
15 chapter 316 to solicit or obtain patients personally or
16 through an agent regardless of whether the information is
17 derived directly from the report or a summary of that report
18 or from another person, solicited patients fraudulently,
19 received a kickback as defined in s. 456.054, violated the
20 patient brokering provisions of s. 817.505, or presented or
21 caused to be presented a false or fraudulent insurance claim
22 within the meaning of s. 817.234(1)(a), and also find that,
23 within the meaning of s. 817.234(1)(a), patient authorization
24 cannot be obtained because the patient cannot be located or is
25 deceased, incapacitated, or suspected of being a participant
26 in the fraud or scheme, and if the subpoena is issued for
27 specific and relevant records. For purposes of this
28 subsection, if the patient refuses to cooperate, is
29 unavailable, or fails to execute a patient release, the
30 department may obtain patient records pursuant to a subpoena
31 without written authorization from the patient.

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

1 Section 21. Subsection (4) is added to section
2 456.063, Florida Statutes, to read:
3 456.063 Sexual misconduct; disqualification for
4 license, certificate, or registration.--
5 (4) Each board, or the department if there is no
6 board, may adopt rules to implement the requirements for
7 reporting allegations of sexual misconduct, including rules to
8 determine the sufficiency of the allegations.
9 Section 22. Subsection (4) of section 456.072, Florida
10 Statutes, is amended to read:
11 456.072 Grounds for discipline; penalties;
12 enforcement.--
13 (4) In addition to any other discipline imposed
14 through final order, or citation, entered on or after July 1,
15 2001, pursuant to this section or discipline imposed through
16 final order, or citation, entered on or after July 1, 2001,
17 for a violation of any practice act, the board, or the
18 department when there is no board, shall assess costs related
19 to the investigation and prosecution of the case. Such costs
20 related to the investigation and prosecution include, but are
21 not limited to, salaries and benefits of personnel, costs
22 related to the time spent by the attorney and other personnel
23 working on the case, and any other expenses incurred by the
24 department for the case. The board, or the department when
25 there in no board, shall determine the amount of costs to be
26 assessed after its consideration of an affidavit of itemized
27 costs and any written objections thereto.In any case where
28 the board or the department imposes a fine or assessment and
29 the fine or assessment is not paid within a reasonable time,
30 such reasonable time to be prescribed in the rules of the
31 board, or the department when there is no board, or in the

1 order assessing such fines or costs, the department or the
2 Department of Legal Affairs may contract for the collection
3 of, or bring a civil action to recover, the fine or
4 assessment.
5 Section 23. Subsections (1) and (5) of section
6 456.073, Florida Statutes, as amended by section 1 of chapter
7 2003-27, Laws of Florida, are amended to read:
8 456.073 Disciplinary proceedings.--Disciplinary
9 proceedings for each board shall be within the jurisdiction of
10 the department.
11 (1) The department, for the boards under its
12 jurisdiction, shall cause to be investigated any complaint
13 that is filed before it if the complaint is in writing, signed
14 by the complainant, and legally sufficient. A complaint filed
15 by a state prisoner against a health care practitioner
16 employed by or otherwise providing health care services within
17 a facility of the Department of Corrections is not legally
18 sufficient unless there is a showing that the prisoner
19 complainant has exhausted all available administrative
20 remedies within the state correctional system before filing
21 the complaint. However, if the Department of Health determines
22 after a preliminary inquiry of a state prisoner's complaint
23 that the practitioner may present a serious threat to the
24 health and safety of any individual who is not a state
25 prisoner, the Department of Health may determine legal
26 sufficiency and proceed with discipline. The Department of
27 Health shall be notified within 15 days after the Department
28 of Corrections disciplines or allows a health care
29 practitioner to resign for an offense related to the practice
30 of his or her profession. A complaint is legally sufficient if
31 it contains ultimate facts that show that a violation of this

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

1 chapter, of any of the practice acts relating to the
2 professions regulated by the department, or of any rule
3 adopted by the department or a regulatory board in the
4 department has occurred. In order to determine legal
5 sufficiency, the department may require supporting information
6 or documentation. The department may investigate, and the
7 department or the appropriate board may take appropriate final
8 action on, a complaint even though the original complainant
9 withdraws it or otherwise indicates a desire not to cause the
10 complaint to be investigated or prosecuted to completion. The
11 department may investigate an anonymous complaint if the
12 complaint is in writing and is legally sufficient, if the
13 alleged violation of law or rules is substantial, and if the
14 department has reason to believe, after preliminary inquiry,
15 that the violations alleged in the complaint are true. The
16 department may investigate a complaint made by a confidential
17 informant if the complaint is legally sufficient, if the
18 alleged violation of law or rule is substantial, and if the
19 department has reason to believe, after preliminary inquiry,
20 that the allegations of the complainant are true. The
21 department may initiate an investigation if it has reasonable
22 cause to believe that a licensee or a group of licensees has
23 violated a Florida statute, a rule of the department, or a
24 rule of a board. Notwithstanding subsection (13), the
25 department may investigate information filed pursuant to s.
26 456.041(4) relating to liability actions with respect to
27 practitioners licensed under chapter 458 or chapter 459 which
28 have been reported under s. 456.049 or s. 627.912 within the
29 previous 6 years for any paid claim that exceeds $50,000.
30 Except as provided in ss. 458.331(9), 459.015(9), 460.413(5),
31 and 461.013(6), when an investigation of any subject is

1 undertaken, the department shall promptly furnish to the
2 subject or the subject's attorney a copy of the complaint or
3 document that resulted in the initiation of the investigation.
4 The subject may submit a written response to the information
5 contained in such complaint or document within 20 days after
6 service to the subject of the complaint or document. The
7 subject's written response shall be considered by the probable
8 cause panel. The right to respond does not prohibit the
9 issuance of a summary emergency order if necessary to protect
10 the public. However, if the secretary, or the secretary's
11 designee, and the chair of the respective board or the chair
12 of its probable cause panel agree in writing that such
13 notification would be detrimental to the investigation, the
14 department may withhold notification. The department may
15 conduct an investigation without notification to any subject
16 if the act under investigation is a criminal offense.
17 (5) A formal hearing before an administrative law
18 judge from the Division of Administrative Hearings shall be
19 held pursuant to chapter 120 if there are any disputed issues
20 of material fact. The determination of whether or not a
21 licensee has violated the laws and rules regulating the
22 profession, including a determination of the reasonable
23 standard of care, is a conclusion of law to be determined by
24 the board, or department when there is no board, and is not a
25 finding of fact to be determined by an administrative law
26 judge.The administrative law judge shall issue a recommended
27 order pursuant to chapter 120. Notwithstanding s. 120.569(2),
28 the department shall notify the division within 45 days after
29 receipt of a petition or request for a formal hearing.~~If any~~
30 ~~party raises an issue of disputed fact during an informal~~
31

1 ~~hearing, the hearing shall be terminated and a formal hearing~~
2 ~~pursuant to chapter 120 shall be held.~~
3 Section 24. Subsections (1) and (2) of section
4 456.077, Florida Statutes, are amended to read:
5 456.077 Authority to issue citations.--
6 (1) Notwithstanding s. 456.073, the board, or the
7 department if there is no board, shall adopt rules to permit
8 the issuance of citations. The citation shall be issued to the
9 subject and shall contain the subject's name and address, the
10 subject's license number if applicable, a brief factual
11 statement, the sections of the law allegedly violated, and the
12 penalty imposed. The citation must clearly state that the
13 subject may choose, in lieu of accepting the citation, to
14 follow the procedure under s. 456.073. If the subject disputes
15 the matter in the citation, the procedures set forth in s.
16 456.073 must be followed. However, if the subject does not
17 dispute the matter in the citation with the department within
18 30 days after the citation is served, the citation becomes a
19 public final order and does not constitute ~~constitutes~~
20 discipline for a first offense, but does constitute discipline
21 for a second or subsequent offense. The penalty shall be a
22 fine or other conditions as established by rule.
23 (2) The board, or the department if there is no board,
24 shall adopt rules designating violations for which a citation
25 may be issued. Such rules shall designate as citation
26 violations those violations for which there is no substantial
27 threat to the public health, safety, and welfare or no
28 violation of standard of care involving injury to a patient.
29 Violations for which a citation may be issued shall include
30 violations of continuing education requirements; failure to
31 timely pay required fees and fines; failure to comply with the

1 requirements of ss. 381.026 and 381.0261 regarding the
2 dissemination of information regarding patient rights; failure
3 to comply with advertising requirements; failure to timely
4 update practitioner profile and credentialing files; failure
5 to display signs, licenses, and permits; failure to have
6 required reference books available; and all other violations
7 that do not pose a direct and serious threat to the health and
8 safety of the patient or involve a violation of standard of
9 care that has resulted in injury to a patient.
10 Section 25. Section 456.078, Florida Statutes, is
11 amended to read:
12 456.078 Mediation.--
13 (1) Notwithstanding the provisions of s. 456.073, the
14 board, or the department when there is no board, shall adopt
15 rules to designate which violations of the applicable
16 professional practice act are appropriate for mediation. The
17 board, or the department when there is no board, shall ~~may~~
18 designate as mediation offenses those complaints where harm
19 caused by the licensee:
20 (a) Is economic in nature except any act or omission
21 involving intentional misconduct, ~~or~~
22 (b) Can be remedied by the licensee, ~~.~~
23 (c) Is not a standard of care violation involving any
24 type of injury to a patient, or
25 (d) Does not result in an adverse incident.
26 (2) For the purposes of this section, an "adverse
27 incident" means an event that results in:
28 (a) The death of a patient;
29 (b) Brain or spinal damage to a patient;
30 (c) The performance of a surgical procedure on the
31 wrong patient;

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

1 (d) The performance of a wrong-site surgical
2 procedure;
3 (e) The performance of a surgical procedure that is
4 medically unnecessary or otherwise unrelated to the patient's
5 diagnosis or medical condition;
6 (f) The surgical repair of damage to a patient
7 resulting from a planned surgical procedure, which damage is
8 not a recognized specific risk as disclosed to the patient and
9 documented through the informed-consent process;
10 (g) The performance of a procedure to remove unplanned
11 foreign objects remaining from a surgical procedure; or
12 (h) The performance of any other surgical procedure
13 that breached the standard of care.
14 (3)~~(2)~~ After the department determines a complaint is
15 legally sufficient and the alleged violations are defined as
16 mediation offenses, the department or any agent of the
17 department may conduct informal mediation to resolve the
18 complaint. If the complainant and the subject of the complaint
19 agree to a resolution of a complaint within 14 days after
20 contact by the mediator, the mediator shall notify the
21 department of the terms of the resolution. The department or
22 board shall take no further action unless the complainant and
23 the subject each fail to record with the department an
24 acknowledgment of satisfaction of the terms of mediation
25 within 60 days of the mediator's notification to the
26 department. A successful mediation shall not constitute
27 discipline.In the event the complainant and subject fail to
28 reach settlement terms or to record the required
29 acknowledgment, the department shall process the complaint
30 according to the provisions of s. 456.073.
31

(4)~~(3)~~ Conduct or statements made during mediation are inadmissible in any proceeding pursuant to s. 456.073. Further, any information relating to the mediation of a case shall be subject to the confidentiality provisions of s. 456.073.

(5)~~(4)~~ No licensee shall go through the mediation process more than three times without approval of the department. The department may consider the subject and dates of the earlier complaints in rendering its decision. Such decision shall not be considered a final agency action for purposes of chapter 120.

(6)~~(5)~~ Any board created on or after January 1, 1995, shall have 6 months to adopt rules designating which violations are appropriate for mediation, after which time the department shall have exclusive authority to adopt rules pursuant to this section. A board shall have continuing authority to amend its rules adopted pursuant to this section.

Section 26. Subsection (9) is added to section 458.311, Florida Statutes, to read:

458.311 Licensure by examination; requirements; fees.--

(9) In addition to other information required under this section, an applicant for licensure or relicensure must submit the following information to the department:

(a) The name of the applicant's insurance carrier;

(b) If the applicant is self-insured, a description of how, such as a certificate of deposit;

(c) The dates of insurance coverage;

(d) The cost of insurance coverage;

(e) The terms and limits of insurance coverage, including policy changes;

1 (f) The identity of the hospital or group name if
2 coverage is provided by an entity other than the licensee;
3 (g) Whether the licensee is covered by insurance;
4 (h) The applicant's specialty of practice; and
5 (i) The name of the county or counties in which the
6 licensee practices medicine.
7
8 A licensee seeking a renewal license must include the
9 specified information for the 2 years prior to the renewal
10 date. The department shall include the information provided on
11 the application form in its computer database.
12 Section 27. Subsection (5) is added to section
13 459.0055, Florida Statutes, to read:
14 459.0055 General licensure requirements.--
15 (5) In addition to other information required under
16 this section, an applicant for licensure or relicensure must
17 submit the following information to the department:
18 (a) The name of the applicant's insurance carrier;
19 (b) If the applicant is self-insured, a description of
20 how, such as a certificate of deposit;
21 (c) The dates of insurance coverage;
22 (d) The cost of insurance coverage;
23 (e) The terms and limits of insurance coverage,
24 including policy changes;
25 (f) The identity of the hospital or group name if
26 coverage is provided by an entity other than the licensee;
27 (g) Whether the licensee is covered by insurance;
28 (h) The applicant's specialty of practice; and
29 (i) The name of the county or counties in which the
30 licensee practices medicine.
31

A licensee seeking a renewal license must include the specified information for the 2 years prior to the renewal date. The department shall include the information provided on the application form in its computer database.

Section 28. Effective upon this act becoming a law and applying to claims accruing on or after that date, section 458.320, Florida Statutes, is amended to read:

458.320 Financial responsibility.--

(1) As a condition of licensing and maintaining an active license, and prior to the issuance or renewal of an active license or reactivation of an inactive license for the practice of medicine, an applicant must ~~shall~~ by one of the following methods demonstrate to the satisfaction of the board and the department financial responsibility to pay claims and costs ancillary thereto arising out of the rendering of, or the failure to render, medical care or services:

(a) Establishing and maintaining an escrow account consisting of cash or assets eligible for deposit in accordance with s. 625.52 in the per claim amounts specified in paragraph (b). The required escrow amount set forth in this paragraph may not be used for litigation costs or attorney's fees for the defense of any medical malpractice claim.

(b) Obtaining and maintaining professional liability coverage in an amount not less than $100,000 per claim, with a minimum annual aggregate of not less than $300,000, from an authorized insurer as defined under s. 624.09, from a surplus lines insurer as defined under s. 626.914(2), from a risk retention group as defined under s. 627.942, from the Joint Underwriting Association established under s. 627.351(4), or through a plan of self-insurance as provided in s. 627.357. The required coverage amount set forth in this paragraph may

1 not be used for litigation costs or attorney's fees for the
2 defense of any medical malpractice claim.
3 (c) Obtaining and maintaining an unexpired,
4 irrevocable letter of credit, established pursuant to chapter
5 675, in an amount not less than $100,000 per claim, with a
6 minimum aggregate availability of credit of not less than
7 $300,000. The letter of credit must ~~shall~~ be payable to the
8 physician as beneficiary upon presentment of a final judgment
9 indicating liability and awarding damages to be paid by the
10 physician or upon presentment of a settlement agreement signed
11 by all parties to such agreement when such final judgment or
12 settlement is a result of a claim arising out of the rendering
13 of, or the failure to render, medical care and services. The
14 letter of credit may not be used for litigation costs or
15 attorney's fees for the defense of any medical malpractice
16 claim. The ~~Such~~ letter of credit must ~~shall~~ be nonassignable
17 and nontransferable. Such letter of credit must ~~shall~~ be
18 issued by any bank or savings association organized and
19 existing under the laws of this state or any bank or savings
20 association organized under the laws of the United States
21 which ~~that~~ has its principal place of business in this state
22 or has a branch office that ~~which~~ is authorized under the laws
23 of this state or of the United States to receive deposits in
24 this state.
25 (2) Physicians who perform surgery in an ambulatory
26 surgical center licensed under chapter 395 and, as a
27 continuing condition of hospital staff privileges, physicians
28 who have ~~with~~ staff privileges must ~~shall~~ also ~~be required to~~
29 establish financial responsibility by one of the following
30 methods:
31

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

1 (a) Establishing and maintaining an escrow account
2 consisting of cash or assets eligible for deposit in
3 accordance with s. 625.52 in the per claim amounts specified
4 in paragraph (b). The required escrow amount set forth in this
5 paragraph may not be used for litigation costs or attorney's
6 fees for the defense of any medical malpractice claim.
7 (b) Obtaining and maintaining professional liability
8 coverage in an amount not less than $250,000 per claim, with a
9 minimum annual aggregate of not less than $750,000 from an
10 authorized insurer as defined under s. 624.09, from a surplus
11 lines insurer as defined under s. 626.914(2), from a risk
12 retention group as defined under s. 627.942, from the Joint
13 Underwriting Association established under s. 627.351(4),
14 through a plan of self-insurance as provided in s. 627.357, or
15 through a plan of self-insurance which meets the conditions
16 specified for satisfying financial responsibility in s.
17 766.110. The required coverage amount set forth in this
18 paragraph may not be used for litigation costs or attorney's
19 fees for the defense of any medical malpractice claim.
20 (c) Obtaining and maintaining an unexpired irrevocable
21 letter of credit, established pursuant to chapter 675, in an
22 amount not less than $250,000 per claim, with a minimum
23 aggregate availability of credit of not less than $750,000.
24 The letter of credit must ~~shall~~ be payable to the physician as
25 beneficiary upon presentment of a final judgment indicating
26 liability and awarding damages to be paid by the physician or
27 upon presentment of a settlement agreement signed by all
28 parties to such agreement when such final judgment or
29 settlement is a result of a claim arising out of the rendering
30 of, or the failure to render, medical care and services. The
31 letter of credit may not be used for litigation costs or

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

attorney's fees for the defense of any medical malpractice claim. The ~~Such~~ letter of credit must ~~shall~~ be nonassignable and nontransferable. The ~~Such~~ letter of credit must ~~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 which ~~that~~ has its principal place of business in this state or has a branch office that ~~which~~ is authorized under the laws of this state or of the United States to receive deposits in this state.

This subsection shall be inclusive of the coverage in subsection (1).

(3)(a) ~~The financial responsibility requirements of subsections (1) and (2) shall apply to claims for incidents that occur on or after January 1, 1987, or the initial date of licensure in this state, whichever is later.~~

~~(b)~~ Meeting the financial responsibility requirements of this section or the criteria for any exemption from such requirements must ~~shall~~ be established at the time of issuance or renewal of a license ~~on or after January 1, 1987~~.

(b)~~(c)~~ Any person may, at any time, submit to the department a request for an advisory opinion regarding such person's qualifications for exemption.

(4)(a) Each insurer, self-insurer, risk retention group, or Joint Underwriting Association must ~~shall~~ promptly notify the department of cancellation or nonrenewal of insurance required by this section. Unless the physician demonstrates that he or she is otherwise in compliance with the requirements of this section, the department shall suspend the license of the physician pursuant to ss. 120.569 and

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

120.57 and notify all health care facilities licensed under chapter 395 of such action. Any suspension under this subsection remains ~~shall remain~~ in effect until the physician demonstrates compliance with the requirements of this section. If any judgments or settlements are pending at the time of suspension, those judgments or settlements must be paid in accordance with this section unless otherwise mutually agreed to in writing by the parties. This paragraph does not abrogate a judgment debtor's obligation to satisfy the entire amount of any judgment~~, except that a license suspended under paragraph (5)(g) shall not be reinstated until the physician demonstrates compliance with the requirements of that provision~~.

(b) If financial responsibility requirements are met by maintaining an escrow account or letter of credit as provided in this section, upon the entry of an adverse final judgment arising from a medical malpractice arbitration award, from a claim of medical malpractice either in contract or tort, or from noncompliance with the terms of a settlement agreement arising from a claim of medical malpractice either in contract or tort, the licensee shall pay the entire amount of the judgment together with all accrued interest, or the amount maintained in the escrow account or provided in the letter of credit as required by this section, whichever is less, within 60 days after the date such judgment became final and subject to execution, unless otherwise mutually agreed to in writing by the parties. If timely payment is not made by the physician, the department shall suspend the license of the physician pursuant to procedures set forth in subparagraphs (5)(g)3., 4., and 5. Nothing in this paragraph shall abrogate

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

a judgment debtor's obligation to satisfy the entire amount of any judgment.

