HOUSE OF REPRESENTATIVES STAFF ANALYSIS

BILL #: CS/CS/CS/CS/HB 479 Medical Malpractice
SPONSOR(S): Judiciary Committee; Health Care Appropriations Subcommittee; Health & Human Services Access Subcommittee; Civil Justice Subcommittee; Horner and others
TIED BILLS: None **IDEN./SIM. BILLS:** CS/SB 1590, SB 1892

REFERENCE	ACTION	ANALYST	STAFF DIRECTOR or BUDGET/POLICY CHIEF
1) Civil Justice Subcommittee	12 Y, 3 N, As CS	Billmeier	Bond
2) Health & Human Services Access Subcommittee	11 Y, 4 N, As CS	Poche	Schoolfield
3) Health Care Appropriations Subcommittee	11 Y, 3 N, As CS	Clark	Pridgeon
4) Judiciary Committee	15 Y, 3 N, As CS	Billmeier	Havlicak

SUMMARY ANALYSIS

This bill makes numerous changes to affect medical malpractice litigation in Florida.

This bill allows a prospective defendant to interview a claimant's health care providers without the presence of the claimant if the prospective defendant provides 10 days notice of the intent to interview. It requires the claimant to execute an authorization for release of health information.

This bill creates an "expert witness certificate" that an expert witness who is licensed in another jurisdiction must obtain before testifying in a medical negligence case or providing an affidavit in the presuit portion of a medical negligence case. This bill provides for discipline against the license of a physician, osteopathic physician or dentist that provides misleading, deceptive, or fraudulent expert witness testimony related to the practice of medicine or the practice of dentistry.

This bill provides for the creation of an informed consent form related to cataract surgery. Such a form is admissible in evidence and its use creates a rebuttable presumption that the physician properly disclosed the risks of cataract surgery.

This bill provides that medical malpractice insurance contracts must contain a clause stating whether the physician or dentist has a right to "veto" any admission of liability or offer of judgment made within policy limits by the insurer. Current law prohibits such provisions in medical malpractice insurance contracts.

This bill provides that records, policies, or testimony of an insurer's reimbursement policies or reimbursement decisions relating to the care provided to the plaintiff are not admissible in any civil action and provides that a health care provider's failure to comply with, or breach of, any federal requirement is not admissible in any medical negligence case.

This bill provides that a plaintiff in a medical negligence action must prove by clear and convincing evidence that the failure of a health care provider to order, perform, or administer supplemental diagnostic tests is a breach of the standard of care.

This bill provides that a hospital is not liable for the negligence of a health care provider with whom the hospital has entered into a contract unless the hospital expressly directs or exercises actual control over the specific conduct which caused the injury.

This bill provides additional immunity from civil liability for volunteer team physicians.

The bill has an insignificant fiscal impact associated with implementation of the bill, however, the Department of Health can absorb these costs within existing resources.

FULL ANALYSIS

I. SUBSTANTIVE ANALYSIS

A. EFFECT OF PROPOSED CHANGES:

Overview of Medical Malpractice Litigation

This bill makes changes to numerous statutes relating to medical malpractice litigation. In general, a medical malpractice action proceeds as follows.

- Prior to the filing of a lawsuit, the claimant (the person injured by medical negligence or a party bringing a wrongful death action arising from an incidence of medical malpractice) and defendant (a physician, other medical professional, hospital, or other healthcare facility) are required to conduct "presuit" investigations to determine whether medical negligence occurred and what damages, if any, are appropriate.[1]

- Upon completion of its presuit investigation, the claimant must provide each prospective defendant with a notice of intent to initiate litigation ("presuit notice").[2]

- For a period of 90 days after the presuit notice is mailed to each potential defendant, no lawsuit can be filed and the statute of limitations is tolled.[3] During that time, the parties are required to conduct informal discovery, including the taking of unsworn statements, the exchange of relevant documents, written questions, and an examination of the claimant.[4]

- Upon completion of the presuit investigation and informal discovery process, each potential defendant is required to respond to the claimant and either (1) reject the claim; (2) make a settlement offer; or (3) offer to admit liability and proceed to arbitration to determine damages.[5] At that point, the claimant can either accept the defendant's offer or proceed with the filing of a lawsuit.[6]

- If the case proceeds to trial, economic damages are not capped and noneconomic damages are capped at $1 million recoverable from practitioners and $1.5 million recoverable from nonpractitioners.[7] Damages are apportioned based on comparative fault.[8]

The 2003 Legislation

In 2003, the Legislature adopted ch. 2003-416, L.O.F., in response to dramatic increases in medical malpractice liability insurance premiums and the "functional unavailability" of malpractice insurance for some physicians.[9] The legislation, among other things, created a cap on noneconomic damages, created requirements for expert witness testimony, provided for additional presuit discovery, and required the Office of Insurance Regulation to report yearly on the medical malpractice insurance market in Florida. The reports[10] show the number of closed claims, the amount of damages paid, and the total gross medical malpractice insurance premium reported to the Office of Insurance Regulation since the enactment of ch. 2003-416, L.O.F.:

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[1] Section 766.203, F.S.
[2] Section 766.106, F.S.
[3] Section 766.106, F.S.
[4] Section 766.205, F.S.
[5] Section 766.106, F.S.
[6] *Id*.
[7] Section 766.118, F.S.
[8] Section 766.112, F.S.
[9] Section 766.201(1), F.S.
[10] Information compiled from the Medical Malpractice Closed Claim Database and Rate Filing Annual Reports created by the Office of Insurance Regulation, 2005-2010. The closed claim and damages information are contained in the "Executive Summary" of each report. These reports can be accessed at http://www.floir.com/DataReports/datareports.aspx

Claims, Damages and Insurance Premiums			
Year	Closed Claims	Total Damages	Total Premiums
2004	3,574	$664 million	$860 million
2005	3,753	$677 million	$850 million
2006	3,811	$602 million	$847 million
2007	3,553	$523 million	$663 million
2008	3,336	$519 million	$596 million
2009	3,087	$570 million	$550 million

The Office of Insurance Regulation report summarized the insurance rate filings in 2009:

> On average, rates for companies writing physicians and surgeons' malpractice insurance in the admitted market decreased 8.2%.[11]

The report noted, regarding the decrease in premium:

> This represents a dramatic decrease (36%) in the overall medical malpractice premium reported in Florida in 2009 from what was reported in 2004. This is attributable to the lowering of rates. However, it may also be due to new arrangements by physicians including the use of individual bonding, purchasing malpractice insurance through hospitals/employers as well as utilization of self-insurance funds, or other non-traditional insurance mechanisms.[12]

The report summarized the growth of Florida's medical malpractice insurance market since 2004. In 2009, the Office of Insurance Regulation reported that 22 companies wrote 80% of the direct written premium in medical malpractice insurance and compared that number to prior years:

> This year, achieving the 80% market share requirement again required the inclusion of 22 insurers as in the previous year; 17 were required in the 2007 report, 15 insurers for the 2006 annual report, 12 in the 2005 annual report, and only 11 for the 2004 report.[13]

According to information provided by the Office of State Court Administrator, 1,248 medical malpractice cases were filed in Florida in 2010.

Issues Addressed by the Bill

Presuit Investigation, Presuit Notice, and Presuit Discovery

Background

Section 766.203(2), F.S., requires a claimant to investigate whether there are any reasonable grounds to believe whether any named defendant was negligent in the care and treatment of the claimant and whether such injury resulted in injury to the claimant prior to issuing a presuit notice. The claimant must corroborate reasonable grounds to initiate medical negligence litigation by submitting an affidavit from a medical expert.[14] After completion of presuit investigation, a claimant must send a presuit notice to each prospective defendant.[15] The presuit notice must include 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, and copies of all of the medical records relied upon

[11] Florida Office of Insurance Regulation, "2010 Annual Report – October 1, 2010 - Medical Malpractice Financial Information Closed Claim Database and Rate Filings" at page 4.
[12] *Id.* at 12.
[13] *Id.* at 11.
[14] Section 766.203(2), F.S.
[15] Section 766.166(2)(a), F.S.

by the expert in signing the affidavit.[16] However, the requirement of providing the list of known health care providers may not serve as grounds for imposing sanctions[17] for failure to provide presuit discovery.[18]

Once the presuit notice is provided, no suit may be filed for a period of 90 days. During the 90-day period, the statute of limitations is tolled and the prospective defendant must conduct an investigation to determine the liability of the defendant.[19] Once the presuit notice is received, the parties must make discoverable information available without formal discovery.[20] Informal discovery includes:

1. Unsworn statements - Any party may require other parties to appear for the taking of an unsworn statement.

2. Documents or things - Any party may request discovery of documents or things.

3. Physical and mental examinations - A prospective defendant may require an injured claimant to appear for examination by an appropriate health care provider. Unless otherwise impractical, a claimant is required to submit to only one examination on behalf of all potential defendants.

