1 A bill to be entitled
2 An act relating to medical incidents; providing
3 legislative findings; amending s. 391.025, F.S.; providing
4 that the Children's Medical Services Act applies to
5 infants receiving compensation under the Florida Birth-
6 Related Neurological Injury Compensation Plan; amending s.
7 391.029, F.S.; providing that infants receiving
8 compensation under the Florida Birth-Related Neurological
9 Injury Compensation Plan are eligible for the Children's
10 Medical Services program; requiring the plan to reimburse
11 the program for certain costs; creating s. 395.0056, F.S.;
12 requiring the Agency for Health Care Administration to
13 review complaints submitted if the defendant is a
14 hospital; amending s. 395.0191, F.S.; deleting requirement
15 that persons act in good faith to avoid liability or
16 discipline for their actions regarding the awarding of
17 staff membership or clinical privileges; amending s.
18 395.0197, F.S.; revising provisions relating to internal
19 risk management programs; requiring a system for
20 notification of patients that are the subject of an
21 adverse incident; requiring additional reports to and by
22 the Department of Health and the Agency for Health Care
23 Administration; repealing s. 395.0198, F.S., relating to
24 public records exemptions for notification of adverse
25 incidents; creating s. 395.1012, F.S.; requiring
26 hospitals, ambulatory surgical centers, and mobile
27 surgical facilities to establish patient safety plans,
28 officers, and committees; creating s. 395.1051, F.S.;
29 requiring certain facilities to notify patients about
30 adverse incidents under specified conditions; amending s.

31 456.013, F.S.; requiring certain information to be
32 included in courses for certain health care practitioners
33 relating to prevention of medical errors; amending s.
34 456.025, F.S.; eliminating certain restrictions on the
35 setting of licensure renewal fees for health care
36 practitioners; amending s. 456.039, F.S.; providing
37 additional information required to be furnished to the
38 Department of Health for licensure purposes; amending s.
39 456.041, F.S., relating to practitioner profiles;
40 requiring the Department of Health to compile certain
41 specified information in a practitioner profile;
42 establishing a timeframe for certain health care
43 practitioners to report specified information; providing
44 for disciplinary action and a fine for untimely
45 submissions; deleting provisions that provide that a
46 profile need not indicate whether a criminal history check
47 was performed to corroborate information in the profile;
48 authorizing the department or regulatory board to
49 investigate any information received; requiring the
50 department to provide an easy-to-read narrative
51 explanation concerning final disciplinary action taken
52 against a practitioner; requiring a hyperlink to each
53 final order on the department's website which provides
54 information about disciplinary actions; requiring the
55 department to provide a hyperlink to certain comparison
56 reports pertaining to claims experience; requiring the
57 department to include the date that a reported
58 disciplinary action was taken by a licensed facility and a
59 characterization of the practitioner's conduct that
60 resulted in the action; deleting provisions requiring the

61 department to consult with a regulatory board before
62 including certain information in a health care
63 practitioner's profile; providing for a penalty for
64 failure to comply with the timeframe for verifying and
65 correcting a practitioner profile; requiring the
66 department to add a statement to a practitioner profile
67 when the profile information has not been verified by the
68 practitioner; requiring the department to provide, in the
69 practitioner profile, an explanation of disciplinary
70 action taken and the reason for sanctions imposed;
71 requiring the department to include a hyperlink to a
72 practitioner's website when requested; providing that
73 practitioners licensed under ch. 458 or ch. 459, F.S.,
74 shall have claim information concerning an indemnity
75 payment greater than a specified amount posted in the
76 practitioner profile; amending s. 456.042, F.S.; providing
77 for the update of practitioner profiles; designating a
78 timeframe within which a practitioner must submit new
79 information to update his or her profile; amending s.
80 456.049, F.S.; revising requirements for the reporting of
81 claims; providing that such reports shall be made to the
82 Office of Insurance Regulation rather than the Department
83 of Health; amending s. 456.051, F.S.; establishing the
84 responsibility of the Department of Health to provide
85 reports of professional liability actions and
86 bankruptcies; requiring the department to include such
87 reports in a practitioner's profile within a specified
88 period; deleting an obsolete cross reference; amending s.
89 456.057, F.S.; authorizing the Department of Health to
90 utilize subpoenas to obtain patient records without

91 patients' consent under certain circumstances; creating s.
92 456.0575, F.S.; requiring licensed health care
93 practitioners to notify patients about adverse incidents
94 under certain conditions; amending s. 456.072, F.S.;
95 providing for determining the amount of any costs to be
96 assessed in a disciplinary proceeding; amending s.
97 456.073, F.S.; authorizing the Department of Health to
98 investigate certain paid claims made on behalf of
99 practitioners licensed under ch. 458 or ch. 459, F.S.;
100 extending the time for the Department of Health to refer a
101 request for an administrative hearing; providing that
102 certain findings are not findings of fact and reserving
103 such determinations to the regulatory boards or the
104 Department of Health when there is no board; eliminating
105 the requirement for certain formal hearings; amending s.
106 456.077, F.S.; revising provisions relating to designation
107 of certain citation violations; amending s. 456.078, F.S.;
108 revising provisions relating to designation of certain
109 mediation offenses; amending s. 458.320, F.S., relating to
110 financial responsibility requirements for medical
111 physicians; requiring maintenance of financial
112 responsibility as a condition of licensure of physicians;
113 providing for payment of any outstanding judgments or
114 settlements pending at the time a physician is suspended
115 by the Department of Health; requiring the department to
116 suspend the license of a medical physician who has not
117 paid, up to the amounts required by any applicable
118 financial responsibility provision, any outstanding
119 judgment, arbitration award, other order, or settlement;
120 prohibiting the expenditure of certain funds for defense

121 expenditures; correcting a cross reference; amending s.
122 458.331, F.S., relating to grounds for disciplinary action
123 against a physician; redefining the term "repeated
124 malpractice"; revising the minimum amount of a claim
125 against a licensee which will trigger a departmental
126 investigation; requiring administrative orders issued by
127 an administrative law judge or the Board of Medicine for
128 certain practice violations by physicians to specify
129 certain information; conforming terminology; creating s.
130 458.3311, F.S.; establishing emergency procedures for
131 disciplinary actions; amending s. 459.0085, F.S., relating
132 to financial responsibility requirements for osteopathic
133 physicians; requiring maintenance of financial
134 responsibility as a condition of licensure of osteopathic
135 physicians; providing for payment of any outstanding
136 judgments or settlements pending at the time an
137 osteopathic physician is suspended by the Department of
138 Health; requiring that the department suspend the license
139 of an osteopathic physician who has not paid, up to the
140 amounts required by any applicable financial
141 responsibility provision, any outstanding judgment,
142 arbitration award, other order, or settlement; prohibiting
143 the expenditure of certain funds for defense expenditures;
144 correcting a cross reference; amending s. 459.015, F.S.;
145 increasing the amount of paid liability claims requiring
146 investigation by the Department of Health; revising the
147 definition of "repeated malpractice" to conform; creating
148 s. 459.0151, F.S.; establishing emergency procedures for
149 disciplinary actions; amending s. 461.013, F.S., relating
150 to grounds for disciplinary action against a podiatric

151 physician; redefining the term "repeated malpractice";
152 amending the minimum amount of a claim against such a
153 physician which will trigger a department investigation;
154 requiring administrative orders issued by an
155 administrative law judge or board for certain practice
156 violations by physicians to specify certain information;
157 conforming terminology; creating s. 461.0131, F.S.;
158 establishing emergency procedures for disciplinary
159 actions; amending s. 466.028, F.S., relating to grounds
160 for disciplinary action against a dentist or a dental
161 hygienist; redefining the term "dental malpractice";
162 revising the minimum amount of a claim against a dentist
163 which will trigger a departmental investigation; amending
164 s. 624.462, F.S.; authorizing health care providers to
165 form a commercial self-insurance fund; correcting a cross
166 reference; amending s. 627.062, F.S.; providing that an
167 insurer may not require arbitration of a rate filing for
168 medical malpractice insurance; providing additional
169 requirements for medical malpractice insurance rate
170 filings; providing that portions of judgments and
171 settlements entered against a medical malpractice insurer
172 for bad faith actions or for punitive damages against the
173 insurer, as well as related taxable costs and attorney's
174 fees, may not be included in an insurer's rate base;
175 providing for review of rate filings by the Office of
176 Insurance Regulation for excessive, inadequate, or
177 unfairly discriminatory rates; requiring insurers to apply
178 a discount or surcharge based on the health care
179 provider's loss experience; requiring annual rate filings;
180 requiring medical malpractice insurers to make rate

181 filings which take effect no later than January 1, 2004,
182 and which reflect the impact of medical malpractice
183 legislation enacted during the 2003 Special Session D of
184 the Legislature; providing for retroactive application of
185 such rate filings; providing requirements for rate
186 deviation by insurers; authorizing adjustments to filed
187 rates in the event any provision of medical malpractice
188 legislation enacted during the 2003 Special Session D of
189 the Legislature is declared invalid by a court of
190 competent jurisdiction; providing that certain rates for
191 medical malpractice insurance shall remain in effect until
192 the effective date of a new rate filing approved under
193 this section; providing an exception to the applicability
194 of ch. 120, F.S., and s. 287.057, F.S., in certain rate
195 filing; amending s. 627.357, F.S.; requiring the Financial
196 Services Commission to adopt rules that ensure the
197 solvency of a trust fund; deleting the prohibition against
198 formation of medical malpractice self-insurance funds;
199 amending s. 627.4147, F.S.; requiring earlier notice of
200 decisions to cancel or not renew certain insurance
201 policies to insureds under certain circumstances;
202 requiring prior notification of a rate increase;
203 conforming terminology; creating s. 627.41495, F.S.;
204 providing for consumer participation in review of medical
205 malpractice insurance rate changes; providing for public
206 inspection; amending s. 627.912, F.S.; revising the
207 medical negligence closed claim reports that must be filed
208 with the Office of Insurance Regulation; applying such
209 requirements to additional persons and entities; providing
210 the Department of Health with access to such reports;

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

211 requiring the Department of Health to review such reports
212 and to determine whether it potentially involves conduct
213 subject to discipline; providing for the mandatory
214 imposition of a fine or disciplinary action for failing to
215 report; increasing the maximum fine which may be imposed;
216 requiring reports to obtain additional information;
217 authorizing the Financial Services Commission to adopt
218 rules; requiring the Office of Insurance Regulation to
219 prepare summaries of closed claim reports of prior years
220 and to prepare an annual report and analysis of closed
221 claim and insurer financial reports; amending s. 641.19,
222 F.S.; revising definitions to provide that health care
223 providers providing services pursuant to coverage provided
224 under a health maintenance organization contract are not
225 employees or agents of the health maintenance
226 organization; providing exceptions; amending s. 641.51,
227 F.S.; proscribing a health maintenance organization's
228 right to control the professional judgment of a physician;
229 providing that a health maintenance organization shall not
230 be vicariously liable for the medical negligence of a
231 health care provider; providing exceptions; amending s.
232 766.102, F.S.; correcting a cross reference; revising
233 requirements for health care providers who offer
234 corroborating medical expert opinion and expert testimony
235 in medical negligence actions; prohibiting contingency
236 fees for an expert witness; requiring certification that
237 an expert witness has not previously been found guilty of
238 fraud or perjury; amending s. 766.106, F.S.; defining the
239 term "claims for medical negligence;" deleting provisions
240 relating to voluntary arbitration in conflict with s.

241 766.207, F.S.; providing that liability is deemed admitted
242 when an offer is made by a defendant to arbitrate;
243 revising requirements for presuit notice and for an
244 insurer's or self-insurer's response to a claim; requiring
245 that a claimant provide the Agency for Health Care
246 Administration with a copy of the complaint alleging
247 medical negligence; requiring the agency to review such
248 complaints for licensure noncompliance; permitting written
249 questions during informal discovery; requiring a claimant
250 to execute a medical information release to authorize
251 defendants in medical negligence actions to take unsworn
252 statements from a claimant's treating physicians; imposing
253 limits on such statements; providing that the claimant or
254 the claimant's representative has the right to be present
255 when such statements are taken; amending s. 766.108, F.S.;
256 providing for mandatory mediation in medical negligence
257 causes of action under certain circumstances; conforming
258 terminology; creating s. 766.118, F.S.; providing
259 definitions; providing limitations on noneconomic damages
260 which can be awarded in causes of action involving medical
261 negligence; providing applicability with respect to
262 comparative fault and setoff reductions; providing for
263 nonapplicability; creating s. 766.1185, F.S.; providing
264 that an action for bad faith may not be brought against a
265 medical malpractice insurer if such insurer offers to pay
266 policy limits within a specified time period; providing
267 for factors to be considered in determining whether a
268 medical malpractice insurer has acted in bad faith;
269 amending s. 766.202, F.S.; defining "health care
270 provider"; redefining the terms "claimant," "economic

271 damages," "medical expert," and "noneconomic damages";
272 extending the definitions of economic and noneconomic
273 damages to include any such damages recoverable under the
274 Wrongful Death Act or general law; creating s. 766.2021,
275 F.S.; limiting the amount of damages which may be
276 recovered against insurers, prepaid limited health service
277 organizations, health maintenance organizations, or
278 prepaid health clinics; amending s. 766.203, F.S.;
279 providing for discovery of opinions and statements
280 tendered during presuit investigation; correcting cross
281 references; conforming terminology; amending s. 766.206,
282 F.S.; providing for dismissal of a claim under certain
283 circumstances; requiring the court to make certain reports
284 concerning a medical expert who fails to meet
285 qualifications; amending s. 766.207, F.S.; providing for
286 the applicability of the Wrongful Death Act and general
287 law to arbitration awards; correcting a cross reference;
288 amending s. 766.209, F.S.; revising applicable damages
289 available in voluntary binding arbitration relating to
290 claims of medical negligence; correcting a cross
291 reference; amending s. 766.304, F.S.; providing that a
292 claimant may not receive compensation from the Florida
293 Birth-Related Neurological Injury Compensation Plan if
294 damages are provided pursuant to a settlement or a final
295 judgment in a civil action is entered; prohibiting the
296 filing of civil actions under certain circumstances;
297 amending s. 766.305, F.S.; revising the information
298 required to be included in a petition seeking recovery
299 from the Florida Birth-Related Neurological Injury
300 Compensation Plan; revising requirements for the service

301 of such petitions; requiring claimants to provide certain
302 information to the Florida Birth-Related Neurological
303 Injury Compensation Association; amending s. 766.309,
304 F.S.; authorizing bifurcation of certain proceedings;
305 providing for an interlocutory appeal; amending s. 766.31,
306 F.S.; providing a death benefit under the Florida Birth-
307 Related Neurological Injury Compensation Plan in lieu of
308 funeral expenses; providing that claimants are not liable
309 for certain expenses under certain circumstances; amending
310 s. 766.314, F.S.; correcting terminology; authorizing
311 certain hospitals to pay assessments on behalf of certain
312 health care professionals; providing for the dates of
313 coverage of a participating physician; creating s.
314 768.0981, F.S.; providing that insurers, prepaid limited
315 health service organizations, health maintenance
316 organizations, or prepaid health clinics shall not be held
317 liable for medical negligence of health care contractors
318 unless the entity expressly directed or exercised actual
319 control over the action resulting in injury; amending s.
320 768.13, F.S.; revising guidelines for immunity from
321 liability under the Good Samaritan Act; amending s.
322 768.28, F.S.; providing that certain health care
323 practitioners acting under contract with the board of
324 trustees of a state university are considered agents of
325 the state for the application of the doctrine of sovereign
326 immunity; providing for indemnification of the state by
327 such practitioners; amending s. 768.77, F.S.; prescribing
328 a method for itemization of specific categories of damages
329 awarded in medical negligence actions; creating s.
330 1004.08, F.S.; requiring patient safety instruction for

331 certain students in public schools, colleges, and
332 universities; creating s. 1005.07, F.S.; requiring patient
333 safety instruction for certain students in nonpublic
334 schools, colleges, and universities; amending s. 1006.20,
335 F.S.; requiring completion of a uniform preparticipation
336 physical evaluation and history form incorporating
337 recommendations of the American Heart Association;
338 deleting provisions requiring practitioners to certify
339 that students are physically capable of participating in
340 interscholastic athletic competition; defining the terms
341 "patient safety data" and "patient safety organization";
342 providing for use of patient safety data by a patient
343 safety organization; providing limitations on use of
344 patient safety data; providing for protection of patient-
345 identifying information; providing for determination of
346 whether the privilege applies as asserted; providing that
347 an employer may not take retaliatory action against an
348 employee who makes a good faith report concerning patient
349 safety data; requiring the Division of Administrative
350 Hearings to designate administrative law judges who have
351 special qualifications for hearings involving certain
352 health care practitioners; requiring the Department of
353 Health to study the efficacy and constitutionality of
354 medical review panels; requiring a report; directing the
355 Agency for Health Care Administration to conduct or
356 contract for a study to determine what information to
357 provide to the public comparing hospitals, based on
358 inpatient quality indicators developed by the federal
359 Agency for Healthcare Research and Quality; requiring a
360 report; requiring a study and report by the Agency for

361 Health Care Administration regarding the establishment of
362 a patient safety entity; specifying elements of the
363 report; requiring the Office of Program Policy Analysis
364 and Government Accountability to study and report to the
365 Legislature on requirements for coverage by the Florida
366 Birth-Related Neurological Injury Compensation
367 Association; providing civil immunity for certain
368 participants in quality improvement processes; requiring
369 the Office of Program Policy Analysis and Government
370 Accountability and the Office of the Auditor General to
371 conduct an audit of the Department of Health's health care
372 practitioner disciplinary process and certain closed
373 claims and to report to the Legislature; creating a
374 workgroup to study the health care practitioner
375 disciplinary process; providing for workgroup membership;
376 requiring a report; providing legislative findings and
377 intent regarding provision of emergency medical services
378 and care; requiring that a specific statement be included
379 in each final settlement statement relating to medical
380 negligence actions; requiring the Office of Program Policy
381 Analysis and Government Accountability to study the
382 feasibility and merits of authorizing the Public Counsel
383 to participate in insurance rate filings for medical
384 malpractice insurance; providing appropriations;
385 reenacting and amending s. 458.319(5)(b), F.S., to
386 incorporate by reference amendments to s. 456.039, F.S.;
387 amending ss. 163.01, 456.048, 624.461, and 627.733, F.S.;
388 correcting cross references; amending ss. 766.112,
389 766.113, 766.201, 766.303, and 768.21, F.S.; conforming
390 terminology; preserving sovereign immunity and the

391 abrogation of certain joint and several liability;
392 providing severability; providing applicability; providing
393 for construction of the act in pari materia with laws
394 enacted during the 2003 Regular Session or a 2003 special
395 session of the Legislature; providing effective dates.
396
397 Be It Enacted by the Legislature of the State of Florida:
398
399 Section 1. Findings.--
400 (1) The Legislature finds that Florida is in the midst of
401 a medical malpractice insurance crisis of unprecedented
402 magnitude.
403 (2) The Legislature finds that this crisis threatens the
404 quality and availability of health care for all Florida
405 citizens.
406 (3) The Legislature finds that the rapidly growing
407 population and the changing demographics of Florida make it
408 imperative that students continue to choose Florida as the place
409 they will receive their medical educations and practice
410 medicine.
411 (4) The Legislature finds that Florida is among the states
412 with the highest medical malpractice insurance premiums in the
413 nation.
414 (5) The Legislature finds that the cost of medical
415 malpractice insurance has increased dramatically during the past
416 decade and both the increase and the current cost are
417 substantially higher than the national average.
418 (6) The Legislature finds that the increase in medical
419 malpractice liability insurance rates is forcing physicians to
420 practice medicine without professional liability insurance, to

421 leave Florida, to not perform high-risk procedures, or to retire
422 early from the practice of medicine.
423 (7) The Legislature finds that there are certain elements
424 of damage presently recoverable that have no monetary value,
425 except on a purely arbitrary basis, while other elements of
426 damage are either easily measured on a monetary basis or reflect
427 ultimate monetary loss.
428 (8) The Governor created the Governor's Select Task Force
429 on Healthcare Professional Liability Insurance to study and make
430 recommendations to address these problems.
431 (9) The Legislature has reviewed the findings and
432 recommendations of the Governor's Select Task Force on
433 Healthcare Professional Liability Insurance.
434 (10) The Legislature finds that the Governor's Select Task
435 Force on Healthcare Professional Liability Insurance has
436 established that a medical malpractice insurance crisis exists
437 in the State of Florida which can be alleviated by the adoption
438 of comprehensive legislatively enacted reforms.
439 (11) The Legislature finds that making high-quality health
440 care available to the citizens of this state is an overwhelming
441 public necessity.
442 (12) The Legislature finds that ensuring that physicians
443 continue to practice in Florida is an overwhelming public
444 necessity.
445 (13) The Legislature finds that ensuring the availability
446 of affordable professional liability insurance for physicians is
447 an overwhelming public necessity.
448 (14) The Legislature finds, based upon the findings and
449 recommendations of the Governor's Select Task Force on
450 Healthcare Professional Liability Insurance, the findings and

451 recommendations of various study groups throughout the nation,
452 and the experience of other states, that the overwhelming public
453 necessities of making quality health care available to the
454 citizens of this state, of ensuring that physicians continue to
455 practice in Florida, and of ensuring that those physicians have
456 the opportunity to purchase affordable professional liability
457 insurance cannot be met unless a cap on noneconomic damages is
458 imposed.
459 (15) The Legislature finds that the high cost of medical
460 negligence claims can be substantially alleviated by imposing a
461 limitation on noneconomic damages in medical negligence actions.
462 (16) The Legislature further finds that there is no
463 alternative measure of accomplishing such result without
464 imposing even greater limits upon the ability of persons to
465 recover damages for medical negligence.
466 (17) The Legislature finds that the provisions of this act
467 are naturally and logically connected to each other and to the
468 purpose of making quality health care available to the citizens
469 of Florida.
470 (18) The Legislature finds that each of the provisions of
471 this act is necessary to alleviate the crisis relating to
472 medical malpractice insurance.
473 Section 2. Subsection (1) of section 391.025, Florida
474 Statutes, is amended to read:
475 391.025 Applicability and scope.--
476 (1) This act applies to health services provided to
477 eligible individuals who are:
478 (a) Enrolled in the Medicaid program.~~;~~
479 (b) Enrolled in the Florida Kidcare program.~~; and~~
480 (c) Uninsured or underinsured, provided that they meet the

481 financial eligibility requirements established in this act, and
482 to the extent that resources are appropriated for their care.
483 (d) Infants who receive an award of compensation pursuant
484 to s. 766.31(1).
485 Section 3. Paragraph (f) is added to subsection (2) of
486 section 391.029, Florida Statutes, to read:
487 391.029 Program eligibility.--
488 (2) The following individuals are financially eligible for
489 the program:
490 (f) An infant who receives an award of compensation
491 pursuant to s. 766.31(1), provided the Florida Birth-Related
492 Neurological Injury Compensation Association shall reimburse the
493 Children's Medical Services Network the state's share of funding,
494 which funding shall be used to obtain matching federal funds
495 under Title XXI of the Social Security Act.
496
497 The department may continue to serve certain children with
498 special health care needs who are 21 years of age or older and
499 who were receiving services from the program prior to April 1,
500 1998. Such children may be served by the department until July
501 1, 2000.
502 Section 4. Section 395.0056, Florida Statutes, is created
503 to read:
504 395.0056 Litigation notice requirement.--Upon receipt of a
505 copy of a complaint filed against a hospital as a defendant in a
506 medical negligence action as required by s. 766.106(2), the
507 agency shall:
508 (1) Review its adverse incident report files pertaining to
509 the licensed facility that is the subject of the complaint to
510 determine whether the facility timely complied with the

511 requirements of s. 395.0197.
512 (2) Review the incident that is the subject of the
513 complaint and determine whether it involved conduct by a
514 licensee which is potentially subject to disciplinary action.
515 Section 5. Subsection (7) of section 395.0191, Florida
516 Statutes, is amended to read:
517 395.0191 Staff membership and clinical privileges.--
518 (7) There shall be no monetary liability on the part of,
519 and no cause of action for injunctive relief or damages shall
520 arise against, any licensed facility, its governing board or
521 governing board members, medical staff, or disciplinary board or
522 against its agents, investigators, witnesses, or employees, or
523 against any other person, for any action arising out of or
524 related to carrying out the provisions of this section, absent
525 taken in good faith and without intentional fraud in carrying
526 out the provisions of this section.
527 Section 6. Section 395.0197, Florida Statutes, is amended
528 to read:
529 395.0197 Internal risk management program.--
530 (1) Every licensed facility shall, as a part of its
531 administrative functions, establish an internal risk management
532 program that includes all of the following components:
533 (a) The investigation and analysis of the frequency and
534 causes of general categories and specific types of adverse
535 incidents to patients.
536 (b) The development of appropriate measures to minimize
537 the risk of adverse incidents to patients, including, but not
538 limited to:
539 1. Risk management and risk prevention education and
540 training of all nonphysician personnel as follows:

541 a. Such education and training of all nonphysician
542 personnel as part of their initial orientation; and
543 b. At least 1 hour of such education and training annually
544 for all personnel of the licensed facility working in clinical
545 areas and providing patient care, except those persons licensed
546 as health care practitioners who are required to complete
547 continuing education coursework pursuant to chapter 456 or the
548 respective practice act.
549 2. A prohibition, except when emergency circumstances
550 require otherwise, against a staff member of the licensed
551 facility attending a patient in the recovery room, unless the
552 staff member is authorized to attend the patient in the recovery
553 room and is in the company of at least one other person.
554 However, a licensed facility is exempt from the two-person
555 requirement if it has:
556 a. Live visual observation;
557 b. Electronic observation; or
558 c. Any other reasonable measure taken to ensure patient
559 protection and privacy.
560 3. A prohibition against an unlicensed person from
561 assisting or participating in any surgical procedure unless the
562 facility has authorized the person to do so following a
563 competency assessment, and such assistance or participation is
564 done under the direct and immediate supervision of a licensed
565 physician and is not otherwise an activity that may only be
566 performed by a licensed health care practitioner.
567 4. Development, implementation, and ongoing evaluation of
568 procedures, protocols, and systems to accurately identify
569 patients, planned procedures, and the correct site of the
570 planned procedure so as to minimize the performance of a

571 surgical procedure on the wrong patient, a wrong surgical
572 procedure, a wrong-site surgical procedure, or a surgical
573 procedure otherwise unrelated to the patient's diagnosis or
574 medical condition.
575 (c) The analysis of patient grievances that relate to
576 patient care and the quality of medical services.
577 (d) A system for informing a patient or an individual
578 identified pursuant to s. 765.401(1) that the patient was the
579 subject of an adverse incident as defined in subsection (5).
580 Such notice shall be given by an appropriately trained person
581 designated by the licensed facility as soon as practicable to
582 allow the patient an opportunity to minimize damage or injury.
583 (e)~~(d)~~ The development and implementation of an incident
584 reporting system based upon the affirmative duty of all health
585 care providers and all agents and employees of the licensed
586 health care facility to report adverse incidents to the risk
587 manager, or to his or her designee, within 3 business days after
588 their occurrence.
589 (2) The internal risk management program is the
590 responsibility of the governing board of the health care
591 facility. Each licensed facility shall hire a risk manager,
592 licensed under s. 395.10974, who is responsible for
593 implementation and oversight of such facility's internal risk
594 management program as required by this section. A risk manager
595 must not be made responsible for more than four internal risk
596 management programs in separate licensed facilities, unless the
597 facilities are under one corporate ownership or the risk
598 management programs are in rural hospitals.
599 (3) In addition to the programs mandated by this section,
600 other innovative approaches intended to reduce the frequency and

601 severity of medical malpractice and patient injury claims shall
602 be encouraged and their implementation and operation
603 facilitated. Such additional approaches may include extending
604 internal risk management programs to health care providers'
605 offices and the assuming of provider liability by a licensed
606 health care facility for acts or omissions occurring within the
607 licensed facility. Each licensed facility shall annually report
608 to the agency and the department the name and judgments entered
609 against each health care practitioner for which it assumes
610 liability. The agency and the department, in their respective
611 annual reports, shall include statistics that report the number
612 of licensed facilities that assume such liability and the number
613 of health care practitioners, by profession, for whom the
614 facilities assume liability.
615 (4) The agency shall adopt rules governing the
616 establishment of internal risk management programs to meet the
617 needs of individual licensed facilities. Each internal risk
618 management program shall include the use of incident reports to
619 be filed with an individual of responsibility who is competent
620 in risk management techniques in the employ of each licensed
621 facility, such as an insurance coordinator, or who is retained
622 by the licensed facility as a consultant. The individual
623 responsible for the risk management program shall have free
624 access to all medical records of the licensed facility. The
625 incident reports are part of the workpapers of the attorney
626 defending the licensed facility in litigation relating to the
627 licensed facility and are subject to discovery, but are not
628 admissible as evidence in court. A person filing an incident
629 report is not subject to civil suit by virtue of such incident
630 report. As a part of each internal risk management program, the

631 incident reports shall be used to develop categories of
632 incidents which identify problem areas. Once identified,
633 procedures shall be adjusted to correct the problem areas.
634 (5) For purposes of reporting to the agency pursuant to
635 this section, the term "adverse incident" means an event over
636 which health care personnel could exercise control and which is
637 associated in whole or in part with medical intervention, rather
638 than the condition for which such intervention occurred, and
639 which:
640 (a) Results in one of the following injuries:
641 1. Death;
642 2. Brain or spinal damage;
643 3. Permanent disfigurement;
644 4. Fracture or dislocation of bones or joints;
645 5. A resulting limitation of neurological, physical, or
646 sensory function which continues after discharge from the
647 facility;
648 6. Any condition that required specialized medical
649 attention or surgical intervention resulting from nonemergency
650 medical intervention, other than an emergency medical condition,
651 to which the patient has not given his or her informed consent;
652 or
653 7. Any condition that required the transfer of the
654 patient, within or outside the facility, to a unit providing a
655 more acute level of care due to the adverse incident, rather
656 than the patient's condition prior to the adverse incident;
657 (b) Was the performance of a surgical procedure on the
658 wrong patient, a wrong surgical procedure, a wrong-site surgical
659 procedure, or a surgical procedure otherwise unrelated to the
660 patient's diagnosis or medical condition;

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661 (c) Required the surgical repair of damage resulting to a
662 patient from a planned surgical procedure, where the damage was
663 not a recognized specific risk, as disclosed to the patient and
664 documented through the informed-consent process; or
665 (d) Was a procedure to remove unplanned foreign objects
666 remaining from a surgical procedure.
667 (6)(a) Each licensed facility subject to this section
668 shall submit an annual report to the agency summarizing the
669 incident reports that have been filed in the facility for that
670 year. The report shall include:
671 1. The total number of adverse incidents.
672 2. A listing, by category, of the types of operations,
673 diagnostic or treatment procedures, or other actions causing the
674 injuries, and the number of incidents occurring within each
675 category.
676 3. A listing, by category, of the types of injuries caused
677 and the number of incidents occurring within each category.
678 4. A code number using the health care professional's
679 licensure number and a separate code number identifying all
680 other individuals directly involved in adverse incidents to
681 patients, the relationship of the individual to the licensed
682 facility, and the number of incidents in which each individual
683 has been directly involved. Each licensed facility shall
684 maintain names of the health care professionals and individuals
685 identified by code numbers for purposes of this section.
686 5. A description of all malpractice claims filed against
687 the licensed facility, including the total number of pending and
688 closed claims and the nature of the incident which led to, the
689 persons involved in, and the status and disposition of each
690 claim.

