HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: HB 1821 (PCB IN 04-05) Medical Negligence
SPONSOR(S): Committee on Insurance and Rep. Berfield
TIED BILLS: None **IDEN./SIM. BILLS:** None

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR
1) Insurance	14 Y, 9 N	Cooper	Cooper
2)			
3)			
4)			
5)			

SUMMARY ANALYSIS

In 2002-2003 Florida was in the midst of a medical liability insurance crisis. Medical malpractice carriers were leaving the state, discontinuing coverage, and increasing premiums dramatically. Faced with liability insurance that was either unavailable or unaffordable, health care providers curtailed or terminated their services. Concerns were raised that access to quality health care was threatened. In response, the 2003 Legislature passed a comprehensive bill, SB 2-D, relating to medical incidents (chapter No. 2003-416, Laws of Florida). The new law focused on improvements to patient safety and provider discipline and reforms in the areas of insurance and civil litigation.

Physicians, and groups representing physicians, report that medical liability insurance premiums are still extremely high and that access to quality health care is now, and will continue to be, compromised if more reform measures are not adopted.

This bill addresses several topics relating to medical negligence. It provides clearer legislative intent by specifying that tort claims involving vulnerable adults qualifying as medical negligence complaints must be brought pursuant to chapter 766, F.S. (the medical negligence statute). The proposed bill also limits the ability of hospitals to place additional financial responsibility requirements on physicians while clarifying that hospitals do not have any legal duty under the statutory provisions relating to financial responsibility for physicians.

The bill creates additional expert witness requirements for those who wish to testify in medical negligence cases. It specifies that in order to testify, a medical expert must be either licensed in Florida to practice medicine or certified in Florida. In the area of insurance, the proposed bill deletes the current requirement that only the insurer may settle a malpractice case if an offer is within policy limits. It establishes new requirements for the use of periodic payments relating to future economic and noneconomic damages. The proposed bill immunizes certain providers of emergency services and care as well as private medical schools providing health services in public hospitals. It also limits attorney advertising relating to medical negligence claims.

The fiscal impact of the sovereign immunity provisions of the bill to the private and public sectors is indeterminate, but may be significant.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. DOES THE BILL:

1. Reduce government?	Yes[]	No[X]	N/A[]
2. Lower taxes?	Yes[]	No[]	N/A[X]
3. Expand individual freedom?	Yes[X]	No[]	N/A[]
4. Increase personal responsibility?	Yes[]	No[]	N/A[X]
5. Empower families?	Yes[]	No[]	N/A[X]

For any principle that received a "no" above, please explain:

The proposed bill makes certain health care providers agents of the state. It also creates a medical expert certification process to be administered by the Board of Medicine and the Board of Osteopathic Medicine.

B. EFFECT OF PROPOSED CHANGES:

BACKGROUND

Because of the breadth of issues relating to medical negligence and the comprehensive nature of the law passed last summer, this analysis will only provide background information on the new law and information relating to those areas of the current law relating specifically to the changes proposed by this bill.

Areas of the Law Addressed in 2003

Testimony, documents, and affidavits presented to the Legislature during 2002-2003 and reports by the House Select Committee on Medical Liability Insurance and the Governor's Select Task Force on Healthcare Professional Liability Insurance established that Florida was in the midst of a medical malpractice insurance crisis that threatened the quality and availability of health care for all Florida citizens. Based on this record, the Legislature found that making high quality health care available, ensuring physicians continue to practice, and ensuring the availability of affordable professional liability insurance to physicians were overwhelming public necessities. Accordingly, the Legislature responded by passing comprehensive improvements to patient safety and practitioner discipline, insurance reform, and litigation reform.

Patient Safety Improvements

There are many provisions in the new law that encourage the health care industry to improve patient safety and quality of care.

The law increases self-policing by hospitals and physicians by:

- Requiring hospitals establish patient safety plans and committees.
- Protecting information used to analyze errors from use in lawsuits.
- Protecting hospital medical boards from litigation when they discipline physicians.

The law increases physician and hospital responsibility to patients and consumers by:

- Requiring hospitals and physicians to personally notify patients when they have been harmed.

- Making available more useful information to consumers on the Internet about malpractice and discipline of specific physicians.
- Requiring physicians to be financially responsible to injured patients.

The law required a study to determine how to provide consumers with better information to help them choose the safest hospitals with the best quality of care. The law also provides for increased training and education in patient safety by requiring college and university health care training programs to provide instruction in patient safety and requiring doctors to have training in misdiagnosed conditions.

Laying the groundwork for a major initiative to address patient safety throughout the state, the law required a study to determine the most cost effective location, structure, and funding to build a statewide infrastructure to improve patient safety. The patient safety initiative will coordinate efforts to identify and correct the sources of medical errors and use new technologies.

Practitioner Discipline Improvements

The law improves the discipline of practitioners in order to better prevent harm to patients, lawsuits, and higher insurance costs. It provides for emergency disciplinary proceedings for doctors who commit gross and repeated negligence. The law also facilitates investigation and prosecution of discipline cases by:

- Enabling the Department of Health to subpoena the physician's patient records in disciplinary proceedings.
- Requiring specialized Administrative Law Judges with experience in health care to hear discipline cases.

The law also mandated two studies and reports on practitioner discipline. The Department of Health was required to convene a workgroup by September 1 to determine ways to improve discipline and report back to the Legislature. The Auditor General and OPPAGA were required to carry out a joint study of the existing disciplinary process.

Insurance Reform

The new law addresses the need to make medical liability insurance more available by establishing alternative forms of insurance, improving the regulation of the medical malpractice insurance industry, and providing immediate rate relief for providers.

The law affords health care providers new opportunities to self-insure by allowing the formation of medical malpractice self-insurance trust funds, subject to Office of Insurance Regulation oversight for solvency. It also authorizes groups of 10 or more physicians to establish commercial self-insurance funds.

The law requires medical malpractice insurers to make a rate filing once each year, which must be sworn to by two company officers. The law also includes new standards for setting medical malpractice rates. The standards exclude bad faith and punitive damage losses from the insurer's rate base and prohibit costs attributed to investment losses.