4. Written questions - Any party may request answers to written questions.

5. Medical information release - The claimant must execute a medical information release that allows a prospective defendant to take unsworn statements of the claimant's treating physicians. The claimant or claimant's legal representative has the right to attend the taking of such unsworn statements.[21]

Section 766.106(7), F.S., provides that a failure to cooperate during the presuit investigation may be grounds to strike claims made or defenses raised. Statements, discussions, documents, reports, or work product generated during the presuit process are not admissible in any civil action and participants in the presuit process are immune from civil liability arising from participation in the presuit process.[22]

At or before the end of the 90 days, the prospective defendant must respond by rejecting the claim, making a settlement offer, or making an offer to arbitrate in which liability is deemed admitted, at which point arbitration will be held only on the issue of damages.[23] Failure to respond constitutes a rejection of the claim.[24] If the defendant rejects the claim, the claimant can file a lawsuit.

Ex Parte Interviews with Physicians by Defense Counsel

Background

In many civil cases, counsel for any party can meet with any potential witness who is willing to speak without notice to the opposing counsel. In 1984, the Florida Supreme Court ruled that there was no common law or statutory privilege of confidentiality as to physician-patient communications[25] and that there was no prohibition on defense counsel communicating with a claimant's physicians. In 1988, the

[16] Section 766.106(2)(a), F.S.
[17] Sanctions can include the striking of pleadings, claims, or defenses, the exclusion of evidence, or, in extreme cases, dismissal of the case.
[18] Section 766.106(2)(a), F.S.
[19] Section 766.106(3), (4), F.S.
[20] Section 766.106(6)(a), F.S. The statute also provides that failure to make information available is grounds for dismissal of claims or defenses.
[21] Section 766.106(6), F.S.
[22] Section 766.106(5), F.S.
[23] Section 766.106(3)(b), F.S.
[24] Section 766.106(3)(c), F.S.
[25] See *Coralluzzo v. Fass*, 671 So.2d 149 (Fla. 1984),

Legislature enacted a statute to create a physician-patient privilege.[26] The current version of the statute provides, in relevant part:

> Except as otherwise provided in this section and in s. 440.13(4)(c), [patient medical records] may not be furnished to, and the medical condition of a patient may not be discussed with, any person other than the patient or the patient's legal representative or other health care practitioners and providers involved in the care or treatment of the patient, except upon written authorization of the patient.[27]

The statute provides some exceptions to the confidentiality in medical malpractice cases but the Florida Supreme Court has ruled that defense counsel are barred by the statute from having an ex parte conference with a claimant's current treating physicians.[28]

The Governor's Select Task Force on Healthcare Professional Liability Insurance noted problems caused by the inability of defense counsel to interview a claimant's treating physicians:

> [T]he defendant is frequently in the position of having to investigate the plaintiff's medical history or current condition in order to discover other possible causes of the plaintiff's injury that could be used in defending the action. In addition, this information is often useful in determining the strength of the plaintiff's case, which the defendant could use to decide whether to settle the claim or proceed to trial. It is often necessary to interview several of the plaintiff's treating healthcare providers in order to acquire this information. But, because formal discovery is an expensive and time consuming process, defendants are often unable to adequately gather this information in preparation of their defense.[29]

Opponents of allowing defendants access to ex parte interviews with treating physicians argued the system was not broken. The report continued:

> The problem the Legislature corrected was the private, closed-door meetings between insurance adjusters, defense lawyers, and the person being sued. Typically, the person being sued would speak with his or her colleagues and say "I need your help here. I'm getting sued. I need you to help me out on either the causation issue or the liability issue or the damage issue".
>
> The present system is not broken. Crafting language to go back prior to 1988, to allow unfettered access, is not appropriate. To allow a situation where a defense lawyer or an insurance adjuster and the doctor go to see a patient's treating physician on an informal basis would further drive a wedge between that physician and the patient."[30]

In 2003, the Legislature amended s. 706.106, F.S., to require a claimant to execute a medical information release to allow prospective defendants to take unsworn statements of the claimant's treating physician on issues relating to the personal injury or wrongful death during the presuit process. The claimant and counsel are entitled to notice, an opportunity to be heard, and to attend the taking of the statement. The legislation did not provide for ex parte interviews by defense counsel with a claimant's treating physicians.[31]

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[26] Chapter 88-208, Laws of Florida
[27] Section 456.057(7)(a), F.S.
[28] *See Acosta v. Richter*, 671 So.2d 149 (Fla. 1996).
[29] Report of the Govenor's Select Task Force on Healthcare Professional Liability Insurance (2003) at p. 231. The Report can be accessed at www.doh.state.fl.us/myflorida/DOH-Large-Final%20Book.pdf
[30] Report of the Govenor's Select Task Force on Healthcare Professional Liability Insurance (2003) at p. 233 (internal footnotes omitted).
[31] Chapter 2003-416, Laws of Florida

Effect of the Bill

This bill provides that a prospective defendant or his or her legal representative may interview the claimant's treating health care providers without the presence of the claimant or the claimant's legal representative. This bill provides that a prospective defendant or his or her representative must provide the claimant with 10 days notice prior such interview.

This bill also makes changes to the presuit provision relating to unsworn statements. It removes the provision requiring a claimant to execute a medical release from s. 766.106, F.S., and creates a new release provision.

This bill requires a claimant to execute an "authorization for release of protected health information" and include it with the presuit notice of intent to initiate litigation. The form is provided in the bill and authorizes the disclosure of protected health information that is potentially relevant to the claim of personal injury or wrongful death. The bill provides that the presuit notice is void if it is not accompanied by the executed authorization form. It further provides that the presuit notice is retroactively void from the date of issuance if the authorization is revoked and that "any tolling effect that the presuit notice may have had on any applicable statute-of-limitations period is retroactively rendered void."

Specifically, the form that claimants are required to execute provides that representatives of the potential defendant may obtain and disclose information from health care providers for facilitating the investigation and evaluation of the medical negligence claim described in the presuit notice or defending against any litigation arising out of the medical negligence claim made on the basis of the presuit notice.

The form informs the claimant of the type of health information that may be obtained by defendants and defendant's counsel and from whom that information can be obtained. The form informs claimants of the extent of the authorization, that the authorization expires upon the resolution of the claim, that executing the authorization is not a condition of continued treatment, and that the claimant has the right to revoke the authorization at any time. The form has a section where claimants can list health providers to which the authorization does not apply. The claimant must certify that such health care information is not potentially relevant to the claim.