691
692 Each report shall update status and disposition for all prior
693 reports.
694 (b) The information reported to the agency pursuant to
695 paragraph (a) which relates to persons licensed under chapter
696 458, chapter 459, chapter 461, or chapter 466 shall be reviewed
697 by the agency. The agency shall determine whether any of the
698 incidents potentially involved conduct by a health care
699 professional who is subject to disciplinary action, in which
700 case the provisions of s. 456.073 shall apply.
701 (c) The report submitted to the agency shall also contain
702 the name and license number of the risk manager of the licensed
703 facility, a copy of its policy and procedures which govern the
704 measures taken by the facility and its risk manager to reduce
705 the risk of injuries and adverse incidents, and the results of
706 such measures. The annual report is confidential and is not
707 available to the public pursuant to s. 119.07(1) or any other
708 law providing access to public records. The annual report is not
709 discoverable or admissible in any civil or administrative
710 action, except in disciplinary proceedings by the agency or the
711 appropriate regulatory board. The annual report is not available
712 to the public as part of the record of investigation for and
713 prosecution in disciplinary proceedings made available to the
714 public by the agency or the appropriate regulatory board.
715 However, the agency or the appropriate regulatory board shall
716 make available, upon written request by a health care
717 professional against whom probable cause has been found, any
718 such records which form the basis of the determination of
719 probable cause.
720 ~~(7) The licensed facility shall notify the agency no later~~

~~than 1 business day after the risk manager or his or her designee has received a report pursuant to paragraph (1)(d) and can determine within 1 business day that any of the following adverse incidents has occurred, whether occurring in the licensed facility or arising from health care prior to admission in the licensed facility:~~

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

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

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

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

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

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

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

(a) The death of a patient;

(b) Brain or spinal damage to a patient;

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

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

751 (e) The performance of a wrong surgical procedure;
752 (f) The performance of a surgical procedure that is
753 medically unnecessary or otherwise unrelated to the patient's
754 diagnosis or medical condition;
755 (g) The surgical repair of damage resulting to a patient
756 from a planned surgical procedure, where the damage is not a
757 recognized specific risk, as disclosed to the patient and
758 documented through the informed-consent process; or
759 (h) The performance of procedures to remove unplanned
760 foreign objects remaining from a surgical procedure.
761
762 The agency may grant extensions to this reporting requirement
763 for more than 15 days upon justification submitted in writing by
764 the facility administrator to the agency. The agency may require
765 an additional, final report. These reports shall not be
766 available to the public pursuant to s. 119.07(1) or any other
767 law providing access to public records, nor be discoverable or
768 admissible in any civil or administrative action, except in
769 disciplinary proceedings by the agency or the appropriate
770 regulatory board, nor shall they be available to the public as
771 part of the record of investigation for and prosecution in
772 disciplinary proceedings made available to the public by the
773 agency or the appropriate regulatory board. However, the agency
774 or the appropriate regulatory board shall make available, upon
775 written request by a health care professional against whom
776 probable cause has been found, any such records which form the
777 basis of the determination of probable cause. The agency may
778 investigate, as it deems appropriate, any such incident and
779 prescribe measures that must or may be taken in response to the
780 incident. The agency shall review each incident and determine

781 whether it potentially involved conduct by the health care
782 professional who is subject to disciplinary action, in which
783 case the provisions of s. 456.073 shall apply.
784 (8)~~(9)~~ The agency shall publish on the agency's website,
785 no less than quarterly, a summary and trend analysis of adverse
786 incident reports received pursuant to this section, which shall
787 not include information that would identify the patient, the
788 reporting facility, or the health care practitioners involved.
789 The agency shall publish on the agency's website an annual
790 summary and trend analysis of all adverse incident reports and
791 malpractice claims information provided by facilities in their
792 annual reports, which shall not include information that would
793 identify the patient, the reporting facility, or the
794 practitioners involved. The purpose of the publication of the
795 summary and trend analysis is to promote the rapid dissemination
796 of information relating to adverse incidents and malpractice
797 claims to assist in avoidance of similar incidents and reduce
798 morbidity and mortality.
799 (9)~~(10)~~ The internal risk manager of each licensed
800 facility shall:
801 (a) Investigate every allegation of sexual misconduct
802 which is made against a member of the facility's personnel who
803 has direct patient contact, when the allegation is that the
804 sexual misconduct occurred at the facility or on the grounds of
805 the facility.
806 (b) Report every allegation of sexual misconduct to the
807 administrator of the licensed facility.
808 (c) Notify the family or guardian of the victim, if a
809 minor, that an allegation of sexual misconduct has been made and
810 that an investigation is being conducted.

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

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

(a) Notify the local police; and

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

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

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

(12)~~(13)~~ In addition to any penalty imposed pursuant to this section, the agency shall require a written plan of

841 correction from the facility. For a single incident or series of
842 isolated incidents that are nonwillful violations of the
843 reporting requirements of this section, the agency shall first
844 seek to obtain corrective action by the facility. If the
845 correction is not demonstrated within the timeframe established
846 by the agency or if there is a pattern of nonwillful violations
847 of this section, the agency may impose an administrative fine,
848 not to exceed $5,000 for any violation of the reporting
849 requirements of this section. The administrative fine for
850 repeated nonwillful violations shall not exceed $10,000 for any
851 violation. The administrative fine for each intentional and
852 willful violation may not exceed $25,000 per violation, per day.
853 The fine for an intentional and willful violation of this
854 section may not exceed $250,000. In determining the amount of
855 fine to be levied, the agency shall be guided by s.
856 395.1065(2)(b). ~~This subsection does not apply to the notice~~
857 ~~requirements under subsection (7).~~

858 (13)~~(14)~~ The agency shall have access to all licensed
859 facility records necessary to carry out the provisions of this
860 section. The records obtained by the agency under subsection
861 (6), subsection (7) ~~(8)~~, or subsection (9) ~~(10)~~ are not
862 available to the public under s. 119.07(1), nor shall they be
863 discoverable or admissible in any civil or administrative
864 action, except in disciplinary proceedings by the agency or the
865 appropriate regulatory board, nor shall records obtained
866 pursuant to s. 456.071 be available to the public as part of the
867 record of investigation for and prosecution in disciplinary
868 proceedings made available to the public by the agency or the
869 appropriate regulatory board. However, the agency or the
870 appropriate regulatory board shall make available, upon written

871 request by a health care professional against whom probable
872 cause has been found, any such records which form the basis of
873 the determination of probable cause, except that, with respect
874 to medical review committee records, s. 766.101 controls.
875 (14)~~(15)~~ The meetings of the committees and governing
876 board of a licensed facility held solely for the purpose of
877 achieving the objectives of risk management as provided by this
878 section shall not be open to the public under the provisions of
879 chapter 286. The records of such meetings are confidential and
880 exempt from s. 119.07(1), except as provided in subsection (13)
881 ~~(14)~~.
882 (15)~~(16)~~ The agency shall review, as part of its licensure
883 inspection process, the internal risk management program at each
884 licensed facility regulated by this section to determine whether
885 the program meets standards established in statutes and rules,
886 whether the program is being conducted in a manner designed to
887 reduce adverse incidents, and whether the program is
888 appropriately reporting incidents under this section.
889 (16)~~(17)~~ There shall be no monetary liability on the part
890 of, and no cause of action for damages shall arise against, any
891 risk manager, licensed under s. 395.10974, for the
892 implementation and oversight of the internal risk management
893 program in a facility licensed under this chapter or chapter 390
894 as required by this section, for any act or proceeding
895 undertaken or performed within the scope of the functions of
896 such internal risk management program if the risk manager acts
897 without intentional fraud.
898 (17)~~(18)~~ A privilege against civil liability is hereby
899 granted to any licensed risk manager or licensed facility with
900 regard to information furnished pursuant to this chapter, unless

901 the licensed risk manager or facility acted in bad faith or with
902 malice in providing such information.
903 (18)~~(19)~~ If the agency, through its receipt of any reports
904 required under this section or through any investigation, has a
905 reasonable belief that conduct by a staff member or employee of
906 a licensed facility is grounds for disciplinary action by the
907 appropriate regulatory board, the agency shall report this fact
908 to such regulatory board.
909 (19)~~(20)~~ It shall be unlawful for any person to coerce,
910 intimidate, or preclude a risk manager from lawfully executing
911 his or her reporting obligations pursuant to this chapter. Such
912 unlawful action shall be subject to civil monetary penalties not
913 to exceed $10,000 per violation.
914 Section 7. Section 395.0198, Florida Statutes, is
915 repealed.
916 Section 8. Section 395.1012, Florida Statutes, is created
917 to read:
918 395.1012 Patient safety.--
919 (1) Each licensed facility shall adopt a patient safety
920 plan. A plan adopted to implement the requirements of 42 C.F.R.
921 s. 482.21 shall be deemed to comply with this requirement.
922 (2) Each licensed facility shall appoint a patient safety
923 officer and a patient safety committee, which shall include at
924 least one person who is neither employed by nor practicing in
925 the facility, for the purpose of promoting the health and safety
926 of patients, reviewing and evaluating the quality of patient
927 safety measures used by the facility, and assisting in the
928 implementation of the facility patient safety plan.
929 Section 9. Section 395.1051, Florida Statutes, is created
930 to read:

931 395.1051 Duty to notify patients.--An appropriately
932 trained person designated by each licensed facility shall inform
933 each patient, or an individual identified pursuant to s.
934 765.401(1), in person about adverse incidents that result in
935 serious harm to the patient. Notification of outcomes of care
936 that result in harm to the patient under this section shall not
937 constitute an acknowledgement or admission of liability, nor can
938 such notifications be introduced as evidence.
939 Section 10. Subsection (7) of section 456.013, Florida
940 Statutes, is amended to read:
941 456.013 Department; general licensing provisions.--
942 (7) The boards, or the department when there is no board,
943 shall require the completion of a 2-hour course relating to
944 prevention of medical errors as part of the licensure and
945 renewal process. The 2-hour course shall count towards the total
946 number of continuing education hours required for the
947 profession. The course shall be approved by the board or
948 department, as appropriate, and shall include a study of root-
949 cause analysis, error reduction and prevention, and patient
950 safety. In addition, the course approved by the Board of
951 Medicine and the Board of Osteopathic Medicine shall include
952 information relating to the five most misdiagnosed conditions
953 during the previous biennium, as determined by the board. If the
954 course is being offered by a facility licensed pursuant to
955 chapter 395 for its employees, the board may approve up to 1
956 hour of the 2-hour course to be specifically related to error
957 reduction and prevention methods used in that facility.
958 Section 11. Subsection (1) of section 456.025, Florida
959 Statutes, is amended to read:
960 456.025 Fees; receipts; disposition.--

961 (1) It is the intent of the Legislature that all costs of
962 regulating health care professions and practitioners shall be
963 borne solely by licensees and licensure applicants. It is also
964 the intent of the Legislature that fees should be reasonable and
965 not serve as a barrier to licensure. Moreover, it is the intent
966 of the Legislature that the department operate as efficiently as
967 possible and regularly report to the Legislature additional
968 methods to streamline operational costs. Therefore, the boards
969 in consultation with the department, or the department if there
970 is no board, shall, by rule, set renewal fees which:
971 (a) Shall be based on revenue projections prepared using
972 generally accepted accounting procedures;
973 (b) Shall be adequate to cover all expenses relating to
974 that board identified in the department's long-range policy
975 plan, as required by s. 456.005;
976 (c) Shall be reasonable, fair, and not serve as a barrier
977 to licensure;
978 (d) Shall be based on potential earnings from working
979 under the scope of the license;
980 (e) Shall be similar to fees imposed on similar licensure
981 types;
982 ~~(f) Shall not be more than 10 percent greater than the fee~~
983 ~~imposed for the previous biennium;~~
984 (f)~~(g)~~ Shall not be more than 10 percent greater than the
985 actual cost to regulate that profession for the previous
986 biennium; and
987 (g)~~(h)~~ Shall be subject to challenge pursuant to chapter
988 120.
989 Section 12. Paragraph (a) of subsection (1) of section
990 456.039, Florida Statutes, is amended to read:

991 456.039 Designated health care professionals; information
992 required for licensure.--
993 (1) Each person who applies for initial licensure as a
994 physician under chapter 458, chapter 459, chapter 460, or
995 chapter 461, except a person applying for registration pursuant
996 to ss. 458.345 and 459.021, must, at the time of application,
997 and each physician who applies for license renewal under chapter
998 458, chapter 459, chapter 460, or chapter 461, except a person
999 registered pursuant to ss. 458.345 and 459.021, must, in
1000 conjunction with the renewal of such license and under
1001 procedures adopted by the Department of Health, and in addition
1002 to any other information that may be required from the
1003 applicant, furnish the following information to the Department
1004 of Health:
1005 (a)1. The name of each medical school that the applicant
1006 has attended, with the dates of attendance and the date of
1007 graduation, and a description of all graduate medical education
1008 completed by the applicant, excluding any coursework taken to
1009 satisfy medical licensure continuing education requirements.
1010 2. The name of each hospital at which the applicant has
1011 privileges.
1012 3. The address at which the applicant will primarily
1013 conduct his or her practice.
1014 4. Any certification that the applicant has received from
1015 a specialty board that is recognized by the board to which the
1016 applicant is applying.
1017 5. The year that the applicant began practicing medicine.
1018 6. Any appointment to the faculty of a medical school
1019 which the applicant currently holds and an indication as to
1020 whether the applicant has had the responsibility for graduate

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1021 medical education within the most recent 10 years.
1022 7. A description of any criminal offense of which the
1023 applicant has been found guilty, regardless of whether
1024 adjudication of guilt was withheld, or to which the applicant
1025 has pled guilty or nolo contendere. A criminal offense committed
1026 in another jurisdiction which would have been a felony or
1027 misdemeanor if committed in this state must be reported. If the
1028 applicant indicates that a criminal offense is under appeal and
1029 submits a copy of the notice for appeal of that criminal
1030 offense, the department must state that the criminal offense is
1031 under appeal if the criminal offense is reported in the
1032 applicant's profile. If the applicant indicates to the
1033 department that a criminal offense is under appeal, the
1034 applicant must, upon disposition of the appeal, submit to the
1035 department a copy of the final written order of disposition.
1036 8. A description of any final disciplinary action taken
1037 within the previous 10 years against the applicant by the agency
1038 regulating the profession that the applicant is or has been
1039 licensed to practice, whether in this state or in any other
1040 jurisdiction, by a specialty board that is recognized by the
1041 American Board of Medical Specialties, the American Osteopathic
1042 Association, or a similar national organization, or by a
1043 licensed hospital, health maintenance organization, prepaid
1044 health clinic, ambulatory surgical center, or nursing home.
1045 Disciplinary action includes resignation from or nonrenewal of
1046 medical staff membership or the restriction of privileges at a
1047 licensed hospital, health maintenance organization, prepaid
1048 health clinic, ambulatory surgical center, or nursing home taken
1049 in lieu of or in settlement of a pending disciplinary case
1050 related to competence or character. If the applicant indicates

1051 that the disciplinary action is under appeal and submits a copy
1052 of the document initiating an appeal of the disciplinary action,
1053 the department must state that the disciplinary action is under
1054 appeal if the disciplinary action is reported in the applicant's
1055 profile.
1056 9. Relevant professional qualifications as defined by the
1057 applicable board.
1058 Section 13. Section 456.041, Florida Statutes, is amended
1059 to read:
1060 456.041 Practitioner profile; creation.--
1061 (1)(a) ~~Beginning July 1, 1999,~~ The Department of Health
1062 shall compile the information submitted pursuant to s. 456.039
1063 into a practitioner profile of the applicant submitting the
1064 information, except that the Department of Health shall ~~may~~
1065 develop a format to compile uniformly any information submitted
1066 under s. 456.039(4)(b). Beginning July 1, 2001, the Department
1067 of Health may compile the information submitted pursuant to s.
1068 456.0391 into a practitioner profile of the applicant submitting
1069 the information.
1070 (b) Within 30 calendar days after receiving an update of
1071 information required for the practitioner's profile, the
1072 department shall update the practitioner's profile in accordance
1073 with the requirements of subsection (7).
1074 (2) On the profile published under subsection (1), the
1075 department shall indicate whether ~~if~~ the information provided
1076 under s. 456.039(1)(a)7. or s. 456.0391(1)(a)7. is or is not
1077 corroborated by a criminal history check conducted according to
1078 this subsection. ~~If the information provided under s.~~
1079 ~~456.039(1)(a)7. or s. 456.0391(1)(a)7. is corroborated by the~~
1080 ~~criminal history check, the fact that the criminal history check~~

1081 ~~was performed need not be indicated on the profile.~~ The
1082 department, or the board having regulatory authority over the
1083 practitioner acting on behalf of the department, shall
1084 investigate any information received by the department or the
1085 board ~~when it has reasonable grounds to believe that the~~
1086 ~~practitioner has violated any law that relates to the~~
1087 ~~practitioner's practice~~.
1088 (3) The Department of Health shall ~~may~~ include in each
1089 practitioner's practitioner profile that criminal information
1090 that directly relates to the practitioner's ability to
1091 competently practice his or her profession. The department must
1092 include in each practitioner's practitioner profile the
1093 following statement: "The criminal history information, if any
1094 exists, may be incomplete; federal criminal history information
1095 is not available to the public." The department shall provide in
1096 each practitioner profile, for every final disciplinary action
1097 taken against the practitioner, an easy-to-read narrative
1098 description that explains the administrative complaint filed
1099 against the practitioner and the final disciplinary action
1100 imposed on the practitioner. The department shall include a
1101 hyperlink to each final order listed in its Internet website
1102 report of dispositions of recent disciplinary actions taken
1103 against practitioners.
1104 (4) The Department of Health shall include, with respect
1105 to a practitioner licensed under chapter 458 or chapter 459, a
1106 statement of how the practitioner has elected to comply with the
1107 financial responsibility requirements of s. 458.320 or s.
1108 459.0085. The department shall include, with respect to
1109 practitioners subject to s. 456.048, a statement of how the
1110 practitioner has elected to comply with the financial

1111 responsibility requirements of that section. The department
1112 shall include, with respect to practitioners licensed under
1113 ~~chapter 458, chapter 459, or~~ chapter 461, information relating
1114 to liability actions which has been reported under s. 456.049 or
1115 s. 627.912 within the previous 10 years for any paid claim that
1116 exceeds $5,000. <u>The department shall include, with respect to</u>
1117 <u>practitioners licensed under chapter 458 or chapter 459,</u>
1118 <u>information relating to liability actions which has been</u>
1119 <u>reported under ss. 456.049 and 627.912 within the previous 10</u>
1120 <u>years for any paid claim that exceeds $100,000.</u> Such claims
1121 information shall be reported in the context of comparing an
1122 individual practitioner's claims to the experience of other
1123 practitioners within the same specialty, or profession if the
1124 practitioner is not a specialist~~, to the extent such information~~
1125 ~~is available to the Department of Health~~. <u>The department must</u>
1126 <u>provide a hyperlink in such practitioner's profile to all such</u>
1127 <u>comparison reports.</u> If information relating to a liability
1128 action is included in a practitioner's practitioner profile, the
1129 profile must also include the following statement: "Settlement
1130 of a claim may occur for a variety of reasons that do not
1131 necessarily reflect negatively on the professional competence or
1132 conduct of the practitioner. A payment in settlement of a
1133 medical malpractice action or claim should not be construed as
1134 creating a presumption that medical malpractice has occurred."
1135 (5) The Department of Health <u>shall</u> ~~may not~~ include <u>the</u>
1136 <u>date of a hospital or ambulatory surgical center</u> disciplinary
1137 action taken by a licensed hospital or an ambulatory surgical
1138 center<u>, in accordance with the requirements of s. 395.0193,</u> in
1139 the practitioner profile. <u>The department shall state whether the</u>
1140 <u>action related to professional competence and whether it related</u>

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1141 to the delivery of services to a patient.

1142 (6) The Department of Health may include in the
1143 practitioner's practitioner profile any other information that
1144 is a public record of any governmental entity and that relates
1145 to a practitioner's ability to competently practice his or her
1146 profession. ~~However, the department must consult with the board~~
1147 ~~having regulatory authority over the practitioner before such~~
1148 ~~information is included in his or her profile.~~

1149 (7) Upon the completion of a practitioner profile under
1150 this section, the Department of Health shall furnish the
1151 practitioner who is the subject of the profile a copy of it for
1152 review and verification. The practitioner has a period of 30
1153 days in which to review and verify the contents of the profile
1154 and to correct any factual inaccuracies in it. The Department of
1155 Health shall make the profile available to the public at the end
1156 of the 30-day period regardless of whether the practitioner has
1157 provided verification of the profile content. A practitioner
1158 shall be subject to a fine of up to $100 per day for failure to
1159 verify the profile contents and to correct any factual errors in
1160 his or her profile within the 30-day period. The department
1161 shall make the profiles available to the public through the
1162 World Wide Web and other commonly used means of distribution.
1163 The department must include the following statement, in boldface
1164 type, in each profile that has not been reviewed by the
1165 practitioner to which it applies: "The practitioner has not
1166 verified the information contained in this profile."

1167 (8) The Department of Health must provide in each profile
1168 an easy-to-read explanation of any disciplinary action taken and
1169 the reason the sanction or sanctions were imposed.

1170 (9) The Department of Health may provide one link in each

1171 profile to a practitioner's professional Internet website if the
1172 practitioner requests that such a link be included in his or her
1173 profile.
1174 (10)~~(8)~~ Making a practitioner profile available to the
1175 public under this section does not constitute agency action for
1176 which a hearing under s. 120.57 may be sought.
1177 Section 14. Section 456.042, Florida Statutes, is amended
1178 to read:
1179 456.042 Practitioner profiles; update.--A practitioner
1180 must submit updates of required information within 15 days after
1181 the final activity that renders such information a fact. The
1182 Department of Health shall update each practitioner's
1183 practitioner profile periodically. An updated profile is subject
1184 to the same requirements as an original profile ~~with respect to~~
1185 ~~the period within which the practitioner may review the profile~~
1186 ~~for the purpose of correcting factual inaccuracies~~.
1187 Section 15. Section 456.049, Florida Statutes, is amended
1188 to read:
1189 456.049 Health care practitioners; reports on professional
1190 liability claims and actions.--
1191 ~~(1)~~ Any practitioner of medicine licensed pursuant to the
1192 provisions of chapter 458, practitioner of osteopathic medicine
1193 licensed pursuant to the provisions of chapter 459, podiatric
1194 physician licensed pursuant to the provisions of chapter 461, or
1195 dentist licensed pursuant to the provisions of chapter 466 shall
1196 report to the Office of Insurance Regulation ~~department~~ any
1197 claim or action for damages for personal injury alleged to have
1198 been caused by error, omission, or negligence in the performance
1199 of such licensee's professional services or based on a claimed
1200 performance of professional services without consent pursuant to

1201 ~~if the claim was not covered by an insurer required to report~~
1202 ~~under~~ s. 627.912 ~~and the claim resulted in:~~
1203 ~~(a) A final judgment in any amount.~~
1204 ~~(b) A settlement in any amount.~~
1205 ~~(c) A final disposition not resulting in payment on behalf~~
1206 ~~of the licensee~~.
1207
1208 ~~Reports shall be filed with the department no later than 60 days~~
1209 ~~following the occurrence of any event listed in paragraph (a),~~
1210 ~~paragraph (b), or paragraph (c).~~
1211 ~~(2) Reports shall contain:~~
1212 ~~(a) The name and address of the licensee.~~
1213 ~~(b) The date of the occurrence which created the claim.~~
1214 ~~(c) The date the claim was reported to the licensee.~~
1215 ~~(d) The name and address of the injured person. This~~
1216 ~~information is confidential and exempt from s. 119.07(1) and~~
1217 ~~shall not be disclosed by the department without the injured~~
1218 ~~person's consent. This information may be used by the department~~
1219 ~~for purposes of identifying multiple or duplicate claims arising~~
1220 ~~out of the same occurrence.~~
1221 ~~(e) The date of suit, if filed.~~
1222 ~~(f) The injured person's age and sex.~~
1223 ~~(g) The total number and names of all defendants involved~~
1224 ~~in the claim.~~
1225 ~~(h) The date and amount of judgment or settlement, if any,~~
1226 ~~including the itemization of the verdict, together with a copy~~
1227 ~~of the settlement or judgment.~~
1228 ~~(i) In the case of a settlement, such information as the~~
1229 ~~department may require with regard to the injured person's~~

1230 ~~incurred and anticipated medical expense, wage loss, and other~~
1231 ~~expenses.~~
1232 ~~(j) The loss adjustment expense paid to defense counsel,~~
1233 ~~and all other allocated loss adjustment expense paid.~~
1234 ~~(k) The date and reason for final disposition, if no~~
1235 ~~judgment or settlement.~~
1236 ~~(l) A summary of the occurrence which created the claim,~~
1237 ~~which shall include:~~
1238 ~~1. The name of the institution, if any, and the location~~
1239 ~~within such institution, at which the injury occurred.~~
1240 ~~2. The final diagnosis for which treatment was sought or~~
1241 ~~rendered, including the patient's actual condition.~~
1242 ~~3. A description of the misdiagnosis made, if any, of the~~
1243 ~~patient's actual condition.~~
1244 ~~4. The operation or the diagnostic or treatment procedure~~
1245 ~~causing the injury.~~
1246 ~~5. A description of the principal injury giving rise to~~
1247 ~~the claim.~~
1248 ~~6. The safety management steps that have been taken by the~~
1249 ~~licensee to make similar occurrences or injuries less likely in~~
1250 ~~the future.~~
1251 ~~(m) Any other information required by the department to~~
1252 ~~analyze and evaluate the nature, causes, location, cost, and~~
1253 ~~damages involved in professional liability cases.~~
1254 Section 16. Section 456.051, Florida Statutes, is amended
1255 to read:
1256 456.051 Reports of professional liability actions;
1257 bankruptcies; Department of Health's responsibility to
1258 provide.--
1259 (1) The report of a claim or action for damages for

1260 personal injury which is required to be provided to the
1261 Department of Health under s. 456.049 or s. 627.912 is public
1262 information except for the name of the claimant or injured
1263 person, which remains confidential as provided in s. ~~ss.~~
1264 ~~456.049(2)(d) and~~ 627.912(2)(e). The Department of Health shall,
1265 upon request, make such report available to any person. The
1266 department shall make such report available as a part of the
1267 practitioner's profile within 30 calendar days after receipt.
1268 (2) Any information in the possession of the Department of
1269 Health which relates to a bankruptcy proceeding by a
1270 practitioner of medicine licensed under chapter 458, a
1271 practitioner of osteopathic medicine licensed under chapter 459,
1272 a podiatric physician licensed under chapter 461, or a dentist
1273 licensed under chapter 466 is public information. The Department
1274 of Health shall, upon request, make such information available
1275 to any person. The department shall make such report available
1276 as a part of the practitioner's profile within 30 calendar days
1277 after receipt.
1278 Section 17. Paragraph (a) of subsection (7) of section
1279 456.057, Florida Statutes, is amended to read:
1280 456.057 Ownership and control of patient records; report
1281 or copies of records to be furnished.--
1282 (7)(a)1. The department may obtain patient records
1283 pursuant to a subpoena without written authorization from the
1284 patient if the department and the probable cause panel of the
1285 appropriate board, if any, find reasonable cause to believe that
1286 a health care practitioner has excessively or inappropriately
1287 prescribed any controlled substance specified in chapter 893 in
1288 violation of this chapter or any professional practice act or
1289 that a health care practitioner has practiced his or her

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1290 profession below that level of care, skill, and treatment
1291 required as defined by this chapter or any professional practice
1292 act and also find that appropriate, reasonable attempts were
1293 made to obtain a patient release.
1294 2. The department may obtain patient records and insurance
1295 information pursuant to a subpoena without written authorization
1296 from the patient if the department and the probable cause panel
1297 of the appropriate board, if any, find reasonable cause to
1298 believe that a health care practitioner has provided inadequate
1299 medical care based on termination of insurance and also find
1300 that appropriate, reasonable attempts were made to obtain a
1301 patient release.
1302 3. The department may obtain patient records, billing
1303 records, insurance information, provider contracts, and all
1304 attachments thereto pursuant to a subpoena without written
1305 authorization from the patient if the department and probable
1306 cause panel of the appropriate board, if any, find reasonable
1307 cause to believe that a health care practitioner has submitted a
1308 claim, statement, or bill using a billing code that would result
1309 in payment greater in amount than would be paid using a billing
1310 code that accurately describes the services performed, requested
1311 payment for services that were not performed by that health care
1312 practitioner, used information derived from a written report of
1313 an automobile accident generated pursuant to chapter 316 to
1314 solicit or obtain patients personally or through an agent
1315 regardless of whether the information is derived directly from
1316 the report or a summary of that report or from another person,
1317 solicited patients fraudulently, received a kickback as defined
1318 in s. 456.054, violated the patient brokering provisions of s.
1319 817.505, or presented or caused to be presented a false or

1320 fraudulent insurance claim within the meaning of s.
1321 817.234(1)(a), and also find that, within the meaning of s.
1322 817.234(1)(a), patient authorization cannot be obtained because
1323 the patient cannot be located or is deceased, incapacitated, or
1324 suspected of being a participant in the fraud or scheme, and if
1325 the subpoena is issued for specific and relevant records.
1326 4. Notwithstanding subparagraphs 1.-3., when the
1327 department investigates a professional liability claim or
1328 undertakes action pursuant to s. 456.049 or s. 627.912, the
1329 department may obtain patient records pursuant to a subpoena
1330 without written authorization from the patient if the patient
1331 refuses to cooperate or the department attempts to obtain a
1332 patient release and the failure to obtain the patient records
1333 would be detrimental to the investigation.
1334 Section 18. Section 456.0575, Florida Statutes, is created
1335 to read:
1336 456.0575 Duty to notify patients.--Every licensed health
1337 care practitioner shall inform each patient, or an individual
1338 identified pursuant to s. 765.401(1), in person about adverse
1339 incidents that result in serious harm to the patient.
1340 Notification of outcomes of care that result in harm to the
1341 patient under this section shall not constitute an
1342 acknowledgement of admission of liability, nor can such
1343 notifications be introduced as evidence.
1344 Section 19. Subsection (4) of section 456.072, Florida
1345 Statutes, is amended to read:
1346 456.072 Grounds for discipline; penalties; enforcement.--
1347 (4) In addition to any other discipline imposed through
1348 final order, or citation, entered on or after July 1, 2001,
1349 pursuant to this section or discipline imposed through final

1350 order, or citation, entered on or after July 1, 2001, for a
1351 violation of any practice act, the board, or the department when
1352 there is no board, shall assess costs related to the
1353 investigation and prosecution of the case. Such costs related to
1354 the investigation and prosecution include, but are not limited
1355 to, salaries and benefits of personnel, costs related to the
1356 time spent by the attorney and other personnel working on the
1357 case, and any other expenses incurred by the department for the
1358 case. The board, or the department when there in no board, shall
1359 determine the amount of costs to be assessed after its
1360 consideration of an affidavit of itemized costs and any written
1361 objections thereto. In any case where the board or the
1362 department imposes a fine or assessment and the fine or
1363 assessment is not paid within a reasonable time, such reasonable
1364 time to be prescribed in the rules of the board, or the
1365 department when there is no board, or in the order assessing
1366 such fines or costs, the department or the Department of Legal
1367 Affairs may contract for the collection of, or bring a civil
1368 action to recover, the fine or assessment.
1369 Section 20. Subsections (1) and (5) of section 456.073,
1370 Florida Statutes, as amended by section 1 of chapter 2003-27,
1371 Laws of Florida, are amended to read:
1372 456.073 Disciplinary proceedings.--Disciplinary
1373 proceedings for each board shall be within the jurisdiction of
1374 the department.
1375 (1) The department, for the boards under its jurisdiction,
1376 shall cause to be investigated any complaint that is filed
1377 before it if the complaint is in writing, signed by the
1378 complainant, and legally sufficient. A complaint filed by a
1379 state prisoner against a health care practitioner employed by or

1380 otherwise providing health care services within a facility of
1381 the Department of Corrections is not legally sufficient unless
1382 there is a showing that the prisoner complainant has exhausted
1383 all available administrative remedies within the state
1384 correctional system before filing the complaint. However, if the
1385 Department of Health determines after a preliminary inquiry of a
1386 state prisoner's complaint that the practitioner may present a
1387 serious threat to the health and safety of any individual who is
1388 not a state prisoner, the Department of Health may determine
1389 legal sufficiency and proceed with discipline. The Department of
1390 Health shall be notified within 15 days after the Department of
1391 Corrections disciplines or allows a health care practitioner to
1392 resign for an offense related to the practice of his or her
1393 profession. A complaint is legally sufficient if it contains
1394 ultimate facts that show that a violation of this chapter, of
1395 any of the practice acts relating to the professions regulated
1396 by the department, or of any rule adopted by the department or a
1397 regulatory board in the department has occurred. In order to
1398 determine legal sufficiency, the department may require
1399 supporting information or documentation. The department may
1400 investigate, and the department or the appropriate board may
1401 take appropriate final action on, a complaint even though the
1402 original complainant withdraws it or otherwise indicates a
1403 desire not to cause the complaint to be investigated or
1404 prosecuted to completion. The department may investigate an
1405 anonymous complaint if the complaint is in writing and is
1406 legally sufficient, if the alleged violation of law or rules is
1407 substantial, and if the department has reason to believe, after
1408 preliminary inquiry, that the violations alleged in the
1409 complaint are true. The department may investigate a complaint

