1988

Session Law 88-001

Florida Senate & House of Representatives

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<th>Year</th>
<th>Session</th>
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<th>Prime Bill#</th>
<th>Sponsor Comp./Sim. Bills</th>
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<td>88-1</td>
<td>HB 1, 8, 16, 16</td>
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<th>JIMC Hist. Senate Leg. Cites pp.#s</th>
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**Committee Records**

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<th>H/S Committee/Year</th>
<th>Record Series: Folder Title, etc.</th>
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**Senate/House Journals**

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**Tape Recordings**

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**Other Documentation**

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HR. Senate, meeting file: Joint Working Group on Federal Taxation

Bill S-18, HB 7 - 2
Thinking file: 1985, Feb. 2
Jud meeting file: 1972, Feb. 2
Bill file: 7 - E

J. Jones

19/108
87 Laws

87-42 Punitive Damages / Treble
1059503

87-173 Mediation & Arbitration

87-249 Civil Cases / Settlements

Other 1987 Bills (Rev. 5-25-87)

1380 — sim. — 5950
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1196 998
837
1988 BILL HISTORIES
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<tr>
<th>Session</th>
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FLORIDA LEGISLATURE

FINAL
LEGISLATIVE BILL
INFORMATION

1987 Special Sessions B, C, D
1988 Regular Session
1988 Special Sessions E, F

RE: Chapter 88-1

Special Session "E"
Bills

prepared by:

Joint Legislative Management Committee
Legislative Information Division
Capitol Building, Room 826 — 488-4371
FLORIDA LEGISLATURE—SPECIAL SESSION E—1988

HISTORY OF SENATE BILLS

S 1-E GENERAL BILL by D.C. Childers (Identical H 4-E, Compare H 1-E, H 6-E, CS/ENG/H 7-E, S 2-E, S 3-E, S 5-E, CS/ENG/S 6-E)

Medical Negligence: provides that, except when right of subrogation exists, amount of damages awarded to medical malpractice claimant be reduced by an amount of all collateral source payments; requires investigation to determine negligent care/treatment & written expert opinion finding medical negligence evidence prior to filing notice of intent to initiate medical malpractice litigation, provides for discovery of documents prior to suit filing, etc. Amends F.S. Effective Date 04/01/88

02/02/88 SENATE Prefiled

02/02/88 SENATE Introduced, referred to Commerce, Appropriations - SJ 1, On Committee agenda—Commerce, 02/02/88, 2:30 pm, Room—A—Not considered - SJ 5, On Committee agenda— Appropriations, 02/03/88, 9:00 am, Room—A—If received - SJ 5

02/04/88 SENATE Died in Committee on Commerce, Died /Sum /Compare bill passed, refer to CS/SB 6-E (Ch 86-1)

S 2-E GENERAL BILL by Myers (Similar H 1-E, CS/ENG/H 7-E, Compare H 4-E, H 6-E, S 1-E, S 3-E, CS/ENG/S 6-E)

Elmed Medical Incident Recovery Act of 1988, creates plan for prompt resolution of medical negligence claims, provides applicability of & procedure for mandatory present investigation & medical expert corroboration of medical negligence claims & defenses by prospective parties, provides for voluntary binding arbitration of medical negligence claims, etc. Amends F.S. Effective Date Upon becoming law

02/02/88 SENATE Filed, Introduced, referred to Commerce, Appropriations - SJ 2, On Committee agenda—Commerce, 02/02/88, 2:30 pm, Room—A—Not considered - SJ 5, On Committee agenda— Appropriations, 02/03/88, 9:00 am, Room—A—If received - SJ 5

02/04/88 SENATE Died in Committee on Commerce, Died /Sum /Compare bill passed, refer to CS/SB 6-E (Ch 86-1)

S 3-E GENERAL BILL by Myers (Compare H 217, H 1-E, H 4-E, H 6-E, CS/ENG/H 7-E, S 1-E, S 2-E, CS/ENG/S 6-E)

Medical Malpractice: requires notice to Professional Regulation Dept before filing claims for medical malpractice, provides for offers to pay claimants net economic losses & provides for arbitration when amount of such losses, or amount of attorney fees, cannot be agreed upon, provides for disciplinary training program for members of Boards of Osteopathic Medical Examiners, Podiatric Medicine, & Dentistry, etc. Amends F.S. Effective Date 07/01/88

02/02/88 SENATE Filed, Introduced, referred to Commerce, Appropriations - SJ 2, On Committee agenda— Commerce, 02/02/88, 2:30 pm, Room—A—Not considered -SJ 5, On Committee agenda— Appropriations, 02/03/88, 9:00 am, Room—A—If received - SJ 5

02/04/88 SENATE Died in Committee on Commerce, Died /Sum /Compare bill passed, refer to CS/SB 6-E (Ch 86-1)
S 6-E GENERAL BILL by Haire and others (Compare H 4-E, S 1-b, CS/ENG/S 8-E)

Medical Malpractice/Arbitration. Provides for mandatory arbitration of civil cases involving claims for medical negligence; provides for selection of arbitrators; provides for referral of cases to arbitration; provides for procedures for hearings, provides for arbitration awards & judgments, provides for trial de novo & for assessment of attorney's fees & costs in certain circumstances. Effective Date 07/01/88 or upon becoming law, whichever occurs later.

02/02/88 SENATE Filed, Introduced, referred to Commerce, Appropriations -SJ 3. On Committee agenda—Commerce, 02/02/88, 2:30 pm. Room-A—Not considered —SJ 5. On Committee agenda—Approprations, 02/03/88, 9:00 am, Room-A—If received —SJ 5

02/04/88 SENATE Died in Committee on Commerce, idem /Sim /Compare bill passed, refer to CS/SS 6-E (Ch 82-1)

S 6-E GENERAL BILL/CS/ENG by Appropriations, Commerce (Similar CS/ENG/H 7-E, Compare ENG/H 69, H 131, H 217, H 1-1-b, H 3-E, H 4-E, H 8-E, H 11-E, CS/S 89, CS/S 876, S 1-E, S 2-E, S 3-E, S 5-E, S 9-E)

Medical Practice, creates Medical Quality Assurance Plan within Prof Reg Dept, creates Medical Regulation Bureau, provides antitrust immunity through establishment of state-mandated peer review process, provides immunity from civil liability to physicians, hospital & certain hospital employees rendering medical care or treatment in response to emergency within hospital or trauma center, provides for selection of arbitration panels, etc. Amends S Appropriation. 22,204,209 Effective Date 02/08/88

02/02/88 SENATE Filed, Introduced, referred to Commerce, Appropriations -SJ 3. On Committee agenda—Commerce, 02/02/88, 2:30 pm, Room-A —SJ 5, Comm Report. Favorable with 18 amendment(s) by Commerce —SJ 6

02/04/88 SENATE Now in Appropriations —SJ 6, On Committee agenda— Appropriations, 02/03/86, 9:00 am, Room-A—SJ 5, Comm Report. CS by Appropriations, placed on Calendar —SJ 6, CS read first time —SJ 6, Placed on Special Order Calendar —SJ 7, CS passed as amended, YEAS 29 NAYS 10 —SJ 13, Conference Committee appointed (Subject to confirmation) Senators Jennings, Barron, Haire, Kirkpatrick & Mymi, & alternates, Derstany, Kiser & Thomas —SJ 14

02/03/88 HOUSE In Messages, Received, placed on Calendar—HJ 28, Read second time, Amendments adopted, Read third time, CS passed as amended, YEAS 100 NAYS 18—HJ 30, Requested Senate to concur—HJ 30

02/04/88 SENATE In Messages, Refused to concur requests House receive/appoint Conference Commit, Conference Committee appointed Senators Jennings, Barron, Haire, Kirkpatrick, & Meyers, & alternates, Derstany, Kiser, Thomas & Don Childers —SJ 16

02/04/88 HOUSE In Messages, Refused to recede—HJ 33, Conference Committee appointed Rep. Ogden, Bell, Upchurch, Lipman, Patchett, Alia Burke, Thomas, D Jones, Simon—HJ 34

02/04/88 SENATE Conference Committee Report received —SJ 30, Conference Committee Report adopted—HJ 44, Passed as amended by Conference Committee Report, YEAS 79 NAYS 28—HJ 54

02/04/88 HOUSE In Messages, Conference Committee Report received—HJ 38, Conference Committee Report adopted—HJ 64, Passed as amended by Conference Committee Report, YEAS 79 NAYS 28—HJ 64

02/04/88 Ordered engrossed. Then enrolled —SJ 45

02/05/88 Signed by Officers and presented to Governor

02/08/88 Approved by Governor, Chapter No 88-1, amended by 1988 Regular Session CS/CS/HH #19 (Ch 88-277), CS/SS 1078 (Ch 88-208), HH 1020 (Ch 88-192) & CS/HH 1677 (Ch 88-294)
FLORIDA LEGISLATURE—SPECIAL SESSION E—1988
HISTORY OF HOUSE BILLS

H 1-E GENERAL BILL by Bill, Patchett; Clements; Lippman; Shelley; Grindle; Guber; Sanderson; Cassa, Sansom; Ireland, Rocklin; Gardner; Goode; Metcalfe; Renke; Simone, Ascheri; Hodges; Martin; Thomas; Mortham, Hanson; Stone, Figg; Metcalfe, Rehm; Tobiasson; Long; Smith, Kelly; Hawkins; Carlton, Irvine, Baister, Locke, Croft, Reddick; Hill; Troxler; Garcia; Guzman and others (Similar CS/ENG/H 7-E, H 3-E, Compare H 217, H 4-E, H 5-E, H 11-E, S 1-E, S 3-E, CS/ENG/S 6-E)

Fina Medical Incident Recovery Act, creates "Florida Medical Incident Recovery Act of 1988", provides procedures for prompt resolution of medical complaints & claims, including present investigation & procedures for voluntary binding arbitration, provides for no-fault compensation for birth-related neurological injuries, provides specified immunity from civil liability for persons & facilities rendering medical emergency care services, etc. Amends F S Appropriation. Effective Date. Upon becoming law
01/08/88 HOUSE Prefiled
02/02/88 HOUSE Introduced, referred to Insurance, Appropriations -HJ 3
02/04/88 HOUSE Died in Committees on Insurance. Vote/Am/Compare bill passed, refer to CS/SB 6-E (Ch 88-1)

H 3-E GENERAL BILL by Kelly (Identical H 131, Similar H 392, H 1200, CS/S 89, S 191, S 9-E, Compare H 217, CS/ENG/H 7-E, H 11-E, CS/ENG/S 6-E)

Professions & Occupations/Regulation, revises various provisions re regulation of professions & occupations, authorizes professional regulatory boards to defer compliance with continuing education requirements, modifies eligibility requirements for licensure examination of foreign-trained professionals, authorizes disclosure of confidential patient-psychiatric communications when necessary to warn of patient threat, etc. Amends Ch 455, 468 347, 458 022, 460 408 Effective Date 10/01/88
01/07/88 HOUSE Prefiled
02/02/88 HOUSE Introduced allowed -HJ 3, Introduced, referred to Regulatory Reform, Appropriations -HJ 3, On Committee agenda—Regulatory Reform, 02/02/88, upon adjournment of House Health Care Committee, 417C
02/04/88 HOUSE Comm Report. Favorable with 8 amendment(s) by Regulatory Reform - HJ 9, Now in Appropriations - HJ 9, Withdrawn from Appropriations - HJ 9, Placed on Calendar, Withdrawn from Calendar, Withdrawn from further cut. Vote/Am/Compare Bill passed, refer to CS/SB 6-E (Ch 88-1) - HJ 9
S 879 GENERAL BILL/CS by Commerce; Commerce (Similar CS/CS/ENG/H 819, Compare H 131, H 217, CS/S 89, CS/ENG/S 1076, CS/ENG/S 6-E)

Medical Incidents, creates Medical Quality Assurance Div within D P R; places licensing boards for various health care professions within div, provides for disciplinary proceedings against hospitals, provides civil immunity & prohibition from discharge to persons reporting re incompetence, impairment, or unprofessional conduct of specified health care providers, provides for reports in lieu of certain psychiatric patient records, etc Amends F S Appropriation $22,203,209

Effective Date Upon becoming law

04/06/88 SENATE Filed

04/18/88 SENATE Introduced, referred to Commerce, Appropriations -S J 111

04/29/88 SENATE Extension of time granted Committee Commerce

05/12/88 SENATE On Committee agenda— Commerce, 05/16/88, 2 00 pm, Room-A

05/13/88 SENATE Extension of time granted Committee Commerce

05/16/88 SENATE Comm Report. CS by Commerce -S J 366

05/24/88 SENATE CS read first time -S J 368, Now in Appropriations -S J 366

05/26/88 SENATE On Committee agenda— Appropriations, 05/27/88, 9 00 am, Room-A - S J 430

05/27/88 SENATE Comm Report Favorable with 1 amendment(s) by Appropriations, placed on Calendar -S J 464

06/01/88 SENATE Placed on Special Order Calendar -S J 611 & -S J 612; Amendment adopted, Iden /Sim House Bill substituted -S J 646, Laid on Table under Rule, Iden /Sim /Compare Bill passed, refer to CS/CS/HB 819 (Ch 88-277) & CS/SB 1076 (Ch 88-208) -S J 671
S 481  GENERAL BILL/CS/ENG by Economic, Community and Consumer Affairs; Kirkpatrick (Compare ENG/H 1626, CS/H 1647, CS/S 800)

Social Workers & Counselors/License, prescribes qualifications for licensure as clinical social worker, marriage & family therapist, or mental health counselor, authorizes Professional Regulation Dept. to enjoin violations. Amends 491,005, 012 Effective Date Upon becoming law.
03/18/88 SENATE Prefiled
03/31/88 SENATE Referred to Economic, Community and Consumer Affairs, Appropriations
04/05/88 SENATE Introduced, referred to Economic, Community and Consumer Affairs, Appropriations -SJ 47
04/07/88 SENATE On Committee agenda—Economic, Community and Consumer Affairs, 04/11/88, 2:00 pm, Room-H
04/11/88 SENATE Comm Report. CS by Economic, Community and Consumer Affairs -SJ 91
04/13/88 SENATE CS read first time -SJ 103, Now in Appropriations -SJ 91
05/04/88 SENATE Extension of time granted Committee Appropriations
05/10/88 SENATE Withdrawn from Appropriations -SJ 261, Placed on Calendar
06/01/88 SENATE Placed on Special Order Calendar -SJ 611 & -SJ 612, CS passed as amended, YEAS 36 NAYS 0 -SJ 694
06/01/88 HOUSE In Messages
06/02/88 HOUSE Received, referred to Regulatory Reform -HJ 1200
06/07/88 HOUSE Died in Committee on Regulatory Reform, Died/Sim/Compare bill passed, refer to HB 1626 (Ch. 85-392)

S 483  GENERAL BILL/CS by Economic, Community and Consumer Affairs; Kirkpatrick (Similar H 1058, Compare ENG/H 1626, CS/S 800)

Nursing/Protocol & Discipline, provides conforming language, authorizes Professional Reg. Dept. to require filing of certain protocols with said dept., provides for restriction of certain nurses’ practices. Amends 464,003, 018 Effective Date Upon becoming law.
03/14/88 SENATE Prefiled
03/31/88 SENATE Referred to Economic, Community and Consumer Affairs
04/05/88 SENATE Introduced, referred to Economic, Community and Consumer Affairs -SJ 47
04/15/88 SENATE Extension of time granted Committee Economic, Community and Consumer Affairs
04/18/88 SENATE On Committee agenda—Economic, Community and Consumer Affairs, 04/20/88, 2:00 pm, Room-H
04/20/88 SENATE Comm Report: CS by Economic, Community and Consumer Affairs, placed on Calendar -SJ 168
04/29/88 SENATE CS read first time -SJ 178
05/03/88 SENATE Placed on Special Order Calendar -SJ 192
05/10/88 SENATE Placed on Special Order Calendar -SJ 211, CS passed, YEAS 37 NAYS 0 -SJ 222
05/05/88 HOUSE In Messages
05/17/88 HOUSE Received, referred to Regulatory Reform, Appropriations -HJ 453
06/07/88 HOUSE Died in Committee on Regulatory Reform, Died/Sim/Compare bill passed, refer to HB 1626 (Ch. 85-392)
S 904 GENERAL BILL/CS/CS by Appropriations, Commerce (Compare CS/ENG/H 1872)
Health Care Cost-Containment. (SUNSET) creates and act, provides immunity to hospitals for releasing certain data; provides law governing hospital budgets, revised uniform system of financial reporting for hospitals & provides procedures for grouping hospitals, creates "Health Planning Act," establishes state center for health statistics, etc. Amends FS Appropriation $300,000 Effective Date 10/01/88 except as otherwise provided
04/01/88 SENATE Filed
04/18/88 SENATE Introduced, referred to Commerce, Appropriations
-SJ 113
01/23/88 SENATE Extension of time granted Committee Commerce
05/13/88 SENATE Extension of time granted Committee Commerce
05/16/88 SENATE Comm Report CS by Commerce -SJ 352
05/16/88 SENATE CS read first time -SJ 312, Now in Appropriations -SJ 352
05/19/88 SENATE Extension of time granted Committee Appropriations
05/23/88 SENATE On Committee agenda—Appropriations, 05/24/88, 2:00 pm, Room-A
05/24/88 SENATE Comm Report CS/CS by Appropriations, placed on Calendar -SJ 426
05/26/88 SENATE CS read first time -SJ 427
05/30/88 SENATE Placed on Special Order Calendar -SJ 463, Amendments adopted -SJ 522, Amended House Bill substituted -SJ 524, Laid on Table under Rule, Iden/Sim/Compare Bill passed, refer to CS/HB 1673 (Ch 88-394) -SJ 536

S 1018 GENERAL BILL by Kirkpatrick (Compare ENG/H 1626, CS/S 630)
Impaired Practitioners Committee, provides for appointment of veterinarian to Impaired Practitioners Committee, provides procedures for treatment of impaired veterinarians, provides for employment of consultants, provides for confidentiality & disclosure of certain information, prohibits certain collaboration, provides penalties & immunity Amends 465, 474, 2414, Effective Date Upon becoming law
04/06/88 SENATE Filed
04/18/88 SENATE Introduced, referred to Economic, Community and Consumer Affairs, Appropriations -SJ 123, On Committee agenda—Economic, Community and Consumer Affairs, 04/20/88, 2:00 pm, Room-H
04/20/88 SENATE Comm Report Favorable by Economic, Community and Consumer Affairs -SJ 166
04/21/88 SENATE Now in Appropriations -SJ 166
05/04/88 SENATE Extension of time granted Committee Appropriations
05/17/88 SENATE Withdrawn from Appropriations -SJ 308, Placed on Calendar
06/01/88 SENATE Placed on Special Order Calendar -SJ 611 & -SJ 612, Passed, YEAS 33 NAYS 0 -SJ 672
06/01/88 HOUSE In Message
06/01/88 HOUSE Referred to Regulatory Reform -HJ 1494
06/07/88 HOUSE Died in Committee on Regulatory Reform, Iden/Sim/Compare bill passed, refer to HB 1626 (Ch 88-392)
S 1051 GENERAL BILL/ENG by Kirkpatrick (Similar CS/H 1647, Compare H 64, H 131, H 392, ENG/H 1828, S 12, CS/S 40, CS/ENG/S 185, S 191, CS/CS/S 446, S 496, CS/S 600, S 801)

Professional & Occupational Fees; provides for review or challenge of exams by applicants, revises maximum exam fees to include actual cost of exams for acupuncturists, physicians, osteopathic & chiropractic physicians, nurses, pharmacists, dentists, nursing home admin., respiratory therapists & care practitioners, emballers, engineers, land surveyors, C P A's, veterinarians, architects, landscape architects, opticians, physical therapists & aestheticians, etc. Amends F S Effective Date 10/01/88.

04/08/88 SENATE Filed
04/19/88 SENATE Introduced, referred to Economic, Community and Consumer Affairs - SJ 130
04/25/88 SENATE On Committee agenda — Economic, Community and Consumer Affairs, 04/27/88, 9:00 am, Room - H
04/27/88 SENATE Comm. Report Favorable by Economic, Community and Consumer Affairs, placed on Calendar - SJ 194
06/01/88 SENATE Placed on Special Order Calendar - SJ 611 & - SJ 612, was taken up - SJ 678, Passed as amended, YEAS 36 NAYS 0 - SJ 681; Reconsidered; Amendment adopted; Passed as amended, YEAS 37 NAYS 0 - SJ 690

06/02/88 HOUSE In Messengers
06/06/88 HOUSE Received, placed on Calendar - HJ 1517, Read second time, Amendments adopted, Read third time, Passed as amended, YEAS 114 NAYS 0 - HJ 1521

06/06/88 SENATE In Messengers
06/07/88 SENATE Concurred, Passed as amended, YEAS 33 NAYS 0 - SJ 1116
06/07/88 HOUSE Ordered engrossed, then enrolled - SJ 1116
07/01/88 Signed by Officers and presented to Governor
07/01/88 Approved by Governor, Chapter No 88-208.

S 1076 GENERAL BILL/CS/ENG by Judiciary-Civil: Malehorn (Similar CS/H 498, Compare H 131, H 217, CS/S 879)

Patient Records/Copying Fees: provides limitation on copying fees charged by health care facilities & health care practitioners for providing copies of patient records, provides for confidentiality & provides exception. Amends 395 017, 4/5 241 Effective Date: 07/01/88

04/08/88 SENATE Note: This bill amends 1988 Special Session 'E' CS/SB 6-E, Ch 88-1, Filed
04/21/88 SENATE Introduced, referred to Health and Rehabilitative Services; Judiciary-Civil - SJ 144
04/29/88 SENATE Extension of time granted Committee Health and Rehabilitative Services
05/10/88 SENATE Withdrawn from Health and Rehabilitative Services - SJ 392, Now in Judiciary-Civil
05/11/88 SENATE On Committee agenda—Judiciary-Civil, 05/19/88, 9:15 am, Room - B - SJ 341
05/19/88 SENATE Comm. Report CS by Judiciary-Civil, placed on Calendar - SJ 359
06/23/88 SENATE CS read first time - SJ 361
06/23/88 SENATE Placed on Consent Calendar - SJ 718, CS passed as amended, YEAS 34 NAYS 0 - SJ 773, Reconsidered, Amendment adopted; CS passed as amended, YEAS 34 NAYS 0 - SJ 775
06/01/88 HOUSE In Messages, Received, placed on Calendar - HJ 1382, Read second time, Read third time; CS passed, YEAS 112 NAYS 0 - HJ 1382
06/16/88 Ordered enrolled - SJ 1008
06/16/88 Signed by Officers and presented to Governor
07/01/88 Approved by Governor, Chapter No 88-209.
S 1168 GENERAL BILL/CS by Economic, Community and Consumer Affairs; Kirkpatrick (Compare ENG/H 1626, CS/S 600)

Dentistry: provides that dentist who accepts or renew license to practice dentistry in this state has given implied consent to submitting handwriting example to DPH under certain circumstances, provides that such dentist has waived confidentiality of certain medical report, establishes standards & procedures for handling impaired practitioners, adds person licensed under Dentistry to Impaired Practitioners Committee, etc. Amend Ch 452, 455:26. Effective Date Upon becoming law

04/12/88 SENATE Filed
04/21/88 SENATE On Committee Agenda—Economic, Community and Consumer Affairs, Finance, Taxation and Claims—SJ 153
04/25/88 SENATE Extension of time granted Committee Economic, Community and Consumer Affairs

05/1/88 SENATE Extension of time granted Committee Economic, Community and Consumer Affairs

05/18/88 SENATE CS read first time—SJ 361, Now in Finance, Taxation and Claims—SJ 358
05/25/88 SENATE Withdrawn from Finance, Taxation and Claims—SJ 461, Placed on Calendar

06/01/88 SENATE Placed on Special Order Calendar—SJ 611 &—SJ 612, CS passed, YEAS 35 NAYS 0 —SJ 662

06/03/88 HOUSE In Messages

06/07/88 HOUSE Placed on Calendar

06/07/88 SENATE In Messages, Died in Messages, Iden /Sim /Compare Bill passed, refer to HB 1522 (Ch. 88-39)

S 1176 GENERAL BILL/CS by Economic, Community and Consumer Affairs; Marzollo (Compare ENG/H 1626, CS/S 600)

Medical Faculty Certificate/Practitioners' Certificate: specifies conditions under which holder of such certificate may practice medicine. Amend Ch 452, 3145 Effective Date

07/01/88

04/12/88 SENATE Filed
04/21/88 SENATE Introduced, referred to Economic, Community and Consumer Affairs—SJ 153
04/25/88 SENATE On Committee Agenda—Economic, Community and Consumer Affairs, 04/27/88, 9:00 am, Room—H


05/19/88 SENATE CS read first time—SJ 361, Now in Finance, Taxation and Claims—SJ 358
05/25/88 SENATE Withdrawn from Finance, Taxation and Claims—SJ 461, Placed on Calendar

06/01/88 SENATE Placed on Special Order Calendar—SJ 611 &—SJ 612, CS passed, YEAS 35 NAYS 0 —SJ 662

06/03/88 HOUSE In Messages

06/07/88 HOUSE Placed on Calendar

05/03/88 SENATE CS read first time—SJ 219
05/17/88 SENATE Placed on Special Order Calendar—SJ 290 &—SJ 291

05/18/88 SENATE Placed on Consent Calendar—SJ 310; CS passed; YEAS 34 NAYS 0 —SJ 344

05/18/88 HOUSE In Messages

05/20/88 HOUSE Placed on Calendar

05/30/88 HOUSE Placed on Consent Calendar—SJ 310; CS passed; YEAS 34 NAYS 0 —SJ 344

06/01/88 HOUSE Placed on Special Order Calendar

06/01/88 HOUSE Placed on Calendar

06/03/88 HOUSE Placed on Regular Calendar

06/03/88 HOUSE Placed on Special Order Calendar

06/03/88 HOUSE Placed on Calendar

06/18/88 HOUSE Ordered enrolled—SJ 1008

07/01/88 HOUSE Approved by Governor; Chapter No 88-218
**H 88 GENERAL BILL/ENG by Dunbar (Compare CS/CS/ENG/H 819, CS/ENG/H 7-E, CS/ENG/S 6-E)**

Medical Malpractice Testimony: provides that it is unlawful for certain persons to threaten, coerce, intimidate, or discipline any licensed physician or any licensed nurse under certain circumstances, provides penalty; provides for civil actions. Creates 295-0116 Effective Date 10/01/88

11/09/87 HOUSE Filed
11/14/87 HOUSE Referred to Judiciary
02/12/88 HOUSE Subreferred to Subcommittee on Court Systems, Probate and Consumer Law
02/17/88 HOUSE On subpoena agenda—Judiciary, 03/02/88, 3:30 pm, 214C, On Committee agenda, pending subcommittee action—Judiciary, 03/09/88, 1:30 pm, 214C
03/09/88 HOUSE Preliminary Committee Action by Judiciary Favorable with 2 amendments
03/24/88 HOUSE Comm Report Favorable with 2 amendment(s) by Judiciary placed on Calendar
04/07/88 HOUSE Introduced, referred to Judiciary—HJ 14, Subreferred to Subcommittee on Court Systems, Probate and Consumer Law. Preliminary Committee Action by Judiciary Favorable with 2 amendments, Comm Report Favorable with 2 amendments by Judiciary, placed on Calendar—HJ 79
05/09/88 HOUSE Placed on Special Order Calendar
05/13/88 HOUSE Read second time—HJ 917. Amendments adopted. Read third time. Passed as amended, YEAS 117 NAYS 0—HJ 918
07/11/88 SENATE In Messengers
07/01/88 SENATE Received, referred to Commerce; Judiciary—Civil—SJ 615
07/07/88 SENATE Died in Committee on Commerce. HJ/Sim /Compare bill passed, refer to CS/CS/HB 819 (Ch 88-277)

**H 88 GENERAL BILL/ENG by Kelly; D.L. Jones (Identical H 3-E, Similar CS/CS/ENG/H 819, CS/CS/ENG/H 1626, CS/CS/ENG/H 1647, CS/ENG/H 7-E, H 11-E, 279, ENG/S 1031, CS/ENG/S 1076, CS/ENG/S 6-E)**

Communications, regulation, modify various provisions re regulation, requires, authorizes professional regulatory boards to defer on. communication requirements, modifies eligibility requirements for foreign-trained professionals, authorizes disclosure of certain communications when necessary to warn of patient. Effective Date 10/01/88

12/18/87 HOUSE Pref。
01/11/88 HOUSE Referred to Finance & Taxation, Appropriations
01/15/88 HOUSE Subreferred to House Resolution, On subcommittee agenda—Regulatory, 01/31/88, 8:00 am, Morris Hall, On Committee action—Regulatory
04/06/88 HOUSE Introduced, referred to Regulatory Reform, Finance & Taxation, Appropriations—HJ 18, Subreferred to Subcommittee on Professional Regulation, On subcommittee agenda—Regulatory Reform, 04/06/88, 8:00 am, Morris Hall, or 04/07/88, 10:00 am, Morris Hall if no action is completed on 04/06/88
04/06/88 HOUSE Subcommittee Recommendation pending ratification by full Committee Favorable with 2 amendments
06/07/88 HOUSE Died in Committee on Regulatory Reform. HJ/Sim /Compare bill passed, refer to SB 1031 (Ch 88-205), CS/SB 1076 (Ch 88-206), CS/CS/HB 819 (Ch 88-277) & HB 1626 (Ch 88-392)
H 217 GENERAL BILL by Regulatory Reform; Lippman; D.L. Jones; Kelly (Similar H 11-E, Compare H 131, CB/ENG/H #109, H 1-E, H 3-E, H 6-E, CS/ENG/H 7-E, CS/S 89, CS/S 9-E, CS/ENG/S 1078, S 3-E, CS/ENG/S 6-E, S 9-E)

Medical Practice, provides access to confidential patient records for certain proceedings of Professional Regulation Dept, provides for dept review & investigation of incidents which may involve conduct subject to discipline, provides for reports in lieu of certain psychiatric-patient records; requires physicians, osteopathic physicians, podiatrists & dentists to report professional liability claims & actions to dept., etc. Amends F.S. Effective Date Upon becoming law except as otherwise provided.

01/29/88 HOUSE Prefiled
02/11/88 HOUSE Referred to Finance & Taxation, Appropriations
04/05/88 HOUSE Introduced, referred to Finance & Taxation, Appropriations - HJ 26
05/07/88 HOUSE On Committee agenda - Finance & Taxation, 05/11/88, 1:30 pm, 21-HOB - For subreferral only
06/07/88 HOUSE Died in Committee on Finance & Taxation, Iden /Sim / Compare bill passed, refer to CS/SB 1076 (Ch 88-206) & CS/CS/HB 819 (Ch 88-277)

H 392 GENERAL BILL by Gonzalez-Quevedo; Díaz-Balart (Identical S 191, Similar H 131, H 1200, H 3-E, CS/ENG/S 600, ENG/S 1031)

Professions & Occupations/License: provides for establishment of initial license fee by rule, modifies eligibility requirements for examination for licensure of foreign-trained professionals, deletes provisions re special license for pediatric technicians, includes acupuncture under provisions regulating advertisement by health care providers of free or discounted services, etc. Amends Ch 455, repeals 455-2182 Effective Date 10/01/88

02/22/88 HOUSE Prefiled
03/30/88 HOUSE Referred to Regulatory Reform; Finance & Taxation; Appropriations
04/05/88 HOUSE Introduced, referred to Regulatory Reform, Finance & Taxation; Appropriations
04/13/88 HOUSE Withdrawn from Regulatory Reform, Finance & Taxation, Appropriations, Withdrawn from further cons., Iden /Sim / Compare Bill passed, refer to SR 1031 (Ch 88-205) & HB 1626 (Ch 88-392) - HJ 167

H 498 GENERAL BILL/CS by Health Care; Smith; Renke; Kelly and others (Similar CS/ENG/S 1078, Compare H 131, H 217)

Patient Records/Copying Fees, provides limitation on copying fees charged by health care facilities & health care practitioners for providing copies of patient records, provides for confidentiality & provides exception Amends 395-017, 455-241 Effective Date Upon becoming law.

03/04/88 HOUSE Prefiled
03/17/88 HOUSE Referred to Health Care, Appropriations
04/16/88 HOUSE Introduced, referred to Health Care, Appropriations - HJ 50
04/07/88 HOUSE On Subcommittee agenda - Health Care, 04/11/88, 1:15 pm, 317C
04/11/88 HOUSE Subcommittee Recommendation pending ratification by full Committee Favorable with 1 amendment, On Committee agenda - Health Care, 04/13/88, 3:30 pm, 317C - Not considered
04/18/88 HOUSE Subreferred to Subcommittee on Health Regulation
04/19/88 HOUSE On Committee agenda - Health Care, 04/21/88, 9:00 am, 317C - Temporarily passed
04/22/88 HOUSE On Committee agenda - Health Care, 04/26/88, 1:15 pm, 317C
04/26/88 HOUSE Preliminary Committee Action by Health Care Favorable as a Committee Substitute
05/03/88 HOUSE Comm Report, CS by Health Care - HJ 317, CS read first time - HJ 315, Now in Appropriations - HJ 317
05/10/88 HOUSE Withdrawn from Appropriations - HJ 361, Placed on Calendar
05/31/88 HOUSE Placed on Special Order Calendar
06/01/88 HOUSE Retained on Regular Calendar
06/07/88 HOUSE Died on Calendar, Iden /Sim / Compare Bill passed, refer to CS/SB 1076 (Ch 88-206)
H 800 GENERAL BILL by Health & Rehabilitative Services; Deutsch (Compare CS/CS/H 598, CS/ENG/H 644, S 771, CS/B 887, S 1274)
Adult Congregate Living Facilities, makes it unlawful to knowingly refer person for residency to unlicensed facility, requires H R S Dept to maintain list of licensed facilities in each district & to provide certain notice, provides for right of entry into & inspection of said facilities, prohibits license renewal for facilities with outstanding fines, requires H R S Dept to conduct study of mentally ill persons residing in such facilities, etc Amends Ch 400, 381-4935 Effective Date 10/01/88
03/14/88 HOUSE Prefiled
03/22/88 HOUSE Referred to Health & Rehabilitative Services -HJ 58
04/07/88 HOUSE Subreferred to Subcommittees on Aging, Mental Health and Substance Abuse, On subcommittee agenda—Health & Rehabilitative Services, 04/11/88, 3:30 pm, 16-HOB—Temporarily passed
04/12/88 HOUSE On subcommittee agenda—Health & Rehabilitative Services, 04/16/88, 8:00 am, 24-HOB
04/14/88 HOUSE Subcommittee Recommendation pending ratification by full Committee Favorable with 4 amendments, On Committee agenda, pending subcommittees action—Health & Rehabilitative Services, 04/14/88, 9:00 am, 21-HOB, Preliminary Committee Action by Health & Rehabilitative Services Favorable as a Committee Substitute
04/25/88 HOUSE Comm Report, CS by Health & Rehabilitative Services, placed on Calendar —HJ 249, CS read first time —HJ 249
04/26/88 HOUSE Placed on Special Order Calendar, Read second time —HJ 252
05/03/88 HOUSE Read third time, HJ 249, CS read first time —HJ 249
05/04/88 SENATE In Messages
05/10/88 SENATE Received, referred to Health and Rehabilitative Services —SJ 264
05/19/88 SENATE Extension of time granted Committee Health and Rehabilitative Services
05/19/88 SENATE On Committee agenda—Health and Rehabilitative Services, 05/23/88, 2:00 pm, Room—A
05/23/88 SENATE Comm Report Favorable with 2 amendment(s) by Health and Rehabilitative Services, placed on Calendar —SJ 366
05/30/88 SENATE Placed on Special Order Calendar —SJ 463
05/31/88 SENATE Placed on Special Order Calendar —SJ 549, CS passed as amended, YEAS 34 NAYS 0 —SJ 549
06/01/88 HOUSE In Messages
06/01/88 HOUSE Was taken up—HJ 1187, Considered, CS passed as amended, YEAS 115 NAYS 0 —HJ 1190
06/01/88 Ordered engrossed, then enrolled
06/21/88 Signed by Officers and presented to Governor
07/06/88 Vetted by Governor, refer to CS/H 844 (Ch 88-350)

H 738 GENERAL BILL by Bass (Compare ENG/H 1628, CS/B 600)
Medical Review Committee/Immunity, adds committees of specified professional service corporations operated for practice of medicine to definition of "medical review committees" for purpose of making applicable thereto duties & immunities of such medical review committees. Amends 768 40. Effective Date 10/01/88
03/23/88 HOUSE Prefiled
03/31/88 HOUSE Referred to judiciary
04/05/88 HOUSE Introduced, referred to Judiciary —HJ 69
04/12/88 HOUSE Subreferred to Subcommittees on Court Systems, Probate and Consumer Law, On Committee agenda—Judiciary, 04/14/88, 3:30 pm, 214C—For ratification of substitute bill passed, refer to HB 1628 (Ch. 88-392)
H 819 GENERAL BILL/CS/CS/ENG by Appropriations, Regulatory Reform; Judiciary; Upchurch; Simon (Similar CS/S 879, Compare ENG/H 69, H 131, H 217, CS/S 89)

Medical Incident: provides for director of Medical Quality Assurance Div of Prof Reg Dept, provides for quarterly medical incident reports by licensed health care facilities, provides for proceedings for summary suspension or restriction of license of health care practitioner, provides for reports in lieu of certain psychiatric patient records, amends provisions created by Ch 88-1 (Medical Incident), etc. Amends FS; Appropriation $20,000,000 Effective Date 07/05/88

03/20/88 HOUSE Note: This bill amended 1988 Special Session 'E' CS/SB 6-E, Ch 88-1, Profiled

04/06/88 HOUSE Introduced, referred to Regulatory Reform, Appropriations -HJ 76, Subcomm of Regulatory Reform, On committee agenda—Regulatory Reform, 04/07/88, 10:00 am, Morris Hall


04/12/88 HOUSE On Committee agenda—Appropriations, 04/14/88, 10:00 am, Morris Hall

04/19/88 HOUSE Comm. Report, CS/CS by Appropriations, placed on Calendar --HJ 206, CS read first time--HJ 206

04/21/88 HOUSE Placed on Special Order Calendar, Read second time, Amendment adopted --HJ 222

04/25/88 HOUSE Read third time, CS passed as amended. YEAS 114 NAYS 0--HJ 217

04/26/88 SENATE In Messages

05/03/88 SENATE Received, referred to Commerce; Appropriations--SJ 220

05/10/88 SENATE Extension of time granted Committee Commerce

05/27/88 SENATE Extension of time granted Committee Commerce

06/01/88 SENATE Withdrawn from Commerce; Appropriations--SJ 645, Substituted for CS/SB 870--SJ 646, CS passed as amended, YEAS 32 NAYS 0--SJ 671

06/01/88 HOUSE In Messages

06/2/88 HOUSE Was taken up--HJ 1226; Amendments to Senate amendments adopted, Concurrent in Senate amendments as amended. CS passed as further amended. YEAS 113 NAYS 0--HJ 1226

06/2/88 SENATE In Messages

06/03/88 SENATE Was taken up--SJ 817, Concurrent, CS passed as amended, YEAS 36 NAYS 1--SJ 820

06/07/88 Ordered engrossed, then enrolled

06/17/88 Signed by Officers and presented to Governor

07/07/88 Approved by Governor, Chapter No. 88-277

H 1058 GENERAL BILL by Morse (Similar CS/S 483, Compare ENG/H 1826, CS/600)

Nursing/Protocol & Discipline: amends provision re protocol for advanced in specialized nursing practice to require that copy of protocol be filed with Professional Reg Dept.; amends provision re disciplinary actions to authorize Board of Nursing, as disciplinary measure, to restrict nursing practice. Amends 464.040, 018 Effective Date 10/01/88

04/06/88 HOUSE Filed

04/15/88 HOUSE Introduced, referred to Regulatory Reform; Appropriations--HJ 100

06/07/88 HOUSE Died in Committee on Regulatory Reform, Iden /Sim / Compare bill passed, refer to HB 1626 (Ch 85-92)

H 1861 GENERAL BILL by Health Care; Guber; Abrams (Compare CS/ENG/H 1873)

Registered Nurse/Shortage, directs Hospital Cost Containment Board to conduct special study of nursing shortage in Fla., stipulates necessary content of said study, provides for special technical assistance panel, provides for completion Appropriation: $200,000 Effective Date Upon becoming law

04/27/88 HOUSE Filed

05/02/88 HOUSE Introduced, referred to Appropriations--HJ 284

06/07/88 HOUSE Died in Committee on Appropriations, Iden /Sim / Compare bill passed, refer to CS/HB 1673 (Ch 85-94)
H 1828 GENERAL BILL/ENG by Regulatory Reform; Lippman; Kelly and others (Similar CS/S 600, Compare H 131, H 392, H 736, H 1058, CS/H 1646, CS/H 1847, CS/S 88, S 191, CS/ENG/S 481, CSS 483, S 1016, ENG/S 1031, CS/S 1188, CS/S 1178)

Professional & Occupational Boards, provides that dept. licensing exam questions & answers are not subject to discovery in admin. proceeding; licens boards created by other chapters within D P R., provides exception for certain physicians re appointment to board, limits liability of certain past board members, requires certain practitioners to provide copies of records to patients on request, adds to membership of Impaired Practitioners Committee, etc. Amends F S Effective Date 10/01/88 except as otherwise provided.

05/04/88 HOUSE Note This bill amends 1988 Special Session 'E' CS/SB 6-E, Ch 88-1, Filed
05/23/88 HOUSE Introduced, referred to Appropriations - HJ 627
05/26/88 HOUSE Withdrawn from Appropriations - HJ 826, Placed on Calendar
05/31/88 HOUSE Placed on Special Order Calendar; Read second time - HJ 968; Amendments adopted, Read third time, Passed as amended, YEAS 115 NAYS 0 - HJ 971
06/01/88 SENATE In Messages
06/03/88 SENATE Received, referred to Economic, Community and Consumer Affairs - SJ 916, Immediately withdrawn from Economic, Community and Consumer Affairs, Substituted for CS/SB 600 - SJ 916, Passed as amended, YEAS 35 NAYS 0 - SJ 919
06/03/88 HOUSE In Messages
06/06/88 HOUSE Concurred, Motion to reconsider tabled, Passed as further amended, YEAS 115 NAYS 1 - HJ 1628
06/06/88 HOUSE Ordered engrossed, then enrolled
06/21/88 HOUSE Signed by Officers and presented to Governor
07/06/88 HOUSE Approved by Governor, Chapter No &----382

H 1626 GENERAL BILL/CS by Appropriations, Regulatory Reform, Lippman; Kelly, Sansom (Similar CS/ENG/H 72, ENG/H 1268, CS/S 88)

Construction Industry/Regulation, provides for membership, quorum, & probable case panels of Construction Industry Licensing Board, provides for renewals & fees, provides enforcement mechanism re persons engaged in contracting who are not certified & registered, provides for certification by endorsement, provision for issuance & renewal of certificates & registrations, provides responsibilities of primary & secondary qualifying agents, etc Amends Chs Ch 489, 276 303, 455 240, Appropriation $28,000 Effective Date 10/01/88 except as otherwise provided.

05/04/88 HOUSE Filed
05/11/88 HOUSE Introduced, referred to Finance & Taxation, Appropriations - HJ 447
05/12/88 HOUSE Withdrawn from Finance & Taxation - HJ 470, Now in Appropriations - HJ 470
05/23/88 HOUSE On Committee agenda - Appropriations, 05/24/88, 8:00 am, Morris Hall
05/24/88 HOUSE Preliminary Committee Action by Appropriations Favorable as a Committee Substitute
05/27/88 HOUSE Comm Report CS by Appropriations, placed on Calendar - HJ 908, CS read first time - HJ 904
05/31/88 HOUSE Placed on Special Order Calendar, Idem/Sim Senate Bill substituted, Laid on Table under Rule, Idem /Sim / Compare Bill passed, refer to CS/SB 155 (Ch 88-155), CS/HB 72 (Vetoed by Governor 07/06/88) & HJ 1626 (Ch 88-382) - HJ 1032
MISC. CORRESPONDENCE, PROPOSALS, ETC.
December 8, 1987

Pamela Birch Fort
Staff Director, Florida Senate
Committee on Commerce
410 Senate Office Building
Tallahassee, Florida 32399-1100

Dear Ms. Fort:

Thank you for the opportunity to review the preliminary draft of the proposed Senate Bill relating to health care particularly with regard to neurologically impaired infants as well as the House preliminary draft as well. In addition, I reviewed the academic task force medical malpractice recommendations and have had the opportunity in the past to discuss some of my concerns with Professor Dewar at the Academic Task Force in Gainesville.

As I discussed on the telephone with you my primary concern relates to a careful definition of "birth-related neurologic injury" that defines the population at risk so that a number can be provided by our CMS Perinatal System to provide estimates from which actuaries can project the potential cost of this legislation to both the state and society at large.

I will address my comments predominantly to preliminary draft 3-279-88 and the definition on page 10 of Birth-Related Neurologic Injury with the existing language and what I would propose as potentially more quantitative and more appropriate for consideration. The existing draft states: "Birth-related neurologic injury means an injury in a live birth to the brain or spinal cord of an infant that is caused by the deprivation of oxygen, or by mechanical injury, which occurs in the course of labor, delivery or resuscitation in the immediate post delivery period in a hospital and that renders the infant permanently non-ambulatory, aphasic, incontinent, and in need of assistance in all phases of daily living." (Overstrike marks the portion that should be rewritten as below.)

I would submit for your consideration a definition that avoids the conjunctive use of all of the conditions enumerated being required as we have no data base to project either the medical propriety or the actual number of infants who are the combination of non-ambulatory and aphasic and incontinent and in need of assistance in all phases of daily living. I would submit for your consideration substitute language: "and that renders the infant profoundly neurologically and developmentally impaired by an assessment of__
standardized infant development with a mental development index less than equal to 50, such as but not limited to, the Bayley scale of infant development or an alternative test as designated by the Perinatal Advisory Council, administered at not later than 24 months or if at a later age a neurologic and developmental evaluation at a Florida Children's Medical Services developmental center which demonstrates that the child is non-ambulatory and/or aphasic and in need of assistance in all phases of daily living."

With that definition in view it is possible to provide the data in Attachment I which is an analysis of data as a composite derived from the Dept. of HRS, Children's Medical Services Perinatal Data System from July 1, 1980 to June 30, 1987 and most specifically for the time period of July 1 to Dec. 31, 1985 to coincide with the Neonatal Intensive Care Study of the Florida Hospital Cost Containment Board published January 1987 which documents all neonatal care in the State of Florida for the period of July 1 to Dec. 31, 1985. Although the incidence and occurrence data are for the period of six months, I have annualized the estimates of severely impaired children by birthweight categories of the extremely low birthweight premature, the medium range premature infant and the full term infant to give a total population of 333 annually at a time when Florida had 163,732 births. I would estimate 185,000 births in 1987 such that 1987 occurrence data should be increased by 13% for a total of 376 severely and profoundly neurologically impaired children. Projections for 1988 can be derived from the Division of Health.

It must be recognized that this may be a worst case scenario inasmuch as there are a number of significant disclaimers that must be considered in assessing the validity of this data. I will try to enumerate some of the assumptions:

1. Infants with congenital anomalies, genetic anomalies or overwhelming illnesses not of obstetric origin who have neurologic defects may be included in this data. Additional resources would need to be devoted to remove such patients from the data base and decrease the incidence. This is potentially achievable through the Department of Pediatrics at the University of Florida in Gainesville.

2. This study assumes that all abnormal children are evaluated.

3. This study assumes that the incidence is equal in non-state funded RPICCs to the State funded RPICCs when in most likelihood by evaluation of acuity the State funded RPICCs care for the sickest infants.

4. This study does not allow for late deaths because of the morbidity of the primary illness which would decrease the pool and is known to occur with increased frequency.

5. This study assumes that all infants who needed NICU access were provided same and that all cases were reported.

6. This study assumes that all profoundly injured infants at the time of birth were provided services in one of the 39 identified newborn special care centers. It must be recognized that only 10 of those were state funded.

7. Some infants may not have been evaluated who have hospitalization durations of one year or more and continue as ventilator dependent children.

8. These statistics are derived from data in 1985; because of technologic developments in improved ventilation there may be more survivors who are neurologically impaired in 1987/88.
I recognize that all of this detail is extremely overwhelming and that the magnitude is much greater than anticipated by those who drafted this preliminary bill. I do not think the data is unrealistic; it is verifiable and must be viewed in the context of the assumptions that I have enumerated.

Dr. Michael Resnick, Dr. Mario Ariet, Dr. Richard Buccarelli and Dr. G. S. Schiebler at the University of Florida have been extremely helpful in providing access to this information along with the full support of Dr. William Ausbon, CMS Program Director to support the need for current information to guide legislative planning. We will all be happy to cooperate as members of the State University System in providing further information to guide your considerations.

I will correspond separately on behalf of the Florida Pediatric Society who have asked me to comment with regard to some of the issues in addition to the definition in this bill.

Sincerely,

John S. Curran, M.D.
Professor and Acting Chairman
Department of Pediatrics
CMS Neonatal Consultant

cc: Gerold Schiebler, M.D.
    Michael Resnick, Ph.D.
    Mario Ariet, M.D.
    W. W. Ausbon, M.D.
    R. Buccarelli, M.D.

Attachment
### ANALYSIS OF DATA COMPOSITE
SIX MONTHS 1985
State RPICC and HCCB Derived Data

<table>
<thead>
<tr>
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<td>RPICC</td>
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<td>RPICC</td>
<td>NonRPICC</td>
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<td>( \leq 50 )</td>
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<tr>
<td>500-1000g</td>
<td>163</td>
<td>-</td>
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<td>1112</td>
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<td>2671</td>
<td>1847</td>
<td>13.3%</td>
<td>1131</td>
<td>3.7%</td>
</tr>
</tbody>
</table>

6 MONTH DATA
with the Association is adjudicated by the Joint Conference Board under the terms of the agreement, an individual employer enjoys no direct representation; rather, the individual employer is forced to rely upon the union for representation on the Joint Conference Board. If the union disagrees with the individual employer's construction of the agreement in a dispute between the employer and the employer association, the union can refuse to arbitrate the claim by having its five voting members on the Joint Conference Board vote with the association. In these circumstances, neutral arbitration is completely precluded. The union, of course, owes no statutory or contractual duty of fair representation to the individual employers. Because the arbitral machinery makes no provision for representation of the individual employer in a dispute with the Association, the agreement lacks a fundamental characteristic of arbitration agreements—selection of the arbitrators by the parties to the dispute. Atlas, as an individual employer, cannot reasonably be expected to depend upon union representation in arbitrating a dispute with the Association over interpretation of the agreement. The Court in Schneider found a similar lack of direct representation to be evidence of the absence of any agreement to arbitrate, concluding that "[i]t is unreasonable to infer that the parties ... intended the trustees to rely on the Union to arbitrate their disputes with the employer." 466 U.S. at 375, 104 S.Ct. at 1851.

CONCLUSION

Because the collective bargaining agreement does not "manifest by plain language" the parties' intent to require disputes between an employer and its bargaining representative to be settled by arbitration, we reverse the district court's award of summary judgment and remand with instructions to enter judgment for Atlas.

REVERSED.

Timothy A. PATRICK, M.D.,
Plaintiff-Appellee,

v.


Nos. 85-3759, 85-4071.

United States Court of Appeals,
Ninth Circuit.

Argued and Submitted March 4, 1986.

Doctor brought action against doctors who were partners in medical clinic for violations of Sherman Act and for interference with prospective economic advantage under Oregon law. The United States District Court for the District of Oregon, Edward Leavy, J., awarded judgment on jury verdict against some of the defendant doctors and clinic on Sherman Act claims and awarded damages against some of the doctors on state law claim, and doctors appealed. The Court of Appeals, Fletcher, Circuit Judge, held that: (1) state action doctrine exempted from federal antitrust liability medical peer review-associated activities; (2) failure to instruct as to various state law immunities was error, for purposes of state law claim; and (3) judgments against defendant doctors on state law claim would be reversed and remanded for new trial based on failure to instruct.

Reversed and remanded.

1. Monopolies 12(15.5)

State action doctrine exempts from federal antitrust laws actions by state such as passage of laws by legislature or pro-
mulation of rules by state Supreme Court acting in its legislative capacity.

2. Monopolies \(\equiv\) 12(15.5)

State action doctrine, exempting from federal antitrust laws actions by state, is grounded in history or language of Sherman Act, neither of which suggests that the Act was intended as limit on actions of state. Sherman Anti-Trust Act, \$ 1 et seq., 15 U.S.C.A. \$ 1 et seq.

3. Monopolies \(\equiv\) 12(15.5)

When challenged activity is not undertaken directly by legislature or state Supreme Court, but rather is carried out by others pursuant to state authorization, "closer analysis" is required to determine whether state action doctrine applies to exempt challenged activity from federal antitrust laws.

4. Monopolies \(\equiv\) 12(15.5)

To acquire immunity from federal antitrust laws under state action doctrine, activity not undertaken directly by legislature or state Supreme Court must be taken pursuant to clearly articulated and affirmatively expressed state policy and must be subject to active supervision by state.

5. Monopolies \(\equiv\) 12(15.5)

To demonstrate "clear articulation" of state policy, so as to permit activity not undertaken directly by legislature or state Supreme Court to be exempted from federal antitrust laws under state action doctrine, actors need not point to specific authority for anticompetitive activity, but rather, it is enough that they show that legislature contemplated kind of activity complained of, that is, that legislature intended to replace competition with regulation in relevant market.

6. Monopolies \(\equiv\) 12(15.5)

Oregon, by compelling doctors to review their competitors, has affirmatively expressed policy to replace pure competition with some regulation, for purposes of determining whether peer review-related activities are exempted from federal antitrust laws under state action doctrine. ORS 441.015(1), 441.030, 441.055(3)(c, d).

7. Monopolies \(\equiv\) 12(15.5)

Supervision by Oregon Board of Medical Examiners, a state agency, was equivalent to supervision by state, for purposes of determining whether peer review-related activities mandated by Oregon statutes were exempted from federal antitrust laws under state action doctrine.

8. Monopolies \(\equiv\) 12(15.5)

Combination of internal review by hospitals, review by Oregon Board of Medical Examiners, and review by courts constitutes adequate supervision of peer review-related activities mandated by Oregon statutes, for purposes of exempting such activities from federal antitrust laws under state action doctrine.

9. Monopolies \(\equiv\) 12(15.5)

Doctor's activities as member of Oregon Board of Medical Examiners were exempt from federal antitrust liability under state action doctrine, despite another doctor's complaints about actions taken as part of BOME's consideration of complaints against medical practitioners; complained-about doctor gave BOME information about practitioners, participated in discussion of case, and drafted reprimand letter, but BOME was state agency authorized by legislature to receive such complaints and investigate and act on them. ORS 677.265, 677.415.

10. Monopolies \(\equiv\) 12(15.5)

Actions within scope of state official's authority, taken pursuant to express state policy, which are contemplated by statutory scheme, are actions of state, and therefore immune from liability under federal antitrust laws.

11. Monopolies \(\equiv\) 12(15.5)

Once Court of Appeals has determined that state has acted to replace competition with regulation in given market, out of respect for sovereignty of state, federal antitrust laws are displaced, and subjective motivations of individual actors protected by state action doctrine are irrelevant.
12. Monopolies $=12(15.5)$

Whether state agents or others acting pursuant to state authorization have acted in bad faith is generally question for state courts, with state action doctrine protecting such actions from federal antitrust liability.

13. Monopolies $=12(15.5)$

Fact that Oregon only immunizes good-faith medical peer review activity demonstrated that complaining doctor had state law remedy for any actions taken against him in bad faith, but did not alter basic fact that challenged actions that were related to peer review activity mandated by Oregon statutes were those of state, for purposes of applicability of state action doctrine to exempt such actions from federal antitrust liability. ORS 41.675(4).

