Medical Malpractice 101

Overview of Medical Liability Cases

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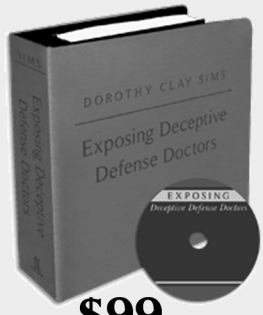

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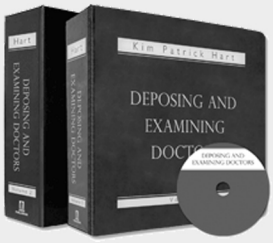

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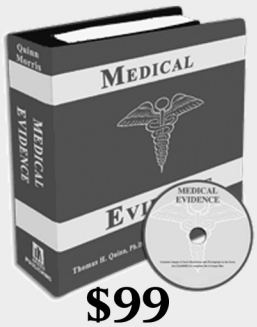

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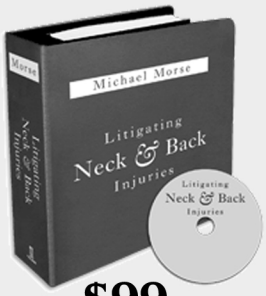

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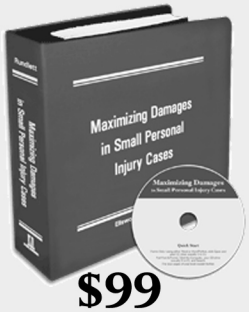

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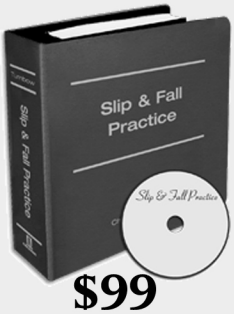

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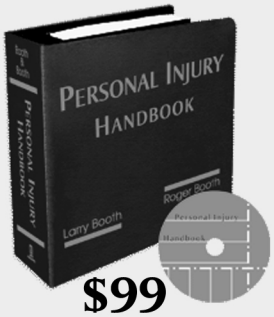

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Medical Malpractice 101: Overview of Medical Liability Cases
Agenda

Part I – 9:15 a.m. – 10:45 a.m.

I. Pre-Suit Activity
   a. Meeting the Client – "You Get the Call" (10 Minutes)
   b. Medical Records – "How am I Going to Understand the Medicine" (15 Minutes)
      i. Getting Medical Records
      ii. Electronic Medical Records
      iii. Evaluating Medical Records
   c. Expert Review (10 Minutes)
      i. The Role of the Treating Physician
      ii. Sources for Expert Witnesses
   d. Rejecting or Accepting the Case (10 Minutes)
      i. Can You Establish Liability and Causation?
      ii. Are the Damages Significant?
      iii. Are There Problems with the Clients?
      iv. Is There a Problem with the Defendant Healthcare Provider?
      v. Is There Another Reason to Take or Not to Take the Case?
      vi. Declining the Case - Declination Letter
   e. Statutes of Limitations (10 Minutes)
      i. Discovery Rule
      ii. Continuing Course of Treatment
      iii. Fraudulent Concealment
      iv. Foreign Objects
      v. Tolling Events
   f. Elements of a Medical Negligence Case (25 Minutes)
      i. Standard of Care/Liability
         1. General Theories of Liability & Case Examples
            a. Failure to Diagnose
            b. Failure to Treat
            c. Failure to Monitor
            d. Unnecessary Treatment
            e. Known Complications
            f. Informed Consent
            g. Loss of Chance
            h. Psychiatric Malpractice
            i. Negligent Credentialing
            j. Prenatal Torts
         2. Proximate Cause

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3. Damages - Assessing Damages

BREAK – 10:45 a.m. – 11:00 a.m.

Part II - 11:00 a.m. – 12:30 p.m.

II. The Anatomy of the Malpractice Law Suit
  a. Pre-Trial Activity (25 Minutes)
    i. Pleadings & Discovery
      1. The Complaint
        a. The Parties
        b. Vicarious Liability
      2. Interrogatories – Bills of Particulars
      3. Discovery Demands/Documents
        a. Rules/Regulations/Protocols
        b. Medical Records/Billing Records/Insurance Claims
      4. Depositions
      5. Expert Disclosure
    ii. Trial Prep (15 Minutes)
      1. Evidence – Getting it In/Keeping it Out
      2. Witnesses
        a. Preparing
        b. Investigation
      3. Proposed Jury Charges
        a. The Trial (1 Hour)
        b. Jury Selection
        c. Opening
        d. Cross of Defendant
        e. Direct of Plaintiff
        f. Direct & Cross of Experts
        g. Charge Conference
        h. Summations
        i. Verdict

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Contents

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MEDICAL MALPRACTICE 101

Introduction

Malpractice is professional negligence and medical malpractice is the negligence of a doctor or healthcare provider. An action for medical malpractice is a negligence action for personal injuries or wrongful death that occurred during the course of medical treatment. This "negligence" is most commonly referred to as a departure from the good and accepted standards of practice among medical professionals. While this may sound simple to prove, just what constitutes the accepted standard of care and what constitutes a departure there from may require an advanced knowledge and understanding of medicine, and particularly medical terminology. For an attorney, prosecuting or defending a medical malpractice action, this is merely the beginning. These alleged departures from the standard of care must be molded to fit within the framework of the procedural and substantive laws that apply to malpractice cases in the appropriate jurisdiction. This requires a technical mastery of the principles of medicine and negligence law. This is something that can only be acquired with experience. This course, Medical Malpractice 101, will provide the basic framework for the anatomy of a malpractice case. It is an introduction. Both you and your clients will be well served by associating yourselves with experienced co-counsel while you develop the skills and expertise to handle these complex cases on your own.[1]

[1] These materials were prepared by Abend & Silber, PLLC as part of a Continuing Legal Education program or for publication in a professional journal and do not constitute legal advice. You are cautioned that because the law is continuously evolving and widely variable from jurisdiction to jurisdiction, all or portions of these materials might not be up to date or applicable in your jurisdiction at the time you read it.

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I. Pre-Suit Activity:

As an attorney aspiring to handle malpractice cases, you should have an organizational structure at your office so that there's a system in place to intake, investigate and process your cases. Medical malpractice cases are unlike routine negligence cases. The medical records from one case alone could very easily dwarf the files of ten accident cases combined.

A. Meeting the Client – "You Get the Call"

There are a few ways you may receive the initial lead regarding a prospective malpractice case. An experienced attorney with a t rack record of successful verdicts and settlements will likely receive many leads from a network of referring attorneys. Attorneys who do not handle malpractice cases regularly will usually be smart enough to know not to handle a malpractice case on their own. Some of these attorneys may handle personal injury cases and may even be able to screen the calls before making the referrals but many attorneys who may be handling bankruptcies, immigration, real estate or some other totally unrelated field may not even want to screen the call. As soon as they hear malpractice, they get you on the phone. As experienced malpractice lawyers, we tell our referrers to contact us about every inquiry. Sometimes, it may not sound like a viable case to the inexperienced, but we'd rather make that decision ourselves.

In other instances, you may receive direct inquiries which might be a referral from a former client, a personal friend, a response to an advertisement or even via

email if you have a web presence. Regardless of how you get the lead, the initial contact with the client begins a dialogue which will include fact finding, data collection, research and review.

The initial client interview is the earliest opportunity you will have to screen this potential case and will be crucial to your decision to even think about proceeding further. You will want to gather as much relevant information as you can so you can make an educated decision as to whether you will want to invest your time and resources into this potential matter.

After making an initial determination not to reject the case outright, the investigation begins. There are many possible ways this inquiry might go from initial contact to a lawsuit being filed but most certainly, if you intend to pursue, you will be obtaining the most detailed history from the client, obtaining all of the medical records, reviewing medical literature and conferring with expert witnesses. We will discuss these aspects of the investigation as they effect the important decisions you will have to make about whether to proceed with the case.

B. Medical Records – "How am I Going to Understand the Medicine?"

a. *Getting Medical Records*

After taking a detailed history from your client, you should be able to identify the basic records you will need to evaluate the potential case. We

will discuss specific types of medical records and what to do with them a little later. Every malpractice attorney asks themselves the question of how they will learn to understand medical records. Obviously with time and experience, the terminology becomes more familiar and certain medical-legal themes become easily recognizable. In an automobile accident case, it may seem obvious that upon retention, you will request the emergency and hospital records as well as the records of the treating doctors. In malpractice cases, at least at first, you will want to obtain the records of the defendant doctor or hospital. The process by which you do this varies by jurisdiction but is similar to how you would get the records in a regular personal injury case. However, once a malpractice case is filed and the defendant doctors or medical facilities have retained counsel, any further requests for records should be directed though their counsel or via discovery device.

Access to medical records is controlled by state and federal statutes. HIPPA, the Health Insurance Portability and Accountability Act of 1996, is a b road sweeping statute regulating health insurance and health information, among other things. A ccording to the United States Department of Health and Human Services "The HIPAA Privacy Rule provides federal protections for personal health information held by covered entities and gives patients an array of rights with respect to that information. At the same time, the Privacy Rule is balanced so that it

permits the disclosure of personal health information needed for patient care and other important purposes."

Healthcare providers cannot prevent access to your client's records but the mechanism of getting those records is subject to varying state laws. The most common way of getting those records is to have your client execute a release form or authorization for you to obtain the records. A sample of a New York court approved, HIPPA compliant, authorization form is provided in the accompanying materials. Many states have similar forms which can be found rather easily online.

Typically, the client will be asked to sign an authorization form for each doctor or facility that treated them. This process can be cumbersome, particularly where there is an ongoing course of treatment. The end result can be monthly or even weekly mailings back and forth between lawyer and client just to keep up to date with authorizations. Add litigation to the mix where you will be obligated to provide these authorizations to one or several law firms representing the defendants in the case and it can become a logistical nightmare. One smart judge in New York that long presided over a l arge inventory of malpractice cases which were often delayed because of authorization exchanges came up with an idea to simplify the process. The solution was an amendment to the New York Public Health Law which allows the client to give the lawyer a power of

attorney to execute the HIPPA authorizations on their behalf. The amendment to the law has become known as the Sklar Law, in recognition of Judge Stanley Sklar who worked tirelessly to see this law enacted. It has dramatically streamlined the process. If your state doesn't have a similar law, consider working with your trial lawyers association or bar association to bring this efficient idea to your state.

Medical records may be expensive to obtain. Medical providers have a right to charge for copying and mailing records. A two week hospital admission could easily produce a chart that is several hundred pages long. Obviously, if the medical provider is a defendant in a lawsuit you will absolutely need every single page of those records. However, you may choose at the very outset of your investigation to limit your request to specific portions of the chart. For instance, if your claim involves an injury during the course of a surgical procedure, you may want to limit your request to the operative report, anesthesia records, recovery room records admission and discharge notes. Of course this is totally dependent on the nature of the case. You also may want to avoid sending blanket requests to a hospital for their records. You may end up with records that are totally unrelated. You do not need the records relating to the labor and delivery of your client's three children when you are investigating her failure to diagnose appendicitis case. You can limit the request for records to a specific time frame to solve that problem.

b. *Electronic Medical Records*

In today's electronic age, many more facilities are using automated systems for generating and storing medical records. This presents several issues for practitioners. A traditional paper chart required medical professionals to make written entries in chronological order. In a basic hospital admission one would customarily expect to see, among many variants, Triage/ER records, admission notes, assessments, consultation notes, physician's orders, progress notes, nurse's notes, procedure reports, laboratory and diagnostic test results and a discharge summary. One would expect these entries to be chronologic. Making a change or adding information to an entry would be fairly evident from a margin entry or a cross out. However, if you receive a computerized record of neatly typed records it may be impossible to know if there was a subsequent entry or whether the entry was altered in some way, whether it was by addition or removal. If this is an issue in a case, it may require computer forensics for complete evaluation. Another issue results from the database that the medical personnel are using. When traditional checklists were used the doctor or nurse would check boxes or circle items from a lengthy list of items. But entering this information at a computer terminal, there may be many options for them to check or pull down from menus but none of the unchecked options will appear in the chart when you receive a paper print out. For example, in the materials is a "pre-anesthesia" review of systems check list from a surgical procedure. There is an exhaustive list of items

one would presume the anesthesiologist is supposed to answer based on a conversation with the patient. Most of these yes or no questions are blank and the evidence is right there on paper. In a computer-generated review of systems there may be dozens or even hundreds of variables on the intake screen for the physician but if an answer is not inputted at the terminal, the paper printout may not even list any of those blank or unanswered questions. One must take great care in analyzing and evaluating these computer generated records.

c. *Evaluating Medical Records*

Your client's medical records will be among the most critical evidence you will need in any malpractice case. We have attached an example of some common medical records (in simplest form) to the materials. We will briefly review these common types of medical records and identify key strategies for mining the records for compelling evidence. Rarely will a physician admit malpractice in a hospital chart. Being intimately familiar with the types of documents you will see in the records and how those documents interplay with each other can help you put these puzzle pieces together to form the complete picture.

C. Expert Review

After thoroughly interviewing your client and then obtaining and reviewing the medical records to satisfy yourself that the potential case is still worth pursuing, the next step is to get the opinion of an expert in the appropriate field to confirm

that there was in fact a deviation from the standard of care and that the deviation was the cause of some injury or damage to the client. This will be one of the most critical tasks in the entire process. Your goal, of course, is to find a physician who is willing to testify that the defendants conduct did not meet the standard of care and that this resulted in damage to the plaintiff. Often you will need different experts to answer each of those questions. For instance, in a failure to timely diagnose colon cancer case, you may need an internist or gastroenterologist for the issue of the delayed diagnosis and an oncologist for the issue of whether the delayed diagnosis had an effect on the spread of the cancer. When seeking an expert it is important not to just look for someone who is flexible and willing to stretch their opinion. This person may be subject to vigorous cross examination at some point in time and you want to make sure their opinion can withstand that. You should be able to identify possible defenses and review these with the expert before you proceed so that you can be sure that the case is a strong one.

a. *The Role of the Treating Physician*

The doctor or doctors who assume care of your client after the malpractice has occurred can be a useful resource. Most of the time, they will not be interested in getting involved in the case, particularly when they may be in the same medical community as the defendants but it is always worth taking the chance. On occasion, you may find one who is so bothered by the circumstances that they will agree to offer their critical opinion.

Additionally, you might find that even if they are not willing to testify

regarding liability issues, they may have less of a concern testifying about proximate causation or other ancillary issues.

b. *Locality Rule?*

In some states, Tennessee for example, the statutory medical malpractice laws specifically require that the standard of care incorporate a "community" requirement that holds a physician to the standard of care in the "community" in which the defendant practices or in a similar community. In such circumstances you will need to make sure that the expert practices in the same or a similar community as the defendants. For example, if the defendant practices in an urban academic based medical center, your expert should have similar credentials. If the defendant practices in a more rural area you would need an expert from a similar community. Many jurisdictions have eliminated the locality rule and it is up to the fact finder to determine whether the expert's opinion of the standard of care is reasonable under the circumstances. Even if your case is in a jurisdiction that does not follow the locality rule, it would be unwise for you to retain a Harvard trained doctor who practices at a major academic medical center to testify in a case against a small town doctor.

c. *Sources for Expert Witnesses*

Experienced malpractice lawyers often have relationships with physicians who are willing to review cases. If you handle birth injury cases, you will certainly have a relationship with an obstetrician/gynecologist that you can

consult with on subsequent cases. That expert may in turn be able to refer you to a pediatric expert or a neonatologist, etc. In addition to your own network of experts, referrals from other attorneys are a great way to find experts. While some colleagues may be resistant to sharing experts, all in all you will find that many are willing to share and in turn, may be eager to contact you to get suggestions for their own needs. These referrals from colleagues are an excellent way to get qualified experts because you will have the benefit of your colleague's prior experience with the expert and you will have a credible introduction to the expert based on the expert's comfort level with your referring source. If you subscribe to your jurisdiction's Jury Verdict reporter, you may also see cases with similarity to some of your own and you can contact the lawyer or the experts from that source as well. Lastly, there are many services available commercially that may be able to secure experts for cases. These services often have relationships with a large number of potential witnesses so if you need an expert in an obscure specialty or in a particular jurisdiction, a service may be the way to go. Obviously you need to screen any potential expert before you retain them to make sure they are not vulnerable to cross examination for giving inconsistent testimony in the past or that they simply testify too much to have the credibility that your case requires.

D. Rejecting or Accepting the Case

a. *Can You Establish Liability and Causation?*

b. *Are the Damages Significant?*
c. *Are There Problems with the Clients?*
d. *Is There a Problem with the Defendant Healthcare Provider?*
e. *Is There Another Reason to Take or Not to Take the Case?*
f. *Declining the Case - Declination Letter*

E. Statutes of Limitations

The statute of limitations in any jurisdiction will define the time period within which your case must be filed in court. There is no hard and fast rule for determining what limitations period will govern any particular case. The only hard and fast rule is to file your action before the deadline. To do so, you must be able to identify the proposed defendants and theories of liability and to quickly be able to identify and deviations from the "normal" limitations period applicable to cases against individual and private defendants. Because many states and localities operate municipal or public benefit hospitals which may offer certain protections for their employees, it is essential that a detailed investigation of the parties be undertaken from the outset so that you can record the most conservative estimate of the limitations deadline in your computer and diary and make sure your case is filed before that date. You are wise to not waste time commencing actions as you can always add or change parties before the expiration of the statute of limitations but you do not have that luxury if you file at the last minute.

a. *Discovery Rule*

A discovery rule "tolls" the statute of limitations until such time as a plaintiff knows or reasonably should have known that they were the victim of malpractice. We see this most commonly with delayed diagnosis cases.