(5) The requirements of subsections (1), (2), and (3) do ~~shall~~ not apply to:

(a) Any person licensed under this chapter who practices medicine exclusively as an officer, employee, or agent of the Federal Government or of the state or its agencies or its subdivisions. For the purposes of this subsection, an agent of the state, its agencies, or its subdivisions is a person who is eligible for coverage under any self-insurance or insurance program authorized by the provisions of s. 768.28(15).

(b) Any person whose license has become inactive under this chapter and who is not practicing medicine in this state. Any person applying for reactivation of a license must show either that such licensee maintained tail insurance coverage which provided liability coverage for incidents that occurred on or after January 1, 1987, or the initial date of licensure in this state, whichever is later, and incidents that occurred before the date on which the license became inactive; or such licensee must submit an affidavit stating that such licensee has no unsatisfied medical malpractice judgments or settlements at the time of application for reactivation.

(c) Any person holding a limited license pursuant to s. 458.317 and practicing under the scope of such limited license.

(d) Any person licensed or certified under this chapter who practices only in conjunction with his or her teaching duties at an accredited medical school or in its main teaching hospitals. Such person may engage in the practice of medicine to the extent that such practice is incidental to and

1 a necessary part of duties in connection with the teaching
2 position in the medical school.
3 (e) Any person holding an active license under this
4 chapter who is not practicing medicine in this state. If such
5 person initiates or resumes any practice of medicine in this
6 state, he or she must notify the department of such activity
7 and fulfill the financial responsibility requirements of this
8 section before resuming the practice of medicine in this
9 state.
10 (f) Any person holding an active license under this
11 chapter who meets all of the following criteria:
12 1. The licensee has held an active license to practice
13 in this state or another state or some combination thereof for
14 more than 15 years.
15 2. The licensee has either retired from the practice
16 of medicine or maintains a part-time practice of no more than
17 1,000 patient contact hours per year.
18 3. The licensee has had no more than two claims for
19 medical malpractice resulting in an indemnity exceeding
20 $25,000 within the previous 5-year period.
21 4. The licensee has not been convicted of, or pled
22 guilty or nolo contendere to, any criminal violation specified
23 in this chapter or the medical practice act of any other
24 state.
25 5. The licensee has not been subject within the last
26 10 years of practice to license revocation or suspension for
27 any period of time; probation for a period of 3 years or
28 longer; or a fine of $500 or more for a violation of this
29 chapter or the medical practice act of another jurisdiction.
30 The regulatory agency's acceptance of a physician's
31 relinquishment of a license, stipulation, consent order, or

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

other settlement, offered in response to or in anticipation of the filing of administrative charges against the physician's license, constitutes ~~shall be construed as~~ action against the physician's license for the purposes of this paragraph.

6. The licensee has submitted a form supplying necessary information as required by the department and an affidavit affirming compliance with ~~the provisions of~~ this paragraph.

7. The licensee must ~~shall~~ submit biennially to the department certification stating compliance with the provisions of this paragraph. The licensee must ~~shall~~, upon request, demonstrate to the department information verifying compliance with this paragraph.

A licensee who meets the requirements of this paragraph must ~~shall be required either to~~ post notice in the form of a sign prominently displayed in the reception area and clearly noticeable by all patients or provide a written statement to any person to whom medical services are being provided. The ~~Such~~ sign or statement must read as follows ~~shall state~~ that: "Under Florida law, physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. However, certain part-time physicians who meet state requirements are exempt from the financial responsibility law. YOUR DOCTOR MEETS THESE REQUIREMENTS AND HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This notice is provided pursuant to Florida law."

(g) Any person holding an active license under this chapter who agrees to meet all of the following criteria:

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

1 1. Upon the entry of an adverse final judgment arising
2 from a medical malpractice arbitration award, from a claim of
3 medical malpractice either in contract or tort, or from
4 noncompliance with the terms of a settlement agreement arising
5 from a claim of medical malpractice either in contract or
6 tort, the licensee shall pay the judgment creditor the lesser
7 of the entire amount of the judgment with all accrued interest
8 or either $100,000, if the physician is licensed pursuant to
9 this chapter but does not maintain hospital staff privileges,
10 or $250,000, if the physician is licensed pursuant to this
11 chapter and maintains hospital staff privileges, within 60
12 days after the date such judgment became final and subject to
13 execution, unless otherwise mutually agreed to in writing by
14 the parties. Such adverse final judgment shall include any
15 cross-claim, counterclaim, or claim for indemnity or
16 contribution arising from the claim of medical malpractice.
17 Upon notification of the existence of an unsatisfied judgment
18 or payment pursuant to this subparagraph, the department shall
19 notify the licensee by certified mail that he or she shall be
20 subject to disciplinary action unless, within 30 days from the
21 date of mailing, he or she either:
22 a. Shows proof that the unsatisfied judgment has been
23 paid in the amount specified in this subparagraph; or
24 b. Furnishes the department with a copy of a timely
25 filed notice of appeal and either:
26 (I) A copy of a supersedeas bond properly posted in
27 the amount required by law; or
28 (II) An order from a court of competent jurisdiction
29 staying execution on the final judgment pending disposition of
30 the appeal.
31

CODING: Words ~~stricken~~ are deletions; words <u>underlined</u> are additions.

1 2. The Department of Health shall issue an emergency
2 order suspending the license of any licensee who, after 30
3 days following receipt of a notice from the Department of
4 Health, has failed to: satisfy a medical malpractice claim
5 against him or her; furnish the Department of Health a copy of
6 a timely filed notice of appeal; furnish the Department of
7 Health a copy of a supersedeas bond properly posted in the
8 amount required by law; or furnish the Department of Health an
9 order from a court of competent jurisdiction staying execution
10 on the final judgment pending disposition of the appeal.
11 3. Upon the next meeting of the probable cause panel
12 of the board following 30 days after the date of mailing the
13 notice of disciplinary action to the licensee, the panel shall
14 make a determination of whether probable cause exists to take
15 disciplinary action against the licensee pursuant to
16 subparagraph 1.
17 4. If the board determines that the factual
18 requirements of subparagraph 1. are met, it shall take
19 disciplinary action as it deems appropriate against the
20 licensee. Such disciplinary action shall include, at a
21 minimum, probation of the license with the restriction that
22 the licensee must make payments to the judgment creditor on a
23 schedule determined by the board to be reasonable and within
24 the financial capability of the physician. Notwithstanding any
25 other disciplinary penalty imposed, the disciplinary penalty
26 may include suspension of the license for a period not to
27 exceed 5 years. In the event that an agreement to satisfy a
28 judgment has been met, the board shall remove any restriction
29 on the license.
30 5. The licensee has completed a form supplying
31 necessary information as required by the department.

1
2 A licensee who meets the requirements of this paragraph shall
3 be required either to post notice in the form of a sign
4 prominently displayed in the reception area and clearly
5 noticeable by all patients or to provide a written statement
6 to any person to whom medical services are being provided.
7 Such sign or statement shall state: "Under Florida law,
8 physicians are generally required to carry medical malpractice
9 insurance or otherwise demonstrate financial responsibility to
10 cover potential claims for medical malpractice. YOUR DOCTOR
11 HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This
12 is permitted under Florida law subject to certain conditions.
13 Florida law imposes penalties against noninsured physicians
14 who fail to satisfy adverse judgments arising from claims of
15 medical malpractice. This notice is provided pursuant to
16 Florida law."
17 (6) Any deceptive, untrue, or fraudulent
18 representation by the licensee with respect to any provision
19 of this section shall result in permanent disqualification
20 from any exemption to mandated financial responsibility as
21 provided in this section and shall constitute grounds for
22 disciplinary action under s. 458.331.
23 (7) Any licensee who relies on any exemption from the
24 financial responsibility requirement shall notify the
25 department, in writing, of any change of circumstance
26 regarding his or her qualifications for such exemption and
27 shall demonstrate that he or she is in compliance with the
28 requirements of this section.
29 <u>(8) Notwithstanding any other provision of this</u>
30 <u>section, the department shall suspend the license of any</u>
31 <u>physician against whom has been entered a final judgment,</u>

1 arbitration award, or other order or who has entered into a
2 settlement agreement to pay damages arising out of a claim for
3 medical malpractice, if all appellate remedies have been
4 exhausted and payment up to the amounts required by this
5 section has not been made within 30 days after the entering of
6 such judgment, award, or order or agreement, until proof of
7 payment is received by the department or a payment schedule
8 has been agreed upon by the physician and the claimant and
9 presented to the department. This subsection does not apply to
10 a physician who has met the financial responsibility
11 requirements in paragraphs (1)(b) and (2)(b).
12 (9)~~(8)~~ The board shall adopt rules to implement the
13 provisions of this section.
14 Section 29. Effective upon this act becoming a law and
15 applying to claims accruing on or after that date, section
16 459.0085, Florida Statutes, is amended to read:
17 459.0085 Financial responsibility.--
18 (1) As a condition of licensing and maintaining an
19 active license, and prior to the issuance or renewal of an
20 active license or reactivation of an inactive license for the
21 practice of osteopathic medicine, an applicant must ~~shall~~ by
22 one of the following methods demonstrate to the satisfaction
23 of the board and the department financial responsibility to
24 pay claims and costs ancillary thereto arising out of the
25 rendering of, or the failure to render, medical care or
26 services:
27 (a) Establishing and maintaining an escrow account
28 consisting of cash or assets eligible for deposit in
29 accordance with s. 625.52 in the per-claim amounts specified
30 in paragraph (b).
31

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

(b) Obtaining and maintaining professional liability coverage in an amount not less than $100,000 per claim, with a minimum annual aggregate of not less than $300,000, from an authorized insurer as defined under s. 624.09, from a surplus lines insurer as defined under s. 626.914(2), from a risk retention group as defined under s. 627.942, from the Joint Underwriting Association established under s. 627.351(4), or through a plan of self-insurance as provided in s. 627.357. The required coverage amount set forth in this paragraph may not be used for litigation costs or attorney's fees for the defense of any medical malpractice claim.

(c) Obtaining and maintaining an unexpired, irrevocable letter of credit, established pursuant to chapter 675, in an amount not less than $100,000 per claim, with a minimum aggregate availability of credit of not less than $300,000. The letter of credit must ~~shall~~ be payable to the osteopathic physician as beneficiary upon presentment of a final judgment indicating liability and awarding damages to be paid by the osteopathic 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 must ~~shall~~ be nonassignable and nontransferable. Such letter of credit must ~~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 which ~~that~~ has its principal place of business in this state or has a branch office that ~~which~~ is authorized under the laws of this state or of the United States to receive deposits in this state.

1 (2) Osteopathic physicians who perform surgery in an
2 ambulatory surgical center licensed under chapter 395 and,as
3 a continuing condition of hospital staff privileges,
4 osteopathic physicians who have ~~with~~ staff privileges must
5 ~~shall~~ also ~~be required to~~ establish financial responsibility
6 by one of the following methods:
7 (a) Establishing and maintaining an escrow account
8 consisting of cash or assets eligible for deposit in
9 accordance with s. 625.52 in the per-claim amounts specified
10 in paragraph (b).
11 (b) Obtaining and maintaining professional liability
12 coverage in an amount not less than $250,000 per claim, with a
13 minimum annual aggregate of not less than $750,000 from an
14 authorized insurer as defined under s. 624.09, from a surplus
15 lines insurer as defined under s. 626.914(2), from a risk
16 retention group as defined under s. 627.942, from the Joint
17 Underwriting Association established under s. 627.351(4),
18 through a plan of self-insurance as provided in s. 627.357, or
19 through a plan of self-insurance that ~~which~~ meets the
20 conditions specified for satisfying financial responsibility
21 in s. 766.110.
22 (c) Obtaining and maintaining an unexpired,
23 irrevocable letter of credit, established pursuant to chapter
24 675, in an amount not less than $250,000 per claim, with a
25 minimum aggregate availability of credit of not less than
26 $750,000. The letter of credit must ~~shall~~ be payable to the
27 osteopathic physician as beneficiary upon presentment of a
28 final judgment indicating liability and awarding damages to be
29 paid by the osteopathic physician or upon presentment of a
30 settlement agreement signed by all parties to such agreement
31 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. The ~~Such~~ letter of credit must ~~shall~~ be nonassignable and nontransferable. The ~~Such~~ letter of credit must ~~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 which ~~that~~ has its principal place of business in this state or has a branch office that ~~which~~ is authorized under the laws of this state or of the United States to receive deposits in this state.

This subsection shall be inclusive of the coverage in subsection (1).

(3)(a) ~~The financial responsibility requirements of subsections (1) and (2) shall apply to claims for incidents that occur on or after January 1, 1987, or the initial date of licensure in this state, whichever is later.~~

~~(b)~~ Meeting the financial responsibility requirements of this section or the criteria for any exemption from such requirements must ~~shall~~ be established at the time of issuance or renewal of a license ~~on or after January 1, 1987~~.

(b)~~(c)~~ Any person may, at any time, submit to the department a request for an advisory opinion regarding such person's qualifications for exemption.

(4)(a) Each insurer, self-insurer, risk retention group, or joint underwriting association must ~~shall~~ promptly notify the department of cancellation or nonrenewal of insurance required by this section. Unless the osteopathic physician demonstrates that he or she is otherwise in compliance with the requirements of this section, the department shall suspend the license of the osteopathic

1 physician pursuant to ss. 120.569 and 120.57 and notify all
2 health care facilities licensed under chapter 395, part IV of
3 chapter 394, or part I of chapter 641 of such action. Any
4 suspension under this subsection remains ~~shall remain~~ in
5 effect until the osteopathic physician demonstrates compliance
6 with the requirements of this section. If any judgments or
7 settlements are pending at the time of suspension, those
8 judgments or settlements must be paid in accordance with this
9 section unless otherwise mutually agreed to in writing by the
10 parties. This paragraph does not abrogate a judgment debtor's
11 obligation to satisfy the entire amount of any judgment ~~except~~
12 ~~that a license suspended under paragraph (5)(g) shall not be~~
13 ~~reinstated until the osteopathic physician demonstrates~~
14 ~~compliance with the requirements of that provision~~.
15 (b) If financial responsibility requirements are met
16 by maintaining an escrow account or letter of credit as
17 provided in this section, upon the entry of an adverse final
18 judgment arising from a medical malpractice arbitration award,
19 from a claim of medical malpractice either in contract or
20 tort, or from noncompliance with the terms of a settlement
21 agreement arising from a claim of medical malpractice either
22 in contract or tort, the licensee shall pay the entire amount
23 of the judgment together with all accrued interest or the
24 amount maintained in the escrow account or provided in the
25 letter of credit as required by this section, whichever is
26 less, within 60 days after the date such judgment became final
27 and subject to execution, unless otherwise mutually agreed to
28 in writing by the parties. If timely payment is not made by
29 the osteopathic physician, the department shall suspend the
30 license of the osteopathic physician pursuant to procedures
31 set forth in subparagraphs (5)(g)3., 4., and 5. Nothing in

1 this paragraph shall abrogate a judgment debtor's obligation
2 to satisfy the entire amount of any judgment.
3 (5) The requirements of subsections (1), (2), and (3)
4 do ~~shall~~ not apply to:
5 (a) Any person licensed under this chapter who
6 practices medicine exclusively as an officer, employee, or
7 agent of the Federal Government or of the state or its
8 agencies or its subdivisions. For the purposes of this
9 subsection, an agent of the state, its agencies, or its
10 subdivisions is a person who is eligible for coverage under
11 any self-insurance or insurance program authorized by the
12 provisions of s. 768.28(15).
13 (b) Any person whose license has become inactive under
14 this chapter and who is not practicing medicine in this state.
15 Any person applying for reactivation of a license must show
16 either that such licensee maintained tail insurance coverage
17 that ~~which~~ provided liability coverage for incidents that
18 occurred on or after January 1, 1987, or the initial date of
19 licensure in this state, whichever is later, and incidents
20 that occurred before the date on which the license became
21 inactive; or such licensee must submit an affidavit stating
22 that such licensee has no unsatisfied medical malpractice
23 judgments or settlements at the time of application for
24 reactivation.
25 (c) Any person holding a limited license pursuant to
26 s. 459.0075 and practicing under the scope of such limited
27 license.
28 (d) Any person licensed or certified under this
29 chapter who practices only in conjunction with his or her
30 teaching duties at a college of osteopathic medicine. Such
31 person may engage in the practice of osteopathic medicine to

1 the extent that such practice is incidental to and a necessary
2 part of duties in connection with the teaching position in the
3 college of osteopathic medicine.
4 (e) Any person holding an active license under this
5 chapter who is not practicing osteopathic medicine in this
6 state. If such person initiates or resumes any practice of
7 osteopathic medicine in this state, he or she must notify the
8 department of such activity <u>and fulfill the financial</u>
9 <u>responsibility requirements of this section before resuming</u>
10 <u>the practice of osteopathic medicine in this state</u>.
11 (f) Any person holding an active license under this
12 chapter who meets all of the following criteria:
13 1. The licensee has held an active license to practice
14 in this state or another state or some combination thereof for
15 more than 15 years.
16 2. The licensee has either retired from the practice
17 of osteopathic medicine or maintains a part-time practice of
18 osteopathic medicine of no more than 1,000 patient contact
19 hours per year.
20 3. The licensee has had no more than two claims for
21 medical malpractice resulting in an indemnity exceeding
22 $25,000 within the previous 5-year period.
23 4. The licensee has not been convicted of, or pled
24 guilty or nolo contendere to, any criminal violation specified
25 in this chapter or the practice act of any other state.
26 5. The licensee has not been subject within the last
27 10 years of practice to license revocation or suspension for
28 any period of time, probation for a period of 3 years or
29 longer, or a fine of $500 or more for a violation of this
30 chapter or the medical practice act of another jurisdiction.
31 The regulatory agency's acceptance of an osteopathic

physician's relinquishment of a license, stipulation, consent order, or other settlement, offered in response to or in anticipation of the filing of administrative charges against the osteopathic physician's license, constitutes ~~shall be construed as~~ action against the physician's license for the purposes of this paragraph.

6. The licensee has submitted a form supplying necessary information as required by the department and an affidavit affirming compliance with ~~the provisions of~~ this paragraph.

7. The licensee must ~~shall~~ submit biennially to the department a certification stating compliance with ~~the provisions of~~ this paragraph. The licensee must ~~shall~~, upon request, demonstrate to the department information verifying compliance with this paragraph.

A licensee who meets the requirements of this paragraph must ~~shall be required either to~~ post notice in the form of a sign prominently displayed in the reception area and clearly noticeable by all patients or ~~to~~ provide a written statement to any person to whom medical services are being provided. The ~~Such~~ sign or statement must read as follows ~~shall state that~~: "Under Florida law, osteopathic physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. However, certain part-time osteopathic physicians who meet state requirements are exempt from the financial responsibility law. YOUR OSTEOPATHIC PHYSICIAN MEETS THESE REQUIREMENTS AND HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This notice is provided pursuant to Florida law."