14. Federal Courts $=944$

Judgment for doctor on federal antitrust claims would be reversed and remanded to district court for determination of whether doctor had actionable antitrust claims remaining based on conduct other than peer review process mandated by Oregon statutes, where much of the evidence presented related to actions associated with peer review process that were exempt from federal antitrust laws under state action doctrine

15. Federal Courts $=933$

Grant of attorney fees awarded to doctor who brought federal antitrust action as prevailing party in antitrust action would be reversed, where judgment for doctor on antitrust claims was being reversed and remanded. Clayton Act, § 4, 15 U.S.C.A. § 15.

16. Federal Courts $=638$

Where district court was aware of party's position on any issue and refuses to give instruction, no further objection is necessary to preserve refusal to give instruction for appeal.

17. Federal Courts $=638$

Antitrust defendants' claims that district court failed to instruct correctly as to various state law immunities were properly before Court of Appeals, despite plaintiff's claim that defendants did not adequately object to failure to give their instructions, where trial court granted continuing objections to instructions not given, and court was aware of defendants' position on immunities, with arguments having been made in pretrial brief and in support of motions for directed verdicts.

18. States $=79$

Doctor, who chaired investigative committee of Oregon Board of Medical Examiners, was entitled to same immunity on claim under Oregon law for interference with prospective economic advantage that judge would receive. ORS 677.335(1).

19. Federal Courts $=418$

Oregon's judicial immunity, rather than judicial immunity standards from federal civil rights cases, which might be different, governed judicial immunity applicable to doctor acting as member of Oregon Board of Medical Examiners on claim under Oregon law for interference with prospective economic advantage.

20. States $=79$

Doctor's activities as member of Oregon Board of Medical Examiners were immune from liability with respect to claim under Oregon law for interference with prospective economic advantage of another doctor unless jurisdiction of BOME was clearly absent.

21. States $=211$

Failure to give requested instruction to effect that actions undertaken by doctor as member of Oregon Board of Medical Examiners were immune from liability on claim under Oregon law for interference with prospective economic advantage was error, where all actions of doctor complained of fell within scope of his statutory duties and involved questions well within jurisdiction of BOME.

22. States $=211$

Failure to instruct that witnesses before Oregon Board of Medical Examiners were immune from civil liability for their testimony unless they committed perjury.
was error, with respect to doctors who testified before BOME and were defendants in claim under Oregon law for interference with prospective economic advantage. ORS 677.335(2).

23. States \(\equiv\text{211}\)

Failure to give requested instruction that every action on or before numerous committees mentioned in action, by doctor against other doctors for interference with prospective economic advantage based on Oregon law, was entitled to good-faith immunity was error, even though jury was instructed that defendant doctors were immune from liability for good-faith activities taken before, or as members of, ad hoc committees, where Oregon statute gave doctors who served on or communicated information to hospital committees or governing bodies good-faith immunity from civil liability, and instructions as whole did not give any indication that defendants' conduct other than that involving single ad hoc committee might be immune. ORS 41.675(4)

24. Federal Courts \(\equiv\text{911}\)

Judgment against doctor in action by another doctor under Oregon law for interference with prospective economic advantage had to be reversed, where failure to give requested instructions on various state law immunities was erroneous, most damning evidence against defendant doctor was evidence of his duplicity related to Oregon Board of Medical Examiners, and fact that such conduct was immunized would likely have affected jury decision.

25. Federal Courts \(\equiv\text{911}\)

Judgments against doctors who were defendants in action by another doctor under Oregon law alleging interference with prospective economic advantage would be reversed, even though award of punitive damages against doctors made it unclear how much significance should be attached to erroneous failure to give instruction on availability of good-faith immunity under Oregon law, where jury had been instructed on several theories that might result in liability of defendant doctors, making it impossible to say which theory or theories jury adopted, it could not be determined to what extent jury was influenced by immunized conduct of another defendant doctor in arriving at its damage figures, and proper instruction with respect to various state law immunities would more likely than not have changed either determination of liability or of damages as to the defendant doctors.


Herbert H. Anderson, Theodore C. Falk, Spears, Lubersky, Campbell, Bledsoe, Anderson & Young, Portland, Or., for amicus curiae Oregon Ass'n of Hospitals.


Appeal from the United States District Court for the District of Oregon.

Before FLETCHER, ALARCON and WIGGINS, Circuit Judges.

FLETCHER, Circuit Judge:

Appellants, partners in the Astoria Clinic, a medical clinic, appeal from a jury verdict in favor of Dr. Timothy Patrick, a surgeon in Astoria, for violations of Sherman Act sections 1 and 2 and for interference with prospective economic advantage under Oregon law. Because the conduct at the heart of the antitrust claims is exempt from liability under the state action doctrine, we reverse the judgment on the Sher-
man Act claims. Because the trial court failed to instruct the jury properly as to applicable statutory immunities, we reverse the judgment on the state law claims as well. We remand to the district court for determination of whether Patrick has antitrust claims that survive and for a new trial on the state law claim.

BACKGROUND

Astoria is a city of 10,000 people located in the northwest corner of Oregon. The only hospital in Astoria is Columbia Memorial. Columbia Memorial is a secondary hospital capable of handling some, but not all, forms of complex surgery. The nearest hospital, Ocean Beach Hospital in Ilwaco, Washington, is a primary care hospital. During the relevant time frame, a majority of the Columbia Memorial medical staff were employees or partners of the Astoria Clinic.

Appellee Timothy Patrick is trained in general and vascular (blood vessel) surgery. In 1972, he joined the Astoria Clinic. After his initial one-year contract expired, he was asked to become a partner. Because he felt he had not been paid in proportion to the income he had produced for the Clinic, he chose to open an independent practice in Astoria. James Weber is a general surgeon who came to Astoria as an employee of Patrick in 1979. Patrick fired him in 1981 and Weber, in turn, set up an independent practice in Astoria.

Appellants William Burget, Jorma Leinasser, Richard Kettlekamp, Patrick Meyer, Gary Boelling, Robert Niekes, Franklin Russell, Leigh Dolin, Richard Harris and Daniel Rappaport were all partners in the Astoria Clinic when this suit was filed in 1981. Appellant Tzu Sung Chiang was added to the suit when he became a partner in 1982.

1. We present the evidence in the light most favorable to Patrick.

2. Hospitals are classed as primary, secondary and tertiary in increasing order of sophistication.

From the outset the doctors in the Clinic reacted negatively to Patrick’s establishment of an independent practice. Patrick received virtually no surgical referrals from the Clinic. During a period when there was no general surgeon at the Clinic, patients were referred to hospitals 50 or more miles away for surgery. If Patrick (or Weber, when he was associated with Patrick) treated a “Clinic patient,” the Clinic doctors would react angrily. The record contains several examples of confrontations resulting from the perceived theft of patients. Some of these took place in front of the patients themselves. The Clinic doctors also were not interested in helping Patrick with his own patients. Clinic surgeons consistently refused to enter into cross-coverage agreements with Patrick that would provide care for each other’s patients if one of them needed to be out of town. Clinic doctors also were reluctant to give consultations. At the same time, the Clinic doctors repeatedly criticized Patrick for failure to get outside consultations and adequate back-up coverage.

The pattern of treatment of emergency room patients suggested that the Clinic doctors were attempting to make Patrick’s patients their own and to prevent new ones from seeing him. Witnesses testified that they had come to the emergency room, asked for Dr. Patrick, and were told he was not available. Later, they discovered that Patrick was available and that no attempt had been made to contact him. Emergency room patients without a regular doctor tended to be treated by Astoria Clinic doctors rather than Patrick or Weber. During the period when the Clinic had no general surgeon, surgical emergencies were often sent to out of town hospitals rather than to Patrick.

The Clinic doctors explained that their reluctance to deal with Patrick was due to his contentiousness and lack of skill. However, the only other partner at the time the suit was filed, Leroy Steinmann, was originally named as a defendant, but was dismissed at the close of Patrick’s case at trial.
ever, there was uncontroverted testimony that Patrick never had any trouble getting along with the doctors at Ocean Beach and that he had been offered a partnership in the Astoria Clinic. There also was a great deal of testimony that Patrick was quite a good surgeon.

In the fall of 1979, after Weber had joined Patrick, the difficult relations between Patrick and the Clinic doctors erupted into more serious confrontations. The Clinic doctors attacked Weber in various ways soon after his arrival, and they increased their hostility toward Patrick. However, as soon as Weber left Patrick's employ, he was invited to join the Clinic.

An incident that triggered disciplinary action against Patrick occurred shortly after Weber's arrival. Patrick operated on a Mr. Willie to repair injuries suffered in an accident. Patrick almost immediately left town for the weekend. He left Weber in charge, even though Weber was scheduled to leave for Chicago Sunday morning. Patrick told Weber to check in on Willie early Sunday and, if he looked fine, to ask Dr. Linehan, a general practitioner, to cover until Patrick's anticipated return Sunday afternoon. Weber checked on Willie at 5:00 a.m. and finding him stable, left for Chicago.

Before Patrick returned, Willie's condition worsened. The nurses called Dr. Linehan, who did not feel competent to handle the problem that had arisen. Without calling Patrick, who was only 90 minutes away by car, Linehan asked Dr. Boelling for help. Boelling refused, saying that he had bailed Patrick out enough. The hospital chief of staff then assigned Dr. Harris, a Cl-previous to the case, Patrick would have returned immediately had he been called.

Boelling wrote a letter complaining about Weber's handling of the case. The hospital staff executive committee decided to refer the Willie matter to the Oregon Board of Medical Examiners (BOME) along with charts from 14 other cases handled by Patrick. At the time this committee sent the charts, the three-member investigative committee of the BOME was chaired by Dr. Russell of the Astoria Clinic. Drs. Boelling and Harris testified at the request of the investigative committee.

When Patrick and Weber met with the investigative committee, they were assured that the Willie case was the only case of Patrick's under review. Russell told them he would not participate in discussion of the case because of a "conflict" between them and his "group." However, the chairman of the BOME, Dr. Tanaka, was never informed of the conflict of interest, and Russell proceeded to brief the whole Board on Patrick's cases. Patrick and Weber then spoke with the full Board; again, only the Willie case was discussed.

The BOME voted to issue a reprimand letter. Russell was asked to draft it. The Board issued Russell's draft, with some changes made by the BOME administrator. The letter stated that it was based on the evaluation of fifteen charts; it criticized Patrick's handling of the Willie case, and noted that Patrick was careless in his medical practices generally. After receiving the letter, Patrick wrote to the BOME requesting a review of the proceedings. Over Russell's objection, the BOME sent Patrick a list of the 14 other charts that had been reviewed. Patrick had not been the treating doctor in some of the cases. He again wrote to the BOME, threatening legal action unless a new hearing was granted or the letter withdrawn. Again over Russell's objection, Tanaka agreed to meet with Patrick.

At the meeting, Patrick acknowledged that the BOME's criticism of the Willie matter was justified. After discussion of the other charts, Tanaka agreed the letter overstated matters. However, the BOME did not retract or amend the letter after Russell indicated that he knew of other cases of Patrick's that would justify the criticism. After Patrick filed a petition for judicial review, the BOME retracted the letter entirely.

In the peer review proceedings within the hospital, Patrick's cases were reviewed.
by Clinic doctors, were discussed more often and criticized more thoroughly than those of other surgeons. For a period of several months, while Dr. Harris was Chief of Surgery, Patrick was given no cases of other doctors to review at all. He threatened to withdraw from the peer review process completely unless it was administered fairly. A rotating system of review was established and, subsequently, there were fewer problems. However, Patrick put forth numerous examples at trial to demonstrate that cases of other doctors similar to those that got him into serious trouble went unreviewed by the hospital’s processes.4 Harris, in particular, seems to have been free from scrutiny.

In 1981, at Harris’s urging, the medical staff began proceedings to terminate Patrick’s privileges at the hospital. The executive committee voted to recommend termination of privileges because Patrick’s care of his patients was below the standards of the hospital. Patrick was allowed a hearing at which the executive committee presented the case against him, and he presented a defense. The charges against Patrick were drawn up at a meeting at the Astoria Clinic board room attended by the hospital administrator, an attorney appointed by the hospital to represent the executive committee, Drs. Kettlekamp and Harris. The charges originally encompassed 21 cases, some of which were not Patrick’s. The nine cases that eventually comprised the evidence against Patrick were selected from a period in which Patrick had performed 2000-2500 surgeries. Of the nine, two were performed while Patrick was still at the Astoria Clinic. The experts at trial disagreed as to the magnitude of Patrick’s errors in the nine cases. The jury easily could have concluded that the mishaps in the cases did not justify termination of privileges.

Dr. Boelling chaired the ad hoc committee that heard the charges and the defense. Boelling agreed to serve as chairman despite the fact that he had testified to the BOME against Patrick about some of the cases that were before the committee. Patrick did not learn of this conflict of interest until several months after the proceedings were initiated.

At the hearings, Patrick attempted to show that the peer review process had treated his cases differently from analogous cases of other doctors. The committee was inattentive during his presentation. Patrick’s counsel asked the doctors on the committee to testify as to their personal knowledge of the cases discussed as part of the defense and as to their personal biases against Patrick. The committee members refused. Patrick, convinced that the outcome was preordained, and reluctant to allow the revocation of hospital privileges to appear on his record, resigned from the hospital. He then applied for, and was granted, staff privileges at Ocean Beach Hospital.

Patrick filed this suit in early 1981 before the proceedings to terminate his hospital privileges were concluded. He alleged violations of sections 1 and 2 of the Sherman Act and interference with prospective economic advantage under Oregon law. Trial commenced December 3, 1984. The jury returned a verdict against Drs. Russell, Boelling and Harris on the section 1 count, against “The Astoria Clinic” on the section 2 count, and awarded Patrick $650.

4. The most serious evidence of unequal treatment involved a Dr. McLaughlin, an alcoholic. In his early years in Astoria, there were times he could not be reached when he had been drinking. In 1978, while employed by Dr. Foster, a non-Clinic doctor, McLaughlin had some sort of breakdown during an operation and could not proceed. The hospital chiefs of staff and of surgery told Foster that he would have to chaperone McLaughlin whenever he operated. Foster fired McLaughlin, who then set up independent offices in the Astoria Clinic building. Although he began attending Alcoholics Anonymous meetings after his breakdown, he subsequently appeared in the emergency room intoxicated. He did not report himself to the BOME as an impaired physician until he had been attending AA meetings for two years. None of the behavior was ever the subject of peer review proceedings. After being moved to the Clinic building, McLaughlin received the bulk of the orthopedic referrals from the Clinic doctors and was elected Chief of Staff of the hospital.
000 for the antitrust violations, which the court trebled. The jury also awarded $20,000 in compensatory and $90,000 in punitive damages against Boelling, Russell and Harns on the state law claim. The court awarded Patrick $228,600 in attorney's fees. The Clinic doctors timely appeal.

DISCUSSION

I. Antitrust Claims

[1, 2] Appellants claim that their peer review activities at the hospital and in the BOME were mandated by statute and are exempt from federal antitrust liability under the state action doctrine. The doctrine exempts from the antitrust laws actions by the state such as passage of laws by the legislature or promulgation of rules by the state Supreme Court acting in its legislative capacity. *Hoover v. Ronwin*, 466 U.S. 558, 567-68, 104 S.Ct. 1988, 1994-95, 80 L.Ed.2d 590 (1984). The doctrine is grounded in the history or language of the Sherman Act, neither of which suggests that the Act was intended to limit the actions of a state. *See Parker v. Brown*, 317 U.S. 341, 350-51, 63 S.Ct. 307, 313, 87 L.Ed. 315 (1943).

[3, 4] When the challenged activity is not undertaken directly by the legislature or Supreme Court, but rather is carried out by others pursuant to state authorization, "closer analysis" is required. *Hoover*, 466 U.S. at 568, 104 S.Ct. at 1995. "In such cases, it becomes important to assure that the anticompetitive conduct of the state's representative was contemplated by the state." *Id.* To acquire antitrust immunity, such conduct must be *clearly articulated and affirmatively expressed state policy and must be subject to active supervision by the state.* *Southern Motor Carriers Rate Conference, Inc. v. United States*, 471 U.S. 48, 105 S.Ct. 1721, 1727, 85 L.Ed.2d 36 (1985), *see Hoover*, 466 U.S. at 569, 104 S.Ct. at 1995; *Llewellyn v. Crothers*, 765 F.2d 769, 773 (9th Cir.1985).

[5] To demonstrate "clear articulation," the defendants need not point to specific authority for anticompetitive activity; it is enough that they show that the legislature contemplated the kind of activity complained of. *Town of Hallie v. City of Eau Claire*, 471 U.S. 34, 105 S.Ct. 1713, 1719, 85 L.Ed.2d 24 (1985) *See Benson v. Arizona State Board of Dental Examiners*, 673 F.2d 272, 276 n. 8 (9th Cir.1982). That is, it must be clear that the legislature intended to replace competition with regulation in the relevant market. *Southern Motor Carriers*, 105 S.Ct. at 1731.

[6] Oregon's statutory scheme demonstrates such an intent. Oregon requires that its health care facilities be licensed. Or.Rev.Stat. § 41.015(1). To maintain the license, the governing board of each facility must insure that procedures exist for granting or restricting privileges of the medical staff and that the medical staff is organized in such a manner as effectively to review one another's professional practices at the facility to reduce morbidity and mortality and to improve patient care. Or. Rev.Stat. §§ 41.030, 41.055(3)(c) & (d). Under the Oregon scheme, consumers are not given unlimited choice as to the physicians they prefer; the hospitals can restrict patients' access to doctors whose performances are determined to be substandard. Moreover, the scheme mandates that other doctors take an active part in the regulation. Thus, peer review constitutes regulation by competitors, especially in a small community such as Astoria or in a very specialized field. *See Marrese v. Interequal, Inc.*, 748 F.2d 373, 388 (7th Cir.1984), cert. denied, — U.S. —, 105 S.Ct. 3501, 87 L.Ed.2d 632 (1985). Compulsion is the best evidence of a state policy. *Southern Motor Carriers*, 105 S.Ct. at 1729; *see Town of Hallie*, 105 S.Ct. at 1720. Oregon, by compelling physicians to review their competitors, affirmatively has expressed a to this statutory scheme.
policy to replace pure competition with some regulation.\footnote{Oregon also provides good faith immunity to the participants in the peer review process. Or. Rev. Stat. § 41.675(4). One court has held that of market conditions or “pointed reexamination” of the program).

\footnote{6} The peer review process is supervised actively by the state. To maintain licenses, health care facilities regularly must review privilege termination and restriction procedures to assure their conformity to applicable law. Or. Rev. Stat. § 441.030, 441.0563(c). When a health care facility terminates or restricts the privileges of a physician, it must promptly report to the BOME all facts and circumstances that caused the termination or restraint. Or. Rev. Stat. § 441.820(1). Supervision by the Board, a state agency, is equivalent to supervision by the state. Benson, 673 F.2d at 278. The hospital’s decisions terminating or restricting privileges are also judicially reviewable. Oregon courts have reviewed adverse privilege decisions to determine if they were made in good faith pursuant to fair procedures and were supported by the facts. See Straube v. Emmanuel Lutheran Charity Board, 287 Or. 375, 600 P.2d 381, 386-87 (1979), cert. denied, 445 U.S. 966, 100 S.Ct. 1657, 64 L.Ed.2d 242 (1980); Huffaker v. Bailey, 273 Or. 273, 540 P.2d 1398, 1401 (1975); see also Or. Rev. Stat. 41.6755) (rule that peer review proceedings confidential inapplicable in judicial proceedings challenging adverse privilege decision). The combination of internal review by the hospital, review by the BOME, and review by the courts constitutes adequate supervision. See Tambone v. Memorial Hospital, 635 F.Supp. 508, 514-15 (N.D. Ill. 1986) (no state supervision where records of peer review not automatically transmitted to state agencies); see also Hoover, 466 U.S. at 572 n. 22 (availability of judicial review evidence of state action); cf. California Liquor Dealers Ass’n v. Mutual Aluminum, Inc., 445 U.S. 97, 105-06, 100 S.Ct. 937, 943, 63 L.Ed.2d 223 (1980) (no supervision of state authorized resale price maintenance where no review of reasonableness of price schedules, no monitoring of market conditions or “pointed reexamination” of the program).

The Seventh Circuit, addressing Indiana’s scheme, which is nearly identical to Oregon’s, has concluded that peer review is exempt from antitrust liability. Marreros v. Interqual, Inc., 748 F.2d 373 (7th Cir. 1984). The court in Marreros stated that given the state statutory scheme, “it runs contrary to the very concepts of state sovereignty and federalism for a federal court to review the conduct of a peer review committee, under the guise of the Sherman Act...” Id. at 395.

Patrick points out that a recent district court case, Quinn v. Kent General Hospital, Inc., 617 F.Supp. 1226 (D. Del. 1985) disagrees with the result reached by Marreros. See 617 F.Supp. at 1238-39. The Quinn court found that peer review proceedings, properly applied, do not restrict competition and concluded that the state had not intended to replace competition with regulation by mandating peer review. Id. at 1239 & n. 10. We disagree. The peer review process allows doctors to agree to eliminate a competitor from the market because they believe his or her product is substandard. An analogous scheme would allow General Motors, Chrysler and Ford to review the safety of Toyotas to determine if the public should be allowed to drive them. Clearly such an arrangement would raise antitrust concerns. The fact that the state’s regulations may be wise and in the best interest of consumers does not alter the fact that the regulations limit free competition. See FTC v. Indiana Federation of Dentists, — U.S. —, 106 S.Ct. 2009, 2020, 90 L.Ed.2d 445 (1986).

\footnote{8} Dr. Russell’s activities as a member of the BOME also are exempt from antitrust liability under the state action doctrine. Patrick complains about Russell’s actions taken as part of the BOME’s consideration of complaints against medical practitioners (Patrick and Weber). Russell gave the Board information such immunity alone demonstrates clear articulation. See Tambone v. Memorial Hospital, 635 F.Supp. 508, 513 (N.D. Ill. 1986).
tion about the practitioners, participated in discussion of the case, and drafted a reprimand letter. The BOME is the state agency authorized by the legislature to receive such complaints and to investigate and act on them. Or.Rev.Stat. §§ 677.255, 677.415. Actions within the scope of a state official’s authority, taken pursuant to express state policy, which are contemplated by the statutory scheme, are actions of the state and therefore immune. See Llewellyn, 765 F.2d at 774-75; see also Southern Motor Carriers, 105 S. Ct. at 1730 (immunity available when state agency’s activity taken pursuant to policy approved by state legislature). Russell’s activities meet this test.

[11, 12] There was substantial evidence that the defendants acted in bad faith in the hospital’s peer review process and in the BOME proceedings. Patrick argues that the state action doctrine does not immunize bad faith conduct. This argument misconstrues the nature of the doctrine. Once we have determined that a state has acted to replace competition with regulation in a given market, out of respect for the sovereignty of the state, federal antitrust laws simply are displaced. See Hoover, 465 U.S. at 574, 104 S.Ct. at 1998. The subjective motivations of the individual actors are irrelevant. Llewellyn, 765 F.2d at 774; see Hoover, 465 U.S. at 581 n. 34, 104 S.Ct. at 2002 n. 34. Actions otherwise immune do not “forfeit that protection merely because the state’s attempted exercise of its own power is imperfect in execution under its own law.” Llewellyn, 765 F.2d at 774; see Hoover, 465 U.S. at 572 n. 22, 104 S.Ct. at 1997 n. 22. (whether state committee followed applicable state Supreme Court rules irrelevant to applicability of the doctrine); Sonitrol of Fresno, Inc. v. American Telephone & Telegraph Co., 629 F.Supp. 1089, 1097-1100 (D.D.C. 1986) (state action doctrine applies to acts of ratesetting agency despite tactics of deception and misrepresentation of phone companies seeking rate increases). Whether state agents or others acting pursuant to state authorization have acted in bad faith is generally a question for the state courts. See id. (quoting Areeda, Antitrust Immunity for “State Action” After Lafayette, 95 Harv.L.Rev 435, 453 (1981)). “A contrary conclusion would compel the federal courts to intrude upon internal state affairs whenever a plaintiff could present colorable allegations of bad faith on the part of defendants.” Id.

[13] Patrick cites the statute that immunizes good faith peer review activity to demonstrate that Oregon has authorized only good faith conduct. See Or.Rev.Stat. § 41.675(4). However, we doubt that a state ever authorizes bad faith actions as such, any more than it authorizes errors of fact or law or procedural irregularities. See Llewellyn, 765 F.2d at 774; Areeda, 95 Harv.L.Rev. at 450. The fact that Oregon only immunizes good faith conduct demonstrates that Patrick had a state law remedy for any actions taken against him in bad faith, but does not alter the basic fact that the actions challenged in this case were those of the state. See generally Marrese, 748 F.2d at 932 (applying state action doctrine despite similar good faith immunity statute).

[14, 15] Because much of the evidence presented in this case related to actions exempt under the state action doctrine, we reverse the judgment on the antitrust claims and remand to the district court to determine if Patrick has actionable antitrust claims remaining based on conduct other than the peer review process.

II. State Law Claim

[16-21] Appellants argue that we must reverse the judgment on the state law claim because the district court failed to instruct the jury correctly as to various

7. We do not decide whether Patrick may have waived any state law remedies by resigning rather than completing the review process and appealing to the Oregon courts.

8. Because attorney’s fees were awarded to Patrick as prevailing party in an antitrust action, see 15 U.S.C. § 15 (1982), we also reverse the grant of fees.
state law immunities.\textsuperscript{9} Dr. Russell, as a member of BOME, is entitled to the same immunity that a judge would receive. Or. Rev.Stat. § 677.335(1). Under Oregon law, judges are immune from personal liability for acts taken in the performance of judicial business unless jurisdiction for their actions is clearly absent.\textsuperscript{10} \textit{Utley v. City of Independence}, 240 Or. 384, 402 P.2d 91, 92-93 (1965); \textit{Quast v City of Ontario}, 43 Or.App. 557, 603 P.2d 1210, 1210-11 (1979); \textit{see Higgins v. Redding}, 34 Or.App. 1029, 580 P.2d 580 (1978) Immunity applies even if the judge’s jurisdiction is questionable. \textit{Utley}, 402 P.2d at 92. Dr Russell’s activities as a member of BOME therefore were immune unless jurisdiction was clearly absent: As we have noted, all the actions complained of fell within the scope of his statutory duties and involved questions well within the jurisdiction of the BOME. Thus, the trial court erred by failing to give the requested instruction to the effect that actions undertaken as a member of BOME are immune from state law liability.

\textbf{[22, 23]} Witnesses before the BOME are immune from civil liability under Oregon law for their testimony unless they commit perjury. Or.Rev.Stat. § 677.335(2). The trial court erred in not giving an instruction to reflect that immunity as applied to Drs. Boelling and Harris. Finally, doctors who serve on or communicate information to hospital committees or governing bodies have good faith immunity from civil liability. Or.Rev.Stat. § 41.675(4). The jury was told that the defendants were immune from liability for good faith activities taken before, or as members of the ad hoc committees.\textsuperscript{11} However, every action on or before any of the numerous committees mentioned in this case was entitled to good faith immunity. The trial court erred in failing to give defendants’ requested instruction making that clear.\textsuperscript{12}

\textbf{[24, 25]} To require reversal, error in a civil case must more probably than not have affected the verdict. \textit{Haddad v. Lockheed California Corp.}, 720 F.2d 1454, 1459 (9th Cir.1983). The judgment against Dr. Russell must be reversed. The most damning evidence against him was the evidence of his duplicity at the BOME; the fact that this conduct was immunized would likely have affected the jury’s decision. The case for reversing the judgments against Drs. Harris and Boelling is closer. The jury, by awarding punitive damages against them, found that some of their conduct amounted to “deliberate disregard for the rights of others or reckless indifference to such rights.” We believe this equates to a finding of bad faith. Thus, it is unclear how much significance should be attached to the absence of a good faith immunity instruction. However, the court instructed the jury on several theories that might result in liability of the

9. Patrick contends that appellant did not adequately object to the failure to give their instructions, and so these complaints are not properly before this court. However, the trial court granted continuing objections to instructions not given. Where a trial court is aware of a certain prejudice and refuses to give an instruction, no further objection is necessary to preserve it for appeal. See \textit{Brown v. Aventco Investment Co.}, 603 F.2d 1347, 1371 (9th Cir. 1979). In this case, the court was aware of the Clinic doctors’ position on immunities (the arguments were made in the pretrial brief and in support of motions for directed verdicts), and so the issues are properly before us.

10. Patrick argues that judicial immunity standards from federal civil rights cases should govern. See, \textit{e.g.}, \textit{Stump v. Sparkman}, 435 U.S. 349, 98 S.Ct. 1099, 55 L.Ed.2d 331 (1978) However, the issue is to what extent Oregon has immuni-
making it impossible to say which theory or theories the jury adopted. Moreover, since the verdict form did not require the jury to allocate responsibility for damages to particular defendants or particular conduct, we cannot tell whether or to what extent the jury was influenced by Russell's immunized conduct in arriving at its damage figures. The jury was not properly instructed on immunity: to wit, that Boelling and Harris were immune from liability for their testimony before the BOME, that all defendants had qualified immunity as to their conduct pertaining to the various hospital committees; and that Russell had absolute immunity for his conduct as chairman of BOME. Proper instruction with respect to the various immunities would more likely than not have changed either the determination of liability or of damages as to Boelling and Harris. Thus, we reverse the judgments against all three defendants on the state law claim and remand for a new trial.

CONCLUSION

On remand, the district court must determine whether sufficient evidence remains in the case to permit retrial of the antitrust claims. There is no doubt that the evidence, viewed in the light most favorable to Patrick, reveals shabby, unprincipled and unprofessional conduct on the part of the defendants. However, the State of Oregon regulates its health care industry through mandatory peer review and thereby immunizes much of the conduct complained of. The state action doctrine limits Patrick's remedy under the antitrust laws. It does not preclude antitrust liability for anticompetitive conduct outside the peer review process, nor does it preclude resort to state law claims or remedies available in state court.

REVERSED and REMANDED.

13. The court outlined five theories by which the defendants could be liable: refusing to call Patrick when emergency room patients asked for him; failing to refer prospective patients to him; refusing to continue treatment of patients who

UNITED STATES v. WALLACE

Defendant was convicted in the United States District Court for the Central District of California, Manuel L. Real, Chief Judge, of transporting stolen goods having value in excess of $5,000 in interstate commerce and of boarding airplane while concealing dangerous weapon, and he appealed. The Court of Appeals, William D. Browning, District Judge, sitting by designation, held that: (1) evidence indicating ease with which blank airline tickets could be filled in to make tickets appear valid provided reason for jury to find that tickets in defendant's possession had value in excess of $5,000, and (2) district court correctly determined, as matter of law, that "stun gun" was dangerous weapon.

Affirmed.

1. Criminal Law § 577.14

Speedy Trial Act did not require that 30-day trial preparation period begin anew upon filing of substantially similar, superseding indictment and, thus, defendant's speedy trial rights were not violated when trial judge ordered him to stand trial within 30 days. 18 U.S.C.A. § 3161 et seq.

requested Patrick's surgical services; general interference with Patrick's relationships with individual patients; and causing the loss of his staff privileges.
ANTITRUST LAWS—STATE ACTION EXEMPTION
70 L Ed 2d 973

ANNOTATION

WHAT CONSTITUTES "STATE ACTION" UNDER RULE
EXEMPTING STATE AND LOCAL GOVERNMENTAL ACTION
FROM ANTITRUST LAWS—FEDERAL CASES

by

David H. Bathe, J D.

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54 Am Jur 2d, Monopolies, Restraints of Trade, and Unfair
Trade Practices §§ 15, 16
Annotat10ns: See the related matters listed in the annotation,
infra
12 Federal Procedural Forms, L Ed, Monopolies and R estrants of Trade §§ 48.101 et seq
18 Am Jur Pl & Pr Forms (Rev Ed), Monopolies, Restraints of
Trade, and Unfair Trade Practices, Forms 21–30
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I. Introduction

§ 1. Prefatory matters

[a] Scope
In Parker v Brown (1943) 317 US 341, 87 L Ed 315, 63 S Ct 307, the US Supreme Court established a judge-made "state action" exemption from the federal antitrust laws. Under this doctrine, a state, in exercising its sovereign powers, is exempted from the restraints of the federal antitrust laws, and may therefore permissibly undertake certain anticompetitive measures, which would be unlawful if performed by individuals.

This annotation collects and discusses federal cases in which courts, expressly relying on Parker v Brown (1943) 317 US 341, 87 L Ed 315, 63 S Ct 307, have ruled upon the applicability of the state action exemption to particular governmental or public sector conduct of a state alleged to be in violation of the federal antitrust laws.

For purposes of this annotation, governmental or public sector conduct of a state is defined to include actions undertaken by the state legislature, the state executive "branch," the state judicial "branch," state regulatory agencies, independent state boards, commissions and authorities, and subdivisions of the state, such as counties and municipalities.

[b] Related matters
Applicability of federal antitrust laws as affected by other federal statutes or by Federal Constitution 45 L Ed 2d 841.

Minimum fee schedules for attorneys as constituting violation of Sherman Act 15 USCS §§ 1 et seq 44 L Ed 2d 818 (see especially § 6 regarding applicability of state action exemption).

"Learned profession" exemption in federal antitrust laws 15 USCS §§ 1 et seq 39 ALR Fed 774

Application of doctrine exempting from federal antitrust laws joint efforts to influence legislative or executive action 17 ALR Fed 645

Valid governmental action as conferring immunity or exemption from private liability under the federal antitrust laws 12 ALR Fed 329

§ 2. Summary

The Supreme Court did not clarify for 32 years its ruling in Parker v Brown (1943) 317 US 341, 87 L Ed 315, 63 S Ct 307, infra § 3, that states in the exercise of their sovereign powers, were exempt from the federal antitrust laws (§ 3, infra). Beginning with Goldfarb v Virginia State Bar (1975) 421 US 773, 44 L Ed 2d 572, 95 S Ct 2004, 1975-1 CCH Trade Cases ¶ 60355, reh den 423 US 886, 46 L Ed 2d 118, 96 S Ct 162, infra § 4, the Supreme Court broke its silence on the applicability of the state action doctrine to particular sovereign or governmental
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conduct of a state in a series of decisions which limited the availability of the doctrine. These decisions, indicating that not every act of a state is automatically exempted from the antitrust laws, established certain standards which are required to be met for the exemption to apply.

The standards for application of the doctrine, as articulated by the Supreme Court and lower court decisions, insist that in order for the exemption to apply, the alleged anticompetitive activity must be "manifested" by the state acting as sovereign (§ 4, infra). Additionally, the challenged restraint must be clearly articulated and affirmatively expressed as state policy, and the policy must be actively supervised by the state itself (§ 5, infra). Some decisions also indicate that the importance of the state's regulatory interest in the matter is also to be considered in determining the applicability of the state action doctrine (§ 6, infra). Also, the courts have established that municipalities and other political subdivisions of a state may avail themselves of the doctrine, but only if the anticompetitive activities of the subdivision are shown to have a sufficient nexus to an anticompetitive policy of the state, the subdivision essentially being regarded as an agent of the state for certain governmental or regulatory functions (§ 7, infra).

The federal courts have ruled on the applicability of the state doctrine to state instrumentalities and subdivisions in a variety of factual contexts, their primary focus being on the particular alleged anticompetitive activities themselves, rather than on the particular regulatory field pursuant to which the actions took place. The regulatory fields in which particular activities of state instrumentalities have been examined in determining the applicability of the state action doctrine include regulation of professional groups (§ 8, infra), alcohol and tobacco (§ 9, infra), transportation (§ 10, infra), insurance (§ 11, infra), education (§ 12, infra), and other miscellaneous fields (§ 13, infra). In regard to municipalities or other local governmental units, the regulatory fields examined include the regulation of airports (§ 15, infra) and other public facilities (§ 14, infra), utilities (§ 16, infra), land use (§ 17, infra), and alcohol and tobacco (§ 18, infra).

II. General principles

§ 3. The Parker doctrine

Beginning with the doctrine's full articulation in Parker v Brown (1943) 317 US 341, 87 L Ed 315, 63 S Ct 307 (hereinafter referred to as the Parker Case), the U.S. Supreme Court has generally adhered to the principle that a state, acting in its sovereign capacity, is exempted from the restraints of federal antitrust laws when pursuing conduct which otherwise would be violative of such laws if carried out by an individual.

In the Parker Case, the court ruled upon the validity, under the Sherman Act (15 USCS §§ 1 et seq.), of a California agricultural prorate program, whereby a state agricultural prorate advisory commission was created to adopt and enforce regulatory programs for the marketing of agricultural commodities produced in the state, so as to restrict competition among growers and maintain prices in the distribution of the commodities to packers. The court stated that the Sherman Act is not intended to restrain "a state or its officers or agents from activities directed by its legis-
"According to the court, such an intent is not likely to be attributed to Congress, given the nation’s "dual system of government in which, under the Constitution, states are sovereign, save only as Congress may constitutionally subtract from their authority." The court held that the California prorate program was thus exempt from the Sherman Act, finding that it was never intended to operate by force of an agreement or a combination between individuals, but rather, it derived its authority and efficacy from the legislative command of the state, and was not intended to operate or become effective without that command. The court recognized that a state does not give immunity to those who violate the Sherman Act merely by authorizing them to violate it, or by declaring an action to be lawful. The court nevertheless upheld the validity of the program, even though producers proposed the prorate zones for marketing programs which also required the approval of the producers, the court finding that it was the state, acting through the commission, which ultimately adopted and enforced the program in the execution of a governmental policy.

§ 4. Prerequisite of doctrine that state require the anticompetitive action as sovereign

It has been recognized in cases applying the state action doctrine of Parker v Brown (1943) 317 US 341, 87 L Ed 315, 63 S Ct 307, that not all actions of state instrumentalities constitute state action which is exempted from the federal antitrust laws. The following cases have either recognized or applied the rule that the threshold inquiry in determining if an anticompetitive action is state action is whether the activity is required by the state acting as sovereign, in that the conduct in question must be compelled by direction of the state acting as sovereign.


Seventh Circuit—Kurek v Pleasure Driveway & Park Dist. (1977, CA7 Ill)
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557 F2d 580, 1977-1 CCH Trade Cases ¶ 61448, motion den (CA7 Ill) 574 F2d 892, 1978-1 CCH Trade Cases ¶ 61924 and vacated for further consideration 435 US 992, 56 L Ed 2d 81, 98 S Ct 1642, 1978-1 CCH Trade Cases ¶ 61986, prior opinion reinstated on remand (CA7 Ill) 583 F2d 378, 1978-2 CCH Trade Cases ¶ 62219, cert den 439 US 1090, 59 L Ed 2d 57, 99 S Ct 873, 1978-1 CCH Trade Cases ¶ 62219, cert den 439 US 1090, 59 L Ed 2d 57, 99 S Ct 873, the court stated that the rule that an anticompetitive restraint be compelled by the state acting as sovereign in order for the state action exemption to apply is one indication that the Supreme Court was no longer inclined, if ever it was, to accept superficial and mechanical applications of a rule that antitrust inquiry ends upon a finding of governmental actions or laws being involved.

The rule as to political subdivisions, regarding the applicability of the state action doctrine, that an adequate state mandate exists for anticompetitive activities if it is found, from the authority given a governmental entity to operate in a particular area, that the legislature contemplated the action complained of (see § 7, infra) has also been applied by some lower court decisions in determining whether such a mandate exists for state-instrumentalities, as opposed to counties, or other subdivisions of the state.


Fifth Circuit—Hennessey v National Collegiate Athletic Assn (1977, CA5 Ala) 564 F2d 1136, 1977-2 CCH Trade Cases ¶ 61770, Feminist Women's Health Center, Inc v Mohammad (1978, CA5 Fla)...
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586 F.2d 530, 1978-2 CCH Trade Cases ¶ 62382, reh den (CA5 Tex) 591 F.2d 1343 and cert den 444 US 924, 62 L Ed 2d 180, 100 S Ct 262.


It was noted in Princeton Community Phone Book, Inc v Bate (1978, CA3 NJ) 582 F.2d 706, 1978-2 CCH Trade Cases ¶ 62138, cert den 439 US 966, 58 L Ed 2d 424, 99 S Ct 454, that an adequate state mandate for anticompetitive activities of governmental units exists when it is found from the authority given a governmental entity to operate in a particular area that the legislature contemplated the kind of action complained of. The court, in ruling upon the applicability of the state action doctrine to a state agency, stated that under such a rule, the state need not have contemplated the precise action complained of, as long as it contemplated the kind of action for which objection was made.

In Feminist Women’s Health Center v Mohammad (1978, CA5 Fl) 586 F.2d 530, 1978-2 CCH Trade Cases ¶ 62382, reh den (CA5 Fl) 591 F.2d 1343 and cert den 444 US 924, 62 L Ed 2d 180, 100 S Ct 262, the rule was stated to mean that an official of the state agency in question enjoys immunity to the extent that his conduct was within the scope of authority granted to his position by the state legislature, the court noting that the scope of authority may be demonstrated by explicit language in state statutes, or may be inferred from the nature of the powers and duties given to a particular governmental entity.

§ 6. Requirement that the anticompetitive restraint have sufficient nexus to state policy

A number of cases have set forth an additional standard, regarding the relation of the anticompetitive restraint to state policy, that must be met in order for the anticompetitive restraints of state instrumentalities to be considered acts of government by the state as sovereign, and therefore immune from antitrust scrutiny under Parker v Brown (1943) 317 US 341, 87 L Ed 315, 307.

The following cases have either recognized or applied the rule that for the state action rule to apply, the challenged restraint must be clearly articulated and affirmatively expressed as state policy, and that the policy must be actively supervised by the state itself.


Second Circuit—Morgan v Division of Liquor Control, etc. (1981, CA2 Conn) 664 F.2d 353, 1981-2 CCH Trade Cases ¶ 64366.

Third Circuit—Princeton Community Phone Book, Inc v Bate (1978, CA3 NJ)
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Horsemen's Benev & Protective Asso v Pennsylvania Horse Racing Com (1982, Ed Pa) 530 F Supp 1098, 1982-1 CCH Trade Cases ¶ 64004

Fourth Circuit—Highfield Water Co v Public Service Com (1980, DC Md) 488 F Supp 1176, 1980-1 CCH Trade Cases ¶ 63808

Fifth Circuit—Foley v The Alabama State Bar (1981, CA5 Ala) 648 F2d 355, 1981-1 CCH Trade Cases ¶ 64099


Seventh Circuit—Schissel v Stephens (1981, ND Ill) 525 F Supp 763, 1982-1 CCH Trade Cases ¶ 64702

Eighth Circuit—Westborough Mall, Inc v Cape Girardeau (1981, ED Mo) 532 F Supp 284

Ninth Circuit—Benson v Arizona State Bd of Dental Examiners (1982, CA9 Ariz) 673 F2d 272, 1982-1 CCH Trade Cases ¶ 64684


This rule was first articulated by the Supreme Court in Bates v State Bar of Arizona (1977) 433 US 350, 53 L Ed 2d 810, 97 S Ct 2691, 51 Ohio Ops 3d 60, 1977-2 CCH Trade Cases ¶ 61573, reh den 434 US 881, 54 L Ed 2d 164, 98 S Ct 242, where it was noted that the concern that federal antitrust policy may be unnecessarily and inappropriately subordinated to state policy is reduced where the state policy is clearly and affirmatively expressed, and the state's supervision is active.

In New Motor Vehicle Board v Orrin W Fox Co (1978) 439 US 96, 58 L Ed 2d 361, 99 S Ct 403, 1978-2 CCH Trade Cases ¶ 62349, the Supreme Court based its ruling on whether a state regulatory scheme was outside the reach of the antitrust laws under the state action doctrine. In 1978, the court ruled on whether the state regulatory scheme was a system of regulation, clearly articulated and affirmatively expressed, designed to displace unfettered business freedom in the area regulated. The court also noted that the duration of the restraint was subject to ongoing regulatory supervision.

In California Retail Liquor Dealers Asso v Midal Aluminum, Inc (1980) 445 US 97, 63 L Ed 2d 233, 100 S Ct 937, 1980-1 CCH Trade Cases ¶ 63201, it was stated that the two-pronged test for antitrust immunity under the Parker doctrine was, first, that the challenged restraint must be clearly articulated and affirmatively expressed as state policy, and second, that the policy must be actively supervised by the state itself. In ruling on whether the restraint at issue was actively supervised by the state, the Supreme Court stated that the national policy in favor of competition cannot be thwarted by creating a cloak of state involvement over what is essentially a private price-fixing arrangement, the court noting the teaching of the Parker Case that a state does not give immunity to those who violate the Sherman Act (15 USCS §§ 1 et seq.) by authorizing them to violate it, or by declaring that their action is lawful.

§ 6. Importance of state regulatory interest

The Supreme Court and a number of lower court decisions have considered the importance of the state's regulatory interest in the field in which the anticompetitive restraint is alleged to have occurred, when determining whether the state action doctrine of Parker v Brown (1943) 317 US 341, 87 L Ed 315, 63 S Ct 307, is applicable.


Third Circuit—Princeton Community Phone Book, Inc v Bate (1978, CA3 NJ) 582 F2d 706, 1978-2 CCH Trade Cases
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§ 7. Availability of Parker doctrine to state subdivisions

A number of federal court decisions have followed the principle that although municipalities or other state subdivisions are not within the Parker doctrine simply by their status as such, the anticompetitive conduct of a state subdivision is protected by the state action exemption if the conduct is carried out pursuant to state policy to displace competition with regulation or monopoly public service.


The court stated in Peoples Cab Co v Bloom (1971, DC Pa) 330 F Supp 1235, 1971 CCH Trade Cases ¶ 73686, affd on other grounds (CA3 Pa) 472 F2d 163, that it was not the intention of Congress to interfere with or restrain state action or official action directed by a state in those fields where the state has an interest and right to regulate or even limit competition in a business charged with a public trust or interest.

In Allstate Beer, Inc v Julius Wile Sons & Co. (1979, ND Ga) 479 F Supp 605, it was found necessary to examine the state’s purpose in regulating the conduct in issue in order to determine the applicability of the state action exemption, the court finding the state’s regulatory interest to be strong, where, according to the court, the responsibility for regulating the particular field has been traditionally left to the states under the U.S. Constitution.
Thus, in Lafayette v Louisiana Power & Light Co. (1978) 435 US 389, 55 L Ed 2d 364, 98 S Ct 1123, 1978-1 CCH Trade Cases ¶ 61936, the Supreme Court ruled in a plurality opinion that cities do not receive all the federal deference of the states that create them, the cities themselves not being sovereign, according to the opinion. Accordingly, the plurality opinion stated that it was unwilling to presume that Congress intended to exclude anticompetitive municipal action from the reach of the antitrust laws, merely because of their status as such, in light of the serious economic dislocations which could result if cities were free to place their own parochial interests above the nation’s economic goals reflected in the antitrust laws. However, the plurality opinion, finding that the actions of the municipalities, as instrumentalities of the state for the convenient administration of government within their limits, may reflect state policy, therefore concluded that the Parker doctrine exempts only anticompetitive conduct engaged in as an act of government by the state as sovereign, or, by its subdivisions, pursuant to state policy to displace competition with regulation or monopoly public service. Chief Justice Burger, while concurring in the judgment, disagreed with the plurality opinion in that he would supplement the inquiry as to whether there was a state policy to displace competition with regulation or monopoly public service, with a further inquiry as to whether the implied exemption from federal law was necessary in order to make the regulatory scheme work, and even then only to the minimum extent necessary. Justice Marshall, while agreeing with Chief Justice Burger’s supplemental inquiry, joined with the plurality opinion on the basis that the plurality opinion necessarily incorporated Chief Justice Burger’s concern.

The Supreme Court in Community Communications Co. v Boulder (1982) 455 US 40, 70 L Ed 2d 810, 102 S Ct 835, 1982-1 CCH Trade Cases ¶ 64448, referring to the rule that the state action
doctrine would shield municipal conduct from antitrust liability if the conduct was engaged in pursuant to state policy to displace competition with regulation or monopoly public service, stated that the rule is simply a recognition that a state may frequently choose to effect its policies through the instrumentality of its cities and towns.

It was stated in Community Builders, Inc v Phoenix (1981, CA9 Ariz) 652 F2d 823, 1981-2 CCH Trade Cases ¶ 64207, that the test to be applied, in determining whether the actions of a county were exempt under the state action doctrine, is whether the county's actions constituted conduct engaged in pursuant to state policy to displace competition with monopoly public service. The court ruled that it was not necessary for a county to have complied with all portions of the state statute constituting an explicit state policy prohibiting competition in order for the county to be exempt from the antitrust laws.

According to a number of decisions, the state policy to displace competition need not be shown by specific and detailed statutory authority in order for the state action doctrine to apply to municipalities. Rather, it is sufficient according to these decisions that it is found from the authority given a governmental entity to operate in a particular area that the legislature contemplated the kind of action complained of. The following cases have either applied or recognized this mode of analysis when determining whether a municipality or other subordinate governmental unit is entitled to the state action defense.


First Circuit—Corey v Look (1981, CA1 Mass) 641 F2d 32, 1980-81 CCH Trade Cases ¶ 63793

Second Circuit—Guthrie v Genesee County (1980, WD NY) 494 F Supp 950, 1980-81 CCH Trade Cases ¶ 63605


Thus, in Lafayette v Louisiana Power & Light Co. (1978) 435 US 389, 55 L Ed
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2d 364, 98 S Ct 1123, 1978-1 CCH Trade Cases ¶61936, a plurality of the Supreme Court stated that a political subdivision need not necessarily be able to point to a specific, detailed legislative authorization in order to assert the state action defense. According to the opinion, a subordinate governmental unit's claim to immunity is not as readily established as the claim by a state government, but an adequate state mandate for anticompetitive activities of cities and other subordinate governmental units does exist when it is found from the authority given a governmental entity to operate in a particular area that the legislature contemplated the kind of action complained of.

According to the court in Corey v Look (1981, CA! Mass) 641 F2d 32, 1980-81 CCH Trade Cases ¶63793, a political subdivision, in order to show that the legislature contemplated the kind of action complained of, must illustrate the requisite state legislative intent, absent explicit statutory language, by demonstrating by convincing reasoning that the challenged restraint is necessary to the successful operation of the legislative scheme that the state as sovereign has established.

It was stated in Grason Electric Co v Sacramento Municipal Utility Dist (1981, ED Cal) 526 F Supp 276, 1981-2 CCH Trade Cases ¶64406, that broad general organic statutes are not sufficient in order to comply with the rule that an adequate state mandate for anticompetitive activities of cities and other subordinate governmental units exists either through specific and detailed statutory language, or when it is found, from the authority given a governmental entity to operate in a particular area, that the legislature contemplated the kind of action complained of.

It has also been stated that in order for a political subdivision to be found to be acting pursuant to a state policy to displace competition, the state policy must be clearly articulated and affirmatively expressed, and must be actively supervised by the state itself.

The Supreme Court, in Community Communications Co v Boulder (1982) 455 US 40, 70 L Ed 2d 810, 102 S Ct 835, 1982-1 CCH Trade Cases ¶64448, ruled that in order for a municipal ordinance to be exempt from antitrust scrutiny, it must constitute the action of the state itself in its sovereign capacity, or a municipal action in furtherance or implementation of clearly articulated and affirmatively expressed state policy. According to the court, this requirement cannot be met where the state's position is one of mere neutrality respecting the alleged anticompetitive actions of the municipality.

Although the Supreme Court in the above case explicitly found it unnecessary upon the facts in the case to determine whether the state policy relied upon by the municipality must also be actively supervised by the state, a number of lower court decisions have either recognized or applied both the requirement that the state policy be clearly articulated and affirmatively expressed, and the requirement that the policy be actively supervised by the state.


Fifth Circuit—Affiliated Capital Corp. v Houston (1981, SD Tex) 519 F Supp 991, 1982-1 CCH Trade Cases ¶64627.


It was stated in Corey v Look (1981, CA! Mass) 641 F2d 32, 1980-81 CCH Trade Cases ¶63793, that state political subdivisions must meet the requirement that the challenged restraint be one clearly articulated and affirmatively ex-
pressed as state policy, and be actively supervised by the state itself, by reference to state statutes showing that the legislature contemplated the kind of action complained of.

Similarly, in Grason Electric Co v Sacramento Municipal Utility Dist. (1981, ED Cal 526 F Supp 276, 1981-2 CCH Trade Cases ¶ 64406, it was stated that the requirement that the state policy relied on by a political subdivision be clearly articulated and affirmatively expressed, and be actively supervised by the state itself, is an explication of the rule that the legislature must have contemplated the kind of action complained of. Therefore, it is necessary, according to the court, to inquire whether the challenged activity is done pursuant to a clearly articulated and affirmatively expressed policy to supplant competition, which is actively supervised by the state.

III. Application of Parker doctrine to particular cases

A. State regulatory activities

§ 8. Regulation of particular professions

A number of federal court decisions have held particular activities of state instrumentalities, in regulating legal and other professional groups, to be exempt from the federal antitrust laws under the state action doctrine articulated in Parker v Brown (1943) 317 US 341, 87 L Ed 315, 63 S Ct 307.

In Bates v State Bar of Arizona (1977) 433 US 350, 53 L Ed 2d 810, 97 S Ct 2691, 51 Ohio Misc 1, 5 Ohio Op 3d 60, 1977-2 CCH Trade Cases ¶ 61573, reh den 434 US 881, 54 L Ed 2d 164, 98 S Ct 242, the Supreme Court held that a disciplinary rule prohibiting commercial advertising by attorneys, imposed and enforced by the state Supreme Court and the state bar, did not violate the Sherman Act (15 USCS §§ 1 et seq.), as the disciplinary rule was exempt from the Act under the state action exemption of the Parker Case. The court found that the challenged restraint was the affirmative command of the state Supreme Court, which, according to the court, was the ultimate body wielding the state's power over the practice of law, and that the restraint was thus compelled by direction of the state acting as sovereign. Although the state bar played a part in the enforcement of the rules, the court noted that its role was completely defined by the state Supreme Court, which was found to be the real party in interest even though the state bar was the appellee, since the state bar was acting as the agent of the state court under its continuous supervision. According to the court, the concern that federal policy was being unnecessarily and inappropriately subordinated to state policy was reduced, since the disciplinary rules reflected a clear articulation of state policy with regard to state behavior, and since the rules were subject to pointed re-examination by the state Supreme Court as policymaker. The court also emphasized that the regulation of the activities of the bar was at the core of the state's power to protect the public, and that controls over solicitation and advertising by attorneys had long been subject to the state's oversight.

Similarly, the actions of members of a state Supreme Court advisory committee, alleged to have violated the Sherman Act (15 USCS §§ 1 et seq.) by issuing a binding opinion prohibiting the purchase of classified listings in a telephone directory, were held to be exempt under the state action exemption in Princeton Community Phone Book, Inc v Bate (1978, CA3 NJ) 582 F2d 706, 1978-2 CCH Trade Cases ¶ 62138, cert den 439 US 966, 58 L Ed 2d 424, 99 S Ct 454. The court based its holding on a number of factors. First, the court found that the committee was created by the state Supreme Court to serve the state judiciary, and that its members were appointed by the state Supreme Court, and thus, the sole purpose of the committee was to act as an agent of the state. Second, it was found that the state Supreme Court rules did contemplate an anticompetitive effect in allowing restrictions on the use of telephone directory listings, the court finding the intent of the rules to restrain competition in lawyer advertising in general to be sufficient for the restriction in question to have been within the contemplated anticom-
petitive effect. The court also noted that the committee bore a closer relationship to the state than do cities, and that there was unquestionably a state policy to replace competition with regulation in regard to advertising or publicizing legal services. Third, the court stated that the regulation of the bar was at the core of the state's power to protect the public. Finally, the court found the state action exemption to be applicable, notwithstanding that the committee was interpreting an unclear command of the state Supreme Court in enforcing their interpretation of the state Supreme Court's rules, since the committee was acting as part of an agency created by the state Supreme Court for the sole purpose of serving the state, the strength of that relationship to the state Supreme Court therefore counterbalancing the fact of the unclear command.