For example, a plaintiff might not know that they have a case until their disease is ultimately diagnosed. If the disease should have been diagnosed more than a few years before, it is conceivable that their statute of limitations will have expired prior to their even knowing they had the disease. Forty-five states have enacted some form of a date of discovery rule specifically for medical malpractice or generally for all personal injury actions. New York is one of those few that do not have any discovery rule at all and so the limitations period starts when the wrong occurred whether they know about it or not. These rules vary widely from state to state and the prudent practitioner is urged to review their jurisdiction's applicable rules.

b. *Continuing Course of Treatment*

Many jurisdictions toll the limitations period based on the plaintiff's continuing course of treatment. The start of the limitations period is postponed until treatment of the particular ailment is concluded. So if a surgeon botches a surgical procedure, the limitations period does not begin on the date of the surgery, but rather the last date that the surgeon treats the patient in relation to this injury. Again, the rules related to continuous treatment vary widely from jurisdiction to jurisdiction and must be carefully examined.

c. *Fraudulent Concealment*

Similar to a discovery rule, many jurisdictions recognize a toll of the limitations period where fraud or fraudulent concealment of the

malpractice is provable. The limitations period in these cases may be measured from the date that the plaintiff knew or reasonably should have known about the fraud. Our caveat again: check your local rules as these tolling provisions and rules vary widely from jurisdiction to jurisdiction.

d. *Foreign Objects*

Another example of a rule similar to the discovery rule is a foreign object rule which applies to cases where a foreign object (surgical instrument, gauze, etc.) is left inside the plaintiff's body. Here, there may be a toll until such time as the plaintiff finds out about or reasonably should have known about the foreign object. The distinction between the discovery rule and a foreign object rule in a jurisdiction that has both may simply be the length of the tolling period. In New York for example where there is no discovery rule, there is a foreign object rule which gives the plaintiff one year from the time the object is found or reasonably should have been found. Exactly what is a foreign object is also debatable. Again, in New York, chemical compounds, fixation devices or prosthetics are not foreign objects under the theory that intentionally implanted devices cannot be considered foreign objects. The oft cited example is that of a suture, improperly placed in the wrong organ during a surgical repair is a fixation device and not a foreign object subject to a discovery like limitations toll.

e. *Wrongful Death*

Some jurisdictions have separate and distinct limitations periods for wrongful death causes of action which may differ from the limitations

period for medical malpractice. There may very well be two limitations periods arising out of one negligent act.

f. *Federal Tort Claims Act (FTCA)*

The Federal Tort Claims act applies to actions against the United States and its agencies (VA, Department of Health & Human Services, etc.) and employees. The FTCA is a waiver of sovereign immunity and as such, the act is fraught with technicalities and traps for the unwary. Furthermore, these technicalities have been litigated all across the country and have produced a wide ranging analysis by the differing Federal District Courts and Circuit Courts of Appeals so once again, practitioners are urged to review their local laws. Generally, the federal statute of limitations for claims under FTCA provides two timelines: (1) an administrative claim must be filed within two years of the date the claim accrues first; and (2) suit must be filed within six months of an agency's final denial of the claim. What constitutes accrual at each stage and how it is measured is a source of controversy and variation. The jurisdiction is the Federal District Court. There is no jury trial and there are restrictions on the amount of contingency fees you can charge. You must review these rules before accepting the case and filing the suit.

F. Elements of a Medical Negligence Case

a. *Standard of Care/Liability*- The plaintiff must prove that the defendant(s) departed from good and accepted medical practice in each instance. The

following are several examples of typical medical malpractice cases.

1. General Theories of Liability & Case Examples

- Failure to Diagnose: In medical malpractice cases it is often the case that the initial injury is deemed "a risk of the procedure" however the failure to diagnose that condition is a departure from good and accepted medical practice. The best way to understand this is by an example. If a doctor perforates the colon during a routine colonoscopy that act in and of itself may not be a "departure". It is generally understood to be an accepted complication of the procedure. But, if the doctor fails to diagnose the perforation after signs and symptoms are apparent then that would be malpractice. Another classic example of the failure to diagnose case relates to cancers. It is axiomatic that the sooner a cancer is diagnosed the greater the likelihood of successful treatment. When a doctor fails to recognize the apparent signs or symptoms of a malignancy or fails to order the appropriate screening tests, there may be liability.

- Failure to Treat: We represented a 59 year old man that died as a result of a sudden heart attack. The patient presented to his family doctor and on each visit he is found

to have abnormal blood pressure combined with a history of smoking and a family history of heart disease. The doctor indicated a diagnosis of hypertension or high blood pressure but failed to perform an EKG or obtain lab tests including routine blood work during the 5 year period she treated the patient. Additionally the doctor failed to make any referral to a cardiologist. We claimed that all of these departures resulted in his death.

- Unnecessary Treatment: The best example of this type of case is surgery to the wrong body part. We represented someone that went in for surgery on their left knee and underwent surgery on his right knee. It is unbelievable that something like this happens but even at the best hospitals your surgeon (or a member of the surgical staff will ask you to initial the body part being operated on). It may seem primitive but these measures are essential for helping to prevent these egregious mistakes.

- Birth Injury Cases: These are some of the most tragic cases we deal with. These cases involve devastating neurological injuries sustained by babies during the course of the labor and delivery. More often than not they involve a deprivation of oxygen that has serious and permanent

consequences for the child.

- Known Complications
- Informed Consent
- Loss of Chance
- Psychiatric Malpractice
- Negligent Credentialing

b. *Proximate Cause*: In medical malpractice cases, nothing is more complicated than the issue of causation. Failure to diagnose cancer cases presents the best example. Let's assume you have a client walk into your office and she tells you that she was just diagnosed with lung cancer but that a month earlier she had an outpatient surgery and a chest x-ray was done as part of the pre surgical screening and nobody mentioned anything to her about cancer. Sure enough, you have the two films compared and the mass was missed a month earlier. The question in malpractice and more particularly, in causation, is what difference does it make? In failure to diagnose cancer cases a month does not make enough of a difference to pursue a case. Here is a more complicated example. We represented a woman that was clearly the victim of malpractice. In fact, her radiologist admitted that he missed a mass on her lung in a chest x-ray. This error delayed the diagnosis and treatment of her lung cancer by a year causing a substantial decrease in her chance for a cure and long term survival. In fact, during the year the disease metastasized to her liver and brain and eventually caused her death. If the story ended there then it

would be a relatively straightforward case. Of course, it is more complicated than that. Colon cancer was also found and an examination by several pathologists that we retained indicated that our client was suffering from two separate primary cancers. This took a relatively simple case and turned it into one of the most complex.

c. *Damages - Assessing Damages*

It is always important to analyze the potential damages of a given case. You may have the most glaring case of malpractice but if the plaintiff has not (or will not) sustained any meaningful damages then it is not a case to pursue. The threshold of how much is enough is different for every firm.

II. The Anatomy of the Malpractice Law Suit

A. Pre-Trial Activity

a. *Pleadings & Discovery*

i. **The Complaint**

1. The Parties: Identifying defendants

Once you've obtained the medical records and had them reviewed it is now important to determine who you are going to sue—this can only be done by a thorough examination of the medical chart—this often involves a need to obtain the identification of signatures. This can be done by contacting the risk management department of the particular hospital. An

important maxim is that when identifying possible defendants it is better to be over inclusive than under inclusive. You can always discontinue against a defendant at a later stage of the litigation but you may run out of time within which to add parties.

2. Expert's Affidavit or Certification

Varying jurisdictions have varying rules regarding an expert's affidavit or certification as to the potential merits of the case at the time of a law suit's filing or shortly thereafter. You are urged to carefully review the local laws to determine the filing requirements. In some states, such as New Jersey, an affidavit from a physician or physicians in the same specialty as the defendants must be filed with the court within 60 days of the defendant's answer, with very limited exception, attesting to the merits of the causes of action. This has been held to be a jurisdictional requirement and a dismissal for failure to comply has been held to be with prejudice – case over. In New York, on the other hand, the law requires a certificate of merit from the attorney that he or she has consulted with an expert and the expert has advised that the cause of action is meritorious – a much easier standard to

comply with.[1] Because of the potential consequences of this and the varying degrees of applicability, this ought to be of foremost concern when drafting your complaint.

3. Vicarious Liability

In most jurisdictions, a hospital is vicariously liable for the conduct of its employees under the legal principle of *respondeat superior* or vicarious liability. While some physicians practicing in a hospital setting may be acting as an independent contractor for the hospital, in many jurisdictions, a doctrine of implied agency or agency-in-fact has developed in the law to hold the hospital liable for the conduct of doctors practicing there. This is often very fact specific. The typical example is when a patient is brought in through the emergency room and seeking the services of the hospital, generally, for treatment. The patient does not engage a p articular physician but is treated by whoever is present at that time. Implied agency holds that even contracts between the physician and hospital which make the physician an independent contractor are irrelevant to the

[1] New York is one of the remaining jurisdictions where you do not need to disclose the name of your expert until the expert is called to the witness stand at trial. There are no expert depositions. This follows the old model where it was necessary to protect experts from intimidation from their colleagues if it as known that they were testifying for a plaintiff. As a result, some of the basic procedural rules are unlike the majority of jurisdictions because of the need to protect the expert's identity.

question of vicarious liability. In other words the hospital cannot hide behind these secret contracts when it holds itself out as treating the patient. The consequences of these legal relationships could impact available insurance coverage and whether you can hold a defendant hospital responsible for the conduct of a non-party who may have been thought to be an employee. Interrogatories – Bills of Particulars

ii. **Discovery Demands/Documents**

1. Rules/Regulations/Protocols: These should always be requested in any case involving a hospital. This can be especially helpful in nursing home cases involving the failure to prevent and treat decubitus ulcers or bedsores. Every hospital or skilled nursing facility should have rules and regulations regarding wound care protocol and the prevention of bedsores. O nce you obtain the applicable rules and regulations they can be invaluable in comparing them to the patient's chart.
2. Medical Records/Billing Records/Insurance Claims: Billing records and Insurance Claims forms are helpful when you are trying to identify all parties and records, especially when the client's recollection is

faulty. If a doctor or hospital received payment you can rest assured that there is a record with the insurance company. This is often the best way to obtain a good chronology of where the patient went during the course of his or treatment.

iii. **Depositions**

Medical records provide you with many of the facts for any medical encounter but many records are illegible or provide a dearth of information. The deposition of the defendants can help fill in the blanks. Additionally, the deposition of the defendant gives you an opportunity to obtain information regarding why the defendant did or did not do certain things. Anyone can ask a defendant to simply translate their records but a good deposition is more than that. The best way to approach a deposition is to determine in advance what you hope to gain from it. It is important to think about your theory of the case and what you need to prove at trial. If you don't know that before the deposition then it is impossible to conduct a meaningful deposition. The next time you will be questioning the witness is at trial so you want to ensure that when you are finished there is no question left unanswered. Another point is too often lawyers like to cross examine witnesses at a deposition. It is far better to save this for trial. While, it is important to let the witness know you are in charge you are much

better served by asking open ended questions then by suggesting an answer at this stage of the proceeding. There are exceptions to this rule but you want to cover every eventuality and lock the defendant into a position so there is no wiggle room. The most important thing to be gained from a deposition is to learn what type of witness the defendant will make at the time of trial. This is not something that can be gleaned from the medical records or the credentials of the witness. There are some people that no matter what they say a jury will never believe.

iv. **Expert Disclosure**

Every state is different but you must serve disclosure of the experts you plan to call. Of course, in preparing your disclosure you want to make sure that everything you expect your expert to testify about is contained in the document. It is always better to be over inclusive then to be precluded at the time of trial. Nothing is worse than paying you expert to come to Court to testify and having a judge preclude them from testifying. It is equally important to examine the other party's disclosure for any discrepancy from testimony. We have had success in having defendant's experts precluded from testifying.

Additionally, it is useful, once you have determined the identity of the expert, to obtain as much information about the expert as

possible. In addition to biographical information it is invaluable to obtain transcripts of any prior testimony.

B. Trial Prep

a. *Evidence – Getting it In/Keeping it Out*: Before you start a trial you must determine what you need to prove and how you are going to prove it. You may be able to explain your case to a jury in an opening or closing statement or to a judge in a pre-trial conference but it is the actual testimony that gives life to your claims. A claim unsupported by evidence is a recipe for a defense verdict. It is important to determine in advance how you will get each and every piece of evidence admitted into evidence. It is equally important to think about any evidence that you wish to be inadmissible. If there is question of admissibility then you should be prepared with a memo or motion in limine on the issue. If possible, a conference with opposing counsel in advance of trial can be helpful in stipulating to what evidence will and will not be admissible at the time of trial.

b. *Witnesses*

i. **Preparing**

Obviously preparation is important to any good examination. While there is probably no such thing as too much preparation you don't want a witness to seem like an over rehearsed robot that has simply memorized a script. Preparation of expert witnesses can be

difficult especially when it comes to scheduling but I don't recommend putting an expert on the stand unless you have had an opportunity to prepare them. Make sure to utilize your prep time to prepare any witness for the likely cross examination points that defense counsel will make. It is much better to make the expert, or any witness, aware of the case's shortcomings in advance rather than be surprised on cross examination. Along those lines it is important to provide the expert with all necessary material and records in advance. A favorite avenue for cross examination is inquiring of all the various documents a witness has failed to review.

ii. **Investigation**

Before you cross examine any witness it is helpful to know as much as possible about them. Some of the physicians testifying may have published articles or given prior testimony that are at odds with the proposed testimony in the pending lawsuit. If you are able to find that this can make for very effective cross examination. Unfortunately, it requires hours and hours of pouring over transcripts and arcane medical journals. Even if you don't find something directly on point you will have gained a valuable insight into the witnesses thinking and manner of testimony. Good investigation is never a waste of time. The above is also true of your own witnesses. It would not be pleasant to put someone on

the stand that has previously taken a contrary position. It is import to ask your witnesses about this in your pre-trial meetings.

c. *Proposed Jury Charges*
We recommend preparing your proposed charge as soon as possible. It helps to refine your theories and prepare your case for jury presentation. Remember this is what the jury will hear after all evidence is presented so if you have presented your case with this in mind you will be well served. It is advisable to tailor the proposed testimony and key points in your summation to the eventual charge.

C. Trial

a. *Jury Selection*
This is your first chance to make an impression with the jury and your only chance in advance of the verdict to hear what they have to say on the topic of medical malpractice cases and so this is a very important and meaningful part of the trial. What you really what to discuss with your panel are their feelings regarding medical malpractice cases. Many potential jurors may have strong feelings regarding medical malpractice cases. It is important to flesh out those feelings and get the others in the room that may not feel as strongly talking about it so you can identify others in the room that might feel similarly. The goal here is to deselect those who may have some bias against malpractice cases generally or the subject matter of the case on trial more particularly.

b. *Opening*

This is your opportunity to create a theme for your case. There are many

different ways to conduct an opening statement. The traditional manner is to prevent a roadmap of what you intend to prove to the jury. Another effective manner is to attempt to grab the attention of the jury by starting with some gripping detail about the case.

c. *Cross of Defendant*

The cross examination of the defendant is the most anticipated part of the trial from the jury's vantage. The first practical point we suggest (if permissible in your jurisdiction) is that you subpoena the defendant as a witness and call them as a witness during the plaintiff's case. This is the preferred way to start a med-mal trial. It sets the tone for the case and it also has the strategic advantage of controlling how the defendant is first presented to the jury. Obviously, defense counsel would rather wait until the plaintiff rests and has heard all of plaintiff's proof before hearing from the defendant. Additionally, defense counsel would prefer to introduce the defendant to jury on his direct case in order to highlight the strengths of the witness. Occasionally, defense counsel will recall the defendant on their direct case but that will provide a second opportunity for cross-examination. The cross-examination of any witness requires intense preparation. Since you obtained the pre-trial deposition of the defendant you know what the witness is going to say. This makes following the maxim, "never ask a witness a question unless you know the answer" easy to follow. Unlike a deposition, you don't want to ask the witness every question. Each question should serve a purpose. In your preparation you

should think about what it is you hope to gain from calling the witness and how it enhances your case. Attention spans are shrinking so if you are asking a question merely to hear the sound of your own voice you will lose the jury. We recommend scripting your questions in advance and indicating the deposition excerpt that forms the basis of the questions so you know exactly where to turn if the defendant gives you an inconsistent response. Once the questions are prepared, outline the different areas of inquiry in a short list that is easily accessible. Unlike the opening or closing statement, where you do not want to use notes, it is appropriate to read the questions. The outline can help refocus you if you get distracted or the witnesses responses take you in a different direction. Not surprisingly, some of the best cross-examination occurs when the defendant attempts to change his story or waiver in any manner. An effective cross-examination can take a small inconsistency and destroy the credibility of the witness.

d. *Direct of Plaintiff*

Preparation is more important with the plaintiff than any witness and by preparation we don't just mean what the witness will say. Proper preparation of the plaintiff includes their dress, mannerisms, sound and most importantly eye contact. The jury is eagerly anticipating hearing from the plaintiff and a good plaintiff's direct can go a long way towards establishing their credibility, which is essential to a successful trial. A lawyer can give the most eloquent summation but if the plaintiff does not

effectively communicate their story then you will have an uphill battle.

e. *Direct & Cross of Experts*

Obviously preparation and organization is key. Remember, this is where you are making out your prima facie case and you want to do so in a clear and logical fashion. The best direct examinations of experts are when they are the stars not the lawyers. This is not the lawyer's time to show off about their amazing knowledge of medicine. You want the witness to do the talking.

The cross-examination of an expert in a medical malpractice case is not for the faint of heart. You will invariably be questioning someone whose knowledge of the subject matter is exponentially greater than yours and you are well advised not to challenge them on the point. Fortunately, the goal of the exercise is not to prove who knows more about the growth rate of a squamous cell carcinoma (they do!).

The most effective cross examination of an expert occurs when you have obtained prior inconsistent statements in the form of publications or testimony and can attack the credibility of the witness. Unfortunately, that does not always occur. The plaintiff's expert is an excellent resource for good avenues of cross examination.

f. *Charge Conference*

g. *Summations*

We recommend writing a summation but we strongly recommend

delivering one without the use of notes. While this does not work for everyone it certainly adds to your credibility. One of the advantages of being the plaintiff is that you get to go last so you have the opportunity to hear the defendant's summation. Listen to the defendant's summation. While you don't have to rebut each one of the defendant's arguments it is advisable to address them in some manner. If you are busy rehearsing your own summation while defense counsel is speaking you may miss a golden opportunity. A good summation should clearly articulate what the evidence has shown and should be told in a manner consistent with the theme you hopefully developed during your opening statement. If the trial has gone well then the evidence has built on that theme and the summation is the crescendo. You want your summation to be credible. If you completely misstate what the evidence showed then you will lose the jury.

h. Verdict

Be prepared for any motions post-verdict.

Polling of the jury.