1410 made by a confidential informant if the complaint is legally
1411 sufficient, if the alleged violation of law or rule is
1412 substantial, and if the department has reason to believe, after
1413 preliminary inquiry, that the allegations of the complainant are
1414 true. The department may initiate an investigation if it has
1415 reasonable cause to believe that a licensee or a group of
1416 licensees has violated a Florida statute, a rule of the
1417 department, or a rule of a board. Notwithstanding subsection
1418 (13), the department may investigate information filed pursuant
1419 to s. 456.041(4) relating to liability actions with respect to
1420 practitioners licensed under chapter 458 or chapter 459 which
1421 have been reported under s. 456.049 or s. 627.912 within the
1422 previous 6 years for any paid claim that exceeds $50,000. Except
1423 as provided in ss. 458.331(9), 459.015(9), 460.413(5), and
1424 461.013(6), when an investigation of any subject is undertaken,
1425 the department shall promptly furnish to the subject or the
1426 subject's attorney a copy of the complaint or document that
1427 resulted in the initiation of the investigation. The subject may
1428 submit a written response to the information contained in such
1429 complaint or document within 20 days after service to the
1430 subject of the complaint or document. The subject's written
1431 response shall be considered by the probable cause panel. The
1432 right to respond does not prohibit the issuance of a summary
1433 emergency order if necessary to protect the public. However, if
1434 the secretary, or the secretary's designee, and the chair of the
1435 respective board or the chair of its probable cause panel agree
1436 in writing that such notification would be detrimental to the
1437 investigation, the department may withhold notification. The
1438 department may conduct an investigation without notification to
1439 any subject if the act under investigation is a criminal

1440 offense.
1441 (5)(a) A formal hearing before an administrative law judge
1442 from the Division of Administrative Hearings shall be held
1443 pursuant to chapter 120 if there are any disputed issues of
1444 material fact. The determination of whether a licensee has
1445 violated the laws and rules regulating the profession, including
1446 a determination of the reasonable standard of care, is a
1447 conclusion of law to be determined by the board, or department
1448 when there is no board, and is not a finding of fact to be
1449 determined by an administrative law judge. The administrative
1450 law judge shall issue a recommended order pursuant to chapter
1451 120. ~~If any party raises an issue of disputed fact during an~~
1452 ~~informal hearing, the hearing shall be terminated and a formal~~
1453 ~~hearing pursuant to chapter 120 shall be held.~~
1454 (b) Notwithstanding s. 120.569(2), the department shall
1455 notify the Division of Administrative Hearings within 45 days
1456 after receipt of a petition or request for a hearing that the
1457 department has determined requires a formal hearing before an
1458 administrative law judge.
1459 Section 21. Subsections (1) and (2) of section 456.077,
1460 Florida Statutes, are amended to read:
1461 456.077 Authority to issue citations.--
1462 (1) Notwithstanding s. 456.073, the board, or the
1463 department if there is no board, shall adopt rules to permit the
1464 issuance of citations. The citation shall be issued to the
1465 subject and shall contain the subject's name and address, the
1466 subject's license number if applicable, a brief factual
1467 statement, the sections of the law allegedly violated, and the
1468 penalty imposed. The citation must clearly state that the
1469 subject may choose, in lieu of accepting the citation, to follow

1470 the procedure under s. 456.073. If the subject disputes the
1471 matter in the citation, the procedures set forth in s. 456.073
1472 must be followed. However, if the subject does not dispute the
1473 matter in the citation with the department within 30 days after
1474 the citation is served, the citation becomes a public final
1475 order and does not constitute ~~constitutes~~ discipline for a first
1476 offense, but does constitute discipline for a second or
1477 subsequent offense. The penalty shall be a fine or other
1478 conditions as established by rule.
1479 (2) The board, or the department if there is no board,
1480 shall adopt rules designating violations for which a citation
1481 may be issued. Such rules shall designate as citation violations
1482 those violations for which there is no substantial threat to the
1483 public health, safety, and welfare or no violation of standard
1484 of care involving injury to a patient. Violations for which a
1485 citation may be issued shall include violations of continuing
1486 education requirements; failure to timely pay required fees and
1487 fines; failure to comply with the requirements of ss. 381.026
1488 and 381.0261 regarding the dissemination of information
1489 regarding patient rights; failure to comply with advertising
1490 requirements; failure to timely update practitioner profile and
1491 credentialing files; failure to display signs, licenses, and
1492 permits; failure to have required reference books available; and
1493 all other violations that do not pose a direct and serious
1494 threat to the health and safety of the patient or involve a
1495 violation of standard of care that has resulted in injury to a
1496 patient.
1497 Section 22. Subsections (1) and (2) of section 456.078,
1498 Florida Statutes, are amended to read:
1499 456.078 Mediation.--

1500 (1) Notwithstanding the provisions of s. 456.073, the
1501 board, or the department when there is no board, shall adopt
1502 rules to designate which violations of the applicable
1503 professional practice act are appropriate for mediation. The
1504 board, or the department when there is no board, shall ~~may~~
1505 designate as mediation offenses those complaints where harm
1506 caused by the licensee is economic in nature, except any act or
1507 omission involving intentional misconduct, ~~or~~ can be remedied by
1508 the licensee, is not a standard-of-care violation involving any
1509 type of injury to a patient, or does not result in an adverse
1510 incident. For the purposes of this section, an "adverse
1511 incident" means an event that results in:
1512 (a) The death of a patient;
1513 (b) Brain or spinal damage to a patient;
1514 (c) The performance of a surgical procedure on the wrong
1515 patient;
1516 (d) The performance of a wrong-site surgical procedure;
1517 (e) The performance of a surgical procedure that is
1518 medically unnecessary or otherwise unrelated to the patient's
1519 diagnosis or medical condition;
1520 (f) The surgical repair of damage to a patient resulting
1521 from a planned surgical procedure, which damage is not a
1522 recognized specific risk as disclosed to the patient and
1523 documented through the informed-consent process;
1524 (g) The performance of a procedure to remove unplanned
1525 foreign objects remaining from a surgical procedure; or
1526 (h) The performance of any other surgical procedure that
1527 breached the standard of care.
1528 (2) After the department determines a complaint is legally
1529 sufficient and the alleged violations are defined as mediation

1530 offenses, the department or any agent of the department may
1531 conduct informal mediation to resolve the complaint. If the
1532 complainant and the subject of the complaint agree to a
1533 resolution of a complaint within 14 days after contact by the
1534 mediator, the mediator shall notify the department of the terms
1535 of the resolution. The department or board shall take no further
1536 action unless the complainant and the subject each fail to
1537 record with the department an acknowledgment of satisfaction of
1538 the terms of mediation within 60 days of the mediator's
1539 notification to the department. A successful mediation shall not
1540 constitute discipline. In the event the complainant and subject
1541 fail to reach settlement terms or to record the required
1542 acknowledgment, the department shall process the complaint
1543 according to the provisions of s. 456.073.
1544 Section 23. Effective upon this act becoming a law and
1545 applying to claims accruing on or after that date, section
1546 458.320, Florida Statutes, is amended to read:
1547 458.320 Financial responsibility.--
1548 (1) As a condition of licensing and maintaining an active
1549 license, and prior to the issuance or renewal of an active
1550 license or reactivation of an inactive license for the practice
1551 of medicine, an applicant must ~~shall~~ by one of the following
1552 methods demonstrate to the satisfaction of the board and the
1553 department financial responsibility to pay claims and costs
1554 ancillary thereto arising out of the rendering of, or the
1555 failure to render, medical care or services:
1556 (a) Establishing and maintaining an escrow account
1557 consisting of cash or assets eligible for deposit in accordance
1558 with s. 625.52 in the per claim amounts specified in paragraph
1559 (b). The required escrow amount set forth in this paragraph may

1560 not be used for litigation costs or attorney's fees for the
1561 defense of any medical negligence claim.
1562 (b) Obtaining and maintaining professional liability
1563 coverage in an amount not less than $100,000 per claim, with a
1564 minimum annual aggregate of not less than $300,000, from an
1565 authorized insurer as defined under s. 624.09, from a surplus
1566 lines insurer as defined under s. 626.914(2), from a risk
1567 retention group as defined under s. 627.942, from the Joint
1568 Underwriting Association established under s. 627.351(4), or
1569 through a plan of self-insurance as provided in s. 627.357. The
1570 required coverage amount set forth in this paragraph may not be
1571 used for litigation costs or attorney's fees for the defense of
1572 any medical negligence claim.
1573 (c) Obtaining and maintaining an unexpired, irrevocable
1574 letter of credit, established pursuant to chapter 675, in an
1575 amount not less than $100,000 per claim, with a minimum
1576 aggregate availability of credit of not less than $300,000. The
1577 letter of credit must ~~shall~~ be payable to the physician as
1578 beneficiary upon presentment of a final judgment indicating
1579 liability and awarding damages to be paid by the physician or
1580 upon presentment of a settlement agreement signed by all parties
1581 to such agreement when such final judgment or settlement is a
1582 result of a claim arising out of the rendering of, or the
1583 failure to render, medical care and services. The letter of
1584 credit may not be used for litigation costs or attorney's fees
1585 for the defense of any medical negligence claim. The ~~Such~~ letter
1586 of credit must ~~shall~~ be nonassignable and nontransferable. The
1587 ~~Such~~ letter of credit must ~~shall~~ be issued by any bank or
1588 savings association organized and existing under the laws of
1589 this state or any bank or savings association organized under

1590 the laws of the United States <u>which</u> ~~that~~ has its principal place
1591 of business in this state or has a branch office <u>that</u> ~~which~~ is
1592 authorized under the laws of this state or of the United States
1593 to receive deposits in this state.
1594 (2) <u>Physicians who perform surgery in an ambulatory</u>
1595 <u>surgical center licensed under chapter 395 and,</u> as a continuing
1596 condition of hospital staff privileges, physicians <u>who have</u> ~~with~~
1597 staff privileges <u>must</u> ~~shall~~ also ~~be required to~~ establish
1598 financial responsibility by one of the following methods:
1599 (a) Establishing and maintaining an escrow account
1600 consisting of cash or assets eligible for deposit in accordance
1601 with s. 625.52 in the per claim amounts specified in paragraph
1602 (b). <u>The required escrow amount set forth in this paragraph may</u>
1603 <u>not be used for litigation costs or attorney's fees for the</u>
1604 <u>defense of any medical negligence claim.</u>
1605 (b) Obtaining and maintaining professional liability
1606 coverage in an amount not less than $250,000 per claim, with a
1607 minimum annual aggregate of not less than $750,000 from an
1608 authorized insurer as defined under s. 624.09, from a surplus
1609 lines insurer as defined under s. 626.914(2), from a risk
1610 retention group as defined under s. 627.942, from the Joint
1611 Underwriting Association established under s. 627.351(4),
1612 through a plan of self-insurance as provided in s. 627.357, or
1613 through a plan of self-insurance <u>that</u> ~~which~~ meets the conditions
1614 specified for satisfying financial responsibility in s. 766.110.
1615 <u>The required coverage amount set forth in this paragraph may not</u>
1616 <u>be used for litigation costs or attorney's fees for the defense</u>
1617 <u>of any medical negligence claim.</u>
1618 (c) Obtaining and maintaining an unexpired irrevocable
1619 letter of credit, established pursuant to chapter 675, in an

1620 amount not less than $250,000 per claim, with a minimum
1621 aggregate availability of credit of not less than $750,000. The
1622 letter of credit must ~~shall~~ be payable to the physician as
1623 beneficiary upon presentment of a final judgment indicating
1624 liability and awarding damages to be paid by the physician or
1625 upon presentment of a settlement agreement signed by all parties
1626 to such agreement when such final judgment or settlement is a
1627 result of a claim arising out of the rendering of, or the
1628 failure to render, medical care and services. The letter of
1629 credit may not be used for litigation costs or attorney's fees
1630 for the defense of any medical negligence claim. The ~~Such~~ letter
1631 of credit must ~~shall~~ be nonassignable and nontransferable. The
1632 ~~Such~~ letter of credit must ~~shall~~ be issued by any bank or
1633 savings association organized and existing under the laws of
1634 this state or any bank or savings association organized under
1635 the laws of the United States which ~~that~~ has its principal place
1636 of business in this state or has a branch office that ~~which~~ is
1637 authorized under the laws of this state or of the United States
1638 to receive deposits in this state.
1639
1640 This subsection shall be inclusive of the coverage in subsection
1641 (1).
1642 (3)(a) ~~The financial responsibility requirements of~~
1643 ~~subsections (1) and (2) shall apply to claims for incidents that~~
1644 ~~occur on or after January 1, 1987, or the initial date of~~
1645 ~~licensure in this state, whichever is later.~~
1646 ~~(b)~~ Meeting the financial responsibility requirements of
1647 this section or the criteria for any exemption from such
1648 requirements must ~~shall~~ be established at the time of issuance
1649 or renewal of a license ~~on or after January 1, 1987~~.

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

1650 <u>(b)</u>~~(c)~~ Any person may, at any time, submit to the
1651 department a request for an advisory opinion regarding such
1652 person's qualifications for exemption.
1653 (4)(a) Each insurer, self-insurer, risk retention group,
1654 or Joint Underwriting Association <u>must</u> ~~shall~~ promptly notify the
1655 department of cancellation or nonrenewal of insurance required
1656 by this section. Unless the physician demonstrates that he or
1657 she is otherwise in compliance with the requirements of this
1658 section, the department shall suspend the license of the
1659 physician pursuant to ss. 120.569 and 120.57 and notify all
1660 health care facilities licensed under chapter 395 of such
1661 action. Any suspension under this subsection <u>remains</u> ~~shall~~
1662 ~~remain~~ in effect until the physician demonstrates compliance
1663 with the requirements of this section<u>. If any judgments or</u>
1664 <u>settlements are pending at the time of suspension, those</u>
1665 <u>judgments or settlements must be paid in accordance with this</u>
1666 <u>section unless otherwise mutually agreed to in writing by the</u>
1667 <u>parties. This paragraph does not abrogate a judgment debtor's</u>
1668 <u>obligation to satisfy the entire amount of any judgment</u>~~, except~~
1669 ~~that a license suspended under paragraph (5)(g) shall not be~~
1670 ~~reinstated until the physician demonstrates compliance with the~~
1671 ~~requirements of that provision~~.
1672 (b) If financial responsibility requirements are met by
1673 maintaining an escrow account or letter of credit as provided in
1674 this section, upon the entry of an adverse final judgment
1675 arising from a medical malpractice arbitration award, from a
1676 claim of medical malpractice either in contract or tort, or from
1677 noncompliance with the terms of a settlement agreement arising
1678 from a claim of medical malpractice either in contract or tort,
1679 the licensee shall pay the entire amount of the judgment

1680 together with all accrued interest, or the amount maintained in
1681 the escrow account or provided in the letter of credit as
1682 required by this section, whichever is less, within 60 days
1683 after the date such judgment became final and subject to
1684 execution, unless otherwise mutually agreed to in writing by the
1685 parties. If timely payment is not made by the physician, the
1686 department shall suspend the license of the physician pursuant
1687 to procedures set forth in subparagraphs (5)(g)3., 4., and 5.
1688 Nothing in this paragraph shall abrogate a judgment debtor's
1689 obligation to satisfy the entire amount of any judgment.
1690 (5) The requirements of subsections (1), (2), and (3) <u>do</u>
1691 ~~shall~~ not apply to:
1692 (a) Any person licensed under this chapter who practices
1693 medicine exclusively as an officer, employee, or agent of the
1694 Federal Government or of the state or its agencies or its
1695 subdivisions. For the purposes of this subsection, an agent of
1696 the state, its agencies, or its subdivisions is a person who is
1697 eligible for coverage under any self-insurance or insurance
1698 program authorized by the provisions of s. 768.28<u>(16)</u>~~(15)~~.
1699 (b) Any person whose license has become inactive under
1700 this chapter and who is not practicing medicine in this state.
1701 Any person applying for reactivation of a license must show
1702 either that such licensee maintained tail insurance coverage
1703 <u>that</u> ~~which~~ provided liability coverage for incidents that
1704 occurred on or after January 1, 1987, or the initial date of
1705 licensure in this state, whichever is later, and incidents that
1706 occurred before the date on which the license became inactive;
1707 or such licensee must submit an affidavit stating that such
1708 licensee has no unsatisfied medical malpractice judgments or
1709 settlements at the time of application for reactivation.

1710 (c) Any person holding a limited license pursuant to s.
1711 458.317 and practicing under the scope of such limited license.
1712 (d) Any person licensed or certified under this chapter
1713 who practices only in conjunction with his or her teaching
1714 duties at an accredited medical school or in its main teaching
1715 hospitals. Such person may engage in the practice of medicine to
1716 the extent that such practice is incidental to and a necessary
1717 part of duties in connection with the teaching position in the
1718 medical school.
1719 (e) Any person holding an active license under this
1720 chapter who is not practicing medicine in this state. If such
1721 person initiates or resumes any practice of medicine in this
1722 state, he or she must notify the department of such activity and
1723 fulfill the financial responsibility requirements of this
1724 section before resuming the practice of medicine in this state.
1725 (f) Any person holding an active license under this
1726 chapter who meets all of the following criteria:
1727 1. The licensee has held an active license to practice in
1728 this state or another state or some combination thereof for more
1729 than 15 years.
1730 2. The licensee has either retired from the practice of
1731 medicine or maintains a part-time practice of no more than 1,000
1732 patient contact hours per year.
1733 3. The licensee has had no more than two claims for
1734 medical malpractice resulting in an indemnity exceeding $25,000
1735 within the previous 5-year period.
1736 4. The licensee has not been convicted of, or pled guilty
1737 or nolo contendere to, any criminal violation specified in this
1738 chapter or the medical practice act of any other state.
1739 5. The licensee has not been subject within the last 10

1740 years of practice to license revocation or suspension for any
1741 period of time; probation for a period of 3 years or longer; or
1742 a fine of $500 or more for a violation of this chapter or the
1743 medical practice act of another jurisdiction. The regulatory
1744 agency's acceptance of a physician's relinquishment of a
1745 license, stipulation, consent order, or other settlement,
1746 offered in response to or in anticipation of the filing of
1747 administrative charges against the physician's license,
1748 constitutes ~~shall be construed as~~ action against the physician's
1749 license for the purposes of this paragraph.
1750 6. The licensee has submitted a form supplying necessary
1751 information as required by the department and an affidavit
1752 affirming compliance with ~~the provisions of~~ this paragraph.
1753 7. The licensee must ~~shall~~ submit biennially to the
1754 department certification stating compliance with ~~the provisions~~
1755 ~~of~~ this paragraph. The licensee must ~~shall~~, upon request,
1756 demonstrate to the department information verifying compliance
1757 with this paragraph.
1758
1759 A licensee who meets the requirements of this paragraph must
1760 ~~shall be required either to~~ post notice in the form of a sign
1761 prominently displayed in the reception area and clearly
1762 noticeable by all patients or provide a written statement to any
1763 person to whom medical services are being provided. The ~~Such~~
1764 sign or statement must read as follows ~~shall state that~~: "Under
1765 Florida law, physicians are generally required to carry medical
1766 malpractice insurance or otherwise demonstrate financial
1767 responsibility to cover potential claims for medical
1768 malpractice. However, certain part-time physicians who meet
1769 state requirements are exempt from the financial responsibility

1770 law. YOUR DOCTOR MEETS THESE REQUIREMENTS AND HAS DECIDED NOT TO
1771 CARRY MEDICAL MALPRACTICE INSURANCE. This notice is provided
1772 pursuant to Florida law."
1773 (g) Any person holding an active license under this
1774 chapter who agrees to meet all of the following criteria:
1775 1. Upon the entry of an adverse final judgment arising
1776 from a medical malpractice arbitration award, from a claim of
1777 medical malpractice either in contract or tort, or from
1778 noncompliance with the terms of a settlement agreement arising
1779 from a claim of medical malpractice either in contract or tort,
1780 the licensee shall pay the judgment creditor the lesser of the
1781 entire amount of the judgment with all accrued interest or
1782 either $100,000, if the physician is licensed pursuant to this
1783 chapter but does not maintain hospital staff privileges, or
1784 $250,000, if the physician is licensed pursuant to this chapter
1785 and maintains hospital staff privileges, within 60 days after
1786 the date such judgment became final and subject to execution,
1787 unless otherwise mutually agreed to in writing by the parties.
1788 Such adverse final judgment shall include any cross-claim,
1789 counterclaim, or claim for indemnity or contribution arising
1790 from the claim of medical malpractice. Upon notification of the
1791 existence of an unsatisfied judgment or payment pursuant to this
1792 subparagraph, the department shall notify the licensee by
1793 certified mail that he or she shall be subject to disciplinary
1794 action unless, within 30 days from the date of mailing, he or
1795 she either:
1796 a. Shows proof that the unsatisfied judgment has been paid
1797 in the amount specified in this subparagraph; or
1798 b. Furnishes the department with a copy of a timely filed
1799 notice of appeal and either:

1800 (I) A copy of a supersedeas bond properly posted in the
1801 amount required by law; or
1802 (II) An order from a court of competent jurisdiction
1803 staying execution on the final judgment pending disposition of
1804 the appeal.
1805 2. The Department of Health shall issue an emergency order
1806 suspending the license of any licensee who, after 30 days
1807 following receipt of a notice from the Department of Health, has
1808 failed to: satisfy a medical malpractice claim against him or
1809 her; furnish the Department of Health a copy of a timely filed
1810 notice of appeal; furnish the Department of Health a copy of a
1811 supersedeas bond properly posted in the amount required by law;
1812 or furnish the Department of Health an order from a court of
1813 competent jurisdiction staying execution on the final judgment
1814 pending disposition of the appeal.
1815 3. Upon the next meeting of the probable cause panel of
1816 the board following 30 days after the date of mailing the notice
1817 of disciplinary action to the licensee, the panel shall make a
1818 determination of whether probable cause exists to take
1819 disciplinary action against the licensee pursuant to
1820 subparagraph 1.
1821 4. If the board determines that the factual requirements
1822 of subparagraph 1. are met, it shall take disciplinary action as
1823 it deems appropriate against the licensee. Such disciplinary
1824 action shall include, at a minimum, probation of the license
1825 with the restriction that the licensee must make payments to the
1826 judgment creditor on a schedule determined by the board to be
1827 reasonable and within the financial capability of the physician.
1828 Notwithstanding any other disciplinary penalty imposed, the
1829 disciplinary penalty may include suspension of the license for a

period not to exceed 5 years. In the event that an agreement to satisfy a judgment has been met, the board shall remove any restriction on the license.

5. The licensee has completed a form supplying necessary information as required by the department.

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~~: "Under Florida law, physicians are generally required to carry medical malpractice insurance or otherwise demonstrate financial responsibility to cover potential claims for medical malpractice. YOUR DOCTOR HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE INSURANCE. This is permitted under Florida law subject to certain conditions. Florida law imposes penalties against noninsured physicians who fail to satisfy adverse judgments arising from claims of medical malpractice. This notice is provided pursuant to Florida law."

(6) Any deceptive, untrue, or fraudulent representation by the licensee with respect to any provision of this section shall result in permanent disqualification from any exemption to mandated financial responsibility as provided in this section and shall constitute grounds for disciplinary action under s. 458.331.

(7) Any licensee who relies on any exemption from the financial responsibility requirement shall notify the department, in writing, of any change of circumstance regarding

1860 his or her qualifications for such exemption and shall
1861 demonstrate that he or she is in compliance with the
1862 requirements of this section.
1863 (8) Notwithstanding any other provision of this section,
1864 the department shall suspend the license of any physician
1865 against whom has been entered a final judgment, arbitration
1866 award, or other order or who has entered into a settlement
1867 agreement to pay damages arising out of a claim for medical
1868 malpractice, if all appellate remedies have been exhausted and
1869 payment up to the amounts required by this section has not been
1870 made within 30 days after the entering of such judgment, award,
1871 or order or agreement, until proof of payment is received by the
1872 department or a payment schedule has been agreed upon by the
1873 physician and the claimant and presented to the department. This
1874 subsection does not apply to a physician who has met the
1875 financial responsibility requirements in paragraphs (1)(b) and
1876 (2)(b).
1877 (9)~~(8)~~ The board shall adopt rules to implement the
1878 provisions of this section.
1879 Section 24. Paragraph (t) of subsection (1) and subsection
1880 (6) of section 458.331, Florida Statutes, are amended to read:
1881 458.331 Grounds for disciplinary action; action by the
1882 board and department.--
1883 (1) The following acts constitute grounds for denial of a
1884 license or disciplinary action, as specified in s. 456.072(2):
1885 (t) Gross or repeated malpractice or the failure to
1886 practice medicine with that level of care, skill, and treatment
1887 which is recognized by a reasonably prudent similar physician as
1888 being acceptable under similar conditions and circumstances. The
1889 board shall give great weight to the provisions of s. 766.102

1890 when enforcing this paragraph. As used in this paragraph,
1891 "repeated malpractice" includes, but is not limited to, three or
1892 more claims for medical malpractice within the previous 5-year
1893 period resulting in indemnities being paid in excess of $50,000
1894 ~~$25,000~~ each to the claimant in a judgment or settlement and
1895 which incidents involved negligent conduct by the physician. As
1896 used in this paragraph, "gross malpractice" or "the failure to
1897 practice medicine with that level of care, skill, and treatment
1898 which is recognized by a reasonably prudent similar physician as
1899 being acceptable under similar conditions and circumstances,"
1900 shall not be construed so as to require more than one instance,
1901 event, or act. Nothing in this paragraph shall be construed to
1902 require that a physician be incompetent to practice medicine in
1903 order to be disciplined pursuant to this paragraph. A
1904 recommended order by an administrative law judge or a final
1905 order of the board finding a violation under this paragraph
1906 shall specify whether the licensee was found to have committed
1907 "gross malpractice," "repeated malpractice," or "failure to
1908 practice medicine with that level of care, skill, and treatment
1909 which is recognized as being acceptable under similar conditions
1910 and circumstances," or any combination thereof, and any
1911 publication by the board must so specify.
1912 (6) Upon the department's receipt from an insurer or self-
1913 insurer of a report of a closed claim against a physician
1914 pursuant to s. 627.912 or from a health care practitioner of a
1915 report pursuant to s. 456.049, or upon the receipt from a
1916 claimant of a presuit notice against a physician pursuant to s.
1917 766.106, the department shall review each report and determine
1918 whether it potentially involved conduct by a licensee that is
1919 subject to disciplinary action, in which case the provisions of

1920 s. 456.073 shall apply. However, if it is reported that a
1921 physician has had three or more claims with indemnities
1922 exceeding $50,000 ~~$25,000~~ each within the previous 5-year
1923 period, the department shall investigate the occurrences upon
1924 which the claims were based and determine if action by the
1925 department against the physician is warranted.
1926 Section 25. Section 458.3311, Florida Statutes, is created
1927 to read:
1928 458.3311 Emergency procedures for disciplinary
1929 action.--Notwithstanding any other provision of law to the
1930 contrary, no later than 30 days after a third report of a
1931 professional liability claim against a licensed physician has
1932 been submitted, within a 60-month period, as required by ss.
1933 456.049 and 627.912, the Department of Health shall initiate an
1934 emergency investigation and the Board of Medicine shall conduct
1935 an emergency probable cause hearing to determine whether the
1936 physician should be disciplined for a violation of s.
1937 458.331(1)(t) or any other relevant provision of law.
1938 Section 26. Effective upon this act becoming a law and
1939 applying to claims accruing on or after that date, section
1940 459.0085, Florida Statutes, is amended to read:
1941 459.0085 Financial responsibility.--
1942 (1) As a condition of licensing and maintaining an active
1943 license, and prior to the issuance or renewal of an active
1944 license or reactivation of an inactive license for the practice
1945 of osteopathic medicine, an applicant must ~~shall~~ by one of the
1946 following methods demonstrate to the satisfaction of the board
1947 and the department financial responsibility to pay claims and
1948 costs ancillary thereto arising out of the rendering of, or the
1949 failure to render, medical care or services:

1950 (a) Establishing and maintaining an escrow account
1951 consisting of cash or assets eligible for deposit in accordance
1952 with s. 625.52 in the per-claim amounts specified in paragraph
1953 (b). The required escrow amount set forth in this paragraph may
1954 not be used for litigation costs or attorney's fees for the
1955 defense of any medical negligence claim.
1956 (b) Obtaining and maintaining professional liability
1957 coverage in an amount not less than $100,000 per claim, with a
1958 minimum annual aggregate of not less than $300,000, from an
1959 authorized insurer as defined under s. 624.09, from a surplus
1960 lines insurer as defined under s. 626.914(2), from a risk
1961 retention group as defined under s. 627.942, from the Joint
1962 Underwriting Association established under s. 627.351(4), or
1963 through a plan of self-insurance as provided in s. 627.357. The
1964 required coverage amount set forth in this paragraph may not be
1965 used for litigation costs or attorney's fees for the defense of
1966 any medical negligence claim.
1967 (c) Obtaining and maintaining an unexpired, irrevocable
1968 letter of credit, established pursuant to chapter 675, in an
1969 amount not less than $100,000 per claim, with a minimum
1970 aggregate availability of credit of not less than $300,000. The
1971 letter of credit must ~~shall~~ be payable to the osteopathic
1972 physician as beneficiary upon presentment of a final judgment
1973 indicating liability and awarding damages to be paid by the
1974 osteopathic physician or upon presentment of a settlement
1975 agreement signed by all parties to such agreement when such
1976 final judgment or settlement is a result of a claim arising out
1977 of the rendering of, or the failure to render, medical care and
1978 services. The letter of credit may not be used for litigation
1979 costs or attorney's fees for the defense of any medical

1980 negligence claim. The ~~Such~~ letter of credit must ~~shall~~ be
1981 nonassignable and nontransferable. The ~~Such~~ letter of credit
1982 must ~~shall~~ be issued by any bank or savings association
1983 organized and existing under the laws of this state or any bank
1984 or savings association organized under the laws of the United
1985 States which ~~that~~ has its principal place of business in this
1986 state or has a branch office that ~~which~~ is authorized under the
1987 laws of this state or of the United States to receive deposits
1988 in this state.
1989 (2) Osteopathic physicians who perform surgery in an
1990 ambulatory surgical center licensed under chapter 395 and, as a
1991 continuing condition of hospital staff privileges, osteopathic
1992 physicians who have ~~with~~ staff privileges must ~~shall~~ also ~~be~~
1993 ~~required to~~ establish financial responsibility by one of the
1994 following methods:
1995 (a) Establishing and maintaining an escrow account
1996 consisting of cash or assets eligible for deposit in accordance
1997 with s. 625.52 in the per-claim amounts specified in paragraph
1998 (b). The required escrow amount set forth in this paragraph may
1999 not be used for litigation costs or attorney's fees for the
2000 defense of any medical negligence claim.
2001 (b) Obtaining and maintaining professional liability
2002 coverage in an amount not less than $250,000 per claim, with a
2003 minimum annual aggregate of not less than $750,000 from an
2004 authorized insurer as defined under s. 624.09, from a surplus
2005 lines insurer as defined under s. 626.914(2), from a risk
2006 retention group as defined under s. 627.942, from the Joint
2007 Underwriting Association established under s. 627.351(4),
2008 through a plan of self-insurance as provided in s. 627.357, or
2009 through a plan of self-insurance that ~~which~~ meets the conditions

2010 specified for satisfying financial responsibility in s. 766.110.
2011 The required coverage amount set forth in this paragraph may not
2012 be used for litigation costs or attorney's fees for the defense
2013 of any medical negligence claim.
2014 (c) Obtaining and maintaining an unexpired, irrevocable
2015 letter of credit, established pursuant to chapter 675, in an
2016 amount not less than $250,000 per claim, with a minimum
2017 aggregate availability of credit of not less than $750,000. The
2018 letter of credit must ~~shall~~ be payable to the osteopathic
2019 physician as beneficiary upon presentment of a final judgment
2020 indicating liability and awarding damages to be paid by the
2021 osteopathic physician or upon presentment of a settlement
2022 agreement signed by all parties to such agreement when such
2023 final judgment or settlement is a result of a claim arising out
2024 of the rendering of, or the failure to render, medical care and
2025 services. The letter of credit may not be used for litigation
2026 costs or attorney's fees for the defense of any medical
2027 negligence claim. The ~~Such~~ letter of credit must ~~shall~~ be
2028 nonassignable and nontransferable. The ~~Such~~ letter of credit
2029 must ~~shall~~ be issued by any bank or savings association
2030 organized and existing under the laws of this state or any bank
2031 or savings association organized under the laws of the United
2032 States which ~~that~~ has its principal place of business in this
2033 state or has a branch office that ~~which~~ is authorized under the
2034 laws of this state or of the United States to receive deposits
2035 in this state.
2036
2037 This subsection shall be inclusive of the coverage in subsection
2038 (1).
2039 (3)(a) ~~The financial responsibility requirements of~~

2040 ~~subsections (1) and (2) shall apply to claims for incidents that~~
2041 ~~occur on or after January 1, 1987, or the initial date of~~
2042 ~~licensure in this state, whichever is later.~~
2043 ~~(b)~~ Meeting the financial responsibility requirements of
2044 this section or the criteria for any exemption from such
2045 requirements must ~~shall~~ be established at the time of issuance
2046 or renewal of a license ~~on or after January 1, 1987~~.
2047 (b)~~(c)~~ Any person may, at any time, submit to the
2048 department a request for an advisory opinion regarding such
2049 person's qualifications for exemption.
2050 (4)(a) Each insurer, self-insurer, risk retention group,
2051 or joint underwriting association must ~~shall~~ promptly notify the
2052 department of cancellation or nonrenewal of insurance required
2053 by this section. Unless the osteopathic physician demonstrates
2054 that he or she is otherwise in compliance with the requirements
2055 of this section, the department shall suspend the license of the
2056 osteopathic physician pursuant to ss. 120.569 and 120.57 and
2057 notify all health care facilities licensed under chapter 395,
2058 part IV of chapter 394, or part I of chapter 641 of such action.
2059 Any suspension under this subsection remains ~~shall remain~~ in
2060 effect until the osteopathic physician demonstrates compliance
2061 with the requirements of this section. If any judgments or
2062 settlements are pending at the time of suspension, those
2063 judgments or settlements must be paid in accordance with this
2064 section unless otherwise mutually agreed to in writing by the
2065 parties. This paragraph does not abrogate a judgment debtor's
2066 obligation to satisfy the entire amount of any judgment ~~except~~
2067 ~~that a license suspended under paragraph (5)(g) shall not be~~
2068 ~~reinstated until the osteopathic physician demonstrates~~
2069 ~~compliance with the requirements of that provision~~.