1 (g) Any person holding an active license under this
2 chapter who agrees to meet all of the following criteria.
3 1. Upon the entry of an adverse final judgment arising
4 from a medical malpractice arbitration award, from a claim of
5 medical malpractice either in contract or tort, or from
6 noncompliance with the terms of a settlement agreement arising
7 from a claim of medical malpractice either in contract or
8 tort, the licensee shall pay the judgment creditor the lesser
9 of the entire amount of the judgment with all accrued interest
10 or either $100,000, if the osteopathic physician is licensed
11 pursuant to this chapter but does not maintain hospital staff
12 privileges, or $250,000, if the osteopathic physician is
13 licensed pursuant to this chapter and maintains hospital staff
14 privileges, within 60 days after the date such judgment became
15 final and subject to execution, unless otherwise mutually
16 agreed to in writing by the parties. Such adverse final
17 judgment shall include any cross-claim, counterclaim, or claim
18 for indemnity or contribution arising from the claim of
19 medical malpractice. Upon notification of the existence of an
20 unsatisfied judgment or payment pursuant to this subparagraph,
21 the department shall notify the licensee by certified mail
22 that he or she shall be subject to disciplinary action unless,
23 within 30 days from the date of mailing, the licensee either:
24 a. Shows proof that the unsatisfied judgment has been
25 paid in the amount specified in this subparagraph; or
26 b. Furnishes the department with a copy of a timely
27 filed notice of appeal and either:
28 (I) A copy of a supersedeas bond properly posted in
29 the amount required by law; or
30
31

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

1 (II) An order from a court of competent jurisdiction
2 staying execution on the final judgment, pending disposition
3 of the appeal.
4 2. The Department of Health shall issue an emergency
5 order suspending the license of any licensee who, after 30
6 days following receipt of a notice from the Department of
7 Health, has failed to: satisfy a medical malpractice claim
8 against him or her; furnish the Department of Health a copy of
9 a timely filed notice of appeal; furnish the Department of
10 Health a copy of a supersedeas bond properly posted in the
11 amount required by law; or furnish the Department of Health an
12 order from a court of competent jurisdiction staying execution
13 on the final judgment pending disposition of the appeal.
14 3. Upon the next meeting of the probable cause panel
15 of the board following 30 days after the date of mailing the
16 notice of disciplinary action to the licensee, the panel shall
17 make a determination of whether probable cause exists to take
18 disciplinary action against the licensee pursuant to
19 subparagraph 1.
20 4. If the board determines that the factual
21 requirements of subparagraph 1. are met, it shall take
22 disciplinary action as it deems appropriate against the
23 licensee. Such disciplinary action shall include, at a
24 minimum, probation of the license with the restriction that
25 the licensee must make payments to the judgment creditor on a
26 schedule determined by the board to be reasonable and within
27 the financial capability of the osteopathic physician.
28 Notwithstanding any other disciplinary penalty imposed, the
29 disciplinary penalty may include suspension of the license for
30 a period not to exceed 5 years. In the event that an
31

1 agreement to satisfy a judgment has been met, the board shall
2 remove any restriction on the license.
3 5. The licensee has completed a form supplying
4 necessary information as required by the department.
5
6 A licensee who meets the requirements of this paragraph shall
7 be required either to post notice in the form of a sign
8 prominently displayed in the reception area and clearly
9 noticeable by all patients or to provide a written statement
10 to any person to whom medical services are being provided.
11 Such sign or statement shall state: "Under Florida law,
12 osteopathic physicians are generally required to carry medical
13 malpractice insurance or otherwise demonstrate financial
14 responsibility to cover potential claims for medical
15 malpractice. YOUR OSTEOPATHIC PHYSICIAN HAS DECIDED NOT TO
16 CARRY MEDICAL MALPRACTICE INSURANCE. This is permitted under
17 Florida law subject to certain conditions. Florida law
18 imposes strict penalties against noninsured osteopathic
19 physicians who fail to satisfy adverse judgments arising from
20 claims of medical malpractice. This notice is provided
21 pursuant to Florida law."
22 (6) Any deceptive, untrue, or fraudulent
23 representation by the licensee with respect to any provision
24 of this section shall result in permanent disqualification
25 from any exemption to mandated financial responsibility as
26 provided in this section and shall constitute grounds for
27 disciplinary action under s. 459.015.
28 (7) Any licensee who relies on any exemption from the
29 financial responsibility requirement shall notify the
30 department in writing of any change of circumstance regarding
31 his or her qualifications for such exemption and shall

1 demonstrate that he or she is in compliance with the
2 requirements of this section.
3 (8) If a physician is either a resident physician,
4 assistant resident physician, or intern in an approved
5 postgraduate training program, as defined by the board's
6 rules, and is supervised by a physician who is participating
7 in the Florida Birth-Related Neurological Injury Compensation
8 Plan, such resident physician, assistant resident physician,
9 or intern is deemed to be a participating physician without
10 the payment of the assessment set forth in s. 766.314(4).
11 (9) Notwithstanding any other provision of this
12 section, the department shall suspend the license of any
13 osteopathic physician against whom has been entered a final
14 judgment, arbitration award, or other order or who has entered
15 into a settlement agreement to pay damages arising out of a
16 claim for medical malpractice, if all appellate remedies have
17 been exhausted and payment up to the amounts required by this
18 section has not been made within 30 days after the entering of
19 such judgment, award, or order or agreement, until proof of
20 payment is received by the department or a payment schedule
21 has been agreed upon by the osteopathic physician and the
22 claimant and presented to the department. This subsection does
23 not apply to an osteopathic physician who has met the
24 financial responsibility requirements in paragraphs (1)(b) and
25 (2)(b).
26 (10) ~~(9)~~ The board shall adopt rules to implement the
27 provisions of this section.
28 Section 30. Civil immunity for members of or
29 consultants to certain boards, committees, or other
30 entities.--
31

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

1 (1) Each member of, or health care professional
2 consultant to, any committee, board, group, commission, or
3 other entity shall be immune from civil liability for any act,
4 decision, omission, or utterance done or made in performance
5 of his duties while serving as a member of or consultant to
6 such committee, board, group, commission, or other entity
7 established and operated for purposes of quality improvement
8 review, evaluation, and planning in a state-licensed health
9 care facility. Such entities must function primarily to
10 review, evaluate, or make recommendations relating to:
11 (a) The duration of patient stays in health care
12 facilities;
13 (b) The professional services furnished with respect
14 to the medical, dental, psychological, podiatric,
15 chiropractic, or optometric necessity for such services;
16 (c) The purpose of promoting the most efficient use of
17 available health care facilities and services;
18 (d) The adequacy or quality of professional services;
19 (e) The competency and qualifications for professional
20 staff privileges;
21 (f) The reasonableness or appropriateness of charges
22 made by or on behalf of health care facilities; or
23 (g) Patient safety, including entering into contracts
24 with patient safety organizations.
25 (2) Such committee, board, group, commission, or other
26 entity must be established in accordance with state law or in
27 accordance with requirements of the Joint Commission on
28 Accreditation of Healthcare Organizations, established and
29 duly constituted by one or more public or licensed private
30 hospitals or behavioral health agencies, or established by a
31 governmental agency. To be protected by this section, the act,

1 decision, omission, or utterance may not be made or done in
2 bad faith or with malicious intent.
3 Section 31. Patient safety data privilege.--
4 (1) As used in this section, the term:
5 (a) "Patient safety data" means reports made to
6 patient safety organizations, including all health care data,
7 interviews, memoranda, analyses, root cause analyses, products
8 of quality assurance or quality improvement processes,
9 corrective action plans, or information collected or created
10 by a health care facility licensed under chapter 395, Florida
11 Statutes, or a health care practitioner as defined in section
12 456.001(4), Florida Statutes, as a result of an occurrence
13 related to the provision of health care services which
14 exacerbates an existing medical condition or could result in
15 injury, illness, or death.
16 (b) "Patient safety organization" means any
17 organization, group, or other entity that collects and
18 analyzes patient safety data for the purpose of improving
19 patient safety and health care outcomes and that is
20 independent and not under the control of the entity that
21 reports patient safety data.
22 (2) Patient safety data shall not be subject to
23 discovery or introduction into evidence in any civil or
24 administrative action. However, information, documents, or
25 records otherwise available from original sources are not
26 immune from discovery or use in any civil or administrative
27 action merely because they were also collected, analyzed, or
28 presented to a patient safety organization. Any person who
29 testifies before a patient safety organization or who is a
30 member of such a group may not be prevented from testifying as
31 to matters within his or her knowledge, but he or she may not

1 be asked about his or her testimony before a patient safety
2 organization or the opinions formed by him or her as a result
3 of the hearings.
4 (3) Unless otherwise provided by law, a patient safety
5 organization shall promptly remove all patient-identifying
6 information after receipt of a complete patient safety data
7 report unless such organization is otherwise permitted by
8 state or federal law to maintain such information. Patient
9 safety organizations shall maintain the confidentiality of all
10 patient-identifying information and may not disseminate such
11 information, except as permitted by state or federal law.
12 (4) The exchange of patient safety data among health
13 care facilities licensed under chapter 395, Florida Statutes,
14 or health care practitioners as defined in section 456.001(4),
15 Florida Statutes, or patient safety organizations which does
16 not identify any patient shall not constitute a waiver of any
17 privilege established in this section.
18 (5) Reports of patient safety data to patient safety
19 organizations do not abrogate obligations to make reports to
20 the Department of Health, the Agency for Health Care
21 Administration, or other state or federal regulatory agencies.
22 (6) An employer may not take retaliatory action
23 against an employee who in good faith makes a report of
24 patient safety data to a patient safety organization.
25 Section 32. Each final settlement statement relating
26 to medical malpractice shall include the following statement:
27 "The decision to settle a case may reflect the economic
28 practicalities pertaining to the cost of litigation and is
29 not, alone, an admission that the insured failed to meet the
30 required standard of care applicable to the patient's
31 treatment. The decision to settle a case may be made by the

1 insurance company without consulting its client for input,
2 unless otherwise provided by the insurance policy."
3 Section 33. Paragraph (t) of subsection (1) and
4 subsection (6) of section 458.331, Florida Statutes, are
5 amended to read:
6 458.331 Grounds for disciplinary action; action by the
7 board and department.--
8 (1) The following acts constitute grounds for denial
9 of a license or disciplinary action, as specified in s.
10 456.072(2):
11 (t) Gross or repeated malpractice or the failure to
12 practice medicine with that level of care, skill, and
13 treatment which is recognized by a reasonably prudent similar
14 physician as being acceptable under similar conditions and
15 circumstances. The board shall give great weight to the
16 provisions of s. 766.102 when enforcing this paragraph. As
17 used in this paragraph, "repeated malpractice" includes, but
18 is not limited to, three or more claims for medical
19 malpractice within the previous 5-year period resulting in
20 indemnities being paid in excess of $50,000 ~~$25,000~~ each to
21 the claimant in a judgment or settlement and which incidents
22 involved negligent conduct by the physician. As used in this
23 paragraph, "gross malpractice" or "the failure to practice
24 medicine with that level of care, skill, and treatment which
25 is recognized by a reasonably prudent similar physician as
26 being acceptable under similar conditions and circumstances,"
27 shall not be construed so as to require more than one
28 instance, event, or act. Nothing in this paragraph shall be
29 construed to require that a physician be incompetent to
30 practice medicine in order to be disciplined pursuant to this
31 paragraph. A recommended order by an administrative law judge

1 or a final order of the board finding a violation under this
2 paragraph shall specify whether the licensee was found to have
3 committed "gross malpractice," "repeated malpractice," or
4 "failure to practice medicine with that level of care, skill,
5 and treatment which is recognized as being acceptable under
6 similar conditions and circumstances," or any combination
7 thereof, and any publication by the board must so specify.
8 (6) Upon the department's receipt from an insurer or
9 self-insurer of a report of a closed claim against a physician
10 pursuant to s. 627.912 or from a health care practitioner of a
11 report pursuant to s. 456.049, or upon the receipt from a
12 claimant of a presuit notice against a physician pursuant to
13 s. 766.106, the department shall review each report and
14 determine whether it potentially involved conduct by a
15 licensee that is subject to disciplinary action, in which case
16 the provisions of s. 456.073 shall apply. However, if it is
17 reported that a physician has had three or more claims with
18 indemnities exceeding $50,000 ~~$25,000~~ each within the previous
19 5-year period, the department shall investigate the
20 occurrences upon which the claims were based and determine if
21 action by the department against the physician is warranted.
22 Section 34. Section 458.3311, Florida Statutes, is
23 created to read:
24 458.3311 Emergency procedures for disciplinary
25 action.--Notwithstanding any other provision of law to the
26 contrary, no later than 30 days after a third report of a
27 professional liability claim against a licensed physician has
28 been submitted, within a 60-month period, as required by ss.
29 456.049 and 627.912, the Department of Health shall initiate
30 an emergency investigation and the Board of Medicine shall
31 conduct an emergency probable cause hearing to determine

1 whether the physician should be disciplined for a violation of
2 s. 458.331(1)(t) or any other relevant provision of law.
3 Section 35. Paragraph (x) of subsection (1) and
4 subsection (6) of section 459.015, Florida Statutes, are
5 amended to read:
6 459.015 Grounds for disciplinary action; action by the
7 board and department.--
8 (1) The following acts constitute grounds for denial
9 of a license or disciplinary action, as specified in s.
10 456.072(2):
11 (x) Gross or repeated malpractice or the failure to
12 practice osteopathic medicine with that level of care, skill,
13 and treatment which is recognized by a reasonably prudent
14 similar osteopathic physician as being acceptable under
15 similar conditions and circumstances. The board shall give
16 great weight to the provisions of s. 766.102 when enforcing
17 this paragraph. As used in this paragraph, "repeated
18 malpractice" includes, but is not limited to, three or more
19 claims for medical malpractice within the previous 5-year
20 period resulting in indemnities being paid in excess of
21 $50,000~~$25,000~~ each to the claimant in a judgment or
22 settlement and which incidents involved negligent conduct by
23 the osteopathic physician. As used in this paragraph, "gross
24 malpractice" or "the failure to practice osteopathic medicine
25 with that level of care, skill, and treatment which is
26 recognized by a reasonably prudent similar osteopathic
27 physician as being acceptable under similar conditions and
28 circumstances" shall not be construed so as to require more
29 than one instance, event, or act. Nothing in this paragraph
30 shall be construed to require that an osteopathic physician be
31 incompetent to practice osteopathic medicine in order to be

1 disciplined pursuant to this paragraph. A recommended order
2 by an administrative law judge or a final order of the board
3 finding a violation under this paragraph shall specify whether
4 the licensee was found to have committed "gross malpractice,"
5 "repeated malpractice," or "failure to practice osteopathic
6 medicine with that level of care, skill, and treatment which
7 is recognized as being acceptable under similar conditions and
8 circumstances," or any combination thereof, and any
9 publication by the board shall so specify.
10 (6) Upon the department's receipt from an insurer or
11 self-insurer of a report of a closed claim against an
12 osteopathic physician pursuant to s. 627.912 or from a health
13 care practitioner of a report pursuant to s. 456.049, or upon
14 the receipt from a claimant of a presuit notice against an
15 osteopathic physician pursuant to s. 766.106, the department
16 shall review each report and determine whether it potentially
17 involved conduct by a licensee that is subject to disciplinary
18 action, in which case the provisions of s. 456.073 shall
19 apply. However, if it is reported that an osteopathic
20 physician has had three or more claims with indemnities
21 exceeding $50,000 ~~$25,000~~ each within the previous 5-year
22 period, the department shall investigate the occurrences upon
23 which the claims were based and determine if action by the
24 department against the osteopathic physician is warranted.
25 Section 36. Section 459.0151, Florida Statutes, is
26 created to read:
27 459.0151 Emergency procedures for disciplinary
28 action.--Notwithstanding any other provision of law to the
29 contrary, no later than 30 days after a third report of a
30 professional liability claim against a licensed osteopathic
31 physician has been submitted, within a 60-month period, as

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

1 required by ss. 456.049 and 627.912, the Department of Health
2 shall initiate an emergency investigation and the Board of
3 Osteopathic Medicine shall conduct an emergency probable cause
4 hearing to determine whether the physician should be
5 disciplined for a violation of s. 459.015(1)(x) or any other
6 relevant provision of law.
7 Section 37. The Division of Administrative Hearings
8 shall designate at least two administrative law judges who
9 shall specifically preside over actions involving the
10 Department of Health or boards within the Department of Health
11 and a health care practitioner as defined in section 456.001,
12 Florida Statutes. Each designated administrative law judge
13 must be a member of The Florida Bar in good standing and must
14 have experience working in the health care industry or have
15 attained board certification in health care law from The
16 Florida Bar.
17 Section 38. Paragraph (s) of subsection (1) and
18 paragraph (a) of subsection (5) of section 461.013, Florida
19 Statutes, are amended to read:
20 461.013 Grounds for disciplinary action; action by the
21 board; investigations by department.--
22 (1) The following acts constitute grounds for denial
23 of a license or disciplinary action, as specified in s.
24 456.072(2):
25 (s) Gross or repeated malpractice or the failure to
26 practice podiatric medicine at a level of care, skill, and
27 treatment which is recognized by a reasonably prudent
28 podiatric physician as being acceptable under similar
29 conditions and circumstances. The board shall give great
30 weight to the standards for malpractice in s. 766.102 in
31 interpreting this section. As used in this paragraph,

1 "repeated malpractice" includes, but is not limited to, three
2 or more claims for medical malpractice within the previous
3 5-year period resulting in indemnities being paid in excess of
4 $50,000~~$10,000~~ each to the claimant in a judgment or
5 settlement and which incidents involved negligent conduct by
6 the podiatric physicians. As used in this paragraph, "gross
7 malpractice" or "the failure to practice podiatric medicine
8 with the level of care, skill, and treatment which is
9 recognized by a reasonably prudent similar podiatric physician
10 as being acceptable under similar conditions and
11 circumstances" shall not be construed so as to require more
12 than one instance, event, or act. A recommended order by an
13 administrative law judge or a final order of the board finding
14 a violation under this paragraph shall specify whether the
15 licensee was found to have committed "gross malpractice,"
16 "repeated malpractice," or "failure to practice podiatric
17 medicine with that level of care, skill, and treatment which
18 is recognized as being acceptable under similar conditions and
19 circumstances," or any combination thereof, and any
20 publication by the board must so specify.
21 (5)(a) Upon the department's receipt from an insurer
22 or self-insurer of a report of a closed claim against a
23 podiatric physician pursuant to s. 627.912, or upon the
24 receipt from a claimant of a presuit notice against a
25 podiatric physician pursuant to s. 766.106, the department
26 shall review each report and determine whether it potentially
27 involved conduct by a licensee that is subject to disciplinary
28 action, in which case the provisions of s. 456.073 shall
29 apply. However, if it is reported that a podiatric physician
30 has had three or more claims with indemnities exceeding
31 $50,000~~$25,000~~ each within the previous 5-year period, the

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

1 department shall investigate the occurrences upon which the
2 claims were based and determine if action by the department
3 against the podiatric physician is warranted.
4 Section 39. Section 461.0131, Florida Statutes, is
5 created to read:
6 461.0131 Emergency procedures for disciplinary
7 action.--Notwithstanding any other provision of law to the
8 contrary, no later than 30 days after a third report of a
9 professional liability claim against a licensed podiatric
10 physician has been submitted, within a 60-month period, as
11 required by ss. 456.049 and 627.912, the Department of Health
12 shall initiate an emergency investigation and the Board of
13 Podiatric Medicine shall conduct an emergency probable cause
14 hearing to determine whether the physician should be
15 disciplined for a violation of s. 461.013(1)(s) or any other
16 relevant provision of law.
17 Section 40. Paragraph (x) of subsection (1) of section
18 466.028, Florida Statutes, is amended to read:
19 466.028 Grounds for disciplinary action; action by the
20 board.--
21 (1) The following acts constitute grounds for denial
22 of a license or disciplinary action, as specified in s.
23 456.072(2):
24 (x) Being guilty of incompetence or negligence by
25 failing to meet the minimum standards of performance in
26 diagnosis and treatment when measured against generally
27 prevailing peer performance, including, but not limited to,
28 the undertaking of diagnosis and treatment for which the
29 dentist is not qualified by training or experience or being
30 guilty of dental malpractice. For purposes of this paragraph,
31 it shall be legally presumed that a dentist is not guilty of

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

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 41. Subsections (2) and (3) of section 624.462, Florida Statutes, are 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

1 period of 1 year for purposes other than that of obtaining or
2 providing insurance pursuant to this section. Each member of
3 a commercial self-insurance trust fund established pursuant to
4 this subsection must maintain membership in the self-insurance
5 trust fund organized pursuant to s. 627.357; ~~or~~
6 3. A group of 10 or more health care providers, as
7 defined in s. 627.351(4)(h), for purposes of providing medical
8 malpractice coverage; or
9 4.~~3.~~ A not-for-profit group comprised of no less than
10 10 condominium associations as defined in s. 718.103(2), which
11 is incorporated under the laws of this state, which restricts
12 its membership to condominium associations only, and which has
13 been organized and maintained in good faith for a continuous
14 period of 1 year for purposes other than that of obtaining or
15 providing insurance.
16 (b)1. In the case of funds established pursuant to
17 subparagraph (a)2. or subparagraph (a)4.~~subparagraph (a)3.~~,
18 operated pursuant to a trust agreement by a board of trustees
19 which shall have complete fiscal control over the fund and
20 which shall be responsible for all operations of the fund.
21 The majority of the trustees shall be owners, partners,
22 officers, directors, or employees of one or more members of
23 the fund. The trustees shall have the authority to approve
24 applications of members for participation in the fund and to
25 contract with an authorized administrator or servicing company
26 to administer the day-to-day affairs of the fund.
27 2. In the case of funds established pursuant to
28 subparagraph (a)1. or subparagraph (a)3., operated pursuant to
29 a trust agreement by a board of trustees or as a corporation
30 by a board of directors which board shall:
31