State judges were held in Adams v American Bar Assn (1975, ED Pal 400 F Supp 219, to be immune under the Parker doctrine from a suit alleging violations of the Sherman Act (15 USCS §§ 1 et seq) The judges, being sued for their setting of minimum fee schedules, their enforcement of attorney licensing statutes, and their refusal to let certain plaintiffs, none of whom were members of the bar, represent their colleagues in other criminal matters, were characterized by the court as being sued in their judicial capacity, and were therefore not subject to the antitrust laws.

It was held in Horsemen's Benev & Protective Asso v Pennsylvania Horse Racing Com (1982, ED Pa 530 F Supp 1098, 1982-1 CCH Trade Cases ¶ 64604, that a state horseracing commission was protected by state action immunity in a lawsuit alleging that the commission had violated the Sherman Act (15 USCS §§ 1 et seq) by establishing a schedule of jockey fees, the court finding that the alleged restraint was clearly articulated and affirmatively expressed as state policy, and that the restraint was actively supervised by the state. The court first held that the restraint was clearly articulated and affirmatively expressed as state policy, although the legislature did not specifically or expressly confer upon the commission the power to fix jockey fees, because the commission was authorized by the state legislature to set jockey fees, and the commission had clearly articulated and affirmatively expressed a fee schedule. Finding that the commission was not stripped of the protection of state action immunity because the commission was alleged to only passively "rubber stamp" fee schedules proposed by a jockeys' guild, the court then held that the fee schedule was actively supervised by the state, because the fee schedule was ultimately determined by a state commission, and not by private parties, and because the fee schedule was subject to pointed re-examination by the commission when it enforced the schedule with penal sanctions.

In Hitchcock v Collenberg (1956, DC Md) 140 F Supp 894, affd 353 US 919, 1 L Ed 2d 718, 77 S Ct 679, a suit challenging a state law, requiring naturopaths be licensed by state boards of medical examiners in order to practice medicine, as violative of the federal antitrust laws, the court held that the answer to the antitrust challenge was that under the Parker Case, the antitrust laws applied to individual activity and not to state activity, the actions of the state boards of medical examiners therefore being exempt from the federal antitrust laws, since all the matters charged as being in violation of the antitrust laws were regulations prescribed by the state legislature.

In Foley v The Alabama State Bar (1981, CA5 Ala) 648 F2d 355, 1981-1 CCH Trade Cases ¶ 64099, a lower court's denial of a motion for a preliminary injunction against a state bar's enforcement of disciplinary rules against lawyer advertising, alleged to be in violation of the Sherman Act (15 USCS §§ 1 et seq), was upheld, the court holding that the attorney seeking the injunction had failed to show a substantial likelihood of prevailing on the merits as to the assertion that the state action exemption of the Parker Case was inapplicable to the state bar or to the president and the general counsel of the state bar. The court reasoned that the state bar acted as an agent of the state in enforcing the disciplinary rules, since the rules of the state bar were effectively the rules.
of the state Supreme Court, and the state bar was a component of the state judiciary, subject to the supervision of the state Supreme Court.

A state board of dental examiners, alleged to have violated the Sherman Act (15 USCS §§ 1 et seq.) by allowing dentists licensed in other states to only receive restricted permits to practice as employees of charitable clinics, if they have not taken an examination of the state in question, was held in Benson v. Arizona State Bd of Dental Examiners (1982, CA9 Ariz.) 673 F2d 272, 1982-1 CCH Trade Cases ¶ 64684, to be entitled to state action antitrust immunity. The court held that the state's regulation of dentistry satisfied the criteria for application of the doctrine, the court finding, first, that the challenged system was clearly articulated and affirmatively expressed as state policy, since the statutes authorized the board to administer examinations as a prerequisite for a dental license, and to establish a system of restricted permits, and second, that the system was actively supervised by the state itself, since the system was supervised by the board as a state agency. Rejecting the argument that the board was not entitled to immunity because the legislative authority did not contemplate the anticompetitive action at issue, the court found that the board did not act outside the scope of the legislature's directives, as the statutes merely permitted, but did not mandate, that the board adopt a system of reciprocity. The court also held that the requirement was met that there exist a strong state interest in the challenged restraint, finding that state regulation of the healing professions, including dentistry, served a vital role in protecting the public, and was a traditional state function.

On the other hand, a number of other federal court decisions have held particular activities of state instrumentalities, in regulating legal and other professional groups, to not be exempt from the federal antitrust laws under the state action doctrine articulated in Parker v Brown (1943) 317 US 341, 87 L Ed 315, 63 S Ct 307.

Thus, in Goldfarb v Virginia State Bar (1975) 421 US 773, 44 L Ed 2d 572, 95 S Ct 2004, 1975-1 CCH Trade Cases ¶ 60355, reh den 423 US 886, 46 L Ed 2d 118, 96 S Ct 162, the Supreme Court held that the state action exemption from the antitrust provisions of the Sherman Act (15 USCS §§ 1 et seq.) was not applicable to the publication of a minimum fee schedule for lawyers by a county bar association, which was found not to be a state agency by the court, or to the enforcement thereof by the state bar, which was found to be a state agency. The court found that the state bar's enforcement of the minimum fee schedule, through the issuance of fee schedule reports and ethical opinions stating that deviation from minimum fee schedules might lead to disciplinary action, was not beyond the reach of the Act, since no state law or rule of the state's highest court required such activities, and although the ethical codes of the state's highest court mentioned advisory fee schedules, they did not direct either the state bar or the county bar association to supply them, or require the type of price floor which arose from their activities, and since there was no showing that the state's highest court approved the state bar's ethical opinions.

The director of a state board of medical examiners was found in Feminist Women's Health Center, Inc. v Mohammad (1978, CA5 Fla.) 586 F2d 530, 1978-2 CCH Trade Cases ¶ 62382, reh den (CA5 Fla.) 591 F2d 1343 and cert den 444 US 924, 62 L Ed 2d 180, 100 S Ct 262, on a motion for summary judgment, not to be necessarily entitled to the protection of the state action exemption of the Parker Case, the court finding that it was conceivable under the facts in the case that the director would not be entitled to immunity. According to the court, the conduct of the director, alleged to have participated in a larger conspiracy, in violation of the Sherman Act (15 USCS §§ 1 et seq.), to boycott an abortion clinic and to fix prices for abortions by using his position as director to coerce a doctor from leaving the clinic, was not within the scope of authority granted to the board of medical examiners by the state legislature. The court held that the director's alleged coercion of the doctor to leave the clinic was not in the nature of...
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a private reprimand authorized by the state medical act, since the director acted entirely on his own in the matter, there being no formal finding of guilt and no order entered by the board itself. It was also found that the director's action was not an exercise of whatever residual disciplinary power that may have been granted by the statutes, since no hearing had been held on the matter, and that the director's telephone call to the doctor could not be construed as a form of administrative warning letter authorized by statute.

In United States v Texas State Board of Public Accountancy (1978, WD Tex) 464 F Supp 400, 1978-1 CCH Trade Cases ¶62039, mod on other grounds (CA5 Tex) 592 F2d 919, 1979-1 CCH Trade Cases ¶65546, reh den (CA5 Tex) 595 F2d 1221 and cert den 444 US 925, 62 L Ed 2d 190, 100 S Ct 262, it was held that the action of a state board of public accountancy in promulgating a rule which prohibited a public accountant from making a competitive bid for professional services, alleged to violate the Sherman Act (15 USCS §§ 1 et seq.), was not exempt from the provisions of the Act under the Parker doctrine. The court, finding that the state accountancy act was cast in permissive and not mandatory language, and only allowed for the adoption of rules appropriate for maintenance of high standards of integrity in the accountancy profession, held that nowhere in the statute did the state as sovereign mandate the anticompetitive conduct required by the board's rule, that the policy was not dictated by the state, and, additionally, that it could not be said that the statute in any way concerned or contemplated the kind of action complained of.

The publication and distribution of a fee schedule by a state bar, alleged to be in violation of the Sherman Act (15 USCS §§ 1 et seq.), was also held to not be exempt from antitrust scrutiny under the state action doctrine in United States v Oregon State Bar (1974, DC Or) 385 F Supp 507, 1974-2 CCH Trade Cases ¶75400. The court first found that the state bar did not have the status of the state, but was a public corporation and an instrumentality of the judicial department, and that since the state bar was comprised of private attorneys, and the fee schedules were adopted and approved by the bar's board of governors, but not adopted or approved by the state Supreme Court or by the state legislature, the actions of the state bar could only be exempted under the state action doctrine of the Parker Case if the promulgation of the fee schedule was pursuant to a legislative mandate. The court held that there did not exist the substantial state direction and involvement required to meet the legislative mandate requirement so as to elevate the bar's activities to the plateau of state action immunity, since there was no state statute specifically authorizing the promulgation of the fee schedule, there was no federal statute explicitly recognizing or implicitly authorizing the fee schedule, and the fee schedule was not debated in public hearings or approved by a disinterested state commission. According to the court, the state code of professional responsibility adopted by the state Supreme Court, which prohibited clearly excessive fees, and prior state court decisions which referred to fee schedules in the determination of reasonable fees with apparent approval, did not amount to a legislative command that the bar formulate a fee schedule, since the state Supreme Court's prohibition against clearly excessive fees could certainly be enforced without the existence of an official fee schedule, and since the prior use of suggested fee schedules by courts was not sufficient to stamp them with the imprimatur of the state legislature.

§9. Regulation of alcohol and tobacco

Anticompetitive restraints undertaken pursuant to state programs regulating the distribution or sale of alcohol have been found in a number of instances by the federal courts not to be entitled to the state action exemption of Parker v Brown (1943) 317 US 341, 87 L Ed 315, 63 S Ct 307, on the basis that the restraints were not shown to have a sufficient nexus to the state in order to be considered governmental action. Thus, a state statutory plan for wine pricing, which required the filing of fair
was not contemplated by the legislature, the court finding that the authority's actions were not within the scope of any anticompetitive conduct which might have been characterized as having been contemplated by the legislature in order to secure complete and reliable carrier service and proper maintenance of the port facilities. The court alternatively found that the authority's conduct also failed to satisfy the requirement that the challenged anticompetitive restraint be imposed pursuant to a state policy to displace competition with regulation or monopoly public service, reasoning that the legislature had adopted no governmental policy to displace competition in the conduct of international commerce on a trade route completely removed and unrelated to Puerto Rico, but instead, had focused on insuring adequate carrier and passenger service between Puerto Rico and the mainland.

In Allegheny Uniforms v Howard Uniform Co (1974, WD Pa) 384 F Supp 460, 1974-2 CCH Trade Cases ¶75405, the court refused to grant a state port authority's motion to dismiss for failure to state a claim in a civil antitrust action alleging that the port authority had violated the Sherman Act (15 USCS §§ 1 et seq ) by conspiring with a labor union, a uniform manufacturer and a uniform distributor to subsidize the authority's operators for the purchase of uniforms for the authority's employees only if the uniforms were purchased from the defendant manufacturer and defendant distributor, and by refusing to subsidize the purchase of similar uniforms from the plaintiff uniform manufacturer. The court held that the port authority had failed to meet its burden of proof at that stage of the proceedings that, as a matter of law, state action authorized the authority to undertake the alleged action. Finding that the state legislature did not specifically empower the port authority to manufacture or sell uniforms to its operators, the court concluded that the port authority was therefore subject to the antitrust laws, even though it did have the power under its enabling legislation to require employees to wear uniforms of a specific type, design, color, and so on, and to agree to subsidize part of the purchase price, because the port authority was not performing a function mandated by the legislature.

§ 11. Regulation of insurance

Federal court decisions have also held the state action doctrine of Parker v Brown (1943) 317 US 341, 87 L Ed 315, 63 S Ct 307, to be applicable to particular activities undertaken by state entities pursuant to their regulation of the insurance industry.

It was held in Miley v John Hancock Mut Life Ins. Co (1957, DC Mass) 242 F2d 758, cert den 355 US 828, 2 L Ed 2d 41, 78 S Ct 38, that the Sherman Act (15 USCS §§ 1 et seq ) did not apply to the actions of a state commission, authorized by state statute to negotiate group insurance contracts for state employees, in allegedly conspiring with certain insurance companies to deprive another insurance company of a possible insurance contract with the commission. The court held that under the Parker Case, the Sherman Act did not apply, because the actions of the commission were undertaken pursuant to its official duties as agent of the state for the negotiation of contracts under state statute.

In Allstate Ins Co v Lanier (1966, CA4 NC) 361 F2d 870, 1966 CCH Trade Cases ¶71856, cert den 386 US 930, 17 L Ed 2d 212, 87 S Ct 290, a state automobile insurance regulatory program, which required insurance companies selling automobile liability insurance to adhere to rates established by a rating bureau composed of all insurance companies, and approved, modified, or disapproved by the state commissioner of insurance, was held to not be subject to challenge under the Sherman Act (15 USCS §§ 1 et seq ) or the McCarran-Ferguson Act (15 USCS §§ 1011 et seq ) The program, which also provided that the commissioner could approve upward deviations, but not downward deviations, from the prescribed rates, was upheld by the court under the Parker case, notwithstanding the active role of the insurance companies in establishing the rates, because the rating bureau was under the
active supervision of the state through the state commissioner of insurance.

In determining the applicability of the state action doctrine of Parker v Brown (1943) 317 US 341, 87 L Ed 315, 63 S Ct 307, to a particular activity of a state entity in the field of insurance regulation, one court has held the exemption to be inapplicable to a particular activity challenged to be in violation of the antitrust laws.

Thus, a summary judgment granted in favor of a state insurance commissioner, charged with having violated the Sherman Act (15 USCS §§ 1 et seq.), on the basis that as a state official he was immune from suit, was reversed in Bankers Life & Casualty Co v Larson (1958, CA5 Ill) 257 F2d 377, cert den 358 US 879, 3 L Ed 2d 109, 79 S Ct 117, the court framing the issue to be whether as a matter of law all of the acts done by the commissioner were official acts done for the sole purpose of carrying out his official duties, thereby immunizing him from suit, and not personal acts done as a part of a conspiracy against an insurance company. The court held that as required by the Parker case, there was no authority, statutory or otherwise, authorizing the commissioner to conspire with persons to restrain commerce or exempting them from suit if they do so, noting that the claim of immunity of the commissioner, charged with conspiring to destroy an insurance company’s business in a number of states and to prevent its expansion into other states, was really based not on any claim that if he did conspire he would nevertheless be immune, but on his insistence that everything he did was in the line of duty or within the scope of his authority as a state officer, and not as a conspirator.

§ 12. Regulation of Education

A particular activity of a state instrumentality, relating to the regulation of education, has been held not to be entitled to the state action exemption of Parker v Brown (1943) 317 US 341, 87 L Ed 315, 63 S Ct 307.

To that effect, the action of a nationally based collegiate athletic association in establishing a bylaw which limited the number of assistant coaches its member colleges could employ, alleged to be in violation of the Sherman Act (15 USCS §§ 1 et seq.), was held in Hennessey v National Collegiate Athletic Assocs (1977, CA5 Ala) 564 F2d 1136, 1977-2 CCH Trade Cases ¶ 61770, to not be entitled to the state action exemption. The court held that it was clear that the laws of the state in which the particular university employing the complaining coaches existed did not require or intend, if indeed they even permitted, the particular state university to participate in a multi-university accord which limited the number of coaches. The court also noted that one could ask whether, to be entitled to the exemption, the association would have to show that the bylaw was adopted as a result of the votes of member institutions, each member acting as directed or intended by their state legislatures.

It has also been held in a case concerning the actions of a state instrumentality in the field of education that the particular activity was exempt from the antitrust laws under Parker v Brown (1943) 317 US 341, 87 L Ed 315, 63 S Ct 307.

In Saenz v University Interscholastic League (1973, CA5 Tex) 487 F2d 1026, 1973-2 CCH Trade Cases ¶ 74803, it was held that a university interscholastic league was a state agency exempt from the Sherman Act (15 USCS §§ 1 et seq.) under the Parker doctrine. The court found that the league, alleged to have conspired to reject a complaining manufacturer’s slide rule for use in the league’s interscholastic slide rule contest, was a component of a division of the state university, which, according to the court, was inarguably a state agency or governmental body. The court held that the league was imbued with ample characteristics to warrant a determination that the league was an agency of the state, because the league was organized and administered annually as part of a division of the state university, its administrative authority, the state executive committee was appointed by the president of the university, its employees were employed and paid by the university, its office space and support facilities were provided by the university; its
that made it possible to enact the Civil Rights Act of 1964,1 or to our prior interpretation of the very provision the Court construes today. Accordingly, I respectfully dissent.

RICHARD J LAZARUS, Assistant to the Solicitor General (CHARLES FRIED, Sol Gen; DONALD B AYER, Dpy Sol Gen; CHARLES A SHANOR, Equal Employment Opportunity Commission Gen. Counsel; Gwendolyn Young Reams, Assoc Gen Counsel; Vella M Fink, Asst Gen Counsel, and Donna A Brusoski, EEOC atty, on the briefs for petitioner. JAMES L STONE Denver, Colo. (Brent T JOHNSON, and FAIRFIELD and WOODS, P.C. on the briefs for respondent.

TIMOTHY A PATRICK, PETITIONER v WILLIAM M. BURGET ET AL.

ON WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE NINTH CIRCUIT

Syllabus

No 86-1145 Argued February 22, 1988—Decided May 16, 1988

Petitioner, an Astoria, Oregon, surgeon, declined an invitation by respondents to join them as a partner in the Astoria Clinic and instead began an independent practice in competition with the Clinic. Thereafter, petitioner encountered difficulties in his professional dealings with Clinic physicians; summarizing a respondents' statement of and participation in, peer-review proceedings to terminate petitioner's privileges at Astoria's only hospital, a majority of whose staff members were employees or partners of the Clinic, on the ground that his care of his patients was below the hospital's standards. Petitioner filed suit in Federal District Court, alleging that respondents had violated §§ 1 and 2 of the Sherman Act by initiating and participating in the peer-review proceedings in order to reduce competition from petitioner rather than to improve patient care. Ultimately, the court entered a judgment against respondents, but the court of Appeals reversed on the ground that respondent's conduct was immune from antitrust scrutiny under the state-action doctrine of * * * Parker v. Brown, 317 U. S. 341 (1942), and its progeny, because Oregon has articulated a policy in favor of peer review and actively supervises the peer-review process.

Held. The state-action doctrine does not protect Oregon physicians from federal antitrust liability for their activities on hospital peer-review committees. The "active supervision" prong of the test used to determine whether private parties may claim state-action immunity requires that particular time. Thus, as true of the examples given by the majority. See ante, at 7. In the phrase "terminating work on the job-site knowing that it will resume the next day," it is the words used after the word "terminating" that convey the promise of future events, not the word "terminating" itself. The context in which "terminate" is used in § 706(c), however, negates the possibility that future activity by the State was contemplated because Congress provided that state proceedings must have been earlier terminated.

The majority seeks to construe the statute in a manner that preserves an opportunity for a State to resuscitate its proceedings upon the conclusion of federal proceedings. Although such an advantage may be prudent, it is not covered by the statute, and the failure to afford it does not "tarnish on its head the purposes of the statute." See ante, at 11. That the statute operates to prevent concurrent jurisdiction over claims filed over 240 days after the prohibited practice occurred does not frustrate congressional intent to protect state enforcement efforts. What is being denied is not state, but federal intervention.

1See Monaco Corp v. Silver, 447 U. S. 907, 819-822 (1980). Although it is perfectly clear that nothing in the legislative history contains any suggestion that complainants in deferral States were to be allowed to proceed with less diligence than those in nondelayal States (who must file within 180 days), the Court assumes that the entire class of claims filed after 240 days is entitled to specially favored treatment. See ante, at 11. Moore v. Sunbeam Corp., 459 F. 2d 811, 822-826, 829-830 (CA7 1972). In Monaco, 447 U. S., at 821, we stated: "Congress chose to prohibit the filing of any federal charge until after state proceedings had been completed or until 60 days had passed, whichever came sooner."

Justice MARSHALL delivered the opinion of the Court.

The question presented in this case is whether the state-action doctrine of Parker v. Brown, 317 U. S. 341 (1942), protects physicians in the State of Oregon from federal antitrust liability for their activities on hospital peer-review committees.

I

Astoria, Oregon, where the events giving rise to this lawsuit took place, is a city of approximately 10,000 people located in the northwest corner of the State. The only hospital in Astoria is the Columbia Memorial Hospital (CMH). Astoria also is the home of a private group-medical practice called the Astoria Clinic. At all times relevant to this case, a majority of the staff members at the CMH were employees or partners of the Astoria Clinic.

Petitioner Timothy Patrick is a general and vascular surgeon. He became an employee of the Astoria Clinic and a member of the CMH's medical staff in 1972. One year later, the partners of the Clinic, who are the respondents in this case, invited petitioner to become a partner of the Clinic. Petitioner declined this offer and instead began an independent practice in competition with the surgical practice of the Clinic. Petitioner continued to serve on the medical staff of the CMH.

After petitioner established his independent practice, the physicians associated with the Astoria Clinic consistently refused to have professional dealings with him. Petitioner received virtually no referrals from physicians at the Clinic, even though the Clinic at times did not have a general surgeon on its staff. Rather than refer surgery patients to petitioner, Clinic doctors referred them to surgeons located as far as 50 miles from Astoria. In addition, Clinic physicians showed reluctance to assist petitioner with his own patients. Clinic doctors often declined to give consultations, and Clinic surgeons refused to provide back-up coverage for patients under petitioner's care. At the same time, Clinic physicians repeatedly criticized petitioner for failing to obtain outside consultations and adequate back-up coverage.

In 1979, respondent Gary Boelling, a partner at the Clinic, complained to the executive committee of the CMH's medical staff about an incident in which petitioner had left a patient in the care of a recently hired associate, who then left the patient unattended. The executive committee decided to refer this complaint, along with information about other cases

* * *

1 Petitioner originally named all of the partners of the Astoria Clinic as defendants. One partner, however, was dismissed from the suit at the close of petitioner's case at trial.
handled by petitioner, to the state Board of Medical Examiners (BOME). Respondent Franklin Russell, another partner at the Clinic, chaired the committee of the BOME that investigated these matters. The members of the BOME committee criticized petitioner's medical practices to the full BOME, which then issued a letter of reprimand that had been drafted by Russell. The BOME retracted this letter in its entirety after petitioner sought judicial review of the BOME proceedings.

Two years later, at the request of respondent Richard Harris, a Clinic surgeon, the executive committee of the CMH's medical staff initiated a review of petitioner's hospital privileges. The committee voted to recommend the termination of petitioner's privileges on the ground that petitioner's care of his patients was below the standards of the hospital. Petitioner demanded a hearing, as provided by hospital bylaws, and a five-member ad hoc committee, chaired by respondent Boelling, heard the charges and defense. Petitioner requested that the members of the committee testify as to their personal bias against him, but they refused to accommodate this request. Before the committee rendered its decision, petitioner resigned from the hospital staff rather than risk termination.1

During the course of the hospital peer-review proceedings, petitioner filed this lawsuit in the United States District Court for the District of Oregon. Petitioner alleged that the partners of the Astoria Clinic had violated §§ 1 and 2 of the Sherman Act, ch. 647, 26 Stat. 209, 15 U.S.C. §§ 1, 2. Specifically, petitioner contended that the Clinic partners had initiated and participated in the hospital peer-review proceedings to reduce competition from petitioner rather than to improve patient care. Respondents denied this assertion, and the District Court submitted the dispute to the jury with instructions that it could rule in favor of petitioner only if it found that respondents' conduct was the result of a specific intent to injure or destroy competition. The jury returned a verdict against respondents Russell, Boelling, and Harris on the § 1 claim and against all of the respondents on the § 2 claim. It awarded damages of $550,000 on the two antitrust claims taken together. The District Court, as required by law, see 15 U.S.C. § 15(a), 38 Stat. 731, trebled the antitrust damages.

The Court of Appeals for the Ninth Circuit reversed. See 800 F. 2d 1498 (1986). It found that there was substantial evidence that respondents had acted in bad faith in the peer-review process.1 The court held, however, that even if respondents had used the peer-review process to disadvantage a competitor rather than to improve patient care, their conduct in the peer-review proceedings was immune from antitrust scrutiny. The court reasoned that the peer-review activities of physicians in Oregon fall within the state action exemption from antitrust liability because Oregon has articulated a policy in favor of peer review and actively supervises the peer-review process. The court therefore reversed the judgment of the District Court as to petitioner's antitrust claims.

We granted certiorari, 484 U.S. — (1987), to decide whether the state action doctrine protects respondents' hospital peer-review activities from antitrust challenge.1 We now reverse.

II

In Parker v. Brown, 317 U.S. 341 (1942), this Court considered whether the Sherman Act prohibits anticompetitive actions of a State. Petitioner in that case was a raisin producer who brought suit against the California Director of Agriculture to enjoin the enforcement of a marketing plan adopted under the State's Agricultural Prorate Act. That statute restricted competition among food producers in the State in order to stabilize prices and prevent economic waste. Relying on principles of federalism and state sovereignty, this Court refused to find in the Sherman Act "an unexpressed purpose to nullify a state's control over its officers and agents." Id., at 351. The Sherman Act, the Court held, was not intended "to restrain state action or official action directed by a state." Ibid.

Although Parker involved a suit against a state officer, the Court subsequently recognized that Parker's federalism rationale demanded that the state action exemption also apply in certain suits against private parties. See, e.g., Southern Motor Carriers Rate Conference, Inc. v. United States, 471 U.S. 48 (1985). If the Federal Government or a private litigant always could enforce the Sherman Act against private parties, then a State could not effectively implement a program restraining competition among them. The Court, however, also sought to ensure that private parties could claim state action immunity from Sherman Act liability only when their anticompetitive acts were truly the product of state regulation. We accordingly established a rigorous two-pronged test to determine whether anticompetitive conduct engaged in by private parties should be deemed state action and thus shielded from the antitrust laws. See California Retail Liquor Dealers Assn. v. Midcal Aluminum, Inc., 445 U.S. 97 (1980). First, "the challenged restraint must be 'one clearly articulated and affirmatively expressed as state policy.'" Id., at 105, quoting Lafayette v. Louisiana Power & Light Co., 435 U.S. 389, 410 (1978) (opinion of BRENNAN, J.). Second, the anticompetitive conduct must "be 'actively supervised' by the State itself." California Retail Liquor Dealers Assn. v. Midcal Aluminum, Inc., supra, at 105, quoting Lafayette v. Louisiana Power & Light Co., supra, at 410 (opinion of BRENNAN, J.). Only if an anticompetitive act of a private party meets both of these requirements is it fairly attributable to the State.

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1The court below did not address any issues arising from petitioner's decision to resign from the hospital staff prior to the ad hoc committee's determination, and respondents did not raise this matter in their response to the petition for certiorari. Accordingly, we do not address the significance, if any, of petitioner's resignation.

2Viewing the evidence in the light most favorable to petitioner, as appropriate in light of the verdicts rendered by the jury, the Court of Appeals characterized respondents' conduct as "shabby, unprofessional, and unprofessional." 800 F. 2d, at 1509.

3The Court of Appeals also determined that respondent Russell's activities as a member of the BOME likewise were immune from antitrust liability under the state-action doctrine. As we read the petition for writ of certiorari in this case, petitioner has declined to challenge this holding of the Court of Appeals. Indeed, petitioner asserts that this holding makes no difference to him because he suffered little or no damage from the BOME proceedings or respondent Russell's participation therein. Because petitioner has not brought this aspect of the Court of Appeals' decision before us, we express no view as to its correctness.

4The petition for certiorari also presented the question whether, assuming that respondent Russell's activities as a member of the BOME constitute state action and thus cannot directly form the basis for antitrust liability, evidence of those activities is admissible under state rules which indicates the presence of a nonimmune conspiracy in which Russell and others engaged. A close reading of the opinion below, however, reveals that the Court of Appeals did not address this question. This Court usually would decline to consider questions presented in a petition for certiorari that have not been considered by the lower court. See, e.g., Youngblood v. Miller, 425 U.S. 321, 324 (1976) (per curiam). We see no reason to depart from this practice in the case at bar. Accordingly, we take no position on the evidentiary question raised by petitioner.

...
In this case, we need not consider the "clear articulation" prong of the *Medical* test, because the "active supervision" requirement is not satisfied. The active supervision requirement stems from the recognition that "[w]here a private party is engaging in the anticompetitive activity, there is a real danger that he is acting to further his own interests, rather than the governmental interests of the State" (Haltie v. Eau Claire, 471 U. S. 34, 47 (1985); see id., at 45 ("A private party . . . may be presumed to be acting primarily on his or its own behalf")). The requirement is designed to ensure that the state action doctrine will shelter only the particular anticompetitive acts of private parties that, in the judgment of the State, actually further regulatory policies.Id., at 46-47. To accomplish this purpose, the active supervision requirement mandates that the State exercise ultimate control over the challenged anticompetitive conduct. Cf. *Southern Motor Carriers Rate Conference, Inc v. United States*, supra, at 31 (noting that state public service commissions "have and exercise ultimate authority and control over all intrastate rates"); *Parker v. Brown*, supra, at 352 (stressing, that a marketing plan proposed by raisin growers could not take effect unless approved by a state board). The mere presence of some state involvement or monitoring does not suffice. See *Jepson v. Liquor Corp. of Hawai*., 473 U. S. 389 (1985).

Indeed, the statutory scheme reflects no other ways in which the Health Division may supervise the peer-review process. The requirement administratively requires a hospital's procedures; that authority does not encompass the actual decisions made by hospital peer-review committees. The restraint challenged in this case (and in most cases of its kind) consists not in the procedures used to terminate hospital privileges, but in the termination of privileges itself. The State does not actively supervise this restraint unless a state official has and exercises ultimate authority over private privilege determinations. Oregon law does not give the Health Division this authority: under the statutory scheme, the Health Division has no power to review private peer-review decisions and overturn a decision that fails to accord with state policy. Thus, the activities of the Health Division under Oregon law cannot satisfy the active supervision requirement of the state action doctrine.

Similarly, the BOME does not engage in active supervision over private peer-review decisions. The principal function of the BOME is to regulate the licensing of physicians in the State. As respondents note, Oregon hospitals are required by statute to notify the BOME promptly of a decision to terminate or restrict privileges. See Ore. Rev. Stat. § 441.820(1) (1987). Neither this statutory provision nor any other, however, indicates that the BOME has the power to approve or disapprove private privilege decisions. The apparent purpose of the reporting requirement is to give the BOME an opportunity to determine whether additional action on its part, such as revocation of a physician's license, is warranted. *Certainly, respondents have not shown that the BOME in practice reviews privilege decisions or that it ever has asserted the authority to reverse them.*

The only remaining alleged supervisory authority in this case is the state judiciary. The Court of Appeals agreed, that Oregon's courts directed review privilege-termination decisions and that this judicial review constitutes active state supervision. This Court has not previously considered whether state courts, acting in their judicial capacity, can adequately supervise private conduct for purposes of the state action doctrine. All of our prior cases concerning state supervision over private parties have involved administrative agencies. See, e.g., *Southern Motor Carriers Rate Conference, Inc v. United States*, 471 U. S. 48 (1985), or state supreme courts with agency-like responsibilities over the organized bar, see *Bates v. State Bar of Arizona*, 433 U. S. 350 (1977). This case, however, does not require us to decide the broad question whether judicial review of private conduct ever can constitute active supervision, because judicial review of privilege-termination decisions in Oregon, if such review exists at all, falls far short of satisfying the active supervision requirement.

As an initial matter, it is not clear that Oregon law affords any direct judicial review of private peer-review decisions. Oregon has no statute expressly providing for judicial review of privilege terminations. Moreover, we are aware of no case in which an Oregon court has held that judicial review of
peer-review decisions is available. The two cases that respondents have cited certainly do not hold that a physician whose privileges have been terminated by a private hospital is entitled to judicial review. In each of these cases, the Oregon Supreme Court assumed, but expressly did not decide, that a complaining physician was entitled to the kind of review he requested. See Straude v. Emanuel Lutheran Charity Board, 257 Ore. 373, 383, 500 P. 2d 381, 386 (1979) ("We have assumed (but not decided) for the purpose of this case that plaintiff is entitled to 'fair procedure' as a common law right"); Hufnaker v. Bailey, 273 Ore. 273, 275, 540 P. 2d 1398, 1399 (1975) ("In view of our conclusion that petitioner cannot prevail even assuming the case is properly before us, we find it unnecessary to decide these interesting questions of [reviewability]. Therefore, we assume, but do not decide, that the hospital's decisions are subject to review by mandamus.").

Moreover, the Oregon courts have indicated that even if they were to provide judicial review of hospital peer-review proceedings, the review would be of a very limited nature. The Oregon Supreme Court, in its most recent decision addressing this matter, stated that a court "should [not] decide the merits of plaintiff's dismissal" and that "[i]t would be unwise for a court to do more than to make sure that some sort of reasonable procedure was afforded and that there was evidence from which it could be found that plaintiff's conduct posed a threat to patient care."

In the FLSA context, we reverse the judgment of the Court of Appeals. The standard "willfulness" adopted in the FLSA — that the employer either knew or showed reckless disregard as to whether its conduct was prohibited by the FLSA — must be satisfied in order for the 3-year statute of limitations to apply. That standard represents a fair reading of the Act's plain language, since it comports with the general understanding that the word "willful" refers to conduct that is "voluntary," "deliberate," or "intentional," and not merely negligent. In contrast, the statute's plain language does not support the Jiffy June standard, which effectively limits the normal 2-year statute of limitations to employers who are unaware of the FLSA and its potential applicability, and thereby virtually obliterates the distinction between willful and nonwillful violations which Congress obviously intended to draw. Also rejected is the alternative, two-step standard espoused by the Secretary, whereby an FLSA violation would be deemed "willful" if the employer, recognizing it might be covered by the FLSA, acted without a reasonable basis for believing that it was complying with the statute. This standard would permit a finding of willfulness to be based on nothing more than negligence, or, perhaps, on a completely good-faith but incorrect assumption that a pay plan complied with the FLSA in all respects, and thereby fails to give effect to the plain statutory language.

799 F. 2d 80, affirmed.

STEVEJS J., delivered the opinion of the Court, in which REHNQUIST, C. J., and WHITE, O'CONNOR, SCALIA, and KENNEDY, JJ., joined. MARSHALL, J., filed a dissenting opinion, in which BRENNAN and BLACKMUN, JJ., joined.

JUSTICE STEVENS delivered the opinion of the Court.

The question presented concerns the meaning of the word "willful" as used in the statute of limitations applicable to civil
SUMMARY AND ANALYSIS

Sixth, Eighth Circuits Differ
On Abortion Notification Statutes

Two state statutory schemes that require minors to notify their parents before having an abortion met different fates this month. The U.S. Court of Appeals for the Sixth Circuit invalidated Ohio’s abortion statute, primarily because of its cumbersome “judicial bypass” procedure. The en banc Eighth Circuit, however, upheld a Minnesota scheme that requires minors to notify both parents or submit to a judicial bypass. (Akron Center for Reproductive Health v. Slaby, CA 6, No. 86-1664, 8/12/88, Hodgson v. Minnesota, CA 8 (en banc), No. 86-5423, 8/8/88)

The Ohio statute prohibits performance of an abortion on an emancipated minor unless the person performing the abortion notifies a parent 24 hours in advance or a juvenile court dispenses with the notification requirement. A minor who chooses the judicial bypass option must comply with complex pleading requirements and prove by clear and convincing evidence that she is sufficiently mature to make the decision without notification or that notification would be contrary to her best interests.

Requiring that notice be given by the person performing the abortion unduly burdens the minor’s right to an abortion, the Sixth Circuit held, emphasizing that the state offered no evidence to show that having a doctor give notice promotes the state’s interest in ensuring that a well-informed decision is made. The court also found the pleading requirements of the bypass procedure constitutionally unsound, because they limit the grounds upon which a court can consider whether notification is necessary. Moreover, the clear and convincing evidence standard unconstitutionally increases the risk of an erroneous deprivation of the right to have an abortion. Finally, the court said that the possibility of a 22 day delay under the bypass procedure is unduly burdensome, and that the confidentiality provisions of the statute are not adequate to protect the minor’s privacy. (Page 2106)

The Minnesota statute differs in several respects, most notably in its requirement that notice be given to both parents. The district court determined that the two-parent notification requirement as applied to Minnesota minors who live with one parent—some 42 percent—interfered with rather than enhanced the state’s interest in encouraging parent-child communication.

But the Eighth Circuit refused to focus on minors from broken families, examining the statute instead for its impact on minors as a whole. When viewed in that context, and when paired with a judicial bypass provision, the court concluded that the statute passes constitutional muster. (Page 2105)

Florida Hospital Peer-Review Decisions
Held Exempt From Antitrust Liability

A private hospital and members of its medical staff who participated in a decision to revoke a doctor’s staff privileges are immune from the doctor’s claim that they conspired to restrain competition in violation of the Sherman Act, the U.S. Court of Appeals for the Eleventh Circuit held August 8. In a case of apparent first impression, the court decided that judicial review provided by the Florida courts for medical peer-review decisions constitutes active state supervision for purposes of the state action exemption from antitrust liability. (Bolt v. Halifax Hospital Medical Center, CA 11, No. 84-3256, 8/8/88)

The U.S. Supreme Court has held that private conduct may be exempt from the antitrust laws if the challenged restraint on competition is “clearly articulated” as state policy and “actively supervised” by the state itself. The court in this case had little difficulty concluding that Florida law clearly articulates a policy favoring medical peer review. But the active supervision question proved more difficult.

A few months ago, in Patrick v.Burget, 56 LW 4430 (1988), the Supreme Court said that “[t]he state does not actively supervise [the termination of hospital staff privileges] unless a state official has and exercises ultimate authority over private privilege determinations.” A state official has this kind of authority only if he or she has “power to review private peer-review decisions and overturn a decision that fails to accord with state policy.”

Although it conceded that so far the Supreme Court has found active supervision only in cases involving supervision by a state agency or by a state
NEW COURT DECISIONS
Digests of Significant Opinions Not Yet Generally Reported

Antitrust

EXEMPTIONS—*

Judicial review by Florida courts of medical peer-review determinations constitutes active state supervision for purposes of state action exemption from antitrust liability.

(Bolt v Halifax Hospital Medical Center, CA 11, No 84-5256, 8/8/88)

A doctor whose medical staff privileges were revoked sued the private hospital and members of its medical staff alleging violations of the federal antitrust laws. The alleged co-conspirators were the hospital and the members of its medical staff who took part in the peer-review decision to revoke the doctor’s privileges.

We perceive no basis for holding that a hospital is legally incapable of conspiring with the members of its medical staff. Relying on the rule that a corporation cannot conspire with its officers and directors, some courts have held that a hospital likewise cannot conspire with its medical staff for purposes of liability under the Sherman Act. This analogy is faulty. A hospital and the members of its medical staff, in contrast to a corporation and its agents, are legally separate entities, and consequently there is no similar danger that what is in fact unilateral activity would be bootstrapped into a “conspiracy.”

We turn to the question whether the defendants are exempt from antitrust liability under the state action doctrine. To ensure that the state action doctrine, derived from Parker v Brown, 317 U.S. 341 (1943), is used to immunize only those activities that are truly the product of state regulation, the Supreme Court has developed a rigorous two-pronged test to be applied when a private party claims entitlement to the exemption: (1) the challenged restraint must be clearly articulated and affirmatively expressed as state policy, and (2) the conduct in question must be actively supervised by the state itself.

We have little difficulty concluding that Florida law expressed a clearly articulated policy sanctioning the kind of peer review the hospital used in reaching its decision to revoke the doctor’s privileges. The question whether Florida actively supervised peer-review determinations is a more difficult one. In Patrick v Burget, 56 LW 4430 (1988), the Supreme Court held that “[t]he state does not actively supervise the [termination of hospital staff privileges] unless a state official has and exercises ultimate authority over private privilege determinations.” A state official has this kind of authority only if he or she has “power to review private peer-review decisions and overturn a decision that fails to accord with state policy.”

A possible supervisory authority is the state judiciary. To date, the Supreme Court has found active state supervision only in cases involving supervision by a state agency, or by a state supreme court charged with regulating the professional conduct of the members of its bar. The Supreme Court has left open the question whether judicial review in the context of a traditional lawsuit may constitute active state supervision.

We perceive no principled basis for distinguishing traditional judicial review from agency review, however. The purpose of the active state supervision requirement is to ensure that the conduct in question is in fact the product of state regulation. A state may choose to regulate private economic activity through a state agency, it may just as readily choose to regulate such activity through its courts. Indeed, regulation through the judiciary may be more likely to ensure accurate implementation of the state’s policy, for courts are especially well suited to divine, interpret, and enforce legislative policy.

Although agency review and judicial review differ in some respects, these differences do not detract from our conclusion that judicial review may constitute active state supervision for purposes of the state action exemption. That judicial review may be provided without express legislative authorization does not make that review any less a form of regulation by the state. It is sufficient if the legislature clearly articulates a policy and then acquiesces in the court’s implementation of that policy. Further, that judicial review is not automatic in the sense that it must be triggered by the affirmative act of an aggrieved party does not make the state’s supervision any less effective. A legislature may conclude that the most efficient way for the state to achieve its regulatory goals is to review only those cases in which a complaint has been lodged, it may quite legitimately presume that parties who believe they have been injured by conduct inconsistent with state policy will act on their self-interest and seek redress for the wrong that has been worked against them. In terms of the state achieving its regulatory goals, then, the global result will likely closely approximate the result that would be reached if the state reviewed each decision as a matter of course.

Of course, judicial review cannot constitute active state supervision unless it is available on an established basis and is of a sufficiently probing nature. To be sufficiently probing, the scope of judicial review must first of all encompass the fairness of procedures used in reaching the decision. Furthermore, it must involve consideration of whether the criteria used by the decision-makers were consistent with state policy and whether the decision had a sufficient basis in fact. Our review of the Florida case law convinces us that such review is available in the Florida courts—Tjoftat, J.

Civil Rights

IMMUNITY—

Private defendants may assert qualified immunity defense in wrongful attachment actions under 42 USC 1983.

(Jones v Preut & Mauldin, CA 11, en banc, No 86-7415, 8/10/88)

A farmer hired an equipment repairer to fix his cotton pickers. Alabama law provides equipment repairers with a mechanic’s lien against vehicles upon which they perform work. When the repair bill was not paid, the repairer’s attorney filed actions to foreclose on the mechanic’s lien and also filed affidavits for attachment of the equipment and bonds to secure the farmer against wrongful attachment. The attachment proceedings were in conformity with Alabama law. The equipment was seized pursuant to the writs of attachment and later sold at auction.

The farmer filed a suit under 42 USC 1983 alleging that the prejudgment seizure of his cotton pickers violated his rights under the Due Process Clause. The district court found that the defendant acted in good faith reliance upon laws that were not clearly unconstitutional. This finding raises
Medical suit could set precedent

Barred surgeon challenges law

By VAL ELLICOTT
Palm Beach Post Staff Writer

WEST PALM BEACH — A Palm Beach County surgeon is waging a possibly precedent-setting fight to scrap a Florida law designed to protect doctors who discipline their peers.

The surgeon, Dr. Luis Guerrero, a former president of the Palm Beach County Medical Society, is suing Humana Hospital in West Palm Beach. He claims the hospital barred him from performing major surgery because other staff doctors in his specialty — general surgery — wanted “to eliminate him as a source of economic competition.”

That claim by itself is not unusual. Guerrero’s lawyer, Jack Scarola, said such suits will become more common as medicine becomes increasingly competitive.

“There are going to be physicians whose privileges are attacked for the wrong reasons,” Scarola said. “As doctors’ income shrinks, as federal regulations impose pressure for price reduction, you can anticipate that the same kinds of anti-competitive activities present in other industries are going to be present in the medical profession as well.”

Doctors whose staff privileges are restricted or suspended by hospital peer review committees often file retaliatory damage suits. But Guerrero is one of the first Florida physicians, if not the first, to challenge the constitutionality of the state law, lawyers say.

That law requires a doctor who sues a hospital for damages — claiming the hospital unjustifiably took away his staff privileges — to post bond to cover the legal expenses of the hospital and the individual doctors he is suing. Should he lose his case, the bond pays those expenses.

The bond requirement, passed in 1985 along with a host of other measures aimed at easing the state’s medical malpractice crisis, recognized that doctors who police their colleagues are easily intimidated by the threat of a damage suit.

The measure “protects doctors participating in the peer medical review process ... from the unmeritorious reprisal suits which had become commonplace” before the bond requirement was passed, Atlee Wampler III, Humana’s attorney, argued in court papers.

He and Humana administrator Neil Vernegaard said Guerrero’s suit threatens that protection.

In fact, said Vernegaard, if Guerrero wins his case against Humana, “it would become impossible for me to get physicians to serve on (peer review) committees.”

As a result, Guerrero’s suit “is significant not only for physician discipline, but for public safety,” because physicians reluctant to act against incompetent colleagues could allow bad doctors to continue practicing, said Stephen Masterson, general counsel to the Academy of Florida Trial Lawyers.

Guerrero claims Florida’s bond requirement violates his constitutional right to access to the courts. He says he can’t afford to put up the $150,000 it is estimated that Humana will spend initially to defend his suit.

The bond requirement allows only “the wealthiest doctors” to seek damages when they are disciplined unjustifiably by their staff at a hospital, said Scarola, Guerrero’s lawyer, of Montgomery, Searcy & Denney in West Palm Beach.

Guerrero, a general surgeon, lost the first round of his fight in July, when Palm Beach County Circuit Judge Jack H. Cook upheld the constitutionality of the bond requirement.

“While the bond restricts Dr. Guer-
supreme court in regulating the bar, the Eleventh Circuit stated that there is "no principled basis for distinguishing traditional judicial review from agency review." It cautioned, however, that judicial review does not rise to the level of active state supervision unless it is available on an established basis and is of a sufficiently probing nature.

Here, the court was satisfied that the Florida courts provide such review. The state courts have recognized that a physician whose staff privileges have been revoked has a cause of action for injunctive relief. They have also required that staff-privilege terminations be accomplished in accordance with hospital bylaws (Page 2101)

Medical Researchers Can't Exploit Body Tissues Without Patient's Consent

In a case of apparent first impression, the California Court of Appeal, Second District, declared July 21 that persons have a property right in their bodily tissues. So ruling, the court held that a patient can maintain an action for conversion against his treating physician and others who, without his consent, used cells taken from his body to develop commercially valuable pharmaceutical products. (Moore v. Regents of the University of California, Calif CtApp 2 Dist, No. B021195, 7/21/88)

After the patient's spleen was removed as part of his treatment for leukemia, his doctor and a researcher at a university hospital, without the patient's knowledge or consent, determined that his cells were unique. Through the science of genetic engineering, the defendants developed from his cells a cell-line capable of producing pharmaceutical products estimated to be worth three billion dollars by 1990. The defendants patented the cell-line along with methods of producing many products therefrom and entered into commercial agreements with private firms for rights to the cell-line and its products. They continued to take tissues from the patient for almost seven years following the removal of his spleen.

The patient brought a lawsuit based on these events. The court determined that the patient's allegation of a property right in his own tissue "is sufficient as a matter of law". The court professed difficulty in reconciling the defendants' assertion of their property interest in the removed tissue and the resulting cell-line with their contention that the source of the material has no rights therein. "Without these small indispensable pieces of plaintiff, there could have been no three billion dollar cell-line," the court said.

The fact that the defendants' skill and efforts modified the tissue and enhanced its value did not change the court's mind on the existence of a conversion. "A patient must have the ultimate power to control what becomes of his or her tissues." To hold otherwise, the court said, "would open the door to a massive invasion of human privacy and dignity in the name of medical progress." (Page 2111)

Private Defendants Enjoy Qualified Immunity In Wrongful Attachment Suit

Private defendants may assert the defense of qualified immunity in wrongful attachment suits under 42 USC 1983, according to a deeply divided U.S. Court of Appeals for the Eleventh Circuit, sitting en banc. The majority said its Aug. 10 ruling was a logical extension of Lugar v. Edmondson Oil Co., 457 US 922 (1982), which held that private defendants may be liable under Section 1983 but expressly reserved the issue of the availability of qualified immunity. (Jones v. Preuit & Mauldin, CA 11 (en banc), No. 86-7415, 8/10/88)

When a farmer failed to pay for repairs to his cotton picker, the repairer's attorney had the equipment attached, seized, and sold in accordance with Alabama law. The farmer sued under Section 1983, alleging that the attachment of his property without prior notice or hearing violated due process.

The majority reasoned that the existence of a good faith defense in common law wrongful attachment suits supports the availability of qualified immunity in present day Section 1983 suits. While public officials are accorded immunity to ensure a willing supply of public servants, the court said, "[s]imilar powerful policy considerations" support qualified immunity for private individuals here. When a citizen in good faith invokes proceedings authorized by law, he should not have to fear liability resulting from the legislature's hidden constitutional error. The court added that since Lugar "rests on the premise that private and public actors may sometimes be equated, there is little reason to deny to private defendants the type of immunity that has been granted to public defendants."

The majority further declared that the repairer could not have known that it was violating the farmer's clearly established rights, given the state of the law in 1982. Accordingly, six judges found the defendants entitled to qualified immunity, while one judge concurred in the result on other grounds.

Five dissenting judges contended that extension of qualified immunity to private individuals is unjustified because, unlike public officials, they do not exercise official discretion or formulate policy. The dissenters also argued that the procedures invoked by the repairer violated clearly established constitutional rights. (Page 2101)

IRS Can Question Propriety Of Fees Authorized By State Trial Court

The IRS is entitled to enforcement of summonses it issued in the course of investigating the propriety of
87 / 2Ans

87 - 42  Positive Damages/Interest
H 343  10, 500

87 - 173  Mediation & Arbitration
(51 = 379
10, 5,499  Comp. 573", 975
(Coll. HCF)

87 - 249  Civil Litigation/Defendants
(51 = 866  Sim., H 321

OTHER 1957 BILLS (Ex. 5,555)

H 1380
1458
1146
837
A bill to be entitled
An act relating to medical malpractice;
providing legislative intent; amending s.
627.351, F.S.; providing for additional members
and reappointment of the Board of Governors of
the Joint Underwriting Association; providing
for a premium stabilization plan with respect
to medical malpractice; requiring certain
physicians and osteopaths to obtain a minimum
level of coverage from the association;
providing for assessments against insurers;
prohibiting insurers from selling certain
malpractice coverage to physicians; providing a
repealer for the plan; creating s. 768.606,
F.S.; providing a standard of care for medical
emergencies; providing for severability;
providing an effective date.

WHEREAS, the Legislature believes it is essential to
the health and well-being of all citizens of the state that
complete medical care be available, and

WHEREAS, the Legislature finds that physicians are
faced with dramatic increases in the cost of medical
malpractice insurance coverage, notwithstanding past
legislative attempts to stabilize insurance premiums, and

WHEREAS, due to the dramatic increases in premiums,
many physicians are forced to discontinue carrying medical
malpractice insurance, thereby exposing themselves to
financial risk, and

WHEREAS, the Legislature recognizes that the absence of
adequate financial protection and affordable malpractice

CODING: Words struck are deletions; words underlined are additions.
insurance coverage may prevent persons injured by negligent medical care from recovering damages for their injuries, and

WHEREAS, the Legislature recognizes the need for physicians to maintain adequate medical malpractice insurance coverage or financial resources sufficient to satisfy claims as evidenced by the enactment of the financial responsibility requirements in 1985 and 1986, and

WHEREAS, the increase in medical malpractice insurance is most acute in the high-risk specialty areas of medical practice and has forced many physicians to curtail the provision of high-risk services and the practice of medicine in this state, and

WHEREAS, the Legislature recognizes that some physicians are reluctant to treat emergency room patients because of the risk of liability and the high cost of medical malpractice insurance, especially for high-risk specialists, and

WHEREAS, the Legislature recognizes the interdependence of physicians practicing in all medical specialties, and

WHEREAS, the Legislature seeks to stabilize the cost of medical malpractice insurance premiums for physicians practicing in high-risk medical specialties by redistributing a portion of this cost to a broader base of physicians and to hospitals, and

WHEREAS, the Legislature recognizes that hospitals constitute facilities for the provision of medical care and services and are required by law to implement safety and risk management programs, and

WHEREAS, the Legislature recognizes the dependence of hospitals on the services of physicians, and the ability of

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hospitals to control and grant staff privileges to physicians, and

WHEREAS, the Legislature finds that hospitals are the site of most incidents of medical malpractice, and

WHEREAS, requiring hospitals to be financially responsible for certain acts of physicians results in insurance cost savings through greater claims administration efficiencies and greater incentives for hospitals to implement sound safety and risk management programs, and

WHEREAS, the Legislature believes all citizens of the state will benefit from efforts to stabilize the cost of health care and maintain the availability of emergency and high-risk health care, NOW, THEREFORE,

Be It Enacted by the Legislature of the State of Florida:

Section 1. Legislative intent.--The Legislature recognizes as an important public objective the necessity to stabilize the cost of medical malpractice insurance without abrogating the right of the public to recover reasonable damages for injuries resulting from negligent medical care. The Legislature further recognizes the overwhelming public necessity to ensure the availability of medical malpractice insurance and emergency medical services. Therefore, it is the intent of the Legislature to ensure the availability and affordability of medical malpractice insurance through the premium stabilization plan established in this act. Further, it is the intent of the Legislature that existing medical malpractice insurers be utilized to service insurance contracts issued under the premium stabilization plan.

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Section 2. Paragraphs (c), (d) and (e) of subsection (4) of section 627.351, Florida Statutes, 1986 Supplement, are amended, and paragraph (k) is added to said subsection, to read:

627.351 Insurance risk apportionment plans.--
(4) MEDICAL MALPRACTICE RISK APPORTIONMENT.--
(c) The Joint Underwriting Association shall operate subject to the supervision and approval of a board of governors consisting of representatives of five of the insurers participating in the Joint Underwriting Association, an attorney to be named by The Florida Bar, a physician to be named by The Florida Medical Association, a physician to be named by the Insurance Commissioner, a dentist who is a member of the Florida Dental Association to be named by the Insurance Commissioner, and a hospital representative to be named by the Florida Hospital Association, and a representative of the general public to be named by the Insurance Commissioner.

Effective June 15, 1987, or upon the effective date of this act, whichever is later, the Insurance Commissioner shall appoint three of the five representatives of insurers, the physician, the dentist, and the representative of the general public. Also effective June 15, 1987, or upon the effective date of this act, whichever is later, The Florida Bar, the Florida Medical Association and The Florida Hospital Association shall either appoint new representatives or reappoint existing representatives. Effective July 1, 1988, the Insurance Commissioner shall appoint the other two representatives of insurers. All representatives shall serve 2-year terms and may be reappointed to subsequent terms. The board of governors shall choose, during the first meeting of the board after June 15 of each year, one of its members to

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serve as chairman of the board and another member to serve as vice chairman of the board. There shall be no liability on the part of, and no cause of action of any nature shall arise against, any member insurer, self-insurer, or its agents or employees, the Joint Underwriting Association or its agents or employees, members of the board of governors, or the department or its representatives for any action taken by them in the performance of their powers and duties under this subsection.

(d) The plan shall provide coverage for claims arising out of the rendering of, or failure to render, medical care or services and, in the case of health care facilities, coverage for bodily injury or property damage to the person or property of any patient arising out of the insured's activities, in appropriate policy forms for all health care providers as defined in paragraph (h). The plan shall include, but shall not be limited to:

1. Classifications of risks and rates which reflect past and prospective loss and expense experience in different areas of practice and in different geographical areas. To assure that plan rates are adequate to pay claims and expenses, the Joint Underwriting Association shall develop a means of obtaining loss and expense experience; and the plan shall file such experience, when available, with the department in sufficient detail to make a determination of rate adequacy. Within 60 days after a rate filing, the department shall approve such rates or rate revisions as are fully supported by the filing. In addition to provisions for claims and expenses, the ratemaking formula may include a factor for projected claims trending and a margin for
contingencies. The use of trend factors shall not be found to be inappropriate.