2070 (b) If financial responsibility requirements are met by
2071 maintaining an escrow account or letter of credit as provided in
2072 this section, upon the entry of an adverse final judgment
2073 arising from a medical malpractice arbitration award, from a
2074 claim of medical malpractice either in contract or tort, or from
2075 noncompliance with the terms of a settlement agreement arising
2076 from a claim of medical malpractice either in contract or tort,
2077 the licensee shall pay the entire amount of the judgment
2078 together with all accrued interest or the amount maintained in
2079 the escrow account or provided in the letter of credit as
2080 required by this section, whichever is less, within 60 days
2081 after the date such judgment became final and subject to
2082 execution, unless otherwise mutually agreed to in writing by the
2083 parties. If timely payment is not made by the osteopathic
2084 physician, the department shall suspend the license of the
2085 osteopathic physician pursuant to procedures set forth in
2086 subparagraphs(5)(g)3., 4., and 5. Nothing in this paragraph
2087 shall abrogate a judgment debtor's obligation to satisfy the
2088 entire amount of any judgment.
2089 (5) The requirements of subsections (1), (2), and (3) do
2090 ~~shall~~ not apply to:
2091 (a) Any person licensed under this chapter who practices
2092 medicine exclusively as an officer, employee, or agent of the
2093 Federal Government or of the state or its agencies or its
2094 subdivisions. For the purposes of this subsection, an agent of
2095 the state, its agencies, or its subdivisions is a person who is
2096 eligible for coverage under any self-insurance or insurance
2097 program authorized by the provisions of s. 768.28(16)~~(15)~~.
2098 (b) Any person whose license has become inactive under
2099 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 that ~~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. 459.0075 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 a college of osteopathic medicine. Such person may engage in the practice of osteopathic medicine to the extent that such practice is incidental to and a necessary part of duties in connection with the teaching position in the college of osteopathic medicine.

(e) Any person holding an active license under this chapter who is not practicing osteopathic medicine in this state. If such person initiates or resumes any practice of osteopathic medicine in this state, he or she must notify the department of such activity and fulfill the financial responsibility requirements of this section before resuming the practice of osteopathic medicine in this state.

(f) Any person holding an active license under this chapter who meets all of the following criteria:

1. The licensee has held an active license to practice in this state or another state or some combination thereof for more than 15 years.

2130 2. The licensee has either retired from the practice of
2131 osteopathic medicine or maintains a part-time practice of
2132 osteopathic medicine of no more than 1,000 patient contact hours
2133 per year.
2134 3. The licensee has had no more than two claims for
2135 medical malpractice resulting in an indemnity exceeding $25,000
2136 within the previous 5-year period.
2137 4. The licensee has not been convicted of, or pled guilty
2138 or nolo contendere to, any criminal violation specified in this
2139 chapter or the practice act of any other state.
2140 5. The licensee has not been subject within the last 10
2141 years of practice to license revocation or suspension for any
2142 period of time, probation for a period of 3 years or longer, or
2143 a fine of $500 or more for a violation of this chapter or the
2144 medical practice act of another jurisdiction. The regulatory
2145 agency's acceptance of an osteopathic physician's relinquishment
2146 of a license, stipulation, consent order, or other settlement,
2147 offered in response to or in anticipation of the filing of
2148 administrative charges against the osteopathic physician's
2149 license, constitutes ~~shall be construed as~~ action against the
2150 physician's license for the purposes of this paragraph.
2151 6. The licensee has submitted a form supplying necessary
2152 information as required by the department and an affidavit
2153 affirming compliance with ~~the provisions of~~ this paragraph.
2154 7. The licensee must ~~shall~~ submit biennially to the
2155 department a certification stating compliance with ~~the~~
2156 ~~provisions of~~ this paragraph. The licensee must ~~shall~~, upon
2157 request, demonstrate to the department information verifying
2158 compliance with this paragraph.
2159

2160 A licensee who meets the requirements of this paragraph must
2161 ~~shall be required either to~~ post notice in the form of a sign
2162 prominently displayed in the reception area and clearly
2163 noticeable by all patients or ~~to~~ provide a written statement to
2164 any person to whom medical services are being provided. The ~~Such~~
2165 sign or statement must read as follows ~~shall state that~~: "Under
2166 Florida law, osteopathic physicians are generally required to
2167 carry medical malpractice insurance or otherwise demonstrate
2168 financial responsibility to cover potential claims for medical
2169 malpractice. However, certain part-time osteopathic physicians
2170 who meet state requirements are exempt from the financial
2171 responsibility law. YOUR OSTEOPATHIC PHYSICIAN MEETS THESE
2172 REQUIREMENTS AND HAS DECIDED NOT TO CARRY MEDICAL MALPRACTICE
2173 INSURANCE. This notice is provided pursuant to Florida law."
2174 (g) Any person holding an active license under this
2175 chapter who agrees to meet all of the following criteria:
2176 1. Upon the entry of an adverse final judgment arising
2177 from a medical malpractice arbitration award, from a claim of
2178 medical malpractice either in contract or tort, or from
2179 noncompliance with the terms of a settlement agreement arising
2180 from a claim of medical malpractice either in contract or tort,
2181 the licensee shall pay the judgment creditor the lesser of the
2182 entire amount of the judgment with all accrued interest or
2183 either $100,000, if the osteopathic physician is licensed
2184 pursuant to this chapter but does not maintain hospital staff
2185 privileges, or $250,000, if the osteopathic physician is
2186 licensed pursuant to this chapter and maintains hospital staff
2187 privileges, within 60 days after the date such judgment became
2188 final and subject to execution, unless otherwise mutually agreed
2189 to in writing by the parties. Such adverse final judgment shall

2190 include any cross-claim, counterclaim, or claim for indemnity or
2191 contribution arising from the claim of medical malpractice. Upon
2192 notification of the existence of an unsatisfied judgment or
2193 payment pursuant to this subparagraph, the department shall
2194 notify the licensee by certified mail that he or she shall be
2195 subject to disciplinary action unless, within 30 days from the
2196 date of mailing, the licensee either:
2197 a. Shows proof that the unsatisfied judgment has been paid
2198 in the amount specified in this subparagraph; or
2199 b. Furnishes the department with a copy of a timely filed
2200 notice of appeal and either:
2201 (I) A copy of a supersedeas bond properly posted in the
2202 amount required by law; or
2203 (II) An order from a court of competent jurisdiction
2204 staying execution on the final judgment, pending disposition of
2205 the appeal.
2206 2. The Department of Health shall issue an emergency order
2207 suspending the license of any licensee who, after 30 days
2208 following receipt of a notice from the Department of Health, has
2209 failed to: satisfy a medical malpractice claim against him or
2210 her; furnish the Department of Health a copy of a timely filed
2211 notice of appeal; furnish the Department of Health a copy of a
2212 supersedeas bond properly posted in the amount required by law;
2213 or furnish the Department of Health an order from a court of
2214 competent jurisdiction staying execution on the final judgment
2215 pending disposition of the appeal.
2216 3. Upon the next meeting of the probable cause panel of
2217 the board following 30 days after the date of mailing the notice
2218 of disciplinary action to the licensee, the panel shall make a
2219 determination of whether probable cause exists to take

2220 disciplinary action against the licensee pursuant to
2221 subparagraph 1.
2222 4. If the board determines that the factual requirements
2223 of subparagraph 1. are met, it shall take disciplinary action as
2224 it deems appropriate against the licensee. Such disciplinary
2225 action shall include, at a minimum, probation of the license
2226 with the restriction that the licensee must make payments to the
2227 judgment creditor on a schedule determined by the board to be
2228 reasonable and within the financial capability of the
2229 osteopathic physician. Notwithstanding any other disciplinary
2230 penalty imposed, the disciplinary penalty may include suspension
2231 of the license for a period not to exceed 5 years. In the event
2232 that an agreement to satisfy a judgment has been met, the board
2233 shall remove any restriction on the license.
2234 5. The licensee has completed a form supplying necessary
2235 information as required by the department.
2236
2237 A licensee who meets the requirements of this paragraph must
2238 ~~shall be required either to~~ post notice in the form of a sign
2239 prominently displayed in the reception area and clearly
2240 noticeable by all patients or ~~to~~ provide a written statement to
2241 any person to whom medical services are being provided. The ~~Such~~
2242 sign or statement must read as follows ~~shall state~~: "Under
2243 Florida law, osteopathic physicians are generally required to
2244 carry medical malpractice insurance or otherwise demonstrate
2245 financial responsibility to cover potential claims for medical
2246 malpractice. YOUR OSTEOPATHIC PHYSICIAN HAS DECIDED NOT TO CARRY
2247 MEDICAL MALPRACTICE INSURANCE. This is permitted under Florida
2248 law subject to certain conditions. Florida law imposes strict
2249 penalties against noninsured osteopathic physicians who fail to

2250 satisfy adverse judgments arising from claims of medical
2251 malpractice. This notice is provided pursuant to Florida law."
2252 (6) Any deceptive, untrue, or fraudulent representation by
2253 the licensee with respect to any provision of this section shall
2254 result in permanent disqualification from any exemption to
2255 mandated financial responsibility as provided in this section
2256 and shall constitute grounds for disciplinary action under s.
2257 459.015.
2258 (7) Any licensee who relies on any exemption from the
2259 financial responsibility requirement shall notify the department
2260 in writing of any change of circumstance regarding his or her
2261 qualifications for such exemption and shall demonstrate that he
2262 or she is in compliance with the requirements of this section.
2263 (8) If a physician is either a resident physician,
2264 assistant resident physician, or intern in an approved
2265 postgraduate training program, as defined by the board's rules,
2266 and is supervised by a physician who is participating in the
2267 Florida Birth-Related Neurological Injury Compensation Plan,
2268 such resident physician, assistant resident physician, or intern
2269 is deemed to be a participating physician without the payment of
2270 the assessment set forth in s. 766.314(4).
2271 <u>(9) Notwithstanding any other provision of this section,</u>
2272 <u>the department shall suspend the license of any osteopathic</u>
2273 <u>physician against whom has been entered a final judgment,</u>
2274 <u>arbitration award, or other order or who has entered into a</u>
2275 <u>settlement agreement to pay damages arising out of a claim for</u>
2276 <u>medical negligence, if all appellate remedies have been</u>
2277 <u>exhausted and payment up to the amounts required by this section</u>
2278 <u>has not been made within 30 days after the entering of such</u>
2279 <u>judgment, award, or order or agreement, until proof of payment</u>

2280 is received by the department or a payment schedule has been
2281 agreed upon by the osteopathic physician and the claimant and
2282 presented to the department. This subsection does not apply to
2283 an osteopathic physician who has met the financial
2284 responsibility requirements in paragraphs (1)(b) and (2)(b).
2285 (10)~~(9)~~ The board shall adopt rules to implement the
2286 provisions of this section.
2287 Section 27. Paragraph (x) of subsection (1) and subsection
2288 (6) of section 459.015, Florida Statutes, are amended to read:
2289 459.015 Grounds for disciplinary action; action by the
2290 board and department.--
2291 (1) The following acts constitute grounds for denial of a
2292 license or disciplinary action, as specified in s. 456.072(2):
2293 (x) Gross or repeated malpractice or the failure to
2294 practice osteopathic medicine with that level of care, skill,
2295 and treatment which is recognized by a reasonably prudent
2296 similar osteopathic physician as being acceptable under similar
2297 conditions and circumstances. The board shall give great weight
2298 to the provisions of s. 766.102 when enforcing this paragraph.
2299 As used in this paragraph, "repeated malpractice" includes, but
2300 is not limited to, three or more claims for medical malpractice
2301 within the previous 5-year period resulting in indemnities being
2302 paid in excess of $50,000 ~~$25,000~~ each to the claimant in a
2303 judgment or settlement and which incidents involved negligent
2304 conduct by the osteopathic physician. As used in this paragraph,
2305 "gross malpractice" or "the failure to practice osteopathic
2306 medicine with that level of care, skill, and treatment which is
2307 recognized by a reasonably prudent similar osteopathic physician
2308 as being acceptable under similar conditions and circumstances"
2309 shall not be construed so as to require more than one instance,

2310 event, or act. Nothing in this paragraph shall be construed to
2311 require that an osteopathic physician be incompetent to practice
2312 osteopathic medicine in order to be disciplined pursuant to this
2313 paragraph. A recommended order by an administrative law judge or
2314 a final order of the board finding a violation under this
2315 paragraph shall specify whether the licensee was found to have
2316 committed "gross malpractice," "repeated malpractice," or
2317 "failure to practice osteopathic medicine with that level of
2318 care, skill, and treatment which is recognized as being
2319 acceptable under similar conditions and circumstances," or any
2320 combination thereof, and any publication by the board shall so
2321 specify.
2322 (6) Upon the department's receipt from an insurer or self-
2323 insurer of a report of a closed claim against an osteopathic
2324 physician pursuant to s. 627.912 or from a health care
2325 practitioner of a report pursuant to s. 456.049, or upon the
2326 receipt from a claimant of a presuit notice against an
2327 osteopathic physician pursuant to s. 766.106, the department
2328 shall review each report and determine whether it potentially
2329 involved conduct by a licensee that is subject to disciplinary
2330 action, in which case the provisions of s. 456.073 shall apply.
2331 However, if it is reported that an osteopathic physician has had
2332 three or more claims with indemnities exceeding $50,000 ~~$25,000~~
2333 each within the previous 5-year period, the department shall
2334 investigate the occurrences upon which the claims were based and
2335 determine if action by the department against the osteopathic
2336 physician is warranted.
2337 Section 28. Section 459.0151, Florida Statutes, is created
2338 to read:
2339 459.0151 Emergency procedures for disciplinary

2340 action.--Notwithstanding any other provision of law to the
2341 contrary, no later than 30 days after a third report of a
2342 professional liability claim against a licensed osteopathic
2343 physician has been submitted, within a 60-month period, as
2344 required by ss. 456.049 and 627.912, the Department of Health
2345 shall initiate an emergency investigation and the Board of
2346 Osteopathic Medicine shall conduct an emergency probable cause
2347 hearing to determine whether the physician should be disciplined
2348 for a violation of s. 459.015(1)(x) or any other relevant
2349 provision of law.
2350 Section 29. Paragraph (s) of subsection (1) and paragraph
2351 (a) of subsection (5) of section 461.013, Florida Statutes, are
2352 amended to read:
2353 461.013 Grounds for disciplinary action; action by the
2354 board; investigations by department.--
2355 (1) The following acts constitute grounds for denial of a
2356 license or disciplinary action, as specified in s. 456.072(2):
2357 (s) Gross or repeated malpractice or the failure to
2358 practice podiatric medicine at a level of care, skill, and
2359 treatment which is recognized by a reasonably prudent podiatric
2360 physician as being acceptable under similar conditions and
2361 circumstances. The board shall give great weight to the
2362 standards for negligence ~~malpractice~~ in s. 766.102 in
2363 interpreting this section. As used in this paragraph, "repeated
2364 malpractice" includes, but is not limited to, three or more
2365 claims for medical malpractice within the previous 5-year period
2366 resulting in indemnities being paid in excess of $50,000 ~~$10,000~~
2367 each to the claimant in a judgment or settlement and which
2368 incidents involved negligent conduct by the podiatric
2369 physicians. As used in this paragraph, "gross malpractice" or

2370 "the failure to practice podiatric medicine with the level of
2371 care, skill, and treatment which is recognized by a reasonably
2372 prudent similar podiatric physician as being acceptable under
2373 similar conditions and circumstances" shall not be construed so
2374 as to require more than one instance, event, or act. A
2375 recommended order by an administrative law judge or a final
2376 order of the board finding a violation under this paragraph
2377 shall specify whether the licensee was found to have committed
2378 "gross malpractice," "repeated malpractice," or "failure to
2379 practice podiatric medicine with that level of care, skill, and
2380 treatment which is recognized as being acceptable under similar
2381 conditions and circumstances," or any combination thereof, and
2382 any publication by the board must so specify.
2383 (5)(a) Upon the department's receipt from an insurer or
2384 self-insurer of a report of a closed claim against a podiatric
2385 physician pursuant to s. 627.912, or upon the receipt from a
2386 claimant of a presuit notice against a podiatric physician
2387 pursuant to s. 766.106, the department shall review each report
2388 and determine whether it potentially involved conduct by a
2389 licensee that is subject to disciplinary action, in which case
2390 the provisions of s. 456.073 shall apply. However, if it is
2391 reported that a podiatric physician has had three or more claims
2392 with indemnities exceeding $50,000 ~~$25,000~~ each within the
2393 previous 5-year period, the department shall investigate the
2394 occurrences upon which the claims were based and determine if
2395 action by the department against the podiatric physician is
2396 warranted.
2397 Section 30. Section 461.0131, Florida Statutes, is created
2398 to read:
2399 461.0131 Emergency procedures for disciplinary

2400 action.--Notwithstanding any other provision of law to the
2401 contrary, no later than 30 days after a third report of a
2402 professional liability claim against a licensed podiatric
2403 physician has been submitted, within a 60-month period, as
2404 required by ss. 456.049 and 627.912, the Department of Health
2405 shall initiate an emergency investigation and the Board of
2406 Podiatric Medicine shall conduct an emergency probable cause
2407 hearing to determine whether the physician should be disciplined
2408 for a violation of s. 461.013(1)(s) or any other relevant
2409 provision of law.
2410 Section 31. Paragraph (x) of subsection (1) of section
2411 466.028, Florida Statutes, is amended to read:
2412 466.028 Grounds for disciplinary action; action by the
2413 board.--
2414 (1) The following acts constitute grounds for denial of a
2415 license or disciplinary action, as specified in s. 456.072(2):
2416 (x) Being guilty of incompetence or negligence by failing
2417 to meet the minimum standards of performance in diagnosis and
2418 treatment when measured against generally prevailing peer
2419 performance, including, but not limited to, the undertaking of
2420 diagnosis and treatment for which the dentist is not qualified
2421 by training or experience or being guilty of dental malpractice.
2422 For purposes of this paragraph, it shall be legally presumed
2423 that a dentist is not guilty of incompetence or negligence by
2424 declining to treat an individual if, in the dentist's
2425 professional judgment, the dentist or a member of her or his
2426 clinical staff is not qualified by training and experience, or
2427 the dentist's treatment facility is not clinically satisfactory
2428 or properly equipped to treat the unique characteristics and
2429 health status of the dental patient, provided the dentist refers

2430 the patient to a qualified dentist or facility for appropriate
2431 treatment. As used in this paragraph, "dental malpractice"
2432 includes, but is not limited to, three or more claims within the
2433 previous 5-year period which resulted in indemnity being paid,
2434 or any single indemnity paid in excess of $25,000 ~~$5,000~~ in a
2435 judgment or settlement, as a result of negligent conduct on the
2436 part of the dentist.
2437 Section 32. Subsections (2), (3), and (6) of section
2438 624.462, Florida Statutes, are amended to read:
2439 624.462 Commercial self-insurance funds.--
2440 (2) As used in ss. 624.460-624.488, "commercial self-
2441 insurance fund" or "fund" means a group of members, operating
2442 individually and collectively through a trust or corporation,
2443 that must be:
2444 (a) Established by:
2445 1. A not-for-profit trade association, industry
2446 association, or professional association of employers or
2447 professionals which has a constitution or bylaws, which is
2448 incorporated under the laws of this state, and which has been
2449 organized for purposes other than that of obtaining or providing
2450 insurance and operated in good faith for a continuous period of
2451 1 year;
2452 2. A self-insurance trust fund organized pursuant to s.
2453 627.357 and maintained in good faith for a continuous period of
2454 1 year for purposes other than that of obtaining or providing
2455 insurance pursuant to this section. Each member of a commercial
2456 self-insurance trust fund established pursuant to this
2457 subsection must maintain membership in the self-insurance trust
2458 fund organized pursuant to s. 627.357; ~~or~~
2459 3. A group of 10 or more health care providers, as defined

2460 in s. 627.351(4)(h), for purposes of providing medical
2461 malpractice coverage; or
2462 4.~~3.~~ A not-for-profit group comprised of no less than 10
2463 condominium associations as defined in s. 718.103(2), which is
2464 incorporated under the laws of this state, which restricts its
2465 membership to condominium associations only, and which has been
2466 organized and maintained in good faith for a continuous period
2467 of 1 year for purposes other than that of obtaining or providing
2468 insurance.
2469 (b)1. In the case of funds established pursuant to
2470 subparagraph (a)2. or subparagraph (a)4.~~3.~~, operated pursuant to
2471 a trust agreement by a board of trustees which shall have
2472 complete fiscal control over the fund and which shall be
2473 responsible for all operations of the fund. The majority of the
2474 trustees shall be owners, partners, officers, directors, or
2475 employees of one or more members of the fund. The trustees
2476 shall have the authority to approve applications of members for
2477 participation in the fund and to contract with an authorized
2478 administrator or servicing company to administer the day-to-day
2479 affairs of the fund.
2480 2. In the case of funds established pursuant to
2481 subparagraph (a)1. or subparagraph (a)3., operated pursuant to a
2482 trust agreement by a board of trustees or as a corporation by a
2483 board of directors which board shall:
2484 a. Be responsible to members of the fund or beneficiaries
2485 of the trust or policyholders of the corporation;
2486 b. Appoint independent certified public accountants, legal
2487 counsel, actuaries, and investment advisers as needed;
2488 c. Approve payment of dividends to members;
2489 d. Approve changes in corporate structure; and

2490 e. Have the authority to contract with an administrator
2491 authorized under s. 626.88 to administer the day-to-day affairs
2492 of the fund including, but not limited to, marketing,
2493 underwriting, billing, collection, claims administration, safety
2494 and loss prevention, reinsurance, policy issuance, accounting,
2495 regulatory reporting, and general administration. The fees or
2496 compensation for services under such contract shall be
2497 comparable to the costs for similar services incurred by
2498 insurers writing the same lines of insurance, or where available
2499 such expenses as filed by boards, bureaus, and associations
2500 designated by insurers to file such data. A majority of the
2501 trustees or directors shall be owners, partners, officers,
2502 directors, or employees of one or more members of the fund.
2503 (3) Each member of a commercial self-insurance trust fund
2504 established pursuant to this section, except a fund established
2505 pursuant to subparagraph (2)(a)3., must maintain membership in
2506 the association or self-insurance trust fund established under
2507 s. 627.357. Membership in a not-for-profit trade association,
2508 industry association, or professional association of employers
2509 or professionals for the purpose of obtaining or providing
2510 insurance shall be in accordance with the constitution or bylaws
2511 of the association, and the dues, fees, or other costs of
2512 membership shall not be different for members obtaining
2513 insurance from the commercial self-insurance fund. The
2514 association shall not be liable for any actions of the fund nor
2515 shall it have any responsibility for establishing or enforcing
2516 any policy of the commercial self-insurance fund. Fees,
2517 services, and other aspects of the relationship between the
2518 association and the fund shall be subject to contractual
2519 agreement.

2520 (6) A governmental self-insurance pool created pursuant to
2521 s. 768.28(16)~~(15)~~ shall not be considered a commercial self-
2522 insurance fund.
2523 Section 33. Paragraph (a) of subsection (6) of section
2524 627.062, Florida Statutes, as amended by section 1064 of chapter
2525 2003-261, Laws of Florida, is amended, and subsections (7) and
2526 (8) are added to said section, to read:
2527 627.062 Rate standards.--
2528 (6)(a) After any action with respect to a rate filing that
2529 constitutes agency action for purposes of the Administrative
2530 Procedure Act, except for a rate filing for medical malpractice
2531 insurance, an insurer may, in lieu of demanding a hearing under
2532 s. 120.57, require arbitration of the rate filing. Arbitration
2533 shall be conducted by a board of arbitrators consisting of an
2534 arbitrator selected by the office, an arbitrator selected by the
2535 insurer, and an arbitrator selected jointly by the other two
2536 arbitrators. Each arbitrator must be certified by the American
2537 Arbitration Association. A decision is valid only upon the
2538 affirmative vote of at least two of the arbitrators. No
2539 arbitrator may be an employee of any insurance regulator or
2540 regulatory body or of any insurer, regardless of whether or not
2541 the employing insurer does business in this state. The office
2542 and the insurer must treat the decision of the arbitrators as
2543 the final approval of a rate filing. Costs of arbitration shall
2544 be paid by the insurer.
2545 (7)(a) The provisions of this subsection apply only with
2546 respect to rates for medical malpractice insurance and shall
2547 control to the extent of any conflict with other provisions of
2548 this section.
2549 (b) Any portion of a judgment entered or settlement paid

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2550 as a result of a statutory or common-law bad faith action and
2551 any portion of a judgment entered which awards punitive damages
2552 against an insurer may not be included in the insurer's rate
2553 base and shall not be used to justify a rate or rate change. Any
2554 common-law bad faith action identified as such and any portion
2555 of a settlement entered as a result of a statutory bad faith
2556 action or portion of a settlement wherein an insurer agrees to
2557 pay specific punitive damages may not be used to justify a rate
2558 or rate change. The portion of the taxable costs and attorney's
2559 fees which is identified as being related to the bad faith and
2560 punitive damages in these judgments and settlements may not be
2561 included in the insurer's rate base and may not be utilized to
2562 justify a rate or rate change.
2563 (c) Upon reviewing a rate filing and determining whether
2564 the rate is excessive, inadequate, or unfairly discriminatory,
2565 the office shall consider, in accordance with generally accepted
2566 and reasonable actuarial techniques, past and present
2567 prospective loss experience, either using loss experience solely
2568 for this state or giving greater credibility to this state's
2569 loss data after applying actuarially sound methods of assigning
2570 credibility to such data.
2571 (d) Rates shall be deemed excessive if, among other
2572 standards established by this section, the rate structure
2573 provides for replenishment of reserves or surpluses from
2574 premiums when the replenishment is attributable to investment
2575 losses.
2576 (e) The insurer must apply a discount or surcharge based
2577 on the health care provider's loss experience or shall establish
2578 an alternative method giving due consideration to the provider's
2579 loss experience. The insurer must include in the filing a copy

2580 of the surcharge or discount schedule or a description of the
2581 alternative method used and must provide a copy of such schedule
2582 or description, as approved by the office, to policyholders at
2583 the time of renewal and to prospective policyholders at the time
2584 of application for coverage.
2585 (f) Each medical malpractice insurer must make a rate
2586 filing under this section, sworn to by at least two executive
2587 officers of the insurer, at least once each calendar year.
2588 (8)(a)1. No later than 60 days after the effective date of
2589 medical malpractice legislation enacted during the 2003 Special
2590 Session D of the Florida Legislature, the office shall calculate
2591 a presumed factor that reflects the impact the changes contained
2592 in such legislation will have on rates for medical malpractice
2593 insurance and shall issue a notice informing all insurers
2594 writing medical malpractice coverage of such presumed factor. In
2595 determining the presumed factor, the office shall use generally
2596 accepted actuarial techniques and standards provided in this
2597 section in determining the expected impact on losses, expenses,
2598 and investment income of the insurer. To the extent that the
2599 operation of a provision of any medical malpractice legislation
2600 enacted during the 2003 Special Session D of the Florida
2601 Legislature is stayed pending a constitutional challenge, the
2602 impact of that provision shall not be included in the
2603 calculation of a presumed factor under this subparagraph.
2604 2. No later than 60 days after the office issues its
2605 notice of the presumed rate change factor under subparagraph 1.,
2606 each insurer writing medical malpractice coverage in this state
2607 shall submit to the office a rate filing for medical malpractice
2608 insurance, which will take effect no later than January 1, 2004,
2609 and apply retroactively to policies issued or renewed on or

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2610 after the effective date of medical malpractice legislation
2611 enacted during the 2003 Special Session D of the Florida
2612 Legislature. Except as authorized under paragraph (b), the
2613 filing shall reflect an overall rate reduction at least as great
2614 as the presumed factor determined under subparagraph 1. With
2615 respect to policies issued or renewed on or after the effective
2616 date of such legislation and prior to the effective date of the
2617 rate filing required by this subsection, the office shall order
2618 the insurer to make a refund of the amount that was charged in
2619 excess of the rate that is approved.
2620 (b) Any insurer or rating organization that contends that
2621 the rate provided for in paragraph (a) is excessive, inadequate,
2622 or unfairly discriminatory shall separately state in its filing
2623 the rate it contends is appropriate and shall state with
2624 specificity the factors or data that it contends should be
2625 considered in order to produce such appropriate rate. The
2626 insurer or rating organization shall be permitted to use all of
2627 the generally accepted actuarial techniques provided in this
2628 section in making any filing pursuant to this subsection. The
2629 office shall review each such exception and approve or
2630 disapprove it prior to use. It shall be the insurer's burden to
2631 actuarially justify any deviations from the rates required to be
2632 filed under paragraph (a). The insurer making a filing under
2633 this paragraph shall include in the filing the expected impact
2634 of all malpractice legislation enacted during the 2003 Special
2635 Session D of the Florida Legislature on losses, expenses, and
2636 rates.
2637 (c) If any provision of medical malpractice legislation
2638 enacted during the 2003 Special Session D of the Florida
2639 Legislature is held invalid by a court of competent

2640 jurisdiction, the office shall permit an adjustment of all
2641 medical malpractice rates filed under this section to reflect
2642 the impact of such holding on such rates so as to ensure that
2643 the rates are not excessive, inadequate, or unfairly
2644 discriminatory.
2645 (d) Rates approved on or before July 1, 2003, for medical
2646 malpractice insurance shall remain in effect until the effective
2647 date of a new rate filing approved under this subsection.
2648 (e) The calculation and notice by the office of the
2649 presumed factor pursuant to paragraph (a) is not an order or
2650 rule that is subject to chapter 120. If the office enters into a
2651 contract with an independent consultant to assist the office in
2652 calculating the presumed factor, such contract shall not be
2653 subject to the competitive solicitation requirements of s.
2654 287.057.
2655 Section 34. Subsections (6) and (10) of section 627.357,
2656 Florida Statutes, as amended by section 1107 of chapter 2003-
2657 261, Laws of Florida, are amended to read:
2658 627.357 Medical malpractice self-insurance.--
2659 (6) The commission shall adopt rules to implement this
2660 section, including rules that ensure that a trust fund remains
2661 solvent and maintains a sufficient reserve to cover contingent
2662 liabilities under subsection (7) in the event of its
2663 dissolution.
2664 ~~(10) A self-insurance fund may not be formed under this~~
2665 ~~section after October 1, 1992.~~
2666 Section 35. Subsection (1) of section 627.4147, Florida
2667 Statutes, is amended to read:
2668 627.4147 Medical malpractice insurance contracts.--
2669 (1) In addition to any other requirements imposed by law,