The law requires the reporting of additional closed-claims information and its analysis by the Office of Insurance Regulation to better track insurance costs.

The law addressed demands for immediate rate relief. It required all medical malpractice insurers to file rates that reflected a rate reduction set by the Office of Insurance Regulation.

The rate reduction was set to reflect the effects of the bill's malpractice reforms. The law:

- Required a rate filing effective January 1, 2004, a "presumptive factor" determined by Office of Insurance Regulation to reflect the impacts of the bill. This factor was established at -7.8 percent.
- The new rate applied retroactively to policies issued or renewed on or after September 15, 2003.
- An insurer was permitted to file deviations from presumptive rate change, but had the burden of proof to justify deviation.
- Any deviation from the established rate factor was subject to prior approval of the Office of Insurance Regulation.

The law also prevented insurance companies from raising medical malpractice rates above the level in effect on July 1, 2003, before the new rates were approved by the Office of Insurance Regulation.

Litigation Reform

The law provides a cap on noneconomic damages, such as pain and suffering. (There is no cap on economic damages, such as medical costs or lost wages.) The law provides for two categories of defendants. Practitioners, such as physicians, are in one category. Other defendants, such as hospitals, are in the second category. These caps on noneconomic damages work as follows:

In most medical malpractice cases against practitioners:

- There is a cap of $500,000 per claimant against practitioners (including doctors, dentists, optometrists, physical therapists, nurse practitioners, and assistants working under them).
- All claimants may recover a total of $1,000,000 aggregate.
- No practitioner is liable for more than $500,000.

In most medical malpractice cases against non-practitioners:

- There is a cap of $750,000 per claimant against other non-practitioner defendants (including hospitals).
- All claimants may recover a total of $1,500,000.

In cases involving death or permanent vegetative state, all claimants may recover a total of $1,000,000 from practitioners and $1,500,000 from non-practitioners. In cases that do not involve death or permanent vegetative state, the patient injured by medical negligence may recover a total of $1,000,000 from practitioners and $1,500,000 from non-practitioners if the patient suffers a catastrophic injury and the trial judge finds that a manifest injustice would occur if the lower cap was imposed. The law defines catastrophic injury to include serious spinal cord injuries, amputations, brain injuries, serious burns, blindness, or loss of reproductive organs.

In emergency care situations the law provides different caps for practitioners and non-practitioners:

- There is a $150,000 cap per claimant against practitioners providing emergency services with $300,000 aggregate.

- There is a $750,000 cap per claimant against non-practitioners providing emergency services with $1,500,000 aggregate.

There is no "piercing" of the emergency room cap.

In addition to caps, the law provides for an increased exchange of information during the presuit process. It requires the claimant to provide medical records with the presuit notice and to provide the names of all treating physicians. It permits the defendant to take unsworn statements of the claimant's treating physicians. The law permits all parties to request answers to written questions during presuit.

The law provides for increased sanctions for failing to cooperate in the presuit process. Also, the law requires all parties to attend mandatory mediation within 120 days after the filing of the lawsuit.

In the area of bad faith, the new law established conditions for which a medical malpractice insurance company cannot be held in bad faith for refusing to settle a claim. An insurer can not be determined to have acted in bad faith if it makes a tender of the insured party's policy limits by the earlier of:

- 210 days after the complaint is served on the defendant (with provision for 60 day extensions by court in any subsequent bad faith action), or
- 60 days after completion of specified discovery activity (including disclosure of witnesses, production of documents, depositions, and mediation).

The law lists nine factors to be considered for determining bad faith. These include:

- The insurer's willingness to negotiate.
- The insurer's methods of investigating and evaluating the claim.
- Information provided to the insured; and
- Actions of the claimant.

Prior to 2003, the law did not provide any such "safe harbor" of conditions that protect an insurer from bad faith lawsuits or any statutory factors for consideration by the trier of fact. The new law retained prior law as to the amount that can be recovered in a bad faith action (the entire amount of the excess judgment in the medical malpractice action, regardless of policy limits).

AREAS OF THE LAW ADDRESSED BY THIS BILL

Hospital Staff Membership and Clinical Privileges

The Legislature in 2003 amended the hospital licensure law to strengthen the ability of hospitals to discipline providers. Specifically, the law states that there shall be no monetary liability on the part of, and no cause of action for injunctive relief or damages shall arise against, any licensed facility, its governing board or governing board members, medical staff, or disciplinary board or against its agents, investigators, witnesses, or employees, or against any other person, for any action related to staff membership, absent intentional fraud.[1]

Based on testimony before the Committee on Insurance in 2004, this bill includes new provisions requiring hospitals to establish internal protocols for the revocation or suspension of staff privileges or other disciplinary actions against a member of the medical staff, relating to staff membership or clinical privileges. It also provides a hospital acting in accordance with its internal protocols is presumed to have acted reasonably under the circumstances absent clear and convincing evidence to the contrary.

Civil Actions Regarding Vulnerable Adults

Currently, a vulnerable adult who has been abused, neglected, or exploited has a statutorily created cause of action against any perpetrator and may recover actual and punitive damages The action may be brought by the vulnerable adult, or that person's guardian, by a person or organization acting on behalf of the vulnerable adult with the consent of that person or that person's guardian, or by the personal representative of the estate of a deceased victim without regard to whether the cause of death resulted from the abuse, neglect, or exploitation. The action may be brought in any court of competent jurisdiction to enforce such action and to recover actual and punitive damages for any deprivation of or infringement on the rights of a vulnerable adult. A party who prevails in any such action may be entitled to recover reasonable attorney's fees, costs of the action, and damages. The remedies provided in the

[1] s. 395.0191, F.S.

statute are in addition to and cumulative with other legal and administrative remedies available to a vulnerable adult.[2] Operators of nursing homes and assisted living facilities are explicitly exempted from this statute although causes of actions are permitted under s. 400.023 and s.400.429, F.S., respectively.