2. A rating plan which reasonably recognizes the prior claims experience of insureds.

3. Provisions as to rates for:
   a. Insureds who are retired or semiretired.
   b. The estates of deceased insureds.
   c. Part-time professionals.

4. Protection in an amount not to exceed $250,000 per claim, $750,000 annual aggregate for health-care providers other than hospitals and in an amount not to exceed $1.5 million per claim, $5 million annual aggregate for hospitals. Such coverage for health care providers other than hospitals shall be available as primary coverage and as excess coverage for the layer of coverage between the primary coverage and the total limits of $250,000 per claim, $750,000 annual aggregate. The plan shall also provide tail coverage in these amounts to insureds whose claims-made coverage with another insurer or trust has or will be terminated. Such tail coverage shall provide coverage for incidents that occurred during the claims-made policy period for which a claim is made after the policy period.

5. A risk management program for insureds of the association. This program shall include, but not be limited to: investigation and analysis of frequency, severity, and causes of adverse or untoward medical injuries; development of measures to control these injuries; systematic reporting of medical incidents; investigation and analysis of patient complaints; and auditing of association members to assure implementation of this program. The plan may refuse to insure any insured who refuses or fails to comply with the risk

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management program implemented by the association. Prior to
cancellation or refusal to renew an insured, the association
shall provide the insured 60 days' notice of intent to cancel
or non-renew and shall further notify the insured of any
action which must be taken to be in compliance with the risk
management program.

§. A premium stabilization plan, which shall provide
coverage to physicians as provided herein.

a. Physicians with hospital staff privileges shall
obtain coverage under the premium stabilization plan in an
amount equal to at least $250,000 per claim and $750,000
annual aggregate. All other physicians shall obtain coverage
under the premium stabilization plan in an amount equal to at
least $100,000 per claim and $300,000 annual aggregate. The
requirements of this subparagraph shall not apply to:

(I) Any physician who elects to meet the financial
responsibility requirements of s. 458.320 or s. 459.0085 by
any authorized method other than obtaining professional
liability coverage from an authorized insurer as defined under
s. 624.09, from a surplus lines insurer as defined under s.
626.914(2), or through a plan of self-insurance as provided in
s. 627.357.

(II) Any physician who is exempt from the financial
responsibility requirements of s. 458.320 or s. 459.0085 and
who chooses not to obtain professional liability coverage from
any type of insurance or self-insurance organization.

(III) Any physician who meets the financial
responsibility requirements of s. 458.320 or s. 459.0085 by
being provided professional liability coverage by a hospital
or hospitals at which the physician has staff privileges.
However, any physician electing to purchase professional
liability insurance shall purchase the amounts required by
this sub-subparagraph from the premium stabilization plan.

b. Each physician who is covered under a professional
liability insurance policy in effect on June 30, 1987, which
is issued by an insurer or self-insurance trust fund and which
meets the financial responsibility requirements of s. 458.320
or s. 459.0085, shall obtain coverage under the premium
stabilization plan upon the termination date of the policy,
but in no event later than July 1, 1988. All other physicians
shall obtain coverage beginning on July 1, 1987.

c. The premium stabilization plan shall make coverage
available to physicians in amounts up to $1 million per claim
with a $3 million annual aggregate limit. Such amounts of
coverage shall be inclusive of any amounts of coverage
required to be obtained pursuant to sub-subparagraph e.

d. The premium stabilization plan shall provide
coverage on a claims-made basis. In order to eliminate gaps
in coverage, the initial policies issued by the premium
stabilization plan to physicians who make timely application
therefor shall include a retroactive date for covering prior
acts, which date coincides with the coverage of any
professional liability policy issued by an authorized insurer
or authorized self-insurance trust fund covering the physician
immediately prior to obtaining coverage through the premium
stabilization plan. Coverage under the premium stabilization
plan shall include tail coverage without an additional premium
for retirement, death, and disability, if a physician is
covered by the premium stabilization plan immediately prior to

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retirement, death, or disability and subject to such other reasonable conditions as provided in the plan of operation.

e. The initial rates to be charged by the association for coverage provided under the premium stabilization plan shall be established by the department based on the considerations set forth in subparagraphs 1., 2., and 3., and taking into account the rates charged for similar coverage by the five largest medical malpractice insurers operating in the state on the effective date of this act. After January 31, 1988, the association may establish new rates for the premium stabilization plan in the manner provided in subparagraph 1.

f. Rates for any class of physician within a rating territory shall not exceed five times the rates for any other class of physician in the same rating territory, provided that total premiums projected under the plan shall be sufficient to maintain actuarial soundness. The provisions of this sub-subparagraph shall apply only to the minimum levels of coverage required under sub-subparagraph e.

g. Notwithstanding any other provisions of this subparagraph, any physician who has incurred two or more claims resulting in indemnities exceeding $125,000 each in the preceding 5 years or who has incurred three or more claims resulting in indemnities exceeding $10,000 each in the preceding 5 years shall not obtain coverage under the premium stabilization plan. Payment of a claim or judgment by an uninsured physician shall be considered a claim resulting in indemnity. Any physician who cannot obtain coverage under the premium stabilization plan may obtain coverage from the Joint Underwriting Association or from any other authorized insurer or self-insurance trust fund.

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h. In the event an underwriting deficit exists for any policy year the premium stabilization plan is in effect, any surplus which has accrued from previous years and is not projected within reasonable actuarial certainty to be needed for payment of claims in the year the surplus arose shall be used to offset the deficit to the extent available. If there is any remaining deficit under the premium stabilization plan, such deficit shall be recovered from the companies participating in the joint underwriting plan in the proportion that the net direct premiums of each such member written during the calendar year immediately preceding the end of the policy year for which there is a deficit assessment bears to the aggregate net direct premiums written in this state by all members of the association. The term "premiums" as used herein means premiums for the lines of insurance defined in s. 624.605(1)(b), (k), and (q), including premiums for such coverage issued under package policies.

i. The association shall market the policies issued under the premium stabilization plan directly to physicians and is hereby prohibited from paying sales commissions. However, the association may contract with existing medical malpractice insurers or self-insurance trust funds to service the insurance contracts issued by the association, in exchange for a reasonable fee. The fee paid by the association may include amounts for field underwriting, but shall not include marketing costs, and may include amounts based on any underwriting profits generated by the contracts serviced by the insurer or trust.

j. The requirements of this subparagraph shall be continuous conditions of a physician's licensure under chapters 458 and 459. Prior to the issuance or renewal of an
active license or reactivation of an inactive license for the
practice of medicine under either of such chapters, the
applicant shall demonstrate to the Department of Professional
Regulation and the appropriate regulatory board that the
requirements of this subparagraph have been met. If any
physician fails to comply with the requirements of this
subparagraph, the agency issuing the license to practice for
such physician shall immediately suspend the license of such
physician. The suspension shall remain in effect until such
time as the physician complies with the provisions of this
subparagraph.

k. Effective October 1, 1990, the association shall
not issue policies, other than policies providing only tail
coverage, to physicians under the premium stabilization plan
and no physician shall be required to obtain coverage from the
plan on or after such date. However, the association shall
continue to provide for the administration of claims and
collection of such fees and assessments as authorized by this
subparagraph.

l. As used in this subparagraph:
(1) "Physician" means any physician licensed under
chapter 458 and any osteopathic physician licensed under
chapter 459.
(II) "Termination date" means the last day of the
policy period, the date of renewal, or the date the policy is
canceled by the insurer or insured.

m. It shall be a violation of the Florida Insurance
Code for an insurer or self-insurance trust fund to provide
professional liability coverage to a physician when the
insurer or trust knew or should have known that the physician

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was required by this subparagraph to obtain such coverage from
the premium stabilization plan.

(e) In the event an underwriting deficit exists for
any policy year the plan is in effect, any surplus which has
accrued from previous years and is not projected within
reasonable actuarial certainty to be needed for payment of
claims in the year the surplus arose shall be used to offset
the deficit to the extent available.

1. As to remaining deficit, except those relating to
deficit assessment coverage, each policyholder shall pay to
the association a premium contingency assessment not to exceed
one-third of the premium payment paid by such policyholder to
the association for that policy year. The association shall
pay no further claims on any policy for the policyholder who
fails to pay the premium contingency assessment.

2. If there is any remaining deficit under the plan
after maximum collection of the premium contingency
assessment, such deficit shall be recovered from the companies
participating in the plan in the proportion that the net
direct premiums of each such member written during the
calendar year immediately preceding the end of the policy year
for which there is a deficit assessment bears to the aggregate
net direct premiums written in this state by all members of
the association. The term "premiums" as used herein means
premiums for the lines of insurance defined in s.
624.605(1)(b), (k), and (q), including premiums for such
coverage issued under package policies.

1. This paragraph shall not apply to the premium
stabilization plan described in subparagraph (d)6.
(k) The premiums collected by the Joint Underwriting Association under this subsection are exempt from the premium tax imposed under s. 624.509.

Section 3. Section 768.606, Florida Statutes, is created to read:

768.606 Medical emergency standard of care.--

(1) Any hospital licensed under chapter 395, any employee of such hospital working in a clinical area and providing patient care, and any person licensed to practice medicine who renders medical care or treatment in response to a medical emergency 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 care or treatment if such care or treatment is provided in good faith and with due regard for the prevailing professional standard of care. For the purposes of this subsection, a "medical emergency" is a sudden or unexpected situation or occurrence resulting in a serious medical condition demanding immediate medical attention for which the patient enters the hospital through the emergency room or trauma center. This subsection shall not apply to any act or omission of medical care provided after the patient has been stabilized, except that if surgery is required, this subsection shall apply to any act or omission of medical care provided prior to post-surgical stabilization.

(2) The provisions of subsection (1) shall apply to the acts or omissions of a physician licensed under chapter 458 or 459 only if the physician is:

(a) Certified as a specialist for the medical procedures performed, either by one of the appropriate American specialty boards accredited by the Council on Medical
Education of the American Medical Association, or by one of the appropriate specialty boards of the American Osteopathic Association:

(b) Possesses the education, training, and experience required as a prerequisite for examination by one of such specialty boards, or

(c) Is certified by the credentialing committee or equivalent hospital committee as having a level of skill, training, and experience which is equivalent to certification by one of such boards.

Section 4. Severability.—If any provision of this act or the application thereof to any person or circumstance is held invalid, the invalidity shall not affect any other provision or application of the act which can be given effect without the invalid provision or application, and to this end the provisions of this act are declared to be severable.

Section 5. This act shall take effect upon becoming a law.
BILL #: CS/HB 1458 (PCB INS 87-20)
RELATING TO: Medical Malpractice
SPONSOR(S): Committee on Insurance
EFFECTIVE DATE: Upon becoming a law
COMPANION BILL(S):
OTHER COMMITTEES OF REFERENCE: (1) Appropriations
(2)

I. SUMMARY

This bill creates a "premium stabilization plan" within the existing medical malpractice Joint Underwriting Association (JUA). Physicians are required to purchase insurance from the plan if they choose to meet the financial responsibility requirements of ss. 458.320 or 459.008, F.S., by purchasing insurance. The rates to be charged by the plan are to be designed so that no physician pays more than five times the lowest rate charged by the plan for similar coverage. Also, the bill provides for a new standard of care to be applied in medical malpractice cases arising out of emergency situations.

Section-by-Section Analysis

Section 1: This section sets forth legislative intent.

Section 2: This section changes the makeup of the board of governors of the medical malpractice insurance Joint Underwriting Association (JUA), creates a "premium stabilization" plan within the JUA, and grants an exemption from premium taxes to the JUA.

Under current law, the JUA's board of governors consists of eight members: five representatives of insurers participating in the JUA, an attorney named by the Florida Bar, a physician named by the Florida Medical Association and a hospital representative named by the Florida Hospital Association. This bill expands the membership of the board of governor's to eleven members by adding a physician, a dentist who is a member of the Florida Dental Association and a representative of the general public, all three to be named by the Insurance Commissioner. Additionally, the Insurance Commissioner is given the power to appoint the five members who are representatives of insurers.
This section also requires all physicians licensed under chapters 458 and 459, F.S., who choose to meet the financial responsibility requirement by purchasing insurance to obtain coverage from the JUA under the premium stabilization plan. Physicians with hospital staff privileges are required to purchase coverage of $250,000 per claim and $750,000 annual aggregate. Physicians who do not have hospital staff privileges are required to purchase coverage of $100,000 per claim and $300,000 annual aggregate. Physicians who are employed by governments, who hold inactive licenses and do not practice medicine in this state, and who hold a limited license are not required to obtain coverage from the premium stabilization plan.

Physicians are required to obtain the required coverage on the latter of July 1, 1987, or the termination date of their current insurance policy, but in no event later than July 1, 1988.

In addition to the required coverage, the premium stabilization plan will offer coverage up to $1 million per claim, $3 million annual aggregate to those physicians who wish to obtain coverage in excess of the coverage required by the bill. Physicians are free to obtain insurance coverage in excess of the required coverage from any other insurer.

Physicians who are bad risks are prohibited from obtaining coverage under the premium stabilization plan, but are free to obtain the required coverage from the regular JUA or from another insurer. The bill defines a bad risk as any physician who has had 2 claims exceeding $125,000 each in the preceding 5 years, or who has had claims exceeding $10,000 each in the preceding 5 years.

If the premium stabilization plan has a deficit for any plan year, the deficit is to be recovered from casualty insurers who write liability insurance, medical malpractice insurance, or miscellaneous insurance.

The bill prohibits the association from paying sales commissions on the premiums charged to physicians and requires the association to market the policies directly to physicians. However, the bill allows the JUA to contract with existing insurers to service the contracts issued by the JUA. The fee paid to service insurance contracts may include amounts for field underwriting.

The Insurance Commissioner is given the authority to set the initial rates to be charged under the Premium Stabilization Plan. The bill provides that rates shall be designed so that the rates charged the highest risk physicians for the required coverages do not exceed five times the rate charged the lowest risk physicians.

Effective October 1, 1990, the JUA is prohibited from issuing new policies under the premium stabilization plan, except for tail coverage policies.

Finally, the bill provides an exemption from premium taxes to the JUA.
Section 3: This section provides a new standard of care to be used to determine if a health care provider is liable for damages as a result of providing medical care in an emergency situation. The bill provides that there is no liability if "care or treatment" is provided in good faith and with due regard for the prevailing professional standards of care. The bill provides a definition of "medical emergency."

This standard of care is applicable solely to physicians who are certified as specialists for the medical procedures performed, who qualify for certification due to their education and experience, or who are certified by a hospital committee as having skill, training and experience equivalent to that required for certification.

Section 4: Provides a severability clause.

Section 5: This act shall take effect upon becoming a law.

II. ECONOMIC IMPACT

A. Public

The requirement that all physicians wishing to purchase insurance must do so from the premium stabilization plan, coupled with the cap on rates to the highest risk physicians, should result in savings of 25-40 percent of current premium payments for physicians in the high risk specialties, e.g., neurosurgery, obstetrics, etc. The premium payments by physicians in low risk specialties should remain approximately what they are today or may increase up to 5 percent.

For high risk physicians, the largest savings are generated from the cap on rates. The cap, in turn, has the effect of increasing the premiums for the low risk physicians. However, this increase is offset primarily by savings inherent in the premium stabilization plan. The plan will not pay commissions (current commissions on medical malpractice insurance are average 7 percent of the premium) or premium taxes (1-2%). Additionally, rates set by the plan will not have a profit factor built in.

Finally, the change in the standard of care for emergency situations should result in a reduction in premiums, especially for high risk physicians. The amount of this decrease, however, cannot be determined at this time. Also, some patients who would recover damages under the current standard of care may be denied recovery under the new standard.

B. Government

Premium tax receipts will be reduced due to the exemption granted the JUA. The amount of reduction cannot be determined at this time.
III. STATE COMPREHENSIVE PLAN IMPACT
This bill is consistent with the state's policy of "ensuring that necessary health services are available to all Floridians ..." [s. 187.201(6)(b)2.]

IV. COMMENTS
This bill passed the House, but was not taken up by the Senate.

V. AMENDMENTS
This bill originated as a committee bill in the Insurance Committee. The bill was substantially amended in the Appropriations Committee and made into a Committee Substitute. Finally, the bill was substantially amended on the House floor prior to passage.

VI. PREPARED BY: Jose A. Diez-Arquelles

VII. STAFF DIRECTOR: Jose A. Diez-Arquelles
Testimony Before the Senate Commerce Committee  
By Insurance Commissioner Bill Gunter  

November 3, 1987  Tallahassee, Florida  

Thank you Madam Chairman, Members of the Senate Commerce Committee. I thank you for this opportunity to express my continuing concerns over malpractice insurance issues as we approach a possible Special Session on those issues.

I would like to express my appreciation for the work of the Academic Task Force in creating a comprehensive database on which we can all rely, and in accelerating its timetable for recommendations so that we now have a better basis for discussion.

I have also been encouraged by indications that the Department of Professional Regulation is making a real commitment to physician discipline that must be a part of any medical malpractice solution.

I do continue to have the following serious concerns:

* First, under the proposals that have emerged so far, Florida would continue to rely heavily on a single insurance company for its malpractice coverage. This has been a formula for repeated disasters in the past as insurance companies with large numbers of policyholders have announced plans to pull out of the state.

For that reason, I am proposing legislation that would trigger immediate implementation of a statewide nonprofit insurance pool if rates rise higher than three times the Medical Price Index, or if insurers once again significantly withdraw from the Florida market.

The Task Force expressed concern that such a pool would "severely impair" the private insurance market. I think we should be at least as concerned about actions by the private insurance market that would "severely impair" Florida's health care system.

* Second, I am concerned that proposals so far do not provide adequate incentives to keep enough high-risk medical specialists like obstetricians and neurosurgeons practicing their specialties.

For that reason, I will be proposing a program to identify special "areas of critical state concern" as to the availability of medical services. Where the availability of needed medical specialties is significantly below ideal levels, doctors will be offered malpractice premium supplements to cap their insurance costs at 15 percent of gross income. These premium supplements would be funded by Insurance Department Regulatory Trust funds. This program would be subject to sunset review after two years.

* And finally, despite the willingness of some insurers to provide coverage to more Florida doctors, I am concerned that many doctors will be left out in the cold. According to the October 23rd FAIA Agent's Bulletin, coverage to be provided by CNA will be "subject to its normal underwriting guidelines," meaning, in other words, that CNA reserves the right to refuse coverage to some doctors.

For that reason, I am recommending that coverage available from the Florida Medical Malpractice Joint Underwriting Association be raised to $1 million per incident, $3 million per year. That is the level of coverage required for many doctors who practice in Florida's hospitals.

For too long, the medical care on which Floridians depend has been buffeted by unpredictable market decisions of major national insurance companies. The atmosphere of panic and uncertainty has been paid for in human life. It is time for Florida to take her future in her own hands.
Since we proposed the statewide nonprofit insurance pool to protect Florida doctors from sudden loss of coverage through insurance company pullouts, or dramatic increases in premiums, we've seen some malpractice insurers become more cooperative in providing coverage. I welcome this change, however it may have been motivated.

But I can't help remembering how often in the past we have been led down the garden path with such promises. Ten years ago, our doctors depended overwhelmingly on the Argonaut insurance company for medical malpractice insurance. When Argonaut decided to pull out of Florida, thousands of doctors were left high and dry.

Last spring, with more than 5000 malpractice policyholders, the St. Paul insurance company announced plans to pull out of Florida. This time, the panic affected not just doctors, but the entire health care system. I don't need to remind this Committee what we were all reading in the daily papers around that time – that chaos in emergency, delivery and operating rooms was costing human lives.

Florida doctors have been left standing at the altar once too often with insurance company promises. So while I'm willing to assume that malpractice insurers mean it when they say they'll insure St. Paul's doctors... and while I'm willing to give credence to their implied promises to modify their underwriting standards and to keep rates down, I'd like to also see us ready, if the need arises to say to companies threatening to leave Florida: "We've got other options."

All of you are familiar with the Insurance Department proposal to provide for a secure source of malpractice insurance whether the commercial insurance companies stay or go. The economies incorporated in that insurance mechanism are adequate to substantially reduce premiums for high-risk specialists without significantly affecting the premiums other doctors pay.

I'm proposing the statewide pool approach now be considered strictly as a safety net to be triggered only:

* A. If the cost of medical malpractice skyrockets again, once the legislature has turned out the lights and gone home... Specifically, if the price of insurance increases at a rate greater than three times the Medical Price Index; or

* B. If we find ourselves without adequate insurance availability such as was threatened when St. Paul announced its intention to leave the state... Specifically, if more than 25 percent of the doctors are forced to resort to the Joint Underwriting Association.

If our fears of disappointment are misplaced, the statewide pool I have proposed need never see the light of day. Bear in mind, we have no other guarantees. We have no security that insurance coverage being offered won't dramatically increase in price once again in the months to come, or that the commercial insurers will even stay in Florida.

But granting the existence of an ongoing commercial market, something still needs to be done to make sure that high malpractice premiums don't create a financial disincentive for certain medical specialists to practice where they are needed. The Academic Task Force has reported that some obstetricians pay nearly a quarter of their gross income for malpractice coverage.

The practical effect of those costs has been to make obstetric care hard to find in Florida's rural communities. Jackson County has just one obstetrician practicing today. Liberty and Calhoun Counties have none. I
agree with the Task Force that we need to counter this disincentive with supplements to offset high premium costs.

But the Academic Task Force salary cap of $75,000 would preclude most high-risk medical specialists. My proposal is to do away with the income ceiling and take another approach to limiting those to whom the supplements are paid.

Under our proposal, the Department of Health and Rehabilitative Services would identify areas of critical state concern as to the availability of particular needed medical specialties. Physicians willing to practice in those areas would have malpractice premiums capped at 15 percent of gross income.

As an example, Liberty, Calhoun and Jackson Counties could be defined as areas of critical state concern for obstetric care. Again, it may be that some of Florida's urban counties are significantly below the ideal per capita ratio of practicing neurosurgeons. Those counties could be defined as areas of critical state concern for neurological care.

The Task Force has proposed to fund such a supplement through a tax on medical malpractice premiums, adding to an already overburdened funding base. Since this program would most likely be sunset after two years, I believe funds from the Department of Insurance Regulatory Trust Fund would provide adequate funding.

Finally, I'm pleased with the recommendations of the Academic Task Force on physician discipline, and the spirit with which the Department of Professional Regulation has indicated its commitment to follow those recommendations.

If barriers to effective discipline can be removed through a concentration of those responsibilities within DPR; if the impediments to fast action that have resulted from "probable cause panels" can be resolved, and if the more practical "preponderance of evidence" standard can be adopted, then I believe physician discipline can make a real contribution to solving the malpractice problem.

In closing, I would just like to say once more that I'm generally heartened by the efforts of the Academic Task Force. I believe they have found many of the needles that were lost in this haystack. Our task now is to use those efforts to produce comprehensive and effective legislation that will insure that disruptions to Florida's health care delivery system become a distant memory, not a tradition.

Thank you.
The 1975 Florida Legislature, as a part of the "The Medical Malpractice Reform Act of 1975", enacted legislation establishing this insurance underwriting pool to afford reasonable medical malpractice insurance to eligible health care providers. The Florida Insurance Department was given the responsibility for adoption of a plan of operation in conformity with the statutory authority.

Responsibility for supervision of the FMMJUA is vested in a Board of Governors consisting of eight representatives from the Florida Medical Association, Florida Hospital Association, The Florida Bar and the insurance industry. Subject to final approval of the Insurance Commissioner, the Board of Governors approves insurance rates, rate classifications, policy forms and otherwise sets Association policy under the framework of the Plan of Operation. Operational and administrative functions are performed by a general manager and staff located in Tallahassee.

Customer service such as policy issuance, claims and accounting, is provided (in the name of the FMMJUA) by one or more eligible insurance companies (designated as servicing carrier) through licensed general lines insurance agents. Initially the FMMJUA operated with two servicing carriers, the Hartford and the U.S.F. & G. These two companies served the organization well during the critical first years. After four years of operation, the St. Paul became the only servicing carrier for the issuance of coverage and the Hartford and U.S.F. & G. continue only for the handling of claims arising under policies which they previously issued. The FMMJUA also receives outside actuarial, audit, investment and legal services under contract.

Insurance protection is afforded under provisions of the so-called "occurrence" policy form which provides coverage for all claims arising from incidents that occurred during the policy period, but without regard to when the claim is reported and made against the insured.

Policies contain both Assessable and Participating Policy Provisions due to the non-profit structure of the FMMJUA. Subject to plans approved by the Insurance Department, surplus funds, after payment of claims and expenses, are returned to policyholders on a pro-rata basis. Should there be an underwriting deficit, individual policyholders for the deficit years may be required to pay premium contingency assessments, not to exceed one-third of the premium paid for the association year for which the deficit was recorded. Remaining underwriting deficits are fully absorbed by the participating insurance companies and self-insurers. Actual loss experience and rate levels are the major factors that cause a surplus or deficit.

The normal policy period is one year, however, policies are written to expire on July 1 of each year. For example, a new application requesting a January 1 effective date will be issued at a pro-rata premium for six months. Upon renewal the policy term would be one year. Premiums for policies with terms over six months may be paid by installments, otherwise, the premium must be paid in full.

A fully completed application with premium payment is a prerequisite for obtaining coverage. All licensed general lines insurance agents are eligible to submit applications to the FMMJUA and otherwise perform necessary administrative functions and policyholder service to health care providers seeking coverage. The FMMJUA has no licensed agents of its own.

Coverage limits currently available are to a maximum of $1,500,000 per claim and $5,000,000 annual aggregate for hospitals, and a maximum of $250,000 per claim and $750,000 annual aggregate for all other eligible policyholders.
Coverage through the FMMJUA is determined by Florida Statutes. The current Florida Statute defines those eligible for coverage in the FMMJUA as follows:

1. "Health Care Provider" means

   Hospitals licensed under chapter 395;
   Physicians licensed under chapter 458;
   Osteopaths licensed under chapter 459;
   Podiatrists licensed under chapter 461;
   Dentists licensed under chapter 466;
   Chiropractors licensed under chapter 460;
   Naturopaths licensed under chapter 462;
   Nurses licensed under chapter 464;
   Clinical Laboratories registered under chapter 483;
   Physicians' Assistants certified under chapter 458;
   Physical Therapists and
   Physical Therapist Assistants licensed under chapter 468;
   Health Maintenance Organizations certified under part II of chapter 641;
   Ambulatory Surgical Centers licensed under chapter 395;
   Other Medical Facilities as defined in subparagraph 2;
   Blood Banks, Plasma Centers, Industrial Clinics, and
   Renal Dialysis Facilities;
   Professional Associations, Partnerships, Corporations, Joint Ventures,
   or other associations for professional activity by health care providers.

2. "Other Medical Facility" means a facility the primary purpose of which is to provide human medical diagnostic services, or a facility providing non-surgical human medical treatment, and in which the patient is admitted to and discharged from said facility within the same working day, and which is not part of a hospital. However, the terms "other medical facility" shall not be construed to include a facility existing for the primary purpose of performing terminations of pregnancy or an office maintained by a physician or dentist for the practice of medicine.

The FMMJUA administrative office in Tallahassee is responsible for overall results. It monitors and supervises the services purchased under contract and provides other services.

Operations generally follow normal insurance practices. Premiums collected and invested are used to pay claims and expenses.

The only costs of the FMMJUA to member companies are assessments based on unprofitable operations, if this contingency occurs, after assessments to policyholders have been made.
Bernard Webb  
Georgia State University  
University Plaza  
Atlanta, Georgia 30303  

Dear Mr. Webb:

Attached is the information we discussed briefly on the phone yesterday showing how the rates were derived for the Association proposed by the Department of Insurance.

If you have any questions, please give me a call.

Sincerely,

Jerome F. Vogel, A.C.A.S., M.A.A.A.  
Actuary, Bureau of Rates  
904/488-4439

cc: Gerald Wester  
Dale Hazlett  
Jack Nicholson
Bernard Webb  
Georgia State University  
University Plaza  
Atlanta, Georgia 30303  

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JFV/dm  
attachments  

cc: Gerald Wester  
    Dale Hazlett  
    Jack Nicholson
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FMMJUA rates are occurrence rates. Florida Physicians Insurance Company has rates 50 percent higher in Palm Beach County than in remainder of State. These rates do not contain the stock purchase required by Florida Physicians Insurance Company nor do they contain the contribution to surplus required by the Physicians Protective Trust Fund.

D/B = Dade and Broward Counties
ROS = Remainder of State
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<td>31,972</td>
<td>24,273</td>
</tr>
</tbody>
</table>

Florida physicians has rates 50 percent higher in Palm Beach County than in the remainder of the state. These rates do not contain the stock purchase required by Florida Physicians Ins. Co. Nor do they contain the contribution to surplus required by Physicians Protective. D/B = Dade and Broward Counties
ROS = Remainder of State
<table>
<thead>
<tr>
<th>1000000 PER CLAIM 3000000 ANNUAL AGGREGATE</th>
<th>9/15/87</th>
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<tr>
<td><strong>ST PAUL</strong></td>
<td><strong>FL PHYS</strong></td>
</tr>
<tr>
<td>EFF.</td>
<td>EFF.</td>
</tr>
<tr>
<td>TER.</td>
<td>7-1-87</td>
</tr>
<tr>
<td><strong>80159 SURGERY - OTOLARYNGOLOGY - NO PLASTIC SURGERY</strong></td>
<td></td>
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<tr>
<td>D/B</td>
<td>99,957</td>
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<tr>
<td>ROS</td>
<td>50,202</td>
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<tr>
<td><strong>80145 SURGERY - UROLOGICAL</strong></td>
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<tr>
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<td><strong>80143 GENERAL SURGERY</strong></td>
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<td>ROS</td>
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<td><strong>80144 THORACIC SURGERY</strong></td>
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<td>ROS</td>
<td>66,482</td>
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<tr>
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<td><strong>80155 SURGERY - OTOLARYNGOLOGY - INCLUDING PLASTIC SURGERY</strong></td>
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<td>D/B</td>
<td>99,957</td>
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<tr>
<td>ROS</td>
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<td><strong>80153 OBSTETRICS</strong></td>
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<td>ROS</td>
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<td><strong>80154 ORTHOPEDIC SURGERY</strong></td>
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<td>D/B</td>
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</tr>
<tr>
<td>ROS</td>
<td>66,482</td>
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<tr>
<td><strong>30152 NEUROLOGICAL SURGERY</strong></td>
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<td>D/B</td>
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<td><strong>80150 CARDIOVASCULAR SURGERY</strong></td>
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<td>D/B</td>
<td>132,519</td>
</tr>
<tr>
<td>ROS</td>
<td>60,482</td>
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</tbody>
</table>

Florida physicians has rates 50 percent higher in Palm Beach County than in the remainder of State. These rates do not contain the stock purchase required by Florida Physicians Ins. Co. Nor do they contain the contribution to surplus required by Physicians Protective. D/B - Dade and Broward Counties ROS - Remainder of State
MEMORANDUM

August 11, 1987

TO: Dale Hazlett
FROM: Jerry Vogel
SUBJECT: Rates for Association Plan

Attached is a chart giving rates for the proposed association. Note that in addition to the explanation in the footnotes that a relativity of 1.5 was used for Dade and Broward and that the rates assume the tort reforms would take effect immediately on all claims.

If the latter assumption is not true, the rates would be the same as those presented in my August 7 memo to Gerald Wester on the above subject.

JV/dm
attachment
DEPARTMENT OF INSURANCE  
August 11, 1987

$1,000,000/$3,000,000 MATURE CLAIMS MADE

RATE COMPARISONS FOR PROPOSED MEDICAL MALPRACTICE INSURANCE POOL

<table>
<thead>
<tr>
<th>TERRITORY</th>
<th>@ 7-1-87 AVERAGE RATE (1)</th>
<th>ESTIMATED POOL RATE (2)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dade &amp; Broward</td>
<td>$19,415</td>
<td>$30,442</td>
</tr>
<tr>
<td>Rest of State</td>
<td>10,277</td>
<td>16,058</td>
</tr>
<tr>
<td></td>
<td>$13,585</td>
<td>$20,102</td>
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</tbody>
</table>

(1) The average of rates are based on a weighted average of St. Paul, Physicians Protective Trust Fund and Florida Physicians Insurance Company rates effective July 1, 1987 as presented in the Academic Task Force report.

(2) The rates are estimated based on administrative costs of 10%, plus 11.5% savings from proposed change in collateral source rule and the 1985–86 reforms. Rate for the highest risk specialties are 5.0 times the lowest risk with the income effect built into the rate level, only for the first $250,000/$750,000 of coverage. Sales commissions and profit factors have been eliminated from the rates.
January 14, 1988

The Honorable Bob Martinez
Governor

The Honorable Jon Mills
Speaker
House of Representatives

The Honorable John W. Vogt
President of the Senate

Dear Sirs:

Despite the reforms of the early 1970's and 1980's, Florida's medical malpractice premiums, frequency and size of claims have continued to rise. Most recently, Florida experienced a serious decline in the availability of trauma and emergency care. In addition, two major medical malpractice insurance companies withdrew from the insurance market, thus compounding the effect on the delivery of health care services in this state.

In an effort to seek a solution to these medical liability issues, Governor Bob Martinez, Senate President John Vogt and House of Representatives Speaker Jon Mills created a 12-member working group to develop recommendations for legislative consideration.

This working group has deliberated and received testimony and information from interested and knowledgeable groups, particularly the Academic Task Force for the Review of the Insurance and Tort Systems.

The Task Force was created in 1986 to provide a comprehensive study of issues affecting the insurance and tort systems. Pursuant to a request by the Governor, however, the Task Force conducted an expedited review specifically addressing the medical malpractice situation. Its recommendations were released on November 6, 1987. The Task Force presented its medical malpractice recommendations to the working group on November 19, 1987. These recommendations, which are based on extensive research and data, have become the cornerstone of meaningful, effective, and innovative proposals for resolution of the medical malpractice situation in Florida.
Acknowledging the Task Force findings and recommendations, the working group specifically recommends that the following concepts be embraced by the Florida Legislature in its comprehensive solution to the problems associated with medical malpractice in this state.

1. **Prompt resolution of medical negligence claims**

   These provisions should include components to provide early review of claims by both parties to encourage settlement and arbitration procedures as an alternative to the costly trial system.

   The plan should require both parties to conduct presuit investigations and corroborate their claims and responses with the written opinion of a medical expert. Access to medical records should be provided to facilitate these investigations and the prompt resolution of both meritorious and non-meritorious claims.

   The Joint Working Group recommends that the Legislature enact provisions which require the submission of any civil action involving medical malpractice to mandatory non-binding arbitration. The arbitration panel, composed of attorneys certified by the chief judge of each judicial circuit, conducts an expedited informal hearing and issues an arbitration award. Either party could reject the award and demand a trial *de novo*, at which the arbitration award would be inadmissible. However, a party would be entitled to attorney's fees if the judgment entered at trial was within a specified percent of the arbitration award which was rejected by the other party.

   Additionally, and subject to the approval by the electors of a constitutional amendment authorizing a limitation of damages in civil actions, legislation should be enacted which provides a system of voluntary binding arbitration which includes incentives to both parties to participate, including prompt payment of damages without need to prove liability, limitations upon non-economic damages, and payment of attorney's fees. Arbitration panels should include members selected by the parties.
2. Medical Care Availability Assistance Plan

Legislation should include an insurance subsidy fund to provide assistance to certain physicians who can establish that the high cost of medical malpractice premiums are causing financial difficulties which may affect the physicians' availability to provide medical services.

Eligibility criteria for physicians should include active full-time practice, medical malpractice premiums in excess of a specified percentage of gross income, and an absence of factors indicating that the physician is a bad risk.

3. Birth-related Neurological Injury Compensation Plan

Provisions should be included which allow physicians and hospitals to participate in a no-fault system of compensation for certain birth-related neurological injuries. Compensation should include medical expenses, loss of earnings, and costs and attorney's fees. The system should be funded by assessments against physicians and hospitals and should provide for deficit assessments against certain casualty insurers.

4. Medical Emergency Care Liability Reform

The legislation should address the circumstances under which an emergency or trauma patient may recover for medical negligence, including consideration of granting certain civil immunity to emergency health care providers who treat emergency or trauma patients. Emergency care facilities should be required to provide emergency care without regard to the ability of the patient to pay the costs of such care.
5. Enhanced Regulation of Health Care Providers

Provisions should be included which are designed to encourage greater cooperation of health care providers and patients with regulatory investigations. The Department of Professional Regulation should be reorganized by the creation of a new division to provide for the regulation of physicians and osteopathic physicians. The current regulatory boards for these physicians should be transferred to this division. Provision should also be made for peer review within each licensed medical facility for the evaluation of physician practice. Participants in such review should be protected from retaliatory civil actions. Enhanced requirements for the reporting of instances of malpractice should also be imposed upon health care practitioners.

6. Constitutional Reform

An amendment to Florida's Constitution should be included to authorize the Legislature to limit damages in certain civil actions as a means of ensuring the immediate application of medical liability, insurance, and regulatory reforms.
Pamela Birch Fort  
Staff Director  
Senate Commerce Committee  
410 Senate Office Building  
Tallahassee, Florida 32399-1100

Dear Ms. Fort:

We have conducted an analysis of the Florida Medical Malpractice Closed Claims data to get an estimate of the cost of the proposed Florida Birth Related Neurological Injury Compensation Plan.

We examined all claims reported to the Department since October of 1985 when our reporting form was revised to give us information on the severity of the claim and the injured persons age. From this data we looked at every claim both with and without indemnity with a birth age of 0 and with permanent disability that was significant, i.e., loss of use of a limb, deafness, loss of use of one eye, or worse. We looked at each of these claims to see if it was a birth related injury qualifying under the compensation plan. There were approximately sixty (60) such claims a year reported.

The use of claims with permanent significant disability is judged to be approximately the same as the standard in the House Bill (version 251-179E-12-7) of a birth injury, "...which renders the infant permanently and substantially mentally and physically impaired." The Academic Task Force had discussed the Virginia definition of a birth injury as one "...that renders the infant permanently non-ambulatory, aphasic, incontinent, and in need of assistance in all phases of daily living." This definition is narrower and claims falling under this definition cannot be estimated from the closed claim data.

The cost of such claims was estimated from two sources. We looked at the indemnity from the closed claim report for claims with the severity covered by the bill and we talked with individuals involved in the settlement of such claims. It appears that the cost of a permanent and total disability claim on a present value basis would be about $1,000,000. The less severe claim would be about 40% of this or $400,000. These values represent the cost if enough money is set aside at the time of the claim to pay lifetime benefits to the injured person. Investment income from these funds would be used to help pay the benefits. Based on the severity of the claims the total cost of the sixty (60) ... a year would be $45,000,000.
The funding for this program would be as follows:

<table>
<thead>
<tr>
<th>Source</th>
<th>Fee</th>
<th>Number</th>
<th>Annual Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>OB</td>
<td>$5,000/Doctor</td>
<td>1,000</td>
<td>$5,000,000</td>
</tr>
<tr>
<td>Physicians</td>
<td>250/Doctor</td>
<td>20,000</td>
<td>5,000,000</td>
</tr>
<tr>
<td>Hospital</td>
<td>50/Birth</td>
<td>170,000</td>
<td>8,500,000</td>
</tr>
<tr>
<td>Insurance Cos.</td>
<td>.25% of Liab. Prem.</td>
<td>$1,500,000,000</td>
<td>3,750,000</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td></td>
<td></td>
<td><strong>$22,250,000</strong></td>
</tr>
</tbody>
</table>

On a fully funded basis, given the assumptions above, the statutory funding would clearly be inadequate. It is important to note that in the initial years of this program actual payments to injured persons would be much lower than the fully funded cost. However, each year newly injured persons would be added to the system until the actual cash payments would considerably exceed the funding.

The above estimate of the potential cost may be understated if there are currently a significant number of birth injuries that do not enter the tort liability system. An analysis of the potential number of claims due to birth related neurologic injury was conducted by Dr. John S. Curran. He used a more restrictive definition of eligible injury that is similar to the Virginia definition described above and developed 333 potential claims per year. See the attached report for complete details. It is important to note that claims not of obstetric origin are included in Dr. Curran's data. The potential number of claims could be much closer to that indicated by the closed claim data if the non-obstetric causes were removed.

Using closed claim data as described above, we estimated the effect on obstetricians medical malpractice premiums of eliminating the identified birth injury claims. It is estimated that about 40% of obstetricians closed claim payments arise from birth injuries that would be covered by this plan.

Sincerely,

Jerome F. Vogel, A.C.A.S., M.A.A.A.
Actuary, Bureau of Rates
904/488-4439

JFV/dm

cc: Gerald Wester
Dale Hazlett
Jack Nicholson
Brian Deffenbaugh
Bill Leary, Staff Director, House Insurance Committee
February 2, 1988

Robert Henderson  
House of Representatives  
House Office Building Room 20  
Insurance Committee  
Tallahassee, Florida 32301

Dear Mr. Henderson:

This letter is to follow our telephone conversation on the evening of February 1 with regard to definition of "Birth Related Neurologic Injury" originally in Section 23, paragraph (2). In the interest of avoidance of the ambiguities inherent to infants of low birth weight (prematures) having birth-related neurologic injury, I would support the addition of the words of term gestation so that the language would read "which renders the infant of term gestation permanently and substantially mentally and physically impaired. The hearing process could itself delineate the criteria acceptable for meeting that definition.

After removing infants with congenital anomalies, genetic anomalies or overwhelming illnesses not of obstetric origin there would remain approximately 180 severely and profoundly neurologically impaired children. If the definition were to be limited to of term gestation this number could reduced to one-third or approximately 60 births annually. Based on my training and experience I believe that this is a reasonable number for those infants of term gestation in the State of Florida who sustain a birth related neurologic injury to the brain or spinal cord caused by oxygen deprivation or mechanical injury which occurs in the course of labor, delivery, resuscitation or until stabilization is completed.

Thank you for the opportunity to comment.

Sincerely,

John S. Curran, M.D.  
Professor and Acting Chairman

JSC:jf
MEMORANDUM
August 18, 1987

TO: Brian Deffenbaugh
FROM: Jerry Vogel
SUBJECT: Medical Malpractice Insurance Pool Rates

Attached is a derivation of the expected savings under the proposed Medical Malpractice Insurance Pool.

JV/dm
attachment

cc: Gerald Wester
    Dale Hazlett
    Jack Nicholson
August 18, 1987

Proposed Medical Malpractice Insurance Pool
Comparison of Rate Level with Commercial Insurer Rates

A. Profit and Expense in Commercial Insurer Rates vs. Medical Malpractice Insurance Pool Rates

<table>
<thead>
<tr>
<th>Item</th>
<th>Commercial Insurer (1)</th>
<th>Med Mal Pool</th>
</tr>
</thead>
<tbody>
<tr>
<td>Agent Commission</td>
<td>6.20% (2)</td>
<td>0%</td>
</tr>
<tr>
<td>Unallocated Loss Adjustment Expense &amp; Fixed Expense</td>
<td>8.22</td>
<td>8.5% (4)</td>
</tr>
<tr>
<td>Premium Tax</td>
<td>2.02</td>
<td>0</td>
</tr>
<tr>
<td>General &amp; Other Acquisition Expense</td>
<td>3.40</td>
<td>1.5% (4)</td>
</tr>
<tr>
<td>Target Profit</td>
<td>4.30 (3)</td>
<td>0</td>
</tr>
<tr>
<td><strong>Total</strong></td>
<td><strong>24.14%</strong></td>
<td><strong>10.0%</strong></td>
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Effect on rates of difference in expenses
-15.7%

B. Income offset for territory Relativity Difference
+11.5%

C. Income offset for limitation on High Risk Specialties
+10.4%

D. Effect of Tort Reform from proposed changes and the 1985-86 Reforms
-11.5%

E. Net reduction for limits of $250,000/$750,000 limits for Family Practice - No Surgery, Remainder of State
- 8.2% (5)

F. Net reduction for limits in excess of $250,000/$750,000 for Family Practice - No Surgery, Remainder of State
-16.8% (6)

G. Average Net Reduction for $1,000,000/$3,000,000 limits for Family Practice - No Surgery, Remainder of State
-11.0% (7)

(1) Based on St. Paul filing effective 7-1-87 as adjusted by Department Order.
(2) Includes effect of premium discount.
(3) Department Order reduced rates to after tax target profit.
(4) General expense is estimated as 15% of total Medical Malpractice Pool.
(5) A x B x C x D = E
(6) A x B = D = F
(7) E and F weighted by premium for $250,000/$750,000 and excess of $250,000 to $750,000.
FACT SHEET
ON MEDICAL MALPRACTICE PROPOSALS

November 3, 1987

PREMIUM SUPPLEMENT BASED ON AREAS OF CRITICAL STATE CONCERN

1. The Department of Health and Rehabilitative Services would identify areas of critical state concern, based on the availability of needed medical specialists. HRS would use federal ratios that represent the ideal ratio of specialists to population, as well as other variables.

2. Needed specialists practicing in areas of critical state concern would qualify for a premium supplement if their medical malpractice insurance premiums are more than 15 percent of their gross operating revenue.

3. The supplement would last for two years and be funded from the Insurance Department's regulatory trust fund, which contains $50 million in insurance company fines and fees.

MANDATORY INSURANCE POOL WITH TRIGGER

1. A statewide, mandatory, non-profit insurance pool for doctors would be created only if triggered by one of two events:

   * The cost of medical malpractice insurance increases by more than three times the Medical Price Index in any 12 months, or
   * More than 25 percent of Florida's doctors purchase coverage from the Florida Medical Malpractice Joint Underwriting Association (FMMJUA), signaling a serious cutback in the availability of malpractice insurance.

INCREASED LIMITS IN THE FMMJUA

1. Increase the maximum amount of coverage that doctors may purchase from the FMMJUA to $1 million per occurrence, $3 million aggregate. The current limits of $250,000 per occurrence, $750,000 aggregate prevent the JUA from being a viable source of insurance for doctors, since many hospitals require $1 million/$3 million limits for doctors who wish to have hospital privileges.
Testimony Before the Senate Commerce Committee  
By Insurance Commissioner Bill Gunter  

November 3, 1987 – Tallahassee, Florida

Thank you Madam Chairman, Members of the Senate Commerce Committee. I thank you for this opportunity to express my continuing concerns over malpractice insurance issues as we approach a possible Special Session on those issues.

I would like to express my appreciation for the work of the Academic Task Force in creating a comprehensive database on which we can all rely, and in accelerating its timetable for recommendations so that we now have a better basis for discussion.

I have also been encouraged by indications that the Department of Professional Regulation is making a real commitment to physician discipline that must be a part of any medical malpractice solution.

I do continue to have the following serious concerns:

* First, under the proposals that have emerged so far, Florida would continue to rely heavily on a single insurance company for its malpractice coverage. This has been a formula for repeated disasters in the past as insurance companies with large numbers of policyholders have announced plans to pull out of the state.

For that reason, I am proposing legislation that would trigger immediate implementation of a statewide nonprofit insurance pool if rates rise higher than three times the Medical Price Index, or if insurers once again significantly withdraw from the Florida market.

The Task Force expressed concern that such a pool would "severely impair" the private insurance market. I think we should be at least as concerned about actions by the private insurance market that would "severely impair" Florida's health care system.

* Second, I am concerned that proposals so far do not provide adequate incentives to keep enough high-risk medical specialists like obstetricians and neurosurgeons practicing their specialties.

For that reason, I will be proposing a program to identify special “areas of critical state concern” as to the availability of medical services. Where the availability of needed medical specialties is significantly below ideal levels, doctors will be offered malpractice premium supplements to cap their insurance costs at 15 percent of gross income. These premium supplements would be funded by Insurance Department Regulatory Trust funds. This program would be subject to sunset review after two years.

* And finally, despite the willingness of some insurers to provide coverage to more Florida doctors, I am concerned that many doctors will be left out in the cold. According to the October 23rd FAIA Agent's Bulletin, coverage to be provided by CNA will be "subject to its normal underwriting guidelines," meaning, in other words, that CNA reserves the right to refuse coverage to some doctors.

For that reason, I am recommending that coverage available from the Florida Medical Malpractice Joint Underwriting Association be raised to $1 million per incident, $3 million per year. That is the level of coverage required for many doctors who practice in Florida's hospitals.

For too long, the medical care on which Floridians depend has been buffeted by unpredictable market decisions of major national insurance companies. The atmosphere of panic and uncertainty has been paid for in human life. It is time for Florida to take her future in her own hands.
Since we proposed the statewide nonprofit insurance pool to protect Florida doctors from sudden loss of coverage through insurance company pullouts, or dramatic increases in premiums, we've seen some malpractice insurers become more cooperative in providing coverage. I welcome this change, however it may have been motivated.

But I can't help remembering how often in the past we have been led down the garden path with such promises. Ten years ago, our doctors depended overwhelmingly on the Argonaut insurance company for medical malpractice insurance. When Argonaut decided to pull out of Florida, thousands of doctors were left high and dry.

Last spring, with more than 5000 malpractice policyholders, the St. Paul insurance company announced plans to pull out of Florida. This time, the panic affected not just doctors, but the entire health care system. I don't need to remind this Committee what we were all reading in the daily papers around that time - that chaos in emergency, delivery and operating rooms was costing human lives.

Florida doctors have been left standing at the altar once too often with insurance company promises. So while I'm willing to assume that malpractice insurers mean it when they say they'll insure St. Paul's doctors... and while I'm willing to give credence to their implied promises to modify their underwriting standards and to keep rates down, I'd like to also see us ready, if the need arises, to say to companies threatening to leave Florida: "We've got other options."

All of you are familiar with the Insurance Department proposal to provide for a secure source of malpractice insurance whether the commercial insurance companies stay or go. The economies incorporated in that insurance mechanism are adequate to substantially reduce premiums for high-risk specialists without significantly affecting the premiums other doctors pay.

I'm proposing the statewide pool approach now be considered strictly as a safety net to be triggered only:

* A. If the cost of medical malpractice skyrockets again, once the legislature has turned out the lights and gone home... Specifically, if the price of insurance increases at a rate greater than three times the Medical Price Index; or
* B. If we find ourselves without adequate insurance availability such as was threatened when St. Paul announced its intention to leave the state... Specifically, if more than 25 percent of the doctors are forced to resort to the Joint Underwriting Association.

If our fears of disappointment are misplaced, the statewide pool I have proposed need never see the light of day. Bear in mind, we have no other guarantees. We have no security that insurance coverage being offered won't dramatically increase in price once again in the months to come, or that the commercial insurers will even stay in Florida.

But granting the existence of an ongoing commercial market, something still needs to be done to make sure that high malpractice premiums don't create a financial disincentive for certain medical specialists to practice where they are needed. The Academic Task Force has reported that some obstetricians pay nearly a quarter of their gross income for malpractice coverage.

The practical effect of those costs has been to make obstetric care hard to find in Florida's rural communities. Jackson County has just one obstetrician practicing today. Liberty and Calhoun Counties have none. I
agree with the Task Force that we need to counter this disincentive with supplements to offset high premium costs.

But the Academic Task Force salary cap of $75,000 would preclude most high-risk medical specialists. My proposal is to do away with the income ceiling and take another approach to limiting those to whom the supplements are paid.

Under our proposal, the Department of Health and Rehabilitative Services would identify areas of critical state concern as to the availability of particular needed medical specialties. Physicians willing to practice in those areas would have malpractice premiums capped at 15 percent of gross income.

As an example, Liberty, Calhoun and Jackson Counties could be defined as areas of critical state concern for obstetric care. Again, it may be that some of Florida's urban counties are significantly below the ideal per capita ratio of practicing neurosurgeons. Those counties could be defined as areas of critical state concern for neurological care.

The Task Force has proposed to fund such a supplement through a tax on medical malpractice premiums, adding to an already overburdened funding base. Since this program would most likely be sunset after two years, I believe funds from the Department of Insurance Regulatory Trust Fund would provide adequate funding.

Finally, I'm pleased with the recommendations of the Academic Task Force on physician discipline, and the spirit with which the Department of Professional Regulation has indicated its commitment to follow those recommendations.

If barriers to effective discipline can be removed through a concentration of those responsibilities within DPR; if the impediments to fast action that have resulted from "probable cause panels" can be resolved; and if the more practical "preponderance of evidence" standard can be adopted, then I believe physician discipline can make a real contribution to solving the malpractice problem.

In closing, I would just like to say once more that I'm generally heartened by the efforts of the Academic Task Force. I believe they have found many of the needles that were lost in this haystack. Our task now is to use those efforts to produce comprehensive and effective legislation that will insure that disruptions to Florida's health care delivery system become a distant memory, not a tradition.

Thank you.
August 12, 1987

MEDICAL MALPRACTICE INSURANCE POOL PROPOSAL

In response to the high cost of medical malpractice insurance and the negative impact these insurance rates are having on public health services in Florida, Insurance Commissioner Bill Gunter is proposing that the Legislature create a mandatory pool to provide basic medical malpractice insurance to physicians. This proposed pool is similar to that proposed by Gunter during the 1987 regular session of the Legislature; since that time, the Commissioner has refined the plan which is outlined below. Among the most significant changes he is now proposing are: enactment of a structured judgment provision so that certain medical malpractice awards would be paid out over a period of time -- rather than in lump sums; and, the amendment of Florida's collateral source statute to eliminate duplicate health care benefits in certain malpractice cases. Details of the proposal which the Commissioner is urging the Legislature to consider in a special session later this year are:

MANDATORY COVERAGE

*Physicians electing to buy insurance would be required to obtain basic coverage from the pool in the amount of the current financial responsibility requirements: ($250,000 per claim with $750,000 total per year for physicians with staff privileges; $100,000/$300,000 for other physicians).

*Claims-made policies with retro-active prior acts coverage date coinciding with physician's existing insurance.


*Physicians retain the option to be uninsured, as long as they meet state laws relating to financial responsibility.
OPTIONAL COVERAGE

*Coverage for physicians would be available from the pool for up to $1 million per claim with a $3 million total per year.

ORGANIZATION

*The pool would be organized within the current Florida Medical Malpractice Joint Underwriting Association. The Board of Governors would be restructured.

*FMMJUA may contract with existing insurers and trusts to service the policies issued by the pool. Existing insurers may also provide coverage in excess of the amounts provided by the pool.

PREMIUM STABILIZATION PLAN

*Initial rates would be established by the Department of Insurance, taking into account rates currently charged by the five largest medical malpractice insurers in the state.

*Rate classifications would be revised in order to provide the greatest rate relief to the high-risk specialists. To accomplish this, rate differences among medical specialties would be capped. No specialist's rate would be greater than five times that of any other specialty in the same geographical territory (The current ratio exceeds 8 to 1).

*In the event of a deficit, assessments would be made against property and casualty insurers currently subject to FMMJUA assessments. No assessments against policyholders.

*Physicians with 3 or more indemnities greater than $10,000 each in last 5 years, or with 2 or more indemnities greater than $125,000 each in last 5 years, would be ineligible for the premium stabilization plan unless a risk underwriting committee approves the application. Coverage for such physicians must be obtained from existing FMMJUA with assessable policies.

PERIODIC PAYMENT OF JUDGMENT

*Judgments in excess of $50,000 entered against persons insured by FMMJUA would be paid by periodic payments, as structured by the court consistent with itemization by the jury.

COLLATERAL SOURCE (APPLICABLE TO ALL LIABILITY JUDGMENTS)

*The existing collateral source statute would be amended to allow for deduction from the award of duplicate health care benefits from other sources.
DEPARTMENT OF INSURANCE
August 12, 1987

RATE COMPARISONS FOR PROPOSED MEDICAL MALPRACTICE INSURANCE POOL *

<table>
<thead>
<tr>
<th>TERRITORY</th>
<th>AVERAGE RATE (1)</th>
<th>ESTIMATED POOL RATE (2)</th>
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<tr>
<td></td>
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<td>Family Practice - No Surgery</td>
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<tr>
<td>Rest of State</td>
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</table>

(1) The average of rates are based on a weighted average of St. Paul, Physicians Protective Trust Fund and Florida Physicians Insurance Company rates effective July 1, 1987 as presented in the Academic Task Force report.

