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2003 Medical Malpractice Liability Legislative Summary

On August 14, 2003, Governor Jeb Bush of Florida signed into law comprehensive legislation intended to affect litigation reform, safe harbors for insurance bad faith, malpractice insurance rate reductions, broadening of patient safety initiatives, increased scrutiny of healthcare practitioner disciplinary actions, and attempts to cap non-economic damages and medical malpractice cases.

The bill provides that the effective date of this act is to be September 15, 2003 and that provisions, except those changes to Chapter 766 (The Litigation Reform Measures) are to apply retroactively. Changes to Chapter 766 are to affect only those healthcare liability incidents for which a Notice of Intent to Initiate Litigation is mailed on or after the effective September 15, 2003 date. Additionally, the provisions of the bill are intended to be severable wherein, if any provision is declared unconstitutional, there are provisions that can be given effect without the invalid provisions, to remain applicable.

PATIENT SAFETY -SECTION 395.1012

- Each licensed facility must adopt a Patient Safety Plan, appoint a Patient Safety officer and a Patient Safety Committee for the purpose of promoting the health and safety of patients, reviewing and evaluating the quality of patient safety measures used by the facility and assisting in the implementation of the facility patient safety plan.
- Each licensed facility shall inform each patient or representative about adverse incidents that result in serious harm to the patient. Notification of such adverse incidents shall not constitute an acknowledgement or admission of liability, nor can it be introduced as evidence.
- Section 395.1051. Similarly, each licensed healthcare provider shall have the same responsibility to inform patients about adverse incidents that result in serious harm to the patient and such notification shall not constitute acknowledgement of admission or liability nor can it be introduced as evidence.
- Section 456.01575. Civil immunity is broadened for healthcare professional consultants to healthcare facility quality improvement review boards and "Patient Safety Data" reports shall not be subject to discovery or introduction to evidence in any civil or administrative action. Employers may not take retaliatory action against employees who in good faith "make reports of patient safety data to patient safety organizations."

MEDIATION- SECTION 456.078

- The Board may designate as Mediation offenses those complaints where harm caused by the healthcare practitioner licensee is economic in nature except for an act or omission involving intentional misconduct, is not a Standard of Care violation involving a type of injury to a patient, or does not result in an adverse incident (patient death, brain or spinal damage, wrong patient surgery, wrong site surgery, medically unnecessary surgery, damages not recognized as specific risks as disclosed to the patient due to the informed-consent process, the removal of unplanned foreign objects remaining from a surgical procedure.)

FINANCIAL RESPONSIBILITY-Section 458.320 (Physicians) and Section 459.0085(Osteopaths)

- As a condition of licensing and maintaining an active license, the healthcare professional must demonstrate the financial responsibility to pay claims and costs ancillary to the rendering of healthcare services.
- This may include obtaining and maintaining professional liability coverage in an amount not less than \$100,000.00 per claim, \$300,000.00 aggregate; obtaining and maintaining an unexpired irrevocable letter of credit in the amount of \$100,000.00 per claim \$300,000.00 aggregate and neither of these measures may be used for litigation costs or attorneys fees for the defense of any medical malpractice claim.
- Physicians who perform surgery in an ambulatory surgical care center must establish financial responsibility by the same methods including establishing and maintaining an escrow or the obtaining and maintaining professional liability coverage in an amount of no less than \$250,000.00 per claim, \$750,000.00 aggregate.
- The department can suspend the license of any physician against whom has been entered a final judgment, arbitration award or who was entered into a settlement agreement to pay damages rising out of a claim and if all appellate remedies have been exhausted and payment up to the amounts required by this section have not been made within thirty (30) days after the entering of such judgment.
- No later than thirty (30) days after a third report of professional liability claim against a licensed physician has been submitted within a sixty month period, the Department of Health shall initiate emergency investigation and the Board of Health shall conduct emergency probable cause hearing to determine whether the physician should be disciplined. Section 458.3311

PATIENT SAFETY

- Each public and private school that offers degrees in medicine, or nursing shall include within the curricula materials on patient safety and improvement, including communication, and teamwork, epidemiology of patient injuries and medical errors, human factors, studies and reporting systems. Sections 1004.08 and 1005.07.