TITLE XLV

TORTS

CHAPTER 766
MEDICAL MALPRACTICE AND RELATED MATTERS

766.101 Medical review committee, immunity from liability.—

(1) As used in this section:

(a) The term "medical review committee" or "committee" means:

1.a. A committee of a hospital or ambulatory surgical center licensed under chapter 395 or a health maintenance organization certificated under part I of chapter 641,

b. A committee of a physician-hospital organization, a provider-sponsored organization, or an integrated delivery system,

c. A committee of a state or local professional society of health care providers,

d. A committee of a medical staff of a licensed hospital or nursing home, provided the medical staff operates pursuant to written bylaws that have been approved by the governing board of the hospital or nursing home,

e. A committee of the Department of Corrections or the Correctional Medical Authority as created under s. 945.602, or employees, agents, or consultants of either the department or the authority or both,

f. A committee of a professional service corporation formed under chapter 621 or a corporation organized under chapter 607 or chapter 617, which is formed and operated for the practice of medicine as defined in s. 458.305(3), and which has at least 25 health care providers who routinely provide health care services directly to patients,

g. A committee of the Department of Children and Family Services which includes employees, agents, or consultants to the department as deemed necessary to provide peer review, utilization review, and mortality review of treatment services provided pursuant to chapters 394, 397, and 916,

h. A committee of a mental health treatment facility licensed under chapter 394 or a community mental

health center as defined in s. 394.907, provided the quality assurance program operates pursuant to the guidelines which have been approved by the governing board of the agency,

i. A committee of a substance abuse treatment and education prevention program licensed under chapter 397 provided the quality assurance program operates pursuant to the guidelines which have been approved by the governing board of the agency,

j. A peer review or utilization review committee organized under chapter 440,

k. A committee of the Department of Health, a county health department, healthy start coalition, or certified rural health network, when reviewing quality of care, or employees of these entities when reviewing mortality records, or

l. A continuous quality improvement committee of a pharmacy licensed pursuant to chapter 465,

which committee is formed to evaluate and improve the quality of health care rendered by providers of health service, to determine that health services rendered were professionally indicated or were performed in compliance with the applicable standard of care, or that the cost of health care rendered was considered reasonable by the providers of professional health services in the area; or

2. A committee of an insurer, self-insurer, or joint underwriting association of medical malpractice insurance, or other persons conducting review under s. 766.106.

(b) The term “health care providers” means physicians licensed under chapter 458, osteopathic physicians licensed under chapter 459, podiatric physicians licensed under chapter 461, optometrists licensed under chapter 463, dentists licensed under chapter 466, chiropractic physicians licensed under chapter 460, pharmacists licensed under chapter 465, or hospitals or ambulatory surgical centers licensed under chapter 395.

(2) A medical review committee of a hospital or ambulatory surgical center or health maintenance organization shall screen, evaluate, and review the professional and medical competence of applicants to, and members of, medical staff. As a condition of licensure, each health care provider shall cooperate with a review of professional competence performed by a medical review committee.

(3)(a) There shall be no monetary liability on the part of, and no cause of action for damages shall arise against, any member of a duly appointed medical review committee, or any health care provider furnishing any information, including information concerning the prescribing of substances listed in s. 893.03(2), to such committee, or any person, including any person acting as a witness, incident reporter to, or investigator for, a medical review committee, for any act or proceeding undertaken or performed within the scope of the functions of any such committee if the committee member or health care provider acts without intentional fraud.

(b) The provisions of this section do not affect the official immunity of an officer or employee of a public corporation.

(4) Except as provided in subsection (3), this section shall not be construed to confer immunity from liability on any professional society or hospital or upon any health professional while performing services other than as a member of a medical review committee or upon any person, including any person acting as a witness, incident reporter to, or investigator for, a medical review committee, for any act or proceeding undertaken or performed outside the scope of the functions of such committee. In any case in which, but for the enactment of the preceding provisions of this section, a cause of action would arise against a hospital, professional society, or an individual health professional, such cause of action shall exist as if the preceding provisions had not been enacted.

(5) The investigations, proceedings, and records of a committee as described in the preceding subsections shall not be subject to discovery or introduction into evidence in any civil or administrative action against a provider of professional health services arising out of the matters which are the subject of

evaluation and review by such committee, and no person who was in attendance at a meeting of such committee shall be permitted or required to testify in any such civil action as to any evidence or other matters produced or presented during the proceedings of such committee or as to any findings, recommendations, evaluations, opinions, or other actions of such committee or any members thereof. However, information, documents, or records otherwise available from original sources are not to be construed as immune from discovery or use in any such civil action merely because they were presented during proceedings of such committee, nor should any person who testifies before such committee or who is a member of such committee be prevented from testifying as to matters within his or her knowledge, but the said witness cannot be asked about his or her testimony before such a committee or opinions formed by him or her as a result of said committee hearings.

(6) In the event that the defendant prevails in an action brought by a health care provider against any person that initiated, participated in, was a witness in, or conducted any review as authorized by this section, the court shall award reasonable attorney's fees and costs to the defendant.

(7)(a) It is the intent of the Legislature to encourage medical review committees to contribute further to the quality of health care in this state by reviewing complaints against physicians in the manner described in this paragraph. Accordingly, the Department of Health may enter into a letter of agreement with a professional society of physicians licensed under chapter 458 or chapter 459, under which agreement the medical or peer review committees of the professional society will conduct a review of any complaint or case referred to the society by the department which involves a question as to whether a physician's actions represented a breach of the prevailing professional standard of care. The prevailing professional standard of care is that level of care, skill, and treatment which, in light of all relevant surrounding circumstances, is recognized as acceptable and appropriate by reasonably prudent similar health care providers. The letter of agreement must specify that the professional society will submit an advisory report to the department within a reasonable time following the department's written and appropriately supported request to the professional society. The advisory report, which is not binding upon the department, constitutes the professional opinion of the medical review committee and must include:

1. A statement of relevant factual findings.

2. The judgment of the committee as to whether the physician's actions represented a breach of the prevailing professional standard of care.

(b) Cases involving possible criminal acts may not be referred to medical review committees, and emergency action by the department needed to protect the public against immediate and substantial threats must not be delayed by any referral of the case to a medical review committee. The department shall refer cases pursuant to this subsection prior to making determinations of probable cause.

(c) So as not to inhibit the willing and voluntary service of professional society members on medical review committees, the department shall use advisory reports from medical committees as background information only and shall prepare its own case using independently prepared evidence and supporting expert opinion for submission to the probable cause panel of a regulatory board formed under chapter 458 or chapter 459. Proceedings of medical review committees are exempt from the provisions of s. 286.011 and s. 24(b), Art. I of the State Constitution, and any advisory reports provided to the department by such committees are confidential and exempt from the provisions of s. 119.07(1) and s. 24(a), Art. I of the State Constitution, regardless of whether probable cause is found. The medical review committee advisory reports and any records created by the medical review committee are not subject to discovery or introduction into evidence in any disciplinary proceeding against a licensee. Further, no person who voluntarily serves on a medical review committee or who investigates a complaint for the committee may be permitted or required to testify in any such disciplinary proceeding as to any evidence or other matters produced or presented during the

proceedings of such committee or as to any findings, recommendations, evaluations, opinions, or other actions of such committee or any members thereof. However, nothing in this section shall be construed to mean that information, documents, or records otherwise available and obtained from original sources are immune from discovery or use in any such disciplinary proceeding merely because they were presented during proceedings of a peer review organization or committee. Members of medical review committees shall assist the department in identifying such original sources when possible.

(d) Professional society representatives who participate in medical reviews and preparation of advisory reports pursuant to this subsection will be reimbursed for per diem and travel expenses consistent with the provisions of s. 112.061 and as provided in the written agreement described in paragraph (a).

(e) There shall be no monetary liability on the part of, and no cause of action shall arise against, any state or local professional society of physicians licensed under chapter 458 or chapter 459, or any member thereof, acting pursuant to the provisions of this subsection without intentional fraud or malice. Further, this subsection does not supersede the provisions of paragraph (3)(a) relating to immunity from liability for medical review committees.

(8) No cause of action of any nature by a person licensed pursuant to chapter 458, chapter 459, chapter 461, chapter 463, part I of chapter 464, chapter 465, or chapter 466 shall arise against another person licensed pursuant to chapter 458, chapter 459, chapter 461, chapter 463, part I of chapter 464, chapter 465, or chapter 466 for furnishing information to a duly appointed medical review committee, to an internal risk management program established under s. 395.0197, to the Department of Health or the Agency for Health Care Administration, or to the appropriate regulatory board if the information furnished concerns patient care at a facility licensed pursuant to part I of chapter 395 where both persons provide health care services, if the information is not intentionally fraudulent, and if the information is within the scope of the functions of the committee, department, or board. However, if such information is otherwise available from original sources, it is not immune from discovery or use in a civil action merely because it was presented during a proceeding of the committee, department, or board.

History.—ss. 1, 2, ch. 72-62; s. 1, ch. 73-50; s. 1, ch. 77-461; s. 285, ch. 79-400; s. 3, ch. 80-353; s. 8, ch. 85-175; s. 1, ch. 87-342; s. 47, ch. 88-277; s. 34, ch. 88-392; s. 25, ch. 88-398; s. 4, ch. 89-281; s. 35, ch. 89-289; s. 16, ch. 89-374; s. 9, ch. 90-341; s. 92, ch. 92-289; s. 37, ch. 93-39; s. 1, ch. 93-155; s. 1, ch. 93-158; s. 1, ch. 94-73; s. 244, ch. 94-218; s. 6, ch. 95-140; s. 422, ch. 96-406; s. 1798, ch. 97-102; s. 80, ch. 97-237; s. 61, ch. 97-264; s. 31, ch. 98-89; ss. 228, 295, ch. 98-166; s. 23, ch. 98-191; s. 6, ch. 99-186; s. 143, ch. 2000-318; s. 86, ch. 2001-277; s. 50, ch. 2009-132.

Note.—Former s. 768.131; s. 768.40.

766.1015 Civil immunity for members of or consultants to certain boards, committees, or other entities.—

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

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

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

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

(d) The adequacy or quality of professional services;

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

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

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

(2) Such committee, board, group, commission, or other entity must be established in accordance with state law or in accordance with requirements of the Joint Commission on Accreditation of Healthcare Organizations, established and duly constituted by one or more public or licensed private hospitals or behavioral health agencies, or established by a governmental agency. To be protected by this section, the act, decision, omission, or utterance may not be made or done in bad faith or with malicious intent.

History.—s. 9, ch. 2003-416; s. 2, ch. 2004-7.

766.1016 Patient safety data privilege.—

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

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

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

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

(3) Unless otherwise provided by law, a patient safety organization shall promptly remove all patient-identifying information after receipt of a complete patient safety data report unless such organization is otherwise permitted by state or federal law to maintain such information. Patient safety organizations shall maintain the confidentiality of all patient-identifying information and may not disseminate such information, except as permitted by state or federal law.

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

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

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

History.—s. 10, ch. 2003-416.

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

(1) In any action for recovery of damages based on the death or personal injury of any person in which it is alleged that such death or injury resulted from the negligence of a health care provider as defined in s. 766.202(4), the claimant shall have the burden of proving by the greater weight of evidence that the alleged actions of the health care provider represented a breach of the prevailing professional standard of care for

that health care provider. The prevailing professional standard of care for a given health care provider shall be that level of care, skill, and treatment which, in light of all relevant surrounding circumstances, is recognized as acceptable and appropriate by reasonably prudent similar health care providers.

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

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

(3)(a) As used in this subsection, the term:

1. "Insurer" means any public or private insurer, including the Centers for Medicare and Medicaid Services.

2. "Reimbursement determination" means an insurer's determination of the amount that the insurer will reimburse a health care provider for health care services.

3. "Reimbursement policies" means an insurer's policies and procedures governing its decisions regarding health insurance coverage and method of payment and the data upon which such policies and procedures are based, including, but not limited to, data from national research groups and other patient safety data as defined in s. 766.1016.

(b) The existence of a medical injury does not create any inference or presumption of negligence against a health care provider, and the claimant must maintain the burden of proving that an injury was proximately caused by a breach of the prevailing professional standard of care by the health care provider. Any records, policies, or testimony of an insurer's reimbursement policies or reimbursement determination regarding the care provided to the plaintiff is not admissible as evidence in any medical negligence action. However, the discovery of the presence of a foreign body, such as a sponge, clamp, forceps, surgical needle, or other paraphernalia commonly used in surgical, examination, or diagnostic procedures, shall be prima facie evidence of negligence on the part of the health care provider.

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

(5) A person may not give expert testimony concerning the prevailing professional standard of care unless the person is a health care provider who holds an active and valid license and conducts a complete review of the pertinent medical records and meets the following criteria:

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

1. Specialize in the same specialty as the health care provider against whom or on whose behalf the testimony is offered; or specialize in a similar specialty that includes the evaluation, diagnosis, or treatment of the medical condition that is the subject of the claim and have prior experience treating similar patients; and

2. Have devoted professional time during the 3 years immediately preceding the date of the occurrence that is the basis for the action to:

a. The active clinical practice of, or consulting with respect to, the same or similar specialty that includes

the evaluation, diagnosis, or treatment of the medical condition that is the subject of the claim and have prior experience treating similar patients;

b. Instruction of students in an accredited health professional school or accredited residency or clinical research program in the same or similar specialty; or

c. A clinical research program that is affiliated with an accredited health professional school or accredited residency or clinical research program in the same or similar specialty.

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

1. The active clinical practice or consultation as a general practitioner;

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

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

(c) If the health care provider against whom or on whose behalf the testimony is offered is a health care provider other than a specialist or a general practitioner, the expert witness must have devoted professional time during the 3 years immediately preceding the date of the occurrence that is the basis for the action to:

1. The active clinical practice of, or consulting with respect to, the same or similar health profession as the health care provider against whom or on whose behalf the testimony is offered;

2. The instruction of students in an accredited health professional school or accredited residency program in the same or similar health profession in which the health care provider against whom or on whose behalf the testimony is offered; or

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

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

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

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

(9)(a) In any action for damages involving a claim of negligence against a physician licensed under chapter 458, osteopathic physician licensed under chapter 459, podiatric physician licensed under chapter 461, or chiropractic physician licensed under chapter 460 providing emergency medical services in a hospital emergency department, the court shall admit expert medical testimony only from physicians, osteopathic

physicians, podiatric physicians, and chiropractic physicians who have had substantial professional experience within the preceding 5 years while assigned to provide emergency medical services in a hospital emergency department.

(b) For the purposes of this subsection:

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

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

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

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

(12) If a physician licensed under chapter 458 or chapter 459 or a dentist licensed under chapter 466 is the party against whom, or on whose behalf, expert testimony about the prevailing professional standard of care is offered, the expert witness must be licensed under chapter 458, chapter 459, or chapter 466 or possess a valid expert witness certificate issued under s. 458.3175, s. 459.0066, or s. 466.005.

(13) A health care provider's failure to comply with or breach of any federal requirement is not admissible as evidence in any medical negligence case in this state.

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

History.—s. 12, ch. 76-260; s. 8, ch. 77-64; s. 1, ch. 77-174; s. 10, ch. 85-175; s. 78, ch. 88-1; s. 30, ch. 91-110; s. 1149, ch. 97-102; ss. 229, 296, ch. 98-166; s. 48, ch. 2003-416; s. 153, ch. 2004-5; s. 10, ch. 2011-233.

Note.—Former s. 768.45.

766.103 Florida Medical Consent Law.—

(1) This section shall be known and cited as the "Florida Medical Consent Law."

(2) In any medical treatment activity not covered by s. 768.13, entitled the "Good Samaritan Act," this act shall govern.

(3) No recovery shall be allowed in any court in this state against any physician licensed under chapter 458, osteopathic physician licensed under chapter 459, chiropractic physician licensed under chapter 460, podiatric physician licensed under chapter 461, dentist licensed under chapter 466, advanced registered nurse practitioner certified under s. 464.012, or physician assistant licensed under s. 458.347 or s. 459.022 in an action brought for treating, examining, or operating on a patient without his or her informed consent when:

(a)1. The action of the physician, osteopathic physician, chiropractic physician, podiatric physician, dentist, advanced registered nurse practitioner, or physician assistant in obtaining the consent of the patient or another person authorized to give consent for the patient was in accordance with an accepted standard of medical practice among members of the medical profession with similar training and experience in the same or similar medical community as that of the person treating, examining, or operating on the patient for whom the consent is obtained; and

2. A reasonable individual, from the information provided by the physician, osteopathic physician, chiropractic physician, podiatric physician, dentist, advanced registered nurse practitioner, or physician assistant, under the circumstances, would have a general understanding of the procedure, the medically acceptable alternative procedures or treatments, and the substantial risks and hazards inherent in the proposed treatment or procedures, which are recognized among other physicians, osteopathic physicians,

chiropractic physicians, podiatric physicians, or dentists in the same or similar community who perform similar treatments or procedures; or

(b) The patient would reasonably, under all the surrounding circumstances, have undergone such treatment or procedure had he or she been advised by the physician, osteopathic physician, chiropractic physician, podiatric physician, dentist, advanced registered nurse practitioner, or physician assistant in accordance with the provisions of paragraph (a).

(4)(a) A consent which is evidenced in writing and meets the requirements of subsection (3) shall, if validly signed by the patient or another authorized person, raise a rebuttable presumption of a valid consent.

(b) A valid signature is one which is given by a person who under all the surrounding circumstances is mentally and physically competent to give consent.

History.—s. 11, ch. 75-9; s. 21, ch. 85-175; s. 1150, ch. 97-102; s. 62, ch. 97-264; ss. 230, 297, ch. 98-166; s. 2, ch. 2007-176.

Note.—Former s. 768.132; s. 768.46.

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

(1) No action shall be filed for personal injury or wrongful death arising out of medical negligence, whether in tort or in contract, unless the attorney filing the action has made a reasonable investigation as permitted by the circumstances to determine that there are grounds for a good faith belief that there has been negligence in the care or treatment of the claimant. The complaint or initial pleading shall contain a certificate of counsel that such reasonable investigation gave rise to a good faith belief that grounds exist for an action against each named defendant. For purposes of this section, good faith may be shown to exist if the claimant or his or her counsel has received a written opinion, which shall not be subject to discovery by an opposing party, of an expert as defined in s. 766.102 that there appears to be evidence of medical negligence. If the court determines that such certificate of counsel was not made in good faith and that no justiciable issue was presented against a health care provider that fully cooperated in providing informal discovery, the court shall award attorney's fees and taxable costs against claimant's counsel, and shall submit the matter to The Florida Bar for disciplinary review of the attorney.