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

1 a. Be responsible to members of the fund or
2 beneficiaries of the trust or policyholders of the
3 corporation;
4 b. Appoint independent certified public accountants,
5 legal counsel, actuaries, and investment advisers as needed;
6 c. Approve payment of dividends to members;
7 d. Approve changes in corporate structure; and
8 e. Have the authority to contract with an
9 administrator authorized under s. 626.88 to administer the
10 day-to-day affairs of the fund including, but not limited to,
11 marketing, underwriting, billing, collection, claims
12 administration, safety and loss prevention, reinsurance,
13 policy issuance, accounting, regulatory reporting, and general
14 administration. The fees or compensation for services under
15 such contract shall be comparable to the costs for similar
16 services incurred by insurers writing the same lines of
17 insurance, or where available such expenses as filed by
18 boards, bureaus, and associations designated by insurers to
19 file such data. A majority of the trustees or directors shall
20 be owners, partners, officers, directors, or employees of one
21 or more members of the fund.
22 (3) Each member of a commercial self-insurance trust
23 fund established pursuant to this section, except a fund
24 established pursuant to subparagraph (2)(a)3., must maintain
25 membership in the association or self-insurance trust fund
26 established under s. 627.357. Membership in a not-for-profit
27 trade association, industry association, or professional
28 association of employers or professionals for the purpose of
29 obtaining or providing insurance shall be in accordance with
30 the constitution or bylaws of the association, and the dues,
31 fees, or other costs of membership shall not be different for

1 members obtaining insurance from the commercial self-insurance
2 fund. The association shall not be liable for any actions of
3 the fund nor shall it have any responsibility for establishing
4 or enforcing any policy of the commercial self-insurance fund.
5 Fees, services, and other aspects of the relationship between
6 the association and the fund shall be subject to contractual
7 agreement.
8 Section 42. Subsection (7) is added to section
9 627.062, Florida Statutes, as amended by section 1064 of
10 chapter 2003-261, Laws of Florida, to read:
11 627.062 Rate standards.--
12 (7)(a) The provisions of this subsection apply only
13 with respect to rates for medical malpractice insurance and
14 shall control to the extent of any conflict with other
15 provisions of this section.
16 (b) Any portion of a judgment entered or settlement
17 paid as a result of a statutory or common-law, bad-faith
18 action and any portion of a judgment entered which awards
19 punitive damages against an insurer may not be included in the
20 insurer's rate base, and shall not be used to justify a rate
21 or rate change. Any common-law bad-faith action identified as
22 such and any portion of a settlement entered as a result of a
23 statutory or portion of a settlement wherein an insurer agrees
24 to pay specific punitive damages may not be used to justify a
25 rate or rate change. The portion of the taxable costs and
26 attorney's fees which is identified as being related to the
27 bad faith and punitive damages in these judgments and
28 settlements may not be included in the insurer's rate base and
29 may not be utilized to justify a rate or rate change.
30 (c) Upon reviewing a rate filing and determining
31 whether the rate is excessive, inadequate, or unfairly

1 discriminatory, the Office of Insurance Regulation shall
2 consider, in accordance with generally accepted and reasonable
3 actuarial techniques, past and present prospective loss
4 experience, either using loss experience solely for this state
5 or giving greater credibility to this state's loss data.
6 (d) Rates shall be deemed excessive if, among other
7 standards established by this section, the rate structure
8 provides for replenishment of reserves or surpluses from
9 premiums when the replenishment is attributable to investment
10 losses.
11 (e) The insurer must apply a discount or surcharge
12 based on the health care provider's loss experience, or shall
13 establish an alternative method giving due consideration to
14 the provider's loss experience. The insurer must include in
15 the filing a copy of the surcharge or discount schedule or a
16 description of the alternative method used, and must provide a
17 copy of such schedule or description, as approved by the
18 office, to policyholders at the time of renewal and to
19 prospective policyholders at the time of application for
20 coverage.
21 (f) Each insurer must make a rate filing under this
22 section at least once each calendar year.
23 Section 43. The Office of Program Policy Analysis and
24 Government Accountability shall complete a study of the
25 eligibility requirements for a birth to be covered under the
26 Florida Birth-Related Neurological Injury Compensation
27 Association and submit a report to the Legislature by January
28 1, 2004, recommending whether or not the statutory criteria
29 for a claim to qualify for referral to the Florida
30 Birth-Related Neurological Injury Compensation Association
31 under section 766.302, Florida Statutes, should be modified.

1 Section 44. Subsections (6) and (10) of section
2 627.357, Florida Statutes, as amended by section 1107 of
3 chapter 2003-261, Laws of Florida, are amended to read:
4 627.357 Medical malpractice self-insurance.--
5 (6) The commission shall adopt rules to implement this
6 section, including rules that ensure that a trust fund remains
7 solvent and maintains a sufficient reserve to cover contingent
8 liabilities under subsection (7) in the event of its
9 dissolution.
10 ~~(10) A self-insurance fund may not be formed under~~
11 ~~this section after October 1, 1992.~~
12 Section 45. Effective October 1, 2003, section
13 627.4147, Florida Statutes, is amended to read:
14 627.4147 Medical malpractice insurance contracts.--
15 (1) In addition to any other requirements imposed by
16 law, each self-insurance policy as authorized under s. 627.357
17 or insurance policy providing coverage for claims arising out
18 of the rendering of, or the failure to render, medical care or
19 services, including those of the Florida Medical Malpractice
20 Joint Underwriting Association, shall include:
21 (a) A clause requiring the insured to cooperate fully
22 in the review process prescribed under s. 766.106 if a notice
23 of intent to file a claim for medical malpractice is made
24 against the insured.
25 (b)1. Except as provided in subparagraph 2., a clause
26 authorizing the insurer or self-insurer to determine, to make,
27 and to conclude, without the permission of the insured, any
28 offer of admission of liability and for arbitration pursuant
29 to s. 766.106, settlement offer, or offer of judgment, if the
30 offer is within the policy limits. It is against public policy
31 for any insurance or self-insurance policy to contain a clause

1 giving the insured the exclusive right to veto any offer for
2 admission of liability and for arbitration made pursuant to s.
3 766.106, settlement offer, or offer of judgment, when such
4 offer is within the policy limits. However, any offer of
5 admission of liability, settlement offer, or offer of judgment
6 made by an insurer or self-insurer shall be made in good faith
7 and in the best interests of the insured.
8 2.a. With respect to physicians licensed under chapter
9 458 or chapter 459 or dentists licensed under chapter 466, a
10 clause clearly stating whether or not the insured has the
11 exclusive right to veto any offer of admission of liability
12 and for arbitration pursuant to s. 766.106, settlement offer,
13 or offer of judgment if the offer is within policy limits. An
14 insurer or self-insurer shall not make or conclude, without
15 the permission of the insured, any offer of admission of
16 liability and for arbitration pursuant to s. 766.106,
17 settlement offer, or offer of judgment, if such offer is
18 outside the policy limits. However, any offer for admission of
19 liability and for arbitration made under s. 766.106,
20 settlement offer, or offer of judgment made by an insurer or
21 self-insurer shall be made in good faith and in the best
22 interest of the insured.
23 b. If the policy contains a clause stating the insured
24 does not have the exclusive right to veto any offer or
25 admission of liability and for arbitration made pursuant to s.
26 766.106, settlement offer or offer of judgment, the insurer or
27 self-insurer shall provide to the insured or the insured's
28 legal representative by certified mail, return receipt
29 requested, a copy of the final offer of admission of liability
30 and for arbitration made pursuant to s. 766.106, settlement
31 offer or offer of judgment and at the same time such offer is

1 provided to the claimant. A copy of any final agreement
2 reached between the insurer and claimant shall also be
3 provided to the insurer or his or her legal representative by
4 certified mail, return receipt requested not more than 10 days
5 after affecting such agreement.
6 c. Physicians licensed under chapter 458 or chapter
7 459 and dentists licensed under chapter 466 may purchase an
8 insurance policy pursuant to this subparagraph if such
9 policies are available. Insurers may offer such policies,
10 notwithstanding any other provision of law to the contrary.
11 (c) A clause requiring the insurer or self-insurer to
12 notify the insured no less than 90 ~~60~~ days prior to the
13 effective date of cancellation of the policy or contract and,
14 in the event of a determination by the insurer or self-insurer
15 not to renew the policy or contract, to notify the insured no
16 less than 90 ~~60~~ days prior to the end of the policy or
17 contract period. If cancellation or nonrenewal is due to
18 nonpayment or loss of license, 10 days' notice is required.
19 (d) A clause requiring the insurer or self-insurer to
20 notify the insured no less than 60 days prior to the effective
21 date of a rate increase. The provisions of s. 627.4133 shall
22 apply to such notice and to the failure of the insurer to
23 provide such notice to the extent not in conflict with this
24 section.
25 (2) Each insurer covered by this section may require
26 the insured to be a member in good standing, i.e., not subject
27 to expulsion or suspension, of a duly recognized state or
28 local professional society of health care providers which
29 maintains a medical review committee. No professional society
30 shall expel or suspend a member solely because he or she
31

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

1 participates in a health maintenance organization licensed
2 under part I of chapter 641.
3 (3) This section shall apply to all policies issued or
4 renewed after October 1, 2003 ~~1985~~.
5 Section 46. Section 627.41491, Florida Statutes, is
6 created to read:
7 627.41491 Medical malpractice rate comparison.--The
8 Office of Insurance Regulation shall annually publish a
9 comparison of the rate in effect for each medical malpractice
10 insurer and self-insurer and the Florida Medical Malpractice
11 Joint Underwriting Association. Such rate comparison shall be
12 made available to the public through the Internet and other
13 commonly used means of distribution no later than July 1 of
14 each year.
15 Section 47. Section 627.41493, Florida Statutes, is
16 created to read:
17 627.41493 Insurance rate rollback.--
18 (1) For medical malpractice insurance policies issued
19 or renewed on or after July 1, 2003, and before July 1, 2004,
20 every insurer, including the Florida Medical Malpractice Joint
21 Underwriting Association, shall reduce its rates and premiums
22 to levels that were in effect on January 1, 2002.
23 (2) For medical malpractice insurance policies issued
24 or renewed on or after July 1, 2003, and before July 1, 2004,
25 rates and premiums reduced pursuant to subsection (1) may only
26 be increased if the director of the Office of Insurance
27 Regulation finds that the rate reduced pursuant to subsection
28 (1) would result in an inadequate rate. Any such increase must
29 be approved by the director of the Office of Insurance
30 Regulation prior to being used.
31

1 (3) The provisions of this section control to the
2 extent of any conflict with the provision of s. 627.062.
3 Section 48. If, as of July 1, 2004, the director of
4 the Office of Insurance Regulation determines that the rates
5 of the medical malpractice insurers with a combined market
6 share of 50 percent or greater, as measured by net written
7 premiums in this state for medical malpractice for the most
8 recent calendar year, have been reduced to the level in effect
9 on January 1, 2002, but have not remained at that level for
10 the previous year beginning July 1, 2003, or that such medical
11 malpractice insurers have proposed increases from the January
12 1, 2002, level which are greater than 15 percent for either of
13 the next 2 years beginning July 1, 2004, then the Florida
14 Medical Malpractice Insurance Fund established by this act
15 shall begin offering coverage.
16 Section 49. Florida Medical Malpractice Insurance
17 Fund.--
18 (1) FINDINGS AND PURPOSES.--The Legislature finds and
19 declares that there is a compelling state interest in
20 maintaining the availability and affordability of health care
21 services to the people of Florida. This state interest is
22 seriously threatened by the increased cost and decreased
23 availability of medical malpractice insurance to physicians.
24 To the extent that the private sector is unable to maintain a
25 viable and orderly market for medical malpractice insurance,
26 state actions to maintain the availability and affordability
27 of medical malpractice insurance are a valid and necessary
28 exercise of the police power.
29 (2) DEFINITIONS.--As used in this section, the term:
30 (a) "Fund" means the Florida Medical Malpractice
31 Insurance Fund, as created pursuant to this section.

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

1 (b) "Physician" means a physician licensed under
2 chapter 458 or chapter 459, Florida Statutes.
3 (3) FLORIDA MEDICAL MALPRACTICE INSURANCE FUND
4 CREATED.--Effective October 1, 2003, there is created the
5 Florida Medical Malpractice Insurance Fund, which shall be
6 subject to the requirements of this section. However, the fund
7 shall not begin providing or offering coverage until the date
8 the director of the Office of Insurance Regulation determines
9 that the rates of the medical malpractice insurers with a
10 combined market share of 50 percent or greater, as measured by
11 net written premium in this state for medical malpractice for
12 the most recent calendar year, have been reduced to the level
13 in effect on January 1, 2002, but have not remained at that
14 level for the previous year beginning July 1, 2003, or that
15 such medical malpractice insurers have proposed increases from
16 the January 1, 2002, level which are greater than 15 percent
17 for either of the next 2 years beginning July 1, 2004.
18 (a) The fund shall be administered by a board of
19 governors consisting of seven members who are appointed as
20 follows:
21 1. Three members by the Governor;
22 2. Three members by the Chief Financial Officer; and
23 3. One member by the other six board members.
24
25 Board members shall serve at the pleasure of the appointing
26 authority. Two board members must be physicians licensed in
27 this state and the Governor and the Chief Financial Officer
28 shall each appoint one of these physicians.
29 (b) The board shall submit a plan of operation, which
30 must be approved by the Office of Insurance Regulation of the
31 Financial Services Commission. The plan of operation and other

1 actions of the board shall not be considered rules subject to
2 the requirements of chapter 120, Florida Statutes.
3 (c) Except as otherwise provided by this section, the
4 fund shall be subject to the requirements of state law which
5 apply to authorized insurers.
6 (d) Moneys in the fund may not be expended, loaned, or
7 appropriated except to pay obligations of the fund arising out
8 of medical malpractice insurance policies issued to physicians
9 and the costs of administering the fund, including the
10 purchase of reinsurance as the board deems prudent. The board
11 shall enter into an agreement with the State Board of
12 Administration, which shall invest one-third of the moneys in
13 the fund pursuant to sections 215.44-215.52, Florida Statutes.
14 The board shall enter into an agreement with the Division of
15 Treasury of the Department of Financial Services, which shall
16 invest two-thirds of the moneys in the fund pursuant to the
17 requirements for the investment of state funds in chapter 17,
18 Florida Statutes. Earnings from all investments shall be
19 retained in the fund, except as otherwise provided in this
20 section.
21 (e) The fund may employ or contract with such staff
22 and professionals as the board deems necessary for the
23 administration of the fund.
24 (f) There shall be no liability on the part of any
25 member of the board, its agents, or any employee of the state
26 for any action taken by them in the performance of their
27 powers and duties under this section. Such immunity does not
28 apply to any willful tort or to breach of any contract or
29 agreement.
30 (g) The fund is not a member insurer of the Florida
31 Insurance Guaranty Association established pursuant to part II

1 of chapter 631, Florida Statutes. The fund is not subject to
2 sections 624.407, 624.408, 624.4095, and 624.411, Florida
3 Statutes.
4 (4) MEDICAL MALPRACTICE INSURANCE POLICIES.--The board
5 must offer medical malpractice insurance to any physician,
6 regardless of his or her specialty, but may adopt underwriting
7 requirements, as specified in its plan of operation. The fund
8 shall offer limits of coverage of $250,000 per claim/$500,000
9 annual aggregate; $500,000 per claim/$1 million annual
10 aggregate; and $1 million per claim/$2 million annual
11 aggregate. The fund shall also allow policyholders to select
12 from policies with deductibles of $100,000, $200,000, and
13 $250,000; excess coverage limits of $250,000 per claim and
14 $750,000 annual aggregate; $1 million per claim and $3 million
15 annual aggregate; or $2 million and $4 million annual
16 aggregate. The fund shall offer such other limits as specified
17 in its plan of operation.
18 (5) PREMIUM RATES.--The premium rates for coverage
19 offered by the fund must be actuarially sound and shall be
20 subject to the same requirements that apply to authorized
21 insurers issuing medical malpractice insurance, except that:
22 (a) The rates shall not include any factor for
23 profits; and
24 (b) The anticipated future investment income of the
25 fund, as projected in its rate filing, must be approximately
26 equal to the actual investment income that the fund has
27 earned, on average, for the prior 7 years. For those years of
28 the prior 7 years during which the fund was not in operation,
29 the anticipated future investment income must be approximately
30 equal to the actual average investment income earned by the
31 State Board of Administration for the moneys available for

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

1 investment under sections 215.44-215.53, Florida Statutes, and
2 the average annual investment income earned by the Division of
3 Treasury of the Department of Financial Services for the
4 investment of state funds under chapter 17, Florida Statutes,
5 in the same proportion as specified in paragraph (3)(d).
6 (6) TAX EXEMPTION.--The fund shall be a political
7 subdivision of the state and is exempt from the corporate
8 income tax under chapter 220, Florida Statutes, and the
9 premiums shall not be subject to the premium tax imposed by
10 section 624.509, Florida Statutes. It is also the intent of
11 the Legislature that the fund be exempt from federal income
12 taxation. The Financial Services Commission and the fund shall
13 seek an opinion from the Internal Revenue Service as to the
14 tax-exempt status of the fund and shall make such
15 recommendations to the Legislature as the board deems
16 necessary to obtain tax-exempt status.
17 (7) INITIAL CAPITALIZATION.--By July 1, 2004, the
18 Legislature shall provide by law for adequate initial
19 capitalization of the Florida Medical Malpractice Insurance
20 Fund to occur on the date that the Office of Insurance
21 Regulation notifies the Legislature that it has made the
22 determination necessary for the fund to begin providing or
23 offering coverage pursuant to subsection (3).
24 (8) RULES.--The Financial Services Commission may
25 adopt rules to implement and administer the provisions of this
26 section.
27 (9) REVERSION OF FUND ASSETS UPON TERMINATION.--The
28 fund and the duties of the board under this section shall
29 stand repealed on a date 10 years after the date the Florida
30 Medical Malpractice Insurance Fund begins offering coverage
31 pursuant to this section, unless reviewed and saved from

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

1 repeal through reenactment by the Legislature. Upon
2 termination of the fund, all assets of the fund shall revert
3 to the General Revenue Fund.
4 Section 50. (1) Notwithstanding any law to the
5 contrary, if the Florida Medical Malpractice Insurance Fund
6 begins offering coverage as provided in this act, all
7 physicians licensed under chapter 458 or chapter 459, Florida
8 Statutes, as a condition of licensure shall be required to
9 maintain financial responsibility by obtaining and maintaining
10 professional liability coverage in an amount not less than
11 $250,000 per claim, with a minimum annual aggregate of not
12 less than $500,000, from an authorized insurer as defined
13 under section 624.09, Florida Statutes, from a surplus lines
14 insurer as defined under section 626.914(2), Florida Statutes,
15 from a risk retention group as defined under section 627.942,
16 Florida Statutes, from the Joint Underwriting Association
17 established under section 627.351(4), Florida Statutes,
18 through a plan of self-insurance as provided in section
19 627.357 or section 624.462, Florida Statutes, or from the
20 Florida Medical Malpractice Insurance Fund.
21 (2) Physicians and osteopathic physicians who are
22 exempt from the financial responsibility requirements under
23 section 458.320(5)(a), (b), (c), (d), (e), and (f) and section
24 459.0085(5)(a), (b), (c), (d), (e), and (f), Florida Statutes,
25 shall not be subject to the requirements of this section.
26 Section 51. (1) The Office of Insurance Regulation
27 shall order insurers to make a rate filing effective January
28 1, 2004, for medical malpractice which reduces rates by a
29 presumed factor that reflects the impact the changes contained
30 in all medical malpractice legislation enacted by the Florida
31 Legislature in 2003 will have on such rates, as determined by

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

1 the Office of Insurance Regulation. In determining the
2 presumed factor, the office shall use generally accepted
3 actuarial techniques and standards provided in section
4 627.062, Florida Statutes, in determining the expected impact
5 on losses, expenses, and investment income of the insurer.
6 Inclusion in the presumed factor of the expected impact of
7 such legislation shall be held in abeyance during the review
8 of such measure's validity in any proceeding by a court of
9 competent jurisdiction.
10 (2) Any insurer or rating organization that contends
11 that the rate provided for in subsection (1) is excessive,
12 inadequate, or unfairly discriminatory shall separately state
13 in its filing the rate it contends is appropriate and shall
14 state with specificity the factors or data that it contends
15 should be considered in order to produce such appropriate
16 rate. The insurer or rating organization shall be permitted to
17 use all of the generally accepted actuarial techniques, as
18 provided in section 627.062, Florida Statutes, in making any
19 filing pursuant to this subsection. The Office of Insurance
20 Regulation shall review each such exception and approve or
21 disapprove it prior to use. It shall be the insurer's burden
22 to actuarially justify any deviations from the rates filed
23 under subsection (1). Each insurer or rating organization
24 shall include in the filing the expected impact of all
25 malpractice legislation enacted by the Florida Legislature in
26 2003 on losses, expenses, and rates. If any provision of this
27 act is held invalid by a court of competent jurisdiction, the
28 office shall permit an adjustment of all rates filed under
29 this section to reflect the impact of such holding on such
30 rates, so as to ensure that the rates are not excessive,
31 inadequate, or unfairly discriminatory.