The language in the authorization form set forth in the bill appears to comply with federal requirements. In recent years, courts have been dealing with the effect of the federal Health Insurance Portability and Accountability Act of 1996 ("HIPAA") on state medical malpractice litigation. The HIPAA privacy rules prohibit the disclosure of protected health information except in specified circumstances.[32] With limited exceptions, HIPAA's privacy rules preempt any contrary requirement of state law unless the state law is more stringent than the federal rules.[33]

HIPAA rules permit disclosure of health information in a number of circumstances.[34] Health care information may be disclosed if the patient has executed a valid written authorization.[35]

States with statutory provisions that allow for ex parte interviews with claimant's physicians have had to determine whether HIPAA preempted state laws allowing such interviews. Some courts have held that state laws permitting ex parte interviews violate HIPAA.[36] Other courts have held that HIPAA does not prohibit such interviews.[37] Texas dealt with the issue by enacting a law that required a claimant to

[32] 45 C.F.R. s. 164.502
[33] 45 C.F.R. s. 160.203
[34] Circumstances in which health information may be disclosed include in a judicial proceeding, protected information may be disclosed in response to a court order. It may also be disclosed without a court order in response to a subpoena or discovery request if the health care provider receives satisfactory assurances that the requestor has made reasonable efforts to ensure that the subject of the information has been given notice of the request. *See* 45 C.F.R. s. 164.512(3)(1)(i), 45 C.F.R. s. 164.512(e)(1)(ii)(A).
[35] 45 C.F.R. s. 164.508
[36] *See Law v. Zuckerman*, 307 F.Supp.2d 705 (D. Maryland 2004); *Moreland v. Austin*, 670 S.E.2d 68 (Georgia 2008).
[37] *See Holmes v. Nightingale*, 158 P.3d 1039 (Oklahoma 2007).

execute a form authorizing the release of health information. The Texas Supreme Court held that the authorization form complied with the HIPAA requirements.[38] The court specifically rejected the argument that the authorization was not freely given because it was a requirement to proceed with a lawsuit:

> First, while it is true that the [claimants] could not have proceeded with their suit if [the injured person] had not executed the authorization, it was their choice to file the suit in the first instance. Moreover, on several occasions, courts have ordered plaintiffs to execute authorizations compliant with section 164.508.
>
> HIPAA preempts state law only if it would be impossible for a covered entity to comply with both the state and federal requirement, or if it would undermine HIPAA's purposes. While several courts have held that HIPAA preempts state law procedures that would allow ex parte contacts between health care providers and defendants and their representatives, none of them involve situations in which the patient has executed a written release compliant with 45 C.F.R. s. 164.508. Because [the Texas statute at issue] authorizes disclosure under the exact same terms as 45 C.F.R. s. 164.508, it would not be impossible for a health care provider to comply with both laws. Moreover, while the privacy of medical information is the primary goal of the privacy rules, the rules balance that interest against other important needs. Reducing the costs of medical care is a concern underlying both HIPAA and [the Texas statute]. In this case, the legislatively prescribed form authorizes disclosure only to the extent the information would "facilitate the investigation and evaluation" or defense of the health care claim described in the [claimants'] notice. Accordingly, under the circumstances presented, we conclude that HIPAA does not preempt [the Texas statute].[39]

The language in the authorization form in the bill is substantially similar to the language approved by the Texas Supreme Court. This bill also expands the court's authority to dismiss a claim and assess fees if the authorization form is not completed in good faith.

Expert Witness Qualifications

Background

Florida law requires expert witnesses in medical negligence cases to meet certain qualifications. The witness must be a licensed health care provider. If the health care provider against whom or on whose behalf the testimony[40] is offered is a specialist, the expert witness must:

> (1) Specialize in the same or similar specialty as the health care provider against whom or on whose behalf the testimony is offered 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;

[38] *In re: Collins*, 286 S.W.3d 911 (Tex. 2009)
[39] *In re: Collins*, 286 S.W.3d 911, 920 (Tex. 2009)(internal citations omitted).
[40] Section 766.102, F.S., provides qualifications for expert witnesses testifying at trial. Sections 766.202(6) and 766.203, F.S., provide qualifications for expert witnesses that must provide presuit corroboration of negligence claims. The qualifications for trial experts and presuit experts are the same.

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.[41]

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

(1) Have devoted professional time during the 5 years immediately preceding the date of the occurrence that is the basis for the action to:

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

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

c. A clinical research program that is affiliated with an accredited medical school or teaching hospital and that is in the general practice of medicine.[42]

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:

(1) 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 health profession as the health care provider against whom or on whose behalf the testimony is offered;

b. 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

c. 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.[43]

Chapter 458, F.S., governs the regulation of medical practice. Chapter 459, F.S., governs the regulation of osteopathic medicine. Chapter 466, F.S., governs the regulation of dentists. Each chapter creates a board to deal with issues relating to licensing and discipline of physicians, osteopathic physicians and dentists. Under current law, an expert witness is not required to possess a Florida license to practice medicine, osteopathic medicine or dentistry.[44]

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[41] Section 766.102(5), F.S.
[42] Section 766.102(5), F.S.
[43] Section 766.102(5), F.S.
[44] *See Baptist Medical Center of the Beaches, Inc. v. Rhodin*, 40 So.3d 112, 117 (Fla. 1st DCA 2010)(noting that Florida's expert witness statute "does not encompass a universe limited only to Florida licensees").

Effect of the Bill

The bill requires the Department of Health to issue an "expert witness certificate" to a physician or dentist licensed in another state or Canada to provide expert witness testimony in this state. The bill requires the Department to issue the certificate if the physician, osteopathic physician or dentist submits a completed application, pays an application fee of $50, and has not had a previous expert witness certificate revoked by the appropriate board. The application must contain the physician's or dentist's legal name; mailing address, telephone number, and business locations; the names of jurisdictions where the physician or dentist holds an active and valid license; and the license numbers issued to the physician or dentist by other jurisdictions.

The department must approve or deny the certificate within seven business days after receipt of the application and payment of the fee or the application is approved by default. A physician or dentist must notify the appropriate department of his or her intent to rely on a certificate approved by default. The certificate is valid for two years.

The certificate authorizes a physician, osteopathic physician or dentist to provide a verified expert opinion in the presuit stage of a medical malpractice case and to provide testimony about the standard of care in medical negligence litigation. The certificate does not authorize the physician, osteopathic physician or dentist to practice medicine or dentistry and does not require the certificate holder to obtain a license to practice medicine or dentistry.

This bill amends s. 766.102, F.S., relating to the qualifications of expert witness in cases against physicians licensed under ch. 458 or ch. 459, F.S, or dentists licensed under ch. 466, F.S. The bill requires that the expert witness testifying about the standard of care in such cases must be licensed under ch. 458, F.S., ch. 459, F.S., or ch. 466, F.S., or possess a valid expert witness certificate.

This bill also amends s. 766.102(5), F.S., to require that an expert witness conduct a complete review of the pertinent medical records before the witness can give expert testimony.

License Disciplinary Actions

Background

Chapter 458, F.S., regulates medical practice. Chapter 459, F.S., regulates the practice of osteopathic medicine. Chapter 466, F.S., regulates the practice of dentistry. Each chapter creates a board to deal with issues relating to discipline of physicians, osteopathic physicians and dentists. In general, the discipline process under ch. 458, F.S., ch. 459, F.S., and ch. 466, F.S., begins when a complaint is filed against a health care provider alleging a violation of the disciplinary statutes. The Department of Health reviews the case and a department prosecutor presents the case to the appropriate board or probable cause panel of the appropriate board. If probable cause is found, the Department of Health files an administrative complaint. If the health care provider disputes the allegations of the complaint, the provider can request a hearing before an administrative law judge. An attorney for the Department of Health prosecutes the case and the provider may be represented by counsel. The administrative law judge issues a recommended order upon the conclusion of the hearing. The recommended order and any exceptions filed by the parties are considered by the appropriate board and the board determines the appropriate discipline which can include a fine, suspension of the license, or revocation of the license.[45]

Sections 456.072, 458.331, 459.015 and 466.028, F.S., create grounds for which disciplinary action may be taken against a licensee.[46] It is not clear from those statutes whether the boards can impose discipline against a licensee for providing misleading, deceptive, or fraudulent expert witness testimony related to the practice of medicine, osteopathic medicine or dentistry. "Statutes providing for the revocation or suspension of a license to practice are deemed penal in nature and must be strictly

[45] *See* ss. 456.072 and 456.073, F.S.
[46] Section 456.072(2), F.S., deals with discipline against licensees.

construed, with any ambiguity interpreted in favor of the licensee."[47] Section 458.331(1)(k), F.S., provides the following ground for discipline:

> Making deceptive, untrue, or fraudulent representations in or related to the practice of medicine or employing a trick or scheme in the practice of medicine.[48]

Section 466.028(1)(l), F.S., provides the following ground for discipline:

> Making deceptive, untrue, or fraudulent representations in or related to the practice of dentistry.