(2) Upon petition to the clerk of the court where the suit will be filed and payment to the clerk of a filing fee, not to exceed $42, an automatic 90-day extension of the statute of limitations shall be granted to allow the reasonable investigation required by subsection (1). This period shall be in addition to other tolling periods. No court order is required for the extension to be effective. The provisions of this subsection shall not be deemed to revive a cause of action on which the statute of limitations has run.

(3) For purposes of conducting the investigation required by this section, and notwithstanding any other provision of law to the contrary, subsequent to the death of a person and prior to the administration of such person's estate, copies of all medical reports and records, including bills, films, and other records relating to the care and treatment of such person that are in the possession of a health care practitioner as defined in s. 456.001 shall be made available, upon request, to the spouse, parent, child who has reached majority, guardian pursuant to chapter 744, surrogate or proxy pursuant to chapter 765, or attorney in fact of the deceased pursuant to chapter 709. A health care practitioner complying in good faith with the provisions of this subsection shall not be held liable for civil damages attributable to the disclosure of such records or be subject to any disciplinary action based on such disclosure.

History.—s. 12, ch. 85-175; s. 68, ch. 86-160; s. 8, ch. 86-287; s. 71, ch. 95-211; s. 1151, ch. 97-102; s. 1, ch. 2001-155; s. 79, ch. 2004-265; s. 42, ch. 2008-111.

Note.—Former s. 768.495.

766.105 Florida Patient's Compensation Fund.—

(1) DEFINITIONS.—The following definitions apply in the interpretation and enforcement of this section:

(a) The term “fund” means the Florida Patient’s Compensation Fund. The fund is not a state agency, board, or commission. However, for the purposes of s. 199.183(1) only, the fund shall be considered a political subdivision of this state.

(b) The term “health care provider” means any:

1. Hospital licensed under chapter 395.
2. Physician or physician assistant licensed under chapter 458.
3. Osteopathic physician or physician assistant licensed under chapter 459.
4. Podiatric physician licensed under chapter 461.
5. Health maintenance organization certificated under part I of chapter 641.
6. Ambulatory surgical center licensed under chapter 395.
7. “Other medical facility” as defined in paragraph (c).
8. Professional association, partnership, corporation, joint venture, or other association by the individuals set forth in subparagraphs 2., 3., and 4. for professional activity.

(c) The term “other medical facility” means a facility the primary purpose of which is to provide human medical diagnostic services or a facility providing nonsurgical human medical treatment and in which the patient is admitted to and discharged from such facility within the same working day, and which is not part of a hospital. However, a facility existing for the primary purpose of performing terminations of pregnancy, or an office maintained by a physician or dentist for the practice of medicine, shall not be construed to be an “other medical facility.”

(d) The term “hospital” means a hospital licensed under chapter 395.

(e) The term “health maintenance organization” means any health maintenance organization certificated under part I of chapter 641.

(f) The term “occurrence” means an accident or incident, including continuous or repeated exposure to conditions, which results in patient injuries not intended from the standpoint of the insured.

(g) The term “per claim” means all claims per patient arising out of an occurrence.

(h) The term “committee” means a committee or board of trustees of a health care provider or group of health care providers established to make recommendations, policy, or decisions regarding patient institutional utilization, patient treatment, or institutional staff privileges or to perform other administrative or professional purposes or functions.

(i) The term “house physician” means any physician, osteopathic physician, podiatric physician, or dentist except: a physician, osteopathic physician, podiatric physician, or dentist with staff privileges at a hospital; a physician, osteopathic physician, podiatric physician, or dentist providing emergency room services; an anesthesiologist, pathologist, or radiologist; or a physician, osteopathic physician, podiatric physician, or dentist who performs a service for a fee.

(2) COVERAGE.—

(a) Each hospital, unless exempted under this paragraph or paragraph (c), shall, and each health care provider other than a hospital may, pay the yearly fee and assessment or, in cases in which such hospital or health care provider joined the fund after the fiscal year had begun, a prorated fee or assessment into the fund pursuant to subsection (3). Any hospital operated by an agency, subdivision, or instrumentality of the state is exempt from the provisions of this section and is not required to participate in the fund.

(b) Whenever a claim covered under subsection (3) results in a settlement or judgment against a health care provider, the fund shall pay to the extent of its coverage if the health care provider has paid the fees and any assessments required pursuant to subsection (3) for the year in which the incident occurred for which the claim is filed, provides an adequate defense for the fund, and pays the initial amount of the claim up to the applicable amount set forth in paragraph (f) or the maximum limit of the underlying coverage maintained

by the health care provider on the date when the incident occurred for which the claim is filed, whichever is greater. Coverages for such claims shall be provided on an occurrence basis by the fund independently for each fiscal year, such fiscal year to run from January 1 to December 31. The fund may also provide coverages for portions of each fiscal year. The limits of such coverage afforded by the fund for each health care provider other than a hospital may not exceed the total limits for both entry level and fund coverage of $1 million per claim with a $3 million annual aggregate, or $2 million per claim with a $4 million annual aggregate, as selected by the health care provider. In the case of coverage for a hospital, the limit of coverage afforded by the fund may not exceed the total limits for both entry level and fund coverage of $2.5 million per claim with no annual aggregate. The health care provider is responsible for the payment of any amount of a claim in excess of the elected limit. The fund is not responsible for the payment of punitive damages awarded for actual or direct negligence of the health care provider member. The health care provider shall have the same responsibility for punitive damages it would have if it were not a member of the fund. A health care provider may have the necessary funds available for payment when due or may provide underlying financial responsibility by one of the following methods:

1. A bond purchased from a licensed surety company, which bond is in the applicable amount set forth in paragraph (f) per claim and 3 times the applicable per-claim limit in the aggregate per year, plus an additional amount which is sufficient to meet claims defense and expenses; however, a total bond amount for all years equal to reserved loss and expense amounts for known cases plus 3 times the applicable amount set forth in paragraph (f) plus $45,000 shall be the maximum bond amount required;

2. An adequate escrow account in the applicable amount set forth in paragraph (f) per claim and 3 times the per-claim limit in the aggregate per year, plus an additional amount which is sufficient to meet claims defense and expenses; however, a total escrow account for all years equal to reserved loss and expense amounts for known cases plus 3 times the applicable amount set forth in paragraph (f) plus $45,000 shall be the maximum escrow amount required;

3. Medical malpractice insurance in the applicable amount set forth in paragraph (f) or more per claim from a private insurer or the Joint Underwriting Association established under s. 627.351(4); or

4. Self-insurance as provided in s. 627.357, providing coverage in the applicable amount set forth in paragraph (f) or more per claim and 3 times the applicable per-claim limit in the aggregate per year.

(c) Any hospital that can meet one of the following provisions for demonstrating financial responsibility to pay claims and costs ancillary thereto arising out of the rendering of or failure to render medical care or services and for bodily injury or property damage to the person or property of any patient arising out of the activities of the hospital in this state or arising out of the activities of covered individuals listed in paragraph (e) is not required to participate in the fund:

1. Post bond in an amount equivalent to $10,000 per claim for each hospital bed in such hospital, not to exceed a $2.5 million annual aggregate.

2. Establish an escrow account in an amount equivalent to $10,000 per claim for each hospital bed in such hospital, not to exceed a $2.5 million annual aggregate, to the satisfaction of the Agency for Health Care Administration.

3. Obtain professional liability coverage in an amount equivalent to $10,000 or more per claim for each bed in such hospital from a private insurer, from the Joint Underwriting Association established under s. 627.351(4), or through a plan of self-insurance as provided in s. 627.357. However, no hospital may be required to obtain such coverage in an amount exceeding a $2.5 million annual aggregate.

(d)1. Any health care provider who participates in the fund and who does not meet the provisions of paragraph (b) shall not be covered by the fund.

2. Annually, the Agency for Health Care Administration shall require documentation by each hospital that

such hospital is in compliance, and will remain in compliance, with the provisions of this section. The agency shall review the documentation and then deliver the documentation to the board of governors. At least 60 days before the time a license will be issued or renewed, the agency shall request from the board of governors a certification that each hospital is in compliance with the provisions of this section. The board of governors shall not be liable under the law for any erroneous certification. The agency may not issue or renew the license of any hospital which has not been certified by the board of governors. The license of any hospital that fails to remain in compliance or fails to provide such documentation shall be revoked or suspended by the agency.

(e) The coverage afforded by the fund for a participating hospital or ambulatory surgical center shall apply to the officers, trustees, volunteer workers, trainees, committee members (including physicians, osteopathic physicians, podiatric physicians, and dentists), and employees of the hospital or ambulatory surgical center, other than employed physicians licensed under chapter 458, physician assistants licensed under chapter 458, osteopathic physicians licensed under chapter 459, dentists licensed under chapter 466, and podiatric physicians licensed under chapter 461. However, the coverage afforded by the fund for a participating hospital shall apply to house physicians, interns, employed physician residents in a resident training program, or physicians performing purely administrative duties for the participating hospitals other than the treatment of patients. This coverage shall apply to the hospital or ambulatory surgical center and those included in this subsection as one health care provider.

(f) Each health care provider shall be responsible for paying the amount of each settlement or judgment for each claim up to the fund entry level amount it selects. The selected entry level amount shall be not less than the following:

1. As of July 1, 1983: $150,000 per claim or $500,000 per occurrence.
2. As of January 1, 1987: $200,000 per claim or $500,000 per occurrence.
3. As of January 1, 1990: $250,000 per claim or $500,000 per occurrence.

As of January 1, 1990, the minimum entry level amount shall be indexed to the medical component of the consumer price index and shall be adjusted by the fund each year thereafter accordingly.

(3) THE FUND.—

(a) *Purposes*.—There is created a “Florida Patient’s Compensation Fund” for the purpose of paying that portion of any claim arising out of the rendering of or failure to render medical care or services, or arising out of activities of committees, for health care providers or any claim for bodily injury or property damage to the person or property of any patient, including all patient injuries and deaths, arising out of the members’ activities for those health care providers set forth in subparagraphs (1)(b)1., 5., 6., and 7. which is in excess of the fund entry level selected and less than the limit selected under paragraph (2)(b). The fund shall be responsible only for payment of claims against health care providers who are in compliance with the provisions of paragraph (2)(b), of reasonable and necessary expenses incurred in the payment of claims, and of fund administrative expenses.

(b) *Fund administration and operation.*—

1. The fund shall operate subject to the supervision and approval of a board of governors consisting of a representative of the insurance industry appointed by the Chief Financial Officer, an attorney appointed by The Florida Bar, a representative of physicians appointed by the Florida Medical Association, a representative of physicians’ insurance appointed by the Chief Financial Officer, a representative of physicians’ self-insurance appointed by the Chief Financial Officer, two representatives of hospitals appointed by the Florida Hospital Association, a representative of hospital insurance appointed by the Chief Financial Officer, a representative of hospital self-insurance appointed by the Chief Financial Officer, a representative of the osteopathic physicians’ or podiatric physicians’ insurance or self-insurance appointed by the Chief Financial Officer, and a representative of the general public appointed by the Chief Financial Officer. The board of

governors shall, during the first meeting after June 30 of each year, choose one of its members to serve as chair of the board and another member to serve as vice chair of the board. The members of the board shall be appointed to serve terms of 4 years, except that the initial appointments of a representative of the general public by the Chief Financial Officer, an attorney by The Florida Bar, a representative of physicians by the Florida Medical Association, and one of the two representatives of the Florida Hospital Association shall be for terms of 3 years; thereafter, such representatives shall be appointed for terms of 4 years. Subsequent to initial appointments for 4-year terms, the representative of the osteopathic physicians' or podiatric physicians' insurance or self-insurance appointed by the Chief Financial Officer and the representative of hospital self-insurance appointed by the Chief Financial Officer shall be appointed for 2-year terms; thereafter, such representatives shall be appointed for terms of 4 years. Each appointed member may designate in writing to the chair an alternate to act in the member's absence or incapacity. A member of the board, or the member's alternate, may be reimbursed from the assets of the fund for expenses incurred by him or her as a member, or alternate member, of the board and for committee work, but he or she may not otherwise be compensated by the fund for his or her service as a board member or alternate.

2. There shall be no liability on the part of, and no cause of action of any nature shall arise against, the fund or its agents or employees, professional advisers or consultants, members of the board of governors or their alternates, or the Department of Financial Services or the Office of Insurance Regulation of the Financial Services Commission or their representatives for any action taken by them in the performance of their powers and duties pursuant to this section.

(c) *Powers of the fund.*—The fund has the power to:

1. Sue and be sued, and appear and defend, in all actions and proceedings in its name to the same extent as a natural person.

2. Adopt, change, amend, and repeal a plan of operation, not inconsistent with law, for the regulation and administration of the affairs of the fund. The plan and any changes thereto shall be filed with the Office of Insurance Regulation of the Financial Services Commission and are all subject to its approval before implementation by the fund. All fund members, board members, and employees shall comply with the plan of operation.

3. Have and exercise all powers necessary or convenient to effect any or all of the purposes for which the fund is created.

4. Enter into such contracts as are necessary or proper to carry out the provisions and purposes of this section.

5. Employ or retain such persons as are necessary to perform the administrative and financial transactions and responsibilities of the fund and to perform other necessary or proper functions unless prohibited by law.

6. Take such legal action as may be necessary to avoid payment of improper claims.

7. Indemnify any employee, agent, member of the board of governors or his or her alternate, or person acting on behalf of the fund in an official capacity, for expenses, including attorney's fees, judgments, fines, and amounts paid in settlement actually and reasonably incurred by him or her in connection with any action, suit, or proceeding, including any appeal thereof, arising out of his or her capacity in acting on behalf of the fund, if he or she acted in good faith and in a manner he or she reasonably believed to be in, or not opposed to, the best interests of the fund and, with respect to any criminal action or proceeding, he or she had reasonable cause to believe his or her conduct was lawful.

(d) *Fees and assessments.*—Each health care provider, as set forth in subsection (2), electing to comply with paragraph (2)(b) for a given fiscal year shall pay the fees and any assessments established under this section relative to such fiscal year, for deposit into the fund. Those entering the fund after the fiscal year has

begun shall pay a prorated share of the yearly fees for a prorated membership. Actuarially sound membership fees payable annually, semiannually, or quarterly with appropriate service charges shall be established by the fund before January 1 of each fiscal year, based on the following considerations:

1. Past and prospective loss and expense experience in different types of practice and in different geographical areas within the state;
2. The prior claims experience of the members covered under the fund; and
3. Risk factors for persons who are retired, semiretired, or part-time professionals.

Such fees shall be based on not more than three geographical areas, not necessarily contiguous, with five categories of practice and with categories which contemplate separate risk ratings for hospitals, for health maintenance organizations, for ambulatory surgical facilities, and for other medical facilities. The fund is authorized to adjust the fees of an individual member to reflect the claims experience of such member. Each fiscal year of the fund shall operate independently of preceding fiscal years. Participants shall only be liable for assessments for claims from years during which they were members of the fund; in cases in which a participant is a member of the fund for less than the total fiscal year, a member shall be subject to assessments for that year on a pro rata basis determined by the percentage of participation for the year. The fund shall submit to the Office of Insurance Regulation the classifications and membership fees to be charged, and the Office of Insurance Regulation shall review such fees and shall approve them if they comply with all the requirements of this section and fairly reflect the considerations provided for in this section. If the classifications or membership fees do not comply with this section, the Office of Insurance Regulation shall set classifications or membership fees which do comply and which give due recognition to all considerations provided for in this section. Nothing contained herein shall be construed as imposing liability for payment of any part of a fund deficit on the Joint Underwriting Association authorized by s. 627.351(4) or its member insurers. If the fund determines that the amount of money in an account for a given fiscal year is in excess of or not sufficient to satisfy the claims made against the account, the fund shall certify the amount of the projected excess or insufficiency to the Office of Insurance Regulation and request the office to levy an assessment against or refund to all participants in the fund for that fiscal year, prorated, based on the number of days of participation during the year in question. The Office of Insurance Regulation shall approve the request of the fund to refund to, or levy any assessment against, the participants, provided the refund or assessment fairly reflects the same considerations and classifications upon which the membership fees were based. The assessment shall be in an amount sufficient to satisfy reserve requirements for known claims, including expenses to satisfy the claims, made against the account for a given fiscal year. In any proceeding to challenge the amount of the refund or assessment, it is to be presumed that the amount of refund or assessment requested by the fund is correct, if the fund demonstrates that it has used reasonable claims handling and reserving procedures. Additional assessments may be certified and levied in accordance with this paragraph as necessary for any fiscal year. If a fund member objects to his or her assessment, he or she shall, as a condition precedent to bringing legal action contesting the assessment, pay the assessment, under protest, to the fund. The fund may borrow money needed for current operations, if necessary to pay claims and related expenses, fees, and costs timely for a given fiscal year, from an account for another fiscal year until such time as sufficient funds have been obtained through the assessment process. Any such money, together with interest at the mean interest rate earned on the investment portfolio of the fund, shall be repaid from the next assessment for the given fiscal year. If any assessments are levied in accordance with this subsection as a result of claims in excess of $500,000 per occurrence, and such assessments are a result of the liability of certain individuals and entities specified in paragraph (2)(e), only hospitals shall be subject to such assessments. Before approving the request of the fund to charge membership fees, issue refunds, or levy assessments, the Office of Insurance Regulation shall publish notice of the request in the Florida

Administrative Weekly. Pursuant to chapter 120, any party substantially affected may request an appropriate proceeding. Any petition for such a proceeding shall be filed with the Office of Insurance Regulation within 21 days after the date of publication of the notice in the Florida Administrative Weekly.

(e) *Fund accounting and audit.*—

1. Money shall be withdrawn from the fund only upon a voucher as authorized by the board of governors.

2. All books, records, and audits of the fund shall be open for reasonable inspection to the general public, except that a claim file in possession of the fund, fund members, and their insurers is confidential and exempt from the provisions of s. 119.07(1) and s. 24(a), Art. I of the State Constitution until termination of litigation or settlement of the claim, although medical records and other portions of the claim file may remain confidential and exempt as otherwise provided by law. Any book, record, document, audit, or asset acquired by, prepared for, or paid for by the fund is subject to the authority of the board of governors, which shall be responsible therefor.