Section 52. Section 627.912, Florida Statutes, as amended by section 1226 of chapter 2003-261, Laws of Florida, is amended to read:

627.912 Professional liability claims and actions; reports by insurers and health care providers; annual report by office.--

(1)(a) Each self-insurer authorized under s. 627.357 and each commercial self-insurance fund authorized under s. 624.462, authorized insurer, surplus lines insurer, risk retention group, and ~~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 office 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.

3. A final disposition resulting in no payment on behalf of the insured.

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

1 (b) Each health care practitioner and health care
2 facility listed in paragraph (a) must report any claim or
3 action for damages as described in paragraph (a), if the claim
4 is not otherwise required to be reported by an insurer or
5 other insuring entity.
6
7 ~~Reports shall be filed with the department and, if the insured~~
8 ~~party is licensed under chapter 458, chapter 459, chapter 461,~~
9 ~~or chapter 466, with the Department of Health, no later than~~
10 ~~30 days following the occurrence of any event listed in~~
11 ~~paragraph (a) or paragraph (b). The Department of Health shall~~
12 ~~review each report and determine whether any of the incidents~~
13 ~~that resulted in the claim potentially involved conduct by the~~
14 ~~licensee that is subject to disciplinary action, in which case~~
15 ~~the provisions of s. 456.073 shall apply. The Department of~~
16 ~~Health, as part of the annual report required by s. 456.026,~~
17 ~~shall publish annual statistics, without identifying~~
18 ~~licensees, on the reports it receives, including final action~~
19 ~~taken on such reports by the Department of Health or the~~
20 ~~appropriate regulatory board.~~
21 (2) The reports required by subsection (1) shall
22 contain:
23 (a) The name, address, and specialty coverage of the
24 insured.
25 (b) The insured's policy number.
26 (c) The date of the occurrence which created the
27 claim.
28 (d) The date the claim was reported to the insurer or
29 self-insurer.
30 (e) The name and address of the injured person. This
31 information is confidential and exempt from the provisions of

s. 119.07(1), and must not be disclosed by the office ~~department~~ without the injured person's consent, except for disclosure by the office ~~department~~ to the Department of Health. This information may be used by the office ~~department~~ for purposes of identifying multiple or duplicate claims arising out of the same occurrence.

(f) The date of suit, if filed.

(g) The injured person's age and sex.

(h) The total number, ~~and~~ names, and professional license numbers of all defendants involved in the claim.

(i) The date and amount of judgment or settlement, if any, including the itemization of the verdict~~, together with a copy of the settlement or judgment~~.

(j) In the case of a settlement, such information as the office ~~department~~ may require with regard to the injured person's incurred and anticipated medical expense, wage loss, and other expenses.

(k) The loss adjustment expense paid to defense counsel, and all other allocated loss adjustment expense paid.

(l) The date and reason for final disposition, if no judgment or settlement.

(m) A summary of the occurrence which created the claim, which shall include:

1. The name of the institution, if any, and the location within the institution at which the injury occurred.

2. The final diagnosis for which treatment was sought or rendered, including the patient's actual condition.

3. A description of the misdiagnosis made, if any, of the patient's actual condition.

4. The operation, diagnostic, or treatment procedure causing the injury.

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

5. A description of the principal injury giving rise to the claim.

6. The safety management steps that have been taken by the insured to make similar occurrences or injuries less likely in the future.

(n) Any other information required by the commission, by rule,~~office~~ to assist the office in its analysis and evaluation of ~~analyze and evaluate~~ the nature, causes, location, cost, and damages involved in professional liability cases.

(3) ~~Upon request by the Department of Health,~~The office shall provide the Department of Health with electronic access to all ~~any~~ information received under this section related to persons licensed under chapter 458, chapter 459, chapter 461, or chapter 466. ~~For purposes of safety management, the office shall annually provide the Department of Health with copies of the reports in cases resulting in an indemnity being paid to the claimants.~~

(4) There shall be no liability on the part of, and no cause of action of any nature shall arise against, any person or entity ~~insurer~~ reporting hereunder or its agents or employees or the office or its employees for any action taken by them under this section. The office 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, commercial self-insurance fund, medical malpractice self-insurance fund, or risk retention group that violates the requirements of this section. If a healthcare practitioner or health care facility violates the requirements of this section, it shall be considered a violation of the chapter or act under which the practitioner or facility is licensed and shall be grounds for

1 <u>a fine or disciplinary action as such other violations of the</u>
2 <u>chapter or act.</u>~~This subsection applies to claims accruing on~~
3 ~~or after October 1, 1997.~~
4 (5) Any self-insurance program established under s.
5 1004.24 shall report ~~in duplicate~~ to the office any claim or
6 action for damages for personal injuries claimed to have been
7 caused by error, omission, or negligence in the performance of
8 professional services provided by the state university board
9 of trustees through an employee or agent of the state
10 university board of trustees, including practitioners of
11 medicine licensed under chapter 458, practitioners of
12 osteopathic medicine licensed under chapter 459, podiatric
13 physicians licensed under chapter 461, and dentists licensed
14 under chapter 466, or based on a claimed performance of
15 professional services without consent if the claim resulted in
16 a final judgment in any amount, or a settlement in any amount.
17 The reports required by this subsection shall contain the
18 information required by subsection (3) and the name, address,
19 and specialty of the employee or agent of the state university
20 board of trustees whose performance or professional services
21 is alleged in the claim or action to have caused personal
22 injury.
23 <u>(6)(a) The office shall prepare statistical summaries</u>
24 <u>of the closed claims reports filed pursuant to this section,</u>
25 <u>for each year that such reports have been filed, and make such</u>
26 <u>summaries and closed claim reports available on the Internet</u>
27 <u>by July 1, 2005.</u>
28 <u>(b) The office shall prepare an annual report by</u>
29 <u>October 1 of each year, beginning in 2004, which shall be</u>
30 <u>available on the Internet, which summarizes and analyzes the</u>
31 <u>closed claim reports filed pursuant to this section and the</u>

annual financial reports filed by insurers writing medical malpractice insurance in this state. The report must include an analysis of closed claim reports of prior years, in order to show trends in the frequency and amount of claims payments, the itemization of economic and noneconomic damages, the nature of the errant conduct, and such other information as the office determines is illustrative of the trends in closed claims. The report must also analyze the state of the medical malpractice insurance market in Florida, including an analysis of the financial reports of those insurers with a combined market share of at least 80 percent of the net written premium in the state for medical malpractice for the prior calendar year, including a loss ratio analysis for medical malpractice written in Florida and a profitability analysis of each such insurer. The report shall compare the ratios for medical malpractice in Florida compared to other states, based on financial reports filed with the National Association of Insurance Commissioners and such other information as the office deems relevant.

(c) The annual report shall also include a summary of the rate filings that have been approved by the office for the prior calendar year, including an analysis of the trend of direct and incurred losses as compared to prior years.

Section 53. 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. 766.202(4)~~s.~~

1 ~~768.50(2)(b)~~, the claimant shall have the burden of proving by
2 the greater weight of evidence that the alleged actions of the
3 health care provider represented a breach of the prevailing
4 professional standard of care for that health care provider.
5 The prevailing professional standard of care for a given
6 health care provider shall be that level of care, skill, and
7 treatment which, in light of all relevant surrounding
8 circumstances, is recognized as acceptable and appropriate by
9 reasonably prudent similar health care providers.
10 ~~(2)(a) If the health care provider whose negligence is~~
11 ~~claimed to have created the cause of action is not certified~~
12 ~~by the appropriate American board as being a specialist, is~~
13 ~~not trained and experienced in a medical specialty, or does~~
14 ~~not hold himself or herself out as a specialist, a "similar~~
15 ~~health care provider" is one who:~~
16 ~~1. Is licensed by the appropriate regulatory agency of~~
17 ~~this state;~~
18 ~~2. Is trained and experienced in the same discipline~~
19 ~~or school of practice; and~~
20 ~~3. Practices in the same or similar medical community.~~
21 ~~(b) If the health care provider whose negligence is~~
22 ~~claimed to have created the cause of action is certified by~~
23 ~~the appropriate American board as a specialist, is trained and~~
24 ~~experienced in a medical specialty, or holds himself or~~
25 ~~herself out as a specialist, a "similar health care provider"~~
26 ~~is one who:~~
27 ~~1. Is trained and experienced in the same specialty;~~
28 ~~and~~
29 ~~2. Is certified by the appropriate American board in~~
30 ~~the same specialty.~~
31

~~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

1 standard of care by a reasonably prudent similar health care
2 provider.
3 (b) The provisions of this subsection shall apply only
4 when the medical intervention was undertaken with the informed
5 consent of the patient in compliance with the provisions of s.
6 766.103.
7 (3)~~(4)~~ The existence of a medical injury shall not
8 create any inference or presumption of negligence against a
9 health care provider, and the claimant must maintain the
10 burden of proving that an injury was proximately caused by a
11 breach of the prevailing professional standard of care by the
12 health care provider. However, the discovery of the presence
13 of a foreign body, such as a sponge, clamp, forceps, surgical
14 needle, or other paraphernalia commonly used in surgical,
15 examination, or diagnostic procedures, shall be prima facie
16 evidence of negligence on the part of the health care
17 provider.
18 (4)~~(5)~~ The Legislature is cognizant of the changing
19 trends and techniques for the delivery of health care in this
20 state and the discretion that is inherent in the diagnosis,
21 care, and treatment of patients by different health care
22 providers. The failure of a health care provider to order,
23 perform, or administer supplemental diagnostic tests shall not
24 be actionable if the health care provider acted in good faith
25 and with due regard for the prevailing professional standard
26 of care.
27 (5) A person may not give expert testimony concerning
28 the prevailing professional standard of care unless that
29 person is a licensed health care provider and meets the
30 following criteria:
31

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

1 (a) If the health care provider against whom or on
2 whose behalf the testimony is offered is a specialist, the
3 expert witness must:
4 1. Specialize in the same specialty as the health care
5 provider against whom or on whose behalf the testimony is
6 offered; or specialize in a similar specialty that includes
7 the evaluation, diagnosis, or treatment of the medical
8 condition that is the subject of the claim and have prior
9 experience treating similar patients; and
10 2. Have devoted professional time during the 3 years
11 immediately preceding the date of the occurrence that is the
12 basis for the action to:
13 a. The active clinical practice of, or consulting with
14 respect to, the same or similar specialty that includes the
15 evaluation, diagnosis, or treatment of the medical condition
16 that is the subject of the claim and have prior experience
17 treating similar patients;
18 b. An accredited health professional school or
19 accredited residency or clinical research program in the same
20 or similar specialty; or
21 c. A clinical research program that is affiliated with
22 an accredited health professional school or accredited
23 residency or clinical research program in the same or similar
24 speciality.
25 (b) If the health care provider against whom or on
26 whose behalf the testimony is offered is a general
27 practitioner, the expert witness must have devoted
28 professional time during the 5 years immediately preceding the
29 date of the occurrence that is the basis for the action to:
30 1. Active clinical practice or consultation as a
31 general practitioner;

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

1 2. Instruction of students in an accredited health
2 professional school or accredited residency program in the
3 general practice of medicine; or
4 3. A clinical research program that is affiliated with
5 an accredited medical school or teaching hospital and that is
6 in the general practice of medicine.
7 (c) If the health care provider against whom or on
8 whose behalf the testimony is offered is a health care
9 provider other than a specialist or a general practitioner,
10 the expert witness must have devoted professional time during
11 the 3 years immediately preceding the date of the occurrence
12 that is the basis for the action to:
13 1. The active clinical practice of, or consulting with
14 respect to, the same or similar health profession as the
15 health care provider against whom or on whose behalf the
16 testimony is offered;
17 2. The instruction of students in an accredited health
18 professional school or accredited residency program in the
19 same or similar health profession in which the health care
20 provider against whom or on whose behalf the testimony is
21 offered; or
22 3. A clinical research program that is affiliated with
23 an accredited medical school or teaching hospital and that is
24 in the same or similar health profession as the health care
25 provider against whom or on whose behalf the testimony is
26 offered.
27 (6) A physician licensed under chapter 458 or chapter
28 459 who qualifies as an expert witness under subsection (5)
29 and who, by reason of active clinical practice or instruction
30 of students, has knowledge of the applicable standard of care
31 for nurses, nurse practitioners, certified registered nurse

1 anesthetists, certified registered nurse midwives, physician
2 assistants, or other medical support staff may give expert
3 testimony in a medical malpractice action with respect to the
4 standard of care of such medical support staff.
5 (7) Notwithstanding subsection (5), in a medical
6 malpractice action against a hospital, a health care facility,
7 or medical facility, a person may give expert testimony on the
8 appropriate standard of care as to administrative and other
9 nonclinical issues if the person has substantial knowledge, by
10 virtue of his or her training and experience, concerning the
11 standard of care among hospitals, health care facilities, or
12 medical facilities of the same type as the hospital, health
13 care facility, or medical facility whose acts or omissions are
14 the subject of the testimony and which are located in the same
15 or similar communities at the time of the alleged act giving
16 rise to the cause of action.
17 (8) If a health care provider described in subsection
18 (5), subsection (6), or subsection (7) is providing
19 evaluation, treatment, or diagnosis for a condition that is
20 not within his or her specialty, a specialist trained in the
21 evaluation, treatment, or diagnosis for that condition shall
22 be considered a similar health care provider.
23 (9) ~~(6)~~(a) In any action for damages involving a claim
24 of negligence against a physician licensed under chapter 458,
25 osteopathic physician licensed under chapter 459, podiatric
26 physician licensed under chapter 461, or chiropractic
27 physician licensed under chapter 460 providing emergency
28 medical services in a hospital emergency department, the court
29 shall admit expert medical testimony only from physicians,
30 osteopathic physicians, podiatric physicians, and chiropractic
31 physicians who have had substantial professional experience

1 within the preceding 5 years while assigned to provide
2 emergency medical services in a hospital emergency department.
3 (b) For the purposes of this subsection:
4 1. The term "emergency medical services" means those
5 medical services required for the immediate diagnosis and
6 treatment of medical conditions which, if not immediately
7 diagnosed and treated, could lead to serious physical or
8 mental disability or death.
9 2. "Substantial professional experience" shall be
10 determined by the custom and practice of the manner in which
11 emergency medical coverage is provided in hospital emergency
12 departments in the same or similar localities where the
13 alleged negligence occurred.
14 (10) In any action alleging medical malpractice, an
15 expert witness may not testify on a contingency fee basis.
16 (11) Any attorney who proffers a person as an expert
17 witness pursuant to this section must certify that such person
18 has not been found guilty of fraud or perjury in any
19 jurisdiction.
20 (12) This section does not limit the power of the
21 trial court to disqualify or qualify an expert witness on
22 grounds other than the qualifications in this section.
23 Section 54. Section 766.106, Florida Statutes, is
24 amended to read:
25 766.106 Notice before filing action for medical
26 ~~malpractice~~ negligence; presuit screening period; offers for
27 admission of liability and for arbitration; informal
28 discovery; review.--
29 (1) DEFINITIONS.--As used in this section:
30
31

(a) "Claim for medical negligence ~~malpractice~~" means a claim, arising out of the rendering of, or the failure to render, medical care or services.

(b) "Self-insurer" means any self-insurer authorized under s. 627.357 or any uninsured prospective defendant.

(c) "Insurer" includes the Joint Underwriting Association.

(2) PRESUIT NOTICE.--After completion of presuit investigation pursuant to s. 766.203(2)~~s. 766.203~~ and prior to filing a complaint ~~claim~~ for medical negligence ~~malpractice~~, a claimant shall notify each prospective defendant by certified mail, return receipt requested, of intent to initiate litigation for medical negligence ~~malpractice~~. Following the initiation of a suit alleging medical negligence ~~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) PRESUIT INVESTIGATION BY PROSPECTIVE DEFENDANT.--

(a) No suit may be filed for a period of 90 days after notice is mailed to any prospective defendant. During the 90-day period, the prospective defendant or the defendant's insurer or self-insurer shall conduct a review as provided in s. 766.203(3)to determine the liability of the defendant. Each insurer or self-insurer shall have a procedure for the

1 prompt investigation, review, and evaluation of claims during
2 the 90-day period. This procedure shall include one or more
3 of the following:
4 1. Internal review by a duly qualified claims
5 adjuster;
6 2. Creation of a panel comprised of an attorney
7 knowledgeable in the prosecution or defense of medical
8 negligence ~~malpractice~~ actions, a health care provider trained
9 in the same or similar medical specialty as the prospective
10 defendant, and a duly qualified claims adjuster;
11 3. A contractual agreement with a state or local
12 professional society of health care providers, which maintains
13 a medical review committee;
14 4. Any other similar procedure which fairly and
15 promptly evaluates the pending claim.
16
17 Each insurer or self-insurer shall investigate the claim in
18 good faith, and both the claimant and prospective defendant
19 shall cooperate with the insurer in good faith. If the
20 insurer requires, a claimant shall appear before a pretrial
21 screening panel or before a medical review committee and shall
22 submit to a physical examination, if required. Unreasonable
23 failure of any party to comply with this section justifies
24 dismissal of claims or defenses. There shall be no civil
25 liability for participation in a pretrial screening procedure
26 if done without intentional fraud.
27 (b) At or before the end of the 90 days, the
28 prospective defendant or the prospective defendant's insurer
29 or self-insurer shall provide the claimant with a response:
30 1. Rejecting the claim;
31 2. Making a settlement offer; or

1 3. Making an offer of admission of liability and for
2 arbitration on the issue of damages. This offer may be made
3 contingent upon a limit of general damages.
4 (c) The response shall be delivered to the claimant if
5 not represented by counsel or to the claimant's attorney, by
6 certified mail, return receipt requested. Failure of the
7 prospective defendant or insurer or self-insurer to reply to
8 the notice within 90 days after receipt shall be deemed a
9 final rejection of the claim for purposes of this section.
10 (d) Within 30 days of receipt of a response by a
11 prospective defendant, insurer, or self-insurer to a claimant
12 represented by an attorney, the attorney shall advise the
13 claimant in writing of the response, including:
14 1. The exact nature of the response under paragraph
15 (b).
16 2. The exact terms of any settlement offer, or
17 admission of liability and offer of arbitration on damages.
18 3. The legal and financial consequences of acceptance
19 or rejection of any settlement offer, or admission of
20 liability, including the provisions of this section.
21 4. An evaluation of the time and likelihood of
22 ultimate success at trial on the merits of the claimant's
23 action.
24 5. An estimation of the costs and attorney's fees of
25 proceeding through trial.
26 (4) SERVICE OF PRESUIT NOTICE AND TOLLING.--The notice
27 of intent to initiate litigation shall be served within the
28 time limits set forth in s. 95.11. However, during the 90-day
29 period, the statute of limitations is tolled as to all
30 potential defendants. Upon stipulation by the parties, the
31 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.

(5) DISCOVERY AND ADMISSIBILITY.--No statement, discussion, written document, report, or other work product generated by the presuit screening process is discoverable or admissible in any civil action for any purpose by the opposing party. All participants, including, but not limited to, physicians, investigators, witnesses, and employees or associates of the defendant, are immune from civil liability arising from participation in the presuit screening process.

(6) INFORMAL DISCOVERY.--

(a) Upon receipt by a prospective defendant of a notice of claim, the parties shall make discoverable information available without formal discovery. Failure to do so is grounds for dismissal of claims or defenses ultimately asserted.

(b)~~(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:

1.~~(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

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

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.

2.~~(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. Medical records shall be produced as provided in s.766.204.

3.~~(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 prospective 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 prospective ~~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.

(c)~~(8)~~ Each request for and notice concerning informal presuit discovery pursuant to this section must be in writing, and a copy thereof must be sent to all parties. Such a request or notice must bear a certificate of service identifying the name and address of the person to whom the request or notice is served, the date of the request or notice, and the manner of service thereof.

(d)~~(9)~~ Copies of any documents produced in response to the request of any party must be served upon all other parties. The party serving the documents or his or her attorney shall identify, in a notice accompanying the documents, the name and address of the parties to whom the documents were served, the date of service, the manner of service, and the identity of the document served.