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- The Agency for Healthcare Administration shall conduct a study to determine what information is most feasible to provide to the public comparing state licensed hospitals on certain in-patient quality indicators developed by the Federal Agency for Healthcare Quality and Research.
- The Agency for Healthcare Administration is directed to study the implementation requirements to establish a Patient Safety Authority. The purpose of this Authority is to analyze patient safety data and quality patient safety indicators, collect, analyze and evaluate patient safety data, foster the development of statewide electronic infrastructure designed to improve patient care in the delivery of quality healthcare services, identify best practices, assess the patient safety culture, develop core competencies in patient safety, provide continuing education in patient safety, and engage in other activities that improve healthcare quality.
- No later than September 1, 2003, the Department of Health shall convene a group to study the current healthcare practitioner disciplinary process, including representatives of the administrative law and health law sections of the Florida Bar, representatives from the Florida Medical Association, the Florida Osteopathic Medical Association, and from the Florida Dental Association, as well as a consumer member who shall represent their findings no later than January 1, 2004.

COMMERCIAL SELF INSURANCE FUNDS-SECTION 624.462

- Groups of ten or more healthcare providers are now included along with not-for-profit trade organizations and self insurance trust funds for purposes of providing medical malpractice coverage.

RATE STANDARDS- SECTION 627.062

- Provisions of this Section apply only with respect to rates for medical malpractice insurance.
- No portions of judgment or settlements paid as a result of statutory common law bad faith action or punitive damages against an insured may be included in an insurer's rate base and shall not therefore be used to justify a rate or rate change.
- Rate filings shall include loss experience solely for the State of Florida or be of greater credibility to the state's lost data, after applying actuarially sound methods of assigning credibility of such data.
- Rates shall be deemed excessive if the rate structure provides for replenishment of reserves or surpluses from premiums when their replenishment is attributable to investment losses. The insurer must apply a discount or surcharge based on the healthcare provider's loss experience or establish an alternative method giving due consideration of the provider's loss experience. This information must be provided to policyholders at the time of renewal and to prospective policyholders at the time of application for coverage.
- Each medical malpractice insurer must make a rate filing, sworn to by at least two executive officers, at least once every calendar year.
- No later than sixty (60) days after the effective date of this legislation the office shall calculate a "presumed factor" that reflects the impact that the changes contained in such legislations which have rates for medical malpractice insurance and shall issue a notice informing all insurers writing medical malpractice coverage of such presumed factor.
- No later than sixty (60) days after the office issues its notice of the presumed rate change, each insurer writing medical malpractice coverage in the State shall submit to the office of rate filing for medical malpractice insurance which will take effect no later than January 1, 2004 and apply retroactively to policies issued or renewed on or after the effective date of medical malpractice legislation and enacted during the 2003 Special Session D of the Florida Legislature. Those policies issued after the effective date of the Federal Legislation and prior to the effective date of the rate filing shall be subject to refund of the amount that was charged in excess of the rate that was approved.
- Insurers or rating organizations that contend that the rate provided is excessive, inadequate, or unfairly discriminatory shall state in its filing the rate that it contends is appropriate and state with specificity the factors and data upon which it contends should be considered in order to produce such appropriate rate.
- Rates approved on or before July 1, 2003 for medical malpractice insurance shall remain in effect until the effective date of a new rate filing approved this subsection.
- The insurer or self insurer is required to notify the insured no less than sixty (60) days prior to an effective date of a rate increase.
- Upon the filing of a rate change by the medical malpractice insurer self-insurance fund which would result in an average statewide increase of 25% or more, notices of such filings to each policyholder or member is required. Section 627.41495