3. Persons authorized to receive deposits, issue vouchers, or withdraw or otherwise disburse any fund moneys shall post a blanket fidelity bond in an amount reasonably sufficient to protect fund assets. The cost of such bond shall be paid from the fund.

4. Annually, the fund shall furnish, upon request, audited financial reports to any fund participant and to the Office of Insurance Regulation and the Joint Legislative Auditing Committee. The reports shall be prepared in accordance with accepted accounting procedures and shall include income and such other information as may be required by the Office of Insurance Regulation or the Joint Legislative Auditing Committee.

5. Any money held in the fund shall be invested in interest-bearing investments by the board of governors of the fund as administrator. However, in no case may any such money be invested in the stock of any insurer participating in the Joint Underwriting Association authorized by s. 627.351(4) or in the parent company of, or company owning a controlling interest in, such insurer. All income derived from such investments shall be credited to the fund.

6. Any health care provider participating in the fund may withdraw from such participation only at the end of a fiscal year; however, such health care provider shall remain subject to any assessment or any refund pertaining to any year in which such member participated in the fund.

(f) *Claims procedures.*—

1. Any person may file an action against a participating health care provider for damages covered under the fund, except that the person filing the claim may not recover against the fund unless the fund was named as a defendant in the suit. The fund is not required to actively defend a claim until the fund is named therein. If, after the facts upon which the claim is based are reviewed, it appears that the claim will exceed the applicable amount set forth in paragraph (2)(f) or, if greater, the amount of the health care provider's basic coverage, the fund shall appear and actively defend itself when named as a defendant in the suit. In so defending, the fund shall retain counsel and pay out of the account for the appropriate year attorneys' fees and expenses, including court costs incurred in defending the fund. In any claim, the attorney or law firm retained to defend the fund may not be retained to defend the Joint Underwriting Association authorized by s. 627.351(4). The fund is authorized to negotiate with any claimant having a judgment exceeding the applicable amount set forth in paragraph (2)(f) to reach an agreement as to the manner in which that portion of the judgment exceeding such amount is to be paid. Any judgment affecting the fund may be appealed under the Florida Rules of Appellate Procedure, as with any defendant.

2. It is the responsibility of the insurer or self-insurer providing insurance or self-insurance for a health care provider who is also covered by the fund to provide an adequate defense on any claim filed which potentially affects the fund, with respect to such insurance contract or self-insurance contract. The insurer or

self-insurer shall act in a fiduciary relationship toward the fund with respect to any claim affecting the fund. No settlement exceeding the applicable amount set forth in paragraph (2)(f), or any other amount which could require payment by the fund, may be agreed to unless approved by the fund.

3. A person who has recovered a final judgment against the fund or against a health care provider who is covered by the fund may file a claim with the fund to recover that portion of such judgment which is in excess of the applicable amount set forth in paragraph (2)(f) or the amount of the health care provider's basic coverage, if greater, as set forth in paragraph (2)(b). The amount of liability of the fund under a judgment, including court costs, reasonable attorney's fees, and interest, shall be paid in a lump sum, except that any claims for future special damages, as set forth in [1]s. 768.48(1)(a) and (b), shall be paid periodically as they are incurred by the claimant. If a claimant dies while receiving periodic payments, payment for future medical expenses shall cease, but payment for future wage loss, if any, shall continue at a rate of not more than $100,000 per year. The fund may pay a lump sum reflecting the present value of future wage losses in lieu of continuing the periodic payments.

4. Payment of settlements or judgments involving the fund shall be paid in the order received within 60 days after the date of settlement or judgment, unless appealed by the fund. If the account for a given year does not have enough money to pay all of the settlements or judgments, those claims received after the funds are exhausted shall be payable in the order in which they are received. However, no claimant has the right to execute against the fund to the extent that the judgment is for a claim covered in a membership year for which the fund has insufficient assets to pay the claim, as determined by membership fees for such year, investment income generated by such fees, and assessments collected from members for such year. When the fund has insufficient assets to pay claims for a fund year, the fund will not be required to post a supersedeas bond in order to stay execution of a judgment pending appeal. The fund shall retain a reasonable sum of money for payment of administrative and claims expense, which money will not be subject to execution.

5. Except to the extent of the appropriate fund entry level amount selected, if a judgment is entered against the fund for a year in which there are insufficient assets to satisfy the claim, an automatic stay of execution and collection in favor of the fund member shall exist for that portion of the judgment which exceeds the selected entry level amount, and for which fund coverage exists. Such stay shall only be granted to those members who have fully complied with the requirements of fund membership, and such stay shall remain in effect until adequate assessments are collected by the fund to pay the claim. Upon competent proof that the portion of any claim covered by the fund is uncollectible from the fund, the member's stay of execution may be vacated by the court, upon application by the plaintiff and hearing thereon.

6. If a health care provider participating in the fund has coverage in excess of the applicable amount set forth in paragraph (2)(f), such health care provider shall be liable for losses up to the amount of his or her coverage, and such health care provider shall receive an appropriate reduction of the fees and assessments for participation in the fund. Such reduction shall be granted only after such health care provider has proved to the satisfaction of the fund that such health care provider had such coverage during the period of membership of the fiscal year.

7. The manager of the fund or his or her assistant is the agent for service of process for the plan.

(g) *Risk management program.*—The fund shall establish a risk management program as part of its administrative functions. All health care providers, as defined in subparagraphs (1)(b)1., 5., 6., and 7., participating in the fund shall comply with the provisions of the risk management program established by the fund. The risk management program shall include the following components:

1. The investigation and analysis of the frequency and causes of general categories and specific types of adverse incidents causing injury to patients;

2. The development of appropriate measures to minimize the risk of injuries and adverse incidents to

patients;

3. The analysis of patient grievances which relate to patient care and the quality of medical services;

4. The development and implementation of an incident reporting system based upon the affirmative duty of all health care providers and all agents and employees of health care providers and health care facilities to report injuries and incidents; and

5. Auditing of participating health care providers to assure compliance with the provisions of the risk management program.

The fund shall establish a schedule of fee surcharges which it shall levy upon participating health care providers found to be in violation of the provisions of the risk management program. Such schedule shall be subject to approval by the Office of Insurance Regulation and shall provide an escalating scale of surcharges based upon the frequency and severity of the incidents in violation of the risk management program. No health care provider shall be required to pay a surcharge if it has corrected all violations of the provisions of the risk management program and established an affirmative program to remain in compliance by the time its next fee or assessment is due.

(h) *Nonavailability of coverage.*—The fund shall determine, no later than 7 days before the beginning of each fiscal year, whether the total amount of the membership fees to be charged for the fiscal year to health care provider applicants other than hospitals exceeds $5 million and whether the total amount of the membership fees to be charged to hospital applicants exceeds $12.5 million. If the total amount of the membership fees to be charged to health care provider applicants other than hospitals does not exceed $5 million, the fund shall return the membership fees collected from such providers and shall, not later than the day before the beginning of the fiscal year, notify all such providers, advising them that coverage will not be available from the fund. Thereafter, the fund may not issue coverage to any health care provider, including any hospital, for that fiscal year. If the total amount of the membership fees to be charged to hospital applicants for the fiscal year does not exceed $12.5 million, the fund shall return the membership fees collected from the hospitals and shall, not later than the day before the beginning of the fiscal year, notify such hospitals that coverage of hospitals will not be available from the fund. Thereafter, the fund may not issue coverage to any hospital for that fiscal year. If the fund ceases to provide coverage to hospitals, hospitals shall continue to meet the financial responsibility requirements of subparagraph (2)(c)1., subparagraph (2)(c)2., or subparagraph (2)(c)3. An application for fund membership for a particular fiscal year does not guarantee coverage for that year, and the fund is not liable for coverage of an applicant for any fiscal year in which the fund does not provide coverage in accordance with the provisions of this paragraph.

History.—s. 15, ch. 75-9; s. 3, ch. 76-168; s. 6, ch. 76-260; s. 4, ch. 77-64; s. 1, ch. 77-174; s. 1, ch. 77-457; s. 2, ch. 78-47; ss. 1, 2, ch. 79-178; ss. 1, 2, ch. 80-91; s. 1, ch. 80-328; ss. 2, 3, ch. 81-318; ss. 1, 2, 3, ch. 82-236; s. 809(2nd), ch. 82-243; ss. 80, 81, ch. 82-386; s. 2, ch. 82-391; s. 2, ch. 83-206; s. 50, ch. 83-215; ss. 1, 2, ch. 84-163; s. 67, ch. 85-62; s. 1, ch. 88-192; s. 31, ch. 91-110; s. 14, ch. 91-156; s. 4, ch. 91-429; s. 1, ch. 94-84; s. 88, ch. 95-211; s. 423, ch. 96-406; s. 33, ch. 97-93; s. 1799, ch. 97-102; s. 63, ch. 97-264; s. 10, ch. 98-49; s. 231, ch. 98-166; s. 285, ch. 99-8; s. 1899, ch. 2003-261.

[1]**Note.**—Repealed by s. 68, ch. 86-160.

Note.—Former s. 627.353; s. 768.54.

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

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

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

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

(c) “Insurer” includes the Joint Underwriting Association.

(2) PRESUIT NOTICE.—

(a) After completion of presuit investigation pursuant to s. 766.203(2) and prior to filing a complaint for medical negligence, a claimant shall notify each prospective defendant by certified mail, return receipt requested, of intent to initiate litigation for medical negligence. Notice to each prospective defendant must include, if available, a list of all known health care providers seen by the claimant for the injuries complained of subsequent to the alleged act of negligence, all known health care providers during the 2-year period prior to the alleged act of negligence who treated or evaluated the claimant, copies of all of the medical records relied upon by the expert in signing the affidavit, and the executed authorization form provided in s. 766.1065.

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

(3) PRESUIT INVESTIGATION BY PROSPECTIVE DEFENDANT.—

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

1. Internal review by a duly qualified claims adjuster;

2. Creation of a panel comprised of an attorney knowledgeable in the prosecution or defense of medical negligence actions, a health care provider trained in the same or similar medical specialty as the prospective defendant, and a duly qualified claims adjuster;

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

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

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

(b) At or before the end of the 90 days, the prospective defendant or the prospective defendant’s insurer or self-insurer shall provide the claimant with a response:

1. Rejecting the claim;

2. Making a settlement offer; or

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

(c) The response shall be delivered to the claimant if not represented by counsel or to the claimant’s

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

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

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

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

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

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

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

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

(5) DISCOVERY AND ADMISSIBILITY.—A statement, discussion, written document, report, or other work product generated by the presuit screening process is not discoverable or admissible in any civil action for any purpose by the opposing party. All participants, including, but not limited to, physicians, investigators, witnesses, and employees or associates of the defendant, are immune from civil liability arising from participation in the presuit screening process. This subsection does not prevent a physician licensed under chapter 458 or chapter 459 or a dentist licensed under chapter 466 who submits a verified written expert medical opinion from being subject to denial of a license or disciplinary action under s. 458.331(1)(oo), s. 459.015(1)(qq), or s. 466.028(1)(ll).

(6) INFORMAL DISCOVERY.—

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

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

1. Unsworn statements.—Any party may require other parties to appear for the taking of an unsworn statement. Such statements may be used only for the purpose of presuit screening and are not discoverable or admissible in any civil action for any purpose by any party. A party desiring to take the unsworn statement of any party must give reasonable notice in writing to all parties. The notice must state the time and place for taking the statement and the name and address of the party to be examined. Unless otherwise impractical, the examination of any party must be done at the same time by all other parties. Any party may be represented by counsel at the taking of an unsworn statement. An unsworn statement may be recorded electronically, stenographically, or on videotape. The taking of unsworn statements is subject to the provisions of the Florida Rules of Civil Procedure and may be terminated for abuses.

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

control. Medical records shall be produced as provided in s. 766.204.

3. Physical and mental examinations.—A prospective defendant may require an injured claimant to appear for examination by an appropriate health care provider. The prospective defendant shall give reasonable notice in writing to all parties as to the time and place for examination. Unless otherwise impractical, a claimant is required to submit to only one examination on behalf of all potential defendants. The practicality of a single examination must be determined by the nature of the claimant's condition, as it relates to the liability of each prospective defendant. Such examination report is available to the parties and their attorneys upon payment of the reasonable cost of reproduction and may be used only for the purpose of presuit screening. Otherwise, such examination report is confidential and exempt from the provisions of s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

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

5. Unsworn statements of treating health care providers.—A prospective defendant or his or her legal representative may also take unsworn statements of the claimant's treating health care providers. The statements must be limited to those areas that are potentially relevant to the claim of personal injury or wrongful death. Subject to the procedural requirements of subparagraph 1., a prospective defendant may take unsworn statements from a claimant's treating physicians. Reasonable notice and opportunity to be heard must be given to the claimant or the claimant's legal representative before taking unsworn statements. The claimant or claimant's legal representative has the right to attend the taking of such unsworn statements.

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

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

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

History.—s. 14, ch. 85-175; s. 9, ch. 86-287; s. 3, ch. 88-173; s. 48, ch. 88-277; s. 245, ch. 94-218; s. 1, ch. 94-258; s. 424, ch. 96-406; s. 1800, ch. 97-102; s. 164, ch. 98-166; s. 225, ch. 2000-160; s. 166, ch. 2000-318; s. 1, ch. 2000-341; s. 49, ch. 2003-416; s. 11, ch. 2011-233.

Note.—Former s. 768.57.

766.1065 Authorization for release of protected health information.—

(1) Presuit notice of intent to initiate litigation for medical negligence under s. 766.106(2) must be accompanied by an authorization for release of protected health information in the form specified by this section, authorizing the disclosure of protected health information that is potentially relevant to the claim of personal injury or wrongful death. The presuit notice is void if this authorization does not accompany the presuit notice and other materials required by s. 766.106(2).

(2) If the authorization required by this section is revoked, the presuit notice under s. 766.106(2) is deemed retroactively void from the date of issuance, and any tolling effect that the presuit notice may have had on any applicable statute-of-limitations period is retroactively rendered void.

(3) The authorization required by this section shall be in the following form and shall be construed in accordance with the "Standards for Privacy of Individually Identifiable Health Information" in 45 C.F.R. parts 160 and 164:

AUTHORIZATION FOR RELEASE OF
PROTECTED HEALTH INFORMATION

A. I, (...Name of patient or authorized representative...) [hereinafter "Patient"], authorize that (...Name of health care provider to whom the presuit notice is directed...) and his/her/its insurer(s), self-insurer(s), and attorney(s) may obtain and disclose (within the parameters set out below) the protected health information described below for the following specific purposes:

1. Facilitating the investigation and evaluation of the medical negligence claim described in the accompanying presuit notice; or

2. Defending against any litigation arising out of the medical negligence claim made on the basis of the accompanying presuit notice.

B. The health information obtained, used, or disclosed extends to, and includes, the verbal as well as the written and is described as follows:

1. The health information in the custody of the following health care providers who have examined, evaluated, or treated the Patient in connection with injuries complained of after the alleged act of negligence: (List the name and current address of all health care providers). This authorization extends to any additional health care providers that may in the future evaluate, examine, or treat the Patient for the injuries complained of.

2. The health information in the custody of the following health care providers who have examined, evaluated, or treated the Patient during a period commencing 2 years before the incident that is the basis of the accompanying presuit notice.

(List the name and current address of such health care providers, if applicable.)

C. This authorization does not apply to the following list of health care providers possessing health care information about the Patient because the Patient certifies that such health care information is not potentially relevant to the claim of personal injury or wrongful death that is the basis of the accompanying presuit notice.

(List the name of each health care provider to whom this authorization does not apply and the inclusive dates of examination, evaluation, or treatment to be withheld from disclosure. If none, specify "none.")

D. The persons or class of persons to whom the Patient authorizes such health information to be disclosed or by whom such health information is to be used:

1. Any health care provider providing care or treatment for the Patient.

2. Any liability insurer or self-insurer providing liability insurance coverage, self-insurance, or defense to any health care provider to whom presuit notice is given regarding the care and treatment of the Patient.

3. Any consulting or testifying expert employed by or on behalf of (name of health care provider to whom presuit notice was given) and his/her/its insurer(s), self-insurer(s), or attorney(s) regarding the matter of the presuit notice accompanying this authorization.

4. Any attorney (including secretarial, clerical, or paralegal staff) employed by or on behalf of (name of health care provider to whom presuit notice was given) regarding the matter of the presuit notice accompanying this authorization.

5. Any trier of the law or facts relating to any suit filed seeking damages arising out of the medical care or treatment of the Patient.

E. This authorization expires upon resolution of the claim or at the conclusion of any litigation

instituted in connection with the matter of the presuit notice accompanying this authorization, whichever occurs first.

F. The Patient understands that, without exception, the Patient has the right to revoke this authorization in writing. The Patient further understands that the consequence of any such revocation is that the presuit notice under s. 766.106(2), Florida Statutes, is deemed retroactively void from the date of issuance, and any tolling effect that the presuit notice may have had on any applicable statute-of-limitations period is retroactively rendered void.

G. The Patient understands that signing this authorization is not a condition for continued treatment, payment, enrollment, or eligibility for health plan benefits.

H. The Patient understands that information used or disclosed under this authorization may be subject to additional disclosure by the recipient and may not be protected by federal HIPAA privacy regulations.

Signature of Patient/Representative:
Date:
Name of Patient/Representative:
Description of Representative's Authority:
History.—s. 12, ch. 2011-233; s. 83, ch. 2012-5.

[1]**766.107 Court-ordered arbitration.**—

(1) In an action for recovery of damages based on the death or personal injury of any person in which it is alleged that such death or injury resulted from the negligence of a health care provider as defined in [2]s. 768.50(2), the court may require, upon motion by either party, that the claim be submitted to nonbinding arbitration. Within 10 days after the court determines the matter will be submitted to arbitration, the court shall submit to the attorneys for each party the appropriate list of arbitrators prepared pursuant to subsection (2) and shall notify the attorneys of the date by which their selection of an arbitrator must be received by the court.