~~(10) If a prospective defendant makes an offer to admit liability and for arbitration on the issue of damages, the claimant has 50 days from the date of receipt of the offer to accept or reject it. The claimant shall respond in writing to the insurer or self-insurer by certified mail, return receipt requested. If the claimant rejects the offer, he or she may then file suit. Acceptance of the offer of admission of liability and for arbitration waives recourse to any other remedy by the parties, and the claimant's written acceptance of the offer shall so state.~~

~~(a) If rejected, the offer to admit liability and for arbitration on damages is not admissible in any subsequent litigation. Upon rejection of the offer to admit liability and for arbitration, the claimant has 60 days or the remainder of the period of the statute of limitations, whichever period is greater, in which to file suit.~~

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

1 ~~(b) If the offer to admit liability and for~~
2 ~~arbitration on damages is accepted, the parties have 30 days~~
3 ~~from the date of acceptance to settle the amount of damages.~~
4 ~~If the parties have not reached agreement after 30 days, they~~
5 ~~shall proceed to binding arbitration to determine the amount~~
6 ~~of damages as follows:~~
7 ~~1. Each party shall identify his or her arbitrator to~~
8 ~~the opposing party not later than 35 days after the date of~~
9 ~~acceptance.~~
10 ~~2. The two arbitrators shall, within 1 week after they~~
11 ~~are notified of their appointment, agree upon a third~~
12 ~~arbitrator. If they cannot agree on a third arbitrator,~~
13 ~~selection of the third arbitrator shall be in accordance with~~
14 ~~chapter 682.~~
15 ~~3. Not later than 30 days after the selection of a~~
16 ~~third arbitrator, the parties shall file written arguments~~
17 ~~with each arbitrator and with each other indicating total~~
18 ~~damages.~~
19 ~~4. Unless otherwise determined by the arbitration~~
20 ~~panel, within 10 days after the receipt of such arguments,~~
21 ~~unless the parties have agreed to a settlement, there shall be~~
22 ~~a 1-day hearing, at which formal rules of evidence and the~~
23 ~~rules of civil procedure shall not apply, during which each~~
24 ~~party shall present evidence as to damages. Each party shall~~
25 ~~identify the total dollar amount which he or she feels should~~
26 ~~be awarded.~~
27 ~~5. No later than 2 weeks after the hearing, the~~
28 ~~arbitrators shall notify the parties of their determination of~~
29 ~~the total award. The court shall have jurisdiction to enforce~~
30 ~~any award or agreement for periodic payment of future damages.~~
31

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

~~(11) If there is more than one prospective defendant, the claimant shall provide the notice of claim and follow the procedures in this section for each defendant. If an offer to admit liability and for arbitration is accepted, the procedures shall be initiated separately for each defendant, unless multiple offers are made by more than one prospective defendant and are accepted and the parties agree to consolidated arbitration. Any agreement for consolidated arbitration shall be filed with the court. No offer by any prospective defendant to admit liability and for arbitration is admissible in any civil action.~~

~~(12) To the extent not inconsistent with this part, the provisions of chapter 682, the Florida Arbitration Code, shall be applicable to such proceedings.~~

Section 55. Section 766.10651, Florida Statutes, is created to read:

766.10651 Bad faith action against an insurer.--

(1) A cause of action against an insurer for bad faith arising out of a medical negligence claim shall be brought exclusively pursuant to common law and not pursuant to s. 624.155.

(b) An insurer shall not be held to have acted in bad faith for failure to timely pay its policy limits if it tenders its policy limits and meets the reasonable conditions of settlement prior to the conclusion of the presuit screening period in s. 766.106(4); during an extension provided for therein; during a period of 210 days thereafter; or during a 90-day period after the filing of an amended complaint for medical negligence alleging new facts previously unknown to the insurer.

1 (c) If a case is set for trial within 1 year after the
2 date of filing the claim, an insurer shall not be held in bad
3 faith if policy limits are tendered 60 days or more prior to
4 the initial trial date.
5 (2) This section does not apply when, based upon
6 information known earlier to the insurer or its
7 representatives, the insurer could and should have settled the
8 claim within policy limits if it had been acting fairly and
9 honestly toward the insured and with due regard for the
10 insured's interests during the periods specified in paragraph
11 (b) or (c) of subsection (1), whichever is earlier.
12 (3) It is the intent of the Legislature to encourage
13 all insurers, insureds, and their assigns and legal
14 representatives to act in good faith during a medical
15 negligence action, both during the presuit period and the
16 litigation.
17 (4) This subsection expires September 1, 2006, but
18 shall continue to apply to medical negligence claims for which
19 a notice of intent to litigate has been sent prior to
20 September 1, 2006.
21 Section 56. Effective October 1, 2003, and applicable
22 to notices of intent to litigate sent on or after that date,
23 subsection (2), paragraphs (a) and (b) of subsection (3), and
24 subsection (7) of section 766.106, Florida Statutes, as
25 amended by this act, are amended, to read:
26 766.106 Notice before filing action for medical
27 malpractice; presuit screening period; offers for admission of
28 liability and for arbitration; informal discovery; review.--
29 (2)(a) After completion of presuit investigation
30 pursuant to s. 766.203 and prior to filing a claim for medical
31 malpractice, a claimant shall notify each prospective

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

1 defendant by certified mail, return receipt requested, of
2 intent to initiate litigation for medical malpractice. Notice
3 to each prospective defendant must include, if available, a
4 list of all known health care providers seen by the claimant
5 for the injuries complained of subsequent to the alleged act
6 of malpractice, all known health care providers during the
7 2-year period prior to the alleged act of malpractice who
8 treated or evaluated the claimant, and copies of all of the
9 medical records relied upon by the expert in signing the
10 affidavit. The requirement of providing the list of known
11 health care providers may not serve as grounds for imposing
12 sanctions for failure to provide presuit discovery.
13 (b) Following the initiation of a suit alleging
14 medical malpractice with a court of competent jurisdiction,
15 and service of the complaint upon a defendant, the claimant
16 shall provide a copy of the complaint to the Department of
17 Health and, if the complaint involves a facility licensed
18 under chapter 395, the Agency for Health Care Administration.
19 The requirement of providing the complaint to the Department
20 of Health or the Agency for Health Care Administration does
21 not impair the claimant's legal rights or ability to seek
22 relief for his or her claim. The Department of Health or the
23 Agency for Health Care Administration shall review each
24 incident that is the subject of the complaint and determine
25 whether it involved conduct by a licensee which is potentially
26 subject to disciplinary action, in which case, for a licensed
27 health care practitioner, the provisions of s. 456.073 apply,
28 and for a licensed facility, the provisions of part I of
29 chapter 395 apply.
30 (3)(a) No suit may be filed for a period of 90 days
31 after notice is mailed to any prospective defendant. During

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

1 the 90-day period, the prospective defendant's insurer or
2 self-insurer shall conduct a review to determine the liability
3 of the defendant. Each insurer or self-insurer shall have a
4 procedure for the prompt investigation, review, and evaluation
5 of claims during the 90-day period. This procedure shall
6 include one or more of the following:
7 1. Internal review by a duly qualified claims
8 adjuster;
9 2. Creation of a panel comprised of an attorney
10 knowledgeable in the prosecution or defense of medical
11 malpractice actions, a health care provider trained in the
12 same or similar medical specialty as the prospective
13 defendant, and a duly qualified claims adjuster;
14 3. A contractual agreement with a state or local
15 professional society of health care providers, which maintains
16 a medical review committee;
17 4. Any other similar procedure which fairly and
18 promptly evaluates the pending claim.
19
20 Each insurer or self-insurer shall investigate the claim in
21 good faith, and both the claimant and prospective defendant
22 shall cooperate with the insurer in good faith. If the
23 insurer requires, a claimant shall appear before a pretrial
24 screening panel or before a medical review committee and shall
25 submit to a physical examination, if required. Unreasonable
26 failure of any party to comply with this section justifies
27 dismissal of claims or defenses. There shall be no civil
28 liability for participation in a pretrial screening procedure
29 if done without intentional fraud.
30 (b) At or before the end of the 90 days, the insurer
31 or self-insurer shall provide the claimant with a response:

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

1. Rejecting the claim;

2. Making a settlement offer; or

3. Making an offer to arbitrate in which 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.

(8) 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

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

1 party is required to produce discoverable documents or things
2 within that party's possession or control.
3 (c) Physical and mental examinations.--A prospective
4 defendant may require an injured prospective claimant to
5 appear for examination by an appropriate health care provider.
6 The defendant shall give reasonable notice in writing to all
7 parties as to the time and place for examination. Unless
8 otherwise impractical, a prospective claimant is required to
9 submit to only one examination on behalf of all potential
10 defendants. The practicality of a single examination must be
11 determined by the nature of the potential claimant's
12 condition, as it relates to the liability of each potential
13 defendant. Such examination report is available to the parties
14 and their attorneys upon payment of the reasonable cost of
15 reproduction and may be used only for the purpose of presuit
16 screening. Otherwise, such examination report is confidential
17 and exempt from the provisions of s. 119.07(1) and s. 24(a),
18 Art. I of the State Constitution.
19 (d) Written questions.--Any party may request answers
20 to written questions, which may not exceed 30, including
21 subparts. A response must be made within 20 days after receipt
22 of the questions.
23 Section 57. Section 766.108, Florida Statutes, is
24 amended to read:
25 766.108 Mandatory mediation and mandatory settlement
26 conference in medical malpractice actions.--
27 (1) Within 120 days after suit being filed, unless
28 such period is extended by mutual agreement of all parties,
29 all parties shall attend in-person mandatory mediation in
30 accordance with s. 44.102 if binding arbitration under s.
31 766.106 or s. 766.207 has not been agreed to by the parties.

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

1 The Florida Rules of Civil Procedure shall apply to mediation
2 held pursuant to this section.
3 (2)(a)~~(1)~~ In any action for damages based on personal
4 injury or wrongful death arising out of medical malpractice,
5 whether in tort or contract, the court shall require a
6 settlement conference at least 3 weeks before the date set for
7 trial.
8 (b)~~(2)~~ Attorneys who will conduct the trial, parties,
9 and persons with authority to settle shall attend the
10 settlement conference held before the court unless excused by
11 the court for good cause.
12 Section 58. Section 766.118, Florida Statutes, is
13 created to read:
14 766.118 Determination of noneconomic damages.--
15 (1) With respect to a cause of action for personal
16 injury or wrongful death resulting from an occurrence of
17 medical negligence, damages recoverable for noneconomic losses
18 to compensate for pain and suffering, inconvenience, physical
19 impairment, mental anguish, disfigurement, loss of capacity
20 for enjoyment of life, and all other noneconomic damages shall
21 not exceed $500,000 aggregate for all defendant health care
22 practitioners, $500,000 aggregate for all defendant health
23 care facilities, and $500,000 aggregate for all other
24 defendants regardless of the number of claimants involved in
25 the action subject to the limitations set forth in subsection
26 (2).
27 (2) Notwithstanding subsection (1), the trier of fact
28 may award noneconomic damages under this section in an amount
29 not to exceed $2 million per incident in cases where medical
30 negligence results in certain catastrophic injuries including
31 death, coma, severe and permanent brain damage, mastectomy,

1 loss of reproductive capabilities, hemiplegia, quadriplegia,
2 paraplegia, blindness, or a permanent vegetative state.
3 Regardless of the number of individual claimants, the total
4 noneconomic damages that may be awarded for all claims arising
5 out of the same incident, shall be limited to a maximum of $2
6 million aggregate for all defendant practitioners, $2 million
7 aggregate for all defendant facilities, and $2 million
8 aggregate for all other defendants.
9 (3) The maximum amount of noneconomic damages which
10 may be awarded under this section must be adjusted each year
11 on July 1 to reflect the rate of inflation or deflation as
12 indicated in the Consumer Price Index for All Urban Consumers
13 published by the United States Department of Labor. However,
14 the maximum amount of noneconomic damages which may be awarded
15 may not be less than $500,000.
16 (4) Notwithstanding any law to the contrary, the caps
17 on noneconomic damages provided in subsection (1) of this
18 section do not apply to any incident involving a physician or
19 osteopathic physician who is not in compliance with the
20 financial responsibility requirements set forth in ss. 458.320
21 and 459.0085, respectively.
22 (5) This section expires effective September 1, 2006,
23 but shall continue to apply with respect to incidents that
24 occur prior to that date.
25 Section 59. Section 766.202, Florida Statutes, is
26 amended to read:
27 766.202 Definitions; ss. 766.201-766.212.--As used in
28 ss. 766.201-766.212, the term:
29 (1) "Claimant" means any person who has a cause of
30 action for damages based on personal injury or wrongful death
31 arising from medical negligence.

1 (2) "Collateral sources" means any payments made to
2 the claimant, or made on his or her behalf, by or pursuant to:
3 (a) The United States Social Security Act; any
4 federal, state, or local income disability act; or any other
5 public programs providing medical expenses, disability
6 payments, or other similar benefits, except as prohibited by
7 federal law.
8 (b) Any health, sickness, or income disability
9 insurance; automobile accident insurance that provides health
10 benefits or income disability coverage; and any other similar
11 insurance benefits, except life insurance benefits available
12 to the claimant, whether purchased by him or her or provided
13 by others.
14 (c) Any contract or agreement of any group,
15 organization, partnership, or corporation to provide, pay for,
16 or reimburse the costs of hospital, medical, dental, or other
17 health care services.
18 (d) Any contractual or voluntary wage continuation
19 plan provided by employers or by any other system intended to
20 provide wages during a period of disability.
21 (3) "Economic damages" means financial losses that
22 ~~which~~ would not have occurred but for the injury giving rise
23 to the cause of action, including, but not limited to, past
24 and future medical expenses and 80 percent of wage loss and
25 loss of earning capacity to the extent the claimant is
26 entitled to recover such damages under general law, including
27 the Wrongful Death Act.
28 (4) "Health care provider" means any hospital,
29 ambulatory surgical center, or mobile surgical facility as
30 defined and licensed under chapter 395; a birth center
31 licensed under chapter 383; any person licensed under chapter

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

1 458, chapter 459, chapter 460, chapter 461, chapter 462,
2 chapter 463, part I of chapter 464, chapter 466, chapter 467
3 or chapter 486; a clinical lab licensed under chapter 483; a
4 health maintenance organization certificated under part I of
5 chapter 641; a blood bank; a plasma center; an industrial
6 clinic; a renal analysis facility; or a professional
7 association partnership, corporation, joint venturer or other
8 association for professional activity by health care
9 providers.
10 (5)~~(4)~~ "Investigation" means that an attorney has
11 reviewed the case against each and every potential defendant
12 and has consulted with a medical expert and has obtained a
13 written opinion from said expert.
14 (6)~~(5)~~ "Medical expert" means a person duly and
15 regularly engaged in the practice of his or her profession who
16 holds a health care professional degree from a university or
17 college and who meets the requirements of an expert witness as
18 set forth in s. 766.102 ~~has had special professional training~~
19 ~~and experience or one possessed of special health care~~
20 ~~knowledge or skill about the subject upon which he or she is~~
21 ~~called to testify or provide an opinion~~.
22 (7)~~(6)~~ "Medical negligence" means medical malpractice,
23 whether grounded in tort or in contract.
24 (8)~~(7)~~ "Noneconomic damages" means nonfinancial losses
25 that ~~which~~ would not have occurred but for the injury giving
26 rise to the cause of action, including pain and suffering,
27 inconvenience, physical impairment, mental anguish,
28 disfigurement, loss of capacity for enjoyment of life, and
29 other nonfinancial losses to the extent the claimant is
30 entitled to recover such damages under general law, including
31 the Wrongful Death Act.

(9)~~(8)~~ "Periodic payment" means provision for the structuring of future economic damages payments, in whole or in part, over a period of time, as follows:

(a) 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.

(b) 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.

(d) Any portion of the periodic payment 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

1 the claimant shall be paid from that portion of the periodic
2 payment attributable to medical expenses.
3 Section 60. Effective upon this act becoming a law and
4 applicable to all causes of action accruing on or after
5 September 1, 2003, section 766.206, Florida Statutes, is
6 amended to read:
7 766.206 Presuit investigation of medical negligence
8 claims and defenses by court.--
9 (1) After the completion of presuit investigation by
10 the parties pursuant to s. 766.203 and any informal discovery
11 pursuant to s. 766.106, any party may file a motion in the
12 circuit court requesting the court to determine whether the
13 opposing party's claim or denial rests on a reasonable basis.
14 (2) If the court finds that the notice of intent to
15 initiate litigation mailed by the claimant is not in
16 compliance with the reasonable investigation requirements of
17 ss. 766.201-766.212, including a review of the claim and a
18 verified written medical expert opinion by an expert witness
19 as defined in s. 766.202,the court shall dismiss the claim,
20 and the person who mailed such notice of intent, whether the
21 claimant or the claimant's attorney, shall be personally
22 liable for all attorney's fees and costs incurred during the
23 investigation and evaluation of the claim, including the
24 reasonable attorney's fees and costs of the defendant or the
25 defendant's insurer.
26 (3) If the court finds that the response mailed by a
27 defendant rejecting the claim is not in compliance with the
28 reasonable investigation requirements of ss. 766.201-766.212,
29 including a review of the claim and a verified written medical
30 expert opinion by an expert witness as defined in s. 766.202,
31 the court shall strike the defendant's pleading.~~response, and~~

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

1 The person who mailed such response, whether the defendant,
2 the defendant's insurer, or the defendant's attorney, shall be
3 personally liable for all attorney's fees and costs incurred
4 during the investigation and evaluation of the claim,
5 including the reasonable attorney's fees and costs of the
6 claimant.
7 (4) If the court finds that an attorney for the
8 claimant mailed notice of intent to initiate litigation
9 without reasonable investigation, or filed a medical
10 negligence claim without first mailing such notice of intent
11 which complies with the reasonable investigation requirements,
12 or if the court finds that an attorney for a defendant mailed
13 a response rejecting the claim without reasonable
14 investigation, the court shall submit its finding in the
15 matter to The Florida Bar for disciplinary review of the
16 attorney. Any attorney so reported three or more times within
17 a 5-year period shall be reported to a circuit grievance
18 committee acting under the jurisdiction of the Supreme Court.
19 If such committee finds probable cause to believe that an
20 attorney has violated this section, such committee shall
21 forward to the Supreme Court a copy of its finding.
22 (5)(a) If the court finds that the corroborating
23 written medical expert opinion attached to any notice of claim
24 or intent or to any response rejecting a claim lacked
25 reasonable investigation <u>or that the medical expert submitting</u>
26 <u>the opinion did not meet the expert witness qualifications as</u>
27 <u>set forth in s. 766.202(5)</u>, the court shall report the medical
28 expert issuing such corroborating opinion to the Division of
29 Medical Quality Assurance or its designee. If such medical
30 expert is not a resident of the state, the division shall
31

CODING: Words ~~stricken~~ are deletions; words <u>underlined</u> are additions.