It is not clear whether a court would find deceptive or untrue expert testimony in a medical negligence case to be "related to the practice" of medicine, osteopathic medicine or dentistry.[49]

Current law allows discipline against a licensee for "being found by any court in this state to have provided corroborating written medical expert opinion attached to any statutorily required notice of claim or intent or to any statutorily required response rejecting a claim, without reasonable investigation."[50]

Effect of the Bill

The bill amends ss. 458.331, 459.015 and 466.028, F.S., to provide that the appropriate board may impose discipline on a physician or osteopathic physician who provides "deceptive or fraudulent expert witness testimony related to the practice of medicine" or on a dentist who provides "deceptive or fraudulent expert witness testimony related to the practice of dentistry." The disciplinary statutes allow the board to impose discipline against licensees who violate the statutes. The bill provides that an expert witness certificate shall be treated as a license in any disciplinary action and that the holder of an expert witness certificate is subject to discipline by the appropriate board.

The bill also amends ss. 458.331, 459.015 and 466.028, F.S., to provide that the purpose of the disciplinary sections is to "facilitate uniform discipline for those acts made punishable under this section and, to this end, a reference to this section constitutes a general reference under the doctrine of incorporation by reference."

Incorporation by Reference

Background

Current law allows for one section of statute to reference another, or "incorporation by reference." This is commonly done to prevent the repetition of a particular text. There are two kinds of references. A "specific reference" incorporates the language of the statute referenced and becomes a part of the new statute even if the referenced statute is later altered or repealed. The law presumes that the Legislature intends to incorporate the text of the current law as it existed when the reference was created. A law review article explained:

> From a very early time, it has been generally agreed that the legal effect of a specific statutory cross reference is to incorporate the language of the referenced statute into the adopting statute as though set out verbatim, and that in the absence of express legislative intent to the contrary, the Legislature intends that the incorporation by reference shall not be affected by a subsequent change to the referenced law – even its

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[47] *Elmariah v. Board of Medicine*, 574 So.2d 164, 165 (Fla. 1st DCA 1990).
[48] Section 459.015(1)(m), F.S., contains the same language related to osteopathic physicians.
[49] In *Elmariah*, 574 So.2d at 165, the court held that a deceptive application for staff privileges at a hospital was not made "in" the practice of medicine but noted that such an application might be "related" to the practice of medicine. The case demonstrates how a court will construe a statute very strictly in favor of the licensee.
[50] *See* ss. 458.331(1)(jj) and 459.015(1)(mm), F.S.

> repeal. In other words, each referenced provision has two separate existences – as substantive provision and as an incorporation by reference – and neither is thereafter affected by anything that happens to the other.[51]

The second type of referenced statute is a "general reference." The general reference differs from the specific reference in that it presumes that the referenced section may be amended in the future, and any such changes are permitted to be incorporated into the meaning of the adopting statute. Again, Means explained in his article that "when the reference is not to a specific statute, but to the law in general as it applies to a specified subject, the reference takes the law as it exists at the time the law is applied. Thus, in cases of general references, the incorporation does include subsequent changes to the referenced law."[52]

Currently, other provisions of statutes provide statutory intent which allow for references to that statute to be construed as a general reference under the doctrine of incorporation by reference. For example, the statutes which deal with the punishments for criminal offenses contain clauses which allow for any reference to them to constitute a general reference.[53] This means that any time the Legislature amends a criminal offense, these punishment statutes do not have to be reenacted within the text of a bill because it is understood that their text or interpretation may change in the future.

Effect of the Bill

This bill contains a provision providing that the changes to the disciplinary statutes constitute a general reference under the doctrine of incorporation by reference. The incorporation by reference language in this bill could be interpreted to allow amendments to statutes which reference the disciplinary statute so that the reference takes the law as it exists at the time the law is applied.

Informed Consent

Background

The Mayo Clinic website describes cataract surgery as follows:

> Cataract surgery is a procedure to remove the lens of your eye and, in most cases, replace it with an artificial lens. Cataract surgery is used to treat a cataract — the clouding of the normally clear lens of your eye.[54]

Complications after cataract surgery are uncommon and risks include inflammation, infection, bleeding, swelling, retinal detachment, glaucoma, or a secondary cataract.[55]

The doctrine of informed consent requires a physician to advise his or her patient of the material risks of undergoing a medical procedure.[56] Physicians and osteopathic physicians are required to obtain informed consent of patients before performing procedures and are subject to discipline for failing to do so.[57] Florida has codified informed consent in the "Florida Medical Consent Law," s. 766.103, F.S. Section 766.103(3), F.S., provides:

> (3) No recovery shall be allowed in any court in this state against [specified health care providers including physicians and osteopathic physicians] in an action brought for treating, examining, or operating on a patient without his or her informed consent when:

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[51] Earnest Means, "Statutory Cross References - The "Loose Cannon" of Statutory Construction," Florida State University Law Review, Vol. 9, p. 3 (1981).
[52] *Id*.
[53] *See* ss. 775.082, 775.083, and 775.084, F.S.
[54] http://www.mayoclinic.com/health/cataract-surgery/MY00164 (accessed February 19, 2011).
[55] http://www.mayoclinic.com/health/cataract-surgery/MY00164/DSECTION=risks (accessed February 19, 2011).
[56] *See State v. Presidential Women's Center*, 937 So.2d 114, 116 (Fla. 2006)("The doctrine of informed consent is well recognized, has a long history, and is grounded in the common law and based in the concepts of bodily integrity and patient autonomy").
[57] *See* ss. 458.331, F.S., and 459.015, F.S.

> (a)1. The action of the [health care provider] 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 [health care provider], 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 [health care providers] 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 [health care provider] in accordance with the provisions of paragraph (a).

Section 766.103(4), F.S., provides:

> (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. (emphasis added).

The Florida Supreme Court discussed the effect of the rebuttable presumption in the Medical Consent Law in *Pub. Health Trust of Dade County v. Valcin.*[58] In that case, the patient signed two consent forms, one acknowledging that no guarantees had been made concerning the results of the operation and one stating that the surgery had been explained to her.[59] The patient argued that the doctor made oral representations that contradicted the consent forms and made other statements that were not addressed by the consent forms. The court found that such claims could overcome the presumption:

> [W]e note that no conclusive presumption of valid consent, rebuttable only upon a showing of fraud, will apply to the case. The alleged oral warranties, of course, if accepted by the jury may properly rebut a finding of valid informed consent.[60]

A second issue in Valcin was not related to informed consent but was which type of presumption should apply when surgical records related to the surgery at issue were lost. The *Valcin* court discussed the two types of presumptions created under the Evidence Code:

> At this point, we should clarify the type of rebuttable presumption necessitated under this decision. The instant problem should be resolved either by applying a shift in the burden of producing evidence, section 90.302(1), Florida Statutes (1985), or a shift in the burden of proof. § 90.302(2), Fla.Stat. (1985). While the distinction sounds merely technical, it is not. In the former, as applied to this case, the hospital would bear the initial burden of going forward with the evidence establishing its nonnegligence. If it met this burden by the greater weight of the evidence, the presumption would vanish, requiring resolution of the issues as in a typical case. *See Gulle v. Boggs,* 174 So.2d 26 (Fla.1965); C.

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[58] 507 So.2d 596 (Fla. 1987).
[59] *See Pub. Health Trust of Dade County v. Valcin,* 507 so.2d 596, 598 (Fla. 1987).
[60] *Id*. at 599.

> Ehrhardt, *Florida Evidence* § 302.1 (2d ed. 1984). The jury is never told of the presumption.
>
> In contrast, once the burden of proof is shifted under section 90.302(2), the presumption remains in effect even after the party to whom it has been shifted introduces evidence tending to disprove the presumed fact, and "the jury must decide whether the evidence introduced is sufficient to meet the burden of proving that the presumed fact did not exist." Ehrhardt at § 302.2, citing *Caldwell v. Division of Retirement,* 372 So. 2d 438 (Fla. 1979).[61]

The *Valcin* court discussed the second kind of rebuttable presumption:

> The second type of rebuttable presumption, as recognized in s. 90.302(2), F.S., affects the burden of proof, shifting the burden to the party against whom the presumption operates to prove the nonexistence of the fact presumed. "When evidence rebutting such a presumption is introduced, the presumption does not automatically disappear. It is not overcome until the trier of fact believes that the presumed fact has been overcome by whatever degree of persuasion is required by the substantive law of the case." Rebuttable presumptions which shift the burden of proof are "expressions of social policy," rather than mere procedural devices employed "to facilitate the determination of the particular action."
>
> A section 90.302(2) presumption shifts the burden of proof, ensuring that the issue of negligence goes to the jury.[62] (internal citations omitted).