(2)(a) The chief judge of the judicial circuit shall prepare three lists of prospective arbitrators. A claimant's list shall consist of attorneys with experience in handling negligence actions who principally represent plaintiffs and who are eligible and qualified to serve as arbitrators. A defendant's list shall consist of health care practitioners, and attorneys who principally handle the defense of negligence actions, who are eligible and qualified to serve as arbitrators. A third list shall consist of attorneys who are experienced in trial matters but who do not devote a majority of their practice either to the defense or to the representation of plaintiffs in medical negligence matters. The chief judge shall appoint an advisory committee made up of equal numbers of at least three members of the defense bar and three members of the plaintiff's bar, which shall approve the qualifications of the persons on the claimant's list and the persons on the defendant's list. The advisory committee shall assist the chief judge in screening applicants and aiding in the formulation and application of standards for selection of arbitrators. Each committee shall meet at least once a year.

(b) A person may be certified to serve as an attorney arbitrator if the person has been a member of The Florida Bar for at least 5 years and the chief judge determines that he or she is competent to serve as an arbitrator. A person may be certified as a health care practitioner arbitrator if the person has been licensed to practice his or her profession in this state for at least 5 years and the chief judge determines that he or she is competent to serve as an arbitrator. Current lists of all persons certified as arbitrators shall be maintained in the office of the clerk of the circuit court and shall be open to public inspection. An attorney may not be disqualified from appearing and acting as counsel in a case pending before the court because he or she is serving as an arbitrator in another case.

(c) The plaintiff or plaintiffs shall select one arbitrator from the claimant's list and the defendant or defendants shall select one arbitrator from the defendant's list, and each shall notify the chief judge of such selection. If a party does not select his or her arbitrator within 20 days, the party's right to select an arbitrator is waived and the chief judge shall proceed with the selection of an arbitrator from the appropriate list. The two arbitrators selected shall, within 10 days after their selection, select a third arbitrator from the third list. If the arbitrators have not selected the third arbitrator within such 10-day period, the chief judge shall submit three names from the third list to the two arbitrators. Each arbitrator shall strike one name from the list, and the person whose name remains shall be the third arbitrator. No person may serve as an arbitrator in any arbitration in which he or she has a financial or personal interest. The third arbitrator shall disclose any circumstances likely to create a presumption of bias which might disqualify him or her as an impartial arbitrator. Either party may advise the chief judge why an arbitrator should be disqualified from serving. If the third arbitrator resigns, is disqualified, or is unable to perform his or her duties, the chief judge shall appoint a replacement. If an arbitrator selected by one of the parties is unable to serve, that party shall select a replacement arbitrator, unless he or she has waived such right, in which case the replacement shall be selected by the chief judge. The chief judge shall designate one panel member as chair.

(3)(a) Immediately upon the selection of the arbitrators, the clerk of the circuit court shall communicate with the parties and the arbitrators in an effort to ascertain a mutually convenient date for a hearing and shall then schedule and give notice of the date and time of the arbitration hearing. The hearing shall be scheduled within 60 days after the date of the selection and designation of the arbitrators, provided that there has been at least 20 days notice to the parties. Thereafter, the chief judge may for good cause shown grant a continuance of the hearing, provided that the hearing is rescheduled within 90 days after the date of the selection and designation of the arbitrators.

(b) The panel shall consider all relevant evidence and decide the issues of liability, amount of damages, and apportionment of responsibility among the parties. Punitive damages may not be awarded by the arbitration panel.

(c) The arbitration hearing may proceed in the absence of a party who, after due notice, fails to be present, but an award of damages shall not be based solely on the absence of a party.

(d) At least 10 days prior to the date of the arbitration hearing, each party shall furnish every other party with a list of witnesses, if any, and copies or photographs of all exhibits to be offered at the hearing. The arbitrators may refuse to hear any witness or to consider any exhibit which has not been disclosed.

(e) The hearing shall be conducted informally. The Florida Rules of Evidence shall be a guide, but shall not be binding. It is contemplated that the presentation of testimony shall be kept to a minimum and that cases shall be presented to the arbitrators primarily through the statements and arguments of counsel.

(f) The arbitrators may receive and consider the evidence of witnesses by affidavit, but shall give it only such weight as the arbitrators deem it is entitled to after consideration of any objections made to its admission.

(g) Any party may have a recording and transcript of the arbitration hearing made at his or her own expense.

(h) The members of the arbitration panel shall be paid $100 each for each day or portion of a day of service on the arbitration panel. The court shall assess each party equally for such payments.

(i) No member of the arbitration panel shall be liable in damages for any action taken or recommendation made by such member in the performance of his or her duties as a member of the arbitration panel.

(j) The decision of the arbitrators shall be rendered promptly and not later than 30 days after the date of the close of the hearings. The award of the arbitrators shall be immediately provided in writing to the parties. The award shall state the result reached by arbitrators without necessity of factual findings or legal

conclusions. A majority determination shall control the award.

(4) The decision of the arbitration panel shall not be binding. If all parties accept the decision of the arbitration panel, that decision shall be deemed a settlement of the case and it shall be dismissed with prejudice. After the arbitration award is rendered, any party may demand a trial de novo in the circuit court by filing with the clerk of the circuit court and all parties such notice as is required by rules adopted by the Supreme Court.

(5) At the trial de novo, the court shall not admit evidence that there has been an arbitration proceeding, the nature or the amount of the award, or any other matter concerning the conduct of the arbitration proceeding, except that testimony given at an arbitration hearing may be used for the purposes otherwise permitted by the Florida Rules of Evidence or the Florida Rules of Civil Procedure. The trial on the merits shall be conducted without any reference to insurance, insurance coverage, or joinder of the insurer as codefendant in the suit. Panel members may not be called to testify as to the merits of the case.

(6) The Supreme Court may adopt rules to supplement the provisions of this section.

(7) This section shall apply only to actions filed at least 90 days after October 1, 1985.

History.—ss. 15, 49, ch. 85-175; s. 4, ch. 86-286; s. 10, ch. 86-287; s. 1152, ch. 97-102.

[1]**Note.**—This section was created by s. 15, ch. 85-175, and transferred to s. 766.107 by the reviser in 1988. Section 17, ch. 85-175, also created a s. 768.575, which was renumbered by the reviser as s. 768.595 in 1985, transferred to s. 766.109 in 1988, and repealed in 1992. Section 49, ch. 85-175, as amended by s. 4, ch. 86-286, provides, in pertinent part, that "[s]ection 768.575 . . . as created by this act . . . is repealed on October 1, 1988, and shall be reviewed by the Legislature prior to that date."

[2]**Note.**—Repealed by s. 68, ch. 86-160.

Note.—Former s. 768.575.

766.108 Mandatory mediation and mandatory settlement conference in medical negligence actions.—

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

(2)(a) In any action for damages based on personal injury or wrongful death arising out of medical malpractice, whether in tort or contract, the court shall require a settlement conference at least 3 weeks before the date set for trial.

(b) Attorneys who will conduct the trial, parties, and persons with authority to settle shall attend the settlement conference held before the court unless excused by the court for good cause.

History.—s. 19, ch. 85-175; s. 11, ch. 86-287; s. 50, ch. 2003-416.

Note.—Former s. 768.58.

766.110 Liability of health care facilities.—

(1) All health care facilities, including hospitals and ambulatory surgical centers, as defined in chapter 395, have a duty to assure comprehensive risk management and the competence of their medical staff and personnel through careful selection and review, and are liable for a failure to exercise due care in fulfilling these duties. These duties shall include, but not be limited to:

(a) The adoption of written procedures for the selection of staff members and a periodic review of the medical care and treatment rendered to patients by each member of the medical staff;

(b) The adoption of a comprehensive risk management program which fully complies with the substantive requirements of s. 395.0197 as appropriate to such hospital's size, location, scope of services, physical configuration, and similar relevant factors;

(c) The initiation and diligent administration of the medical review and risk management processes

established in paragraphs (a) and (b) including the supervision of the medical staff and hospital personnel to the extent necessary to ensure that such medical review and risk management processes are being diligently carried out.

Each such facility shall be liable for a failure to exercise due care in fulfilling one or more of these duties when such failure is a proximate cause of injury to a patient.

(2) Every hospital licensed under chapter 395 may carry liability insurance or adequately insure itself in an amount of not less than $1.5 million per claim, $5 million annual aggregate to cover all medical injuries to patients resulting from negligent acts or omissions on the part of those members of its medical staff who are covered thereby in furtherance of the requirements of ss. 458.320 and 459.0085. Self-insurance coverage extended hereunder to a member of a hospital's medical staff meets the financial responsibility requirements of ss. 458.320 and 459.0085 if the physician's coverage limits are not less than the minimum limits established in ss. 458.320 and 459.0085 and the hospital is a verified trauma center that has extended self-insurance coverage continuously to members of its medical staff for activities both inside and outside of the hospital. Any insurer authorized to write casualty insurance may make available, but shall not be required to write, such coverage. The hospital may assess on an equitable and pro rata basis the following professional health care providers for a portion of the total hospital insurance cost for this coverage: physicians licensed under chapter 458, osteopathic physicians licensed under chapter 459, podiatric physicians licensed under chapter 461, dentists licensed under chapter 466, and nurses licensed under part I of chapter 464. The hospital may provide for a deductible amount to be applied against any individual health care provider found liable in a law suit in tort or for breach of contract. The legislative intent in providing for the deductible to be applied to individual health care providers found negligent or in breach of contract is to instill in each individual health care provider the incentive to avoid the risk of injury to the fullest extent and ensure that the citizens of this state receive the highest quality health care obtainable.

(3) In order to ensure comprehensive risk management for diagnosis of disease, a health care facility, including a hospital or ambulatory surgical center, as defined in chapter 395, may use scientific diagnostic disease methodologies that use information regarding specific diseases in health care facilities and that are adopted by the facility's medical review committee.

History.—s. 23, ch. 85-175; s. 4, ch. 90-158; s. 93, ch. 92-289; s. 64, ch. 97-264; s. 232, ch. 98-166; s. 144, ch. 2000-318; s. 34, ch. 2002-400; s. 13, ch. 2011-233.

Note.—Former s. 768.60.

766.111 Engaging in unnecessary diagnostic testing; penalties.—

(1) No health care provider licensed pursuant to chapter 458, chapter 459, chapter 460, chapter 461, or chapter 466 shall order, procure, provide, or administer unnecessary diagnostic tests, which are not reasonably calculated to assist the health care provider in arriving at a diagnosis and treatment of a patient's condition.

(2) A violation of this section shall be grounds for disciplinary action pursuant to s. 458.331, s. 459.015, s. 460.413, s. 461.013, or s. 466.028, as applicable.

(3) Any person who prevails in a suit brought against a health care provider predicated upon a violation of this section shall recover reasonable attorney's fees and costs.

History.—s. 26, ch. 85-175; s. 71, ch. 87-226; s. 8, ch. 96-296; s. 71, ch. 97-264.

Note.—Former s. 768.61.

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

(1) SHORT TITLE.—This section may be cited as the "Access to Health Care Act."

(2) FINDINGS AND INTENT.—The Legislature finds that a significant proportion of the residents of this

state who are uninsured or Medicaid recipients are unable to access needed health care because health care providers fear the increased risk of medical negligence liability. It is the intent of the Legislature that access to medical care for indigent residents be improved by providing governmental protection to health care providers who offer free quality medical services to underserved populations of the state. Therefore, it is the intent of the Legislature to ensure that health care professionals who contract to provide such services as agents of the state are provided sovereign immunity.

(3) DEFINITIONS.—As used in this section, the term:

(a) "Contract" means an agreement executed in compliance with this section between a health care provider and a governmental contractor. This contract shall allow the health care provider to deliver health care services to low-income recipients as an agent of the governmental contractor. The contract must be for volunteer, uncompensated services. For services to qualify as volunteer, uncompensated services under this section, the health care provider must receive no compensation from the governmental contractor for any services provided under the contract and must not bill or accept compensation from the recipient, or any public or private third-party payor, for the specific services provided to the low-income recipients covered by the contract.

(b) "Department" means the Department of Health.

(c) "Governmental contractor" means the department, county health departments, a special taxing district with health care responsibilities, or a hospital owned and operated by a governmental entity.

(d) "Health care provider" or "provider" means:

1. A birth center licensed under chapter 383.
2. An ambulatory surgical center licensed under chapter 395.
3. A hospital licensed under chapter 395.
4. A physician or physician assistant licensed under chapter 458.
5. An osteopathic physician or osteopathic physician assistant licensed under chapter 459.
6. A chiropractic physician licensed under chapter 460.
7. A podiatric physician licensed under chapter 461.
8. A registered nurse, nurse midwife, licensed practical nurse, or advanced registered nurse practitioner licensed or registered under part I of chapter 464 or any facility which employs nurses licensed or registered under part I of chapter 464 to supply all or part of the care delivered under this section.
9. A midwife licensed under chapter 467.
10. A health maintenance organization certificated under part I of chapter 641.
11. A health care professional association and its employees or a corporate medical group and its employees.
12. Any other medical facility the primary purpose of which is to deliver human medical diagnostic services or which delivers nonsurgical human medical treatment, and which includes an office maintained by a provider.
13. A dentist or dental hygienist licensed under chapter 466.
14. A free clinic that delivers only medical diagnostic services or nonsurgical medical treatment free of charge to all low-income recipients.
15. Any other health care professional, practitioner, provider, or facility under contract with a governmental contractor, including a student enrolled in an accredited program that prepares the student for licensure as any one of the professionals listed in subparagraphs 4.-9.

The term includes any nonprofit corporation qualified as exempt from federal income taxation under s. 501(a) of the Internal Revenue Code, and described in s. 501(c) of the Internal Revenue Code, which delivers health care services provided by licensed professionals listed in this paragraph, any federally funded community

health center, and any volunteer corporation or volunteer health care provider that delivers health care services.

(e) "Low-income" means:

1. A person who is Medicaid-eligible under Florida law;

2. A person who is without health insurance and whose family income does not exceed 200 percent of the federal poverty level as defined annually by the federal Office of Management and Budget; or

3. Any client of the department who voluntarily chooses to participate in a program offered or approved by the department and meets the program eligibility guidelines of the department.

(4) CONTRACT REQUIREMENTS.—A health care provider that executes a contract with a governmental contractor to deliver health care services on or after April 17, 1992, as an agent of the governmental contractor is an agent for purposes of s. 768.28(9), while acting within the scope of duties under the contract, if the contract complies with the requirements of this section and regardless of whether the individual treated is later found to be ineligible. A health care provider under contract with the state may not be named as a defendant in any action arising out of medical care or treatment provided on or after April 17, 1992, under contracts entered into under this section. The contract must provide that:

(a) The right of dismissal or termination of any health care provider delivering services under the contract is retained by the governmental contractor.

(b) The governmental contractor has access to the patient records of any health care provider delivering services under the contract.

(c) Adverse incidents and information on treatment outcomes must be reported by any health care provider to the governmental contractor if the incidents and information pertain to a patient treated under the contract. The health care provider shall submit the reports required by s. 395.0197. If an incident involves a professional licensed by the Department of Health or a facility licensed by the Agency for Health Care Administration, the governmental contractor shall submit such incident reports to the appropriate department or agency, which shall review each incident and determine whether it involves conduct by the licensee that is subject to disciplinary action. All patient medical records and any identifying information contained in adverse incident reports and treatment outcomes which are obtained by governmental entities under this paragraph are confidential and exempt from the provisions of s. 119.07(1) and s. 24(a), Art. I of the State Constitution.

(d) Patient selection and initial referral must be made solely by the governmental contractor, and the provider must accept all referred patients. However, the number of patients that must be accepted may be limited by the contract, and patients may not be transferred to the provider based on a violation of the antidumping provisions of the Omnibus Budget Reconciliation Act of 1989, the Omnibus Budget Reconciliation Act of 1990, or chapter 395.

(e) If emergency care is required, the patient need not be referred before receiving treatment, but must be referred within 48 hours after treatment is commenced or within 48 hours after the patient has the mental capacity to consent to treatment, whichever occurs later.

(f) Patient care, including any followup or hospital care, is subject to approval by the governmental contractor.

(g) The provider is subject to supervision and regular inspection by the governmental contractor.

A governmental contractor that is also a health care provider is not required to enter into a contract under this section with respect to the health care services delivered by its employees.

(5) NOTICE OF AGENCY RELATIONSHIP.—The governmental contractor must provide written notice to each patient, or the patient's legal representative, receipt of which must be acknowledged in writing, that the provider is an agent of the governmental contractor and that the exclusive remedy for injury or damage suffered as the result of any act or omission of the provider or of any employee or agent thereof acting within

the scope of duties pursuant to the contract is by commencement of an action pursuant to the provisions of s. 768.28. With respect to any federally funded community health center, the notice requirements may be met by posting in a place conspicuous to all persons a notice that the federally funded community health center is an agent of the governmental contractor and that the exclusive remedy for injury or damage suffered as the result of any act or omission of the provider or of any employee or agent thereof acting within the scope of duties pursuant to the contract is by commencement of an action pursuant to the provisions of s. 768.28.

(6) QUALITY ASSURANCE PROGRAM REQUIRED.—The governmental contractor shall establish a quality assurance program to monitor services delivered under any contract between an agency and a health care provider pursuant to this section.

(7) RISK MANAGEMENT REPORT.—The Division of Risk Management of the Department of Financial Services shall annually compile a report of all claims statistics for all entities participating in the risk management program administered by the division, which shall include the number and total of all claims pending and paid, and defense and handling costs associated with all claims brought against contract providers under this section. This report shall be forwarded to the department and included in the annual report submitted to the Legislature pursuant to this section.

(8) REPORT TO THE LEGISLATURE.—Annually, the department shall report to the President of the Senate, the Speaker of the House of Representatives, and the minority leaders and relevant substantive committee chairpersons of both houses, summarizing the efficacy of access and treatment outcomes with respect to providing health care services for low-income persons pursuant to this section.

(9) MALPRACTICE LITIGATION COSTS.—Governmental contractors other than the department are responsible for their own costs and attorney's fees for malpractice litigation arising out of health care services delivered pursuant to this section.

(10) RULES.—The department shall adopt rules to administer this section in a manner consistent with its purpose to provide and facilitate access to appropriate, safe, and cost-effective health care services and to maintain health care quality. The rules may include services to be provided and authorized procedures. Notwithstanding the requirements of paragraph (4)(d), the department shall adopt rules that specify required methods for determination and approval of patient eligibility and referral and the contractual conditions under which a health care provider may perform the patient eligibility and referral process on behalf of the department. These rules shall include, but not be limited to, the following requirements:

(a) The provider must accept all patients referred by the department. However, the number of patients that must be accepted may be limited by the contract.