In 2000, as part of its rewrite of chapter 415 relating to adult protective services, the Legislature eliminated the requirement for abuse investigators of the Department of Children and Families to classify reports of abuse as "confirmed" or "unfounded." The Department still investigates, but now provides the results to law enforcement for further action.

In a conforming amendment, the Legislature deleted the definition of "perpetrator" which was defined as "the person who has been named as causing abuse, neglect, or exploitation of a disabled adult or an elderly person in a report that has been classified as confirmed." In another conforming amendment, the Legislature deleted the reference to "confirmed report" from the civil remedy provisions set forth in s. 415.1111 F.S., whereas the language originally authorized a cause of action against "any perpetrator named in a confirmed report"; the language now authorizes a cause of action for damages against any "perpetrator" (which again, is not defined).

The Legislature in 2000 also significantly expanded the class of individuals protected by chapter 415 to include a "vulnerable adult," who is defined as "a person 18 years of age or older whose ability to perform the normal activities of daily living or to provide for his or her own care or protection is impaired due to a mental, emotional, long-term[3] physical, or developmental disability or dysfunctioning, or brain damage, or the infirmities of aging."

According to the Florida Hospital Association, since the changes in 2000, cases are now being filed against hospitals pursuant to s. 415.1111, F.S., for medical incidents occurring in hospitals. The plaintiffs in these cases argue that s. 415.1111, F.S., applies because the patients are "vulnerable adults" by virtue of their medical condition. There are also claims that the failure to render appropriate medical care, which would otherwise be considered medical malpractice, meets the definition of "neglect" as used in s.415.1111.[4]

A plaintiff derives several advantages by bringing a lawsuit under chapter 415 rather than chapter 766, including who may bring the suit, relaxed standard of proof, attorney fees and costs, and not having to go through all the presuit and other requirements of a typical medical malpractice action. These factors can substantially increase defense costs and consequently, insurance premiums.

Concerns have been raised that if the provisions in s. 415.1111 are not clarified, many of the proposed reforms to alleviate the current crisis will be undermined. It has been suggested that plaintiff attorneys will either ignore the mandates of chapter 766 or at the very least use s. 415.1111 F.S. for "another bite of the apple."

Medical Experts

Currently there are two key provisions in Florida Statutes that establish requirements for medical experts. When the defendant is a specialist the expert must also be a specialist in the same area, and must have devoted time to clinical practice, teaching, or research within the last 3 years. When the

[2] s. 415.1111, F. S.

[3] Added in 2003, s. 4, ch. 2003-57.

[4] Pursuant to s. 415.102 F.S., neglect means "the failure or omission on the part of the caregiver to provide the care, supervision, and services necessary to maintain the physical and mental health of the vulnerable adult, including, but not limited to, food, clothing, medicine, shelter, supervision, and medical services, that a prudent person would consider essential for the well-being of a vulnerable adult. The term "neglect" also means the failure of a caregiver to make a reasonable effort to protect a vulnerable adult from abuse, neglect, or exploitation by others. "Neglect" is repeated conduct or a single incident of carelessness which produces or could reasonably be expected to result in serious physical or psychological injury or a substantial risk of death."

defendant is a general practitioner, the expert must have devoted such time within the last 5 years.[5] An expert may give testimony on administrative issues and non-clinical standards of a facility based on training and experience.[6]

The statute also prohibits contingency fees for expert witnesses[7] and requires attorneys to certify that an expert has not been found guilty of fraud or perjury.[8] Also, the law allows the trial court to qualify or disqualify the expert for other non-statutory reasons.[9]

The second provision relates to the use of the medical expert in the presuit process. Medical expert is defined as "a person duly and regularly engaged in the practice of his or her profession who holds a health care professional degree from a university or college and who meets the requirements of an expert witness as set forth in s. 766.102." [10] Currently, prior to issuing notification of intent to initiate medical negligence litigation, the claimant must conduct an investigation to ascertain that there are reasonable grounds to believe that any named defendant in the litigation was negligent in the care or treatment of the claimant; and such negligence resulted in injury to the claimant. Moreover, corroboration of reasonable grounds to initiate medical negligence litigation must be provided by the claimant's submission of a verified written medical expert opinion from a medical expert as defined in s. 766.202(6).[11]

The bill establishes additional requirements for a medical expert to testify. It provides that the expert must either be licensed to practice in Florida or have obtained a certificate to testify from the Board of Medicine or the Board of Osteopathic Medicine. It also specifies that approval, denial or revocation of a certificate shall be based on a finding that a applicant or certificate holder has been disciplined for actions relating to fraud, coercion, deception, intimidation, dishonesty, undue influence, incompetence, or substance abuse. Application fees are not to exceed the amount necessary to administer the certificate program and certificate renewals shall be available biennially.

In 2003, the House Select Committee on Medical Liability Insurance heard testimony regarding expert witness certification. A witness appearing on behalf of the Academy of Florida Trial Lawyers said that out of state practitioners would not testify in Florida if the certificate requirement was added. A witness appearing of behalf of the FMA countered that such certification is necessary so the state can better control the quality of expert witness testimony. Currently, there is no mechanism for discipline if an out of state expert presents false testimony in Florida. The Academy countered that if an expert testified falsely, the expert could still be reported to the appropriate regulatory agency in their state of residence.

Periodic Payments of Damages

Periodic payment of damages is the payment of damage awards over time, rather than in a lump sum. Section 766.202(8), F.S., defines "periodic payment" as the payment of an award of "future economic damages through structured payments over a period of time, as follows:

a) A specific finding of the dollar amount of periodic payments that will compensate for these future damages after offset for collateral sources shall be made. The total dollar amount of the periodic

[5] s. 766.102(5), F. S.
[6] s. 766.102(7), F. S.
[7] s. 766.102(10), F. S.
[8] s. 766.102(11), F. S.
[9] s. 766.102(12), F. S.

[10] s. 766.202(6), F. S.

[11] s. 766.203(2), F. S.

payments shall equal the dollar amount of all such future damages before any reduction to present value.