(2) The rates are estimated based on administrative costs of 10%, plus 11.5% savings from proposed change in collateral source rule and the 1985-86 reforms. Rate for the highest risk specialties are 5.0 times the lowest risk with the income effect built into the rate level, only for the first $250,000/$750,000 of coverage. Sales commissions and profit factors have been eliminated from the rates.

*Based on $1 million per incident/$3 million total per year coverage, mature claims made rates.
PHYSICIANS' DISCIPLINE PROPOSAL

Insurance Commissioner Bill Gunter is proposing a two-point program to respond to Florida's most urgent medical malpractice insurance needs in a special legislative session this year: first, he is urging adoption of a non-profit, mandatory pool to provide basic malpractice insurance coverage to physicians (Details of that proposal are presented elsewhere in this package). Second, Gunter is offering specific steps Florida can take to reduce the actual incidents of medical malpractice.

In a report on medical malpractice earlier this year, the General Accounting Office reported to Congress that the states should take more aggressive action in disciplining doctors. In addition, the Academic Task Force for the Review of Insurance and Tort Systems found that less than four percent of the physicians in the state account for almost half of the paid claims. More vigorous detection and prosecution of doctors who commit medical malpractice and violate state laws would both enhance public health and reduce cost of medical malpractice insurance.

Commissioner Gunter recommends that the Florida Department of Professional Regulation be given authority, responsibility and resources to aggressively police the medical profession. To accomplish this goal, Gunter is proposing that:

AUTHORITY

*DPR's authority be expanded to investigate any physician on its own motion and that it be required to investigate any complaint that alleges facts that may constitute a violation of the law.

*To provide resources for its expanded authority and responsibility, the Department of Professional Regulation would be required to establish an investigation bureau dedicated to incidents of alleged violations of the medical practice act by physicians. The department would be required to report to the Legislature by May 1, 1988, the extent to which employing or contracting with additional investigators, attorneys, medical experts and others would enhance physician discipline and to what extent these additional positions should be funded by an increase in the physicians' licensing fee.
The membership on the Board of Medical Examiners would be revised to include three members who are on the faculty of Florida medical schools or who are on the staff of Florida teaching hospitals.

To speed up physician discipline cases, the Legislature should eliminate the three-member "probable cause" panel that now reviews investigations prior to the filing of a formal complaint with the Board of Medical Examiners against a physician.

**OBTAINING INFORMATION ON MALPRACTICING PHYSICIANS**

The Department of Professional Regulation would be required to create and advertise a toll-free hotline dedicated to the reporting of medical malpractice incidents and the provision to health care consumers of information of investigations and/or disciplinary proceedings against physicians.

Stricter "whistleblower" protections than currently exist would be enacted so that persons reporting medical malpractice incidents to DPR would be granted greater immunity from liability and employer retaliation.

In view of the fact that as many as 90 percent of medical malpractice cases are settled out of court, Florida should prohibit settlement agreements between malpractice plaintiffs and physicians which bar release of information about the case to DPR.

**OTHER MEASURES**

Penalties should be increased for hospitals that fail to report incidents of malpractice and the state should establish as an affirmative duty on the part of all health care providers that they should report incidents of apparent medical malpractice.

As a condition of licensure, all physicians should be available to participate on a rotating basis on local advisory panels -- analogous to medical jury duty -- to review cases under investigation by DPR in which the department seeks a report as to whether the physician performed in accordance with locally accepted standards of care. These reviews would serve as an investigative resource -- not a binding opinion.

**IN ADDITION**

Commissioner Gunter is also urging the Legislature to consider bills introduced by Representative Fred Lippman in the 1987 session which addressed tougher physician discipline measures. This legislation was adopted by the House but not by the Senate. The proposal strengthens the state's ability to obtain information on possible medical malpractice cases from hospitals and insurers. It provides for prompter and more
efficient distribution of that information to affected agencies. And it clearly establishes that a finding of general incompetence is not required for discipline to take place.
August 14, 1987

Representative Carl Ogden
5345 Ortega Blvd., Suite 14
Jacksonville, FL 32210

Dear Representative Ogden:

The enclosed program represents the work product of an Ad Hoc Committee, composed of nine doctors and nine lawyers, here in Palm Beach County. This committee was not appointed by anyone and was formed independent of any group or association. We are simply doctors and lawyers who felt that if we studied the malpractice problem without emotionalism, we could come to a reasonable compromise which would not only be fair but which would also work. I stress that this plan is no one's but ours, and was not preapproved by any legislator or any body.

Having personally served on Governor Graham's Task Force on Medical Malpractice in 1985, I feel strongly that this package represents a reasonable approach to the current problem. I, and the members of my committee, would be happy to meet with you at your convenience to discuss the merit of this plan. This program will be presented to the Palm Beach County Legislative Delegation on Monday, August 17, 1987, here in Palm Beach County.

Sincerely yours,

THEODORE BABBITT

TB/kas
enclosure
SUMMARY OF PROPOSAL BY
PALM BEACH COUNTY AD HOC COMMITTEE

I. Financing

All physicians and osteopaths in Florida would be required to obtain medical malpractice insurance from a state-run insurance fund. The amount of insurance required would be $250,000. This layer of coverage would be actuarially rated according to specialty. The fund would also offer coverage in excess of $250,000 to $2 million by requiring a $3,500 payment from every member of the fund. While the fund is expected to be actuarially sound, any deficits are to be recovered from all property and casualty insurers in the state. Physicians with two paid claims exceeding $125,000 each in the past three years can be separately rated or not covered. The fund is to be administered by the state by entering into cost plus contracts with present insurance carriers.

II. Tort Reform

A. Pre-Trial Procedures - Plaintiffs and defendants would be required to investigate the claim and obtain the written opinion of an expert prior to initiating litigation or denying a claim. Failure to comply with this requirement may make both the party and the attorney liable for the costs and attorney's fees of the other party. If the defendant(s) admit liability, the issue of damages is decided by binding arbitration instead of by a jury. Where the defendants do not admit liability, the case can proceed to trial after a "prima facie good cause hearing" and a pretrial settlement conference held by a court-appointed mediator (current law provides for a conference, but it is usually conducted by the judge or by counsel for both sides).

B. Damages - Insurers would be prohibited from including a right of subrogation in insurance contracts. In conjunction with the current collateral source statute, this prohibition would result in reducing the amount of a jury award by the amount of insurance a plaintiff is entitled to receive from other sources (e.g. health insurance, workers' compensation, automobile liability, etc.).

In cases decided by arbitration, payment for future economic losses may be structured. Current law provides that payments in excess of $250,000 may be structured, upon the request of any party.
III. Prevention

In actions by physicians seeking reinstatement of hospital staff privileges, the plan places the burden on the physician to show that the hospital lacked substantial competent evidence to act. Also, a grievance procedure patterned after the Florida Bar's grievance procedure should be established. The procedure should have local committees which make probable cause determinations, to be followed by a referee who then makes a recommendation to the Board.

IV. Staff Comments

This proposal is similar to the proposal by the Department of Insurance, except that it requires all physicians to purchase insurance from a state run fund, while the Department's proposal only requires that physicians wishing to purchase insurance purchase it from the fund.

The proposal requires that all physicians purchase $2 million coverage, with the rates for the first $250,000 being actuarially determined according to risk classes and a $3,500 charge to all physicians in the fund for the coverage from $250,000 to $2 million. At this time, staff does not know if the $3,500 charge is sufficient to make the fund actuarially sound.

Also, the provisions requiring binding arbitration when all defendants admit liability may be unconstitutional, since it deprives a plaintiff the right to a jury trial.

JAD/lah
09/08/87
FINANCING

1. Require mandatory insurance for all physicians and osteopaths.

2. Eliminate all alternatives for providing financial security other than purchase of insurance from a State run fund.

3. The State of Florida will administer this fund, by private contract, on a cost plus basis with the present insurance carriers.

4. Coverage will be available to all physicians and osteopaths providing, however, that any such physician or osteopath with two paid claims of over $125,000.00 within a three (3) year period, may be separately rated or refused coverage under the plan. Such physicians would have the alternative of applying to the present joint underwriting association for coverage.

5. The Statute requiring notification to the Department of Professional Regulation should be amended to provide for such notification only for claims resulting in payment in excess of $125,000.00, and providing for notice to the fund as well.

6. The State fund will provide both primary and excess coverage, the premium of which will be paid for on a two step basis. Coverage for the first $250,000.00 will be rated according to specialty. Coverage beyond the basic $250,000.00 primary coverage of $2 million, shall be funded by an equal yearly payment paid by every member of the fund. This payment is anticipated to be $3,500.00 per year.

7. The fund is expected to be actuarially sound, but in the event of any deficit, said deficit shall be paid on an annual basis by all property and casualty insurers in the State of Florida on a pro rata basis determined by the percentage of business done within the State.

8. All coverage will be on a claims made basis and tail coverage will be available on an actuarially sound basis. This is anticipated to be without cost to the member if necessary because of disability, death or retirement, and to cost approximately two times the last annual premium if the member continues the practice of medicine, but an alternative means of coverage becomes necessary because of dissolution of the fund.

9. Coverage above the State mandated limits may be obtained by any member on an open market basis.

10. The fund shall have the same liability for bad faith refusal to settle within the fund's policy limits, as presently exists with respect to private insurers.
TORT REFORM

1. Florida Statute 768.50(4), which was repealed by the 1986 Legislature, should be readopted. This Statute reads as follows:

"Unless otherwise expressly provided by law, no insurer or any other party providing collateral source benefits as defined in subsection (2) shall be entitled to recover the amounts of any such benefits from the defendant or any other person or entity, and no right of subrogation or assignment of rights of recovery shall exist. All policies of insurance providing benefits described in this section shall be construed in accordance with this section after the effective date of this act."

Insurers in the State of Florida, including worker's compensation insurers, personal injury protection insurers, health insurers, and every other type of insurance program shall not be entitled to subrogation as against any funds obtained in medical malpractice litigation. Florida Statute 768.50, providing a set-off for any collateral source of indemnity for any defendant in a medical malpractice action should be readopted.

2. Florida Statute 768.57 should be amended to provide that a Notice of Intent to Initiate Medical Malpractice Litigation may not be sent by a claimant, or attorney for a claimant, unless the sending party has made a reasonable investigation as permitted by the circumstances to determine that there are grounds for a good faith belief that there has been negligence in the care or treatment of the claimant. Such notice must contain the names of all attorneys participating in any fee contract with the potential claimant. Failure of the claimant, or his counsel, to have received a written opinion of an expert as defined in Florida Statute 768.45, that there appears to be evidence of medical negligence shall be prima facie evidence of lack of good faith. The same requirement shall exist with respect to the filing of a lawsuit, in the event of a denial of the claim.

An attorney, or claimant, who files a Notice of Intent to Initiate Action or initiates an action in bad faith is personally liable for attorney's fees and costs, including the reasonable cost of administration and investigation of the claim by a potential defendant or his insurer.

3. Florida Statute 768.57 should be amended to provide that an insurer or defendant or an attorney for said insurer or defendant may not reject a claim or file an answer denying liability unless a reasonable investigation, as permitted by the circumstances, has been made to determine that there are grounds for a good faith belief that there is lack of negligence in the care or treatment of the claimant. Failure of the defendant, the insurer, or the attorney to have a written opinion of an expert, as defined in Florida Statute 768.45, that there appears to be no evidence of medical negligence shall be prima facie evidence that the denial of the claim or filing of an answer was not done in good faith. Any defendant, insurer, or attorney who denies a claim or files an answer in bad faith, shall be personally liable for attorney's fees and costs, including the cost of preparation of the claim on the part of the claimant or claimant's counsel.

4. The claimant or a defendant, or their respective representatives, may file a motion before the court at any time after the filing of the defendant's answer for a showing of good cause. Upon the filing of such a motion, both sides shall provide, at the time of the hearing, a copy of the written report
utilized as a basis for their good faith notice of claim, denial of claim, complaint or answer together with an Affidavit showing that the expert meets the requirements of Florida Statute 768.45. The filing of such a report shall not preclude a party from utilizing additional or other experts at the time of trial.

If the Court finds that the action or answer were filed without good cause, the Court may dismiss the action or strike the answer, or grant such other relief as would be appropriate under the circumstances.

5. Based upon the information received at the hearing on the Motion for Showing of Good Cause, the Court may order a settlement conference pursuant to Florida Statute 768.75. The Court may order that said settlement conference shall be conducted by a Court appointed mediator. The reasonable fee of such a mediator shall be born equally by all parties. The Court appointed mediator shall report to the Court in the event a settlement results and the action can be terminated.

6. In the event that an attorney for the claimant, or an attorney for the defendant, shall be determined to have filed a claim, a rejection of a claim, an action or an answer in bad faith, the Court shall submit the matter to the Florida Bar for disciplinary review of the attorney. Any attorney who files three (3) actions within a five (5) year period which are terminated without a finding of negligence on behalf of the health care provider, shall be referred to the Florida Bar for disciplinary review of the attorney.

7. Florida Statute 768.575, with respect to Court ordered arbitration, should be repealed and in lieu thereof binding arbitration should be adopted in accordance with the following principles:

1) Where there are multiple defendants, all defendants must agree to accept financial responsibility in order to elect binding arbitration;

2) The arbitration panel decides the amount of damages in the case;

3) The arbitration panel has the right to structure future economic loss;

   (a) upon death of the plaintiff, payments for future medical expenses would cease;

   (b) Arbitrators have the right to provide for payments for wage loss after the death of the plaintiff to his dependents for a reasonable time;

   (c) to ensure that the annuity is paid, two financially sound companies should be used. Jurisdiction over the companies would be obtained through the annuity;

4) Attorneys fees for the claimant shall be limited to the schedule adopted by the Supreme Court of Florida for actions in which the defendant has admitted liability.

5) The parties should be able to escape the arbitrators' decision only for the following reasons:

   (a) the decision of the panel is not unanimous;
(b) the decision meets the test for reversal in the Florida Arbitration Code.

If one of these tests is met, a new binding arbitration can be ordered.

6) After the arbitration panel has determined damages, the defendants shall submit any dispute among themselves regarding the apportionment of financial responsibility to binding arbitration. This arbitration panel would be composed of physicians or other medical experts.

8. A Florida Statute should be adopted which will provide that a claimant or decedent's medical records shall be available to the claimant or his attorney at a reasonable charge within ten (10) business days, or a shorter time as provided by the Circuit Court upon motion. It shall not be grounds to refuse access to such medical records that they are not yet completed or that a medical bill is still owing. Failure to provide said records at a reasonable charge shall permit the claimant or his counsel to apply to the Circuit Court for an order requiring access to said records. The Court may order any health care provider refusing reasonable access to said records to pay claimant's attorney's fees and costs made necessary as a result of said refusal. In any hearing held with respect to whether an attorney had good faith for filing a claim or a Notice of Intent to Initiate Action, the Court shall consider any evidence regarding the refusal of a health care provider to provide access to records.

9. The following provisions shall govern the presuit screening period:

A. Notice of intent to initiate litigation sent by certified mail, return receipt requested, to any prospective or potential defendant shall operate as notice to said defendant and any other prospective or potential defendant who bears a legal relationship with the prospective or potential defendant who receives the notice such that actual notice may be reasonably assumed. In any motion to dismiss or abate an action for medical malpractice in which the question of actual or assumed receipt of notice is at issue, said issue shall be a question of fact to be decided by the Court. The notice shall include the names and addresses of all other parties and shall be sent to each party;

B. Methods - upon receipt by a prospective defendant of a notice of intent to initiate litigation, the parties may obtain presuit screening discovery by one or more of the following methods: unsworn statements upon oral examination; production of documents or things; and physical or mental examinations. Unless otherwise provided in this Rule, the parties shall make discoverable information available without formal discovery. Evidence of failure to comply may be grounds for dismissal of claims or defenses ultimately asserted;

C. Procedures for conducting presuit screening discovery -

1) Unsworn statements - the parties may require other parties to appear for the taking of an unsworn statement. Such statements shall only be used for the purpose of presuit screening and are not discoverable or admissible in any civil action for any purpose by any party. A party desiring to take the unsworn statement of any party shall give reasonable notice in writing to all parties. The notice shall state the time and place for taking the statement and the name and address of the party to be examined. Unless otherwise impractical, the examination of any party shall be done at the same time by all other parties. Any party may be represented by counsel at the taking of an unsworn statement. Statements may be electronically recorded, stenographically recorded, or recorded on video tape.
The taking of unsworn statements is subject to the provisions of Rules of Civil Procedure 1.310(d) and may be terminated for abuses. If abuses occur by either party, such abuses shall serve as some evidence of failure of that party to comply with the good faith discovery requirements of Florida Statute 768.57.

2) Documents or things - at any time after receipt by a prospective defendant of a notice of intent to initiate litigation, any party may request discovery documents or things. Said documents or things shall be produced at the expense of the requesting party within twenty (20) days of the date of receipt of the request. A party is required to produce discoverable documents or things within that party's possession or within the control of that party.

Failure of either party to comply with the above time constraints will not relieve that party of its obligation under the Statute, but shall serve as evidence of failure of that party to comply with the good faith discovery requirements.

3) Physical and mental examinations - upon receipt by a prospective defendant of a notice of intent to initiate litigation and within the presuit screening period, a prospective defendant may require an injured prospective plaintiff to appear before a physician or other appropriate expert for examination. The defendant shall give reasonable notice in writing to all parties as to the time and place for the examination.

Unless otherwise impractical, a potential plaintiff shall be required to submit to only one examination on behalf of all potential defendants. The practicality of a single examination shall be determined by the nature of the potential plaintiff's condition, as it relates to the liability of each potential defendant.

The report of the examiner shall be made available to all parties upon payment of the reasonable cost of reproduction. Such report shall not be provided to any uninvolved party at any time. Such report shall only be used for the purpose of presuit screening and the examining physician may not testify concerning the examination in any subsequent civil action for any purpose.

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

E. All requests for physical examinations or notices of unsworn statements, shall be in writing and a copy sent to all parties. Such requests or notices shall bear a certificate of service identifying the name and address of the person to whom the request or notice is served, the date of the request or notice and the manner of serving same.

F. The work product resulting from Florida Statute 768.57(5) is limited to communications, verbal or written, which originate pursuant to the presuit screening process.
PREVENTION

1. In any action seeking reinstatement of staff privileges to any hospital, the burden shall be on the claimant to show that the hospital lacks substantial competent evidence to justify denial of said staff privileges.

In the event that the Court finds that there has been a violation of due process, as a result of the failure of the hospital to follow its medical staff by-laws in the termination or refusal of staff privileges, but that there is substantial competent evidence to justify denial of said privileges, the Court may enter an order continuing the denial of said privileges during the time necessary for the hospital to comply with the said medical staff by-laws.

2. A grievance procedure should be established for health care providers, patterned after the grievance procedure of the Florida Bar, and tied to licensure. Said grievance procedure shall have local grievance committees, with the same ratio of professionals to lay people, as exists under the Florida Bar grievance procedure. Local medical grievance committees may make findings of probable cause, which will then result in the appointment of a referee whose decision shall bear the same relationship to the Board of Medical Examiners as the present decision of Florida Bar referees bears to the Florida Bar, and a physician may be disciplined accordingly, including revocation or suspension of license or other means of discipline similar to those provided for under the Florida Bar grievance procedure.
COMMITTEE MAKE UP

*NINE PHYSICIANS AND NINE LAWYERS FROM PALM BEACH COUNTY

*PHYSICIANS FROM ALL SPECIALTIES

*ATTORNEYS REPRESENTING INSURANCE COMPANIES, DOCTORS, HOSPITALS AND VICTIMS

*NOT AFFILIATED WITH OR APPOINTED BY ANY ORGANIZATION

*DIRECTED BY REE SAILORS, FORMER ADVISOR TO GOVERNOR BOB GRAHAM ON HEALTH ISSUES

*MET ON SATURDAYS OVER PAST TWO MONTHS
METHODS

EVALUATE PROBLEM

REVIEW AVAILABLE DATA

DISCUSS ALTERNATIVE PROPOSALS

BRAINSTORM SOLUTIONS
OBJECTIVES

REDUCE THE INCIDENCE OF INJURY TO PATIENTS

PROVIDE ALTERNATIVES TO LITIGATION AND USE THEM

*DISCOURAGE FRIVOLOUS CLAIMS/LAWSUITS

*PROVIDE INCENTIVES TO EARLY RESOLUTION OF VALID CLAIMS

ENHANCE THE PREDICTABILITY OF THE AMOUNTS AN INSURER WOULD HAVE TO PAY

REDISTRIBUTE PREMIUM BURDEN MORE EQUITABLY

DISTRIBUTE COSTS PASSED ALONG TO PATIENTS MORE EQUITABLY
DIVISION OF PROBLEM

FINANCING (INSURANCE)

RESOLUTION (TORT REFORM)

PREVENTION (RISK MANAGEMENT)
FINANCING

MANDATORY INSURANCE

STATE RUN FUND

AVAILABLE TO ALL

PRIMARY OF $250,000 ON A SPECIALTY BASIS

EXCESS OF $2,000,000 ON A FIXED FEE BASIS ($3,500)

ACTUARILY SOUND

ANY UNDERWRITING SHORTFALL FROM PROPERTY & CASUALTY PREMIUMS

CLAIMS MADE BASIS

TAIL COVERAGE AVAILABLE

EXCESS COVERAGE FROM OPEN MARKET

LIABILITY FOR BAD FAITH
**FINANCIAL DATA**

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*STATE FUND CAN BE CASH FLOW BASIS WITHOUT RESERVES

*BUDGETING ONLY FOR PAID CLAIMS WITH 50% OVER ESTIMATE WOULD GENERATE ADEQUATE RESERVES AND THIS PLAN GENERATES TWICE THAT AMOUNT

*MUST BE MANDATORY AND EXCLUSIVE TO BE ON CASH BASIS

*SAVINGS OF ADMINISTRATIVE AND COMMISSION CHARGES

*SAVINGS BY REDUCTION OF PRIMARY COVERAGE TO $250,000

*SAVINGS BY LACK OF POLICY TAX

*SAVINGS BY NON DUPLICATION

*SAVINGS BY AVOIDING OVER RESERVING

*TOTAL PREMIUM VOLUME OF PROPERTY AND CASUALTY POLICIES INCLUDING HEALTH INSURANCE WRITTEN BY LIFE COMPANIES (INCREASING) AVAILABLE IN EVENT OF
RESOLUTION

ELIMINATE ALL COLLATERAL SOURCE INDEMNITY

NOTICE OF CLAIM REQUIRES INVESTIGATION AND EXPERT

DENIAL OF CLAIM REQUIRES INVESTIGATION AND EXPERT

HEARING BEFORE COURT ON GOOD CAUSE WITH EXPERT REPORTS

PENALTIES TO ATTORNEYS AND PARTIES FOR BAD FAITH

MEDIATION BASED UPON HEARING WITH EARLY SETTLEMENT

DISCIPLINARY REVIEW OF ATTORNEYS IN BAD FAITH

BINDING ARBITRATION WITH ADMITTED RESPONSIBILITY

MEDICAL RECORDS AVAILABLE

PRESUIT SCREENING RULES
PREVENTION

SUBSTANTIAL COMPETENT EVIDENCE JUSTIFIES
DENIAL OF STAFF PRIVILEGES

DENIAL OF PRIVILEGES CONTINUES DURING
COURT REVIEW

GRIEVANCE PROCEDURE FOR HEALTH CARE PROVIDERS

TIED TO LICENSURE
PHYSICIANS AND LAY PEOPLE
HOARD OF MEDICAL EXAMINERS MAY SUSPEND OR REVOKE LICENSE
MEMORANDUM

September 1, 1987

TO: Dale Hazlett

FROM: Jerry Vogel

SUBJECT: Effect of Proposed Changes in Collateral Sources and Structured Settlements for Medical Malpractice

Attached is an analysis of the cost savings that can be expected from revising the collateral sources statute as given in our proposed bill. The estimated reduction is 10.8%.

No estimate has been made of the effect of structured settlements for claims with over $50,000 of future damages. There does not appear to be any data available to calculate the effect of the proposed structured settlement provision. The major unknown element is the extent to which awards are presently being discounted to present value even though a structured settlement is not being used. Since October of 1985 we have asked about structured settlements on our closed claim report. Below is a summary of the data reported to date for those claims where a structured settlement was used.

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<th>No. Paid Claims</th>
<th>Total Indemnity Paid</th>
<th>Cost of Structured Settlement</th>
</tr>
</thead>
<tbody>
<tr>
<td>78</td>
<td>$41,389,211</td>
<td>$34,830,693</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Total Expected Payments</th>
<th>Present Value of Expected Payments</th>
</tr>
</thead>
<tbody>
<tr>
<td>$395,179,947</td>
<td>$26,690,067</td>
</tr>
</tbody>
</table>

From the closed claim data, 3% of claims used a structured settlement and 15% of indemnity payments are structured.

JV/dm
attachment

cc: Gerald Wester
    Dan Buker
    Jack Nicholson
    Brian Deffenbaugh
    Jack Herzog
SAVINGS FROM COLLATERAL SOURCES

An estimate of the effect of including collateral sources as an offset to awards for medical malpractice is outlined below.

A number of assumptions have been used in developing this estimate.

1. Florida is assumed to have the same proportion of population with collateral sources as is shown by U.S. data.

2. The proportion of people with collateral sources in 1984 is a good estimate of collateral sources for the future.

3. The percent of recovery from health insurance as a collateral source is similar for automobile liability claims and medical malpractice claims.

4. There is no reduction in the present premium for individual or group health insurance as a collateral source.

5. There is a reduction in the present premium for social security benefits as a collateral source.

The general procedure for this estimate is as follows:

1. Estimate the percent of the population with available collateral sources.

2. Estimate the percent of recovery for those with available collateral sources.

3. Estimate the percent of total indemnity that could be offset by collateral sources.

4. Savings are the product of 1 through 3 above.

5. The above is estimated separately for medical costs and wage loss.

The estimates are as follows:

A. Medical Costs

1. Estimated percent of population carrying medical insurance @ 1984.
   a. Individual and Group Hospital and Physicians Coverage for those under age 65\(^{(1)}\) 173,445,000
   b. 1984 U.S. Population\(^{(2)}\) 234,443,000
   c. Percent of population with health insurance as a collateral source (a ÷ b) 74\%
2. Estimated percent of recovery for those with available collateral sources.
   a. Average economic loss over $25,000 $52,025\(^{(3)}\)
   b. Average group health recovery 31,231\(^{(3)}\)
   c. Percent reimbursement from group health coverage (b ÷ a) 60% 

It is assumed the recovery from individual policies is the same as group policies.

3. Estimated percent of total award paid for medical losses.
   a. Medical loss from NAIC Closed Claim Study 1975-1978 $179,431,651\(^{(4)}\)
   b. Total indemnity from same source 879,172,791\(^{(4)}\)
   c. Percent of indemnity paid for medical loss (a ÷ b) 20%

4. Savings for medical insurance as a collateral source 
   (l.c. x 2.c. x 3.c.) 8.9%

B. Wage Loss

1. Estimated percent of the population with disability income insurance @ 1984.
   a. Individual group coverage
      i. Short term (Less than two years benefit period) 59,332,000\(^{(5)}\)
      ii. Long term (Five or more years benefit period) 22,944,000\(^{(5)}\)
   b. 1984 U.S. Population 234,443,000\(^{(2)}\)
   c. Percent of population with disability income insurance
      i. Short term 25%
      ii. Long term 10%
   d. Percent of Florida population with potential for wage loss 
      (Florida population under 65) 82\(^{(6)}\)
   e. Potential wage earners with disability income insurance as 
      collateral source (c ÷ d)
      i. Short term 30%
      ii. Long term 12%

2. Estimated percent of recovery for those with available collateral source.
a. Long Term Disability Insurance
   i. Annual wage replaced by disability income insurance plus social security disability
   $15,941 (9)
   ii. Annual wage replaced by social security disability
   ii. Social Security disability starts after six months. Short term benefit is 70% of six months wage plus 20% for remaining 1½ years or
   $10,362
   iii. Disability income insurance recovery (i. - ii.)
   iv. Short term disability insurance recovery (ii ÷ iii)

b. Short Term Disability Income Insurance
   i. Short term disability insurance pays up to two years starting on first day of disability. Average 1984 annual wage is
   $15,941 (9)
   ii. Social Security disability starts after six months. Short term benefit is 70% of six months wage plus 20% for remaining 1½ years or
   $10,362
   iii. Average wage loss in medical malpractice claim
   $88,218 (10)
   iv. Short term disability insurance recovery (ii ÷ iii)

3. Estimated percent of total award paid for wage loss
   a. Wage loss from NAIC closed claim study 1975-1978
   $279,294,905 (4)
   b. Total indemnity from same source
   879,172,791 (4)
   c. Percent of indemnity paid for wage loss (a ÷ b)
   32%

4. Savings for disability income insurance as a collateral source
   (l.e.i x 2.b.iv. x 3.c.) + (l.e.ii. x 2.a.iii. x 3.c.)
   1.9%

C. Total savings from collateral sources (A.4. + B.4.)

1. 1986 Update Source Book of Health Insurance Data, Table 1.1
3. All Industry Research Advisory Committee, Automobile Injuries and Their Compensation in the United States, Table E-8
5. 1986 Update Source Book of Health Insurance Data, Table 1.7
7. Judgement estimate of typical maximum recovery for wage loss under disability policies from social security and policy benefit.
10. Estimated from Florida Medical Malpractice Closed Claims Reports. Average closed claim after 10-1-85 for severity codes 6,7 and 8 (permanent significant, major or grave injury) times 3.c.
ASSOCIATION POOL RATES

   Rating Class 1 statewide Mature Semi-Annual Pure Premium (Incurred Loss and Allocated Loss Adjustment Expense) $2,457

2) Adjustment to annual pure premium effective 7-1-87.
   $2,457 x 2 x 1.05 (1.05 is approximately the adjustment St. Paul made to reflect trend for annual versus six month policies) $5,160

3) Annual Statewide Pure Premium $5,160

4) Adjustment to Territory 1 Pure Premium
   St. Paul average proposed territory relativity is 1.166 from Exhibit F-1 and F-2. Territory 1 pure premium is $5,160 ÷ 1.166 = $4,425

5) Discount for investment income at 8.5% is .795 based on Supplemental Filing Memorandum Part D.

6) Proposed territory relativity is 1.5 instead of 2.0 proposed by St. Paul. The offset for this is 1.115. (Per Penrod 1983 report, 35% of doctors are in Dade & Broward. Ind territory relativity is 33% higher. Net effect is .33 x .35)

7) The rate for any class is limited to five (5) times the family physician - no surgery rate for the first $250,000/$750,000 of coverage. The effect of this is calculated based on the distribution of doctors in Penrod's 1983 report and St. Paul's class relativities. The needed offset is 1.104

8) The effect of the change in collateral source rule plus previous reforms from 1985-86 is estimated as 11.5%. See memo of 9-1-87 for the estimate of the effect of collateral source change.

9) The expense of running the association for all expenses other than allocated loss adjustment expense is estimated as 10%.

10) The base pure premium for $250,000/$750,000 is calculated from items 1) through 9) above as $4,258.

11) The base pure premium for excess of $250,000/$750,000 is item 10) ÷ 7) i.e., removing the effect of the limitation on class relativities, or

12) The applicable class relativities are from the St. Paul filing without limitations noted.
The limits relativity applicable are calculated from the St. Paul filing in Exhibit I and J without the amount for risk loading. The resulting factors are:

<table>
<thead>
<tr>
<th>Class</th>
<th>Limits of Liability</th>
<th>Excess of</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Up to $250,000/$750,000</td>
<td>$250,000/$750,000</td>
</tr>
<tr>
<td>1</td>
<td>1.0</td>
<td>1.0</td>
</tr>
<tr>
<td>2</td>
<td>1.5</td>
<td>1.5</td>
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<tr>
<td>3</td>
<td>2.0</td>
<td>2.0</td>
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<tr>
<td>4</td>
<td>2.7</td>
<td>2.7</td>
</tr>
<tr>
<td>5A</td>
<td>4.0</td>
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<tr>
<td>5</td>
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<tr>
<td>6</td>
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<td>6.0</td>
</tr>
<tr>
<td>7</td>
<td>5.0</td>
<td>7.5</td>
</tr>
<tr>
<td>8</td>
<td>5.0</td>
<td>9.5</td>
</tr>
</tbody>
</table>

13) The limits relativity applicable are calculated from the St. Paul filing in Exhibit I and J without the amount for risk loading. The resulting factors are:

<table>
<thead>
<tr>
<th>Class</th>
<th>Limits of Liability</th>
<th>Excess of</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Up to $250,000/$750,000</td>
<td>$250,000/$750,000</td>
</tr>
<tr>
<td>Class 1 - 4</td>
<td>1.45</td>
<td>.73</td>
</tr>
<tr>
<td>Class 5A - 8</td>
<td>1.47</td>
<td>.99</td>
</tr>
</tbody>
</table>

14) The territory relativity is 1.5 for Dade & Broward and 1.0 for the Remainder of State.

15) Factors for policy ages less than mature will be based on the values in St. Paul's filing as given in Exhibit 15.

16) Factors for tail coverage will be based on the data in the St. Paul filing.

17) The rates for mature coverage are shown below. The premium for $1,000,000 coverage is the total of $250/$750 and $750/$2,250 excess.

(Base x Terr x Limits x Class) Mature Annual Rates

<table>
<thead>
<tr>
<th>Class</th>
<th>$250/$750</th>
<th>$750/$2,250 Excess of $250/$750</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Dade &amp; Broward</td>
<td>Remainder of State</td>
</tr>
<tr>
<td>1</td>
<td>$ 9,261</td>
<td>$ 6,174</td>
</tr>
<tr>
<td>2</td>
<td>12,892</td>
<td>9,261</td>
</tr>
<tr>
<td>3</td>
<td>18,522</td>
<td>12,348</td>
</tr>
<tr>
<td>4</td>
<td>25,005</td>
<td>16,670</td>
</tr>
<tr>
<td>5A</td>
<td>37,556</td>
<td>25,036</td>
</tr>
<tr>
<td>5</td>
<td>42,251</td>
<td>28,166</td>
</tr>
<tr>
<td>6</td>
<td>46,945</td>
<td>31,295</td>
</tr>
<tr>
<td>7</td>
<td>46,295</td>
<td>31,295</td>
</tr>
<tr>
<td>8</td>
<td>46,295</td>
<td>31,295</td>
</tr>
<tr>
<td>Specialty</td>
<td>Physician</td>
<td>Location</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>--------------------</td>
<td>-------------------</td>
</tr>
<tr>
<td>Family Physician - NC Surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Radiology - Diagnostic - Minor Surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Internal Medicine - Minor Surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Emergency Medicine - NC Major Surgery</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Surgery - Family Practice</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Date</td>
<td>D/B</td>
<td>R/G</td>
</tr>
<tr>
<td>------</td>
<td>-----</td>
<td>-----</td>
</tr>
<tr>
<td>1/1/12</td>
<td>77.120</td>
<td>49.430</td>
</tr>
<tr>
<td>1/2/12</td>
<td>77.120</td>
<td>49.430</td>
</tr>
<tr>
<td>1/3/12</td>
<td>77.120</td>
<td>49.430</td>
</tr>
<tr>
<td>1/4/12</td>
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<td>1/8/12</td>
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<td>1/9/12</td>
<td>77.120</td>
<td>49.430</td>
</tr>
<tr>
<td>1/10/12</td>
<td>77.120</td>
<td>49.430</td>
</tr>
</tbody>
</table>

**NOTES:**

- All rates include any applicable state and federal taxes.
- All rates are for inpatient services.
- All rates are for adult patients.
- All rates are for acute care.
- All rates are for medical services.
- All rates are for surgical services.
### PHYSICIAN VS. OTHER COMPARISON

<table>
<thead>
<tr>
<th>PC</th>
<th>TYPHYS</th>
<th>LC</th>
<th>PHYSF</th>
<th>CUNAA</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>7-1-86</td>
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<td>1-7-87</td>
<td>7-1-87</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>1/10</th>
<th>FAMILY PHYSICIAN - NO SURGERY</th>
</tr>
</thead>
<tbody>
<tr>
<td>D/H</td>
<td>0.782</td>
</tr>
<tr>
<td>H/S</td>
<td>10.216</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>0.144</th>
<th>PSYCHIATRY - TO ELECTRO-CONVULSIVE THERAPY</th>
</tr>
</thead>
<tbody>
<tr>
<td>H/S</td>
<td>10.392</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>0.147</th>
<th>PHYSICIAN - DIAGNOSTIC - NO SURGERY</th>
</tr>
</thead>
<tbody>
<tr>
<td>D/H</td>
<td>2.929</td>
</tr>
<tr>
<td>H/S</td>
<td>10.178</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>0.207</th>
<th>INTERNAL MEDICINE - NO SURGERY</th>
</tr>
</thead>
<tbody>
<tr>
<td>H/S</td>
<td>10.375</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>0.273</th>
<th>PEDIATRICS - NO SURGERY</th>
</tr>
</thead>
<tbody>
<tr>
<td>H/S</td>
<td>18.619</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>0.427</th>
<th>FAMILY PRACTICE - MINOR SURGERY</th>
</tr>
</thead>
<tbody>
<tr>
<td>D/H</td>
<td>1.493</td>
</tr>
<tr>
<td>H/S</td>
<td>18.419</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>0.287</th>
<th>RADIOLOGY - DIAGNOSTIC - MINOR SURGERY</th>
</tr>
</thead>
<tbody>
<tr>
<td>D/H</td>
<td>2.952</td>
</tr>
<tr>
<td>H/S</td>
<td>18.419</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>0.287</th>
<th>INTERNAL MEDICINE - MINOR SURGERY</th>
</tr>
</thead>
<tbody>
<tr>
<td>D/H</td>
<td>20.663</td>
</tr>
<tr>
<td>H/S</td>
<td>14.670</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>0.332</th>
<th>GYNECOLOGY - MEDICINE - NO MAJOR SURGERY</th>
</tr>
</thead>
<tbody>
<tr>
<td>D/H</td>
<td>51.039</td>
</tr>
<tr>
<td>H/S</td>
<td>28.320</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>0.114</th>
<th>SURGERY - OPHTHALMOLOGY</th>
</tr>
</thead>
<tbody>
<tr>
<td>D/H</td>
<td>2.970</td>
</tr>
<tr>
<td>H/S</td>
<td>18.419</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>0.117</th>
<th>SURGERY - FAMILY PRACTICE</th>
</tr>
</thead>
<tbody>
<tr>
<td>D/H</td>
<td>77.043</td>
</tr>
<tr>
<td>H/S</td>
<td>N/A</td>
</tr>
</tbody>
</table>

**Note:** These are actual claims made for 1,000,000 LIMITS OF LIABILITY and 50,000 ANNUAL AGGREGATE.

*Amounts are rounded to the nearest thousand.*
<table>
<thead>
<tr>
<th>Speciality</th>
<th>July</th>
<th>August</th>
<th>September</th>
<th>October</th>
<th>November</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical and Surgical Plastic Surgery</td>
<td>47,930</td>
<td>56,702</td>
<td>47,930</td>
<td>56,702</td>
<td>47,930</td>
</tr>
<tr>
<td>Orthopaedic Surgery</td>
<td>89,599</td>
<td>89,599</td>
<td>89,599</td>
<td>89,599</td>
<td>89,599</td>
</tr>
<tr>
<td>General Surgery</td>
<td>74,232</td>
<td>74,232</td>
<td>74,232</td>
<td>74,232</td>
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<tr>
<td>Thoracic Surgery</td>
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<td>110,292</td>
<td>110,292</td>
<td>110,292</td>
<td>110,292</td>
</tr>
<tr>
<td>Anesthesiology</td>
<td>85,599</td>
<td>85,599</td>
<td>85,599</td>
<td>85,599</td>
<td>85,599</td>
</tr>
<tr>
<td>General Surgery - Otolaryngology - Including Plastic Surgery</td>
<td>85,995</td>
<td>85,995</td>
<td>85,995</td>
<td>85,995</td>
<td>85,995</td>
</tr>
<tr>
<td>Obstetrics</td>
<td>136,958</td>
<td>136,958</td>
<td>136,958</td>
<td>136,958</td>
<td>136,958</td>
</tr>
<tr>
<td>Orthopedic Surgery</td>
<td>136,958</td>
<td>136,958</td>
<td>136,958</td>
<td>136,958</td>
<td>136,958</td>
</tr>
<tr>
<td>Neurological Surgery</td>
<td>136,958</td>
<td>136,958</td>
<td>136,958</td>
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<td>136,958</td>
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<tr>
<td>Cardiovascular Surgery</td>
<td>136,958</td>
<td>136,958</td>
<td>136,958</td>
<td>136,958</td>
<td>136,958</td>
</tr>
</tbody>
</table>

**Note:** Values indicate the limits for 1,000,000 limits of liability per occurrence and $1,000,000 annual aggregate.
H 1454 (CONTINUED)
05/28/87 HOUSE On Committee agenda—Appropriations, 05/28/87, 3:30
pm, 21 HOR, Preliminary Committee Action by Appropriations
favorable, as a Committee Substitute, to Calendar
06/02/87 HOUSE Comm. Report CS by Appropriations, placed on Calendar
-JH 1066, CS read first time -JH 1066
06/06/87 HOUSE Died on Calendar

H 1455 GENERAL BILL/CS by Appropriations; Natural Resources;
Martin: Wallace and others (Similar CS/ENG/S 778)
Florida Role in Trail Program, provides legislative intent to provide for acquisi-
tion of abandoned railroad rights-of-way for use as recreational trails; provides
for and program, provides for authority of DNR to acquire land under Fia Rec
reational Trails Act; provides for powers of THT for purposes of program; pro-
scribes for responsibilities of D O T to be abandoned & to-be-abandoned railroad
right-of-ways, etc.; Florida Code, Ch 265, 7.25 251 Effective Date 07/01/87.
05/12/87 HOUSE Filed
05/13/87 HOUSE Introduced, referred to Appropriations -JH 442
05/15/87 HOUSE On Committee agenda—Appropriations, 05/15/87, 3:30
pm, 21 HOR
05/21/87 HOUSE Preliminary Committee Action by Appropriations Favor-
able, as a Committee Substitute, to Calendar
05/25/87 HOUSE Comm. Report CS by Appropriations, placed on Calendar
-JH 635, CS read first time -JH 635
05/28/87 HOUSE Placed on Special Order Calendar
05/29/87 HOUSE Read second time, Read third time, CS passed, YEAS 100
NAYS - JH 782
06/09/87 SENATE In Messages
06/09/87 SENATE Received, referred to Natural Resources and Conservation,
Transportation, Appropriations -SJ 539
06/06/87 SENATE Died in Committee on Natural Resources and Conserva-
tion, Ident/Sum/Compare bill passed, refer to CS/CSB 778
(Ch 87-128)

H 1456 GENERAL BILL/ENG by Natural Resources; Martin
(Compare CS/CS/S 572)
Eminent Domain/Order of Taking, authorizes D O T to acquire certain property
through eminent domain when reasonably necessary for securing applicable envi-
ronmental permits; for interagency agreements, etc. Amendments 337 27; Effective
Date 07/01/87.
05/11/87 HOUSE Filed
05/13/87 HOUSE Introduced, referred to Appropriations -JH 442
05/27/87 HOUSE Withdrawn from Appropriations -JH 442, Placed on Cal-
endar
05/28/87 HOUSE Placed on Special Order Calendar
05/29/87 HOUSE Read second time, Amendments adopted, Read third time,
Passed as amended, YEAS 99 NAYS 2 - JH 791
06/01/87 SENATE In Messages
06/02/87 SENATE Referred, referred to Transportation, Judiciary-Civil
SJ 469
06/04/87 SENATE Withdrawn from Transportation, Judiciary-Civil, Sub-
stituted for CS/CSB 782, Passed, YEAS 29 NAYS SJ 780
06/10/87 Signed by Officers and presented to Governor
06/16/87 HOUSE Approved by Governor, Chapter No 87-242

H 1457 GENERAL BILL/ENG by Natural Resources; Martin
(Identical CS/S 15)
Energy Conservation Standards Act, creates Florida Energy Conservation Stan-
dards Act, provides power of Community Affairs Dept.; specifies products cov-
ered by act, provides for energy conservation standards & requires compliance ther-
ewith, provides for test methods, exemptions & revision of standards, re-
quires manufacturers to submit certification statements, provides for enforce-
ment & penalties, requires reports to Gov. & Legislature by P B C Creates 533 951.
975, Effective Date 01/01/88
06/12/87 HOUSE Filed
06/13/87 HOUSE Introduced, referred to Appropriations -JH 442
06/19/87 HOUSE Withdrawn from Appropriations -JH 442, Placed on Cal-
endar
06/29/87 HOUSE Placed on Special Order Calendar
05/29/87 HOUSE Read second time, Amendment adopted, Read third time,
Passed as amended, YEAS 97 NAYS 5 - JH 782
06/01/87 SENATE In Messages
06/01/87 SENATE Referred, referred to Commerce, Economic, Community
and Consumer Affairs, Appropriations -SJ 469
06/09/87 SENATE Withdrawn from Commerce, Economic, Community
and Consumer Affairs, Appropriations, Substituted for CS/CSB 15; Passed,
YEAS 36 NAYS 1 - SJ 456
06/05/87 HOUSE Ordered enrolled
06/20/87 Signed by Officers and presented to Governor
07/04/87 Approved by Governor, Chapter No 87-271

H 1458 GENERAL BILL/CS/ENG by Appropriations; Insurance;
Ogden; Simon (Compare H 1144, R 974)
Medical Malpractice/Emergency Room, provides for additional members & re-
appointment of Board of Governors of Joint Underwriting Assoc.; provides for
premium stabilization plan re medical malpractice, requires certain physicians
& osteopaths to obtain minimum level of coverage, provides for assessments

(PAGE NUMBERS REFLECT DAILY SENATE AND HOUSE JOURNALS
AND NOT FINAL BOUND JOURNALS)

H 1458 (CONTINUED)
against insurers, prohibits insurers from selling certain malpractice coverage to
physicians, etc. Amendments 267 361, creates 766 606 Effective Date Upon becoming
law
05/12/87 HOUSE Filed
05/13/87 HOUSE Introduced, referred to Appropriations -JH 442
05/20/87 HOUSE On Committee agenda—Appropriations, 05/20/87, 3:30
pm, 21 HOR, Preliminary Committee Action by Appropriations Favorable, as a Committee Substitute, to Calendar
05/25/87 HOUSE Comm. Report CS by Appropriations, placed on Calendar
-JH 853, CS read first time -JH 853
06/01/87 HOUSE Placed on Special Order Calendar, Read second time -JH 853; Amendments adopted, Read third time; CS passed as amended, YEAS 73 NAYS 9 - JH 806
06/02/87 SENATE In Messages
06/03/87 SENATE Received, referred to Health and Rehabilitative Services,
Commerce, Appropriations -SJ 639
06/04/87 SENATE Died in Committee on Health and Rehabilitative Services

H 1459 RESOLUTION by Morse
Armando Valderrama & Elco G. Menoyo, expresses sympathy for those persons
suffering impairment for their beliefs in bringing freedom to their nation &
mankind & recognizes sacrifices & accomplishments of Armando Valderrama
& Elco Gutierrez Menoyo in achieving these ends
06/12/87 HOUSE Filed, Introduced, referred to Judiciary - JH 417
06/05/87 HOUSE Died in Committee on Judiciary

H 1460 RESOLUTION by Deutsch
Rabbi Menashe M. Schleifer; recognizes & commends Rabbi Menas-
heim Mendel Schleifer & the Lubavitch Movement for their efforts to foster
Jewish heritages; universal values & principles throughout the world
05/12/87 HOUSE Filed
05/13/87 HOUSE Introduced, referred to Ethics & Elections - JH 442
05/14/87 HOUSE Withdrawn from Ethics & Elections - JH 666, Placed on
Calendar, Read second time; Adopted - JH 478

H 1461 RESOLUTION by Patchett (Identical S 1341)
Florida Teacher of the Year, Mr. Charles Johnson, a highly skilled language arts teacher at Beachland Elementary School, Indian River County &
his distinguished colleagues for their sincere & dedicated service to education &
to the young people of Florida
05/12/87 HOUSE Filed
05/13/87 HOUSE Introduced, referred to Education, K-12 - JH 442
05/19/87 HOUSE Withdrawn from Education, K-12 - JH 482, Placed on
Calendar, Read second time; Adopted - JH 482

H 1462 RESOLUTION by Jennings; Lombard (Similar S 1348)
Sarah H. S. Basset, CODECARE, recognizes Saratoga High School's Sailors as
the 1987 Class AAAA Baseball Champions of Florida
05/12/87 HOUSE Filed
05/13/87 HOUSE Introduced, referred to Education, K - 12 - JH 442
05/14/87 HOUSE Withdrawn from Education, K - 12 - JH 482; Placed on
Calendar
06/04/87 HOUSE Read second time, Adopted - JH 1256

H 1463 LOCAL BILL/ENG by Tobohassen; Base; Benjamin
Pension/Employee Retiree, amends special act to delete compulsory retire-
ment language, repeals special act re automatic retirement of city employees, su-
percedes existing laws relating thereto; Effective Date 07/02/87
05/13/87 HOUSE Filed
05/14/87 HOUSE Introduced, referred to Community Affairs; Retirement,
Personnel & Collective Bargaining - JH 468
05/21/87 HOUSE Withdrawn from Community Affairs - JH 333, Now in Re-
irement, Personnel & Collective Bargaining
05/27/87 HOUSE Withdrawn from Retirement, Personnel & Collective Bar-
gaining - JH 666, Placed on Calendar
05/28/87 HOUSE Placed on Local Calendar
05/29/87 HOUSE Read second time, Amendments adopted, Read third time,
Passed as amended, YEAS 114 NAYS 0 - JH 768
06/01/87 SENATE In Messages
06/02/87 SENATE Referred, referred to Rules and Calendar - SJ 469
06/03/87 SENATE Considered by Rules and Calendar, placed on Local Calen-
der - SJ 456; Passed, YEAS 33 NAYS SJ 456
06/05/87 HOUSE Ordered enrolled
07/01/87 Signed by Officers and presented to Governor
07/02/87 Became Law without Governor's Signature, Chapter No 87-522

H 1464 RESOLUTION by Arnold; Ireland and others (Similar H 1448, R 1321)
Teachers' Appreciation Week, marks Teachers' Appreciation Week, May 10
through May 16, with special recognition of elementary & secondary school
teachers on May 15, as celebrated by Florida District of Kiwanis International
05/13/87 HOUSE Filed; Introduced, referred to Education, K - 12 - JH 442
05/14/87 HOUSE Withdrawn from Education, K - 12 - JH 453; Placed on
Calendar, Read second time; Adopted - JH 467

H 1465 RESOLUTION by Miller; Trammell; Saunders and others
Representatives Freshman Class Party, accepts with pleasure the hospitality ex-
(CONTINUED ON NEXT PAGE)
S 948 GENERAL BILL by Hal
Insurance/Coverage/Nonavailability, modifies time period that Fla Patient's Compensation Fund has to determine nonavailability of coverage. Amends 768.14 Effective Date Upon becoming law. 04/13/87 SENATE Filed
04/23/87 SENATE Introduced, referred to Commerce -SJ 149
05/08/87 SENATE Extension of time granted Committee Commerce
05/25/87 SENATE Extension of time granted Committee Commerce 06/06/87 SENATE Died in Committee on Commerce

S 949 GENERAL BILL by Peterson
Workers' Comp/Deputy Commissioners, provides for Senate confirmation of deputy commissioners appointed by Governor to make investigations & adjudication in workers' compensation claims. Amends 440.45 Effective Date 10/01/87 04/15/87 SENATE Filed
04/23/87 SENATE Introduced, referred to Commerce, Executive Business -SJ 149
05/09/87 SENATE Extension of time granted Committee Commerce
05/25/87 SENATE Extension of time granted Committee Commerce 06/06/87 SENATE Died in Committee on Commerce

S 950 GENERAL BILL/CS by Health and Rehabilitative Services; Gordon (Similar EN/G 1360, Compare EN/G 1239, S 741, CS/ENG/S 834, S 851, S 909)
Medical Practice/General Provision, provides access to confidential patient records for certain purposes. Professional Reg. Dept., limits public access there-to, expands internal risk management training requirements; requires certain incident reports/surgical procedures, provides for dept. investigation of incidents which may involve grounds for physician discipline, expands membership of Board of Medicine, etc. Amends Ch 395, 455, 468, 627, 768 Effective Date 10/01/87 04/13/87 SENATE Filed
04/23/87 SENATE Introduced, referred to Health and Rehabilitative Services, Commerce, Economic and Consumer Affairs -SJ 149
05/01/87 SENATE Extension of time granted Committee Health and Rehabilitative Services
05/14/87 SENATE On Committee agenda—Health and Rehabilitative Services, 05/19/87, 2:00 pm, Room A. Extension of time granted Committee Health and Rehabilitative Services
05/19/87 SENATE Comm Report CS by Health and Rehabilitative Services -SJ 366
05/25/87 SENATE Withdrawn from Economic, Economic and Consumer Affairs -SJ 366
05/25/87 SENATE Placed on Consent Calendar -SJ 367, Now in Economic, Economic and Consumer Affairs -SJ 367
06/03/87 SENATE Placed on Consent Calendar -SJ 628, Amendment pending -SJ 661
06/04/87 SENATE Placed on Special Order Calendar -SJ 796 & -SJ 707
06/09/87 SENATE Placed on Special Order Calendar -SJ 787, Amendment pending -SJ 972 & -SJ 972
06/06/87 SENATE Died on Calendar

S 951 GENERAL BILL/CS by Education: Thurman (Similar H 1198, Compare CS/ENG/H 802)
School Construction/Tax Materials, requires notice of toxic substances which may be used in performance of contracts for repair or maintenance of public school facilities, provides for public information and responsibility of enforcing safety precautions, etc. Effective Date 10/01/87 04/13/87 SENATE Filed
04/23/87 SENATE Introduced, referred to Education, Appropriations -SJ 150
05/01/87 SENATE Extension of time granted Committee Education
05/11/87 SENATE On Committee agenda—Education, 05/21/87, 2:00 pm, Room A
05/12/87 SENATE Comm Report CS by Education -SJ 388
05/25/87 SENATE CS read first time -SJ 388, Now in Appropriations -SJ 388
06/06/87 SENATE Died in Committee on Appropriations, Iden Sim/Compare bill passed, refer to CS/HB 802 (Ch 87-202)

S 952 GENERAL BILL by Thurman (Identical H 1231)
License/Fees, few spécies persons eligible to receive "The Chosen Few" license plates without payment of license tax. Creates s09.0855 Effective Date 10/01/87 04/13/87 SENATE Filed
04/23/87 SENATE Introduced, referred to Transportation, Finance, Taxation and Claims, Appropriations -SJ 150
05/01/87 SENATE Extension of time granted Committee Transportation
05/06/87 SENATE On Committee agenda—Transportation, 05/12/87, 2:00 pm, Room C
05/12/87 SENATE Comm Report Favorable by Transportation -SJ 293
05/13/87 SENATE Now in Finance, Taxation, and Claims -SJ 293
05/19/87 SENATE Extension of time granted Committee Finance, Taxation and Claims
06/22/87 SENATE On Committee agenda—Finance, Taxation, and Claims, 06/26/87, 2:00 pm, Room 1C
05/26/87 SENATE Comm Report Favorable with 1 amendment(s) by Finance, Taxation and Claims -SJ 416
06/27/87 SENATE Now in Appropriations -SJ 417

S 952 (CONTINUED)
06/03/87 SENATE Withdrawn from Appropriations -SJ 863, Placed on Calendar
06/08/87 SENATE Died on Calendar

S 953 GENERAL BILL by Thurman (Identical H 1122)
Drafts/Handicapped, provides that all required vaccination of registered tax тPeriod on Counties which are licensed & which have been raised for racing in pari-mutuel wagering events shall be under direct supervision & control of pari-mutuel Wagering Div Creates 550 1625 Effective Date 10/01/87 04/13/87 SENATE Filed
04/23/87 SENATE Introduced, referred to Commerce -SJ 150
05/08/87 SENATE Extension of time granted Committee Commerce
06/25/87 SENATE Extension of time granted Committee Commerce
06/06/87 SENATE Died in Committee on Commerce