1 forward such report to the disciplining authority of that
2 medical expert.
3 (b) The court shall ~~may~~ refuse to consider the
4 testimony or opinion attached to any notice of intent or to
5 any response rejecting a claim of ~~such~~ an expert who has been
6 disqualified three times pursuant to this section.
7 Section 61. Subsection (7) of section 766.207, Florida
8 Statutes, is amended to read:
9 766.207 Voluntary binding arbitration of medical
10 negligence claims.--
11 (7) Arbitration pursuant to this section shall
12 preclude recourse to any other remedy by the claimant against
13 any participating defendant, and shall be undertaken with the
14 understanding that damages shall be awarded as provided by
15 general law, including the Wrongful Death Act, subject to the
16 following limitations:
17 (a) Net economic damages shall be awardable,
18 including, but not limited to, past and future medical
19 expenses and 80 percent of wage loss and loss of earning
20 capacity, offset by any collateral source payments.
21 (b) Noneconomic damages shall be limited to a maximum
22 of $250,000 per incident, and shall be calculated on a
23 percentage basis with respect to capacity to enjoy life, so
24 that a finding that the claimant's injuries resulted in a
25 50-percent reduction in his or her capacity to enjoy life
26 would warrant an award of not more than $125,000 noneconomic
27 damages.
28 (c) Damages for future economic losses shall be
29 awarded to be paid by periodic payments pursuant to s.
30 766.202(8) and shall be offset by future collateral source
31 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

1 defendant's offer to arbitrate shall be subject to the
2 provisions of s. 766.209(4).
3 (l) The hearing shall be conducted by all of the
4 arbitrators, but a majority may determine any question of fact
5 and render a final decision. The chief arbitrator shall
6 decide all evidentiary matters.
7
8 The provisions of this subsection shall not preclude
9 settlement at any time by mutual agreement of the parties.
10 Section 62. Subsection (4) is added to section
11 768.041, Florida Statutes, to read:
12 768.041 Release or covenant not to sue.--
13 (4)(a) At trial pursuant to a suit filed under chapter
14 766, or at trial pursuant to s. 766.209, if any defendant
15 shows the court that the plaintiff, or his or her legal
16 representative, has delivered a written release or covenant
17 not to sue to any person in partial satisfaction of the
18 damages sued for, the court shall set off this amount from the
19 total amount of the damages set forth in the verdict and
20 before entry of the final judgment.
21 (b) The amount of the setoff pursuant to this
22 subsection shall include all sums received by the plaintiff,
23 including economic and noneconomic damages, costs, and
24 attorney's fees.
25 Section 63. Paragraph (c) of subsection (2) of section
26 768.13, Florida Statutes, is amended to read:
27 768.13 Good Samaritan Act; immunity from civil
28 liability.--
29 (2)
30 (c)1. Any health care practitioner as defined in s.
31 456.001(4) who is in a hospital attending to a patient of his

1 or her practice or for business or personal reasons unrelated
2 to direct patient care, and who voluntarily responds to
3 provide care or treatment to a patient with whom at that time
4 the practitioner does not have a then-existing health care
5 patient-practitioner relationship, and when such care or
6 treatment is necessitated by a sudden or unexpected situation
7 or by an occurrence that demands immediate medical attention,
8 shall not be held liable for any civil damages as a result of
9 any act or omission relative to that care or treatment, unless
10 that care or treatment is proven to amount to conduct that is
11 willful and wanton and would likely result in injury so as to
12 affect the life or health of another.
13 2. The immunity provided by this paragraph does not
14 apply to damages as a result of any act or omission of
15 providing medical care or treatment unrelated to the original
16 situation that demanded immediate medical attention.
17 3. For purposes of this paragraph, the Legislature's
18 intent is to encourage health care practitioners to provide
19 necessary emergency care to all persons without fear of
20 litigation as described in this paragraph.
21 ~~(c) Any person who is licensed to practice medicine,~~
22 ~~while acting as a staff member or with professional clinical~~
23 ~~privileges at a nonprofit medical facility, other than a~~
24 ~~hospital licensed under chapter 395, or while performing~~
25 ~~health screening services, shall not be held liable for any~~
26 ~~civil damages as a result of care or treatment provided~~
27 ~~gratuitously in such capacity as a result of any act or~~
28 ~~failure to act in such capacity in providing or arranging~~
29 ~~further medical treatment, if such person acts as a reasonably~~
30 ~~prudent person licensed to practice medicine would have acted~~
31 ~~under the same or similar circumstances.~~

1 Section 64. Section 768.77, Florida Statutes, is
2 amended to read:
3 768.77 Itemized verdict.--
4 (1) Except as provided in subsection (2), in any
5 action to which this part applies in which the trier of fact
6 determines that liability exists on the part of the defendant,
7 the trier of fact shall, as a part of the verdict, itemize the
8 amounts to be awarded to the claimant into the following
9 categories of damages:
10 (a)~~(1)~~ Amounts intended to compensate the claimant for
11 economic losses;
12 (b)~~(2)~~ Amounts intended to compensate the claimant for
13 noneconomic losses; and
14 (c)~~(3)~~ Amounts awarded to the claimant for punitive
15 damages, if applicable.
16 (2) In any action for damages based on personal injury
17 or wrongful death arising out of medical malpractice, whether
18 in tort or contract, to which this part applies in which the
19 trier of fact determines that liability exists on the part of
20 the defendant, the trier of fact shall, as a part of the
21 verdict, itemize the amounts to be awarded to the claimant
22 into the following categories of damages:
23 (a) Amounts intended to compensate the claimant for:
24 1. Past economic losses; and
25 2. Future economic losses, not reduced to present
26 value, and the number of years or part thereof which the award
27 is intended to cover;
28 (b) Amounts intended to compensate the claimant for:
29 1. Past noneconomic losses; and
30 2. Future noneconomic losses and the number of years
31 or part thereof which the award is intended to cover; and

1 (c) Amounts awarded to the claimant for punitive
2 damages, if applicable.
3 Section 65. Subsection (5) of section 768.81, Florida
4 Statutes, is amended to read:
5 768.81 Comparative fault.--
6 (5) Notwithstanding any provision of ~~anything in~~ law
7 to the contrary, in an action for damages for personal injury
8 or wrongful death arising out of medical malpractice, whether
9 in contract or tort, the trier of fact shall apportion the
10 total fault only among the claimant and all the joint
11 tortfeasors who are parties to the action when the case is
12 submitted to the jury for deliberation and rendition of the
13 verdict ~~when an apportionment of damages pursuant to this~~
14 ~~section is attributed to a teaching hospital as defined in s.~~
15 ~~408.07, the court shall enter judgment against the teaching~~
16 ~~hospital on the basis of such party's percentage of fault and~~
17 ~~not on the basis of the doctrine of joint and several~~
18 ~~liability~~.
19 Section 66. Nothing in this act constitutes a waiver
20 of sovereign immunity under section 768.28, Florida Statutes,
21 or contravenes the abrogation of joint and several liability
22 contained in section 766.112, Florida Statutes.
23 Section 67. The Office of Program Policy Analysis and
24 Government Accountability and the Office of the Auditor
25 General must jointly conduct an audit of the Department of
26 Health's health care practitioner disciplinary process and
27 closed claims that are filed with the department under section
28 627.912, Florida Statutes. The Office of Program Policy
29 Analysis and Government Accountability and the Office of the
30 Auditor General shall submit a report to the Legislature by
31 January 1, 2005.

1 Section 68. Section 1004.08, Florida Statutes, is
2 created to read:
3 1004.08 Patient safety instructional
4 requirements.--Each public school, college, and university
5 that offers degrees in medicine, nursing, or allied health
6 shall include in the curricula applicable to such degrees
7 material on patient safety, including patient safety
8 improvement. Materials shall include, but need not be limited
9 to, effective communication and teamwork; epidemiology of
10 patient injuries and medical errors; medical injuries;
11 vigilance, attention, and fatigue; checklists and inspections;
12 automation, technological, and computer support; psychological
13 factors in human error; and reporting systems.
14 Section 69. Section 1005.07, Florida Statutes, is
15 created to read:
16 1005.07 Patient safety instructional
17 requirements.--Each private school, college, and university
18 that offers degrees in medicine, nursing, and allied health
19 shall include in the curricula applicable to such degrees
20 material on patient safety, including patient safety
21 improvement. Materials shall include, but need not be limited
22 to, effective communication and teamwork; epidemiology of
23 patient injuries and medical errors; medical injuries;
24 vigilance, attention, and fatigue; checklists and inspections;
25 automation, technological, and computer support; psychological
26 factors in human error; and reporting systems.
27 Section 70. Paragraph (c) of subsection (2) of section
28 1006.20, Florida Statutes, as amended by section 2 of chapter
29 2003-129, Laws of Florida, is amended to read:
30 1006.20 Athletics in public K-12 schools.--
31 (2) ADOPTION OF BYLAWS.--

1 (c) The organization shall adopt bylaws that require
2 all students participating in interscholastic athletic
3 competition or who are candidates for an interscholastic
4 athletic team to satisfactorily pass a medical evaluation each
5 year prior to participating in interscholastic athletic
6 competition or engaging in any practice, tryout, workout, or
7 other physical activity associated with the student's
8 candidacy for an interscholastic athletic team. Such medical
9 evaluation can only be administered by a practitioner licensed
10 under the provisions of chapter 458, chapter 459, chapter 460,
11 or s. 464.012, and in good standing with the practitioner's
12 regulatory board. The bylaws shall establish requirements for
13 eliciting a student's medical history and performing the
14 medical evaluation required under this paragraph, which shall
15 include a physical assessment of the student's physical
16 capabilities to participate in interscholastic athletic
17 competition as contained in a uniform preparticipation
18 physical evaluation and history form. The evaluation form
19 shall incorporate the recommendations of the American Heart
20 Association for participation cardiovascular screening and
21 shall provide a place for the signature of the practitioner
22 performing the evaluation with an attestation that each
23 examination procedure listed on the form was performed by the
24 practitioner or by someone under the direct supervision of the
25 practitioner. The form shall also contain a place for the
26 practitioner to indicate if a referral to another practitioner
27 was made in lieu of completion of a certain examination
28 procedure. The form shall provide a place for the practitioner
29 to whom the student was referred to complete the remaining
30 sections and attest to that portion of the examination. The
31 preparticipation physical evaluation form shall advise

1 students to complete a cardiovascular assessment and shall
2 include information concerning alternative cardiovascular
3 evaluation and diagnostic tests. ~~Practitioners administering~~
4 ~~medical evaluations pursuant to this subsection must, at a~~
5 ~~minimum, solicit all information required by, and perform a~~
6 ~~physical assessment according to, the uniform preparticipation~~
7 ~~form referred to in this paragraph and must certify, based on~~
8 ~~the information provided and the physical assessment, that the~~
9 ~~student is physically capable of participating in~~
10 ~~interscholastic athletic competition. If the practitioner~~
11 ~~determines that there are any abnormal findings in the~~
12 ~~cardiovascular system, the student may not participate until a~~
13 ~~further cardiovascular assessment, which may include an EKG,~~
14 ~~is performed which indicates that the student is physically~~
15 ~~capable of participating in interscholastic athletic~~
16 ~~competition.~~Results of such medical evaluation must be
17 provided to the school. No student shall be eligible to
18 participate in any interscholastic athletic competition or
19 engage in any practice, tryout, workout, or other physical
20 activity associated with the student's candidacy for an
21 interscholastic athletic team until the results of the medical
22 evaluation ~~clearing the student for participation~~ has been
23 received and approved by the school.
24 Section 71. No later than September 1, 2003, the
25 Department of Health shall convene a workgroup to study the
26 current healthcare practitioner disciplinary process. The
27 workgroup shall include a representative of the Administrative
28 Law section of The Florida Bar, a representative of the Health
29 Law section of The Florida Bar, a representative of the
30 Florida Medical Association, a representative of the Florida
31 Osteopathic Medical Association, a representative of the

1 Florida Dental Association, a member of the Florida Board of
2 Medicine who has served on the probable cause panel, a member
3 of the Board of Osteopathic Medicine who has served on the
4 probable cause panel, and a member of the Board of Dentistry
5 who has served on the probable cause panel. The workgroup
6 shall also include one consumer member of the Board of
7 Medicine. The Department of Health shall present the findings
8 and recommendations to the Governor, the President of the
9 Senate, and the Speaker of the House of Representatives no
10 later than January 1, 2004. The sponsoring organizations shall
11 assume the costs of their representative.
12 Section 72. Section 766.1065, Florida Statutes, is
13 created to read:
14 766.1065 Mandatory presuit investigation.--
15 (1) Within 30 days after service of the presuit notice
16 of intent to initiate medical malpractice litigation, each
17 party shall provide to all other parties all medical,
18 hospital, health care, and employment records concerning the
19 claimant in the disclosing party's possession, custody, or
20 control, and the disclosing party shall affirmatively certify
21 in writing that such records constitute all records in that
22 party's possession, custody, or control of that the party has
23 no medical, hospital, health care, or employment records
24 concerning the claimant.
25 (2) Within 60 days after service of the presuit notice
26 of intent to initiate medical malpractice litigation, all
27 parties must be made available for a sworn deposition. A
28 deposition taken pursuant to this section may not be used in
29 any civil action for any purpose by any party.
30 (3) Within 90 days after service of the presuit notice
31 of intent to initiate medical malpractice litigation, all

1 parties must attend in-person mandatory mediation in
2 accordance with s. 44.102, if binding arbitration under s.
3 766.106 or s. 766.207 has not been agreed to by the parties.
4 The Florida Rules of Civil Procedure shall apply to such
5 mediation.
6 (4) If the parties declare an impasse during the
7 mandatory mediation, and if the plaintiff or the defendants so
8 request within 10 days of the impasse, via certified mail to
9 Office of Presuit Screening Administration for a presuit
10 screening panel, the Office of Presuit Screening
11 Administration shall convene such a panel pursuant to s.
12 766.1066. Notwithstanding any other provision of law, the
13 parties may stipulate to waive any proceedings under this
14 section.
15 Section 73. Section 766.1066, Florida Statutes, is
16 created to read:
17 766.1066 Office of Presuit Screening Administration;
18 presuit screening panels.--
19 (1)(a) There is created within the Department of
20 Health, the Office of Presuit Screening Administration. The
21 department shall provide administrative support and service to
22 the office to the extent requested by the director. The office
23 is not subject to any control, supervision, or direction by
24 the department, including, but not limited to, personnel,
25 purchasing, transactions involving real or personal property,
26 and budgetary matters. The director of the office shall be
27 appointed by the Governor and the Cabinet.
28 (b) The office shall, by September 1, 2003, develop
29 and maintain a database of health care providers, attorneys,
30 and mediators available to serve as members of presuit
31 screening panels.

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

1 (c) The Department of Health shall request the
2 relevant regulatory boards to assist the office in developing
3 the database. The office shall request the assistance of The
4 Florida Bar in developing the database. The office shall
5 request the assistance of the Supreme Court in developing the
6 database.
7 (d) Funding for the office's general expenses shall
8 come from a service charge equal to 0.5 percent of the final
9 judgment or arbitration award in each medical malpractice
10 liability case in this state. All parties in such malpractice
11 actions shall in equal parts pay the service charge at the
12 time proceeds from a final judgment or an arbitration award
13 are initially disbursed. Such charge shall be collected by the
14 clerk of the circuit court in the county where the final
15 judgment is entered or the arbitration award is made. The
16 clerk shall remit the service charges to the Department of
17 Revenue for deposit into the Department of Health
18 Administrative Trust Fund. The Department of Revenue shall
19 adopt rules to administer the service charge.
20 (e)1. A person may not be required to serve on a
21 presuit screening panel for more than 2 days.
22 2. A person on a panel shall designate in advance any
23 time period during which he or she will not be available to
24 serve.
25 3. When a plaintiff requests a hearing before a panel,
26 the office shall randomly select members for a panel from
27 available persons in the appropriate categories who have not
28 served on a panel in the past 12 months. If there are no other
29 potential panelists available, a panelist may be asked to
30 serve on another panel within 12 months.
31

1 4. The office shall establish a panel no later than 15
2 days after the receipt of the request for hearing. The office
3 shall set a hearing no later than 30 days after the receipt of
4 the request for hearing.
5 (f) Panel members shall receive reimbursement from the
6 office for their travel expenses.
7 (g) A health care provider who serves on a panel:
8 1. Shall receive credit for 20 hours of continuing
9 medical education for such service;
10 2. Must reside and practice at least 50 miles from the
11 location where the alleged injury occurred;
12 3. Must have had no more than two judgments for
13 medical malpractice liability against him or her within the
14 preceding 5 years and no more than 10 claims of medical
15 malpractice filed against him or her within the preceding 3
16 years; and
17 4. Must hold an active license in good standing in
18 this state and must have been in active practice within the
19 5-year period prior to selection.
20
21 A health care provider who fails to attend the designated
22 panel hearing on two separate occasions shall be reported to
23 his or her regulatory board for discipline and may not receive
24 continuing education credit for participation on the panel.
25 (h) An attorney who serves on a panel:
26 1. Should receive credit for 20 hours of continuing
27 legal education and credit towards pro bono requirements for
28 such service. The Legislature requests that the Supreme Court
29 adopt rules to implement this provision;
30 2. Must reside and practice at least 50 miles from the
31 location where the alleged injury occurred;

1 3. Must have had no judgments for filing a frivolous
2 lawsuit within the preceding 5 years;
3 4. Must hold an active license to practice law in this
4 state and have held an active license in good standing for at
5 least 5 years; and
6 5. Must be a board-certified civil trial lawyer.
7
8 An attorney who fails to attend the designated panel hearing
9 on two separate occasions shall be reported to The Florida
10 Bar.
11 (2)(a) A presuit screening panel shall be composed of
12 five persons, including:
13 1. Two health care providers who are trained in the
14 same or similar medical specialty as the defendant;
15 2. Two attorneys; and
16 3. One circuit certified mediator obtained from a list
17 provided by the clerk of the court in the judicial circuit
18 where a prospective defendant health care provider resides.
19 The mediator shall serve as the presiding officer of the
20 panel.
21 (b) If there is more than one health care provider
22 defendant, the plaintiff shall designate the subject areas in
23 which both health care provider members of the panel must be
24 trained in the medical specialty.
25 (c) A panel member who knowingly has a conflict of
26 interest or potential conflict of interest must disclose it
27 prior to the hearing. The office must replace the conflicted
28 panel member with a panel member from the same category as the
29 member removed because of a conflict of interest. Failure of a
30 panel member to report a conflict of interest shall result in
31 dismissal from the panel and from further service. A health

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

1 care provider member who does not report a conflict of
2 interest shall also be reported to his or her regulatory board
3 for disciplinary action. An attorney member who does not
4 report a conflict of interest shall be reported to The Florida
5 Bar and the office is to request disciplinary action be taken
6 against the attorney.
7 (d) The office shall provide administrative support to
8 the panel.
9 (3) The plaintiff shall be allowed 8 hours to present
10 his or her case. All defendants shall be allowed a total of 8
11 hours collectively to present their case, and a hearing may
12 not exceed a total of 16 hours; however, the panel may hear a
13 case over the course of 2 calendar days.
14 (4)(a) In addition to any other information that may
15 be disclosed under this section and no later than 2 weeks
16 prior to the hearing of the screening panel, the claimant
17 shall provide to the panel and opposing parties a detailed
18 report, supported by one or more verified written medical
19 expert opinion reports from medical experts as defined in this
20 chapter, including a detailed description of the expert
21 witness's qualifications, the precise nature of the witness's
22 opinions regarding each instance in which each defendant is
23 alleged to have breached the prevailing professional standard
24 of care, and a description of the factual basis for each such
25 opinion of negligence. The report shall also include a
26 description of all elements of damages claimed.
27 (b) In addition to any other information that may be
28 disclosed under this section and no later than 1 week prior to
29 the hearing of the screening panel, each defendant shall
30 provide to the panel and opposing parties a detailed report,
31 supported by one or more verified written medical expert

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

1 opinion reports from medical experts as defined in this
2 chapter, including a detailed description of the expert
3 witness's qualifications, the precise nature of the witness's
4 opinions, and a description of the factual basis for each such
5 opinion. If a party fails to comply with the requirements of
6 this section without good cause, the court upon motion shall
7 impose sanctions, including an award of attorney's fees and
8 other costs, against the party failing to comply.
9 (5) All documentary evidence of a type commonly relied
10 upon by reasonably prudent persons in the conduct of their
11 affairs is admissible, whether or not such evidence would be
12 admissible in a trial. The panel may proceed with the hearing
13 and shall render an opinion upon the evidence produced,
14 notwithstanding the failure of a party to appear.
15 (6) A panel shall, by a majority vote for each
16 defendant, determine whether reasonable grounds exists to
17 support a claim of medical negligence. The findings of the
18 panel are not final agency action for purposes of chapter 120.
19 (7) Panel members are immune from civil liability for
20 all communications, findings, opinions, and conclusions made
21 in the course and scope of duties prescribed by this section
22 to the extent provided in s. 768.28.
23 (8) Unless excluded by the judge for good cause shown,
24 the proceedings and findings of a presuit screening panel
25 shall be discoverable and admissible in any subsequent trial
26 arising out of the claim, and the members of the panel may be
27 deposed and called to testify at trial. If the panel's
28 findings, or any testimony or evidence related to the panel's
29 findings or proceedings, are admitted into evidence, the court
30 shall instruct the jury that the findings are not binding and
31

1 shall be considered by the jury equally with all other
2 evidence presented at trial.
3 (9) The statute of limitations as to all potential
4 defendants shall be tolled from the date that any party serves
5 upon the Office of Presuit Screening Administration the
6 request for a medical review panel until the date that the
7 plaintiff receives the panel's findings. These tolling
8 provisions shall be in addition to any other tolling
9 provision.
10 (10) Upon the plaintiff receipt of the presuit
11 screening panel's determination, the plaintiff has 60 days or
12 the remainder of the period of the statute of limitations,
13 whichever period is greater, in which to file suit.
14 (11) The Administration Commission shall adopt rules
15 to administer this section.
16 (12) This section expires effective September 1, 2006,
17 but shall continue to apply with respect to incidents that
18 occur prior to that date.
19 Section 74. Subsection (7) of section 456.013, Florida
20 Statutes, is amended to read:
21 456.013 Department; general licensing provisions.--
22 (7) The boards, or the department when there is no
23 board, shall require the completion of a 2-hour course
24 relating to prevention of medical errors as part of the
25 licensure and renewal process. The 2-hour course shall count
26 towards the total number of continuing education hours
27 required for the profession. The course shall be approved by
28 the board or department, as appropriate, and shall include a
29 study of root-cause analysis, error reduction and prevention,
30 and patient safety. If the course is being offered by a
31 facility licensed pursuant to chapter 395 for its employees,