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

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

A similar definition is provided in section 768.78, F.S., relating to the payment of damages in medical malpractice actions.

Witnesses before the Governor's Task Force on Healthcare Professional Liability Insurance argued that there should not be a distinction between future economic and future noneconomic damages for purposes of allowing periodic payments so both compensate the plaintiff for damages in the future. If a claimant dies after receiving payment for future damages that had not yet been incurred, it can be argued that the plaintiff receives a windfall from the incident.

Witnesses also argued against changing the current system. It can be argued that a plaintiff has a right to the money once the judgment is entered and it should be the plaintiff's decision as to whether the money is expended immediately or invested in an annuity or some other investment providing periodic payments. It is also unclear how changing the timing or method of payment would alter insurance rates.

The Task Force recommended that the Legislature should amend section 766.202, Florida Statutes, to both allow the periodic payment of future noneconomic damages and to terminate the payment of future economic and noneconomic damages upon the death of the plaintiff.

The Florida Medical Association has proposed allowing the defendant the option of paying all damages, economic and noneconomic, as a lump sum reduced to present value and offset by collateral source payments or paying by periodic payments for as long as the condition persist or the claimant lives.

Financial Responsibility

To practice medicine in Florida, physicians are required to show financial responsibility. Pursuant to ss. 458.320 and 459.0085 F.S., applicants for initial licensure or the renewal of their license must, by one of the statutorily specified methods, demonstrate financial responsibility to the satisfaction of the respective Boards and the Department of Health in order to pay claims and costs arising out of the rendering of, or the failure to render, medical care or services. Specifically, the statutes require physicians to have medical malpractice insurance of $250,000 per claim, have an escrow account with such an amount, or have a line of credit in such an amount. Alternatively, the physician can agree to pay any medical malpractice judgment creditor $250,000 per judgment if the physician informs patients he/she does not carry medical malpractice insurance and informs the Department of Health. Physicians with staff privileges at hospitals are also required to establish financial responsibility as a continuing condition of hospital staff privileges.

In a series of recent court decisions it has been noted that hospitals have no common law obligation to assure their staff physicians are financially responsible. However, it has been held that by enacting s.

458.320(2)(b)), the Legislature enacted a statutory duty on the hospitals to ensure their staff physicians are financially responsible.[12]

The bill states that nothing in s.458.320, F.S., relating to financial responsibility creates any duty or legal obligation on the part of any hospital or ambulatory surgical center.

Rights of Insureds in Settlement Decisions

Pursuant to s. 627.4147 F.S, all medical malpractice insurance policies, including self-insurance policies and those of the Florida Medical Malpractice Joint Underwriting Association, must include clauses to:

> (1) require the insured to cooperate fully in the review process prescribed under s. 766.106 if a notice of intent to file a claim for medical malpractice is made against the insured;
>
> (2) authorize the insurer or self-insurer to determine, to make, and to conclude, without the permission of the insured, any offer of admission of liability and for arbitration pursuant to s.766.106, settlement offer, or offer of judgment, if the offer is within the policy limits and if made in good faith and in the best interests of the insured;
>
> (3) direct the insurer or self-insurer to notify the insured no less than 90 days prior to the effective date of cancellation of the policy or contract and, in the event of a determination by the insurer or self-insurer not to renew the policy or contract, to notify the insured no less than 90 days prior to the end of the policy or contract period. If cancellation or non-renewal is due to nonpayment or loss of license, 10 days' notice is required.

The bill deletes the authorization of the insurer to make without the permission of the physician an offer of liability or settlement within the policy limits. It also deletes current law that states that it is against public policy for any insurance policy to contain a clause giving the insured the exclusive right to veto any offer of admission of liability or settlement when such offer is within policy limits.

Sovereign Immunity

Sovereign immunity is an ancient doctrine firmly anchored in common law which insulates the state and any governmental officers, employees, or agents acting on behalf of the state, from a lawsuit. As explained by Justice Holmes, "a sovereign is exempt from suit, not because of any formal conception or obsolete theory, but on the logical and practical ground that there can be no legal right as against the authority that makes the law on which the right depends." Although the extent of immunity has been considerably eroded by both federal and state legislation, it is still retained under a social policy of protecting the state from burdensome interference with the performance of its governmental functions and excessive encroachments on the public treasury. The immunity is absolute and unqualified. However, Article X, Section 13, of the State Constitution permits the Legislature to waive sovereign immunity by general law. The Tort Claims Act, s. 768.28, F.S., enacts the state's waiver of sovereign immunity. Immunity is waived only to the extent that the state or any of its agencies or subdivisions would be liable if a private person would be liable to a claimant. Further, liability does not include punitive damages, interest accrued, or claims in excess of $100,000 per person, or $200,000 per incident. Employees, constitutional officers, and agents of the state and its subdivisions are immune

[12] *Robert v. Paschall,* 767 So.2d 1227 (Fla. 5th DCA 2000), *review denied,* 786 So.2d 1187 (Fla.2001), *Baker v. Tenet Healthsystem Hosp., Inc.* 780 So.2d 170 (Fla. 2d DCA 2001), and *Mercy Hospital, Inc v. Baumgardner*, 2003 WL 23008811 (Fla. 3rd DCA 2003).

from personal liability unless they act in bad faith, with malicious purpose, or in a grossly negligent manner. Any judgment above the cap must be sought from the Legislature through a claims bill. The state and its agencies and subdivisions are authorized to be self-insured, enter into risk management programs, or purchase liability insurance for whatever coverage they choose. For those state executive agencies participating in risk management programs administered by the Department of Financial Services, agency premiums are calculated on the basis of the agency's loss experience. For those choosing to purchase insurance, sovereign immunity may be waived to the extent of the insurance coverage. Although all claims against state agencies or subdivisions in excess of the sovereign immunity cap must be approved by the Legislature in the form of a claims bill, payment of claims against counties, municipalities, hospital districts, or other political subdivisions of the state is almost always directed toward the local governmental entity rather than state general revenue.