(b) The provider shall comply with departmental rules regarding the determination and approval of patient eligibility and referral.

(c) The provider shall complete training conducted by the department regarding compliance with the approved methods for determination and approval of patient eligibility and referral.

(d) The department shall retain review and oversight authority of the patient eligibility and referral determination.

(11) APPLICABILITY.—This section applies to incidents occurring on or after April 17, 1992. This section does not:

(a) Apply to any health care contract entered into by the Department of Corrections which is subject to s. 768.28(10)(a).

(b) Apply to any affiliation agreement or other contract that is subject to s. 768.28(10)(f).

(c) Reduce or limit the rights of the state or any of its agencies or subdivisions to any benefit currently provided under s. 768.28.

History.—s. 1, ch. 92-278; s. 22, ch. 93-129; s. 1, ch. 94-75; s. 246, ch. 94-218; s. 425, ch. 96-406; s. 126, ch. 97-237; s. 9, ch. 97-263; s. 11, ch. 98-49; s. 41, ch. 98-89; s. 233, ch. 98-166; s. 88, ch. 99-3; s. 286, ch. 99-8; s. 49, ch. 2000-242; s. 145, ch.

2000-318; s. 88, ch. 2001-277; s. 114, ch. 2002-1; s. 1900, ch. 2003-261; s. 51, ch. 2003-416; s. 1, ch. 2004-54; s. 1, ch. 2005-118; s. 2, ch. 2011-219.

766.1116 Health care practitioner; waiver of license renewal fees and continuing education requirements.—

(1) As used in this section, the term "health care practitioner" means a physician or physician assistant licensed under chapter 458; an osteopathic physician or physician assistant licensed under chapter 459; a chiropractic physician licensed under chapter 460; a podiatric physician licensed under chapter 461; an advanced registered nurse practitioner, registered nurse, or licensed practical nurse licensed under part I of chapter 464; a dentist or dental hygienist licensed under chapter 466; or a midwife licensed under chapter 467, who participates as a health care provider under s. 766.1115.

(2) Notwithstanding any provision of chapter 458, chapter 459, chapter 460, chapter 461, part I of chapter 464, chapter 466, or chapter 467 to the contrary, any health care practitioner who participates as a health care provider under s. 766.1115 and thereby agrees with a governmental contractor to provide his or her services without compensation and as an agent of the governmental contractor to low-income recipients in accordance with s. 766.1115 for at least 160 hours for each biennial licensure period, or, if the health care practitioner is retired, for at least 800 hours during the licensure period, upon providing sufficient proof from the applicable governmental contractor that the health care practitioner has completed the hours at the time of license renewal under procedures specified by the Department of Health, shall be eligible for:

(a) Waiver of the biennial license renewal fee for an active license; and

(b) Fulfillment of a maximum of 25 percent of the continuing education hours required for license renewal under s. 456.013(9).

History.—s. 2, ch. 2004-54; s. 4, ch. 2009-41.

766.112 Comparative fault.—

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

(2) In an action for damages for personal injury or wrongful death arising out of medical negligence, whether in contract or tort, when an apportionment of damages pursuant to s. 768.81 is attributed to a board of trustees of a state university, the court shall enter judgment against the board of trustees on the basis of the board's percentage of fault and not on the basis of the doctrine of joint and several liability. The sole remedy available to a claimant to collect a judgment or settlement against a board of trustees, subject to the provisions of this subsection, shall be pursuant to s. 768.28.

History.—ss. 79, 80, ch. 88-1; ss. 43, 44, ch. 88-277; s. 32, ch. 91-110; s. 102, ch. 92-33; s. 1, ch. 2002-401; s. 52, ch. 2003-416.

766.113 Settlement agreements; prohibition on restricting disclosure to Division of Medical Quality Assurance.—

(1) Each final settlement agreement relating to medical negligence shall include the following statement: "The decision to settle a case may reflect the economic practicalities pertaining to the cost of litigation and is not, alone, an admission that the insured failed to meet the required standard of care applicable to the patient's treatment. The decision to settle a case may be made by the insurance company without consulting its client for input, unless otherwise provided by the insurance policy."

(2) A settlement agreement involving a claim for medical negligence shall not prohibit any party to the

agreement from discussing with or reporting to the Division of Medical Quality Assurance the events giving rise to the claim.

History.—s. 49, ch. 88-277; s. 53, ch. 2003-416.

766.118 Determination of noneconomic damages.—

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

(a) "Catastrophic injury" means a permanent impairment constituted by:

1. Spinal cord injury involving severe paralysis of an arm, a leg, or the trunk;

2. Amputation of an arm, a hand, a foot, or a leg involving the effective loss of use of that appendage;

3. Severe brain or closed-head injury as evidenced by:

a. Severe sensory or motor disturbances;

b. Severe communication disturbances;

c. Severe complex integrated disturbances of cerebral function;

d. Severe episodic neurological disorders; or

e. Other severe brain and closed-head injury conditions at least as severe in nature as any condition provided in sub-subparagraphs a.-d.;

4. Second-degree or third-degree burns of 25 percent or more of the total body surface or third-degree burns of 5 percent or more to the face and hands;

5. Blindness, defined as a complete and total loss of vision; or

6. Loss of reproductive organs which results in an inability to procreate.

(b) "Noneconomic damages" means noneconomic damages as defined in s. 766.202(8).

(c) "Practitioner" means any person licensed under chapter 458, chapter 459, chapter 460, chapter 461, chapter 462, chapter 463, chapter 466, chapter 467, or chapter 486 or certified under s. 464.012. "Practitioner" also means any association, corporation, firm, partnership, or other business entity under which such practitioner practices or any employee of such practitioner or entity acting in the scope of his or her employment. For the purpose of determining the limitations on noneconomic damages set forth in this section, the term "practitioner" includes any person or entity for whom a practitioner is vicariously liable and any person or entity whose liability is based solely on such person or entity being vicariously liable for the actions of a practitioner.

(2) LIMITATION ON NONECONOMIC DAMAGES FOR NEGLIGENCE OF PRACTITIONERS.—

(a) With respect to a cause of action for personal injury or wrongful death arising from medical negligence of practitioners, regardless of the number of such practitioner defendants, noneconomic damages shall not exceed $500,000 per claimant. No practitioner shall be liable for more than $500,000 in noneconomic damages, regardless of the number of claimants.

(b) Notwithstanding paragraph (a), if the negligence resulted in a permanent vegetative state or death, the total noneconomic damages recoverable from all practitioners, regardless of the number of claimants, under this paragraph shall not exceed $1 million. In cases that do not involve death or permanent vegetative state, the patient injured by medical negligence may recover noneconomic damages not to exceed $1 million if:

1. The trial court determines that a manifest injustice would occur unless increased noneconomic damages are awarded, based on a finding that because of the special circumstances of the case, the noneconomic harm sustained by the injured patient was particularly severe; and

2. The trier of fact determines that the defendant's negligence caused a catastrophic injury to the patient.

(c) The total noneconomic damages recoverable by all claimants from all practitioner defendants under this subsection shall not exceed $1 million in the aggregate.

(3) LIMITATION ON NONECONOMIC DAMAGES FOR NEGLIGENCE OF NONPRACTITIONER DEFENDANTS.—

(a) With respect to a cause of action for personal injury or wrongful death arising from medical negligence of nonpractitioners, regardless of the number of such nonpractitioner defendants, noneconomic damages shall not exceed $750,000 per claimant.

(b) Notwithstanding paragraph (a), if the negligence resulted in a permanent vegetative state or death, the total noneconomic damages recoverable by such claimant from all nonpractitioner defendants under this paragraph shall not exceed $1.5 million. The patient injured by medical negligence of a nonpractitioner defendant may recover noneconomic damages not to exceed $1.5 million if:

1. The trial court determines that a manifest injustice would occur unless increased noneconomic damages are awarded, based on a finding that because of the special circumstances of the case, the noneconomic harm sustained by the injured patient was particularly severe; and

2. The trier of fact determines that the defendant's negligence caused a catastrophic injury to the patient.

(c) Nonpractitioner defendants are subject to the cap on noneconomic damages provided in this subsection regardless of the theory of liability, including vicarious liability.

(d) The total noneconomic damages recoverable by all claimants from all nonpractitioner defendants under this subsection shall not exceed $1.5 million in the aggregate.

(4) LIMITATION ON NONECONOMIC DAMAGES FOR NEGLIGENCE OF PRACTITIONERS PROVIDING EMERGENCY SERVICES AND CARE.—Notwithstanding subsections (2) and (3), with respect to a cause of action for personal injury or wrongful death arising from medical negligence of practitioners providing emergency services and care, as defined in s. 395.002(9), or providing services as provided in s. 401.265, or providing services pursuant to obligations imposed by 42 U.S.C. s. 1395dd to persons with whom the practitioner does not have a then-existing health care patient-practitioner relationship for that medical condition:

(a) Regardless of the number of such practitioner defendants, noneconomic damages shall not exceed $150,000 per claimant.

(b) Notwithstanding paragraph (a), the total noneconomic damages recoverable by all claimants from all such practitioners shall not exceed $300,000.

The limitation provided by this subsection applies only to noneconomic damages awarded as a result of any act or omission of providing medical care or treatment, including diagnosis that occurs prior to the time the patient is stabilized and is capable of receiving medical treatment as a nonemergency patient, unless surgery is required as a result of the emergency within a reasonable time after the patient is stabilized, in which case the limitation provided by this subsection applies to any act or omission of providing medical care or treatment which occurs prior to the stabilization of the patient following the surgery.

(5) LIMITATION ON NONECONOMIC DAMAGES FOR NEGLIGENCE OF NONPRACTITIONER DEFENDANTS PROVIDING EMERGENCY SERVICES AND CARE.—Notwithstanding subsections (2) and (3), with respect to a cause of action for personal injury or wrongful death arising from medical negligence of defendants other than practitioners providing emergency services and care pursuant to obligations imposed by s. 395.1041 or s. 401.45, or obligations imposed by 42 U.S.C. s. 1395dd to persons with whom the practitioner does not have a then-existing health care patient-practitioner relationship for that medical condition:

(a) Regardless of the number of such nonpractitioner defendants, noneconomic damages shall not exceed $750,000 per claimant.

(b) Notwithstanding paragraph (a), the total noneconomic damages recoverable by all claimants from all such nonpractitioner defendants shall not exceed $1.5 million.

(c) Nonpractitioner defendants may receive a full setoff for payments made by practitioner defendants.

The limitation provided by this subsection applies only to noneconomic damages awarded as a result of any act or omission of providing medical care or treatment, including diagnosis that occurs prior to the time the patient is stabilized and is capable of receiving medical treatment as a nonemergency patient, unless surgery is required as a result of the emergency within a reasonable time after the patient is stabilized, in which case the limitation provided by this subsection applies to any act or omission of providing medical care or treatment which occurs prior to the stabilization of the patient following the surgery.

(6) LIMITATION ON NONECONOMIC DAMAGES FOR NEGLIGENCE OF A PRACTITIONER PROVIDING SERVICES AND CARE TO A MEDICAID RECIPIENT.—Notwithstanding subsections (2), (3), and (5), with respect to a cause of action for personal injury or wrongful death arising from medical negligence of a practitioner committed in the course of providing medical services and medical care to a Medicaid recipient, regardless of the number of such practitioner defendants providing the services and care, noneconomic damages may not exceed $300,000 per claimant, unless the claimant pleads and proves, by clear and convincing evidence, that the practitioner acted in a wrongful manner. A practitioner providing medical services and medical care to a Medicaid recipient is not liable for more than $200,000 in noneconomic damages, regardless of the number of claimants, unless the claimant pleads and proves, by clear and convincing evidence, that the practitioner acted in a wrongful manner. The fact that a claimant proves that a practitioner acted in a wrongful manner does not preclude the application of the limitation on noneconomic damages prescribed elsewhere in this section. For purposes of this subsection:

(a) The terms “medical services,” “medical care,” and “Medicaid recipient” have the same meaning as provided in s. 409.901.

(b) The term “practitioner,” in addition to the meaning prescribed in subsection (1), includes any hospital, ambulatory surgical center, or mobile surgical facility as defined and licensed under chapter 395.

(c) The term “wrongful manner” means in bad faith or with malicious purpose or in a manner exhibiting wanton and willful disregard of human rights, safety, or property, and shall be construed in conformity with the standard set forth in s. 768.28(9)(a).

(7) SETOFF.—In any case in which the jury verdict for noneconomic damages exceeds the limits established by this section, the trial court shall reduce the award for noneconomic damages within the same category of defendants in accordance with this section after making any reduction for comparative fault as required by s. 768.81 but before application of a setoff in accordance with ss. 46.015 and 768.041. In the event of a prior settlement or settlements involving one or more defendants subject to the limitations of the same subsection applicable to a defendant remaining at trial, the court shall make such reductions within the same category of defendants as are necessary to ensure that the total amount of noneconomic damages recovered by the claimant does not exceed the aggregate limit established by the applicable subsection. This subsection is not intended to change current law relating to the setoff of economic damages.

(8) ACTIONS GOVERNED BY SOVEREIGN IMMUNITY LAW.—This section shall not apply to actions governed by s. 768.28.

History.—s. 54, ch. 2003-416; s. 204, ch. 2007-230; s. 28, ch. 2011-135.

766.1185 Bad faith actions.—In all actions for bad faith against a medical malpractice insurer relating to professional liability insurance coverage for medical negligence, and in determining whether the insurer could and should have settled the claim within the policy limits had it acted fairly and honestly towards its insured with due regard for her or his interest, whether under statute or common law:

(1)(a) An insurer shall not be held in bad faith for failure to pay its policy limits if it tenders its policy limits and meets other reasonable conditions of settlement by the earlier of either:

1. The 210th day after service of the complaint in the medical negligence action upon the insured. The time period specified in this subparagraph shall be extended by an additional 60 days if the court in the bad

faith action finds that, at any time during such period and after the 150th day after service of the complaint, the claimant provided new information previously unavailable to the insurer relating to the identity or testimony of any material witnesses or the identity of any additional claimants or defendants, if such disclosure materially alters the risk to the insured of an excess judgment; or

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

a. Deposition of all claimants named in the complaint or amended complaint.

b. Deposition of all defendants named in the complaint or amended complaint, including, in the case of a corporate defendant, deposition of a designated representative.

c. Deposition of all of the claimants' expert witnesses.

d. The initial disclosure of witnesses and production of documents.

e. Mediation as provided in s. 766.108.

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

(c) If any party to an action alleging medical negligence amends its witness list after service of the complaint in such action, that party shall provide a copy of the amended witness list to the insurer of the defendant health care provider.

(d) The fact that the insurer did not tender policy limits during the time periods specified in this paragraph is not presumptive evidence that the insurer acted in bad faith.

(2) When subsection (1) does not apply, the trier of fact, in determining whether an insurer has acted in bad faith, shall consider:

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

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

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

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

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

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

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

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

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

(j) In addition to the foregoing, the court shall allow consideration of such additional factors as the court determines to be relevant.

(3) The provisions of s. 624.155 shall be applicable in all cases brought pursuant to that section unless specifically controlled by this section.

(4) An insurer that tenders policy limits shall be entitled to a release of its insured if the claimant accepts the tender.

History.—s. 56, ch. 2003-416.

766.201 Legislative findings and intent.—

(1) The Legislature makes the following findings:

(a) Medical malpractice liability insurance premiums have increased dramatically in recent years, resulting in increased medical care costs for most patients and functional unavailability of malpractice insurance for some physicians.

(b) The primary cause of increased medical malpractice liability insurance premiums has been the substantial increase in loss payments to claimants caused by tremendous increases in the amounts of paid claims.

(c) The average cost of a medical negligence claim has escalated in the past decade to the point where it has become imperative to control such cost in the interests of the public need for quality medical services.

(d) The high cost of medical negligence claims in the state can be substantially alleviated by requiring early determination of the merit of claims, by providing for early arbitration of claims, thereby reducing delay and attorney's fees, and by imposing reasonable limitations on damages, while preserving the right of either party to have its case heard by a jury.

(e) The recovery of 100 percent of economic losses constitutes overcompensation because such recovery fails to recognize that such awards are not subject to taxes on economic damages.

(2) It is the intent of the Legislature to provide a plan for prompt resolution of medical negligence claims. Such plan shall consist of two separate components, presuit investigation and arbitration. Presuit investigation shall be mandatory and shall apply to all medical negligence claims and defenses. Arbitration shall be voluntary and shall be available except as specified.

(a) Presuit investigation shall include:

1. Verifiable requirements that reasonable investigation precede both malpractice claims and defenses in order to eliminate frivolous claims and defenses.

2. Medical corroboration procedures.

(b) Arbitration shall provide:

1. Substantial incentives for both claimants and defendants to submit their cases to binding arbitration, thus reducing attorney's fees, litigation costs, and delay.

2. A conditional limitation on noneconomic damages where the defendant concedes willingness to pay economic damages and reasonable attorney's fees.

3. Limitations on the noneconomic damages components of large awards to provide increased predictability of outcome of the claims resolution process for insurer anticipated losses planning, and to facilitate early resolution of medical negligence claims.

History.—s. 48, ch. 88-1; s. 57, ch. 2003-416.

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

(1) "Claimant" means any person who has a cause of action for damages based on personal injury or wrongful death arising from medical negligence.

(2) "Collateral sources" means any payments made to the claimant, or made on his or her behalf, by or pursuant to:

(a) The United States Social Security Act; any federal, state, or local income disability act; or any other public programs providing medical expenses, disability payments, or other similar benefits, except as prohibited by federal law.

(b) Any health, sickness, or income disability insurance; automobile accident insurance that provides health benefits or income disability coverage; and any other similar insurance benefits, except life insurance benefits available to the claimant, whether purchased by him or her or provided by others.

(c) Any contract or agreement of any group, organization, partnership, or corporation to provide, pay for,

or reimburse the costs of hospital, medical, dental, or other health care services.

(d) Any contractual or voluntary wage continuation plan provided by employers or by any other system intended to provide wages during a period of disability.