2670 each self-insurance policy as authorized under s. 627.357 or s.
2671 624.462 or insurance policy providing coverage for claims
2672 arising out of the rendering of, or the failure to render,
2673 medical care or services, including those of the Florida Medical
2674 Malpractice Joint Underwriting Association, shall include:
2675 (a) A clause requiring the insured to cooperate fully in
2676 the review process prescribed under s. 766.106 if a notice of
2677 intent to file a claim for medical negligence ~~malpractice~~ is
2678 made against the insured.
2679 (b)1. Except as provided in subparagraph 2., a clause
2680 authorizing the insurer or self-insurer to determine, to make,
2681 and to conclude, without the permission of the insured, any
2682 offer of admission of liability and for arbitration pursuant to
2683 s. 766.106, settlement offer, or offer of judgment, if the offer
2684 is within the policy limits. It is against public policy for any
2685 insurance or self-insurance policy to contain a clause giving
2686 the insured the exclusive right to veto any offer for admission
2687 of liability and for arbitration made pursuant to s. 766.106,
2688 settlement offer, or offer of judgment, when such offer is
2689 within the policy limits. However, any offer of admission of
2690 liability, settlement offer, or offer of judgment made by an
2691 insurer or self-insurer shall be made in good faith and in the
2692 best interests of the insured.
2693 2.a. With respect to dentists licensed under chapter 466,
2694 a clause clearly stating whether or not the insured has the
2695 exclusive right to veto any offer of admission of liability and
2696 for arbitration pursuant to s. 766.106, settlement offer, or
2697 offer of judgment if the offer is within policy limits. An
2698 insurer or self-insurer shall not make or conclude, without the
2699 permission of the insured, any offer of admission of liability

2700 and for arbitration pursuant to s. 766.106, settlement offer, or
2701 offer of judgment, if such offer is outside the policy limits.
2702 However, any offer for admission of liability and for
2703 arbitration made under s. 766.106, settlement offer, or offer of
2704 judgment made by an insurer or self-insurer shall be made in
2705 good faith and in the best interest of the insured.
2706 b. If the policy contains a clause stating the insured
2707 does not have the exclusive right to veto any offer or admission
2708 of liability and for arbitration made pursuant to s. 766.106,
2709 settlement offer or offer of judgment, the insurer or self-
2710 insurer shall provide to the insured or the insured's legal
2711 representative by certified mail, return receipt requested, a
2712 copy of the final offer of admission of liability and for
2713 arbitration made pursuant to s. 766.106, settlement offer or
2714 offer of judgment and at the same time such offer is provided to
2715 the claimant. A copy of any final agreement reached between the
2716 insurer and claimant shall also be provided to the insurer or
2717 his or her legal representative by certified mail, return
2718 receipt requested not more than 10 days after affecting such
2719 agreement.
2720 (c) A clause requiring the insurer or self-insurer to
2721 notify the insured no less than 90 ~~60~~ days prior to the
2722 effective date of cancellation of the policy or contract and, in
2723 the event of a determination by the insurer or self-insurer not
2724 to renew the policy or contract, to notify the insured no less
2725 than 90 ~~60~~ days prior to the end of the policy or contract
2726 period. If cancellation or nonrenewal is due to nonpayment or
2727 loss of license, 10 days' notice is required.
2728 (d) A clause requiring the insurer or self-insurer to
2729 notify the insured no less than 60 days prior to the effective

2730 date of a rate increase. The provisions of s. 627.4133 shall
2731 apply to such notice and to the failure of the insurer to
2732 provide such notice to the extent not in conflict with this
2733 section.
2734 Section 36. Section 627.41495, Florida Statutes, is
2735 created to read:
2736 627.41495 Public notice of medical malpractice rate
2737 filings.--
2738 (1) Upon the filing of a proposed rate change by a
2739 medical malpractice insurer or self-insurance fund, which filing
2740 would result in an average statewide increase of 25 percent, or
2741 more, pursuant to standards determined by the office, the insurer
2742 or self-insurance fund shall mail notice of such filing to each
2743 of its policyholders or members.
2744 (2) The rate filing shall be available for public
2745 inspection.
2746 Section 37. Section 627.912, Florida Statutes, as amended
2747 by section 1226 of chapter 2003-261, Laws of Florida, is amended
2748 to read:
2749 627.912 Professional liability claims and actions; reports
2750 by insurers and health care providers; annual report by
2751 office.--
2752 (1)(a) Each self-insurer authorized under s. 627.357 and
2753 each commercial self-insurance fund authorized under s. 624.462,
2754 authorized insurer, surplus lines insurer, risk retention group,
2755 and ~~or~~ joint underwriting association providing professional
2756 liability insurance to a practitioner of medicine licensed under
2757 chapter 458, to a practitioner of osteopathic medicine licensed
2758 under chapter 459, to a podiatric physician licensed under
2759 chapter 461, to a dentist licensed under chapter 466, to a

2760 hospital licensed under chapter 395, to a crisis stabilization
2761 unit licensed under part IV of chapter 394, to a health
2762 maintenance organization certificated under part I of chapter
2763 641, to clinics included in chapter 390, or to an ambulatory
2764 surgical center as defined in s. 395.002, and each insurer
2765 providing professional liability insurance ~~or~~ to a member of The
2766 Florida Bar shall report ~~in duplicate~~ to the office any claim or
2767 action for damages for personal injuries claimed to have been
2768 caused by error, omission, or negligence in the performance of
2769 such insured's professional services or based on a claimed
2770 performance of professional services without consent, if the
2771 claim resulted in:
2772 1.~~(a)~~ A final judgment in any amount.
2773 2.~~(b)~~ A settlement in any amount.
2774 3. A final disposition of a medical negligence claim
2775 resulting in no indemnity payment on behalf of the insured.
2776 (b) Each health care practitioner and health care facility
2777 listed in paragraph (a) must report any claim or action for
2778 damages as described in paragraph (a) if the claim is not
2779 otherwise required to be reported by an insurer or other
2780 insuring entity.
2781
2782 Reports under this subsection shall be filed with the office
2783 ~~and, if the insured party is licensed under chapter 458, chapter~~
2784 ~~459, chapter 461, or chapter 466, with the Department of Health,~~
2785 no later than 30 days following the occurrence of any event
2786 listed in paragraph (a) or paragraph (b). ~~The Department of~~
2787 ~~Health shall review each report and determine whether any of the~~
2788 ~~incidents that resulted in the claim potentially involved~~
2789 ~~conduct by the licensee that is subject to disciplinary action,~~

2790 ~~in which case the provisions of s. 456.073 shall apply. The~~
2791 ~~Department of Health, as part of the annual report required by~~
2792 ~~s. 456.026, shall publish annual statistics, without identifying~~
2793 ~~licensees, on the reports it receives, including final action~~
2794 ~~taken on such reports by the Department of Health or the~~
2795 ~~appropriate regulatory board.~~
2796 (2) The reports required by subsection (1) shall contain:
2797 (a) The name, address, health care provider professional
2798 license number, and specialty coverage of the insured.
2799 (b) The insured's policy number.
2800 (c) The date of the occurrence which created the claim.
2801 (d) The date the claim was reported to the insurer or
2802 self-insurer.
2803 (e) The name and address of the injured person. This
2804 information is confidential and exempt from the provisions of s.
2805 119.07(1), and must not be disclosed by the office without the
2806 injured person's consent, except for disclosure by the office to
2807 the Department of Health. This information may be used by the
2808 office for purposes of identifying multiple or duplicate claims
2809 arising out of the same occurrence.
2810 (f) The date of suit, if filed.
2811 (g) The injured person's age and sex.
2812 (h) The total number, ~~and~~ names, and health care provider
2813 professional license numbers of all defendants involved in the
2814 claim.
2815 (i) The date and amount of judgment or settlement, if any,
2816 including the itemization of the verdict~~, together with a copy~~
2817 ~~of the settlement or judgment~~.
2818 (j) In the case of a settlement, such information as the
2819 office may require with regard to the injured person's incurred

2820 and anticipated medical expense, wage loss, and other expenses.
2821 (k) The loss adjustment expense paid to defense counsel,
2822 and all other allocated loss adjustment expense paid.
2823 (l) The date and reason for final disposition, if no
2824 judgment or settlement.
2825 (m) A summary of the occurrence which created the claim,
2826 which shall include:
2827 1. The name of the institution, if any, and the location
2828 within the institution at which the injury occurred.
2829 2. The final diagnosis for which treatment was sought or
2830 rendered, including the patient's actual condition.
2831 3. A description of the misdiagnosis made, if any, of the
2832 patient's actual condition.
2833 4. The operation, diagnostic, or treatment procedure
2834 causing the injury.
2835 5. A description of the principal injury giving rise to
2836 the claim.
2837 6. The safety management steps that have been taken by the
2838 insured to make similar occurrences or injuries less likely in
2839 the future.
2840 (n) Any other information required by the commission, by
2841 rule, ~~office~~ to assist the office in its analysis and evaluation
2842 of ~~analyze and evaluate~~ the nature, causes, location, cost, and
2843 damages involved in professional liability cases.
2844 (3) ~~Upon request by the Department of Health,~~ The office
2845 shall provide the Department of Health with electronic access to
2846 all ~~any~~ information received under this section related to
2847 persons licensed under chapter 458, chapter 459, chapter 461, or
2848 chapter 466. The Department of Health shall review each report
2849 and determine whether any of the incidents that resulted in the

2850 claim potentially involved conduct by the licensee that is
2851 subject to disciplinary action, in which case the provisions of
2852 s. 456.073 shall apply. ~~For purposes of safety management, the~~
2853 ~~office shall annually provide the Department of Health with~~
2854 ~~copies of the reports in cases resulting in an indemnity being~~
2855 ~~paid to the claimants.~~
2856 (4) There shall be no liability on the part of, and no
2857 cause of action of any nature shall arise against, any person or
2858 entity ~~insurer~~ reporting hereunder or its agents or employees or
2859 the office or its employees for any action taken by them under
2860 this section. The office shall ~~may~~ impose a fine of $250 per day
2861 per case, but not to exceed a total of $10,000 ~~$1,000~~ per case,
2862 against an insurer, commercial self-insurance fund, medical
2863 malpractice self-insurance fund, or risk retention group that
2864 violates the requirements of this section, except that the
2865 office may impose a fine of $250 per day per case, not to exceed
2866 a total of $1,000 per case, against an insurer providing
2867 professional liability insurance to a member of the Florida Bar,
2868 which insurer violates the provisions of this section. If a
2869 health care practitioner or health care facility violates the
2870 requirements of this section, it shall be considered a violation
2871 of the chapter or act under which the practitioner or facility
2872 is licensed and shall be grounds for a fine or disciplinary
2873 action as such other violations of the chapter or act. ~~This~~
2874 ~~subsection applies to claims accruing on or after October 1,~~
2875 ~~1997.~~
2876 (5) Any self-insurance program established under s.
2877 1004.24 shall report ~~in duplicate~~ to the office any claim or
2878 action for damages for personal injuries claimed to have been
2879 caused by error, omission, or negligence in the performance of

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

2880 professional services provided by the state university board of
2881 trustees through an employee or agent of the state university
2882 board of trustees, including practitioners of medicine licensed
2883 under chapter 458, practitioners of osteopathic medicine
2884 licensed under chapter 459, podiatric physicians licensed under
2885 chapter 461, and dentists licensed under chapter 466, or based
2886 on a claimed performance of professional services without
2887 consent if the claim resulted in a final judgment in any amount,
2888 or a settlement in any amount. The reports required by this
2889 subsection shall contain the information required by subsection
2890 (3) and the name, address, and specialty of the employee or
2891 agent of the state university board of trustees whose
2892 performance or professional services is alleged in the claim or
2893 action to have caused personal injury.
2894 (6)(a) The office shall prepare statistical summaries of
2895 the closed claims reports for medical negligence filed pursuant
2896 to this section, for each year that such reports have been
2897 filed, and make such summaries and closed claim reports
2898 available on the Internet by July 1, 2005.
2899 (b) The office shall prepare an annual report by October 1
2900 of each year, beginning in 2004, which shall be available on the
2901 Internet, that summarizes and analyzes the closed claim reports
2902 for medical negligence filed pursuant to this section and the
2903 annual financial reports filed by insurers writing medical
2904 malpractice insurance in this state. The report must include an
2905 analysis of closed claim reports of prior years, in order to
2906 show trends in the frequency and amount of claims payments, the
2907 itemization of economic and noneconomic damages, the nature of
2908 the errant conduct, and such other information as the office
2909 determines is illustrative of the trends in closed claims. The

2910 report must also analyze the state of the medical malpractice
2911 insurance market in Florida, including an analysis of the
2912 financial reports of those insurers with a combined market share
2913 of at least 80 percent of the net written premium in the state
2914 for medical malpractice insurance for the prior calendar year,
2915 including a loss ratio analysis for medical malpractice
2916 insurance written in Florida and a profitability analysis of
2917 each such insurer. The report shall compare the ratios for
2918 medical malpractice in Florida to those of other states, based
2919 on financial reports filed with the National Association of
2920 Insurance Commissioners and such other information as the office
2921 deems relevant.
2922 (c) The annual report shall also include a summary of the
2923 rate filings for medical malpractice insurance that have been
2924 approved by the office for the prior calendar year, including an
2925 analysis of the trend of direct and incurred losses as compared
2926 to prior years.
2927 Section 38. Subsections (11), (12), and (17) of section
2928 641.19, Florida Statutes, as amended by section 1555 of chapter
2929 2003-261, Laws of Florida, are amended to read:
2930 641.19 Definitions.--As used in this part, the term:
2931 (11) "Health maintenance contract" means any contract
2932 entered into by a health maintenance organization with a
2933 subscriber or group of subscribers to provide coverage for
2934 comprehensive health care services in exchange for a prepaid per
2935 capita or prepaid aggregate fixed sum.
2936 (12) "Health maintenance organization" means any
2937 organization authorized under this part which:
2938 (a) Provides, through arrangements with other persons,
2939 emergency care, inpatient hospital services, physician care

2940 including care provided by physicians licensed under chapters
2941 458, 459, 460, and 461, ambulatory diagnostic treatment, and
2942 preventive health care services.;
2943 (b) Provides, either directly or through arrangements with
2944 other persons, health care services to persons enrolled with
2945 such organization, on a prepaid per capita or prepaid aggregate
2946 fixed-sum basis.;
2947 (c) Provides, either directly or through arrangements with
2948 other persons, comprehensive health care services which
2949 subscribers are entitled to receive pursuant to a contract.;
2950 (d) Provides physician services, by physicians licensed
2951 under chapters 458, 459, 460, and 461, directly through
2952 physicians who are either employees or partners of such
2953 organization or under arrangements with a physician or any group
2954 of physicians.; and
2955 (e) If offering services through a managed care system,
2956 has then the managed care system must be a system in which a
2957 primary physician licensed under chapter 458, or chapter 459,
2958 chapter and chapters 460, or chapter and 461 is designated for
2959 each subscriber upon request of a subscriber requesting service
2960 by a physician licensed under any of those chapters, and is
2961 responsible for coordinating the health care of the subscriber
2962 of the respectively requested service and for referring the
2963 subscriber to other providers of the same discipline when
2964 necessary. Each female subscriber may select as her primary
2965 physician an obstetrician/gynecologist who has agreed to serve
2966 as a primary physician and is in the health maintenance
2967 organization's provider network.
2968
2969 Except in cases in which the health care provider is an employee

2970 of the health maintenance organization, the fact that the health
2971 maintenance organization arranges for the provision of health
2972 care services under this chapter does not create an actual
2973 agency, apparent agency, or employer-employee relationship
2974 between the health care provider and the health maintenance
2975 organization for purposes of vicarious liability for the medical
2976 negligence of the health care provider.
2977 (17) "Subscriber" means an entity or individual who has
2978 contracted, or on whose behalf a contract has been entered into,
2979 with a health maintenance organization for health care coverage
2980 ~~services~~ or other persons who also receive health care coverage
2981 ~~services~~ as a result of the contract.
2982 Section 39. Subsection (3) of section 641.51, Florida
2983 Statutes, is amended to read:
2984 641.51 Quality assurance program; second medical opinion
2985 requirement.--
2986 (3) The health maintenance organization shall not have the
2987 right to control the professional judgment of a physician
2988 licensed under chapter 458, chapter 459, chapter 460, or chapter
2989 461 concerning the proper course of treatment of a subscriber
2990 ~~shall not be subject to modification by the organization or its~~
2991 ~~board of directors, officers, or administrators, unless the~~
2992 ~~course of treatment prescribed is inconsistent with the~~
2993 ~~prevailing standards of medical practice in the community~~.
2994 However, this subsection shall not be considered to restrict a
2995 utilization management program established by an organization or
2996 to affect an organization's decision as to payment for covered
2997 services. Except in cases in which the health care provider is
2998 an employee of the health maintenance organization, the health
2999 maintenance organization shall not be vicariously liable for the

3000 medical negligence of the health care provider, whether such
3001 claim is alleged under a theory of actual agency, apparent
3002 agency, or employer-employee relationship.
3003 Section 40. Section 766.102, Florida Statutes, is amended
3004 to read:
3005 766.102 Medical negligence; standards of recovery; expert
3006 witness.--
3007 (1) In any action for recovery of damages based on the
3008 death or personal injury of any person in which it is alleged
3009 that such death or injury resulted from the negligence of a
3010 health care provider as defined in s. 766.202(4) ~~768.50(2)(b)~~,
3011 the claimant shall have the burden of proving by the greater
3012 weight of evidence that the alleged actions of the health care
3013 provider represented a breach of the prevailing professional
3014 standard of care for that health care provider. The prevailing
3015 professional standard of care for a given health care provider
3016 shall be that level of care, skill, and treatment which, in
3017 light of all relevant surrounding circumstances, is recognized
3018 as acceptable and appropriate by reasonably prudent similar
3019 health care providers.
3020 ~~(2)(a) If the health care provider whose negligence is~~
3021 ~~claimed to have created the cause of action is not certified by~~
3022 ~~the appropriate American board as being a specialist, is not~~
3023 ~~trained and experienced in a medical specialty, or does not hold~~
3024 ~~himself or herself out as a specialist, a "similar health care~~
3025 ~~provider" is one who:~~
3026 ~~1. Is licensed by the appropriate regulatory agency of~~
3027 ~~this state;~~
3028 ~~2. Is trained and experienced in the same discipline or~~
3029 ~~school of practice; and~~

3030 ~~3. Practices in the same or similar medical community.~~
3031 ~~(b) If the health care provider whose negligence is~~
3032 ~~claimed to have created the cause of action is certified by the~~
3033 ~~appropriate American board as a specialist, is trained and~~
3034 ~~experienced in a medical specialty, or holds himself or herself~~
3035 ~~out as a specialist, a "similar health care provider" is one~~
3036 ~~who:~~
3037 ~~1. Is trained and experienced in the same specialty; and~~
3038 ~~2. Is certified by the appropriate American board in the~~
3039 ~~same specialty.~~
3040
3041 ~~However, if any health care provider described in this paragraph~~
3042 ~~is providing treatment or diagnosis for a condition which is not~~
3043 ~~within his or her specialty, a specialist trained in the~~
3044 ~~treatment or diagnosis for that condition shall be considered a~~
3045 ~~"similar health care provider."~~
3046 ~~(c) The purpose of this subsection is to establish a~~
3047 ~~relative standard of care for various categories and~~
3048 ~~classifications of health care providers. Any health care~~
3049 ~~provider may testify as an expert in any action if he or she:~~
3050 ~~1. Is a similar health care provider pursuant to paragraph~~
3051 ~~(a) or paragraph (b); or~~
3052 ~~2. Is not a similar health care provider pursuant to~~
3053 ~~paragraph (a) or paragraph (b) but, to the satisfaction of the~~
3054 ~~court, possesses sufficient training, experience, and knowledge~~
3055 ~~as a result of practice or teaching in the specialty of the~~
3056 ~~defendant or practice or teaching in a related field of~~
3057 ~~medicine, so as to be able to provide such expert testimony as~~
3058 ~~to the prevailing professional standard of care in a given field~~
3059 ~~of medicine. Such training, experience, or knowledge must be as~~

3060 ~~a result of the active involvement in the practice or teaching~~
3061 ~~of medicine within the 5-year period before the incident giving~~
3062 ~~rise to the claim.~~
3063 (2)~~(3)~~(a) If the injury is claimed to have resulted from
3064 the negligent affirmative medical intervention of the health
3065 care provider, the claimant must, in order to prove a breach of
3066 the prevailing professional standard of care, show that the
3067 injury was not within the necessary or reasonably foreseeable
3068 results of the surgical, medicinal, or diagnostic procedure
3069 constituting the medical intervention, if the intervention from
3070 which the injury is alleged to have resulted was carried out in
3071 accordance with the prevailing professional standard of care by
3072 a reasonably prudent similar health care provider.
3073 (b) The provisions of this subsection shall apply only
3074 when the medical intervention was undertaken with the informed
3075 consent of the patient in compliance with the provisions of s.
3076 766.103.
3077 (3)~~(4)~~ The existence of a medical injury shall not create
3078 any inference or presumption of negligence against a health care
3079 provider, and the claimant must maintain the burden of proving
3080 that an injury was proximately caused by a breach of the
3081 prevailing professional standard of care by the health care
3082 provider. However, the discovery of the presence of a foreign
3083 body, such as a sponge, clamp, forceps, surgical needle, or
3084 other paraphernalia commonly used in surgical, examination, or
3085 diagnostic procedures, shall be prima facie evidence of
3086 negligence on the part of the health care provider.
3087 (4)~~(5)~~ The Legislature is cognizant of the changing trends
3088 and techniques for the delivery of health care in this state and
3089 the discretion that is inherent in the diagnosis, care, and

3090 treatment of patients by different health care providers. The
3091 failure of a health care provider to order, perform, or
3092 administer supplemental diagnostic tests shall not be actionable
3093 if the health care provider acted in good faith and with due
3094 regard for the prevailing professional standard of care.
3095 (5) A person may not give expert testimony concerning the
3096 prevailing professional standard of care unless that person is a
3097 licensed health care provider and meets the following criteria:
3098 (a) If the health care provider against whom or on whose
3099 behalf the testimony is offered is a specialist, the expert
3100 witness must:
3101 1. Specialize in the same specialty as the health care
3102 provider against whom or on whose behalf the testimony is
3103 offered; or specialize in a similar specialty that includes the
3104 evaluation, diagnosis, or treatment of the medical condition
3105 that is the subject of the claim and have prior experience
3106 treating similar patients; and
3107 2. Have devoted professional time during the 3 years
3108 immediately preceding the date of the occurrence that is the
3109 basis for the action to:
3110 a. The active clinical practice of, or consulting with
3111 respect to, the same or similar specialty that includes the
3112 evaluation, diagnosis, or treatment of the medical condition
3113 that is the subject of the claim and have prior experience
3114 treating similar patients;
3115 b. The instruction of students in an accredited health
3116 professional school or accredited residency or clinical research
3117 program in the same or similar specialty; or

3118 c. A clinical research program that is affiliated with an
3119 accredited health professional school or accredited residency or
3120 clinical research program in the same or similar specialty.
3121 (b) If the health care provider against whom or on whose
3122 behalf the testimony is offered is a general practitioner, the
3123 expert witness must have devoted professional time during the 5
3124 years immediately preceding the date of the occurrence that is
3125 the basis for the action to:
3126 1. Active clinical practice or consultation as a general
3127 practitioner;
3128 2. The instruction of students in an accredited health
3129 professional school or accredited residency program in the
3130 general practice of medicine; or
3131 3. A clinical research program that is affiliated with an
3132 accredited medical school or teaching hospital and that is in
3133 the general practice of medicine.
3134 (c) If the health care provider against whom or on whose
3135 behalf the testimony is offered is a health care provider other
3136 than a specialist or a general practitioner, the expert witness
3137 must have devoted professional time during the 3 years
3138 immediately preceding the date of the occurrence that is the
3139 basis for the action to:
3140 1. The active clinical practice of, or consulting with
3141 respect to, the same or similar health profession as the health
3142 care provider against whom or on whose behalf the testimony is
3143 offered;
3144 2. The instruction of students in an accredited health
3145 professional school or accredited residency program in the same
3146 or similar health profession in which the health care provider
3147 against whom or on whose behalf the testimony is offered; or

3148 3. A clinical research program that is affiliated with an
3149 accredited medical school or teaching hospital and that is in
3150 the same or similar health profession as the health care
3151 provider against whom or on whose behalf the testimony is
3152 offered.
3153 (6) A physician licensed under chapter 458 or chapter 459
3154 who qualifies as an expert witness under subsection (5) and who,
3155 by reason of active clinical practice or instruction of
3156 students, has knowledge of the applicable standard of care for
3157 nurses, nurse practitioners, certified registered nurse
3158 anesthetists, certified registered nurse midwives, physician
3159 assistants, or other medical support staff may give expert
3160 testimony in a medical negligence action with respect to the
3161 standard of care of such medical support staff.
3162 (7) Notwithstanding subsection (5), in a medical
3163 negligence action against a hospital, health care facility, or
3164 medical facility, a person may give expert testimony on the
3165 appropriate standard of care as to administrative and other
3166 nonclinical issues if the person has substantial knowledge, by
3167 virtue of his or her training and experience, concerning the
3168 standard of care among hospitals, health care facilities, or
3169 medical facilities of the same type as the hospital, health care
3170 facility, or medical facility whose acts or omissions are the
3171 subject of the testimony and which are located in the same or
3172 similar communities at the time of the alleged act giving rise
3173 to the cause of action.
3174 (8) If a health care provider described in subsection (5),
3175 subsection (6), or subsection (7) is providing evaluation,
3176 treatment, or diagnosis for a condition that is not within his
3177 or her specialty, a specialist trained in the evaluation,

3178 treatment, or diagnosis for that condition shall be considered a
3179 similar health care provider.
3180 (9)~~(6)~~(a) In any action for damages involving a claim of
3181 negligence against a physician licensed under chapter 458,
3182 osteopathic physician licensed under chapter 459, podiatric
3183 physician licensed under chapter 461, or chiropractic physician
3184 licensed under chapter 460 providing emergency medical services
3185 in a hospital emergency department, the court shall admit expert
3186 medical testimony only from physicians, osteopathic physicians,
3187 podiatric physicians, and chiropractic physicians who have had
3188 substantial professional experience within the preceding 5 years
3189 while assigned to provide emergency medical services in a
3190 hospital emergency department.
3191 (b) For the purposes of this subsection:
3192 1. The term "emergency medical services" means those
3193 medical services required for the immediate diagnosis and
3194 treatment of medical conditions which, if not immediately
3195 diagnosed and treated, could lead to serious physical or mental
3196 disability or death.
3197 2. "Substantial professional experience" shall be
3198 determined by the custom and practice of the manner in which
3199 emergency medical coverage is provided in hospital emergency
3200 departments in the same or similar localities where the alleged
3201 negligence occurred.
3202 (10) In any action alleging medical negligence, an expert
3203 witness may not testify on a contingency-fee basis.
3204 (11) Any attorney who proffers a person as an expert
3205 witness pursuant to this section must certify that such person
3206 has not been found guilty of fraud or perjury in any
3207 jurisdiction.

3208 (12) This section does not limit the power of the trial
3209 court to disqualify or qualify an expert witness on grounds
3210 other than the qualifications in this section.
3211 Section 41. Section 766.106, Florida Statutes, is amended
3212 to read:
3213 766.106 Notice before filing action for medical negligence
3214 ~~malpractice~~; presuit screening period; offers for admission of
3215 liability and for arbitration; informal discovery; review.--
3216 (1) DEFINITIONS.--As used in this section:
3217 (a) "Claim for medical negligence" or "claim for medical
3218 malpractice" means a claim arising out of the rendering of, or
3219 the failure to render, medical care or services.
3220 (b) "Self-insurer" means any self-insurer authorized under
3221 s. 627.357 or any uninsured prospective defendant.
3222 (c) "Insurer" includes the Joint Underwriting Association.
3223 (2) PRESUIT NOTICE.--
3224 (a) After completion of presuit investigation pursuant to
3225 s. 766.203(2) and prior to filing a complaint ~~claim~~ for medical
3226 negligence ~~malpractice~~, a claimant shall notify each prospective
3227 defendant by certified mail, return receipt requested, of intent
3228 to initiate litigation for medical negligence ~~malpractice~~.
3229 Notice to each prospective defendant must include, if available,
3230 a list of all known health care providers seen by the claimant
3231 for the injuries complained of subsequent to the alleged act of
3232 negligence, all known health care providers during the 2-year
3233 period prior to the alleged act of negligence who treated or
3234 evaluated the claimant, and copies of all of the medical records
3235 relied upon by the expert in signing the affidavit. The
3236 requirement of providing the list of known health care providers
3237 may not serve as grounds for imposing sanctions for failure to

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3238 provide presuit discovery.

3239 (b) Following the initiation of a suit alleging medical
3240 negligence ~~malpractice~~ with a court of competent jurisdiction,
3241 and service of the complaint upon a defendant, the claimant
3242 shall provide a copy of the complaint to the Department of
3243 Health and, if the complaint involves a facility licensed under
3244 chapter 395, the Agency for Health Care Administration. The
3245 requirement of providing the complaint to the Department of
3246 Health or the Agency for Health Care Administration does not
3247 impair the claimant's legal rights or ability to seek relief for
3248 his or her claim for medical negligence. The Department of
3249 Health or the Agency for Health Care Administration shall review
3250 each incident that is the subject of the complaint and determine
3251 whether it involved conduct by a licensee which is potentially
3252 subject to disciplinary action, in which case, for a licensed
3253 health care practitioner, the provisions of s. 456.073 apply,
3254 and for a licensed facility, the provisions of part I of chapter
3255 395 apply.

3256 (3) PRESUIT INVESTIGATION BY PROSPECTIVE DEFENDANT.--

3257 (a) No suit may be filed for a period of 90 days after
3258 notice is mailed to any prospective defendant. During the 90-day
3259 period, the prospective defendant or the defendant's insurer or
3260 self-insurer shall conduct a review as provided in s. 766.203(3)
3261 to determine the liability of the defendant. Each insurer or
3262 self-insurer shall have a procedure for the prompt
3263 investigation, review, and evaluation of claims during the 90-
3264 day period. This procedure shall include one or more of the
3265 following:

3266 1. Internal review by a duly qualified claims adjuster;

3267 2. Creation of a panel comprised of an attorney

3268 knowledgeable in the prosecution or defense of medical
3269 negligence ~~malpractice~~ actions, a health care provider trained
3270 in the same or similar medical specialty as the prospective
3271 defendant, and a duly qualified claims adjuster;
3272 3. A contractual agreement with a state or local
3273 professional society of health care providers, which maintains a
3274 medical review committee;
3275 4. Any other similar procedure which fairly and promptly
3276 evaluates the pending claim.
3277
3278 Each insurer or self-insurer shall investigate the claim in good
3279 faith, and both the claimant and prospective defendant shall
3280 cooperate with the insurer in good faith. If the insurer
3281 requires, a claimant shall appear before a pretrial screening
3282 panel or before a medical review committee and shall submit to a
3283 physical examination, if required. Unreasonable failure of any
3284 party to comply with this section justifies dismissal of claims
3285 or defenses. There shall be no civil liability for participation
3286 in a pretrial screening procedure if done without intentional
3287 fraud.
3288 (b) At or before the end of the 90 days, the prospective
3289 defendant or the prospective defendant's insurer or self-insurer
3290 shall provide the claimant with a response:
3291 1. Rejecting the claim;
3292 2. Making a settlement offer; or
3293 3. Making an offer to arbitrate, in which case liability
3294 is deemed admitted and arbitration will be held only ~~of~~
3295 ~~admission of liability and for arbitration~~ on the issue of
3296 damages. This offer may be made contingent upon a limit of
3297 general damages.