Effect of the Bill

The bill requires that the Boards of Medicine and Osteopathic Medicine to adopt rules establishing a standard informed consent form setting forth recognized specific risks relating to cataract surgery. The boards must consider information from physicians and osteopathic physicians regarding specific recognized risks of cataract surgery and must consider informed consent forms used in other states. The rule must be proposed within 90 days of the effective date of the bill.

The bill provides that in a civil action or administrative proceeding against a physician or osteopathic physician based on the failure to properly disclose the risks of cataract surgery, a properly executed informed consent form is admissible and creates a rebuttable presumption that the physician or osteopathic physician properly disclosed the risks.

Reports of Adverse Incidents

Current Law

Sections 458.351 and 459.026, F.S., require health care providers practicing in an office setting to report "adverse incidents" to the Department of Health and requires the Department of Health to review such incidents to determine whether disciplinary action is appropriate. Hospitals and other facilities licensed under s. 395.0197, F.S., also have adverse incident reporting requirements. In general, adverse incidents are incidents resulting in death, brain or spinal damage, wrong site surgical procedures, or cases of performing the wrong surgical procedure.[63]

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[61] *Id*. at 600.
[62] *Id*. at 600-01.
[63] *See generally* s. 458.351, F.S., for examples of incidents required to be reported. Sections 459.026 and 395.0197, F.S., contain reporting requirements for osteopathic physicians and hospitals.

Effect of the Bill

The bill provides that incidents resulting from recognized specific risks described in the signed consent forms (discussed elsewhere in this analysis) related to cataract surgery are not considered adverse incidents for purposes of ss. 458.351, 459.026, and 395.0197, F.S.

"Consent to Settle" Clauses in Medical Malpractice Insurance Contracts

Background

Section 627.4147, F.S., contains provisions relating to medical malpractice insurance contracts. Among other things, medical malpractice insurance contracts must include a clause requiring the insured to cooperate fully in the presuit review process if a notice of intent to file a claim for medical malpractice is made against the insured.

In addition, the insurance contract must include a clause authorizing the insurer or self-insurer to "determine, to make, and to conclude, without the permission of the insured, any offer of admission of liability and for arbitration pursuant to s. 766.106, settlement offer, or offer of judgment, if the offer is within the policy limits."[64] The statute further provides that it is against public policy for any insurance policy to contain a clause giving the insured the exclusive right to veto any offer for admission of liability and for arbitration, settlement offer, or offer of judgment, when such offer is within the policy limits. However, the statute provides that the insurer must act in good faith and in the best interests of the insured.[65]

The provision giving insurers the exclusive right to settle claims within policy limits was enacted in 1985.[66] Subsequent to that legislation, there have been causes where physicians argued that insurance companies improperly settled claims.[67] In *Rogers v. Chicago Insurance Company*,[68] a physician sued his malpractice carrier for failing to exercise good faith in settling a claim. He argued that the claim was completely defensible and he was damaged by the settlement because of, among other things, his inability to obtain medical malpractice insurance.[69] The court held that the statute did not create a cause of action for the physician and explained:

> Roger's interpretation of the statute would make its primary purpose, which is not to allow insured's to veto malpractice settlements, meaningless. We say that because, if an insurer did settle with the claimant over the objection of the insured, the insurer would then be exposed to unlimited damages for increased insurance premiums, inability to get insurance, or other far removed and unknown collateral damages. No insurer would take that risk and the objecting insured would thus have the veto which the statute purports to eliminate.
>
> We conclude that the statutory language, requiring that any settlement be in the best interests of the insured, means the interests of the insured's rights under the policy, not some collateral effect unconnected with the claim. For example, the insured may have a counterclaim in the malpractice lawsuit for services rendered, which should not be ignored. Nor should the insurer be able to settle with the claimant and leave the doctor exposed to a personal judgment for contribution by another defendant in the same case. By including the language that any settlement must be in the best interest of the insured, the legislature was merely making it clear that, although it was providing that an insured

[64] Section 627.4147(1)(b)1., F.S.
[65] Section 627.4147(1)(b)1., F.S.
[66] *See Shuster v. South Broward Hosp. Dist. Physicians' Professional Liability Ins. Trust*, 591 So.2d 174, 176 n. 1 (Fla. 1992).
[67] In addition to the case discussed in this analysis, see *Freeman v. Cohen*, 969 So.2d 1150 (Fla. 4th DCA 2008).
[68] 964 So.2d 280 (Fla. 4th DCA 2007).
[69] *See Rogers v. Chicago Ins. Co.*, 964 So.2d 280, 281 (Fla. 4th DCA 2007).

> cannot veto a settlement, the power to settle is not absolute and must still be in the best interests of the insured[.][70]

In dissent, Judge Warner argued that the majority effectively writes the "good faith" provision out of the statute:

> The majority suggests that Rogers's interpretation would render meaningless part of the statute in that an insured could veto malpractice settlements by objecting. I do not agree. If the insurer has fulfilled its obligation of good faith in investigating and evaluating the case, and it has considered the best interests of the insured, then it can settle the case. The insured cannot veto the settlement...
>
> The statutory obligation of good faith and best interest provides the only protection to a doctor against insurance companies who may settle unfounded cases simply because it is cheaper to settle than to defend. That is a decision in the insurer's own interests, which it could do under *Shuster* but is not consistent, in my view, with its duties under section 627.4147. The majority opinion takes this statutory protection away from the physician. I would read the statute as written and allow Dr. Rogers's cause of action to proceed[.][71]

Effect of the Bill

This bill allows medical malpractice insurance policies to contain provisions allowing physicians to "veto" settlement offers made to the insurance company that are within policy limits. Instead of not allowing such provisions, the bill would require that policies "clearly" state whether the physician has the exclusive right to veto settlements.

Standard of Proof in Cases Relating to Supplemental Diagnostic Tests

Background

Section 766.102(4), F.S., provides that 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."

Section 766.102, F.S., provides that a claimant in a medical negligence action must prove by "the greater weight of the evidence" that actions of the health care provider represented a breach of the prevailing professional standard of care. Greater weight of the evidence means the "more persuasive and convincing force and effect of the entire evidence in the case."[72]

Other statutes, such as license disciplinary statutes, require a heightened standard of proof called "clear and convincing evidence." Clear and convincing evidence has been described as follows:

> [C]lear and convincing evidence requires that the evidence must be found to be credible; the facts to which the witnesses testify must be distinctly remembered; the testimony must be precise and explicit and the witnesses must be lacking in confusion as to the facts in issue. The evidence must be of such weight that it produces in the mind of the trier of fact a firm belief or conviction, without hesitancy, as to the truth of the allegations sought to be established.[73]

Section 766.111, F.S., prohibits a health care provider from ordering, procuring, providing, or administering unnecessary diagnostic tests.

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[70] *Id.* at 284.
[71] *Id.* at 285-86(Warner, J., dissenting).
[72] *Castillo v. E.I. Du Pont De Nemours & Co., Inc.*, 854 So.2d 1264, 1277 (Fla. 2003)
[73] *Inquiry Concerning Davey*, 645 So.2d 398, 404 (Fla. 1994)(quoting *Slomowitz v. Walker*, 429 So.2d 797, 800 (Fla. 4th DCA 1983).

Effect of the Bill

The bill provides that the claimant in a medical negligence case where the death or injury resulted from a failure of a health care provider to order, perform, or administer supplemental diagnostic tests must prove that the health care provider breached the standard of care by clear and convincing evidence. This bill would have the effect of making such claims more difficult to prove. Standards of proof in other medical negligence cases would remain unchanged.

Exclusion of Evidence

Background

Section 90.402, F.S., provides that all relevant evidence is admissible, except as a provided by law. Section 90.401, F.S, defines "relevant evidence" as evidence tending to prove or disprove a material fact. The trial court judge determines whether evidence is admissible at trial and a decision on the admissibility is reviewable for an abuse of discretion.