S 954 GENERAL BILL by Thurman (Identical H 11119, Compare CS/ENG/H 1432)
Elections/Residency Requirement, creates provision re residency requirement for public officers & candidates for public office; requires that certain candidates or public officials have only one declared residence, requires omission from ballot of name of any candidate found in violation of residency requirement, grants Elections Commission authority to impose penalties, & determine such violations, etc. Creates 99.013, amend 109.18, 25, 26, 114.01 Effective Date 01/01/88 04/13/87 SENATE Filed
04/23/87 SENATE Introduced, referred to Judiciary-Civil -SJ 150
05/01/87 SENATE Extension of time granted Committee Judiciary-Civil
05/19/87 SENATE On Committee agenda—Judiciary-Civil, 05/21/87, 2:00 pm, Room 1C, Temporarily postponed
05/29/87 SENATE Extension of time granted Committee Judiciary-Civil
06/06/87 SENATE Died in Committee on Judiciary-Civil

S 955 GENERAL BILL by Scott (Similar H 1127, S 969)
Entertain Zone Jobs/Tax Credit, amends provision re enterprise zone job tax credit against corporate income tax, to allow for computation re new jobs & replacement workers based on unemployment compensation reports, provides for applicability to particular taxpayers. Amends 220.81, Effective Date Upon becoming law 04/13/87 SENATE Filed
04/23/87 SENATE Introduced, referred to Finance, Taxation and Claims -SJ 150
05/04/87 SENATE Extension of time granted Committee Finance, Taxation and Claims
05/19/87 SENATE Extension of time granted Committee Finance, Taxation and Claims
06/02/87 SENATE Extension of time granted Committee Finance, Taxation and Claims
06/08/87 SENATE Died in Committee on Finance, Taxation and Claims

S 956 GENERAL BILL/CS by Economic, Community and Consumer Affairs; Kircpatrick (Identical EN/G 1377, Compare CS/ENG/H 370)
Construction/Industry Regulation, revises exemptions from regulation provided for sale/installation of certain finished products, construction/improvement of owner-occupied structures, work performed by licensed dealers in liquefied petroleum gas & heating or air conditioning units, provides rulemaking authority of Construction Industry Licensing Bd., specific requirements re subcontracting of certain swimming pool work & roofing, etc. Amends 490,103, 113; creates 490.1108 Effective Date 10/01/87 04/13/87 SENATE Filed
04/23/87 SENATE Introduced, referred to Economic, Community and Consumer Affairs -SJ 150
05/07/87 SENATE Extension of time granted Committee Economic, Community and Consumer Affairs
06/21/87 SENATE Extension of time granted Committee Economic, Community and Consumer Affairs
05/25/87 SENATE Comm Report CS by Economic, Community and Consumer Affairs, placed on Calendar -SJ 418
06/27/87 SENATE CS read first time -SJ 420
05/28/87 SENATE Placed on Consent Calendar -SJ 499, CS passed, VAS 38 NAYS 6 -SJ 513
06/01/87 HOUSE In Messages
06/02/87 HOUSE Received, placed on Calendar -HJ 923
06/06/87 HOUSE Died on Calendar, Iden Sim/Compare bill passed, refer to CS/SB 370 (Ch 87 310) & HB 1377 (Ch 87-230)

S 957 GENERAL BILL/ENG by Kirkpatrick (Similar H 1052)
Optometrist/License Renewal, authorizes Board of Optometry to waive continuing education requirement. Amends 454.008 Effective Date 07/10/87 04/13/87 SENATE Filed
04/23/87 SENATE Introduced, referred to Economic, Community and Consumer Affairs -SJ 150
06/07/87 SENATE Extension of time granted Committee Economic Community and Consumer Affairs
06/14/87 SENATE On Committee agenda—Economic, Community and Consumer Affairs, 06/18/87, 2:00 pm, Room H

(Continued on next page)
H 833 (CONTINUED)
04/20/87 HOUSE Subreferred to Subcommittee IV
05/26/87 HOUSE Withdrawn from Natural Resources—HJ 574: Now in Appropriations
05/28/87 HOUSE Withdrawn from Appropriations—HJ 704, Placed on Calendar
06/22/87 HOUSE Placed on Special Order Calendar
06/01/87 HOUSE Retained on Regular Calendar
06/05/87 HOUSE Died on Calendar

H 834 GENERAL BILL by Gonzalez-Quevedo (Compare H 878, H 879)
Controlled substances: requires treatment of controlled substances analogs as controlled substances, amends provisions re treatment of controlled substances & delegation of authority to Attorney General; exempts law enforcement officers acting in official capacity from penalty provisions re distribution of said substances; Amends 817.663, 817.665, 838.03, creates 893.142 Effective Date 10/01/87
04/03/87 HOUSE Prefiled
04/06/87 HOUSE Introduced, referred to Criminal Justice, Appropriations
04/30/87 HOUSE Subreferred to Subcommittee on Crimes, Penalties and Prosecutions
05/04/87 HOUSE On Committee agenda—Criminal Justice, 05/06/87, 3:30 pm, Morton Hall, for ratification of subreferral
06/06/87 HOUSE Died in Committee on Criminal Justice

H 835 GENERAL BILL by Gonzalez-Quevedo (Identical S 860)
Casing, Gambling/Cruise Vessels: imposes tax on gross receipts from conduct of casing gambling on vessels while cruising between points in the state, or to & from a single point in state, if vessel does not dock at any point outside state during cruise; requires criminal penalties for violations of tax laws & reporting of gross receipts derived from gaming & winnings; provides for disposition of tax revenues, provides for collection & enforcement of tax, etc Effective Date 10/01/87
04/03/87 HOUSE Prefiled
04/06/87 HOUSE Introduced, referred to Regulated Industries & Licensing, Finance & Taxation, Appropriations—HJ 102
04/10/87 HOUSE Subreferred to Subcommittee on Patents & the Lottery
04/28/87 HOUSE On Committee agenda—Regulated Industries & Licensing, 04/30/87, 8:00 am, 414C, for ratification of subreferral
06/06/87 HOUSE Died in Committee on Regulated Industries & Licensing

H 836 GENERAL BILL by Gonzalez-Quevedo (Identical S 1138, Compare CN/RI 817, S 722)
Retirement-Out-of-state Teaching: defines term "out-of-state teaching service" and provides conditions for receiving out-of-state teaching service credits; Amends 121.021, 081 Effective Date 07/01/87
04/03/87 HOUSE Prefiled
01/09/87 HOUSE Introduced, referred to Retirement, Personnel & Collective Bargaining, Appropriations—HJ 103
04/20/87 HOUSE Subreferred to Subcommittee on Retirement
06/06/87 HOUSE Died in Committee on Retirement, Personnel & Collective Bargaining

H 837 GENERAL BILL by Gonzalez-Quevedo; Morse
Medical Malpractice—Exemption: exempts from medical malpractice insurance requirements licensed physicians who have retired & practiced only gratuitously; Amends 458.320, 459.0058 Effective Date 10/01/87
04/03/87 HOUSE Prefiled
04/06/87 HOUSE Introduced, referred to Insurance, Appropriations—HJ 103
04/22/87 HOUSE Withdrawn from Insurance; Appropriations, Referred to Judiciary; Appropriations—HJ 214
04/29/87 HOUSE Subreferred to Subcommittee on Court Systems, Probate and Consumer Law; On Committee agenda—HJCAYT, 04/30/87, 8:00 am, 214C, for ratification of subreferral
06/06/87 HOUSE Died in Committee on Judiciary

H 838 GENERAL BILL by Young (Compare CS/ENG/H 1432, CS/ENG/S 448)
Campaign Financing/Candidate Defined: defines "candidate" to mean an individual who has qualified for nomination or election to any office in compliance with provisions of law re candidates, campaign expenses & contesting elections; Amends 106.011 Effective Date 01/01/88
04/03/87 HOUSE Prefiled
04/06/87 HOUSE Introduced, referred to Ethics & Elections—HJ 103
04/17/87 HOUSE Subreferred to Subcommittee on Elections, On committee agenda—Ethics & Elections, 04/21/87, 11:15 pm, 212 HBOS—Temporarily passed
06/06/87 HOUSE Died in Committee on Ethics & Elections

H 839 GENERAL BILL by Community Affairs; Lozano (Similar CS/8 605)
Community Services Block Grant Program: amends definitions of terms in "department" to refer to Community Affairs Dept. to conform to governmental reorganization; provides for administration of act by that dept., for state funding through appropriation; specifies use of state-appropriated funds, etc Effective Date 07/01/87 or upon becoming law, whichever occurs later
04/03/87 HOUSE Prefiled

H 840 GENERAL BILL/CS/CS by Appropriations; Higher Education; Sansom (Compare CS/ENG/H 864, CS/8 1074)
Community Colleges: funding, provides for fee waiver calculations, provides for carry forward of certain funds; revives limitations re contributions; authorizes institutions to continue offering certain vocational education programs, authorizes establishment & maintenance of personnel classification & pay plan for community college administrative employees, exempts certain administrative employees from career service, etc Amends 110.204, 240.311, 36.335, 36 Effective Date 07/01/87
04/03/87 HOUSE Prefiled
04/09/87 HOUSE Introduced, referred to Higher Education, Appropriations—HJ 103
04/15/87 HOUSE On Committee agenda—Higher Education, 04/17/87, 8:30 am, 212 HOB, for subreferral—Meeting cancelled
04/20/87 HOUSE On Committee agenda—Higher Education, 04/22/87, 1:15 pm, 212 HOB, for subreferral
04/22/87 HOUSE Subreferred to Administration and Finance
04/23/87 HOUSE On Committee agenda—Higher Education, 04/27/87, 3:30 pm, 212 HOB, or if not finished, 04/29/87, 8:30 am, 212 HOB
04/27/87 HOUSE Preliminary Committee Action by Higher Education Favorable, as a Committee Substitute
04/29/87 HOUSE Committee Report CS by Higher Education—HJ 321; CS read first time—HJ 321, Now in Appropriations—HJ 321, On subcommittee agenda—Appropriations, if not finished, 04/29/87, 3:30 pm, 214C—Not received in time for meeting
05/12/87 HOUSE Subreferred to Subcommittee on Education
05/25/87 HOUSE On Committee agenda—Appropriations, 05/26/87, 8:00 am, 214 HOB—Temporarily passed
06/28/87 HOUSE On Committee agenda—Appropriations, 06/28/87, 3:30 pm, 214 HOB; Preliminary Committee Action by Appropriations, if not finished, 06/29/87, 11:15 pm, 214 HOB, as a Committee Substitute
06/01/87 HOUSE Comm. Report CS/CS by Appropriations, placed on Calendar—HJ 920, CS read first time—HJ 920
06/02/87 HOUSE Placed on Special Order Calendar; Read second time, Read third time, Passed as amended, VFA 112 NAYS 0—HJ 729
06/28/87 SENATE Placed in Message

PAGE NUMBERS REFLECT DAILY SENATE AND HOUSE JOURNALS AND NOT FINAL BOUND JOURNALS

H 841 GENERAL BILL/ENG by Gonzalez-Quevedo and others (Compare H 554, CS/S 1248)
Jose Martinez-McCarron Scholarship: establishes Jose Martinez Scholarship Foundation, establishes "Ronald F. McNair Memorial Scholarship Program," provides for eligibility criteria & funding for Administration Dept., for trust fund; specifies maximum amount for each annual award; requires unused award money be returned to trust fund, etc Creates 229.0609 Effective Date 01/01/88
05/05/87 HOUSE Prefiled
04/03/87 HOUSE Introduced, referred to Higher Education, Appropriations—HJ 103
04/15/87 HOUSE On Committee agenda—Higher Education, 04/17/87, 8:30 am, 212 HOB, for subreferral—Meeting cancelled
04/20/87 HOUSE On Committee agenda—Higher Education, 04/22/87, 1:15 pm, 214 HOB, for subreferral
04/22/87 HOUSE Subreferred to Subcommittee on Planning and Programs
06/12/87 HOUSE Withdrawn from Higher Education—HJ 417, Now in Appropriations
05/18/87 HOUSE Withdrawn from Appropriations—HJ 480, Placed on Calendar
05/28/87 HOUSE Placed on Special Order Calendar
06/28/87 HOUSE Read second time, Amendments adopted; Read third time, Passed as amended, YFAS 112 NAYS 0—HJ 729
05/28/87 SENATE In Message

(CONTINUED ON NEXT PAGE)
H 1374 GENERAL BILL/ENG by Youth; Reddick and others
School Health Services, provides for statewide student health needs assessment, provides rulemaking authority Creates 402-321 Appropriations $297,766. Effective Date. 07/01/87.
04/28/87 HOUSE Filed
05/01/87 HOUSE Introduced, referred to Appropriations - HJ 323
05/12/87 HOUSE Withdrawn from Appropriations - HJ 417, Placed on Calendar
05/28/87 HOUSE Placed on Special Order Calendar
06/03/87 HOUSE Retained on Regular Calendar
06/06/87 HOUSE Died on Calendar, Iden /Sim /Compare Bill passed, refer to SB 614 (Ch 87-323)
H 1374 GENERAL BILL/ENG by Youth; Reddick and others
School Health Services, provides for statewide student health needs assessment, provides rulemaking authority Creates 402-321 Appropriations $297,766. Effective Date. 07/01/87.
04/28/87 HOUSE Filed
05/01/87 HOUSE Introduced, referred to Appropriations - HJ 323
05/12/87 HOUSE On Committee agenda - Appropriations, 05/21/87, 3:30 pm, 21 HOB
05/22/87 HOUSE Preliminary Committee Action by Appropriations. Favorable, with 1 amendment, to Calendar
05/22/87 HOUSE Comm Report. Favorable with 1 amendment(s) to Appropriations, placed on Calendar - HJ 567
06/02/87 HOUSE Placed on Special Order Calendar, Read second time, Amendment adopted, Read third time, Failed to pass, YEAS 61 NAYS 58 - HJ 1010, Reconsidered, Passed as amended, YEAS 78 NAYS 42 - HJ 1010
06/03/87 SENATE In Messages, Referred to Education, Appropriations - SJ 637
06/06/87 SENATE Died in Committee on Education
H 1376 GENERAL BILL by Regulatory Reform; Metcalf; Morse, Gonzalez-Quevedo (Similar CS/ENG/S 878, Compare H 844, S 1216)
Veterinarian/Licensee/Parent/Boy, amends provisions re education & examination requirements for licensure & for licensure by endorsement, amends provisions re grounds for disciplinary actions, makes animal rabies vaccine a legend drug, corrects cross-references, etc. Amends 474 207, 214, 217, 2141, 455 241, creates 499 035 Effective Date 10/01/87.
04/28/87 HOUSE Filed
05/01/87 HOUSE Introduced, referred to Appropriations - HJ 323
05/12/87 HOUSE Withdrawn from Appropriations - HJ 417, Placed on Calendar
05/19/87 HOUSE Placed on Special Order Calendar
05/27/87 HOUSE Iden /Sim Senate Bill substituted, Laid on Table under Rule, Iden /Sim /Compare Bill passed, refer to CS/SS 878 (Ch 87-333) - HJ 642
H 1376 GENERAL BILL by Regulatory Reform; Metcalf and others (Similar CS/S 752)
Realty/Licensing, revises Professional Regulation Dept.'s duties re license renewal, adds exemption on real estate brokers, sellers & schools; reissues license renewal fee cap, revises continuing education requirements, reissues renewal period for real estate licenses, revises procedures for Real Estate Recovery Fund fee collections; revises prohibition of certain Real Estate Recovery Fund claims Amends 455 203, 475 011, 125, 182, 482, 483 Effective Date. Upon becoming law.
04/28/87 HOUSE Filed
06/01/87 HOUSE Introduced, referred to Finance & Taxation, Appropriations - HJ 323
05/12/87 HOUSE Withdrawn from Finance & Taxation - HJ 417, Now in Appropriations
06/01/87 HOUSE Withdrawn from Appropriations - HJ 493, Placed on Calendar
05/28/87 HOUSE Placed on Special Order Calendar
06/01/87 HOUSE Read second time, Read third time, Passed, YEAS 116 NAYS 0 - HJ 899
06/01/87 SENATE In Messages
06/03/87 SENATE Received, referred to Economic, Community and Consumer Affairs - SJ 631
06/04/87 SENATE Withdrawn from Economic, Community and Consumer Affairs. Substituted for CS/SS 752, Passed as amended, YEAS 34 NAYS 0 - SJ 778
06/04/87 HOUSE In Messages
06/05/87 HOUSE Message was taken up - HJ 1261, Amendments to Senate amendments adopted, Considered in Senate amendments as amended, Passed as amended, YEAS 113 NAYS 0 - HJ 1263
06/05/87 SENATE In Messages
06/06/87 SENATE Died in Messages
H 1377 GENERAL BILL/ENG by Regulatory Reform, Langton (Identical CS/S 956, Compare CS/ENG/S 376)
Construction Industry Regulation, revises exemptions from regulation provided for sale/installation of certain finished products, construction/improvement of owner-occupied structures, work performed by licensed dealers in liquidated petroleum gas, construction/repair of air conditioning units, provides rulemaking authority of Construction Industry Licensing Bd., specifies requirements re subcontracting of certain swimming pool work & roofing, etc. Amends 459 103, 113, creates 488 106 Effective Date 10/01/87
04/28/87 HOUSE Filed
06/01/87 HOUSE Introduced, referred to Appropriations - HJ 323
06/12/87 HOUSE Withdrawn from Appropriations - HJ 417, Placed on Calendar
06/03/87 HOUSE Placed on Special Order Calendar
06/01/87 HOUSE Read second time - HJ 898, Amendment pending - HJ 898
06/02/87 HOUSE Pending amendment adopted, Amendment adopted, Read third time, Passed as amended, YEAS 106 NAYS 1 - HJ 104
06/03/87 SENATE In Messages, Referred, referred to Economic, Community and Consumer Affairs - SJ 637, Withdrawn from Economic, Community and Consumer Affairs. Passed, YEAS 31 NAYS 0 - SJ 704
06/03/87 SENATE Ordered enrolled
06/03/87 Signed by Officers and presented to Governor
06/03/87 Approved by Governor, Chapter No 87-255
H 1378 GENERAL BILL by Regulatory Reform; Ostrau (Similar CS/ENG/S 744)
Refrigeration/Compliance, revises provisions re qualifications of applicants for license as barbers, provides prerequisites for examination, provides for examination of persons licensed in another state, revises provisions re licensure & license renewal by endorsement of persons licensed in another state or country, provides for fee increases, etc. Amends 474 114, 144, 192 Effective Date. 10/01/87.
06/01/87 HOUSE Filed
06/12/87 HOUSE Withdrawn from Finance & Taxation - HJ 417, Now in Appropriations
05/28/87 HOUSE Withdrawn from Appropriations - HJ 704, Placed on Calendar
06/01/87 HOUSE Placed on Special Order Calendar
06/12/87 HOUSE Read second time, Iden /Sim Senate Bill substituted, Laid on Table under Rule, Iden /Sim /Compare Bill passed, refer to CS/SS 744 (Ch 87-390) - HJ 864
H 1379 GENERAL BILL by Regulatory Reform, Lippman (Similar ENG/S 389)
Sunburn/Sunplay/Review & Relief Data (SUNDOWN/SUNSET) provides for future report & legislative review of certain provisions re advisory boards subject to executive agencies & provisions of laws regulating programs & functions, etc Amends F.S Effective Date. Upon becoming law.
04/28/87 HOUSE Filed
05/01/87 HOUSE Introduced, placed on Calendar - HJ 324
05/06/87 HOUSE Placed on Special Order Calendar
06/12/87 HOUSE Read second time, Iden /Sim Senate Bill substituted, Laid on Table under Rule, Iden /Sim /Compare Bill passed, refer to SB 359 (Ch 87-60) - HJ 409
H 1380 GENERAL BILL/ENG by Regulatory Reform; Lippman (Similar CS/S 960, Compare ENG/H 1239, S 741, CS/ENG/S 834, S 881, S 900)
Medical Practice/General Revise, provides access to confidential patient records for certain records for Professional Reg. Dept., limits public access there to, expands internal risk management training requirements, requires certain incident reports on surgical auditories, provides for: investigatory incident which may involve grounds for physician discipline, modifies membership requirements of Board of Medicine, etc Amends Cha 365, 455, 458, 459, 627, 768 Effective Date 10/01/87.
04/28/87 HOUSE Filed
06/01/87 HOUSE Introduced, referred to Finance & Taxation, Appropriations - HJ 324
06/12/87 HOUSE Withdrawn from Finance & Taxation - HJ 417, Now in Appropriations
06/26/87 HOUSE Withdrawn from Appropriations - HJ 608, Placed on Calendar
06/26/87 HOUSE Placed on Special Order Calendar
06/01/87 HOUSE Read second time, Amendments adopted, Read third time, Passed, YEAS 116 NAYS 1 - HJ 901
06/01/87 HOUSE From Engrossing, Reconsidered, Amendments renumbered, withdrawn, Passed as amended, YEAS 106 NAYS 0 - HJ 901
06/01/87 SENATE In Messages
06/03/87 SENATE Amended, referred to Health and Rehabilitative Services, Economic, Community and Consumer Affairs - SJ 637
06/06/87 SENATE Died in Committee on Health and Rehabilitative Services
H 1381 RESOLUTION by Burnsed and others (Identical H 1283, S 1304)
Flea, Sheriffs Boys Ranch, commends sheriffs & citizens of Fla & Fla Sheriffs Youth Ranches, Inc., for establishment in 1957 of Fla Sheriffs Boys Ranch & for continuous operation for 30 years.
04/28/87 HOUSE Filed
05/01/87 HOUSE Introduced, referred to Youth - HJ 324
05/15/87 HOUSE Withdrawn from Youth - HJ 402, Placed on Calendar
05/19/87 HOUSE Read second time, Adopted - HJ 483

(PAGE NUMBERS REFLECT DAILY SENATE AND HOUSE JOURNALS AND NOT FINAL BOUND JOURNALS)
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FILE 1 GENERAL & MISC.

1988 BILL HISTORIES
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FILE 2 REPORTS & STUDIES

= Academic Task Force for Review of the Insurance & Tort Systems:

(1) Preliminary Fact-Finding Report on Medical Malpractice, 2/14/87

(2) Medical Malpractice Recommendations (DRAFT) 10/27/87

(3) ___________ 11/6/87


FILE 3 SB 6-E

BILLS & STAFF ANALYSES

FILE 4 OTHER SPECIAL SESSION "E" BILLS & STAFF ANALYSES

FILE 5 FSU LAW REVIEW ARTICLES

RE: Medical Malpractice (1975-1988)
An act relating to medical incidents; providing legislative findings and intent regarding regulatory reform; amending s. 20.30, F.S.; creating the Division of Medical Quality Assurance within the Department of Professional Regulation; providing duties of the division and bureau, requiring a report; placing the licensing boards for various health care professions within the division; amending s. 395.0115, F.S.; providing antitrust immunity through establishment of a state-mandated peer review process; requiring licensed facilities to provide for peer review of physicians who provide health care services at such facilities and providing procedures therefor; requiring report of final disciplinary actions to the Division of Medical Quality Assurance for further investigation; providing for peer review panel immunity and for confidentiality of records; creating s. 395.0146, F.S.; requiring a certificate of need from the Department of Health and Rehabilitative Services for termination or reduction of emergency or trauma services; amending s. 395.017, F.S.; providing maximum charge for copying records; providing access to confidential patient records for certain proceedings of the Department of Professional Regulation; limiting public access thereto; amending s. 395.041, F.S.; expanding internal risk management education and training requirements; requiring certain incident reports relating to surgical procedures; requiring report of certain incidents to the department; limiting public access; providing for department review and investigation of incidents which may involve conduct subject to discipline; providing administrative fines for violation of reporting requirements; providing for annual review of risk management programs; protecting risk managers from liability for implementation of risk management programs; requiring a report to the Legislature; amending s. 395.504, F.S., to correct a cross-reference; amending s. 455.225, F.S.; providing civil immunity and prohibition from discharge to persons reporting with respect to incompetence, impairment, or unprofessional conduct of specified health care providers; providing penalties; amending s. 455.241,
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F.S.; providing for reports of patient records; creating s. 455.2415, F.S.; providing for disclosure of patient communications under certain circumstances; amending s. 455.242, F.S.; providing for disposition of records of physicians who terminate practice or relocate; amending s. 455.245, F.S.; providing conditions for considering emergency suspension or restriction of a license; creating s. 455.247, F.S.; requiring physicians, osteopathic physicians, podiatrists, and dentists to report professional liability claims and actions to the department; specifying contents; creating s. 455.28, F.S.; requiring reporting of certain physicians for violation of grounds for disciplinary action; providing a penalty; requiring investigation of probable disciplinary violations; amending s. 458.303, F.S.; revising exemption of certain commissioned medical officers from specified medical practice provisions; amending s. 458.307, F.S.; modifying membership of the Board of Medicine; specifying composition of probable cause panels; providing for a training program; providing for completion of a panel's work; amending s. 458.311, F.S., relating to requirements for licensure of physicians by examination; providing for an investigative process; providing for restricted licenses; amending s. 458.313, F.S.; providing for an investigative process for licensure by endorsement; requiring certain active practice; providing for restricted licenses; amending s. 458.315, F.S.; prohibiting issuance of temporary certificates for practice in areas of critical need to certain persons by endorsement; amending s. 458.3165, F.S.; providing for biennial renewal of public psychiatry certificates; amending s. 458.319, F.S.; increasing the maximum fee for renewal of a license to practice medicine; requiring evidence of active practice for license renewal; providing for supervised practice; amending ss. 458.320 and 459.0085, F.S.; authorizing physicians and osteopathic physicians to use risk retention groups to meet financial responsibility requirements; amending s. 458.327, F.S.; providing a penalty for leading the public to believe that one is licensed as a medical doctor, or is engaged in the licensed practice of medicine, without a license; creating ss. 458.3295, 459.0145, F.S.; prohibiting a concerted effort by a physician or osteopathic physician to refuse emergency room treatment to patients; authorizing a circuit court to enjoin such conduct; providing a penalty; amending ss. 458.331 and 459.015, F.S.; providing additional grounds for disciplinary action against physicians and osteopathic physicians; providing penalties and providing priorities for application thereof; establishing the burden of proof for administrative actions against physicians; providing for injunctive relief; providing for department review and investigation of claims; amending ss. 458.3315, 459.0155, F.S.; providing that a physician or osteopathic physician who is believed to be impaired must execute a release of his medical records to a consultant retained by the Department of Professional Regulation and limiting the use which the consultant may make of such records; amending s. 458.337, F.S.; specifying requirements for reports by medical organizations and hospitals when the physician has resigned; amending s. 458.345, F.S.;
establishing requirements for registration of resident physicians and interns; providing a fee; restricting renewal or extension; prohibiting registration of certain persons; increasing a penalty; amending ss. 458.347 and 459.022, F.S.; allowing extended temporary certification of physician assistants and osteopathic physician assistants; amending s. 459.0055, F.S.; providing for an investigative process for licensure of osteopathic physicians; amending s. 459.008, F.S.; requiring evidence of active practice for license renewal; providing for supervised practice; amending s. 459.0092, F.S.; increasing the maximum fee for renewal of a license to practice osteopathic medicine; amending ss. 460.413, 461.013, 464.018, 465.016, and 466.028, F.S.; providing additional grounds for disciplinary action against chiropractic physicians, podiatrists, nurses, pharmacists, and dentists; amending s. 627.912, F.S.; requiring insurers to report certain claims against dentists; providing for department review and investigation; providing for an annual report; amending s. 641.55, F.S.; providing for department review and investigation of certain incidents reported by health maintenance organization internal risk management programs; limiting public access, requiring report of certain incidents relating to surgical procedures; amending s. 768.13, F.S.; providing immunity from civil liability to physicians, hospitals, and certain hospital employees rendering medical care or treatment in response to an emergency within a hospital or trauma center; providing exceptions to such immunity; amending s. 768.45, F.S.; prescribing matters to be considered by the trier of fact in a claim of negligence for services provided in a hospital emergency room; limiting who may give expert medical testimony; amending s. 768.78, F.S.; providing additional methods of payments of damage awards; providing legislative findings and intent; providing definitions; providing applicability of and procedure for mandatory presuit investigation and medical expert corroboration of medical negligence claims and defenses by prospective parties; requiring availability of medical records for presuit screening of claims and defenses and providing penalties, providing for presuit discovery of medical negligence claims and defenses and providing immunity with respect thereto; providing for presuit investigation of medical negligence claims and defenses by the court, and providing penalties for lack of reasonable investigation in filing or in corroborating medical negligence claims or defenses; providing for nonbinding arbitration of civil cases involving claims for medical negligence; providing for selection of arbitration panels; providing for referral of cases to arbitration and procedures for referral; providing procedures for hearings; providing for arbitration awards and judgments; providing for trial de novo; providing for assessment of attorney's fees and costs in certain circumstances; providing for appeal of award; creating the Florida Birth-Related Neurological Injury Compensation Plan; providing legislative findings and intent; providing definitions; providing exclusiveness of remedy; providing for the hearing of claims by deputy commissioners of the Division of Workers' Compensation of
the Department of Labor and Employment Security; providing procedure for the filing of claims and responses; providing for medical disciplinary review; providing for tolling of the statute of limitations; providing for hearings, parties, and discovery; providing for review by a medical advisory panel; providing for determination of claims; providing a presumption as to injury; providing for binding nature of findings; providing for awards for birth-related neurological injuries, and for notice of such awards; providing for conclusiveness of determination or award; providing for appeal; providing for enforcement of awards; providing a limitation on the bringing of claims; creating the Birth-Related Neurological Injury Compensation Trust Fund within the Department of Insurance and providing for administration of the fund by the Florida Birth-Related Neurological Injury Compensation Association pursuant to a plan of operation approved by said department; providing for assessments for participation in the plan; providing for actuarial valuation of the fund by the department; providing for membership and a board of directors for the association; providing powers and duties of the association; providing for notice to obstetrical patients of participation in the plan; providing for certain appropriations; providing for assessment by certain boards; amending s. 768.81, F.S.; providing for an apportionment of damages based on a party's percentage of fault and not on the basis of the doctrine of joint and several liability; requiring medical malpractice insurers to reflect certain savings in rate filings and schedules; providing an effective date.

WHEREAS, the Legislature finds that there is in Florida a financial crisis in the medical liability insurance industry, and

WHEREAS, it is the sense of the Legislature that if the present crisis is not abated, many persons who are subject to civil actions will be unable to purchase liability insurance, and many injured persons will therefore be unable to recover damages for either their economic losses or their noneconomic losses, and

WHEREAS, the people of Florida are concerned with the increased cost of litigation and the need for a review of the tort and insurance laws, and

WHEREAS, the Legislature believes that, in general, the cost of medical liability insurance is excessive and injurious to the people of Florida and must be reduced, and

WHEREAS, the Legislature finds that there are certain elements of damage presently recoverable that have no monetary value, except on a purely arbitrary basis, while other elements of damage are either easily measured on a monetary basis or reflect ultimate monetary loss, and

WHEREAS, the Legislature desires to provide a rational basis for determining damages for noneconomic losses which may be awarded in certain civil actions, recognizing that such noneconomic losses should be fairly compensated and that the interests of the injured party should be balanced against the interests of society as a whole,
in that the burden of compensating for such losses is ultimately borne by all persons, rather than by the tortfeasor alone, and

WHEREAS, the Legislature created the Academic Task Force for Review of the Insurance and Tort Systems which has studied the medical malpractice problems currently existing in the State of Florida, and

WHEREAS, the Legislature has reviewed the findings and recommendations of the Academic Task Force relating to medical malpractice, and

WHEREAS, the Legislature finds that the Academic Task Force has established that a medical malpractice crisis exists in the State of Florida which can be alleviated by the adoption of comprehensive legislatively enacted reforms, and

WHEREAS, the magnitude of this compelling social problem demands immediate and dramatic legislative action, NOW, THEREFORE,

Be It Enacted by the Legislature of the State of Florida:

Section 1. Legislative findings and intent.--The Legislature finds that the costs, both in terms of real dollars and access, to the public for quality health care are so high that not all Floridians can be guaranteed an acceptable level of care. The Legislature further finds that the strict regulation of health care practitioners is imperative to maintaining the quality of health care delivered in the state. It is, therefore, the intent of the Legislature to encourage health care practitioners to report possible instances of malpractice by offering them protection from civil suit. It is, further, the intent of the Legislature to facilitate the maintenance of medical practice in Florida by promptly and fairly disciplining health care practitioners whose performance is outside acceptable limits.

Section 2. Section 20.30, Florida Statutes, is amended to read:

20.30 Department of Professional Regulation.--There is created a Department of Professional Regulation.

(1) The head of the Department of Professional Regulation is the Secretary of Professional Regulation. The secretary shall be appointed by the Governor subject to confirmation by the Senate. The secretary shall serve at the pleasure of the Governor.

(2) The following divisions of the Department of Professional Regulation are established:

(a) Division of Examination and Licensure.

(b) Division of Professions.

(c) Division of Medical Quality Assurance.

1. The director of the division shall be a deputy assistant secretary of professional regulation and shall be appointed by the Secretary of the Department of Professional Regulation.

2. The division shall concentrate sufficient resources and efforts on the investigation and discipline of physicians in...
violation of the unprofessional conduct provisions of the applicable
practice acts as are necessary to meet the challenge of identifying
those physicians who are not providing adequate medical care in order
to take forceful corrective measures to assure quality medical care
throughout the state.

3. The division shall coordinate closely with the Office of
Health Planning and Regulation in the Department of Health and
Rehabilitative Services to ensure that the state's regulation of
health care facilities and the physicians who practice therein is
consistent and offers adequate protection to the public.

4. The division shall establish and maintain a disciplinary
training program for division staff and board members designed to
ensure the proper and appropriate administration of medical quality
assurance. The program shall provide for initial and periodic
training in the grounds for disciplinary action, the actions which
may be taken, changes in any relevant law, sanctions which are most
appropriate for specified types of unprofessional conduct, guidelines
for the conduct of hearings, and any other matters which the division
shall determine may be necessary or useful.

(d) Division of Real Estate.

1. The director of the division shall be appointed by the
Secretary of Professional Regulation, subject to approval by a
majority of the Florida Real Estate Commission.

2. The offices of the Division of Real Estate shall be located in
Orlando.

(e) Division of Regulation.

(3) There shall be a director of the Division of Examination and
Licensure, a director of the Division of Professions, a deputy
assistant secretary of the Division of Medical Quality Assurance, a
director of the Division of Regulation, and a director of the
Division of Real Estate. Each division director shall directly
administer his division and shall be responsible to the secretary of
the department.

(4) The following boards are established within the Department of
Professional Regulation, Division of Professions:

(a) Board of Accountancy, created under chapter 473.
(b) Board of Acupuncture, created under chapter 457.
(c) Board of Architecture, created under part I of chapter
481.
(d) Board of Auctioneers, created under part VI of chapter
468.
(e) Barbers' Board, created under chapter 476.
(f) Board of Chiropractic, created under chapter 460.
(g) Construction Industry Licensing Board, created under part
I of chapter 489.

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(f) the Board of Cosmetology, created under chapter 477.

(g) the Electrical Contractors' Licensing Board, created under part II of chapter 489.

(h) the Board of Professional Engineers, created under chapter 471.

(i) the Board of Funeral Directors and Embalmers, created under chapter 470.

(j) the Board of Professional Land Surveyors, created under chapter 472.

(k) the Board of Landscape Architecture, created under part II of chapter 481.

(l) the Board of Massage, created under chapter 480.

(m) the Board of Osteopathic Medical Examiners, created under chapter 462.

(n) the Board of Landscape Architecture, created under chapter 464.

(o) the Board of Nursing Home Administrators, created under part III of chapter 468.

The following boards are established within the Department of Professional Regulation, Division of Medical Quality Assurance:

(a) the Board of Medicine, created under chapter 458.

(b) the Board of Osteopathic Medical Examiners, created under chapter 459.

(c) the Board of Acupuncture, created under chapter 457.

(d) the Board of Chiropractic, created under chapter 460.

(e) the Board of Dentistry, created under chapter 466.

(f) the Board of Naturopathic Examiners, created under chapter 462.
(g) Board of Nursing, created under chapter 464.
(h) Board of Optometry, created under chapter 463.
(i) Board of Pharmacy, created under chapter 465.
(j) Board of Podiatry, created under chapter 461.
(k) Board of Veterinary Medicine, created under chapter 474.

(6) The members of each board shall be appointed by the Governor, subject to confirmation by the Senate. Lay members on the board shall be appointed pursuant to subsection (7). Members shall be appointed for 4-year terms. A vacancy on the board shall be filled for the unexpired portion of the term in the same manner as the original appointment. No member shall serve more than two consecutive terms on the board.

(7) Each board with five or more members shall have at least two lay members who are not, and have never been, members or practitioners of the profession regulated by such board or of any closely related profession. Each board with fewer than five members shall have at least one lay member who is not, and has never been, a member or practitioner of the profession regulated by such board or of any closely related profession.

(8) No board, with the exception of joint coordinations, shall be transferred from its location on July 1, 1979, without legislative authorization.

Chapter 79-36, Laws of Florida, shall not be construed to supersede the abolition of any board within the Department of Professional Regulation, pursuant to the Regulatory Reform Act of 1976, as amended by chapter 77-457, Laws of Florida, or as subsequently amended.

Section 3. Section 395.0115, Florida Statutes, is amended to read:

395.0115 Licensed facilities; peer review; disciplinary powers.--

(1) It is the intent of the Legislature that good-faith participants in the process of investigating and disciplining physicians pursuant to the state-mandated peer review process shall, in addition to receiving immunity from retaliatory tort suits pursuant to s. 455.225(11), be protected from federal antitrust suits filed under the Sherman Act, 15 U.S.C.A., s. 1 et seq. Such intent is within the public policy of the state to secure the provision of quality medical services to its citizens.

(2) Each licensed facility, as a condition of licensure, shall provide for peer review of physicians who deliver health care services at the facility. Each facility shall develop written, binding procedures by which such peer review shall be conducted. Such procedures shall include:

(a) Mechanism for choosing the membership of the body or bodies that conduct peer review.

(b) Adoption of rules of order for the peer review process.
(c) Fair review of the case with the physician involved.

(d) Mechanism to identify and avoid conflict of interest on the part of the peer review panel members.

(e) Recording of agendas and minutes which do not contain confidential material, for review by the Division of Medical Quality Assurance of the Department of Professional Regulation.

(f) Mechanism for advising the Division of Medical Quality Assurance in writing of all new procedures for and changes to existing peer review procedures.

(g) Process for amending peer review procedures when the Division of Medical Quality Assurance advises the facility in writing that the procedures do not meet the requirements of the law.

(h) Review, at least annually, of the peer review procedures by the governing board of the facility.

(i) Focus of the peer review process on review of professional practices at the facility to reduce morbidity and mortality and to improve patient care.

(3) If the governing board of any licensed facility has a reasonable belief that conduct by a staff member or physician who delivers health care services at the facility may constitute one or more grounds for discipline as provided in this subsection, a peer review panel of the board shall investigate and determine whether grounds for discipline exist with respect to such staff member or physician. The governing board of any licensed facility, after considering the recommendations of its peer review panel medical staff, shall suspend, deny, revoke, or curtail the staff privileges, or reprimand, counsel, or require education, of any such staff member or physician after a final determination has been made that one or more of the following grounds exist:

(a) Incompetence.

(b) Being found to be a habitual user of intoxicants or drugs to the extent that he is deemed dangerous to himself or others.

(c) Mental or physical impairment which may adversely affect patient care.

(d) Being found liable by a court of competent jurisdiction for medical negligence or malpractice involving negligent conduct.

(e) One or more settlements exceeding $10,000 for medical negligence or malpractice involving negligent conduct by the staff member.

(f) Medical negligence other than as specified in paragraphs (d) or (e).

(g) Failure to comply with the policies, procedures, or directives of the risk management program or any quality assurance committees of any licensed facility.

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However, the procedures for such actions shall comply with the standards outlined by the Joint Commission on Accreditation of Hospitals, the American Osteopathic Association, the Accreditation Association for Ambulatory Health Care, and the "Medicare/Medicaid Conditions of Participation," as such procedures existed on January 1, 1985. The procedures shall be adopted pursuant to hospital bylaws.

(4) All final disciplinary actions taken under subsection (3) shall be reported within 10 working days to the Division of Medical Quality Assurance in writing and shall specify the disciplinary action taken and the specific grounds therefor. The division shall treat each report and determine whether it potentially involved conduct by the licensee that is subject to disciplinary action, in which case the provisions of s. 455.255 shall apply. However, the report shall not be subject to inspection under the provisions of chapter 119 even if the division's investigation results in a finding of probable cause.

(5) There shall be no monetary liability on the part of, and no cause of action for damages shall arise against, any licensed facility, its governing body and governing body members, peer review panel, medical staff, or disciplinary body, or its agents, investigators, witnesses, employees, or any other person for any action taken without intentional fraud in carrying out the provisions of this section.

(6) The proceedings and records of peer review panels, committees, and governing bodies which relate solely to actions taken in carrying out the provisions of this section shall not under any circumstances be subject to inspection under the provisions of chapter 119; nor shall meetings held pursuant to achieving the objectives of such panels, committees, and governing bodies be open to the public under the provisions of chapter 286.

(7) The investigations, proceedings, and records of the board as described in this section shall not be subject to discovery or introduction into evidence in any civil action against a provider of professional health services arising out of the matters which are the subject of evaluation and review by such board, and no person who was in attendance at a meeting of such board shall be permitted or required to testify in any such civil action as to any evidence or other matters produced or presented during the proceedings of such board or as to any findings, recommendations, evaluations, opinions, or other actions of such board or any members thereof. However, information, documents, or records otherwise available from original sources are not to be construed as immune from discovery or use in any such civil action merely because they were presented during proceedings of such board; nor should any person who testifies before such board or who is a member of such board be prevented from testifying as to matters within his knowledge, but such witness cannot be asked about his testimony before such a board or opinions formed by him as a result of such board hearings.

(8)(a) In the event that the defendant prevails in an action brought by a staff member or physician who delivers health care services at the facility against any person or entity that initiated, participated in, was a witness in, or conducted any review as authorized by this section, the court shall award reasonable attorney's fees and costs to the defendant.
(b) As a condition of any staff member or physician bringing any action against any person or entity that initiated, participated in, was a witness in, or conducted any review as authorized by this section and before any responsive pleading is due, the staff member or physician shall post a bond or other security, as set by the court having jurisdiction of the action, in an amount sufficient to pay the costs and attorney’s fees.

Section 4. Section 395.0146, Florida Statutes, is created to read:

395.0146 Certificate of need for termination or reduction of emergency or trauma services.—Notwithstanding any provision of chapter 381, a hospital licensed under this chapter which operates an emergency room or trauma center may not terminate or substantially reduce the availability of emergency or trauma service without first obtaining from the Department of Health and Rehabilitative Services a certificate of need for such termination or reduction in service. An application for such a certificate of need may not be approved by the department unless the applicant shows that no need exists in the applicable service area for continuing such service.

Section 5. Subsection (1) and paragraph (e) of subsection (3) of section 395.017, Florida Statutes, are amended to read:

395.017 Patient records; copies; examination.—

(1) Any licensed facility shall, upon request, and only after discharge of the patient, furnish to any person admitted therein for care and treatment or treated thereat, or to any such person’s guardian, curator, or personal representative, or to anyone designated by such person in writing, a true and correct copy of all patient records, including X rays, concerning such person, which records are in the possession of the licensed facility, except progress notes and consultation report sections of a psychiatric nature concerning the care and treatment performed by the licensed facility, provided the person requesting such records agrees to pay a charge not to exceed the actual cost of copying the records, including reasonable staff time.

(3) Patient records shall have a privileged and confidential status and shall not be disclosed without the consent of the person to whom they pertain, but appropriate disclosure may be made without such consent to:

(e) The Department of Professional Regulation upon subpoena issued pursuant to s. 455.223, but the records obtained thereby shall be used solely for the purpose of the Department of Professional Regulation and the appropriate professional board in its investigation, prosecution, and appeal of disciplinary proceedings. If the Department of Professional Regulation requests copies of such records, the facility shall charge no more than its actual copying costs, including reasonable staff time. The records shall otherwise be sealed and shall not be available to the public pursuant to s. 119.07 or any other statute providing access to records, nor shall they be available to the public as part of the record of
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investigation for and prosecution in disciplinary proceedings made available to the public by the Department of Professional Regulation or the appropriate regulatory board. However, the Department of Professional Regulation shall make available, upon written request by a practitioner against whom probable cause has been found, any such records which form the basis of the determination of probable cause, or

Section 6. The introductory paragraph and paragraph (b) of subsection (1) and subsections (5) and (6) of section 395.041, Florida Statutes, are amended, present subsection (7) is renumbered and amended, subsections (8), (9), and (10) are renumbered as subsections (12), (13), and (14), respectively, and new subsections (7), (9), (10), and (11) are added to said section, to read:

395.041 Internal risk management program.--

(1) Every facility licensed under this chapter—chapter-389, or chapter 390 shall, as a part of its administrative functions, establish an internal risk management program which shall include the following components:

(b) The development of appropriate measures to minimize the risk of injuries and adverse incidents to patients, including annual risk management and risk prevention education and training of all nonphysician personnel as follows:

1. Such education and training of all nonphysician personnel as part of their initial orientation; and

2. At least 1 hour of such education and training annually for all nonphysician personnel of the facility working in clinical areas and providing patient care;

(5)(a) Each licensed facility subject to this section shall submit an annual report to the department summarizing the incident reports that have been filed in the facility for that year. The report shall be on a form prescribed by rule of the department and shall include:

1. The total number of adverse incidents causing injury to patients.

2. A listing, by category, of the types of operations, diagnostic or treatment procedures, or other actions causing the injuries, and the number of incidents occurring within each category.

3. A listing, by category, of the types of injuries caused and the number of incidents occurring within each category.

4. A code number utilizing the health care professionals licensure number and a separate code number identifying all other individuals directly involved in adverse incidents causing injury to patients, the relationship of the individual to the facility, and the number of incidents in which each individual has been directly involved. Each facility shall maintain names of the health care professionals and individuals identified by code numbers for purposes of this section act.

5. A description of all malpractice claims filed against the facility, including the total number of pending and closed claims and
the nature of the incident which led to, the persons involved in, and
the status and disposition of each claim. Each report shall update
status and disposition for all prior reports.

6. A report of all disciplinary actions pertaining to patient
care taken against any medical staff member, including the nature and
cause of the action.

(b) The information reported to the department pursuant to
paragraph (a) which relates to persons licensed under chapter 458,
chapter 459, chapter 461, or chapter 466 shall also be reported to
the Department of Professional Regulation on a quarterly basis. The
Department of Professional Regulation shall review the information
and determine whether any of the incidents potentially involved
conduct by a licensee that is subject to disciplinary action, in
which case the provisions of s. 455.225 shall apply.

(c) The annual report shall also contain the name of the risk
manager of the facility, a copy of its policy and procedures which
govern the measures taken by the facility and its risk manager to
reduce the risk of injuries and adverse or untoward incidents, and
the results of such measures. This report shall be held confidential
and shall not be available to the public pursuant to s. 119.07 or any
other law providing access to public records, nor be discoverable or
admissible in any civil or administrative action, except in
disciplinary proceedings by the department, the Department of
Professional Regulation, and the appropriate regulatory board. This
report shall not be available to the public as part of the record of
investigation for and prosecution in disciplinary proceedings made
available to the public by the department, the Department of
Professional Regulation, or the appropriate regulatory board.
However, the Department of Professional Regulation shall make
available, upon written request by a practitioner against whom
probable cause has been found, any such records which form the basis
of the determination of probable cause.

(6) If an adverse or untoward incident, whether occurring in the
facility or arising from health care prior to admission in the
facility, results in:

(a) The death of a patient;

(b) Severe brain or spinal damage to a patient;

(c) A surgical procedure being performed on the wrong patient;

(d) A surgical procedure unrelated to the patient's diagnosis or
medical needs being performed on any patient,

the facility shall report this incident to the department within 3
working days of its occurrence. A more detailed follow-up report
shall be submitted to the department within 10 days after the first
report. The department may require an additional, final report.
Reports under this subsection shall be sent immediately by the
department to the Department of Professional Regulation whenever they
involve a health care provider licensed under chapter 458, chapter
459, chapter 461, or chapter 466. These reports shall not be
available to the public pursuant to s. 119.07 or any other law
providing access to public records, nor be discoverable or admissible
in any civil or administrative action, except in disciplinary
proceedings by the department, the Department of Professional Regulation, and the appropriate regulatory boards, nor shall they be available to the public as part of the record of investigation for and prosecution in disciplinary proceedings made available to the public by the Department of Professional Regulation or the appropriate regulatory board. However, the Department of Professional Regulation shall make available, upon written request by a practitioner against whom probable cause has been found, any such records which form the basis of the determination of probable cause. The department may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken in response to the incident. The Department of Professional Regulation shall review each incident and determine whether it potentially involved conduct by the licensee that is subject to disciplinary action, in which case the provisions of s. 455.225 shall apply. This subsection shall take effect January 1, 1986.

(7) In addition to any penalty imposed pursuant to s. 395.018, the department may impose an administrative fine, not to exceed §5,000, for any violation of the reporting requirements of subsection (5) or subsection (6). This subsection shall take effect July 1, 1989.

(8) The department and, upon subpoena issued pursuant to s. 455.223, the Department of Professional Regulation shall have access to all facility records necessary to carry out the provisions of this section. The records obtained are not available to public access, nor shall they be discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the department, the Department of Professional Regulation, and the appropriate regulatory boards, nor shall records obtained pursuant to s. 455.223 be available to the public as part of the record of investigation for and prosecution in disciplinary proceedings made available to the public by the Department of Professional Regulation or the appropriate regulatory board. However, the Department of Professional Regulation shall make available, upon written request by a practitioner against whom probable cause has been found, any such records which form the basis of the determination of probable cause, except that, with respect to medical review committee records, the provisions of s. 768.40 shall control.

(9) The department shall review, no less than annually, the risk management program at each facility regulated by this section to determine whether the program meets standards established in statutes and rules, whether the program is being conducted in a manner designed to reduce adverse incidents, and whether the program is appropriately reporting incidents under subsections (5) and (6).

(10) There shall be no monetary liability on the part of, and no cause of action for damages shall arise against, any risk manager, certified under part IX of chapter 626, for the implementation and oversight of the risk management program in a facility licensed under this chapter or chapter 390 as required by this section, for any act or proceeding undertaken or performed within the scope of the functions of such risk management program if the risk manager acts without intentional fraud.

(11) By December 1, 1988, the Department of Professional Regulation, in coordination with representatives of the Florida Society of Health care Risk Managers, shall report to the Legislature on classifications of adverse or untoward incidents, which involve...
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results similar in nature to those in subsection (6) and potentially involve conduct by licensees that is subject to disciplinary action, and on time frames for reporting such incidents. Such additional incidents shall be related directly to the department’s duties to investigate and reduce incidents of medical malpractice. The department shall propose a level of incident reporting with benefits from reduced malpractice that outweigh the costs of its implementation. The report to the Legislature shall include proposals for the content of the incident reports, the uses of the incident reports, the availability of the reports to the Department of Health and Rehabilitative Services, and the appropriate level of confidentiality of the reports.

Section 7. Subsection (8) of section 395.504, Florida Statutes, is amended to read:

395.504 Powers and duties of board.--To properly carry out its authority, the board:

(8) Shall designate executive staff members to issue preliminary findings pursuant to s. 395.509(9).

Section 8. Subsection (7) of section 455.225, Florida Statutes, is amended, and subsection (11) is added to said section, to read

455.225 Disciplinary proceedings.--

(7) Any proceeding for the purpose of summary suspension or restriction of a license pursuant to s. 120.60(8) shall be conducted by the secretary or his designee, who shall issue the final summary order.

(11)(a) No person who reports in any capacity, whether or not required by law, information to the Division of Medical Quality Assurance with regard to the incompetence, impairment, or unprofessional conduct of any health care provider licensed under chapter 458, chapter 459, chapter 460, chapter 461, chapter 462, chapter 463, chapter 464, chapter 465, or chapter 466 shall be held liable in any civil action for reporting against such health care provider if such person acts without intentional fraud or malice.

(b) No facility licensed under chapter 395, health maintenance organization certificated under part II of chapter 641, physician licensed under chapter 458, or osteopathic physician licensed under chapter 459 shall discharge, threaten to discharge, intimidate, or coerce any employee or staff member by reason of such employee’s or staff member’s report to the division about a physician licensed under chapter 458, chapter 459, chapter 460, chapter 461, or chapter 466 who may be guilty of incompetence, impairment, or unprofessional conduct so long as such report is given without intentional fraud or malice.

(c) In any civil suit brought outside the protections of paragraphs (a) and (b), where intentional fraud or malice is alleged, the person alleging intentional fraud or malice shall be liable for all court costs and for the other party’s reasonable attorney’s fees if intentional fraud or malice is not proved.

Section 9. Section 455.241, Florida Statutes, is amended to read:

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455.241 Patient records; report or copies of records to be furnished.—

(1) Any health care practitioner licensed pursuant to chapter 458, chapter 459, chapter 460, chapter 461, chapter 462, chapter 463, chapter 464, chapter 466, or chapter 474 who makes a physical or mental examination of, or administers treatment to, any person shall, upon request of such person or his legal representative, furnish copies of all reports or records made of such examination or treatment, including 

X rays; except that when a patient's psychiatric records are requested by him or his legal representative, the practitioner may provide a report of examination and treatment in lieu of copies of records. However, upon a patient's written request, complete copies of the patient's psychiatric records shall be provided directly to a subsequent treating psychiatrist. The furnishing of such report or copies shall not be conditioned upon payment of a disputed fee for services rendered.

(2) Such records shall not be furnished to any person other than the patient or his legal representative, except upon written authorization of the patient. However, such records may be furnished without written authorization to any person, firm, or corporation which has procured or furnished such examination or treatment with the patient's consent or when compulsory physical examination is made pursuant to Rule 1.360, Florida Rules of Civil Procedure, in which case copies of the medical record shall be furnished to both the defendant and the plaintiff. Such records may be furnished in any civil or criminal action, unless otherwise prohibited by law, upon the issuance of a subpoena from a court of competent jurisdiction and proper notice to the patient or his legal representative by the party seeking such records. The Department of Professional Regulation may obtain patient records pursuant to a subpoena without written authorization from the patient if the department and the probable cause panel of the appropriate board, if any, find reasonable cause to believe that a practitioner has excessively or inappropriately prescribed any controlled substance specified in chapter 893 in violation of s. 458.331(1)(q), s. 459.015(1)(q), s. 461.013(1)(p), s. 462.14(1), s. 466.028(1)(q), or s. 474.214(1)(x) or (y) or that a practitioner has practiced his profession below that level of care, skill, and treatment required as defined by s. 458.331(1)(t), s. 459.015(1)(t), s. 460.413(1)(s), s. 461.013(1)(t), s. 462.14(1)(t), s. 463.016(1)(g), s. 464.019(1)(f), s. 466.028(1)(y), or s. 474.214(1)(g); but the patient record obtained by the department pursuant to this subsection shall be used solely for the purpose of the department and board in disciplinary proceedings. The record shall otherwise be sealed and shall not be available to the public pursuant to the provisions of s. 119.07 or any other statute providing access to public records. Nothing in this section shall be construed to limit the assertion of the psychotherapist-patient privilege under s. 90.503 in regard to records of treatment for mental or nervous disorders by a medical practitioner licensed pursuant to chapter 458 or chapter 459 who has primarily diagnosed and treated mental and nervous disorders for a period of not less than 3 years, inclusive of psychiatric residency. However, the practitioner shall release records of treatment for medical conditions even if the practitioner has also treated the patient for mental or nervous disorders. If the department has found reasonable cause under this section and the psychotherapist-patient privilege is asserted, the department may petition the circuit court for an in camera review of the records by expert medical practitioners.
appointed by the court to determine if the records or any part thereof are protected under the psychotherapist-patient privilege.