3298 (c) The response shall be delivered to the claimant if not
3299 represented by counsel or to the claimant's attorney, by
3300 certified mail, return receipt requested. Failure of the
3301 prospective defendant or insurer or self-insurer to reply to the
3302 notice within 90 days after receipt shall be deemed a final
3303 rejection of the claim for purposes of this section.
3304 (d) Within 30 days after ~~of~~ receipt of a response by a
3305 prospective defendant, insurer, or self-insurer to a claimant
3306 represented by an attorney, the attorney shall advise the
3307 claimant in writing of the response, including:
3308 1. The exact nature of the response under paragraph (b).
3309 2. The exact terms of any settlement offer, or admission
3310 of liability and offer of arbitration on damages.
3311 3. The legal and financial consequences of acceptance or
3312 rejection of any settlement offer, or admission of liability,
3313 including the provisions of this section.
3314 4. An evaluation of the time and likelihood of ultimate
3315 success at trial on the merits of the claimant's action.
3316 5. An estimation of the costs and attorney's fees of
3317 proceeding through trial.
3318 (4) SERVICE OF PRESUIT NOTICE AND TOLLING.--The notice of
3319 intent to initiate litigation shall be served within the time
3320 limits set forth in s. 95.11. However, during the 90-day period,
3321 the statute of limitations is tolled as to all potential
3322 defendants. Upon stipulation by the parties, the 90-day period
3323 may be extended and the statute of limitations is tolled during
3324 any such extension. Upon receiving notice of termination of
3325 negotiations in an extended period, the claimant shall have 60
3326 days or the remainder of the period of the statute of
3327 limitations, whichever is greater, within which to file suit.

3328 (5) DISCOVERY AND ADMISSIBILITY.--No statement,
3329 discussion, written document, report, or other work product
3330 generated by the presuit screening process is discoverable or
3331 admissible in any civil action for any purpose by the opposing
3332 party. All participants, including, but not limited to,
3333 physicians, investigators, witnesses, and employees or
3334 associates of the defendant, are immune from civil liability
3335 arising from participation in the presuit screening process.
3336 (6) INFORMAL DISCOVERY.--
3337 (a) Upon receipt by a prospective defendant of a notice of
3338 claim, the parties shall make discoverable information available
3339 without formal discovery. Failure to do so is grounds for
3340 dismissal of claims or defenses ultimately asserted.
3341 (b)~~(7)~~ Informal discovery may be used by a party to obtain
3342 unsworn statements, the production of documents or things, ~~and~~
3343 physical and mental examinations, and answers to written
3344 questions, as follows:
3345 1.~~(a)~~ Unsworn statements.--Any party may require other
3346 parties to appear for the taking of an unsworn statement. Such
3347 statements may be used only for the purpose of presuit screening
3348 and are not discoverable or admissible in any civil action for
3349 any purpose by any party. A party desiring to take the unsworn
3350 statement of any party must give reasonable notice in writing to
3351 all parties. The notice must state the time and place for taking
3352 the statement and the name and address of the party to be
3353 examined. Unless otherwise impractical, the examination of any
3354 party must be done at the same time by all other parties. Any
3355 party may be represented by counsel at the taking of an unsworn
3356 statement. An unsworn statement may be recorded electronically,
3357 stenographically, or on videotape. The taking of unsworn

3358 statements is subject to the provisions of the Florida Rules of
3359 Civil Procedure and may be terminated for abuses.
3360 2. ~~(b)~~ Documents or things.--Any party may request
3361 discovery of documents or things. The documents or things must
3362 be produced, at the expense of the requesting party, within 20
3363 days after the date of receipt of the request. A party is
3364 required to produce discoverable documents or things within that
3365 party's possession or control. Medical records shall be produced
3366 as provided in s. 766.204.
3367 3. ~~(c)~~ Physical and mental examinations.--A prospective
3368 defendant may require an injured ~~prospective~~ claimant to appear
3369 for examination by an appropriate health care provider. The
3370 prospective defendant shall give reasonable notice in writing to
3371 all parties as to the time and place for examination. Unless
3372 otherwise impractical, a ~~prospective~~ claimant is required to
3373 submit to only one examination on behalf of all potential
3374 defendants. The practicality of a single examination must be
3375 determined by the nature of the potential claimant's condition,
3376 as it relates to the liability of each prospective ~~potential~~
3377 defendant. Such examination report is available to the parties
3378 and their attorneys upon payment of the reasonable cost of
3379 reproduction and may be used only for the purpose of presuit
3380 screening. Otherwise, such examination report is confidential
3381 and exempt from the provisions of s. 119.07(1) and s. 24(a),
3382 Art. I of the State Constitution.
3383 4. Written questions.--Any party may request answers to
3384 written questions, which may not exceed 30, including subparts.
3385 A response must be made within 20 days after receipt of the
3386 questions.
3387 5. Medical information release.--The claimant must execute

3388 a medical information release that allows a prospective
3389 defendant or his or her legal representative to take unsworn
3390 statements of the claimant's treating physicians. The statements
3391 must be limited to those areas that are potentially relevant to
3392 the claim of personal injury or wrongful death. Subject to the
3393 procedural requirements of subparagraph 1., a prospective
3394 defendant may take unsworn statements from a claimant's treating
3395 physicians. The claimant or the claimant's legal representative
3396 has the right to be present during the taking of such unsworn
3397 statements.
3398 (c)(8) Each request for and notice concerning informal
3399 presuit discovery pursuant to this section must be in writing,
3400 and a copy thereof must be sent to all parties. Such a request
3401 or notice must bear a certificate of service identifying the
3402 name and address of the person to whom the request or notice is
3403 served, the date of the request or notice, and the manner of
3404 service thereof.
3405 (d)(9) Copies of any documents produced in response to the
3406 request of any party must be served upon all other parties. The
3407 party serving the documents or his or her attorney shall
3408 identify, in a notice accompanying the documents, the name and
3409 address of the parties to whom the documents were served, the
3410 date of service, the manner of service, and the identity of the
3411 document served.
3412 (7) SANCTIONS.--Failure to cooperate on the part of any
3413 party during the presuit investigation may be grounds to strike
3414 any claim made, or defense raised, by such party in suit.
3415 (10) If a prospective defendant makes an offer to admit
3416 liability and for arbitration on the issue of damages, the
3417 claimant has 50 days from the date of receipt of the offer to

3418 ~~accept or reject it. The claimant shall respond in writing to~~
3419 ~~the insurer or self-insurer by certified mail, return receipt~~
3420 ~~requested. If the claimant rejects the offer, he or she may then~~
3421 ~~file suit. Acceptance of the offer of admission of liability and~~
3422 ~~for arbitration waives recourse to any other remedy by the~~
3423 ~~parties, and the claimant's written acceptance of the offer~~
3424 ~~shall so state.~~
3425 ~~(a) If rejected, the offer to admit liability and for~~
3426 ~~arbitration on damages is not admissible in any subsequent~~
3427 ~~litigation. Upon rejection of the offer to admit liability and~~
3428 ~~for arbitration, the claimant has 60 days or the remainder of~~
3429 ~~the period of the statute of limitations, whichever period is~~
3430 ~~greater, in which to file suit.~~
3431 ~~(b) If the offer to admit liability and for arbitration on~~
3432 ~~damages is accepted, the parties have 30 days from the date of~~
3433 ~~acceptance to settle the amount of damages. If the parties have~~
3434 ~~not reached agreement after 30 days, they shall proceed to~~
3435 ~~binding arbitration to determine the amount of damages as~~
3436 ~~follows:~~
3437 ~~1. Each party shall identify his or her arbitrator to the~~
3438 ~~opposing party not later than 35 days after the date of~~
3439 ~~acceptance.~~
3440 ~~2. The two arbitrators shall, within 1 week after they are~~
3441 ~~notified of their appointment, agree upon a third arbitrator. If~~
3442 ~~they cannot agree on a third arbitrator, selection of the third~~
3443 ~~arbitrator shall be in accordance with chapter 682.~~
3444 ~~3. Not later than 30 days after the selection of a third~~
3445 ~~arbitrator, the parties shall file written arguments with each~~
3446 ~~arbitrator and with each other indicating total damages.~~
3447 ~~4. Unless otherwise determined by the arbitration panel,~~

3448 ~~within 10 days after the receipt of such arguments, unless the~~
3449 ~~parties have agreed to a settlement, there shall be a 1-day~~
3450 ~~hearing, at which formal rules of evidence and the rules of~~
3451 ~~civil procedure shall not apply, during which each party shall~~
3452 ~~present evidence as to damages. Each party shall identify the~~
3453 ~~total dollar amount which he or she feels should be awarded.~~
3454 ~~5. No later than 2 weeks after the hearing, the~~
3455 ~~arbitrators shall notify the parties of their determination of~~
3456 ~~the total award. The court shall have jurisdiction to enforce~~
3457 ~~any award or agreement for periodic payment of future damages.~~
3458 ~~(11) If there is more than one prospective defendant, the~~
3459 ~~claimant shall provide the notice of claim and follow the~~
3460 ~~procedures in this section for each defendant. If an offer to~~
3461 ~~admit liability and for arbitration is accepted, the procedures~~
3462 ~~shall be initiated separately for each defendant, unless~~
3463 ~~multiple offers are made by more than one prospective defendant~~
3464 ~~and are accepted and the parties agree to consolidated~~
3465 ~~arbitration. Any agreement for consolidated arbitration shall be~~
3466 ~~filed with the court. No offer by any prospective defendant to~~
3467 ~~admit liability and for arbitration is admissible in any civil~~
3468 ~~action.~~
3469 ~~(12) To the extent not inconsistent with this part, the~~
3470 ~~provisions of chapter 682, the Florida Arbitration Code, shall~~
3471 ~~be applicable to such proceedings.~~
3472 Section 42. Section 766.108, Florida Statutes, is amended
3473 to read:
3474 766.108 Mandatory mediation and mandatory settlement
3475 conference in medical negligence ~~malpractice~~ actions.--
3476 (1) Within 120 days after the suit is filed, unless such
3477 period is extended by mutual agreement of all parties, all

3478 parties shall attend in-person mandatory mediation in accordance
3479 with s. 44.102 if binding arbitration under s. 766.207 has not
3480 been agreed to by the parties. The Florida Rules of Civil
3481 Procedure shall apply to mediation held pursuant to this
3482 section.
3483 (2)(a)~~(1)~~ In any action for damages based on personal
3484 injury or wrongful death arising out of medical negligence
3485 ~~malpractice~~, whether in tort or contract, the court shall
3486 require a settlement conference at least 3 weeks before the date
3487 set for trial.
3488 (b)~~(2)~~ Attorneys who will conduct the trial, parties, and
3489 persons with authority to settle shall attend the settlement
3490 conference held before the court unless excused by the court for
3491 good cause.
3492 Section 43. Section 766.118, Florida Statutes, is created
3493 to read:
3494 766.118 Determination of noneconomic damages.--
3495 (1) DEFINITIONS.--As used in this section:
3496 (a) "Catastrophic injury" means a permanent impairment
3497 constituted by:
3498 1. Spinal cord injury involving severe paralysis of an
3499 arm, a leg, or the trunk;
3500 2. Amputation of an arm, a hand, a foot, or a leg
3501 involving the effective loss of use of that appendage;
3502 3. Severe brain or closed-head injury as evidenced by:
3503 a. Severe sensory or motor disturbances;
3504 b. Severe communication disturbances;
3505 c. Severe complex integrated disturbances of cerebral
3506 function;
3507 d. Severe episodic neurological disorders; or

3508 e. Other severe brain and closed-head injury conditions at
3509 least as severe in nature as any condition provided in sub-
3510 subparagraphs a.-d.;
3511 4. Second-degree or third-degree burns to 25 percent or
3512 more of the total body surface or third-degree burns to 5
3513 percent or more of the face and hands;
3514 5. Blindness, defined as a complete and total loss of
3515 vision; or
3516 6. Loss of reproductive organs which results in an
3517 inability to procreate.
3518 (b) "Noneconomic damages" means noneconomic damages as
3519 defined in s. 766.202(8).
3520 (c) "Practitioner" means any person licensed under chapter
3521 458, chapter 459, chapter 460, chapter 461, chapter 462, chapter
3522 463, chapter 466, chapter 467, or chapter 486 or certified under
3523 s. 464.012. "Practitioner" also means any association,
3524 corporation, firm, partnership, or other business entity under
3525 which such practitioner practices or any employee of such
3526 practitioner or entity acting in the scope of his or her
3527 employment. For the purpose of determining the limitations on
3528 noneconomic damages set forth in this section, the term
3529 "practitioner" includes any person or entity for whom a
3530 practitioner is vicariously liable and any person or entity
3531 whose liability is based solely on such person being vicariously
3532 liable for the actions of a practitioner.
3533 (2) LIMITATION ON NONECONOMIC DAMAGES FOR NEGLIGENCE OF
3534 PRACTITIONERS.--
3535 (a) With respect to a cause of action for personal injury
3536 or wrongful death arising from medical negligence of
3537 practitioners, regardless of the number of such practitioner

3538 defendants, noneconomic damages shall not exceed $500,000 per
3539 claimant. No practitioner shall be liable for more than $500,000
3540 in noneconomic damages under this paragraph, regardless of the
3541 number of claimants.
3542 (b) Notwithstanding paragraph (a), if the negligence
3543 resulted in a permanent vegetative state or death, the total
3544 noneconomic damages recoverable by a claimant under this
3545 subsection, regardless of the number of such practitioner
3546 defendants, shall not exceed $1 million. If the negligence did
3547 not result in a permanent vegetative state or death, the patient
3548 injured by medical negligence of a practitioner may recover
3549 noneconomic damages not to exceed $1 million if:
3550 1. The trial court determines that a manifest injustice
3551 would occur unless increased noneconomic damages are awarded,
3552 based on a finding that because of the special circumstances of
3553 the case the noneconomic harm sustained by the injured patient
3554 was particularly severe; and
3555 2. The trier of fact determines that the defendant's
3556 negligence caused a catastrophic injury to the patient.
3557 (c) The total noneconomic damages recoverable by all
3558 claimants from all practitioner defendants under this subsection
3559 shall not exceed $1 million in the aggregate.
3560 (3) LIMITATION ON NONECONOMIC DAMAGES FOR NEGLIGENCE OF
3561 NONPRACTITIONERS.--
3562 (a) With respect to a cause of action for personal injury
3563 or wrongful death arising from medical negligence of
3564 nonpractitioner defendants, regardless of the number of such
3565 nonpractitioner defendants, noneconomic damages shall not exceed
3566 $750,000 per claimant.
3567 (b) Notwithstanding paragraph (a), if the negligence

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3568 resulted in a permanent vegetative state or death, the total
3569 noneconomic damages recoverable by a claimant under this
3570 subsection, regardless of the number of such nonpractitioner
3571 defendants, shall not exceed $1.5 million. If the negligence did
3572 not result in a permanent vegetative state or death, the patient
3573 injured by medical negligence of a nonpractitioner may recover
3574 noneconomic damages not to exceed $1.5 million if:
3575 1. The trial court determines that a manifest injustice
3576 would occur unless increased noneconomic damages are awarded,
3577 based on a finding that because of the special circumstances of
3578 the case the noneconomic harm sustained by the injured patient
3579 was particularly severe; and
3580 2. The trier of fact determines that the defendant's
3581 negligence caused a catastrophic injury to the patient.
3582 (c) Nonpractitioner defendants are subject to the cap on
3583 noneconomic damages provided in this subsection regardless of
3584 the theory of liability, including vicarious liability.
3585 (d) The total noneconomic damages recoverable by all
3586 claimants from all nonpractitioner defendants under this
3587 subsection shall not exceed $1.5 million in the aggregate.
3588 (4) LIMITATION ON NONECONOMIC DAMAGES FOR NEGLIGENCE OF
3589 PRACTITIONERS PROVIDING EMERGENCY SERVICES AND
3590 CARE.--Notwithstanding subsections (2) and (3), with respect to
3591 a cause of action for personal injury or wrongful death arising
3592 from medical negligence of practitioners providing emergency
3593 services and care, as defined in s. 395.002(10), or providing
3594 services as provided in s. 401.265, to persons with whom the
3595 practitioner does not have a then-existing health care
3596 practitioner-patient relationship for the medical condition for
3597 which such services and care are being provided:

3598 (a) Regardless of the number of such practitioner
3599 defendants, noneconomic damages shall not exceed $150,000 per
3600 claimant.
3601 (b) Notwithstanding paragraph (a), the total noneconomic
3602 damages recoverable by all claimants from all such practitioner
3603 defendants shall not exceed $300,000.
3604 (5) LIMITATION ON NONECONOMIC DAMAGES FOR NEGLIGENCE OF
3605 NONPRACTITIONERS PROVIDING EMERGENCY SERVICES AND
3606 CARE.--Notwithstanding subsections (2) and (3), with respect to
3607 a cause of action for personal injury or wrongful death arising
3608 from medical negligence of defendants other than practitioners
3609 providing emergency services and care pursuant to obligations
3610 imposed by ss. 395.1041 and 401.45 to persons with whom the
3611 treating practitioner does not have a then-existing health care
3612 practitioner-patient relationship for the medical condition for
3613 which such services and care are being provided:
3614 (a) Regardless of the number of such nonpractitioner
3615 defendants, noneconomic damages shall not exceed $750,000 per
3616 claimant.
3617 (b) Notwithstanding paragraph (a), the total noneconomic
3618 damages recoverable by all claimants from all such
3619 nonpractitioner defendants shall not exceed $1.5 million.
3620 (c) Nonpractitioner defendants may receive a full setoff
3621 for payments made by practitioner defendants.
3622 (6) SETOFF.--In any case in which the jury verdict for
3623 noneconomic damages exceeds the limits established by this
3624 section, the trial court shall reduce the award for noneconomic
3625 damages within the same category of defendants in accordance
3626 with this section after making any reduction for comparative
3627 fault as required by s. 768.81 but before application of a

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3628 setoff in accordance with ss. 46.015 and 768.041. In the event
3629 of a prior settlement or settlements involving one or more
3630 defendants subject to the limitations of the same subsection
3631 applicable to a defendant remaining at trial, the court shall
3632 make such reductions within the same category of defendants as
3633 are necessary to ensure that the total amount of noneconomic
3634 damages recovered by the claimant does not exceed the aggregate
3635 limit established by the applicable subsection. This subsection
3636 is not intended to change current law relating to the setoff of
3637 economic damages.
3638 (7) ACTIONS GOVERNED BY SOVEREIGN IMMUNITY LAW.--This
3639 section does not apply to actions governed by s. 768.28.
3640 Section 44. Section 766.1185, Florida Statutes, is created
3641 to read:
3642 766.1185 Bad faith actions involving claims relating to
3643 claims of medical negligence.--In all actions for bad faith
3644 against a medical malpractice insurer relating to professional
3645 liability insurance coverage for medical negligence, and in
3646 determining whether the insurer could and should have settled
3647 the claim within the policy limits had it acted fairly and
3648 honestly towards its insured with due regard for her or his
3649 interest, whether brought under statute or common law:
3650 (1)(a) An insurer shall not be held liable in bad faith
3651 for failure to pay its policy limits if it tenders its policy
3652 limits and meets other reasonable conditions of settlement by
3653 the earlier of either:
3654 1. The 210th day after service of the complaint in the
3655 medical negligence action upon the insured. The time period in
3656 this subparagraph shall be extended by an additional 60 days if
3657 the court in the bad faith action finds that, at any time during

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3658 such period and after the 150th day after service of the
3659 complaint, the claimant provided new information previously
3660 unavailable to the insurer relating to the identity or testimony
3661 of any material witnesses or the identity or any additional
3662 claimants or defendants, if such disclosure materially alters
3663 the risk to the insured of an excess judgment; or
3664 2. The 60th day after the conclusion of all of the
3665 following:
3666 a. Deposition of all claimants named in the complaint or
3667 amended complaint.
3668 b. Deposition of all defendants named in the complaint or
3669 amended complaint, including, in the case of a corporate
3670 defendant, deposition of a designated representative.
3671 c. Deposition of all of the claimant's expert witnesses.
3672 d. Disclosure of witnesses and production of documents.
3673 e. Mediation.
3674 (b) Either party may request that the court enter an order
3675 finding that the other party has unnecessarily or
3676 inappropriately delayed any of the events specified in
3677 subparagraph (a)2. If the court finds that the claimant was
3678 responsible for such unnecessary or inappropriate delays,
3679 subparagraph (a)1. shall not apply. If the court finds that the
3680 defendant was responsible for such unnecessary or inappropriate
3681 delays, subparagraph (a)2. shall not apply.
3682 (c) The fact that the insurer did not tender policy limits
3683 during the time periods specified in this subsection does not
3684 create any presumption with respect to the issue of whether the
3685 insurer acted in bad faith.
3686 (2) When subsection (1) does not apply, the court, in
3687 determining whether an insurer has acted in bad faith, shall

3688 consider:

3689 (a) The insurer's willingness to negotiate with the
3690 claimant in anticipation of settlement.

3691 (b) The propriety of the insurer's methods of
3692 investigating and evaluating the claim.

3693 (c) Whether the insurer informed the insured of the offer
3694 to settle within the limits of coverage, the right to retain
3695 personal counsel, and the risk of litigation.

3696 (d) Whether the insured denied liability or requested that
3697 the case be defended after the insurer fully advised the insured
3698 as to the facts and risks.

3699 (e) Whether the claimant imposed any condition, other than
3700 the tender of policy limits, on the settlement of the claim.

3701 (f) Whether the claimant provided relevant information to
3702 the insurer on a timely basis.

3703 (g) Whether and when other defendants in the case settled
3704 or were dismissed from the case.

3705 (h) Whether there were multiple claimants seeking, in the
3706 aggregate, compensation in excess of policy limits from the
3707 defendant or the defendant's insurer.

3708 (i) Whether the insured misrepresented material facts to
3709 the insurer or made material omissions of fact to the insurer.

3710

3711 Upon motion of either party, the court may allow consideration
3712 of such additional factors as it determines to be relevant.

3713 (3) Nothing in this section shall be construed to prohibit
3714 an insured from assigning a cause of action to a third-party
3715 claimant for the insurer's failure to act fairly and honestly
3716 towards its insured with due regard for the insured's interest.

3717 (4) An insurer that tenders policy limits shall be

3718 entitled to a release of its insured if the claimant accepts the
3719 tender.
3720 (5) The provisions of s. 624.155 shall be applicable in
3721 all cases brought pursuant to that section unless specifically
3722 controlled by this section.
3723 Section 45. Section 766.202, Florida Statutes, is amended
3724 to read:
3725 766.202 Definitions; ss. 766.201-766.212.--As used in ss.
3726 766.201-766.212, the term:
3727 (1) "Claimant" means any person who has a cause of action
3728 for damages based on personal injury or wrongful death arising
3729 from medical negligence.
3730 (2) "Collateral sources" means any payments made to the
3731 claimant, or made on his or her behalf, by or pursuant to:
3732 (a) The United States Social Security Act; any federal,
3733 state, or local income disability act; or any other public
3734 programs providing medical expenses, disability payments, or
3735 other similar benefits, except as prohibited by federal law.
3736 (b) Any health, sickness, or income disability insurance;
3737 automobile accident insurance that provides health benefits or
3738 income disability coverage; and any other similar insurance
3739 benefits, except life insurance benefits available to the
3740 claimant, whether purchased by him or her or provided by others.
3741 (c) Any contract or agreement of any group, organization,
3742 partnership, or corporation to provide, pay for, or reimburse
3743 the costs of hospital, medical, dental, or other health care
3744 services.
3745 (d) Any contractual or voluntary wage continuation plan
3746 provided by employers or by any other system intended to provide
3747 wages during a period of disability.

3748 (3) "Economic damages" means financial losses that ~~which~~
3749 would not have occurred but for the injury giving rise to the
3750 cause of action, including, but not limited to, past and future
3751 medical expenses and 80 percent of wage loss and loss of earning
3752 capacity, to the extent the claimant is entitled to recover such
3753 damages under general law, including the Wrongful Death Act.
3754 (4) "Health care provider" means any hospital, ambulatory
3755 surgical center, or mobile surgical facility as defined and
3756 licensed under chapter 395; any birth center licensed under
3757 chapter 383; any person licensed under chapter 458, chapter 459,
3758 chapter 460, chapter 461, chapter 462, chapter 463, part I of
3759 chapter 464, chapter 466, chapter 467, or chapter 486; any
3760 clinical lab licensed under chapter 483; a health maintenance
3761 organization certificated under part I of chapter 641; a blood
3762 bank; a plasma center; an industrial clinic; a renal dialysis
3763 facility; or a professional association partnership,
3764 corporation, joint venture, or other association for
3765 professional activity by health care providers.
3766 (5)~~(4)~~ "Investigation" means that an attorney has reviewed
3767 the case against each and every potential defendant and has
3768 consulted with a medical expert and has obtained a written
3769 opinion from said expert.
3770 (6)~~(5)~~ "Medical expert" means a person duly and regularly
3771 engaged in the practice of his or her profession who holds a
3772 health care professional degree from a university or college and
3773 who meets the requirements of an expert witness as set forth in
3774 s. 766.102 ~~has had special professional training and experience~~
3775 ~~or one possessed of special health care knowledge or skill about~~
3776 ~~the subject upon which he or she is called to testify or provide~~
3777 ~~an opinion~~.

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3778 (7)~~(6)~~ "Medical negligence" means medical malpractice,
3779 whether grounded in tort or in contract.
3780 (8)~~(7)~~ "Noneconomic damages" means nonfinancial losses
3781 that ~~which~~ would not have occurred but for the injury giving
3782 rise to the cause of action, including pain and suffering,
3783 inconvenience, physical impairment, mental anguish,
3784 disfigurement, loss of capacity for enjoyment of life, and other
3785 nonfinancial losses, to the extent the claimant is entitled to
3786 recover such damages under general law, including the Wrongful
3787 Death Act.
3788 (9)~~(8)~~ "Periodic payment" means provision for the
3789 structuring of future economic damages payments, in whole or in
3790 part, over a period of time, as follows:
3791 (a) A specific finding of the dollar amount of periodic
3792 payments which will compensate for these future damages after
3793 offset for collateral sources shall be made. The total dollar
3794 amount of the periodic payments shall equal the dollar amount of
3795 all such future damages before any reduction to present value.
3796 (b) The defendant shall be required to post a bond or
3797 security or otherwise to assure full payment of these damages
3798 awarded. A bond is not adequate unless it is written by a
3799 company authorized to do business in this state and is rated A+
3800 by Best's. If the defendant is unable to adequately assure full
3801 payment of the damages, all damages, reduced to present value,
3802 shall be paid to the claimant in a lump sum. No bond may be
3803 canceled or be subject to cancellation unless at least 60 days'
3804 advance written notice is filed with the court and the claimant.
3805 Upon termination of periodic payments, the security, or so much
3806 as remains, shall be returned to the defendant.
3807 (c) The provision for payment of future damages by

3808 periodic payments shall specify the recipient or recipients of
3809 the payments, the dollar amounts of the payments, the interval
3810 between payments, and the number of payments or the period of
3811 time over which payments shall be made.
3812 Section 46. Section 766.2021, Florida Statutes, is created
3813 to read:
3814 766.2021 Limitation on damages against insurers, prepaid
3815 limited health service organizations, health maintenance
3816 organizations, or prepaid health clinics.--An entity licensed or
3817 certificated under chapter 624, chapter 636, or chapter 641
3818 shall not be liable for the medical negligence of a health care
3819 provider with whom the licensed or certificated entity has
3820 entered into a contract in any amount greater than the amount of
3821 damages that may be imposed by law directly upon the health care
3822 provider, and any suits against such entity shall be subject to
3823 all provisions and requirements of evidence in this chapter and
3824 other requirements imposed by law in connection with suits
3825 against health care providers for medical negligence.
3826 Section 47. Section 766.203, Florida Statutes, is amended
3827 to read:
3828 766.203 Presuit investigation of medical negligence claims
3829 and defenses by prospective parties.--
3830 (1) APPLICATION OF PRESUIT INVESTIGATION.--Presuit
3831 investigation of medical negligence claims and defenses pursuant
3832 to this section and ss. 766.204-766.206 shall apply to all
3833 medical negligence~~, including dental negligence,~~ claims and
3834 defenses. This shall include:
3835 (a) Rights of action under s. 768.19 and defenses thereto.
3836 (b) Rights of action involving the state or its agencies
3837 or subdivisions, or the officers, employees, or agents thereof,

3838 pursuant to s. 768.28 and defenses thereto.

3839 (2) PRESUIT INVESTIGATION BY CLAIMANT.--Prior to issuing
3840 notification of intent to initiate medical negligence
3841 ~~malpractice~~ litigation pursuant to s. 766.106, the claimant
3842 shall conduct an investigation to ascertain that there are
3843 reasonable grounds to believe that:

3844 (a) Any named defendant in the litigation was negligent in
3845 the care or treatment of the claimant; and

3846 (b) Such negligence resulted in injury to the claimant.

3847

3848 Corroboration of reasonable grounds to initiate medical
3849 negligence litigation shall be provided by the claimant's
3850 submission of a verified written medical expert opinion from a
3851 medical expert as defined in s. 766.202(6) ~~(5)~~, at the time the
3852 notice of intent to initiate litigation is mailed, which
3853 statement shall corroborate reasonable grounds to support the
3854 claim of medical negligence.

3855 (3) PRESUIT INVESTIGATION BY PROSPECTIVE DEFENDANT.--Prior
3856 to issuing its response to the claimant's notice of intent to
3857 initiate litigation, during the time period for response
3858 authorized pursuant to s. 766.106, the prospective defendant or
3859 the defendant's insurer or self-insurer shall conduct an
3860 investigation as provided in s. 766.106(3) to ascertain whether
3861 there are reasonable grounds to believe that:

3862 (a) The defendant was negligent in the care or treatment
3863 of the claimant; and

3864 (b) Such negligence resulted in injury to the claimant.

3865

3866 Corroboration of lack of reasonable grounds for medical
3867 negligence litigation shall be provided with any response

3868 rejecting the claim by the defendant's submission of a verified
3869 written medical expert opinion from a medical expert as defined
3870 in s. 766.202(6)~~(5)~~, at the time the response rejecting the
3871 claim is mailed, which statement shall corroborate reasonable
3872 grounds for lack of negligent injury sufficient to support the
3873 response denying negligent injury.
3874 (4) PRESUIT MEDICAL EXPERT OPINION.--The medical expert
3875 opinions and statements required by this section are subject to
3876 discovery. The opinions shall specify whether any previous
3877 opinion by the same medical expert has been disqualified and if
3878 so the name of the court and the case number in which the ruling
3879 was issued.
3880 Section 48. Section 766.206, Florida Statutes, is amended
3881 to read:
3882 766.206 Presuit investigation of medical negligence claims
3883 and defenses by court.--
3884 (1) After the completion of presuit investigation by the
3885 parties pursuant to s. 766.203 and any informal discovery
3886 pursuant to s. 766.106, any party may file a motion in the
3887 circuit court requesting the court to determine whether the
3888 opposing party's claim or denial rests on a reasonable basis.
3889 (2) If the court finds that the notice of intent to
3890 initiate litigation mailed by the claimant is not in compliance
3891 with the reasonable investigation requirements of ss. 766.201-
3892 766.212, including a review of the claim and a verified written
3893 medical expert opinion by a medical expert as defined in s.
3894 766.202, the court shall dismiss the claim, and the person who
3895 mailed such notice of intent, whether the claimant or the
3896 claimant's attorney, shall be personally liable for all
3897 attorney's fees and costs incurred during the investigation and

3898 evaluation of the claim, including the reasonable attorney's
3899 fees and costs of the defendant or the defendant's insurer.
3900 (3) If the court finds that the response mailed by a
3901 defendant rejecting the claim is not in compliance with the
3902 reasonable investigation requirements of ss. 766.201-766.212,
3903 including a review of the claim and a verified written medical
3904 expert opinion by a medical expert as defined in s. 766.202, the
3905 court shall strike the defendant's pleading. ~~response, and~~ The
3906 person who mailed such response, whether the defendant, the
3907 defendant's insurer, or the defendant's attorney, shall be
3908 personally liable for all attorney's fees and costs incurred
3909 during the investigation and evaluation of the claim, including
3910 the reasonable attorney's fees and costs of the claimant.
3911 (4) If the court finds that an attorney for the claimant
3912 mailed notice of intent to initiate litigation without
3913 reasonable investigation, or filed a medical negligence claim
3914 without first mailing such notice of intent which complies with
3915 the reasonable investigation requirements, or if the court finds
3916 that an attorney for a defendant mailed a response rejecting the
3917 claim without reasonable investigation, the court shall submit
3918 its finding in the matter to The Florida Bar for disciplinary
3919 review of the attorney. Any attorney so reported three or more
3920 times within a 5-year period shall be reported to a circuit
3921 grievance committee acting under the jurisdiction of the Supreme
3922 Court. If such committee finds probable cause to believe that an
3923 attorney has violated this section, such committee shall forward
3924 to the Supreme Court a copy of its finding.
3925 (5)(a) If the court finds that the corroborating written
3926 medical expert opinion attached to any notice of claim or intent
3927 or to any response rejecting a claim lacked reasonable

3928 investigation, or that the medical expert submitting the opinion
3929 did not meet the expert witness qualifications as set forth in
3930 s. 766.202(5), the court shall report the medical expert issuing
3931 such corroborating opinion to the Division of Medical Quality
3932 Assurance or its designee. If such medical expert is not a
3933 resident of the state, the division shall forward such report to
3934 the disciplining authority of that medical expert.
3935 (b) The court shall ~~may~~ refuse to consider the testimony
3936 or opinion attached to any notice of intent or to any response
3937 rejecting a claim of ~~such~~ an expert who has been disqualified
3938 three times pursuant to this section.
3939 Section 49. Subsection (7) of section 766.207, Florida
3940 Statutes, is amended to read:
3941 766.207 Voluntary binding arbitration of medical
3942 negligence claims.--
3943 (7) Arbitration pursuant to this section shall preclude
3944 recourse to any other remedy by the claimant against any
3945 participating defendant~~,~~ and shall be undertaken with the
3946 understanding that damages shall be awarded as provided by
3947 general law, including the Wrongful Death Act, subject to the
3948 following limitations:
3949 (a) Net economic damages shall be awardable, including,
3950 but not limited to, past and future medical expenses and 80
3951 percent of wage loss and loss of earning capacity, offset by any
3952 collateral source payments.
3953 (b) Noneconomic damages shall be limited to a maximum of
3954 $250,000 per incident, and shall be calculated on a percentage
3955 basis with respect to capacity to enjoy life, so that a finding
3956 that the claimant's injuries resulted in a 50-percent reduction
3957 in his or her capacity to enjoy life would warrant an award of

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3958 not more than $125,000 noneconomic damages.