Currently, information about whether an insurer reimbursed a physician for performing a particular procedure or test is subject to admission as evidence during a trial based on whether it is relevant. The trial judge makes an individual determination as to whether such evidence is admissible.

Effect of the Bill

The bill amends s. 766.102, F.S., to provide that records, policies, or testimony of an insurer's[74] reimbursement policies[75] or reimbursement determination regarding the care provided to the plaintiff are not admissible as evidence in medical negligence actions.

The bill amends s. 766.102, F.S., to provide that 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. Evidence of a health care provider's compliance with federal requirements could be admissible if the trial judge found it to be relevant.

Hospital Liability for Independent Contractors

Background

The Florida Supreme Court has described the doctrine of vicarious liability:

> The concept of vicarious liability can be described as follows: “A person whose liability is imputed based on the tortuous acts of another is liable for the entire share of comparative responsibility assigned to the other.” Vicarious liability is often justified on the policy grounds that it ensures that a financially responsible party will cover damages. Thus, the vicariously liable party is liable for the entire share of the fault assigned to the active tortfeasor. The vicariously liable party has not breached any duty to the plaintiff; its liability is based solely on the legal imputation of responsibility for another party's tortuous acts. The vicariously liable party is liable only for the amount of liability apportioned to the tortfeasor. In sum, the doctrine of vicarious liability takes a party that is free of legal fault and visits upon that party the negligence of another.[76]

[74] The bill defines "insurer" as "any public or private insurer, including the Centers for Medicare and Medicaid Services."
[75] The bill defines "reimbursement policies" as "an insurer's policies and procedures
[76] *American Home Assur. Co. v. National Railroad Passenger Corp.*, 908 So.2d 459, 467-468 (Fla. 2005)(internal citations omitted).

Generally, a hospital may not be held liable for the negligence of independent contractor physicians to whom it grants staff privileges.[77] "Vicarious liability does not therefore necessarily attach to the hospital for the doctors' acts or omissions."[78] One court has explained:

> While some hospitals employ their own staff of physicians, others enter into contractual arrangements with legal entities made up of an association of physicians to provide medical services as independent contractors with the expectation that vicarious liability will not attach to the hospital for the negligent acts of those physicians.[79]

However, a hospital may be held vicariously liable for the acts of independent contractor physicians if the physicians act with the apparent authority of the hospital.[80] Apparent authority exists only if all three of the following elements are present: (a) a representation by the purported principal; (b) a reliance on that representation by a third party; and (c) a change in position by the third party in reliance on the representation.[81]

There are numerous cases in Florida appellate courts where courts have struggled over the issue of whether the hospital should be liable for the negligence of an independent contractor physician. Some cases involve the apparent authority issue. Others involve the issue of whether the hospital has a nondelegable duty to provide certain medical services. One court found:

> Even where a physician is an independent contractor, however, a hospital that "undertakes by [express or implied] contract to do for another a given thing" is not allowed to "escape [its] contractual liability [to the patient] by delegating performance under a contract to an independent contractor."[82]

One argument in favor of imposing such a duty on hospitals is:

> This trend suggests that hospitals should be vicariously liable as a general rule for activities within the hospital where the patient cannot and does not realistically have the ability to shop on the open market for another provider. Given modern marketing approaches in which hospitals aggressively advertise the quality and safety of the services provided within their hospitals, it is quite arguable that hospitals should have a nondelegable duty to provide adequate radiology departments, pathology laboratories, emergency rooms, and other professional services necessary to the ordinary and usual functioning of the hospital. The patient does not usually have the option to pick among several independent contractors at the hospital and has little ability to negotiate and bargain in this market to select a preferred radiology department. The hospital, on the other hand, has great ability to assure that competent radiologists work within an independent radiology department and to bargain with those radiologists to provide adequate malpractice protections for their mutual customers. I suspect that medical economics would work better if the general rule placed general vicarious liability upon the hospital for these activities.[83]

In March 2003, the Florida Supreme Court issued its opinion in *Villazon v. Prudential Health Care Plan*.[84] In *Villazon*, the court considered whether vicarious liability theories could make an HMO liable for the negligence of a physician who had a contract with the HMO. The court held that the HMO Act did not provide a cause of action against the HMO for negligence of the physician but that a suit could

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[77] *See Insinga v. LaBella*, 543 So.2d 209 (Fla. 1989).
[78] *Pub. Health Trust of Dade County v. Valcin*, 507 So.2d 596, 601 (Fla. 1987).
[79] *Roessler v. Novak*, 858 So.2d 1158, 1162 (Fla. 2d DCA 2003).
[80] *See Stone v. Palms West Hosp.*, 941 So.2d 514 (Fla. 4th DCA 2006).
[81] *See Roessler v. Novak*, 858 So.2d 1158, 1161 (Fla. 2d DCA 2003).
[82] *Shands Teaching Hosp. and Clinic, Inc. v. Juliana*, 863 So.2d 343, 349 n. 9 (Fla. 1st DCA 2003). *But see Jones v. Tallahassee Memorial Regional Healthcare, Inc*. 923 So.2d 1245 (Fla. 1st DCA 2006)(refusing to extend the nondelegable duty doctrine to physicians).
[83] *Roessler v. Novak*, 858 So.2d 1158, 1164-65 (Fla. 2d DCA 2003)(Altenbernd, C.J., concurring).
[84] 843 So.2d 842 (Fla. 2003).

proceed under common law theories of negligence under certain circumstances.[85] It noted that the "existence of an agency relationship is normally one for the trier of fact to decide."[86] The court explained that the physician's contractual independent contractor status does not alone preclude a finding of agency and remanded the case for consideration of whether the insurer exercised sufficient control over the physician's actions such that an agency relationship existed or whether agency could be established under an apparent agency theory.[87]

Subsequent to *Villazon*, the Legislature passed ch. 2003-416, L.O.F., which created s. 768.0981, F.S. Section 768.0981, F.S., provides:

> An entity licensed or certified under chapter 624, chapter 636, or chapter 641[88] 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, other than an employee of such licensed or certified entity, unless the licensed or certified entity expressly directs or exercises actual control over the specific conduct that caused injury.

The statute provides that insurers, HMOs, prepaid limited health service organizations, and prepaid health clinics are not liable for the negligence of health care providers with whom the entity has a contract unless the entity expressly directed or exercised actual control over the specific conduct that caused the injury.

Appellate courts in Florida have more recently examined the nondelegable duty issue, with differing opinions. As a result, the law is unsettled across the state regarding the liability of hospitals for the negligent acts or omissions of medical providers with whom they contract to provide medical services within the hospital, but over whom they do not have direct control of the manner in which the services are provided.

In *Wax v. Tenet Health System Hospitals, Inc.*,[89] [90], the wife of a deceased patient brought a medical malpractice action against the surgeon who operated on her husband, the hospital where the surgery was completed and others. The husband underwent elective hernia surgery, during which he suffered respiratory failure and died. The wife's wrongful death claim alleged negligence in the pre-surgical assessment, in the administration and management of anesthesia during surgery, and in the failed attempts to resuscitate the husband after he stopped breathing.[91] Specifically, for purposes of this analysis, the wife alleged that the hospital had a nondelegable duty to provide anesthesiology services and was directly liable for the negligence of the anesthesiologist with whom the hospital had contracted to provide services.[92]

The *Wax* court agreed with the plaintiff that the statutory definition of "hospital"[93] and a specific regulation of hospitals established under statutory authority by the Agency for Health Care

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[85] *See Villazon v. Prudential Health Care Plan, Inc.,* 843 So.2d 842, 852 (Fla. 2003).
[86] *Id. a*t 853.
[87] *Id.* at 855-56.
[88] Chapter 624, F.S., provides for licensing of health insurers under the Florida Insurance Code. Chapter 636, F.S., provides for licensing of prepaid limited health service organizations and discount medical plan organizations. Chapter 641, F.S., provides for licensing of health maintenance organizations and prepaid health clinics.
[89] 955 so.2d 1 (Fla. 4th DCA 2006).
[90] The case was originally heard in 2006. Following the filing of a Motion for Rehearing and a Motion for Rehearing En Banc by appellees, both of which were denied, the Court realized that it failed to resolve all issues and delivered an opinion regarding the hospital's liability for the alleged negligence of the anesthesiologist. The opinion was issued on May 7, 2007. *See* Wax, 955 So.2d at 6.
[91] *See Wax v. Tenet Health System Hospitals, Inc*., 955 So.2d 1, 3 (Fla. 4th DCA 2006).
[92] *See id.* at 6.
[93] Section 395.002(13)(b), F.S. (2005) defines "hospital" as an establishment that, among other things, regularly makes available "treatment facilities for surgery."