Agents of the state are generally covered by the state's sovereign immunity, and may include persons or entities, not permanently employed by the state, that enter into contracts with the state. To be considered an agent, rather than an independent contractor, a certain degree of control or supervision must be exerted by the governmental entity over the activities the agent undertakes on the entity's behalf. The resolution of whether an individual is an agent of the government is a mixed question of law and fact. To invoke sovereign immunity, the agency relationship must not only be expressed contractually, but must be established factually in the actual execution of the contract.

In the area of health services, entities which seek to be agents pursuant to s. 768.28, F.S., are immune pursuant to three different statutory approaches.

General Statutory Provisions

First, as previously indicated, s. 768.28 (9), F. S., specifies that no officer, employee or agent of the state shall be personally liable in tort unless the employee acted outside the scope of his or her employment or in bad faith. Therefore, under this general provision a specific provider of health services who functioned legally as an agent could be protected from lawsuit.

Specific Statutory Definitions

Second, within the definition of "officer, employee or agent", specific providers of health care services are designated as agents, thereby immunizing these entities. Pursuant to s. 768.28 (9) (b), F.S., members of the Florida Health Services Corps who provide uncompensated care to medically indigent persons referred by the Department of Health are explicitly defined to be officers, employees or agents of the state. Likewise, health care provider serving clients pursuant to s. 766.1115, F.S., are also considered to be officers, employees or agents.

Section 766.1115, F.S., originally created in 1992 and reenacted in 1997, provides sovereign immunity to private-sector health care providers who contract as agents of governmental entities for the purpose of providing free health care services to low-income clients of the entities. Unlike the general provisions of s. 768.28, F.S., this section establishes the conditions that must be in the contract for the health care provider to be considered an agent of the governmental contractor. The contract must provide: 1) a right of dismissal of the provider by the governmental contractor; 2) a governmental contractor's right to access to patient records; 3) that adverse incidents and treatment outcomes be reported by the provider; 4) patient selection and referral be made solely by the governmental contractor, and that the provider accept all referred patients; 5) that the patient be referred within 48 hours after emergency care is provided; 6) that patient care be subject to the governmental contractor approval; 7) that the provider be subject to the supervision and inspection by the governmental contractor.

The statute also requires the governmental contractor to provide written notice to all clients that the provider is an agent of the contractor and that the exclusive remedy for injury is under the sovereign immunity statute. Moreover, this section requires the governmental contractor to establish a quality assurance program to monitor contractual health services under this statute.

Specific Statutory Provisions

The third approach in s. 768.28, F.S., to immunize providers of health services is found in subsections (10), (11), and (12). Here, specific entities are granted agency status. These include: 1) health care providers who contract with the Department of Corrections to provide health care to inmates; 2) regional poison control centers coordinated and supervised under the Division of Children's Medical Services of the Department of Health, 3) providers of services to children and families in need of services under contract with the Department of Juvenile Justice and 4) health care practitioners, who have contracted with a state university board of trustees to provide medical services to a student athlete for participation in or as a result of intercollegiate athletics. For these entities, agency status is predicated on three conditions. One, providers must contractually agree to act as agents. Two, providers must act within the scope of and pursuant to guidelines established in the contract or by rule. Three, providers must indemnify the state for any liabilities incurred up to the limits set forth in s. 768.28, F.S.

Regardless of which approach is taken to immunize entities by conveying agency status, the fundamental issue remains whether an agency relationship actually exists. Accordingly, to better understand this question, it is necessary to review more thoroughly the salient features of what constitutes agency relationships.

Law Relating to Agency Status

The Florida Supreme Court has held that a person or entity may share in governmental immunity only when performing activities within the scope of a true agency relationship with a sovereign. Stated another way, an entity or business acting as an independent contractor of the government, and not as a true agent, logically cannot share in the full panorama of the government's immunity (This is not to say that an independent contractor cannot also be an agent, as will be discussed later).

Under Florida law, the essential elements of an agency relationship are (1) acknowledgment by the principal that the agent will act for it, (2) the agent's acceptance of the undertaking, and (3) control by the principal over the actions of the agent. Of these, the issue of control is central to the determination of agency. In a true agency relationship the principal must control, the means used to achieve the outcome, and not just the outcome itself. Central to this determination are questions as to who has the right to direct what shall be done, and when and how it shall be done. Control over the person as well as the performance of the work to the extent of prescribing the manner in which the work shall be executed and to the methods and details by which the desired results is to be accomplished, is also a key feature in establishing an agency relationship.

In the specific area of health services the courts have provided guidance as to the factors that must be present to ensure immunity for providers. In Stoll v. Noel, 694 So.2d 701 (Fla. 1997) the issue before the Florida Supreme Court was whether immunity pursuant to s. 768.28, F.S., should be granted to physician consultants who contracted with the Department of Children's Medical Services (CMS) of the then Department of Health and Rehabilitative Services (HRS). The Supreme Court held that the physicians were agents of the state and thus were entitled to statutory immunity.

In reaching its decision the Court focused primarily on the degree of control retained or exercised by CMS. The Court found that:

1. CMS required each consultant as a condition of participating in the CMS program, to agree to abide by the terms published in its HRS Manual and CMS Consultant's Guide which contained CMS policies and rules governing its relationship with the consultants.

2. The Consultant's Guide stated that all services provided to Children's Medical Services' patients be authorized in advance by the clinical medical director.

3. The language of the HRS Manual ascribed to CMS responsibility to supervise and direct the medical care of all CMS patients and supervisory authority over all personnel.

4. The manual also granted to the CMS medical director absolute authority over payment for treatment proposed by consultants.

5. The HRS Manual and the Consultant's Guide demonstrate that CMS has final authority over all care and treatment provided to CMS patients, and it could have referred to allow a physician consultant's recommended course of treatment of any CMS patient for either medical or budgetary reasons.

Also, the court noted that its conclusion was buttressed by HRS's acknowledgment that the manual created an agency relationship between CMS and its physician consultants, and despite its potential liability in the case, by HRS acknowledgment of full financial responsibility for the physicians' actions.