3959 (c) Damages for future economic losses shall be awarded to
3960 be paid by periodic payments pursuant to s. 766.202(9) ~~(8)~~ and
3961 shall be offset by future collateral source payments.

3962 (d) Punitive damages shall not be awarded.

3963 (e) The defendant shall be responsible for the payment of
3964 interest on all accrued damages with respect to which interest
3965 would be awarded at trial.

3966 (f) The defendant shall pay the claimant's reasonable
3967 attorney's fees and costs, as determined by the arbitration
3968 panel, but in no event more than 15 percent of the award,
3969 reduced to present value.

3970 (g) The defendant shall pay all the costs of the
3971 arbitration proceeding and the fees of all the arbitrators other
3972 than the administrative law judge.

3973 (h) Each defendant who submits to arbitration under this
3974 section shall be jointly and severally liable for all damages
3975 assessed pursuant to this section.

3976 (i) The defendant's obligation to pay the claimant's
3977 damages shall be for the purpose of arbitration under this
3978 section only. A defendant's or claimant's offer to arbitrate
3979 shall not be used in evidence or in argument during any
3980 subsequent litigation of the claim following the rejection
3981 thereof.

3982 (j) The fact of making or accepting an offer to arbitrate
3983 shall not be admissible as evidence of liability in any
3984 collateral or subsequent proceeding on the claim.

3985 (k) Any offer by a claimant to arbitrate must be made to
3986 each defendant against whom the claimant has made a claim. Any
3987 offer by a defendant to arbitrate must be made to each claimant

3988 who has joined in the notice of intent to initiate litigation,
3989 as provided in s. 766.106. A defendant who rejects a claimant's
3990 offer to arbitrate shall be subject to the provisions of s.
3991 766.209(3). A claimant who rejects a defendant's offer to
3992 arbitrate shall be subject to the provisions of s. 766.209(4).
3993 (l) The hearing shall be conducted by all of the
3994 arbitrators, but a majority may determine any question of fact
3995 and render a final decision. The chief arbitrator shall decide
3996 all evidentiary matters.
3997
3998 The provisions of this subsection shall not preclude settlement
3999 at any time by mutual agreement of the parties.
4000 Section 50. Paragraph (a) of subsection (3) and paragraph
4001 (c) of subsection (4) of section 766.209, Florida Statutes, are
4002 amended to read:
4003 766.209 Effects of failure to offer or accept voluntary
4004 binding arbitration.--
4005 (3) If the defendant refuses a claimant's offer of
4006 voluntary binding arbitration:
4007 (a) The claim shall proceed to trial ~~without limitation on~~
4008 ~~damages~~, and the claimant, upon proving medical negligence,
4009 shall be entitled to recover <u>damages subject to the limitations</u>
4010 <u>in s. 766.118,</u> prejudgment interest, and reasonable attorney's
4011 fees up to 25 percent of the award reduced to present value.
4012 (4) If the claimant rejects a defendant's offer to enter
4013 voluntary binding arbitration:
4014 (c) Damages for future economic losses shall be awarded to
4015 be paid by periodic payments pursuant to s. 766.202<u>(9)</u>~~(8)~~, and
4016 shall be offset by future collateral source payments.
4017 Section 51. Section 766.304, Florida Statutes, is amended

4018 to read:
4019 766.304 Administrative law judge to determine claims.--The
4020 administrative law judge shall hear and determine all claims
4021 filed pursuant to ss. 766.301-766.316 and shall exercise the
4022 full power and authority granted to her or him in chapter 120,
4023 as necessary, to carry out the purposes of such sections. The
4024 administrative law judge has exclusive jurisdiction to determine
4025 whether a claim filed under this act is compensable. No civil
4026 action may be brought until the determinations under s. 766.309
4027 have been made by the administrative law judge. If the
4028 administrative law judge determines that the claimant is
4029 entitled to compensation from the association, or if the
4030 claimant accepts an award issued pursuant to s. 766.31, no civil
4031 action may be brought or continued in violation of the
4032 exclusiveness of remedy provisions of s. 766.303. If it is
4033 determined that a claim filed under this act is not compensable,
4034 neither the doctrine of collateral estoppel nor res judicata
4035 shall prohibit the claimant from pursuing any and all civil
4036 remedies available under common law and statutory law. The
4037 findings of fact and conclusions of law of the administrative
4038 law judge shall not be admissible in any subsequent proceeding;
4039 however, the sworn testimony of any person and the exhibits
4040 introduced into evidence in the administrative case are
4041 admissible as impeachment in any subsequent civil action only
4042 against a party to the administrative proceeding, subject to the
4043 Rules of Evidence. An award ~~action~~ may not be awarded or paid
4044 ~~brought~~ under ss. 766.301-766.316 if the claimant recovers under
4045 a settlement or a final judgment is entered in a civil action.
4046 The division may adopt rules to promote the efficient
4047 administration of, and to minimize the cost associated with, the

4048 prosecution of claims.
4049 Section 52. Section 766.305, Florida Statutes, is amended
4050 to read:
4051 766.305 Filing of claims and responses; medical
4052 disciplinary review.--
4053 (1) All claims filed for compensation under the plan shall
4054 commence by the claimant filing with the division a petition
4055 seeking compensation. Such petition shall include the following
4056 information:
4057 (a) The name and address of the legal representative and
4058 the basis for her or his representation of the injured infant.
4059 (b) The name and address of the injured infant.
4060 (c) The name and address of any physician providing
4061 obstetrical services who was present at the birth and the name
4062 and address of the hospital at which the birth occurred.
4063 (d) A description of the disability for which the claim is
4064 made.
4065 (e) The time and place the injury occurred.
4066 (f) A brief statement of the facts and circumstances
4067 surrounding the injury and giving rise to the claim.
4068 ~~(g) All available relevant medical records relating to the~~
4069 ~~birth-related neurological injury, and an identification of any~~
4070 ~~unavailable records known to the claimant and the reasons for~~
4071 ~~their unavailability.~~
4072 ~~(h) Appropriate assessments, evaluations, and prognoses,~~
4073 ~~and such other records and documents as are reasonably necessary~~
4074 ~~for the determination of the amount of compensation to be paid~~
4075 ~~to, or on behalf of, the injured infant on account of the birth-~~
4076 ~~related neurological injury.~~
4077 ~~(i) Documentation of expenses and services incurred to~~

4078 ~~date, which indicates any payment made for such expenses and~~
4079 ~~services, and by whom.~~
4080 ~~(j) Documentation of any applicable private or~~
4081 ~~governmental source of services or reimbursement relative to the~~
4082 ~~impairments.~~
4083 (2) The claimant shall furnish the division with as many
4084 copies of the petition as required for service upon the
4085 association, any physician and hospital named in the petition,
4086 and the Division of Medical Quality Assurance, along with a $15
4087 filing fee payable to the Division of Administrative Hearings.
4088 Upon receipt of the petition, the division shall immediately
4089 serve the association, by service upon the agent designated to
4090 accept service on behalf of the association, by registered or
4091 certified mail, and shall mail copies of the petition<u>, by</u>
4092 <u>registered or certified mail,</u> to any physician<u>, health care</u>
4093 <u>provider,</u> and hospital named in the petition, <u>and furnish a copy</u>
4094 <u>by regular mail to</u> the Division of Medical Quality Assurance~~,~~
4095 and the Agency for Health Care Administration.
4096 <u>(3) The claimant shall furnish to the Florida Birth-Related</u>
4097 <u>Neurological Injury Compensation Association one copy of the</u>
4098 <u>following information, which shall be filed with the association</u>
4099 <u>within 10 days after the filing of the petition as set forth in</u>
4100 <u>subsection (1):</u>
4101 <u>(a) All available relevant medical records relating to the</u>
4102 <u>birth-related neurological injury and an identification of any</u>
4103 <u>unavailable records known to the claimant and the reasons for</u>
4104 <u>their unavailability.</u>
4105 <u>(b) Appropriate assessments, evaluations, and prognoses and</u>
4106 <u>such other records and documents as are reasonably necessary for</u>
4107 <u>the determination of the amount of compensation to be paid to, or</u>

4108 on behalf of, the injured infant on account of the birth-related
4109 neurological injury.
4110 (c) Documentation of expenses and services incurred to
4111 date, which indicates any payment made for such expenses and
4112 services and by whom.
4113 (d) Documentation of any applicable private or governmental
4114 source of services or reimbursement relative to the impairments.
4115
4116 The information contained in paragraphs (a)-(d) is confidential
4117 and exempt pursuant to the provisions of s. 766.315(5)(b).
4118 (4)(3) The association shall have 45 days from the date of
4119 service of a complete claim, filed pursuant to subsections (1)
4120 and (2), in which to file a response to the petition and to
4121 submit relevant written information relating to the issue of
4122 whether the injury alleged is a birth-related neurological
4123 injury.
4124 (5)(4) Upon receipt of such petition, the Division of
4125 Medical Quality Assurance shall review the information therein
4126 and determine whether it involved conduct by a physician
4127 licensed under chapter 458 or an osteopathic physician licensed
4128 under chapter 459 that is subject to disciplinary action, in
4129 which case the provisions of s. 456.073 shall apply.
4130 (6)(5) Upon receipt of such petition, the Agency for
4131 Health Care Administration shall investigate the claim, and if
4132 it determines that the injury resulted from, or was aggravated
4133 by, a breach of duty on the part of a hospital in violation of
4134 chapter 395, it shall take any such action consistent with its
4135 disciplinary authority as may be appropriate.
4136 (7)(6) Any claim which the association determines to be
4137 compensable may be accepted for compensation, provided that the

4138 acceptance is approved by the administrative law judge to whom
4139 the claim for compensation is assigned.
4140 Section 53. Subsection (4) is added to section 766.309,
4141 Florida Statutes, to read:
4142 766.309 Determination of claims; presumption; findings of
4143 administrative law judge binding on participants.--
4144 (4) If it is in the interest of judicial economy or if
4145 requested by the claimant, the administrative law judge may
4146 bifurcate the proceeding, first addressing compensability and
4147 notice pursuant to s. 766.316 and then addressing an award
4148 pursuant to s. 766.31, if any, in a separate proceeding. The
4149 administrative law judge may issue a final order on
4150 compensability and notice which is subject to appeal under s.
4151 766.311 prior to issuance of an award pursuant to s. 766.31.
4152 Section 54. Subsection (1) of section 766.31, Florida
4153 Statutes, is amended to read:
4154 766.31 Administrative law judge awards for birth-related
4155 neurological injuries; notice of award.--
4156 (1) Upon determining that an infant has sustained a birth-
4157 related neurological injury and that obstetrical services were
4158 delivered by a participating physician at the birth, the
4159 administrative law judge shall make an award providing
4160 compensation for the following items relative to such injury:
4161 (a) Actual expenses for medically necessary and reasonable
4162 medical and hospital, habilitative and training, family
4163 residential or custodial care, professional residential, and
4164 custodial care and service, for medically necessary drugs,
4165 special equipment, and facilities, and for related travel.
4166 However, such expenses shall not include:
4167 1. Expenses for items or services that the infant has

4168 received, or is entitled to receive, under the laws of any state
4169 or the Federal Government, except to the extent such exclusion
4170 may be prohibited by federal law.
4171 2. Expenses for items or services that the infant has
4172 received, or is contractually entitled to receive, from any
4173 prepaid health plan, health maintenance organization, or other
4174 private insuring entity.
4175 3. Expenses for which the infant has received
4176 reimbursement, or for which the infant is entitled to receive
4177 reimbursement, under the laws of any state or the Federal
4178 Government, except to the extent such exclusion may be
4179 prohibited by federal law.
4180 4. Expenses for which the infant has received
4181 reimbursement, or for which the infant is contractually entitled
4182 to receive reimbursement, pursuant to the provisions of any
4183 health or sickness insurance policy or other private insurance
4184 program.
4185
4186 Expenses included under this paragraph shall be limited to
4187 reasonable charges prevailing in the same community for similar
4188 treatment of injured persons when such treatment is paid for by
4189 the injured person.
4190 (b)1. Periodic payments of an award to the parents or
4191 legal guardians of the infant found to have sustained a birth-
4192 related neurological injury, which award shall not exceed
4193 $100,000. However, at the discretion of the administrative law
4194 judge, such award may be made in a lump sum.
4195 2. A death benefit for the infant in an amount of $10,000
4196 ~~Payment for funeral expenses not to exceed $1,500~~.
4197 (c) Reasonable expenses incurred in connection with the

4198 filing of a claim under ss. 766.301-766.316, including
4199 reasonable attorney's fees, which shall be subject to the
4200 approval and award of the administrative law judge. In
4201 determining an award for attorney's fees, the administrative law
4202 judge shall consider the following factors:
4203 1. The time and labor required, the novelty and difficulty
4204 of the questions involved, and the skill requisite to perform
4205 the legal services properly.
4206 2. The fee customarily charged in the locality for similar
4207 legal services.
4208 3. The time limitations imposed by the claimant or the
4209 circumstances.
4210 4. The nature and length of the professional relationship
4211 with the claimant.
4212 5. The experience, reputation, and ability of the lawyer
4213 or lawyers performing services.
4214 6. The contingency or certainty of a fee.
4215
4216 Should there be a final determination of compensability and the
4217 claimants accept the award under this section, the claimants
4218 shall not be liable for any expenses, including attorney's fees,
4219 incurred in connection with the filing of a claim under ss.
4220 766.301-766.316 other than those awarded under this section.
4221 Section 55. Subsection (4) of section 766.314, Florida
4222 Statutes, as amended by section 4 of chapter 2003-258, Laws of
4223 Florida, and paragraph (a) of subsection (5) of said section, as
4224 amended by section 1901 of chapter 2003-261, Laws of Florida,
4225 are amended to read:
4226 766.314 Assessments; plan of operation.--
4227 (4) The following persons and entities shall pay into the

4228 association an initial assessment in accordance with the plan of
4229 operation:
4230 (a) On or before October 1, 1988, each hospital licensed
4231 under chapter 395 shall pay an initial assessment of $50 per
4232 infant delivered in the hospital during the prior calendar year,
4233 as reported to the Agency for Health Care Administration;
4234 provided, however, that a hospital owned or operated by the
4235 state or a county, special taxing district, or other political
4236 subdivision of the state shall not be required to pay the
4237 initial assessment or any assessment required by subsection (5).
4238 The term "infant delivered" includes live births and not
4239 stillbirths, but the term does not include infants delivered by
4240 employees or agents of the board of trustees of a state
4241 university ~~Regents~~, those born in a teaching hospital as defined
4242 in s. 408.07, or those born in a teaching hospital as defined in
4243 s. 395.806 that have been deemed by the association as being
4244 exempt from assessments since fiscal year 1997 to fiscal year
4245 2001. The initial assessment and any assessment imposed pursuant
4246 to subsection (5) may not include any infant born to a charity
4247 patient (as defined by rule of the Agency for Health Care
4248 Administration) or born to a patient for whom the hospital
4249 receives Medicaid reimbursement, if the sum of the annual
4250 charges for charity patients plus the annual Medicaid
4251 contractuals of the hospital exceeds 10 percent of the total
4252 annual gross operating revenues of the hospital. The hospital is
4253 responsible for documenting, to the satisfaction of the
4254 association, the exclusion of any birth from the computation of
4255 the assessment. Upon demonstration of financial need by a
4256 hospital, the association may provide for installment payments
4257 of assessments.

4258 (b)1. On or before October 15, 1988, all physicians
4259 licensed pursuant to chapter 458 or chapter 459 as of October 1,
4260 1988, other than participating physicians, shall be assessed an
4261 initial assessment of $250, which must be paid no later than
4262 December 1, 1988.
4263 2. Any such physician who becomes licensed after September
4264 30, 1988, and before January 1, 1989, shall pay into the
4265 association an initial assessment of $250 upon licensure.
4266 3. Any such physician who becomes licensed on or after
4267 January 1, 1989, shall pay an initial assessment equal to the
4268 most recent assessment made pursuant to this paragraph,
4269 paragraph (5)(a), or paragraph (7)(b).
4270 4. However, if the physician is a physician specified in
4271 this subparagraph, the assessment is not applicable:
4272 a. A resident physician, assistant resident physician, or
4273 intern in an approved postgraduate training program, as defined
4274 by the Board of Medicine or the Board of Osteopathic Medicine by
4275 rule;
4276 b. A retired physician who has withdrawn from the practice
4277 of medicine but who maintains an active license as evidenced by
4278 an affidavit filed with the Department of Health. Prior to
4279 reentering the practice of medicine in this state, a retired
4280 physician as herein defined must notify the Board of Medicine or
4281 the Board of Osteopathic Medicine and pay the appropriate
4282 assessments pursuant to this section;
4283 c. A physician who holds a limited license pursuant to s.
4284 458.317 and who is not being compensated for medical services;
4285 d. A physician who is employed full time by the United
4286 States Department of Veterans Affairs and whose practice is
4287 confined to United States Department of Veterans Affairs

4288 hospitals; or

4289 e. A physician who is a member of the Armed Forces of the
4290 United States and who meets the requirements of s. 456.024.

4291 f. A physician who is employed full time by the State of
4292 Florida and whose practice is confined to state-owned
4293 correctional institutions, a county health department, or state-
4294 owned mental health or developmental services facilities, or who
4295 is employed full time by the Department of Health.

4296 (c) On or before December 1, 1988, each physician licensed
4297 pursuant to chapter 458 or chapter 459 who wishes to participate
4298 in the Florida Birth-Related Neurological Injury Compensation
4299 Plan and who otherwise qualifies as a participating physician
4300 under ss. 766.301-766.316 shall pay an initial assessment of
4301 $5,000. However, if the physician is either a resident
4302 physician, assistant resident physician, or intern in an
4303 approved postgraduate training program, as defined by the Board
4304 of Medicine or the Board of Osteopathic Medicine by rule, and is
4305 supervised in accordance with program requirements established
4306 by the Accreditation Council for Graduate Medical Education or
4307 the American Osteopathic Association by a physician who is
4308 participating in the plan, such resident physician, assistant
4309 resident physician, or intern is deemed to be a participating
4310 physician without the payment of the assessment. Participating
4311 physicians also include any employee of the board of trustees of
4312 a state university ~~Regents~~ who has paid the assessment required
4313 by this paragraph and paragraph (5)(a), and any certified nurse
4314 midwife supervised by such employee. Participating physicians
4315 include any certified nurse midwife who has paid 50 percent of
4316 the physician assessment required by this paragraph and
4317 paragraph (5)(a) and who is supervised by a participating

4318 physician who has paid the assessment required by this paragraph
4319 and paragraph (5)(a). Supervision for nurse midwives shall
4320 require that the supervising physician will be easily available
4321 and have a prearranged plan of treatment for specified patient
4322 problems which the supervised certified nurse midwife may carry
4323 out in the absence of any complicating features. Any physician
4324 who elects to participate in such plan on or after January 1,
4325 1989, who was not a participating physician at the time of such
4326 election to participate and who otherwise qualifies as a
4327 participating physician under ss. 766.301-766.316 shall pay an
4328 additional initial assessment equal to the most recent
4329 assessment made pursuant to this paragraph, paragraph (5)(a), or
4330 paragraph (7)(b).

4331 (d) Any hospital located in any county with a gross
4332 population in excess of 1.1 million as of January 1, 2003, as
4333 determined by the Agency for Health Care Administration, pursuant
4334 to the Health Care Responsibility Act, may elect to pay the
4335 assessment for the participating physician and the certified
4336 nurse midwife if the hospital first determines that the primary
4337 motivating purpose for making such payment is to ensure coverage
4338 for the hospital's patients under the provisions of ss. 766.301-
4339 766.316, provided no hospital may restrict any participating
4340 physician or certified nurse midwife, directly or indirectly,
4341 from being on the staff of hospitals other than the staff of the
4342 hospital making such payment. Each hospital shall file with the
4343 association an affidavit setting forth specifically the reasons
4344 why such hospital elected to make such payment on behalf of each
4345 participating physician and certified nurse midwife. The payments
4346 authorized pursuant to this paragraph shall be in addition to the
4347 assessment set forth in paragraph (5)(a).

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4348 (5)(a) Beginning January 1, 1990, the persons and entities
4349 listed in paragraphs (4)(b) and (c), except those persons or
4350 entities who are specifically excluded from said provisions, as
4351 of the date determined in accordance with the plan of operation,
4352 taking into account persons licensed subsequent to the payment
4353 of the initial assessment, shall pay an annual assessment in the
4354 amount equal to the initial assessments provided in paragraphs
4355 (4)(b) and (c). If the payment of such annual assessment by a
4356 participating physician is received by the association by
4357 January 31 of any calendar year, the participating physician
4358 shall qualify as a participating physician for that entire
4359 calendar year. If the payment is received after January 31 of
4360 any calendar year, the participating physician shall only
4361 qualify as a participating physician for that calendar year from
4362 the date the payment was received by the association. On January
4363 1, 1991, and on each January 1 thereafter, the association shall
4364 determine the amount of additional assessments necessary
4365 pursuant to subsection (7), in the manner required by the plan
4366 of operation, subject to any increase determined to be necessary
4367 by the Office of Insurance Regulation pursuant to paragraph
4368 (7)(b). On July 1, 1991, and on each July 1 thereafter, the
4369 persons and entities listed in paragraphs (4)(b) and (c), except
4370 those persons or entities who are specifically excluded from
4371 said provisions, shall pay the additional assessments which were
4372 determined on January 1. Beginning January 1, 1990, the entities
4373 listed in paragraph (4)(a), including those licensed on or after
4374 October 1, 1988, shall pay an annual assessment of $50 per
4375 infant delivered during the prior calendar year. The additional
4376 assessments which were determined on January 1, 1991, pursuant
4377 to the provisions of subsection (7) shall not be due and payable

4378 by the entities listed in paragraph (4)(a) until July 1.
4379 Section 56. Section 768.0981, Florida Statutes, is created
4380 to read:
4381 768.0981 Limitation on actions against insurers, prepaid
4382 limited health service organizations, health maintenance
4383 organizations, or prepaid health clinics.--An entity licensed or
4384 certificated under chapter 624, chapter 636, or chapter 641
4385 shall not be liable for the medical negligence of a health care
4386 provider with whom the licensed or certificated entity has
4387 entered into a contract, other than an employee of such licensed
4388 or certificated entity, unless the licensed or certificated
4389 entity expressly directs or exercises actual control over the
4390 specific conduct that caused injury.
4391 Section 57. Subsection (2) of section 768.13, Florida
4392 Statutes, is amended to read:
4393 768.13 Good Samaritan Act; immunity from civil
4394 liability.--
4395 (2)(a) Any person, including those licensed to practice
4396 medicine, who gratuitously and in good faith renders emergency
4397 care or treatment either in direct response to emergency
4398 situations related to and arising out of a public health
4399 emergency declared pursuant to s. 381.00315, a state of
4400 emergency which has been declared pursuant to s. 252.36 or at
4401 the scene of an emergency outside of a hospital, doctor's
4402 office, or other place having proper medical equipment, without
4403 objection of the injured victim or victims thereof, shall not be
4404 held liable for any civil damages as a result of such care or
4405 treatment or as a result of any act or failure to act in
4406 providing or arranging further medical treatment where the
4407 person acts as an ordinary reasonably prudent person would have

4408 acted under the same or similar circumstances.
4409 (b)1. Any health care provider, including a hospital
4410 licensed under chapter 395, providing emergency services
4411 pursuant to obligations imposed by 42 U.S.C. s. 1395dd, s.
4412 395.401, s. 395.1041, or s. 401.45 ~~any employee of such hospital~~
4413 ~~working in a clinical area within the facility and providing~~
4414 ~~patient care, and any person licensed to practice medicine who~~
4415 ~~in good faith renders medical care or treatment necessitated by~~
4416 ~~a sudden, unexpected situation or occurrence resulting in a~~
4417 ~~serious medical condition demanding immediate medical attention,~~
4418 ~~for which the patient enters the hospital through its emergency~~
4419 ~~room or trauma center, or necessitated by a public health~~
4420 ~~emergency declared pursuant to s. 381.00315~~ shall not be held
4421 liable for any civil damages as a result of such medical care or
4422 treatment unless such damages result from providing, or failing
4423 to provide, medical care or treatment under circumstances
4424 demonstrating a reckless disregard for the consequences so as to
4425 affect the life or health of another.
4426 2. The immunity provided by this paragraph applies ~~does~~
4427 ~~not apply~~ to damages as a result of any act or omission of
4428 providing medical care or treatment, including diagnosis:
4429 a. Which occurs prior to the time ~~after~~ the patient is
4430 stabilized and is capable of receiving medical treatment as a
4431 nonemergency patient, unless surgery is required as a result of
4432 the emergency within a reasonable time after the patient is
4433 stabilized, in which case the immunity provided by this
4434 paragraph applies to any act or omission of providing medical
4435 care or treatment which occurs prior to the stabilization of the
4436 patient following the surgery.~~; or~~
4437 b. Which is related ~~Unrelated~~ to the original medical

4438 emergency.
4439 3. For purposes of this paragraph, "reckless disregard" as
4440 it applies to a given health care provider rendering emergency
4441 medical services shall be such conduct that ~~which~~ a health care
4442 provider knew or should have known, at the time such services
4443 were rendered, created an unreasonable risk of injury so as to
4444 affect the life or health of another, and such risk was
4445 substantially greater than that which is necessary to make the
4446 conduct negligent. ~~would be likely to result in injury so as to~~
4447 ~~affect the life or health of another, taking into account the~~
4448 ~~following to the extent they may be present:~~
4449 ~~a. The extent or serious nature of the circumstances~~
4450 ~~prevailing.~~
4451 ~~b. The lack of time or ability to obtain appropriate~~
4452 ~~consultation.~~
4453 ~~c. The lack of a prior patient-physician relationship.~~
4454 ~~d. The inability to obtain an appropriate medical history~~
4455 ~~of the patient.~~
4456 ~~e. The time constraints imposed by coexisting emergencies.~~
4457 4. Every emergency care facility granted immunity under
4458 this paragraph shall accept and treat all emergency care
4459 patients within the operational capacity of such facility
4460 without regard to ability to pay, including patients transferred
4461 from another emergency care facility or other health care
4462 provider pursuant to Pub. L. No. 99-272, s. 9121. The failure of
4463 an emergency care facility to comply with this subparagraph
4464 constitutes grounds for the department to initiate disciplinary
4465 action against the facility pursuant to chapter 395.
4466 (c)1. Any health care practitioner as defined in s.
4467 456.001(4) who is in a hospital attending to a patient of his or

4468 her practice or for business or personal reasons unrelated to
4469 direct patient care, and who voluntarily responds to provide
4470 care or treatment to a patient with whom at that time the
4471 practitioner does not have a then-existing health care patient-
4472 practitioner relationship, and when such care or treatment is
4473 necessitated by a sudden or unexpected situation or by an
4474 occurrence that demands immediate medical attention, shall not
4475 be held liable for any civil damages as a result of any act or
4476 omission relative to that care or treatment, unless that care or
4477 treatment is proven to amount to conduct that is willful and
4478 wanton and would likely result in injury so as to affect the
4479 life or health of another.
4480 2. The immunity provided by this paragraph does not apply
4481 to damages as a result of any act or omission of providing
4482 medical care or treatment unrelated to the original situation
4483 that demanded immediate medical attention.
4484 3. For purposes of this paragraph, the Legislature's
4485 intent is to encourage health care practitioners to provide
4486 necessary emergency care to all persons without fear of
4487 litigation as described in this paragraph.
4488 ~~(c) Any person who is licensed to practice medicine, while~~
4489 ~~acting as a staff member or with professional clinical~~
4490 ~~privileges at a nonprofit medical facility, other than a~~
4491 ~~hospital licensed under chapter 395, or while performing health~~
4492 ~~screening services, shall not be held liable for any civil~~
4493 ~~damages as a result of care or treatment provided gratuitously~~
4494 ~~in such capacity as a result of any act or failure to act in~~
4495 ~~such capacity in providing or arranging further medical~~
4496 ~~treatment, if such person acts as a reasonably prudent person~~
4497 ~~licensed to practice medicine would have acted under the same or~~

4498 ~~similar circumstances.~~

4499 Section 58. Present subsections (12) through (19) of
4500 section 768.28, Florida Statutes, as amended by section 9 of
4501 chapter 2003-159, Laws of Florida, section 1903 of chapter 2003-
4502 261, Laws of Florida, and section 1 of chapter 2003-290, Laws of
4503 Florida, are renumbered as subsections (13) through (20),
4504 respectively, and a new subsection (12) is added to said section
4505 to read:

4506 768.28 Waiver of sovereign immunity in tort actions;
4507 recovery limits; limitation on attorney fees; statute of
4508 limitations; exclusions; indemnification; risk management
4509 programs.--

4510 (12)(a) A health care practitioner, as defined in s.
4511 456.001(4), who has contractually agreed to act as an agent of a
4512 state university board of trustees to provide medical services
4513 to a student athlete for participation in or as a result of
4514 intercollegiate athletics, to include team practices, training,
4515 and competitions, shall be considered an agent of the respective
4516 state university board of trustees for the purposes of this
4517 section while acting within the scope of and pursuant to
4518 guidelines established in that contract. The contract shall
4519 provide for the indemnification of the state by the agent for
4520 any liabilities incurred up to the limits set forth in this
4521 chapter.

4522 (b) This subsection shall not be construed as designating
4523 persons providing contracted health care services to athletes as
4524 employees or agents of a state university board of trustees for
4525 the purposes of chapter 440.

4526 Section 59. Section 768.77, Florida Statutes, is amended
4527 to read:

4528 768.77 Itemized verdict.--

4529 (1) Except as provided in subsection (2), in any action to
4530 which this part applies in which the trier of fact determines
4531 that liability exists on the part of the defendant, the trier of
4532 fact shall, as a part of the verdict, itemize the amounts to be
4533 awarded to the claimant into the following categories of
4534 damages:

4535 (a)~~(1)~~ Amounts intended to compensate the claimant for
4536 economic losses;

4537 (b)~~(2)~~ Amounts intended to compensate the claimant for
4538 noneconomic losses; and

4539 (c)~~(3)~~ Amounts awarded to the claimant for punitive
4540 damages, if applicable.