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

(4) "Health care provider" means any hospital, ambulatory surgical center, or mobile surgical facility as defined and licensed under chapter 395; a birth center licensed under chapter 383; any person licensed under chapter 458, chapter 459, chapter 460, chapter 461, chapter 462, chapter 463, part I of chapter 464, chapter 466, chapter 467, part XIV of chapter 468, or chapter 486; a clinical lab licensed under chapter 483; a health maintenance organization certificated under part I of chapter 641; a blood bank; a plasma center; an industrial clinic; a renal dialysis facility; or a professional association partnership, corporation, joint venture, or other association for professional activity by health care providers.

(5) "Investigation" means that an attorney has reviewed the case against each and every potential defendant and has consulted with a medical expert and has obtained a written opinion from said expert.

(6) "Medical expert" means a person duly and regularly engaged in the practice of his or her profession who holds a health care professional degree from a university or college and who meets the requirements of an expert witness as set forth in s. 766.102.

(7) "Medical negligence" means medical malpractice, whether grounded in tort or in contract.

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

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

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

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

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

History.—s. 49, ch. 88-1; s. 1153, ch. 97-102; s. 58, ch. 2003-416; s. 3, ch. 2011-195.

766.2021 Limitation on damages against insurers, prepaid limited health service organizations, health maintenance organizations, or prepaid health clinics.—An entity licensed or certified under chapter 624, chapter 636, or chapter 641 shall not be liable for the medical negligence of a health care provider with whom the licensed or certified entity has entered into a contract in any amount greater than the amount of damages that may be imposed by law directly upon the health care provider, and any suits against such entity

shall be subject to all provisions and requirements of evidence in this chapter and other requirements imposed by law in connection with suits against health care providers for medical negligence.

History.—s. 59, ch. 2003-416.

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

(1) APPLICATION OF PRESUIT INVESTIGATION.—Presuit investigation of medical negligence claims and defenses pursuant to this section and ss. 766.204-766.206 shall apply to all medical negligence claims and defenses. This shall include:

(a) Rights of action under s. 768.19 and defenses thereto.

(b) Rights of action involving the state or its agencies or subdivisions, or the officers, employees, or agents thereof, pursuant to s. 768.28 and defenses thereto.

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

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

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

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

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

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

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

Corroboration of lack of reasonable grounds for medical negligence litigation shall be provided with any response rejecting the claim by the defendant's submission of a verified written medical expert opinion from a medical expert as defined in s. 766.202(6), at the time the response rejecting the claim is mailed, which statement shall corroborate reasonable grounds for lack of negligent injury sufficient to support the response denying negligent injury.

(4) PRESUIT MEDICAL EXPERT OPINION.—The medical expert opinions required by this section are subject to discovery. The opinions shall specify whether any previous opinion by the same medical expert has been disqualified and if so the name of the court and the case number in which the ruling was issued.

History.—s. 50, ch. 88-1; s. 26, ch. 88-277; s. 33, ch. 91-110; s. 113, ch. 92-33; s. 3, ch. 92-278; s. 60, ch. 2003-416; s. 154, ch. 2004-5.

766.204 Availability of medical records for presuit investigation of medical negligence claims and defenses; penalty.—

(1) Copies of any medical record relevant to any litigation of a medical negligence claim or defense shall be provided to a claimant or a defendant, or to the attorney thereof, at a reasonable charge within 10 business days of a request for copies, except that an independent special hospital district with taxing authority which owns two or more hospitals shall have 20 days. It shall not be grounds to refuse copies of such medical records that they are not yet completed or that a medical bill is still owing.

(2) Failure to provide copies of such medical records, or failure to make the charge for copies a

reasonable charge, shall constitute evidence of failure of that party to comply with good faith discovery requirements and shall waive the requirement of written medical corroboration by the requesting party.

(3) A hospital shall not be held liable for any civil damages as a result of complying with this section.

History.—s. 51, ch. 88-1; s. 27, ch. 88-277; s. 246, ch. 98-166.

766.205 Presuit discovery of medical negligence claims and defenses.—

(1) Upon the completion of presuit investigation pursuant to s. 766.203, which investigation has resulted in the mailing of a notice of intent to initiate litigation in accordance with s. 766.106, corroborated by medical expert opinion that there exist reasonable grounds for a claim of negligent injury, each party shall provide to the other party reasonable access to information within its possession or control in order to facilitate evaluation of the claim.

(2) Such access shall be provided without formal discovery, pursuant to s. 766.106, and failure to so provide shall be grounds for dismissal of any applicable claim or defense ultimately asserted.

(3) Failure of any party to comply with this section shall constitute evidence of failure of that party to comply with good faith discovery requirements and shall waive the requirement of written medical corroboration by the party seeking production.

(4) No statement, discussion, written document, report, or other work product generated solely by the presuit investigation process is discoverable or admissible in any civil action for any purpose by the opposing party. All participants, including, but not limited to, hospitals and other medical facilities, and the officers, directors, trustees, employees, and agents thereof, physicians, investigators, witnesses, and employees or associates of the defendant, are immune from civil liability arising from participation in the presuit investigation process. Such immunity from civil liability includes immunity for any acts by a medical facility in connection with providing medical records pursuant to s. 766.204(1) regardless of whether the medical facility is or is not a defendant.

History.—s. 52, ch. 88-1; s. 28, ch. 88-277; s. 34, ch. 91-110.

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

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

(2) If the court finds that the notice of intent to initiate litigation mailed by the claimant does not comply with the reasonable investigation requirements of ss. 766.201-766.212, including a review of the claim and a verified written medical expert opinion by an expert witness as defined in s. 766.202, or that the authorization accompanying the notice of intent required under s. 766.1065 is not completed in good faith by the claimant, the court shall dismiss the claim, and the person who mailed such notice of intent, whether the claimant or the claimant's attorney, is personally liable for all attorney's fees and costs incurred during the investigation and evaluation of the claim, including the reasonable attorney's fees and costs of the defendant or the defendant's insurer.

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

(4) If the court finds that an attorney for the claimant mailed notice of intent to initiate litigation without

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

(5)(a) If the court finds that the corroborating written medical expert opinion attached to any notice of claim or intent or to any response rejecting a claim lacked reasonable investigation or that the medical expert submitting the opinion did not meet the expert witness qualifications as set forth in s. 766.102(5), the court shall report the medical expert issuing such corroborating opinion to the Division of Medical Quality Assurance or its designee. If such medical expert is not a resident of the state, the division shall forward such report to the disciplining authority of that medical expert.

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

History.—s. 53, ch. 88-1; s. 29, ch. 88-277; s. 35, ch. 91-110; s. 61, ch. 2003-416; s. 155, ch. 2004-5; s. 14, ch. 2011-233.

766.207 Voluntary binding arbitration of medical negligence claims.—

(1) Voluntary binding arbitration pursuant to this section and ss. 766.208-766.212 shall not apply to rights of action involving the state or its agencies or subdivisions, or the officers, employees, or agents thereof, pursuant to s. 768.28.

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

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

(4) The arbitration panel shall be composed of three arbitrators, one selected by the claimant, one selected by the defendant, and one an administrative law judge furnished by the Division of Administrative Hearings who shall serve as the chief arbitrator. In the event of multiple plaintiffs or multiple defendants, the arbitrator selected by the side with multiple parties shall be the choice of those parties. If the multiple parties cannot reach agreement as to their arbitrator, each of the multiple parties shall submit a nominee, and the director of the Division of Administrative Hearings shall appoint the arbitrator from among such nominees.

(5) The arbitrators shall be independent of all parties, witnesses, and legal counsel, and no officer, director, affiliate, subsidiary, or employee of a party, witness, or legal counsel may serve as an arbitrator in the proceeding.

(6) The rate of compensation for medical negligence claims arbitrators other than the administrative law judge shall be set by the chief judge of the appropriate circuit court by schedule providing for compensation of not less than $250 per day nor more than $750 per day or as agreed by the parties. In setting the schedule, the chief judge shall consider the prevailing rates charged for the delivery of professional services in the

community.

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

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

(b) Noneconomic damages shall be limited to a maximum of $250,000 per incident, and shall be calculated on a percentage basis with respect to capacity to enjoy life, so that a finding that the claimant's injuries resulted in a 50-percent reduction in his or her capacity to enjoy life would warrant an award of not more than $125,000 noneconomic damages.

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

(d) Punitive damages shall not be awarded.

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

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

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

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

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

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

(k) Any offer by a claimant to arbitrate must be made to each defendant against whom the claimant has made a claim. Any offer by a defendant to arbitrate must be made to each claimant who has joined in the notice of intent to initiate litigation, as provided in s. 766.106. A defendant who rejects a claimant's offer to arbitrate shall be subject to the provisions of s. 766.209(3). A claimant who rejects a defendant's offer to arbitrate shall be subject to the provisions of s. 766.209(4).

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

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

(8) Any issue between the defendant and the defendant's insurer or self-insurer as to who shall control the defense of the claim and any responsibility for payment of an arbitration award, shall be determined under existing principles of law; provided that the insurer or self-insurer shall not offer to arbitrate or accept a claimant's offer to arbitrate without the written consent of the defendant.

(9) The Division of Administrative Hearings is authorized to promulgate rules to effect the orderly and efficient processing of the arbitration procedures of ss. 766.201-766.212.

(10) Rules promulgated by the Division of Administrative Hearings pursuant to this section, s. 120.54, or s. 120.65 may authorize any reasonable sanctions except contempt for violation of the rules of the division or failure to comply with a reasonable order issued by an administrative law judge, which is not under judicial review.

History.—s. 54, ch. 88-1; s. 30, ch. 88-277; s. 36, ch. 91-110; s. 114, ch. 92-33; s. 4, ch. 92-278; s. 2, ch. 94-161; s. 304, ch. 96-410; s. 1801, ch. 97-102; s. 89, ch. 99-3; s. 62, ch. 2003-416.

766.208 Arbitration to allocate responsibility among multiple defendants.—

(1) The provisions of this section shall apply when more than one defendant has participated in voluntary binding arbitration pursuant to s. 766.207.

(2) Within 20 days after the determination of damages by the arbitration panel in the first arbitration proceeding, those defendants who have agreed to voluntary binding arbitration shall submit any dispute among them regarding the apportionment of financial responsibility to a separate binding arbitration proceeding. Such proceeding shall be with a panel of three arbitrators, which panel shall consist of the administrative law judge who presided in the first arbitration proceeding, who shall serve as the chief arbitrator, and two medical practitioners appointed by the defendants, except that if a hospital licensed pursuant to chapter 395 is involved in the arbitration proceeding, one arbitrator appointed by the defendants shall be a certified hospital risk manager. In the event the defendants cannot agree on their selection of arbitrators within 20 days after the determination of damages by the arbitration panel in the first arbitration proceeding, a list of not more than five nominees shall be submitted by each defendant to the director of the Division of Administrative Hearings, who shall select the other arbitrators but shall not select more than one from the list of nominees of any defendant.

(3) The administrative law judge appointed to serve as the chief arbitrator shall convene the arbitrators for the purpose of determining allocation of responsibility among multiple defendants within 65 days after the determination of damages by the arbitration panel in the first arbitration proceeding.

(4) The arbitration panel shall allocate financial responsibility among all defendants named in the notice of intent to initiate litigation, regardless of whether the defendant has submitted to arbitration. The defendants in the arbitration proceeding shall pay their proportionate share of the economic and noneconomic damages awarded by the arbitration panel. All defendants in the arbitration proceeding shall be jointly and severally liable for any damages assessed in arbitration. The determination of the percentage of fault of any defendant not in the arbitration case shall not be binding against that defendant, nor shall it be admissible in any subsequent legal proceeding.

(5) Payment by the defendants of the damages awarded by the arbitration panel in the first arbitration proceeding shall extinguish those defendants' liability to the claimant and shall also extinguish those defendants' liability for contribution to any defendants who did not participate in arbitration.

(6) Any defendant paying damages assessed pursuant to this section or s. 766.207 shall have an action for contribution against any nonarbitrating person whose negligence contributed to the injury.

History.—s. 55, ch. 88-1; s. 31, ch. 88-277; s. 305, ch. 96-410.

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

(1) A proceeding for voluntary binding arbitration is an alternative to jury trial and shall not supersede the right of any party to a jury trial.

(2) If neither party requests or agrees to voluntary binding arbitration, the claim shall proceed to trial or to any available legal alternative such as offer of and demand for judgment under s. 768.79 or offer of settlement under s. 45.061.

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

(a) The claim shall proceed to trial, and the claimant, upon proving medical negligence, shall be entitled to recover damages subject to the limitations in s. 766.118, prejudgment interest, and reasonable attorney's fees up to 25 percent of the award reduced to present value.

(b) The claimant's award at trial shall be reduced by any damages recovered by the claimant from arbitrating codefendants following arbitration.

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

(a) The damages awardable at trial shall be limited to net economic damages, plus noneconomic damages not to exceed $350,000 per incident. The Legislature expressly finds that such conditional limit on noneconomic damages is warranted by the claimant's refusal to accept arbitration, and represents an appropriate balance between the interests of all patients who ultimately pay for medical negligence losses and the interests of those patients who are injured as a result of medical negligence.

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

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

(5) Jury trial shall proceed in accordance with existing principles of law.

History.—s. 56, ch. 88-1; s. 32, ch. 88-277; s. 63, ch. 2003-416; s. 156, ch. 2004-5.

766.21 Misarbitration.—

(1) At any time during the course of voluntary binding arbitration of a medical negligence claim pursuant to s. 766.207, the administrative law judge serving as chief arbitrator on the arbitration panel, if he or she determines that agreement cannot be reached, shall be authorized to dissolve the arbitration panel and request the director of the Division of Administrative Hearings to appoint two new arbitrators from lists of three to five names timely provided by each party to the arbitration. Not more than one arbitrator shall be appointed from the list provided by any party, unless only one list is timely filed.

(2) Upon appointment of the new arbitrators, arbitration shall proceed at the direction of the chief arbitrator in accordance with the provisions of ss. 766.201-766.212.

(3) At any time after the allocation arbitration hearing under s. 766.208 has concluded, the administrative law judge serving as chief arbitrator on the arbitration panel is authorized to dissolve the arbitration panel and declare the proceedings concluded if he or she determines that agreement cannot be reached.

History.—s. 57, ch. 88-1; s. 33, ch. 88-277; s. 306, ch. 96-410; s. 1802, ch. 97-102.

766.211 Payment of arbitration award; interest.—

(1) Within 20 days after the determination of damages by the arbitration panel pursuant to s. 766.207, the defendant shall:

(a) Pay the arbitration award, including interest at the legal rate, to the claimant; or

(b) Submit any dispute among multiple defendants to arbitration pursuant to s. 766.208.

(2) Commencing 90 days after the award rendered in the arbitration procedure pursuant to s. 766.207, such award shall begin to accrue interest at the rate of 18 percent per year.

History.—s. 58, ch. 88-1; s. 34, ch. 88-277.

766.212 Appeal of arbitration awards and allocations of financial responsibility.—

(1) An arbitration award and an allocation of financial responsibility are final agency action for purposes of s. 120.68. Any appeal shall be taken to the district court of appeal for the district in which the arbitration took place, shall be limited to review of the record, and shall otherwise proceed in accordance with s. 120.68. The amount of an arbitration award or an order allocating financial responsibility, the evidence in support of either, and the procedure by which either is determined are subject to judicial scrutiny only in a proceeding instituted pursuant to this subsection.

(2) No appeal shall operate to stay an arbitration award; nor shall any arbitration panel, arbitration panel member, or circuit court stay an arbitration award. The district court of appeal may order a stay to prevent manifest injustice, but no court shall abrogate the provisions of s. 766.211(2).

(3) Any party to an arbitration proceeding may enforce an arbitration award or an allocation of financial responsibility by filing a petition in the circuit court for the circuit in which the arbitration took place. A petition may not be granted unless the time for appeal has expired. If an appeal has been taken, a petition may not be granted with respect to an arbitration award or an allocation of financial responsibility that has been stayed.

(4) If the petitioner establishes the authenticity of the arbitration award or of the allocation of financial responsibility, shows that the time for appeal has expired, and demonstrates that no stay is in place, the court shall enter such orders and judgments as are required to carry out the terms of the arbitration award or allocation of financial responsibility. Such orders are enforceable by the contempt powers of the court; and execution will issue, upon the request of a party, for such judgments.

History.—s. 59, ch. 88-1; s. 35, ch. 88-277.

766.301 Legislative findings and intent.—

(1) The Legislature makes the following findings:

(a) Physicians practicing obstetrics are high-risk medical specialists for whom malpractice insurance premiums are very costly, and recent increases in such premiums have been greater for such physicians than for other physicians.

(b) Any birth other than a normal birth frequently leads to a claim against the attending physician; consequently, such physicians are among the physicians most severely affected by current medical malpractice problems.

(c) Because obstetric services are essential, it is incumbent upon the Legislature to provide a plan designed to result in the stabilization and reduction of malpractice insurance premiums for providers of such services in Florida.

(d) The costs of birth-related neurological injury claims are particularly high and warrant the establishment of a limited system of compensation irrespective of fault. The issue of whether such claims are covered by this act must be determined exclusively in an administrative proceeding.

(2) It is the intent of the Legislature to provide compensation, on a no-fault basis, for a limited class of catastrophic injuries that result in unusually high costs for custodial care and rehabilitation. This plan shall apply only to birth-related neurological injuries.

History.—s. 60, ch. 88-1; s. 1, ch. 98-113.

766.302 Definitions; ss. 766.301-766.316.—As used in ss. 766.301-766.316, the term:

(1) “Association” means the Florida Birth-Related Neurological Injury Compensation Association established in s. 766.315 to administer the Florida Birth-Related Neurological Injury Compensation Plan and the plan of operation established in s. 766.314.

(2) “Birth-related neurological injury” means injury to the brain or spinal cord of a live infant weighing at least 2,500 grams for a single gestation or, in the case of a multiple gestation, a live infant weighing at least 2,000 grams at birth caused by oxygen deprivation or mechanical injury occurring in the course of labor, delivery, or resuscitation in the immediate postdelivery period in a hospital, which renders the infant permanently and substantially mentally and physically impaired. This definition shall apply to live births only and shall not include disability or death caused by genetic or congenital abnormality.

(3) “Claimant” means any person who files a claim pursuant to s. 766.305 for compensation for a birth-related neurological injury to an infant. Such a claim may be filed by any legal representative on behalf of an injured infant; and, in the case of a deceased infant, the claim may be filed by an administrator, personal representative, or other legal representative thereof.

(4) “Administrative law judge” means an administrative law judge appointed by the division.