Administration (AHCA)[94] established that the hospital had an express legal duty to furnish anesthesia services to patients that were "consistent with established standards."[95] The court found that the imposition of this duty on all surgical hospitals to provide non-negligent anesthesia services was important enough to be nondelegable without the express consent to the contrary of the patient.[96] The hospital was found liable for the negligence of the anesthesiologist that caused the death of Wax under the theory of nondelegable duty.

In *Tarpon Springs Hospital Foundation, Inc. v. Reth,*[97] the personal representative of a deceased patient filed a medical negligence claim against the anesthesiologist, nurse anesthetists, the anesthesia practice, and the hospital, alleging that negligent anesthesia services were provided to the patient, causing his death.[98] The hospital and other defendants appealed the trial court's order granting the plaintiff's amended motion for new trial and the denial of the hospital's motion for directed verdict.[99] The 2nd District Court of Appeal considered the same argument of the plaintiff related to the identical statutes and rules as were presented to the 4th District Court of Appeal in *Wax.* However, the court in *Reth* concluded that, while the hospital had a statutory obligation to maintain an anesthesia department within the hospital that is directed by a physician member of the hospital's professional staff, the statutes and rules do not impose a nondelegable duty to provide non-negligent anesthesia services to surgical patients of the hospital.[100] The court reversed the denial of the hospital's motion for directed verdict and remanded this case to the trial court with instructions that it enter a judgment in favor of the hospital.[101]

Noting the conflict among the District Courts of Appeal regarding the applicability of the theory of nondelegable duty to the contractual relationship between hospital and medical provider in medical negligence claims, the Second District certified the conflict to the Florida Supreme Court for further review.[102] However, as of the date of this analysis, the Florida Supreme Court has not resolved the conflict.

Effect of the Bill

The bill amends s. 768.0981, F.S. to provide that a hospital is not liable for the medical negligence of a health care provider with whom the hospital has entered into a contract, other than an employee of the hospital, unless the hospital expressly directs or exercises actual control over the specific conduct that caused injury. This bill would limit the inquiry as to whether the hospital "expressly" directed or exercised actual control over the conduct that caused the injury.

Volunteer Physicians

Background

Section 768.135, F.S., provides limited immunity from civil liability for "volunteer team physicians." The statute provides:

> Any person licensed to practice medicine pursuant to chapter 458, chapter 459, chapter 460, chapter 461, or chapter 466:

[94] Rule 59A-3.2085(4), F.A.C. states "[e]ach Class I and Class II hospital, and each Class III hospital providing surgical or obstetrical services, shall have an anesthesia department, service or similarly titled unit directed by a physician member of the organized professional staff."
[95] *See Wax*, 955 So.2d at 8.
[96] *See id.* at 9.
[97] 40 So.3d 823 (Fla. 2d DCA 2010).
[98] *See Reth*, 40 So.3d at 823.
[99] *See id.* at 824.
[100] *See id.*
[101] *See id.*
[102] *See Tarpon Springs Hospital Foundation, Inc. v. Reth*, 40 So.3d 823, 824 (Fla. 2d DCA 2010).

(1) Who is acting in the capacity of a volunteer team physician in attendance at an athletic event sponsored by a public or private elementary or secondary school; and

(2) Who gratuitously and in good faith prior to the athletic event agrees to render emergency care or treatment to any participant in such event in connection with an emergency arising during or as the result of such event, without objection of such participant,

shall not be held liable for any civil damages as a result of such care or treatment or as a result of any act or failure to act in providing or arranging further medical treatment when such care or treatment was rendered as a reasonably prudent person similarly licensed to practice medicine would have acted under the same or similar circumstances.

In *Weiss v. Pratt*,[103] the court questioned whether the statute provided any protections for volunteer physicians:

> If section 768.135 provides immunity for a volunteer physician, how does its protection differ from basic tort law? Before a physician can be held liable for medical negligence, the plaintiff must prove that the physician fell below the standard of care of a reasonable physician under similar circumstances. *See* Fla. Std. Jury Instr. (Civ.) 402.4a. Section 768.135 appears to provide no more protection (save the "similarly licensed" requirement) than general tort law. The statute purports to provide immunity, but its protection is illusory. If the legislature intended to provide some additional layer of protection to those physicians who volunteer their services, then perhaps the statute needs another look.[104]

Section 1006.20, F.S., requires a medical examinations before children can participate in certain school sport activities.

Effect of this Bill

This bill limits the liability of volunteer team physicians and health care providers who volunteer to provide evaluations pursuant to s. 1006.20(2)(c), F.S., to situations where treatment was rendered in a "wrongful manner." This bill defines "wrongful manner" as "bad faith or with malicious purpose or in a manner exhibiting wanton and willful disregard of human rights, safety, or property."

B. SECTION DIRECTORY:

Section 1: Creates s. 458.3175, F.S., relating to expert witness certificates.

Section 2: Amends s. 458.331, F.S., relating to grounds for disciplinary action and action by the board and department.

Section 3: Amends s. 458.351, F.S., relating to reports of adverse incidents in office practice settings.

Section 4: Creates s. 459.0066, F.S., relating to expert witness certificates.

Section 5: Amends s. 459.015, F.S., relating to grounds for disciplinary action and action by the board and department.

Section 6: Creates s. 466.005, F.S., relating to expert witness certificates.

Section 7: Amends s. 466.028, F.S., relating to grounds for disciplinary action or action by the board.

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[103] 53 So.3d 395 (Fla. 4th DCA 2011).
[104] *Weiss v. Pratt*, 53 So.3d 395, 401 (Fla. 4th DCA 2011).

Section 8: Amends s. 459.026, F.S., relating to reports of adverse incidents in office practice settings.

Section 9: Amends s. 627.4147, F.S., relating to medical malpractice insurance contracts.

Section 10: Amends s. 766.102, F.S., relating to medical negligence, standards of recovery, and expert witnesses.

Section 11: Amends s. 766.106, relating to notice before filing action for medical negligence; presuit screening period; offers for admission of liability and for arbitration; informal discovery; review.

Section 12: Creates s. 766.1065, F.S., relating to authorization for release of protected health information.

Section 13: Amends s. 766.206, F.S., relating to presuit investigation of medical negligence claims.

Section 14: Amends s. 768.0981, F.S., relating to limitations on actions against insurers, prepaid limited health service organizations, health maintenance organizations, hospitals, or prepaid health clinics.

Section 15: Amends s. 768.135, F.S., relating to volunteer team physicians.

Section 16: Provides an effective date of July 1, 2011.

II. FISCAL ANALYSIS & ECONOMIC IMPACT STATEMENT

A. FISCAL IMPACT ON STATE GOVERNMENT:

1. Revenues:

   The bill requires physicians and dentists licensed in another state or Canada to pay a fee of not more than $50 to obtain an expert witness certificate in order to provide an expert witness opinion or provide expert testimony relating to the standard of care in a medical malpractice case involving a physician or dentist. The department estimates that during the first year there will be approximately 2,478 expert witness certificates applied for, thereby resulting in revenues of $123,900 to be deposited within the Medical Quality Assurance Trust Fund.

2. Expenditures:

   The Department of Health will require additional budget authority in contracted services for application processing and one OPS position to implement the provisions of the bill. The estimated cost will be less than $58,000 and will be absorbed within existing department resources.

B. FISCAL IMPACT ON LOCAL GOVERNMENTS:

1. Revenues:

   None.

2. Expenditures:

   None.