PROFESSIONAL LIABILITY CLAIMS AND ACTIONS - SECTION 627.912

- Self insurers, commercial self insurance funds, authorized insurers, surplus license insurers, risk retention groups or joint underwriting associations providing professional liability insurance to physicians, osteopaths, podiatrists, dentists, hospitals, crisis stabilization units, health maintenance organizations, ambulatory surgical care centers, and to members of the Florida Bar shall report claims or actions for damages for personal injuries claimed to have been caused by errors, omissions, or negligence in performance of said insured professional services if the claim resulted in:
 1. A Final Judgment in any amount.
 2. A Settlement in any amount.
 3. A final disposition of a medical malpractice claim resulting in no indemnity payment or on behalf of the insured.
 4. The office shall impose a fine of \$250.00 per day per not to exceed a total of \$10,000.00 for a violation of requirement of the section and if a healthcare practitioner or facility violates the requirements of this section, it shall be considered a violation and shall be grounds for a fine or disciplinary action.
- Statistical summaries of the closed claim reports shall be available on the Internet by July 1, 2005.
- Manual reports beginning in October 1, 2004, shall summarize and analyze the closed claim reports for medical malpractice including analysis of closed claim reports of prior years, trends in their frequency in the amount of claims payments, itemization of economic and non-economic damages, nature of the conduct, analysis of the state of the medical malpractice insurance market in Florida, analysis of the financial reports of those insurers or the combined market share of at least 80% of the net written premium in the State, loss cost analysis for medical malpractice written in Florida, profitability analysis for each insurer, a comparison of ratios for medical malpractice in Florida compared to other states, a summary of the rate filings for medical malpractice which has been approved by the office for the prior calendar year.

HEALTH MAINTENANCE ORGANIZATIONS-SECTION 641.19

- Except in cases in which the healthcare provider is an employee of the health maintenance organization, the fact that the HMO arranges for the provision of healthcare services does not create an actual agency, apparent agency, or an employer-employee relationship for the purposes of vicarious liability for the medical negligence of the healthcare provider.

EXPERT WITNESS-SECTION 766.102

- A person may not give expert testimony concerning the prevailing professional standard of care unless they are a licensed healthcare provider, specializing in the same specialty as the healthcare provider or specializing in similar specialty that includes the evaluation, diagnoses or treatment of the medical condition that is the subject of the claim and have devoted professional time during the three years immediately preceding the date of the occurrence that is the basis for the action, in the active clinical practice of or consulting in the same or similar specialty, or the instruction of students in an accredited health professional school or residency, or a clinical research program in the same or similar specialty.
- If the healthcare provider is a general practitioner, the expert witness must have devoted professional time during the five years immediately preceding the date of the occurrence which is the basis of the action to the active clinical practice or consultation as a general practitioner, the instruction of students in an accredited health professional school or residency program or a clinical research program that is in general practice of medicine.
- If the healthcare provider against whom or on whose behalf, the testimony is offered is a healthcare provider other than a specialist or general practitioner, the expert witness must have devoted professional time during the three years immediately preceding the date of the occurrence that is the basis for the action or in the act of clinical practice or instruction of students, or clinical research program and the same or similar healthcare profession as a healthcare provider.
- Physicians licensed under Chapter 458 or 459 may give expert testimony on the standard of care of nurses, nurse practitioners, certified registered nurse anesthetist, certified registered nurse midwives, physician assistants, or other medical support staff.
- An expert witness may not testify on a contingency fee basis and any attorney who proffers a person as an expert witness pursuant to the section must certify that such person has not been found guilty of fraud or perjury in any jurisdiction. This does not limit the power of the trial court to disqualify or qualify an expert witness on grounds other than the qualifications of the section.

NOTICE BEFORE FILING ACTION FOR MEDICAL NEGLIGENCE- SECTION 766.106

- Notice to each prospective defendant must include a list of all known healthcare providers seen by the claimant for the injuries complained of subsequent to the alleged act of negligence, all known healthcare providers during the two year period prior to the alleged act of negligence who treated or evaluated the claimant and copies of all the medical records relied upon by the expert in signing the affidavit.
- Upon receipt by a prospective defendant of a notice of a claim, the party shall make discoverable information available without formal discovery. Failure to do is grounds for dismissal of claims or defense is ultimately asserted.
- Any party may request answers to written questions, the number of which may not exceed thirty (30) including subparts. The response must be made within twenty (20) days after receipt of the questions.
- The claimant must execute a medical information release that allows a prospective defendant or his or her legal representative to take unsworn statements of the claimant's treating physicians.

MANDATORY MEDIATION-SECTION 766.108

- Within 120 days after the suit is filed, unless such period is extended by mutual agreement of both parties, all parties shall attend in-person mandatory mediation accordance with Section 44.102, if binding arbitration under Section 76.207 has not been agreed to by the parties.