(3) All patient records obtained by the Department of Professional Regulation and any other documents identifying the patient by name shall be used solely for the purpose of the Department of Professional Regulation and the appropriate regulatory board in its investigation, prosecution, and appeal of disciplinary proceedings. The records shall be sealed and shall not be available to the public as part of the record of investigation for and prosecution in disciplinary proceedings made available to the public by the Department of Professional Regulation or the appropriate regulatory board.

(4) A health care practitioner furnishing copies of reports or records pursuant to this section shall charge no more than the actual cost of copying, including reasonable staff time, or the amount specified in administrative rule by the appropriate regulatory board.

Section 10. Section 455.2415, Florida Statutes, is created to read:

455.2415 Communications confidential; exceptions.--Communications between a patient and a psychiatrist, as defined in s. 394.455(2)(e), shall be held confidential and shall not be disclosed except upon the request of the patient or his legal representative. Provision of psychiatric records and reports shall be governed by s. 455.241. Notwithstanding any other provisions of this section or s. 90.503, where:

(1) A patient is engaged in a treatment relationship with a psychiatrist;

(2) Such patient has made an actual threat to physically harm an identifiable victim or victims; and

(3) The treating psychiatrist makes a clinical judgment that the patient has the apparent capability to commit such an act and that it is more likely than not that in the near future the patient will carry out that threat,

the psychiatrist may disclose patient communications to the extent necessary to warn any potential victim or to communicate the threat to a law enforcement agency. No civil or criminal action shall be instituted and there shall be no liability on account of disclosure of otherwise confidential communications by a psychiatrist in disclosing a threat pursuant to this section.

Section 11. Section 455.242, Florida Statutes, is amended to read:

455.242 Disposition of records of deceased practitioners or practitioners relocating or terminating practice.--Each board created under the provisions of chapter 458, chapter 459, chapter 460, chapter 461, chapter 462, chapter 463, chapter 464, chapter 466, or chapter 474 shall provide by rule for the disposition, under said chapter, of the medical records of practitioners which are in existence at the time of the death of the practitioner dies, terminates his practice, or relocates and is no longer available to his patients and which pertain to the practitioner's patients.
rules shall provide for disposition of such records by the estate of the practitioner and shall provide that the records shall be retained for at least 1 year after the practitioner's death, termination of practice, or relocation. In the case of the death of the practitioner, the rules shall provide for the disposition of such records by the estate of the practitioner.

Section 12. Subsection (3) is added to section 455.245, Florida Statutes, to read:

455.245 Health care practitioners; immediate suspension of license for certain convictions.--

(3) If the board has previously found any physician or osteopathic physician in violation of the provisions of s. 458.331(1)(t) or s. 459.015(1)(y), in regard to his treatment of three or more patients, and the probable cause panel of the board finds probable cause of an additional violation of that section, then the secretary shall review the matter to determine if an emergency suspension or restriction order is warranted. Nothing in this section shall be construed so as to limit the secretary's authority to issue an emergency order.

Section 13. Section 455.247, Florida Statutes, is created to read:

455.247 Health care practitioners; reports on professional liability claims and actions.--

(1) Any practitioner of medicine licensed pursuant to the provisions of chapter 458, practitioner of osteopathic medicine licensed pursuant to the provisions of chapter 459, podiatrist licensed pursuant to the provisions of chapter 461, or dentist licensed pursuant to the provisions of chapter 466 shall report to the department any claim or action for damages for personal injury claimed to have been caused by error, omission, or negligence in the performance of such licensee's professional services or based on a claimed performance of professional services without consent if the claim was not covered by an insurer required to report under s. 627.912 and the claim resulted in:

(a) A final judgment in any amount.

(b) A settlement in any amount.

(c) A final disposition not resulting in payment on behalf of the licensee.

Reports shall be filed with the department no later than 60 days following the occurrence of any event listed in paragraph (a), paragraph (b), or paragraph (c).

(2) Reports shall contain:

(a) The name and address of the licensee.

(b) The date of the occurrence which created the claim.

(c) The date the claim was reported to the licensee.
(d) The name and address of the injured person. This information shall be privileged and confidential and shall not be disclosed by the department without the injured person's consent. This information may be used by the department for purposes of identifying multiple or duplicate claims arising out of the same occurrence.

(e) The date of suit, if filed.

(f) The injured person's age and sex.

(g) The total number and names of all defendants involved in the claim.

(h) The date and amount of judgment or settlement, if any, including the itemization of the verdict, together with a copy of the settlement or judgment.

(i) In the case of a settlement, such information as the department may require with regard to the injured person's incurred and anticipated medical expense, wage loss, and other expenses.

(j) The loss adjustment expense paid to defense counsel, and all other allocated loss adjustment expense paid.

(k) The date and reason for final disposition, if no judgment or settlement.

(l) A summary of the occurrence which created the claim, which shall include:

1. The name of the institution, if any, and the location within such institution, at which the injury occurred.

2. The final diagnosis for which treatment was sought or rendered, including the patient's actual condition.

3. A description of the misdiagnosis made, if any, of the patient's actual condition.

4. The operation or the diagnostic or treatment procedure causing the injury.

5. A description of the principal injury giving rise to the claim.

6. The safety management steps that have been taken by the licensee to make similar occurrences or injuries less likely in the future.

(m) Any other information required by the department to analyze and evaluate the nature, causes, location, cost, and damages involved in professional liability cases.

Section 14. Section 455.28, Florida Statutes, is created to read:

455.28 Reporting of violations of grounds for disciplinary action; penalty.--

(1) Any person licensed under chapter 458 (physicians), 459 (osteopathic physicians), 460 (chiropractic physicians), 461 (podiatrists), 464 (nurses), 465 (pharmacists), or 466 (dentists),
shall report to the Division of Medical Quality Assurance any physician who the licensee knows has violated the grounds for disciplinary action set out in the law under which that physician is licensed and who provides health care services in a facility licensed under chapter 395 in which the licensee also provides such services. Any licensee who fails to report a physician as required by this subsection shall be subject to the appropriate penalty under that licensee's licensing provisions.

(2) Complaints alleging probable disciplinary violations shall be investigated by the division.

Section 15. Paragraph (c) of subsection (1) of section 458.303, Florida Statutes, is amended to read:

458.303 Provisions not applicable to other practitioners; exceptions, etc.--


(c) Commissioned medical officers of the Armed Forces of the United States and of the Public Health Service of the United States while on active duty and while acting within the scope of their military or public health responsibilities.

Section 16. Subsection (2) of section 458.307, Florida Statutes, is amended, subsection (4) is renumbered as subsection (6), and new subsections (4) and (5) are added to said section, to read:

458.307 Board of Medicine.--

(2)(a) Ten members of the board must be licensed physicians in good standing in this state who are residents of the state and who have been engaged in the practice or teaching of medicine for at least 4 years immediately prior to their appointment. Two of the physicians must be on the faculty of a medical school in this state or on the full-time staff of a teaching hospital in this state. At least one of the 10 physicians must be a graduate of a foreign medical school. The remaining three members must be residents of the state who are not, and have never been, licensed health care practitioners. One member must be a hospital risk manager certified under part IX of chapter 626. At least one member of the board must be 60 years of age or older.

(b) The board shall establish at least one, but not more than two, probable cause panels to meet the responsibilities set out in s. 455.225(3). Each probable cause panel shall be composed of three members, one of whom shall be a lay member. One physician member may, if provided for in administrative rule, be a past board member who is not currently appointed to the board.

(4) The board, in conjunction with the department, shall establish a disciplinary training program for board members. The program shall provide for initial and periodic training in the grounds for disciplinary action, the actions which may be taken by the board and the department, changes in relevant statutes and rules, and any relevant judicial and administrative decisions. After January 1, 1989, no member of the board shall participate on probable
cause panels or in disciplinary decisions of the board unless he has completed the disciplinary training program.

(5) During the time members are appointed to a probable cause panel, they shall attempt to complete their work on every case presented to them. In the event that consideration of a case is begun but not completed during the term of those members on the panel, they may reconvene as a probable cause panel, in addition to the panels established under paragraph (2)(b), for the purpose of completing their deliberations on that case.

Section 17. Subsection (5) of section 458.311, Florida Statutes, is renumbered and amended, subsections (4) and (6) are renumbered as subsections (5) and (9), respectively, and new subsections (4), (7), and (8) are added to said section, to read:

458.311 Licensure by examination; requirements; fees.—

(4) The department and the board shall assure that applicants for licensure meet the criteria in subsection (1) through an investigative process. When the investigative process is not completed within the time set out in s. 120.60(2), and the department or board has reason to believe that the applicant does not meet the criteria, the secretary or his designee may issue a 90-day licensure delay which shall be in writing and sufficient to notify the applicant of the reason for the delay. The provisions of this subsection shall control over any conflicting provisions of s. 120.60(2).

(6) The board may not certify to the department for licensure each applicant who passes the examination and meets the requirements of this chapter shall be licensed as a physician with rights as defined by law. The department may not issue a license to any applicant who is under investigation in another jurisdiction for an offense which would constitute a violation of this chapter until such investigation is completed. Upon completion of the investigation, the provisions of s. 458.331 shall apply.

(7) Each applicant who passes the examination and meets the requirements of this chapter shall be licensed as a physician with rights as defined by law.

(8) Upon certification by the board, the department shall impose conditions, limitations, or restrictions on a license by examination if the applicant is on probation in another jurisdiction for an act which would constitute a violation of this chapter.

Section 18. Paragraph (a) of subsection (1) of section 458.313, Florida Statutes, is amended, subsections (3), (4), and (5) are renumbered as subsections (5), (6), and (8), respectively, and new subsections (3), (4), and (7) are added to said section, to read:

458.313 Licensure by endorsement; requirements; fees.—

(1) The department shall issue a license by endorsement to any applicant who, upon applying to the department and remitting a fee not to exceed $400 set by the board, demonstrates to the board that he has met the qualifications for licensure in s. 458.311(1)(b)-(f) and:
(a) Has obtained a passing score, as established by rule of the board, on the licensure examination of the Federation of State Medical Boards of the United States, Inc. (FLEX) or on the examination of the National Board of Medical Examiners, provided that said examination required shall have been so taken within the 10 years immediately preceding the filing of his application for licensure under this section, and shows evidence of the active practice of medicine within the previous 4 years; or

(3) The department and the board shall assure that applicants for licensure by endorsement meet applicable criteria in this chapter through an investigative process. When the investigative process is not completed within the time set out in s. 120.60(2), and the department or board has reason to believe that the applicant does not meet the criteria, the secretary or his designee may issue a 90-day licensure delay which shall be in writing and sufficient to notify the applicant of the reason for the delay. The provisions of this subsection shall control over any conflicting provisions of s. 120.60(2).

(4) If the applicant has not actively practiced medicine within the previous 4 years, the board shall certify the applicant to the department for licensure by endorsement subject to the condition that the applicant work under the supervision of another physician for a period, not to exceed 1 year, as determined by the board based on its determination of the licensee’s ability to practice medicine. The supervising physician shall have had no probable cause findings against him within the previous 3 years.

(7) Upon certification by the board, the department shall impose conditions, limitations, or restrictions on a license by endorsement if the applicant is on probation in another jurisdiction for an act which would constitute a violation of this chapter.

Section 19. The introductory paragraph of section 458.315, Florida Statutes, is amended, and subsection (4) is added to said section, to read:

458.315 Temporary certificate for practice in areas of critical need.--Any physician who is licensed to practice in any other state, whose license is currently valid, and who pays a fee of $100 may be issued a temporary certificate to practice in communities of Florida where there is a critical need for physicians and the population is less than 7,500. The Board of Medicine Medteal-Examte9 may issue this temporary certificate with the following restrictions:

(4) The board shall not certify to the department for licensure by endorsement any physician who is under investigation in another state for an act which would constitute a violation of this chapter until such time as the investigation is complete, at which time the provisions of s. 458.331 shall apply.

Section 20. Paragraph (b) of subsection (1) of section 458.3165, Florida Statutes, is amended to read:

458.3165 Public psychiatry certificate.--The board shall issue a public psychiatry certificate to an individual who remits an application fee not to exceed $100, as set by the board, who is a board certified psychiatrist, who is licensed to practice medicine without restriction in another state, and who meets the requirements in s. 458.311(1)(a)-(f) and (6)45.
(1) Such certificate shall:

(b) Be issued and renewable biennially annually if the secretary of the Department of Health and Rehabilitative Services and the chairman of the department of psychiatry at one of the public medical schools or the chairman of the department of psychiatry at the accredited medical school at the University of Miami recommend in writing that the certificate be issued or renewed.

Section 21. Subsection (1) of section 458.319, Florida Statutes, is amended to read:

458.319 Renewal of license.--

(1) The department shall renew a license upon receipt of the renewal application, evidence that the applicant has actively practiced medicine, or has been on the active teaching faculty of an accredited medical school, within the previous 4 years, and fee not to exceed $500 $250. If the licensee has not actively practiced medicine within the previous 4 years, the board shall certify the licensee to the department for renewal of the license subject to the condition that the licensee work under the supervision of another physician for a period, not to exceed 1 year, as determined by the board based on its determination of the licensee's ability to practice medicine. The supervising physician shall have had no probable cause findings against him within the previous 3 years.

Section 22. Paragraph (b) of subsection (1), paragraph (b) of subsection (2), and paragraph (a) of subsection (4) of section 458.320, Florida Statutes, are amended to read:

458.320 Financial responsibility.--

(1) As a condition of licensing and prior to the issuance or renewal of an active license or reactivation of an inactive license for the practice of medicine, an applicant shall by one of the following methods demonstrate to the satisfaction of the board and the department financial responsibility to pay claims and costs ancillary thereto arising out of the rendering of, or the failure to render, medical care or services:

(b) Obtaining and maintaining professional liability coverage in an amount not less than $100,000 per claim, with a minimum annual aggregate of not less than $300,000, from an authorized insurer as defined under s. 624.09, from a surplus lines insurer as defined under s. 626.914(2), from a risk retention group as defined under s. 627.942, from the Joint Underwriting Association established under s. 627.351(4), or through a plan of self-insurance as provided in s. 627.357.

(2) As a continuing condition of hospital staff privileges, physicians with staff privileges shall also be required to establish financial responsibility by one of the following methods:

(b) Obtaining and maintaining professional liability coverage in an amount not less than $250,000 per claim, with a minimum annual aggregate of not less than $750,000 from an authorized insurer as defined under s. 624.09, from a surplus lines insurer as defined under s. 626.914(2), from a risk retention group as defined under s. 627.942, from the Joint Underwriting Association established under s. 627.351(4), or through a plan of self-insurance as provided in s. 627.357.
627.351(4), or through a plan of self-insurance as provided in s. 627.357.

(4)(a) Each insurer, self-insurer, risk retention group, or Joint Underwriting Association shall promptly notify the Department of Professional Regulation of cancellation or nonrenewal of insurance required by this section. Unless the physician demonstrates that he is otherwise in compliance with the requirements of this section, the Department of Professional Regulation shall suspend the license of the physician pursuant to s. 120.57 and notify all health care facilities licensed under chapter 395 of such action. Any suspension under this subsection shall remain in effect until the physician demonstrates compliance with the requirements of this section, except that a license suspended under paragraph (5)(g) shall not be reinstated until the physician demonstrates compliance with the requirements of that provision.

Section 23. Paragraph (d) is added to subsection (2) of section 458.327, Florida Statutes, to read:

458.327 Penalty for violations.--

(2) Each of the following acts constitutes a misdemeanor of the first degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084:

(d) Leading the public to believe that one is licensed as a medical doctor, or is engaged in the licensed practice of medicine, without holding a valid, active license.

Section 24. Section 458.3295, Florida Statutes, is created to read:

458.3295 Concerted effort to refuse emergency room treatment to patients; penalties.--

(1) A physician licensed pursuant to this chapter may not instigate or engage in a concerted effort to refuse to render services to a patient in a hospital emergency room either through such physicians' failing to report for duty, such physicians' absenting themselves from their positions, such physicians' submitting their resignations, such physicians' abstaining from the full and faithful performance of their medical duties, or such physicians' otherwise causing conduct that adversely affects the services of the hospital. For the purposes of this subsection, the term "concerted" means contrived or arranged by agreement, planned or devised together, or done or performed together in cooperation.

(2) If a physician or group of physicians engages in conduct in violation of subsection (1), either the department or the hospital where the conduct occurs may file suit in circuit court to enjoin such conduct.

(a) Upon such suit being filed, the court shall conduct a hearing, with notice to the department, the board, and all interested parties, at the earliest practicable time. If the plaintiff makes a showing that a violation of subsection (1) is in progress or that there is a clear, real, and present danger that such a violation is about to commence, the court shall issue a temporary injunction enjoining such violation. Upon final hearing, the court shall either make the injunction permanent or dissolve it.
(b) A physician found to be in contempt of court for violating such an injunction shall be fined an amount considered appropriate by the court, but not less than $5,000. In determining the appropriate fine, the court shall objectively consider the extent of services lost to the hospital and its patients.

(3) A violation by a physician of subsection (1) constitutes ground for disciplinary action against him by the board, including the suspension or revocation of his license, and subjects him to liability for any damages that the hospital or any patient therein sustains as a result of the violation.

Section 25. Paragraphs (b), (m), and (t) of subsection (1) and subsections (2) and (5) of section 458.331, Florida Statutes, are amended, paragraphs (hh), (ii), (jj), and (kk) are added to subsection (1), subsections (3) through (6) are renumbered as subsections (4) through (7), respectively, and new subsections (3) and (8) are added to said section, to read:

458.331 Grounds for disciplinary action; action by the board and department.--

(1) The following acts shall constitute grounds for which the disciplinary actions specified in subsection (2) may be taken:

(b) Having a license or the authority to practice medicine revoked, suspended, or otherwise acted against, including the denial of licensure, by the licensing authority of any jurisdiction, including its agencies or subdivisions state-territory-or--country. The licensing authority's acceptance of a physician's relinquishment of a license, stipulation, consent order, or other settlement, offered in response to or in anticipation of the filing of administrative charges against the physician's license, shall be construed as action against the physician's license.

(m) Failing to keep written medical records justifying the course of treatment of the patient, including, but not limited to, patient histories, examination results, and test results, records of drugs prescribed, dispensed, or administered, and reports of consultations and hospitalizations.

(t) Gross or repeated malpractice or the failure to practice medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances. The board shall give great weight to the provisions of s. 768.45 when enforcing this paragraph. As used in this paragraph, "repeated malpractice" includes, but is not limited to, three or more claims for medical malpractice within the previous 5-year period resulting in indemnities being paid in excess of $10,000 each to the claimant in a judgment or settlement and which incidents involved negligent conduct by the physician. As used in this paragraph, "gross malpractice" or "the failure to practice medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar physician as being acceptable under similar conditions and circumstances," shall not be construed so as to require more than one instance, event, or act. Nothing in this paragraph shall be construed to require that a physician be incompetent to practice medicine in order to be disciplined pursuant to this paragraph.
Misrepresenting or concealing a material fact at any time during any phase of a licensing or disciplinary process or procedure.

Improperly interfering with an investigation or with any disciplinary proceeding.

Failing to report to the Division of Medical Quality Assurance, as required by s. 455.28, any physician licensed under chapter 458 or osteopathic physician licensed under chapter 459 who the physician knows has violated the grounds for disciplinary action set out in the law under which that physician or osteopathic physician is licensed and who provides health care services in a facility licensed under chapter 395, or a health maintenance organization certificated under part II of chapter 641, in which the physician also provides services.

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.

When the board finds any person guilty of any of the grounds set forth in subsection (1), it may enter an order imposing one or more of the following penalties:

(a) Refusal to certify, or certification with restrictions, to the department an application for licensure, certification, or registration.

(b) Revocation or suspension of a license.

(c) Restriction of practice.

(d) Imposition of an administrative fine not to exceed $5,000 for each count or separate offense.

(e) Issuance of a reprimand.

(f) Placement of the physician on probation for a period of time and subject to such conditions as the board may specify, including, but not limited to, requiring the physician to submit to treatment, to attend continuing education courses, to submit to reexamination, or to work under the supervision of another physician.

(g) Issuance of a letter of concern.

(h) Corrective action.

(i) Refund of fees billed to and collected from the patient.

In determining what action is appropriate, the board must first consider what sanctions are necessary to protect the public or to compensate the patient. Only after those sanctions have been imposed may the disciplining authority consider and include in the order requirements designed to rehabilitate the physician. All costs associated with compliance with orders issued under this subsection are the obligation of the physician.
(3) In any administrative action against a physician which does not involve revocation or suspension of license, the division shall have the burden, by the greater weight of the evidence, to establish the existence of grounds for disciplinary action. The division shall establish grounds for revocation or suspension of license by clear and convincing evidence.

(6) Upon the department's receipt from an insurer or self-insurer of a report of a closed claim against a physician pursuant to s. 627.912 or from a health care practitioner of a report pursuant to s. 455.247, or upon the receipt from a claimant of a presumptive notice against a physician pursuant to s. 768.57, the department shall review each report and determine whether it potentially involved conduct by a licensee that is subject to disciplinary action, in which case the provisions of s. 455.225 shall apply. However, if it is reported that a physician has had the Department of Insurance of the name of a physician having three or more claims with indemnities exceeding $10,000 each within the previous 5-year period, including reports for the 3-year period preceding the effective date of this act, the department shall investigate the occurrences upon which the claims were based and determine if action by the department against the physician is warranted.

(8) If any physician regulated by the Division of Medical Quality Assurance is guilty of such unprofessional conduct, negligence, or mental or physical incapacity or impairment that the division determines that the physician is unable to practice with reasonable skill and safety and presents a danger to patients, the division shall be authorized to maintain an action in circuit court enjoining such physician from providing medical services to the public until the physician demonstrates the ability to practice with reasonable skill and safety and without danger to patients.

Section 26. Paragraph (a) of subsection (4) of section 458.3315, Florida Statutes, is amended to read:

458.3315 Treatment programs for impaired practitioners.—

(4)(a) Whenever the consultant is notified that there is reason to believe that a practitioner licensed under this chapter is impaired as a result of the misuse or abuse of alcohol or drugs, or both, or due to a mental condition, which could affect the practitioner's ability to practice his profession, and no complaint against the practitioner other than impairment exists, the reporting of such information shall not constitute a complaint within the meaning of s. 455.255 if the probable cause panel of the board under which the practitioner is licensed finds that:

1. The practitioner has acknowledged his impairment problem;
2. The practitioner has voluntarily enrolled in an appropriate, approved treatment program; and
3. The practitioner has voluntarily withdrawn from his practice or limited the scope of his practice as determined by the panel in each case, until such time as the panel is satisfied that he has successfully completed an approved treatment program; and
4. The practitioner has executed releases for medical records, authorizing the release of all records of evaluations, diagnoses, and treatment of the practitioner, including records of treatment for
emotional or mental conditions, to the consultant. The consultant shall make no copies or reports of records that do not regard the issue of the practitioner's impairment and his participation in a treatment program.

Section 27. Paragraph (a) of subsection (1) of section 458.337, Florida Statutes, is amended to read:

458.337 Reports of disciplinary actions by medical organizations and hospitals.--

(1)(a) The department shall be notified when any physician:

1. Has been removed or suspended or has had any other disciplinary action taken by his peers within any professional medical association, society, body, or professional standards review organization established pursuant to s. 249F of Pub. L. No. 92-603 or similarly constituted professional organization, whether or not such association, society, body, or organization is local, regional, state, national, or international in scope; or

2. Has been disciplined—includes allowing the physician to resign, by a licensed hospital, health maintenance organization, prepaid health clinic, ambulatory surgical center, or nursing home or the medical staff of such a hospital, health maintenance organization, prepaid health clinic, ambulatory surgical center, or nursing home, including allowing the physician to resign, for any act that constitutes a violation of this chapter. If a physician resigns or withdraws from privileges when such facility notifies the physician that it is conducting an investigation or inquiry regarding an act which is potentially a violation of this chapter, the facility shall complete its investigation or inquiry and shall notify the department of the physician's resignation or withdrawal from privileges. If the completed investigation or inquiry results in a finding that such act constitutes a violation of this chapter for which the facility would have disciplined the physician or allowed him to resign or withdraw from privileges.

Section 28. Section 458.345, Florida Statutes, is amended to read:

458.345 Registration of resident physicians and interns; list of hospital employees; penalty.--

(1) Any person desiring to practice as a resident physician, assistant resident physician, house physician, or intern in this state who does not hold a valid, active license issued under this chapter shall apply to the department to be registered and shall remit a fee not to exceed $100 as set by the board. The department shall register any applicant the board certifies has met the following requirements:

(a) Is at least 21 years of age.

(b) Has not committed any act or offense within or without the state which would constitute the basis for refusal to certify an application for licensure pursuant to s. 458.331.

(c) Is a graduate of a medical school or college as specified in s. 458.311(1)(f).
(2) Registration under this section shall automatically expire after 2 years and shall neither be renewed nor extended, unless the registrant is in an approved postgraduate training program, as defined by the board by rule.

(3) The board shall not certify to the department for registration any applicant who is under investigation in any state or jurisdiction for an act which would constitute the basis for imposing a disciplinary penalty specified in s. 458.331(2)(b) until such time as the investigation is completed, at which time the provisions of s. 458.331 shall apply.

(4) Every person practicing as a resident physician, assistant resident physician, house physician, or intern in this state shall register with the department, showing the date upon which he started to practice as aforesaid within this state. Every hospital employing a resident physician, assistant resident physician, house physician, or intern shall, on January 1 and July 1 of each year, furnish the department with a list of its employees and such other information as the board may direct. Unless previously authorized by the board, no person registered under this section may be employed as a house physician or act as a resident physician, an assistant resident physician, or an intern in a hospital of this state for more than 2 years without a valid, active license, except that resident physicians, assistant resident physicians, and interns in approved training programs listed by the board in rule shall be exempt from this limitation. Any person willfully violating this section shall be guilty of a misdemeanor of the first or second degree, punishable as provided in s. 775.082, s. 775.083, or s. 775.084.

(5) Persons required to reregister under this section on the effective date of this act shall complete that registration within 1 year.

Section 29. Paragraphs (a) and (e) of subsection (7) of section 458.347, Florida Statutes, are amended to read:

458.347 Physician's assistants.--

(7) PHYSICIAN'S ASSISTANT CERTIFICATION.--

(a) Any person desiring to be certified as a physician's assistant must apply to the department. The department shall issue a certificate to any person who the board certifies has met the following requirements:

1. Is at least 18 years of age.

2. Has satisfactorily passed a proficiency examination by an acceptable score established by the National Commission on Certification of Physician's Assistants.

3. Has completed the application form and remitted an application fee not to exceed $100 as set by the board. An application for certification made by a physician's assistant shall include all of the following:

   a. A certificate of completion of an approved physician's assistant training program.

   b. A sworn statement of any prior felony convictions.
c. A sworn statement of any previous revocation or denial of licensure or certification in any state.

d. Two letters of recommendation.

e. The full name, Florida medical license number, and address of the supervising physician.

f. The specialty of the supervising physician.

(e) Notwithstanding the provisions of paragraph (a)2., the board may grant temporary certification to a recent graduate of an approved program to expire upon receipt of scores of the proficiency examination administered by the National Commission on Certification of Physician's Assistants. An applicant who has passed the proficiency examination may be granted permanent certification. An applicant failing the proficiency examination is no longer temporarily certified, but may reapply for a 1-year extension of temporary certification. If an applicant fails the examination two times, he is no longer eligible for certification.

Section 30. Subsection (4) is added to section 459.0055, Florida Statutes, to read:

459.0055 General licensure requirements.--

(4) The department and the board shall assure that applicants for licensure meet applicable criteria in this chapter through an investigative process. When the investigative process is not completed within the time set out in s. 120.60(2), and the department or board has reason to believe that the applicant does not meet the criteria, the secretary or his designee may issue a 90-day licensure delay which shall be in writing and sufficient to notify the applicant of the reason for the delay. The provisions of this subsection shall control over any conflicting provisions of s. 120.60(2).

Section 31. Subsection (1) of section 459.008, Florida Statutes, is amended to read:

459.008 Renewal of licenses and certificates.--

(1) The department shall renew a license or certificate upon receipt of the renewal application, evidence that the applicant has actively practiced osteopathic medicine, or has been on the active teaching faculty of an accredited osteopathic medical school, within the previous 4 years, and fee. If the licensee has not actively practiced osteopathic medicine within the previous 4 years, the board shall certify the licensee to the department for renewal of the license subject to the condition that the licensee work under the supervision of another osteopathic physician for a period, not to exceed 1 year, as determined by the board based on its determination of the licensee's ability to practice osteopathic medicine. The supervising physician shall have had no probable cause findings against him within the previous 3 years.

Section 32. Paragraph (b) of subsection (1), paragraph (b) of subsection (2), and paragraph (a) of subsection (4) of section 459.0085, Florida Statutes, are amended to read:

459.0085 Financial responsibility.--
(1) As a condition of licensing and prior to the issuance or renewal of an active license or reactivation of an inactive license for the practice of osteopathic medicine, an applicant shall by one of the following methods demonstrate to the satisfaction of the board and the department financial responsibility to pay claims and costs ancillary thereto arising out of the rendering of, or the failure to render, medical care or services:

(b) Obtaining and maintaining professional liability coverage in an amount not less than $100,000 per claim, with a minimum annual aggregate of not less than $300,000, from an "authorized insurer" as defined under s. 624.09, from a surplus lines insurer as defined under s. 626.914(2), from a risk retention group as defined under s. 627.942, from the Joint Underwriting Association established under s. 627.351(4), or through a plan of self-insurance as provided in s. 627.357.

(2) As a continuing condition of hospital staff privileges, osteopathic physicians with staff privileges shall also be required to establish financial responsibility by one of the following methods:

(b) Obtaining and maintaining professional liability coverage in an amount not less than $250,000 per claim, with a minimum annual aggregate of not less than $750,000 from an authorized insurer as defined under s. 624.09, from a surplus lines insurer as defined under s. 626.914(2), from a risk retention group as defined under s. 627.942, from the Joint Underwriting Association established under s. 627.351(4), or through a plan of self-insurance as provided in s. 627.357.

(4)(a) Each insurer, self-insurer, risk retention group, or Joint Underwriting Association shall promptly notify the Department of Professional Regulation of cancellation or nonrenewal of insurance required by this section. Unless the osteopathic physician demonstrates that he is otherwise in compliance with the requirements of this section, the Department of Professional Regulation shall suspend the license of the osteopathic physician pursuant to s. 120.57 and notify all health-care facilities licensed under chapter 395 of such action. Any suspension under this subsection shall remain in effect until the osteopathic physician demonstrates compliance with the requirements of this section, except that a license suspended under paragraph (5)(g) shall not be reinstated until the osteopathic physician demonstrates compliance with the requirements of that provision.

Section 33. Subsection (2) of section 459.0092, Florida Statutes, is amended to read

459.0092 Fees.--The board shall set fees according to the following schedule:

(2) The fee for biennial renewal of licensure or certification shall not exceed $300.

Section 34. Section 459.0145, Florida Statutes, is created to read:

459.0145 Concerted effort to refuse emergency room treatment to patients; penalties. --
(1) A physician licensed pursuant to this chapter may not instigate or engage in a concerted effort to refuse to render services to a patient in a hospital emergency room either through such physicians' failing to report for duty, such physicians' absenting themselves from their positions, such physicians' submitting their resignations, such physicians' abstaining from the full and faithful performance of their medical duties, or such physicians' otherwise causing conduct that adversely affects the services of the hospital. For the purposes of this subsection, the term "concerted" means contrived or arranged by agreement, planned or devised together, or done or performed together in cooperation.

(2) If a physician or group of physicians engages in conduct in violation of subsection (1), either the department or the hospital where the conduct occurs may file suit in circuit court to enjoin such conduct.

(a) Upon such suit being filed, the court shall conduct a hearing, with notice to the department, the board, and all interested parties, at the earliest practicable time. If the plaintiff makes a showing that a violation of subsection (1) is in progress or that there is a clear, real, and present danger that such a violation is about to commence, the court shall issue a temporary injunction enjoining such violation. Upon final hearing, the court shall either make the injunction permanent or dissolve it.

(b) A physician found to be in contempt of court for violating such an injunction shall be fined an amount considered appropriate by the court, but not less than $5,000. In determining the appropriate fine, the court shall objectively consider the extent of services lost to the hospital and its patients.

(3) A violation by a physician of subsection (1) constitutes ground for disciplinary action against him by the board, including the suspension or revocation of his license, and subjects him to liability for any damages that the hospital or any patient therein sustains as a result of the violation.

Section 35. Paragraphs (b), (p), and (y) of subsection (1) and subsections (2) and (5) of section 459.015, Florida Statutes, are amended, paragraphs (kk), (ll), (mm), and (nn) are added to subsection (1), subsections (3) through (6) are renumbered as subsections (4) through (7), respectively, and new subsections (3) and (8) are added to said section, to read:

459.015 Grounds for disciplinary action by the board.--

(1) The following acts shall constitute grounds for which the disciplinary actions specified in subsection (2) may be taken:

(b) Having a license or the authority to practice osteopathic medicine revoked, suspended, or otherwise acted against, including the denial of licensure, by the licensing authority of any jurisdiction, including its agencies or subdivisions state, territory, or country. The licensing authority's acceptance of a physician's relinquishment of license, stipulation, consent order, or other settlement, offered in response to or in anticipation of the filing of administrative charges against the physician, shall be construed as action against the physician's license.
(p) Failing to keep written medical records justifying the course of treatment of the patient, including, but not limited to, patient histories, examination results, and test results, records of drugs prescribed, dispensed, or administered, and reports of consultations and hospitalizations.

(y) Gross or repeated malpractice or the failure to practice osteopathic medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar osteopathic physician as being acceptable under similar conditions and circumstances. The board shall give great weight to the provisions of s. 768.45 when enforcing this paragraph. As used in this paragraph, "repeated malpractice" includes, but is not limited to, three or more claims for medical malpractice within the previous 5-year period resulting in indemnities being paid in excess of $10,000 each to the claimant in a judgment or settlement and which incidents involved negligent conduct by the osteopathic physician. As used in this paragraph, "gross malpractice" or "the failure to practice osteopathic medicine with that level of care, skill, and treatment which is recognized by a reasonably prudent similar osteopathic physician as being acceptable under similar conditions and circumstances" shall not be construed so as to require more than one instance, event, or act. Nothing in this paragraph shall be construed to require that an osteopathic physician be incompetent to practice osteopathic medicine in order to be disciplined pursuant to this paragraph.

(k) Misrepresenting or concealing a material fact at any time during any phase of a licensing or disciplinary process or procedure.

(1) Improperly interfering with an investigation or with any disciplinary proceeding.

(mm) Failing to report to the Division of Medical Quality Assurance, as required by s. 455.28, any physician licensed under chapter 458 or osteopathic physician licensed under chapter 459 who the osteopathic physician knows has violated the grounds for disciplinary action set out in the law under which that physician or osteopathic physician is licensed and who provides health care services in a facility licensed under chapter 395, or a health maintenance organization certified under part II of chapter 641, in which the osteopathic physician also provides services.

(nn) 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.

(2) When the board finds any person guilty of any of the grounds set forth in subsection (1), it may enter an order imposing one or more of the following penalties:

(a) Refusal to certify, or certify with restrictions, to the department an application for certification, licensure, renewal, or reactivation.

(b) Revocation or suspension of a license or certificate.

(c) Restriction of practice.
(d) Imposition of an administrative fine not to exceed $5,000 for each count or separate offense.

(e) Issuance of a reprimand.

(f) Issuance of a letter of concern.

(g) Placement of the osteopathic physician on probation for a period of time and subject to such conditions as the board may specify, including, but not limited to, requiring the osteopathic physician to submit to treatment, attend continuing education courses, submit to reexamination, or work under the supervision of another osteopathic physician.

(h) Corrective action.

(1) Refund of fees billed to and collected from the patient.

In determining what action is appropriate, the board must first consider what sanctions are necessary to protect the public or to compensate the patient. Only after those sanctions have been imposed may the disciplining authority consider and include in the order requirements designed to rehabilitate the physician. All costs associated with compliance with orders issued under this subsection are the obligation of the physician.

(3) In any administrative action against a physician which does not involve revocation or suspension of license, the division shall have the burden, by the greater weight of the evidence, to establish the existence of grounds for disciplinary action. The division shall establish grounds for revocation or suspension of license by clear and convincing evidence.

(6)§ Upon the department's receipt from an insurer or self-insurer of a report of a closed claim against an osteopathic physician pursuant to s. 627.912, or upon the receipt from a claimant of a presuit notice against an osteopathic physician pursuant to s. 768.57, the department shall review each report and determine whether it potentially involved conduct by a licensee that is subject to disciplinary action, in which case the provisions of s. 455.225 shall apply. However, if it is reported that an osteopathic physician has had the Department of Insurance of the name of an osteopathic physician having three or more claims with indemnities exceeding $10,000 each within the previous 5-year period, including reports for the 3-year period preceding October 17, 1985, the department shall investigate the occurrences upon which the claims were based and determine if action by the department against the osteopathic physician is warranted.

(8) If any osteopathic physician regulated by the Division of Medical Quality Assurance is guilty of such unprofessional conduct, negligence, or mental or physical incapacity or impairment that the division determines that the osteopathic physician is unable to practice with reasonable safety and presents a danger to patients, the division shall be authorized to maintain an action in circuit court enjoining such osteopathic physician from providing medical services to the public until the osteopathic physician demonstrates the ability to practice with reasonable skill and safety and without danger to patients.
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Section 36. Paragraph (a) of subsection (4) of section 459.0155, Florida Statutes, is amended to read:

459.0155 Treatment programs for impaired practitioners.--

(4)(a) Whenever the consultant is notified and there is reason to believe that a practitioner licensed by the state under this chapter is impaired as a result of the misuse or abuse of alcohol or drugs, or both, or due to a mental condition, which could affect the practitioner's ability to practice his profession, and no complaint against the practitioner other than impairment exists, the reporting of such information shall not constitute a complaint within the meaning of s. 455.225 if the probable cause panel of the board under which the practitioner is licensed finds that:

1. The practitioner has acknowledged his impairment problem;

2. The practitioner has voluntarily enrolled in an appropriate, approved treatment program; and

3. The practitioner has voluntarily withdrawn from his practice or limited the scope of his practice, as determined by the panel in each case, until such time as the panel is satisfied that he has successfully completed an approved treatment program; and-

4. The practitioner has executed releases for medical records, authorizing the release of all records of evaluations, diagnoses, and treatment of the practitioner, including records of treatment for emotional or mental conditions, to the consultant. The consultant shall make no copies or reports of records that do not regard the issue of the practitioner's impairment and his participation in a treatment program.

Section 37. Paragraph (a) of subsection (7) of section 459.022, Florida Statutes, is amended, and paragraph (f) is added to said subsection, to read:

459.022 Osteopathic physician assistants.--

(7) OSTEOPATHIC PHYSICIAN ASSISTANT CERTIFICATION.--

(a) Any person desiring to be certified in this state as an osteopathic physician assistant shall apply to the department. The department shall issue a certificate to any person who the board certifies has met the following requirements:

1. Is at least 18 years of age.

2. Has satisfactorily passed a proficiency examination by an acceptable score established by the National Commission on Certification of Physician Assistants.

3. Has completed the application form and remitted an application fee not to exceed $100 as set by the board. An application for certification made by an osteopathic physician assistant shall include all of the following:

a. A certificate of completion of an approved physician assistant training program.

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b. A sworn statement of any prior felony convictions.

c. A sworn statement of any previous revocation or denial of licensure or certification in any state.

d. Two letters of recommendation.

e. The full name, Florida osteopathic medical license number, and address of the supervising physician.

f. The specialty of the supervising osteopathic physician.

(f) Notwithstanding the provisions of subparagraph (a)2., the board may grant temporary certification to a recent graduate of an approved program to expire upon receipt of scores of the proficiency examination administered by the National Commission on Certification of Physician's Assistants. An applicant who has passed the proficiency examination may be granted permanent certification. An applicant failing the proficiency examination is no longer temporarily certified, but may reapply for a 1-year extension of temporary certification. If an applicant fails the examination two times, he is no longer eligible for certification.

Section 38. Paragraph (hh) is added to subsection (1) of section 460.413, Florida Statutes, to read:

460.413 Grounds for disciplinary action; action by the board.--

(1) The following acts shall constitute grounds for which the disciplinary actions specified in subsection (2) may be taken:

(hh) Failing to report to the Division of Medical Quality Assurance, as required by s. 455.28, any physician licensed under chapter 458 or osteopathic physician licensed under chapter 459 who the chiropractic physician knows has violated the grounds for disciplinary action set out in the law under which that physician or osteopathic physician is licensed and who provides health care services in a facility licensed under chapter 395, or a health maintenance organization certified under part II of chapter 441, in which the chiropractic physician also provides services.

Section 39. Paragraph (bb) is added to subsection (1) of section 461.013, Florida Statutes, and paragraph (a) of subsection (5) of said section is amended, to read:

461.013 Grounds for disciplinary action; action by the board; investigations by department.--

(1) The following acts shall constitute grounds for which the disciplinary actions specified in subsection (2) may be taken:

(bb) Failing to report to the Division of Medical Quality Assurance, as required by s. 455.28, any physician licensed under chapter 458 or osteopathic physician licensed under chapter 459 who the podiatrist knows has violated the grounds for disciplinary action set out in the law under which that physician or osteopathic physician is licensed and who provides health care services in a facility licensed under chapter 395, or a health maintenance organization certified under part II of chapter 641, in which the podiatrist also provides services.
(5)(a) Upon the department's receipt from an insurer or self-insurer of a report of a closed claim against a podiatrist pursuant to s. 627.912, or upon the receipt from a claimant of a presuit notice against a podiatrist pursuant to s. 768.57, the department shall review each report and determine whether it potentially involved conduct by a licensee that is subject to disciplinary action, in which case the provisions of s. 455.225 shall apply. However, if it is reported that a podiatrist has had the Department of Insurance of the name of a podiatrist having three or more claims with indemnities exceeding $10,000 each within the previous 5-year period, including reports for the 3-year period preceding October 1, 1986, the department shall investigate the occurrences upon which the claims were based and determine if action by the department against the podiatrist is warranted.

Section 40. Paragraph (k) is added to subsection (1) of section 464.018, Florida Statutes, to read:

464.018 Disciplinary actions.--

(1) The following acts shall be grounds for disciplinary action set forth in this section:

(k) Failing to report to the Division of Medical Quality Assurance, as required by s. 455.28, any physician licensed under chapter 458 or osteopathic physician licensed under chapter 459 who the nurse knows has violated the grounds for disciplinary action set out in the law under which that physician or osteopathic physician is licensed and who provides health care services in a facility licensed under chapter 395, or a health maintenance organization certificated under part II of chapter 641, in which the nurse also provides services.

Section 41. Paragraph (o) is added to subsection (1) of section 465.016, Florida Statutes, to read:

465.016 Disciplinary actions.--

(1) The following acts shall be grounds for disciplinary action set forth in this section:

(o) Failing to report to the Division of Medical Quality Assurance, as required by s. 455.28, any physician licensed under chapter 458 or osteopathic physician licensed under chapter 459 who the pharmacist knows has violated the grounds for disciplinary action set out in the law under which that physician or osteopathic physician is licensed and who provides health care services in a facility licensed under chapter 395, or a health maintenance organization certificated under part II of chapter 641, in which the pharmacist also provides services.

Section 42. Paragraph (ii) is added to subsection (1) of section 466.028, Florida Statutes, and subsection (6) of said section is amended, to read:

466.028 Grounds for disciplinary action; action by the board.--

(1) The following acts shall constitute grounds for which the disciplinary actions specified in subsection (2) may be taken:
(11) Failing to report to the Division of Medical Quality Assurance, as required by s. 455.28, any physician licensed under chapter 458 or osteopathic physician licensed under chapter 459 who the dentist knows has violated the grounds for disciplinary action set out in the law under which that physician or osteopathic physician is licensed and who provides health care services in a facility licensed under chapter 395, or a health maintenance organization certified under part II of chapter 641, in which the dentist also provides services.

(6) Upon the department's receipt from an insurer or self-insurer of a report of a closed claim against a dentist pursuant to s. 627.912, or upon the receipt from a claimant of a suit notice against a dentist pursuant to s. 768.57, the department shall review each report and determine whether it potentially involved conduct by a licensee that is subject to disciplinary action, in which case the provisions of s. 455.225 shall apply. However, if it is reported that a dentist has had the Department of Insurance of the name of a dentist—subject any indemnity paid in excess of $5,000 in a judgment or settlement or has had any dentist—having three or more claims for dental malpractice within the previous 5-year period which resulted in indemnity being paid, the department shall investigate the occurrence upon which the claims were based and determine if action by the department against the dentist is warranted.

Section 43. Subsections (1) and (3) and paragraph (e) of subsection (2) of section 627.912, Florida Statutes, are amended to read:

627.912 Professional liability claims and actions; reports by insurers.—

(1) Each self-insurer authorized under s. 627.356 or s. 627.357 and each insurer or joint underwriting association providing professional liability insurance to a practitioner of medicine licensed pursuant to the provisions of chapter 458, to a practitioner of osteopathic medicine licensed pursuant to the provisions of chapter 459, to a podiatrist licensed pursuant to the provisions of chapter 461, to a dentist licensed pursuant to the provisions of chapter 466, to a hospital licensed pursuant to the provisions of chapter 395, to clinics included in chapter 389 and chapter 390, to an ambulatory surgical center as defined in s. 395.002(2), or to a member of The Florida Bar shall report in duplicate to the Department of Insurance any claim or action for damages for personal injuries claimed to have been caused by error, omission, or negligence in the performance of such insured's professional services or based on a claimed performance of professional services without consent, if the claim resulted in:

(a) A final judgment in any amount.

(b) A settlement in any amount.

(c) A final disposition not resulting in payment on behalf of the insured.

Reports shall be filed with the department and, if the insured party is licensed pursuant to chapter 458, chapter 459, chapter 461, or chapter 466, with the Department of Professional Regulation, no later than 60 days following the occurrence of any event listed in
paragraph (a), paragraph (b), or paragraph (c). The Department of Professional Regulation shall review each report and determine whether any of the incidents that resulted in the claim potentially involved conduct by the licensee that is subject to disciplinary action, in which case the provisions of s. 455.225 shall apply. The Department of Professional Regulation, as part of the annual report required by s. 455.2285, shall publish annual statistics, without identifying licensees, on the reports it receives, including final action taken on such reports by the Department of Professional Regulation or the appropriate regulatory board:

(2) The reports required by subsection (1) shall contain:

(e) The name and address of the injured person. This information shall be privileged and confidential and shall not be disclosed by the department without the injured person's consent. This information may be used by the department for purposes of identifying multiple or duplicate claims arising out of the same occurrence.

(3) The department shall screen the reports and send to the Department of Professional Regulation and the appropriate regulatory board copies of the reports of any physicians or osteopaths having three or more claims with indemnities exceeding $19,898 each within the previous 5-year period including screening reports for the 3-year period preceding October 17, 1985. With respect to any such report, the Department of Professional Regulation shall be authorized to obtain the name of the patient to whom the report applies directly from the insurer or self-insurer filing the report, and the insurer or self-insurer shall promptly furnish the name of the patient to the department when requested. For purposes of safety management, the department shall annually provide the Department of Health and Rehabilitative Services with copies of the reports in cases resulting in an indemnity being paid to the claimants.

Section 44. Subsections (5) and (6) of section 641.55, Florida Statutes, as renumbered from section 641.395 by chapter 87-236, Laws of Florida, are amended to read:

641.55 Internal risk management program --

(5)(a) Each health maintenance organization subject to this section shall submit an annual report to the Department of Health and Rehabilitative Services summarizing the incident reports that have been filed in the health maintenance organization for that year pertaining to services rendered on the premises of the health maintenance organization. The report shall be on a form prescribed by rule of the Department of Health and Rehabilitative Services and shall include with respect to medical services rendered on the premises of the health maintenance organization:

1. The total number of adverse incidents causing injury to patients.

2. A listing, by category, of the types of operations, diagnostic or treatment procedures, or other actions causing the injuries and the number of incidents occurring within each category.

3. A listing, by category, of the types of injuries caused and the number of incidents occurring within each category.
4. The name of each individual or provider responsible for adverse incidents causing injury to patients, the relationship of the individual or provider to the health maintenance organization, and the number of incidents in which each individual or provider has been directly involved.

5. A description of all medical malpractice claims filed against the health maintenance organization or its providers, including the total number pending and closed, the nature of the incident which led to the claims, the persons involved in the claim, and the status and disposition of each claim. Each report shall update status and disposition for all prior reports.

6. A report of all disciplinary actions taken against any provider or any medical staff member of the health maintenance organization, including the nature and cause of the action.

(b) The information reported to the department pursuant to subparagraphs (a) 4., 5., and 6. which relates to persons licensed under Chapter 458, Chapter 459, Chapter 461, or Chapter 466 shall also be reported to the Department of Professional Regulation. The Department of Professional Regulation shall review the information and determine whether any of the incidents potentially involved conduct by a licensee that is subject to disciplinary action, in which case the provisions of s. 455.225 shall apply.

(c)(b) The annual report shall also contain the name of the risk manager of the health maintenance organization, a copy of its policy and procedures which govern the measures taken by the organization and its risk manager to reduce the risk of injuries and adverse or untoward incidents, and the results of these measures. This report shall be held confidential and shall not be available to the public pursuant to s. 119.07 or any other law providing access to public records, nor shall the report be discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the Department of Professional Regulation and the appropriate regulatory board. This report shall not be available to the public as part of the record of investigation for and prosecution in disciplinary proceedings made available to the public by the Department of Professional Regulation or the appropriate regulatory board. However, the Department of Professional Regulation shall make available, upon written request by a practitioner against whom probable cause has been found, any such records which form the basis of the determination of probable cause.

6. If an adverse or untoward incident, whether occurring in the facilities of the health maintenance organization or arising from health care prior to admission to the facilities of the organization or in the facility of one of its providers, results in:

(a) The death of a patient; or

(b) Severe brain or spinal damage to a patient;

(c) A surgical procedure being performed on the wrong patient; or

(d) A surgical procedure unrelated to the patient's diagnosis or medical needs being performed on any patient.

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the organization shall report this incident to the Department of Health and Rehabilitative Services within 3 working days of its occurrence. A more detailed follow-up report shall be submitted to the Department of Health and Rehabilitative Services within 10 days after the first report. The department may require an additional, final report. Reports under this subsection shall be sent immediately by the department to the Department of Professional Regulation whenever they involve a health care provider licensed under chapter 458, chapter 459, chapter 461, or chapter 466. These reports shall not be available to the public pursuant to s. 119.07 or any other law providing access to public records, nor be discoverable or admissible in any civil or administrative action, except in disciplinary proceedings by the Department of Professional Regulation and the appropriate regulatory board, nor shall they be available to the public as part of the record of investigation for and prosecution in disciplinary proceedings made available to the public by the Department of Professional Regulation or the appropriate regulatory board. However, the Department of Professional Regulation shall make available, upon written request by a practitioner against whom probable cause has been found, any such records which form the basis of the determination of probable cause. The Department of Health and Rehabilitative Services may investigate, as it deems appropriate, any such incident and prescribe measures that must or may be taken by the health maintenance organization in response to the incident. The Department of Professional Regulation shall review each incident and determine whether it potentially involved conduct by the licensee that is subject to disciplinary action, in which case the provisions of s. 455.225 shall apply. The requirements of this subsection shall take effect January 17, 1986.

The gross data compiled pursuant to this section or s. 395.041 shall be furnished by the Department of Health and Rehabilitative Services upon request to health maintenance organizations to be utilized for risk management purposes. The department may promulgate rules necessary to carry out the provisions of this section.

Section 45. Legislative findings and intent.--

(1) The Legislature makes the following findings:

(a) The adequate delivery of medical emergency care services is a priority health care need and can have a dramatic impact in reducing civil lawsuits which ultimately result in high medical malpractice insurance premiums. Therefore, the delivery of emergency medical care represents an essential public service.

(b) Medical emergency care providers are often faced with civil lawsuits brought on behalf of medical emergency care patients, many of which may not be the direct result of substandard care, but rather may be prompted by recovery of such patient to less than full mental and physical health due to the severe nature of the medical emergency.

(c) Civil lawsuits brought on behalf of medical emergency care patients are often the result of factors beyond the control of the medical emergency care facility or the provider rendering such care, including, but not limited to:

1. The severe nature of many such emergencies; and

2. The fact that the emergency patient may not have had a previously established medical relationship with the defendant, may
have been unknown to the defendant, and may have been unconscious or unable to provide essential information, such as medical history, allergies to drugs, and other relevant facts.

(2) It is the intent of the Legislature to promote the availability of emergency medical care by providing immunity from civil liability to hospitals and trauma centers and the medical emergency care providers rendering care therein to medical emergency patients, unless such care is rendered with reckless disregard for the life or health of the patient.

Section 46. Section 768.13, Florida Statutes, is amended to read:

768.13 Good Samaritan Act; immunity from civil liability.--

(1) This act shall be known and cited as the "Good Samaritan Act."

(2)(a) Any person, including those licensed to practice medicine, who gratuitously and in good faith renders emergency care or treatment at the scene of an emergency outside of a hospital, doctor's office, or other place having proper medical equipment, without objection of the injured victim or victims thereof, 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 where the person acts as an ordinary reasonably prudent man would have acted under the same or similar circumstances.

(b) Any hospital licensed under chapter 395, any employee of such hospital working in a clinical area within the facility and providing patient care, and any person licensed to practice medicine who gratuitously and in good faith renders medical emergency care or treatment necessitated by a sudden, unexpected situation or occurrence resulting in a serious medical condition demanding immediate medical attention, for which the patient enters the hospital through its emergency room in response to a "code blue" emergency, shall not be held liable for any civil damages as a result of such medical care or treatment, unless such damages result from providing, or failing to provide, medical care or treatment under circumstances demonstrating a reckless disregard for the consequences so as to affect the life or health of another.

2. The immunity provided by this paragraph does not apply to damages as a result of any act or omission of providing medical care or treatment:

a. Which occurs after the patient is stabilized and is capable of receiving medical treatment as a nonemergency patient, unless surgery is required as a result of the emergency within a reasonable time after the patient is stabilized, in which case the immunity provided by this paragraph applies to any act or omission of providing medical care or treatment which occurs prior to the stabilization of the patient following the surgery;

b. Unrelated to the original medical emergency; or as a result of any act or failure to act in providing or arranging further medical treatment where the person acts as a reasonably prudent person licensed to practice medicine who would have acted under the same or similar circumstances;
3. For purposes of this paragraph, "reckless disregard" as it applies to a given health care provider rendering emergency medical services shall be such conduct which a health care provider knows or should know would be likely to result in injury so as to affect the life or health of another, taking into account the following to the extent they may be present:
   a. The extent or serious nature of the circumstances prevailing.
   b. The lack of time or ability to obtain appropriate consultation.
   c. The lack of a prior patient-physician relationship.
   d. The inability to obtain an appropriate medical history of the patient.
   e. The time constraints imposed by coexisting emergencies.

(3) Any person, including those licensed to practice veterinary medicine, who gratuitously and in good faith renders emergency care or treatment to an injured animal at the scene of an emergency on or adjacent to a roadway 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 where the person acts as an ordinary reasonably prudent man would have acted under the same or similar circumstances.

Section 47. Section 768.78, Florida Statutes, is amended to read:

768.78 Alternative methods of payment of damage awards.--

(1)(a) In any action to which this part applies in which the trier of fact makes an award to compensate the claimant for future economic losses which exceed $250,000, payment of amounts intended to compensate the claimant for these losses shall be made by one of the following means, unless an alternative method of payment of damages is provided in this section:

1. The defendant may make a lump-sum payment for all damages so assessed, with future economic losses and expenses reduced to present value; or

2. Subject to the provisions of this subsection, the court shall, at the request of either party, unless the court determines that manifest injustice would result to any party, enter a judgment ordering future economic damages, as itemized pursuant to s. 768.77(1)(a), in excess of $250,000 to be paid in whole or in part by periodic payments rather than by a lump-sum payment.