In 1999, the Fourth District Court of Appeal decided a case which provides additional insight into how the courts look at this issue. In Theodore ex rel. Theodore v. Graham, 733 So.2d 538 (Fla. App. 4 Dist. 1999) the issue was whether Dr. Annie Dawn-Marie Graham was entitled to summary judgment based on her affirmative defense of sovereign immunity. The case arose out of an incident involving a patient at the Regional Perinatal Intensive Care Center (RPICC) who was treated by Dr. Graham, the obstetrical director of the center. The trial court granted Graham's motion for summary judgment, ruling that the case was controlled by Stoll v. Noel. In so doing, the court viewed the record in the light most favorable to the plaintiffs and ruled that as a matter of law the plaintiff was not entitled to relief.

The District Court reversed and remanded. The Court found that the employment contract did not reserve to the government that extensive control over the patient's course of treatment which justified the result in Stoll. Central to the Court's findings were the following:

1. Determination of medical eligibility and final medical decision for admission of a patient was made by Graham;

2. Provisions in Graham's contract with HRS indicated an independent contractor status including assumption of liability for negligence and indemnification of HRS for damages arising out of her own negligent acts in the course of the operation of the contract;

3. An attachment to her contract which required Graham to develop a protocol establishing transfer procedures for patients with high risk needs;

4. Unlike the situation in Stoll, no provision incorporated in Graham's contract gave the government the right to control Graham's decision regarding patient treatment;

5. Testimony by Graham that her contract with HRS placed no restriction on the exercise of her professional judgment in treating patients. The department never attempted to dictate policies or procedures regarding how the government wanted her to diagnose and handle patients.

Given these findings the Court held that the issue of whether Graham was an agent of the state entitled to the s. 768.28 (9) (a) defense of sovereign immunity was a question of fact that could not be resolved by summary judgment. Hence, the case was remanded to the trial court for further litigation.

Changes Proposed by the Bill

The proposed bill presents findings regarding the importance of providing emergency services and care and regarding the value of private medical schools providing health services to patients of public hospitals. It extends the limitations on liability found ins.768.28, F.S. to providers of emergency services of care (i.e. practitioners, hospitals and trauma centers) by making those entities agents of the state. It

requires those agents to indemnify the state for defense costs and costs to the state up to the liability limits. It also delineates sanctions against those providers for failure to reimburse the state.

The bill also immunizes private medical schools that, via contract, provide health services to patients in public hospitals. Presently, there is not any provision to indemnify the state for any costs.

The effect of these proposed changes to patients who have been injured by the negligence of those granted agency status would vary. If a patient's economic and noneconomic damages are below the limitations found in s. 768.28, F.S., the effect is negligible. If a patient's damages are above those limits, the only recourse to recover an amount above those caps is from the passage of a claims bill.

Limits on Attorney Advertising

Present Situation

Current law provides that solicitation of legal business can be punished both as a second-degree misdemeanor and as a violation of an attorney's professional ethics.[13] Under Rule 4-7.4(a) of the Rules Regulating the Florida Bar:

> The term "solicit" includes contact in person, by telephone, telegraph, or facsimile, or by other communication directed to a specific recipient and includes (i) any written form of communication directed to a specific recipient and not meeting the requirements of subdivision (b) of this rule, and (ii) any electronic mail communication directed to a specific recipient and not meeting the requirements of subdivision (c) of rule 4-7.6 [governing e-mail communications].

There is no analogous definition of the term "solicit" in s. 877.02, F.S., the statute making solicitation of legal business a second-degree misdemeanor and thus subject to criminal prosecution as well as professional discipline. That section provides, in pertinent part:

1. It shall be unlawful for any person or her or his agent, employee or any person acting on her or his behalf, to solicit or procure through solicitation either directly or indirectly legal business, or to solicit or procure through solicitation a retainer, written or oral, or any agreement authorizing an attorney to perform or render legal service, or to make it a business to solicit or procure such business, retainers or agreements; provided, however, that nothing herein shall prohibit or be applicable to banks, trust companies, lawyer reference services, legal aid associations, lay collection agencies, railroad companies, insurance companies and agencies, and real estate companies and agencies, in the conduct of their lawful businesses, and in connection therewith and incidental thereto forwarding legal matters to attorneys at law when such forwarding is authorized by the customers or clients of said businesses and is done pursuant to the canons of legal ethics as pronounced by the Supreme Court of Florida.

2. It shall be unlawful for any person in the employ of or in any capacity attached to any hospital, sanitarium, police department, wrecker service or garage, prison or court, or for a person authorized to furnish bail bonds, investigators, photographers, insurance or public adjusters, to communicate directly or indirectly with any attorney or person acting on said attorney's behalf for the purpose of aiding, assisting or abetting such attorney in the solicitation of legal business or the procurement through solicitation of a retainer, written or oral, or any agreement authorizing the attorney to perform or render legal services.

[13] *See* s. 877.02, F.S.; FLA. BAR R. 4-7.4(a). Of course, by making solicitation of legal business a crime, the statute applies to non-lawyers, while the Bar rule, by its own terms, does not.

The Florida Supreme Court has held that, despite leaving "solicitation" undefined, this statute is not unconstitutionally vague or overbroad.[14] Nor does it intrude on the court's exclusive authority under the state constitution to promulgate rules of procedure and to regulate the practice of law.[15]

Additionally, the Supreme Court of the United States has examined the area of attorney advertising fairly frequently in its First Amendment jurisprudence. The Court has held that attorneys may be prohibited from directly soliciting clients for pecuniary gain,[16] although they may not be prohibited from volunteering to provide legal services free of charge.[17] A state cannot impose a blanket prohibition on attorney advertisements,[18] restrict attorneys from advertising the nature and price of their services or from advertising for particular types of cases,[19] or prohibit targeted mailings directed at potential clients.[20] It may, however, require a reasonable delay in such mailings following a tort or disaster.[21]

Proposed Changes

This bill creates s. 877.025, F.S., criminalizing solicitation of legal business relating to the filing of a claim for medical negligence. This bill first states a number of legislative findings, namely that, the Legislature has determined that legal advertising that solicits business, or incites a person to file medical negligence suits, destroys personal responsibility, fosters frivolous litigation, and demeans the practice of law. The findings further specify that, by creating these problems, such solicitation creates a crisis in the state's judicial system, fostering a compelling state interest in the regulation of attorney advertising set forth in the rest of the bill.