SETTLEMENT AGREEMENTS-SECTION 766.113

- Each final settlement agreement relating to the medical negligence shall include the following statement: "The decision to settle a case may reflect the economic practicalities pertaining to the costs of litigation 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."

DETERMINATION OF NON-ECONOMIC DAMAGES-SECTION 766.118

- "Catastrophic injury" is defined as spinal cord injury, amputation, severe brain or closed head injury, severe sensory and motor nerves disturbances, severe communication disturbances, severe complex integrated disturbances of cerebral function, severe episodic neurologic disorders, secondary or third degree burns of 25% or more of the total body surface or third degree burns of 5% or more to the face or hands, blindness, or loss of reproductive organs which results in inability to procreate.
- No practitioner shall be liable for more than \$500,000.00 in non-economic damages regardless of the number of claimants.
- If negligence resulted in permanent vegetative state or death, the total non-economic damages recoverable from all practitioners, regardless of the number of claimants shall not exceed \$1,000,000.00.
- In cases which do not involve death or permanent vegetative state, the patient may recover non-economic damages not to exceed \$1,000,000.00 if the trial court determines that a manifest injustice would occur unless increased non-economic damages are awarded and the trier of fact determined that the defendant's negligence caused a catastrophic injury.
- The total amount of economic damages recoverable to all claimants from all practitioner defendants under this shall not exceed \$1,000,000.00 in aggregate.
- Limitation on non-economic damage for negligence of non-practitioner defendants shall not exceed \$750,000.00 per claimant. If negligence resulted in permanent vegetative state or death, the total non-economic damages shall not exceed \$1,500,000.00. In cases that do not involve death or permanent vegetative state, the patient may recover non-economic damages not to exceed \$1,500,000.00 if the trial court determines that a manifest injustice would occur based on a finding that the non-economic harm sustained by the patient was particularly severe and the trier of fact determines that the defendant's negligence caused catastrophic injury to the patient. The total non-economic damages recovered by all claimants from all non-practitioner defendants under this subsection shall not exceed \$1,500,000.00 in aggregate. Non-practitioner defendants are subject to the cap on non-economic damages provided in this subsection regardless of the theory of liability, including vicarious liability.
- With respect to a cause of action for personal injury or wrongful death arising from medical negligence of practitioner providing emergency care services as defined in Section 395.002(10) or providing services as provided in Section 401.265 or providing services pursuant to obligations imposed by 42 U.S.C. Section 1395dd, economic damages shall not exceed \$150,000.00 per claimant and the total non-economic damages recovered by all claimant's from all such practitioners shall not exceed \$300,000.00.
- For non-practitioner defendants providing emergency services under the same sections regardless of the number of non-practitioner defendants, non-

economic damages shall not exceed \$750,000.00 per claimant nor shall all claimants exceed \$1,500,000.00. Non-practitioner defendants may receive a full setoff for payments made by practitioner defendants.

BAD FAITH ACTIONS SECTION 766.1185

- 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 the service of the Complaint in the medical negligence action upon the insured. The time shall be extended an additional sixty (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 to the insured relating to the testimony of material witnesses; or
 2. The 60th day after the conclusion of the deposition of all claimants named in the Complaint, the deposition of all defendants named in the Complaint, the deposition of all the claimant's expert witnesses, the initial disclosure of witnesses and production of documents, and mediation provided for in Section 766.108. The fact that the insured did not tender the policy limits during the time period specified in this paragraph is not presumptive evidence that the insurer acted in bad faith.
- When subsection 1 does not apply, the trier of fact in determining whether insurer is acting in bad faith, shall consider: their willingness to negotiate with the claimant in anticipation of settlement; the propriety of the insurer's methods of investigation and evaluation of the claim; whether the insurer timely informed the insured of an offer to settle within the limits of coverage, the right to retain personal counsel, the risk of litigation; whether the insured denied liability or requested that the case be defended after the insurer fully advised insured of the facts and risks; whether the claimant imposed any condition other than the tender of the policy limits or the settlement of the claim; whether the claimant provided relevant information to the insurer on a timely basis; whether and when other defendants in the case settled or were dismissed from the case; whether there were multiple claimants seeking, in the aggregate, compensation in excess of policy limits from the defendant or the defendant's insurer; whether the insured misrepresented material facts to the insurer or made material omissions of fact to the insurer; or such additional factors as the court determines to be relevant.
- The bad faith section of the Bill does not completely absolve an insurance company of the obligation to act in good faith towards the insured position, nor does it change who could bring an bad faith cause of action and nor does it change the amount of recovery in bad faith cause of action. If the insurer is found to have acted in bad faith, it is still responsible for the entire excess judgment.