C. DIRECT ECONOMIC IMPACT ON PRIVATE SECTOR:

The bill requires physicians and dentists licensed in another state or Canada to pay a fee of not more than $50 to obtain an expert witness certificate in order to provide an expert witness opinion or provide expert testimony relating to the standard of care in a medical malpractice case involving a physician or dentist.

D. FISCAL COMMENTS:

The fiscal impact on private parties is speculative.

III. COMMENTS

A. CONSTITUTIONAL ISSUES:

1. Applicability of Municipality/County Mandates Provision:

This bill does not appear to require counties or municipalities to take an action requiring the expenditure of funds, reduce the authority that counties or municipalities have to raise revenue in the aggregate, nor reduce the percentage of state tax shared with counties or municipalities.

2. Other:

Access to Courts

This bill contains a provision that increases the standard of proof in certain medical negligence actions from preponderance of the evidence to clear and convincing evidence. This bill further provides that a hospital is not liable, with some exceptions, for the medical negligence of a health care provider with whom the hospital has entered into a contract. Article 1, s. 21, Fla. Const., provides that the "courts shall be open to every person for redress of any injury, and justice shall be administered without sale, denial or delay." In *Kluger v. White*,[105] the Florida Supreme Court explained the constitutional limitation on the ability of the Legislature to abolish a civil cause of action:

> We hold, therefore, that where a right of access to the courts for redress for a particular injury has been provided by statutory law predating the adoption of the Declaration of Rights of the Constitution of the State of Florida, or where such right has become a part of the common law of the State pursuant to Fla. Stat. s. 2.01, F.S.A., the Legislature is without power to abolish such a right without providing a reasonable alternative to protect the rights of the people of the State to redress for injuries, unless the Legislature can show an overpowering public necessity for the abolishment of such right, and no alternative method of meeting such public necessity can be shown.

In *Eller v. Shova*,[106] the court applied *Kluger* to a case that changed the standard of proof from simple negligence to gross negligence in some workers compensation actions:

> In analyzing [the standard quoted above] in *Kluger*, we stated that a statute that merely changed the degree of negligence necessary to maintain a tort action did not abolish a right to redress for an injury.

Justice Kogan warned that the ability to change the standard of proof is not unlimited:

> [F]ew would question that access to the courts is being denied if the legislature purports to preserve a cause of action but then insulates defendants with conclusive, irrebuttable presumptions. Such a “cause of action” would be little more than a legal sham used to circumvent article 1, section 21.[107]

Rules of Practice and Procedure in the Courts

This bill changes provisions relating to expert witnesses and the admissibility of evidence during a civil trial. Article V, s. 2(a), Fla. Const., provides that the Florida Supreme Court "shall adopt rules for

[105] 281 So.2d 1, 4 (Fla. 1983).
[106] 630 So.2d 537, 540 (Fla. 1993).
[107] *Eller v. Shova*, 630 So.2d 537, 543 (Fla. 1993)(Kogan, J., concurring in result only).

the practice and procedure" in all courts. The Florida Supreme Court has interpreted this provision to mean that the court has the exclusive power to create rules of practice and procedure. This bill provides requirements for expert witnesses who do not possess a Florida license, provides for admissibility of informed consent forms, and provides for exclusion of certain evidence even if the evidence is otherwise relevant. If a court were to find that any of these requirements encroached on the court's rulemaking power, it could hold the provisions invalid.

This bill provides that certain documents are admissible in evidence. The Florida Supreme Court has held that some portions of the Evidence Code are substantive and can be set by the Legislature and some portions are procedural and can only be set by the rules of court. If a court were to find that the provisions in this bill related to admission of evidence are procedural, it could hold the provisions invalid pursuant to art. V, s. 2, Fla. Const.

B. RULE-MAKING AUTHORITY:

This bill requires that the Boards of Medicine and Osteopathic Medicine adopt rules establishing a standard informed consent form setting forth recognized specific risks relating to cataract surgery. The boards must consider information from physicians and osteopathic physicians regarding specific recognized risks of cataract surgery and must consider informed consent forms used in other states.

C. DRAFTING ISSUES OR OTHER COMMENTS:

None.

IV. AMENDMENTS/ COMMITTEE SUBSTITUTE CHANGES

The Civil Justice Subcommittee considered the bill on March 8, 2011, and adopted six amendments. The amendments:

- List the specific information that must be provided to the Department of Health in order for an out-of-state physician to receive an expert witness certificate and remove the requirement that boards make rules to implement the expert witness certificate program;
- Provide that the Department of Health will have the duty of issuing the expert witness certificates and give the Department 7 business days rather than 5 business days to issue the certificates;
- Provide that the Board of Medicine and the Board of Osteopathic Medicine will have the authority to discipline holders of expert witness certificates;
- Provide that the provision of the bill relating that limits the admission of evidence relating to insurer reimbursement policies and practices only applies in medical negligence actions;
- Provide that a prospective defendant may interview a claimant's health care providers if the health care providers agree to be interviewed;
- Remove the provisions of the bill that exempt the rule requiring the creation of a new informed consent form for cataract surgery from possible legislative review; and
- Remove the requirement that the trial judge include a rebuttable presumption in the jury instructions.

This bill, as amended, was reported favorably as a committee substitute.

On March 23, 2011, the Health & Human Services Access Subcommittee adopted a strike-all amendment and an amendment to the strike-all amendment. The strike-all amendment:

- Requires an expert witness testifying for or against a dentist to be a licensed dentist under ch. 466, F.S., or possess an expert witness certificate issued under s. 466.005, F.S.
- Subjects a dentist licensed under chapter 466, F.S., to denial of a license or disciplinary action under s. 466.028(1)(ll) related to the submission of a verified written expert medical opinion.
- Creates s. 466.005, F.S., requiring the Department of Health to issue an expert witness certificate to a dentist licensed out-of-state or in Canada upon the satisfaction of requirements established by statute and payment of an application fee of $50.
- Makes an expert witness certificate issued under s. 466.005, F.S., valid for 2 years from the date of issuance.

- Allows the holder of an expert witness certificate issued under s. 466.005, F.S., to provide a verified written medical expert opinion as provided in s. 766.203, F.S., and provide expert testimony in pending medical negligence actions against a dentist regarding the prevailing standard of care.
- Clarifies that an expert witness certificate issued under s. 466.005, F.S., does not authorize a dentist to engage in the practice of dentistry and does not require a dentist, not otherwise licensed to practice dentistry in Florida, to obtain a license to practice dentistry or to pay license fees.
- Requires an expert witness certificate to be considered a license for purpose of disciplinary action and subjects the holder of the certificate to discipline to the Board of Dentistry.
- Renders as ground for denial of a license or disciplinary action the provision of misleading, deceptive, or fraudulent expert witness testimony related to the practice of dentistry.

The amendment to the strike-all amendment changed the number of years of professional time required to be devoted to active clinical practice, student instruction or clinical research on the part of an expert witness testifying against a health care provider from five to three years.

The bill was reported favorably as a Committee Substitute.

On April 8, 2011, the Health Care Appropriations Subcommittee considered the bill and adopted one amendment. The amendment:

- Removes the provision that allows a defendant or defense counsel in a medical negligence case to interview a claimant's treating health care providers without notice to the claimant or claimant's counsel;
- Removes the provision that allows a defendant or defense counsel to take unsworn statements of the claimant's health care providers without having to complete a medical information release; and
- Removes the requirement that the claimant execute an "authorization of release of protected health information" to be included with the presuit notice of intent to initiate litigation that allows the defendant access to a claimant's health care providers and medical records.

The bill was reported favorably as a Committee Substitute.

The Judiciary Committee considered the bill on April 14, 2011. The committee adopted amendments to:

- Allow a defendant or defense counsel in a medical negligence case to interview a claimant's treating health care providers without the claimant or claimant's attorney present with 10 days notice to the claimant or claimant's counsel;
- Allow a defendant or defense counsel to take unsworn statements of the claimant's health care providers without having to complete a medical information release;
- Remove the requirement that the claimant execute an "authorization of release of protected health information" to be included with the presuit notice of intent to initiate litigation that allows the defendant access to a claimant's health care providers and medical records; and
- Provide additional protection from civil liability for volunteer team physicians.

This bill, as amended, was reported favorably as a committee substitute. This analysis reflects the Judiciary committee substitute.