This bill provides that it is unlawful to advertise using any form of electronic or other media, in a manner that solicits legal business for a profit for the filing of a claim for medical negligence. It then defines "solicit" to mean entreating, requesting or inciting another to use the services of an attorney or law firm. However, the bill provides that this term specifically does not mean, include, or prohibit a statement in such advertisement of:

- the name of an attorney or law firm;
- the type of practice of such attorney or law firm;
- the right of an injured or aggrieved person to seek redress if such person's rights have been violated;
- a public service type announcement, so long as it does not entreat, request, or incite another to use the services of an attorney or law firm; or
- those matters expressly permitted by Rule 4-7.2(c)(11) of the Rules Regulating the Florida Bar.[22]

This bill then specifies that all forms of electronic or other media advertising by attorneys or law firms not permitted by s. 877.025, F.S., is prohibited. This bill provides that a single instance of such advertising shall be the basis for a civil penalty of $1000 for the first offense and $10,000 for each subsequent offense, defining an offense as a single advertisement published in a single print publication or through a single electronic media outlet, regardless of the number of times or in how many issues it is republished in the same publication or through the same media outlet. This bill also provides that such unlawful attorney advertising may be the basis for an injunction based on a

[14] *See Carricarte v. State*, 384 So.2d 1261 (Fla. 1980); *State ex rel. Farber v. Williams*, 183 So.2d 537 (Fla. 1966).
[15] *See Pace v. State*, 368 So.2d 340 (Fla. 1979) (citing Art. V, ss. 2 and 15, Fla. Const.).
[16] *See Ohralik v. Ohio State Bar Assn.*, 436 U.S. 447 (1978).
[17] *See In re Primus*, 436 U.S. 412 (1978).
[18] *See Bates v. State Bar of Arizona*, 433 U.S. 350 (1977).
[19] *See Zauderer v. Office of Disciplinary Counsel*, 471 U.S. 626 (1985).
[20] *See Shapero v. Kentucky Bar Assn.*, 486 U.S. 466 (1988).
[21] *See Florida Bar v. Went For It, Inc.*, 515 U.S. 618 (1995) (upholding the 30-day delay of FLA. BAR R. 4-7.4(b)(1)(A)).
[22] This rule provides a number of matters which may be included in advertising and presumed not to be solicitous.

presumption that no legal remedy is sufficient. Under this bill, the Attorney General and the Florida Bar have standing to pursue these enforcement mechanisms

C. SECTION DIRECTORY:

Section 1. Amends s. 395.0191 -- *Staff membership and clinical privileges.*

Section 2. Amends s. 415.111, F.S. -- *Civil actions.*

Section 3. Amends s. 458.320, F.S. -- *Financial responsibility*

Section 4. Creates s. 458.3175, F.S. -- *Expert witness certificate.*

Section 5. Creates s. 459.0066, F.S. -- *Expert witness certificate* (osteopathic physician).

Section 6. Creates s. 466.0115, F.S. -- *Expert witness certificate* (dentist).

Section 7. Amends s. 627.4147, F.S. -- *Medical malpractice insurance contracts.*

Section 8. Amends s. 766.102, F.S. -- *Medical negligence; standards of recovery; expert witness.*

Section 9. Amends s. 766.202, F.S. -- *Definitions; ss. 766-201-766.212.*

Section 10. Amends s. 768.78, F.S. -- *Alternative methods of payment of damage awards.*

Section 11. Legislative findings and intent.

Section 12. Amends s. 766.1115, F.S. -- *Health care providers; creation of agency relationship with governmental contractors.*

Section 13. Amends s. 768.28, F.S. -- *Waiver of sovereign immunity in tort actions; recovery limits; limitation on attorney fees; statute of limitations; exclusions; indemnification; risk management programs.*

Section 14. Creates s. 877.025, F.S. --- *Solicitation of for-profit legal services relating to medical negligence or retainers therefore; penalty.*

Section 15. Provides an effective date of upon becoming law.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues: For DOH: This bill provides for an expert witness application fee in an amount set by the board to cover the costs of the program. Assuming a fee set at $650 and assuming 200 applicants per year the first two years revenues are estimated at $260,000.
2. Expenditures: Sections 3(1) and 4(1) require expert witness certification for out of state physicians. Total expenditures are estimated for year 1 at $138,114 and year 2 at $118,251.

Fiscal impact of the proposed bill for Department of Health

	Year 1	Year 2
Salary		
1 RSII, PG 17, at 10% above minimum plus 28% for benefits. No lapse	$ 37,794	$ 37,794
Expense		
Non-recurring expense	$ 3,061	
Recurring expense package with limited travel	$ 10,841	
OCO		
Non-recurring OCO package	$ 1,500	

Sections 3(2) and 4(2): Revocation or denial of expert witness certification (enforcement impact):

Salary		
1 Invest Spec II, PG 20, at 10% above minimum plus 28% for benefits. No lapse (CSU)	$ 44,149	$ 44,249
OPS		
Expert Witness to review disciplinary cases (PSU)	$ 20,000	$ 20,000
Expenses		
Non-recurring expense for 1 FTE	$ 3,061	
Recurring expense package for 1 professional at maximum travel	$ 16,208	$ 16,208
OCO		
OCO package for 1 FTE	$ 1,500	
Total	$ 138,114	$ 118,251

B. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

Some parties injured due to medical negligence committed by an agent of the state will have their ability to recover full economic and noneconomic damages limited to the amounts specified by s. 768.28, F.S.