HEALTH CARE PROVIDER

- "Healthcare provider" under Section 766.201 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 or Chapter 486; a clinical lab licensed under Chapter 483; a health maintenance organization certified or certificated under Part I of Chapter 641; a blood bank; a plasma center, industrial clinic; a renal dialysis facility; or a professional association partnership, corporation, joint venture, or other association for professional activity for healthcare providers.

ITEMIZED VERDICTS -SECTION 768.77

- In an action based on personal injury, wrongful death arising out of medical malpractice whether in tort or contract, the trial shall, as part of the verdict, itemize the amounts to be awarded to the claimant and to the following categories of damages: past economic losses; future economic losses, not reduced to present value and the number of years or part thereof which the award is entitled to cover; past non-economic losses; and future non-economic losses and the number of years or part thereof which the award is intended to cover; and amounts awarded to the claimant for punitive damages, if applicable.

MEDICAL REVIEW PANELS

- The Department of Health shall study and report to the legislature as to whether medical review panels should be included as part of a pre-suit process as part of a medical malpractice litigation no later than December 31, 2003.
- The Bill does not extend sovereign immunity to emergency rooms and physicians who provide emergency care, but does extend sovereignty to any physician who contracts with the State University or University to provide medical services to a student who participates in intercollegiate athletics.
- The physician is to indemnify the State for the amount the State would be liable (\$100,000.00).
- Because a physician is on an HMO panel will not make the HMO liable for the negligence of the physician. The Bill provides that health insurers and HMO's will fall under the same cap as the healthcare provider and that an HMO or health insurer will not be liable for the medical negligence of a physician unless it is specifically directed or actually controlled the conduct that caused the injury.

HEALTHCARE PROFESSIONAL DISCIPLINE

- First defense citations are not considered disciplinary and are not required to be reported to the National Practitioner Data Bank. These citations are not to be given in the case of an adverse incident, but can be used to close minor standard of care cases.
- The 10% limit on licensure fee increase is now deleted.
- The relevant boards may now require information for a licensure requiring "relevant professional qualifications."
- The Department of Health has thirty (30) days to update a physician profile after receiving new information and must investigate all information received regarding profiling even if it does not appear that the law related to the practice of medicine was violated.
- For physicians and osteopathic physicians, only those liability cases over \$100,000.00 will be included in the physician's profile, this has been changed from the current amount of \$5,000.00. Included in the profile, the information regarding hospital disciplinary action.
- All closed claim information reported to the Office of Insurance Regulation not the Department of Health is to be included in the Physician's profile within thirty (30) days.
- A physician licensed in Florida has thirty (30) days to verify the contents of his initial profile once it is completed and failure to verify the initial profile and make any corrections could result in the fine of up to \$100.00 a day for failure to verify.

- A currently licensed practitioner has fifteen (15) days to update their profile after information changes.
- The Department of Health is allowed to obtain patient records without patient consent or the proof of the probable cause panel.
- The Department of Health is allowed to investigate a closed claim of over \$50,000.00, even if the six year Statute of Limitations in Florida Statute 456.073 (13) has passed.
- A successful Mediation dispute does not constitute discipline and is therefore not reported to the National Practitioner Data Bank.

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Dr. Ragan is Of Counsel and practices from the firm's Miami office. His primary areas of practice include representing physicians, dentists, and nurses in civil and administrative litigation, insurance coverage issues, hospital and nursing home defense litigation, and health care regulatory compliance. He also has extensive field experience as a health care practitioner (dentist) and recently held senior executive positions in the insurance industry. Dr. Ragan is an accomplished speaker and author, and is an active member of the Florida Bar, American Dental Association, Florida Dental Association, Annenberg Center for Health Policy, and Defense Research Institute.

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