4541 (2) In any action for damages based on personal injury or
4542 wrongful death arising out of medical negligence, whether in
4543 tort or contract, to which this part applies in which the trier
4544 of fact determines that liability exists on the part of the
4545 defendant, the trier of fact shall, as a part of the verdict,
4546 itemize the amounts to be awarded to the claimant into the
4547 following categories of damages:

4548 (a) Amounts intended to compensate the claimant for:

4549 1. Past economic losses; and

4550 2. Future economic losses, not reduced to present value,
4551 and the number of years or part thereof which the award is
4552 intended to cover;

4553 (b) Amounts intended to compensate the claimant for:

4554 1. Past noneconomic losses; and

4555 2. Future noneconomic losses and the number of years or
4556 part thereof which the award is intended to cover; and

4557 (c) Amounts awarded to the claimant for punitive damages,

4558 if applicable.
4559 Section 60. Section 1004.08, Florida Statutes, is created
4560 to read:
4561 1004.08 Patient safety instructional requirements.--Every
4562 public school, college, and university that offers degrees in
4563 medicine, nursing, and allied health shall include in the
4564 curricula applicable to such degrees material on patient safety,
4565 including patient safety improvement. Materials shall include,
4566 but need not be limited to, effective communication and
4567 teamwork; epidemiology of patient injuries and medical errors;
4568 vigilance, attention, and fatigue; checklists and inspections;
4569 automation and technological and computer support; psychological
4570 factors in human error; and reporting systems.
4571 Section 61. Section 1005.07, Florida Statutes, is created
4572 to read:
4573 1005.07 Patient safety instructional requirements.--Every
4574 nonpublic school, college, and university that offers degrees in
4575 medicine, nursing, and allied health shall include in the
4576 curricula applicable to such degrees material on patient safety,
4577 including patient safety improvement. Materials shall include,
4578 but need not be limited to, effective communication and
4579 teamwork; epidemiology of patient injuries and medical errors;
4580 vigilance, attention, and fatigue; checklists and inspections;
4581 automation and technological and computer support; psychological
4582 factors in human error; and reporting systems.
4583 Section 62. Paragraph (c) of subsection (2) of section
4584 1006.20, Florida Statutes, as amended by section 2 of chapter
4585 2003-129, Laws of Florida, is amended to read:
4586 1006.20 Athletics in public K-12 schools.--
4587 (2) ADOPTION OF BYLAWS.--

4588 (c) The organization shall adopt bylaws that require all
4589 students participating in interscholastic athletic competition
4590 or who are candidates for an interscholastic athletic team to
4591 satisfactorily pass a medical evaluation each year prior to
4592 participating in interscholastic athletic competition or
4593 engaging in any practice, tryout, workout, or other physical
4594 activity associated with the student's candidacy for an
4595 interscholastic athletic team. Such medical evaluation can only
4596 be administered by a practitioner licensed under the provisions
4597 of chapter 458, chapter 459, chapter 460, or s. 464.012, and in
4598 good standing with the practitioner's regulatory board. The
4599 bylaws shall establish requirements for eliciting a student's
4600 medical history and performing the medical evaluation required
4601 under this paragraph, which shall include a physical assessment
4602 of the student's physical capabilities to participate in
4603 interscholastic athletic competition as contained in a uniform
4604 preparticipation physical evaluation and history form. The
4605 evaluation form shall incorporate the recommendations of the
4606 American Heart Association for participation cardiovascular
4607 screening and shall provide a place for the signature of the
4608 practitioner performing the evaluation with an attestation that
4609 each examination procedure listed on the form was performed by
4610 the practitioner or by someone under the direct supervision of
4611 the practitioner. The form shall also contain a place for the
4612 practitioner to indicate if a referral to another practitioner
4613 was made in lieu of completion of a certain examination
4614 procedure. The form shall provide a place for the practitioner
4615 to whom the student was referred to complete the remaining
4616 sections and attest to that portion of the examination. The
4617 preparticipation physical evaluation form shall advise students

4618 to complete a cardiovascular assessment and shall include
4619 information concerning alternative cardiovascular evaluation and
4620 diagnostic tests. ~~Practitioners administering medical~~
4621 ~~evaluations pursuant to this subsection must, at a minimum,~~
4622 ~~solicit all information required by, and perform a physical~~
4623 ~~assessment according to, the uniform preparticipation form~~
4624 ~~referred to in this paragraph and must certify, based on the~~
4625 ~~information provided and the physical assessment, that the~~
4626 ~~student is physically capable of participating in~~
4627 ~~interscholastic athletic competition. If the practitioner~~
4628 ~~determines that there are any abnormal findings in the~~
4629 ~~cardiovascular system, the student may not participate until a~~
4630 ~~further cardiovascular assessment, which may include an EKG, is~~
4631 ~~performed which indicates that the student is physically capable~~
4632 ~~of participating in interscholastic athletic competition.~~
4633 Results of such medical evaluation must be provided to the
4634 school. No student shall be eligible to participate in any
4635 interscholastic athletic competition or engage in any practice,
4636 tryout, workout, or other physical activity associated with the
4637 student's candidacy for an interscholastic athletic team until
4638 the results of the medical evaluation have ~~clearing the student~~
4639 ~~for participation has~~ been received and approved by the school.
4640 Section 63. Patient safety data privilege.--
4641 (1) As used in this section, the term:
4642 (a) "Patient safety data" means reports made to patient
4643 safety organizations, including all health care data,
4644 interviews, memoranda, analyses, root cause analyses, products
4645 of quality assurance or quality improvement processes,
4646 corrective action plans, or information collected or created by
4647 a health care facility licensed under chapter 395, Florida

4648 Statutes, or a health care practitioner as defined in s.
4649 456.001(4), Florida Statutes, as a result of an occurrence
4650 related to the provision of health care services which
4651 exacerbates an existing medical condition or could result in
4652 injury, illness, or death.
4653 (b) "Patient safety organization" means any organization,
4654 group, or other entity that collects and analyzes patient safety
4655 data for the purpose of improving patient safety and health care
4656 outcomes and that is independent and not under the control of
4657 the entity that reports patient safety data.
4658 (2) Patient safety data shall not be subject to discovery
4659 or introduction into evidence in any civil or administrative
4660 action. However, information, documents, or records otherwise
4661 available from original sources are not immune from discovery or
4662 use in any civil or administrative action merely because they
4663 were also collected, analyzed, or presented to a patient safety
4664 organization. Any person who testifies before a patient safety
4665 organization or who is a member of such a group may not be
4666 prevented from testifying as to matters within his or her
4667 knowledge, but he or she may not be asked about his or her
4668 testimony before a patient safety organization or the opinions
4669 formed by him or her as a result of the hearings.
4670 (3) Unless otherwise provided by law, a patient safety
4671 organization shall promptly remove all patient-identifying
4672 information after receipt of a complete patient safety data
4673 report unless such organization is otherwise permitted by state
4674 or federal law to maintain such information. Patient safety
4675 organizations shall maintain the confidentiality of all patient-
4676 identifying information and may not disseminate such
4677 information, except as permitted by state or federal law.

4678 (4) The exchange of patient safety data among health care
4679 facilities licensed under chapter 395, Florida Statutes, or
4680 health care practitioners as defined in s. 456.001(4), Florida
4681 Statutes, or patient safety organizations which does not
4682 identify any patient shall not constitute a waiver of any
4683 privilege established in this section.
4684 (5) Reports of patient safety data to patient safety
4685 organizations do not abrogate obligations to make reports to the
4686 Department of Health, the Agency for Health Care Administration,
4687 or other state or federal regulatory agencies.
4688 (6) An employer may not take retaliatory action against an
4689 employee who in good faith makes a report of patient safety data
4690 to a patient safety organization.
4691 Section 64. The Division of Administrative Hearings shall
4692 designate at least two administrative law judges who shall
4693 specifically preside over actions involving the Department of
4694 Health or boards within the Department of Health. Each
4695 designated administrative law judge must be a member of The
4696 Florida Bar in good standing and must have legal, managerial, or
4697 clinical experience in issues related to health care or have
4698 attained board certification in health care law from The Florida
4699 Bar.
4700 Section 65. (1) The Department of Health shall study and
4701 report to the Legislature as to whether medical review panels
4702 should be included as part of the presuit process in medical
4703 negligence litigation. Medical review panels review a medical
4704 negligence case during the presuit process and make judgments on
4705 the merits of the case based on established standards of care
4706 with the intent of reducing the number of frivolous claims. The
4707 panel's report could be used as admissible evidence at trial or

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4708 for other purposes. The department's report should address:
4709 (a) Historical use of medical review panels and similar
4710 pretrial programs in this state, including the mediation panels
4711 created by chapter 75-9, Laws of Florida.
4712 (b) Constitutional issues relating to the use of medical
4713 review panels.
4714 (c) The use of medical review panels or similar programs
4715 in other states.
4716 (d) Whether medical review panels or similar panels should
4717 be created for use during the presuit process.
4718 (e) Other recommendations and information that the
4719 department deems appropriate.
4720 (f) In submitting its report with respect to paragraphs
4721 (a)-(c), the department should identify at a minimum:
4722 1. The percentage of medical negligence claims submitted
4723 to the panels during the time period the panels were in
4724 existence.
4725 2. The percentage of claims that were settled while the
4726 panels were in existence and the percentage of claims that were
4727 settled in the 3 years prior to the establishment of such panels
4728 or, for each panel which no longer exists, 3 years after the
4729 dissolution of such panels.
4730 3. In those state where panels have been discontinued,
4731 whether additional safeguards have been implemented to avoid the
4732 filing of frivolous lawsuits and what those additional
4733 safeguards are.
4734 4. How the rates for medical malpractice insurance in
4735 states utilizing such panels compares with the rates in states
4736 not utilizing such panels.
4737 5. Whether, and to what extent, a finding by a panel is

4738 subject to review and the burden of proof required to overcome a
4739 finding by the panel.
4740 (2) If the department finds that medical review panels or
4741 a similar structure should be created in this state, it shall
4742 include draft legislation to implement its recommendations in
4743 its report.
4744 (3) The department shall submit its report to the Speaker
4745 of the House of Representatives and the President of the Senate
4746 no later than December 31, 2003.
4747 Section 66. (1) The Agency for Health Care Administration
4748 shall conduct or contract for a study to determine what
4749 information is most feasible to provide to the public comparing
4750 state-licensed hospitals on certain inpatient quality indicators
4751 developed by the federal Agency for Healthcare Research and
4752 Quality. Such indicators shall be designed to identify
4753 information about specific procedures performed in hospitals for
4754 which there is strong evidence of a link to quality of care. The
4755 Agency for Health Care Administration or the study contractor
4756 shall refer to the hospital quality reports published in New
4757 York and Texas as guides during the evaluation.
4758 (2) The following concepts shall be specifically addressed
4759 in the study report:
4760 (a) Whether hospital discharge data about services can be
4761 translated into understandable and meaningful information for
4762 the public.
4763 (b) Whether the following measures are useful consumer
4764 guides relating to care provided in state-licensed hospitals:
4765 1. Inpatient mortality for medical conditions.
4766 2. Inpatient mortality for procedures.
4767 3. Utilization of procedures for which there are questions

4768 of overuse, underuse, or misuse.
4769 4. Volume of procedures for which there is evidence that a
4770 higher volume of procedures is associated with lower mortality.
4771 (c) Whether there are quality indicators that are
4772 particularly useful relative to the state's unique demographics.
4773 (d) Whether all hospitals should be included in the
4774 comparison.
4775 (e) The criteria for comparison.
4776 (f) Whether comparisons are best within metropolitan
4777 statistical areas or some other geographic configuration.
4778 (g) The identification of several Internet websites to
4779 which such a report should be published to achieve the broadest
4780 dissemination of the information.
4781 (3) The Agency for Health Care Administration shall
4782 consider the input of all interested parties, including
4783 hospitals, physicians, consumer organizations, and patients, and
4784 submit a final report to the Governor, the President of the
4785 Senate, and the Speaker of the House of Representatives by
4786 January 1, 2004.
4787 Section 67. Comprehensive study and report on the creation
4788 of a patient safety entity.--
4789 (1) The Agency for Health Care Administration, in
4790 consultation with the Department of Health and existing patient
4791 safety centers, is directed to study the need for, and the
4792 implementation requirements of, establishing a patient safety
4793 entity. The entity would be responsible for performing
4794 activities and functions designed to improve patient safety and
4795 the quality of care delivered by health care facilities and
4796 health care practitioners.
4797 (2) In undertaking its study, the agency shall examine and

4798 evaluate a patient safety entity that would, either directly or
4799 by contract or through a consortium of university-based patient
4800 safety centers:
4801 (a) Analyze data, reports, records, memoranda, or analyses
4802 concerning adverse incidents reported to the Agency for Health
4803 Care Administration pursuant to s. 395.0197, Florida Statutes,
4804 for the purpose of recommending changes in practices and
4805 procedures that may be implemented by health care practitioners
4806 and health care facilities to prevent future adverse incidents.
4807 (b) Collect, analyze, and evaluate patient safety data
4808 submitted voluntarily by a health care practitioner or health
4809 care facility. The entity would communicate to health care
4810 practitioners and health care facilities changes in practices
4811 and procedures that may be implemented for the purpose of
4812 improving patient safety and preventing future patient safety
4813 events from resulting in serious injury or death. At a minimum,
4814 the entity would:
4815 1. Be designed and operated by an individual or entity
4816 with demonstrated expertise in health care quality data and
4817 systems analysis, health information management, systems
4818 thinking and analysis, human factors analysis, and
4819 identification of latent and active errors.
4820 2. Include procedures for ensuring its confidentiality,
4821 timeliness, and independence.
4822 (c) Foster the development of a statewide electronic
4823 infrastructure, which would be implemented in phases over a
4824 multiyear period, that is designed to improve patient care and
4825 the delivery and quality of health care services by health care
4826 facilities and practitioners. The electronic infrastructure
4827 would be a secure platform for communication and the sharing of

4828 clinical and other data, such as business data, among providers
4829 and between patients and providers. The electronic
4830 infrastructure would include a "core" electronic medical record.
4831 Health care providers would have access to individual electronic
4832 medical records, subject to the consent of the individual. The
4833 right, if any, of other entities, including health insurers and
4834 researchers, to access the records would need further
4835 examination and evaluation by the agency.
4836 (d) As a statewide goal of reducing the occurrence of
4837 medication error, inventory hospitals to determine the current
4838 status of implementation of computerized physician medication
4839 ordering systems, barcode point of care systems, or other
4840 technological patient safety implementation, and recommend a
4841 plan for expediting implementation statewide or, in hospitals
4842 where the agency determines that implementation of such systems
4843 is not practicable, alternative methods to reduce medication
4844 errors. The agency shall identify in its plan any barriers to
4845 statewide implementation and shall include recommendations to
4846 the Legislature of statutory changes that may be necessary to
4847 eliminate those barriers.
4848 (e) Identify best practices and share this information
4849 with health care providers.
4850 (f) Engage in other activities that improve health care
4851 quality, improve the diagnosis and treatment of diseases and
4852 medical conditions, increase the efficiency of the delivery of
4853 health care services, increase administrative efficiency, and
4854 increase access to quality health care services.
4855 (3) The agency shall also consider ways in which a patient
4856 safety entity would be able to facilitate the development of no-
4857 fault demonstration projects as means to reduce and prevent

4858 medical errors and promote patient safety.
4859 (4) The agency shall seek information and advice from and
4860 consult with hospitals, physicians, other health care providers,
4861 attorneys, consumers, and individuals involved with and
4862 knowledgeable about patient safety and quality-of-care
4863 initiatives.
4864 (5) In evaluating the need for, and the operation of, a
4865 patient safety entity, the agency shall determine the costs of
4866 implementing and administering an entity and suggest funding
4867 sources and mechanisms.
4868 (6) The agency shall complete its study and issue a report
4869 to the Legislature by February 1, 2004. In its report, the
4870 agency shall include specific findings, recommendations, and
4871 proposed legislation.
4872 Section 68. The Office of Program Policy Analysis and
4873 Government Accountability shall complete a study of the
4874 eligibility requirements for a birth to be covered under the
4875 Florida Birth-Related Neurological Injury Compensation
4876 Association and submit a report to the Legislature by January 1,
4877 2004, recommending whether the statutory criteria for a claim to
4878 qualify for referral to the Florida Birth-Related Neurological
4879 Injury Compensation Association under s. 766.302, Florida
4880 Statutes, should be modified.
4881 Section 69. Civil immunity for members of or consultants
4882 to certain boards, committees, or other entities.--
4883 (1) Each member of, or health care professional consultant
4884 to, any committee, board, group, commission, or other entity
4885 shall be immune from civil liability for any act, decision,
4886 omission, or utterance done or made in performance of his or her
4887 duties while serving as a member of or consultant to such

4888 committee, board, group, commission, or other entity established
4889 and operated for purposes of quality improvement review,
4890 evaluation, and planning in a state-licensed health care
4891 facility. Such entities must function primarily to review,
4892 evaluate, or make recommendations relating to:
4893 (a) The duration of patient stays in health care
4894 facilities;
4895 (b) The professional services furnished with respect to
4896 the medical, dental, psychological, podiatric, chiropractic, or
4897 optometric necessity for such services;
4898 (c) The purpose of promoting the most efficient use of
4899 available health care facilities and services;
4900 (d) The adequacy or quality of professional services;
4901 (e) The competency and qualifications for professional
4902 staff privileges;
4903 (f) The reasonableness or appropriateness of charges made
4904 by or on behalf of health care facilities; or
4905 (g) Patient safety, including entering into contracts with
4906 patient safety organizations.
4907 (2) Such committee, board, group, commission, or other
4908 entity must be established in accordance with state law or in
4909 accordance with requirements of the Joint Commission on
4910 Accreditation of Healthcare Organizations, established and duly
4911 constituted by one or more public or licensed private hospitals
4912 or behavioral health agencies, or established by a governmental
4913 agency. To be protected by this section, the act, decision,
4914 omission, or utterance may not be made or done in bad faith or
4915 with malicious intent.
4916 Section 70. The Office of Program Policy Analysis and
4917 Government Accountability and the Office of the Auditor General

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4918 must jointly conduct an audit of the Department of Health's
4919 health care practitioner disciplinary process and closed claims
4920 that are filed with the department under s. 627.912, Florida
4921 Statutes. The Office of Program Policy Analysis and Government
4922 Accountability and the Office of the Auditor General shall
4923 submit a report to the Legislature by January 1, 2005.
4924 Section 71. No later than September 1, 2003, the
4925 Department of Health shall convene a workgroup to study the
4926 current health care practitioner disciplinary process. The
4927 workgroup shall include a representative of the Administrative
4928 Law section of The Florida Bar, a representative of the Health
4929 Law section of The Florida Bar, a representative of the Florida
4930 Medical Association, a representative of the Florida Osteopathic
4931 Medical Association, a representative of the Florida Dental
4932 Association, a member of the Florida Board of Medicine who has
4933 served on a probable cause panel, a member of the Board of
4934 Osteopathic Medicine who has served on a probable cause panel,
4935 and a member of the Board of Dentistry who has served on a
4936 probable cause panel. The workgroup shall also include one
4937 consumer member of the Board of Medicine. The Department of
4938 Health shall present the findings and recommendations to the
4939 Governor, the President of the Senate, and the Speaker of the
4940 House of Representatives no later than January 1, 2004. The
4941 sponsoring organizations shall assume the costs of their
4942 representatives.
4943 Section 72. The Legislature finds and declares it to be of
4944 vital importance that emergency services and care be provided by
4945 hospitals, physicians, and emergency medical services providers
4946 to every person in need of such care. The Legislature finds that
4947 providers of emergency medical services and care are critical

4948 elements in responding to disaster and emergency situations that
4949 might affect our local communities, state, and country. The
4950 Legislature recognizes the importance of maintaining a viable
4951 system of providing for the emergency medical needs of residents
4952 of this state and visitors to this state. The Legislature and
4953 the Federal Government have required such providers of emergency
4954 medical services and care to provide emergency services and care
4955 to all persons who present themselves to hospitals seeking such
4956 care. The Legislature has further mandated that prehospital
4957 emergency medical treatment or transport may not be denied by
4958 emergency medical services providers to persons who have or are
4959 likely to have an emergency medical condition. Such governmental
4960 requirements have imposed a unilateral obligation for providers
4961 of emergency medical services and care to provide services to
4962 all persons seeking emergency care without ensuring payment or
4963 other consideration for provision of such care. The Legislature
4964 also recognizes that providers of emergency medical services and
4965 care provide a significant amount of uncompensated emergency
4966 medical care in furtherance of such governmental interest. A
4967 significant proportion of the residents of this state who are
4968 uninsured or are Medicaid or Medicare recipients are unable to
4969 access needed health care because health care providers fear the
4970 increased risk of medical malpractice liability. Such patients,
4971 in order to obtain medical care, are frequently forced to seek
4972 care through providers of emergency medical services and care.
4973 Providers of emergency medical services and care in this state
4974 have reported significant problems with both the availability
4975 and affordability of professional liability coverage. Medical
4976 malpractice liability insurance premiums have increased
4977 dramatically and a number of insurers have ceased providing

4978 medical malpractice coverage for emergency medical services and
4979 care in this state. This results in a functional unavailability
4980 of malpractice coverage for some providers of emergency medical
4981 services and care. The Legislature further finds that certain
4982 specialist physicians have resigned from serving on hospital
4983 staffs or have otherwise declined to provide on-call coverage to
4984 hospital emergency departments due to increased medical
4985 malpractice liability exposure created by treating such
4986 emergency department patients. It is the intent of the
4987 Legislature that hospitals, emergency medical services
4988 providers, and physicians be able to ensure that patients who
4989 might need emergency medical services treatment or
4990 transportation or who present themselves to hospitals for
4991 emergency medical services and care have access to such needed
4992 services.
4993 Section 73. Each final settlement statement relating to
4994 medical negligence shall include the following statement: "The
4995 decision to settle a case may reflect the economic
4996 practicalities pertaining to the cost of litigation and is not,
4997 alone, an admission that the insured failed to meet the required
4998 standard of care applicable to the patient's treatment. The
4999 decision to settle a case may be made by the insurance company
5000 without consulting its client for input, unless otherwise
5001 provided by the insurance policy."
5002 Section 74. The Office of Program Policy Analysis and
5003 Government Accountability shall study the feasibility and merits
5004 of authorizing the Public Counsel to examine insurance rate
5005 filings for medical malpractice insurance submitted to the
5006 Office of Insurance Regulation, to make recommendations to the
5007 office regarding such rate filings, and to represent the public

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

5008 in any hearing related to such rate filings. The study must
5009 include an evaluation of the effectiveness of the current
5010 authority of the Office of Insurance Consumer Advocate to
5011 perform such functions and comparable functions exercised in
5012 other states.
5013 Section 75. The sum of $687,786 is appropriated from the
5014 Medical Quality Assurance Trust Fund to the Department of
5015 Health, and seven positions are authorized, for the purpose of
5016 implementing this act during the 2003-2004 fiscal year. The sum
5017 of $1,629,994 is appropriated from the Health Care Trust Fund to
5018 the Agency for Health Care Administration, and eleven positions
5019 are authorized, for the purpose of implementing this act during
5020 the 2003-2004 fiscal year.
5021 Section 76. The sum of $1,450,000 is appropriated from the
5022 Insurance Regulatory Trust Fund in the Department of Financial
5023 Services to the Office of Insurance Regulation for the purpose
5024 of implementing this act during the 2003-2004 fiscal year.
5025 Section 77. For the purpose of incorporating the amendment
5026 to section 456.039, Florida Statutes, in references thereto,
5027 paragraph (b) of subsection (5) of section 458.319, Florida
5028 Statutes, is reenacted and amended to read:
5029 458.319 Renewal of license.--
5030 (5)
5031 (b) At any time during the licensee's legislative term of
5032 office and during the period of 60 days after the licensee
5033 ceases to be a member of the Legislature, the licensee may file
5034 a completed renewal application that shall consist solely of:
5035 1. A license renewal fee of $250 for each year the
5036 licensee's license renewal has been continued and extended
5037 pursuant to the terms of this subsection since the last

5038 otherwise regularly scheduled biennial renewal year and each
5039 year during which the renewed license shall be effective until
5040 the next regularly scheduled biennial renewal date;
5041 2. Documentation of the completion by the licensee of 10
5042 hours of continuing medical education credits for each year from
5043 the effective date of the last renewed license for the licensee
5044 until the year in which the application is filed;
5045 3. The information from the licensee expressly required in
5046 s. 456.039(1)(a)~~1.-8.~~ and (b), and (4)(a), (b), and (c).
5047 Section 78. Paragraph (h) of subsection (3) of section
5048 163.01, Florida Statutes, is amended to read:
5049 163.01 Florida Interlocal Cooperation Act of 1969.--
5050 (3) As used in this section:
5051 (h) "Local government liability pool" means a reciprocal
5052 insurer as defined in s. 629.021 or any self-insurance program
5053 created pursuant to s. 768.28(16)~~(15)~~, formed and controlled by
5054 counties or municipalities of this state to provide liability
5055 insurance coverage for counties, municipalities, or other public
5056 agencies of this state, which pool may contract with other
5057 parties for the purpose of providing claims administration,
5058 processing, accounting, and other administrative facilities.
5059 Section 79. Paragraph (a) of subsection (2) of section
5060 456.048, Florida Statutes, is amended to read:
5061 456.048 Financial responsibility requirements for certain
5062 health care practitioners.--
5063 (2) The board or department may grant exemptions upon
5064 application by practitioners meeting any of the following
5065 criteria:
5066 (a) Any person licensed under chapter 457, chapter 460,
5067 chapter 461, s. 464.012, chapter 466, or chapter 467 who

5068 practices exclusively as an officer, employee, or agent of the
5069 Federal Government or of the state or its agencies or its
5070 subdivisions. For the purposes of this subsection, an agent of
5071 the state, its agencies, or its subdivisions is a person who is
5072 eligible for coverage under any self-insurance or insurance
5073 program authorized by the provisions of s. 768.28(16)~~(15)~~ or who
5074 is a volunteer under s. 110.501(1).
5075 Section 80. Section 624.461, Florida Statutes, is amended
5076 to read:
5077 624.461 Definition.--For the purposes of the Florida
5078 Insurance Code, "self-insurance fund" means both commercial
5079 self-insurance funds organized under s. 624.462 and group self-
5080 insurance funds organized under s. 624.4621. The term "self-
5081 insurance fund" does not include a governmental self-insurance
5082 pool created under s. 768.28(16)~~(15)~~.
5083 Section 81. Paragraph (b) of subsection (3) of section
5084 627.733, Florida Statutes, is amended to read:
5085 627.733 Required security.--
5086 (3) Such security shall be provided:
5087 (b) By any other method authorized by s. 324.031(2), (3),
5088 or (4) and approved by the Department of Highway Safety and
5089 Motor Vehicles as affording security equivalent to that afforded
5090 by a policy of insurance or by self-insuring as authorized by s.
5091 768.28(16)~~(15)~~. The person filing such security shall have all
5092 of the obligations and rights of an insurer under ss. 627.730-
5093 627.7405.
5094 Section 82. Section 766.112, Florida Statutes, is amended
5095 to read:
5096 766.112 Comparative fault.--

5097 (1) Notwithstanding anything in law to the contrary, in an
5098 action for damages for personal injury or wrongful death arising
5099 out of medical negligence ~~malpractice~~, whether in contract or
5100 tort, when an apportionment of damages pursuant to this section
5101 is attributed to a teaching hospital as defined in s. 408.07,
5102 the court shall enter judgment against the teaching hospital on
5103 the basis of such party's percentage of fault and not on the
5104 basis of the doctrine of joint and several liability.
5105 (2) In an action for damages for personal injury or
5106 wrongful death arising out of medical negligence ~~malpractice~~,
5107 whether in contract or tort, when an apportionment of damages
5108 pursuant to s. 768.81 is attributed to a board of trustees of a
5109 state university, the court shall enter judgment against the
5110 board of trustees on the basis of the board's percentage of
5111 fault and not on the basis of the doctrine of joint and several
5112 liability. The sole remedy available to a claimant to collect a
5113 judgment or settlement against a board of trustees, subject to
5114 the provisions of this subsection, shall be pursuant to s.
5115 768.28.
5116 Section 83. Section 766.113, Florida Statutes, is amended
5117 to read:
5118 766.113 Settlement agreements; prohibition on restricting
5119 disclosure to Division of Medical Quality Assurance.--A
5120 settlement agreement involving a claim for medical negligence
5121 ~~malpractice~~ shall not prohibit any party to the agreement from
5122 discussing with or reporting to the Division of Medical Quality
5123 Assurance the events giving rise to the claim.
5124 Section 84. Paragraphs (c) and (d) of subsection (1) of
5125 section 766.201, Florida Statutes, are amended to read:
5126 766.201 Legislative findings and intent.--

5127 (1) The Legislature makes the following findings:
5128 (c) The average cost of defending a medical negligence
5129 ~~malpractice~~ claim has escalated in the past decade to the point
5130 where it has become imperative to control such cost in the
5131 interests of the public need for quality medical services.
5132 (d) The high cost of medical negligence ~~malpractice~~ claims
5133 in the state can be substantially alleviated by requiring early
5134 determination of the merit of claims, by providing for early
5135 arbitration of claims, thereby reducing delay and attorney's
5136 fees, and by imposing reasonable limitations on damages, while
5137 preserving the right of either party to have its case heard by a
5138 jury.
5139 Section 85. Subsection (2) of section 766.303, Florida
5140 Statutes, is amended to read:
5141 766.303 Florida Birth-Related Neurological Injury
5142 Compensation Plan; exclusiveness of remedy.--
5143 (2) The rights and remedies granted by this plan on
5144 account of a birth-related neurological injury shall exclude all
5145 other rights and remedies of such infant, her or his personal
5146 representative, parents, dependents, and next of kin, at common
5147 law or otherwise, against any person or entity directly involved
5148 with the labor, delivery, or immediate postdelivery
5149 resuscitation during which such injury occurs, arising out of or
5150 related to a medical negligence ~~malpractice~~ claim with respect
5151 to such injury; except that a civil action shall not be
5152 foreclosed where there is clear and convincing evidence of bad
5153 faith or malicious purpose or willful and wanton disregard of
5154 human rights, safety, or property, provided that such suit is
5155 filed prior to and in lieu of payment of an award under ss.
5156 766.301-766.316. Such suit shall be filed before the award of

5157 the division becomes conclusive and binding as provided for in
5158 s. 766.311.
5159 Section 86. Subsection (8) of section 768.21, Florida
5160 Statutes, is amended to read:
5161 768.21 Damages.--All potential beneficiaries of a recovery
5162 for wrongful death, including the decedent's estate, shall be
5163 identified in the complaint, and their relationships to the
5164 decedent shall be alleged. Damages may be awarded as follows:
5165 (8) The damages specified in subsection (3) shall not be
5166 recoverable by adult children and the damages specified in
5167 subsection (4) shall not be recoverable by parents of an adult
5168 child with respect to claims for medical negligence ~~malpractice~~
5169 as defined by s. 766.106(1).
5170 Section 87. Nothing in this act constitutes a waiver of
5171 sovereign immunity under s. 768.28, Florida Statutes, or
5172 contravenes the abrogation of joint and several liability
5173 contained in s. 766.112, Florida Statutes.
5174 Section 88. If any provision of this act or the
5175 application thereof to any person or circumstance is held
5176 invalid, the invalidity does not affect other provisions or
5177 applications of the act which can be given effect without the
5178 invalid provision or application, and to this end the provisions
5179 of this act are declared severable.
5180 Section 89. It is the intent of the Legislature to apply
5181 the provisions of this act to prior medical incidents to the
5182 extent such application is not prohibited by the state or
5183 federal constitution, except that the amendments to chapter 766,
5184 Florida Statutes, provided in this act shall apply only to any
5185 medical incident for which a notice of intent to initiate
5186 litigation is mailed on or after the effective date of this act.

5187 Section 90. If any law amended by this act was also
5188 amended by a law enacted at the 2003 Regular Session or a 2003
5189 special session of the Legislature, such laws shall be construed
5190 as if they had been enacted at the same session of the
5191 Legislature, and full effect shall be given to each if possible.
5192 Section 91. Except as otherwise provided herein, this act
5193 shall take effect September 15, 2003.