C. FISCAL COMMENTS:

The provisions of the proposed bill relating to sovereign immunity appear to have a substantial, indeterminate fiscal impact. The number of claims for medical negligence that will be affected by this bill is unknown. All claims relating to the negligent provision of emergency services and care, as well as health services provided by certain private medical schools, will be defended by the state. These costs will include investigations and management of all litigation cases, as well as eventual liability for damages. Claimants will have a right ultimately to pursue a claims bill. Some claimants who have reduced or nonexistent incomes due to their medical malpractice injuries and high medical expenses with insufficient means to pay for care will likely become eligible for Medicaid.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

The bill does not require cities or counties to expend funds.

2. Other:

Sovereign Immunity

Making providers of emergency services and care, as well private medical schools, agents of the state raises an issue of whether a claimant's access to court is being impermissibly infringed. If a true agency relationship (with sufficient control over the agent by the principal) is established, then, consistent with court decisions regarding sovereign immunity, the access to court argument should be resolved in favor of the state. However, if these entities are found not to be agents of the state, then the courts will likely apply the test enunciated in Kluger v White.[23]

In Kluger, the Florida Supreme Court considered the Legislature's power to abolish causes of action. At issue was a statute which abolished causes of action to recover for property damage caused by an automobile accident unless the damage exceeded $550. The court held that the statute violated the access to courts provision of the state constitution.

The "access to courts provision" (article 1, section 21) of the Declaration of Rights in the Florida Constitution requires that the courts "be open to every person for redress of any injury". In Kluger, the court held that where a right to access to the courts for redress for a particular injury predates the adoption of the declaration of rights in the 1968 state constitution, the legislature cannot abolish the right without providing a reasonable alternative (commensurate benefit) unless the legislature can show (1) an overpowering public necessity to abolish the right and (2) no alternative method of meeting such public necessity.

Regulation of Commercial Speech

Both the First Amendment to the Constitution of the United States and Article I, Section 4 of the Florida Constitution protect freedom of speech.[24] Florida courts, and federal courts applying Florida law, have interpreted the state constitutional provision to accord with the protections of the First Amendment: i.e., the state constitution guarantees no more protection than does the federal constitution, and Florida regards federal case law interpreting the First Amendment's protection of

[23] *Kluger v. White*, 281 So. 2d 1 (Fla. 1973).

[24] The Free Speech Clause of the First Amendment applies to the states through incorporation in the Due Process Clause of the Fourteenth Amendment. *See Gitlow v. New York*, 268 U.S. 652 (1925).

free speech as authoritative with respect to its own free-speech provision.[25] It is possible that this bill may raise concerns under these provisions.

The Supreme Court of the United States has held that the First Amendment protects commercial speech.[26] However, the Court has also recognized that there is a "'commonsense' distinction between speech proposing a commercial transaction, which occurs in an area traditionally subject to government regulation, and other varieties of speech."[27] Therefore, while commercial speech is protected to an extent, regulation of commercial speech is subject to a lower standard of judicial scrutiny than is regulation of other forms of speech.[28]

The basic framework for analyzing any regulation of commercial speech was laid out by the Court in *Central Hudson Gas & Elec. Corp. v. Public Service Commission of New York.*[29] Under *Central Hudson*, government may ban commercial speech that is deliberately misleading or relates to unlawful activity,[30] but if the speech does neither of these things, the regulation in question must meet a three-prong test:

a. The government must have a substantial interest in restricting the speech;
b. The regulation must directly advance the asserted interest; and
c. The regulation must be narrowly tailored to serving the asserted interest.[31]

In 2001, the Florida Supreme Court had the opportunity to apply *Central Hudson* to a statute similar to the one amended by this bill, namely the prohibition on unlawful insurance solicitation provided in s. 817.234(8), F.S. In *State v. Bradford*,[32] a licensed chiropractor was convicted of insurance solicitation, and contended that the statutory prohibition was an unconstitutional restriction of commercial speech. The court agreed, finding that although the state's interest in preventing insurance fraud was substantial enough to meet the first prong of the *Central Hudson* test, the fact that intent to defraud was not an element of the crime made the statute fall fatally short of either of the other two prongs.[33]

Thus, it is possible that, applying *Bradford*, a court could find that some or all of this bill's provisions do not meet the *Central Hudson* test and are thus unconstitutional restrictions on commercial speech. It is also possible, however, that the broader interests asserted in this bill's legislative findings could make it distinguishable from the statute at issue in *Bradford*, thus requiring more sweeping regulation that could be regarded as narrowly-tailored for lack of any more narrowly-tailored alternative that would actually remedy the asserted problems.

B. RULE-MAKING AUTHORITY:

None.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

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[25] *See, e.g.*, *University Books and Videos, Inc. v. Metropolitan Dade County*, 78 F.Supp.2d 1327 (S.D. Fla. 1999); *Cafe Erotica v. Department of Transportation*, 830 So.2d 181 (Fla. 1st DCA 2002); *State v. Globe Communications Corp.*, 622 So.2d 1066 (Fla. 4th DCA 1993); *Florida Canners Assn. v. Department of Citrus*, 371 So.2d 503 (Fla. 2d DCA 1979).
[26] *See Virginia Pharmacy Board v. Virginia Citizens Consumer Council*, 425 U.S. 748 (1976).
[27] *Ohralik* at 455-56 (1978).
[28] *See id.*
[29] 447 U.S. 557 (1980).
[30] This part of commercial-speech doctrine predates *Central Hudson*. *See, e.g.*, *Friedman v. Rogers*, 440 U.S. 1 (1979) (false or misleading advertising); *Pittsburgh Press Co. v. Human Relations Commission*, 413 U.S. 376 (1973) (speech promoting an unlawful transaction).
[31] *See id. See also Board of Trustees of the State University of New York v. Fox*, 492 U.S. 469 (1989).
[32] 787 So.2d 811 (Fla. 2001).
[33] *See id.* at 821-27. The court also found that, even if the statute met the second prong, it would not meet the third.

IV. AMENDMENTS/COMMITTEE SUBSTITUTE CHANGES

None.