1 the board may approve up to 1 hour of the 2-hour course to be
2 specifically related to error reduction and prevention methods
3 used in that facility. The Board of Medicine and the Board of
4 Osteopathic Medicine shall also require as a condition of
5 licensure and license renewal that each physician and
6 physician assistant complete a 2-hour board-approved
7 continuing education course relating to the five most
8 misdiagnosed conditions, as determined by the board, during
9 the previous biennium. This continuing education course shall
10 count towards the total number of continuing education hours
11 required for those physicians and physician assistants.
12 Section 75. Paragraph (a) of subsection (3) of section
13 766.209, Florida Statutes, is amended to read:
14 766.209 Effects of failure to offer or accept
15 voluntary binding arbitration.--
16 (3) If the defendant refuses a claimant's offer of
17 voluntary binding arbitration:
18 (a) The claim shall proceed to trial ~~without~~
19 ~~limitation on damages~~, and the claimant, upon proving medical
20 negligence, shall be entitled to recover damages as provided
21 in s. 766.118, prejudgment interest, and reasonable attorney's
22 fees up to 25 percent of the award reduced to present value.
23 Section 76. Subsection (1) of section 391.025, Florida
24 Statutes, is amended to read:
25 391.025 Applicability and scope.--
26 (1) This act applies to health services provided to
27 eligible individuals who are:
28 (a)1. Enrolled in the Medicaid program;
29 2.~~(b)~~ Enrolled in the Florida Kidcare program; and
30 3.~~(c)~~ Uninsured or underinsured, provided that they
31 meet the financial eligibility requirements established in

1 this act, and to the extent that resources are appropriated
2 for their care; or.
3 (b) Infants who receive an award of compensation under
4 s. 766.31(1).
5 Section 77. Paragraph (f) is added to subsection (2)
6 of section 391.029, Florida Statutes, to read:
7 391.029 Program eligibility.--
8 (2) The following individuals are financially eligible
9 for the program:
10 (f) An infant who receives an award of compensation
11 under s. 766.31(1). The Florida Birth-Related Neurological
12 Injury Compensation Association shall reimburse the Children's
13 Medical Services Network the state's share of funding, which
14 must thereafter be used to obtain matching federal funds under
15 Title XXI of the Social Security Act.
16
17 The department may continue to serve certain children with
18 special health care needs who are 21 years of age or older and
19 who were receiving services from the program prior to April 1,
20 1998. Such children may be served by the department until
21 July 1, 2000.
22 Section 78. Section 766.304, Florida Statutes, is
23 amended to read:
24 766.304 Administrative law judge to determine
25 claims.--The administrative law judge shall hear and determine
26 all claims filed pursuant to ss. 766.301-766.316 and shall
27 exercise the full power and authority granted to her or him in
28 chapter 120, as necessary, to carry out the purposes of such
29 sections. The administrative law judge has exclusive
30 jurisdiction to determine whether a claim filed under this act
31 is compensable. No civil action may be brought until the

1 determinations under s. 766.309 have been made by the
2 administrative law judge. If the administrative law judge
3 determines that the claimant is entitled to compensation from
4 the association, or if the claimant accepts an award issued
5 under s. 766.31, no civil action may be brought or continued
6 in violation of the exclusiveness of remedy provisions of s.
7 766.303. If it is determined that a claim filed under this act
8 is not compensable, neither the doctrine of collateral
9 estoppel nor res judicata shall prohibit the claimant from
10 pursuing any and all civil remedies available under common law
11 and statutory law. The findings of fact and conclusions of law
12 of the administrative law judge shall not be admissible in any
13 subsequent proceeding; however, the sworn testimony of any
14 person and the exhibits introduced into evidence in the
15 administrative case are admissible as impeachment in any
16 subsequent civil action only against a party to the
17 administrative proceeding, subject to the Rules of Evidence.
18 An award ~~action~~ may not be made or paid ~~brought~~ under ss.
19 766.301-766.316 if the claimant recovers under a settlement or
20 a final judgment is entered in a civil action. The division
21 may adopt rules to promote the efficient administration of,
22 and to minimize the cost associated with, the prosecution of
23 claims.
24 Section 79. Subsections (1) and (2) of section
25 766.305, Florida Statutes, are amended, present subsections
26 (3), (4), (5), and (6) of that section are redesignated as
27 subsections (4), (5), (6), and (7), respectively, and a new
28 subsection (3) is added to that section to read:
29 766.305 Filing of claims and responses; medical
30 disciplinary review.--
31

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

(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.~~

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

1 (2) The claimant shall furnish the division with as
2 many copies of the petition as required for service upon the
3 association, any physician and hospital named in the petition,
4 and the Division of Medical Quality Assurance, along with a
5 $15 filing fee payable to the Division of Administrative
6 Hearings. Upon receipt of the petition, the division shall
7 immediately serve the association, by service upon the agent
8 designated to accept service on behalf of the association, by
9 registered or certified mail, and shall mail copies of the
10 petition, by registered or certified mail, to any physician,
11 health care provider, and hospital named in the petition, and
12 shall furnish a copy by regular mail to the Division of
13 Medical Quality Assurance, and the Agency for Health Care
14 Administration.
15 (3) The claimant shall furnish to the Florida
16 Birth-Related Neurological Injury Compensation Association the
17 following information, which must be filed with the
18 association within 10 days after the filing of the petition as
19 set forth in s. 766.305(1):
20 (a) All available relevant medical records relating to
21 the birth-related neurological injury and a list identifying
22 any unavailable records known to the claimant and the reasons
23 for the records' unavailability.
24 (b) Appropriate assessments, evaluations, and
25 prognoses and such other records and documents as are
26 reasonably necessary for the determination of the amount of
27 compensation to be paid to, or on behalf of, the injured
28 infant on account of the birth-related neurological injury.
29 (c) Documentation of expenses and services incurred to
30 date which identifies any payment made for such expenses and
31 services and the payor.

1 (d) Documentation of any applicable private or
2 governmental source of services or reimbursement relative to
3 the impairments.
4
5 The information required by (a)-(d) shall remain confidential
6 and exempt under the provisions of s. 766.315(5)(b).
7 Section 80. Paragraph (b) of subsection (1) of section
8 766.31, Florida Statutes, is amended to read:
9 766.31 Administrative law judge awards for
10 birth-related neurological injuries; notice of award.--
11 (1) Upon determining that an infant has sustained a
12 birth-related neurological injury and that obstetrical
13 services were delivered by a participating physician at the
14 birth, the administrative law judge shall make an award
15 providing compensation for the following items relative to
16 such injury:
17 (b)1. Periodic payments of an award to the parents or
18 legal guardians of the infant found to have sustained a
19 birth-related neurological injury, which award shall not
20 exceed $100,000. However, at the discretion of the
21 administrative law judge, such award may be made in a lump
22 sum.
23 2. Death benefit for the infant in an amount of
24 $10,000 ~~Payment for funeral expenses not to exceed $1,500~~.
25 Section 81. Paragraph (a) and paragraph (c) of
26 subsection (4) of section 766.314, Florida Statutes, as
27 amended by section 4 of chapter 2003-258, Laws of Florida, are
28 amended, paragraph (d) is added to that subsection, and
29 paragraph (a) of subsection (5) of that section is amended to
30 read:
31 766.314 Assessments; plan of operation.--

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

1 (4) The following persons and entities shall pay into
2 the association an initial assessment in accordance with the
3 plan of operation:
4 (a) On or before October 1, 1988, each hospital
5 licensed under chapter 395 shall pay an initial assessment of
6 $50 per infant delivered in the hospital during the prior
7 calendar year, as reported to the Agency for Health Care
8 Administration; provided, however, that a hospital owned or
9 operated by the state or a county, special taxing district, or
10 other political subdivision of the state shall not be required
11 to pay the initial assessment or any assessment required by
12 subsection (5). The term "infant delivered" includes live
13 births and not stillbirths, but the term does not include
14 infants delivered by employees or agents of the board of
15 trustees of a state university ~~Board of Regents~~ or those born
16 in a teaching hospital as defined in s. 408.07. The initial
17 assessment and any assessment imposed pursuant to subsection
18 (5) may not include any infant born to a charity patient (as
19 defined by rule of the Agency for Health Care Administration)
20 or born to a patient for whom the hospital receives Medicaid
21 reimbursement, if the sum of the annual charges for charity
22 patients plus the annual Medicaid contractuals of the hospital
23 exceeds 10 percent of the total annual gross operating
24 revenues of the hospital. The hospital is responsible for
25 documenting, to the satisfaction of the association, the
26 exclusion of any birth from the computation of the assessment.
27 Upon demonstration of financial need by a hospital, the
28 association may provide for installment payments of
29 assessments.
30 (c) ~~On or before December 1, 1988,~~Each physician
31 licensed pursuant to chapter 458 or chapter 459 who wishes to

1 participate in the Florida Birth-Related Neurological Injury
2 Compensation Plan and who otherwise qualifies as a
3 participating physician under ss. 766.301-766.316 shall pay an
4 initial assessment of $5,000. However, if the physician is
5 either a resident physician, assistant resident physician, or
6 intern in an approved postgraduate training program, as
7 defined by the Board of Medicine or the Board of Osteopathic
8 Medicine by rule, and is supervised in accordance with program
9 requirements established by the Accreditation Council for
10 Graduate Medical Education or the American Osteopathic
11 Association by a physician who is participating in the plan,
12 such resident physician, assistant resident physician, or
13 intern is deemed to be a participating physician without the
14 payment of the assessment. Participating physicians also
15 include any employee of the board of trustees of a state
16 university ~~Board of Regents~~ who has paid the assessment
17 required by this paragraph and paragraph (5)(a), and any
18 certified nurse midwife supervised by such employee.
19 Participating physicians include any certified nurse midwife
20 who has paid 50 percent of the physician assessment required
21 by this paragraph and paragraph (5)(a) and who is supervised
22 by a participating physician who has paid the assessment
23 required by this paragraph and paragraph (5)(a). Supervision
24 for nurse midwives shall require that the supervising
25 physician will be easily available and have a prearranged plan
26 of treatment for specified patient problems which the
27 supervised certified nurse midwife may carry out in the
28 absence of any complicating features. Any physician who
29 elects to participate in such plan on or after January 1,
30 1989, who was not a participating physician at the time of
31 such election to participate and who otherwise qualifies as a

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

1 participating physician under ss. 766.301-766.316 shall pay an
2 additional initial assessment equal to the most recent
3 assessment made pursuant to this paragraph, paragraph (5)(a),
4 or paragraph (7)(b).
5 (d) Any hospital located in a county with a population
6 in excess of 1.1 million as of January 1, 2003, as determined
7 by the Agency for Health Care Administration under the Health
8 Care Responsibility Act, may elect to pay the fee for the
9 participating physician and the certified nurse midwife if the
10 hospital first determines that the primary motivating purpose
11 for making such payment is to ensure coverage for the
12 hospital's patients under the provisions of ss.
13 766.301-766.316; however, no hospital may restrict any
14 participating physician or nurse midwife, directly or
15 indirectly, from being on the staff of hospitals other than
16 the staff of the hospital making the payment. Each hospital
17 shall file with the association an affidavit setting forth
18 specifically the reasons why the hospital elected to make the
19 payment on behalf of each participating physician and
20 certified nurse midwife. The payments authorized under this
21 paragraph shall be in addition to the assessment set forth in
22 paragraph (5)(a).
23 (5)(a) Beginning January 1, 1990, the persons and
24 entities listed in paragraphs (4)(b) and (c), except those
25 persons or entities who are specifically excluded from said
26 provisions, as of the date determined in accordance with the
27 plan of operation, taking into account persons licensed
28 subsequent to the payment of the initial assessment, shall pay
29 an annual assessment in the amount equal to the initial
30 assessments provided in paragraphs (4)(b) and (c). If payment
31 of the annual assessment by a physician is received by the

1 association by January 31 of any calendar year, the physician
2 shall qualify as a participating physician for that entire
3 calendar year. If the payment is received after January 31 of
4 any calendar year, the physician shall qualify as a
5 participating physician for that calendar year only from the
6 date the payment was received by the association.On January
7 1, 1991, and on each January 1 thereafter, the association
8 shall determine the amount of additional assessments necessary
9 pursuant to subsection (7), in the manner required by the plan
10 of operation, subject to any increase determined to be
11 necessary by the Department of Insurance pursuant to paragraph
12 (7)(b). On July 1, 1991, and on each July 1 thereafter, the
13 persons and entities listed in paragraphs (4)(b) and (c),
14 except those persons or entities who are specifically excluded
15 from said provisions, shall pay the additional assessments
16 which were determined on January 1. Beginning January 1, 1990,
17 the entities listed in paragraph (4)(a), including those
18 licensed on or after October 1, 1988, shall pay an annual
19 assessment of $50 per infant delivered during the prior
20 calendar year. The additional assessments which were
21 determined on January 1, 1991, pursuant to the provisions of
22 subsection (7) shall not be due and payable by the entities
23 listed in paragraph (4)(a) until July 1.
24 Section 82. Seven positions are authorized and the sum
25 of $454,766 is appropriated from the General Revenue Fund to
26 the Department of Health, Office of Presuit Screening
27 Administration, to implement the provisions of this act for
28 the 2003-2004 fiscal year.
29 Section 83. The sum of $687,786 is appropriated from
30 the Medical Quality Assurance Trust Fund to the Department of
31 Health, and seven positions are authorized, for the purpose of

1 implementing this act during the 2003-2004 fiscal year. The
2 sum of $452,122 is appropriated from the General Revenue Fund
3 to the Agency for Health Care Administration, and five
4 positions are authorized, for the purpose of implementing this
5 act during the 2003-2004 fiscal year.
6 Section 84. The sum of $2,150,000 is appropriated from
7 the Insurance Regulatory Trust Fund in the Department of
8 Financial Services to the Office of Insurance Regulation for
9 the purpose of implementing this act during the 2003-2004
10 fiscal year.
11 Section 85. If any law that is amended by this act was
12 also amended by a law enacted at the 2003 Regular Session or a
13 2003 special session of the Legislature, such laws shall be
14 construed as if they had been enacted during the same session
15 of the Legislature, and full effect should be given to each if
16 that is possible.
17 Section 86. If any provision of this act or its
18 application to any person or circumstance is held invalid, the
19 invalidity does not affect other provisions or applications of
20 the act which can be given effect without the invalid
21 provision or application, and to this end the provisions of
22 this act are severable.
23 Section 87. Except as otherwise expressly provided in
24 this act, this act shall take effect September 1, 2003.
25
26
27
28
29
30
31

STATEMENT OF SUBSTANTIAL CHANGES CONTAINED IN
COMMITTEE SUBSTITUTE FOR
Senate Bill 2-C

The CS for SB 2-C makes the following changes:

Authorizes the Agency for Health Care Administration (AHCA) to adopt rules for certification of quality improvement programs.

Deletes a requirement in s. 395.0191, F.S., that persons act in good faith to avoid liability or discipline for their actions regarding the awarding of staff membership or clinical privileges.

Removes a provision relating to peer review, which added mental or physical abuse of staff as a ground for discipline and which capped monetary liability of persons involved in peer review at $250,000 except when intentional fraud is involved.

Deletes requirements for licensed facilities to notify AHCA within 1 business day of the occurrence of certain adverse incidents. Repeals s. 395.0198, F.S., which provided a public records exemption for adverse incident notifications.

Removes a requirement for licensed hospitals to offer testing for sexually transmissible diseases to certain victims of sexual abuse.

Restores existing statutory language on health care practitioner license renewal fees in s. 456.025, F.S., which requires that fees be no more than 10 percent greater than the actual cost to regulate the health care profession for the previous biennium.

Changes the time in which the Department of Health (DOH) must update a practitioner profile from 45 business days to 30 calendar days after receiving an update of information. Changes the time from 45 calendar days to 30 calendar days in which DOH must include reports for liability actions and bankruptcy in a practitioner's profile.

Removes a provision that authorized health care practitioner regulatory boards to adopt rules to establish standards of practice for prescribing drugs to patients via the Internet.

Notwithstanding the 6-year limitation on the investigation or filing of an administrative complaint, DOH is authorized to investigate professional liability actions reported in the previous 6 years rather than 10 years for any paid claim exceeding $50,000.

Revises requirements for the determination of conclusions of law and findings of fact by DOH or boards for standard of care violations involving practitioners under the department or boards' regulatory jurisdiction.

Deletes language which would have revised the applicable burden of proof required for the prosecution of disciplinary cases involving health care practitioners. Establishes

emergency procedures for the discipline of medical physicians, osteopathic physicians, and podiatric physicians who have reported three closed malpractice claims within a 60-month period to the Office of Insurance Regulation (OIR).

Revises requirements for alternative disciplinary procedures by providing that the issuance of a citation may not include standard of care violations involving patient injury. Citations for the first offense do not constitute discipline, but citations for the second or subsequent offenses do constitute discipline. Revises requirements for disciplinary violations which may be subject to mediation to exclude specified offenses.

Provides that a commercial self-insurance fund formed by 10 or more health care providers is limited to providing medical malpractice coverage. Also clarifies that the members of the fund are not required to maintain membership in a professional or trade association.

Removes a provision that would have disallowed insurers from submitting a disapproved rate filing to arbitration.

Moves the annual rate filing requirement for medical malpractice insurance to the rating law provisions that apply specifically to medical malpractice insurance.

Deletes the section of the bill that creates an excess profits law for medical malpractice insurance.

Deletes the section of the bill that requires OIR to hold a public hearing upon request of a policyholder for a medical malpractice rate filing with a statewide average increase of 25 percent or greater.

Consolidates and revises all closed claim reporting requirements to: (1) require reporting by all types of insurance and self-insurance entities, including specified health care practitioners and facilities for claims not otherwise reported; (2) include reports of claims resulting in non payment; (3) include professional license numbers; (4) provide for electronic access to the DOH for all closed claim data and otherwise delete separate reporting to DOH; (5) provide that violations by health care providers of reporting requirements constitutes a violation of their practice act; and (6) require OIR to prepare an annual report analyzing the closed claim reports, financial reports submitted by insurers, approved rate filings and loss trends.

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

Deletes the section of the bill that applies various consumer protection laws to the business of insurance.

Revises presuit screening panel membership. The term "health care provider" is inserted in lieu of "physician" so that a panel will include health care providers of the same type as the defendant, i.e., dentists will be included on a panel reviewing an allegation of medical malpractice against a

1 dentist.

2 Revises the provisions relating to who may testify against or on behalf of a health care provider to clarify the three
3 categories under which someone may testify as a specialist, as a general practitioner or as someone other than a specialist
4 or general practitioner.

5 Revises the organization of s. 766.106, F.S., relating to presuit notice and screening, to (1) add subheadings, (2)
6 refer to medical negligence in lieu of medical malpractice, (3) add statutory cross-references relating to presuit
7 investigations also found in s. 766.203, F.S., (4) relocate new provisions relating to common-law bad-faith actions
8 against insurers into its own created section of law, (5) eliminate conflicting provisions relating to voluntary binding
9 arbitration which predated similar provisions in s.766.207, F.S., and (6) make other technical corrective changes to
10 terminology consistent with chapter 766, F.S.

11 Revises s. 766.202, F.S., relating to the definitions applicable to presuit medical negligence claims and voluntary
12 binding arbitration, to add an updated definition for "health care provider" which is also cross-referenced to refer to whom
13 presuit procedures apply for actions based on personal injury or wrongful death arising from medical negligence.
14
Clarifies that the caps on noneconomic damages applicable in
15 medical negligence trials is applicable to trials that take place following a defendant's refusal to accept a claimant's
16 offer of voluntary binding arbitration.

17 Adds infants who receive a Florida Birth-Related Neurological Injury Compensation Association (NICA) award to the Children's
18 Medical Services program, requires reimbursement to CMS for services, and makes the reimbursement eligible for federal
19 matching funds.

20 Provides that medical records and related information in a claim are to be filed with NICA, rather than with the Division
21 of Administrative Hearings, and be included within a current public records exemption.
22
Creates a $10,000 death benefit for an infant and strikes
23 requirements to pay funeral expenses up to $1,500.

24 Permits a hospital in a county of more than 1.1 million gross population as of January 1, 2003, to pay the NICA fee for
25 participating physicians and midwives.

26 Deletes assessments on certain health providers and entities to fund the Florida Center for Excellence in Health Care and
27 requires DOH to submit a budget for financing of the center's operations for approval by the Legislature.
28
Deletes requirements for osteopathic physicians to maintain
29 "tail" coverage for claims after a professional liability insurance coverage policy has elapsed.
30
31