(b) In entering a judgment ordering the payment of such future damages by periodic payments, the court shall make a specific finding of the dollar amount of periodic payments which will compensate the judgment creditor for these future damages after offset for collateral sources. The total dollar amount of the periodic payments shall equal the dollar amount of all such future damages before any reduction to present value, less any attorney's fees payable from future damages in accordance with paragraph (f) subsection (6). The period of time over which the periodic payments shall be made is the period of years determined by the trier of fact in arriving at its itemized verdict and shall not be extended if the plaintiff lives...
beyond the determined period. If the claimant has been awarded damages to be discharged by periodic payments and the claimant dies prior to the termination of the period of years during which periodic payments are to be made, the remaining liability of the defendant, reduced to present value, shall be paid into the estate of the claimant in a lump sum. The court may order that the payments be equal or vary in amount, depending upon the need of the claimant.

(c) As a condition to authorizing periodic payments of future damages, the court shall require the defendant to post a bond or security or otherwise to assure full payment of these damages awarded by the judgment. A bond is not adequate unless it is written by a company authorized to do business in this state and is rated A+ by Best's. If the defendant is unable to adequately assure full payment of the damages, the court shall order that all damages be paid to the claimant in a lump sum pursuant to the verdict. No bond may be canceled or be subject to cancellation unless at least 60 days' advance written notice is filed with the court and the judgment creditor. Upon termination of periodic payments, the court shall order the return of the security, or so much as remains, to the judgment debtor.

(d) In the event that the court finds that the judgment debtor has exhibited a continuing pattern of failing to timely make the required periodic payments, the court shall:

a. Order that all remaining amounts of the award be paid by lump sum within 30 days after entry of the order;

b. Order that, in addition to the required periodic payments, the judgment debtor pay the claimant all damages caused by the failure to timely make periodic payments, including court costs and attorney's fees; or

c. Enter other orders or sanctions as appropriate to protect the judgment creditor.

If it appears that the judgment debtor may be insolvent or that there is a substantial risk that the judgment debtor may not have the financial responsibility to pay all amounts due and owing the judgment creditor, the court may:

a. Order additional security;

b. Order that the balance of payments due be placed in trust for the benefit of the claimant;

c. Order that all remaining amounts of the award be paid by lump sum within 30 days after entry of the order; or

d. Order such other protection as may be necessary to assure the payment of the remaining balance of the judgment.

The judgment providing for payment of future damages by periodic payments shall specify the recipient or recipients of the payments, the dollar amounts of the payments, the interval between payments, and the number of payments or the period of time over which payments shall be made. Periodic payments shall be subject to modification only as specified in this subsection section.
(f) Claimant's attorney's fee, if payable from the judgment, shall be based upon the total judgment, adding all amounts awarded for past and future damages. The attorney's fee shall be paid from past and future damages in the same proportion. If a claimant has agreed to pay his attorney's fees on a contingency fee basis, the claimant shall be responsible for paying the agreed percentage calculated solely on the basis of that portion of the award not subject to periodic payments. The remaining unpaid portion of the attorney's fees shall be paid in a lump sum by the defendant, who shall receive credit against future payments for this amount. However, the credit against each future payment is limited to an amount equal to the contingency fee percentage of each periodic payment. Any provision of this paragraph subsection may be modified by the agreement of all interested parties.

(g) Nothing in this subsection section shall preclude any other method of payment of awards, if such method is consented to by the parties.

(2)(a) In any action for damages based on personal injury or wrongful death arising out of medical malpractice, whether in tort or contract, in which the trier of fact makes an award to compensate the claimant for future economic losses, payment of amounts intended to compensate the claimant for these losses shall be made by one of the following means:

1. The defendant may make a lump-sum payment for all damages so assessed, with future economic losses and expenses reduced to present value; or

2. The court shall, at the request of either party, enter a judgment ordering future economic damages, as itemized pursuant to s. 768.68, to be paid by periodic payments rather than lump sum.

(b) For purposes of this subsection "periodic payment" means provision for the spreading of future economic damage payments, in whole or in part, over a period of time, as follows:

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

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

3. The provision for payment of future damages by periodic payments shall specify the recipient or recipients of the payments, the dollar amounts of the payments, the interval between payments, and the number of payments or the period of time over which payments shall be made.
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Section 48. Legislative findings and intent.--

(1) The Legislature makes the following findings:

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

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

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

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

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

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

(a) Presuit investigation shall include:

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

2. Medical corroboration procedures.

(b) Arbitration shall provide:

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

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

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

Section 49. Definitions.--As used in sections 48-59, the term:
(1) "Claimant" means any person who has a cause of action arising from medical negligence.

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

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

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

(c) Any contract or agreement of any group, organization, partnership, or corporation to provide, pay for, or reimburse the costs of hospital, medical, dental, or other health care services.

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

(3) "Economic damages" means financial losses which would not have occurred but for the injury giving rise to the cause of action, including, but not limited to, past and future medical expenses and 80 percent of wage loss and loss of earning capacity.

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

(5) "Medical expert" means a person duly and regularly engaged in the practice of his profession who holds a health care professional degree from a university or college and has had special professional training and experience or one possessed of special health care knowledge or skill about the subject upon which he is called to testify or provide an opinion.

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

(7) "Noneconomic damages" means nonfinancial losses which would not have occurred but for the injury giving rise to the cause of action, including pain and suffering, inconvenience, physical impairment, mental anguish, disfigurement, loss of capacity for enjoyment of life, and other nonfinancial losses.

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

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

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

Section 50. Presuit investigation of medical negligence claims and defenses by prospective parties.--

(1) Presuit investigation of medical negligence claims and defenses pursuant to sections 50-53 shall apply to all medical negligence, including dental negligence, claims and defenses. This shall include:

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

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

(2) Prior to issuing notification of intent to initiate medical malpractice litigation pursuant to s. 768.57, Florida Statutes, the claimant shall conduct an investigation to ascertain that there are reasonable grounds to believe that:

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

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

Corroboration of reasonable grounds to initiate medical negligence litigation shall be provided by the claimant's submission of a verified written medical expert opinion from a medical expert as defined in section 49(5), at the time the notice of intent to initiate litigation is filed, which statement shall corroborate reasonable grounds to support the claim of medical negligence.

(3) Prior to issuing its response to the claimant's notice of intent to initiate litigation, during the time period for response authorized pursuant to s. 768.57, Florida Statutes, the defendant or the defendant's insurer or self-insurer shall conduct an investigation to ascertain whether there are reasonable grounds to believe that:

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

(b) Such negligence resulted in injury to the claimant.
Corroboration of lack of reasonable grounds for medical negligence litigation shall be provided with any response rejecting the claim by the defendant's submission of a verified written medical expert opinion from a medical expert as defined in section 49(5), at the time the response rejecting the claim is filed, which statement shall corrobore reasonable grounds for lack of negligent injury sufficient to support the response denying negligent injury.

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

Section 51. Availability of medical records for presuit screening of medical negligence claims and defenses; penalty.--

(1) Copies of any medical record relevant to any litigation of a medical negligence claim or defense shall be provided to a claimant or a defendant, or to the attorney thereof, at a reasonable charge within 10 business days of a request for copies. It shall not be grounds to refuse copies of such medical records that they are not yet completed or that a medical bill is still owing.

(2) Failure to provide copies of such medical records, or failure to make the charge for copies a reasonable charge, shall constitute evidence of failure of that party to comply with good-faith discovery requirements and shall waive the requirement of written medical corroboration by the requesting party.

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

Section 52. Presuit discovery of medical negligence claims and defenses.--

(1) Upon the completion of presuit investigation pursuant to section 50, which investigation has resulted in the filing of a notice of intent to initiate litigation in accordance with s. 768.57, Florida Statutes, corroborated by medical expert opinion that there exist reasonable grounds for a claim of negligent injury, each party shall provide to the other party reasonable access to information within its possession or control, in order to facilitate evaluation of the claim.

(2) Such access shall be provided without formal discovery, pursuant to s. 768.57, Florida Statutes, and failure to so provide shall be grounds for dismissal of any applicable claim or defense ultimately asserted.

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

(4) No statement, discussion, written document, report, or other work product generated solely by the presuit screening process is discoverable or admissible in any civil action for any purpose by the opposing party. All participants, including, but not limited to, hospitals and other medical facilities, and the officers, directors, trustees, employees, and agents thereof, physicians, investigators, witnesses, and employees or associates of the defendant, are immune.
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from civil liability arising from participation in the presuit screening process. Such immunity from civil liability includes immunity for any acts by a medical facility in connection with providing medical records pursuant to section 51(1) regardless of whether the medical facility is or is not a defendant.

Section 53. Presuit investigation of medical negligence claims and defenses by court.--

(1) After the completion of presuit investigation by the parties pursuant to section 50 and any informal discovery pursuant to s. 768.57, Florida Statutes, any party may file a motion in the circuit court requesting the court to determine whether the opposing party's claim or denial rests on a reasonable basis.

(2) If the court finds that the notice of intent to initiate litigation filed by the claimant is not in compliance with the reasonable investigation requirements of sections 48-59, the court shall dismiss the claim, and the person who filed such notice of intent, whether the claimant or the claimant's attorney, shall be personally liable for all attorney's fees and costs incurred during the investigation and evaluation of the claim, including the reasonable attorney's fees and costs of the defendant or the defendant's insurer.

(3) If the court finds that the response filed by a defendant rejecting the claim is not in compliance with the reasonable investigation requirements, the court shall strike the defendant's response, and the person who filed such response, whether the defendant, the defendant's insurer, or the defendant's attorney, shall be personally liable for all attorney's fees and costs incurred during the investigation and evaluation of the claim, including the reasonable attorney's fees and costs of the claimant.

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

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

(b) The court may refuse to consider the testimony of such an expert who has been disqualified three times pursuant to this section.
Section 54. Voluntary binding arbitration of medical negligence claims.—

(1) Voluntary binding arbitration pursuant to sections 54-59 shall not apply to rights of action involving the state or its agencies or subdivisions, or the officers, employees, or agents thereof, pursuant to s. 768.28, Florida Statutes.

(2) Upon the completion of presuit investigation with preliminary reasonable grounds for a medical negligence claim intact, the parties may elect to have damages determined by an arbitration panel. Such election may be initiated by either party by serving a request for voluntary binding arbitration of damages within 90 days of service of the claimant's notice of intent to initiate litigation upon the defendant. The evidentiary standards for voluntary binding arbitration of medical negligence claims shall be as provided in s. 120.58(1)(a), Florida Statutes. To the extent not inconsistent with sections 48-59, voluntary binding arbitration of medical negligence claims shall utilize the procedures in s. 44.304, Florida Statutes.

(3) Upon receipt of a party's request for such arbitration, the opposing party may accept the offer of voluntary binding arbitration within 30 days. However, in no event shall the defendant be required to respond to the request for arbitration sooner than 90 days after service of the notice of intent to initiate litigation under s. 768.57, Florida Statutes. Such acceptance within the time period provided by this subsection shall be a binding commitment to comply with the decision of the arbitration panel. The liability of any insurer shall be subject to any applicable insurance policy limits.

(4) The arbitration panel shall be composed of three arbitrators, one selected by the claimant, one selected by the defendant, and one an administrative hearing officer furnished by the Division of Administrative Hearings who shall serve as the chief arbitrator with the authority granted a chief arbitrator under s. 44.304, Florida Statutes. In the event of multiple plaintiffs or multiple defendants, the arbitrator selected by the side with multiple parties shall be the choice of those parties. If the multiple parties cannot reach agreement as to their arbitrator, each of the multiple parties shall submit a nominee, and the director of the Division of Administrative Hearings shall appoint the arbitrator from among such nominees.

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

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

(7) Arbitration pursuant to this section shall preclude recourse to any other remedy by the claimant against any participating defendant, and shall be undertaken with the understanding that:
(a) Net economic damages shall be awardable, including, but not limited to, past and future medical expenses and 80 percent of wage loss and loss of earning capacity, offset by any collateral source payments.

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

(c) Damages for future economic losses shall be awarded to be paid by periodic payments pursuant to section 49(8), and shall be offset by future collateral source payments.

(d) Punitive damages shall not be awarded.

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

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

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

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

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

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

(k) Any offer by a claimant to arbitrate must be made to each defendant against whom the claimant has made a claim. Any offer by a defendant to arbitrate must be made to each claimant who has joined in the notice of intent to initiate litigation, as provided in s. 768.57, Florida Statutes. A defendant who rejects a claimant's offer to arbitrate shall be subject to the provisions of section 56(3). A claimant who rejects a defendant's offer to arbitrate shall be subject to the provisions of section 56(4).

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

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

(9) The Division of Administrative Hearings is authorized to promulgate rules to effect the orderly and efficient processing of the arbitration procedures of sections 48-59.

(10) Rules promulgated by the Division of Administrative Hearings pursuant to this section, s. 120.53 or s. 120.65, may authorize any reasonable sanctions except contempt for violation of the rules of the Division or failure to comply with a reasonable order issued by a Hearing Officer, which is not under judicial review.

Section 55. Arbitration to allocate responsibility among multiple defendants.--

(1) The provisions of this section shall apply when more than one defendant has participated in voluntary binding arbitration pursuant to section 54.

(2) Within 20 days after the determination of damages by the arbitration panel in the first arbitration proceeding, those defendants who have agreed to voluntary binding arbitration shall submit any dispute among them regarding the apportionment of financial responsibility to a separate binding arbitration proceeding. Such proceeding shall be with a panel of three arbitrators, which panel shall consist of the administrative hearing officer who presided in the first arbitration proceeding, who shall serve as the chief arbitrator with the authority granted a chief arbitrator under s. 44.304, Florida Statutes, and two medical practitioners appointed by the defendants, except that if a hospital licensed pursuant to chapter 395, Florida Statutes, is involved in the arbitration proceeding, one arbitrator appointed by the defendants shall be a certified hospital risk manager. In the event the defendants cannot agree on their selection of arbitrators within 20 days after the determination of damages by the arbitration panel in the first arbitration proceeding, a list of not more than five nominees shall be submitted by each defendant to the director of the Division of Administrative Hearings, who shall select the other arbitrators but shall not select more than one from the list of nominees of any defendant.

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

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

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

(6) Any defendant paying damages assessed pursuant to this section or section 54 shall have an action for contribution against any nonarbitrating person whose negligence contributed to the injury.

Section 56. Effects of failure to offer or accept voluntary binding arbitration.---

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

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

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

(a) The claim shall proceed to trial without limitation on damages, and the claimant, upon proving medical negligence, shall be entitled to recover prejudgment interest, and reasonable attorney's fees up to 25 percent of the award reduced to present value.

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

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

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

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

(c) Damages for future economic losses shall be awarded to be paid by periodic payments pursuant to section 49(9), and shall be offset by future collateral source payments.
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(5) Jury trial shall proceed in accordance with existing principles of law.

Section 57. Misarbitration.--

(1) At any time during the course of voluntary binding arbitration of a medical negligence claim pursuant to section 54 or section 55, the administrative hearing officer serving as chief arbitrator on the arbitration panel, if he determines that agreement cannot be reached, shall be authorized to dissolve the arbitration panel and request the director of the Division of Administrative Hearings to appoint two new arbitrators from new lists of five names provided by each party to the arbitration. Not more than one arbitrator shall be appointed from the list provided by any party.

(2) Upon appointment of the new arbitrators, arbitration shall proceed at the direction of the chief arbitrator in accordance with the provisions of sections 48-59.

Section 58. Payment of arbitration award; interest.--

(1) Within 20 days after the determination of damages by the arbitration panel pursuant to section 54, the defendant shall:

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

(b) Submit any dispute among multiple defendants to arbitration pursuant to section 59.

(2) Commencing 90 days after the award rendered in the arbitration procedure pursuant to section 10, such award shall begin to accrue interest at the rate of 18 percent per year.

Section 59. Appeal of arbitration award.--An arbitration award is a final agency action for purposes of ss. 120.68 and 120.69, Florida Statutes. Any appeal of an award shall be taken to the district court of appeal and shall be limited to review on the record, and not de novo.

Section 60. Legislative findings and intent.--

(1) The Legislature makes the following findings:

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

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

(c) Because obstetric services are essential, it is incumbent upon the Legislature to provide a plan designed to result in the stabilization and reduction of malpractice insurance premiums for providers of such services in Florida.
(d) The costs of birth-related neurological injury claims are particularly high and warrant the establishment of a limited system of compensation irrespective of fault.

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

Section 61. Definitions.--As used in sections 60-75, the term:

(1) "Association" means the Florida Birth-Related Neurological Injury Compensation Association established in section 74 to administer the Florida Birth-Related Neurological Injury Compensation Plan and the Birth-Related Neurological Injury Compensation Trust Fund established in section 73.

(2) "Birth-related neurological injury" means injury to the brain or spinal cord of an infant of term gestation caused by oxygen deprivation or mechanical injury occurring in the course of labor, delivery, or resuscitation in the immediate post-delivery period in a hospital, which renders the infant permanently and substantially mentally and physically impaired. This definition shall apply to live births only and shall not include disability or death caused by genetic or congenital abnormality.

(3) "Claimant" means any person who files a claim pursuant to section 64 for compensation for a birth-related neurological injury to an infant. Such a claim may be filed by any legal representative on behalf of an injured infant; and, in the case of a deceased infant, the claim may be filed by an administrator, personal representative, or other legal representative thereof.

(4) "Deputy commissioner" means a deputy commissioner of the Division of Workers' Compensation of the Department of Labor and Employment Security.

(5) "Division" means the Division of Workers' Compensation of the Department of Labor and Employment Security.

(6) "Hospital" means any hospital licensed in Florida.

(7) "Participating physician" means a physician licensed in Florida to practice medicine who practices obstetrics or performs obstetrical services either full time or part time and who had paid at the time of the injury the assessment required for participation in the birth-related neurological injury compensation plan for the year in which the injury occurred. Such term shall not apply to:

(a) Any physician who practices medicine as an officer, employee, or agent of the Federal Government or of the state or its agencies or its subdivisions. For the purposes of this subsection, an agent of the state, its agencies or subdivisions is a person who is eligible for coverage under any self-insurance or insurance program authorized by the provisions of s. 768.28(13).

(b) Any physician who practices obstetrics in conjunction with his teaching duties at an accredited medical school or in its main teaching hospitals.
Section 62. Florida Birth-Related Neurological Injury Compensation Plan; exclusiveness of remedy.--

(1) There is established the Florida Birth-Related Neurological Injury Compensation Plan for the purpose of providing compensation, irrespective of fault, for birth-related neurological injury claims. Such plan shall apply to births occurring on or after January 1, 1989, and shall be administered by the Florida Birth-Related Neurological Injury Compensation Association.

(2) The rights and remedies granted by this plan on account of a birth-related neurological injury shall exclude all other rights and remedies of such infant, his personal representative, parents, dependents, and next of kin, at common law or otherwise, arising out of or related to a medical malpractice claim with respect to such injury; except that a civil action shall not be foreclosed where there is clear and convincing evidence of bad faith or malicious purpose or willful and wanton disregard of human rights, safety, or property, provided that such suit is filed prior to and in lieu of payment of an award under sections 60-75. Such suit shall be filed before the award of the division becomes conclusive and binding as provided for in section 70.

(3) Sovereign immunity is hereby waived on behalf of the Birth-Related Neurological Injury Compensation Association solely to the extent necessary to assure payment of compensation as provided in section 69.

Section 63. Deputy commissioner of Division of Workers' Compensation to determine claims.--The deputy commissioner shall hear and determine all claims filed pursuant to sections 60-75 and shall exercise the full power and authority granted to him with respect to workers' compensation claims, as necessary, to carry out the purposes of such sections.

Section 64. Filing of claims and responses; medical disciplinary review.--

(1) All claims filed for compensation under the plan shall commence by the claimant filing with the division a petition seeking compensation. Such petition shall include the following information:

(a) The name and address of the legal representative and the basis for his representation of the injured infant.

(b) The name and address of the injured infant.

(c) The name and address of any physician providing obstetrical services who was present at the birth and the name and address of the hospital at which the birth occurred.

(d) A description of the disability for which the claim is made.

(e) The time and place the injury occurred.

(f) A brief statement of the facts and circumstances surrounding the injury and giving rise to the claim.

(g) All available relevant medical records relating to the birth-related neurological injury, and an identification of any unavailable
records known to the claimant and the reasons for their unavailability.

(h) Appropriate assessments, evaluations, and prognoses, and such other records and documents as are reasonably necessary for the determination of the amount of compensation to be paid to, or on behalf of, the injured infant on account of the birth-related neurological injury.

(i) Documentation of expenses and services incurred to date, which indicates any payment made for such expenses and services, and by whom.

(j) Documentation of any applicable private or governmental source of services or reimbursement relative to the impairments.

(2) The claimant shall furnish the division with as many copies of the petition as required for service upon the association, any physician and hospital named in the petition, and the Division of Medical Quality Assurance, along with a $15 filing fee for deposit in the Workers' Compensation Administration Trust Fund. Upon receipt of the petition, the division shall immediately serve the association, by service upon the agent designated to accept service on behalf of the association, by registered or certified mail, and shall mail copies of the petition to any physician and hospital named in the petition, the Division of Medical Quality Assurance, the Department of Health and Rehabilitative Services, and the medical advisory review panel provided for in section 67.

(3) The association shall have 45 days from the date of service in which to file a response to the petition and to submit relevant written information relating to the issue of whether the injury alleged is a birth-related neurological injury.

(4) Upon receipt of such petition, the Division of Medical Quality Assurance shall review the information therein and determine whether it involved conduct by a physician licensed under chapter 458, Florida Statutes, or an osteopathic physician licensed under chapter 459, Florida Statutes, that is subject to disciplinary action, in which case the provisions of s. 455.225, Florida Statutes, shall apply.

(5) Upon receipt of such petition, the Department of Health and Rehabilitative Services shall investigate the claim, and if it determines that the injury resulted from, or was aggravated by, a breach of duty on the part of a hospital in violation of chapter 395, Florida Statutes, it shall take any such action consistent with its disciplinary authority as may be appropriate.

Section 65. Tolling of statute of limitations.--The statute of limitations with respect to any civil action that may be brought by, or on behalf of, an injured infant allegedly arising out of, or related to, a birth-related neurological injury shall be tolled by the filing of a claim in accordance with sections 60-75, and the time such claim is pending or is on appeal shall not be computed as part of the period within which such civil action may be brought.

Section 66. Hearing; parties; discovery.--

(1) The deputy commissioner shall set the date for a hearing no sooner than 60 days and no later than 120 days after the filing by a
claimant of a petition in compliance with section 64. The deputy commissioner shall immediately notify the parties of the time and place of such hearing, which shall be held in the county where the injury occurred unless otherwise agreed to by the parties and authorized by the division.

(2) The parties to the hearing shall include the claimant and the association.

(3) Any party to a proceeding under sections 60-75 may, upon application to the deputy commissioner setting forth the materiality of the evidence to be given, serve interrogatories or cause the depositions of witnesses residing within or without the state to be taken, the costs thereof to be taxed as expenses incurred in connection with the filing of a claim. Such depositions shall be taken after giving notice and in the manner prescribed for the taking of depositions in actions at law, except that they shall be directed to the deputy commissioner before whom the proceedings may be pending.

Section 67. Medical advisory panel review and recommendations; procedure.--

(1) Each claim filed with the division under sections 60-75 shall be reviewed by a medical advisory panel of three qualified physicians of whom one shall be a neurosurgeon, one shall be an obstetrician, and one shall be a pediatrician. The panel shall file its report, with its recommendation as to whether the injury for which the claim is filed is a birth-related neurological injury, with the division at least 10 days prior to the date set for the hearing. At the request of the division, at least one member of the panel shall be available to testify at the hearing. The deputy commissioner shall consider, but not be bound by, the recommendation of the panel.

(2) The division shall develop a plan which provides the method and procedure for such medical advisory panel review and shall develop such plan in coordination with the Division of Medical Quality Assurance of the Department of Professional Regulation and the Children's Medical Services Program Office of the Department of Health and Rehabilitative Services.

Section 68. Determination of claims; presumption; findings of deputy commissioner binding on participants.--

(1) Upon completion of the hearing, the deputy commissioner shall make the following determinations based upon all available evidence:

(a) Whether the injury claimed is a birth-related neurological injury.

1. A rebuttable presumption shall arise that the injury alleged is a birth-related neurological injury where it has been demonstrated, to the satisfaction of the deputy commissioner, that the infant has sustained a brain or spinal cord injury caused by oxygen deprivation or mechanical injury and that the infant was thereby rendered permanently and substantially mentally and physically impaired.

2. If either party disagrees with such presumption, that party shall have the burden of proving that the injury alleged is not a birth-related neurological injury.
(b) Whether obstetrical services were delivered by a participating physician at the birth.

(c) How much compensation, if any, is awardable pursuant to section 69.

(2) If the deputy commissioner determines that the injury alleged is not a birth-related neurological injury or that obstetrical services were not delivered by a participating physician at the birth, he shall enter an order and shall cause a copy of such order to be sent immediately to the parties by registered or certified mail.

(3) By becoming a participating physician, a physician shall be bound for all purposes by the finding of the deputy commissioner or any appeal thereto with respect to whether such injury is a birth-related neurological injury.

Section 69. Deputy commissioner awards for birth-related neurological injuries; notice of award.--

(1) Upon determining that an infant has sustained a birth-related neurological injury and that obstetrical services were delivered by a participating physician at the birth, the deputy commissioner shall make an award providing compensation for the following items relative to such injury:

(a) Actual expenses for medically necessary and reasonable medical and hospital, rehabilitative, residential, and custodial care and service, for medically necessary drugs, special equipment, and facilities, and for related travel; or in lieu of compensation for such items, custodial care in a state-designated facility, if custodial care in a state-designated facility is available. However, such expenses shall not include:

1. Expenses for items or services that the infant has received, or is entitled to receive, under the laws of any state or the Federal Government, except to the extent such exclusion may be prohibited by federal law.

2. Expenses for items or services that the infant has received, or is contractually entitled to receive, from any prepaid health plan, health maintenance organization, or other private insuring entity.

3. Expenses for which the infant has received reimbursement, or for which the infant is entitled to receive reimbursement, under the laws of any state or the Federal Government, except to the extent such exclusion may be prohibited by federal law.

4. Expenses for which the infant has received reimbursement, or for which the infant is contractually entitled to receive reimbursement, pursuant to the provisions of any health or sickness insurance policy or other private insurance program.

Expenses included under this paragraph shall be limited to reasonable charges prevailing in the same community for similar treatment of injured persons when such treatment is paid for by the injured person.
(b) Periodic payments of an award to the parent or legal guardian of the infant found to have sustained a birth-related neurological injury, which award shall not exceed $100,000. However, at the discretion of the deputy commissioner, such award may be made in a lump sum.

(c) Reasonable expenses incurred in connection with the filing of a claim under sections 60-75, including reasonable attorney's fees, which shall be subject to the approval and award of the deputy commissioner.

(2) The award shall require the immediate payment of expenses previously incurred and shall require that future expenses be paid as incurred.

(3) A copy of the award shall be sent immediately by registered or certified mail to each person served with a copy of the petition under section 64(2).

Section 70. Conclusiveness of determination or award; appeal.--

(1) A determination of the deputy commissioner as to qualification of the claim for purposes of compensability under section 68 or an award by the deputy commissioner pursuant to section 69 shall be conclusive and binding as to all questions of fact. Review of an order of a deputy commissioner shall be by appeal to the District Court of Appeal. Appeals shall be filed in accordance with rules of procedure prescribed by the Supreme Court for review of such orders.

(2) In case of an appeal from an award of the deputy commissioner, the appeal shall operate as a suspension of the award, and the association shall not be required to make payment of the award involved in the appeal until the questions at issue therein shall have been fully determined.

Section 71. Enforcement of awards.--

(1) The deputy commissioner shall have full authority to enforce his awards and to protect himself from any deception or lack of cooperation in reaching his determination as to any award. Such authority shall include the power to petition the circuit court for an order of contempt.

(2) A party may, if the circumstances so warrant, petition the circuit court for enforcement of a final award by the deputy commissioner.

Section 72. Limitation on claim.--Any claim for compensation under sections 55-70 that is filed more than 7 years after the birth of an infant alleged to have a birth-related neurological injury shall be barred.

Section 73. Birth-Related Neurological Injury Compensation Trust Fund.--

(1) There is hereby created within the Department of Insurance the Birth-Related Neurological Injury Compensation Trust Fund to finance the Florida Birth-Related Neurological Injury Compensation Plan.
(2) Such fund shall be administered by the Florida Birth-Related Neurological Injury Compensation Association established in section 74, in accordance with the following requirements:

(a) On or before July 1, 1988, the directors of the association shall submit to the Department of Insurance for review a plan of operation which shall provide for the efficient administration of the fund and for prompt processing of claims against and awards made from the fund. The plan of operation shall include provision for:

1. Establishment of necessary facilities;

2. Management of the fund;

3. Processing of claims against the fund;

4. Initial and annual assessment of the persons and entities listed in subsection (4) to pay awards and expenses, which assessments shall be on an actuarially sound basis subject to the limits set forth in subsection (4); and

5. Any other matters necessary for the efficient operation of the birth-related neurological injury compensation plan.

(b) The plan of operation shall be subject to approval by the Department of Insurance after consultation with representatives of interested individuals and organizations. If the Department of Insurance disapproves all or any part of the plan of operation, the directors shall within 30 days submit for review an appropriate revised plan of operation. If the directors fail to do so, the Department of Insurance shall promulgate a plan of operation. The plan of operation approved or promulgated by the Department of Insurance shall become effective and operational upon order of the Department of Insurance.

(c) Amendments to the plan of operation may be made by the directors of the plan, subject to the approval of the Department of Insurance.

(3) All assessments paid pursuant to the plan of operation shall be deposited in the Birth-Related Neurological Injury Compensation Trust Fund. The fund and any income therefrom shall be disbursed only for the payment of awards under sections 60-75 and for the payment of the reasonable expenses of administering the fund.

(4) On or before March 1, 1988, the following persons and entities shall pay into the fund an initial assessment in accordance with the plan of operation:

(a) Each physician who wishes to participate in the Florida Birth-Related Neurological Injury Compensation Plan and who otherwise qualifies as a participating physician under sections 60-75 shall pay an initial assessment of $5,000.

(b) Each hospital licensed under chapter 395, Florida Statutes, shall pay an initial assessment of $50 per infant delivered during the prior calendar year, as reported in the most recent annual licensure survey of hospitals. Each hospital owned or operated by the state or a county, special taxing district, or other political subdivision of the state shall not be required to pay the initial assessment or any assessment required by subsection (5). The term
"infant delivered during the prior calendar year" shall not include infants delivered by a physician employed by the State or any political subdivision thereof.

(c) All physicians licensed by the state as of March 1, 1988, other than participating physicians, shall pay into the fund an initial assessment of $250, in the manner required by the plan of operation.

(5)(a) Beginning January 1, 1990, the persons and entities listed in subsection (4), as of the date determined in accordance with the plan of operation, shall pay an annual assessment in the amount equal to their initial assessments, in the manner required by the plan of operation.

(b) If the assessments collected pursuant to subsection (4) and the appropriation of funds provided by section 76 of this act to the fund from the Insurance Commissioner's Regulatory Trust Fund are insufficient to maintain the fund on an actuarially sound basis, there is hereby appropriated for transfer to the fund from the Insurance Commissioner's Regulatory Trust Fund an additional amount of up to $20 million.

(c)1. Taking into account the assessments collected pursuant to subsection (4) and appropriations from the Insurance Commissioner's Regulatory Trust Fund, if required to maintain the fund on an actuarially sound basis, the Department of Insurance shall require each entity licensed to issue casualty insurance as defined in s. 624.605(1)(b), (k), and (q), Florida Statutes, to pay into the fund an annual assessment in an amount determined by the department pursuant to paragraph (7)(a), in the manner required by the plan of operation.

2. All annual assessments shall be made on the basis of net direct premiums written for the business activity which forms the basis for each such entity's inclusion as a funding source for the plan in the state during the prior year ending December 31, as reported to the Department of Insurance, and shall be in the proportion that the net direct premiums written by each carrier on account of the business activity forming the basis for its inclusion in the plan bears to the aggregate net direct premiums for all such business activity written in this state by all such entities.

3. No entity listed in this paragraph shall be individually liable for an annual assessment in excess of 0.25 percent of that entity's net direct premiums written.

4. Casualty insurance carriers shall be entitled to recover their initial and annual assessments through a surcharge on future policies, a rate increase applicable prospectively, or a combination of the two.

(6)(a) The Department of Professional Regulation shall collect and enforce collection of all assessments required to be paid by participating and nonparticipating physicians pursuant to sections 60-75. Failure of a physician to pay such assessment is grounds for disciplinary action pursuant to chapter 458 or chapter 459, Florida Statutes.

(b) The Department of Health and Rehabilitative Services shall collect and enforce collection of all assessments required to be paid
by hospitals pursuant to sections 60-75. Failure of a hospital to pay such assessment is grounds for disciplinary action pursuant to s. 395.018, Florida Statutes.

(c) Assessments collected pursuant to this subsection shall be transferred to the Department of Insurance for deposit in the fund.

(7)(a) The Department of Insurance shall undertake an actuarial investigation of the requirements of the fund based on the fund's experience in the first year of operation, including without limitation the assets and liabilities of the fund. Pursuant to such investigation, the Department of Insurance shall establish the rate of contribution of the entities listed in paragraph (5)(c) for the tax year beginning January 1, 1990. Following the initial valuation, the Department of Insurance shall cause an actuarial valuation to be made of the assets and liabilities of the fund no less frequently than biennially. Pursuant to the results of such valuations, the Department of Insurance shall prepare a statement as to the contribution rate applicable to the entities listed in paragraph (5)(c). However, at no time shall the rate be greater than 0.25 percent of net direct premiums written.

(b) If the Department of Insurance finds that the fund cannot be maintained on an actuarially sound basis based on the assessments and appropriations listed in subsections (4) and (5), the department shall increase the assessments specified in subsection (4) on a proportional basis as needed.

Section 74. Florida Birth-Related Neurological Injury Compensation Association; board of directors.--

(1)(a) The Florida Birth-Related Neurological Injury Compensation Plan shall be governed by a board of five directors which shall be known as the Florida Birth-Related Neurological Injury Compensation Association.

(b) The directors shall be appointed for staggered terms of 3 years or until their successors are appointed and have qualified.

(c) The directors shall be appointed by the Insurance Commissioner as follows:

1. One citizen representative.
2. One representative of participating physicians.
3. One representative of hospitals.
4. One representative of casualty insurers.
5. One representative of physicians other than participating physicians.

(2)(a) The Insurance Commissioner may select the representative of the participating physicians from a list of at least three names to be recommended by the Florida Obstetric and Gynecologic Society; the representative of hospitals from a list of at least three names to be recommended by the Florida Hospital Association; the representative of casualty insurers from a list of at least three names, one of which is recommended by the American Insurance Association, one by the Alliance of American Insurers, and one by the
National Association of Independent Insurers; and the representative of physicians other than participating physicians from a list of three names to be recommended by the Florida Medical Association and a list of three names to be recommended by the Florida Osteopathic Medical Association. In no case shall the Insurance Commissioner be bound to make any appointment from among the nominees of such respective associations.

(b) The Insurance Commissioner shall promptly notify the appropriate medical association upon the occurrence of any vacancy, and like nominations may be made for the filling of the vacancy.

(3) The directors shall act by majority vote with five directors constituting a quorum for the transaction of any business or the exercise of any power of the plan. The directors shall serve without salary, but each director shall be reimbursed for actual and necessary expenses incurred in the performance of his official duties as a director of the plan, in accordance with s. 112.061, Florida Statutes. The directors shall not be subject to any liability with respect to the administration of the plan.

(4) The board of directors shall have the power to:

(a) Administer the plan.

(b) Administer the Birth-Related Neurological Injury Compensation Trust Fund.

(c) Administer the payment of claims on behalf of the plan.

(d) Direct the investment and reinvestment of any surplus in the fund over losses and expenses, provided that any investment income generated thereby remains in the fund.

(e) Reinsure the risks of the fund in whole or in part.

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

(g) Have and exercise all powers necessary or convenient to effect any or all of the purposes for which the plan is created.

(h) Enter into such contracts as are necessary or proper to administer the plan.

(i) Employ or retain such persons as are necessary to perform the administrative and financial transactions and responsibilities of the plan and to perform other necessary and proper functions not prohibited by law.

(j) Take such legal action as may be necessary to avoid payment of improper claims.

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

Section 75. Notice to obstetrical patients of participation in the plan.--Each hospital and each participating physician under the Florida Birth-Related Neurological Injury Compensation Plan shall provide notice to the obstetrical patients thereof as to participation in the limited no-fault alternative for birth-related neurological injuries. Such notice shall be provided on forms furnished by the association and shall include a clear and concise explanation of a patient's rights and limitations under the plan.

Section 76. Appropriations.--

(1) There is hereby appropriated to the Department of Professional Regulation 89 positions and $1.4 million from the Professional Regulation Trust Fund for fiscal year 1987-1988 to carry out the purposes of this act.

(2) There is hereby appropriated to the Department of Administration, Division of Administrative Hearings 5 positions and $207,168 from the General Revenue Fund and 5 positions and $65,000 from the Administrative Trust Fund for the 1987-1988 fiscal year to implement the provisions of this act. Additional salary rate of $380,425 is provided to the Division.

(3) There is hereby appropriated to the Department of Insurance 9 positions and $149,616 from the Insurance Commissioner's Regulatory Trust Fund for the 1987-1988 fiscal year to implement the provisions of this act.

(4) Effective January 1, 1990, there is hereby appropriated for transfer the sum of $20 million from the Insurance Commissioner's Regulatory Trust Fund to the Birth-Related Neurological Injury Trust Fund.

Section 77. Notwithstanding any other provision of law, the Board of Medicine and the Board of Osteopathic Medical Examiners are hereby authorized to make a one-time fee assessment and renewal within the fee limitations of this act.

Section 78. Subsection (6) is added to section 768.45, Florida Statutes, to read.

768.45 Medical negligence; standards of recovery.--

(6)[a] In any action for damages involving a claim of negligence against a physician licensed under chapter 458, osteopathic physician licensed under chapter 459, podiatrist licensed under chapter 461, or chiropractor licensed under chapter 460 providing emergency medical services in a hospital emergency department, the court shall admit expert medical testimony only from physicians, osteopathic physicians, podiatrists, and chiropractors who have had substantial professional experience within the preceding 5 years while assigned to provide emergency medical services in a hospital emergency department.

(b) For the purposes of this subsection:
The term "emergency medical services" means those medical services required for the immediate diagnosis and treatment of medical conditions which, if not immediately diagnosed and treated, could lead to serious physical or mental disability or death.

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

Section 79. Subsection (6) is added to section 768.81, Florida Statutes, to read:

768.81 Comparative fault.--

(6) Notwithstanding anything in law to the contrary, in an action for damages for personal injury or wrongful death arising out of medical malpractice, whether in contract or tort, when an apportionment of damages pursuant to this section is attributed to a teaching hospital as defined in s. 395.502(22), the court shall enter judgment against each party liable on the basis of such party's percentage of fault and not on the basis of the doctrine of joint and several liability.

Section 80. In an action for damages for personal injury or wrongful death arising out of medical malpractice, whether in contract or tort, when an apportionment of damages pursuant to s. 768.81, Florida Statutes, is attributed to the Board of Regents, the court shall enter judgment against each party liable on the basis of such party's percentage of fault and not on the basis of the doctrine of joint and several liability. The sole remedy available to a claimant to collect damages, subject to the provisions of this section, against the Board of Regents shall be pursuant to s. 768.28, Florida Statutes.

Section 81. Notwithstanding the provisions of s. 627.0625, Florida Statutes, insurers issuing insurance in this state shall reflect in their filings for rates, rating schedules, or rating manuals for medical malpractice insurance any savings or other effects realized by the insurer as a result of this act.

Section 82. If any provision of this act or the application thereof to any person or circumstance is held invalid, the invalidity shall not affect other provisions or applications of the act which can be given effect without the invalid provision or application, and to this end the provisions of this act are declared severable.

Section 83. The Supreme Court of the State of Florida is requested to adopt a standard jury instruction for use in medical negligence cases involving alleged negligence occurring in hospital emergency rooms. It is requested that such jury instruction carry out the legislative intent as provided in section 45 with respect to the standard of care and the exigencies of medical treatment in hospital emergency rooms.

Section 84. Section 768.66, Florida Statutes, is hereby repealed.

Section 85. In the event that this act does not result in savings in medical malpractice premiums beyond those which would be otherwise realized, it is the desire of the Legislature that the provisions of this act be readressed by the Legislature.
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Section 86. This act does not apply to causes of action arising prior to the effective date of this act.

Section 87. This act shall take effect upon becoming a law.

Approved by the Governor February 8, 1988.

Filed in Office Secretary of State February 8, 1988.

CHAPTER 88-2

Senate Bill No. 11-E

An act relating to operation of commercial motor vehicles; amending s. 316.302, F.S.; revising provisions with respect to operation of a commercial motor vehicle solely within this state; limiting periods of time when a driver may be on duty; providing that certain commercial vehicle operators are exempt from described rules; providing that the amendments to s. 316.302, F.S., shall be invalid under certain circumstances; providing for severability of the provisions of the act; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Paragraphs (a) and (b) of subsection (2) of section 316.302, Florida Statutes, are amended, and paragraph (g) is added to said subsection, to read:

316.302 Commercial motor vehicles; transportation of hazardous materials; safety regulations; enforcement.

(2)(a) A person who operates a commercial motor vehicle solely within this state need not comply with 49 C.F.R. ss. 391.11(b)(1) and 395.3(a) and (b).

(b) A person who operates a commercial motor vehicle solely within this state may, after 8 hours rest, and following the required initial motor vehicle inspection be permitted to operate any part of the first 15 on-duty hours, but may not be permitted to operate a commercial motor vehicle after that until the requirements of another 8 hours rest has been fulfilled. Such person shall not be on duty more than 72 hours in any period of 7 consecutive days, but carriers operating every day in a week may permit drivers to remain on duty for a total of not more than 84 hours in an period of 8 consecutive days; however, 24 consecutive hours off duty shall constitute the end of any such period of 7 or 8 consecutive days. Upon request of the Department of Transportation, motor carriers shall furnish time records or other written verification to that department so that the Department of Transportation can determine compliance with this paragraph. These time records must be furnished to the Department of Transportation within 10 days after receipt of that department's request. Falsification of such information is subject to a civil penalty not to exceed $50. The provisions of this paragraph do not apply to drivers of public utility vehicles during periods of severe weather or other emergencies.

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A bill to be entitled
An act relating to negligence; amending s. 768.13, F.S.; providing an exemption from civil liability for licensed medical personnel working gratuitously in nonprofit medical facilities; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Paragraph (c) is added to subsection (2) of section 768.13, Florida Statutes, to read:

768.13 Good Samaritan Act; immunity from civil liability.--

(2)

(c) Any person licensed to practice medicine and acting as a staff member or with professional clinical privileges at a nonprofit medical facility, other than a hospital licensed under chapter 395, shall not be held liable for any civil damages as a result of care or treatment provided gratuitously in such capacity as a result of any act or failure to act in such capacity in providing or arranging further medical treatment, if such person acts as a reasonably prudent person licensed to practice medicine would have acted under the same or similar circumstances.

Section 2. This act shall take effect October 1, 1988.

SENATE SUMMARY

Provides a civil liability exemption for licensed medical personnel working in a nonprofit medical facility.

CODING: Words stricken are deletions; words underlined are additions.
A bill to be entitled
An act relating to negligence; amending s.
768.13, F.S., providing an exemption from civil
liability for licensed medical personnel who
gratuitously and in good faith perform health
screening services; providing an effective
date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Subsection (4) is added to section 768.13,
Florida Statutes, to read:

768.13 Good Samaritan Act; immunity from civil
liability.--

(4) Any person licensed to practice medicine who
gratuitously and in good faith performs health screening
services shall not be held liable for any civil damages as a
result of such services or as a result of any act or failure
to act in providing or arranging further health screening
services, or medical treatment, where the person acts as a
reasonably prudent person licensed to practice medicine who
would have acted under the same or similar circumstances.

Section 2. This act shall take effect October 1, 1988.

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HOUSE SUMMARY

Provides a civil liability exemption for licensed medical
personnel who gratuitously and in good faith perform
health screening services.

CODING: Words strucken are deletions; words underlined are additions.
This publication was produced at an average cost of 1.5 cents per single page in compliance with the Rules and for the information of members of the Legislature and the public.
A bill to be entitled
An act relating to negligence; amending s. 768.13, F.S., providing an exemption from civil liability for licensed medical personnel who gratuitously and in good faith perform health screening services; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Subsection (4) is added to section 768.13, Florida Statutes, to read:

768.13 Good Samaritan Act; immunity from civil liability.--

(4) Any person licensed to practice medicine who gratuitously and in good faith performs health screening services shall not be held liable for any civil damages as a result of such services or as a result of any act or failure to act in providing or arranging further health screening services, or medical treatment, where the person acts as a reasonably prudent person licensed to practice medicine who would have acted under the same or similar circumstances.

Section 2. This act shall take effect October 1, 1988.

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HOUSE SUMMARY

Provides a civil liability exemption for licensed medical personnel who gratuitously and in good faith perform health screening services.

CODING: Words strucken are deletions; words underlined are additions.
This publication was produced at an average cost of 1.12 cents per single page in compliance with the Rules and for the information of members of the Legislature and the public.
A bill to be entitled

An act relating to negligence; amending s. 768.13, F.S.; providing an exemption from civil liability for licensed medical personnel working gratuitously in nonprofit medical facilities; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Paragraph (c) is added to subsection (2) of section 768.13, Florida Statutes, to read:

768.13 Good Samaritan Act; immunity from civil liability.--
(2)
(c) Any person licensed to practice medicine and acting as a staff member or with professional clinical privileges at a nonprofit medical facility, other than a hospital licensed under chapter 395, shall not be held liable for any civil damages as a result of care or treatment provided gratuitously in such capacity as a result of any act or failure to act in such capacity in providing or arranging further medical treatment, if such person acts as a reasonably prudent person licensed to practice medicine would have acted under the same or similar circumstances.

Section 2. This act shall take effect October 1, 1988.

SENATE SUMMARY

Provides a civil liability exemption for licensed medical personnel working in a nonprofit medical facility.

CODING: Words stricken are deletions; words underlined are additions.
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**CODING:** Words stricken are deletions; words underlined are additions.
A bill to be entitled

An act relating to negligence; amending s. 768.13, F.S.; providing an exemption from civil liability for licensed medical personnel working gratuitously in nonprofit medical facilities; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Paragraph (c) is added to subsection (2) of section 768.13, Florida Statutes, to read:

(c) Any person licensed to practice medicine and acting as a staff member or with professional clinical privileges at a nonprofit medical facility, other than a hospital licensed under chapter 395, shall not be held liable for any civil damages as a result of care or treatment provided gratuitously in such capacity as a result of any act or failure to act in such capacity in providing or arranging further medical treatment, if such person acts as a reasonably prudent person licensed to practice medicine would have acted under the same or similar circumstances.

Section 2. This act shall take effect October 1, 1988.

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SENATE SUMMARY

Provides a civil liability exemption for licensed medical personnel working in a nonprofit medical facility

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discharge the common liability. The failure of the Department of Insurance or the appropriate agency to make final disposition of a claim within 6 months after it is filed shall be deemed a final denial of the claim for purposes of this section. The provisions of this subsection do not apply to such claims as may be asserted by counterclaim pursuant to s. 768.14.

(12) Every claim against the state or one of its agencies or subdivisions for damages for a negligent or wrongful act or omission pursuant to this section shall be forever barred unless the civil action is commenced by filing a complaint in the court of appropriate jurisdiction within 4 years after such claim accrues; except that any action for contribution-the-action must be commenced within the limitations provided in s. 768.31(4) and an action for damages arising from medical malpractice must be commenced within the limitations for such an action in s. 95.11(4).

Section 2. This act shall take effect October 1, 1988.

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SENATE SUMMARY

Limiting the time in which medical malpractice actions against the state may be commenced.

This publication was produced at an average cost of 1.12 cents per single page in compliance with the Rules and for the information of members of the Legislature and the public.

CODING: Words stricken are deletions; words underlined are additions.
A bill to be entitled
An act relating to medical malpractice actions
against the state, amending s. 768.28, F.S.;
prescribing the statute of limitations for such
actions; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Paragraph (a) of subsection (6), and
subsection (12) of section 768.28, Florida Statutes, are
amended to read:

768.28 Waiver of sovereign immunity in tort actions;
recovery limits; limitation on attorney fees; statute of
\(4\) limitations; exclusions.--

(6)(a) An action may not be instituted on a claim
against the state or one of its agencies or subdivisions
unless the claimant presents the claim in writing to the
appropriate agency, and also, except as to any claim against a
municipality, presents such claim in writing to the Department
of Insurance, within 3 years after such claim accrues and the
Department of Insurance or the appropriate agency denies the
claim in writing; except that, if such claim is for damages
arising from medical malpractice, it must be presented within
2 years after it accrues and, if such claim is for
contribution pursuant to s. 768.31, it must shall be so
presented within 6 months after the judgment against the
tortfeasor seeking contribution has become final by lapse of
time for appeal or after appellate review or, if there is no
such judgment, within 6 months after the tortfeasor seeking
contribution has either discharged the common liability by
payment or agreed, while the action is pending against him, to

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A bill to be entitled
An act relating to medical malpractice actions
against the state; amending s. 768.28, F.S.;
prescribing the statute of limitations for such
actions and providing that agency failure to
dispose of a claim within 90 days after mailing
notice under s. 768.57, F.S., shall be deemed a
final denial; amending s. 768.57, F.S., to
conform; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Paragraph (a) of subsection (6) and
subsection (12) of section 768.28, Florida Statutes, are
amended to read:

768.28 Waiver of sovereign immunity in tort actions;
recovery limits; limitation on attorney fees; statute of
limitations; exclusions.--

(6)(a) An action may not be instituted on a claim
against the state or one of its agencies or subdivisions
unless the claimant presents the claim in writing to the
appropriate agency, and also, except as to any claim against a
municipality, presents such claim in writing to the Department
of Insurance, within 3 years after such claim accrues and the
Department of Insurance or the appropriate agency denies the
claim in writing; except that if such claim is for damages
arising from medical malpractice, it must be presented within
the time period provided for the mailing of a notice of intent
to initiate litigation pursuant to s. 768.57, and except that,
if such claim is for contribution pursuant to s. 768.31, it
must shall be so presented within 6 months after the judgment

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against the tortfeasor seeking contribution has become final by lapse of time for appeal or after appellate review or, if there is no such judgment, within 6 months after the tortfeasor seeking contribution has either discharged the common liability by payment or agreed, while the action is pending against him, to discharge the common liability. The failure of the Department of Insurance or the appropriate agency to make final disposition of a claim, other than a claim for medical malpractice, within 6 months after it is filed shall be deemed a final denial of the claim for purposes of this section. For purposes of this subsection, in medical malpractice actions the failure of the Department of Insurance or the appropriate agency to make final disposition of a claim within 90 days after it is mailed shall be deemed a final denial of the claim. The provisions of this subsection do not apply to such claims as may be asserted by counterclaim pursuant to s. 768.14.

(12) Every claim against the state or one of its agencies or subdivisions for damages for a negligent or wrongful act or omission pursuant to this section shall be forever barred unless the civil action is commenced by filing a complaint in the court of appropriate jurisdiction within 4 years after such claim accrues; except that an with respect to any action for contribution—the action must be commenced within the limitations provided in s. 768.31(4) and an action for damages arising from medical malpractice must be commenced within the limitations for such an action in s. 95.11(4).

Section 2. Paragraph (a) of subsection (3) of section 768.57, Florida Statutes, is amended to read:

CODING: Words stricken are deletions; words underlined are additions.
768.57 Notice before filing action for medical malpractice; presuit screening period; offers for admission of liability and for arbitration; review.--

(3)(a) No suit may be filed for a period of 90 days after notice is mailed to the prospective defendant, except that this period shall be 180 days if controlled by s.

768.28(1a) Reference to the 90-day period includes such extended-period. During the 90-day period, the prospective defendant's insurer or self-insurer shall conduct a review to determine the liability of the defendant. Each insurer or self-insurer shall have a procedure for the prompt investigation, review, and evaluation of claims during the 90-day period. This procedure shall include one or more of the following:

1. Internal review by a duly qualified claims adjuster;

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

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

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

Each insurer or self-insurer shall investigate the claim in good faith, and both the claimant and prospective defendant shall cooperate with the insurer in good faith. If the insurer requires, a claimant shall appear before a pretrial

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screening panel or before a medical review committee and shall submit to a physical examination, if required. Unreasonable failure of any party to comply with this section justifies dismissal of claims or defenses. There shall be no civil liability for participation in a pretrial screening procedure if done without intentional fraud.

Section 3. This act shall take effect October 1, 1988.

This publication was produced at an average cost of 1.12 cents per single page in compliance with the Rules and for the information of members of the Legislature and the public.
A bill to be entitled
An act relating to negligence; amending s.
768.13, F.S.; providing an exemption from civil
liability for licensed medical personnel
working gratuitously in nonprofit medical
facilities; providing an exemption from civil
liability for licensed medical personnel who
gratuitously and in good faith perform health
screening services; providing an effective
date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Paragraph (c) is added to subsection (2) of
section 768.13, Florida Statutes, as amended by section 46 of
chapter 88-1, Laws of Florida, and subsection (4) is added to
said section to read:

768.13 Good Samaritan Act; immunity from civil
liability.--

(2)

(c) Any person licensed to practice medicine and
acting as a staff member or with professional clinical
privileges at a nonprofit medical facility, other than a
hospital licensed under chapter 395, shall not be held liable
for any civil damages as a result of care or treatment,
powered gratuitously in such capacity as a result of any act
or failure to act in such capacity in providing or arranging
further medical treatment, if such person acts as a reasonably
prudent person licensed to practice medicine would have acted
under the same or similar circumstances.

CODING: Words stricken are deletions; words underlined are additions.
(4) Any person licensed to practice medicine who gratuitously and in good faith performs health screening services shall not be held liable for any civil damages as a result of such services or as a result of any act or failure to act in providing or arranging further health screening services, or medical treatment, where the person acts as a reasonably prudent person licensed to practice medicine would have acted under the same or similar circumstances.

Section 2. This act shall take effect October 1, 1980.

STATEMENT OF SUBSTANTIAL CHANGES CONTAINED IN COMMITTEE SUBSTITUTE FOR Senate Bills 42 and 49

Combines Senate Bills 42 and 49 into a single bill.
A bill to be entitled
An act relating to negligence; amending s.
768.13, F.S.; providing an exemption from civil liability for licensed medical personnel working gratuitously in nonprofit medical facilities; providing an effective date.

Be It Enacted by the Legislature of the State of Florida:

Section 1. Paragraph (c) is added to subsection (2) of section 768.13, Florida Statutes, as amended by section 46 of chapter 88-1, Laws of Florida, to read:

768.13 Good Samaritan Act; immunity from civil liability.--

(2)

(c) Any person licensed to practice medicine and acting as a staff member or with professional clinical privileges at a nonprofit medical facility, other than a hospital licensed under chapter 395, shall not be held liable for any civil damages as a result of care or treatment provided gratuitously in such capacity as a result of any act or failure to act in such capacity in providing or arranging further medical treatment, if such person acts as a reasonably prudent person licensed to practice medicine would have acted under the same or similar circumstances.

Section 2. This act shall take effect October 1, 1988.

STATEMENT OF SUBSTANTIAL CHANGES CONTAINED IN COMMITTEE SUBSTITUTE FOR
Committee Substitute for Senate Bills 42 & 49

CS/CS/SBs 42 and 49 deletes the grant of immunity for doctors who gratuitously and in good faith perform health screening services.

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